

Vermont EMS SIREN

(Statewide Incident REporting Network)

Creating an Electronic Patient Care Report (ePCR)

Introduction

This guide will take you through how to document an incident in SIREN Elite. The workflow listed in this guide is that of the required fields for what's anticipated to be an “average call” for First Response as of November 2022. This guide will review of the NEMIS 3.5 patient care report.

This guide is not a comprehensive review of every section/field and the documentation requirements are subject to change. Some sections/fields will display information that is specific to an agency and in these sections, this guide will not precisely match what will show for you. These areas have been noted.

This guide primarily reviews the fields that are mandatory for most First Response patient care reports. Not all of the available fields that display in SIREN will be discussed in this guide. Additionally, what information is required will be dependent on the responses that are documented in the report. As information is entered in the report, the system will automatically guide you through which details are needed by flagging the required fields in red.

Example: If a responding unit is canceled by Dispatch prior to arrival on scene, the number of required fields will decrease from approximately 45 to approximately 9.

Navigating this Guide

This guide follows the order in which an average provider documents an incident.

Each page of this file will include an overall view of how your screen will display, with areas of interest magnified.

Recommendations for making documentation easier and more efficient for providers have been included throughout this guide, and these suggestions will display on the page that discusses the applicable section.

Finally, each page of this guide will include information in the upper right-hand corner, detailing what type of data is being collected on the page in question. The information will fall into one of three categories: Operations, Clinical and Reimbursement.

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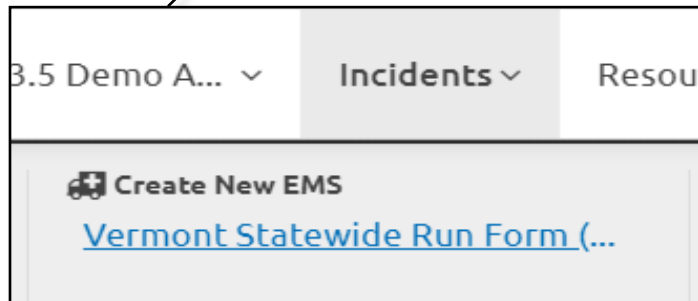
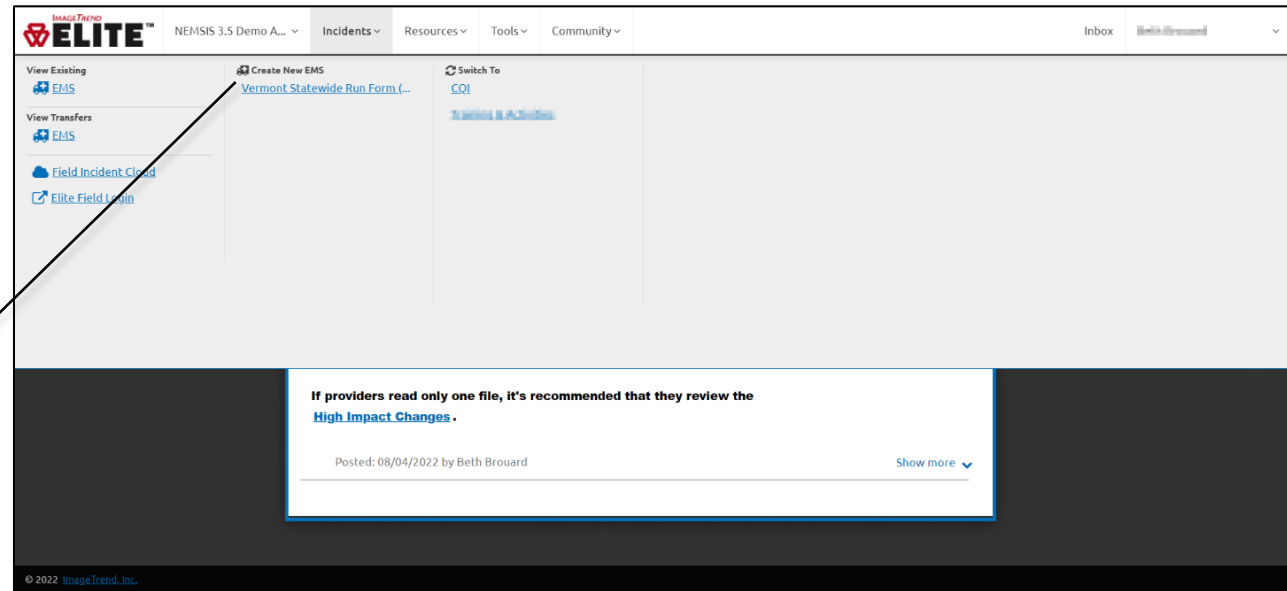
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Creating a New Form

Steps

After logging in, click:

- Incidents
- Vermont Statewide Run Form



Additional Information

If you click on View Existing EMS, you will be able to view all incident records that you have created.

Navigating Through the Patient Care Report

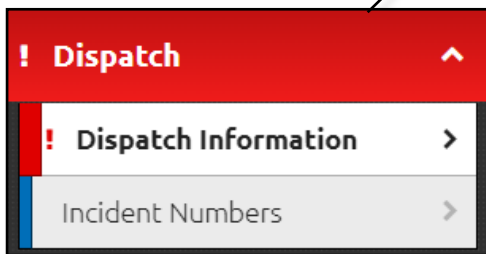
If you're unable to obtain a name or other information, there is a prohibition sign (circle with a line through it) that you can click on. You can then choose define why this information isn't being reported. You will see these prohibition signs in many areas of the system and they're there in case you don't have data that's listed as required or the requested information is not applicable.



The Times button will need to be chosen in order to enter information in that section—SIREN won't automatically take you to that area.



You can “jump around” by selecting any section on the left



The Validation Score shows on the bottom of the screen and currently reads of -42. With each entry into a red (aka required) field, this brings you closer to a perfect 100. The red fields will also turn to blue, making it easy to see what's left.

-42
Validation

You can navigate through the form in order by clicking on Next.

Unfortunately, there is not a “Back” button and if you need to revisit a previous section, you will need to select the Section (example: Dispatch) and Panel (example: Dispatch Information) on the left.

