Alabama Office of Emergency Medical Services
Patient Care Reporting Guidelines
Updated January 12, 2024 / Addendum May 12, 2026

OVERVIEW

Electronic Patient Care Reports serve as mandated, standardized and time-validated permanent records of the responses of EMS crews to the calls for help of ill and injured citizens and the disposition of those cases. They serve many purposes including as sources of investigative and research data, sources of case history for clinicians and insurance payers, and as documentation protective against litigation.

BACKGROUND

"NEMSIS" is an acronym for the National Emergency Medical Services Information System. Alabama has participated in NEMSIS along with all other states and some territories since 2003. States and participating territories are under agreement with the federal government under a memorandum of understanding to require and collect electronic patient care reports and to subsequently transmit a specified portion of each report to the NEMSIS records repository in Utah. Submitted data is used at the federal, state, regional, local and service levels for research purposes.

RESPONSIBILITY

- Emergency Medical Services Personnel are responsible for the completion and submission of an electronic Patient Care Report (e-PCR) to the Emergency Medical Provider Service for who the patient care was provided. (EMS Rules 2020: 420-2-1- .21 (1))

- Emergency Medical Provider Service operators are required to acquire and maintain access to an electronic patient care reporting software (approved by the OEMS Director) to provide a mechanism for their personnel to create and submit e-PCRs. (EMS RULES 2020: 420-2-1- .11 (5) 6., 420-2-1- .21 (2))

TOPIC SECTIONS

- INTERPRETATION OF SITUATIONS REQUIRING e-PCR DOCUMENTATION
  1. In the operation of Emergency Medical Services, units are either dispatched to the location of a call for help (passive detection) or while traveling, encounter a scene within which a call for help exists (active detection). An EMS unit, in service and ready for call, has a duty to act if passively or actively dispatched to a call for help within normal parameters of service.

  2. Initiation of a patient care encounter begins with Incident Recognition and Access of the 9-1-1 System. Direct involvement of a provider begins with Access/Dispatch of that provider. At the time of passive or active detection/dispatch, the Duty to Act of the provider is engaged to the situation. Once the Duty to Act is engaged the case MUST be documented via e-PCR.

  3. Possible Dispositions Requiring Documentation – The dispositions listed were added to the elements with initiation of Version 3.5. They are integrated to define the nature of the unit's actions and interactions more exactly. NOTE: An electronic patient care report (ePCR) is the record of an EMS unit response and not just patient care. Every EMS unit responded to a scene should complete an ePCR whether they participated in patient care or not.

eDisposition.27 (Unit Disposition)

- Patient Contact Made
- Cancelled on Scene
- Cancelled Prior to Arrival at Scene
- No Patient Contact
- No Patient Found
- Non-Patient Incident (Not Otherwise Listed)

eDisposition.28 (Patient Evaluation/Care)

- Patient Evaluated and Care Provided
- Patient Evaluated and Refused Care
- Patient Evaluated, No Care Required
- Patient Refused Evaluation/Care
- Patient Support Services Provided

eDisposition.29 (Crew Disposition)

- Initiated and Continued Primary Care
- Initiated Primary Care and Transferred to Another EMS Crew
- Provided Care Supporting Primary EMS Crew
- Assumed Primary Care from Another EMS Crew
- Incident Support Services Provided (Including Standby)
- Back in Service, No Care/Support Services Required
- Back in Service, Care/Support Services Refused

eDisposition.30 (Transport Disposition)

- Transport by This EMS Unit (This Crew Only)
- Transport by This EMS Unit, with a Member of Another Crew
- Transport by Another EMS Unit
- Transport by Another EMS Unit, with a Member of This Crew
- Patient Refused Transport
- Non-Patient Transport (Not Otherwise Listed)
- No Transport

eDisposition.31 (Reason for Refusal/Release)

- Against Medical Advice
- Patient/Guardian Indicates Ambulance Transport is Not Necessary
- Released Following Protocol Guidelines
- Released to Law Enforcement
- Patient/Guardian States Intent to Transport by Other Means
- DNR
- Medical/Physician Orders for Life Sustaining Treatment
- Other, Not Listed

eDisposition.32 (Level of Care Provided per Protocol)

- BLS – All Levels
- ALS – AEMT/Intermediate
- ALS – Paramedic
- EMS and Other Health Care
- Critical Care
- Integrated Health Care
- No Care Provided

4. Explanations/Examples of Dispositions Requiring Documentation
   NOTE: All dispositions are valid for both emergency and non-emergency responses/situations.

Disposition/Item	***Explanation/Example***
eDisposition.27	**UNIT DISPOSITION**
Patient Contact Made	• Unit was dispatched to a scene where a patient was contacted. • Unit was not dispatched but contacted a patient ("ran up" or "waved down" on a patient scene).
Cancelled on Scene	• Unit was dispatched, arrived on scene, and was cancelled (verbally or waved off) by someone with proper authority to do so on scene. • *NOTE: Highly encouraged to document identity of who cancelled unit on scene*.
Cancelled Prior to Arrival at Scene.	• Responding unit is cancelled by entity with authority to do so. • *NOTE: Highly encouraged to document identity of who cancelled unit prior to arrival on scene.*
No Patient Contact	• Responding unit arrives on scene to find patient (who exists) being transported by another EMS unit, POV or law enforcement. No patient care relationship is established. *NOTE: Highly encouraged to document reason there was no contact.*
No Patient Found	• Responding unit arrives on scene and does not find a patient at location of dispatch. *NOTE: Highly encouraged to document efforts to locate patient to establish due diligence.*
Non-Patient Incident (Not Otherwise Listed)	• Utilization of unit for non-patient related activity. *Example: Body (decedent) transport. Fire standby without patient interaction. Law Enforcement standby without patient interaction.*
eDisposition.28	**PATIENT EVALUATION/CARE**
Patient Evaluated and Care Provided	• At least primary assessment with provided care documented in other areas of report. *NOTE: Highly encouraged to take 2 or more sets of vital signs on every patient – in any situation.*
Patient Evaluated and Refused Care	• At least primary assessment. Refused any care. *NOTE: Highly encouraged to extensively document efforts to persuade patient to allow treatment. If patient will allow vitals to be taken, take 2 sets if possible.*
Patient Evaluated, No Care Required	• At least primary assessment. No obvious illness or injury. *NOTE: Highly encouraged to extensively document assessment, vitals, and pertinent negatives given situation. Example: Patient asked for unit response to home only to request to have their vitals checked.*
Patient Refused Evaluation/Care	• Refusal for evaluation and care by a lucid patient legally able to make that decision. Chemical impairment affects decision making. *NOTE: Highly encouraged to document indicators of patient lucidity and efforts to encourage patient care. HINT: If in doubt remember you can contact online medical control.*
Patient Support Services Provided	• No care necessary for a patient. *Example: Lifted uninjured, otherwise normal patient from floor. NOTE: Highly encouraged to document the reasons why illness or injury were not suspected. HINT: It is never a bad idea to take a set of vitals on a patient lift assist even if they have no complaint.*
eDisposition.29	**CREW DISPOSITION**
Initiated and Continued Primary Care	Arrived on the scene first, and/or arrived on the scene as the highest level of provider on scene to assume patient care responsibility. Continued care of patient throughout treatment and transport.
Initiated Primary Care and Transferred to Another EMS Crew	Arrived on the scene first, and/or arrived on the scene as the highest level of provider on scene to assume patient care responsibility; transferred care responsibility to provider of equal or higher level on another EMS crew, for purpose of transport, etc. *NOTE: Highly encouraged to document name of service and provider patient care was transferred to.*
Provided Care Supporting Primary EMS Crew	Arrived on scene and assisted primary crew in patient care. Worked cooperatively or under direction of primary crew. *NOTE: Highly encouraged to document functions provided and name of service and providers for which care support was provided. Example: "Provided CPR and assisted with patient movement to unit."*

