A. INTRODUCTION

1. The following is the procedure for the proper completion of a Florida EMS Report as required by Florida Statute 401 and the Miami-Dade Fire Rescue (MDFR) Department and when directed by an EMS Field Supervisor. Procedure 36 ONLY applies when an ePCR is NOT available AND a paper report is authorized by an EMS Field Supervisor. In all other circumstances, Procedure 40 shall direct EMS documentation.

2. An individual Florida EMS Report will be completed for each EMS related call received. This includes special assignments, such as falling out of bed, any call where no patient is found, where the patient was gone on arrival (GOA), or calls where a person refuses treatment for any reason. The minimum information required on these calls will be completion of the INCIDENT INFORMATION SECTION and an entry in the NARRATIVE SECTION listing all available information that clarifies your actions or inaction's. If your assessment of an individual's condition suggests that it is non-emergent in nature, a complete Florida EMS Report is still required.

   Unit Captains are responsible for ensuring that a Florida EMS Report is completed for every EMS related call.

3. There are only two instances in which a Florida EMS Report is not required. These are:

   a) A unit is canceled prior to arrival by the FAO.

   b) A unit is canceled after arrival by another MDFR unit.

Note: If your unit is canceled after arrival by a non-MDFR unit, you must complete a Florida EMS Report documenting in the narrative section the name and/or unit I.D. of the canceling party. This includes law enforcement officers, ambulance attendants, on-scene doctors and nurses, etc.

4. Information provided in the "Boxed" areas of the Florida EMS Report will be printed in CAPITAL letters.

5. Reports will be clear, legible, filled out in black ink only and completed by end of shift.

6. A complete Florida EMS Report will be given to any Squad accepting a patient.

B. INCIDENT INFORMATION SECTION

1. INCIDENT NUMBER - Enter the alarm number.

2. DATE - Lead zeros are required on all dates.

3. LICENSE # - Enter license number, the first person listed will be the one signing the report. If the MDFR personnel is a First Responder only, enter their name in the narrative section. When two units respond to an incident, the crew identification numbers of the personnel providing hands on care, or at least both units OIC's I.D.#'s will be entered.

4. UNIT # - Enter the three digit unit number followed by the shift.

Forty-hour staff will use "D" for forty-hour shift. This does not include special events or any peak load units.

5. TIMES - Use military time and complete as required. Lead zeros are required. The times specified with an asterisk (*) will be provided by Fire Alarm or CAD.

   a) CALL RECEIVED* - Enter the time the call was received by FAO.

   b) DISPATCH* - Enter the time your unit was notified to respond to the call.

   c) DEPART - Enter the time your unit departed its location and was en route to the scene of the incident.

   d) ARRIVAL * - Enter the time your unit arrived at the location of the incident or LZ.

   e) PT. CONTACT - Enter the time the EMT or Paramedic began patient assessment.

   f) ALERT TIME* - Time Trauma, STEMI, Stroke Alert is declared.

   g) TRANS ARRIVED* - Enter the time the transporting or transferring vehicle arrived. This includes the arrival of Air Rescue.

   h) PATIENT DEPART - Enter the time the patient actually leaves the scene to a hospital or LZ. If your unit is dispatched to another call before the patient leaves the scene enter: "9999" for the time.

   i) UNIT DEPART* - If your unit is transporting, enter the time your unit departed the scene.

   j) ARRIVED* - Enter the time your Rescue unit arrived at the hospital or landing zone with the patient.

   k) AVAILABLE* - Enter the time that your unit is in service and ready to respond to another call.

6. DEPARTMENT ID - Enter the last appropriate number. Miami Dade Fire Rescue is 1312, Air Rescue is 1313.

7. ALERTS - Fill in the appropriate box to indicate if a Trauma, STEMI, Stroke Alert was declared

8. TRANSPORT BY - Fill in the appropriate box.

9. ID # - Insert the appropriate ID number (found on the EMS Reference Sheet) for ambulance transfers/other agency or hospital transports.

10. STUDY - Fill in the designated number for a specific ongoing study that the report qualifies for.

11. NUMBER OF PATIENTS TRANSPORTED - Enter the number of patients transported by the same unit at the same time. Lead zeros are required.

