AMBULATORY CARE REPORT

Pre-Hospital Emergency Care Council

ORG

FOR MINOR INJURIES COMPLETE SECTION 1 ONLY

SECTION 1 INCIDENT INFORMATION

Venue | Post No | Location of Incident | WHERE IN VENUE

Event Type | Time at Patient | Date | HH MM | DD MM YYYY

Surname | First Name

DOB | DD MM YYYY | Age | YRS | Gender | M/F

CLINICAL INFORMATION

Chief Complaint | Time of Onset | HH MM | Date of Onset | DD MM YYYY

CARE MANAGEMENT

☐ Observe and Supportive Care ☐ RICE ☐ Wound Management ☐ Other (details below)

DETAILS

TREATED BY

PIN | PIN

Further Observation/Care Required ☐ Yes * ☐ No

* IF YOU ENTERED YES RECORD PATIENT ADDRESS, NEXT OF KIN, TELEPHONE NO. AND PROGRESS TO COMPLETE SECTIONS 2 AND 3

PATIENT ADDRESS

NEXT OF KIN (NOK) | TELEPHONE (NOK)

PATIENT DISPOSITION

☐ Discharged ☐ Transferred to ED ☐ Referred to GP ☐ Refused further care *

HH MM Time

* DECLINED TREATMENT TO BE COMPLETED IN SECTION 3

ADDITIONAL INFORMATION

SECTION 2 CLINICAL INFORMATION

Primary Survey

A ☐ Clear ☐ Partially Obstructed ☐ Obstructed

C **C Spine** ☐ Suspect ☐ Not Indicated

B ☐ Normal ☐ Abnormal ☐ Fast ☐ Slow ☐ Absent

C **PULSE** ☐ Present ☐ Regular ☐ Absent ☐ Irregular | Rate RATE | Haemorrhage ☐ Yes ☐ No

SKIN ☐ Normal ☐ Pale ☐ Flushed ☐ Cyanosed | **Cap-Refill** ☐ <2 Sec ☐ >2 Sec

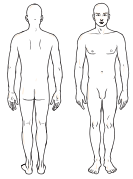
D Loss of consciousness before arrival ☐ Yes ☐ No ☐ Unknown **AVPU**

E

☐ A Abrasion ☐ B Burn ☐ C Contusion ☐ D Dislocation ☐ # Fracture

☐ P Pain ☐ R Rash ☐ S Swelling ☐ N Numbness ☐ W Wound

% BURN | % BURN | RA RL LA LL



CLINICAL IMPRESSION

CARDIAC	☐	OBS/GYNAE	☐
MEDICAL	☐	RESPIRATORY	☐
NEUROLOGICAL	☐	TRAUMA	☐

General	☐ Syncope/Collapse	☐ Nausea/Vomiting
☐ Abdominal Pain	☐ Behavioural Disorder	☐ Poisoning
☐ Allergic Reaction	☐ Illness Unknown	☐ Other General

Patient's Medical Observations

A ALLERGIES ☐ NKA ☐ Unknown

M MEDICATIONS ☐ None ☐ Unknown ☐ As supplied

P PAST MEDICAL HISTORY ☐ None ☐ Unknown

L LAST INTAKE ☐ Solids ☐ Liquids ☐ Unknown

DESCRIBE | HH MM Time

E EVENT

MECHANISM OF INJURY

☐ Assault	☐ Injury to child
☐ Attack/animal/insect bite	☐ Machinery accidents
☐ Chemical poisoning	☐ Smoke, fire and flames
☐ Submersion	☐ Water transport accident
☐ Electrocution	☐ Other
☐ Excessive cold	**CIRCUMSTANCES**
☐ Excessive heat	☐ Accident
☐ Fall	☐ Event of undetermined intent
☐ Firearm injury	☐ Intentional self harm

SECTION 3 MEDICATION TREATMENT

HH MM | MEDICATION

DOSE | ROUTE | PIN

HH MM | MEDICATION

DOSE | ROUTE | PIN

HH MM | MEDICATION

DOSE | ROUTE | PIN

VITAL OBSERVATION

	Time 1	Time 2
Observation Times	HH MM	HH MM
Pulse Rate & Rhythm (R) Regular (I) Irregular	RATE	RATE
ECG Rhythm	RHYTHM	RHYTHM
Respiratory Rate	RATE	RATE
Respiratory Quality 1. Normal 2. Laboured 3. Shallow 4. Wheeze 5. Rales 6. Retract 7. Absent	LEFT RIGHT	LEFT RIGHT
Peak Expiratory Flow Rate	RATE	RATE
$\%SpO_2$	$\%SpO_2$	$\%SpO_2$
CAP Refill	REFILL	REFILL
Blood Glucose Level mmol/L	GLUCOSE	GLUCOSE
Pain Score	PAIN	PAIN

Blood Pressure Systolic	SYS	SYS
Dystolic	DIA	DIA
Temperature ˚C	˚C	˚C
Pupils Size: See Chart below Reaction: (+) Reacts (-) No (c) Eyes Closed L	SIZE REACTION	SIZE REACTION
R	SIZE REACTION	SIZE REACTION

1 2 3 4 5 6 7 8

Glasgow Coma Scale

Eye 4. Spontaneous 3. To voice 2. To pain 1. None	EYE	EYE
Verbal 5. Orientated 4. Confused 3. Incomp. words 2. Incomp sounds 1. None	VERBAL	VERBAL
Motor 6. Obeys 5. Local. Pain 4. Flex. to Pain 3. Abn. flex. 2. Ext. to pain 1. None	MOTOR	MOTOR
Total GCS	TOTAL	TOTAL

DECLINED TREATMENT

AID TO "DECISION MAKING CAPACITY"

1. Patient verbalises/communicates understanding of clinical situation?	☐ Yes	☐ No
2. Patient verbalises/communicates appreciation of applicable risk?	☐ Yes	☐ No
3. Patient verbalises/communicates ability to make alternative plan of care?	☐ Yes	☐ No

I/We witness that the patient has declined treatment.

