

# LEON COUNTY E.M.S.

## Standard Operating Guideline

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Title: Patient Care Report Delivery to Receiving Facilities  
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### I. PURPOSE:

To ensure delivery of accurate records of medical care given by LCEMS personnel in compliance with standard medical records practices.

### II. GUIDELINE:

EMS patient care reports are to be completed on all patients whom LCEMS assesses, treats and / or transports. The patient care record in all instances will accurately describe the services provided to the patient, any and all pertinent scene information, an accurate and complete patient assessment and accurate and complete treatments. A copy of a completed report will be provided to the receiving facility at time of patient delivery whenever possible. Any crew being utilized within system status must be available for call after patient delivery and cleanup. In these instances a verbal report and/or preliminary copy of the patient care report will be given to a receiving RN or MD and a signature will be obtained on the patient care report whenever possible.

### III. PROCEDURE:

1. Patient care reports or ambulance run reports are to be completed as soon as possible after the incident. This assures completeness and accuracy. At no time shall patient information, notes or reports be removed from LCEMS or taken home for completion.
2. It is the responsibility of the crew member who cared for the patient to complete the patient care record, and assure delivery to the receiving facility. A completed copy will be printed at the provided printers and given to the receiving RN or MD.
3. The patient's name and incident number will be entered into the LifePak 15 for all patients who are placed on the cardiac monitor. A copy of the patient's cardiac rhythm records shall be left at the receiving facility.
4. For patients who are transported. A completed Ambulance Run Report is to be left at the following locations at time of patient delivery to that institution:

- A. TMH - Bixler Emergency Center: Leave a completed copy and any ECG with the Facilitator located in the area of the Bixler Emergency Center that the patient was delivered to. The ECG, when left with the Ambulance Run Report, must have the patient's name documented on it.
  
  - B. Capital Regional Medical Center - Emergency Department: Leave the completed copy of the Ambulance Run Report with the Emergency Department registration staff. When an ECG procedure is performed, leave a copy of the ECG (with the patient's name documented on it) with the Emergency Department registration staff.
  
  - C. Any VA Hospital - Leave a completed copy of the Ambulance Run Report at the "Travel Officer's" office (must have beginning and ending odometer readings).
  
  - D. All Other Hospitals - Leave a copy of the completed Ambulance Run Report with the facility.
5. Any crew being utilized in system status must be available after patient delivery and equipment clean-up. If the patient care report is not complete, a verbal report and/or a preliminary copy of the patient care report must be given to the receiving RN or MD including; incident location, incident type, date, time, crew members, agency, any available patient demographics, medical history, chief complaint, assessment findings, vital signs, clinical impression, treatments, responses to treatments, disposition of patient, and date/time report was given to the receiving facility.