12. PATIENT DISPOSITION - Fill in the appropriate box.

    a) TREAT/TRANS. GEN HOSPITAL - MDFR treated and transported patient to a non-trauma center.

    b) TREAT/TRANS PRIVATE VEHICLE - MDFR treated and released patient for private transport.

    c) TREATED NO TRANS. REQ - MDFR treated and the patient required no further emergency care.

    d) NO TREATMENT REQUIRED - MDFR evaluated the patient and no treatment was required.

    e) CALL CANCELLED - Call cancelled prior to arrival or on-scene.

    f) TREAT/TRANS. TRAUMA CTR. - MDFR treated and transported patient to a trauma center.

    g) TREAT/TRANSFERRED CARE - MDFR treated and released patient to another agency.

    h) TREATED/REFUSED TRANS - Patient treated by MDFR and then refused transport.

    i) REFUSED CARE - Patient was at the scene and refused treatment, whether injured or not.

    j) DEATH ON SCENE - Patient "pronounced" dead at scene (Protocol 27), whether or not treatment was attempted.

    k) NO PATIENT FOUND - No person found upon arrival.

    l) DNRO - MDFR upon arrival found patient with valid Do Not Resuscitate Order.

    m) INTERFACILITY TRANSFER - MDFR transported a patient from hospital to hospital.

13. RESPONSE/TRANS. MODE - Fill in the appropriate box for "To Scene" and "From Scene".

14. CALL LEVEL - Call level must be indicated as ALS, BLS or OTHER. A missed IV will be ALS. Exam only or exam with oxygen only will be indicated as BLS. Assessment using a glucometer and/or ECG will be BLS. Standby with PSD or public assist are examples of "other".

15. MILEAGE - Indicate total miles of transport from the scene to a medical facility, or total miles transferring from scene to LZ.

16. INCIDENT LOCATION - Address or location where patient contact is made. You may NOT enter "SAME" in this area.

17. INCIDENT ZIP CODE - Enter postal zip code of INCIDENT LOCATION (required for all responses).

C. PATIENT INFORMATION SECTION

1. PATIENT LAST NAME - Enter the patient's last name. In cases where the patient's LAST NAME is not obtainable, document "UNKNOWN".
2. PATIENT FIRST NAME - Enter the patient's first name. In cases where the patient's FIRST NAME is not obtainable, document "UNKNOWN".
3. PATIENT ADDRESS - Document the patient's home mailing address. In cases where the patient's address is not obtainable, document "UNKNOWN". In the event the address does not fit in this section, enter the address in the narrative section and document "SEE NARRATIVE".
4. ZIP CODE - Enter the patient's zip code. Use the four boxes that follow ZIP CODE for Country if other than USA.
5. SOCIAL SECURITY NUMBER - Enter the patient's Social Security number on all patient's transported by your unit. If not available, explain in narrative and document "N/A".
6. GENDER - Fill in the appropriate box.
7. DATE OF BIRTH - Required on all patients if available. In cases where the patient's DATE OF BIRTH is not obtainable, document "UNKNOWN".
8. AGE - Enter the patient's age, either as provided by the patient or the best estimate by field personnel. If age is given in months, completely mark the M box.
9. PATIENT # - Enter the patient number, when more than a single patient is involved with a single incident (i.e., "1 of 3").
10. ETHNIC ORIGIN - Fill in one category only.

D. PATIENT ASSESSMENT SECTION

This section should indicate the findings of the patient exam, history and condition and should be supported by the documentation in the narrative area of the report. Entries in these fields should reflect the relevant clinical findings, or lack of findings, for the proper assessment and treatment of the patient. The information boxes contained in this section are for data collection.

1. CHIEF COMPLAINT - What the patient tells you, or why others such as family or bystander called. This section requires an entry for all patients.
2. ALLERGIES - Indicate none, unknown, or specific allergy.
3. CURRENT MEDS - Indicate none, unknown or list all medications the patient is currently taking. Do not write “see list”.
4. INITIAL VITALS -
    a) Time taken - Time initial vitals are taken. Lead zeros are required in the time box only.
    b) Systolic - Document systolic BP.

c) Diastolic - Document diastolic BP. If BP was obtained via palpation, fill in PALP box.

d) Capillary Refill - Required for all pediatric patients.

e) Pulse - Document the patient's palpable pulse. This box will not contain any electronic readings.

f) Resp. - The patient's respiratory rate without assistance.

g) Glucose - Document the initial glucose reading when required.

h) SaO2 - Document SaO2 per Procedure 10.

i) Pupils - Fill in the appropriate boxes for left and right pupils. If "Normal" is selected, no other selection is required.