Assumed Primary Care from Another EMS Crew	Arrived second on scene with transport responsibility, and/or as highest level of care provider, and received patient care responsibility from initial crew. *NOTE: Highly encouraged to document name of service and provider from whom you assumed patient care responsibility.*
Incident Support Services Provided (Including Standby)	Dispatched/Scheduled for a support services situation. Includes standby status such as sporting events, fireground standbys, law enforcement standby requests, delivery of equipment or supplies to a patient care scene. *NOTE: No patient care was provided by crew.*
Back in Service, No Care/Support Services Required	Typically dispatched to scene for potential of supporting primary care providers and/or providing support services and neither were needed or requested by care providers on scene. *NOTE: Highly recommended to document name of service and possibly providers on scene providing care.*
Back in Service, Care/Support Services Refused	Typically dispatched to scene for potential of supporting primary care providers and/or providing support services and upon offering assistance it was refused by care providers on scene. *NOTE: Highly encouraged to document name of service and provider declining offer of assistance.*
eDisposition.30	**TRANSPORT DISPOSITION**
Transport by This EMS Unit (This Crew Only)	The reporting unit crew transports patient to destination without a rider from another crew.
Transport by This EMS Unit, with a Member of Another Crew	The reporting unit transports patient to destination WITH a rider from another crew. *NOTE: It does not matter if the reporting unit crew or the rider has primary patient care responsibility.*
Transport by Another EMS Unit	The reporting unit has transferred care of the patient to the crew of the transporting unit.
Transport by Another EMS Unit, with a Member of this Unit.	The reporting unit has a crewmember that has remained with the patient while being transported by another EMS unit. *NOTE: It does not matter if the reporting unit crew or the rider has primary patient care responsibility.*
Patient Refused Transport	Patient was offered opportunity of transport to the destination (usually hospital) and refused the opportunity of transport. *NOTE: Highly recommend documentation of efforts to advise patient of any medical need to be transported.*
Non-Patient Transport (Not Otherwise Listed)	Examples include transport of a decedent to the morgue or funeral home, transport of organs for transplantation or medications needed by another unit or hospital. *NOTE: Highly recommend documentation of exact material transported and reason for transport by EMS unit.*
No Transport	Unit arrived on scene with potential to transport and no transport occurred. *Examples: Patient was found to be deceased and no transport by this EMS unit was necessary. Patient was transported by law enforcement.*
eDisposition.31	**REASON FOR REFUSAL/RELEASE**
Against Medical Advice	A lucid patient, under informed consent, refuses to be transported by your unit despite being warned regarding the medical conditions necessitating transport and the possible consequences of refusing transport and/or seeking medical care at the physician level. *NOTE: Highly recommend extensive documentation of assessment findings and efforts to inform patient and convince them to be transported.*
Patient/Guardian Indicates Ambulance Transport is Not Necessary	A patient who is competent to make an informed medical decision in a situation where diligent assessment yields no obvious indications of illness or injury, or a legally recognized guardian who is competent to make an informed medical decision for an incompetent/underaged patient where diligent assessment yields no obvious indications of illness or injury, declines transport. *NOTE: Highly recommend extensive documentation of situation parameters.*
Released Following Protocol Guidelines	See Alabama EMS Operational Guidelines, Section 18.07 Patient Rights and Refusal of Care. *NOTE: Situation does not qualify for "Against Medical Advice" category. Highly recommend extensive documentation of situational parameters.*
Released to Law Enforcement	In lieu of EMS transport by this unit, patient is taken into custody by law enforcement.
Patient/Guardian States Intent to Transport by Other Means	In lieu of EMS transport by this unit, the patient, or their legally recognized guardian (for underage or incompetent patient) declares their intent to transport to the destination facility via other means (privately owned vehicle, etc.).
DNR	Patient has a Portable Do Not Resuscitate (DNR) or Pediatric Palliative or End of Life (PPEL) order and meets standards outlined in EMS Rule 420-2-1-.04 and is not transported. *NOTE: Unless a "DNAR" or "PPEL" order is issued, any patient who sustains a cardiopulmonary arrest will receive full cardiopulmonary resuscitation with the objective of restoring life. If a DNAR order has been issued, the family may countermand that order and request that resuscitation be attempted. HINT: When in doubt contact online medical control physician.*

Medical/Physician Orders for Life Sustaining Treatment	The patient is not transported and is released subsequent to physician direction. Typically, the patient is judged by online medical control or physician in legal control of scene to have medical condition/injury that is incompatible with life. Physician direction results in either the termination of prehospital intervention (cessation of a code after 20 minutes without response) or withholding of resuscitative efforts due to assessment findings or mechanism. *NOTE: Name, location, MDPID (Medical Direction Physician Identification Number) and communication with physician should be fully documented.*
Other, Not Listed	Reason for Refusal/Release not otherwise categorized on this list. *NOTE: The reason for Refusal/Release indicated by this selection should be fully documented.*
eDisposition.32	**LEVEL OF CARE PROVIDED PER PROTOCOL**
	The level of care should be defined by the situation, medications, and procedures provided to the patient based on what is allowed in the Alabama EMS protocols. This is not a reflection of the provider levels providing care, but the actual care given-for example, BLS care provided by a paramedic would be entered as "BLS". NEMSIS states that this element benefits reviews of performance, resource demand and utilization, and reimbursement coding.
BLS – All Levels	Intervention provided was equivalent to the maximum available within the scope of practice of the Alabama EMT
ALS – AEMT/Intermediate	Intervention provided was equivalent to the maximum available within the scope of practice of the Alabama AEMT or the Alabama Intermediate.
ALS – Paramedic	Intervention provided was equivalent to the maximum available within the scope of practice of the Alabama Paramedic.
EMS and Other Health Care	Intervention provided (typically during transport) was comprised of that provided by the unit EMS crew and that of other health care providers not belonging to the crew. *NOTE: Examples include EMS unit and crew transporting a patient with a flight crew to or from a landing site or zone and EMS ground unit transporting a hospital's neonatal transport team*
Critical Care	Intervention provided was equivalent to the maximum available within the scope of practice of the Alabama Paramedic with Critical Care Endorsement.
Integrated Health Care	Intervention provided (typically during transport) was comprised of that provided by the unit EMS crew that includes other health care providers (physician, R.N., etc.). *NOTE: Example is EMS unit and crew composed of a Paramedic and R.N. team.*
No Care Provided	Intervention (by this unit) was unnecessary. *NOTE: Examples include arriving second on scene and assisting a care-providing-unit (while not personally providing patient care), transportation of a decedent (body), medications, or equipment.*

NOTES ON ELEMENTS VERSUS NARRATIVE

Elements are utilized on electronic formats for the purpose of categorization. Just because an element (or "click box") exists does not mean that further narrative documentation is unnecessary. For example, a procedure box can be used to document the date and time of the procedure (endotracheal intubation, intravenous access, etc.) but it cannot document your reason for performing the procedure. Rationale for procedures, medications, etc., are often reviewed in litigation and insurance evaluations. Procedures and medications require INDICATIONS for application/administration. Due diligence in documentation requires straightforward recording of the reasons why non-routine procedures (such as IV, ETT, defibrillation, etc.) are performed. Further, often during litigation the case is tried years after the event took place. Straightforward narrative may be the only method of recalling not "what you did" but "why you did it."

