

Ambulance Call Report Completion Manual

Version 3.0

Comes into force on April 1, 2017

**Emergency Health Services Branch
Ministry of Health and Long-Term Care**



To all users of this publication:

The information contained herein has been carefully compiled and is believed to be accurate at date of publication.

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Ambulance Call Report Completion Manual

Version 3.0

Part 1 - Preface

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Part 1 – Preface

Preface

The *Ambulance Call Report* (ACR) is an essential medical record for documenting information about circumstances and events relevant to the proper provision of ambulance services.

The information contained on a completed ACR can be used in several ways. These include:

Clinical

Information about the call history, patient assessment findings, patient care provided and the response to treatment is very useful to receiving facilities which have to plan the ongoing care for the patient.

Administrative

Statistics can assist in maintaining effective ambulance services and provide valuable information for future planning.

Research

ACR information can be used to help answer quality assurance and research oriented questions, which in turn can contribute to advances in prehospital care.

Legal

ACRs may be may be required as part of an investigation and/or legal proceeding.

Part 2 – Definitions of Terms Used Throughout the Manual

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Part 2 – Definitions of Terms Used Throughout the Manual

Definitions of Terms Used Throughout the Manual

Patient

Patient refers to an individual for whom a request for ambulance service was made and who a paramedic has made contact with for the purpose of assessment, patient care and/or transport, regardless of whether or not an assessment is conducted, patient care is provided, or the patient is transported by ambulance.

eACR

Electronic Ambulance Call Report - refers to a means of collection and retention of patient and patient care documentation using an electronic format and includes all information that is included on the paper ACR. The eACR is considered equivalent to the paper ACR.

Call

Refers to a request for ambulance service.

Page

The front side of the ACR is considered one page. The use of subsequent pages for additional documentation is discussed later in the manual. For ease of description within this manual, the front of the ACR has been divided into left and right sides. The left side consists of the Demographics, Clinical Information and Physical Exam sections. The right side includes the Clinical Treatment/Procedures, Results and General Administration sections. Any reference to “page(s)” refers to the paper ACR only.

Section

Refers to an area of the ACR where similar types of information are grouped.

Field

Refers to a specific location within a section of the ACR where a paramedic enters various types of information.

Part 3 – Introduction

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Part 3 – Introduction

Introduction

The *Ambulance Call Report Completion Manual* provides a detailed section-by-section orientation to the ACR and provides direction regarding the information to be documented within specific fields on the form. The layout of the ACR as described in this manual refers specifically to the paper ACR. The section and fields listed in this manual are applicable to both the paper ACR and eACRs; however, the data fields on the eACR may be in a different order than outlined in this manual. In all instances, the required information must be documented regardless of the method of data input on the eACR.

This manual applies equally to both, paper based ACR and eACR. Where ACR is stated in this document, the statement applies equally to the eACR unless stated otherwise.

Electronic Ambulance Call Reports

If an Ambulance Service Operator utilizes an electronic version of the ACR, the Operator shall ensure that the eACR includes all components of the paper ACR. Although the format of the eACR may differ from the paper ACR, paramedics shall complete the eACR with the equivalent information required of the paper ACR as directed in this manual in accordance with the *Ontario Ambulance Documentation Standards*. Where applicable, copies of patient and patient care documentation completed in electronic format shall be made available and distributed in accordance with the completion and the distribution requirements listed in this document.

eACRs shall have equivalent sections/fields and paramedics shall utilize the appropriate data entry fields to document the required information. Additionally, eACRs shall have equivalent prompts, codes and reference information available to paramedics to assist them in correctly inputting data.

Part 4 – Design Highlights of the ACR

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Part 4 – Design Highlights of the ACR

Design Highlights of the ACR

The following information refers to the design highlights of the paper ACR. The eACR includes all information that is printed on the paper ACR but may display the information differently and in an order that is not consistent with the paper ACR. eACRs may only allow for treatment language to be accessed via dropdown window or other data input means without displaying a specific code. In such cases, the paramedic will input the equivalent information on the eACR as required by this manual.

Sequencing of Information

The ACR has been designed to record information in a sequence that approximates the order in which call events occur and/or information is received. In addition, the size of the ACR has been designed to further facilitate its use and to allow for clinical documentation space and valuable resource information.

Grouping of Information

Similar types of information have been grouped together under nine different sections:

Front of the ACR

- Demographics
- Clinical Information
- Physical Exam
- Clinical Treatment/Procedures & Results
- General Administration

Reverse side of the ACR

- Codes
- Reference Information
- Aid to Capacity Evaluation
- Refusal of Service

Prompts

To further assist paramedics in completing an ACR, “check boxes” () have been included in some sections. These “check boxes” allow a paramedic to simply mark commonly documented findings/information without having to write them out in full each time.

Ghosted scripts are included in all fields requiring a date and/or time to assist in ensuring that this information is documented in a consistent manner.

Codes

Some form fields have been designed to record specific codes that assist in capturing data related to various types and categories of information. All codes have been printed on the reverse side of the ACR form for quick reference

Reference Information

Pediatric vital sign parameters, pain scales as well as Apgar and Glasgow Coma Scales are included on the reverse side of the ACR to assist paramedics in documenting findings in less common situations.

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Part 5 – Completion Requirements

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Part 5 – Completion Requirements

Completion Requirements

ACRs and eACRs must be completed in accordance with the *Ontario Ambulance Documentation Standards*.

In addition to the completion requirements for patient and patient care documentation described in the *Ontario Ambulance Documentation Standards*, any associated biometric data shall be included with the ACR/eACR.

Biometric data may include but is not limited to:

1. Vital signs;
2. Electrocardiogram results;
3. Cardiopulmonary Resuscitation (CPR) process data;
4. Percentage of oxygen saturation; and
5. End-tidal carbon dioxide measure.

Distribution

The ACR is a multi-part form comprised of four (4) copies. Each page is white and each copy is easily identifiable by name at the bottom right side of the form.

Copies of the ACR are to be distributed as follows:

1. Original **Patient Chart Copy**. This copy is left with the receiving hospital staff or the Coroner (with the exception of patient refusal of service calls).
2. 2nd Copy **Billing Office Copy**. This copy is distributed according to local policy/procedure. The design of the billing copy limits the clinical treatment details but allows for billing-specific information to be present.
3. 3rd Copy **Base Hospital Copy**. This copy is forwarded to the local Base Hospital according to local policy/procedure.
4. 4th Copy **Ambulance Service Copy**. This copy is retained by the Ambulance Service for their records.

The copies of the eACR are to be distributed accordingly.

Part 6 – General Rules

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Part 6 – General Rules

General Rules

1. This manual is consistent with the requirements for patient care documentation as found in the *Ontario Ambulance Documentation Standards*.
2. An ACR shall be completed for each request for ambulance service where the paramedics arrive at a scene as directed by a Central Ambulance Communications Centre/Ambulance Communication Service (CACC/ACS), whether or not an assessment is conducted, patient care is provided, or the patient is transported by ambulance.
3. All paramedics assigned to an ambulance call shall ensure that the ACR documentation requirements described in Part 4 of the *Ontario Ambulance Documentation Standards* are met.
4. The ACR shall be completed as soon as possible and no later the end of the scheduled shift or work assignment during which the call occurred.
5. Documentation must be accurate, legible and complete. Thorough documentation enhances the credibility of information contained on the ACR and of the paramedic crew who complete the form. Credibility is an important consideration during calls and during post-call inquiries.
6. Print clearly using block (capital) letters on the paper ACR.
7. In instances where more than one patient is assessed, an ACR shall be completed for each patient assessed by a paramedic.
8. If information applicable to a section/field cannot be obtained, document “CNO” (Could Not Obtain) in the section/field. An explanation as to why this information is not available should be documented in the “Remarks” section of the ACR or equivalent field of the eACR.
9. The information documented on an ACR is confidential.
10. The 24-hour clock format is to be used when documenting times (e.g. midnight is 00:00 hrs).
11. Ensure that defibrillators are synchronized with an atomic clock regularly so that documented times remain useful tools for clinical quality improvement.
12. When documenting on a paper ACR, use ink and press hard enough to make the required four (4) copies.
13. Unless otherwise stated, when documenting on a paper ACR all numbers and codes are to be entered in a “right justified” fashion.
14. When documenting on a paper ACR, draw a single line through any errors and initial.

15. Ensure all data entered on the eACR is correct prior to submitting the completed form to the receiving facility. If an error and/or omission is identified after submission of the completed eACR to the receiving facility, the paramedic will not revise the original eACR to make the edits. Instead, the paramedic will document the corrections and/or omissions in a clearly identified addendum to accompany the original eACR as per the distribution requirements listed in this document.
16. A paramedic who participates in the completion of any report shall sign the report.

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Part 7 – Section Details



Part 7 – Section Details

Section Details

Detailed descriptions of the fields contained within each section of the ACR as well as direction regarding how specific information must be documented have been included in this manual, where applicable.

Note: Images of specific fields/sections in this manual are visual representations of the paper ACR. eACRs may be displayed and organized differently than the paper version of the ACR. Paramedics are responsible for ensuring all required information as outlined in this manual is entered into the equivalent sections/fields of the eACR.

Hospital Registration Number

This field has been included on the ACR for hospital staff to document a patient’s hospital registration/chart number directly to the form. This will facilitate the cross referencing of the hospital registration number and the ACR.

Demographics

Demographics						
Service Name		Service No.	CACC/ACS	Call Number		Call Date YYYY / MM / DD
Last Name			First Name			
Age	Sex	Weight (kg)	Date of Birth YYYY / MM / DD	Health Insurance Number		Version
Mailing Address						
Street No.	Street Name		City/Town		Province	Postal Code Country
Pick-up Location or Sending Facility (City/Town) <input type="checkbox"/> Same as Mailing Address Above					Pick-up Code	

Service Name

Enter the name of the ambulance service assigned to the call.

Service No.

Enter the Emergency Health Services Branch 3-digit number for the ambulance service assigned to the call.

CACC/ACS

CACC/ACS		

Enter the appropriate CACC/ACS ARIS identification number of the CACC/ACS dispatching the ambulance. The following table lists CACCs/ACS's and their designated ARIS numbers:

ARIS Number	CACC/ACS (listed alphabetically)
921	Cambridge
930	Georgian
920	Hamilton
961	Kenora
942	Kingston
934	Lindsay
910	London
454	Mississauga
958	Muskoka
923	Niagara
953	North Bay
931	Oshawa
940	Ottawa
959	Parry Sound
941	Renfrew
951	Sault Ste. Marie
950	Sudbury
960	Thunder Bay
952	Timmins
933	Toronto
911	Wallaceburg
912	Windsor

Call Number

Enter the exact call number provided by the CACC/ACS. The “Call Number” is a key identifier and is required.

Call Date

Enter the date of the call numerically using YYYY/MM/DD format.

Last Name

Enter the complete last name of the patient.

First Name

Enter the complete first name of the patient. If the initial(s) of a middle name is known, it can be entered after the first name.

Age

Enter the patient’s age. If the actual age cannot be determined, an estimated age is acceptable if indicated as such (*e.g.* approx. 85, ~85).