5. MEDICAL HISTORY - Fill in all boxes that are applicable. If no medical history, fill in "none". If other, fill in "other" and utilize the space provided.

6. AIRWAY - On initial assessment, indicate if the patient's airway is Patent or Obstructed.

7. BREATHING - Fill in the appropriate box.

8. BREATH SOUNDS - Fill in the appropriate box.

9. CIRCULATION - Fill in the appropriate box.

10. LOCATION - Indicate the location you used to check for a pulse. Only one box is required to be filled in.

11. SKIN TEMP - Fill in the appropriate box.

12. SKIN PERFUSION - Fill in the appropriate box. If "other" is used, must be documented in narrative section.

13. SKIN MOISTURE - Fill in the appropriate box. If "other" is used, must be documented in narrative section.

14. GLASGOW COMA SCORE - Complete for all patients older than 5 years. For younger patients indicate the level of consciousness and type of response in the Narrative Section.

E. VITALS SECTION

Record any ECG monitoring and treatment. Any medications (exceeding oxygen and IV fluids) must be documented according to time administered, dose and route of administration. A second set of vitals will be required for all patients transported, transferred, refusing transportation, or if the initial vital sign is outside the normal limits, or if relevant to the patient’s history, condition, or after a medication is administered. If any part of the vital signs cannot be assessed or re-assessed indicate the reason in the narrative section.

Capnographer readings will be required anytime a MDFR unit transports a patient that is intubated. One reading will be documented during initial intubation, or in the case of an inter-hospital transport, upon initial receipt of an intubated patient. A second reading will be documented upon release to an approved health care facility.

F. INTERVENTIONS SECTION

1. ECG - Fill in the appropriate box for the initial rhythm and rhythm upon release.
2. AIRWAY INTERVENTIONS - Indicate the intervention(s) attempted/used to stabilize the patient's airway. The boxes to the right allow you to record the number of attempts and if the attempt was successful (S), or unsuccessful (U). The (3+) indicates that 3 or more attempts of this intervention were made by your crew. When oxygen is delivered, fill in the appropriate device and liters-per-minute (LPM).
3. CIRCULATION INTERVENTIONS - Indicate the intervention(s) attempted/used to assist the patient's circulation. Indicate what ECG monitoring was done - if any.
4. MCI - Fill in if a multiple causality incident was declared.
5. INCAPACITATED - Fill in if the Incapacitated Person's Law was implemented (Protocol 2).
6. SECONDARY INTERVENTIONS - Fill in all applicable.
7. COMMUNITY SERVICE REFERRAL - Fill in if when an Elder Links / Community Service Referral form is completed (Protocol 29).
8. FLUIDS - Fluids must be recorded as to the access location, route, the attempts, and success/unsuccessful of the IV attempt, the type of fluid and the rate and volume administered. Medicated drips will be recorded in the "Treatment" area of the VITALS section and/or the "P" - plan section of the narrative.
9. MEDICATIONS - Insert all applicable medication codes (found on the EMS Reference Sheet) administered.
10. AED ONLY PRIOR TO EMS - Refers to the incidents where an AED was administered prior to the arrival of MDFR (i.e., lay public, PSD, etc.). Excludes incidents in which CPR was administered in combination with the use of an AED.
11. AED AND CPR PRIOR TO EMS - Refers to the use of an AED in combination with CPR prior to the arrival of MDFR (i.e., lay public, PSD, etc.).
12. CPR ONLY PRIOR TO EMS - Refers to the use of CPR prior to the arrival of MDFR (i.e., lay public, PSD, etc.). Excludes incidents in which an AED was administered in combination with CPR.
13. AED ONLY BY EMS - Refers to incidents where an AED was administered by MDFR. Excludes incidents in which CPR was administered in combination with the use of an AED.
14. AED & CPR BY EMS - Refers to the use of an AED in combination with CPR by MDFR.
15. CPR ONLY BY EMS - Refers to the use of CPR by MDFR. Excludes incidents where an AED was administered in combination with CPR.

NOTE: Numbers 14-17 address the Return Of Spontaneous Circulation (ROSC). This category contains information on whether or not spontaneous circulation (palpable pulse or blood pressure) was restored in the field and present upon delivery from EMS to an Emergency Department (ED). Fill in only one box if appropriate for numbers 14-16.

