Patient Narrative (Basic Format):

PI: state age of patient, patients' gender

C/c: chief complaint, What does the patient state is the problem? Why were you dispatched?

HPI: *Subjective account of what, where, when leading to this event.* Patient statements, bystander statements, care givers, spouses, and family members. Any and all information you are told or read about your patient. (i.e. Stated speed of vehicle, seat belts, etc…)

PHX: Past medical history (i.e. Seizures, CHF, CVA, HTN, Diabetes, etc…)

MEDS: Medications that the patient is currently taking and/or prescribed to take

ALLER: Any allergies to medications or materials (i.e. latex gloves or Band-Aids)

EXAM: How did you find your patient? (Sitting, tripod, prone, supine, standing, ambulatory, etc…); What is your patients level of consciousness? (Person, place, date or time, event); Anxious, lethargic, calm, confused, argumentative, etc.. Dizziness? Weakness? Fever? Quality of patients skin? (Wet, dry, pale, cool, hot, tenting…); Baseline Vitals (first set includes blood pressure, pulse irregular/regular/strong/weak, respirations/rate/vol, spo2, pupils, temp, lung sounds, DEX, etc)

> **HEENT:** Head, ears, eyes, nose and throat. Eyes PEARL? Jaundice? Good or poor tracking? Trauma? Fluids? Facial drooping? Deformities, discoloration? Sight or hearing disabilities? JVD?
> **CHEST:** Lung sounds? Shortness of breath? Chest rise equal or not. Pain on Palp? Pain on inspiration or expirations? Respiration rate. Tidal volume, shallow, deep, labored, unlabored, Chest pain is sharp, tearing, dull, heaviness, frequency, position of comfort, duration, radiating, Pain Scale 1- 10? Deformities? Fluids? Accessory muscle usage?
> **SPINE:** Pain on palpation of spine (CTL), Deformities? Paralysis? Weakness? Numbness or tingling? Pain with or without movement? Point of tenderness? Fluids? Discoloration?
> **ABD:** Nausea and vomiting? Examination of all four quadrants, Pain on palp, distention, soft, hard, pulsatile mass, rigidity, twisting pain, guarding, bowel tones present? Deformities, fluids, discoloration? Pain scale 1 – 10? Flanking pain? GI questions. Bowel movement status and quality of?
> **PELVIS:** Stable, Pain on palp? Deformities? Incontinence? Renal bleeding? Vaginal discharge? Possibly pregnant?
> **EXTREM:** Upper and lower must be observed. Pulses, Sensation and Movement (PMS or CMS), Deformities? Limited movement? Unequal or equal grip? Extension and retention of feet? Fluids? Visible discoloration or bruising? Pain?

IMP: Rule outs, Possible….. (i.e. R/o head injury secondary to GLF)

PLAN: List everything done in chronological order (ie. Exam, vitals, provide O2 @4 lpm NC, CTL cleared, 2nd vitals (b/p, pulse, resp rate, spo2, dex, etc), secondary exam provided by Medic Biggie, assisted Medic 3 with loading onto gurney, no further action required)

DISP: Who's care did you leave them in? Where did the patient go? (i.e. Patient released to Medic Biggie for ALS transport to SJH)