Enter the age unit beside the age. Age unit is entered as “Y” for years, “M” for months and “D” for days.

Enter the age of pediatric patients in the following manner:

- <1 month, enter as days (“D”)
- 1 month to <2 years, enter as months (“M”)
- ≥2 years, enter as years (“Y”)

Sex

Enter the sex of the patient by entering “M” for male or “F” for female. Sex of the patient is indicated on the patient’s health card.

Weight (kg)

Enter the weight of the patient in kilograms (1 kg = 2.2 lbs). If the actual weight cannot be determined, an estimated weight is acceptable if indicated as such (*e.g.* approx. 70, ~70).

Date of Birth

Date of Birth YYYY / MM / DD

Enter the patient’s date of birth provided by the patient, through patient identification or by another credible source. Enter the full date of birth of the patient (year, month, day) whenever possible. If a full birth date is not available, a partial date is acceptable (*e.g.* year).

Enter the full 4-digit year of birth. For example, if a patient’s year of birth is 2001 then enter “2001”.

Health Insurance Number

Health Insurance Number									
-------------------------	--	--	--	--	--	--	--	--	--

Enter the patient’s 10-digit Ontario Health Insurance Number in the boxes provided. A patient’s “Health Insurance Number” is an important tool that may be used to track a patient through the health care system. If a valid Ontario Health Insurance Number is neither available nor provided, enter CNO in the appropriate field. This field is reserved for Ontario Health Insurance Numbers only.

Version

Version		
---------	--	--

Enter the patient’s 2-letter Ontario Health Insurance Version Code in the 2 boxes provided.

Mailing Address

Mailing Address					
Street No.	Street Name	City/Town	Province	Postal Code	Country

Enter the complete mailing address of the patient (street, city/town, province, postal code and country), if available. If the patient has no fixed address, enter No Fixed Address in the “Street Name” field. If the patient is unable to provide a complete address, enter CNO in the appropriate fields.

Pick-up Location or Sending Facility

Pick-up Location or Sending Facility (City/Town)	<input type="checkbox"/> Same as Mailing Address Above
--	---

Enter the location at which the patient is picked up. Include as much detail as possible (*e.g.* street/city/location description). If the pick-up location is a highway, give the Hwy. # and the number of kilometers to the nearest crossroad, intersection or prominent landmark.

If the pick-up location is the same as the mailing address, check the box “Same as **Mailing address** Above”.

If the patient is being picked up from a facility that you have already listed as the mailing address, provide the name of the facility and check the “Same as **Mailing Address** Above” box.

If the patient is not being picked up at the sending facility, the name of the sending facility should be entered in this section of the form (*e.g.* hospital, clinic, etc.).

Pick Up Code

Pick-up Code

The “Pick-up Code” identifies the location where the patient is picked up. Choose one from the list of codes on the reverse side of the ACR that best describes the pick-up location.

If none of the options describe the pick-up location, enter “Z” (other) and provide details regarding the location in the “Remarks” section.

Pick-up codes refer to the physical nature of the location rather than how it relates to the patient. For example, a pick-up in a hotel is coded “G” regardless of whether the patient was an employee or a guest in the hotel. In some cases, more than one code could apply. In these cases, choose the more general description (*e.g.* a restaurant or store in a hotel would still be coded [“G” hotel]).

Clinical Information

Clinical Information																		
Date of Occurrence YYYY / MM / DD	Time of Occurrence HH : MM	Chief Complaint <input type="checkbox"/> Positive for FREI																
Incident History		MOHLTC DNR Confirmation Number																
		<table border="1"> <thead> <tr> <th></th> <th>Trauma Location</th> <th>Problem Type</th> <th>Site/Type Mechanism</th> </tr> </thead> <tbody> <tr> <td>1</td> <td></td> <td></td> <td></td> </tr> <tr> <td>2</td> <td></td> <td></td> <td></td> </tr> <tr> <td>3</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Trauma Location	Problem Type	Site/Type Mechanism	1				2				3			
	Trauma Location	Problem Type	Site/Type Mechanism															
1																		
2																		
3																		

The “Clinical Information” section is to be used to record the clinically significant information about the patient.

Date of Occurrence

Date of Occurrence
 YYYY / MM / DD

Enter the date of the occurrence as obtained from the patient, bystander/family, first responders or other paramedics if present.

Time of Occurrence

Time of Occurrence
 HH : MM

Enter the actual or estimated time at which the patient’s signs and symptoms started and necessitated the call for ambulance assistance (e.g. time of fall, time seizure started, time of onset of shortness of breath, etc.).

Chief Complaint



Enter a description of the nature of the call. For emergency calls, document the patient’s chief complaint as determined by paramedics on arrival at the scene, not the dispatch information. Relate this information in the patient’s “own words” whenever possible. For example: “chest pain after snow shovelling” or “woke up with the worst headache ever”. Mechanisms of injury such as “MVC” or “fall” are not complaints and as such are not appropriate entries for this section.

For transfers, provide specific details regarding the type of transfer (e.g. “Returning to sending hospital following a CT scan”).

Positive for FREI

Positive for FREI

This check box should be checked if the patient screens positive for a febrile respiratory/enteric illness. Current screening tools must be used when assessing patients for FREI.

Incident History

Enter information specifically related to the patient’s current condition and the source of the information. Sources of information may include the patient, relatives or bystanders. A description of how and where the patient was found by paramedics should be documented. Include symptoms being experienced by the patient as well as events leading up to the illness/injury. Use as much detail as possible and include pertinent negative findings relating to the chief complaint, if applicable.

Example: “Patient’s spouse advised crew that the patient had been shoveling snow for about 45 minutes (since 17:00 hrs) prior to complaining of chest pain (at 17:45 hrs). Patient states that the chest pain radiates down his left arm and rates the pain as 6 out of 10. Patient denies any shortness of breath”.

MOHLTC DNR Confirmation No.

MOHLTC DNR Confirmation Number						

The patient’s unique *MOHLTC Do Not Resuscitate (DNR) Confirmation Form* serial number is documented in this section. The number is obtained from the *MOHLTC DNR Confirmation Form* (upper right hand corner of the form). This number shall be documented any time a patient with a valid *MOHLTC DNR Confirmation Form* is in the care of a paramedic crew regardless if the patient experiences a cardiac arrest or not.

Trauma Problem Site/Type

Trauma Problem Site/Type		
Location	Type	Mechanism
1		
2		
3		

This area is used to identify the location, type and mechanism for traumatic injuries/problems identified during the assessment and management of a patient. For **example**, a knife wound to the chest would be coded as follows:

- “Location”: “15” (Chest)
- “Type”: “37” (Penetrating/Perforation)
- “Mechanism”: “63” (Stabbing)

A maximum of three problems can be entered in this area. The three (3) most serious problems are to be documented. If more than three (3) traumatic injuries/problems are identified, the others can be entered in the “Physical Exam” section of the ACR.

Relevant Past History

Relevant Past History	Provided by:	<input type="checkbox"/> Patient	<input type="checkbox"/> Other: _____				
	<input type="checkbox"/> Previously Healthy	<input type="checkbox"/> Cardiac	<input type="checkbox"/> Stroke/TIA	<input type="checkbox"/> Seizure	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer	<input type="checkbox"/> CNO
		<input type="checkbox"/> Respiratory	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Other (list below)	
Details _____							

Check the appropriate check box/boxes to indicate the category of past illness. At a minimum, one (1) box must always be checked. These boxes provide quick reference in the event that medical staff are scanning the ACR and will also serve to simplify data entry for research purposes.

Use the blank lines to enter past historical information that is relevant to the current condition together with the sources of the information. For **example**; “Triple bypass three (3) years ago”.

Medications	<input type="checkbox"/> None	<input type="checkbox"/> Nitrates	<input type="checkbox"/> Insulin/Oral Diabetic Meds	<input type="checkbox"/> Phosphodiesterase Inhibitors
	<input type="checkbox"/> CNO	<input type="checkbox"/> ASA	<input type="checkbox"/> Blood thinner/Anticoagulants	<input type="checkbox"/> Salbutamol <input type="checkbox"/> Furosemide
Other _____				

Check boxes have been included in this section to assist paramedics in documenting medications commonly prescribed to patients. Check the appropriate box to indicate medications that the patient is currently taking (include dosage if available for the medication checked). The form of medication should also be documented, (e.g. spray, tablet, paste, etc.).

If the patient is taking a medication not included in the check box options, enter the names of the medication(s) in the blank lines below the check boxes. If the patient is not currently taking medications, check the “None” box.

Allergies

Allergies	<input type="checkbox"/> NKA	<input type="checkbox"/> CNO	<input type="checkbox"/> Other – list below
Details _____			

Check boxes have been included in this section as well as the ability to list any allergies (medication and environmental) that the patient may have in the space provided. Include details regarding the patient’s response to the allergen, if possible.

If it is confirmed that the patient has no allergies, the “NKA” (No Known Allergies) check box is to be checked.

Treatment Prior to Arrival

Treatment Prior to Arrival	<input type="checkbox"/> None	<input type="checkbox"/> EFRT	<input type="checkbox"/> Physician	<input type="checkbox"/> Fire	<input type="checkbox"/> Bystander	<input type="checkbox"/> CNO
	<input type="checkbox"/> Midwife	<input type="checkbox"/> Other Paramedic	<input type="checkbox"/> Nurse	<input type="checkbox"/> Police	<input type="checkbox"/> Self	<input type="checkbox"/> Other (list below)
Details _____						

This field is used to indicate whether or not care was provided to the patient prior to the arrival of the paramedics. If no care was provided, the “None” box must be checked. If care was provided to the patient, check the appropriate box to indicate who provided care prior to paramedic arrival. Use the blank lines to enter a description of the care provided to the patient. If more than one box is checked, provide as much detail as possible regarding the care provided.

Also record any response to the care provided. Indicate whether the patient was moved or repositioned before the arrival of paramedics (e.g. “Bystanders placed patient semi-prone and wrapped in a blanket at the scene”).

Extended notes for any care rendered prior to the arrival of paramedics should be carried over to the “Remarks” section of the ACR.

Cardiac Arrest Information

Cardiac Arrest Information					Date	Start Time
Arrest Witnessed By	<input type="checkbox"/> Bystander	<input type="checkbox"/> Trained Responder	<input type="checkbox"/> Paramedic	<input type="checkbox"/> Unwitnessed	YYYY / MM / DD	HH : MM
CPR Started By	<input type="checkbox"/> Bystander	<input type="checkbox"/> Trained Responder	<input type="checkbox"/> Paramedic	<input type="checkbox"/> None	YYYY / MM / DD	HH : MM
First Shock by	<input type="checkbox"/> Bystander	<input type="checkbox"/> Trained Responder	<input type="checkbox"/> Paramedic		YYYY / MM / DD	HH : MM

Arrest Witnessed by

Arrest Witnessed By	<input type="checkbox"/> Bystander	<input type="checkbox"/> Trained Responder	<input type="checkbox"/> Paramedic	<input type="checkbox"/> Unwitnessed	YYYY / MM / DD	HH : MM
---------------------	------------------------------------	--	------------------------------------	--------------------------------------	----------------	---------

A cardiac arrest is considered witnessed when a patient is seen or heard to collapse. Check the appropriate box to identify who witnessed the cardiac arrest.

