

NorthStar EMS SOAP & CHART Documentation Elements

Subjective / History - What You Are Told

1. What the patient tells you is their Chief complaint. Include history of the present event and answers to your OPQRST & SAMPLE questions. Use direct quotes ("...") for specific patient reported information.
2. What other people tell you: dispatcher, other responders, witnesses, police.
3. Previous medical history.
4. Current medications.
5. Allergies.
6. PCP & pertinent specialty MD's

Objective / Assessment - What You See/Hear/Feel

1. Initial impression of the patient, describe the patient, specifically age and gender including his or her location and position.
2. General observations and other noteworthy information such as environmental conditions, patient behavior, description of the scene, damage to the vehicle, or location specific evidence.
3. Physical exam findings and level of consciousness. It can be separated into primary (ABCDs) and secondary (body systems head to toe, so it's easy to remember).
4. Diagnostic equipment, Vital signs, Breath sounds.
5. Include appropriate pertinent negative findings here.

Assessment / Complaint - Your Diagnosis

1. Field or working diagnosis is reported here (may not be what was dispatched, or identified by patient as Chief Complaint).
2. If more than one complaint list significant problems in order of importance
3. Include any possible Differential Diagnosis

Plan / Rx Transport - What You Did

1. This is the only portion of your patient care report that should be chronological.
2. Describe what was done for the patient and how they responded to treatment.
3. Include what was done prior to your arrival, how care was discontinued or transferred, report any improvement or deterioration of patient condition during transport.
4. Where was patient brought and who assumed care of patient at receiving facility.
5. Include information about who had control of the patient's personal belongings upon your departure or where they were left.

Remember the importance of this document:

- ◆ It is a legal document you may have to defend in court much later, after your memory has faded.
- ◆ It is an historical record of the event from which a bill of service will be generated.
- ◆ It is a medical record that must be treated confidentially, as defined by HIPAA regulations.

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