16. AED ADMINISTERED PRIOR TO EMS & ROSC AT ER - Fill in "yes" if the cardiac arrest patient was in a shockable rhythm when an AED was administered prior to the arrival of MDFR and ROSC present at ED release.

17. AED ADMINISTERED BY EMS & ROSC AT ER - Fill in "yes" if the cardiac arrest patient was in a shockable rhythm when an AED was administered by MDFR and ROSC present at ED release.

18. NO AED ADMINISTERED AND ROSC AT ER - Fill in "yes" if the cardiac arrest patient was in a shockable rhythm, no AED was used and ROSC present at ED release.

19. ROSC PRESENT AT ER - Fill in "yes" if the cardiac arrest patient was NOT in a shockable rhythm but ROSC present at ED release.

G. TRAUMA INFO SECTION

This area must be completed if the nature of call is trauma related or if a medical patient sustained an injury secondary to the medical complaint.

1. INJURY SITE/TYPE - Indicate injury(s) the patient has sustained by filling in the corresponding boxes(s) in the matrix for site and type of injury (choose up to five). If there is no injury, completely fill in the "none" box in the upper left corner.

2. CAUSE OF INJURY - Write in the injury code number (from the EMS Reference Sheet) that best describes the injury (choose up to three).

3. DATE OF INJURY - Enter the date on which the injury occurred.

4. PROTECTION - Entry is required in this area when the cause of injury is motor vehicle crash, marine vehicle crash or bicycle crash. Fill in all applicable.

5. PATIENT LOCATION - Fill in the box that denotes the location of the patient in or the vehicle. If "other" is chosen, explain in the narrative.

6. VEHICLE DEFORMITY - An entry is required in this area when the cause of injury is motor vehicle crash and a deformity to the vehicle is suspected to be the result of the patient’s impact with any of the surfaces indicated.

7. PARAMEDIC JUDGMENT - Must be filled-in when a Trauma Alert is declared using paramedic judgment (only to be used if patient does not meet category 1 or 2 criteria).

8. ADULT CATEGORY #1 - Fill in one box if the patient is a Trauma Alert and meets one of the criteria (choose only one).

9. ADULT CATEGORY #2 - Fill in two boxes if the patient is a Trauma Alert and meets two of the criteria (only to be used if patient does not meet category 1 criteria).

10. PEDIATRIC CATEGORY #1 - Fill in one box if the patient is a Trauma Alert and meets one of the criteria (choose only one).

11. PEDIATRIC CATEGORY #2 - Fill in two boxes if the patient is a Trauma Alert and meets two of the criteria (only to be used if patient does not meet category 1 criteria).

NOTE: A Trauma Alert Criteria must be selected if a Trauma Alert is declared.

H. NARRATIVE SECTION

The narrative should be completed as the sequence of events took place, from arrival until the patient's release. All treatment initiated by BLS and ALS units on each patient will be documented on each report. All components of the SOAP format are required when completing the narrative section.

1. PROVIDER ASSESSMENT - Fill in the most appropriate code from the EMS Reference Sheet (required on all calls).

2. S SUBJECTIVE - What the patient, family, or bystanders tell you about the condition.

3. O OBJECTIVE - Your findings or non-findings upon arrival and from the completion of a thorough patient assessment. This information must be complete, including information that is relevant to the chief complaint even though it may have been covered in previous sections.

4. A ASSESSMENT - This information is reflected in the above PROVIDER ASSESSMENT code boxes.

5. P PLAN OF ACTION - Describe your patient management. Document all treatments given to the patient in the order in which they were given as well as changes in the patient's condition that are observed following treatment. This area should also indicate the condition of the patient upon release.

   If in the SOAP format information is received after the appropriate section is completed, denote the applicable SOAP letter with a circle and add the information to the left edge of the narrative section.

6. If additional space is necessary, complete a Supplemental Narrative form and attach it to the Florida EMS Report.

I. LEAD CREW & REVIEWER AREA

1. LEAD CREW (SIGNATURE) - Signed by OIC or acting OIC. If acting for training purposes, both unit OIC and FF must sign report. When two units provide patient care, each OIC must sign the report.

2. LEAD CREW (PRINT NAME) - OIC is to clearly print their name with rank. Acting OIC's will enter A/Lt. or A/Capt. If acting for training purposes, both unit OIC and FF must print their name report. When two units provide patient care, each OIC must print their name on the report.

