DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

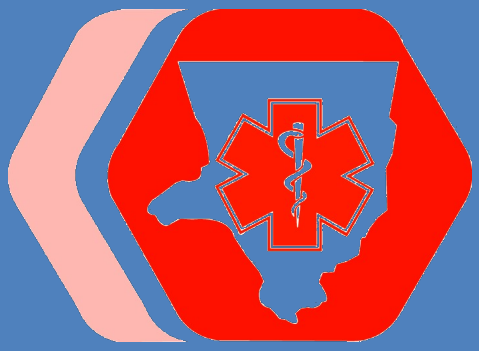
SUBJECT: **BASE HOSPITAL DOCUMENTATION MANUAL**

MICN/BASE PHYSICIAN
REFERENCE NO. 644

Base Hospital Documentation Manual

Los Angeles County

Emergency Medical Services Agency



LANCET TECHNOLOGY
Innovative Data Solutions
by eso

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COMMON NULL VALUES

Definition

These values are to be used with each of the data elements described in this document which have been defined to accept the Null Values

Field Values

- **F6**: Not Documented
- **F7**: Not Applicable

Additional Information

- For any collection of data to be of value and reliably represent intended information, a strong commitment must be made to ensure that data collected are complete and accurate
- Not Documented: This null value code applies if the documentation being referenced has nothing recorded in a specific field
- Not Applicable: This null value code applies if the data field referenced does not apply to the patient (e.g., “Reason for No Transport” if patient was transported)

NOTIFICATIONS

LOG

Definition

Number assigned by the hospital to each notification call that coincides with its numbered entry on a notification call log

Additional Information

- **Required** field for all notification calls
- Format is unique to each individual hospital
- Enter information into 'Log #' field on Base 1 tab in TEMIS. Information entered will auto-fill 'Log #' field on Notification tab

Uses

- Assists in locating the coinciding audio file

Data Source Hierarchy

- Notification Form
- Notification Log

NOTIFICATION ONLY?

Definition

Field indicating whether record being entered into TEMIS was a notification call

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- Field is auto-filled with “N” and should be changed by user to “Y” when entering a notification call
- If changed to “Y”, go directly to the Notification tab to do data entry, do not enter any data into any other fields on the Base 1, Base 2, or Dispo/QI tabs
- Notifications, regardless if received from another base hospital or a public provider and regardless of the method, the base line or land line, utilized to make the notification, need to be entered into TEMIS
- If a base hospital erroneously receives a notification for a patient that is <u>not</u> transported to their facility, those notifications should <u>not</u> be entered
- Notifications from <u>public</u> providers for 9-1-1 IFTs need to be entered
- Notifications from <u>private</u> providers for IFTs and non-9-1-1 calls should <u>not</u> be entered

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Notification Form
- Notification Log
- Audio Records

SEQUENCE NUMBER

Definition

Unique, alphanumeric EMS record number provided by the paramedic, and found pre-printed at the top right corner of EMS report form hard copies. Electronically assigned to electronic patient care records (ePCRs) from approved providers

Additional Information

- **Required** field for all notification calls: data entry cannot begin without this number
- Consists of two letters and six digits on pre-printed EMS Report Forms; or two letters, ten digits if obtained from an approved ePCR provider. Neither format should contain spaces.
- If sequence number is missing or incorrectly documented, every effort must be taken by the base hospital to obtain it – either by reviewing the audio recording, or by contacting the appropriate provider agency directly. Only after all efforts to obtain the actual sequence number have been exhausted may a request be made of the EMS Agency for assistance, or as a last resort, a 'dummy' sequence number, in a **timely** fashion.
- A fictitious sequence number **should not** be generated for any reason.

Uses

- Unique patient identifier
- Essential link between other EMS Agency databases

Data Source Hierarchy

- Notification Form
- Notification Log
- Audio Records
- EMS Record
- Fire Station Logs
- EMS Agency

DATE

Definition

Date of notification call

Field Values

- Collected as MMDDYYYY

Additional Information

- **Required** field for all notification calls
- Excluding midnight crossover from New Year's Eve to New Year's Day, the last two digits of the date must match the first two numeric digits in a 12-digit sequence number

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- Notification Form
- Notification Log

TIME

Definition

Time of day that notification was initiated

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- **Required** field for all notification calls

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- Notification Form
- Notification Log

PROVIDER CODE

Definition

Two-letter code for the EMS provider primarily responsible for the patient's prehospital care

Field Values

PUBLIC PROVIDERS			
AF	Arcadia Fire	**LV**	La Verne Fire
AH	Alhambra Fire	**MB**	Manhattan Beach Fire
AV	Avalon Fire	**MF**	Monrovia Fire
BA	Burbank Airport Fire	**MO**	Montebello Fire
BF	Burbank Fire	**MP**	Monterey Park Fire
BH	Beverly Hills Fire	**OT**	Other Provider
CC	Culver City Fire	**PF**	Pasadena Fire
CF	LA County Fire	**RB**	Redondo Beach Fire
CG	US Coast Guard	**SA**	San Marino Fire
CI	LA City Fire	**SG**	San Gabriel Fire
CM	Compton Fire	**SI**	Sierra Madre Fire
CS	LA County Sheriff	**SM**	Santa Monica Fire
DF	Downey Fire	**SP**	South Pasadena Fire
ES	El Segundo Fire	**SS**	Santa Fe Springs Fire
FS	U.S. Forest Service	**TF**	Torrance Fire
GL	Glendale Fire	**VE**	Ventura County Fire
LB	Long Beach Fire	**VF**	Vernon Fire
LH	La Habra Heights Fire	**WC**	West Covina Fire
PRIVATE PROVIDERS			
AR	American Medical Response	**WM**	West Med/McCormick Ambulance Service
CA	CARE Ambulance		

Additional Information

- **Required** field for all notification calls
- Refers to the public EMS provider agency providing notification for arrival of 9-1-1 patients, including 9-1-1 IFTs, or the transporting provider for calls downgraded from ALS to BLS
- Notification of arrival of IFTs or non-9-1-1 calls from private providers should not be entered

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Notification Form
- Notification Log
- Audio Records

PROVIDER UNIT

Definition

Alphanumeric apparatus code consisting of type of vehicle + numeric vehicle identifier for the paramedic unit establishing base contact or providing notification

Field Values

- AB: Private Ambulance
- AT: Assessment Truck
- AE: Assessment Engine
- BK: Bike
- BT: Boat
- CT: Cart
- HE: Helicopter
- PE: Paramedic Engine
- PT: Paramedic Truck
- SQ: Squad
- RA: Rescue

Additional Information

- **Required** field for all notification calls
- This is a free-text field – the values above reflect those commonly used by EMS providers

Uses

- System evaluation and monitoring

Data Hierarchy

- Notification Form
- Notification Log
- Audio Records

AGE

Definition

Numeric value for the age (actual or best approximation) of the patient

Field Values

- Enter the numeric age value

Additional Information

- **Required** field for all notification calls
- Must also indicate unit of age

Uses

- Allows for data sorting and tracking by age
- Assists with patient identification
- Epidemiological statistics

Data Source Hierarchy

- Notification Form
- Notification Log
- Audio Records

AGE UNITS

Definition

Checkboxes indicating units of measurement used to report the age of the patient

Field Values

- **Y**rs: Years – used for patients 2 years old or older
- **YE:** Years Estimated
- **M**os: Months – used for patients 1 month to 23 months old
- **ME:** Months Estimated
- **W**ks: Weeks – used for patients whose age is reported in weeks instead of months
- **WE:** Weeks Estimated
- **D**ays: Days – used for patients 1 to 29 days old
- **DE:** Days Estimated
- **H**rs: Hours – used for patients who are newborn and up to 23 hours old
- **HE:** Hours Estimated

Additional Information

- **Required** field for all notification calls

Uses

- Assists with patient identification
- Epidemiological statistics
- System evaluation and monitoring

Data Source Hierarchy

- Notification Form
- Notification Log
- Audio Records

GENDER

Definition

Checkbox indicating the gender of the patient

Field Values

- **M**: Male
- **F**: Female
- **N**: Nonbinary

Additional Information

- **Required** field for all notification calls
- Patients who are undergoing or have undergone a hormonal and/or surgical sex reassignment should be coded using their stated preference
- Patients unable to state their preference should be coded per paramedic observation/judgment
- Nonbinary is a gender option within the State of California for individuals whose gender identity is not exclusively male or female

Uses

- Assists with patient identification
- Epidemiological statistics
- System evaluation and monitoring

Data Source Hierarchy

- Notification Form
- Notification Log
- Audio Records

PROVIDER IMPRESSION

Definition

Four-letter code(s) representing the provider's impression of the patient's presentation

Field Values

ABOP	Abdominal Pain/Problems	**ELCT**	Electrocution	**PREG**	Pregnancy Complications
AGDE	Agitated Delirium	**ENTP**	ENT/Dental Emergencies	**LABR**	Pregnancy/Labor
CHOK	Airway Obstruction/Choking	**NOBL**	Epistaxis	**RARF**	Respiratory Arrest/Failure
ETOH	Alcohol Intoxication	**EXNT**	Extremity Pain/Swelling – Non-Traumatic	**SOBB**	Resp. Distress/Bronchospasm
ALRX	Allergic Reaction	**EYEP**	Eye Problem – Unspecified	**RDOT**	Resp. Distress/Other
ALOC	ALOC – Not Hypoglycemia or Seizure	**FEVR**	Fever	**CHFF**	Resp. Distress/Pulmonary Edema/CHF
ANPH	Anaphylaxis	**GUDO**	Genitourinary Disorder – Unspecified	**SEAC**	Seizure – Active
PSYC	Behavioral/Psychiatric Crisis	**DCON**	HazMat Exposure	**SEPI**	Seizure – Postictal
BPNT	Body Pain – Non-Traumatic	**HPNT**	Headache – Non-Traumatic	**SEPS**	Sepsis
BRUE	BRUE	**HYPR**	Hyperglycemia	**SHOK**	Shock
BURN	Burns	**HYTN**	Hypertension	**SMOK**	Smoke Inhalation
COMO	Carbon Monoxide	**HEAT**	Hyperthermia	**STNG**	Stings/Venomous Bites
CANT	Cardiac Arrest– Non-Traumatic	**HYPO**	Hypoglycemia	**STRK**	Stroke/CVA/TIA
DYSR	Cardiac Dysrhythmia	**HOTN**	Hypotension	**DRWN**	Submersion/Drowning
CPNC	Chest Pain – Not Cardiac	**COLD**	Hypothermia/Cold Injury	**SYNC**	Syncope/Near Syncope
CPMI	Chest Pain – STEMI	**INHL**	Inhalation Injury	**CABT**	Traumatic Arrest – Blunt
CPSC	Chest Pain – Suspected Cardiac	**LOGI**	Lower GI Bleeding	**CAPT**	Traumatic Arrest – Penetrating
BRTH	Childbirth (Mother)	**FAIL**	Medical Device Malfunction – Fail	**TRMA**	Traumatic Injury
COFL	Cold/Flu Symptoms	**NAVM**	Nausea/Vomiting	**UPGI**	Upper GI Bleeding
DRHA	Diarrhea	**BABY**	Newborn	**VABL**	Vaginal Bleeding
DIZZ	Dizziness/Vertigo	**NOMC**	No Medical Complaint	**WEAK**	Weakness – General
DEAD	DOA – Obvious Death	**ODPO**	Overdose/Poisoning/Ingestion		
DYRX	Dystonic Reaction	**PALP**	Palpitations		

Additional Information

- **Required** field for all notification calls
- First copy of Provider Impression cannot be a null value
- Do not enter more than one copy of the same Provider Impression code

Uses

- System evaluation and monitoring
- Epidemiological statistics

Data Source Hierarchy

- Notification Form
- Notification Log
- Audio Records

HOSP DISPO

Definition

Checkbox indicating the emergency department disposition of patients transported to the base hospital as the receiving facility

Field Values

- **D**ischarged: Patient was discharged home from the emergency department
- **W**ard: Patient was admitted to a medical/surgical ward
- **S**tepdown: Patient was admitted to a Direct Observation Unit (DOU), Stepdown Unit, or Telemetry Unit
- **I**CU: Patient was admitted to an Intensive Care Unit or Cardiac Care Unit
- Obser**V**ation: Observation unit (provides < 24 hour stays)
- O**R**: Patient was transferred directly from the emergency department to the operating room
- **C**ath Lab: Patient was transferred directly from the emergency department to the Cardiac Catheterization Lab
- I**N**terventional Radiology: Patient was transferred directly from the emergency department to Interventional Radiology for embolization, angiography, etc.
- **E**xpired in ED: Patient died in the emergency department
- O**B**: Patient was admitted to an obstetrics department
- **T**ransferred to: Patient was transferred directly from the emergency department to another healthcare facility – document the name of the facility or the three-letter hospital code in the space provided
- **O**ther: Patient disposition other than those listed above – document disposition on the line provided
- ED Diagnosis: Emergency department diagnosis as documented by a physician – is entered into TEMIS as an ICD-10 code

Additional Information

- **Required** field for all patients for whom the base hospital notified is also the receiving facility
- May be completed later by personnel other than the MICN/MD initially notified

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Notification Form
- Notification Log
- ED Records
- Other Hospital Records

DISPO COMM.

Definition

Space provided for documentation of any additional information related to the patient's disposition from the ED

Field Values

- Free text

Uses

- Space for documentation, if needed

Data Source Hierarchy

- Notification Form
- Notification Log
- ED Records
- Other Hospital Records

DIAGNOSIS

Definition

Emergency department diagnosis as documented by a physician

Field Values

- ICD-10 codes

Additional Information

- **Required** field for all patients for whom the base hospital notified is also the receiving facility
- May be completed later by personnel other than the MICN/MD initially notified

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Notification Form
- Notification Log
- ED Records
- Other Hospital Records

BASE CONTACTS

GEN INFO

LOG

Definition

Number assigned by the hospital to each base contact that coincides with its numbered entry on a base contact call log

Additional Information

- **Required** field for all base hospital contacts
- Format is unique to each individual hospital

Uses

- Unique patient identifier
- Assists in locating the coinciding audio file

Data Source Hierarchy

- Base Hospital Log
- Base Hospital Form

NOTIFICATION ONLY?

Definition

Field indicating whether record being entered into TEMIS was a notification call

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- Field is auto-filled with “N” and should remain as “N” for all base contacts entered into TEMIS

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Audio Records

MCI PATIENT?

Definition

Field indicating whether the incident involved three or more patients

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- Field is auto filled with “N” unless changed by user to “Y”

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

SEQUENCE NUMBER

Definition

Unique, alphanumeric EMS record number provided by the paramedic, and found pre-printed at the top right corner of EMS report form hard copies. Electronically assigned to ePCRs from approved providers

Additional Information

- **Required** field for all base hospital contacts: data entry cannot begin without this number
- Consists of two letters and six digits on pre-printed EMS Report Forms; or two letters, ten digits if obtained from an approved ePCR provider. Neither format should contain spaces.
- If sequence number is missing or incorrectly documented, every effort must be taken by the base hospital to obtain it – either by reviewing the audio recording, or by contacting the appropriate provider agency directly. Only after all efforts to obtain the actual sequence number have been exhausted may a request be made of the EMS Agency for assistance, or as a last resort, a 'dummy' sequence number, in a **timely** fashion.
- A fictitious sequence number **should not** be generated for any reason.

Uses

- Unique patient identifier
- Essential link between other EMS Agency databases

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log
- Audio Records
- EMS Record
- Fire Station Logs
- EMS Agency

PG 2

Definition

Checkbox indicating that a Base Hospital Form supplemental page was used

Uses

- Use when extra space is needed for documentation of additional Drugs, ECGs, Treatments, and/or Comments

Data Source Hierarchy

- Base Hospital Form Page 2
- Base Hospital Form

DATE

Definition

Date of base hospital contact

Field Values

- Collected as MMDDYYYY

Additional Information

- **Required** field for all base hospital contacts
- Excluding midnight crossover from New Year's Eve to New Year's Day, the last two digits of the date must match the first two numeric digits in a 12-digit sequence number

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log

TIME

Definition

Time of day that base hospital contact was initiated

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- **Required** field for all base hospital contacts

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log

LOCATION

Definition

Two-letter code indicating where the incident occurred

Field Values

AI	Airport/Transport Center	**ON**	Ocean
AM	Ambulance	**PA**	Park
BA	Beach	**PL**	Parking Lot
CL	Cliff/Canyon	**PO**	Pool
CO	Commercial Establishment	**PS**	Psych Urgent Care
DC	Dialysis Center	**PV**	Public Venue/Event
DO	Healthcare Provider's Office/Clinic	**RA**	Recreation Area
FA	Farm/Ranch	**RE**	Restaurant
FR	Freeway	**RI**	Residential Institution
FS	Fire Station	**RL**	Religious Building
GY	Health Club/Gym	**RS**	Retail Store
HO	Home	**RT**	Railroad Track
HT	Hotel	**RV**	River
IN	Industrial/Construction Area	**SB**	Sobering Center
JA	Jail	**SC**	School/College/University
LA	Lake	**ST**	Street/Highway
MB	Military Base	**UC**	Urgent Care
MC	Hospital/Medical Center	**WI**	Wilderness Area
NH	Nursing Home	**OT**	Other
OF	Office		

Additional Information

- Location codes are listed on the back of pages 1 and 4 of the Base Hospital Form
- Additional details can be written on the adjacent line: e.g., the name of the facility or business, or any other useful information

Uses

- Allows for data sorting and tracking by incident location
- Epidemiological statistics

Data Source Hierarchy

- Base Hospital Form
- Audio Records

PROVIDER CODE

Definition

Two-letter code for the EMS provider primarily responsible for the patient's prehospital care

Field Values

PUBLIC PROVIDERS			
AF	Arcadia Fire	**LV**	La Verne Fire
AH	Alhambra Fire	**MB**	Manhattan Beach Fire
AV	Avalon Fire	**MF**	Monrovia Fire
BA	Burbank Airport Fire	**MO**	Montebello Fire
BF	Burbank Fire	**MP**	Monterey Park Fire
BH	Beverly Hills Fire	**OT**	Other Provider
CC	Culver City Fire	**PF**	Pasadena Fire
CF	LA County Fire	**RB**	Redondo Beach Fire
CG	US Coast Guard	**SA**	San Marino Fire
CI	LA City Fire	**SG**	San Gabriel Fire
CM	Compton Fire	**SI**	Sierra Madre Fire
CS	LA County Sheriff	**SM**	Santa Monica Fire
DF	Downey Fire	**SP**	South Pasadena Fire
ES	El Segundo Fire	**SS**	Santa Fe Springs Fire
FS	U.S. Forest Service	**TF**	Torrance Fire
GL	Glendale Fire	**VE**	Ventura County Fire
LB	Long Beach Fire	**VF**	Vernon Fire
LH	La Habra Heights Fire	**WC**	West Covina Fire
PRIVATE PROVIDERS			
AA	American Professional Ambulance Corp.	**LT**	Liberty Ambulance
AB	Ambulife Ambulance, Inc.	**LY**	Lynch EMS Ambulance
AN	Antelope Ambulance Service	**MI**	MedResponse, Inc.
AR	American Medical Response	**MR**	MedReach Ambulance
AT	All Town Ambulance, LLC	**MT**	MedCoast Ambulance
AU	AmbuServe Ambulance	**MY**	Mercy Air
AW	AMWest Ambulance	**PE**	Premier Medical Transport
AZ	Ambulnz Health, Inc.	**PN**	PRN Ambulance, Inc.
CA	CARE Ambulance	**RE**	REACH Air Medical Service
CL	CAL-MED Ambulance	**RR**	Rescue Services (Medic-1)
CO	College Coastal Care, LLC	**RY**	Royalty Ambulance
EA	Emergency Ambulance	**SO**	Southern California Ambulance
EX	Explorer 1 Ambulance & Medical Services	**SY**	Symons Ambulance
FC	First Care Ambulance	**TR**	Trinity Ambulance
FM	Firstmed Ambulance Services, Inc.	**VA**	Viewpoint Ambulance, Inc.
GG	Go Green Ambulance	**WE**	Westcoast Ambulance
GU	Guardian Ambulance Service	**WM**	West Med/McCormick Ambulance Service
LE	Lifeline Ambulance		

Additional Information

- **Required** field for all base hospital contacts
- Refers to the EMS provider establishing base contact

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log
- Audio Records

PROVIDER UNIT

Definition

Alphanumeric apparatus code consisting of type of vehicle + numeric vehicle identifier for the paramedic unit establishing base contact

Field Values

- AB: Private Ambulance
- AT: Assessment Truck
- AE: Assessment Engine
- BK: Bike
- BT: Boat
- CT: Cart
- HE: Helicopter
- PE: Paramedic Engine
- PT: Paramedic Truck
- SQ: Squad
- RA: Rescue

Additional Information

- **Required** field for all base hospital contacts
- This is a free-text field – the values above reflect those commonly used by EMS providers

Uses

- System evaluation and monitoring

Data Hierarchy

- Base Hospital Form
- Base Hospital Log
- Audio Records

PT. # __ OF __

Definition

Number identifying the patient amongst the total number of patients involved in an incident

Additional Information

- **Required** field for all base hospital contacts
- If there is only one patient write "Pt.# 1 of 1"
- If there are two patients, and the patient is identified by the paramedics as the second patient, write "Pt.# 2 of 2"

Uses

- Assists with patient identification and tracking
- Identifies multiple-patient incidents
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log
- Audio Records

AGE

Definition

Numeric value for the age (actual or best approximation) of the patient

Field Values

- Enter the numeric age value

Additional Information

- **Required** field for all base hospital contacts
- Must also indicate unit of age
- If the age is estimated, mark the “Est.” checkbox on the Base Hospital Form

Uses

- Allows for data sorting and tracking by age
- Assists with patient identification
- Epidemiological statistics

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log
- Audio Records

AGE UNITS

Definition

Checkboxes indicating units of measurement used to report the age of the patient

Field Values

- **Y**rs: Years – used for patients 2 years old or older
- **YE:** Years Estimated
- **M**os: Months – used for patients 1 month to 23 months old
- **ME:** Months Estimated
- **W**ks: Weeks – used for patients whose age is reported in weeks instead of months
- **WE:** Weeks Estimated
- **D**ays: Days – used for patients 1 to 29 days old
- **DE:** Days Estimated
- **H**rs: Hours – used for patients who are newborn and up to 23 hours old
- **HE:** Hours Estimated

Additional Information

- **Required** field for all base hospital contacts
- If the unit of age is estimated, mark the "Est." checkbox on the Base Hospital Form and enter the unit of age as "YE", "ME", "WE", "DE", or "HE"

Uses

- Assists with patient identification
- Epidemiological statistics
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log
- Audio Records

GENDER

Definition

Checkbox indicating the gender of the patient

Field Values

- **M**: Male
- **F**: Female
- **N**: Nonbinary

Additional Information

- **Required** field for all base hospital contacts
- Patients who are undergoing or have undergone a hormonal and/or surgical sex reassignment should be coded using their stated preference
- Patients unable to state their preference should be coded per paramedic observation/judgment
- Nonbinary is a gender option within the State of California for individuals whose gender identity is not exclusively male or female

Uses

- Assists with patient identification
- Epidemiological statistics
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log
- Audio Records

WEIGHT

Definition

Numeric value of the weight of the patient

Field Values

- Up to three-digit numeric field

Additional Information

- **Required** field for all pediatric base contacts and base contacts with the following provider impressions:
  - CPSC/CPMI (pediatric patients)
  - LABR (pediatric patients)
- All weights should be documented in kilograms
- For pediatric patients, document the measured weight in kilograms obtained from the length-based pediatric resuscitation tape, if applicable
- If the pediatric patient is shorter or taller than the length-based pediatric resuscitation tape, mark the “Too Short” or “Too Tall” checkbox, and estimate the weight in kilograms

Uses

- Assists with determination of appropriate treatment
- Epidemiological statistics

Data Source Hierarchy

- Base Hospital Form
- Audio Records

WEIGHT UNITS

Definition

Checkbox indicating unit of measurement used to report patient's weight

Field Values

- **K**g: Kilograms

Additional Information

- **Required** field for all pediatric base contacts and base contacts with the following provider impressions:
  - CPSC/CPMI (pediatric patients)
  - LABR (pediatric patients)
- All weights should be documented in kilograms only
- For pediatric patients, document the measured weight in kilograms obtained from the length-based pediatric resuscitation tape, if applicable
- If the pediatric patient is shorter or taller than the length-based pediatric resuscitation tape, mark the "Too Short" or "Too Tall" checkbox, and estimate the patient's weight in kilograms