5. Documentation of Refusals, Etc.
    a. Documentation cannot be overemphasized in cases where patient care is applied and/or suspended by patient request.
    b. Refusals and suspensions by request absolutely require the patient to sign a waiver of liability, or for a witness to sign witnessing the patient's signature and/or decision to refuse or suspend.
    c. Witnesses to look for are family members, police officers, fire officials (not your department) or unbiased bystanders.
    d. An old rule of EMS is "If you didn't write it down, you didn't do it." Meaning you cannot prove in court that you did (or did not do) an action that was not documented.

- **ALABAMA CUSTOM ELEMENTS**

EMSA (Emergency Medical Stroke Assessment) Elements

The EMSA (Emergency Medical Stroke Assessment) Elements are custom elements unique to Alabama. The purpose of EMSA is to assign a score to an acute stroke patient that reflects the likelihood of the necessity of surgical intervention for an acute thrombo-occlusive stroke (surgical thrombectomy). They reflect the assessment tool used in the stroke hospitals of the Alabama Stroke System. The assessment tool was developed by Toby Gropin, MD, FAHA and others involved in stroke management and associated with Alabama's Acute Health System. Dr. Gropin is the Director of the Comprehensive Neurovascular and Stroke Center at UAB.

Preliminary education for use of the EMSA tool was conducted among Alabama Emergency Medical Provider Services (EMS Services and Departments) for approximately two years prior to the introduction of the EMSA elements within Alabama's NEMSIS reporting system on March 1, 2022. The e- PCR software vendors performing sales and service to our state's Emergency Medical Provider Services (EMPS) were made aware on 11/8/2021 of the addition of these custom elements through the NEMSIS website. It is their responsibility to their clients to implement the EMSA elements. As described in the preliminary training, it is the responsibility of each EMPS to assure that the elements are set up in their vendor's system utilized by them.

It is the responsibility of each individual licensee as the reporter of their e-PCR's to both correctly record data within the EMSA elements and to appropriately contact the state's Trauma Call Center (TCC) to enter an applicable patient into the Alabama Stroke System in the prehospital phase of care. The Stroke System ID Number supplied by TCC operator is then to be entered into the e-PCR in the appropriate place (eOutcome.04 – External Report ID/Number) and the system type element (eOutcome.03 – External Report ID/Number Type) shall be selected as "Stroke Registry."

EMSA is required to be utilized on every patient care report upon which patient assessment was recorded and is recorded only once (not serially) during the patient care process. EMSA evaluation should be used in conjunction with, and not as a replacement of, other stroke scales, such as the Cincinnati Stroke Scale or FAST Stroke Scale. All NEMSIS software platforms used in Alabama should include the EMSA elements. It is the recommendation of the Alabama OEMS that the first EMSA element (emsa.SuspectedOccurrence-EMSA-Suspected Acute (New Onset) Stroke/CVA Occurrence) be set by default to "No" or less preferably "Unknown." It then can be selected as "Yes" if the reporter suspects a new onset acute stroke has occurred.

OVERVIEW OF ELEMENTS AND THEIR USE

- emsa.SuspectedOccurrence-EMSA-Suspected Acute (New Onset) Stroke/CVA Occurrence "Do you suspect an acute (new onset) stroke/cva occurred? CHOICES: Yes, No, Unknown

IF ABOVE ELEMENT IS ANSWERED "YES"

- emsa.TimeFactor-EMSA-Time Factor Date/Time "The approximate date/time that the complaint was noticed." 10 ANS: Date/Time

• emsa.Onset-EMSA-Onset “Was the onset of this complaint acute/rapid or gradual/slow?” CHOICES: Acute/rapid, Gradual/slow

• emsa.Pain-EMSA-Pain “Does the patient experience head pain with this complaint?” CHOICES: Yes, No

• emsa.AlabamaStrokeSystemEntry-EMSA-Alabama Stroke System Entry “Did you enter this patient into the Alabama Stroke System?” CHOICES: Yes, No

• emsa.E1-EMSA-Horizontal Gaze “Patient Horizontal Gaze. Ask patient to keep their head still and follow your finger left to right with their eyes.” CHOICES: Normal-Equivalent Movement, Abnormal-Patient is unable to follow as well in one direction compared to the other.

• emsa.M2-EMSA-Facial Weakness “Facial Weakness. Ask patient to show their teeth or smile.” CHOICES: Normal-Bilaterally equivalent smile (both sides), Abnormal-Unilateral facial droop (one side does not move as well as the other).

• emsa.M3=EMSA-Arm Weakness “Arm Weakness. Ask patient to hold out both arms, palms up, for 10 seconds with eyes closed.” CHOICES: Normal-Both arms behave the same and do not drift away or down from position start, Abnormal-One arm does not move or drifts downward compared to the other.

• emsa.M4-EMSA-Leg Weakness “Leg Weakness. Ask patient to lift up one leg and then the other, hold 5 seconds each.” CHOICES: Normal-Both legs behave the same and do not drift down during 5 second lift, Abnormal-One leg does not move or drifts down compared to the other

• emsa.SA5-EMSA-Naming “Naming. Ask the patient to name your watch and pen (“What is the name of this object?”)” CHOICES: Normal-Patient clearly says “watch” or “pen” or gives brand name, Abnormal-Patient slurs words, says the wrong words (either one) or is unable to speak.

• emsa.SA6-EMSA-Repetition “Repetition. Ask the patient to repeat “They heard him speak on the radio last night” after you.” CHOICES: Normal-Patient remembers and clearly says the phrase when requested, Abnormal- Patient slurs words, says the wrong words, or is unable to speak

NOTES:

**If you answer “YES” to the suspected occurrence question (Do you suspect a new onset stroke/cva has occurred) then you will have to answer the other questions and the patient should be put into the Alabama Stroke System.

**If you are on a call and are cancelled, or other situations where there IS NOT PATIENT CONTACT, you should answer the suspected occurrence question (Do you suspect a new onset stroke/cva has occurred) with either “NO” or “UNKNOWN”. YOU MUST ANSWER THIS QUESTION FOR THE e-PCR to pass validation.