A **Trained Responder** is defined as anyone who has a duty to act in an emergency as part of their employment and may include police officers, firefighters, security guards and hospital/long term care home staff, etc. A **Bystander** is defined as an individual who is not a tasked emergency responder with a duty to act (e.g. family member).

If more than one type of responder witnessed the cardiac arrest, check the box that corresponds to the witness with the highest level of training. Only one (1) box may be selected in this section.

If a bystander or trained responder is able to provide an actual or estimated time of arrest, enter it in this field. If the paramedic crew witnesses the arrest, document the actual time of the arrest including the year, month, day, hour and minute.

CPR Started by

CPR Started By	<input type="checkbox"/> Bystander	<input type="checkbox"/> Trained Responder	<input type="checkbox"/> Paramedic	<input type="checkbox"/> None	YYYY / MM / DD	HH : MM
----------------	------------------------------------	--	------------------------------------	-------------------------------	----------------	---------

Check the appropriate box to identify who initiated CPR if applicable. Only one (1) box may be checked. For the purposes of this field, the definitions for a **Trained Responder** and a **Bystander** are the same as the “Arrest Witnessed By” field.

If there was a valid *MOHLTC DNR Confirmation Form*, but CPR was initiated, check the box that indicates who started CPR as well as ensuring that the *MOHLTC DNR Confirmation Form* serial number is documented in the appropriate field. If no CPR was started, check “None”.

Enter the date and time CPR was initiated. Enter the year, month, day, hour and minute whenever possible.

First Shock by

First Shock By	<input type="checkbox"/> Bystander	<input type="checkbox"/> Trained Responder	<input type="checkbox"/> Paramedic		YYYY / MM / DD	HH : MM
----------------	------------------------------------	--	------------------------------------	--	----------------	---------

Check the appropriate box to identify who delivered the first shock to the patient, if applicable. Only one (1) box may be checked. For the purposes of this field, the definitions for a **Trained Responder** and a **Bystander** are the same as the “Arrest Witnessed by” and the “CPR Started by” fields.

Enter the date and time that the first shock was delivered to the patient by any provider, if applicable. Document the year, month, day, hour and minute.

Physical Exam

Physical Exam	
General Appearance	Skin Colour: _____ Skin Condition: _____

Head/Neck	Trachea <input type="checkbox"/> - Midline Shifted <input type="checkbox"/> - R <input type="checkbox"/> - L JVD <input type="checkbox"/> - Elevated <input type="checkbox"/> - Not Elevated

Chest	Air Entry <input type="checkbox"/> - Bilaterally Decreased <input type="checkbox"/> - R <input type="checkbox"/> - L Breath Sounds <input type="checkbox"/> - Clear <input type="checkbox"/> - Wheezes <input type="checkbox"/> - Crackles <input type="checkbox"/> - Rub <input type="checkbox"/> - Absent

Abdomen	<input type="checkbox"/> - Soft <input type="checkbox"/> - Rigid <input type="checkbox"/> - Distended <input type="checkbox"/> - Tender <input type="checkbox"/> - Mass <input type="checkbox"/> - Pulsatile <input type="checkbox"/> - RU <input type="checkbox"/> - LU <input type="checkbox"/> - LL <input type="checkbox"/> - RL <input type="checkbox"/> - Center
Back/Pelvis	<input type="checkbox"/> - Unremarkable
Extremities	<input type="checkbox"/> - Unremarkable Peripheral Edema <input type="checkbox"/> - Absent <input type="checkbox"/> - Present Pedal Pulse <input type="checkbox"/> - Absent <input type="checkbox"/> - Present

The “Physical Exam” section is sub divided into six categories:

1. General Appearance (Skin Colour/Skin Condition)
2. Head/Neck
3. Chest
4. Abdomen
5. Back/Pelvis
6. Extremities

The five anatomical locations include check boxes to aid the paramedic in documenting common assessment findings. In addition to check boxes, blank lines are provided to record both the physical examination that is performed on the patient and the resultant findings. Assessments must be based on the patient’s chief complaint and history.

Minimum assessment requirements for specific categories based on a patient’s presenting problem(s) may be found within the current versions of the *Basic Life Support Patient Care Standards* and the *Advanced Life Support Patient Care Standards*.

General Appearance (Skin Colour/Skin Condition)

General Appearance	Skin Colour: _____	Skin Condition: _____

Enter the initial presentation of the patient. Include details regarding such information as where the patient was found (*e.g.* on the floor, in the car, *etc.*), level of consciousness and a general description of the patient’s condition as it relates to their mental status (*e.g.* patient confused or disoriented), level of distress (mild, moderate, severe), obvious wounds and deformities.

Using the reference information provided on the reverse side of the ACR, enter the word that best describes the colour and condition of the patient’s skin in the spaces provided.

Head/Neck

Head/Neck	Trachea	<input type="checkbox"/> - Midline	Shifted	<input type="checkbox"/> - R	<input type="checkbox"/> - L	JVD	<input type="checkbox"/> - Elevated	<input type="checkbox"/> - Not Elevated

Trachea Trachea - Midline Shifted - R - L

Check the most appropriate box to indicate the position of the trachea.

JVD JVD - Elevated - Not Elevated

Check the most appropriate box to indicate whether jugular vein distension (JVD) is elevated or not elevated.

Utilize the blank lines to document any further remarkable/pertinent negative findings on the head and neck.

Chest

Chest	Air Entry	<input type="checkbox"/> - Bilaterally	Decreased	<input type="checkbox"/> - R	<input type="checkbox"/> - L	Breath Sounds	<input type="checkbox"/> - Clear	<input type="checkbox"/> - Wheezes	<input type="checkbox"/> - Crackles	<input type="checkbox"/> - Rub	<input type="checkbox"/> - Absent

Air Entry

Check the appropriate box to indicate normal or decreased air entry in the lungs. Use the blank lines to enter any further remarkable/pertinent negative findings regarding the patient’s chest assessment and air entry.

Breath Sounds

Check the appropriate box to indicate the quality of breath sounds and adventitious sounds (if present).

Abdomen

Abdomen	<input type="checkbox"/> - Soft	<input type="checkbox"/> - Rigid	<input type="checkbox"/> - Distended	<input type="checkbox"/> - Tender	<input type="checkbox"/> - Mass	<input type="checkbox"/> - Pulsatile	<input type="checkbox"/> - RU	<input type="checkbox"/> - LU	<input type="checkbox"/> - LL	<input type="checkbox"/> - RL	<input type="checkbox"/> - Center
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Check the appropriate box to indicate abdominal examination findings and section of the abdomen that has abnormal characteristics. Use the blank lines to enter any further remarkable findings regarding the patient’s abdomen.

Back/Pelvis



Enter any positive or pertinent negative findings with regards to the back and/or pelvis (e.g. pain and/or crepitus noted on palpation of the pelvis) or check the “Unremarkable” box.

Extremities

Extremities	<input type="checkbox"/> - Unremarkable	Peripheral Edema	<input type="checkbox"/> - Absent	<input type="checkbox"/> - Present	Pedal Pulse	<input type="checkbox"/> - Absent	<input type="checkbox"/> - Present
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Peripheral Edema

Check the appropriate box to indicate whether Peripheral Edema is absent or present.

Pedal Pulse

Check the appropriate box to indicate whether a Pedal Pulse is absent or present.

Call Number/Page

Call Number	Page	of

As the entire front side of the ACR is considered Page 1 of the document, if additional pages are required to document “Clinical Treatment/Procedures and Results”, paramedics may use another ACR for this purpose. Paramedics are not required to complete the left side of the ACR (“Demographics”, “Clinical Information” and “Physical Exam”) on any additional pages. Additional pages, when completed are to be securely attached to Page 1 of the ACR. It is important that paramedics enter the call number for the call in the space provided at the top of the right hand corner of any additional pages.

Page numbers must be assigned to any additional pages added to an ACR. For example, if an additional page is completed, enter the “Call Number” and “Page 1 of 2” in the appropriate area in the upper right corner of the original form. On the second page enter the “Call Number” and “Page 2 of 2”.

Clinical Treatment/Procedures & Results

Clinical Treatment/Procedures								Results							
Time HH : MM	Procedure Code	Dose/Unit	Route	Pulse Rate	Resp. Rate	B/P Sys/Dia	Temp.	Reading/ Code	SpO ₂	EtCO ₂	GCS	Pupils R ± L ±	Pain Scale	Crew Mbr. No.	

All clinical treatments and procedures and the results of each are to be entered in this section of the ACR. The time that the treatment and /or procedure was completed must be entered for all.

Treatments and procedures must be documented in chronological order. Vital signs and other data are documented under the appropriate headings within the ghosted lines as outlined in the Vital Signs sections.

When a procedure code is used, provide a brief narrative to describe the procedure through the columns and across the ghosted lines. If extra space is required to document narratives, paramedics may continue the narrative on the line below, or use a second ACR if required.

Codes 800-899 are reserved for Study Drugs and should be detailed in Procedures. Codes 900-999 are reserved for User Defined procedures as directed by service operators.

For **example** (see “Sample” below), when a paramedic initiates an intravenous to Keep Vein Open, it would be documented as follows:

- The time in HH:MM format would be entered in the “Time” column.
- “341” the code for IV cannulation would be entered in the “Procedure Code” column.
- A narrative such as “20ga 1.16 Insyte Left forearm” would be written in the adjacent columns.
- “Successful and secured” would be written across the columns under “Results”.

On a new line, the paramedic would then document a new procedure for connecting the intravenous line which is attached to a 500 ml bag of normal saline. This procedure would be documented as follows:

- The time in HH:MM format would be entered in the “Time” column.
- “345” the code for Normal Saline, would be entered in the “Procedure Code” column.
- A narrative such as “0.9% NaCl 500 ml bag TKVO at 30 ml/hr” would be entered across the ghosted lines adjacent to the procedure code.
- “Patent and running well” could be written across the columns under “Results”.

Sample

Clinical Treatment/Procedures								Results						
Time HH : MM	Procedure Code	Dose/Unit	Route	Pulse Rate	Resp. Rate	B/P Sys/Dia	Temp.	Reading/ Code	SpO ₂	EtCO ₂	GCS	Pupils R ± L ±	Pain Scale	Crew Mbr. No.
1435	341	20ga 1.16" INSYTE LEFT FOREARM							SUCCESSFUL AND SECURED					
1436	345	0.9% NaCl 500 ml BAG TKVO AT 30 ml/hr							PATENT AND RUNNING WELL					

Time

Enter the time at which a treatment or procedure was performed. If the time is an estimate use “~” or “approx.” as well as the time.

Procedure Code

Enter the appropriate procedure code for each medication, treatment or procedure. Codes are listed on the reverse side of the ACR. To assist paramedics in completing the ACR, procedure codes are divided into groups based on the type of procedure.

Dose/Unit

Whenever a medication is given, the dose administered and unit of measure is to be documented.