Uses

- Assists with determination of appropriate treatment
- Epidemiological statistics

Data Source Hierarchy

- Base Hospital Form
- Audio Records

PEDS WEIGHT COLOR CODE

Definition

Color that corresponds with the length of an infant or child as measured on a length-based pediatric resuscitation tape

Field Values

- Grey: **3**, **4**, or **5** kg (newborn infants)
- P**I**nk: 6-7 kg (~3 -6 mos)
- **R**ed: 8-9 kg (~7-10 mos)
- P**U**rple: 10-11 kg (~12-18 mos)
- **Y**ellow: 12-14 kg (~19-35 mos)
- **W**hite: 15-18 kg (~3-4 yrs)
- **B**lue: 19-22 kg (~5-6 yrs)
- **O**range: 24-28 kg (~7-9 yrs)
- Gr**E**en: 30-36 kg, or about 80 lbs (~10-12 yrs)
- **T**oo Tall: patient is longer than tape
- Too **S**hort: patient is shorter than tape

Additional Information

- **Required** field for all pediatric base contacts
- Document the measured weight in kilograms obtained from the length-based pediatric resuscitation tape, if applicable
- If the pediatric patient is shorter or taller than the length-based pediatric resuscitation tape, mark the “Too Short” or “Too Tall” checkbox, and estimate the patient’s weight in kilograms

Uses

- Assists with determination of appropriate treatment
- Epidemiological statistics
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

HOSPITAL CODE

Definition

Three-letter code for the base hospital contacted

Field Values

AMH	Methodist Hospital of Southern California	**NRH**	Dignity Health - Northridge Hospital Medical Center
AVH	Antelope Valley Hospital	**PVC**	Pomona Valley Hospital Medical Center
CAL	Dignity Health - California Hospital Medical Center	**PIH**	PIH Health Whittier Hospital
CSM	Cedars-Sinai Medical Center	**QVH**	Emanate Health Queen of the Valley Hospital
GWT	Adventist Health - Glendale	**SFM**	St. Francis Medical Center
HCH	Providence Holy Cross Medical Center	**SJS**	Providence Saint Joseph Medical Center
HGH	LAC Harbor - UCLA Medical Center	**SMM**	Dignity Health - Saint Mary Medical Center
HMH	Huntington Hospital	**TOR**	Torrance Memorial Medical Center
HMN	Henry Mayo Newhall Hospital	**UCL**	Ronald Reagan UCLA Medical Center
LCM	Providence Little Co. of Mary Medical Center Torrance	**USC**	LAC+USC Medical Center
LBM	MemorialCare Long Beach Medical Center		

Additional Information

- **Required** field for all base hospital contacts
- Codes are also listed on the back of pages 1 and 4 of the Base Hospital Form

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log

COMMUNICATION TYPE

Definition

Checkbox indicating the device used by the paramedic to establish base hospital contact

Field Values

- **R**adio: Radio
- **P**hone: Telephone/Cell Phone
- **V**MED28: formerly known as Hospital Emergency Administrative Radio (HEAR)

Additional Information

- **Required** field for all base hospital contacts

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form

CALL TYPE

Definition

Checkboxes indicating the level of EMS encounter

Field Values

- 9-1-1 **C**all: Paramedics establish base contact for online medical direction based upon a complete patient report (includes Against Medical Advice calls and calls downgraded from ALS to BLS)
- 9-1-1 R**E**-Triage: Patient, meeting the 9-1-1 trauma re-triage criteria defined in Reference No. 506, is transferred from the ED of an acute care facility emergently via 9-1-1 to the ED of a designated trauma center
- IF**T** (Interfacility Transfer): Patient is being transferred via ALS from one acute care facility to another

Additional Information

- **Required** field for all base hospital contacts

Uses

- System evaluation and monitoring
- Establishes system participants' roles and responsibilities

Data Source Hierarchy

- Base Hospital Form
- Audio Records

ASSESSMENT

PROVIDER IMPRESSION

Definition

Four-letter code(s) representing the provider's impression of the patient's presentation

Field Values

ABOP	Abdominal Pain/Problems	**ELCT**	Electrocution	**PREG**	Pregnancy Complications
AGDE	Agitated Delirium	**ENTP**	ENT/Dental Emergencies	**LABR**	Pregnancy/Labor
CHOK	Airway Obstruction/Choking	**NOBL**	Epistaxis	**RARF**	Respiratory Arrest/Failure
ETOH	Alcohol Intoxication	**EXNT**	Extremity Pain/Swelling – Non-Traumatic	**SOBB**	Resp. Distress/Bronchospasm
ALRX	Allergic Reaction	**EYEP**	Eye Problem – Unspecified	**RDOT**	Resp. Distress/Other
ALOC	ALOC – Not Hypoglycemia or Seizure	**FEVR**	Fever	**CHFF**	Resp. Distress/Pulmonary Edema/CHF
ANPH	Anaphylaxis	**GUDO**	Genitourinary Disorder – Unspecified	**SEAC**	Seizure – Active
PSYC	Behavioral/Psychiatric Crisis	**DCON**	HazMat Exposure	**SEPI**	Seizure – Postictal
BPNT	Body Pain – Non-Traumatic	**HPNT**	Headache – Non-Traumatic	**SEPS**	Sepsis
BRUE	BRUE	**HYPR**	Hyperglycemia	**SHOK**	Shock
BURN	Burns	**HYTN**	Hypertension	**SMOK**	Smoke Inhalation
COMO	Carbon Monoxide	**HEAT**	Hyperthermia	**STNG**	Stings/Venomous Bites
CANT	Cardiac Arrest– Non-Traumatic	**HYPO**	Hypoglycemia	**STRK**	Stroke/CVA/TIA
DYSR	Cardiac Dysrhythmia	**HOTN**	Hypotension	**DRWN**	Submersion/Drowning
CPNC	Chest Pain – Not Cardiac	**COLD**	Hypothermia/Cold Injury	**SYNC**	Syncope/Near Syncope
CPMI	Chest Pain – STEMI	**INHL**	Inhalation Injury	**CABT**	Traumatic Arrest – Blunt
CPSC	Chest Pain – Suspected Cardiac	**LOGI**	Lower GI Bleeding	**CAPT**	Traumatic Arrest – Penetrating
BRTH	Childbirth (Mother)	**FAIL**	Medical Device Malfunction – Fail	**TRMA**	Traumatic Injury
COFL	Cold/Flu Symptoms	**NAVM**	Nausea/Vomiting	**UPGI**	Upper GI Bleeding
DRHA	Diarrhea	**BABY**	Newborn	**VABL**	Vaginal Bleeding
DIZZ	Dizziness/Vertigo	**NOMC**	No Medical Complaint	**WEAK**	Weakness – General
DEAD	DOA – Obvious Death	**ODPO**	Overdose/Poisoning/Ingestion		
DYRX	Dystonic Reaction	**PALP**	Palpitations		

Additional Information

- **Required** field for all base hospital contacts
- First copy of Provider Impression cannot be a null value
- Do not enter more than one copy of the same Provider Impression code
- Provider Impression codes are found on the back of pages 1 and 4 of the Base Hospital Form

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log
- Audio Records

CHIEF COMPLAINT CODES

Definition

Two-letter code(s) representing the patient's most significant medical or trauma complaints

Field Values – Trauma Codes

- **N**o **A**pparent Injury (**NA**): No complaint, or signs or symptoms of injury following a traumatic event
- **BU**rns/Elec. Shock (**BU**): Thermal or chemical burn, or electric shock
- **C**ritical **B**urn (**CB**): Patients ≥ 15 years of age with 2nd (partial thickness) and 3rd (full thickness) degree burns involving ≥ 20% Total Body Surface Area (TBSA) **OR** patients ≤ 14 years of age with 2nd and 3rd degree burns involving 10% TBSA
- SBP <**90** (<70 if under 1y) (**90**): Systolic blood pressure less than 90mmHg in a patient greater than one year of age (or systolic blood pressure less than 70mmHg in a patient less than one year of age) following a traumatic event
- **RR** <10/>29 (<20 if <1y) (**RR**): A sustained respiratory rate greater than 29 breaths/minute, or respiratory rate of less than 10 breaths/minute (or less than 20 breaths/minute in a patient less than one year of age), following a traumatic event
- **S**usp. Pelvic F**X** (**SX**): Suspected pelvic fracture, excluding isolated hip fractures from a ground level fall
- **S**pinal **C**ord Injury (**SC**): Suspected spinal cord injury, or presence of weakness/paralysis/paresthesia following a traumatic event
- **I**npatient **T**rauma (**IT**): Interfacility transfer (IFT) of an admitted, injured patient from one facility to an inpatient bed at another facility, excluding ER to ER transfers
- **U**ncontrolled **B**leeding (**UB**): Extremity bleeding requiring use of a tourniquet or hemostatic dressing
- **T**rauma Arrest (**BT** or **PT**): Cessation of cardiac output and effective circulation due to blunt or penetrating force
- **H**ead (**BH** or **PH**): Injury to the head or skull in the area from above the eyebrows to behind the ears, due to blunt or penetrating force. This code can also be applied in association with facial injuries when it is likely that the brain is involved
- GCS ≤**14** (**14**): Blunt force head injury associated with a Glasgow Coma Scale score of less than or equal to 14
- **F**ace/Mouth (**BF** or **PF**): Injury to the anterior aspect of the face, mouth, or skull, from and including the eyebrows, down to and including the angle of the jaw and the ears, due to blunt or penetrating force
- **N**eck (**BN** or **PN**): Injury or pain to the area between the angle of the jaw and clavicles (including probable cervical spine injuries) due to blunt or penetrating force
- **B**ack (**BB** or **PB**): Injury to the area from the shoulders to the buttocks (but not including the buttocks) due to blunt or penetrating force
- **C**hest (**BC** or **PC**): Injury to the anterior chest in the area between the clavicle and the xyphoid process, bordered on either side by the posterior axillary line, due to blunt or penetrating force
- **F**lail **C**hest (**FC**): Blunt force injury to the chest wall resulting in an unstable chest wall, characterized by paradoxical chest wall movement with respirations

- Tension **P**neum (**BP** or **PP**): Air enters the pleural space due to blunt or penetrating force, and creates pressure on chest organs. Signs and symptoms can include: SOB, tachypnea, decreased or absent lung sounds on one side, shock, neck vein distention, and/or tracheal deviation
- **A**bdomen (**BA** or **PA**): Injury to any of the abdominal quadrants, flanks, or pelvis due to blunt or penetrating force
- **D**iffuse Abd. Tender. (**BD**): Blunt force injury to the abdomen resulting in tenderness in two or more quadrants
- **G**enitals (**BG** or **PG**): Injury to the external reproductive structures due to blunt or penetrating force
- Buttoc**K**s (**BK** or **PK**): Injury to the buttocks due to blunt or penetrating force
- **E**xtremities (**BE** or **PE**): Injury or pain to the shoulders, arms, hands, legs, or feet due to blunt or penetrating force
- E**X**trem. above knee/elbow (**PX**): Penetrating force injury to an extremity, proximal to (above) the knee or elbow
- F**R**actures ≥ 2 long bones (**BR**): Blunt force injury resulting in apparent fracture of 2 or more proximal long bones (humerus, femur)
- Amputat**I**on above wrist/ankle (**BI** or **PI**): Amputation proximal to (above) the wrist or ankle due to blunt or penetrating force
- Neur/**V**asc/Mangled (**BV** or **PV**): Injury to an extremity with neurological and/or vascular compromise, or that is crushed, degloved, or mangled due to blunt or penetrating force
- Minor **L**acerations (**BL** or **PL**): Superficial or non-serious lacerations, abrasions, or contusions involving the skin or subcutaneous tissue, due to blunt or penetrating force

Field Values – Medical Codes

- **A**bd/**P**elvic Pain (**AP**): Pain or discomfort in the abdomen or pelvic region not associated with trauma
- **A**gitated **D**elirium (**AD**): Acute onset of extreme agitation and combative or bizarre behavior that may be accompanied by paranoid delusions, hallucinations, aggression with unusual increase in human strength, and hyperthermia
- **A**llergic **R**eaction (**AR**): Acute onset of rash, hives, itching, redness of the skin, runny nose, facial and/or airway swelling, wheezing, shortness of breath, and/or abdominal pain in apparent reaction to ingestion or contact with a substance.
- **A**ltered **L**OC (**AL**): Any state of arousal other than normal, such as confusion, lethargy, combativeness, coma, etc., not associated with trauma
- **A**pneic **E**pisode (**AE**): Episode of cessation of respiration for a brief or prolonged period of time
- B**EH**avioral (**EH**): Abnormal behavior of apparent mental or emotional origin
- Bleeding **O**ther **S**ite (**OS**): Bleeding from a site not elsewhere listed that is not associated with trauma (e.g. dialysis shunt)
- Brief **R**esolved **U**nexplained Event (**RU**): An event occurring in an infant <1 year of age when the observer reports a sudden, brief, and now resolved episode of ≥1 of the following: cyanosis or pallor, absent, decreased, or irregular breathing, marked change in tone (hyper – or hypotonia), and altered level of responsiveness
- **C**ardiac **A**rrest (**CA**): Sudden cessation of cardiac output and effective circulation not associated with trauma

- **C**hest **P**ain (**CP**): Pain in the anterior chest occurring anywhere from the clavicles to the lower costal margins not associated with trauma
- **CH**oking/Airway Obstruction (**CH**): Acute onset of apnea, choking and/or difficulty breathing due to apparent partial or complete obstruction of the airway
- **C**ough/**C**ongestion (**CC**): Cough and/or congestion in the chest, nasal passages, or throat
- **D**evice (Medical) **C**omplaint (**DC**): Any complaint associated with a patient's existing medical device (e.g. G-tube, AICD, ventilator, etc.)
- **DI**zzy (**DI**): The patient complains of sensation of spinning or feeling off-balance. If associated with complaint of weakness, code both complaints
- **DO**A (**DO**): Patient is determined to be dead upon arrival of EMS, as per the Prehospital Care Manual
- **DY**srhythmia (**DY**): Cardiac monitor indicates an abnormal cardiac rhythm (SVT, VT, etc.)
- **FE**ver (**FE**): Patient exhibits or complains of an elevated body temperature
- **F**oreign **B**ody (**FB**): Patient complains of a foreign body anywhere in the body
- **GI** Bleed (**GI**): Signs or symptoms of gastrointestinal bleeding such as vomiting blood, coffee-ground emesis, melena, rectal bleeding, etc.
- **H**ead **P**ain (**HP**): Headache or any other type of head pain not associated with trauma
- **HY**poglycemia (**HY**): Patient is symptomatic and has a measured blood glucose level that is below normal
- **I**npatient **M**edical (**IM**): Interfacility transfer (IFT) of an admitted, ill (not injured) patient from one facility to an inpatient bed at another facility
- **LA**bor (**LA**): Patient is greater than 20 weeks pregnant, and experiencing signs or symptoms of labor such as uterine contractions, vaginal bleeding, spontaneous rupture of membranes, crowning, etc.
- **L**ocal **N**euro Signs (**LN**): Weakness, numbness, or paralysis of a body part or region – including slurred speech, facial droop, and/or expressive aphasia
- **N**ausea/**V**omiting (**NV**): Patient is vomiting, or complains of nausea and/or vomiting
- **N**ear **D**rowning (**ND**): Submersion causing water inhalation, unconsciousness, or death not associated with trauma
- **N**eck/**B**ack Pain (**NB**): Pain in any area from base of skull and the shoulders to the buttocks not associated with trauma
- **N**e**W**born (**NW**): Newborn infant delivered out of the hospital setting
- **N**o Medical **C**omplaint (**NC**): No complaint, or signs or symptoms of illness in a patient not involved in a traumatic event
- **NO**sebleed (**NO**): Bleeding from the nose, not associated with trauma
- **OB**stetrics (**OB**): Any complaints, signs, or symptoms which may be related to a known pregnancy (e.g., bleeding, abdominal pain/cramping, high blood pressure, edema, convulsions, severe headaches)
- **O**ther **P**ain (**OP**): Complaint of pain at a site not listed, and which is not associated with trauma (e.g. toothache, ear pain, etc.)
- **O**ver**D**ose (**OD**): Ingestion of or contact with a drug or other substance in quantities greater than recommended or generally practiced
- **P**alpitation**S** (**PS**): Sensation that the heartbeat is irregular or fast
- **PO**isoning (**PO**): Ingestion of or contact with a toxic substance
- **R**espiratory **A**rrest (**RA**): Sudden cessation of breathing not associated with trauma

- **SE**izure (**SE**): Convulsions or involuntary body movements or gaze (not associated with trauma), or signs, symptoms, or history of recent seizure
- **S**hortness of **B**reath (**SB**): Sensation of not being able to catch one's breath, and/or signs or symptoms of difficulty breathing such as gasping, wheezing, rapid respiratory rate, cyanosis, retractions, use of accessory muscles, etc.
- **SY**ncope (**SY**): Transient loss of consciousness, including sensation of "near syncope" when other associated symptoms such as weakness/dizziness do not apply
- **VA**ginal Bleeding (**VA**): Abnormal vaginal bleeding
- **WE**ak (**WE**): Patient complains of feeling weak, or exhibits signs or symptoms of decreased strength and/or muscle tone
- **OT**her (**OT**): Signs or symptoms not listed above, that are not associated with trauma

Additional Information

- **Required** field for all base hospital contacts
- First copy of Chief Complaint cannot be a null value
- Do not enter more than one copy of the same chief complaint
- If the patient has multiple complaints, enter in order of significance
- Two-letter codes for trauma chief complaints can be derived from the bolded, capitalized letters in the Trauma area of the Base Hospital Form
- Medical complaint codes are found on the back of pages 1 and 4 of the Base Hospital Form
- Medical complaints should not be documented with trauma complaints, unless it is suspected that a medical complaint preceded/caused the injury, or vice versa (e.g., chest pain/dizziness that caused an MVA, or seizure activity following a blow to the head.) Do not document a medical complaint such as "HP" (head pain) if the pain is due to a gunshot wound to the head – instead use only the trauma code of "PH."
- All trauma chief complaint codes also require a mechanism of injury

Uses

- System evaluation and monitoring
- Epidemiological statistics

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log
- Audio Records

LEVEL OF DISTRESS

Definition

Checkboxes indicating paramedics' impression of the level of discomfort or severity of illness of the patient, based on assessment of signs, symptoms, and complaints

Field Values

- **N**one: The patient appears well and has no acute signs or symptoms related to the incident. Advanced life support techniques and transportation may not be necessary
- Mil**D**: Indicates that the patient does not have a life-threatening problem. Advanced life support techniques and transportation may not be necessary
- **M**oderate: Patient may have a life-threatening problem, or the degree of patient discomfort is high. Advanced life support techniques, base hospital contact, and patient transportation are usually necessary
- **S**evere: Refers to a life-threatening condition. Advanced life support techniques, base hospital contact, and patient transportation are generally necessary

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

mLAPSS MET

Definition

Checkboxes indicating whether the patient met all Modified Los Angeles Prehospital Stroke Screen (mLAPSS) criteria

Field Values

- **Y**: Yes, patient met all mLAPSS criteria
- **N**: No, patient did not meet all mLAPSS criteria

Additional Information

- mLAPSS criteria include:
  - No history of seizures or epilepsy
  - Age ≥ 40
  - At baseline, patient is not wheelchair bound or bedridden
  - Blood glucose value between 60 and 400 mg/dL
  - Obvious asymmetry or unilateral weakness is observed in one or more of the following:
    - Facial Smile/Grimace
    - Grip
    - Arm Strength
- **Required** field for all base hospital contacts with a provider impression code of “STRK”, or a destination of Primary Stroke Center, “PSC”, or Comprehensive Stroke Center, “CSC”
- If mLAPSS performed, blood glucose value must also be documented
- Patients who meet mLAPSS criteria with LKWT < 24 hrs. should also have a LAMS performed and be transported, at a minimum, to the nearest available Primary Stroke Cener (PSC)
- Patients who do not meet mLAPSS criteria can still be transported to the nearest available PSC or Comprehensive Stroke Center (CSC) if the provider or base hospital still has a high suspicion of stroke or large vessel occlusion (LVO)

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Stroke Center Log
- Audio Records

LAST KNOWN WELL DATE

Definition

Date when the patient was last known to be well, symptom-free, or at baseline or usual state of health

Field Values

- Collected as MMDDYYYY

Additional Information

- **Required** field for all base hospital contacts with a provider impression code of “STRK”, a “Y” value for “mLAPSS Met”, or with a destination of “PSC” or “CSC” for suspected stroke
- If unknown, enter “Not Applicable” (F7)

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Stroke Center Log
- Audio Records

LAST KNOWN WELL TIME

Definition

Time of day when the patient was last known to be well, symptom-free, or at baseline or usual state of health

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- **Required** field for all base hospital contacts with a provider impression code of “STRK”, a “Y” value for “mLAPSS Met”, or with a destination of “PSC” or “CSC” for suspected stroke
- If unknown, enter “Not Applicable” (F7)

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Stroke Center Log
- Audio Records

LAMS SCORE

Definition

Patient's total score for the Los Angeles Motor Scale (LAMS)

Field Values

- Numeric value range from 0 to 5

Additional Information

- LAMS includes 3 components:
  - Facial Droop
    - Absent=0
    - Present=1
  - Arm Drift
    - Absent=0
    - Drifts Down=1
    - Falls Rapidly=2
  - Grip Strength
    - Normal=0
    - Weak Grip=1
    - No Grip=2
- **Required** field for all base hospital contacts with a "Y" value for "mLAPSS Met"
- Patients with a LAMS score of < 4 should be transported to the nearest available PSC
- Patients with a LAMS score of ≥ 4 should be transported to the nearest available CSC
- LAMS can still be performed on patients who do not meet mLAPSS criteria if the provider or base hospital has a high suspicion of stroke or LVO

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Stroke Center Log
- Audio Records

PROTOCOL

Definition

Four- or five-digit code of the Medical Treatment Protocol (MTP) utilized by the EMS provider

Field Values

1201	Assessment		
1202	General Medical	**1202-P**	General Medical (Pediatric)
1203	Diabetic Emergencies	**1203-P**	Diabetic Emergencies (Pediatric)
1204	Fever/Sepsis	**1204-P**	Fever/Sepsis (Pediatric)
1205	GI/GU Emergencies	**1205-P**	GI/GU Emergencies (Pediatric)
1206	Medical Device Malfunction	**1206-P**	Medical Device Malfunction (Pediatric)
1207	Shock/Hypotension	**1207-P**	Shock/Hypotension (Pediatric)
1208	Agitated Delirium	**1208-P**	Agitated Delirium (Pediatric)
1209	Behavioral/Psychiatric Crisis	**1209-P**	Behavioral/Psychiatric Crisis (Pediatric)
1210	Cardiac Arrest	**1210-P**	Cardiac Arrest (Pediatric)
1211	Cardiac Chest Pain		
1212	Cardiac Dysrhythmia-Bradycardia	**1212-P**	Cardiac Dysrhythmia-Bradycardia (Pediatric)
1213	Cardiac Dysrhythmia-Tachycardia	**1213-P**	Cardiac Dysrhythmia-Tachycardia (Pediatric)
1214	Pulmonary Edema/CHF		
1215	Childbirth (Mother)	**1215-P**	Childbirth (Mother) (Pediatric)
		1216-P	Newborn/Neonatal Resuscitation (Pediatric)
1217	Pregnancy Complication	**1217-P**	Pregnancy Complication (Pediatric)
1218	Pregnancy/Labor	**1218-P**	Pregnancy/Labor (Pediatric)
1219	Allergy	**1219-P**	Allergy (Pediatric)
1220	Burns	**1220-P**	Burns (Pediatric)
1221	Electrocution	**1221-P**	Electrocution (Pediatric)
1222	Hyperthermia (Environmental)	**1222-P**	Hyperthermia (Environmental) (Pediatric)
1223	Hypothermia/Cold Injury	**1223-P**	Hypothermia/Cold Injury (Pediatric)
1224	Stings/Venomous Bites	**1224-P**	Stings/Venomous Bites (Pediatric)
1225	Submersion	**1225-P**	Submersion (Pediatric)
1226	ENT/Dental Emergencies	**1226-P**	ENT/Dental Emergencies (Pediatric)
1228	Eye Problem	**1228-P**	Eye Problem (Pediatric)
1229	ALOC	**1229-P**	ALOC (Pediatric)
1230	Dizziness/Vertigo	**1230-P**	Dizziness/Vertigo (Pediatric)
1231	Seizure	**1231-P**	Seizure (Pediatric)
1232	Stroke/CVA/TIA	**1232-P**	Stroke/CVA/TIA (Pediatric)
1233	Syncope/Near Syncope	**1233-P**	Syncope/Near Syncope (Pediatric)
1234	Airway Obstruction	**1234-P**	Airway Obstruction (Pediatric)

		1235-P	BRUE (Pediatric)
1236	Inhalation Injury	**1236-P**	Inhalation Injury (Pediatric)
1237	Respiratory Distress	**1237-P**	Respiratory Distress (Pediatric)
1238	Carbon Monoxide Exposure	**1238-P**	Carbon Monoxide Exposure (Pediatric)
1239	Dystonic Reaction	**1239-P**	Dystonic Reaction (Pediatric)
1240	HazMat	**1240-P**	HazMat (Pediatric)
1241	Overdose/Poisoning/Ingestion	**1241-P**	Overdose/Poisoning/Ingestion (Pediatric)
1242	Crush Injury/Syndrome	**1242-P**	Crush Injury/Syndrome (Pediatric)
1243	Traumatic Arrest	**1243-P**	Traumatic Arrest (Pediatric)
1244	Traumatic Injury	**1244-P**	Traumatic Injury (Pediatric)
1245	COVID		

Additional Information

- **Required** field for all base hospital contacts
- More than one protocol can be used
- Do not enter more than one copy of the same protocol number
- Protocol identified must correlate to the provider impression

Uses

- Allows for data sorting and tracking by protocol
- Assists with determination of appropriate treatment
- System evaluation and monitoring
- Epidemiological statistics

Data Source Hierarchy

- Base Hospital Form
- Audio Records

O/P,Q,R,S,T

Definition

Acronym used as a tool to assess and document the following symptom attributes:

- **O/P**: Onset/Provocation
- **Q**: Quality
- **R**: Region/Radiation/Relief
- **S**: Severity
- **T**: Time

Field Values

- Free text

Uses

- Prompts thorough assessment and documentation of patient's symptoms
- Assists with determination of appropriate treatment and transport

Data Source Hierarchy

- Base Hospital Form
- Audio Records

MEDICAL HX

Definition

Space to indicate previous medical problem(s) experienced by the patient, if applicable

Field Values

- Free text

Uses

- Prompts thorough assessment and documentation of patient's symptoms
- Assists with determination of appropriate treatment and transport

Data Source Hierarchy

- Base Hospital Form
- Audio Records

MEDICATIONS

Definition

Space to indicate medications currently being taken by the patient, if applicable

Field Values

- Free text

Additional Information

- Indicate patient compliance, if applicable
- Include nonprescription drugs and herbal supplements

Uses

- Assists with determination of appropriate treatment and transport

Data Source Hierarchy

- Base Hospital Form
- Audio Records

ALLERGIES

Definition

Checkbox and space to indicate patient history of adverse reactions or allergies to medications or other substances, if applicable

Field Values

- Free text, or
- NKA: No known allergies checkbox

Additional Information

- If the patient has no known allergies, mark the “NKA” box
- Allergies to non-medication items may be listed if they are related to the current problem or potential treatments (e.g., adhesive tape, or latex)

Uses

- Patient safety

Data Source Hierarchy

- Base Hospital Form
- Audio Records

DNR/AHCD/POLST?

