DOCUMENTATION REQUIREMENTS

I. Whenever contact with a patient/victim is made regardless of treatment or transport, an approved PCR (or acceptable system approved form) shall be completed in full for each patient/victim.

II. The patient care report is an **OFFICIAL LEGAL DOCUMENT** and must be reviewed and signed by all pre-hospital personnel participating in the care of the patient/person.

III. All treatment and/or assessments must be documented regardless of whether transportation occurs.

IV. The patient care report is to be retained by the ambulance service provider according to internal document retention policy.

V. The Resource Hospital will receive a copy of the patient care report or access to a printable version of the record.

VI. The receiving hospital will receive a copy of the patient care report at the conclusion of the run.

VII. Cardiac monitoring data shall be uploaded to the Electronic Medical Record (EMR) for the following situations:
   A. Cardiac arrest
   B. STEMI
   C. EKG performed
   D. Advanced airway
   E. Cardioversion
   F. Defibrillation
   G. Pacing.

Written: 1988
Reviewed: 11/92; 11/2/95; 3/00; 12/06; 5/10; 5/11; 8/15; 8/17
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MDC Approval: 1988; 12/3/92; 11/2/95; 6/13/96; 3/00; 12/4/07; 9/7/10; 11/17/15; 9/20/17
IDPH Approval: 1988; 1/5/93; 9/17/96; 5/00; 10/24/08; 11/24/10; 2/25/16; 12/21/17
Implementation: 1/1/89; 9/1/93; 12/1/96; 10/00; 1/1/10; 1/1/11; 3/1/16; 8/1/18