Pocket Paramedic

History Taking And Diagnosis Pocketbook 2.0

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Medical Model of History taking

(Formulate your history taking structure using this model)

Presenting complaint - brief description e.g. chest pain, breathing difficulties, abdominal pain.

History of Presenting Complaint - detailed description of presenting complaint, base your questions around SOCRATES/SOCATE.

Past Medical History - what existing health problems does the patient already have?

Medications - what medication does the patient take?

Social History – lifestyle, smoker, alcohol consumption, drug use, living situation, carers, DoLs in place, DNR.

Family History - any health conditions that run within their family e.g. heart disease, stroke, diabetes.

Review of Systems – ask specific questions relating to all bodily systems (see next page)

Review of systems

(perform a systems review relevant to the presenting complaint)

General:
fever, rigors, weight loss, fatigue, bruising, rash

Neurological:
headaches, dizziness, vision problems, FAST symptoms, photophobia, neck stiffness, non-blanching rash, LOC, weakness, numbness, tingling, fits.

Cardiorespiratory:
chest pain, SOB /wheeze, cough/sputum (blood-stained?), palpitations, lower limb pain/swelling.

Gastrointestinal:
abdominal pain, back pain, nausea/vomiting (haematemesis?) bowel habit change, blood or mucous in stool, dysphagia (inability to swallow).

Urological:
frequency, volume, painful to pass, haematuria, increased urge.

Musculoskeletal:
Joint pain, stiffness, swelling.

Skin:
Pale, clammy, sweaty, bruises, lacerations, rash.

Gynaecological:
PV bleed/discharge, chance of pregnancy, sexually active, LMP, LMP normal, contraceptive use.

SOCRATES can be used as a history taking prompt when the presenting complaint is related to pain:

S - Site
Where is the pain?

O - Onset
When did it start?
What were you doing when it came on?

C - Character
Can you describe the pain you're experiencing?

R - Radiate
Does the pain move anywhere else?

A - Associated Symptoms
Do you have any other symptoms?

T - Timing
Is the pain constant or intermittent?

E - Exacerbating/Relieving
Does anything make the pain improve or get worse?

S - Severity
Can you score the pain out of 10?

SOCRATES CAN BE ADJUSTED TO SOCATE FOR NON PAIN RELATED SYMPTOMS:

S - SYMPTOM/SITUATION

WHAT'S THE REASON FOR YOUR CALL TODAY?

O - ONSET

WHEN DID THIS START?
WHAT WERE YOU DOING WHEN IT CAME ON?

C - CHARACTER

CAN YOU DESCRIBE HOW IT FEELS?

A - ASSOCIATED SYMPTOMS

DO YOU HAVE ANY OTHER SYMPTOMS?

T - TIMING

CONSTANT OR INTERMITTENT?

E - EXACERBATING/RELIEVING

DOES ANYTHING MAKE IT IMPROVE OR GET WORSE?

HEADACHE

HEADACHE HISTORY TAKING QUESTIONS

Site: where exactly in your head is the pain?

Onset: when did it start? what were you doing when it started?

Character: can you describe the pain you're experiencing?

Radiate: does the pain move anywhere?

Associated Symptoms:
-dizziness?
-vision or speech problems?
-numbness/altered sensation in face or limbs?
-facial droop?
-unilateral limb weakness?
-new onset of Confusion?
-LOC?
-seizure activity?
-photophobia? /neck stiffness? /non-blanching rash?
-is there a history of trauma to the head?
-if yes, is your patient taking anticoagulant medication?

timing
- is the pain constant or intermittent?

exacerbating and Relieving factors
- does anything make the pain better or worse?

severity
- on a scale of 1-10 where would you score your pain?

SINISTER HEADACHES

CVA (STROKE) - MAIN SYMPTOMS: FACIAL DROOP, SLURRED SPEECH, SUDDEN INABILITY TO PRODUCE OR UNDERSTAND SPEECH/INAPPROPRIATE WORD SELECTION, UNILATERAL ARM AND/OR LEG WEAKNESS, PARALYSIS OF ONE SIDE OF THE BODY.