The EMSA Score is a number between 0 and 6. For every question answered “abnormal” the patient given 1 point. Completely normal is 0 points and any score greater than 4 is suspected of large

vessel occlusion (LVO) and may require thrombectomy. The scorable questions are contained in the EMSA card included below. NOTE: Copies of this card are available on request from the Alabama OEMS so it can be carried by individuals or placed on units for reference. The reporter is responsible for including the EMSA score of an applicable patient into the body of the narrative. The TCC operators began requesting the EMSA Score of a patient placed into the Statewide Stroke System on April 29, 2022.

EMSA (Emergency Medical Stroke Assessment) was developed by the UAB Department of Neurology. A video can be accessed in the following link: http://www.kaltura.com/tiny/xr3fh

Emergency Medical Stroke Assessment (EMSA)	
	Abnormal?
E: Eye Movement	
Horizontal Gaze Ask patient to keep their head still and follow your finger left to right with their eyes In aphasic patients, call the patient's name on one side and then the other Abnormal: Patient is unable to follow as well in one direction compared to the other	☐
M: Motor – Asymmetric Face, Arm, or Leg Weakness	
Facial Weakness Ask patient to show their teeth or smile In aphasic patients, look for asymmetric grimace to pain Abnormal: One side of the face does not move as well as the other	☐
Arm Weakness Ask patient to hold out both arms, palms up, for 10 seconds with eyes closed In aphasic patients, hold the patients arms up and let go Abnormal: One arm does not move or drifts down compared to the other	☐
Leg Weakness Ask patient to lift up one leg and then the other for 5 seconds In aphasic patients, hold up one leg and let go, then repeat on the other side Abnormal: One leg does not move or drifts down compared to the other	☐
SA: Slurred Speech or Aphasia	
Naming Ask patient to name your watch and pen Abnormal: Patient slurs words, says the wrong words, or is unable to speak	☐
Repetition Ask patient to repeat "They heard him speak on the radio last night" after you Abnormal: Patient slurs words, says the wrong words, or is unable to speak	☐

- ACUTE HEALTH SYSTEMS DOCUMENTATION

1. Alabama Trauma and Health System (ATHS)

Alabama is the only state in the United States with the capability to constantly monitor the status of every trauma hospital and route the trauma patient to the most appropriate hospital every time. The system was developed to reduce the societal burden of trauma and to save lives. The system itself collects data initiated by prehospital EMS and entered by participating hospitals. Review of prehospital EMS data is often done to perform quality assurance and quality improvement (QA/QI) for the Alabama Trauma System. Participating hospitals are granted a designated as a Level 1, 2 or 3 Trauma Hospital based upon available physicians and services. Level 1 Trauma Centers are the most capable to treat severe trauma.

The purpose of the ATHS is to maximize care for trauma patients with "The Golden Hour" of the case. Patients who meet Alabama Trauma and Health System inclusion criteria should be "put into the system" by the prehospital EMS team initiating care at the scene by calling the ATHS Central Operator at 1-800-359-0123. The operator will then advise the most appropriate destination to treat the patient's condition at the time of entry. Inclusion criteria and entry instructions are listed in the Acute Health Systems/Trauma System protocol on pages 14-16 of the 10th Edition of the Alabama EMS Patient Care Protocols available online at the Alabama OEMS website.

Documentation concerns for Trauma System entry are as follows:

The e-PCR has two elements that should be filled when the TCC operator is called, and a trauma number is given; eOutcome.03 (External Report ID/Number Type) should be selected as "Trauma Registry" and eOutcome.04 (External Report ID/Number) should be the number given by the ATCC operator (will be 6-7 digits long). The e-PCR also has element eInjury.03 which should be a dropdown box with the criteria for transport to a trauma center. This field should be populated with criteria requiring entry into the Trauma System.

2. Alabama Statewide Stroke System

The Alabama Statewide Stroke System was activated on October 30, 2017. The system works similarly to the Trauma System, with the goal to be routing of the patient to the most appropriate facility for the patient's condition and early recognition of large vessel obstruction which may require surgical intervention. Participating hospitals are designated as Level 1, 2, or 3 depending upon stroke treatment capabilities (physicians and services available).

The Emergency Medical Stroke Evaluation (EMSA) elements were integrated into the Alabama e-PCR as custom elements (as described above) to facilitate patient entry into the Stroke System. If the first element, Suspected Occurrence of Acute Strove, is recorded as "yes" then the patient care provider is expected to have called the Central Operator at 1-800-359-0123 and entered the patient into the Stroke System and to have received a number. The operator will route the ambulance to the most appropriate destination hospital, call for helicopter EMS to transport if necessary, and alert the destination hospital as done with severe trauma patients. Inclusion criteria and entry instructions are listed in the Acute Health Systems/Stroke System protocol on pages 17-18 of the 10th Edition of the Alabama EMS Patient Care Protocols available online at the Alabama OEMS website.

The e-PCR has two elements that should be filled when the ATCC operator is called, and a stroke number is given; eOutcome.03 (External Report ID/Number Type) should be selected as "Stroke Registry" and eOutcome.04 (External Report ID/Number) should be the number given by the ATCC operator (will be 6-7 digits long). This is in addition to the completion of the EMSA elements as described above. The EMSA score (0-6) should be recorded within the narrative as being the "EMSA Score = "if the patient is suspected of having an acute stroke.

3. The Alabama Statewide Cardiac/STEMI System

CARES
The Alabama Department of Public Health (ADPH) and the Office of Emergency Medical Services (OEMS) have partnered with Cardiac Arrest Registry to Enhance Survival (CARES) to measure and improve outcomes statewide from out of hospital cardiac arrest. Extra documentation is not required for the CARES system to work.

STEMI System
A system like the Trauma and Stroke Systems is projected and under development to maximize treatment of ST-elevation myocardial infarction cases encountered in the prehospital environment. Prehospital care providers would utilize 12-lead electrocardiography and contact the ATCC operator to be routed to the most appropriate facility to treat the patient's condition. The drop-down box for eOutcome.03 (External Report ID/Number Type) can possibly contain a 14 choice "STEMI Registry" but it is not yet used statewide as the Statewide STEMI System is not yet operational. The Birmingham Regional EMS System (BREMSS) currently has a region-specific STEMI system that may and should use those elements.

- BEST PRACTICES NARRATIVE DOCUMENTATION

Narrative documentation is neither straightforward or standardized in either EMS training or quality assurance and improvement programs within most Alabama EMS services who submit e-PCRs. The following is an overview of functions that the narrative section of e-PCR performs and various preferred approaches to write narratives.

1. Function of the Narrative Section

Elements of an e-PCR record and timestamp assessments, procedures, medication administrations and record the response of the patient to each procedure and medication. Each procedure and administration are recorded under its own unique identification number. The elements are primarily used to count and categorize actions, for example, the number of naloxone administrations in a period for a certain area. Compliance requires that all assessments, procedures, and administrations be recorded in the appropriate elements.

