Ambulance Call Report Completion Manual

Version 3.0
Comes into force on April 1, 2017

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

Ontario

To all users of this publication:

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

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Document Control

Version Number (status)	Date of Issue	Comes into Force Date	Brief Description of Change
2.0	2000	2000	Existing document
3.0	March 29, 2016	April 1, 2017	Finalized version

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Ambulance Call Report Completion Manual

Version 3.0

Part 1 - Preface

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Preface

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

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

Clinical

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

Administrative

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

Research

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

Legal

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

Part 2 – Definitions of Terms Used Throughout the Manual

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Definitions of Terms Used Throughout the Manual

Patient

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

eACR

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

Call

Refers to a request for ambulance service.

Page

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

Section

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

Field

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

Part 3 – Introduction

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Part 3 – Introduction

Introduction

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

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

Electronic Ambulance Call Reports

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

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

Part 4 – Design Highlights of the ACR

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Part 4 – Design Highlights of the ACR

Design Highlights of the ACR

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

Sequencing of Information

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

Grouping of Information

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

Front of the ACR

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

Reverse side of the ACR

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

Prompts

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

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

Codes

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

Reference Information

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

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Part 5 – Completion Requirements

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Part 5 – Completion Requirements

Completion Requirements

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

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

Biometric data may include but is not limited to:

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

Distribution

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

Copies of the ACR are to be distributed as follows:

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

The copies of the eACR are to be distributed accordingly.

Part 6 – General Rules

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Part 6 – General Rules

General Rules

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

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

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Part 7 – Section Details

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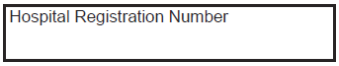
Part 7 – Section Details

Section Details

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

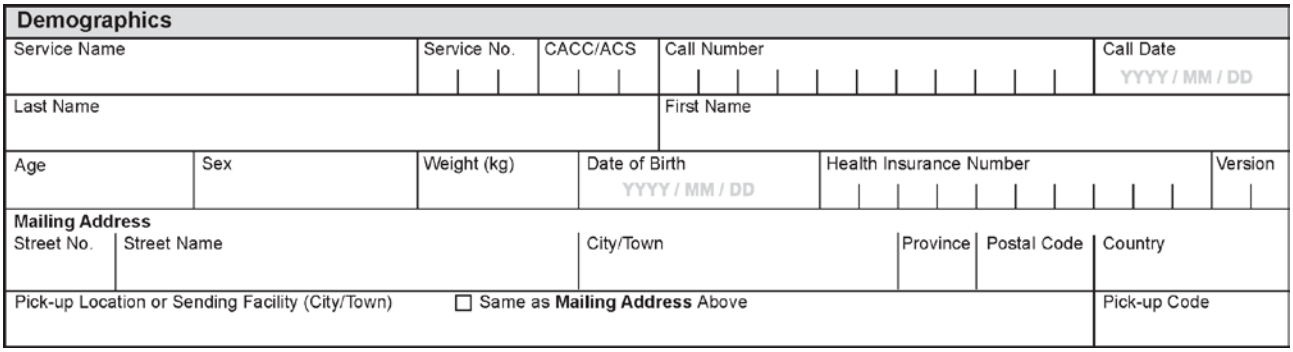
Note: Images of specific fields/sections in this manual are visual representations of the paper ACR. eACRs may be displayed and organized differently than the paper version of the ACR. Paramedics are responsible for ensuring all required information as outlined in this manual is entered into the equivalent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



Hospital Registration Number

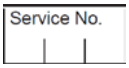
This field has been included on the ACR for hospital staff to document a patient's hospital registration/chart number directly to the form. This will facilitate the cross referencing of the hospital registration number and the ACR.

Demographics



Service Name

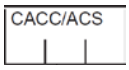
Enter the name of the ambulance service assigned to the call.



Service No.

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

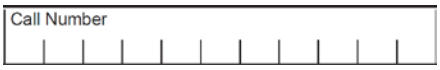
CACC/ACS



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

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

Call Number



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

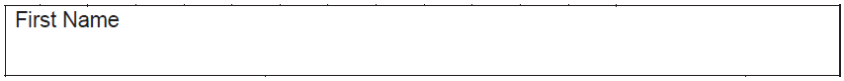
Call Date

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

Last Name

Enter the complete last name of the patient.

First Name



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

Age

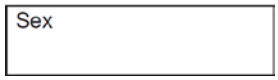
Enter the patient's age. If the actual age cannot be determined, an estimated age is acceptable if indicated as such (*e.g.* approx. 85, ~85).

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

Enter the age of pediatric patients in the following manner:

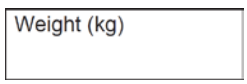
<1 month, enter as days ("D")
1 month to <2 years, enter as months ("M")
≥2 years, enter as years ("Y")

Sex



Enter the sex of the patient by entering **"M"** for male or **"F"** for female. Sex of the patient is indicated on the patient's health card.

Weight (kg)



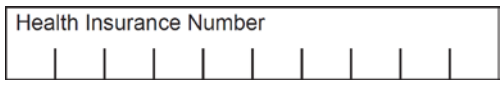
Enter the weight of the patient in kilograms (1 kg = 2.2 lbs). If the actual weight cannot be determined, an estimated weight is acceptable if indicated as such (*e.g.* approx. 70, ~70).

Date of Birth

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

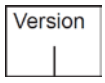
Enter the full 4-digit year of birth. For example, if a patient's year of birth is 2001 then enter "2001".

Health Insurance Number



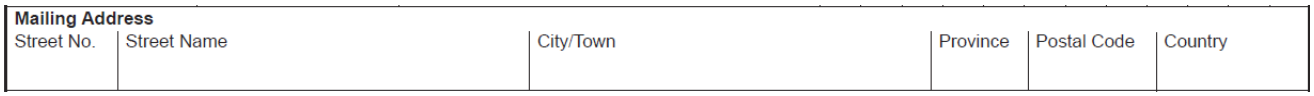
Enter the patient's 10-digit Ontario Health Insurance Number in the boxes provided. A patient's "Health Insurance Number" is an important tool that may be used to track a patient through the health care system. If a valid Ontario Health Insurance Number is neither available nor provided, enter CNO in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

Version



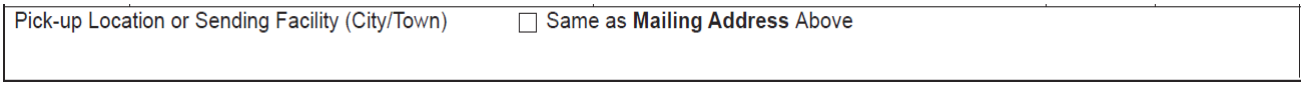
Enter the patient's 2-letter Ontario Health Insurance Version Code in the 2 boxes provided.

Mailing Address



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

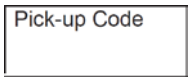
Pick-up Location or Sending Facility



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

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

If the patient is being picked up from a facility that you have already listed as the mailing address, provide the name of the facility and check the "Same as **Mailing Address** Above" box.
If the patient is not being picked up at the sending facility, the name of the sending facility should be entered in this section of the form (*e.g.* hospital, clinic, etc.).

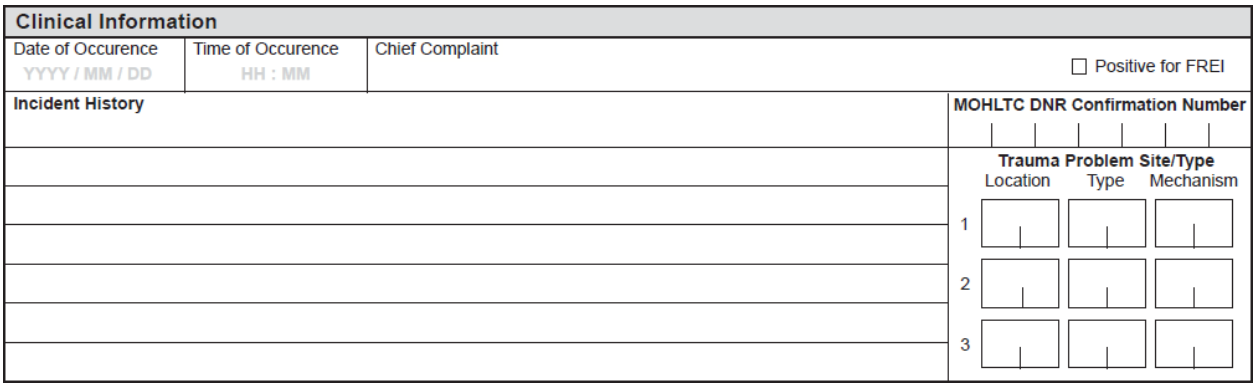


Pick Up Code

The “Pick-up Code” identifies the location where the patient is picked up. Choose one from the list of codes on the reverse side of the ACR that best describes the pick-up location.
If none of the options describe the pick-up location, enter “Z” (other) and provide details regarding the location in the “Remarks” section.