I/We have advised the patient to consult with his/her own doctor as soon as possible or should his/her condition deteriorate to call 999 for emergency medical assistance.

PIN (1)/Name (1) PIN (2)/Name (2)

and report Decline of treatment and or transport.

Patient reviewed by
PIN/MCRN/Name

Ambulatory Care Report (ACR) Completion Guide

SECTION 1

INCIDENT INFORMATION

Venue
Enter the name of the place where the event is happening.

Post No
Enter the number assigned to the post in the venue.

Location of Incident
Enter the location of the incident at the venue.

Event Type
Enter type of event. For example: Music, Horse Show, etc.

Time at Patient and Date
Enter the time and date you arrived at the patient or the time and date the patient arrived to you.

Surname / First name
Enter the patient surname and first name separately.

DOB (Date of Birth), Age, Gender
Enter the date of birth, age and gender of the patient.

CLINICAL INFORMATION

Chief Complaint
Enter the principal reason the patient is requesting care.

Time of Onset, Date of Onset
Enter the time of onset of the symptoms and the date of onset.

CARE MANAGEMENT

Observe and Supportive Care
Tick box if observation and/or any supportive care is administered.

RICE
Tick box if rest, ice, compression and/or elevation is administered.

Wound Management
Tick box if any type of wound management is administered.

Other
Tick this box if treatment, which is not listed, is deemed necessary and record in the DETAILS section below.

TREATED BY

Enter the PIN of the PHECC registered practitioner or organisation PIN of the responder engaged in the care of the patient.

Further Observation/Care Required Yes or No
If the patient requires further observation and/or care, do the following:
Tick the Yes box
Record the patient's address, name and telephone number of the next of kin.

PATIENT DISPOSITION

Tick the appropriate box depending on patient pathway following his care: Discharge, Transferred to ED, or Referred to GP. If the patient refuses care, tick Refused further care, enter Time and complete Declined Treatment in Section 3.

ADDITIONAL INFORMATION

Complete if required for any patient information you feel is relevant.

SECTION 2

CLINICAL INFORMATION

Primary Survey
Tick the appropriate box in A, B, C, D and E following assessment of patient.

This should be completed as you are assessing the patient or as close as possible to the time you are carrying out the assessment.

When completing E also enter the following:

- Place appropriate letter on body image – for example place W on body image for wound on arm.
- Following burns calculation using Wallace Rule of Nines:
  i) enter the % burn in the box provided
  ii) tick box for appropriate limb - for example RA for right arm.

CLINICAL IMPRESSION

Enter an early clinical impression of the patient's presenting illness/injury based on the combination of information available to you following your assessment.

Tick box as appropriate :
Cardiac, Medical, Neurological, OBS/Gynae, Respiratory or Trauma. Or select a more specific clinical impression under General if more appropriate.

If there is additional clinical impression information which is relevant record it in the blank space provided.

PATIENT MEDICAL OBSERVATIONS

In AMPLE survey, tick box as appropriate.
In E, record in free text the event or the activity the patient was engaged in prior to the incident or injury occurring.

Mechanism of Injury

Record the mechanism by which the injury occurred by ticking the appropriate box.

SECTION 3

MEDICATION TREATMENT

Enter the time, name, dose and route of medication administered. Enter the PIN of the practitioner administering the medication.

VITAL OBSERVATION

Record observations numerically as they are carried out on the patient.

Time 1 and Time 2 refers to the capture of the 1st and the 2nd set of vital observations.

If it is necessary to record additional observations another ACR should be commenced. Please complete the patient identifying details on the additional report and staple the two reports together.

DECLINED TREATMENT

In the event of the patient refusing treatment, this section must be completed by two practitioners or two responders. The practitioners or responders will assess the patient's decision making capacity by selecting Yes or No to all three questions and report to Control Centre/Other.

Patient reviewed by

Enter PHECC PIN, Board Altranais or Organisation PIN, Medical Council registration number or name of person with responsibility for reviewing the patient at the end of their episode of care.

HANDOVER OF ACR

In all circumstances of patient handover the following should apply:

The top copy of the ACR should accompany the patient.

The bottom copy of the ACR will remain the property of the service provider who administers care to the patient.

All patient reports recording the patient's care will be handed over to the ED/destination facility as part of the record of the continuum of care for the patient.

All entries in black ball point.

Date to be entered as dd/mm/yyyy.

Time to be entered as 24 hour clock: 00:00.

It is important that you record patient data that is complete, valid, accurate, reliable, relevant, legible and available in a timely manner so that healthcare decisions are made based on high quality information which will result in quality safe care being delivered to the patient.