The narrative section of an e-PCR tells the complete story of a scene response and patient care situation. It is likely the least understood part of the e-PCR. The e-PCR elements can tell a reader what was done and when it was done, but they cannot convey "why" it was done. Any patient care intervention must be done secondary to an "indication" (reason) for that intervention. Every EMS Provider makes dozens of complex decisions on every call, based upon personal scope of practice, training, and experience. Appropriate decisions are frequently made which cannot be validated by information in a drop-down menu. A wise EMS Provider gives rationale for decisions made to enact treatment and transport of a patient. The best use of the narrative is the following:

THIS IS WHAT I OBSERVED <-> THIS IS WHAT I DID <-> THIS IS WHY I DID IT
OBJECTIVITY IS THE KEY TO GOOD DOCUMENTATION

As the Patient Care Report serves as a prehospital medical record, treatment criteria must be carefully documented to validate billing for services provided. Similarly Patient Care Reports serve as a legal record for events that occurred on the call and may be used in legal processes to validate the legality and necessity of actions of EMS providers on the scene. Least obviously, Patient Care Reports are used in Quality Assurance and Quality Improvement processes at the individual, service, city, county, region, state, and federal levels.

2. Approaches to Writing the Narrative

A professional narrative should be thorough. It should contain specific information pertaining to the observation of situation, signs, symptoms, histories, and complaints; as well as any precautions taken, and any interventions or treatments administered. Many e-PCR platforms will assist the reporter by placing data into the narrative. Many experienced reporters just use an acronym to chart their own written thoughts in a concise flowing manner. Many use a combination of the two methods cut save time while maximizing recorded information. Whether or not an automated feature is utilized the narrative should be reviewed thoroughly and edited to ensure that the 15 language is accurate, is readable and is EXACTLY what the reporter wants on the report to provide facts that are accurate, defendable, and objective. Always remember that your professional capacities and reputation are represented by what you write and approve for submission.

1. Common Acronyms Used in Narratives

   Generally, all aspects of a narrative should be accomplished in complete sentences with appropriate punctuation. Remember, if you write like you are unprofessional you will look unprofessional while you are defending your actions in court. Also, any narrative format should start with the “who, what, where, when and why” of the dispatch process as well as a description of what was found upon scene arrival, EVEN in cases of being cancelled on a scene.

- S.O.A.P. NARRATIVE (Some variations exist.)
  - Subjective – History of the incident. Why you were called. What you are told. How the patient described their symptoms. Dispatch information and your perception of the scene.
  - Objective – Comments are added in including your assessment findings, vehicle damage or other observations, patient positioning, viral signs (at least, initial vital signs) EKG findings and other non-opinionated facts.
  - Assessment – Your differential diagnosis (what you believe you are treating and what you believe you are ruling out).
  - Plan – What you did to treat your patient (interventions, IVs, medications) include what (if any) was done prior to your arrival, what was done on scene and what was done in transport.

- C.H.A.R.T. NARRATIVE (Some variations exist.)
  - Complaint – Chief complaint (If patient’s own words, use “quote-unquote” format – use quotation marks).
  - History – History of the present illness. Patient’s recent medical history. Patient’s chronic medical history. Any pertinent history is outlined.

- Assessment - Your differential diagnosis (what you believe you are treating and what you believe you are ruling out).
- Rx – The patient's prescriptions are listed.
- Treatment - What you did to treat your patient (interventions, IVs, medications) include that (if any) was done prior to your arrival, what was done on scene and what was done in transport.

- D.R.A.A.T.T. NARRATIVE (method advocated by Page, Wolfberg and Wirth – National EMS Law Firm and used herein with permission.)
  - Dispatch – Dispatch information given. Your location when response began.
  - Response – Mode of response. Notations of response process (obstructions, etc.).
  - Arrival – Arrived on scene to find. Notations of arrival and observations.
  - Assessment – Observations, differential diagnosis, etc.
  - Treatment – What you did to treat your patient (interventions, IVs, medications) include what (if any) was done prior to your arrival, what was done on scene.
  - Transport – Documentation of aspects of transport to facility, including treatments, observations, and issues.

- (Assessment Mnemonic) M.U.R.D.E.R.S.I.N.C. Systems Review Assessment
  A review of each body system can be used under the "Assessment" of any mnemonic to indicate either normal or abnormal findings for each body system. Normal findings can be listed as "normal" or "unremarkable". Use of this approach documents that each specific system was considered in assessment.
  - Muscular System –
  - Urinary System –
  - Reproductive System –
  - Digestive System –
  - Endocrine System –
  - Respiratory System –
  - Skeletal System –
  - Integumentary System (skin) –
  - Neurological System –
  - Circulatory System –

  The Systems Review Assessment is also useful for reminding the reporter to ask questions regarding the system. For example, for Musculoskeletal System the assessor would note the development of the muscles. Are they equivalent on either side or is there hypertrophy from exercise or is there atrophy from lack or inability of use? Similarly, for the Urinary System review, if the chief complaint is not urinary pain or other obvious issue, the examiner can ask about changes in urine output including volume, color, smell, or discomfort during urination. A review of the Reproductive System asks a male about any reproductive issues, such as erectile dysfunction and whether any medication is used for that (very important if the patient is experiencing chest pain or symptoms of M.I.). The same for a female asks about the possibility of pregnancy, any history of pathology or surgeries, how many pregnancies have occurred, how many miscarriages and how many live births have occurred

2. Common Problems with Narrative Documentation

- Narrative Conflicts with An Element
  - Reporters sometime report something in the narrative that directly disputes the indicated data of an element. For example, the elements that report the Glasgow Coma Score (GCS) are eVitals.19 through eVitals23 are defaulted at "normal" and the reported GCS = 15. The reporter describes the patient's level of consciousness as "responsive to pain". The data conflicts.
  - The result of conflicting data in a court will depend upon what the basis of the hearing is. The presence of conflicting data is like the presence of conflicting statements given in testimony in court. The conflicting information can bring the reliability, quality, and judgement of the reporter into question. This inference can affect the case of the litigating parties and may weaken the case of an EMS professional answering to defend their own actions in the field.
  - The e-PCR reporter can avoid conflicting statements by carefully reviewing all elements used and all verbiage in the narrative for correctness and appropriate content prior to submitting the e-PCR.

- The Automated Narrative Feature "Muddies" the Narrative
  - Automated narrative devices used within e-PCR platforms are designed to place data from e-PCR elements into the narrative to assist in writing the story of the patient care process. Their use ranges from very helpful to detrimental to the narrative.
  - Proper use of automated narrative features requires a careful review of the narrative section of an e-PCR prior to submission into the EMS Data Repository. Any extraneous text that may be generated into the narrative field should be edited out prior to submission.
  - EXAMPLE OF COMPLETE DATA AND RESULT:
    - eVitals.19 (Glasgow Coma Score-Eye) = No Eye Movement = 1
    - eVitals.20 (Glasgow Coma Score-Verbal) = No Response = 1
    - eVitals.21 (Glasgow Coma Score-Motor) = No Response = 1
    - eVitals.23 (Total Glasgow Coma Score) = 3
    - Possible Narrative Generation: "The patient exhibited NO eye movement, NO verbal response and NO motor response. Total Glasgow Coma Score = 3."
  - EXAMPLE OF INCOMPLETE DATA AND RESULT:
    - eVitals.19 (Glasgow Coma Score-Eye) = (UNFILLED)
    - eVitals.20 (Glasgow Coma Score-Verbal) = (UNFILLED)
    - eVitals.21 (Glasgow Coma Score-Motor) = (UNFILLED)
    - eVitals.23 (Total Glasgow Coma Score) = (UNFILLED)
    - Possible Narrative Generation: "The patient exhibited Total Glasgow Coma Score = ."
  - Automated narrative inserts are specific for individual e-PCR platform software and are often generated by selection of a "button" by the reporter. The actual range of inserted content can usually be preprogrammed. If they are available to the reporter, and especially if they are chosen to be used by the reporter, the text should be reviewed, and any nonsensical text removed prior to "final saving" the report and submitting it to the EMS Repository.