Definition

Checkbox indicating presence of a valid Do Not Resuscitate (DNR), Advance Healthcare Directive (AHCD), or Physician Order for Life Sustaining Treatment (POLST) form for the patient

Field Values

- **Y**: Yes
- **N**: No
- **U**: Unknown

Additional Information

- **Required** field for all base contacts with a provider impression code of "CANT"
- EMS personnel do not need to validate the authenticity of the document provided – should provide base hospital with the type of document and its contents

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

PRIOR TO BASE MEDS

Definition

Checkboxes and spaces indicating medications and dosages administered prior to base contact, if applicable

Field Values

ADE	Adenosine	**KLC**	Ketorolac
ALB	Nebulized Albuterol	**MID**	Midazolam
AMI	Amiodarone	**NAR**	Narcan
ASA	Aspirin	**NTG**	Nitroglycerin
BIC	Sodium Bicarbonate	**OND**	Ondansetron
CAL	Calcium Chloride	**Morphine**	Morphine Sulfate
EPI	Epinephrine	**GLU/GLP**	Glucagon/Glucose Paste
FEN	Fentanyl	**D10**	10% Dextrose

Additional Information

- **Required** field for all base contacts with the following provider impressions:
  - ANPH
  - CANT
  - AGDE/PSYC (Midazolam given, also include route in narrative)
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

PRIOR TO BASE TXS

Definition

Checkboxes indicating treatments rendered prior to base contact, if applicable

Field Values

BMV	Bag-Mask Ventilation	**TC**P	Transcutaneous Pacing
CPAP	Continuous Positive Airway Pressure	**A**ED- **A**nalyzed	AED Analyzed Rhythm
ETT	Endotracheal Tube Intubation	**A**ED- **D**efibrillated	AED Defibrillated Patient
King	King Airway	Needle **TH**oracost.	Needle Thoracostomy
SMR	Spinal Motion Restriction	Tourniquet (**TK**)	Tourniquet
GLucometer	Glucometer Reading	**IV**/IO Fluid ____cc	IV/IO fluid amount in ccs
DEFibrillated X	Defibrillation & number of defibrillation attempts	**OT**her	Other Treatment Not Listed
CAR	Cardioversion		

Additional Information

- **Required** field for all base contacts with the following provider impressions:
  - ANPH
  - CANT
  - AGDE
- Checked Glucometer checkbox should be accompanied by the reading obtained
- Checked Defibrillated checkbox should be accompanied by the number of times defibrillation was performed
- Checked IV/IO Fluid checkbox should be accompanied by the number of ccs of fluid administered to the patient

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

PHYSICAL

LOC

Definition

Checkboxes indicating the patient's initial level of consciousness

Field Values

- **A**lert: Patient is awake and responsive to the environment
- **O** X 3: Patient is oriented to person, time, and place
- **D**isoriented: Patient is not oriented to person, time, and/or place
- **C**ombative: Patient is physically resistant to interaction with on-scene personnel
- No**T** Alert: Patient is awake, but is drowsy or lethargic – may include intoxicated patients
- Nor**M**al for Patient: Patient's behavior, although not typical of most patients, is reported by family, caregivers, etc., to be the same as it was before the incident (e.g., patients who suffer from mental illness, dementia, developmental delays, etc.). Can also be used for infants and children who are age appropriate
- No **R**esponse: Patient is unresponsive to verbal and painful stimuli

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - STRK
  - HOTN
  - SHOK
  - CPSC/CPMI (pediatric patients)
  - BRTH
  - AGDE
  - ANPH
  - BRUE
  - CHOK (severe distress and/or respiratory arrest)
  - ALOC (if persistent or unclear etiology)
  - PSYC (Midazolam given)
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
  - FAIL (VAD malfunction)
  - ODPO (if signing AMA)
  - PREG (if > 20 wks with vaginal bleeding or delivery)
  - LABR (if age ≤ 14 years)
  - SOBB/RDOT/SMOK (severe distress or not improving with CPAP)
  - SEAC/SEPI (pregnant or in status epilepticus)
  - DRWN (if ALOC or needs decompression)
  - TRMA (penetrating eye, TC criteria/guidelines, crush syndrome, or entrapment > 30 minutes)
- Mark all that apply

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

IUP_ WKS

Definition

Checkbox and space indicating the number of weeks of intrauterine pregnancy, if applicable

Additional Information

- **Required** field for all base contacts with the following provider impressions:
  - BRTH
  - PREG (if > 20 weeks with vaginal bleeding or delivery)
  - LABR (if age ≤ 14 years)
  - SEAC/SEPI (pregnant)
- Patients may only be able to provide the number of months, not weeks, of their pregnancy – in this case, pregnancies reported of greater than 4½ months can be assumed to be greater than 20 weeks
- Patients injured while at least 20 weeks pregnant meet trauma triage special considerations for transport to a trauma center

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

SUSPECTED DRUGS/ETOH?

Definition

Checkbox indicating that the situation, patient behavior, or statements made by the patient, family members or bystanders cause the paramedics to suspect that the patient's presentation may be related to alcohol and/or drug use

Additional Information

- **Required** field for all base contacts with the following provider impressions:
  - AGDE
  - ALOC (if persistent or unclear etiology)
  - PSYC (Midazolam given)
  - ODPO (if signing out AMA)
  - SEAC/SEPI (pregnant or in status epilepticus)
- If checked, enter "E" into TEMIS on the Base 1 tab, in the 'Flag' field

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

EYE

Definition

Checkboxes indicating the Glasgow Coma Scale numerical value that corresponds to the patient's initial eye opening response to stimuli

Field Values

- **4**: Spontaneous – opens eyes spontaneously, no stimuli required
- **3**: To Verbal – opens eyes only when spoken to or asked
- **2**: To Pain – opens eyes only in response to noxious stimuli such as sternal rub or nail bed pressure
- **1**: None – patient does not open eyes in response to noxious stimuli

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - BRUE
  - STRK
  - BRTH
  - BABY
  - HOTN
  - AGDE
  - SHOK
  - ANPH
  - DYRX
  - CPSC/CPMI (pediatric patients)
  - CHOK (severe distress and/or respiratory arrest)
  - ALOC (if persistent or unclear etiology)
  - PSYC (Midazolam given)
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
  - FAIL (VAD malfunction)
  - ODPO (if signing AMA)
  - PREG (if > 20 wks with vaginal bleeding or delivery)
  - LABR (if age ≤ 14 years)
  - SOBB/RDOT/SMOK (severe distress or not improving with CPAP)
  - SEAC/SEPI (pregnant or in status epilepticus)
  - DRWN (if ALOC or needs decompression)
  - TRMA (penetrating eye, TC criteria/guidelines, crush syndrome, or entrapment > 30 minutes)
- GCS eye opening values are the same for adult and pediatric patients

Uses

- Element necessary to calculate the overall GCS score
- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

VERBAL

Definition

Checkboxes indicating the Glasgow Coma Scale numerical value that corresponds to the patient's initial verbal response to stimuli

Field Values – Adult and Verbal Pediatric Patients

- **5**: Oriented x 3 – patient is oriented to person, time, and place
- **4**: Confused – patient may respond to questions coherently, but is disoriented or confused
- **3**: Inappropriate – random words or speech unrelated to questions or conversation
- **2**: Incomprehensible – makes incoherent sounds or moans only
- **1**: None – patient has no verbal response to noxious stimuli

Field Values – Infants and Toddlers

- **5**: Smiles and tracks objects, speech appropriate for age
- **4**: Cries but consolable, or confused
- **3**: Inconsistently consolable, or random words
- **2**: Moaning, incoherent sounds only
- **1**: No verbal response to noxious stimuli

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - BRUE
  - STRK
  - BRTH
  - BABY
  - HOTN
  - AGDE
  - SHOK
  - ANPH
  - DYRX
  - CPSC/CPMI (pediatric patients)
  - CHOK (severe distress and/or respiratory arrest)
  - ALOC (if persistent or unclear etiology)
  - PSYC (Midazolam given)
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
  - FAIL (VAD malfunction)
  - ODPO (if signing AMA)
  - PREG (if > 20 wks with vaginal bleeding or delivery)
  - LABR (if age ≤ 14 years)
  - SOBB/RDOT/SMOK (severe distress or not improving with CPAP)
  - SEAC/SEPI (pregnant or in status epilepticus)
  - DRWN (if ALOC or needs decompression)
  - TRMA (penetrating eye, TC criteria/guidelines, crush syndrome, or entrapment > 30 minutes)

Uses

- Element necessary to calculate the overall GCS score
- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

MOTOR

Definition

Checkboxes indicating the Glasgow Coma Scale numerical value that corresponds to the patient's initial motor response to stimuli

Field Values

- **6**: Obedient – obeys verbal commands / spontaneous purposeful movement
- **5**: Purposeful – purposeful movement is made in response to noxious stimuli (e.g., attempts to push away or grab source of stimuli
- **4**: Withdrawal – withdraws body part from source of noxious stimuli
- **3**: Flexion –extremities move towards body core in response to noxious stimuli (decorticate posturing)
- **2**: Extension – extremities move away from body core in response to noxious stimuli (decerebrate posturing)
- **1**: None – patient has no motor response to noxious stimuli

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - BRUE
  - STRK
  - BRTH
  - BABY
  - HOTN
  - AGDE
  - SHOK
  - ANPH
  - DYRX
  - CPSC/CPMI (pediatric patients)
  - CHOK (severe distress and/or respiratory arrest)
  - ALOC (if persistent or unclear etiology)
  - PSYC (Midazolam given)
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
  - FAIL (VAD malfunction)
  - ODPO (if signing AMA)
  - PREG (if > 20 wks with vaginal bleeding or delivery)
  - LABR (if age ≤ 14 years)
  - SOBB/RDOT/SMOK (severe distress or not improving with CPAP)
  - SEAC/SEPI (pregnant or in status epilepticus)
  - DRWN (if ALOC or needs decompression)
  - TRMA (penetrating eye, TC criteria/guidelines, crush syndrome, or entrapment > 30 minutes)
- GCS motor values are the same for adult and pediatric patients

Uses

- Element necessary to calculate the overall GCS score
- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

TOTAL GCS

Definition

Sum of the initial three numerical values documented for each element of the Glasgow Coma Scale.

Field Values

- One- or two-digit numeric value between 3 and 15

Additional Information

- Maximum total score is 15, which is considered normal. Minimum score possible is 3, which may indicate severe or fatal brain injury
  - 3 to 8 may indicate severe brain injury
  - 9 to 13 may indicate moderate brain injury
  - 14 or 15 may indicate mild or no brain injury
- Space is provided for documentation of a repeat GCS, if applicable

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

PUPILS

Definition

Checkboxes indicating findings from assessment of the patient's initial pupillary response to light

Field Values

- **P**ERL: Pupils are equal in size and react to light
- **U**nequal: Pupils are unequal in size
- P**I**npoint: Pupils are extremely constricted
- **F**ixed/Dilated: Pupils are dilated and do not react to light
- **C**ataracts: Cataracts in one or both eyes interfere with pupil exam
- **S**luggish: Pupils react to light slower than normal

Additional Information

- **Required** field for all base contacts with the following provider impressions:
  - STRK
  - AGDE (if able)
  - BRUE
  - CANT
  - ALOC (if persistent or unclear etiology)
  - PSYC (if able)
  - ODPO (if signing AMA)
  - SEAC/SEPI (pregnant or in status epilepticus)
  - DRWN (if assessed)
  - TRMA (penetrating eye, CC=PH, CC=RR (if RR<10), or CC=14)

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

RESPIRATION

Definition

Checkboxes indicating findings from initial assessment of the patient's respiratory system

Field Values

- **C**lear: No abnormal sounds are heard on auscultation
- **N**ormal rate/effort: Breathing appears effortless and rate is within normal limits for patient
- Tidal Volume:
  - **N**: Normal depth of inspiration is observed
  - **+**: Increased depth of inspiration is observed
  - **-**: Decreased depth of inspiration is observed
- **W**heezes: Coarse, whistling sound heard on auscultation, associated with inspiration and/or expiration
- **R**ales: Rattling or crackling noises heard on auscultation, associated with inspiration
- R**H**onchi: Coarse, rattling or snoring sound heard on auscultation, associated with inspiration and/or expiration
- S**T**ridor: High-pitched, audible wheezing sound associated with inspiration and/or expiration
- **L**abored: Breathing appears to be difficult or requires extra effort
- **U**nequal: Chest rise or breath sounds diminished on one side
- **J**VD: Distended jugular veins are observed in the supine patient
- Accessory **M**uscle Use: Patient is using additional muscles to assist with difficulty breathing, such as those of the neck, shoulders, or abdomen
- **A**pnea: Patient is not breathing or stops breathing for periods of time
- **S**noring: Prolonged snorting sound/soft palate vibration that is audible during inspiration

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - STRK
  - HOTN
  - SHOK
  - CPSC/CPMI (pediatric patients)
  - BRTH
  - BABY
  - DYRX
  - ANPH
  - BRUE
  - CANT
  - AGDE (tidal volume only)
  - CHOK (severe distress and/or respiratory arrest)
  - ALOC (if persistent or unclear etiology)
  - PSYC (Midazolam given)
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
  - FAIL (VAD malfunction)

- ODPO (if signing AMA)
- PREG (if > 20 wks. with vaginal bleeding or delivery)
- LABR (if ≤ 14 years)
- SOBB/RDOT/SMOK (severe distress or not improving with CPAP)
- SEAC/SEPI (pregnant or in status epilepticus)
- DRWN (if ALOC or needs decompression)
- TRMA (penetrating eye, TC criteria/guidelines, crush syndrome, or entrapment > 30 min)

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

CAPNOGRAPHY

Definition

The numeric measurement of carbon dioxide present in exhaled air after endotracheal tube (ETT) or supraglottic airway (SGA) insertion, if applicable

Field Values

- Up to three-digit positive numeric values

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - CANT
  - STRK/HOTN/SHOK/CHOK/FAIL/SOBB/RDOT/SMOK/DRWN (if BMV used)

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

WAVEFORM?

Definition

Checkbox indicating whether a waveform is observed on the capnography tracing, if applicable

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - CANT
  - STRK/HOTN/SHOK/CHOK/FAIL/SOBB/RDOT/SMOK/DRWN (if BMV used)

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

ADV AIRWAY

Definition

Checkboxes indicating initial assessment of findings after placement of an advanced airway, if applicable

Field Values

- BS after ETT/King: Mark appropriate box to indicate whether breath sounds are auscultated after placement of an endotracheal tube or King LTs-D
  - **Y**es
  - **N**o
- $ETCO_2$: Mark appropriate box to indicate presence or absence of CO_2 detected after placement of an endotracheal tube or King LTs-D:
  - **+**: present
  - **–**: absent

Additional Information

- **Required** field for all base hospital contacts with advanced airway placement in the field
- Associated provider impressions include:
  - RARF
  - STRK
  - HOTN
  - SHOK
  - CANT
  - CHOK (severe distress and/or respiratory arrest)
  - SOBB/RDOT/SMOK (severe distress or not improving with CPAP)
  - DRWN (if ALOC or needs decompression)
  - TRMA (penetrating eye, TC criteria/guidelines, crush syndrome, or entrapment > 30 min)

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

SKIN

Definition

Checkboxes indicating findings from assessment of the patient's initial skin signs

Field Values

- **N**ML: All aspects of skin assessment (color, temperature, moisture, and appearance) are normal
- **P**ale: Skin appears abnormally pale, ashen, or gray
- Coo**L**/Cold: Skin feels cool or cold to touch
- **D**iaphoretic: Skin is sweaty or moist to touch
- **C**yanotic: Skin or lips appear blue
- **F**lushed: Skin appears red
- **H**ot: Skin feels warmer than normal or hot to touch
- Cap Refill No**R**mal: Capillary refill is less than or equal to 2 seconds
- Cap Refill D**E**layed: Capillary refill is greater than 2 seconds

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - HOTN
  - SHOK
  - CPSC/CPMI (pediatric patients)
  - BRTH
  - BABY
  - DYRX
  - AGDE
  - ANPH
  - BRUE
  - CANT
  - CHOK (severe distress and/or respiratory arrest)
  - ALOC (if persistent or unclear etiology)
  - PSYC (Midazolam given)
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
  - FAIL (VAD malfunction)
  - ODPO (if signing AMA)
  - PREG (if > 20 wks with vaginal bleeding or delivery)
  - LABR (if age ≤ 14 years)
  - SOBB/RDOT/SMOK (severe distress or not improving with CPAP)
  - SEAC/SEPI (pregnant or in status epilepticus)
  - DRWN (if ALOC or needs decompression)
  - TRMA (penetrating eye, TC criteria/guidelines, crush syndrome or entrapment > 30 min)
- Capillary refill must be completed for all pediatric patients without a documented systolic blood pressure

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

GLUCOMETER

Definition

Numeric value of the patient's blood glucose measurement, if applicable

Field Values

- Up to three-digit positive numeric value
- #1: The initial blood glucose level
- #2: The second blood glucose level, if applicable

Additional Information

- **Required** field for all base hospital contacts if mLAPSS is performed, if Protocol 1232 is utilized, or for the following provider impressions:
  - STRK
  - ALOC (if persistent or unclear etiology)
  - PSYC (Midazolam given)
  - ODPO (if signing AMA)
  - PREG/LABR (if history of diabetes or gestational diabetes)
  - SEAC/SEPI (pregnant or in status epilepticus)
  - DRWN (if ALOC or needs decompression)
  - TRMA (if CC=14)
  - HOTN/SHOK (if ALOC)
  - AGDE (if able)
- If equipment used yields an alpha reading indicating blood sugar is "LOW," enter the number "1"
- If equipment used yields an alpha reading indicating blood sugar is "HIGH," enter the number "999"

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

GLUCOMETER ORDERED?

Definition

Checkboxes indicating whether a glucometer was ordered by the base hospital, if applicable

Field Values

- **Y**: Yes
- **N**: No

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

ECG

INITIAL RHYTHM

Definition

Two- or three-letter code indicating patient's initial cardiac rhythm from the cardiac monitor

Field Values

1HB	1st Degree Heart Block	**PEA**	Pulseless Electrical Activity
2HB	2nd Degree Heart Block	**PM**	Pacemaker Rhythm
3HB	3rd Degree Heart Block	**PST**	Paroxysmal Supraventricular Tachycardia
AFI	Atrial Fibrillation	**PVC**	Premature Ventricular Contraction
AFL	Atrial Flutter	**SA**	Sinus Arrhythmia
AGO	Agonal Rhythm	**SB**	Sinus Bradycardia
ASY	Asystole	**SR**	Sinus Rhythm
AVR	Accelerated Ventricular Rhythm	**ST**	Sinus Tachycardia
IV	Idioventricular Rhythm	**SVT**	Supraventricular Tachycardia
JR	Junctional Rhythm	**VF**	Ventricular Fibrillation
PAC	Premature Atrial Contraction	**VT**	Ventricular Tachycardia
PAT	Paroxysmal Atrial Tachycardia		

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - STRK
  - HOTN
  - SHOK
  - CPSC/CPMI (pediatric patients)
  - CANT
  - AGDE (if able)
  - CHOK (severe distress and/or respiratory arrest)
  - ALOC (if persistent or unclear etiology)
  - PSYC (Midazolam given)
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
  - FAIL (VAD malfunction)
  - ODPO (if signing AMA)
  - SOBB/RDOT/SMOK (severe distress or not improving with CPAP)
  - SEAC/SEPI (pregnant or in status epilepticus)
  - DRWN (if ALOC or needs decompression)
  - TRMA (penetrating eye, TC criteria/guidelines, crush syndrome or entrapment > 30 min)
- ECG codes are also found on the back of pages 1 and 4 of the Base Hospital Form
- Additional cardiac rhythm information can be documented in the Assessment section

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

12-LEAD ECG ORDERED?