For example (see sample below), when a paramedic administers 160 mg of ASA to a patient, this procedure should be documented as follows:

The time in HH:MM format would be entered in the “Time” column.

- “504” the code for ASA would be entered in the “Procedure Code” column.
- “160 mg” would be entered in the “Dose/Unit” column.
- “PO” would be entered in the “Route” column.

A narrative such as “Chewed and Swallowed” could be written starting under the “Results” heading

Sample

Clinical Treatment/Procedures								Results						
Time HH : MM	Procedure Code	Dose/Unit	Route	Pulse Rate	Resp. Rate	B/P Sys/Dia	Temp.	Reading/ Code	SpO ₂	EtCO ₂	GCS	Pupils R ± L ±	Pain Scale	Crew Mbr. No.
0056	504	160 mg	PO					CHEWED AND SWALLOWED					1	

Route

When a medication is given, the route of administration must be documented. The appropriate “Routes of Administration” code must be used from the list found on the reverse side of the ACR.

Vital Signs

The assessment of vital signs is considered a procedure and as such must be documented in the “Clinical Treatment/Procedures & Results” section in chronological order. As with all treatments and procedures performed, the time at which the vital signs were measured must be entered in the appropriate field.

Sample

Clinical Treatment/Procedures								Results							
Time HH : MM	Procedure Code	Dose/Unit	Route	Pulse Rate	Resp. Rate	B/P Sys/Dia	Temp.	Reading/ Code	SpO ₂	EtCO ₂	GCS	Pupils R ± L ±	Pain Scale	Crew Mbr. No.	
0425	010	VITAL SIGNS		100	16	120/76	36.7		99	40	15	4+ 4+	0	1	

The minimum vital signs, minimum number of sets and the frequency at which vital signs must be taken based on the patient’s condition are described within the *Basic Life Support Patient Care Standards* and the *Advanced Life Support Patient Care Standards*. Paramedics may be required to follow Base Hospital and Ambulance Service policies with regards to the documentation of vital signs if these policies exceed the minimum requirements described in the *Basic* and *Advanced Life Support Patient Care Standards*.

If the minimum vital sign assessments are not obtained, paramedics must document the reasons in the “Remarks” section of the ACR.

Pulse Rate

Enter a numeric value for the pulse rate. Descriptions of pulse rhythm (regular or irregular) and volume (strong or weak) should be documented in the “Physical Exam” section of the ACR.

Resp. Rate

Enter a numeric value for the rate of respirations. Descriptions of respiratory patterns should be documented in the “Physical Exam” section of the ACR.

B/P Sys/Dia

Enter a numeric value for the blood pressure. If the blood pressure measurement is taken by palpation, document the diastolic value as “P”.

Temp.

Enter a numeric value for temperature in degrees Celsius when appropriate and if available. If the temperature has been assessed by touch, indicate “H”-hot, “C”-cool or “N”-unremarkable.

Reading/Code

Enter the numeric results from diagnostic procedures or ECG rhythm codes. The Reading/Codes column allows paramedics to enter biometric data **not** captured in a standalone column.

“Reading” is a quantitative numeric value that is the result of a test or procedure such as blood glucose reading or carboxyhemoglobin.

“Code” is used for ECG rhythm codes only. The ECG codes can be found on the reverse side of the ACR. This column is design to allow for data entry for any future point of care procedures.

Sample

Clinical Treatment/Procedures								Results						
Time HH : MM	Procedure Code	Dose/Unit	Route	Pulse Rate	Resp. Rate	B/P Sys/Dia	Temp.	Reading/ Code	SpO ₂	EtCO ₂	GCS	Pupils R ± L ±	Pain Scale	Crew Mbr. No.
0030	025	BLOOD GLUCOSE						5.2 mmolL						1
0035	301	RHYTHM INTERPRETATION						40	NORMAL SINUS RHYTHM AT 80					1

SpO₂

Enter a numeric value for oxygen saturation.

EtCO₂

Enter a numeric value for the End-tidal Carbon Dioxide reading. If a colorimetric CO₂ indicator device is used, enter the approximate expired carbon dioxide level based on the comparison of the colour of the indicator to the colour scale provided with the device. Completion of this field is based on the paramedic’s scope of practice and availability of equipment.

GCS

Enter the total numeric value that corresponds to the patient’s response for each indicator. Charts for adult and pediatric patients are provided in the “Reference Information” section on the reverse side of the ACR to assist paramedics in completing the GCS field.

The Glasgow Coma Scale provides a standardized method of recording the patient’s level of awareness. Three indicators are assessed: eye opening, verbal and motor response.

If a GCS value cannot be determined because an indicator cannot be assessed, (*e.g.* eyes bandaged; patient intubated) enter “CNO”. Enter the reason for not assessing the indicator in the “Remarks” section.

Pupils

Enter the numeric value corresponding to the patient’s pupil size. A scale is provided in the “Reference Information” section on the reverse side of the ACR to assist paramedics in completing this field. The reactivity to light for each pupil is also entered in this field. The plus (+) symbol indicates a reactive pupil and the minus (-) symbol indicate a non-reactive pupil.

Pain Scale

Enter a numeric value that corresponds to the patient’s reported level of pain as identified by the “Pain Intensity Scale”, if possible. A scale is provided in the “Reference Information” section on the reverse side of the ACR to assist paramedics in completing this field. The range of the scale is from 0 to 10, with 0 being no pain to 10 being the worst possible.

Crew Mbr. No.

Enter the number of the paramedic administering a medication or performing a procedure (both BLS and ALS). “Crew Member 1” is the attending paramedic and “Crew Member 2” is the second paramedic assigned to the ambulance. “Other” is any other Paramedic, EMA, Paramedic Student, RN, RT, Physician, etc. that assisted with the management of the patient.

For any controlled act performed, only one paramedic, the one who performed the actual controlled act, should be entered as the paramedic performing that procedure.

Remarks

Remarks			
Disposition of Effects <input type="checkbox"/> Receiving Staff <input type="checkbox"/> Family <input type="checkbox"/> Other (list):			
Primary Problem	Problem Code	Sp Trans Code	CTAS Arrive Patient
Deceased <input type="checkbox"/> Obviously dead <input type="checkbox"/> DNR <input type="checkbox"/> BHP TOR <input type="checkbox"/> Pronounced by on scene physician			CTAS Depart Scene
Physician/BHP Name (if pronounced/TOR)	Date YYYY / MM / DD	Time HH : MM	CTAS Arrive Destination

Remarks

Enter any significant information about the call that has not already been entered in another section of the ACR (*e.g.* clinically significant information, name of physician at scene, unusual circumstances surrounding the call) in this section.

Disposition of Effects

Disposition of Effects
<input type="checkbox"/> Receiving Staff <input type="checkbox"/> Family <input type="checkbox"/> Other (list):

The disposition of any personal effects belonging to the patient (e.g. Ontario Health Card, medications, etc.) is to be documented in this section.

Use appropriate check box to indicate to whom the patient’s personal effects were given. For “Other”, indicate in writing who was given the patient’s effects.

Primary Problem

Primary Problem

A description which best categorizes the patient’s primary problem is to be documented in this field. This must reflect the patient’s most immediate priority or obvious condition based on paramedic impression and assessment findings.

The “Primary Problem” must reflect in general terms, the underlying problem or most probable cause of the patient’s presentation as found by the paramedic rather than the patient’s chief complaint (e.g. the patient’s chief complaint may be shortness of breath while the most likely cause may be congestive heart failure). Looking at the chronology of the call from the patient’s perspective, and deciding what happened first can often identify the “Primary Problem”.

Problem Code

Problem Code

Enter a numeric problem code that corresponds to the “Primary Problem” documented in the space provided. Problem codes are listed on the reverse side of the ACR and are organized into broad categories based on body systems, etc.

Sp Trans Code (Special Transport Code)

Sp Trans Code

The applicable two digit Special Transport Code listed on the reverse side of the ACR is to be documented in this field to capture ambulance calls that have utilized a bypass directive included in a specific guideline, standard or protocol. This code is to be documented if a patient meets the specific criteria for any of the following situations:

- Field Trauma Triage Standard
- Acute Stroke Protocol
- STEMI Bypass

For each of the above situation, one of three possible codes is to be utilized if a patient meets the specific criteria:

Trauma

- 01 To be used for patients who met the criteria outlined in the current version of the *Field Trauma Triage Standard* and **were** transported to a Lead Trauma Hospital (LTH).
- 02 To be used for patients who met the criteria outlined in the current version of the *Field Trauma Triage Standard*, but were **not** transported to a (LTH) due to patient condition reasons. Example: A patient met the criteria but developed an uncontrolled airway problem during transport and paramedics diverted to the closest ED.
- 03 To be used for patients who met the criteria outlined in the current version of the *Field Trauma Triage Standard*, but were **not** transported to a LTH due to a hospital reason. Example: A patient met the criteria, but the LTH was unable to accept the patient due to an emergent capacity/facilities issue.

Stroke

- 04 To be used for patients who met the criteria outlined in the current version of the *Acute Stroke Protocol* and **were** transported to a designated Stroke Centre.
- 05 To be used for patients who met the criteria outlined in the current version of the *Acute Stroke Protocol*, but were **not** transported to a designated Stroke Centre due to patient condition reasons. Example: A patient initially met the criteria but became VSA enroute which resulted in paramedics diverting to the closest ED.
- 06 To be used for patients who met the criteria outlined in the current version of the *Acute Stroke Protocol*, but were **not** transported to a designated Stroke Centre due to a hospital reason. Example: A patient initially met the criteria, but the designated Stroke Centre was unable to accept the patient due to an emergent capacity/facilities issue.

STEMI

- 07 To be used for patients who met the criteria outlined in the current version of the *STEMI Hospital Bypass Protocol* and **were** transported to a designated STEMI/PCI Centre.
- 08 To be used for patients who met the criteria outlined in the current version of the *STEMI Hospital Bypass Protocol*, but were **not** transported to a designated STEMI/PCI Centre due to patient condition reasons. Example: A patient met the criteria for STEMI bypass, but was not transported to the STEMI/PCI Centre due to clinical reasons as per the interventionalist.
- 09 To be used for patients who met the criteria outlined in the current version of the *STEMI Hospital Bypass Protocol*, but were **not** transported to a designated STEMI/PCI Centre due to a hospital reason. Example: A patient met the criteria for STEMI bypass, but was not transported to the STEMI/PCI Centre due to the hospital equipment/staff reasons.

Paramedic should document the specific reasons for ‘No-Bypass’ situations in the Remarks section of the ACR.

Canadian Triage and Acuity Scale (CTAS)

CTAS Arrive Patient
CTAS Depart Scene
CTAS Arrive Destination

It is important that the CTAS score be carefully considered and entered in the fields provided on the ACR. CTAS is used to assign a level of acuity to a patient. Acuity refers to the gravity of the situation – the potential for death and/or irreversible illness. CTAS is a tool that more accurately defines the patient’s need for care.

The intent of using a standardized acuity scale is to better communicate the severity of the patient’s problem in a common language to both CACC/ACS and the receiving facility.

Assignment of the CTAS level is to be based upon not only the presenting complaint identified on the initial assessment made by the paramedic, but also on their examination findings and response to treatment.