- Terse (short/too short) Narratives
  - Narratives are meant to be descriptive, easily reviewable summaries of the unit's response, approach to and completion of patient care.
  - Statements within narratives should describe the who, what, when, where, and why of the EMS response. Statements that are too short are not beneficial for the crew involved, for the clinicians or investigators reviewing the record, or the patient. The e-PCR is the State's legal record of the crew's call to action, duty to act, and disposition of the patient.
  - Criteria describing the patient's condition, assessment findings, observations, treatments, and results should be indicated by the elements of the e-PCR and then summarized within the narrative for quick evaluation by a reviewer of the record. Reviewers may include clinicians, investigators, and attorneys.
  - Description should be in complete sentences with appropriate grammar. Abbreviations were previously accepted on hand-written narratives because of space constraints. Electronic narratives typically do not have a maximum character count; thus, abbreviations are neither necessary nor acceptable.

3. Overview of Uses for the Narrative

   - Quick Reference for Clinicians
     - Upon completion and submission of the e-PCR the destination hospital has access to the electronic record through the RESCUE EXCHANGE system (if the appropriate facility ID code was included on the e-PCR). The record then becomes available for the physician team to review to determine what findings and interventions occurred during the treatment and transport process.
     - Physicians throughout the state have requested that some written form of record be made available at the time of transfer of patient. Use of a written note sheet is completely acceptable for this purpose and many ambulance services already use such note sheets. The OEMS is in the process of developing a note sheet for this purpose for distribution. ANY WRITTEN NOTE SHEET WILL NOT REPLACE THE PROCEDURAL USE OF AN E-PCR ON EVERY RESPONSE.
     - The narrative provides a summarized statement of treatments performed and observations made that many clinicians use to guide their in-hospital treatments of patients.

   - Quick Reference for Insurance Payors
     - The basis of successfully filing for insurance payment for EMS services is the accurate reporting of indications, interventions, and responses on EMS reporting documents.
     - Mandatory refiling and review processes are often associated with insufficient and vague charting of rationale and services provided to insurance clients. Repetitive processes serve to slow down payment flow and to increase the costs of filing with avoidable repetition.
     - Insurance adjusters and investigators often center their documentation review of patient care performed on the narrative section of the e-PCR. The necessary documentation may exist in the elements section of the report but may be inadvertently missed by reviewers resulting in an extended or repeated review process for the individual call.

- Quick Reference for Medico-Legal and Investigators
    - In a legal review, if the reporter did not write an action down its completion will remain in question. ("If you didn't write it down you didn't do it.")
    - Observations of EMS personnel are often important in determining safety of a scene. Those observations should be recorded in situations where probable crime investigations will occur. Such situations include, but are not limited to, murders, suicides, assaults, accidents, etc.
    - Any observation made that affects decisions, or may reasonably be questioned later, should be recorded.
    - Generally, it is preferable to have recorded an observation unnecessarily than to have omitted an observation that should have been recorded.

☐ BEST PRACTICES FOR ELECTRONIC SUBMISSION

- Contracted e-PCR platforms are responsible (per NEMSIS) for provision of a feature that validates/indicates that a written e-PCR will pass Alabama's (or, nationwide, the state of operation) Schematron. Technically an e-PCR should not be allowed to submit unless it will pass the state's Schematron.
- Services have the option to set their submissions for either immediate submission by the reporter or delayed submission pending supervisor review. No matter which method is used the Emergency Medical Provider Service is responsible for assuring that an electronic patient care report is submitted to the Alabama EMS Repository for any response their service performs, and that the e-PCR is submitted within the required time period.
- Alabama OEMS provides several free platforms which can be used by Emergency Medical Provider Service supervisory staff to monitor the e-PCR submission and to explore the dynamics of the data recorded by their Service.
    - Submission Summary Email
        - May be requested by any Alabama licensed Emergency Medical Provider Service.
        - Received automated email on Monday mornings at 07:00 with number of unique e-PCRs received in previous seven days (previous Monday at 00:00 to Sunday night at 23:59). Should be compared to run logs for same time period.
        - May designate two recipients per EMPS.
    - Alabama NEMSIS V3 Submission Website
        - May access and download State-form copies of e-PCRs.
        - May lookup e-PCRs by Dispatch Notified Date, Incident Address, Incident #, PCR #, or submission times.
        - May search for e-PCRs by Crew Member ID (License Number), Recorded Disposition, Incident Number, ATCC Number, Date of Incident (Range) Incident Street Address, Incident City, Incident County, Patient Data (SSN. Date of Birth, Age, First Name, Middle Name, Last Name, Destination Code and Dispatch Complaint).
        - May review submission groups (submitted e-PCRs by groups submitted).
        - May review submission statistics (report counts, passes and fails).

- NEMSIS Data Portal (Dashboard)
    - Has preset tools set up to review and cou8nt Incident Data, Medication Data, Procedure Data and Report Submission Data.
    - May download counts and statistics in EXCEL sheets.
    - May download graphs in differing formats.
    - Has presentation graphs that may be copied and pasted into performance reports.
    - IS DESIGNED TO AID IN WRITING REPORTS FOR REVIEWS, QA, QI, ETC.

☐ SUMMARY

1. The electronic patient care report (e-PCR) is the legally required record of a unit's response to a call for help. Each e-PCR records the disposition of the service and individual-level duty to act and the patient/patients involved.
2. An e-PCR must be written and submitted for all EMS responses.
3. It is the legal responsibility of the unit's crew to complete an appropriate e-PCR for any response upon which they are dispatched or answer.
4. It is the legal responsibility of the Emergency Medical Provider Service (EMPS) to provide a platform for the purpose of e-PCR completion and submission for their member's employment-related and assigned responses. It is further the responsibility of the EMPS to assure that all employment-related e-PCRs are completed and submitted within the time limits of the EMS rules.
5. The elements of the e-PCRs are designed to quickly record data that are descriptive of the parameters of the response, which can be used to categorize findings and create an individual record for a procedure/medication administration, and which do not require verbiage to explain.
6. The narrative of the e-PCR is designed to "tell the story" of the response and disposition of the response and describe the responder's rationale for decisions made and actions taken. It summarizes the call in a way that can be reviewed by clinicians, insurance personnel, law enforcement personnel or attorneys to explain the steps taken by responders to best care for a patient's interests and to meet the requirements of the standard of care for the situation. The narrative is considered the most important aspect of the e-PCR. It is a text box and can contain a virtually unlimited amount of text, making it for superior to previous hand-written reports. <u>The quality of the narrative is often used to judge the competence and ability of the crew</u>.
7. Several free-access electronic tools are made available to Alabama-licensed Emergency Medical Provider Services upon request to enhance EMPS surveillance of its electronic reporting and to aid with quantification of data for the purpose of QA, QI and response reporting.