OTHER POSSIBLE SYMPTOMS THAT MAY ACCOMPANY THE ABOVE: HEADACHE, FACIAL OR LIMB NUMBNESS/ALTERED SENSATION, DYSPHAGIA, DIZZINESS, CONFUSION.

TIA - CVA SYMPTOMS THAT HAVE SELF-RESOLVED.

SUBARACHNOID HAEMORRHAGE - SUDDEN SEVERE THUNDERCLAP HEADACHE. CAN ALSO BE ACCOMPANIED BY: VOMITING, CVA SYMPTOMS, LOC/REDUCED GCS (NOTE: SEVERITY OF SYMPTOMS CAN VARY).

MENINGITIS/ENCEPHALITIS – HEADACHE, PHOTOPHOBIA, NECK STIFFNESS, FEVER, SEIZURES (LATE SIGN). A NON-BLANCHING RASH IS TYPICALLY ASSOCIATED WITH MENINGOCOCCAL SEPTICAEMIA.

TEMPORAL ARTERITIS – HEADACHE, VISION LOSS, SCALP TENDERNESS, SHOULDER/NECK/HIP PAIN, FEVER.

SPACE OCCUPYING LESION – HEADACHE, WORSE IN THE SUPINE POSITION, ATAXIA, CHANGES IN PERSONALITY, CONFUSION.

CAROTID DISSECTION - HEADACHE, CVA SYMPTOMS, DROOPY EYELID, PULSATING NOISE HEARD IN EARS.

NON - SINISTER HEADACHES

Sinus Headache - headache described as a pressure, located behind the eyes, frontal lobe, and cheeks. Pain gets worse when leaning forward, may be accompanied by cold-like symptoms.

Tension Headache - headache described as band-like and constricting, often radiates from the neck to the frontal lobe, mild to moderate pain, onset usually later in the day, associated with stress and tiredness.

Cluster Headache - sudden onset, pattern-like occurrence, occurs every day in bouts lasting several weeks to months before having symptom-free periods. The pain is often described as sharp, burning, or piercing and located on one side of the head.

Migraine (use the pounds mnemonic) - Pulsating headache, Onset usually between 4-72 hours, Unilateral head pain, Nausea /vomiting, Disabling intensity, Sensitivity to light (visual aura may also occur).

PRF TEMPLATE - Headache

Presenting complaint: Headache

History of presenting complaint
Insert the following information relating to the pain: Site, onset, character, any radiating pain, associated symptoms, timing of pain (constant or intermittent), exacerbating and relieving factors, score out of 10.

Review of systems (ROS): Document a review of systems relating to the presenting complaint. Use this section to rule out/or include any associated symptoms that may be of concern. Consider the following: Acute vision abnormalities, facial droop, speech problems, unilateral limb weakness, altered face or limb sensations, dysphagia, new confusion, dizziness, LOC, seizure activity, photophobia, neck stiffness, non-blanching rash, related head trauma.

On arrival: Document the situation you were presented with on arrival and the appearance/condition of your patient.

Past medical history
Insert all previous and current medical conditions.

Medications and allergies
Insert the patient's medications and any allergies they may have.

Social history
Insert the following: Living conditions/arrangement, care input, mobility needs, DNR form in place, DoLs in place, lifestyle habits (smoker, recreational drug use, alcohol consumption).

Family history
Insert any relevant medical conditions that exist within the family.

On examination
(Note: Observations to be recorded in the appropriate section of the PRF).

Airway: Is the airway patent? Clear from obstruction/swelling? Stridor heard?

Breathing: Results from your respiratory assessment go here; inspect, palpate, percuss, auscultate. Any abnormalities on inspection? is the percussion note normal - high pitched or dull? Are there added sounds present on auscultation - wheeze, crackles, or pleural rub?

Circulation: Cardiac assessment and ECG findings go here: Any abnormalities on inspection? Heaves and/or thrills present? Any abnormal heart sounds? Any peripheral or sacral oedema? Document ECG findings in the following order: Rhythm, rate, cardiac axis, the PR, QRS and QTc intervals, ST segment, T waves.

Disability: Neurological assessment findings go here: FAST positive or negative? PEARL? Results of your cranial nerve assessment, any acute vision abnormalities? Non-blanching rash? Photophobia? Neck stiffness?