CTAS Arrive Patient

Enter the CTAS level of the patient as determined by the paramedic on arrival at the patient. “CTAS Arrived Patient” will reflect the initial condition of the patient prior to paramedic interventions and serve as a marker for response times as they relate to the patient’s acuity. The additional information provided by the documentation of the “CTAS Arrive Patient” will be useful when reviewing dispatch procedures, vehicle resources and for patient care standards.

CTAS Depart Scene

Enter the CTAS level of the patient as determined by the paramedic at the time of departure from the scene. The “CTAS Depart Scene” will aid in determining the destination (*e.g.* CTAS Level 1 and 2 to the closest most appropriate hospital) and will also reflect any change in the patient’s condition as a result of prehospital interventions on scene prior to transport.

Note: CTAS 0 is used in situations of Obviously Dead/Termination of Resuscitation (TOR).

CTAS Arrive Destination

Enter the CTAS level of the patient as determined by the paramedic upon arrival at destination. The “CTAS Arrive Destination” level will reflect the patient’s acuity level upon arrival at the destination.

Deceased

Deceased <input type="checkbox"/> Obviously dead <input type="checkbox"/> DNR <input type="checkbox"/> BHP TOR <input type="checkbox"/> Pronounced by on scene physician
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Check the appropriate box to indicate if:

- a paramedic determines that the patient is obviously dead.
- the patient has a DNR (with a valid *MOHLTC DNR Confirmation Form*) and resuscitation not initiated.
- a Base Hospital Physician has ordered the termination of resuscitation efforts.
- the patient is pronounced deceased on scene by a member of the College of Physicians and Surgeons of Ontario (document the physician’s contact information in the “Remarks” section of the ACR).

Physician Name/BHP (if pronounced/TOR)

Physician/BHP Name (if pronounced/TOR)
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Enter the name or number where applicable, of the on scene physician pronouncing the patient or the Base Hospital Physician ordering the termination of resuscitation in the space provided.

Date/Time	<table border="1"><tr><td>Date</td><td>Time</td></tr><tr><td>YYYY / MM / DD</td><td>HH : MM</td></tr></table>	Date	Time	YYYY / MM / DD	HH : MM
Date	Time				
YYYY / MM / DD	HH : MM				

Enter the date and the time of pronouncement or the order for termination of resuscitation.

General Administration

General Administration									
Vehicle Number		Station		Status		Hospital Number		Receiving Facility/Destination	
UTM Code			Dispatch	Return	Patient	Sequence	Warning Systems	To Scene To Destination	<input type="checkbox"/> None <input type="checkbox"/> None <input type="checkbox"/> Emergency Systems <input type="checkbox"/> Emergency Systems
Base Hospital Name				Base Hospital Number		Base Hospital Physician Name/No. (if patch)			Patch Log Number
Call Events	Call Received HH : MM : SS	Crew Notified HH : MM : SS	Crew Mobile HH : MM : SS	Arrive Scene HH : MM : SS	Patient Contact HH : MM : SS	Depart Scene HH : MM : SS	Arrive Destination HH : MM : SS	TOC HH : MM : SS	
Paramedic 1 (Attending) No.	Name				Designation	Signature No. 1			
Paramedic 2 No.	Name				Designation	Signature No. 2			
Other	Name				Designation	Signature No. 3			
Other	Name				Designation	Signature No. 4			
Date of ACR Completion YYYY / MM / DD		Time of ACR Completion HH : MM : SS			1 – Patient Chart Copy 3 – Base Hospital Copy		2 – Billing Office Copy 4 – Ambulance Service Copy		

Vehicle Number

Vehicle Number

Enter the 4-digit vehicle number assigned by the Ministry of Health and Long-Term Care, Emergency Health Services Branch.

Station

Station

Enter the station number to which the vehicle has been assigned.

Status

Status

Enter the two-digit code that identifies the status of the vehicle when it was dispatched:

- 00 At Base
- 77 Mobile
- 88 Standby Location
- 99 Maintenance

Hospital Number

Hospital Number

Enter the Ministry of Health and Long-Term Care assigned hospital/institution number for the receiving facility. This information is available through CACC/ACS.

Receiving Facility/Destination

Receiving Facility/Destination

Enter the name of the facility that received the patient from the paramedics.

UTM Code (Universal Transverse Mercator)

UTM Code									
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Enter the 7-digit UTM Code provided by the CACC/ACS. Completion of this field is not required for calls originating at a hospital.

Dispatch

Dispatch	
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Enter the appropriate “Priority Code” that corresponds to the assigned dispatched priority.

The Dispatch Priority Codes are used to identify:

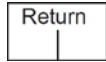
1. the urgency of a response or transport.
2. other use of an ambulance when a patient is not carried.

This is the priority code number that is assigned to the call by the ambulance communications officer. It identifies the priority under which the ambulance responds to the call location (*e.g.* an urgent response would be entered as a Code “4”).

- Code 1 “Deferrable Call” – A non-emergency call that may be delayed without being physically detrimental to the patient.
- Code 2 “Scheduled Call” – A non-emergency call which must be done at a specific time due to the limited availability of special treatment or diagnostic/receiving facilities. Such scheduling is not done because of patient preference or convenience.
- Code 3 “Prompt Call” – An emergency call which may be responded with moderate delay. The patient is stable or under professional care and not in immediate danger.
- Code 4 “Urgent Call” – An emergency call requiring immediate response. The patient is life, limb or function threatened, in immediate danger and time is crucial.
- Code 8 “Standby Call” – Vehicle or paramedic utilization to provide emergency coverage or for anticipation of a call.
- Code 9 “Out of Service/Administration” – A vehicle is either out of service for maintenance at base or is sent to a garage for servicing.

Note: Completion of an ACR is not required for standby and maintenance calls

Return



Enter the appropriate “Priority Code” that corresponds to the assigned return priority for the patient/call. In the event of multiple patient transports, enter the priority for each patient (see “Patient” and “Sequence”).

This is the code that is assigned to the call by paramedics. It identifies the priority under which the patient is transported (*e.g.* a prompt return to a medical facility would be entered as a Code “3”). “Return Priority Codes” must not be confused with the CTAS code.

- Code 1 “Deferrable Call” – A non-emergency call that may be delayed without being physically detrimental to the patient.
- Code 2 “Scheduled Call” – A non-emergency call which must be done at a specific time due to the limited availability of special treatment or diagnostic/receiving facilities. Such scheduling is not done because of patient preference or convenience.
- Code 3 “Prompt Call” – An emergency call which may be responded to with moderate delay. The patient is stable or under professional care and not in immediate danger.
- Code 4 “Urgent Call” – An emergency call requiring an immediate response. The patient is life, limb or function threatened, in immediate danger and time is crucial.
- Code 6 “Deceased Patient” – The transportation of a deceased patient where no resuscitation measures are being performed.

Return priorities for “Code 2” dispatched calls are not always return Code “2”. The return priority could be a Code “1, 2, 3, or 4” based on the urgency of the transport and if the return portion of the trip is for a scheduled appointment. For example, a crew sent to meet an aircraft at a designated time would be dispatched Code “2”. If the patient was being transported to a facility for a scheduled appointment, the return priority would remain a Code “2”. If however, the patient was experiencing crushing chest pain, the return priority would be Code “4”. An emergency call where the return priority is not a “3” or “4” (*e.g.* minor injuries only) should never be labeled as a Code “2”, unless the patient has a ‘scheduled’ appointment.

If no patient is carried, one of the following return priority codes should be used:

- 71 No patient found
- 72 Patient Refused (ensure “Refusal of Service” documentation is completed)
- 73 Patient Deceased
- 74 Patient in Police Custody
- 75 Patient Transported by Other Ambulance (provide vehicle # in remarks section)

If an ambulance is on a return leg for Dispatch Code “8” or “9”, use the following applicable Return Codes:

- Code 8 Standby Call
- Code 9 Out of Service/Administration

Patient

The paramedic will indicate the total number of patients carried in the ambulance during a given call in this field. If no patients were transported, enter “0”.

Sequence

The “Sequence” indicates to which of the multiple patients the ACR information refers. For example, if two patients were transported using the same call number, one patient would be Sequence “1” and the other patient would be Sequence “2”. If no patients were transported, enter “0”.

A separate “Return Priority Code” must be indicated for each patient transported (e.g. Sequence “1” Return “4” / Sequence “2” Return “1”).

Patients should be sequence numbered in the order of the severity of their condition, with the most serious patient documented as Sequence “1”.

Warning Systems

Warning Systems	To Scene	<input type="checkbox"/> None	<input type="checkbox"/> Emergency Systems
	To Destination	<input type="checkbox"/> None	<input type="checkbox"/> Emergency Systems

Check the appropriate box for systems used while travelling to the scene and while travelling from the scene to a destination. If the public address system is used enter a narrative in the “Remarks” section.

Base Hospital

Enter the name of the Base Hospital with which the paramedic is affiliated.

Base Hospital Number

Enter the Base Hospital number with which the paramedic is affiliated.

Base Hospital Physician Name/No. (if patch)

Enter the name or number, if applicable, of the base hospital physician, if contact was made. This field is completed even if no orders are given by the base hospital physician. Document failed patches in the “Remarks” section.

Patch Log Number

Enter the Base Hospital patch log number in this section if applicable.

Call Events (Times)

Call Events	Call Received HH : MM : SS	Crew Notified HH : MM : SS	Crew Mobile HH : MM : SS	Arrive Scene HH : MM : SS	Patient Contact HH : MM : SS	Depart Scene HH : MM : SS	Arrive Destination HH : MM : SS	TOC HH : MM : SS
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Time of call events must be completed on all calls.

Call Received
HH : MM : SS

Enter the time the CACC/ACS received the request for service.

Crew Notified
HH : MM : SS

Enter the time the paramedics were notified of the call by the CACC/ACS.

Crew Mobile
HH : MM : SS

Enter the time the paramedics became mobile to the call scene.

Arrive Scene
HH : MM : SS

Enter the time the paramedics arrived at the call scene.

Patient Contact
HH : MM : SS

Enter the time the paramedics came into actual contact with the patient.

Depart Scene
HH : MM : SS

Enter the time the paramedics departed the scene of the call.

If there is a large discrepancy in time between departing the location where the patient was found and when the paramedics depart the scene in the ambulance, make a record of this in the remarks section (include time and circumstances).

Arrive Destination
HH : MM : SS

Enter the time the paramedics arrived at the receiving destination (*e.g.* hospital, long term care home).

Transfer of Care (TOC)

TOC
HH : MM :SS

Enter the time at which the paramedic concludes the process of transferring the responsibility of patient care to the receiving facility as outlined in the *Basic Life Support Patient Care Standards*.

This process includes providing a verbal report to the receiving facility, transferring care of the patient and the patient's belongings to the receiving facility and can be considered to be complete when the patient is no longer dependent on ambulance service resources (excluding equipment that is being left with the patient, e.g. spinal board).

Paramedic 1 (Attending) No.

Paramedic 1 (Attending) No.				

Enter the 5-digit MOHLTC assigned EHS Number for the paramedic attending on the call.