420-2-1-.21 Patient Care Reporting.

(1) The EMSP providing patient care is responsible for the completion and submission of an electronic Patient Care Report(e-PCR) to the emergency medical provider service within 24 hours.

(2) Each emergency medical provider service shall ensure that an accurate and complete e-PCR is completed and submitted to the OEMS within the required time frames, and use software approved by the OEMS' Director.

(3) Each provider service shall provide a copy of the patient care report to the receiving facility as soon as reasonably possible. In no instance should the delivery of the report exceed 24 hours.

(4) Records and data collected or otherwise captured by the Board, its agents, or designees shall be deemed to be confidential medical records and shall be released only in the following circumstances:

(a) Upon a patient's presentation of a duly signed release.

(b) Records and data may be used by Department staff and staff of other designated agencies in the performance of regulatory duties and in the investigation of disciplinary matters provided that individual patient records used in the course of public hearings shall be handled in a manner reasonably calculated to protect the privacy of individual patients.

(c) Records and data may be used by Department staff and staff of other designated agencies in the performance of authorized quality assurance and improvement activities.

(d) Existing records, data, and reports may be released in any format in which they appear in the Department's database in response to a valid subpoena or order from a court of competent jurisdiction.

(e) Data may be compiled into reports by an emergency medical provider service from the respective emergency medical provider service's collected records.

(f) Aggregate patient care report data may be released to the public in a format reasonably calculated to not disclose the identity of individual patients or proprietary information such as the volume of non-emergency calls undertaken by an individual provider service or insurance and other reimbursement related-information related to an individual provider service.

(g) Records and data shall be disclosed as required by federal and state law.

(h) Any individual or entity designated by the OEMS as having authority to collect or handle data that withholds or releases data or information collected in a manner not pursuant to these rules shall be subject to disciplinary action.

(5) Any individual or entity that is not compliant with the disclosure aspects of this rule is subject to loss of licensure or prosecution under these rules.

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Statutory Authority: Code of Ala. 1975, §22-18-1, et seq.

History: New Rule: Filed September 20, 1996; effective October 24, 1996. Amended: Filed March 20, 2001; effective April 24, 2001. Repealed and New Rule: December 17, 2007; effective January 21, 2008. Repeal and New Rule: Filed March 16, 2017; effective April 30, 2017. Repeal and New Rule: Filed February 20, 2019; effective April 6, 2019. Repeal and New Rule: Filed April 7, 2020; effective June 14, 2020. Repeal and New Rule: Filed February 17, 2022; effective April 14, 2022.

Alabama Office of Emergency Medical Services
Patient Care Reporting Guidelines
Addendum
Updated May 12, 2026

BACKGROUND FOR ADDENDUM

Existing Guidelines delineate various aspects of appropriate reporting and an overview of the Alabama e-PCR and NEMSIS process. Specific mention is not made regarding complete reporting of procedures or medications. This Guidelines Addendum is designed to supplement the original Patient Care Reporting Guidelines updated January 12, 2024.

PROCEDURE DOCUMENTATION

A "Procedure" is any application of care, monitoring, stabilization, etc., for the purpose of patient care. Procedures are recorded in the structure of the e-PCR in the elements eProcedures.01 through eProcedures.13 . These elements are accessed in the electronic form by accessing a "Procedure Box" which generally involves a series of "Drop-Down Menus" to give the field provider a list of choices. Generally the data involved in a Procedure Box include, but are not limited to, Date/Time, Whether Procedure was prior to the EMS unit's arrival, the Procedure performed, equipment size (e.g., ET tube size), the number of attempts made, whether the application/placement was successful, complications resulting, patient response to procedure applied, crewmember applying procedure, role of that crewmember, procedure authorization (protocol, on-line, written, etc.) authorization/physician, and vascular access location-if any.

MEDICATIONS DOCUMENTATION

A "Medication" is any chemical agent administered to a patient in the process of patient care. They are recorded in the elements eMedications.01 through eMedications.12 in a Drop-Down box almost identical to the Procedures box. Generally the data involved in a Medications Box include, but are not limited to, Date/Time, Whether Medication was administered prior to the EMS unit's arrival, the Medication administered, Medication dose and dosage units (e.g., Epinephrine 1:10,000 at 1 mg), response to Medication, complications resulting, crewmember administering Medication, role of that crewmember, Medication authorization (protocol, on-line, written, etc.) authorization/physician, and route of administration of the Medication.

APPLICATIVE PROCESS OF DOCUMENTATION

- Element ePatient.13 (Gender) was ordered deprecated by the Federal government. ePatient.25 (Sex) was designed to replace it. Replacement was directed by implementation of Critical Patch 6 with required go live in November 2025. Alabama will continue to accept ePatient.13 but (1) Patient care MUST be accompanied by use of ePatient.25 (Sex) AND (2) Sex and Gender must MATCH, e.g., a biological male who identifies as a female on ePatient.13 MUST be listed as "male" in ePatient.25.
- Vital Signs are recorded in elements eVitals.01 through eVitals.33 in their own Drop-Down Box in a similar fashion to Procedures and Medications. Vital signs measurement CAN be documented as a Procedure but IS NOT required to be recorded as a Procedure but MUST BE recorded in a Vital Signs box. Two sets of vital signs must be recorded on ANY patient who is transported to a medical care facility and are recommended on ANY patient transported home or evaluated in cases of refusal of care. Vital signs should be at least five minutes apart. Best practice for patients in routine transports are to take a set when leaving the first facility and a second set upon arrival to home or the destination facility AND AT LEAST one set every thirty minutes in transit.
- Invasive Airways are recorded in elements eAirway.01 through eAirway.10 and MUST ALSO BE recorded as a Procedure.
- Medical devices (e.g., ECG monitoring or waveform capnography) are recorded in elements eDevice.01 through eDevice.12 in similar fashion to Procedures and Medications and MUST ALSO BE recorded as a Procedure.
- Oxygen is often disregarded as medication but is a medication when administered by EMS. Oxygen administration must be recorded as a Procedure, which clarifies the route of administration (e.g., "oxygen administration by mask") and MUST ALSO BE recorded as a Medication. The Medication drop-down IS ONLY USED if the oxygen belongs to the unit writing the e-PCR.
- Medications are used by EMS in patient care in either of two broad categories. (1) The medication is a normal stock item within the unit's drug box. (2) The medication was supplied to the care provider/report writer's unit by another agency or the sending hospital for an interhospital transport. Any administration of a medication MUST be recorded as a procedure. **The Medication drop-down IS ONLY USED if the medication belongs to the unit writing the e-PCR.**