Examine: Musculoskeletal/skin/abdominal assessments findings go here: Abnormal abdominal inspection? Bowel sounds heard? Any tenderness on palpation? Any guarding or rebound tenderness? If so which quadrant? Can you feel a palpable or pulsating mass? Any lower back tenderness? Note skin changes/rash/hives, any joint pain/swelling?

Working impression
Enter your preferred and differential diagnosis here.

Care plan
List your treatment plan here. Include extrication method, drugs given and why, assessment before and after treatment, did you travel with any specific monitoring on? Pre-alert call made? Emergency transfer or normal road speed? Any referrals made? If you discharged on scene provide detailed worsening advice (use symptoms of conditions to formulate your advice).

SEIZURES

HERE'S THE INFORMATION YOU NEED TO OBTAIN WHEN A PATIENT HAS A SEIZURE

TYPE OF SEIZURE

- CAN A WITNESS DESCRIBE THE SEIZURE?
- DID THE PATIENT GO COMPLETELY UNRESPONSIVE?
- WAS THERE ANY MUSCLE TWITCHING, LIMB JERKING OR STIFFNESS?
- ANY ABNORMAL EYE MOVEMENT?
- INCONTINENCE? ORAL TRAUMA?

DURATION

- DURATION OF SEIZURE ACTIVITY?
- HAS THE PATIENT HAD MORE THAN ONE SEIZURE?
- HAS THE PATIENT RECEIVED ANY TREATMENT? E.G. BUCCAL MIDAZOLAM?

CAUSE

- IS THE PATIENT KNOWN TO HAVE SEIZURES?
- IF YES, HOW OFTEN DO THEY OCCUR AND HOW DO THEY USUALLY PRESENT? KNOWN EPILEPTIC?
- IS THERE A CARE PLAN IN PLACE RELATING TO THE SEIZURES?
- HISTORY OF DIABETES? RECENT ILLNESS/INFECTION? DIAGNOSED BRAIN TUMOUR? RECENT HEAD INJURY?
- ANY CVA SYMPTOMS REPORTED PRIOR TO THE SEIZURE?
- IS THE PATIENT ALCOHOL DEPENDANT? COULD THEY BE WITHDRAWING?
- ANY HISTORY OF MENTAL HEALTH?
- COULD THE PATIENT HAVE TAKEN AN OVERDOSE?

How to identify different types of Seizures

Focal (simple partial seizure) - awake and aware, altered sensations, some limb twitching may occur.

Focal (complex partial) - no sense of awareness, random body movements /twitching /fiddling, random noises.

Tonic (stiffness) Clonic (jerking) seizure - patient becomes unconscious, uncontrollable muscle jerks and spasms occur throughout the body, incontinence and oral truama may occur, usually followed by a postictal period.

Absences - staring blankly, fluttering eyes, unresponsive, limb jerks.

Myoclonic -a sudden full body twitch often lasting only seconds.

Atonic -all of the patient's muscles suddenly relax, usually causing the patient to fall to the ground.

PRF TEMPLATE - Seizure

Presenting complaint: Seizure.

History of presenting complaint
Events leading up to the seizure, a description of the seizure e.g tonic-clonic, its duration, how many seizures they've had, details of the post-ictal period. Are they known to have seizures? If so what usually causes them? How does their typical seizure present? How often do they typically occur? How are they managed? Record any prescription medication used during seizure.

Review of systems: Document a review of systems relating to the presenting complaint. Use this section to rule out/or include any associated symptoms that may be of concern. Consider the following: No recent head injury, acute vision abnormalities, FAST symptoms prior to seizure, drug use, history of alcohol dependency, recent illness.

On arrival: Document the situation you were presented with on arrival and the appearance/condition of your patient.

Past medical history
Insert all previous and current medical conditions.

Medications and allergies
Insert the patient's medications and any allergies they may have.

Social history
Include the following: Living conditions/arrangement, care input, mobility needs, DNR, DoLs, lifestyle habits (smoker, recreational drug use, alcohol consumption).

Family history
Insert any medical conditions that exist within the family.

