

Medical Documentation Standard



Principles

There should be a formal case sheet completed at the time of the mission recording relevant demographic, clinical, operational details and record of patient management. A copy should accompany the patient. Another copy must be kept at the service headquarters in a manner consistent with patient confidentiality. Core information should include:

Patient: Name
 Date of Birth
 Gender
 Medical record number/Ambulance case reference

Notification: Time/date
 Location/Hospital
 Type (Primary/Secondary/Tertiary/Return)

Problem: Clinical reason for request
 Vital signs (where known)

Response: Despatch time/date
 Urgency
 Mode (Road/RW/FW/other)

Patient contact: Time/date
 Vital signs
 Interventions
 Departure time/date

Admission: Time/date
 Location
 Vital signs

Outcome: Medical record number
 Discharged from hospital/Died