dCHARTE

As we all know, the largest liability risk (second only to vehicle collision) to EMS and to us personally occurs with patient non-transport. Thorough and complete documentation is essential to minimize this risk. Documentation ***must*** include patient demographics, complete vital signs ***with*** times, medications and allergies and a complete “dCHARTe” format narrative that includes:

d

- Dispatch information

C

- Age
- Gender
- Complaint(s)

H

- History of present illness
- Past medical history

A

- Complete assessment

R

- Care/treatment on scene

T

- Transport information (ie. No ambulance transport)

E

- Exceptions
    - Why did patient refuse transport?
    - How/why the patient meets ***all*** refusal criteria.
    - MCEP contact and MCEP direction if the patient does not meet ***all*** refusal criteria.
    - Any advise or cautions shared with the patient (SXS to look for, risks [up to and including death] associated with refusing transport, wound care, PCP follow-up, etc)

One patient per report, every refusal requires a complete report..