On examination
(Note: Observations to be recorded in the specific section of the PRF).

Airway: Is the airway patent? Clear from obstruction/swelling? Oral trauma? Stridor heard? Any facial swelling?

C-spine: Sometimes seizures are accompanied by trauma, include your spinal assessment here if applicable.

Breathing: Results from your respiratory assessment go here; inspect, palpate, percuss, auscultate. Any abnormalities on inspection? Is the percussion note normal, high pitched or dull? Are there any added sounds present on auscultation - wheeze, crackles, pleural rub? Use the TWELVE mnemonic to write a detailed trauma report if applicable (see page 80).

Circulation: Cardiac assessment and ECG findings go here: Any abnormalities on inspection? Heaves and/or thrills present? Any abnormal heart sounds? Any peripheral or sacral oedema? Document ECG findings as follows; rhythm, rate, cardiac axis, the PR, QRS and QTc intervals, ST segment, T wave. Include your trauma report if applicable; pelvis/long bone assessment, firm distended abdomen? Internal/external bleeding?

Disability: Neurological assessment findings go here: FAST positive or negative? Pupil check, cranial nerve assessment, any acute vision abnormalities? Head injury?

Examine: Musculoskeletal/skin and abdominal assessments findings go here: Abnormal abdominal inspection? Bowel sounds heard? Any tenderness on palpation? Any guarding or rebound tenderness? If so which quadrant? Can you feel a palpable or pulsating mass? Any lower back tenderness? Note skin changes/rash/hives, any joint pain/swelling. Include secondary survey findings if trauma related.

Working impression
Enter your preferred and differential diagnosis here, cause of seizure, type of seizure.

Care plan
List your treatment plan here, include extrication method, drugs given and why, assessment before and after treatment, did you travel with any specific monitoring on? Pre-alert? Emergency transfer or normal road speed? Note any referrals made. If you discharged on scene provide detailed worsening advice (use symptoms of conditions to formulate your advice).

Fall/collapse query cause

Fall/collapse query cause

Symptom/situation

- establish the symptom/situation; how can we help you today?

Onset

- when did they fall? time? place?
- Events leading up to the fall.

Character

- can they remember falling?
- how did they fall? was it an intrinsic cause? (caused by illness/dizziness/syncope, etc.) or an extrinsic cause? (caused by a trip or slip)
- was the fall from standing? seated position? at height?
- did it involve furniture? mobility aids?
- what surface did they fall onto?
- how did they land?

Associated Symptoms

- any LOC, if so how long?
- any new pain or injury from the fall?
- headache? dizziness? fast symptoms? seizure activity?
- sob? chest pain? palpitations?
- abdo pain? back pain? urinary symptoms? bowel habits?
- musculoskeletal injuries?

Timing

- how long have they been on the floor?
- any previous falls? if yes when was the last fall? how frequently are falls occurring?

Exacerbating/Relieving factors

- is there anything that makes the patient's mobility worse? anything that could improve their mobility? (e.g. walking aids, symptom management).

Transient Loss of Consciousness (collapse query cause)

(use the WOMAN PE mnemonic to help you identify the cause of the collapse and prompt the appropriate assessments)

VV - Vasovagal syncope- prior to the fall, has your patient been in a hot environment? standing for a prolonged period of time? could they be dehydrated? did they make a quick recovery following the syncope?

O - Orthostatic hypotension (postural) – perform lying, seated, and standing blood pressures to assess for postural hypotension.

M - Mechanical fall - Ask how the patient fell, did they trip/slip? pass out? feel dizzy? unwell?

A - Arrhythmias – undertake a 12 lead ECG to assess for cardiac arrhythmias.

N - Neurological – Ensure a cranial nerve assessment is completed and any abnormal findings considered. could this be a CVA? or a TIA?

P - Psychological – consider a psychological cause, is there a history of mental health problems?

E – Electrolyte imbalance – inspect the 12 lead ECG for hyperacute or flattened T waves, abnormal QTc intervals, and prominent u waves. perform a blood glucose reading.

PRF TEMPLATE - Falls/T-Loc

Presenting complaint: Falls.