Name

Name

Enter the attending paramedic's name. At a minimum the name must include the first initial and full last name.

Designation

Designation

Enter the designation that describes the paramedic's certification level. Paramedic Designation codes are found on the reverse of the ACR. If a paramedic is functioning as a preceptor on the call, the letter "P" must be documented after the Paramedic Designation.

Signature No. 1

Signature No. 1

The attending paramedic writes his/her signature in this field. By signing the ACR, the paramedic attests that to the best of their knowledge the information on the form is complete and accurate.

Paramedic 2 No.

Paramedic 2 No.				

Enter the 5-digit MOHLTC assigned EHS Number for the other paramedic assigned to the call.

Name

Name

Enter the name of the other paramedic assigned to the call. At a minimum the name must include the first initial and full last name.

Designation

Designation

Enter the designation that describes the paramedic’s certification level. Paramedic Designation codes are found on the reverse of the ACR. If a paramedic is functioning as a preceptor on the call, the letter “P” must be documented after the Paramedic Designation.

Signature No. 2

Signature No. 2

The other paramedic assigned to the call writes his/her signature in this field. By signing the ACR, the paramedic attests that to the best of their knowledge the information on the form is complete and accurate.

Other



Space is provided on the ACR to enter the names and signatures for up to two (2) other individuals.

This section is only to be completed if an individual accompanies the patient in the ambulance to assist with or provide patient care (*e.g.* another paramedic, paramedic student, firefighter, nurse, etc.). It is not used to enter the names of individuals accompanying the patient in a non-patient care role (*e.g.* family members).

If another paramedic accompanies the transporting paramedics to assist with patient care, their 5-digit MOHLTC assigned EHS Number and designation must be entered along with their name and signature in the space provided.

Date/Time of ACR Completion

Date of ACR Completion YYYY / MM / DD	Time of ACR Completion HH : MM : SS
--	--

Enter the date and time that the ACR was completed and signed in this field.

Aid to Capacity Assessment

Reverse side of ACR

Aid to Capacity Evaluation (Record Details in 'Remarks' Section)		
Indicate to whom this assessment refers if not the patient [e.g., parent, or substitute decision maker (SDM)]		
<hr/>		
Patient verbalizes/communicates understanding of clinical situation? <i>(e.g., what is wrong with you?)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No - Requires consideration of capacity
Patient verbalizes/communicates appreciation of applicable risks? <i>(e.g. what could happen if I don't help you?)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No - Requires consideration of capacity
Patient verbalizes/communicates ability to make alternative plan for care? <i>(e.g. what will you do once I leave?)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No - Requires consideration of capacity
Responsible adult on scene	<input type="checkbox"/> Yes	<input type="checkbox"/> No

The “Aid to Capacity Assessment” found on the reverse side of the ACR is provided as a tool to assist paramedics in determining whether a patient or substitute decision maker (SDM) is capable of making decisions regarding their treatment.

A patient is presumed to be capable unless a crew has reasonable grounds to believe the patient is incapable to consent to the specific treatment proposed, on the basis of:

- Confused or delusional thinking.
- Unable to make a settled choice.
- Severe pain, acute fear/anxiety.
- Judgement impaired by drugs or alcohol.
- Other observations causing concern.

The patient should be able to demonstrate this understanding and acknowledge the consequences of the decision and this decision should not be based on delusional belief.

Indicate to whom this assessment refers if not the patient (*e.g.* parent, or other substitute decision-maker).

Enter the name of the substitute decision-maker on the line provided (the remainder of this capacity evaluation will then pertain to this substitute decision-maker).

If a substitute decision maker (*e.g.* authorized guardian, attorney for personal care, spouse or partner, child or parent, sibling, other relative) is present, he/she has the same authority as the incapable patient would have, if capable.

Patient verbalizes/communicates understanding of clinical situation.

Does the patient understand the condition he/she has that requires treatment?

Patient verbalizes/communicates appreciation of applicable risks.

Does the patient understand the nature and the risks of their condition and the risks/benefits of the proposed treatment?

Patient verbalizes/communicates ability to make alternative plan for care.

Does the patient have a plan for self-care after your departure?

Responsible adult on scene.

If a capable patient continues to refuse treatment, release the patient into the care of an apparently responsible adult. For the individual assuming responsibility of the patient, provide instructions regarding observation and patient management, physician follow-up, possible complications and other information as deemed appropriate.

Responses in shaded sections require consideration of incapacity.

If “No” is checked to any of the questions indicated in the “Aid to Capacity Evaluation” paramedics must consider whether this patient is capable of consenting to or refusing treatment or being left at the scene and not transported to a medical facility.

A person of any age may be capable to consent to some things and incapable of consent with respect to others, depending on the complexity of the treatment (*e.g.* they may understand what you tell them about oxygen but not about other medications).

Document all findings related to the assessment and the proposed treatment and all findings with respect to the patient’s capacity in the “Remarks” section of the ACR.

The “Refusal of Service” section is located on the reverse side of the ACR.

The “Refusal of Service” section must be completed any time there is a refusal of treatment and/or transportation by a patient or their substitute decision maker (SDM). In the event of a refusal of treatment and/or transport, the paramedic crew is to make every effort to have the patient or the patient’s substitute decision maker complete and sign the appropriate areas of the “Refusal of Service” section.

Patient/SDM

Patient/ Substitute decision maker (SDM) – print name and address / Patient/mandataire spécial (MS) – Nom et adresse en lettres moulées

Enter the name of the patient or SDM along with their respective address. If the “Refusal of Service” section is completed by the SDM, record their relationship to the patient. Obtain the patient or SDM signature and enter the date and time.

Attending Paramedic Signature

I have advised this patient or SDM of the risks to the patient's health that are involved. J'ai avisé le patient ou le MS des risques de cette décision pour la santé du patient.		
Time	Date	Attending Paramedic Signature
HH : MM	YYYY / MM / DD	

The attending paramedic will sign the ACR in the “Attending Paramedic Signature” within the “Refusal of Service” section and enter the time and date.

Paramedic 2/Witness Signature

I was witness to the above-mentioned refusal and that the person has been informed of the risks involved. J'ai été témoin du refus susmentionné et du fait que la personne a été informée des risques de ce refus.			
Time	Date	Non Paramedic Witness Name Nom du témoin autre qu'un ambulancier paramédical	Witness/Paramedic 2 Signature Signature du témoin/d'un 2 ^e ambulancier paramédical
HH : MM	YYYY / MM / DD		

The witness of the refusal will typically be the Paramedic 2 and therefore, is required to provide only a signature along with the time and date.

If there is only one paramedic attending a call, the paramedic is to make every effort to have a witness sign the form. If the witness is a non-paramedic, print the witnesses name under the ‘Non Paramedic Witness Name’ and have the witness sign the ACR.

If the patient, patient’s substitute decision maker, or witness refuses to sign the form, the paramedic crew shall document the circumstances in the “Remarks” section of the ACR.


The paramedic crew shall complete and sign the bottom portion of the “Refusal of Service” section in all cases where treatment and/or transport are refused by the patient or their substitute decision maker.

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Appendix A – Sample ACR



Sample ACR (Front – Left)

		Ministry of Health and Long-Term Care		<i>Confidential when completed</i>		Ambulance Call Report																	
							Hospital Registration Number																
Demographics																							
Service Name		Service No.	CACC/ACS	Call Number		Call Date YYYY / MM / DD																	
Last Name			First Name																				
Age	Sex	Weight (kg)	Date of Birth YYYY / MM / DD	Health Insurance Number		Version																	
Mailing Address Street No.		Street Name		City/Town		Province	Postal Code																
Pick-up Location or Sending Facility (City/Town) <input type="checkbox"/> Same as Mailing Address Above						Pick-up Code																	
Clinical Information																							
Date of Occurrence YYYY / MM / DD		Time of Occurrence HH : MM	Chief Complaint			<input type="checkbox"/> Positive for FREI																	
Incident History						MOHLTC DNR Confirmation Number																	
						<table border="1"> <thead> <tr> <th></th> <th>Trauma Location</th> <th>Problem Type</th> <th>Site/Mechanism</th> </tr> </thead> <tbody> <tr> <td>1</td> <td></td> <td></td> <td></td> </tr> <tr> <td>2</td> <td></td> <td></td> <td></td> </tr> <tr> <td>3</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>			Trauma Location	Problem Type	Site/Mechanism	1				2				3			
	Trauma Location	Problem Type	Site/Mechanism																				
1																							
2																							
3																							
Relevant Past History		Provided by:	<input type="checkbox"/> Patient	<input type="checkbox"/> Other:																			
<input type="checkbox"/> Previously Healthy		<input type="checkbox"/> Cardiac	<input type="checkbox"/> Stroke/TIA	<input type="checkbox"/> Seizure	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer	<input type="checkbox"/> CNO																
Details _____		<input type="checkbox"/> Respiratory	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Other (list below)																	
Medications		<input type="checkbox"/> None	<input type="checkbox"/> Nitrates	<input type="checkbox"/> Insulin/Oral Diabetic Meds	<input type="checkbox"/> Phosphodiesterase Inhibitors																		
Other _____		<input type="checkbox"/> CNO	<input type="checkbox"/> ASA	<input type="checkbox"/> Blood thinner/Anticoagulants	<input type="checkbox"/> Salbutamol	<input type="checkbox"/> Furosemide																	
Allergies		<input type="checkbox"/> NKA	<input type="checkbox"/> CNO	<input type="checkbox"/> Other – list below																			
Details _____																							
Treatment Prior to Arrival		<input type="checkbox"/> None	<input type="checkbox"/> EFRT	<input type="checkbox"/> Physician	<input type="checkbox"/> Fire	<input type="checkbox"/> Bystander	<input type="checkbox"/> CNO																
Details _____		<input type="checkbox"/> Midwife	<input type="checkbox"/> Other Paramedic	<input type="checkbox"/> Nurse	<input type="checkbox"/> Police	<input type="checkbox"/> Self	<input type="checkbox"/> Other (list below)																
Cardiac Arrest Information																							
Arrest Witnessed By		<input type="checkbox"/> Bystander	<input type="checkbox"/> Trained Responder	<input type="checkbox"/> Paramedic	<input type="checkbox"/> Unwitnessed	Date YYYY / MM / DD	Start Time HH : MM																
CPR Started By		<input type="checkbox"/> Bystander	<input type="checkbox"/> Trained Responder	<input type="checkbox"/> Paramedic	<input type="checkbox"/> None	YYYY / MM / DD	HH : MM																
First Shock By		<input type="checkbox"/> Bystander	<input type="checkbox"/> Trained Responder	<input type="checkbox"/> Paramedic		YYYY / MM / DD	HH : MM																
Physical Exam																							
General Appearance		Skin Colour _____			Skin Condition _____																		
Head/Neck Trachea <input type="checkbox"/> - Midline Shifted <input type="checkbox"/> - R <input type="checkbox"/> - L JVD <input type="checkbox"/> - Elevated <input type="checkbox"/> - Not Elevated																							
Chest Air Entry <input type="checkbox"/> - Bilaterally Decreased <input type="checkbox"/> - R <input type="checkbox"/> - L Breath Sounds <input type="checkbox"/> - Clear <input type="checkbox"/> - Wheezes <input type="checkbox"/> - Crackles <input type="checkbox"/> - Rub <input type="checkbox"/> - Absent																							
Abdomen <input type="checkbox"/> - Soft <input type="checkbox"/> - Rigid <input type="checkbox"/> - Distended <input type="checkbox"/> - Tender <input type="checkbox"/> - Mass <input type="checkbox"/> - Pulsatile <input type="checkbox"/> - RU <input type="checkbox"/> - LU <input type="checkbox"/> - LL <input type="checkbox"/> - RL <input type="checkbox"/> - Center																							
Back/Pelvis <input type="checkbox"/> - Unremarkable																							
Extremities <input type="checkbox"/> - Unremarkable Peripheral Edema <input type="checkbox"/> - Absent <input type="checkbox"/> - Present Pedal Pulse <input type="checkbox"/> - Absent <input type="checkbox"/> - Present																							
1881-45 (2015/11) © Queen's Printer for Ontario, 2015 7530-4714																							