Definition

Checkboxes indicating whether a 12-lead ECG was ordered by the base hospital, if applicable

Field Values

- **Y**: Yes
- **N**: No

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

12 LEAD ECG @

Definition

Time of day that a 12-lead ECG was performed, if applicable

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- **Required** field for all base hospital contacts where a 12-lead ECG is performed
- 12-lead ECGs are required for the following provider impressions:
  - CPSC
  - CPMI
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, enter the 12-lead time from the STEMI ECG in this field
- If a poor quality ECG is repeated and the repeat ECG is of good quality, enter the time from the repeat ECG

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- 12-Lead ECG
- SRC Log
- Audio Records

EMS INTERPRETATION

Definition

Checkboxes indicating the EMS personnel's interpretation of the 12-lead ECG, if applicable

Field Values

- **N**orma**L**: EMS personnel interpretation indicates ECG is normal
- **AB**normal: EMS personnel interpretation indicates ECG is abnormal
- STE**MI**: EMS personnel interpretation indicates an ST-Elevation Myocardial Infarction, or manufacturer's equivalent

Additional Information

- **Required** field for all base hospital contacts where a 12-lead ECG is performed
- 12-lead ECGs are required for the following provider impressions:
  - CPSC
  - CPMI
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
- All 12-lead ECGs performed by EMS personnel need an EMS interpretation
- If EMS personnel interpretation indicates an ST-Elevation Myocardial Infarction the patient should be transported to the nearest available STEMI Receiving Center (SRC)
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, enter STEMI (two-letter code **MI**) in this field
- If a poor quality ECG is repeated and the repeat ECG is of good quality, enter the EMS interpretation of the repeat ECG

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- 12-Lead ECG
- SRC Log
- Audio Records

SOFTWARE INTERPRETATION

Definition

Checkboxes indicating the software's interpretation of the 12-lead ECG, if applicable

Field Values

- **N**orma**L**: Electronic interpretation indicates ECG is normal
- **AB**normal: Electronic interpretation indicates ECG is abnormal
- STE**MI**: Electronic interpretation indicates an ST-Elevation Myocardial Infarction

Additional Information

- **Required** field for all base hospital contacts where a 12-lead ECG is performed
- 12-lead ECGs are required for the following provider impressions:
  - CPSC
  - CPMI
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
- If electronic interpretation indicates an ST-Elevation Myocardial Infarction (or manufacturer's equivalent) the patient should be transported to the nearest available SRC
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, enter STEMI (two-letter code **MI**) in this field
- If a poor quality ECG is repeated and the repeat ECG is of good quality, enter the software interpretation of the repeat ECG

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- 12-Lead ECG
- SRC Log
- Audio Records

ARTIFACT?

Definition

Checkbox indicating whether artifact is observed on the 12-lead ECG tracing

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- **Required** field for all base hospital contacts where either the EMS or software interpretation of the 12-lead ECG indicates STEMI
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, use this field to indicate whether artifact is present
- Electronic artifact interferes with accurate ECG interpretation and may indicate need to repeat the ECG. If a poor quality ECG is repeated and the repeat ECG is of good quality, enter the quality of the repeat ECG

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- 12-Lead ECG
- Audio Records

WAVY BASELINE?

Definition

Checkbox indicating whether the baseline of the 12-lead ECG tracing moves with respiration

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- **Required** field for all base hospital contacts where either the EMS or software interpretation of the 12-lead ECG indicates STEMI
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, use this field to indicate whether a wavy baseline is present
- Wavy baseline can interfere with accurate ECG interpretation and may indicate need to reposition leads and repeat the ECG. If a poor quality ECG is repeated and the repeat ECG is of good quality, enter the quality of the repeat ECG

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- 12-Lead ECG
- Audio Records

PACED RHYTHM?

Definition

Checkbox indicating whether the 12-lead ECG or electronic interpretation indicates presence of a pacemaker-generated rhythm

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- **Required** field for all base hospital contacts where either the EMS or software interpretation of the 12-lead ECG indicates STEMI
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, use this field to indicate whether a paced rhythm is present
- Pacemakers can interfere with accurate ECG interpretation and must be reported

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- 12-Lead ECG
- Audio Records

ARREST

WITNESSED BY

Definition

Checkbox indicating witnesses to a patient's collapse due to cardiac arrest, if applicable

Field Values

- **C**itizen: Witnessed by a non-EMS person (e.g., law enforcement, nursing home personnel, bystanders, family, etc.)
- **E**MS: Witnessed by EMS personnel
- **N**one: Not witnessed

Additional Information

- **Required** field for all base hospital contacts with a provider impression code of "CANT"

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

CPR BY

Definition

Checkbox indicating who performed CPR on a patient in cardiac arrest, if applicable

Field Values

- **C**itizen: CPR was initiated by a non-EMS person (e.g., law enforcement, nursing home personnel, bystanders, family, etc.)
- **E**MS: CPR was initiated by EMS
- **N**one: No CPR was initiated

Additional Information

- **Required** field for all base hospital contacts with a provider impression code of “CANT”

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

ARREST TO CPR

Definition

Estimated time, in minutes, from the time of arrest to the time of initiation of CPR, if applicable

Field Values

- Collected as minutes

Additional Information

- **Required** field for all base hospital contacts with a witnessed, non-traumatic cardiac arrest/collapse
- If the arrest was unwitnessed, enter as “Not Applicable” (F7) in TEMIS
- If arrest was witnessed, but minutes from arrest to CPR is not provided, entered as “Not Documented” (F6) in TEMIS

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

RTN OF PULSE (ROSC)?

Definition

Checkbox indicating whether return of spontaneous circulation (ROSC) occurred, which is defined as restoration of a spontaneous perfusing rhythm. Signs of ROSC include: palpable pulse, breathing (more than occasional gasp), a measurable blood pressure and/or a sudden rise in capnography to a normal to high reading, if applicable

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- **Required** field for all base hospital contacts with a provider impression code of "CANT"
- Document "Yes" even if the pulses are lost prior to arrival at the receiving facility
- Adult patients with non-traumatic cardiac arrest, with or without ROSC, that are transported by 9-1-1 should be transported to the nearest available SRC
- Patients in traumatic arrest that are transported by 9-1-1 should be transported in accordance with trauma destination policies

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

RTN OF PULSE (ROSC) @

Definition

Time of day when ROSC occurs, if applicable

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- **Required** field for all base hospital contacts with a provider impression code of “CANT” with ROSC in the field
- Document the time of day ROSC occurs, even if the pulses are lost prior to arrival at the receiving facility
- If patient does not have ROSC, enter as “Not Applicable” (F7) in TEMIS

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

RESUS D/C @

Definition

Time of day when resuscitative measures were terminated or patient was pronounced dead by the base hospital, if applicable

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- **Required** field for all base hospital contacts with a provider impression code of “CANT” where resuscitative measures were discontinued in the field
- If the patient was transported, enter as “Not Applicable” (F7) in TEMIS

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

RESUS D/C RHYTHM

Definition

Two- or three-letter code identifying the cardiac rhythm reported when resuscitative measures were terminated or patient was pronounced dead by the base hospital, if applicable

Field Values

AGO	Agonal	**PEA**	Pulseless Electrical Activity
ASY	Asystole	**VF**	Ventricular Fibrillation
IV	Idioventricular Rhythm		

Additional Information

- **Required** field for all base hospital contacts with a provider impression code of “CANT” where resuscitative measures were discontinued in the field
- If the patient was transported, enter as “Not Applicable” (F7) in TEMIS
- PEA is not a defined rhythm, but rather a finding that may be present at time of pronouncement or termination of resuscitative measures where electrical activity and/or rhythm seen on the cardiac monitor does not produce a palpable pulse or auscultatable heartbeat

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

TOTAL MIN. EMS CPR

Definition

Time in minutes from the initiation of CPR by EMS personnel, to the time when resuscitative measures were terminated or patient was pronounced dead by the base hospital, if applicable

Field Values

- Collected in minutes
- Up to two-digit positive numeric value

Additional Information

- **Required** field for all base hospital contacts with a provider impression code of “CANT” where resuscitative measures were discontinued in the field
- If the patient was transported, enter as “Not Applicable” (F7) in TEMIS

Uses

- Assists with determination of appropriate treatment and transport
- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

VITALS & TXS

O2 @ ___ LPM

Definition

Numeric value of the number of liters per minute of oxygen delivered to the patient, if applicable

Field Values

- One- or two-digit positive numeric value between 2 and 15

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - CANT
  - CHOK (severe distress and/or respiratory arrest)
  - SOBB/RDOT/SMOK (severe distress or not improving with CPAP)
  - DRWN (if ALOC or needs decompression)
  - STRK/HOTN/SHOK/CPSC or CPMI (pediatric patients)/ANPH/BRUE/ALOC (if persistent or unclear etiology)/DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)/TRMA – if O2 given
  - BRTH (if O2 Sat < 94%)
- The oxygen delivery device used must also be indicated

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

TITRATED?

Definition

Checkbox indicating that the number of liters per minute of oxygen ordered by the base hospital was given in a range, to be adjusted to desired effect, if applicable

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- The oxygen delivery device used must also be indicated

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

VIA

Definition

Checkboxes indicating the type of device used to deliver oxygen to the patient, if applicable

Field Values

- **N**C: Nasal Cannula
- **M**ask: Oxygen mask
- **B**MV: Bag-Mask Ventilation
- Blo**W** By: Oxygen delivery device is used to “blow” oxygen towards patient’s face
- E**X**isting Trach.: Patient is being oxygenated/ventilated via an existing tracheostomy tube
- **E**TT: Endotracheal Tube
- **K**ing: King LTS-D (laryngeal tube suction device)
- **C**PAP: Continuous Positive Airway Pressure

Additional Information

- The number of liters per minute of oxygen delivered must also be indicated

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

IV

Definition

Checkboxes indicating type of IV access ordered for the patient

Field Values

- **S**L: Saline Lock device
- **F**C: Fluid challenge –specified amount of IV fluid is ordered to be given over a specified amount of time. In the space provided, enter the number of ccs of IV fluid ordered
- **N**ot Ordered: No IV ordered
- **I**V Unable: Paramedics were not able to successfully establish an IV
- **R**efused: Patient refused to allow paramedics to establish IV access
- I**O**: Intraosseous device
- Pree**X**isting IV: Upon arrival of EMS personnel, the patient already had IV access established (by a clinic, urgent care, doctor's office, etc.)

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - STRK
  - HOTN
  - SHOK
  - CPSC/CPMI (pediatric patients)
  - CHOK (severe distress and/or respiratory arrest)
  - ALOC (if persistent or unclear etiology)
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
  - FAIL (VAD malfunction)
  - PREG (if > 20 wks with vaginal bleeding or delivery)
  - LABR (if age ≤ 14 years)
  - SOBB/RDOT/SMOK (severe distress or not improving)
  - SEAC/SEPI (pregnant or in status epilepticus)
  - DRWN (If ALOC or needs decompression)
  - TRMA (penetrating eye, TC criteria/guidelines, crush syndrome, or entrapment > 30 min)
- IV status is required for the following provider impressions:
  - BRTH
  - DYRX
  - AGDE
  - ANPH
  - CANT

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

TRANSCUTANEOUS PACING @ mA

Definition

Numeric value of the electrical current strength in milliamps (mA) required to achieve capture (as evidenced by a palpable pulse that corresponds with the rhythm observed on the cardiac monitor) during transcutaneous pacing, if applicable

Field Values

- Up to three-digit positive numeric value

Additional Information

- **Required** field for base hospital contacts with the provider impression code of “DYSR” for symptomatic bradycardia

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

RATE

Definition

Numeric value of the rate of capture during transcutaneous pacing (as evidenced by a palpable pulse that corresponds with the rhythm observed on the cardiac monitor), if applicable

Field Values

- Up to three-digit positive numeric value

Additional Information

- **Required** field for base hospital contacts with the provider impression code of “DYSR” for symptomatic bradycardia

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

CAPTURE?

Definition

Checkbox indicating whether mechanical capture (as evidenced by a palpable pulse that corresponds with the rhythm observed on the cardiac monitor) was achieved during transcutaneous pacing, if applicable

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- **Required** field for base hospital contacts with the provider impression code of “DYSR” for symptomatic bradycardia

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

NEEDLE THORACOSTOMY

Definition

Checkbox indicating whether a needle thoracostomy was ordered, if applicable

Field Values

- Y: Yes
- N: No

Additional Information

- If “Yes”, enter “TH” into TEMIS on the Base 2 tab, in the ‘Treatments’ field

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

SPINAL MOTION RESTRICTION?

Definition

Checkbox indicating whether the patient was placed in spinal motion restriction

Field Values

- Y: Yes
- N: No

Additional Information

- **Required** field for all base hospital contacts with a provider impression code of “TRMA”
- If “Yes”, enter “SM” into TEMIS on the Base 2 tab, in the ‘Treatments’ field

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

CMS INTACT

Definition

Checkboxes indicating whether patient's circulation, motor function, and sensation (CMS) were intact before and after spinal motion restriction, if applicable

Field Values

- **I**ntact **B**efore: CMS intact in all extremities prior to spinal motion restriction
- **I**ntact **A**fter: CMS intact in all extremities after spinal motion restriction

Additional Information

- CMS should always be assessed before and after spinal motion restriction
- If checked, "IB" and "IA" should be entered into TEMIS on the Base 2 tab, in the 'Treatments' field

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

SMR REFUSED

Definition

Checkboxes indicating that spinal motion restriction was refused by the patient, if applicable

Field Values

- Y: Yes
- N: No

Additional Information

- **Required** field for all base hospital contacts with a provider impression code of “TRMA”
- If “Yes”, enter “SR” into TEMIS on the Base 2 tab, in the ‘Treatments’ field

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

TOURNIQUET

Definition

Checkbox indicating that a tourniquet (commercial) was applied to control extremity bleeding, if applicable

Additional Information

- If checked, “TK” should be entered into TEMIS on the Base 2 tab, in the ‘Treatments’ field

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

TIME

Definition

Time of day that corresponds to the adjacent vital signs, ECG, and treatments fields

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- May write “PTC” if event occurred prior to base contact – enter as “Not Documented” (F6) in TEMIS
- Time on radio console should only be used if vital signs are repeated during the base contact. Time base contact was initiated <u>should not</u> be used as the time for vital signs obtained prior to base contact

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

B/P

Definition

Numeric values of the patient's systolic and/or diastolic blood pressure

Field Values

- Up to three-digit positive numeric value
- Documented as numeric systolic value/numeric diastolic value

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - STRK
  - HOTN
  - SHOK
  - CPSC/CPMI (pediatric patients)
  - BRTH
  - DYRX
  - CHOK (severe distress and/or respiratory arrest)
  - ALOC (if persistent or unclear etiology)
  - PSYC (Midazolam given)
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
  - FAIL (VAD malfunction)
  - ODPO (if signing AMA)
  - PREG (if > 20 wks with vaginal bleeding or delivery)
  - LABR (if age ≤ 14 years)
  - SOBB/RDOT/SMOK (severe distress or not improving with CPAP)
  - SEAC/SEPI (pregnant or in status epilepticus)
  - DRWN (if ALOC or needs decompression)
  - TRMA (penetrating eye, TC criteria/guidelines, crush syndrome, or entrapment > 30 min)
- If the blood pressure is palpated, write "P" for the diastolic value – enter as "Not Documented" (F6) in TEMIS
- If patient is in cardiac arrest, systolic and diastolic values should be documented as "0"

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

PULSE

Definition

Numeric value of the patient's palpated pulse rate

Field Values

- Up to three-digit positive numeric value

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - STRK
  - HOTN
  - SHOK
  - CPSC/CPMI (pediatric patients)
  - BRTH
  - DYRX
  - BABY
  - CHOK (severe distress and/or respiratory arrest)
  - ALOC (if persistent or unclear etiology)
  - PSYC (Midazolam given)
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
  - FAIL (VAD malfunction)
  - ODPO (if signing AMA)
  - PREG (if > 20 wks with vaginal bleeding or delivery)
  - LABR (if age ≤ 14 years)
  - SOBB/RDOT/SMOK (severe distress or not improving with CPAP)
  - SEAC/SEPI (pregnant or in status epilepticus)
  - DRWN (if ALOC or needs decompression)
  - TRMA (penetrating eye, TC criteria/guidelines, crush syndrome, or entrapment > 30 min)
- Measured in beats palpated per minute
- If the cardiac monitor shows a rhythm that does not produce signs of perfusion, rate should be documented as "0"
- Do not enter the pulse rate associated with CPR, if CPR is in progress, rate should be documented as "0"

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

RR

Definition

Numeric values of the patient's initial, unassisted respiratory rate

Field Values

- Up to three-digit positive numeric value

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - STRK
  - HOTN
  - SHOK
  - CPSC/CPMI (pediatric patients)
  - BRTH
  - DYRX
  - BABY
  - AGDE
  - CHOK (severe distress and/or respiratory arrest)
  - ALOC (if persistent or unclear etiology)
  - PSYC (Midazolam given)
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
  - FAIL (VAD malfunction)
  - ODPO (if signing AMA)
  - PREG (if > 20 wks with vaginal bleeding or delivery)
  - LABR (if age ≤ 14 years)
  - SOBB/RDOT/SMOK (severe distress or not improving with CPAP)
  - SEAC/SEPI (pregnant or in status epilepticus)
  - DRWN (if ALOC or needs decompression)
  - TRMA (penetrating eye, TC criteria/guidelines, crush syndrome, or entrapment > 30 min)
- Measured in breaths per minute
- If patient requires mechanical assistance, then only the unassisted rate, not the assisted rate, should be documented

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

O2 SAT

Definition

Numeric value of the patient's oxygen saturation in the prehospital setting

Field Values

- Up to three-digit percentage from 0 to 100

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - RARF
  - STRK
  - HOTN
  - SHOK
  - CPSC/CPMI (pediatric patients)
  - BRTH
  - DYRX
  - BABY
  - CHOK (severe distress and/or respiratory arrest)
  - ALOC (if persistent or unclear etiology)
  - PSYC (Midazolam given)
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
  - FAIL (VAD malfunction)
  - ODPO (if signing AMA)
  - PREG (if > 20 wks with vaginal bleeding or delivery)
  - LABR (if age ≤ 14 years)
  - SOBB/RDOT/SMOK (severe distress or not improving with CPAP)
  - SEAC/SEPI (pregnant or in status epilepticus)
  - DRWN (if ALOC or needs decompression)
  - TRMA (penetrating eye, TC criteria/guidelines, crush syndrome, or entrapment > 30 min)

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

PAIN

Definition

Numeric value indicating the patient's subjective pain level

Field Values

- Up to two-digit value from 0 to 10

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - CPSC/CPMI (pediatric patients)
  - BRTH
  - PREG (if 20 wks with vaginal bleeding or delivery)
  - LABR (if age ≤ 14 years)
  - TRMA (penetrating eye, TC criteria/guidelines, crush syndrome, or entrapment > 30 min)
- Pain level should be assessed whenever trauma or pain is the provider impression, a mechanism of injury exists, and before and after administration of pain medication

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

CO2

Definition

Numeric value indicating the concentration of carbon dioxide measured by capnography, if applicable

Field Values

- Up to three-digit positive numeric value

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - CANT
  - RARF
  - HOTN, SHOK, FAIL (VAD malfunction) – if BMV used

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

ECG

Definition

Two- or three-letter code indicating the patient's subsequent rhythm(s) on the cardiac monitor, if applicable

Field Values

1HB	1st Degree Heart Block	**PEA**	Pulseless Electrical Activity
2HB	2nd Degree Heart Block	**PM**	Pacemaker Rhythm
3HB	3rd Degree Heart Block	**PST**	Paroxysmal Supraventricular Tachycardia
AFI	Atrial Fibrillation	**PVC**	Premature Ventricular Contraction
AFL	Atrial Flutter	**SA**	Sinus Arrhythmia
AGO	Agonal Rhythm	**SB**	Sinus Bradycardia
ASY	Asystole	**SR**	Sinus Rhythm
AVR	Accelerated Ventricular Rhythm	**ST**	Sinus Tachycardia
IV	Idioventricular Rhythm	**SVT**	Supraventricular Tachycardia
JR	Junctional Rhythm	**VF**	Ventricular Fibrillation
PAC	Premature Atrial Contraction	**VT**	Ventricular Tachycardia
PAT	Paroxysmal Atrial Tachycardia		

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions:
  - DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)
  - TRMA (crush syndrome or entrapment > 30 min) PRN
- Cardiac rhythm should be assessed and documented any time a change is noted, or after any cardiac-related treatments

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

DRUG/DEFIB

Definition

Space for documenting defibrillation/cardioversion and medication codes ordered by the base hospital

Field Values

ADE	Adenosine	**EPI**	Epinephrine
ALB	Nebulized Albuterol	**FEN**	Fentanyl
AMI	Amiodarone	**GLP**	Glucose Paste
ASA	Aspirin	**GLU**	Glucagon
ATR	Atropine	**KLC**	Ketorolac
BEN	Benadryl	**LID**	Lidocaine
BIC	Sodium Bicarbonate	**MID**	Midazolam
CAL	Calcium Chloride	**Morphine**	Morphine Sulfate
CAR	Cardioversion	**NAR**	Narcan
COL	Glucola	**NTG**	Nitroglycerin
D10	D10W	**OND**	Ondansetron
DEF	Defibrillation	**P-EPI**	Push-dose Epinephrine

Additional Information

- **Required** field for all base hospital contacts in which medications are ordered
- Each drug/defibrillation ordered should be written on a separate line so that the dose and results can be clearly documented
- Mark the “Refused” box if the patient refused medication administration and enter “Yes” into TEMIS on the Base 2 tab in the ‘Refused’ field
- Mark the “PRN” box if the medication and/or defibrillation are ordered as PRN and enter “Yes” into TEMIS on the Base 2 tab in the ‘PRN’ field

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

SEDs IN PAST 48 HRS

Definition

Checkboxes indicating whether the patient has used sexually enhancing drugs (SEDs) within the past 48 hours

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- **Required** field for all base hospital contacts with the following provider impressions, if Nitroglycerin is ordered:
  - CPSC
  - CPMI
- Use of SEDs must be assessed prior to ordering nitroglycerin for any patient, regardless of gender

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

DOSE

Definition

Space for numeric value of joules of defibrillation/cardioversion and/or dose of medication ordered by the base hospital

Field Values

- Up to three-digit positive numeric value

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

DOSE UNITS

Definition

The units of medication to be administered or the amount of energy to be delivered for defibrillation/cardioversion

Field Values

- **gm:** grams
- **J:** joules
- **mcg:** micrograms
- **mEq:** milliequivalent
- **mg:** milligrams
- **mL:** milliliter

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

ROUTE

Definition

Two-letter code indicating the route of medication administration ordered by the base hospital, if applicable

Field Values

- **IV**: Intravenous
- **IO**: Intraosseous
- **SQ**: Subcutaneous
- **IM**: Intramuscular
- **PO**: By Mouth (per os)/oral disintegrating tablets (ODT)
- **IN**: Intranasal/Inhalation (e.g., HHN)
- **SL**: Sublingual

Additional Information

- Drug route codes are listed on the back of pages 1 and 4 of the Base Hospital Form

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

TX/RESULTS

Definition

Space for brief documentation of results of medications given or treatments rendered

Field Values

- "**-**": Deteriorated
- "**+**": Improved
- "**N**": No Change
- **0:** 0
- **1:** 1
- **2:** 2
- **3:** 3
- **4:** 4
- **5:** 5
- **6:** 6
- **7:** 7
- **8:** 8
- **9:** 9
- **10:** 10

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

TRAUMA

TRAUMA

Definition

Checkboxes indicating the nature and location of the patient's injury, if applicable

Field Values

- **N**o **A**pparent Injury (**NA**): No complaint, or signs or symptoms of injury following a traumatic event
- **BU**rns/Elec. Shock (**BU**): Thermal or chemical burn, or electric shock
- **C**ritical **B**urn (**CB**): Patients ≥ 15 years of age with 2nd (partial thickness) and 3rd (full thickness) degree burns involving ≥ 20% Total Body Surface Area (TBSA) **OR** patients ≤ 14 years of age with 2nd and 3rd degree burns involving ≥10% TBSA
- SBP <**90** (<70 if under 1y) (**90**): Systolic blood pressure less than 90mmHg in a patient greater than one year of age (or systolic blood pressure less than 70mmHg in a patient less than one year of age) following a traumatic event
- **RR** <10/>29 (<20 if <1y) (**RR**): A sustained respiratory rate greater than 29 breaths/minute, or respiratory rate of less than 10 breaths/minute (or less than 20 breaths/minute in a patient less than one year of age), following a traumatic event
- **S**usp. Pelvic F**X** (**SX**): Suspected pelvic fracture, excluding isolated hip fractures from a ground level fall
- **S**pinal **C**ord Injury (**SC**): Suspected spinal cord injury, or presence of weakness/paralysis/paresthesia following a traumatic event
- **I**npatient **T**rauma (**IT**): Interfacility transfer (IFT) of an admitted, injured patient from one facility to an inpatient bed at another facility, excluding ER to ER transfers
- **U**ncontrolled **B**leeding (**UB**): Extremity bleeding requiring use of a tourniquet or hemostatic dressing
- **T**rauma Arrest (**BT** or **PT**): Cessation of cardiac output and effective circulation due to blunt or penetrating force
- **H**ead (**BH** or **PH**): Injury to the head or skull in the area from above the eyebrows to behind the ears, due to blunt or penetrating force. This code can also be applied in association with facial injuries when it is likely that the brain is involved
- GCS ≤**14** (**14**): Blunt force head injury associated with a Glasgow Coma Scale score of less than or equal to 14
- **F**ace/mouth (**BF** or **PF**): Injury to the anterior aspect of the face, mouth, or skull, from and including the eyebrows, down to and including the angle of the jaw and the ears, due to blunt or penetrating force
- **N**eck (**BN** or **PN**): Injury or pain to the area between the angle of the jaw and clavicles (including probable cervical spine injuries) due to blunt or penetrating force
- **B**ack (**BB** or **PB**): Injury to the area from the shoulders to the buttocks (but not including the buttocks) due to blunt or penetrating force
- **C**hest (**BC** or **PC**): Injury to the anterior chest in the area between the clavicle and the xyphoid process, bordered on either side by the posterior axillary line, due to blunt or penetrating force
- **F**lail **C**hest (**FC**): Blunt force injury to the chest wall resulting in an unstable chest wall, characterized by paradoxical chest wall movement with respirations

