Introduction:

This form was designed to provide the committee with a better picture of the patient’s presentation and the thought process of the provider treating the patient. The PPCRs make it difficult to retrospectively assess what actually occurred on a given call and whether or not the provider’s actions were carried out in a deliberate and logical manner. It is intended that each candidate use this form as a self-teaching / self-assessment tool. The candidate may use any number of resources to answer the questions outlined in this form (textbooks, etc.) but the majority of the discussion should occur with the preceptor who is evaluating the call.

- Call Dispatch
  - What was the call dispatched as?
- Chief Complaint:
  - The primary sign or symptom noticed by the patient. The primary problem is the principal medical cause of the complaint, and is different from the chief complaint.
  - When possible, it is best to express the chief complaint in the patient’s own words.
- Secondary Complaints
  - Signs or symptoms in addition to the chief complaint if any (associated shortness of breath, nausea or vomiting...).
- History of the Present Illness or Injury — the OPQRST mnemonic may be helpful
  - Onset. What was the patient doing when the problem began?
  - Provocation: What makes the problem better or worse?
  - Quality: How does the patient describe the problem/pain?
  - Radiation. Does the pain radiate, or are there any associated problems?
  - Severity: How intense is the pain/problem (10 scale)?
  - Time. How long ago did the problem begin?
- Past Medical History — the AMPLE mnemonic may be helpful
  - Pertinent items regarding the patient’s past medical history may become evident to you during the course of the interview; however, you must keep in mind that what the patient thinks is pertinent to their condition may not always coincide with what you feel is relevant. The **AMPLE** mnemonic may help you cover all of the bases, but use good judgment to guide your investigation into the more important areas of the patient’s history.
    - **Allergies:** to medications, foods, or other substances
    - **Medications:** Prescribed medications should be listed below. It is helpful to determine what the medications were prescribed for and the last time they were taken.
    - **Past Medical Problems:** Does the patient suffer from any chronic illnesses? Are they under the care of a physician for any medical problems? Have they had any recent surgeries?
    - **Last Oral Intake:** What has the patient had to eat or drink in the past 24 hours? Are they digesting it normally?
    - **Events Preceding the Incident:** What was the patient doing prior to the onset of symptoms?
• Medications
  • For each of the patient’s medications you will need to list what it is and what it is typically prescribed for. This information can be found in any commercial ALS field guide or online medical search sites.
  • If the patient has more than 5 medications, list either the 5 you are least familiar with or the 5 that you think are most significant.

Physical Exam / Assessment
  • It is difficult to provide a brief, quality summary of good physical exam technique so we suggest that you re-read the relevant chapters in the ALS textbook used in your E/I/PM course.
  • A couple of items to note:
    • Remember to document pertinent negatives.
    • Remember to document + and — neurological/vascular symptoms before and after immobilization.
    • Provide a complete assessment on each patient and document it in the format that is outlined.

• Differential Diagnosis:
  • This is your impression of what is going on. Use your exam findings and history to provide a best guess as to what is wrong with the patient. We do not expect a detailed diagnosis or complicated medical jargon, just your impression of what the primary problem could be and why. Keep in mind that the differential diagnosis is typically a list of several possible causes. There are no wrong answers.

• Action/Treatment/Medications
  • This portion of the form is designated for you to document the treatment you provided and why (in chronological order). If you gave a medication to the patient, why did you give that particular medication? Always use the protocols as a guideline for your treatment but look a little further and tell us why those medications / treatments are in the protocol. Again, we do not expect a lengthy explanation, or complicated medical terminology, just your impression based on what you have been taught in class, and what you have read from your textbook.

Outcome / Presentation to the ED:
a. Please document what the patient’s condition was on arrival to the ED. Did they get better or worse? Did your treatments improve their condition? Obviously we don’t expect all patients to improve en route to the hospital, but it is helpful for you to look at the outcome of your patient and evaluate what you did well or could have done better.