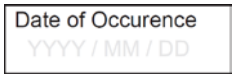
Pick-up codes refer to the physical nature of the location rather than how it relates to the patient. For example, a pick-up in a hotel is coded “G” regardless of whether the patient was an employee or a guest in the hotel. In some cases, more than one code could apply. In these cases, choose the more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

Clinical Information



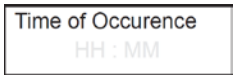
The "Clinical Information" section is to be used to record the clinically significant information about the patient.

Date of Occurrence



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

Time of Occurrence



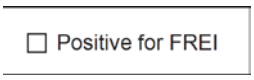
Enter the actual or estimated time at which the patient's signs and symptoms started and necessitated the call for ambulance assistance (*e.g.* time of fall, time seizure started, time of onset of shortness of breath, etc.).

Chief Complaint

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

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

Positive for FREI



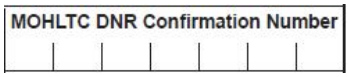
This check box should be checked if the patient screens positive for a febrile respiratory/enteric illness. Current screening tools must be used when assessing patients for FREI.

Incident History

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

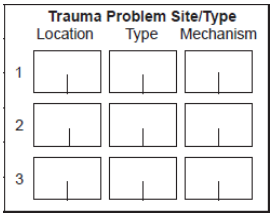
Example: "Patient's spouse advised crew that the patient had been shoveling snow for about 45 minutes (since 17:00 hrs) prior to complaining of chest pain (at 17:45 hrs). Patient states that the chest pain radiates down his left arm and rates the pain as 6 out of 10. Patient denies any shortness of breath".

MOHLTC DNR Confirmation No.



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

Trauma Problem Site/Type

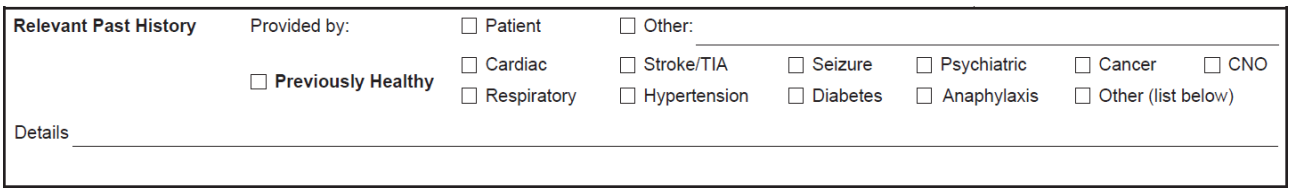


This area is used to identify the location, type and mechanism for traumatic injuries/problems identified during the assessment and management of a patient. For **example**, a knife wound to the chest would be coded as follows:

"Location": "15" (Chest)
"Type": "37" (Penetrating/Perforation)
"Mechanism": "63" (Stabbing)

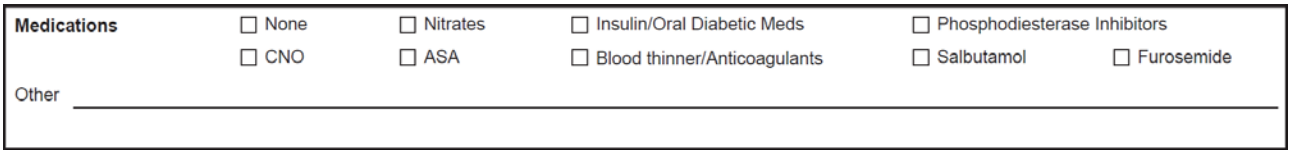
A maximum of three problems can be entered in this area. The three (3) most serious problems are to be documented. If more than three (3) traumatic injuries/problems are identified, the others can be entered in the "Physical Exam" section of the ACR.

Relevant Past History



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

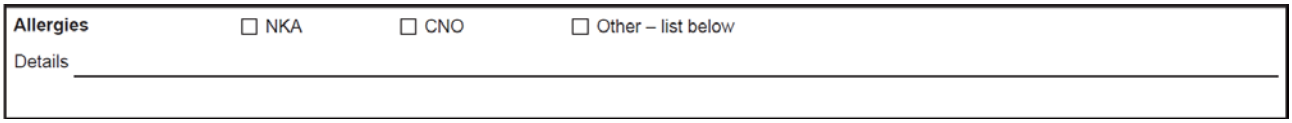
Use the blank lines to enter past historical information that is relevant to the current condition together with the sources of the information. For **example**; "Triple bypass three (3) years ago".



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

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

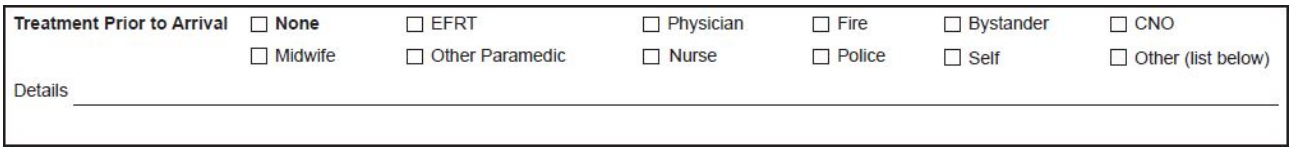
Allergies



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

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

Treatment Prior to Arrival



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

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

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

Cardiac Arrest Information

Cardiac Arrest Information					Date	Start Time
Arrest Witnessed By	☐ Bystander	☐ Trained Responder	☐ Paramedic	☐ Unwitnessed	YYYY / MM / DD	HH : MM
CPR Started By	☐ Bystander	☐ Trained Responder	☐ Paramedic	☐ None	YYYY / MM / DD	HH : MM
First Shock by	☐ Bystander	☐ Trained Responder	☐ Paramedic		YYYY / MM / DD	HH : MM

Arrest Witnessed by

Arrest Witnessed By	☐ Bystander	☐ Trained Responder	☐ Paramedic	☐ Unwitnessed	YYYY / MM / DD	HH : MM

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

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

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

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

CPR Started by

CPR Started By	☐ Bystander	☐ Trained Responder	☐ Paramedic	☐ None	YYYY / MM / DD	HH : MM

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

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

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

First Shock by

First Shock By	☐ Bystander	☐ Trained Responder	☐ Paramedic	YYYY / MM / DD	HH : MM

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

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

Physical Exam

Physical Exam

General Appearance Skin Colour:_____ Skin Condition:_____

Head/Neck Trachea ☐ - Midline Shifted ☐ - R ☐ - L JVD ☐ - Elevated ☐ - Not Elevated

Chest Air Entry ☐ - Bilaterally Decreased ☐ - R ☐ - L Breath Sounds ☐ - Clear ☐ - Wheezes ☐ - Crackles ☐ - Rub ☐ - Absent

Abdomen ☐ - Soft ☐ - Rigid ☐ - Distended ☐ - Tender ☐ - Mass ☐ - Pulsatile ☐ - RU ☐ - LU ☐ - LL ☐ - RL ☐ - Center

Back/Pelvis ☐ - Unremarkable

Extremities ☐ - Unremarkable Peripheral Edema ☐ - Absent ☐ - Present Pedal Pulse ☐ - Absent ☐ - Present

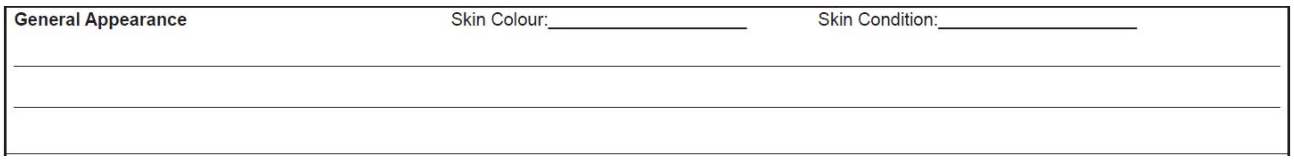
The "Physical Exam" section is sub divided into six categories:

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

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

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

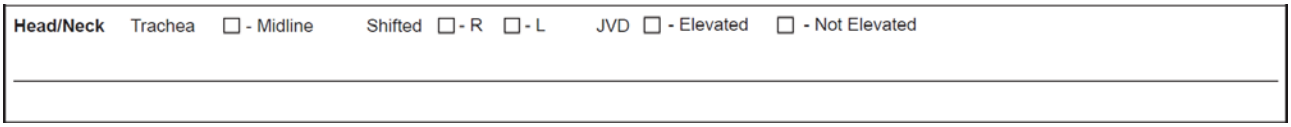
General Appearance (Skin Colour/Skin Condition)