SPECIAL CONSIDERATIONS

BLOOD & BLOOD PRODUCTS

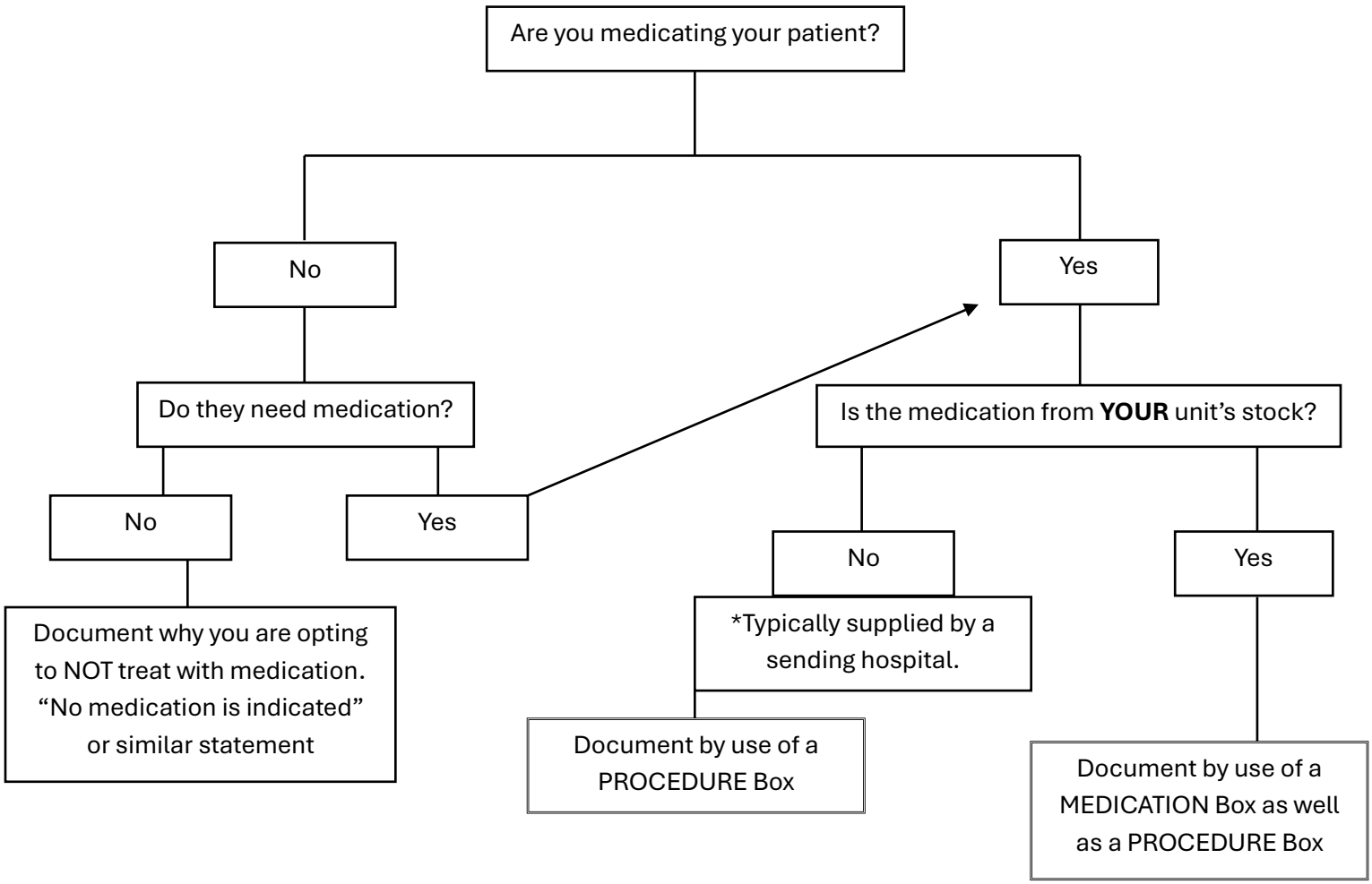
- Blood or blood products administered from the stock of a Critical Care Transport unit MUST be recorded in the Medication drop-down box.
- Blood or blood products supplied by a sending hospital for the purpose of an Interhospital Transport to a destination hospital SHOULD NOT be recorded on a Medication drop-down box but SHOULD be recorded as a procedure.

PREHOSPITAL CHILDBIRTH

- If the crew performs the delivery of an infant in the prehospital environment, the Prehospital Childbirth Delivery MUST be recorded in the Procedures drop-down box with the time of delivery **accurately** recorded in the eProcedures.01 (Date/Time Procedure Performed) element of that procedure box. The eProcedures.01 entry will serve as record of the patient's birth date and time (for vital statistics purposes).
- In situations where prehospital childbirth occurs, the crew is considered to have an additional patient for each newborn delivery and are required to complete an e-PCR for each patient.

GENERAL CONSIDERATIONS

- An applicative protocol should be selected based on the discretion of the prehospital provider writing the report/primary patient care provider.
- That individual MUST sign the report by affixing his/her license number to the appropriate element eOther.08 (Crew Member Completing This Report).
- All procedures recorded MUST include the "Procedure Crew Members ID" in element eProcedures.09, which in Alabama is the member's EMS License Number.
- All medications administrations recorded MUST include the "Medication Crew (Healthcare Professionals) ID" in element eMedications.09, which in Alabama is the member's EMS License Number.



Medications to be documented (ALL listed in Alabama Protocols) to include but not limited to:
acetaminophen, adenosine, albuterol, albuterol/ipratropium (DuoNeb), amiodarone, aspirin, atropine, blood/blood products, calcium chloride, calcium chloride/lactate/ potassium chloride/sodium chloride, calcium gluconate, cefazolin, ceftriaxone, clevidipine, dexamethasone, diazepam, diltiazem, diphenhydramine, dobutamine, dopamine, epinephrine 0.1 mg/ml, epinephrine 1 mg/ml, esmolol, etomidate, famotidine, fentanyl, furosemide, glucagon, glucose, glucose 100 mg/ml, glucose 200 mg/ml, glucose 500 mg/ml, haloperidol, heparin, hydralazine, hydrocortisone, hydromorphone, hydroxocobalamin, ketamine, ketorolac, labetalol, levalbuterol, levetiracetam, lidocaine, lorazepam, magnesium sulfate, mannitol, methylprednisolone, metoclopramide, metoprolol, midazolam, morphine, naloxone, nicardipine, nitroglycerin, nitroglycerin injectable, nitroprusside, nitrous oxide, norepinephrine, ondansetron, **oxygen**, oxytocin, pancuronium, phenylephrine, promethazine, propofol, racemic epinephrine, rocuronium, sodium bicarbonate, sodium chloride 30 mg/ml, sodium chloride 9 mg/ml injectable, sodium chloride 9 mg/ml injectable prefilled syringe, succinylcholine, terbutaline, thiamine, ticagrelor, tranexamic acid, vasopressin, vecuronium, vitamin K1, ANY injectable IV fluid.

NOTE: Oxygen should be documented by medication box (from stock) and procedure box.
NOTE: Document why the medication is indicated. Example "Oxygen administered to treat possible hypoxia / shock" or "Lorazepam administered due to tonic-clonic seizure activity"