Base Hospital and Receiving Center Reports

I. PURPOSE

This policy is to establishes guidelines for essential communication between EMS field providers and receiving facilities. These guidelines pertain to communication prior to arrival at an approved receiving hospital, during communication with the Base Hospital, or during patient care turn over.

II. POLICY

A. The person with the most knowledge of the patient's complaint and current condition will communicate with the receiving hospital or Base Hospital. This will usually be the provider with primary patient care responsibilities. During multi-patient events, this may be the transportation group supervisor or the Incident Commander designee.

B. Receiving hospital reports, including Base Hospital contact, allow the receiving hospital to prepare the appropriate bed, equipment, and personnel to care for the needs of the patient.

C. There are many different formats for giving report including SOAP, SAMPLE, MIVT and SBAR. This policy addresses the minimum acceptable information to be communicated, regardless of the report format utilized.

D. When possible, it is important to keep pre-arrival reports brief and concise.

III. PROCEDURE

A. Receiving Hospital Report:

Receiving hospital communication reports are designed to inform the receiving hospital (Base Hospital or otherwise) of incoming patients. Receiving hospital communication reports should contain:

1. EMS unit identifier, nature/type of call, and if applicable specialty alert notification (i.e. STEMI/Stroke/Sepsis);
2. State urgent concerns/level of concern up front;
3. Patient's age, sex, chief complaint, and level of consciousness/GCS;
4. Brief history of current complaint;
5. Medical history, medications, allergies, and physical findings pertinent to the patient's current medical complaint;
6. Vital signs;
7. Any treatment and response; and
8. ETA to receiving hospital.

B. Base Hospital/Trauma Report:

The Base Hospital may be contacted for a variety of reasons including treatment guideline variation, cessation of efforts and high risk patient refusals. When contacting the Base Hospital, the report should include everything outlined in the receiving hospital report in addition to the following:

Trauma Patients:

1. **M**echanism of injury, including either highway or surface street speed, seatbelt use/airbag deployment, and if extrication required;

2. **I**njuries;
3. **V**ital Signs, including GCS; and
4. **T**reatment, including any spinal motion restriction including, tourniquets placed and estimated blood loss.
5. 5-minute Update:

   The five (5) minute update call should be made when the ambulance is five (5) minutes from the trauma center and should include expanded patient information, including significant changes in vital signs, mental status, physical findings or symptoms.

C. For all other Base Hospital communication, utilize the receiving hospital report format and include the following when applicable:

1. Reason for call (e.g., AMA, additional orders, field treatment guideline variation, Physician on Scene, etc.);
2. Level of Concern; and
3. Destination if other than the Base Hospital

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V. SBAR REPORT

Destination	Activation	Medical
Adult Patients **Agency, Unit, Age, Gender, Type of Call** *(This is Medic 1 with a Twenty-Six, 2-6 year old Male trauma activation)*		
Pediatric Patients **Agency, Unit, Age, Gender, Type of Call** *(This is Medic 1 with a Pediatric Six, 0-6 year old Female requesting trauma destination)*		
	Activation or Destination	**Medical**
Situation **(Mechanism)**	MVA: • Speed (Known MPH and/or Freeway or City Streets) • Type of Impact (roll over, head on, rear end, etc.) • Type of vehicle (Newer model or older model) • Patient Compartment Intrusion/steering wheel intact/ Airbags deployment/restrained driver Motorcycle: • Speed (Known MPH and/or Freeway or City Streets) • Protective Clothing (Helmet, Jacket, etc.) Fall: • Distance, surface, Blood thinners? Assault: • Object • Impact area	• What is the situation? • State urgent issues and immediate needs up front!
Background **(Injuries)**	**Physical Assessment** **EXPOSE AND PALPATE!** **Kill Zones**: Head, Neck, Chest (Anterior & Posterior) Abdomen, Pelvis, Femurs.	• What has happened up to this point? • What past history would be important to know for further patient treatment?
Assessment **(Vital Signs)**	Airway, Breathing, Circulation **Activation**: ABC's, GCS, Pulse, Respirations, Skin signs, Pupils. **Destination**: Full Set of Vitals including: Blood pressure, pulse, respirations, GCS, SpO_2, skin signs, BGL, ECG, lungs and pupils)	• How is the patient now? • Full Set of Vitals including any ECGs • Stable or unstable?
Rx/Tx Recap **(Treatment)**	**Key Treatments** (SMR, medication administered, advance airway, tourniquets, splints, etc.)	• Treatment the outcome? • Concerns?
ETA	ETA to the closest, most appropriate trauma center or Destination decision should be made by MD based on information given. Provide requested hospitla during report	ETA to the appropriate receiving hospital