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

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

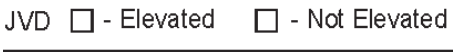
Head/Neck



Trachea

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

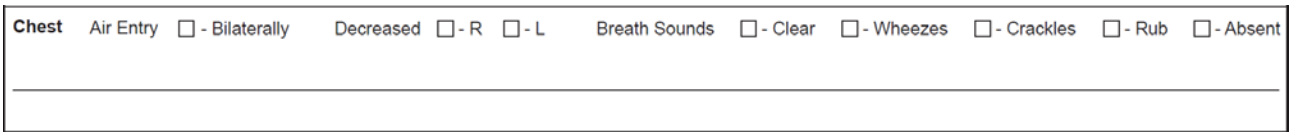
JVD



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

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

Chest



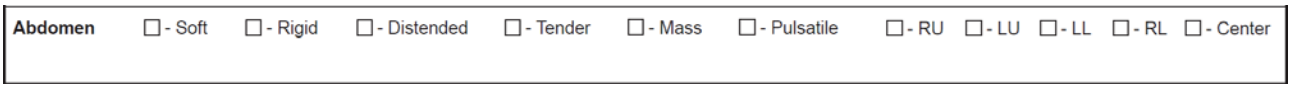
Air Entry

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

Breath Sounds

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

Abdomen

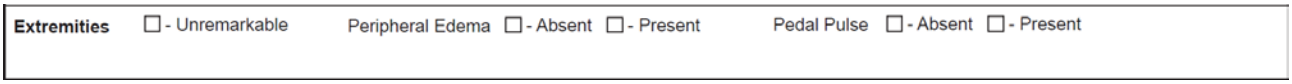


Check the appropriate box to indicate abdominal examination findings and section of the abdomen that has abnormal characteristics. Use the blank lines to enter any further remarkable findings regarding the patient's abdomen.

Back/Pelvis

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

Extremities



Peripheral Edema

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

Pedal Pulse

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

Call Number/Page

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

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

Clinical Treatment/Procedures & Results

Clinical Treatment/Procedures								Results						
Time HH : MM	Procedure Code	Dose/Unit	Route	Pulse Rate	Resp. Rate	B/P Sys/Dia	Temp.	Reading/ Code	SpO_2	$EtCO_2$	GCS	Pupils R ± | L ±	Pain Scale	Crew Mbr. No.

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

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

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

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

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

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

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

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

Sample

Clinical Treatment/Procedures								Results						
Time HH : MM	Procedure Code	Dose/Unit	Route	Pulse Rate	Resp. Rate	B/P Sys/Dia	Temp.	Reading/ Code	SpO_2	$EtCO_2$	GCS	Pupils R ± L ±	Pain Scale	Crew Mbr. No.
1435	341	20ga 1.16" INSYTE LEFT FOREARM						SUCCESSFUL AND SECURED						
1436	345	0.9% NaCl 500 ml BAG TKVO AT 30 ml/hr						PATENT AND RUNNING WELL						

Time

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

Procedure Code

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

Dose/Unit

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

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

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

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

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

Sample

Clinical Treatment/Procedures								Results						
Time HH : MM	Procedure Code	Dose/Unit	Route	Pulse Rate	Resp. Rate	B/P Sys/Dia	Temp.	Reading/ Code	SpO_2	$EtCO_2$	GCS	Pupils R ± L ±	Pain Scale	Crew Mbr. No.
0056	504	160 mg	PO					CHEWED AND SWALLOWED						1

Route

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

Vital Signs

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

Sample

Clinical Treatment/Procedures								Results							
Time HH : MM	Procedure Code	Dose/Unit	Route	Pulse Rate	Resp. Rate	B/P Sys/Dia	Temp.	Reading/ Code	SpO_2	$EtCO_2$	GCS	Pupils R ±	Pupils L ±	Pain Scale	Crew Mbr. No.
0425	010	VITAL SIGNS		100	16	120/76	36.7		99	40	15	4+	4+	0	1

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

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

Pulse Rate

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

Resp. Rate

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

B/P Sys/Dia

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

Temp.

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

Reading/Code

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

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

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

Sample

Clinical Treatment/Procedures								Results						
Time HH : MM	Procedure Code	Dose/Unit	Route	Pulse Rate	Resp. Rate	B/P Sys/Dia	Temp.	Reading/ Code	SpO_2	$EtCO_2$	GCS	Pupils R ± | L ±	Pain Scale	Crew Mbr. No.
0030	025	BLOOD GLUCOSE						5.2 mmoL						1
0035	301	RHYTHM INTERPRETATION						40	NORMAL SINUS RHYTHM AT 80					1

SpO_2

Enter a numeric value for oxygen saturation.

$EtCO_2$

Enter a numeric value for the End-tidal Carbon Dioxide reading. If a colorimetric CO_2 indicator device is used, enter the approximate expired carbon dioxide level based on the comparison of the colour of the indicator to the colour scale provided with the device. Completion of this field is based on the paramedic's scope of practice and availability of equipment.

GCS

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

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

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

Pupils

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

Pain Scale

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

Crew Mbr. No.

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

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

Remarks

<table>
<tr><td colspan="4">Remarks</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4">Disposition of Effects
☐ Receiving Staff ☐ Family ☐ Other (list):</td></tr>
<tr><td>Primary Problem</td><td>Problem Code</td><td>Sp Trans Code</td><td>CTAS Arrive Patient</td></tr>
<tr><td colspan="3">Deceased
☐ Obviously dead ☐ DNR ☐ BHP TOR ☐ Pronounced by on scene physician</td><td>CTAS Depart Scene</td></tr>
<tr><td>Physician/BHP Name (if pronounced/TOR)</td><td>Date
YYYY / MM / DD</td><td>Time
HH : MM</td><td>CTAS Arrive Destination</td></tr>
</table>

Remarks

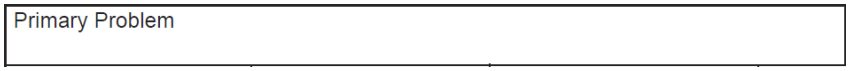
Enter any significant information about the call that has not already been entered in another section of the ACR (*e.g.* clinically significant information, name of physician at scene, unusual circumstances surrounding the call) in this section.

Disposition of Effects

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

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

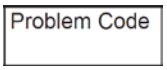
Primary Problem



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

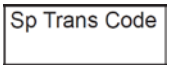
The "Primary Problem" must reflect in general terms, the underlying problem or most probable cause of the patient's presentation as found by the paramedic rather than the patient's chief complaint (*e.g.* the patient's chief complaint may be shortness of breath while the most likely cause may be congestive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

Problem Code



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

Sp Trans Code (Special Transport Code)



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

Field Trauma Triage Standard
Acute Stroke Protocol
STEMI Bypass

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

Trauma

01 To be used for patients who met the criteria outlined in the current version of the *Field Trauma Triage Standard* and **were** transported to a Lead Trauma Hospital (LTH).

02 To be used for patients who met the criteria outlined in the current version of the *Field Trauma Triage Standard,* but were **not** transported to a (LTH) due to patient condition reasons. Example: A patient met the criteria but developed an uncontrolled airway problem during transport and paramedics diverted to the closest ED.

03 To be used for patients who met the criteria outlined in the current version of the *Field Trauma Triage Standard,* but were **not** transported to a LTH due to a hospital reason. Example: A patient met the criteria, but the LTH was unable to accept the patient due to an emergent capacity/facilities issue.

Stroke

04 To be used for patients who met the criteria outlined in the current version of the *Acute Stroke Protocol* and **were** transported to a designated Stroke Centre.

05 To be used for patients who met the criteria outlined in the current version of the *Acute Stroke Protocol,* but were **not** transported to a designated Stroke Centre due to patient condition reasons. Example: A patient initially met the criteria but became VSA enroute which resulted in paramedics diverting to the closest ED.

06 To be used for patients who met the criteria outlined in the current version of the *Acute Stroke Protocol,* but were **not** transported to a designated Stroke Centre due to a hospital reason. Example: A patient initially met the criteria, but the designated Stroke Centre was unable to accept the patient due to an emergent capacity/facilities issue.

STEMI

07 To be used for patients who met the criteria outlined in the current version of the *STEMI Hospital Bypass Protocol* and **were** transported to a designated STEMI/PCI Centre.

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

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

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

Canadian Triage and Acuity Scale (CTAS)

CTAS Arrive Patient
CTAS Depart Scene
CTAS Arrive Destination

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

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

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

CTAS Arrive Patient

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

CTAS Depart Scene

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

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

CTAS Arrive Destination

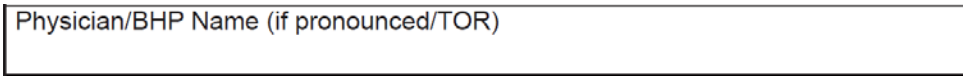
Enter the CTAS level of the patient as determined by the paramedic upon arrival at destination. The "CTAS Arrive Destination" level will reflect the patient's acuity level upon arrival at the destination.

Deceased

Check the appropriate box to indicate if:

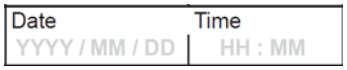
- a paramedic determines that the patient is obviously dead.
- the patient has a DNR (with a valid *MOHLTC DNR Confirmation Form*) and resuscitation not initiated.
- a Base Hospital Physician has ordered the termination of resuscitation efforts.
- the patient is pronounced deceased on scene by a member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

Physician Name/BHP (if pronounced/TOR)



Enter the name or number where applicable, of the on scene physician pronouncing the patient or the Base Hospital Physician ordering the termination of resuscitation in the space provided.