Sample ACR (Billing)

		Ministry of Health and Long-Term Care		<i>Confidential when completed</i>		Ambulance Call Report			
							Hospital Registration Number		
Demographics									
Service Name		Service No.	CACC/ACS	Call Number			Call Date YYYY / MM / DD		
Last Name				First Name					
Age	Sex	Weight (kg)	Date of Birth YYYY / MM / DD	Health Insurance Number			Version		
Mailing Address Street No. Street Name		City/Town		Province	Postal Code	Country			
Pick-up Location or Sending Facility (City/Town)				<input type="checkbox"/> Same as Mailing Address Above			Pick-up Code		
Billing Information									
Charge <input type="checkbox"/> Patient <input type="checkbox"/> Employer <input type="checkbox"/> W.S.I.B. <input type="checkbox"/> D.V.A. <input type="checkbox"/> D.N.D. <input type="checkbox"/> Coroner <input type="checkbox"/> Chargeable Welfare <input type="checkbox"/> Other		No Charge <input type="checkbox"/> Inter-Hospital Transfer <input type="checkbox"/> Home Care <input type="checkbox"/> Homes for Special Care <input type="checkbox"/> Nursing Home Patient <input type="checkbox"/> Home for the Aged <input type="checkbox"/> Recipient General Welfare Assistance <input type="checkbox"/> Other		Billing Evaluation In my professional medical opinion ambulance use was: <input type="checkbox"/> Essential: a medical/other necessity <input type="checkbox"/> Non essential: not a medical necessity/other transport suitable Signature (medical practitioner/approved authority)			<input type="checkbox"/> Payment Received Initials Disposition in Hospital Emergency Dept. <input type="checkbox"/> Refused treatment and released <input type="checkbox"/> treated (observed) and released <input type="checkbox"/> Admitted <input type="checkbox"/> Morgue <input type="checkbox"/> Transferred to another hospital		
DND/RCMP Social Insurance No.		Basic Fee Patient's portion ↓ ↑		Billed by <input type="checkbox"/> Hospital/Clinic <input type="checkbox"/> Operator <input type="checkbox"/> Other				Out Patient <input type="checkbox"/> O.P. Clinic <input type="checkbox"/> Ca. Clinic <input type="checkbox"/> X-Ray <input type="checkbox"/> Other <input type="checkbox"/> In-patient returning <input type="checkbox"/> In-patient discharged	
Registration No.		Hospital Code		Charge for km over 40 ↓ ↑		Other charge ↓ ↑			
				Amount billed ↓ ↑					
1881-45 (2015/10)		Billing Copy				7530-4714			

Sample ACR (Back – Left)

Station Codes	Cardiac	Rhythm Codes	IV Procedures
00 Station #	51 Ischemic	10 Sinus Tachycardia	340 IV Monitoring
01	53 Palpitations	11 PSVT/ST/Atrial Tachycardia	341 IV Cannulation
02	54 Pulmonary Edema	12 Atrial Flutter	342 Lock
etc.	55 Post Arrest	13 Atrial Fibrillation	345 Normal Saline
	56 Cardiogenic Shock	14 Ventricular Tachycardia	349 Other IV Solutions
	57 STEMI	20 Sinus Bradycardia	350 IV Cannulation Unsuccessful
	58 Hyperkalemia	21 First Degree Block	351 Fluid Bous
Status Codes	Non-Traumatic	22 Second Degree Block	353 Blood Sampling
00 At Base	60 Non Ischemic Chest Pain	23 Third Degree Block	355 IV Discontinued (Intentional)
77 Mobile	61 Abdominal/Pelvic/Perineal/Rectal Pain	30 Ventricular Fibrillation	356 IV Discontinued (Unintentional)
88 Standby Location	62 Back Pain	31 Pulseless Ventricular Tachycardia	358 Intraosseous Cannulation Successful
99 Maintenance		32 PEA	359 Intraosseous Cannulation Unsuccessful
Dispatch Priority Codes	Gastrointestinal	33 Asystole	360 Blood/Blood Product Administration
1 Deferrable	63 Nausea/Vomiting/Diarhea	40 NSR	361 CVAD Access
2 Scheduled		42 Paced Rhythm	
3 Prompt	Musculoskeletal/Trauma	43 Junctional Rhythm	Miscellaneous Procedures
4 Urgent	65 Musculoskeletal	44 Sinus Dysrhythmia	366 Termination of Resuscitation – Terminal
8 Standby	67 Trauma/Injury	46 Other (Detail in Procedures)	367 Termination of Resuscitation – Trauma
9 Out of Service/Administration			370 Other Procedure (Detail in Procedures)
Return Priority Codes	Obstetrical/Gynecological	Procedures	372 Carboxyhemoglobin (SpCO)
1 Deferrable	70 Obstetrical <20 weeks	010 Vital Signs	375 Emerg. Dialysis Disconnect
2 Scheduled	71 Obstetrical Emergency	020 Patient Assessment	390 Transfer of Care – Crew to Crew
3 Prompt	72 Gynecological Emergency	025 Blood Sampling-Glucose Determination	400 Base Hospital Physician Patch
4 Urgent	73 Newborn/Neonatal	100 Dressing	401 Receiving Hospital Notified
6 Transport of Deceased Patient	74 Obstetrical ≥20 weeks	101 Control Bleeding	402 BHP Patch Failure (Detail in Results)
		102 Arterial Tourniquet	403 BHP Patch – No BHP Contact
Return Priority-No Transport	Endocrine/Toxicologic	105 Immobilization-Head	404 Coroner Notified
71 No Patient Found	81 Drug/Alcohol Overdose	110 Splint Other	405 Study Procedure (Detail in Procedures)
72 Patient Refused	82 Poisoning/Toxic Exposure	111 Cervical Collar	406 Non Dialysis – CVAD Disconnect
73 Patient Deceased	83 Diabetic Emergency	112 Spinal Board	407 Health Screening Tool
74 Patient in Police Custody	84 Allergic Reaction	113 Junctional Immobolization Extrication Device	
75 Transported by Other Ambulance	85 Anaphylaxis	114 Traction Splint	Medications
8 Standby		115 Adjustable Break Away Stretcher	498 Acetaminophen
9 Out of Service/Administration	General and Minor	116 Lifting Chair	500 Adenosine
	87 Novel Medications	120 Suction	502 Amiodarone
Special Transport Codes	88 Home Medical Technology	129 Oxygen – Filtered High Conc. Mask	503 Antibiotic
01 Pt. Meets Trauma Criteria	89 Lift Assist	130 Oxygen – Assist Conc. Mask	504 ASA
02 No Trauma Bypass – Pt. Condition	90 Inter-facility Transfer	131 Oxygen – Simple Face Mask	505 Atropine
03 No Trauma Bypass – Environmental Emergency	91 Environmental Emergency	132 Oxygen – Nasal Cannula	525 Calcium Gluconate
04 Pt. Meets Stroke Criteria	92 Weakness/Dizziness/Urweil Treatment/Diagnosis & Return Home	133 Oxygen – Other	530 Dextrose
05 No Stroke Bypass – Pt. Condition	93 Convalescent/Invalid/Return Home	141 Oxygen – BVM	531 Diazepam
06 No Stroke Bypass – Hospital Refusal	95 Infectious Disease	142 Oxygen – Mechanical Ventilator	533 Dimenhydrinate
07 Pt. Meets STEMI Criteria	96 Organ Retrieval/Transfer	144 Oxygen – Pocket Mask	534 Diphenhydramine
08 No STEMI Bypass – Pt. Condition	98 Organ Recipient	150 Extricate Patient – e.g. Remove from small room where care cannot be provided	536 Dopamine
09 No STEMI Bypass – Hospital Refusal	99 Other Medical/Trauma (see remarks)	160 OB Delivery	540 Epinephrine 1:1,000
		170 Oro/Nasopharyngeal Airway	541 Epinephrine 1:10,000
Pick-up Codes	Site/Type Codes	180 Restrain Patient-Physical	550 Fentanyl
A Airport/Heliport	A Location	189 Abdo/Chest/Back Thrusts	551 Furosemide
B Apartment/Condo Building	10 Head/Face/Ear/Scalp	211 Symbiot Assist Medication (e.g., Assisted Pt. with own meds)	560 Glucagon
C Construction Site	11 Eye	231 Pt. Transported Supine	561 Glucose-Oral
D Medical Office/Clinic	12 Neck	232 Pt. Transported Semi-Prone	562 Hydrocortisone
E Nursing Outpost	13 Shoulder	233 Pt. Transported Prone	593 Lidocaine
F Factory/Industrial Site/Railway/Dockyard	14 Back/Flank	234 Pt. Transported Semi-Sitting	603 Midazolam
G Hotel	15 Chest	235 Pt. Transported Sitting	604 Morphine
H Hospital (Acute and Non-Acute)	16 Abdomen	236 Ambulatory	610 Naloxone
I Indoor Shopping Mall	17 Pelvis	237 Pt. Transported Lateral	615 Nitroglycerin
J Jail/Prison	18 Genitourinary	239 Infant Restraint Device	620 Oxycotin
K Single Store/Strip Mall	19 Buttocks/Perineum/Rectum	Cardiac Arrest Procedures	650 Salbutamol
L School/College/University	20 Arm (Upper/Elbow/Forearm/Wrist)	297 Therapeutic Hypothermia	651 Sodium Bicarbonate
M Mining Site/Quarry	21 Hand/Finger	298 Defibrillation – Pads On	682 Xylometazoline
N Long-Term Care Home	22 Thigh	299 Automated CPR Device	700 Other Drugs – Detail in Procedures
O Office Building	23 Leg (Knee/Lower Leg/Ankle)	300 CPR	701 Anaesthetic Eye Drops
P Sports Facility/Arena	24 Foot/Toes	301 Rhythm Interpretation	706 Ketorolac
Q Farm	25 Hip	302 Cardioversion	708 Cnidaxime
R House/Town House	B Type	303 Valsalva Manoeuver	710 Pralidoxime Chloride
S Street/Highway/Road	30 Abrasion	306 Defibrillation – Manual	712 Sodium Thiosulfate
T Fairground/Park	31 Amputation	307 Defibrillation – Semi-Automated	800-899 Study Drugs – Details in Procedures
U Retirement Home	32 Avulsion	308 Analyze – SAED	900-999 User Defined
V Golf Course	33 Burn	309 External Pacing	
W Water/Boat	34 Blunt	313 12-Lead Acquisition	Routes of Administration
X Restaurant/Bar	35 Crush	316 Return of Spontaneous Circulation	AE Aerosol
Y Casino	36 Contusion	Airway/Breathing Procedures	BU Buccal
Z Other (Describe in Remarks)	37 Penetrating/Puncture	317 Return of Spontaneous Respiration	ET Endotracheal
	38 Possible Fracture/Dislocation	318 Supraglottic/Alternate Airway Unsuccessful	IM Intramuscular
	39 Laceration	319 Supraglottic/Alternate Airway Unsuccessful	IN Intranasal
	40 Sprain/Strain	320 Needle Thoracostomy	IO Intraosseous
	41 Paralysis/Paresis/esthesia	321 Needle Thoracostomy Unsuccessful	IV Intravenous
	42 Other (Detail in Incident Hx)	322 Needle/Surgical Cricothyrotomy	NB Nebulized
Problem Codes	C Mechanism	323 Needle/Surgical Cricothyrotomy Unsuccessful	PO Oral
VSA	50 Assault	324 Nasotracheal Intubation	PR Rectal
01 Cardiac/Medical	51 Drowning	325 Nasotracheal Intubation Unsuccessful	SL Sublingual
02 Traumatic	52 Electrocutation	326 Orotracheal Intubation	SC Subcutaneous
Airway	53 Fall (Same Level)	327 Orotracheal Intubation Unsuccessful	TO Topical
11 Obstruction (Partial/Complete)	54 Fall from Height/Diving	328 ETT Suctioning	
Breathing	55 Gunshot	331 Magill Forceps/Foreign Body Removal Unsuccessful	Paramedic Designation
21 Dyspnea	56 Hanging	332 Magill Forceps/Foreign Body Removal Unsuccessful	1 Student
24 Respiratory Arrest	57 Machinery	333 Extubation – Any Advanced Airway (Intentional)	2 EMA
Circulation	58 MVC	334 Extubation – Any Advanced Airway (Unintentional)	3 PCP
31 Hemorrhage	59 Motorcycle/Recreational Vehicle	335 Needle Thoracostomy One-way Valve Monitored	4 ACP
33 Hypotension	60 Pedal Bicycle	336 Respiratory System Eval. (ETCO ₂ and SAO ₂)	5 CCP
34 Suspected Sepsis	61 Pedestrian Struck	337 ETT Confirmation	
Neurological	62 Sports	338 SpO ₂	CTAS Codes
41 Stroke/TIA	63 Stabbing	339 PEPF	1 Resuscitation
42 Temp. Loss of Consciousness	64 Fire/Explosion/Thermal	360 Alternative Airway	2 Emergent
43 Altered Level of Consciousness	65 Smoke/Chemical Exposure	361 Alternative Airway – Unsuccessful	3 Urgent
44 Headache	66 Other (detail in Mechanism of Incident Hx)	362 Airway Adjunct/Bougie	4 Less Urgent
45 Behaviour/Psychiatric	Final Patient Status (Destination vs. First Contact)	363 CPAP	5 Non Urgent
46 Active Seizure	4 Improved	384 CPAP - unsuccessful	0 Obviously Dead/TOR
47 Paralysis/Spinal Trauma	4 No Change		
48 Confusion/Disorientation	6 Deteriorated		
49 Unconscious			
50 Post-ictal			