History of presenting complaint
Events leading up to the fall, how they fell, was it an intrinsic cause (caused by illness/dizziness/syncope etc) or an extrinsic cause (mechanical, caused by a trip or slip)? Can they remember falling? Did they fall from standing? At height? Seated position? What surface did they fall on? How did they land? Any LOC? If so how long? Any new pain or injury from the fall? Note the time of the fall and how long the patient has been on the floor. Any previous falls? If yes document frequency and cause.

Review of systems: Document a review of systems relating to the presenting complaint. Use this section to rule out/or include any associated symptoms that may be of concern. Consider the following: LOC/syncope, headache, FAST symptoms, seizure activity, chest pain, SOB, abdominal pain, back pain, dizziness, palpitations, seizure activity.

On arrival: Document the situation you were presented with on arrival and the appearance/condition of your patient.

Past medical history
Insert all previous and current medical conditions.

Medications and allergies
Insert the patient's medications and any allergies they may have.

Social history
Include the following: Living conditions/arrangement, care input, mobility needs, DNR, DoLs, lifestyle habits (smoker, recreational drug use, alcohol consumption).

Family history
Insert any medical conditions that exist within the family if applicable.

On examination
(Note: Observations to be recorded in the specific section of the PRF).

Airway: Is the airway patent? Clear from obstruction/swelling? Stridor heard? Any facial swelling?

C-spine: Insert findings of spinal assessment here; any tenderness? Boney deformity? Altered limb sensation?

Breathing: Include results from your respiratory assessment, use TWELVE as guidance: Trachea central? Wounds/bruising/lacerations on inspection? Emphysema (surgical) present? Laryngeal crepitus? Venous engorgement? Exclude pneumothorax/haemothorax, results of auscultation and percussion assessment, include findings of your medical respiratory assessment where appropriate.

Circulation: Document your pelvis, long bone, and abdominal assessment here, alongside any external/suspected internal bleeding. Document rate and character of pulse. Medical cardiac assessment can also go here: Any abnormalities on inspection? Heaves and/or thrills present? Any abnormal heart sounds? Any peripheral or sacral oedema? Document ECG findings as follows; rhythm, rate, cardiac axis, the PR, QRS and QTc intervals, ST segment, T wave.

Disability: Neurological assessment findings go here: Head injury? Boggy mass? GCS? FAST positive or negative? Pupil check, cranial nerve assessment normal? Any acute vision abnormalities? Evidence of CSF fluid?

Examine: Musculoskeletal/skin/abdominal assessments findings go here. Record your secondary survey findings. Note the presence or absence of a distal pulse and cap refill if an injury is found. Medical abdominal assessment findings can also go here: Abnormal abdominal inspection? Bowel sounds heard? Any tenderness on palpation? If so which quadrant? Can you feel a palpable mass? Any lower back tenderness? Urinary symptoms?

Working impression
Enter your preferred and differential diagnosis findings here. Include cause of the fall, injuries sustained, and medical diagnosis if applicable.

Care plan
List your treatment plan here; include extrication method, drugs given and why, assessment before and after treatment, did you travel with any specific monitoring on? Was the patient collared and boarded? Pre-alert call made? Emergency transfer or normal road speed? Trauma tool used to assess? Any referrals made. If you discharged on scene provide detailed worsening advice (use symptoms of conditions to formulate your advice).

BREATHING DIFFICULTIES/SOB

BREATHING DIFFICULTIES/SOB HISTORY TAKING QUESTIONS

Symptoms/situation

- HOW CAN WE HELP YOU TODAY?
- WHEN DID YOUR BREATHING PROBLEMS START?

Onset

- WHAT WERE YOU DOING WHEN IT STARTED?
- WAS IT A GRADUAL OR SUDDEN ONSET?
- HAS THIS EVER HAPPENED BEFORE?

Character

- CAN YOU DESCRIBE HOW YOUR BREATHING FEELS?

