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Standard Practice for Communicating an EMS Patient Report to Receiving Medical Facilities[1]

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INTRODUCTION

Throughout all areas of emergency medical services (EMS), there exists a need for the EMS provider to consult with medical direction and receiving medical facilities. These consultations can be purely for patient arrival notification, medical consultation, or to request additional medical intervention orders. Within the EMS community, no "standard" reporting scheme exists. Hundreds of verbal reporting formats are currently used. Some agencies divide these further for those assessments involving medical from trauma. Failure to use a standard reporting scheme makes initial student education difficult, makes recording of information cumbersome, and can lead to time delays in patient care or worse yet an error.

This consensus format was developed from a survey sent to over 100 emergency physicians, nurses, and field providers. The 25 that were returned were analyzed to construct the initial draft. One clear theme was present. **Receiving medical facilities want to know the most important information first** . . . medical information that affects the logistics of running a busy emergency department (ED). With the increased use of standing orders, the traditional detailed report to the ED was often not seen as time effective or making any change in the patient's outcome.

This practice uses the acronym **PISA** to describe the information to be presented in a generic patient report. **P** is priority information that is considered absolutely critical if only 15 s of transmission (or reception) is accomplished; **I** is important information that needs to be communicated if an additional 16 to 30 s is available; **S** is significant information that would be transmitted if an additional 31 to 60 s were available; **A** is additional information that should be transmitted if 61+ s are available.

1. Scope

1.1 This practice establishes the EMS standard for communications entailing a patient radio (phone) report to a receiving medical facility.

1.1.1 This report is based on receiving facility needs and is generic for medical, traumatic (ALS), and (BLS) patients.

1.1.2 This report standard is based on the hierarchical information needs of an average medical receiving facility.

1.2 *This international standard was developed in accordance with internationally recognized principles on standardization established in the Decision on Principles for the Development of International Standards, Guides and Recommendations issued by the World Trade Organization Technical Barriers to Trade (TBT) Committee.*

2. Referenced Documents

2.1 *ASTM Standards:*[2]

F1418 Guide for Training the Emergency Medical Technician (Basic) in Roles and Responsibilities (Withdrawn 2007)[3]

F1629 Guide for Establishing Operating Emergency Medical Services and Management Information Systems, or Both (Withdrawn 2015)[3]

F1651 Guide for Training the Emergency Medical Technician (Paramedic) (Withdrawn 2018)[3]

[1] This practice is under the jurisdiction of ASTM Committee F30 on Emergency Medical Services and is the direct responsibility of Subcommittee F30.04 on Communications.

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[2] For referenced ASTM standards, visit the ASTM website, www.astm.org, or contact ASTM Customer Service at service@astm.org. For *Annual Book of ASTM Standards* volume information, refer to the standard's Document Summary page on the ASTM website.

[3] The last approved version of this historical standard is referenced on www.astm.org.

2.2 *Other Documents:*
USDOT National Standard Curriculum for EMT-B[4]
USDOT National Standard Curriculum for EMT-P[4]

3. Terminology

3.1 *Definitions of Terms Specific to This Standard:*

3.1.1 *AVPU*—a brief neurological examination to determine a baseline level of consciousness and to assess central nervous system function. This assessment is universally taught as part of the initial assessment for EMS providers.

3.1.2 **A**lert,
3.1.3 Responds to **V**erbal stimuli,
3.1.4 Responds to **P**ainful stimuli,
3.1.5 **U**nresponsive—no gag or cough.

3.1.6 *Glasgow Coma Scale (GCS)*—standard neurological evaluation that uses eye opening, motor response, and verbal response. This assessment is universally taught as part of the detailed assessment for EMS providers.

3.1.7 *LOC*—level of consciousness.

3.1.8 *PMS*—neurological evaluation checking pulses, motor, sensory status of the four extremities.

3.1.9 *trauma score*—numerical injury rating system based on several parameters that may include patient body region injured, type of injury, central nervous system assessment, and vital sign evaluation.

4. Significance and Use

4.1 This practice establishes the national standard for training the EMT in communicating pertinent patient information to the receiving medical facility.

4.2 Appropriate physiological data and patient assessment information should be collected from the scene or while en route to the receiving medical facility or medical command site.

4.3 This practice is based on the information needs of a receiving medical facility to assist them in medical triage, ED resource management, and the provision of medical direction.

4.4 This practice should be used by those who develop curricula, provide continuing medical education, or desire a needs-based reporting approach.

4.5 This practice should be used to develop documentation aids such as EMS notepads and medical command documentation sheets.

4.6 The communication format in each **PISA** subsection in this practice are not necessarily in sequential order. The report may vary dependent upon patient presentation.

5. Communication of Pertinent Patient Information

5.1 After establishing communications with the receiving medical facility, patient information will be reported in the following format:

5.1.1 Organization of patient medical information into the categories of **P**riority, **I**mportant, **S**ignificant, **A**dditional.

5.1.1.1 **Priority** = "Need to know" or critical information to be transmitted in the 0 to 15 s time frame.

5.1.1.2 **Important** = Additional important information transmitted in the 16 to 30 s time frame.

5.1.1.3 **Significant** = Additional information that supports the critical information; transmitted in the 31 to 60 s time frame.

5.1.1.4 **Additional** = "Nice to know" information transmitted in the 61+ s time frame.

5.1.2 **P—Priority** information items to be communicated:
5.1.2.1 Unit's name or call sign,
5.1.2.2 EMS provider identification,
5.1.2.3 Patient age and gender,
5.1.2.4 AVPU/LOC,
5.1.2.5 Chief complaint, and
5.1.2.6 Mechanism of injury/nature of illness.

5.1.3 **I—Important** information items to be communicated:
5.1.3.1 Respiratory status,
5.1.3.2 Level of distress,
5.1.3.3 Skin color and condition, and
5.1.3.4 Vital signs.

5.1.4 **S—Significant** information items to be communicated:
5.1.4.1 Scene description if pertinent,
5.1.4.2 History of the present illness,
5.1.4.3 Medications taken by patient,
5.1.4.4 Pertinent technical findings,
(1) Pulse oximetry,
(2) Glucometer,
(3) Three-lead/twelve-lead EKG, and
(4) Other.
5.1.4.5 Head/neck assessment, and
5.1.4.6 Glasgow Coma Scale/Trauma Score.

5.1.5 **A—Additional** information items to be added if up to 61+ s were available:
5.1.5.1 Further neurological assessment (if needed),
5.1.5.2 Abdominal assessment/pelvic stabilization,
5.1.5.3 Extremity assessment (PMS),
5.1.5.4 Allergies (if pertinent),
5.1.5.5 Field treatment provided,
5.1.5.6 Response to field treatment,
5.1.5.7 Destination, and
5.1.5.8 Estimated time of arrival.

6. Documentation Template

6.1 Fig. 1 is a sample receiving medical facility form.

7. Keywords

7.1 emergency medical services; patient report form

[4] Available from U.S. Government Printing Office Superintendent of Documents, 732 N. Capitol St., NW, Mail Stop: SDE, Washington, DC 20401, http://www.access.gpo.gov.