→ Next

Additional Information

What's entered in some fields will affect others. For example if you select “Patient Treated, Transferred Care to Another EMS Unit”, the Times section will require a “Patient Contact” date and time, which wasn't required previously. If you choose “Patient Treated, Transported by this EMS Unit”, you will need to add in the Patient Contact time, the En Route Hospital/Left Scene time and Arrived Destination time, in addition to what may have previously been required.


Flagged Concerns: Validation Rules

When a required field is blank or there is an issue, it will have an exclamation mark next to it and be outlined in **Red**. If you click on the exclamation mark, details will list on where to go to fix the problem.

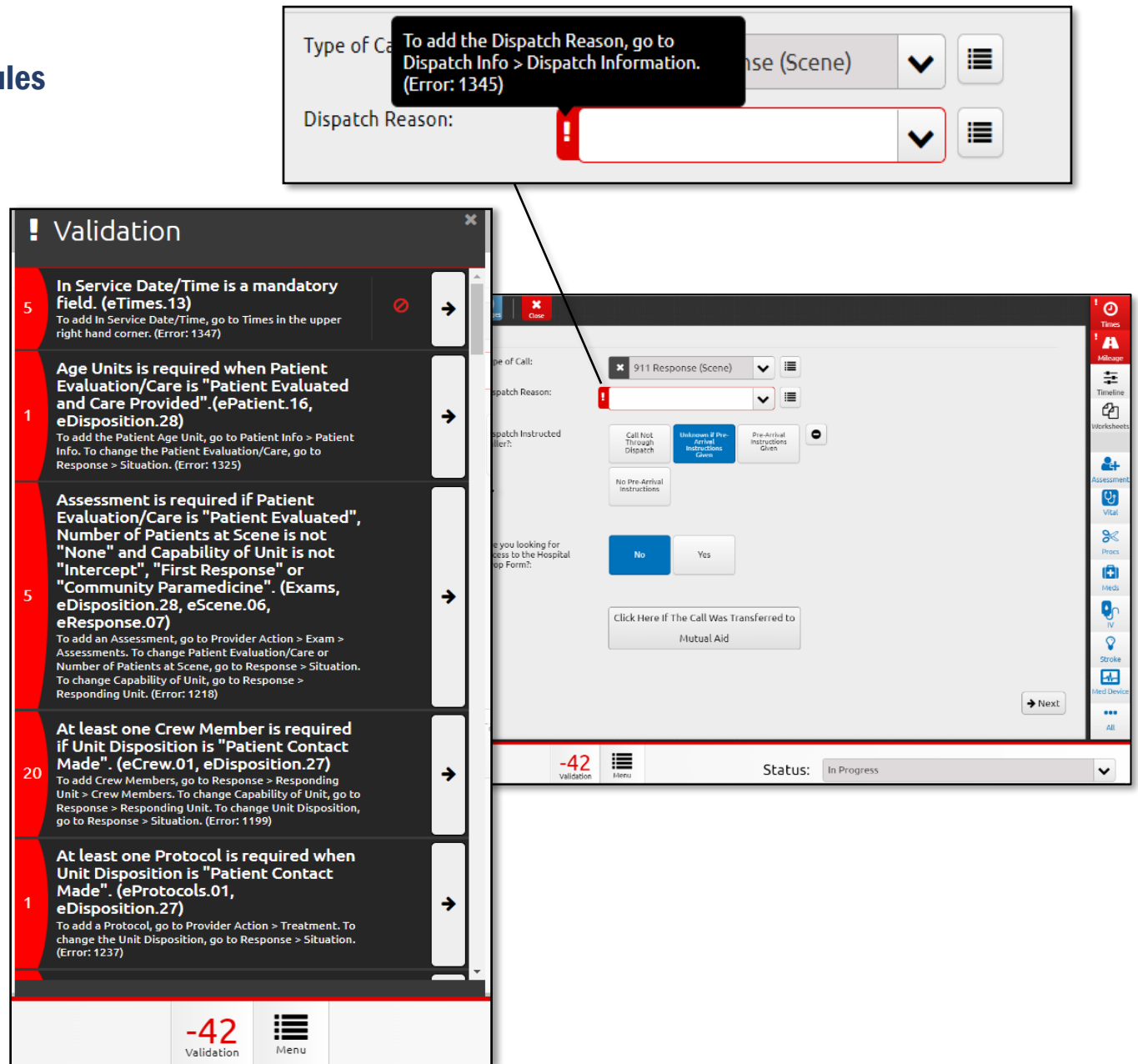
More information can be found if you click on the number in **Red** (or **Yellow**) at the bottom of the page. This will open a list of violations to the Validation Rules, along with the reason for the problem and instructions on where to go to fix the problem.

Validation Rules in **Yellow** are recommended. If these are not resolved, your score will not be impacted.

Validation Rules in **Red** are required. If these are not resolved, points will be subtracted from your total score.

Validation Rules with a red  are mandated items that must be added in order to close the patient care report.

Your incident's validation score must be a minimum of **85** in order to close the incident.



The image shows a screenshot of the ePCR system interface. On the left, a 'Validation' window lists several rules with their scores and instructions:

- 5** In Service Date/Time is a mandatory field. (eTimes.13)
To add In Service Date/Time, go to Times in the upper right hand corner. (Error: 1347)
- 1** Age Units is required when Patient Evaluation/Care is "Patient Evaluated and Care Provided". (ePatient.16, eDisposition.28)
To add the Patient Age Unit, go to Patient Info > Patient Info. To change the Patient Evaluation/Care, go to Response > Situation. (Error: 1325)
- 5** Assessment is required if Patient Evaluation/Care is "Patient Evaluated", Number of Patients at Scene is not "None" and Capability of Unit is not "Intercept", "First Response" or "Community Paramedicine". (Exams, eDisposition.28, eScene.06, eResponse.07)
To add an Assessment, go to Provider Action > Exam > Assessments. To change Patient Evaluation/Care or Number of Patients at Scene, go to Response > Situation. To change Capability of Unit, go to Response > Responding Unit. (Error: 1218)
- 20** At least one Crew Member is required if Unit Disposition is "Patient Contact Made". (eCrew.01, eDisposition.27)
To add Crew Members, go to Response > Responding Unit > Crew Members. To change Capability of Unit, go to Response > Responding Unit. To change Unit Disposition, go to Response > Situation. (Error: 1199)
- 1** At least one Protocol is required when Unit Disposition is "Patient Contact Made". (eProtocols.01, eDisposition.27)
To add a Protocol, go to Provider Action > Treatment. To change the Unit Disposition, go to Response > Situation. (Error: 1237)

At the bottom of the validation window, the score is **-42** and the status is **In Progress**.