- Tension **P**neum (**BP** or **PP**): Air enters the pleural space due to blunt or penetrating force, and creates pressure on chest organs. Signs and symptoms can include: SOB, tachypnea, decreased or absent lung sounds on one side, shock, neck vein distention, and/or tracheal deviation
- **A**bdomen (**BA** or **PA**): Injury to any of the abdominal quadrants, flanks, or pelvis due to blunt or penetrating force
- **D**iffuse Abd. Tender. (**BD**): Blunt force injury to the abdomen resulting in tenderness in two or more quadrants
- **G**enitals (**BG** or **PG**): Injury to the external reproductive structures due to blunt or penetrating force
- Buttoc**K**s (**BK** or **PK**): Injury to the buttocks due to blunt or penetrating force
- **E**xtremities (**BE** or **PE**): Injury or pain to the shoulders, arms, hands, legs, or feet due to blunt or penetrating force
- E**X**tr ↑ knee/elbow (**PX**): Penetrating force injury to an extremity, proximal to (above) the knee or elbow
- F**R**actures ≥ 2 long bones (**BR**): Blunt force injury resulting in apparent fracture of 2 or more proximal long bones (humerus, femur.
- Amputat**I**on ↑ wrist/ankle (**BI** or **PI**): Amputation proximal to (above) the wrist or ankle due to blunt or penetrating force
- Neur/**V**asc/Mangled (**BV** or **PV**): Injury to an extremity with neurological and/or vascular compromise, or that is crushed, degloved, or mangled due to blunt or penetrating force
- Minor **L**acerations (**BL** or **PL**): Superficial or non-serious lacerations, abrasions, or contusions involving the skin or subcutaneous tissue, due to blunt or penetrating force

Additional Information

- **Required** field for all base hospital contacts where patient is reported to be injured or a mechanism of injury is present
- Check all that apply - if the patient has multiple complaints, enter chief complaints in order of significance
- Codes beginning with “B” or “P” indicate Blunt or Penetrating injury, respectively
- Two-letter codes can be derived from the bolded, capitalized letters of the trauma descriptions – trauma codes should be listed in order of significance in the “Chief Complaint Code” fields
- Patients with injuries documented must also have a trauma provider impression code and mechanism of injury documented – and vice versa
- Medical complaints should not be documented with trauma complaints, unless it is suspected that a medical complaint preceded/caused the injury, or vice versa (e.g., chest pain/dizziness that caused an MVA, or seizure activity following a blow to the head.) Do not document a medical complaint such as “HP” (head pain) if the pain is due to a gunshot wound to the head – instead use only the trauma code of “PH.”
- Penetrating injuries may be inflicted by dull objects travelling at high velocity (e.g., bullets), sharp objects with a low velocity, or from a slashing or puncturing force
- Blunt injuries occur from forces that do not typically penetrate the skin (e.g., baseball bat) though lacerations may be caused by the tearing/crushing force of a blunt object or broken bones
- Injury descriptions listed in **red** meet trauma triage criteria for transport to the nearest available trauma center

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

MECHANISM OF INJURY

Definition

Checkboxes indicating how the patient was injured

Field Values

- Protective Devices – **H**e**L**met (**HL**): The patient riding on an unenclosed motorized vehicle/bicycle was wearing a helmet at the time of impact
- Protective Devices – **S**eat **B**elt (**SB**): Patient was wearing a seat belt at the time of impact
- Protective Devices – **A**ir**B**ag (**AB**): Airbag deployed at the time of impact and directly protected the patient
- Protective Devices – **C**ar **S**eat/Booster (**CS**): The patient was riding in a car seat or booster at the time of impact
- **E**nclosed **V**eh. (**EV**): Patient involved in collision while in an enclosed vehicle, such as an automobile, bus, or other enclosed motorized vehicle
- **Ej**ected (**EJ**): Patient was fully or partially thrown from a vehicle, including convertibles and trucks. Does **NOT** include motorcycles
- **EX**tricated @ (**EX**): Time of day that the patient was removed from the vehicle when use of a pneumatic tool was required
- **P**assenger **S**pace Intrusion (**PS**): Intrusion of greater than 12 inches into an occupied passenger space of a motor vehicle, or greater than 18 inches into an unoccupied passenger space – check this box if amount of intrusion is not known or not specified by paramedics
- **12**: Intrusion of greater than 12 inches into an occupied passenger space of a motor vehicle – check this box when amount of intrusion is specified by paramedics
- **18:** Intrusion of greater than 18 inches into an unoccupied passenger space – check this box when amount of intrusion is specified by paramedics
- **S**urvived **F**atal Accident (**SF**): The patient survived a collision where another person **in the same vehicle** was fatally injured
- Impact > **20**mph Unenclosed (**20**): An unenclosed transport crash (e.g., skateboard, bicycle, horse, etc.) hit an object with an estimated impact greater than 20mph
- Ped/Bike: **R**unover/**T**hrown/>20mph (**RT**): Pedestrian, bicyclist, or motorcyclist was struck by an automobile and is thrown, run over, or has an estimated impact of greater than 20mph
- **P**ed/**B**ike < 20mph (**PB**): Pedestrian, bicyclist, or motorcyclist struck by a motorized vehicle, who is NOT thrown or run over, at an estimated impact of less than 20 mph
- **M**otorcycle/**M**oped (**MM**): The patient was riding on a motorcycle or moped at the time of impact
- **TA**ser (**TA**): Injury due to the deployment of a conducted electrical weapon (CEW), e.g. Taser®
- **SP**orts/Rec (**SP**): Any injury that occurs during a sporting or recreational athletic activity, such as aerobics, football, jogging, etc.
- **AS**sault (**AS**): Patient was physically assaulted (kicked, punched, strangled, etc.) by means other than stabbing or shooting
- **ST**abbing (**ST**): A sharp or piercing instrument (e.g. knife, broken glass, ice pick, etc.) caused an injury which penetrated the skin

- **GS**W (**GS**): Gunshot Wound - injury was caused by discharge of a gun (accidental or intentional)
- **AN**imal Bite (**AN**): The teeth of a human, reptile, dog, cat, or other animal inflicted an injury, whether or not the skin was punctured. Insect bites and bee stings are not considered animal bites, and should be coded as "Other"
- **CR**ush (**CR**): Injury sustained as the result of external pressure being placed on body parts between two opposing forces
- **T**elemetry **D**ata (**TD**): Vehicle telemetry data is encountered that is consistent with high risk of serious injury
- **S**pecial **C**onsid. (**SC**): Injured patients that meet Special Considerations due to age greater than 55 years, pregnancy > 20 weeks, age greater than 65 years with a systolic BP of less than 110mmHg, or patients in blunt traumatic full arrest who, based on a paramedic's thorough patient assessment, believes transport is indicated
- **A**nti**C**oagulants (**AC**): Injured patient is on anticoagulant medication other than aspirin (excludes minor extremity injury)
- **FA**ll (**FA**): Any injury resulting from a fall from any height
- >**15** ft. (>10 ft. Peds) (**15**): A vertical, uninterrupted fall of greater than 15 feet for an adult or greater than 10 feet or 3 times the height of the child for a pediatric patient. This mechanism is a subcategory of "Fall." This does not include falling down stairs or rolling down a sloping cliff.
- **S**elf-Inflict'd/**A**ccid. (**SA**): The injury appears to have been accidentally caused by the patient
- **S**elf-Inflict'd/**I**ntent. (**SI**): The injury appears to have been intentionally caused by the patient
- **E**lectrical **S**hock (**ES**): Passage of an electrical current through body tissue because of contact with an electrical source
- **T**hermal **B**urn (**TB**): Burn caused by heat
- **H**azmat **E**xposure (**HE**): The patient was exposed to toxic or poisonous agents, such as liquids, gases, powders, foams, or radioactive material
- **W**ork- **R**elated (**WR**): Injury occurred while patient was working, and may be covered by Worker's Compensation
- **UN**known (**UN**): The cause or mechanism of injury is unknown
- **OT**her (**OT**): A cause of injury or uncontrolled bleeding that does not fall into any of the existing categories

Additional Information

- **Required** field for all base hospital contacts where patient is reported to be injured
- Check all that apply
- Two-letter codes can be derived from the bolded, capitalized letters of the mechanisms of injury (MOI) – MOIs should be listed in order of significance in the MOI code fields
- Patients with a MOI documented must also have a trauma chief complaint and provider impression code documented – and vice versa
- MOIs listed in **red** on the base hospital form meet trauma triage criteria for transport to the nearest available trauma center
- MOIs listed in **blue** on the base hospital form meet trauma guidelines for transport to the nearest available trauma center - strong consideration should be given to a trauma center destination

- Do not enter more than one copy of the same mechanism of injury
- Cannot have a MOI that is only Anticoagulants (AC) or Special Considerations (SC), an additional mechanism of injury must be entered
- If patient has uncontrolled bleeding due to a non-traumatic reason, such as a medical device failure (e.g. AV shunt bleeding), mechanism of injury should be documented as “OT”

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

TRANSPORT

CODE ALL OPTIONS

Definition

Three-letter code for each of the potential patient destination facilities

Field Values

LOS ANGELES COUNTY 9-1-1 RECEIVING			
ACH	Alhambra Hospital Medical Center	KFW	Kaiser Foundation Hospital – West Los Angeles
AHM	Catalina Island Medical Center	LBM	MemorialCare Long Beach Medical Center
AMH	Methodist Hospital of Southern California	LCH	Palmdale Regional Medical Center
AVH	Antelope Valley Hospital	LCM	Providence Little Co. of Mary M.C. - Torrance
BEV	Beverly Hospital	MCP	Mission Community Hospital
BMC	Southern California Hospital at Culver City	MHG	Memorial Hospital of Gardena
CAL	Dignity Health - California Hospital Medical Center	MID	Olympia Medical Center
CHH	Children's Hospital Los Angeles	MLK	Martin Luther King Jr. Community Hospital
CHP	Community Hospital of Huntington Park	MPH	Monterey Park Hospital
CNT	Centinela Hospital Medical Center	NOR	LA Community Hospital at Norwalk
CPM	Coast Plaza Hospital	NRH	Dignity Health - Northridge Hospital Medical Center
CSM	Cedars-Sinai Medical Center	OVM	LAC Olive View-UCLA Medical Center
DCH	PIH Health Downey Hospital	PAC	Pacifica Hospital of the Valley
DFM	Cedars-Sinai Marina Del Rey Hospital	PIH	PIH Health Whittier Hospital
DHL	Lakewood Regional Medical Center	PLB	College Medical Center
ELA	East Los Angeles Doctors Hospital	PVC	Pomona Valley Hospital Medical Center
ENH	Encino Hospital Medical Center	QOA	Hollywood Presbyterian Medical Center
FPH	Emanate Health Foothill Presbyterian Hospital	QVH	Emanate Health Queen of the Valley Hospital
GAR	Garfield Medical Center	SDC	San Dimas Community Hospital
GEM	Greater El Monte Community Hospital	SFM	St. Francis Medical Center
GMH	Dignity Health - Glendale Memorial Hospital and Health Center	SGC	San Gabriel Valley Medical Center
GSH	PIH Health Good Samaritan Hospital	SJH	Providence Saint John's Health Center
GWT	Adventist Health - Glendale	SJS	Providence Saint Joseph Medical Center
HCH	Providence Holy Cross Medical Center	SMH	Santa Monica-UCLA Medical Center
HGH	LAC Harbor-UCLA Medical Center	SMM	Dignity Health - St. Mary Medical Center
HMH	Huntington Hospital	SOC	Sherman Oaks Hospital
HMN	Henry Mayo Newhall Hospital	SPP	Providence Little Co. of Mary M.C. - San Pedro
HWH	West Hills Hospital & Medical Center	TOR	Torrance Memorial Medical Center
ICH	Emanate Health Inter-Community Hospital	TRM	Providence Cedars-Sinai Tarzana Medical Center
KFA	Kaiser Foundation Hospital- Baldwin Park	UCL	Ronald Reagan UCLA Medical Center
KFB	Kaiser Foundation Hospital - Downey	USC	LAC+USC Medical Center
KFH	Kaiser Foundation Hospital – South Bay	VHH	USC Verdugo Hills Hospital
KFL	Kaiser Foundation Hospital – Sunset (Los Angeles)	VPH	Valley Presbyterian Hospital
KFO	Kaiser Foundation Hospital – Woodland Hills	WHH	Whittier Hospital Medical Center
KFP	Kaiser Foundation Hospital – Panorama City	WMH	Adventist Health - White Memorial

ORANGE COUNTY 9-1-1 RECEIVING			
ANH	Anaheim Regional Medical Center	LPI	La Palma Intercommunity Hospital
CHO	Children's Hospital of Orange County	PLH	Placentia Linda Hospital
KHA	Kaiser Foundation Hospital - Anaheim	SJD	St. Jude Medical Center
KFI	Kaiser Foundation Hospital - Irvine	UCI	UCI Medical Center
LAG	Los Alamitos Medical Center	WMC	Western Medical Center Santa Ana
SAN BERNARDINO COUNTY 9-1-1 RECEIVING			
ARM	Arrowhead Regional Medical Center	KFN	Kaiser Foundation Hospital - Ontario
CHI	Chino Valley Medical Center	LLU	Loma Linda University Medical Center
DHM	Montclair Hospital Medical Center	SAC	San Antonio Community Hospital
KFF	Kaiser Foundation Hospital - Fontana		
OTHER COUNTY 9-1-1 RECEIVING			
LRR	Los Robles Hospital & Med Ctr (Ventura)	SJO	St. John Regional Medical Center (Ventura)
SIM	Simi Valley Hospital (Ventura)	RCC	Ridgecrest Regional Hospital (Kern)
NON-BASIC HOSPITALS			
LBV	Long Beach VA	WVA	Wadsworth VA Medical Center

Additional Information

- **Required** field for all base hospital contacts
- A three-letter code for MAR must be documented for all patients, regardless of age
- A three-letter code for EDAP must be documented for all pediatric patients of less than or equal to 14 years of age

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

CHECK ACTUAL DESTINATION

Definition

Checkboxes indicating actual destination of patient

Field Values

- **M**AR: Most Accessible Receiving facility (licensed basic emergency department) that can be reached in the shortest amount of time. Depending on traffic and geography, this may not necessarily be the closest facility. Must be documented for all patients regardless of actual destination
- **E**DAP: Most accessible Emergency Department Approved for Pediatrics approved to receive patients of less than or equal to 14 years of age. Must be documented for all pediatric patients regardless of actual destination
- **T**C: Most accessible Trauma Center approved to receive critically injured patients. Must be documented for all adult patients that meet criteria, guidelines, or special considerations for transport to a TC, regardless of actual destination
- PT**C**: Most accessible Pediatric Trauma Center approved to receive critically injured pediatric patients of less than or equal to 14 years of age. Must be documented for all pediatric patients that meet criteria, guidelines, or special considerations for transport to a PTC, regardless of actual destination
- **P**MC: Most accessible Pediatric Medical Center approved to receive critically ill pediatric patients of less than or equal to 14 years of age. Must be documented for all pediatric patients that meet guidelines for transport to a PMC, regardless of actual destination
- **S**TEMI Receiving Center: Most accessible ST-Elevation Myocardial Infarction (STEMI) Receiving Center approved to receive patients with a suspected STEMI, or transported patients in non-traumatic cardiac arrest, regardless of ROSC. Must be documented for all patients who meet criteria for transport to a SRC, regardless of actual destination
- Prim**A**ry Stroke Center: Most accessible Primary Stroke Center approved to receive suspected stroke patients or patients with a positive mLAPSS exam. Must be documented for all patients who meet guidelines for transport to a PSC, regardless of actual destination
- Comprehensive Stro**K**e Center: Most accessible Comprehensive Stroke Center approved to receive patients with a positive mLAPSS exam and a LAMS score ≥ 4
- Peri**N**atal: Most accessible Perinatal Center approved to receive patients greater than or equal to 20 weeks pregnant. Must be documented for all patients who meet guidelines for transport to a Perinatal Center
- SA**R**T: Most accessible Sexual Assault Response Team facility approved to receive actual or suspected victims of sexual assault/abuse. Must be documented for patients who meet guidelines for transport to a SART Center
- **O**ther: Licensed basic emergency department that may also appropriately receive the patient in addition to those listed above. Most frequently used when the closest facility is inaccessible (e.g., is requesting diversion.) The reason for using “Other” as a destination must be documented in the “Destination Rationale” section

Additional Information

- **Required** field for all base hospital contacts where patients are transported by EMS personnel
- Check only the actual patient destination
- If more than one specialty center option applies, choose the option most applicable to the patient's presentation (e.g., pregnant pediatric patients, or sexually assaulted trauma patients)

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

ETA

Definition

Estimated time of arrival (ETA) for each of the possible destinations documented

Field Values

- Collected as minutes

Additional Information

- **Required** field for each possible destination documented

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio records

CHECK ONE

Definition

Checkboxes indicating whether a specialty center destination was indicated for the patient

Field Values

- **S**pecialty Center **N**ot Required: Patient does not meet guidelines or criteria for transport to a specialty center
- **S**pecialty Center **R**equired/Criteria Met: Patient meets criteria or requirements for transport to a specialty center
- **S**pecialty Center **G**uidelines Met: Patient meets guidelines for transport to a specialty center

Additional Information

- **Required** field for all base hospital contacts
- Check one box only
- If more than one specialty center option applies, choose the option most applicable to the patient's presentation
- If patient meeting requirements, criteria, or guidelines is not transported to the closest specialty center, must indicate reason in the "Destination Rationale" section

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

DESTINATION RATIONALE

Definition

Checkboxes indicating the reason that the patient was transported to a facility other than the most accessible receiving facility or specialty center, if applicable

Field Values

- **E**D Saturation: Most accessible receiving facility or EDAP has requested diversion due to emergency department saturation
- Internal **D**isaster: Most accessible receiving facility or specialty center is closed due to internal disaster such as fire, flood, etc.
- **C**T Diversion: CT scanner at the most accessible receiving facility or specialty center is non-functioning
- I**F**T: Patient is being transferred from one facility to another
- SC Diversion **T**C/PTC: Most accessible TC/PTC is closed due to encumberment of the trauma team or OR
- SC Diversion **P**MC: Most accessible PMC is closed due to lack of critical equipment
- SC Diversion STE**M**I: Most accessible SRC is closed due to Cath lab encumberment or malfunction
- SC Diversion Prim**A**ry Stroke Center: Most accessible primary stroke center is closed when there is no means (CT scan or MRI) to perform diagnostic brain imaging
- SC Diversion Comprehensive Stro**K**e Center: Most accessible comprehensive stroke center is closed due to stroke resource encumberment or critical equipment/interventional radiology room unavailability
- SC Not Accessib**L**e: Specialty center not accessible due to transport time constraints or geography
- Jud**G**ment (Provider/Base): Patient does not meet specialty center criteria, requirements, or guidelines, but is transported to a specialty center based on Base or the Provider judgment; or, meets, but is not transported to a specialty center
- Shared Am**B**ulance: The patient does not meet specialty center criteria, requirements, or guidelines, but is transported to SC because they are sharing an ambulance with a patient who does meet SC criteria/guidelines/requirements
- Minimal In**J**uries: Patient meets trauma criteria or guidelines but is determined to have only minimal injuries which do not warrant transport to a specialty center
- **U**nmanageable Airway: Patient meets specialty center criteria, requirements, or guidelines, but airway cannot be adequately managed due to injury or illness, and patient's life may be jeopardized by transport to any facility but the closest
- **R**equested By: Patient is transported to a facility other than the most accessible receiving facility or specialty center by request from the patient, a family member, patient's private medical doctor (PMD), or other authorized person
- **O**ther: Patient is transported a facility other than the most accessible receiving facility or specialty center for any reason other than those listed above (use space below to briefly document reason)

Additional Information

- **Required** field for all base hospital contacts where the patient is transported to “Other,” (not the closest receiving facility or specialty center)

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

PT TRANSPORTED VIA

Definition

Checkboxes indicating the type of transport unit used

Field Values

- **A**LS: An Advanced Life Support Transport unit in which patient was accompanied by at least one paramedic
- **B**LS: Basic Life Support Transport unit in which patient was accompanied by EMTs only
- **O**ther: Type of transport not listed above
- **H**elicopter ETA: Helicopter transport requested – indicate ETA of helicopter to scene
- **N**o Transport: Patient was not transported (must indicate reason for no transport in the "Reason for No Transport" field)

Additional Information

- **Required** field for all base hospital contacts

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

REASON FOR NO TRANSPORT

Definition

Checkboxes indicating reason why patient was not transported, if applicable

Field Values

- **A**MA: Patient refuses transport
- **D**OA: Patient is determined to be dead on arrival as per Prehospital Care Manual
- **U**nwarranted: Patient's condition does not require transportation to a hospital
- **T**.O.R.: Resuscitative measures are terminated by EMS personnel
- **P**ronounced by: Enter the name of the physician who pronounced the patient dead, if applicable
- **O**ther: Mark this box if the patient was not transported due a reason not listed above

Additional Information

- **Required** field for all base hospital contacts where the patient is not transported

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio Records

TIME CLEAR

Definition

The time of day that paramedic contact with the base hospital ends

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- **Required** field for all base hospital contacts
- Use one timepiece throughout call to ensure accurate time intervals

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form

TIME RECEIVING HOSPITAL NOTIFIED

Definition

The time of day that the receiving hospital was notified of an arriving patient

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- Use one timepiece throughout call to ensure accurate time intervals

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form

NAME OF PERSON NOTIFIED

Definition

Space to document the name of the person at the receiving facility notified of an arriving patient

Field Values

- Free text

Additional Information

- Not necessary if the base hospital is the receiving facility
- Document whatever name is given – e.g., “Mary” or “Dr. Jones”

Uses

- Provides documentation of communication

Data Source Hierarchy

- Base Hospital Form
- Audio Records

MICN/PHYSICIAN

Definition

Signature and certification/identification number of the MICN and/or Base physician contacted

Field Values

- Free text

Additional Information

- **Required** field for all base hospital contacts
- First initial and last name is sufficient for signature
- If **both** a MICN and a physician handle the call, or if a physician is consulted during the run, both names and numbers are documented
- Physician #s are created by each base hospital and are not assigned by Lancet Technology by ESO Solutions or the EMS Agency

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log

TRANSPORT SCENARIOS

Specialty Care Center Not Required

70 y/o female, short of breath x 2 hours, speaking in full sentences, in mild/moderate distress:

TRANSPORT	CODE all options, CHECK actual destination:	CODE	ETA
	☒ MAR	PIH	7
	☐ EDAP (age ≤14)	| |	
	☐ TC	| |	
	☐ PTC (trauma, age ≤14)	| |	
	☐ PMC (medical, age ≤14)	| |	
	☐ STEMI Receiving Center	| |	
	☐ PrimAry Stroke Center	| |	
	☐ Comprehensive StroKe Center	| |	
	☐ PeriNatal (≥20wks pregnancy)	| |	
	☐ SART	| |	
	☐ Other	| |	
	Time Clear	| | |	
	Time Receiving Hospital Notified	| | |	
	Name of Person Notified:		

CHECK ONE:	DESTINATION RATIONALE:
Specialty Center: ☒ Not Required ☐ Required/Criteria Met ☐ Guidelines Met	☐ ED Saturation ☐ Int. Disaster ☐ CT Diversion ☐ IFT SC diversion: ☐ TC/PTC ☐ PMC ☐ STEMI ☐ PrimAry Stroke Center ☐ Comprehensive StroKe Center ☐ SC Not AccessibLe ☐ JudGment *(Provider/Base)* ☐ Shared AmBulance ☐ Minimal InJuries ☐ Unmanageable Airway ☐ Requested by: ☐ Other:
PT TRANSPORTED VIA:	**REASON FOR NO TRANSPORT:**
☒ ALS ☐ BLS ☐ Other ☐ Helicopter-ETA: ____ ☐ No Transport	☐ AMA ☐ DOA ☐ Unwarranted ☐ Other ☐ Pronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ Discharged ☐ Ward ☐ Stepdown ☐ ICU ☐ ObserVation
☐ OR ☐ Cath Lab ☐ INt'l Radiology ☐ Expired in ED ☐ OB
Transferred to: _____ |_|_|_| (Hosp. code) ☐ Other: _____
ED Diagnosis:

- Enter hospital code for the closest MAR
- Indicate the actual destination by checking MAR
- Check Specialty Center: Not Required (SOB as described meets no specialty center criteria or guidelines as per Reference No. 502)
- Destination Rationale is left blank, as there is no deviation from destination principles

Pediatric: EDAP Required

2 y/o male, febrile, witnessed tonic/clonic seizure. No signs of trauma, GCS is improving:

TRANSPORT	CODE all options, CHECK actual destination:	CODE	ETA
	☐ MAR	LCM	5
	☒ EDAP (age ≤14)	LCM	5
	☐ TC	| |	
	☐ PTC (trauma, age ≤14)	| |	
	☐ PMC (medical, age ≤14)	| |	
	☐ STEMI Receiving Center	| |	
	☐ PrimAry Stroke Center	| |	
	☐ Comprehensive StroKe Center	| |	
	☐ PeriNatal (≥20wks pregnancy)	| |	
	☐ SART	| |	
	☐ Other	| |	
	Time Clear	| | |	
	Time Receiving Hospital Notified	| | |	
	Name of Person Notified:		

CHECK ONE:	DESTINATION RATIONALE:
Specialty Center: ☐ Not Required ☒ Required/Criteria Met ☐ Guidelines Met	☐ ED Saturation ☐ Int. Disaster ☐ CT Diversion ☐ IFT SC diversion: ☐ TC/PTC ☐ PMC ☐ STEMI ☐ PrimAry Stroke Center ☐ Comprehensive StroKe Center ☐ SC Not AccessibLe ☐ JudGment *(Provider/Base)* ☐ Shared AmBulance ☐ Minimal InJuries ☐ Unmanageable Airway ☐ Requested by: ☐ Other:
PT TRANSPORTED VIA:	**REASON FOR NO TRANSPORT:**
☒ ALS ☐ BLS ☐ Other ☐ Helicopter-ETA: ____ ☐ No Transport	☐ AMA ☐ DOA ☐ Unwarranted ☐ Other ☐ Pronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ Discharged ☐ Ward ☐ Stepdown ☐ ICU ☐ ObserVation
☐ OR ☐ Cath Lab ☐ INt'l Radiology ☐ Expired in ED ☐ OB
Transferred to: _____ |_|_|_| (Hosp. code) ☐ Other: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR and EDAP
- Indicate the actual destination by checking EDAP
- Check Specialty Center: Required/Criteria Met (EDAP specialty center is required for patients 14yrs of age or younger, as per Reference No. 510)
- Destination Rationale is left blank, as there is no deviation from destination principles

Pediatric: PTC Criteria

5 y/o female, fell from a second story window, GCS 4-6-5. CC = BB, PI=TRMA, MOIs = FA and 15:

TRANSPORT	CODE all options, CHECK actual destination:	CODE	ETA
	☐ MAR	KFL	4
	☐ EDAP (age ≤14)	UCL	7
	☐ TC	| |	
	☒ PTC (trauma, age ≤14)	UCL	7
	☐ PMC (medical, age ≤14)	| |	
	☐ STEMI Receiving Center	| |	
	☐ PrimAry Stroke Center	| |	
	☐ Comprehensive StroKe Center	| |	
	☐ PeriNatal (≥20wks pregnancy)	| |	
	☐ SART	| |	
	☐ Other	| |	
	Time Clear	| | |	
	Time Receiving Hospital Notified	| | |	
	Name of Person Notified:		

CHECK ONE:	DESTINATION RATIONALE:
Specialty Center: ☐ Not Required ☒ Required/Criteria Met ☐ Guidelines Met	☐ ED Saturation ☐ Int. Disaster ☐ CT Diversion ☐ IFT SC diversion: ☐ TC/PTC ☐ PMC ☐ STEMI ☐ PrimAry Stroke Center ☐ Comprehensive StroKe Center ☐ SC Not AccessibLe ☐ JudGment *(Provider/Base)* ☐ Shared AmBulance ☐ Minimal InJuries ☐ Unmanageable Airway ☐ Requested by: ☐ Other:
PT TRANSPORTED VIA:	**REASON FOR NO TRANSPORT:**
☒ ALS ☐ BLS ☐ Other ☐ Helicopter-ETA: ____ ☐ No Transport	☐ AMA ☐ DOA ☐ Unwarranted ☐ Other ☐ Pronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ Discharged ☐ Ward ☐ Stepdown ☐ ICU ☐ ObserVation
☐ OR ☐ Cath Lab ☐ INt'l Radiology ☐ Expired in ED ☐ OB
Transferred to: _____ |_|_|_| (Hosp. code) ☐ Other: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR, EDAP, and PTC
- Indicate the actual destination by checking PTC
- Check Specialty Center: Required/Criteria Met (MOI=15 is criteria for transport to a PTC as per Reference No. 506)
- Destination Rationale is left blank, as there is no deviation from destination principles

Pediatric: PTC Guideline

7 y/o female, auto vs bicycle at less than 5mph, wearing a helmet. CC = BE, PI=TRMA, MOIs = PB and HL:

TRANSPORT	CODE all options, CHECK actual destination:	CODE	ETA
	☐ MAR	HEV	2
	☒ EDAP (age ≤14)	AMH	8
	☐ TC	| |	
	☐ PTC (trauma, age ≤14)	USC	20
	☐ PMC (medical, age ≤14)	| |	
	☐ STEMI Receiving Center	| |	
	☐ PrimAry Stroke Center	| |	
	☐ Comprehensive StroKe Center	| |	
	☐ PeriNatal (≥20wks pregnancy)	| |	
	☐ SART	| |	
	☐ Other	| |	
	Time Clear	| | |	
	Time Receiving Hospital Notified	| | |	
	Name of Person Notified:		

CHECK ONE:	DESTINATION RATIONALE:
Specialty Center: ☐ Not Required ☐ Required/Criteria Met ☒ Guidelines Met	☐ ED Saturation ☐ Int. Disaster ☐ CT Diversion ☐ IFT SC diversion: ☐ TC/PTC ☐ PMC ☐ STEMI ☐ PrimAry Stroke Center ☐ Comprehensive StroKe Center ☐ SC Not AccessibLe ☐ JudGment *(Provider/Base)* ☐ Shared AmBulance ☒ Minimal InJuries ☐ Unmanageable Airway ☐ Requested by: ☐ Other:
PT TRANSPORTED VIA:	**REASON FOR NO TRANSPORT:**
☒ ALS ☐ BLS ☐ Other ☐ Helicopter-ETA: ____ ☐ No Transport	☐ AMA ☐ DOA ☐ Unwarranted ☐ Other ☐ Pronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ Discharged ☐ Ward ☐ Stepdown ☐ ICU ☐ ObserVation
☐ OR ☐ Cath Lab ☐ INt'l Radiology ☐ Expired in ED ☐ OB
Transferred to: _____ |_|_|_| (Hosp. code) ☐ Other: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR, EDAP, and PTC
- Indicate the actual destination by checking EDAP
- Check Specialty Center: Guidelines Met (Auto vs Ped/Bike at less than 20mph [PB] is a guideline for transport to a PTC as per Reference No. 506.) If more than one specialty center option applies, choose the option most applicable to the patient's presentation.
- Check Destination Rationale: Minimal Injuries, as this is the reason patient was not transported to the PTC

Pediatric: PMC Guideline

4 y/o male, witnessed tonic/clonic seizure. No signs of trauma, but GCS is not improving:

TRANSPORT	CODE all options, CHECK actual destination:	CODE	ETA
	☐ MAR	SJS	8
	☐ EDAP (age ≤14)	SJS	8
	☐ TC	| |	
	☐ PTC (trauma, age ≤14)	| |	
	☒ PMC (medical, age ≤14)	CHH	15
	☐ STEMI Receiving Center	| |	
	☐ PrimAry Stroke Center	| |	
	☐ Comprehensive StroKe Center	| |	
	☐ PeriNatal (≥20wks pregnancy)	| |	
	☐ SART	| |	
	☐ Other	| |	
	Time Clear	| | |	
	Time Receiving Hospital Notified	| | |	
	Name of Person Notified:		

CHECK ONE:	DESTINATION RATIONALE:
Specialty Center: ☐ Not Required ☐ Required/Criteria Met ☒ Guidelines Met	☐ ED Saturation ☐ Int. Disaster ☐ CT Diversion ☐ IFT SC diversion: ☐ TC/PTC ☐ PMC ☐ STEMI ☐ PrimAry Stroke Center ☐ Comprehensive StroKe Center ☐ SC Not AccessibLe ☐ JudGment *(Provider/Base)* ☐ Shared AmBulance ☐ Minimal InJuries ☐ Unmanageable Airway ☐ Requested by: ☐ Other:
PT TRANSPORTED VIA:	**REASON FOR NO TRANSPORT:**
☒ ALS ☐ BLS ☐ Other ☐ Helicopter-ETA: ____ ☐ No Transport	☐ AMA ☐ DOA ☐ Unwarranted ☐ Other ☐ Pronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ Discharged ☐ Ward ☐ Stepdown ☐ ICU ☐ ObserVation
☐ OR ☐ Cath Lab ☐ INt'l Radiology ☐ Expired in ED ☐ OB
Transferred to: _____ |_|_|_| (Hosp. code) ☐ Other: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR, EDAP, and PMC
- Indicate the actual destination by checking PMC
- Check Specialty Center: Guidelines Met (persistent altered mental status is a guideline for transport to a PMC, as per Reference No. 510)
- Destination Rationale is left blank, as there is no deviation from destination principles

Perinatal: Specialty Center Guidelines Met

24 y/o female, 22 weeks pregnant with abdominal cramping x 2 hours. No signs of trauma:

TRANSPORT	CODE all options, CHECK actual destination:	CODE	ETA
	☐ MAR	ENH	5
	☐ EDAP (age ≤14)	| |	
	☐ TC	| |	
	☐ PTC (trauma, age ≤14)	| |	
	☐ PMC (medical, age ≤14)	| |	
	☐ STEMI Receiving Center	| |	
	☐ PrimAry Stroke Center	| |	
	☐ Comprehensive StroKe Center	| |	
	☒ PeriNatal (≥20wks pregnancy)	NRH	15
	☐ SART	| |	
	☐ Other	| |	
	Time Clear	| | |	
	Time Receiving Hospital Notified	| | |	
	Name of Person Notified:		

CHECK ONE:	DESTINATION RATIONALE:
Specialty Center: ☐ Not Required ☐ Required/Criteria Met ☒ Guidelines Met	☐ ED Saturation ☐ Int. Disaster ☐ CT Diversion ☐ IFT SC diversion: ☐ TC/PTC ☐ PMC ☐ STEMI ☐ PrimAry Stroke Center ☐ Comprehensive StroKe Center ☐ SC Not AccessibLe ☐ JudGment *(Provider/Base)* ☐ Shared AmBulance ☐ Minimal InJuries ☐ Unmanageable Airway ☐ Requested by: ☐ Other:
PT TRANSPORTED VIA:	**REASON FOR NO TRANSPORT:**
☒ ALS ☐ BLS ☐ Other ☐ Helicopter-ETA: ____ ☐ No Transport	☐ AMA ☐ DOA ☐ Unwarranted ☐ Other ☐ Pronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ Discharged ☐ Ward ☐ Stepdown ☐ ICU ☐ ObserVation
☐ OR ☐ Cath Lab ☐ INt'l Radiology ☐ Expired in ED ☐ OB
Transferred to: _____ |_|_|_| (Hosp. code) ☐ Other: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR and Perinatal Center
- Indicate the actual destination by checking Perinatal Center
- Check Specialty Center: Guidelines Met (patients who are at least 20 weeks pregnant and who appear to have a pregnancy related complaint or complication is a guideline for transport to a Perinatal, as per Reference No. 511)
- Destination Rationale is left blank, as there is no deviation from destination principles

PSC: Specialty Center Guidelines Met

50 y/o male, L facial droop x 1 hr., positive mLAPSS exam, LAMS Score = 2:

TRANSPORT	CODE all options, CHECK actual destination:	CODE	ETA
	☐ MAR	HGH	5
	☐ EDAP (age ≤14)	| |	
	☐ TC	| |	
	☐ PTC (trauma, age ≤14)	| |	
	☐ PMC (medical, age ≤14)	| |	
	☐ STEMI Receiving Center	| |	
	☒ PrimAry Stroke Center	TOR	12
	☐ Comprehensive StroKe Center	| |	
	☐ PeriNatal (>20wks pregnancy)	| |	
	☐ SART	| |	
	☐ Other	| |	
	Time Clear	| | |	
	Time Receiving Hospital Notified	| | |	
	Name of Person Notified:		

CHECK ONE:	DESTINATION RATIONALE:
Specialty Center: ☐ Not Required ☐ Required/Criteria Met ☒ Guidelines Met	☐ ED Saturation ☐ Int. Disaster ☐ CT Diversion ☐ IFT SC diversion: ☐ TC/PTC ☐ PMC ☐ STEMI ☐ PrimAry Stroke Center ☐ Comprehensive StroKe Center ☐ SC Not AccessibLe ☐ JudGment *(Provider/Base)* ☐ Shared AmBulance ☐ Minimal InJuries ☐ Unmanageable Airway ☐ Requested by: ☐ Other:
PT TRANSPORTED VIA:	**REASON FOR NO TRANSPORT:**
☒ ALS ☐ BLS ☐ Other ☐ Helicopter-ETA: ____ ☐ No Transport	☐ AMA ☐ DOA ☐ Unwarranted ☐ Other ☐ Pronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ Discharged ☐ Ward ☐ Stepdown ☐ ICU ☐ ObserVation
☐ OR ☐ Cath Lab ☐ INt'l Radiology ☐ Expired in ED ☐ OB
Transferred to: _____ |_|_|_| (Hosp. code) ☐ Other: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR and PSC
- Indicate the actual destination by checking PSC
- Check Specialty Center: Guidelines Met (positive mLAPSS exam & a LAMS score of 3 or less meets guidelines for transport to a PSC as per Reference No. 521)
- Destination Rationale is left blank, as there is no deviation from destination principles

CSC: Specialty Center Guidelines Met

62 y/o female, R arm drift and no R grip strength x 3 hours, positive mLAPSS exam, LAMS Score = 4:

TRANSPORT	CODE all options, CHECK actual destination:	CODE	ETA
	☐ MAR	QOA	6
	☐ EDAP (age ≤14)	| |	
	☐ TC	| |	
	☐ PTC (trauma, age ≤14)	| |	
	☐ PMC (medical, age ≤14)	| |	
	☐ STEMI Receiving Center	| |	
	☐ PrimAry Stroke Center	QOA	6
	☒ Comprehensive StroKe Center	KFL	9
	☐ PeriNatal (>20wks pregnancy)	| |	
	☐ SART	| |	
	☐ Other	| |	
	Time Clear	| | |	
	Time Receiving Hospital Notified	| | |	
	Name of Person Notified:		

CHECK ONE:	DESTINATION RATIONALE:
Specialty Center: ☐ Not Required ☐ Required/Criteria Met ☒ Guidelines Met	☐ ED Saturation ☐ Int. Disaster ☐ CT Diversion ☐ IFT SC diversion: ☐ TC/PTC ☐ PMC ☐ STEMI ☐ PrimAry Stroke Center ☐ Comprehensive StroKe Center ☐ SC Not AccessibLe ☐ JudGment *(Provider/Base)* ☐ Shared AmBulance ☐ Minimal InJuries ☐ Unmanageable Airway ☐ Requested by: ☐ Other:
PT TRANSPORTED VIA:	**REASON FOR NO TRANSPORT:**
☒ ALS ☐ BLS ☐ Other ☐ Helicopter-ETA: ____ ☐ No Transport	☐ AMA ☐ DOA ☐ Unwarranted ☐ Other ☐ Pronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ Discharged ☐ Ward ☐ Stepdown ☐ ICU ☐ ObserVation
☐ OR ☐ Cath Lab ☐ INt'l Radiology ☐ Expired in ED ☐ OB
Transferred to: _____ |_|_|_| (Hosp. code) ☐ Other: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR, PSC, and CSC
- Indicate the actual destination by checking CSC
- Check Specialty Center: Guidelines Met (positive mLAPSS exam & a LAMS Score of 4 or greater meets guidelines for transport to a CSC as per Reference No. 521)
- Destination Rationale is left blank, as there is no deviation from destination principles

Specialty Center Judgment

66 y/o male, crushing chest pain and SOB for 15min, Abnormal ECG, hx of MI, DM, HTN. MICN directs transport to SRC due to high suspicion of MI:

TRANSPORT	CODE all options, CHECK actual destination:	CODE	ETA
	☐ MAR	CNT	5
	☐ EDAP (age ≤14)	| |	
	☐ TC	| |	
	☐ PTC (trauma, age ≤14)	| |	
	☐ PMC (medical, age ≤14)	| |	
	☒ STEMI Receiving Center	UCL	15
	☐ PrimAry Stroke Center	| |	
	☐ Comprehensive StroKe Center	| |	
	☐ PeriNatal (≥20wks pregnancy)	| |	
	☐ SART	| |	
	☐ Other	| |	
	Time Clear	| | |	
	Time Receiving Hospital Notified	| | |	
	Name of Person Notified:		

CHECK ONE:	DESTINATION RATIONALE:
Specialty Center: ☒ Not Required ☐ Required/Criteria Met ☐ Guidelines Met	☐ ED Saturation ☐ Int. Disaster ☐ CT Diversion ☐ IFT SC diversion: ☐ TC/PTC ☐ PMC ☐ STEMI ☐ PrimAry Stroke Center ☐ Comprehensive StroKe Center ☐ SC Not AccessibLe ☒ JudGment *(Provider/Base)* ☐ Shared AmBulance ☐ Minimal InJuries ☐ Unmanageable Airway ☐ Requested by: ☐ Other:
PT TRANSPORTED VIA:	**REASON FOR NO TRANSPORT:**
☒ ALS ☐ BLS ☐ Other ☐ Helicopter-ETA: ____ ☐ No Transport	☐ AMA ☐ DOA ☐ Unwarranted ☐ Other ☐ Pronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ Discharged ☐ Ward ☐ Stepdown ☐ ICU ☐ ObserVation
☐ OR ☐ Cath Lab ☐ INt'l Radiology ☐ Expired in ED ☐ OB
Transferred to: _____ |_|_|_| (Hosp. code) ☐ Other: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR and SRC
- Indicate the actual destination by checking SRC
- Check Specialty Center Not Required
- Check Destination Rationale: Judgment

9-1-1 Interfacility Transfer

66 y/o male presented by private auto to a non-SRC facility, c/o crushing chest pain and SOB for 15min, ECG in ED shows STEMI. 9-1-1 is activated for rapid transport to closest SRC:

TRANSPORT	CODE all options, CHECK actual destination:	CODE	ETA
	☐ MAR	CNT	0
	☐ EDAP (age ≤14)	| |	
	☐ TC	| |	
	☐ PTC (trauma, age ≤14)	| |	
	☐ PMC (medical, age ≤14)	| |	
	☒ STEMI Receiving Center	UCL	15
	☐ PrimAry Stroke Center	| |	
	☐ Comprehensive StroKe Center	| |	
	☐ PeriNatal (≥20wks pregnancy)	| |	
	☐ SART	| |	
	☐ Other	| |	
	Time Clear	| | |	
	Time Receiving Hospital Notified	| | |	
	Name of Person Notified:		

CHECK ONE:	DESTINATION RATIONALE:
Specialty Center: ☐ Not Required ☒ Required/Criteria Met ☐ Guidelines Met	☐ ED Saturation ☐ Int. Disaster ☐ CT Diversion ☐ IFT SC diversion: ☐ TC/PTC ☐ PMC ☐ STEMI ☐ PrimAry Stroke Center ☐ Comprehensive StroKe Center ☐ SC Not AccessibLe ☐ JudGment *(Provider/Base)* ☐ Shared AmBulance ☐ Minimal InJuries ☐ Unmanageable Airway ☐ Requested by: ☐ Other:
PT TRANSPORTED VIA:	**REASON FOR NO TRANSPORT:**
☒ ALS ☐ BLS ☐ Other ☐ Helicopter-ETA: ____ ☐ No Transport	☐ AMA ☐ DOA ☐ Unwarranted ☐ Other ☐ Pronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ Discharged ☐ Ward ☐ Stepdown ☐ ICU ☐ ObserVation
☐ OR ☐ Cath Lab ☐ INt'l Radiology ☐ Expired in ED ☐ OB
Transferred to: _____ |_|_|_| (Hosp. code) ☐ Other: _____
ED Diagnosis:

- *(Run Type at top right of form is IFT)*
- Enter hospital codes for the closest MAR and SRC
- Indicate the actual destination by checking SRC
- Destination Rationale is left blank, as there is no deviation from destination principles

ED Saturation

55 y/o female, c/o abdominal pain x 3 days. The closest facility has requested diversion due to ED saturation:

TRANSPORT	CODE all options, CHECK actual destination:	CODE	ETA
	☐ MAR	NRH	5
	☐ EDAP (age ≤14)	| |	
	☐ TC	| |	
	☐ PTC (trauma, age ≤14)	| |	
	☐ PMC (medical, age ≤14)	| |	
	☐ STEMI Receiving Center	| |	
	☐ PrimAry Stroke Center	| |	
	☐ Comprehensive StroKe Center	| |	
	☐ PeriNatal (≥20wks pregnancy)	| |	
	☐ SART	| |	
	☒ Other	MCP	12
	Time Clear	| | |	
	Time Receiving Hospital Notified	| | |	
	Name of Person Notified:		

CHECK ONE:	DESTINATION RATIONALE:
Specialty Center: ☒ Not Required ☐ Required/Criteria Met ☐ Guidelines Met	☒ ED Saturation ☐ Int. Disaster ☐ CT Diversion ☐ IFT SC diversion: ☐ TC/PTC ☐ PMC ☐ STEMI ☐ PrimAry Stroke Center ☐ Comprehensive StroKe Center ☐ SC Not AccessibLe ☐ JudGment *(Provider/Base)* ☐ Shared AmBulance ☐ Minimal InJuries ☐ Unmanageable Airway ☐ Requested by: ☐ Other:
PT TRANSPORTED VIA:	**REASON FOR NO TRANSPORT:**
☒ ALS ☐ BLS ☐ Other ☐ Helicopter-ETA: ____ ☐ No Transport	☐ AMA ☐ DOA ☐ Unwarranted ☐ Other ☐ Pronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ Discharged ☐ Ward ☐ Stepdown ☐ ICU ☐ ObserVation
☐ OR ☐ Cath Lab ☐ INt'l Radiology ☐ Expired in ED ☐ OB
Transferred to: _____ |_|_|_| (Hosp. code) ☐ Other: _____
ED Diagnosis:

- Enter hospital code for the closest MAR
- Indicate the actual destination by checking Other, and enter the hospital code for the actual destination
- Check Specialty Center: Not Required (AP as described meets no specialty center criteria or guidelines as per Reference No. 502)
- Destination Rationale is ED Saturation, as patient did not go to the MAR due to diversion request for ED Saturation

Specialty Center Diversion

17 y/o male, single stab wound to LUQ, CC = PA, PI=TRMA, MOI = ST. Most accessible trauma center has requested trauma diversion:

TRANSPORT	CODE all options, CHECK actual destination:	CODE	ETA
	☐ MAR	MHG	8
	☐ EDAP (age ≤14)	| |	
	☐ TC	SFM	10
	☐ PTC (trauma, age ≤14)	| |	
	☐ PMC (medical, age ≤14)	| |	
	☐ STEMI Receiving Center	| |	
	☐ PrimAry Stroke Center	| |	
	☐ Comprehensive StroKe Center	| |	
	☐ PeriNatal (≥20wks pregnancy)	| |	
	☐ SART	| |	
	☒ Other	HGH	15
	Time Clear	| | |	
	Time Receiving Hospital Notified	| | |	
	Name of Person Notified:		

