

# SPOKANE COUNTY FIRE DISTRICT 8

## Standard Operating Procedures

**110.04.01**  
EMS INCIDENT REPORTS



Adopted: 10/03/17  
Reviewed: 11/09/22  
Revised: 11/09/22

Approved:

A handwritten signature in black ink, appearing to read "James J. Rahn", is written over a horizontal line.

**Purpose:** To ensure EMS Incident Reports are completed promptly and accurately.

**References:** Spokane County EMS and Trauma Care Council Operating Procedures-  
General Guidelines G3-G4  
Health Insurance Portability and Accountability Act (HIPAA)

**Procedure:**

The EMS Incident Report is essential for maintaining complete and accurate information related to patient care. For these reasons the EMS report must be completed promptly and accurately.

The Fire District utilizes Electronic Patient Care Records (EPCR). Paper PCR's are only to be used as a backup in case of an EPCR system failure. EPCR's must be completed once the system is back online.

1. Incident Numbers and Times.
  - a) Dispatch will generate the incident number, date and times.
2. Completion of Reports.
  - a) It shall be the responsibility of the EMS provider that provides patient care to complete the incident report. All patient information shall be entered into the EPCR.
3. Computer Entry.
  - a) All EMS incident reports shall be entered into the District's electronic reporting software program.

**Failure to complete an EMS Incident report by the completion of the shift may result in disciplinary action.**

4. Patient Care Report.
  - a) A Patient Care Report will be completed on all EMS incidents. The patient narrative portion will use the approved Spokane County EMS protocol format. The patient narrative will be written in the patient care section of the report.
5. Disposition of Notes, Patient Information & Documents Collected On-Scene.
  - a) At the conclusion of completing reports, all notes, patient information, and documents collected at the scene will be disposed of.



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### Patient Refusal of Treatment/Transport

#### CALL IDENTIFICATION

Patient Name \_\_\_\_\_ Age \_\_\_\_\_  
Call location \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_ Unit# \_\_\_\_\_ Agency Run # \_\_\_\_\_

#### PATIENT ASSESSMENT *Chief Complaint*

**VITAL SIGNS** BP \_\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_  
Oriented to: Person \_\_\_\_\_ Place \_\_\_\_\_ Time \_\_\_\_\_ Situation \_\_\_\_\_

#### GENERAL ASSESSMENT

\_\_\_\_\_  
\_\_\_\_\_

#### PATIENT INFORMED

- Medical Treatment/ambulance transport needed
- Further harm could result without medical evaluation/treatment
- Transport by other than ambulance could be hazardous in light of patient's illness/injury

#### SPECIFIC EMS SERVICE REFUSED

- Patient refused treatment
- Patient refused ambulance transport
- Patient refused ambulance transport to appropriate facility

#### PATIENT DISPOSITION

- Transported by private vehicle.
- Released in care or custody of self.
- Released in care or custody of relative or friend. Name: \_\_\_\_\_
- Released in care or custody of other agency. \_\_\_\_\_ Agency Name \_\_\_\_\_ Name of Responsible Individual \_\_\_\_\_

#### PATIENT INSTRUCTIONS

- Patient instructed to call 9-1-1 or follow up with his/her physician if condition persists or worsens.

#### The following statement should be read to the patient:

The evaluation and / or treatment provided to you by the EMS providers is not a substitute for medical evaluation and treatment by a doctor. By signing this, you indicate that you understand the nature of the proposed care and transportation and that you fully comprehend the potential consequences of this refusal. And that you further attest that you are competent and authorized to make said refusal, that you do forever release and give up any claim, demand, or action against all Emergency Medical Services personnel and their agents and do hereby covenant and agree to hold such persons harmless from any claim, demand, loss, or action for any alleged act or omission in the care or transport in compliance with this refusal. This release is binding on your heirs, executors, and assigns.

_____ Patient signature	_____ Print patient name	_____ Date	_____ Time
_____ Surrogate signature	_____ Print surrogate name	_____ Date	_____ Time
_____ Witness signature	_____ Print witness signature	_____ Date	_____ Time
_____ EMS personnel signature	_____ Print EMS Personnel Name	_____ Date	_____ Time

**Please Forward to Administration**