On the right, a call form is shown with a red exclamation mark next to the 'Dispatch Reason' field. A tooltip indicates: 'To add the Dispatch Reason, go to Dispatch Info > Dispatch Information. (Error: 1345)'.



Type of Data: Operations, Reimbursement

Response and Incident Times

Steps

Under Times, enter:

- Unit Dispatched
- En Route
- Unit Arrived on Scene
- Patient Contact
- In Service

Additional Information

It's recommended that the Times be entered early. If for some reason the website closes, or your computer crashes, doing this step early in your process will make it much easier to pick up where you left off. The required fields are in red.

To easily enter the date, only enter in the time (the right-hand box). When you click out of the time box, the date will auto populate as your current system date (aka today's date).

Caution: If you run a call overnight, it's recommended you double check the dates. You may have been dispatched yesterday and back in service today—but if you use the trick listed above instead of manually entering the date, SIREN will list today's date for your dispatch date.

Want to make the dates and times a little easier?

- After entering in your Unit Dispatched time, hit the Tab button on your keyboard 3 times. This will move you to the next set of times (En Route).
- If you click the little clock to the right of the times, this will populate the time and date stamp for the exact moment you are writing your report.
- If you ended up providing care or even speaking to a patient in any way, add in the Patient Contact time at this point. This will highlight as required once fill out information in the Response > Situation section.

Dispatch Information

Steps

Under Dispatch > Dispatch Information:

- Confirm the Type of Call is correct
 - This will automatically populate as “911 Response (Scene)”.
○ If you are being sent to help in another agency’s primary service area, change this drop down to “Mutual Aid”.
- Enter the Dispatch Reason

The screenshot shows the 'Dispatch Information' form in the ePCR system. On the left is a sidebar with a search bar and a list of expandable sections: Dispatch, Dispatch Information, Incident Numbers, Response, Patient, Patient Condition, Provider Action, Narrative, COVID / PPE, Signatures, Billing, and Service Defined Questions. The main form area is titled 'Dispatch Information' and contains several fields: 'Type of Call' (set to '911 Response (Scene)'), 'Dispatch Reason' (a dropdown menu with a red exclamation mark icon), 'Dispatch Instructed Caller?' (with buttons for 'Call Not Through Dispatch', 'Unknown if Pre-Arrival Instructions Given', 'Pre-Arrival Instructions Given', and 'No Pre-Arrival Instructions'), and 'Are you looking for access to the Hospital Drop Form?' (with 'No' and 'Yes' buttons). At the bottom, there is a button that says 'Click Here If The Call Was Transferred to Mutual Aid' and a 'Next' button. A red arrow points from the 'Dispatch Reason' dropdown in the main form to a larger, detailed view of the dropdown menu shown in the bottom right.

Additional Information

For any drop-down menu, you can scroll through the list (left), or start (right). If you start to type something, the list of options will filter to match your entry.

The first six items listed in Dispatch Reason are the most popular selections from 2017 to 2022.

This image provides a detailed view of the 'Dispatch Reason' dropdown menu. The menu is open, showing a list of options. The first six items are: 'AI', 'Alcohol intoxication', 'Allergic Reaction / Stings', 'Altered Mental Status', 'Transfer / Interfacility / Palliative Care', and 'Fall(s)'. Below these are 'Abdominal Pain / Problems', 'Airmedical Transport', and 'Animal Bite'. The dropdown has a search bar at the top and a red exclamation mark icon on the left side of the list.

Incident Number

Steps

Under Dispatch > Incident Numbers:

- Enter the Dispatch Assigned Incident #, if this does not automatically default
- Enter the Service Use-Response #, if this does not automatically default

The screenshot shows the 'Incident Numbers' form in the ePCR system. A callout box at the top highlights the 'Dispatch Assigned Incident #' field, which is currently empty. Below it, the 'Service Use-Response #' field contains the value '221005417'. The 'For Fire Agencies' section includes an 'NFIRS Number' field with an '+ Add' button. The form has a sidebar on the left with various tabs like 'Dispatch', 'Response', 'Patient', etc. The top bar includes 'Save', 'Print', 'PDF', 'ENG', 'Transfers', 'Messages', and 'Close' buttons. The bottom status bar shows 'No Patient Name Entered', a '-42 Validation' error, a 'Menu' icon, and a 'Status: In Progress' dropdown.

Additional Information

It's recommended that these numbers be different for every call you respond to so if you ever need to find a record in the future, it's easier to locate.

The Dispatch Assigned Incident # is obtained from Dispatch.

Some agencies have this area set up to automatically fill in a predetermined number. What displays and what is required for the Dispatch Assigned Incident # and the Service Use Response #, will be service-specific.

Responding Unit

Steps

Go to Response > Responding Unit and enter:

- Responding Unit Call Sign
 - Depending on your Agency's set up, this may default for you based on the Responding Unit Call Sign.
- EMS Vehicle (Unit) Number
- Capability of Unit
- Level of Care Provided to Patient (regardless of licensure level)

The screenshot shows the 'Responding Unit' form in the ePCR system. The form is divided into several sections, each with a red header and a dropdown arrow. The sections are: Response, Patient, Patient Condition, Provider Action, Narrative, COVID / PPE, Signatures, Billing, and Service Defined Questions. The 'Response' section is expanded, showing the 'Responding Unit' form. The form includes the following fields:

- Responding Unit Call Sign:** A1C, A2C
- EMS Vehicle (Unit) Number:** A1, A2
- Capability of Unit:** A dropdown menu with 'First Response (BLS)' selected.
- Level of Care Provided to Patient (regardless of licensure level):** A dropdown menu with 'BLS - All Levels' selected.
- Crew Members:** A list of crew members with an 'Add' button.

A callout box provides a detailed view of the selection options for each field:

- Responding Unit Call Sign:** A1C, A2C
- EMS Vehicle (Unit) Number:** ASSOCIATED UNIT NUMBERS (A1), OTHER UNIT NUMBERS (A2)
- Capability of Unit:** First Response (BLS)
- Level of Care Provided to Patient (regardless of licensure level):** BLS - All Levels

Additional Information

Adding Crew Members will be reviewed on the next page.