Date/Time

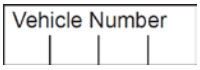


Enter the date and the time of pronouncement or the order for termination of resuscitation.

General Administration

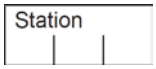
General Administration									
Vehicle Number	Station	Status	Hospital Number	Receiving Facility/Destination					
UTM Code		Dispatch	Return	Patient	Sequence	**Warning Systems**	To Scene ☐ None ☐ Emergency Systems To Destination ☐ None ☐ Emergency Systems		
Base Hospital Name			Base Hospital Number	Base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

Vehicle Number



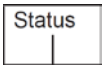
Enter the 4-digit vehicle number assigned by the Ministry of Health and Long-Term Care, Emergency Health Services Branch.

Station



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

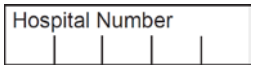
Status



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

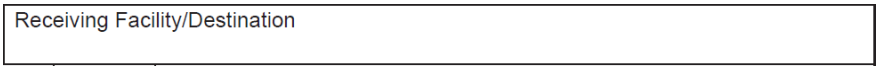
00	At Base
77	Mobile
88	Standby Location
99	Maintenance

Hospital Number



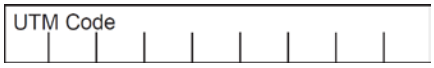
Enter the Ministry of Health and Long-Term Care assigned hospital/institution number for the receiving facility. This information is available through CACC/ACS.

Receiving Facility/Destination



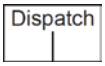
Enter the name of the facility that received the patient from the paramedics.

UTM Code (Universal Transverse Mercator)



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

Dispatch



Enter the appropriate "Priority Code" that corresponds to the assigned dispatched priority.

The Dispatch Priority Codes are used to identify:

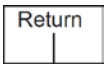
1. the urgency of a response or transport.
2. other use of an ambulance when a patient is not carried.

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

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

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

Return



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

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

Code 1 "Deferrable Call" – A non-emergency call that may be delayed without being physically detrimental to the patient.

Code 2 "Scheduled Call" – A non-emergency call which must be done at a specific time due to the limited availability of special treatment or diagnostic/receiving facilities. Such scheduling is not done because of patient preference or convenience.

Code 3 "Prompt Call" – An emergency call which may be responded to with moderate delay. The patient is stable or under professional care and not in immediate danger.

Code 4 "Urgent Call" – An emergency call requiring an immediate response. The patient is life, limb or function threatened, in immediate danger and time is crucial.

Code 6 "Deceased Patient" – The transportation of a deceased patient where no resuscitation measures are being performed.

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

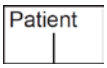
If no patient is carried, one of the following return priority codes should be used:

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

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

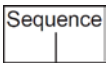
Code 8 Standby Call
Code 9 Out of Service/Administration

Patient



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

Sequence

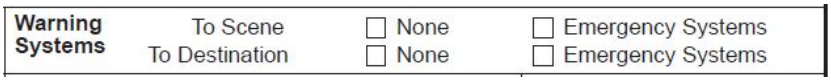


The "Sequence" indicates to which of the multiple patients the ACR information refers. For example, if two patients were transported using the same call number, one patient would be Sequence "1" and the other patient would be Sequence "2". If no patients were transported, enter "0".

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

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

Warning Systems

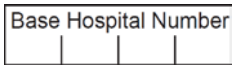


Check the appropriate box for systems used while travelling to the scene and while travelling from the scene to a destination. If the public address system is used enter a narrative in the "Remarks" section.

Base Hospital

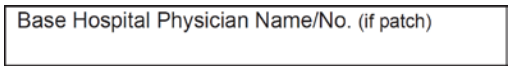
Enter the name of the Base Hospital with which the paramedic is affiliated.

Base Hospital Number



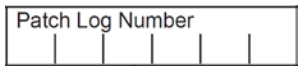
Enter the Base Hospital number with which the paramedic is affiliated.

Base Hospital Physician Name/No. (if patch)



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

Patch Log Number



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

Call Events (Times)

Call Events	Call Received HH : MM : SS	Crew Notified HH : MM : SS	Crew Mobile HH : MM : SS	Arrive Scene HH : MM : SS	Patient Contact HH : MM : SS	Depart Scene HH : MM : SS	Arrive Destination HH : MM : SS	TOC HH : MM :SS

Time of call events must be completed on all calls.

Call Received

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

Crew Notified

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

Crew Mobile

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

Arrive Scene

Enter the time the paramedics arrived at the call scene.

Patient Contact

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

Depart Scene

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

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

Arrive Destination

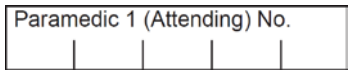
Enter the time the paramedics arrived at the receiving destination (*e.g.* hospital, long term care home).

Transfer of Care (TOC)

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

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

Paramedic 1 (Attending) No.

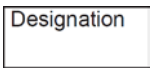


Enter the 5-digit MOHLTC assigned EHS Number for the paramedic attending on the call.

Name

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

Designation

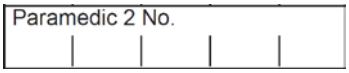


Enter the designation that describes the paramedic's certification level. Paramedic Designation codes are found on the reverse of the ACR. If a paramedic is functioning as a preceptor on the call, the letter "P" must be documented after the Paramedic Designation.

Signature No. 1

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

Paramedic 2 No.

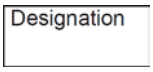


Enter the 5-digit MOHLTC assigned EHS Number for the other paramedic assigned to the call.

Name

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

Designation



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

Signature No. 2

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

Other

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

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

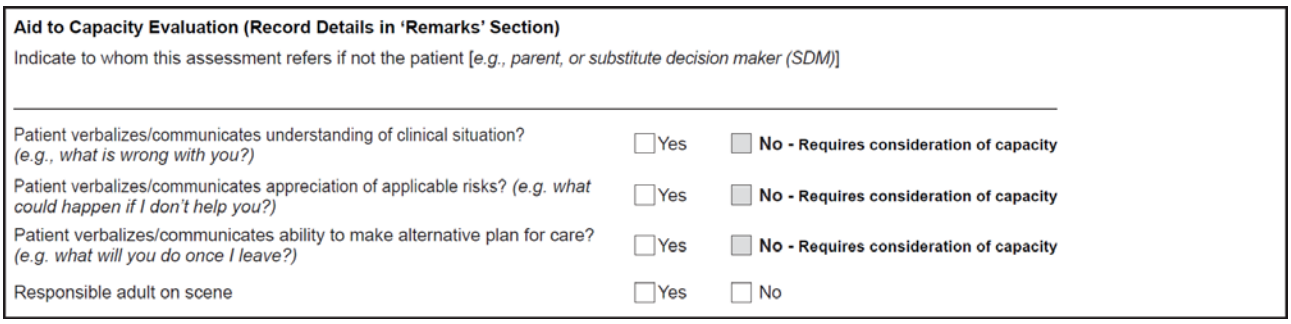
If another paramedic accompanies the transporting paramedics to assist with patient care, their 5-digit MOHLTC assigned EHS Number and designation must be entered along with their name and signature in the space provided.

Date/Time of ACR Completion

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

Aid to Capacity Assessment

Reverse side of ACR



Aid to Capacity Evaluation (Record Details in 'Remarks' Section)

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

Patient verbalizes/communicates understanding of clinical situation? *(e.g., what is wrong with you?)*	☐ Yes	☐ **No - Requires consideration of capacity**
Patient verbalizes/communicates appreciation of applicable risks? *(e.g. what could happen if I don't help you?)*	☐ Yes	☐ **No - Requires consideration of capacity**
Patient verbalizes/communicates ability to make alternative plan for care? *(e.g. what will you do once I leave?)*	☐ Yes	☐ **No - Requires consideration of capacity**
Responsible adult on scene	☐ Yes	☐ No

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

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

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

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

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

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

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

Patient verbalizes/communicates understanding of clinical situation.

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

Patient verbalizes/communicates appreciation of applicable risks.

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

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

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

Responsible adult on scene.

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

Responses in shaded sections require consideration of incapacity.

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

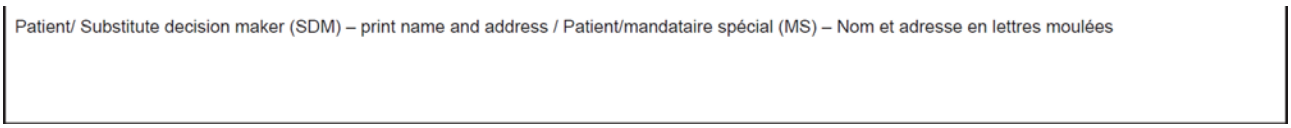
A person of any age may be capable to consent to some things and incapable of consent with respect to others, depending on the complexity of the treatment (*e.g.* they may understand what you tell them about oxygen but not about other medications).