Sample ACR (Back – Right)

Reference Information																																																							
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2" style="text-align: center;">Skin</th> </tr> <tr> <th style="width: 50%;">Colour</th> <th style="width: 50%;">Condition</th> </tr> </thead> <tbody> <tr> <td>Flushed</td> <td>Dry</td> </tr> <tr> <td>Pale</td> <td>Clammy</td> </tr> <tr> <td>Cyanosis</td> <td>Diaphoretic</td> </tr> <tr> <td>Jaundice</td> <td>Unremarkable</td> </tr> <tr> <td>Unremarkable</td> <td></td> </tr> </tbody> </table>		Skin		Colour	Condition	Flushed	Dry	Pale	Clammy	Cyanosis	Diaphoretic	Jaundice	Unremarkable	Unremarkable		<p style="text-align: center;">0 1 2 3 4 5 6 7 8 9 10</p> <p style="text-align: center;">No Pain Mild Pain Moderate Pain Severe Pain Worst Possible Pain</p>																																							
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4 Spontaneous	5 Coos or babbles	6 Obeys commands																																																					
3 To Speech	4 Irritable & constantly cries	5 Withdraws from touch																																																					
2 To Pain	3 Cries to pain	4 Withdraws from pain																																																					
1 None	2 Moans to pain	3 Flexion to pain																																																					
	1 None	2 Extension to pain																																																					
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<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="4" style="text-align: center;">APGAR Score</th> </tr> <tr> <th style="width: 25%;">Parameter</th> <th style="width: 12.5%;">0</th> <th style="width: 12.5%;">1</th> <th style="width: 12.5%;">2</th> </tr> </thead> <tbody> <tr> <td>Appearance</td> <td>Blue or Pale</td> <td>Pink body with blue extremities</td> <td>Completely pink</td> </tr> <tr> <td>Pulse (BPM)</td> <td>0 (absent)</td> <td>slow (<100)</td> <td>≥100</td> </tr> <tr> <td>Grimace Response</td> <td>None</td> <td>Some grimace</td> <td>Good grimace</td> </tr> <tr> <td>Activity and Muscle Tone</td> <td>None, limp</td> <td>Some flexion</td> <td>Active, motion</td> </tr> <tr> <td>Respiratory Effort</td> <td>absent</td> <td><60 min</td> <td>Good, crying</td> </tr> </tbody> </table> <p>APGAR performed at 1 & 5 minutes after delivery Don't wait for APGAR to make decision on resuscitation</p>		APGAR Score				Parameter	0	1	2	Appearance	Blue or Pale	Pink body with blue extremities	Completely pink	Pulse (BPM)	0 (absent)	slow (<100)	≥100	Grimace Response	None	Some grimace	Good grimace	Activity and Muscle Tone	None, limp	Some flexion	Active, motion	Respiratory Effort	absent	<60 min	Good, crying	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="3" style="text-align: center;">Normal Pediatric Vital Signs</th> </tr> <tr> <th style="width: 33%;">Age</th> <th style="width: 33%;">Respiratory Rate</th> <th style="width: 33%;">Heart Rate</th> </tr> </thead> <tbody> <tr> <td>0 – 3 months</td> <td>30 - 60</td> <td>90 - 180</td> </tr> <tr> <td>3 – 6 months</td> <td>30 - 60</td> <td>80 - 160</td> </tr> <tr> <td>6 – 12 months</td> <td>25 - 45</td> <td>80 - 140</td> </tr> <tr> <td>1 – 3 years</td> <td>20 - 30</td> <td>75 - 130</td> </tr> <tr> <td>6 years</td> <td>16 - 24</td> <td>70 - 110</td> </tr> <tr> <td>10 years</td> <td>14 - 20</td> <td>60 - 90</td> </tr> </tbody> </table> <p>Systolic Blood Pressure (for children 1-10 yrs) = 70 + (2x age in years) Weight (kg) = (age x 2) + 10</p>		Normal Pediatric Vital Signs			Age	Respiratory Rate	Heart Rate	0 – 3 months	30 - 60	90 - 180	3 – 6 months	30 - 60	80 - 160	6 – 12 months	25 - 45	80 - 140	1 – 3 years	20 - 30	75 - 130	6 years	16 - 24	70 - 110	10 years	14 - 20	60 - 90
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<p>Aid to Capacity Evaluation (Record Details in 'Remarks' Section)</p> <p>Indicate to whom this assessment refers if not the patient [e.g., parent, or substitute decision maker (SDM)]</p> <hr/> <p>Patient verbalizes/communicates understanding of clinical situation? (e.g., what is wrong with you?) <input type="checkbox"/> Yes <input type="checkbox"/> No - Requires consideration of capacity</p> <p>Patient verbalizes/communicates appreciation of applicable risks? (e.g., what could happen if I don't help you?) <input type="checkbox"/> Yes <input type="checkbox"/> No - Requires consideration of capacity</p> <p>Patient verbalizes/communicates ability to make alternative plan for care? (e.g., what will you do once I leave?) <input type="checkbox"/> Yes <input type="checkbox"/> No - Requires consideration of capacity</p> <p>Responsible adult on scene <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																																																							
<p>Refusal of Service – I have been advised that treatment and/or transportation is available immediately. I refuse such treatment and/or transportation to hospital having been informed of the risks involved. I assume full responsibility arising out of such refusal.</p> <p>Refus de service – On m'a avisé que je pouvais être traité ou transporté à l'hôpital immédiatement. Je refuse d'être traité ou transporté à l'hôpital. J'ai été informé des risques auxquels cette décision m'expose. J'assume l'entière responsabilité de ce refus.</p> <p>Patient/ Substitute decision maker (SDM) – print name and address / Patient/mandataire spécial (MS) – Nom et adresse en lettres moulées</p> <hr/> <p>If SDM, relationship to Patient / Si MS, relation avec le patient</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Time</td> <td style="width: 15%;">Date</td> <td style="width: 70%;">Signature of Patient or SDM / Signature du patient ou du MS</td> </tr> <tr> <td>HH : MM</td> <td>YYYY / MM / DD</td> <td></td> </tr> </table> <p>I have advised this patient or SDM of the risks to the patient's health that are involved. J'ai avisé le patient ou le MS ces risques de cette décision pour la santé du patient.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Time</td> <td style="width: 15%;">Date</td> <td style="width: 70%;">Attending Paramedic Signature</td> </tr> <tr> <td>HH : MM</td> <td>YYYY / MM / DD</td> <td></td> </tr> </table> <p>I was witness to the above-mentioned refusal and that the person has been informed of the risks involved. J'ai été témoin du refus susmentionné et du fait que la personne a été informée des risques de ce refus.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Time</td> <td style="width: 15%;">Date</td> <td style="width: 35%;">Non Paramedic Witness Name Nom du témoin autre qu'un ambulancier paramédical</td> <td style="width: 35%;">Witness/Paramedic 2 Signature Signature du témoin/d'un 2^e ambulancier paramédical</td> </tr> <tr> <td>HH : MM</td> <td>YYYY / MM / DD</td> <td></td> <td></td> </tr> </table>				Time	Date	Signature of Patient or SDM / Signature du patient ou du MS	HH : MM	YYYY / MM / DD		Time	Date	Attending Paramedic Signature	HH : MM	YYYY / MM / DD		Time	Date	Non Paramedic Witness Name Nom du témoin autre qu'un ambulancier paramédical	Witness/Paramedic 2 Signature Signature du témoin/d'un 2 ^e ambulancier paramédical	HH : MM	YYYY / MM / DD																																		
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