This section will show different options for Responding Unit Call Sign, EMS Vehicle (Unit) Number and Crew Members information, based on your agency's set up. The available selections are designed to be service-specific.

Responding Unit: Crew Members

Steps

Under Response > Responding Unit:

- Click *Add* under Crew Members
- Locate the first crew member's name by either scrolling or typing in a part of their first or last name, then select them
- Confirm that the Crew Member Level is correct
 - This may default to the provider's level, depending on your agency's set up.
- Define their role(s) for the incident
 - This may display one or more roles, depending on your agency's set up for this crew member.
- Repeat as needed for all crew members that responded to the incident

Crew Members

+ Add Display as information is entered.

Crew Member ID: [dropdown]

Crew Member Level: [dropdown]

Crew Member Response Role: [Find a Value...]

OK



Crew Members

+ Add Display of the end result.

Crew Member [X]

Crew Member ID: Andicantgetup, Fallon	Crew Member Level: Emergency Medical Responder (EMR)	Crew Member Response Role: Other, At Scene - Other Patient Caregiver
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Crew Member [X]

Crew Member ID: Drive-Fast, Ivanna	Crew Member Level: Emergency Medical Technician (EMT)	Crew Member Response Role: Response - Driver, At Scene - Other Patient Caregiver
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Crew Member [X]

Crew Member ID: Coffee, Anita	Crew Member Level: Paramedic	Crew Member Response Role: At Scene - Primary Patient Caregiver
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Additional Information

Once a member has been added to your run form, and assuming they have rights to do this, they will be able to log into SIREN and view and/or edit the incident.

It's strongly recommended that every crew member that was on the call, is added to your run form—this could impact reimbursement rates, help with later reviewing staffing needs, and ensuring that providers receive “credit” for their work.

Incident Location

Steps

Under Response > Responding Unit:

- Select the Location Type from the drop-down menu
 - Like with all other drop-down selections, the list will shorten if you begin to type
- Enter the first two lines of the address
- Enter the Zip Code
 - The City, State and County will auto-populate based on the Zip Code

Additional Information

There are three options for entering the zip code:

Option 1: Enter the zip code and click “Incident Address Postal Code Lookup”. You can then click on whichever town the call occurred in.

Option 2: Select “Incident Address Location Lookup” to search for the zip code. As you type in the city name and select the state, the correct zip code becomes easier to find. When you have the correct one, click on the name and then click OK.

Option 2: Click on the drop down for “Incident Address Favorite Postal Code” and select the correct option.

Note: This will only work if your agency has set up favorite postal codes. Your Rescue Service Administrator can enable this.

The screenshot shows the 'Incident Location' form in the ePCR system. The form is titled 'Incident Location' and includes fields for Incident Location Type, Incident Street Address, Incident Address Line 2, Incident ZIP Code, Incident Address Favorite Postal Code, Incident City, Incident County, and Incident State. A sidebar on the left shows a navigation menu with options like Dispatch, Response, Patient, and Billing. A right sidebar shows a list of medical equipment and services. The form also includes buttons for 'Incident Address Postal Code Lookup', 'Incident Address Location Lookup', and 'Set Scene GPS Location'.

Scene

Steps

Under Response > Scene:

- Define if your agency was the first one on scene
- If patient care was handed over to another agency, enter this information under “Transferred to Agency Name”
- Add in any additional details regarding the scene

Additional Information

The “Transferred to Agency Name” is not required at this point, but if patient care was turned over to another agency, it will save time if you add the details at this point.

The field “Other Agencies On Scene” is not be required, but it is enormously helpful if the records are reviewed later on.

Situation

Steps

Document what occurred overall for the incident under Response > Situation. These fields will most likely be required:

- Number of Patients at Scene
 - This will default to Single but should be manually changed as needed.
- Unit Disposition
- Patient Evaluation/Care
- Crew Disposition
- Transport Disposition
- Initial Patient Acuity
- Final Patient Acuity
- Cardiac Arrest during this incident?
 - This will be required if there was patient contact.
- Possible Injury?
 - This will be required if there was patient contact.

Exactly which fields are required will be dependent on what responses have been entered so far.

Additional Information

Reason for Refusal/Release may display as a recommended field, depending on the responses selected for the other fields. If it does show, it will be directly below Transport Disposition.

See the next page for a screenshot of how this will display.

The Initial Patient Acuity and Final Patient Acuity should be defined by how the patient presented when the author of the report met them, and at the end of the author's encounter with the patient—regardless of if the patient was seen by a provider that's with another EMS agency.

Disposition Fields Additional Details

Type of Data: Operations

The five fields listed here are all new to the Patient Care Report. As they are new, the definitions for each have been listed:

Unit Disposition: The patient disposition for an EMS event identifying whether patient contact was made.

Patient Evaluation/Care: The patient disposition for an EMS event identifying whether a patient was evaluated and care or services were provided.

Crew Disposition: The crew disposition for this EMS event identifying which crew provided primary patient care or whether support services were required.

Transport Disposition: The transport disposition for an EMS event identifying whether a transport occurred and by which unit.

Reason for Refusal/Release: Describes reason(s) for the patient's refusal of care/transport OR the EMS clinician's decision to release the patient.

Note: The *Reason for Refusal/Release* will only show if there are indications that the patient denied transport.

Unit Disposition:	<div>Patient Contact Made</div> <div>Cancelled on Scene</div> <div>Cancelled Prior to Arrival at Scene</div> <div>No Patient Contact</div> <div>No Patient Found</div> <div>Non-Patient Incident (Not Otherwise Listed)</div>
Patient Evaluation/Care:	<div>Patient Evaluated and Care Provided</div> <div>Patient Evaluated and Refused Care</div> <div>Patient Evaluated, No Care Required</div> <div>Patient Refused Evaluation/Care</div> <div>Patient Support Services Provided</div>
Crew Disposition:	<div>Initiated Primary Care and Transferred to Another EMS Crew (First Response)</div>
Transport Disposition:	<div>Transport by Another EMS Unit</div>
Reason for Refusal/Release:	<div>Find a Value...</div>

Additional Information

If you are looking for definitions on the possible responses for these fields, they can be found at

https://nemsis.org/media/nemsis_v3/release-3.5.0/DataDictionary/PDFHTML/EMSDSTATE/Extended%20Data%20Definitions.pdf, from page 6 to 11.