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

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

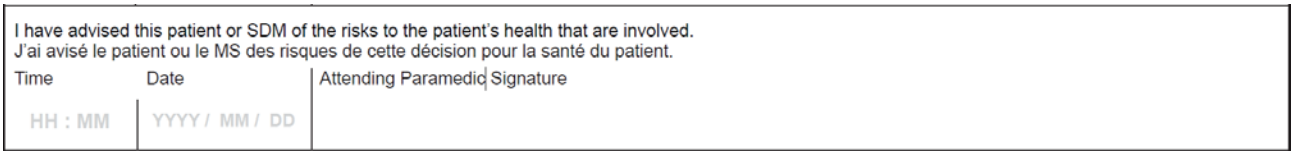
The "Refusal of Service" section must be completed any time there is a refusal of treatment and/or transportation by a patient or their substitute decision maker (SDM). In the event of a refusal of treatment and/or transport, the paramedic crew is to make every effort to have the patient or the patient's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

Patient/SDM



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

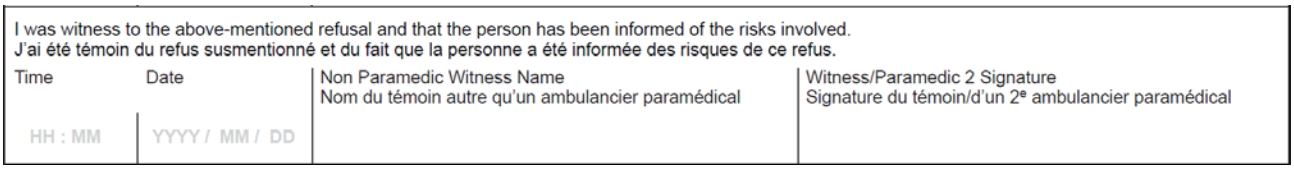
Attending Paramedic Signature


I have advised this patient or SDM of the risks to the patient's health that are involved.
J'ai avisé le patient ou le MS des risques de cette décision pour la santé du patient.

Time	Date	Attending Paramedic Signature
HH : MM	YYYY / MM / DD	

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

Paramedic 2/Witness Signature


I was witness to the above-mentioned refusal and that the person has been informed of the risks involved.
J'ai été témoin du refus susmentionné et du fait que la personne a été informée des risques de ce refus.

Time	Date	Non Paramedic Witness Name Nom du témoin autre qu'un ambulancier paramédical	Witness/Paramedic 2 Signature Signature du témoin/d'un 2e ambulancier paramédical
HH : MM	YYYY / MM / DD		

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

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

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

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

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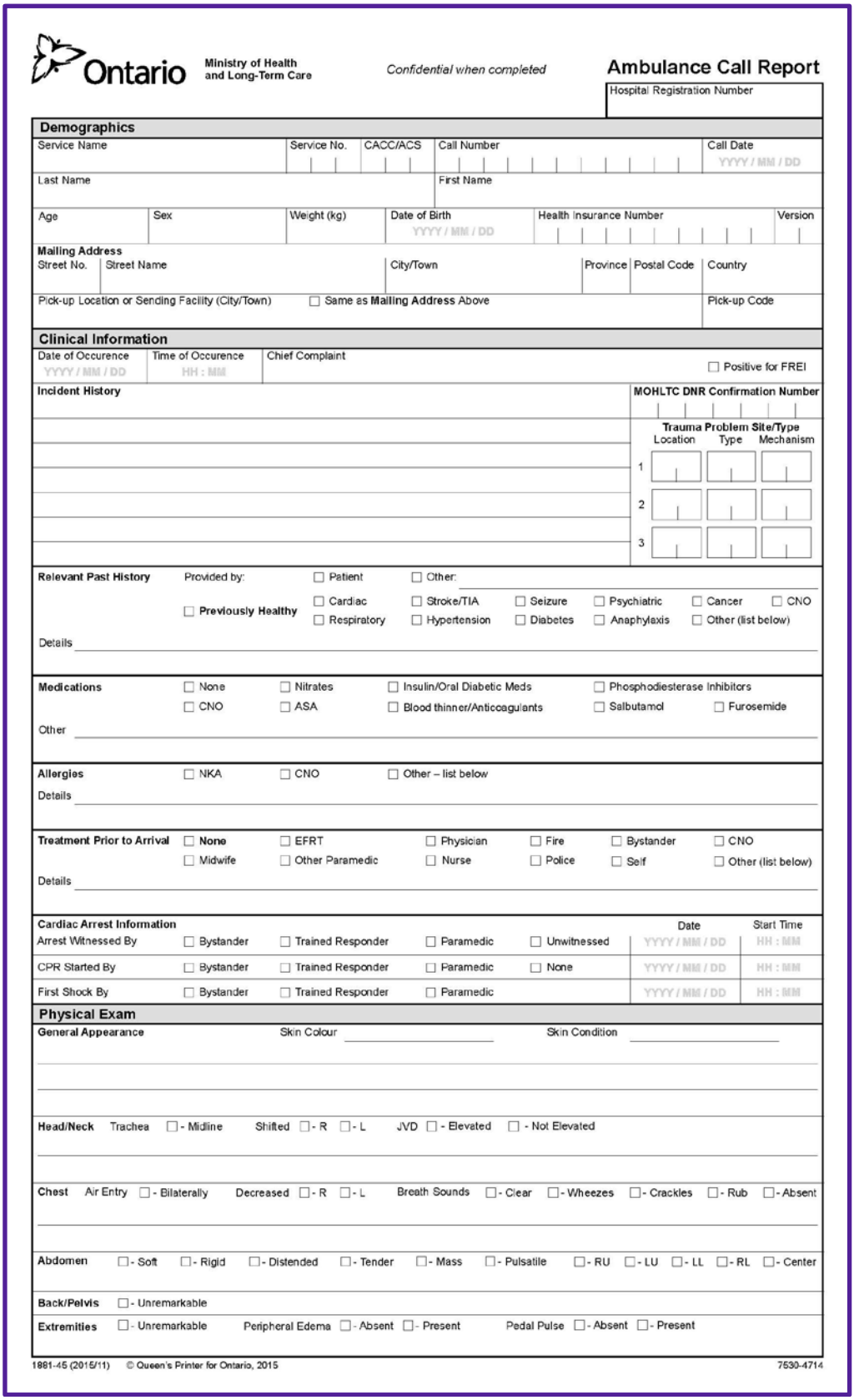
Appendix A – Sample ACR

Sample ACR (Front – Left)



Ontario Ministry of Health and Long-Term Care

Confidential when completed

Ambulance Call Report

Hospital Registration Number

Demographics

Service Name | Service No. | CACC/ACS | Call Number | Call Date (YYYY / MM / DD)

Last Name | First Name

Age | Sex | Weight (kg) | Date of Birth (YYYY / MM / DD) | Health Insurance Number | Version

Mailing Address

Street No. | Street Name | City/Town | Province | Postal Code | Country

Pick-up Location or Sending Facility (City/Town) ☐ Same as **Mailing Address** Above | Pick-up Code

Clinical Information

Date of Occurence (YYYY / MM / DD) | Time of Occurence (HH : MM) | Chief Complaint ☐ Positive for FREI

Incident History | **MOHLTC DNR Confirmation Number**

Trauma Problem Site/Type

	Location	Type	Mechanism
1			
2			
3			

Relevant Past History Provided by: ☐ Patient ☐ Other:

☐ **Previously Healthy** ☐ Cardiac ☐ Stroke/TIA ☐ Seizure ☐ Psychiatric ☐ Cancer ☐ CNO ☐ Respiratory ☐ Hypertension ☐ Diabetes ☐ Anaphylaxis ☐ Other (list below)

Details

Medications ☐ None ☐ Nitrates ☐ Insulin/Oral Diabetic Meds ☐ Phosphodiesterase Inhibitors ☐ CNO ☐ ASA ☐ Blood thinner/Anticoagulants ☐ Salbutamol ☐ Furosemide

Other

Allergies ☐ NKA ☐ CNO ☐ Other – list below

Details

Treatment Prior to Arrival ☐ **None** ☐ EFRT ☐ Physician ☐ Fire ☐ Bystander ☐ CNO ☐ Midwife ☐ Other Paramedic ☐ Nurse ☐ Police ☐ Self ☐ Other (list below)

Details

Cardiac Arrest Information

					Date (YYYY / MM / DD)	Start Time (HH : MM)
Arrest Witnessed By	☐ Bystander	☐ Trained Responder	☐ Paramedic	☐ Unwitnessed		
CPR Started By	☐ Bystander	☐ Trained Responder	☐ Paramedic	☐ None		
First Shock By	☐ Bystander	☐ Trained Responder	☐ Paramedic			

