DOCUMENTATION

Documentation information becomes the legal record of a patient's history and treatment by pre-hospital personnel. It may be used as defense or prosecution if an EMS provider is charged with medical negligence. All narratives must be in CHART form using the templates within ImageTrend.

For every patient contact where the Fire Department makes initial patient contact, the following must be documented in the CHART format in the "Additional Narrative" section on the ImageTrend Fire Incident Report:

- A clear history of the present illness, including chief complaint, time of onset, associated complaints, pertinent negatives, and mechanism of injury.
- A complete physical exam appropriate for the emergency condition.
- Level of consciousness using the AVPU method.
- At least one complete set of vital signs. A complete listing of treatments performed in chronological order.
- For extremity injuries, neurovascular status must be noted before and after immobilization.
- For potential spinal injuries, document motor function before and after immobilization.
- Vitals will be documented every 5 minutes for critical patients and every 15 minutes for non-critical patients.
- Documentation of what EMS Squad patient care was turned over to.

Supporting laws and legal documentation can be found in:
O.C.G.A. § 19-7-5, O.C.G.A. § 31-8-82, O.C.G.A. § 30-5-4