Patient Information

Steps

Under Patient > Patient Demographics, add:

- Patient Last Name
- Patient First Name
- Patient Date of Birth
 - The patient's age and age units will calculate based on the Date of Birth
- Patient Race
- Patient Gender

2 patient records match the information entered. Click [Find a Repeat Patient](#) to add the patient.

Type of Data: Reimbursement

Additional Information

As patient details are added, a banner may show at the top of the page. If your agency has treated the patient before, you will be able to download the patient's details and medical history.

In "Repeat Patient Lookup", you can preview the person by clicking on the eye icon. You can select the person by clicking on the download icon. Downloading the patient information will save you significant time when it comes to documenting the call!

Caution: The Patient Race and Patient Gender should be defined by the patient, not the provider. If the patient did not state their race and/or gender, select the "Unknown" option(s).

First Name	Last Name	Date of Birth	SSN	Gender	Patient Address	Last Picked Up Date
Jane	Doe	05/12/1994	Nothing Entered	Female	Homeless	09/19/2022
John	Doe	01/01/2000	Nothing Entered	Male	101 Main St Burlington, VT 05401	09/26/2022

Patient Address

Steps

Under Patient > Patient Address:

- Enter Lines 1 and 2 for the Patient's Home Address
- Define the Zip Code, City, State and County

Same as Incident Address

Patient Is Homeless

The screenshot shows the 'Patient Address' form in the ePCR system. The form is titled 'Patient Address' and includes a sidebar with navigation options like Dispatch, Response, Patient, Patient Demographics, Patient Address, Guardian / Emergency Contact, Medical History, Patient Condition, Provider Action, Transport, Narrative, COVID / PPE, Signatures, Billing, and Service Defined Questions. The main form area has fields for Patient's Home Address (Line 1 and 2), Patient's Home ZIP Code, Patient Address Favorite Postal Code, Patient's Home City, Patient's Home State, and Patient's Home Country. There are three buttons at the top: 'Repeat Patient Lookup', 'Same as Incident Address', and 'Patient Is Homeless'. A callout box on the right shows a detailed view of these fields and buttons, with arrows pointing to the corresponding fields in the main form.

Additional Information

There are three alternatives to adding the patient's address, that can be utilized:

1. If a repeat patient is selected, the Home Address will automatically fill in based on previous incidents.
2. If "Same as Incident Address" is selected, the Home Address will display the same information as the Incident Address.
3. If "Patient is Homeless" is selected, users will then click "Apply Changes" and a Homeless address will fill in.

Medical History

Medical History Notes:

Start typing here...

Type of Data: Clinical

Medical/Surgical History:

Find a Value...

Steps

Under Patient > Medical History:

- Enter the patient's Medical/Surgical History.
 - If no information can be entered, click on the Null value (circle with a horizontal line) and select the reason.
- Any details on the following can also be entered on this page:
 - Medical History Notes (this is a free text field)
 - Current Medications
 - Medication Allergies
 - Environmental/Food Allergies
 - Response to Drug Use Screening Test
 - Medical History Obtained From
 - Advanced Directives

Additional Information

At a minimum, providers should add any details obtained that could be related to the patient's current illness or injury.

It is recommended that as much information as possible is entered. The details added here will carry forward when a repeat patient is chosen, saving time on future documentation.

Find field...

Save Print PDF EKG Transfer (0) Photos Close

Medical History

Barriers to Patient Care: Find a Value... None Noted

Medical/Surgical History: Find a Value...

Medical History Notes: Start typing here...

Current Medications: Add a grid item...

Medication Allergies

John Smith 73 Validation Status: In Progress

Current Medications

Add a grid item...

Patient Condition

Steps

Under Patient Condition > Assessment:

- Add the Patient Complaint:
 - Click +Add
 - Select the Complaint Type
 - Enter the Complaint
 - (Optional) Add in the Duration of Complaint and the Duration of Complaint Time Units
 - Click Ok
- Enter the Organ/Body System of Chief Complaint
- Define the Primary Symptom
- Enter the Date/Time of Symptom
- Select the provider's current Working Diagnosis
- Enter any details regarding Signs of Suspected Alcohol/Drug Use
 - If this question is Not Applicable, the patient states they have not used drugs or alcohol, the patient refuses to answer, or you are unable to complete this, click on the Null button (the black circle with the line) and choose the correct response.



Additional Information

The Date/Time of Symptom Onset is defined as, "The date and time the symptom began (or was discovered) as it relates to this EMS event. This is described or estimated by the patient, family, and/or healthcare professionals".

Other Associated Symptoms and Other Diagnoses are both optional fields. If drug use is indicated under Signs of Suspected Alcohol/Drug Use, two optional, additional fields will display and allow providers to give details on the suspected or confirmed drug(s) taken by patient and who the drug information was obtained from.

Assessment

Find field...

Save Print PDF EKG Queue Messages Close

Patient Complaints

+ Add

Location on Body of Chief Complaint: [Dropdown] [List Icon] [Null Icon]

Organ/Body System of Chief Complaint: [Dropdown] [List Icon] [Null Icon]

Primary Symptom: [Dropdown] [List Icon]

Date/Time of Symptom Onset: [Date/Time Picker] [Clock Icon] [Null Icon]

Other Associated Symptoms (Choose All That Apply): [Find a Value...] [List Icon] [Null Icon]

Working Diagnosis: [Dropdown] [List Icon]

Other Diagnoses: [Find a Value...] [List Icon] [Null Icon]

Signs of Suspected Alcohol/Drug Use

(Choose All That Apply):

- Patient Admits to Alcohol Use
- Alcohol Containers/Paraphernalia at Scene
- Drug Paraphernalia at Scene

John Smith

Provider Action

Steps

Under Provider Action > Exam:

- Add the Date/Time Last Known Well for the patient.
- If you have completed any assessments or obtained any vitals, this information is entered on this page. Additional details are on the next two pages.

Save

Print

PDF

Exit

Transfer

Messages

Close

Dispatch

Response

Patient

Patient Condition

Provider Action

Exam

Treatment

Transport

Narrative

COVID / PPE

Signatures

Billing

Service Defined Questions

John Smith

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Validation

Menu

Status: In Progress

Exam

Use the Assessment Power Tool to the right.

Assessments

+ Add

Vitals

+ Add

Data/Time Last Known Well:

FAST ED Score (if performed):

Next

Additional Information

The Date/Time Last Known Well is defined as, “The estimated date and time the patient was last known to be well or in their usual state of health. This is described or estimated by the patient, family, and/or bystanders”.