Physical Exam

General Appearance Skin Colour Skin Condition

Head/Neck Trachea ☐ - Midline Shifted ☐ - R ☐ - L JVD ☐ - Elevated ☐ - Not Elevated

Chest Air Entry ☐ - Bilaterally Decreased ☐ - R ☐ - L Breath Sounds ☐ - Clear ☐ - Wheezes ☐ - Crackles ☐ - Rub ☐ - Absent

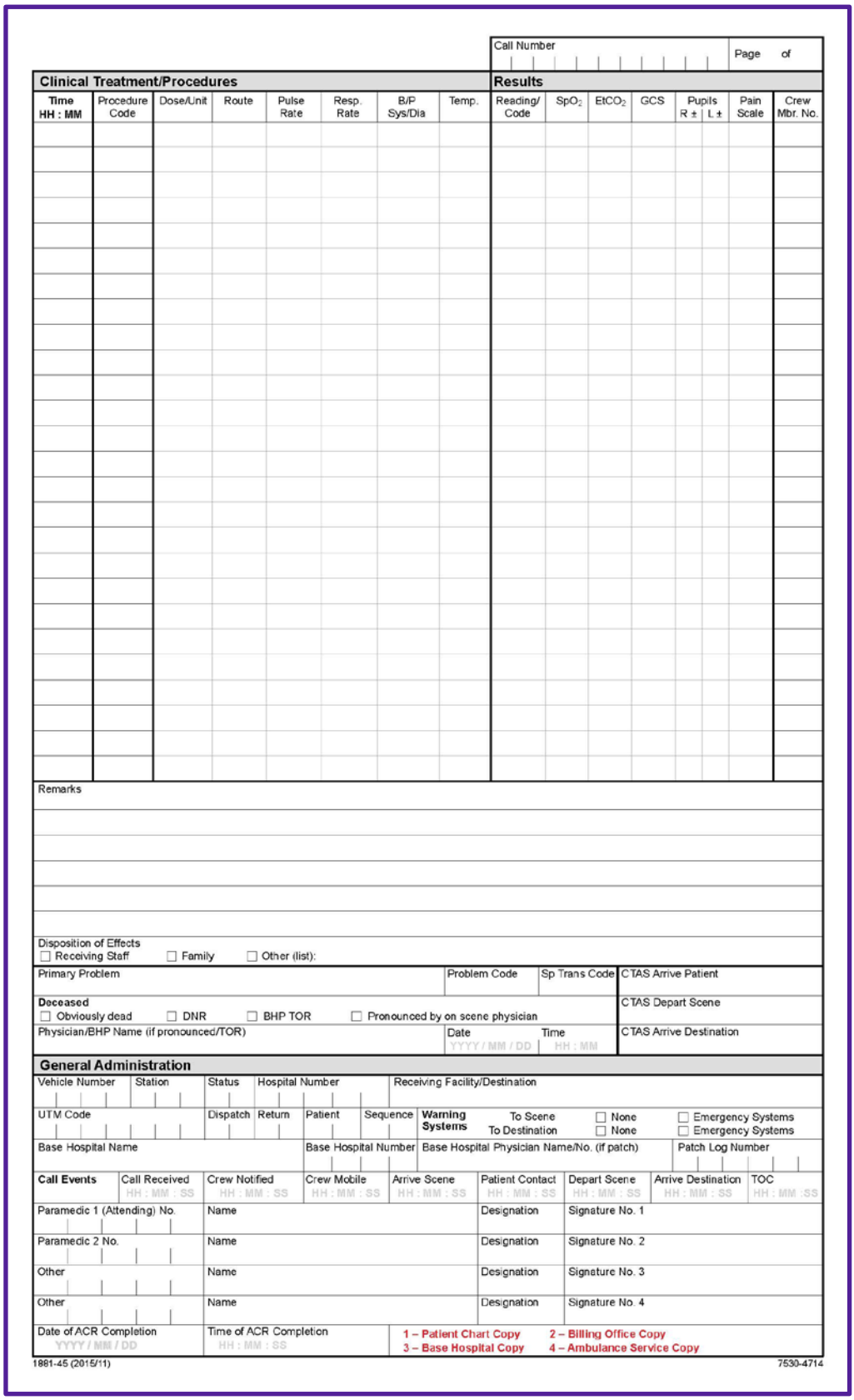
Abdomen ☐ - Soft ☐ - Rigid ☐ - Distended ☐ - Tender ☐ - Mass ☐ - Pulsatile ☐ - RU ☐ - LU ☐ - LL ☐ - RL ☐ - Center

Back/Pelvis ☐ - Unremarkable

Extremities ☐ - Unremarkable Peripheral Edema ☐ - Absent ☐ - Present Pedal Pulse ☐ - Absent ☐ - Present

1881-45 (2015/11) 7530-4714

Sample ACR (Front – Right)



Call Number | Page of

Clinical Treatment/Procedures | **Results**

Time HH : MM	Procedure Code	Dose/Unit	Route	Pulse Rate	Resp. Rate	B/P Sys/Dia	Temp.	Reading/ Code	SpO_2	$EtCO_2$	GCS	Pupils R ±	Pupils L ±	Pain Scale	Crew Mbr. No.

Remarks

Disposition of Effects
☐ Receiving Staff ☐ Family ☐ Other (list):

Primary Problem | Problem Code | Sp Trans Code | CTAS Arrive Patient

Deceased
☐ Obviously dead ☐ DNR ☐ BHP TOR ☐ Pronounced by on scene physician | CTAS Depart Scene

Physician/BHP Name (if pronounced/TOR) | Date YYYY / MM / DD | Time HH : MM | CTAS Arrive Destination

General Administration

Vehicle Number | Station | Status | Hospital Number | Receiving Facility/Destination

UTM Code | Dispatch | Return | Patient | Sequence | **Warning Systems** To Scene ☐ None ☐ Emergency Systems To Destination ☐ None ☐ Emergency Systems

Base Hospital Name | Base Hospital Number | Base Hospital Physician Name/No. (if patch) | Patch Log Number

Call Events	Call Received HH : MM : SS	Crew Notified HH : MM : SS	Crew Mobile HH : MM : SS	Arrive Scene HH : MM : SS	Patient Contact HH : MM : SS	Depart Scene HH : MM : SS	Arrive Destination HH : MM : SS	TOC HH : MM :SS

Paramedic 1 (Attending) No.	Name	Designation	Signature No. 1
Paramedic 2 No.	Name	Designation	Signature No. 2
Other	Name	Designation	Signature No. 3
Other	Name	Designation	Signature No. 4

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

1 – Patient Chart Copy 2 – Billing Office Copy
3 – Base Hospital Copy 4 – Ambulance Service Copy

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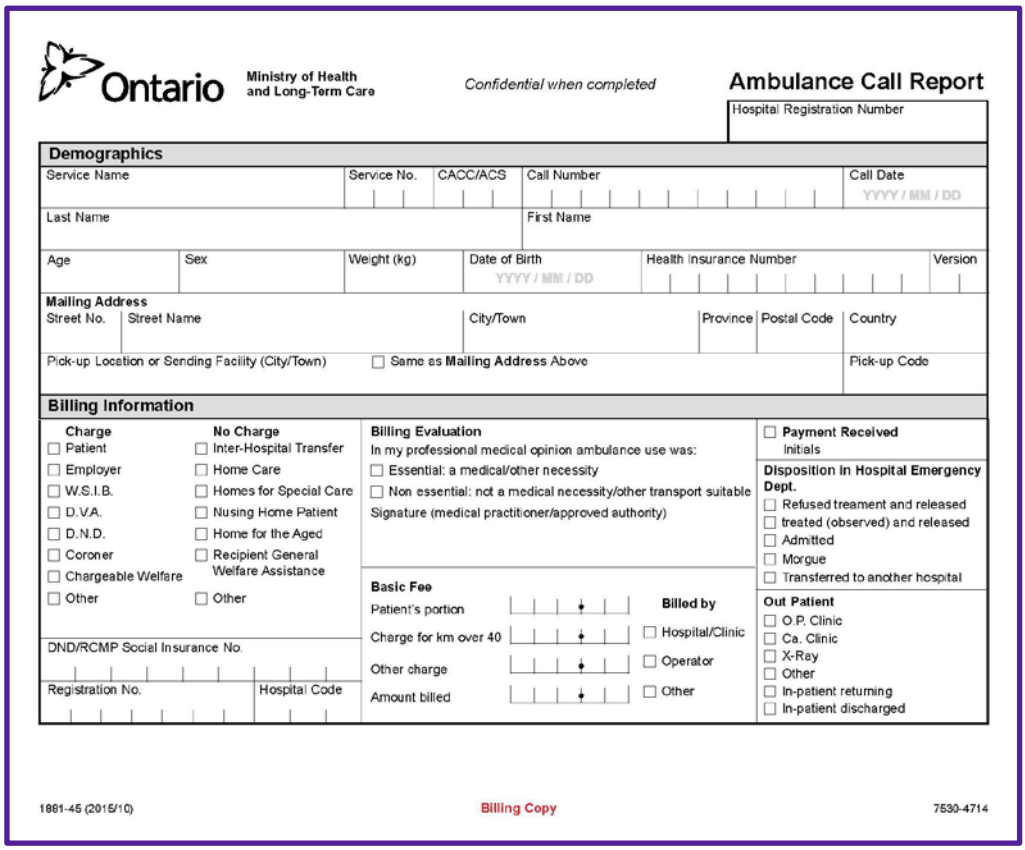
Sample ACR (Billing)