CHECK ONE:	DESTINATION RATIONALE:
Specialty Center: ☐ Not Required ☒ Required/Criteria Met ☐ Guidelines Met	☐ ED Saturation ☐ Int. Disaster ☐ CT Diversion ☐ IFT SC diversion: ☒ TC/PTC ☐ PMC ☐ STEMI ☐ PrimAry Stroke Center ☐ Comprehensive StroKe Center ☐ SC Not AccessibLe ☐ JudGment *(Provider/Base)* ☐ Shared AmBulance ☐ Minimal InJuries ☐ Unmanageable Airway ☐ Requested by: ☐ Other:
PT TRANSPORTED VIA:	**REASON FOR NO TRANSPORT:**
☒ ALS ☐ BLS ☐ Other ☐ Helicopter-ETA: ____ ☐ No Transport	☐ AMA ☐ DOA ☐ Unwarranted ☐ Other ☐ Pronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ Discharged ☐ Ward ☐ Stepdown ☐ ICU ☐ ObserVation
☐ OR ☐ Cath Lab ☐ INt'l Radiology ☐ Expired in ED ☐ OB
Transferred to: _____ |_|_|_| (Hosp. code) ☐ Other: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR and TC
- Indicate the actual destination by checking Other, and enter the hospital code for the actual destination
- Check Specialty Center: Required/Criteria Met (PA is criteria for transport to a TC as per Reference No. 506)
- Destination Rationale is SC Diversion: TC/PTC, as patient was not transported to closest TC due to diversion request

Conducted Electrical Weapon (CEW, aka Taser®)

34 y/o male, status post deployment of a conducted electrical weapon (CEW, trade name Taser®) dart to chest, minor laceration to chest, no other trauma or associated signs or symptoms. CC = PL, PI=TRMA, MOI = TA:

TRANSPORT	CODE all options, CHECK actual destination:	CODE	ETA
	☒ MAR	PLB	3
	☐ EDAP (age ≤14)	| |	
	☐ TC	LBM	5
	☐ PTC (trauma, age ≤14)	| |	
	☐ PMC (medical, age ≤14)	| |	
	☐ STEMI Receiving Center	| |	
	☐ PrimAry Stroke Center	| |	
	☐ Comprehensive StroKe Center	| |	
	☐ PeriNatal (≥20wks pregnancy)	| |	
	☐ SART	| |	
	☐ Other	| |	
	Time Clear	| | |	
	Time Receiving Hospital Notified	| | |	
	Name of Person Notified:		

CHECK ONE:	DESTINATION RATIONALE:
Specialty Center: ☒ Not Required ☐ Required/Criteria Met ☐ Guidelines Met	☐ ED Saturation ☐ Int. Disaster ☐ CT Diversion ☐ IFT SC diversion: ☐ TC/PTC ☐ PMC ☐ STEMI ☐ PrimAry Stroke Center ☐ Comprehensive StroKe Center ☐ SC Not AccessibLe ☐ JudGment *(Provider/Base)* ☐ Shared AmBulance ☐ Minimal InJuries ☐ Unmanageable Airway ☐ Requested by: ☐ Other:
PT TRANSPORTED VIA:	**REASON FOR NO TRANSPORT:**
☐ ALS ☒ BLS ☐ Other ☐ Helicopter-ETA: ____ ☐ No Transport	☐ AMA ☐ DOA ☐ Unwarranted ☐ Other ☐ Pronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ Discharged ☐ Ward ☐ Stepdown ☐ ICU ☐ ObserVation ☐ OR ☐ Cath Lab ☐ INt'l Radiology ☐ Expired in ED ☐ OB

Transferred to: _____ |_|_|_| (Hosp. code) ☐ Other: _____

ED Diagnosis:

- Enter hospital codes for the closest MAR and TC
- Indicate the actual destination by checking MAR
- Check Specialty Center: Not Required (PL is not a criteria or guideline for transport to a TC as per Reference No. 506)
- Destination Rationale is left blank, as there is no deviation from destination principles

Minimal Injuries

17 y/o male, status post leg struck by car in parking lot, minor abrasion to foot, no deformity, no other trauma or associated signs or symptoms. CC = BE, PI=TRMA, MOI = PB:

TRANSPORT	CODE all options, CHECK actual destination:	CODE	ETA
	☒ MAR	BMC	3
	☐ EDAP (age ≤14)	| |	
	☐ TC	UCL	15
	☐ PTC (trauma, age ≤14)	| |	
	☐ PMC (medical, age ≤14)	| |	
	☐ STEMI Receiving Center	| |	
	☐ PrimAry Stroke Center	| |	
	☐ Comprehensive StroKe Center	| |	
	☐ PeriNatal (≥20wks pregnancy)	| |	
	☐ SART	| |	
	☐ Other	| |	
	Time Clear	| | |	
	Time Receiving Hospital Notified	| | |	
	Name of Person Notified:		

CHECK ONE:	DESTINATION RATIONALE:
Specialty Center: ☐ Not Required ☐ Required/Criteria Met ☒ Guidelines Met	☐ ED Saturation ☐ Int. Disaster ☐ CT Diversion ☐ IFT SC diversion: ☐ TC/PTC ☐ PMC ☐ STEMI ☐ PrimAry Stroke Center ☐ Comprehensive StroKe Center ☐ SC Not AccessibLe ☐ JudGment *(Provider/Base)* ☐ Shared AmBulance ☒ Minimal InJuries ☐ Unmanageable Airway ☐ Requested by: ☐ Other:
PT TRANSPORTED VIA:	**REASON FOR NO TRANSPORT:**
☐ ALS ☒ BLS ☐ Other ☐ Helicopter-ETA: ____ ☐ No Transport	☐ AMA ☐ DOA ☐ Unwarranted ☐ Other ☐ Pronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ Discharged ☐ Ward ☐ Stepdown ☐ ICU ☐ ObserVation ☐ OR ☐ Cath Lab ☐ INt'l Radiology ☐ Expired in ED ☐ OB

Transferred to: _____ |_|_|_| (Hosp. code) ☐ Other: _____

ED Diagnosis:

- Enter hospital codes for the closest MAR and TC
- Indicate the actual destination by checking MAR
- Check Specialty Center: Guidelines Met (PB is a guideline for transport to a TC as per Reference No. 506)
- Destination Rationale is Minimal Injuries, as patient was not transported to the closest TC, due to minimal injuries

Shared Ambulance

8 y/o male, restrained rear passenger in a moderate speed MVA. Pt. c/o LLE pain only, no deformity noted. CC = BE, PI=TRMA, MOIs = EV, SB. Patient's mother was unrestrained driver and meets trauma criteria:

TRANSPORT	CODE all options, CHECK actual destination:	CODE	ETA
	☐ MAR	DCH	3
	☐ EDAP (age ≤14)	DCH	3
	☐ TC	| |	
	☐ PTC (trauma, age ≤14)	LBM	20
	☐ PMC (medical, age ≤14)	| |	
	☐ STEMI Receiving Center	| |	
	☐ PrimAry Stroke Center	| |	
	☐ Comprehensive StroKe Center	| |	
	☐ PeriNatal (≥20wks pregnancy)	| |	
	☐ SART	| |	
	☒ Other	SFM	8
	Time Clear	| | |	
	Time Receiving Hospital Notified	| | |	
	Name of Person Notified:		

CHECK ONE:	DESTINATION RATIONALE:
Specialty Center: ☐ Not Required ☒ Required/Criteria Met ☐ Guidelines Met	☐ ED Saturation ☐ Int. Disaster ☐ CT Diversion ☐ IFT SC diversion: ☐ TC/PTC ☐ PMC ☐ STEMI ☐ PrimAry Stroke Center ☐ Comprehensive StroKe Center ☐ SC Not AccessibLe ☐ JudGment *(Provider/Base)* ☒ Shared AmBulance ☐ Minimal InJuries ☐ Unmanageable Airway ☐ Requested by: ☐ Other:
PT TRANSPORTED VIA:	**REASON FOR NO TRANSPORT:**
☒ ALS ☐ BLS ☐ Other ☐ Helicopter-ETA: ____ ☐ No Transport	☐ AMA ☐ DOA ☐ Unwarranted ☐ Other ☐ Pronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ Discharged ☐ Ward ☐ Stepdown ☐ ICU ☐ ObserVation
☐ OR ☐ Cath Lab ☐ INt'l Radiology ☐ Expired in ED ☐ OB
Transferred to: _____ |__|__|__| (Hosp. code) ☐ Other: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR, EDAP, and PTC
- Indicate the child's actual destination by checking Other (patient not transported to MAR, EDAP, or PTC) and enter the hospital code for the actual destination
- Check Specialty Center: Required/Criteria Met (EDAP, PMC or PTC is required for all pediatric patients)
- Destination Rationale is Shared Ambulance, as patient was transported to Other

Patient Request

82 y/o male, c/o cough and fever x 3 days, vital signs stable. Pt. is a Kaiser member and is requesting transport to Kaiser – which is accessible but not the MAR:

TRANSPORT	CODE all options, CHECK actual destination:	CODE	ETA
	☐ MAR	DCH	3
	☐ EDAP (age ≤14)	| |	
	☐ TC	| |	
	☐ PTC (trauma, age ≤14)	| |	
	☐ PMC (medical, age ≤14)	| |	
	☐ STEMI Receiving Center	| |	
	☐ PrimAry Stroke Center	| |	
	☐ Comprehensive StroKe Center	| |	
	☐ PeriNatal (≥20wks pregnancy)	| |	
	☐ SART	| |	
	☒ Other	KFB	6
	Time Clear	| | |	
	Time Receiving Hospital Notified	| | |	
	Name of Person Notified:		

CHECK ONE:	DESTINATION RATIONALE:
Specialty Center: ☒ Not Required ☐ Required/Criteria Met ☐ Guidelines Met	☐ ED Saturation ☐ Int. Disaster ☐ CT Diversion ☐ IFT SC diversion: ☐ TC/PTC ☐ PMC ☐ STEMI ☐ PrimAry Stroke Center ☐ Comprehensive StroKe Center ☐ SC Not AccessibLe ☐ JudGment *(Provider/Base)* ☐ Shared AmBulance ☐ Minimal InJuries ☐ Unmanageable Airway ☒ Requested by: *Patient* ☐ Other:
PT TRANSPORTED VIA:	**REASON FOR NO TRANSPORT:**
☒ ALS ☐ BLS ☐ Other ☐ Helicopter-ETA: ____ ☐ No Transport	☐ AMA ☐ DOA ☐ Unwarranted ☐ Other ☐ Pronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ Discharged ☐ Ward ☐ Stepdown ☐ ICU ☐ ObserVation
☐ OR ☐ Cath Lab ☐ INt'l Radiology ☐ Expired in ED ☐ OB
Transferred to: _____ |__|__|__| (Hosp. code) ☐ Other: _____
ED Diagnosis:

- Enter hospital code for the closest MAR
- Indicate the actual destination by checking Other, and enter the hospital code for the actual destination
- Check Specialty Center: Not Required (CC and FE, as described meet no specialty center criteria or guidelines as per Reference No. 502)
- Destination Rationale is Requested by: Patient, as patient did not go to the MAR due to patient request

AMA

36 y/o female, history of diabetes, status post altered mental status resolved with paramedic administration of D10 for blood glucose of 40. GCS now 4-6-5, vital signs stable. The patient has decided she does not want to be transported and wishes to sign out against medical advice:

TRANSPORT	CODE all options, CHECK actual destination:	CODE	ETA
	☐ MAR	AMH	3
	☐ EDAP (age ≤14)	| |	
	☐ TC	| |	
	☐ PTC (trauma, age ≤14)	| |	
	☐ PMC (medical, age ≤14)	| |	
	☐ STEMI Receiving Center	| |	
	☐ PrimAry Stroke Center	| |	
	☐ Comprehensive StroKe Center	| |	
	☐ PeriNatal (≥20wks pregnancy)	| |	
	☐ SART	| |	
	☐ Other	| |	
	Time Clear	| | |	
	Time Receiving Hospital Notified	| | |	
	Name of Person Notified:		

CHECK ONE:	DESTINATION RATIONALE:
Specialty Center: ☒ Not Required ☐ Required/Criteria Met ☐ Guidelines Met	☐ ED Saturation ☐ Int. Disaster ☐ CT Diversion ☐ IFT SC diversion: ☐ TC/PTC ☐ PMC ☐ STEMI ☐ PrimAry Stroke Center ☐ Comprehensive StroKe Center ☐ SC Not AccessibLe ☐ JudGment *(Provider/Base)* ☐ Shared AmBulance ☐ Minimal InJuries ☐ Unmanageable Airway ☐ Requested by: ☐ Other:
PT TRANSPORTED VIA:	**REASON FOR NO TRANSPORT:**
☐ ALS ☐ BLS ☐ Other ☐ Helicopter-ETA: ____ ☒ No Transport	☒ AMA ☐ DOA ☐ Unwarranted ☐ Other ☐ Pronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ Discharged ☐ Ward ☐ Stepdown ☐ ICU ☐ ObserVation
☐ OR ☐ Cath Lab ☐ INt'l Radiology ☐ Expired in ED ☐ OB
Transferred to: _____ |_|_|_| (Hosp. code) ☐ Other: _____
ED Diagnosis:

- Enter hospital code for the closest MAR
- No actual destination is indicated, as patient is not transported
- Check Specialty Center Not Required (adult with status post medical ALOC does not meet Specialty Center criteria or guidelines)
- Destination Rationale is left blank, as there is no destination
- Reason for No Transport is AMA

Hyperbaric Chamber

25 y/o male, status post scuba diving accident, GCS 2-1-4, no signs of trauma, helicopter transport 5 minutes away:

TRANSPORT	CODE all options, CHECK actual destination:	CODE	ETA
	☐ MAR	AHM	3
	☐ EDAP (age ≤14)	| |	
	☐ TC	| |	
	☐ PTC (trauma, age ≤14)	| |	
	☐ PMC (medical, age ≤14)	| |	
	☐ STEMI Receiving Center	| |	
	☐ PrimAry Stroke Center	| |	
	☐ Comprehensive StroKe Center	| |	
	☐ PeriNatal (≥20wks pregnancy)	| |	
	☐ SART	| |	
	☒ Other	USC	25
	Time Clear	| | |	
	Time Receiving Hospital Notified	| | |	
	Name of Person Notified:		

CHECK ONE:	DESTINATION RATIONALE:
Specialty Center: ☒ Not Required ☐ Required/Criteria Met ☐ Guidelines Met	☐ ED Saturation ☐ Int. Disaster ☐ CT Diversion ☐ IFT SC diversion: ☐ TC/PTC ☐ PMC ☐ STEMI ☐ PrimAry Stroke Center ☐ Comprehensive StroKe Center ☐ SC Not AccessibLe ☐ JudGment *(Provider/Base)* ☐ Shared AmBulance ☐ Minimal InJuries ☐ Unmanageable Airway ☐ Requested by: ☒ Other: HBC
PT TRANSPORTED VIA:	**REASON FOR NO TRANSPORT:**
☐ ALS ☐ BLS ☐ Other ☒ Helicopter-ETA: 5 ☐ No Transport	☐ AMA ☐ DOA ☐ Unwarranted ☐ Other ☐ Pronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ Discharged ☐ Ward ☐ Stepdown ☐ ICU ☐ ObserVation
☐ OR ☐ Cath Lab ☐ INt'l Radiology ☐ Expired in ED ☐ OB
Transferred to: _____ |_|_|_| (Hosp. code) ☐ Other: _____
ED Diagnosis:

- Enter hospital code for the closest MAR
- Indicate the actual destination by checking Other, and enter the hospital code for the actual destination
- Check Specialty Center Not Required (an unconscious patient status post scuba diving accident shall go immediately to a MAC-listed hyperbaric chamber, as per Reference No. 518)
- Destination Rationale is Other: HBC (hyperbaric chamber)

DISPO (IF BASE IS RECEIVING HOSPITAL)

ED DIAGNOSES

Definition

ED diagnosis as documented by a physician

Field Values

- ICD-10 codes

Additional Information

- **Required** field for all patients for whom the base hospital contacted is also the receiving facility
- May be completed later by personnel other than the MICN/MD initially contacted or notified

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- ED Records
- Other Hospital Records

HOSPITAL DISPO

Definition

Checkboxes indicating the emergency department disposition of patients transported to the base hospital

Field Values

- **D**ischarged: Patient was discharged home from the emergency department
- **W**ard: Patient was admitted to a medical/surgical ward
- **S**tepdown: Patient was admitted to a Direct Observation Unit (DOU), Stepdown Unit, or Telemetry Unit
- **I**CU: Patient was admitted to an Intensive Care Unit or Cardiac Care Unit
- Obser**V**ation: Observation unit (provides < 24 hour stays)
- O**R**: Patient was transferred directly from the emergency department to the operating room
- **C**ath Lab: Patient was transferred directly from the emergency department to the Cardiac Catheterization Lab
- I**N**terventional Radiology: Patient was transferred directly from the emergency department to Interventional Radiology for embolization, angiography, etc.
- **E**xpired in ED: Patient died in the emergency department
- O**B**: Patient was admitted to an obstetrics department
- **T**ransferred to: Patient was transferred directly from the emergency department to another healthcare facility – document the name of the facility or the three-letter hospital code in the space provided
- **O**ther: Patient disposition other than those listed above – document disposition on the line provided

Additional Information

- **Required** field for all patients for whom the base hospital contacted is also the receiving facility
- May be completed later by personnel other than the MICN/MD initially contacted or notified

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- ED Records
- Other Hospital Records

DISPO COMM.

Definition

Space provided for documentation of any additional information related to the patient's disposition from the ED

Field Values

- Free text

Uses

- Additional documentation, if needed

Data Source Hierarchy

- Base Hospital Form

XFER FROM ED TO

Definition

Three-letter code for the facility the patient was transferred to, if applicable

Field Values

LOS ANGELES COUNTY 9-1-1 RECEIVING			
ACH	Alhambra Hospital Medical Center	KFW	Kaiser Foundation Hospital – West Los Angeles
AHM	Catalina Island Medical Center	LBM	MemorialCare Long Beach Medical Center
AMH	Methodist Hospital of Southern California	LCH	Palmdale Regional Medical Center
AVH	Antelope Valley Hospital	LCM	Providence Little Co. of Mary M.C. - Torrance
BEV	Beverly Hospital	MCP	Mission Community Hospital
BMC	Southern California Hospital at Culver City	MHG	Memorial Hospital of Gardena
CAL	Dignity Health - California Hospital Medical Center	MID	Olympia Medical Center
CHH	Children's Hospital Los Angeles	MLK	Martin Luther King Jr. Community Hospital
CHP	Community Hospital of Huntington Park	MPH	Monterey Park Hospital
CNT	Centinela Hospital Medical Center	NOR	LA Community Hospital at Norwalk
CPM	Coast Plaza Hospital	NRH	Dignity Health - Northridge Hospital Medical Center
CSM	Cedars-Sinai Medical Center	OVM	LAC Olive View-UCLA Medical Center
DCH	PIH Health Downey Hospital	PAC	Pacifica Hospital of the Valley
DFM	Cedars-Sinai Marina Del Rey Hospital	PIH	PIH Health Whittier Hospital
DHL	Lakewood Regional Medical Center	PLB	College Medical Center
ELA	East Los Angeles Doctors Hospital	PVC	Pomona Valley Hospital Medical Center
ENH	Encino Hospital Medical Center	QOA	Hollywood Presbyterian Medical Center
FPH	Emanate Health Foothill Presbyterian Hospital	QVH	Emanate Health Queen of the Valley Hospital
GAR	Garfield Medical Center	SDC	San Dimas Community Hospital
GEM	Greater El Monte Community Hospital	SFM	St. Francis Medical Center
GMH	Dignity Health - Glendale Memorial Hospital and Health Center	SGC	San Gabriel Valley Medical Center
GSH	PIH Health Good Samaritan Hospital	SJH	Providence Saint John's Health Center
GWT	Adventist Health - Glendale	SJS	Providence Saint Joseph Medical Center
HCH	Providence Holy Cross Medical Center	SMH	Santa Monica-UCLA Medical Center
HGH	LAC Harbor-UCLA Medical Center	SMM	Dignity Health - St. Mary Medical Center
HMH	Huntington Hospital	SOC	Sherman Oaks Hospital
HMN	Henry Mayo Newhall Hospital	SPP	Providence Little Co. of Mary M.C. - San Pedro
HWH	West Hills Hospital & Medical Center	TOR	Torrance Memorial Medical Center
ICH	Emanate Health Inter-Community Hospital	TRM	Providence Cedars-Sinai Tarzana Medical Center
KFA	Kaiser Foundation Hospital- Baldwin Park	UCL	Ronald Reagan UCLA Medical Center
KFB	Kaiser Foundation Hospital - Downey	USC	LAC+USC Medical Center
KFH	Kaiser Foundation Hospital – South Bay	VHH	USC Verdugo Hills Hospital
KFL	Kaiser Foundation Hospital – Sunset (Los Angeles)	VPH	Valley Presbyterian Hospital
KFO	Kaiser Foundation Hospital – Woodland Hills	WHH	Whittier Hospital Medical Center
KFP	Kaiser Foundation Hospital – Panorama City	WMH	Adventist Health - White Memorial

ORANGE COUNTY 9-1-1 RECEIVING			
ANH	Anaheim Regional Medical Center	LPI	La Palma Intercommunity Hospital
CHO	Children's Hospital of Orange County	PLH	Placentia Linda Hospital
FHP	Fountain Valley Regional Hospital and Medical Center	SJD	St. Jude Medical Center
KHA	Kaiser Foundation Hospital - Anaheim	UCI	UCI Medical Center
KFI	Kaiser Foundation Hospital - Irvine	WMC	Western Medical Center Santa Ana
LAG	Los Alamitos Medical Center		
SAN BERNARDINO COUNTY 9-1-1 RECEIVING			
ARM	Arrowhead Regional Medical Center	KFN	Kaiser Foundation Hospital - Ontario
CHI	Chino Valley Medical Center	LLU	Loma Linda University Medical Center
DHM	Montclair Hospital Medical Center	SAC	San Antonio Community Hospital
KFF	Kaiser Foundation Hospital - Fontana		
OTHER COUNTY 9-1-1 RECEIVING			
LRR	Los Robles Hospital & Med Ctr (Ventura)	SJO	St. John Regional Medical Center (Ventura)
SIM	Simi Valley Hospital (Ventura)	RCC	Ridgecrest Regional Hospital (Kern)
NON-BASIC HOSPITALS			
LBV	Long Beach VA	WVA	Wadsworth VA Medical Center

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- ED Records
- Other Hospital Records

LAST

Definition

Patient's last name

Field Values

- Free text

Additional Information

- May be completed later by personnel other than the MICN/MD initially contacted
- Should contain letters only

Uses

- Patient identification
- Link between other databases

Data Source Hierarchy

- Base Hospital Form
- ED Records
- Other Hospital Records

FIRST

Definition

Patient's first name

Field Values

- Free text

Additional Information

- May be completed later by personnel other than the MICN/MD initially contacted
- Should contain letters only

Uses

- Patient identification
- Link between other databases

Data Source Hierarchy

- Base Hospital Form
- ED Records
- Other Hospital Records

M.I.