3. REVIEWER (PRINT & INITIAL) – Not utilized.

J. ABBREVIATED REPORT

1. If an MDFR non-transport unit releases a patient to a Rescue prior to completion of a Florida EMS Report, the non-transport unit OIC must complete and pass-on, at minimum, an Abbreviated EMS Report.

2. If an MDFR unit releases a patient to an ambulance (non-MDFR) prior to completion of a Florida EMS Report, the non-transport unit OIC must complete and pass-on, at minimum, an Abbreviated EMS Report.

3. When a Rescue is requested to clear from a hospital for a call and the report is not completed, the unit OIC must pass-on the HOSPITAL copy of the report which will contain, at minimum, an Abbreviated EMS Report. The Rescue unit will then have the report completed by the end of shift.

An Abbreviated EMS Report will be completed on a Florida EMS Report form and will contain, at minimum, the following:

1. Unit #
2. Alarm #
3. Cause and anatomy of injury if traumatic
4. Two complete set of vitals
5. Chief complaint
6. Narrative covering the minimum of SUBJECTIVE and OBJECTIVE
7. Original signature of LEAD CREW
8. Trauma Alert Criteria if applicable

*Remember an abbreviated report is not a substitute for a completed Florida EMS Report.

K. MAKING CORRECTIONS

If a correction is necessary on the Florida EMS Report:

1. Making corrections of a filled-In box, correct the error by "X"ing out the incorrect box and filling-in the correct box.

2. When correcting an error in the write-in "boxes" area, strike through the incorrect response using a single stroke, not an "X". Then place correction above strikeout.

3. Do not initial corrections.

4. Do not write on the margins of the report. You may write on the perforated edge only.

5. If a major part of a report requires a re-write, use a complete new form (both pages). Attach both reports and forward through normal channels. If the original report is contaminated, try to utilize an uncontaminated page, (yellow, green). If the complete report is unusable, include the original report's ID#, (such as M 0505387), in the narrative of the second report.

6. Reviewers shall not mark or write on completed reports, except for Reviewer's Box.

L. DISTRIBUTION OF COPIES

1. HOSPITAL COPY - Distributed to transporting unit or left at hospital upon patient release. If the copy is eligible, a photo copy may be left. Should there be no transport, the copy is to be left attached so that Central Records can destroy it. Do not dispose of any part of a complete report in the regular garbage.

Florida Statue 401 requires that a completed, legible Florida EMS Report be provided to the receiving hospital. Upon completion of patient care transfer to the receiving facility, if the completed Florida EMS Report Hospital Copy is not legible, photo copy the complete document and provide a legible copy. A completed report requires all dispatch times.

2. STATION COPY - To be retained at the units ‘05’ station. Copies will be filed separately by each unit in a station for a one-month period of time.

3. Remaining Report - Forwarded to the specified reviewer.

4. At no time will copies of a report be distributed from the individual station or unit to any member of the public including family, attorneys or law enforcement investigators. Central Records is the sole source for copies of reports. All interested inquires will be directed there.

M. EMS Signature Form: Assignment of Benefits / HIPAA Acknowledgement / Patient Release (refusal)

1. HIPAA ACKNOWLEDGEMENT - A signature must be obtained for any patient treated by MDFR. If the patient is a minor, obtain parent/guardian signature in Section “A” of the EMS signature form and document their name and relationship next to the signature, refer to Protocol 3 for Treatment of Minors.

   If the patient is physically unable to sign, write "PUTS" (Patient Unable To Sign) on the signature line, the physical condition must be reflected in the EMS report.

   This option may only be exercised on patients who were NOT transported and who did NOT refuse treatment.

   Federal Law as well as Department Policy and Procedure, Protected Health Information I-H-1, requires that every patient must sign the Florida EMS Report acknowledging that they received their HIPAA Privacy information.

   a. Provide the patient or guardian a MDFR HIPAA NOTICE OF PRIVACY PRACTICES form.

   b. Print patient's name in the space provided.

2. ASSIGNMENT OF BENEFITS – All patients transported by MDFR are required to sign an assignment of benefits, this will be done in section “A” of the EMS signature form.

   If the transported patient is unable to sign, there are two options:

i. Request a signature from a representative, as detailed below. If signed by a representative, it must be stated what their relationship is to the patient and the reason the patient could not sign.