Ontario Ministry of Health and Long-Term Care

Confidential when completed

Ambulance Call Report

Hospital Registration Number

Demographics

Service Name	Service No.	CACC/ACS	Call Number	Call Date
				YYYY / MM / DD

Last Name	First Name

Age	Sex	Weight (kg)	Date of Birth	Health Insurance Number	Version
			YYYY / MM / DD		

Mailing Address

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

Pick-up Location or Sending Facility (City/Town) ☐ Same as **Mailing Address** Above — Pick-up Code

Billing Information

Charge
- ☐ Patient
- ☐ Employer
- ☐ W.S.I.B.
- ☐ D.V.A.
- ☐ D.N.D.
- ☐ Coroner
- ☐ Chargeable Welfare
- ☐ Other

No Charge
- ☐ Inter-Hospital Transfer
- ☐ Home Care
- ☐ Homes for Special Care
- ☐ Nusing Home Patient
- ☐ Home for the Aged
- ☐ Recipient General Welfare Assistance
- ☐ Other

DND/RCMP Social Insurance No.

Registration No. | Hospital Code

Billing Evaluation

In my professional medical opinion ambulance use was:
- ☐ Essential: a medical/other necessity
- ☐ Non essential: not a medical necessity/other transport suitable

Signature (medical practitioner/approved authority)

Basic Fee

		Billed by
Patient's portion		☐ Hospital/Clinic
Charge for km over 40		☐ Operator
Other charge		☐ Other
Amount billed		

☐ **Payment Received**
Initials

Disposition in Hospital Emergency Dept.
- ☐ Refused treament and released
- ☐ treated (observed) and released
- ☐ Admitted
- ☐ Morgue
- ☐ Transferred to another hospital

Out Patient
- ☐ O.P. Clinic
- ☐ Ca. Clinic
- ☐ X-Ray
- ☐ Other
- ☐ In-patient returning
- ☐ In-patient discharged

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Sample ACR (Back – Left)

Station Codes
Station #
00
01
02
etc.

Status Codes
00 At Base
77 Mobile
88 Standby Location
99 Maintenance

Dispatch Priority Codes
1 Deferrable
2 Scheduled
3 Prompt
4 Urgent
8 Standby
9 Out of Service/Administration

Return Priority Codes
1 Deferrable
2 Scheduled
3 Prompt
4 Urgent
6 Transport of Deceased Patient

Return Priority-No Transport
71 No Patient Found
72 Patient Refused
73 Patient Deceased
74 Patient in Police Custody
75 Transported by Other Ambulance
8 Standby
9 Out of Service/Administration

Special Transport Codes
01 Pt. Meets Trauma Criteria
02 No Trauma Bypass – Pt.Condition
03 No Trauma Bypass – Hospital Refusal
04 Pt. Meets Stroke Criteria
05 No Stroke Bypass – Pt. Condition
06 No Stroke Bypass – Hospital Refusal
07 Pt. Meets STEMI Criteria
08 No STEMI Bypass – Pt. Condition
09 No STEMI Bypass – Hospital Refusal

Pick-up Codes
A Airport/Heliport
B Apartment/Condo. Building
C Construction Site
D Medical Office/Clinic
E Nursing Outpost
F Factory/Industrial Site/ Railway/Dockyard
G Hotel
H Hospital (Acute and Non-Acute)
I Indoor Shopping Mall
J Jail/Prison
K Single Store/Strip Mall
L School/College/University
M Mining Site/Quarry
N Long-Term Care Home
O Office Building
P Sports Facility/Arena
Q Farm
R House/Town House
S Street/Highway/Road
T Fairground/Park
U Retirement Home
V Golf Course
W Water/Boat
X Restaurant/Bar
Y Casino
Z Other (Describe in Remarks)

Problem Codes
VSA
01 Cardiac/Medical
02 Traumatic

Airway
11 Obstruction (Partial/Complete)

Breathing
21 Dyspnea
24 Respiratory Arrest

Circulation
31 Hemorrhage
33 Hypotension
34 Suspected Sepsis

Neurological
41 Stroke/TIA
42 Temp. Loss of Consciousness
43 Altered Level of Consciousness
44 Headache
45 Behaviour/Psychiatric
46 Active Seizure
47 Paralysis/Spinal Trauma
48 Confusion/Disorientation
49 Unconscious
50 Post-ictal

Cardiac
51 Ischemic
53 Palpitations
54 Pulmonary Edema
55 Post Arrest
56 Cardiogenic Shock
57 STEMI
58 Hyperkalemia

Non-Traumatic
60 Non Ischemic Chest Pain
61 Abdominal/Pelvic/Perineal/ Rectal Pain
62 Back Pain

Gastrointestinal
63 Nausea/Vomiting/Diarrhea

Musculoskeletal/Trauma
66 Musculoskeletal
67 Trauma/Injury

Obstetrical/Gynecological
70 Obstetrical <20 weeks
71 Obstetrical Emergency
72 Gynecological Emergency
73 Newborn/Neonatal
74 Obstetrical ≥20 weeks

Endocrine/Toxicological
81 Drug/Alcohol Overdose
82 Poisoning/Toxic Exposure
83 Diabetic Emergency
84 Allergic Reaction
85 Anaphylaxis

General and Minor
87 Novel Medications
88 Home Medical Technology
89 Lift Assist
90 Inter-facility Transfer
91 Environmental Emergency
92 Weakness/Dizziness/Unwell
93 Treatment/Diagnosis & Return
94 Convalescent/Invalid/Return Home
95 Infectious Disease
96 Organ Retrieval/Transfer
98 Organ Recipient
99 Other Medical/Trauma (see remarks)

Site/Type Codes
A Location
10 Head/Face/Ear/Scalp
11 Eye
12 Neck
13 Shoulder
14 Back/Flank
15 Chest
16 Abdomen
17 Pelvis
18 Genitourinary
19 Buttocks/Perineum/Rectum
20 Arm (Upper/Elbow/Forearm/ Wrist)
21 Hand/Finger
22 Thigh
23 Leg (Knee/Lower Leg/Ankle)
24 Foot/Toes
25 Hip

B Type
30 Abrasion
31 Amputation
32 Avulsion
33 Burn
34 Blunt
35 Crush
36 Contusion
37 Penetrating/Perforation
38 Possible Fracture/Dislocation
39 Laceration
40 Sprain/Strain
41 Paralysis/Paresthesia
42 Other (Detail in Incident Hx)

C Mechanism
50 Assault
51 Drowning
52 Electrocution
53 Fall (Same Level)
54 Fall from Height/Diving
55 Gunshot
56 Hanging
57 Machinery
58 MVC
59 Motorcycle/Recreational Vehicle
60 Pedal Bicycle
61 Pedestrian Struck
62 Sports
63 Stabbing
64 Fire/Explosion/Thermal
65 Smoke/Chemical Exposure
66 Other (detail in Mechanism of Incident Hx)

Final Patient Status (Destination vs. First Contact)
2 Improved
4 No Change
6 Deteriorated

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Rhythm Codes
10 Sinus Tachycardia
11 PSVT/SVT/Atrial Tachycardia
12 Atrial Flutter
13 Atrial Fibrillation
14 Ventricular Tachycardia
20 Sinus Bradycardia
21 First Degree Block
22 Second Degree Block
23 Third Degree Block
30 Ventricular Fibrillation
31 Pulseless Ventricular Tachycardia
32 PEA
33 Asystole
40 NSR
42 Paced Rhythm
43 Junctional Rhythm
44 Sinus Dysrhythmia
46 Other (Detail in Procedures)

Procedures
010 Vital Signs
020 Patient Assessment
025 Blood Sampling-Glucose Determination
100 Dressing
101 Control Bleeding
102 Arterial Tourniquet
105 Immobilization-Head
110 Splint Other
111 Cervical Collar
112 Spinal Board
113 Spinal Immobilization Extrication Device
114 Traction Splint
115 Adjustable Break Away Stretcher
116 Lifting Chair
120 Suction
129 Oxygen – Filtered High Conc. Mask
130 Oxygen – High Conc. Mask
131 Oxygen – Simple Face Mask
132 Oxygen – Nasal Cannula
133 Oxygen – Other
141 Oxygen – BVM
142 Oxygen – Mechanical Ventilator
144 Oxygen – Pocket Mask
150 Extricate Patient – e.g., Remove from small room where care cannot be provided
160 OB Delivery
170 Oro/Nasopharyngeal Airway
180 Restrain Patient-Physical
190 Abdo/Chest/Back Thrusts
211 Symptom Assist Medication (e.g., Assisted Pt. with own meds)
231 Pt. Transported Supine
232 Pt. Transported Semi-Prone
233 Pt. Transported Prone
234 Pt. Transported Semi-Sitting
235 Pt. Transported Sitting
236 Ambulatory
237 Pt. Transported Lateral
239 Infant Restraint Device