Definition

Patient's middle initial

Field Values

- Free text

Additional Information

- May be completed later by personnel other than the MICN/MD initially contacted
- Should contain letters only

Uses

- Patient identification
- Link between other databases

Data Source Hierarchy

- Base Hospital Form
- ED Records
- Other Hospital Records

MEDICAL RECORD

Definition

Patient's medical record #

Field Values

- Free text

Additional Information

- May be completed later by personnel other than the MICN/MD initially contacted
- Should contain numbers only

Uses

- Patient identification
- Link between other databases

Data Source Hierarchy

- Base Hospital Form
- ED Records
- Other Hospital Records

APPENDIX

BASE DATA ENTRY GUIDE

Scenario	Who	Enter Record Into TEMIS?
Public provider calls the receiving base hospital with a **NOTIFICATION** call for a patient who is en route to their facility	Base hospital receiving both the notification call and the patient	Yes
Public provider erroneously calls assigned base hospital with a **NOTIFICATION** call for a patient who is not being transported to the assigned base hospital; receiving facility is another base hospital	Assigned base hospital who took notification call but is not receiving the patient	No
	Base hospital receiving both the notification call from the assigned base hospital and the patient	Yes
Public provider erroneously calls assigned base hospital with a **NOTIFICATION** call for a patient who is not being transported to the assigned base hospital; receiving facility is not a base hospital but is a specialty center	Assigned base hospital that took notification call but is not receiving the patient	No
	Receiving facility (that is a specialty center) that is receiving both the notification call from the assigned base hospital and the patient	No; however, record will be entered, including outcome, into the specialty center database if patient meets inclusion criteria
Public provider erroneously calls assigned base hospital with a **NOTIFICATION** call for a patient who is not being transported to the assigned base hospital; receiving facility is not a base hospital or specialty center	Assigned base hospital that took notification call but is not receiving the patient	No
	Receiving facility (not a base or specialty center) that is receiving both the notification call from the assigned base hospital and the patient	No (eventual goal is to get outcomes from all receiving facilities into TEMIS)
Public provider calls their assigned base hospital with a ***BASE CONTACT***, the assigned base hospital is also the facility receiving the patient	Assigned base hospital	Yes (with outcome)
Public provider calls their assigned base hospital with a ***BASE CONTACT*** but the assigned base hospital is not the receiving facility, the receiving facility is another base hospital. The assigned base hospital notifies the other base hospital receiving the patient that a patient is en route to their facility	Assigned base hospital that received the base contact	Yes (no outcome)
	Base hospital receiving both the notification from the assigned base hospital and the patient	No

REQUIRED DATA FIELDS FOR ALL BASE HOSPITAL CONTACTS

Gen Info:

- Log and Sequence #
- Date and Time of Call
- Provider Code and Unit #
- Age, Age Units, and Gender of Patient
- Pediatric Weight (in kilograms, from length-based tape), if applicable
- Pediatric Weight Color Code, if applicable
- Hospital Code of base handling the run
- Communication and Call Type

Assessment:

- Provider Impression
- Chief Complaint
- Protocol #
- Medical History, if applicable
- Medications, if applicable
- Allergies, if applicable

Vitals/TXs:

- Medications (name) and interventions ordered (name), if applicable

Transport:

- Name of MAR with ETA
- Actual transport destination (if patient was transported)
- Check One
- Pt Transported Via
- Destination Rationale (if applicable)
- Reason for No Transport (if patient was not transported)
- Time Clear
- MICN # (if MICN handled the call)
- Physician # (if the physician handled the call or was consulted by the MICN)

Dispo:

- ED Diagnosis (if the base is the receiving facility)
- Disposition (if the base is the receiving facility)

REQUIRED DATA FIELDS FOR ALL REQUIRED BASE HOSPITAL CONTACTS BY PROVIDER IMPRESSION

PI=RARF

- LOC
- GCS
- Respiration
- Skin
- Capnography # & Waveform
- Initial Rhythm
- Adv. Airway (BS After ETT/King? & ETCO2?), if performed
- 12-Lead ECG information (12-Lead ECG @, EMS & Software Interpretation), if performed
- O2
- IV
- VS (BP, HR, RR, O2 Sat, CO2 #)

PI=STRK

- LOC
- GCS
- Pupils
- Respiration
- mLAPSS
- LAMS (if mLAPSS +)
- LKWD/LKWT
- Glucose
- Capnography # & Waveform, if BMV used
- Initial Rhythm
- 12-Lead ECG information (12-Lead ECG @, EMS & Software Interpretation), if performed
- Adv. Airway (BS After ETT/King? & ETCO2?), if performed
- O2, if given
- IV
- VS (BP, HR, RR, O2 Sat)
- Name of PSC & CSC with ETAs

PI=HOTN/SHOK

- LOC
- GCS
- Respiration
- Skin
- Initial Rhythm
- Capnography # & Waveform, if BMV used
- Adv. Airway (BS After ETT/King? & ETCO2?), if performed
- 12-Lead ECG information (12-Lead ECG @, EMS & Software Interpretation), if performed
- Glucose, if ALOC

- IV/IO
- O2, if given for PI=HOTN
- VS (BP, HR, RR, O2 Sat, CO2 # PRN)

PI=CPSC/CPMI (pediatric patients)

- Weight
- PWCC
- LOC
- GCS
- Respiration
- Skin
- Cap Refill
- Initial Rhythm
- 12-Lead ECG @
- EMS & Software Interpretation
- ECG Quality (artifact, wavy baseline, paced rhythm), for STEMIs
- SED use, if Nitroglycerin is ordered
- IV
- O2, if given
- VS (BP, HR, RR, O2 Sat, Pain)
- Name of EDAP & PMC with ETAs

PI=BRTH

- LOC
- GCS
- Respiration
- Skin
- IUP: _____ wks
- IV status
- O2 (if O2 < 94%)
- VS (BP, HR, RR, O2 Sat, Pain)
- Name of Perinatal with ETA

PI=BABY

- Weight
- PWCC
- GCS
- Respiration
- Skin
- Cap Refill
- VS (HR, RR, O2 Sat)
- Name of EDAP & Perinatal with ETAs

PI=DYRX

- GCS
- Respiration
- Skin
- IV status
- VS (BP, HR, RR, O2 Sat)

PI=AGDE

- LOC
- GCS
- Respiration (tidal volume only)
- Skin
- Pupils, if able
- Suspected Drugs/ETOH
- IV status
- Glucose & Initial Rhythm, if able
- VS (RR only)
- PTBC interventions and Midazolam administration, including Midazolam route

PI=ANPH

- LOC
- GCS
- Respiration
- Skin
- IV status
- O2
- PTBC interventions & medications, including medication route

PI=BRUE

- Weight
- PWCC
- LOC
- GCS
- Pupils
- Respiration
- Skin
- Cap Refill
- O2, if given
- Name of EDAP & PMC with ETAs

PI=CANT

- Pupils
- Respiration, including capnography # & waveform
- Skin
- Initial rhythm
- Witnessed by
- CPR by
- Arrest to CPR
- DNR status
- IV/IO status
- Adv. Airway (BS After ETT/King? & EtCO2?), if performed
- O2
- PTBC interventions and medications, including medication route
- ROSC?
- If ROSC: ROSC time, GCS, vitals 12-Lead ECG time, EMS & Software interpretation, quality (if STEMI)
- If TOR or pronounced: resus d/c time, resus d/c rhythm, total min EMS CPR, reason for no transport, MD name if pronounced
- Name of SRC with ETA

REQUIRED DATA FIELDS FOR BASE HOSPITAL CONTACTS FOR SPECIAL CIRCUMSTANCES BY PROVIDER IMPRESSION

PI=CHOK (severe distress and/or respiratory arrest)

- LOC
- GCS
- Respiration
- Skin
- Cap refill (pediatrics only)
- Capnography # & Waveform, if BMV used
- Adv. Airway (BS After ETT/King? & EtCO2?), if performed
- Initial Rhythm
- 12-Lead ECG information (12-Lead ECG @, EMS & Software Interpretation), if performed
- O2
- IV
- VS (BP, HR, RR, O2 Sat)
- Name of EDAP with ETA

PI=ALOC (if persistent or unclear etiology)

- LOC
- GCS
- Pupils, if able
- Respiration
- Skin
- Glucose
- Suspected Drugs/ETOH
- Initial Rhythm
- 12-Lead ECG information (12-Lead ECG @, EMS & Software Interpretation), if performed
- IV
- O2, if given
- VS (BP, HR, RR, O2 Sat)
- Narrative: signs of trauma or LN

PI=PSYC (Midazolam given)

- LOC
- GCS
- Pupils, if able
- Respiration
- Skin
- PTBC Medications
- Suspected Drugs/ETOH
- Glucose
- Initial Rhythm
- VS (BP, HR, RR, O2 Sat)

- Narrative: restraints needed?

PI=DYSR (symptomatic bradycardia, rapid A-fib, poor perfusion, wide complex tachycardia)

- LOC
- GCS
- Respiration
- Skin
- Cap Refill (pediatric patients)
- PTBC Medications
- Initial Rhythm
- 12-Lead ECG Time
- EMS & Software Interpretation
- O2 (if given)
- IV
- Pacing Information (if performed)
- VS (BP, HR, RR, O2 Sat, repeat rhythm)

PI=FAIL (VAD malfunction)

- LOC
- GCS
- Respiration
- Skin
- Cap Refill (pediatric patients)
- Capnography # & Waveform (if BMV used)
- Initial Rhythm
- IV
- VS (BP, HR, RR, O2 Sat, CO2 # (if BMV used))

PI=ODPO (if signing AMA)

- LOC
- GCS
- Pupils
- Respiration
- Skin
- Cap Refill (pediatric patients)
- Glucose
- Suspected Drugs/ETOH
- Initial Rhythm
- 12-Lead Information (if performed)
- VS (BP, HR, RR, O2 Sat)
- Narrative: intentional/accidental

PI=PREG (if > 20 wks. with vaginal bleeding or delivery)

- LOC
- GCS
- Respiration

- Skin
- IUP: ___ wks
- Glucose (if history of diabetes or gestational diabetes)
- IV
- VS (BP, HR, RR, O2 Sat, pain)
- Name of Perinatal and EDAP with ETAs
- Narrative: estimated blood loss (EBL), prenatal care

PI=LABR (if age ≤ 14 years)

- Weight (in kgs)
- PWCC
- LOC
- GCS
- Respiration
- Skin
- IUP: ___ wks
- Glucose (if history of diabetes or gestational diabetes)
- IV
- VS (BP, HR, RR, O2 Sat, pain)
- Name of Perinatal and EDAP with ETAs
- Narrative: prenatal care

PI=SOBB/RDOT/SMOK (severe distress or not improving with CPAP)

- LOC
- GCS
- Respiration
- Skin
- Cap Refill (pediatric patients)
- Capnography # & Waveform (if BMV used)
- Adv Airway (if performed)
- Initial Rhythm
- 12-Lead Information (if performed)
- O2
- IV
- VS (BP, HR, RR, O2 Sat)

PI=SEAC/SEPI (pregnant or in status epilepticus)

- LOC
- GCS
- Pupils
- Respiration
- Skin
- Cap Refill (pediatric patients)
- IUP: ___ wks
- Suspected Drugs/ETOH

- Glucose
- IV
- Initial Rhythm
- VS (BP, HR, RR, O2 Sat)
- Name of Perinatal with ETA (if pregnant)
- Narrative: due date, gravida/para, complications (if pregnant)

PI=DRWN (if ALOC or needs decompression)

- LOC
- GCS
- Pupils (if assessed)
- Respiration
- Skin
- Cap Refill (pediatric patients)
- Glucose
- Capnography # & Waveform (if BMV used)
- Adv Airway (if performed)
- Initial Rhythm
- 12-Lead Information (if performed)
- O2
- IV
- VS (BP, HR, RR, O2 Sat)
- Narrative: dive telemetry

PI=TRMA (penetrating eye, TC criteria/guidelines, crush syndrome, or entrapment >30 minutes)

- LOC
- GCS
- Pupils (penetrating eye, CC=PH, CC=RR (if RR<10), or CC=14)
- Respiration
- Skin
- Cap Refill (pediatric patients and crushed extremities)
- Adv Airway (if performed)
- Glucose (CC=14)
- Initial Rhythm
- 12-Lead Information (if performed)
- O2 (if given)
- IV
- SMR?
- Needle Thoracostomy?, if applicable
- Tourniquet (if applied)
- Trauma Complaint and MOI
- Extricated @ (if crush/entrapment)
- VS (BP, HR, RR, O2 Sat, pain, repeat rhythm (PRN))
- Name of PTC (pediatrics) and TC (adults) with ETAs
- Narrative: CMS of injured extremities

PROVIDER IMPRESSION DEFINITIONS

Provider Impression (PI) Name	PI Code	Treatment Protocol (TP)	TP Code	Guidelines for use of PI
Abdominal Pain/Problems (GI/GU)	ABOP	GI/GU Emergencies	1205 1205-P	For any pain or problem in the abdominal/flank region that does not have a more specific PI, includes post-surgical complications.
Agitated Delirium	AGDE	Agitated Delirium	1208 1208-P	For Agitated Delirium only. NOT for psychiatric emergencies or other causes of agitation without delirium.
Airway Obstruction/ Choking	CHOK	Airway Obstruction	1234 1234-P	For any upper airway emergency including choking, foreign body, swelling, stridor, croup, and obstructed tracheostomy
Alcohol Intoxication	ETOH	Overdose/ Poisoning/Ingestion	1241 1241-P	For alcohol intoxication if it is the primary problem. Use of secondary PI if the patient has another acute emergency.
Allergic Reaction	ALRX	Allergy	1219 1219-P	For any simple allergic reaction that is isolated to the skin (hives/ urticarial only) and does not meet definition of anaphylaxis
ALOC - Not Hypoglycemia or Seizure	ALOC	ALOC	1229 1229-P	For altered mental status not attributed to a more specific PI (i.e., cause unknown). Use as secondary PI when cause known.
Anaphylaxis	ANPH	Allergy	1219 1219-P	For anaphylaxis.
Behavioral/ Psychiatric Crisis	PSYC	Behavioral/ Psychiatric Crisis	1209 1209-P	For psychiatric crisis that is the primary problem. NOT for anxiety/agitation secondary to medical etiology, use PI related to medical issue.
Body Pain – Non-Traumatic	BPNT	General Medical	1202 1202-P	For pain not related to trauma that is not localized to chest, abdomen, head, or extremity.
BRUE	BRUE	BRUE	1235-P	For a brief resolved unexplained event (BRUE). Patient must be ≤12 months of age and back to baseline on assessment.
Burns	BURN	Burns	1220 1220-P	For any burn injury to skin. For inhalation injury use PI Inhalation Injury. Use with PI Traumatic Injury if other trauma present.
Carbon Monoxide	COMO	Carbon Monoxide Exposure	1238 1238-P	For suspected or known carbon monoxide exposure.
Cardiac Arrest – Non-traumatic	CANT	Cardiac Arrest	1210 1210-P	For non-traumatic cardiac arrest in which any resuscitation is initiated, NOT dead on arrival

Provider Impression (PI) Name	PI Code	Treatment Protocol (TP)	TP Code	Guidelines for use of PI
Cardiac Dysrhythmia	DYSR	Cardiac Dysrhythmia – Bradycardia	1212 1212-P	For any bradycardic rhythm <60bpm.
Cardiac Dysrhythmia	DYSR	Cardiac Dysrhythmia – Tachycardia	1213 1213-P	For any tachydysrhythmia and for sinus tachycardia (ST) of unclear etiology. NOT for ST secondary to known cause – use more specific PI (e.g., Fever)
Chest Pain – Not Cardiac	CPNC	General Medical	1202 1202-P	For musculoskeletal and pleuritic pain and any chest pain that is NOT of possible cardiovascular etiology.
Chest Pain – STEMI	CPMI	Cardiac Chest Pain	1211	For any suspected STEMI, with or without chest pain.
Chest Pain – Suspected Cardiac	CPSC	Cardiac Chest Pain	1211	For any chest pain that is of possible cardiovascular etiology but NOT STEMI (e.g., NSTEMI, pericarditis, dissection).
Childbirth (Mother)	BRTH	Childbirth (Mother)	1215 1215-P	For delivery or imminent delivery of a fetus beyond the first trimester (12 weeks). For <12 weeks use PI Pregnancy Complications.
Cold / Flu Symptoms	COFL	General Medical	1202 1202-P	For minor respiratory illness in a patient without shortness of breath or wheezing; must have normal respiratory rate and O_2 sat (if available).
Diarrhea	DRHA	GI/GU Emergencies	1205 1205-P	For diarrhea without bleeding. NOT for melena, use PI Upper GI Bleeding.
Dizziness/Vertigo	DIZZ	Dizziness/Vertigo	1230 1230-P	For lightheadedness or vertigo, without syncope.
DOA – Obvious Death	DEAD	Cardiac Arrest	1210 1210-P	For non-traumatic cardiac arrest found dead on arrival such that no resuscitation is initiated.
Dystonic Reaction	DYRX	Dystonic Reaction	1239 1239-P	For suspected dystonic reaction (i.e., reaction, typically from antipsychotic medications, causing abnormal contraction of head and neck muscles.)
Electrocution	ELCT	Electrocution	1221 1221-P	For any electrocution injury.
ENT / Dental Emergencies	ENTP	ENT / Dental Emergencies	1226 1226-P	For a problem located in the ear, nose, throat area, except NOT epistaxis – use PI Epistaxis, NOT airway obstruction – use PI Airway Obstruction.
Epistaxis	NOBL	ENT / Dental Emergencies	1226 1226-P	For any bleeding from the nares.
Extremity Pain/ Swelling – Non-Traumatic	EXNT	General Medical	1202 1202-P	For pain, swelling, or other non-traumatic problem of an extremity, includes rashes and non-traumatic bleeding (e.g., varicose vein bleed).
Eye Problem – Unspecified	EYEP	Eye Problem	1228 1228-P	For any pain or problem of the eye or periorbital region, use with PI Traumatic Injury if a traumatic mechanism.

Provider Impression (PI) Name	PI Code	Treatment Protocol (TP)	TP Code	Guidelines for use of PI
Fever	FEVR	Fever	1204 1204-P	For reported or tactile fever that is NOT suspected sepsis. For sepsis use PI Sepsis.
Genitourinary Disorder – Unspecified	GUDO	GI/GU Emergencies	1205 1205-P	For urinary or genital related complaints, except NOT vaginal bleeding – use PI Vaginal Bleeding, NOT trauma-related – use PI Traumatic Injury.
HazMat Exposure	DCON	HAZMAT	1240 1240-P	For any hazardous material (chemical) exposure. May use with another PI (e.g., Inhalation Injury or Burns) when applicable.
Headache – Non-Traumatic	HPNT	General Medical	1202 1202-P	For non-traumatic headache or head pain.
Hyperglycemia	HYPR	Diabetic Emergencies	1203 1203-P	For patients with primary concern for hyperglycemia and/or associated symptoms (blurred vision, frequent urination or thirst) without more specific PI and those requiring field treatment. DO NOT list for incidental finding of hyperglycemia related to another illness.
Hypertension	HYTN	General Medical	1202 1202-P	For patients with primary concern for hypertension without symptoms related to a more specific PI. For symptomatic patients, use related PI as primary (e.g., Headache – Non-traumatic) and Hypertension as secondary. DO NOT list for incidental finding of hypertension.
Hyperthermia	HEAT	Hyperthermia (Environmental)	1222 1222-P	For environmental exposure causing hyperthermia, e.g., heat exhaustion and heat stroke, drugs may also be a contributing factor.
Hypoglycemia	HYPO	Diabetic Emergencies	1203 1203-P	For glucose <60mg/dL.
Hypotension	HOTN	Shock / Hypotension	1207 1207-P	For SBP <90mmHg in adults or <70mmHg in children with transient low BP or rapidly responds to fluid resuscitation and without signs of shock.
Hypothermia / Cold Injury	COLD	Hypothermia / Cold Injury	1223 1223-P	For environmental exposures causing hypothermia and/or frostbite injury.
Inhalation Injury	INHL	Inhalation Injury	1236 1236-P	For any signs/symptoms related to inhaling a gas or substance other than smoke or carbon monoxide.
Lower GI Bleeding	LOGI	GI/GU Emergencies	1205 1205-P	For bleeding from the rectum and/or bright red bloody stools.

Provider Impression (PI) Name	PI Code	Treatment Protocol (TP)	TP Code	Guidelines for use of PI
Medical Device Malfunction – Fail	FAIL	Medical Device Malfunction	1206 1206-P	For a medical device that fails, including VADs, insulin pumps, and shunts. Usually for internal devices, may be used for vent failure if patient is asymptomatic. For symptomatic patients, use PI related to symptoms (e.g., Automated Internal Defibrillator firing – use PI associated with complaint such as Cardiac Dysrhythmia – Tachycardia).
Nausea / Vomiting	NAVM	GI/GU Emergencies	1205 1205-P	For any nausea or vomiting without blood. Not for adverse reaction to opiate administration by EMS, manage with primary PI/TP.
Newborn	BABY	Newborn/Neonatal	1216-P	For any newborn deliveries in the field.
No Medical Complaint	NOMC	Assessment	1201	For patients without any medical, psychiatric or traumatic complaint and no signs of illness on assessment. Usually reserved for non-transports.
Overdose/ Poisoning/Ingestion	ODPO	Overdose/ Poisoning/ Ingestion	1241 1241-P	For any intentional or unintentional overdose/poisoning by any route, includes illicit substances and prescription medications, overdose and/or adverse reactions.
Palpitations	PALP	General Medical	1202 1202-P	For any patient complaint of palpitations (e.g., rapid heart rate beat, skipped beats, chest fluttering) with normal rate and rhythm on the ECG.
Pregnancy Complications	PREG	Pregnancy Complication	1217 1217-P	For any pregnancy-related condition that is not labor. Includes vaginal bleeding in pregnancy, hypertension, and complications of delivery.
Pregnancy / Labor	LABR	Pregnancy Labor	1218 1218-P	For contractions without imminent childbirth.
Respiratory Arrest / Failure	RARF	Respiratory Distress	1237 1237-P	For patients requiring positive-pressure ventilation and/or hypoxia despite 100% oxygen.
Respiratory Distress / Bronchospasm	SOBB	Respiratory Distress	1237 1237-P	For COPD/asthma exacerbations and any bronchospasms/wheezing not from pulmonary edema.
Respiratory Distress / Other	RDOT	Respiratory Distress	1237 1237-P	For patients with pulmonary disease that is not edema or bronchospasm, includes suspected pneumonia, PE, pneumothorax and non-pulmonary and unknown causes of respiratory distress.
Respiratory Distress / Pulmonary Edema / CHF	CHFF	Pulmonary Edema / CHF	1214	For congestive heart failure exacerbation.
Seizure – Active	SEAC	Seizure	1231 1231-P	For seizure witnessed by EMS, whether treated or not.

Provider Impression (PI) Name	PI Code	Treatment Protocol (TP)	TP Code	Guidelines for use of PI
Seizure – Postictal	SEPI	Seizure	1231 1231-P	For any seizure that stopped prior to EMS arrival and there is no further seizure activity during EMS contact.
Sepsis	SEPS	Fever / Sepsis	1204 1204-P	For patients with suspected sepsis (i.e., signs suggestive of sepsis including fever, tachycardia, suspected infection).
Shock	SHOK	Shock / Hypotension	1207 1207-P	For patients with poor perfusion not rapidly responsive to IV fluids.
Smoke Inhalation	SMOK	Inhalation Injury	1236 1236-P	For patients with smoke inhalation.
Stings / Venomous Bites	STNG	Stings / Venomous Bites	1224 1224-P	For snakes, scorpion, insects, and marine envenomations (stingrays, jelly fish). NOT for animal bites, use PI traumatic injury.
Stroke / CVA / TIA	STRK	Stroke / CVA / TIA	1232 1232-P	For suspected stroke or transient ischemic attack (stroke symptoms that resolve rapidly).
Submersion / Drowning	DRWN	Submersion	1225 1225-P	For any submersion injury, including drowning and dive (decompression) emergencies.
Syncope / Near Syncope	SYNC	Syncope / Near Syncope	1233 1233-P	For syncope (transient loss of consciousness). NOT for cardiac arrest, use PI Cardiac Arrest – Non-traumatic only.
Traumatic Arrest – Blunt	CABT	Traumatic Arrest	1243 1243-P	For cardiac arrest with blunt traumatic mechanism, including those declared deceased in the field by Ref. 814. NOT for trauma sustained after cardiac arrest, use PI Cardiac Arrest – Non- traumatic.
Traumatic Arrest – Penetrating	CAPT	Traumatic Arrest	1243 1243-P	For cardiac arrest with penetrating traumatic mechanism, including those declared deceased in the field by Ref. 814.
Traumatic Injury	TRMA	Traumatic Injury	1242 1242-P 1244 1244-P	For any trauma-related injury including crush injury and conducted electrical weapons (CEW). May use in addition to another PI when medical condition also present (e.g., for syncope with trauma – use PI Syncope and PI Traumatic Injury; for CEW use in patient with agitated delirium – use PI Agitated Delirium and PI Traumatic Injury).
Upper GI Bleeding	UPGI	GI/GU Emergencies	1205 1205-P	For vomiting blood or coffee ground emesis, and for melena (i.e., black, tarry stools).
Vaginal Bleeding	VABL	GI/GU Emergencies	1205 1205-P	For vaginal bleeding in the NON-pregnant patient. For vaginal bleeding in pregnancy use PI Pregnancy Complications.
Weakness – General	WEAK	General Weakness	1202 1202-P	For nonfocal weakness, general malaise, and any nonspecific ‘sick’ symptoms.