!

Assessments

+ Add

!

Vitals

+ Add

Date/Time Last Known Well:

!

⌚

⌂

FAST-ED Score (if performed):

Exam

Steps

Under Provider Action > Exam > Assessments:

- Enter the Date and Time the assessment was completed
- Add all assessment findings for that time
- Click Ok or Add Another
- Repeat as needed

Available Exam Fields

The following assessments can be entered on this page:

1. Mental Status
2. Neurological
3. Head
4. Face
5. Eye
6. Neck
7. Heart
8. Chest
9. Lungs
10. Abdomen
11. Pelvic/Genitourinary
12. Spine
13. Skin
14. Extremities

Additional Information

These are available as options on every entry so that providers have the flexibility to document what was obtained. At this time, it is not the expectation that providers will review every item in this list for every patient on every Exam.

Exam

+ Add Another

✓ OK

✕ Cancel

Date/Time of Assessment:

!

Mental Status Assessment:

Find a Value...

Neurological Assessment:

Find a Value...

Head Assessment:

Find a Value...

Face Assessment:

Find a Value...

Eye Exams

+ Add

Neck Assessment:

Find a Value...

Heart Assessment:

Find a Value...

Chest Exams

+ Add

Lung Exams

+ Add

Abdomen Exams

+ Add

Pelvis/Genitourinary Assessment:

Find a Value...

Spine Exams

+ Add

Skin Assessment:

Find a Value...

Extremity Exams

+ Add

Available Exam Fields

The following vitals can be entered on this page:

Type of Data: Clinical, Reimbursement

Vitals

Steps

Under Provider Action > Exam > Vitals:

- Enter the Date and Time the assessment was completed
- Add all assessment findings for that time
- Click “Ok” or “Add Another”
- Repeat as needed

Additional Information

These are available as options on every entry so that providers have the flexibility to document what was obtained. At this time, it is not the expectation that providers will review every item in this list for every patient on every Vitals assessment.

Caution: The Vitals Crew Member will default to the name and license level of the Primary Provider on Scene. If this wasn't the person who obtained the information, this drop down should be changed to reflect the correct provider.

1. Systolic Blood Pressure
2. Diastolic Blood Pressure
3. Method of Blood Pressure
4. Pulse Rate
5. Pulse Rhythm
6. Pulse Quality
7. Method of Pulse Rate Measurement
8. Respiratory Rate
9. Respiratory Effort
10. Blood Glucose Level
11. Blood Glucose Other (High / Low)
12. Pulse Oximetry
13. Pulse Oximetry Qualifier
14. Carbon Dioxide (CO2/ETCO2)
15. Carbon Monoxide (CO)
16. Pain Scale Score
17. Pain Scale Type
18. Level of Responsiveness (AVPU)
19. Temperature
20. Temperature Method
21. Stroke Scale Type
 - a. Facial Palsy
 - b. Arm Weakness
 - c. Speech Changes
 - d. Eye Deviation
 - e. Denial Neglect
 - f. LVO / FAST-ED Score (this will auto-calculate)
22. Stroke Scale Score
23. GCS - Eye
24. GCS - Verbal
25. GCS - Motor
26. GCS - Qualifier
27. Total GCS (this will auto calculate)
28. Revised Trauma Score
29. Vital Comments

Vitals

+ Add Another ✓ OK ✕ Cancel

Obtained Prior to this Unit's EMS Care:

Date/Time Vital Signs Taken:

Vitals Crew Member:

SBP (Systolic Blood Pressure):

DBP (Diastolic Blood Pressure):

Method of Blood Pressure Measurement (optional):

Pulse Rate:

Pulse Rhythm (Optional):

Pulse Quality (Optional):

Method of Pulse Rate Measurement (optional):

Respiratory Rate:

Respiratory Effort:

Blood Glucose Level:

Blood Glucose Other:

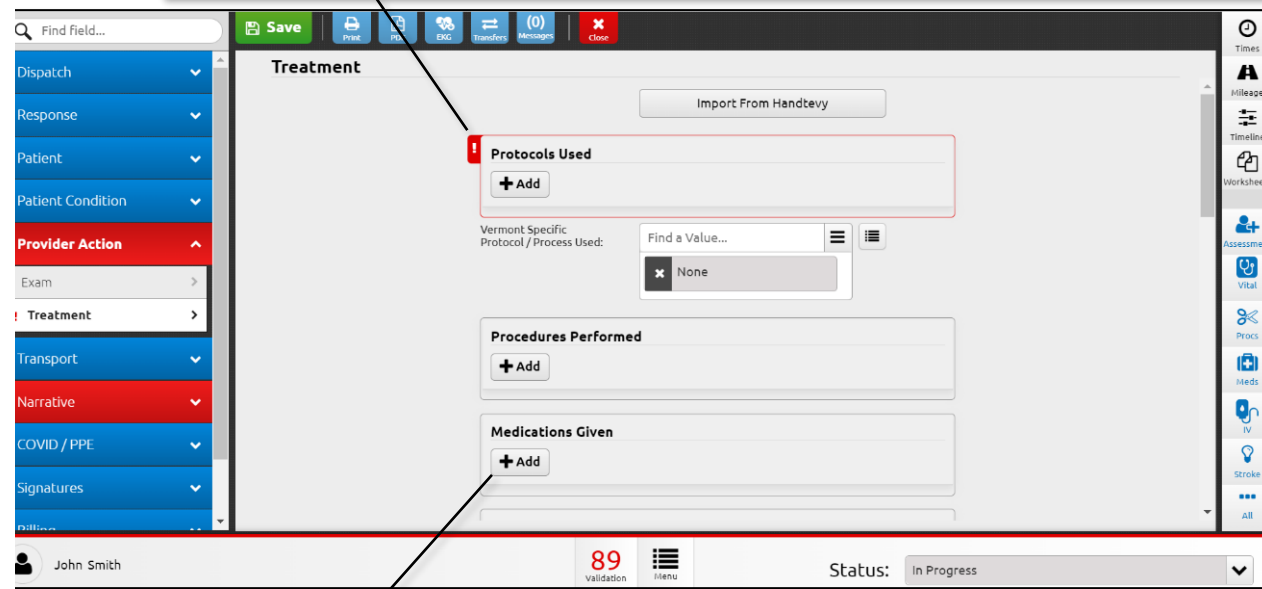
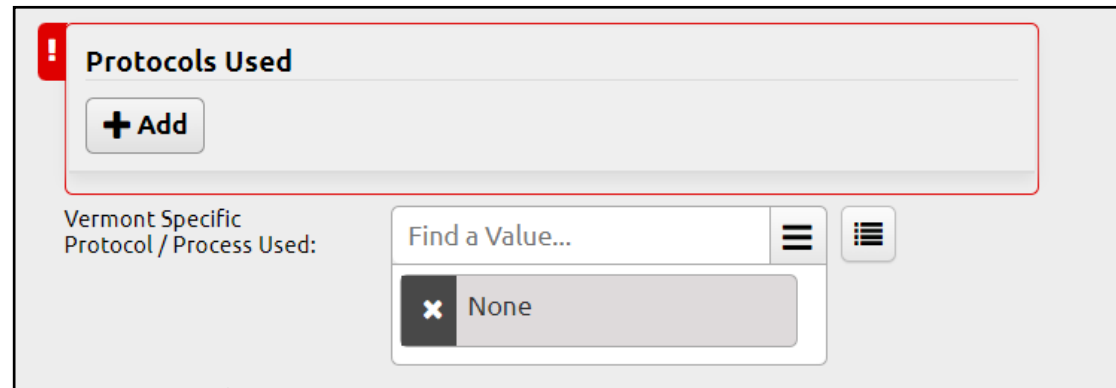
Pulse Oximetry:

Treatment

Steps

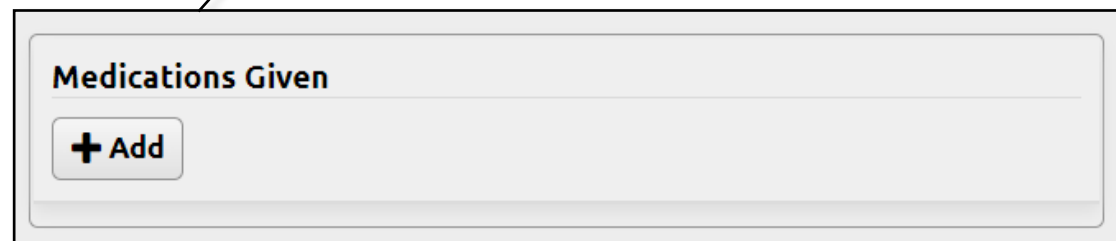
Under Provider Action > Treatment:

- Add the Protocol(s) Used:
 - Click +Add
 - If you leveraged more than the “General – Routine Patient Care/Initial Patient Contact” protocol during your care of the patient, click +Add a second time. You will then change the drop down to the protocol used and confirm the Protocol Age Category.
- Add any medications given, it should be entered here. Additional details are on the next page.



Additional Information

Remember: Even Oxygen counts as a medication!



Medications Given

Steps

Under Provider Action > Treatment > Medications Given:

- Add the Date/Time the Medication was given
- Confirm if the medication was given prior to the EMS unit's care
- The Medication Crew Member and Level of Provider Giving Medication will default to the name and license level of the Primary Provider on Scene. If the medication was given by another provider, this should be updated
- Define the Medication Given
 - The list of available options will adjust based on the Medication Crew Member's license level.
- Enter the Dose, Dose Units and Administration Route, if this information does not automatically populate
 - Some medications have these details set up with default values, which can be changed.
- Enter the Response to Medication
- If applicable, add any Medication Complications or Medication Comments, and adjust the Medication Authorization if needed.
- Click Ok or Add Another.

The screenshot shows the 'Medications Given' form with the following fields and controls:

- Buttons:** '+ Add Another', '✓ OK', and '✗ Cancel' at the top.
- Date/Time Medication Given:** Two text input fields with a red border and a red exclamation mark icon, followed by a clock icon and a minus icon.
- Medication Given Prior to this Unit's EMS Care:** Two buttons: 'No' (blue) and 'Yes' (gray), followed by a minus icon.
- Medication Crew Member:** A dropdown menu with a red border and a red exclamation mark icon, followed by a list icon and a minus icon.
- Level of Provider Giving Medication:** A dropdown menu with a red border and a red exclamation mark icon, followed by a list icon and a minus icon.
- Medication Given:** A dropdown menu with a red border and a red exclamation mark icon, followed by a list icon and a minus icon.
- Dose:** A text input field with a red border and a red exclamation mark icon, followed by a minus icon.
- Dose Units:** A dropdown menu with a red border and a red exclamation mark icon, followed by a list icon and a minus icon.
- Administration Route:** A dropdown menu with a red border and a red exclamation mark icon, followed by a list icon.
- Response to Medication:** Three buttons: 'Improved' (gray), 'Unchanged' (gray), and 'Worse' (gray), followed by a minus icon.
- Medication Complication:** A text input field with the placeholder 'Find a Value...', followed by a list icon and a minus icon.
- Medication Authorization:** Three buttons: 'Protocol (Standing Order)' (blue), 'On-Line (Remote Verbal Order)' (gray), and 'On-Scene' (gray). Below these is a button for 'Written Orders (Patient Specific)' (gray).
- Medication Comments:** A text input field at the bottom.

Narrative

Steps

Under Narrative > Narrative, document the details of the call and the information obtained from the patient by using the CHART template.

C – Chief Complaint

- The patient's primary physical complaint

H – History of Present Illness/Injury (HPI)

- Events leading up to incident
- SAMPLE
- OPQRST
- Medications
- Significant medical history

A – Assessment

- Initial patient presentation
- Assessments (primary and secondary)
- Physical findings
- Associated symptoms
- Pertinent negatives and positives
- Vital signs

R – Rx, Treatment and Response

- Interventions
- Patient's response to interventions

T – Transport / Transfer of Care

- How the patient was moved from where EMS first met the patient, to where the patient was at the end of the encounter.
- Any changes during transport
- To whom patient care was transferred and any additional details related to this.

Additional Information

The Narrative should reflect what occurred during the incident and the information collected by the provider.

Service Defined Questions

Steps

Under Service Defined Questions > Service Defined Questions:

- Answer any questions your agency may have listed here. These requirements will vary from service to service and will be reflective of what your specific agency is looking to collect.