Cardiac Arrest Procedures
297 Therapeutic Hypothermia
298 Defibrillation – Pads On
299 Automated CPR Device
300 CPR
301 Rhythm Interpretation
302 Cardioversion
303 Valsalva Manoeuver
306 Defibrillation – Manual
307 Defibrillation – Semi-Automated
308 Analyze – SAED
309 External Pacing
313 12-Lead Acquisition
316 Return of Spontaneous Circulation

Airway/Breathing Procedures
317 Return of Spontaneous Respirations
318 Supraglottic/Alternate Airway
319 Supraglottic/Alternate Airway Unsuccessful
320 Needle Thoracostomy
321 Needle Thoracostomy Unsuccessful
322 Needle/Surgical Cricothyroidotomy
323 Needle/Surgical Cricothyroidotomy Unsuccessful
324 Nasotracheal Intubation
325 Nasotracheal Intubation Unsuccessful
326 Orotracheal Intubation
327 Orotracheal Intubation Unsuccessful
328 ETT Suctioning
331 Magill Forceps/Foreign Body Removal
332 Magill Forceps/Foreign Body Removal Unsuccessful
333 Extubation – Any Advanced Airway (intentional)
334 Extubation – Any Advanced Airway (Unintentional)
335 Needle Thoracostomy One-way Valve Monitored
336 Respiratory System Eval. ($ETCO_2$ and SAO_2)
337 ETT Confirmation
338 SpO_2
339 PEEP
380 Alternative Airway
381 Alternative Airway – Unsuccessful
382 Airway Adjunct/Bougie
383 CPAP
384 CPAP - unsuccessful

IV Procedures
340 IV Monitoring
341 IV Cannulation
342 Lock
345 Normal Saline
349 Other IV Solutions
350 IV Cannulation Unsuccessful
351 Fluid Bolus
353 Blood Sampling
355 IV Discontinued (Intentional)
356 IV Discontinued (Unintentional)
358 Intraosseous Cannulation Successful
359 Intraosseous Cannulation Unsuccessful
360 Blood/Blood Product Administration
361 CVAD Access

Miscellaneous Procedures
366 Termination of Resuscitation – Medical
367 Termination of Resuscitation – Trauma
370 Other Procedure (Detail in Procedures)
372 Carboxyhemoglobin (SpCO)
375 Emerg. Dialysis Disconnect
390 Transfer of Care – Crew to Crew
400 Base Hospital Physician Patch
401 Receiving Hospital Notified
402 BHP Patch Failure (Detail in Results)
403 BHP Patch – No BHP Contact
404 Coroner Notified
405 Study Procedure (Detail in Procedures)
406 Non Dialysis – CVAD Disconnect
407 Health Screening Tool

Medications
498 Acetaminophen
500 Adenosine
502 Amiodarone
503 Antibiotic
504 ASA
505 Atropine
525 Calcium Gluconate
530 Dextrose
531 Diazepam
533 Dimenhydrinate
534 Diphenhydramine
536 Dopamine
540 Epinephrine 1:1,000
541 Epinephrine 1:10,000
550 Fentanyl
551 Furosemide
560 Glucagon
561 Glucose-Oral
562 Hydroxocobalamin
593 Lidocaine
603 Midazolam
604 Morphine
610 Naloxone
615 Nitroglycerin
620 Oxytocin
650 Salbutamol
651 Sodium Bicarbonate
682 Xylometazoline
700 Other Drugs – Detail in Procedures
701 Anaesthetic Eye Drops
704 Ibuprofen
706 Ketorolac
708 Obidoxime
710 Pralidoxime Chloride
712 Sodium Thiosulfate
800-899 Study Drugs – Details in Procedures
900-999 User Defined

Routes of Administration
AE Aerosol
BU Buccal
ET Endotracheal
IM Intramuscular
IN Intranasal
IO Intraosseous
IV Intravenous
NB Nebulized
PO Oral
PR Rectal
SL Sublingual
SC Subcutaneous
TO Topical

Paramedic Designation
1 Student
2 EMA
3 PCP
4 ACP
5 CCP

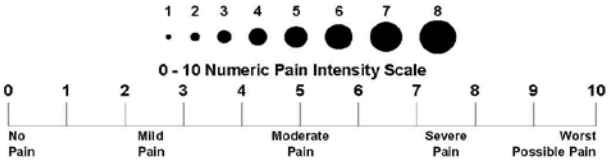
CTAS Codes
1 Resuscitation
2 Emergent
3 Urgent
4 Less Urgent
5 Non Urgent
0 Obviously Dead/TOR

7530-4714

Sample ACR (Back – Right)

Reference Information

Skin	
Colour	**Condition**
Flushed Pale Cyanosis Jaundice Unremarkable	Dry Clammy Diaphoretic Unremarkable



Glasgow Coma Scale		
Eye Opening	**Verbal Response**	**Motor Response**
4 Spontaneous	5 Orientated	6 Obeys commands
3 To Voice	4 Confused	5 Localize (pain)
2 To Pain	3 Inappropriate words	4 Withdraw (pain)
1 None	2 Incomprehensible sounds	3 Flexion (pain)
	1 None	2 Extension (pain)
		1 None

Pediatric Coma Scale		
Eye Opening	**Verbal Response**	**Motor Response**
4 Spontaneous	5 Coos or babbles	6 Obeys commands
3 To Speech	4 Irritable & constantly cries	5 Withdraws from touch
2 To Pain	3 Cries to pain	4 Withdraws from pain
1 None	2 Moans to pain	3 Flexion to pain
	1 None	2 Extension to pain
		1 None

APGAR Score			
Parameter	**0**	**1**	**2**
Appearance	Blue or Pale	Pink body with blue extremities	Completely pink
Pulse (BPM)	0 (absent)	slow (<100)	≥100
Grimace Response	None	Some grimace	Good grimace
Actitivity and Muscle Tone	None, limp	Some flexion	Active, motion
Respiratory Effort	absent	<60 min	Good, crying

APGAR performed at 1 & 5 minutes after delivery
Don't wait for APGAR to make decision on resuscitation

Normal Pediatric Vital Signs		
Age	**Respiratory Rate**	**Heart Rate**
0 – 3 months	30 - 60	90 - 180
3 – 6 months	30 - 60	80 - 160
6 – 12 months	25 - 45	80 - 140
1 – 3 years	20 - 30	75 - 130
6 years	16 - 24	70 - 110
10 years	14 - 20	60 - 90

Systolic Blood Pressure (for children 1-10 yrs) = 70 + (2x age in years)
Weight (kg) = (age x 2) + 10

Definition of Hypoglycemia
≥2 years Glucometry <4.0 mmol/L
<2 years Glucometry <3.0 mmol/L

Aid to Capacity Evaluation (Record Details in 'Remarks' Section)

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

Patient verbalizes/communicates understanding of clinical situation? *(e.g., what is wrong with you?)*	☐ Yes	☐ **No - Requires consideration of capacity**
Patient verbalizes/communicates appreciation of applicable risks? *(e.g., what could happen if I don't help you?)*	☐ Yes	☐ **No - Requires consideration of capacity**
Patient verbalizes/communicates ability to make alternative plan for care? *(e.g., what will you do once I leave?)*	☐ Yes	☐ **No - Requires consideration of capacity**
Responsible adult on scene	☐ Yes	☐ No

Refusal of Service – I have been advised that treatment and/or transportation is available immediately. I refuse such treatment and/or transportation to hospital having been informed of the risks involved. I assume full responsibility arising out of such refusal.

Refus de service – On m'a avisé que je pouvais être traité ou transporté à l'hôpital immédiatement. Je refuse d'être traité ou transporté à l'hôpital. J'ai été informé des risques auxquels cette décision m'expose. J'assume l'entière responsabilité de ce refus.

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

If SDM, relationship to Patient / Si MS, relation avec le patient

Time	Date	Signature of Patient or SDM / Signature du patient ou du MS
HH : MM	YYYY / MM / DD	

I have advised this patient or SDM of the risks to the patient's health that are involved.
J'ai avisé le patient ou le MS des risques de cette décision pour la santé du patient.

Time	Date	Attending Paramedic Signature
HH : MM	YYYY / MM / DD	

I was witness to the above-mentioned refusal and that the person has been informed of the risks involved.
J'ai été témoin du refus susmentionné et du fait que la personne a été informée des risques de ce refus.

Time	Date	Non Paramedic Witness Name Nom du témoin autre qu'un ambulancier paramédical	Witness/Paramedic 2 Signature Signature du témoin/d'un 2e ambulancier paramédical
HH : MM	YYYY / MM / DD		

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