Federal Regulations state any one of the following may sign, as a representative, on behalf of the patient in section "B" of the EMS signature form:

a) The beneficiary's legal guardian

b) A relative or other person who receives Social Security or other governmental benefits on the beneficiary's behalf.

c) A relative or other person who arranges for the beneficiary's treatment or exercises other responsibility for his or her affairs.

ii. If no representative is available, an MDFR care provider must sign section "C" of the EMS signature form AND complete section "D1" or "D2" of the EMS signature form.

Section D1 allows for a representative of the receiving facility to sign, affirming that the patient was transported to the stated hospital.

Federal Regulations do not define who is or is not a representative of the receiving facility but it would generally be accepted that a nurse or other staff who received the patient is adequate. The name of the facility, date and time must also be completed.

For clarification, a signature from a receiving facility representative does NOT place any responsibility for payment on that individual or the receiving facility. The signature only confirms that the patient was transported to the facility.

If you are unable to obtain a signature from a facility representative, "D2" must be completed in addition to a signature in section "C" of the EMS signature form. "D2" requires documentation from the receiving facility be collected and attached to the EMS signature form.

Acceptable forms of documentation include the hospital registration or admissions sheet.

Attachment A has also been provided to detail this process.

3. PATIENT REFUSAL - A signature and initials must be obtained for any patient that refuses treatment and/or evaluation and/or transport (to the most appropriate facility) and/or additional treatment as recommended by MDFR.

There are three options for release/refusal on the signature form. Only the adult patient or parent/ legal guardian of a minor may refuse for a minor. Refer to Protocol 3, Care of Minors, for additional direction in the case of refusal of treatment and/or transport for a minor.

A family member may not refuse treatment and / or transport for an adult patient regardless of any legal paperwork presented on-scene.

Three options on signature form for release/refusal:

1. The patient refuses treatment and transport, OR
2. The patient accepts transport but refuses any recommended treatment(s), OR
3. The patient accepts treatment but refuses transport to the closest appropriate hospital as discussed in Protocol 4.

Any adult patient who requires treatment and/or transport who does not meet the following three conditions must be treated and/or transported.

MDFR Refusal Assessment:

1. Patient is alert to person, place and time
2. Patient denies ETOH or drug use
3. Patient denies suicidal/homicidal ideation

The patient must meet all the criteria of the MDFR Refusal Assessment to sign AND initial any of the release/refusal options.

If the patient is unable to sign and under ordinary circumstances due to a handicap would not be able to sign, write "PUTS" on the signature line and document appropriately in the narrative section. The patient's inability to sign must not be connected in any way to the present illness.

Patient refuses to sign release/refusal:

If a patient meets the MDFR Refusal Assessment criteria but refuses to sign the release/refusal form, it must be clearly documented in the narrative section that the patient refused to sign the release/refusal signature form. In addition to the OIC's signature in the MDFR Refusal Assessment section, attempt to obtain a signature from a family member, witness, or police officer. When all other attempts fail, have a crew member sign as a witness. Have the family member, witness, police officer or crew member sign on the patient signature line and print their name afterward.

N. ECG Strips

All 12 Lead ECG strips will be attached to the Station Copy.

O. Trauma Alert

A completed Florida EMS Run Report should accompany a patient to the Trauma center. If, due to patient care necessity, a completed Florida EMS Run Report is not available upon release to the transporting unit – a complete report will be faxed to the appropriate number below upon returning to the station. If technical difficulties are encountered while attempting to fax the report – forward a copy of the completed report to your EMS Field Supervisor via Interoffice mail with a note explaining the specific technical difficulty encountered.

JMH Ryder Trauma Center FAX: 305-585-0031

Miami Children's Hospital FAX: 305-669-7130

Memorial Regional Hospital FAX: 954-985-1493

P. Conclusion

Documentation of every call is important, regardless of the service level provided. It is the justification of our actions, or non-actions, and proof of the continued, quality care given to the patients seen by Miami Dade Fire Rescue personnel. The need to complete an EMS Report should never delay or interfere with patient management. Remember that the patient report is part of the person's permanent medical record and can be subpoenaed in court. The purpose of the report is to answer questions from the receiving hospital, doctor, police investigator, attorney, or judge.

NOTE:

1. Lead zero's are required for all dates.
2. All times are to be in 24-hour "military time" format.