The screenshot shows the 'Service Defined Questions' interface. On the left is a sidebar with a search bar and a list of categories: Dispatch, Response, Patient, Patient Condition, Provider Action, Transport, Narrative, COVID / PPE, Signatures, Billing, and Service Defined Questions (which is expanded). The main area is titled 'Service Defined Questions' and contains the text 'Your Service Defined Questions will show up here.' The top toolbar includes buttons for Save, Print, PDF, EKG, Transfers, Messages, and Close. The bottom status bar shows the user 'John Smith', a '100 Validation' indicator, a 'Menu' button, and a 'Status: In Progress' dropdown.

Additional Information

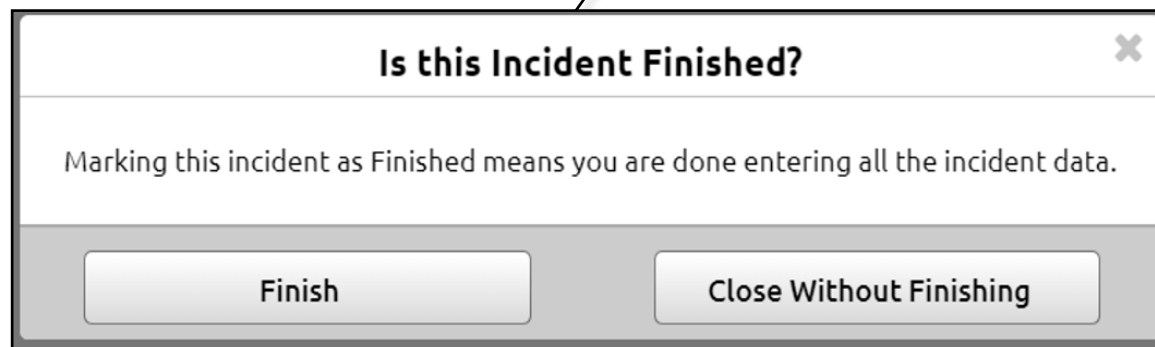
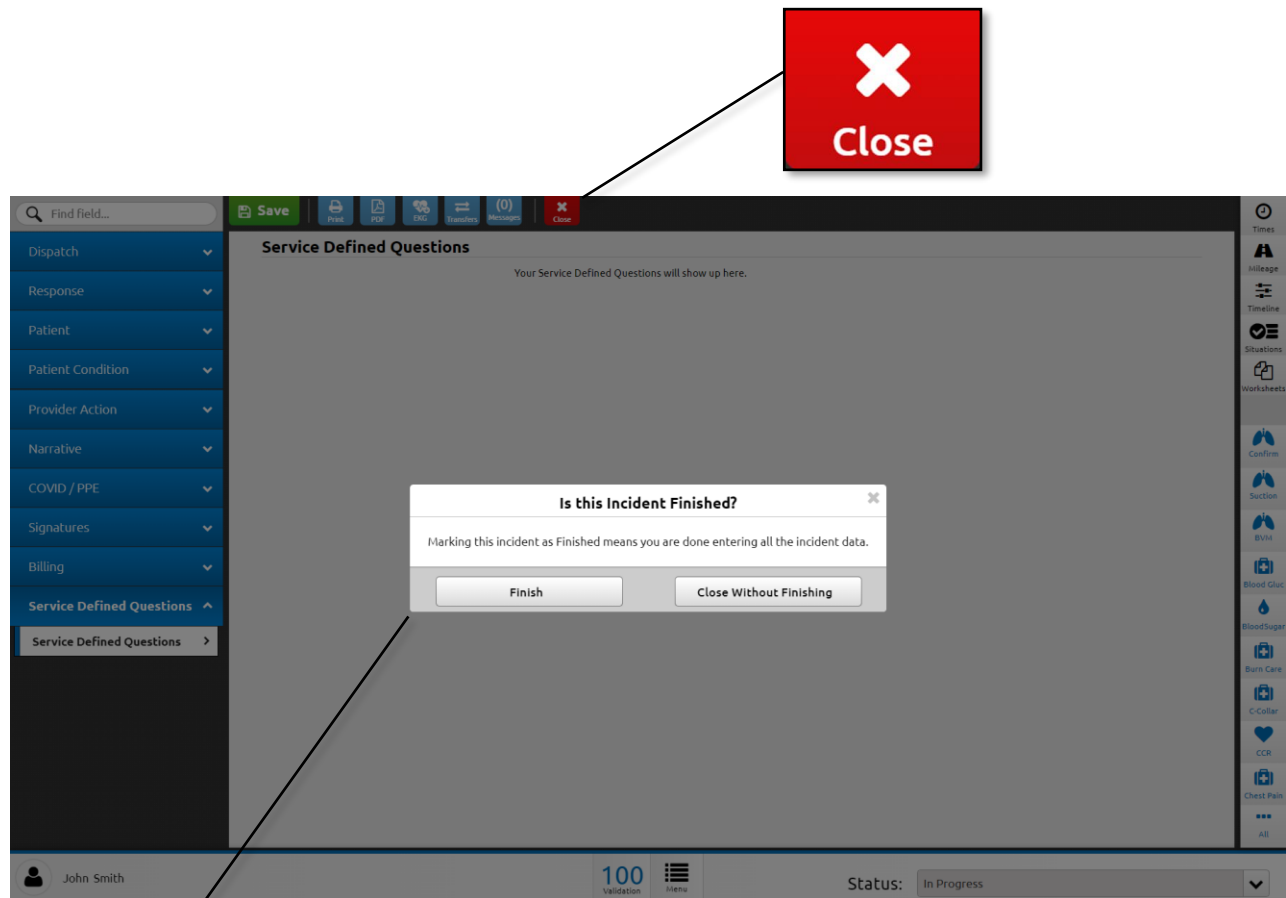
Not all agencies will have Service Defined Questions. If an agency does have them, these will vary from service to service.

Close the Incident

Steps

At the top of the page:

- Click Close
 - If the report is completely done, click Finish
 - If you may need to go back and update details within 24 hours of starting the report, click Close Without Finishing



Additional Help

If you're having any issues at all, there are several resources available:

- Your Agency's SIREN Administrator
- The Data Management Team:
 - Email: Siren@Vermont.gov
- Beth Brouard, AEMT, EMS Data Manager:
 - Email: Bethany.Brouard@Vermont.gov
 - Phone (802) 495-8762