Associated Symptoms

- COUGH? PRODUCTIVE OR NON-PRODUCTIVE?
- WHAT COLOUR IS THE SPUTUM? WHITE? GREEN/YELLOW?
- ANY BLOOD IN THE SPUTUM?
- CHEST PAIN?
- ABDOMINAL PAIN?
- ANY SWELLING/FLUID RETENTION IN THEIR LOWER LIMBS/LOWER BACK/ABDOMEN? (THINK PERIPHERAL/SACRAL OEDEMA AND ASCITES)
- ANY PAIN/ TENDERNESS IN THEIR LOWER LIMBS? (THINK DVT)
- ANY RECENT LONG-HAUL FLIGHTS?
- RECENT SURGERY?
- HISTORY OF IMMOBILITY?
- RECENT TRAUMA?
-ALLERGIES? HIVES?

Timing

- HOW LONG HAVE YOU HAD THESE SYMPTOMS?

Exacerbating/Relieving factors

- DOES ANYTHING IMPROVE YOUR BREATHING OR MAKE IT WORSE?

CAUSES OF BREATHING DIFFICULTIES/SOB

Asthma exacerbation – SOB, chest tightness, cough (often dry or producing clear sputum), audible wheeze often heard, bi-lateral wheeze heard on auscultation, often more pronounced on the expiratory phase. Silent chest in life-threatening asthma.

COPD exacerbation - chronic productive cough, SOB gradually worsening with a prolonged expiration phase, recurrent chest infection, may appear pink in colour with pursed lips and a barrel chest (pink puffer), or cyanosed, and overweight(blue bloater), chest auscultation findings may include: wheeze/pleural rub/consolidation/reduced air entry.

Anaphylaxis - can have a sudden onset of symptoms to include; SOB, hives/rash/erythema, angioedema (swelling to face/tongue/hands/feet), chest tightness, diarrhea and vomiting. Chest auscultation findings can suggest severe bronchospasm and airway compromise: wheeze/stridor/ silent chest.

Pneumonia - SOB, productive cough/blood-stained sputum, sharp pleuritic chest pain, lethargy, fever, nausea/vomiting, abdominal pain. Chest auscultation suggests consolidation: bibasilar crackles, dull percussion note.

Anaemia- fatigue, pale skin, SOB, dizziness, or lightheadedness. Melaena, haematemesis (consider GI bleed as one cause of anaemia). Chest auscultation findings: no abnormalities.

COVID - high temperature, a new, continuous cough, loss or change to sense of smell or taste.

Silent MI - pale, clammy, and sweaty skin. SOB, an absence of chest pain. Chest auscultation normal, ECG changes may show signs of ischemia: ST elevation/ST depression/deep and wide Q waves/ symmetrical T wave inversions.
(High risk patients include: diabetics and elderly females).

Pneumothorax - SOB, chest pain, deviated trachea, decreased air entry, surgical emphysema, high pitched percussion note, reduced O_2 saturations.

Pulmonary Embolism - SOB (sudden onset in some cases), sharp pleuritic chest pain, productive cough/blood-stained sputum. Common risk factors include associated lower limb pain and swelling suggestive of a DVT, recent long haul flight, immobility, the use of contraceptive medication, ongoing chemotherapy.

Chest auscultation: air entry is often normal, but can be reduced over the affected area. The ECG can be normal. Sinus tachycardia is the most common abnormal finding. Deep T wave inversions and the presence of S_1, Q_3, T_3 changes can be seen in a small percentage of patients.

Heart Failure - SOB, worse when lying flat, fatigue/lethargy, chest pain, productive cough/blood stained sputum, oedema in the lower limbs/lower back or abdomen. Chest auscultation suggestive of consolidation: bibasilar crackles with a dull percussion note. Associated ECG findings may include ventricular hypertrophy.

Anxiety -triggered onset, rapid breathing, chest tightness, pins and needles felt in limbs. Symptoms resolve after breathing coaching exercises.

Pocket Paramedic

WELLS SCORE

If PE is a potential diagnosis

CRITERIA	POINTS
Clinical signs and symptoms of DVT	3
~~PE is #1 diagnosis OR~~ equally likely	3
Heart rate > 100	1.5
~~Immobilisation at least 3 days OR~~ surgery in the previous 4 weeks	1.5
~~Previous, objectively diagnosed PE~~ or DVT	1.5
Haemoptysis	3
~~Malignancy w/ treatment within~~ 6 months or palliative	3
TOTAL =	

clinical probability of PE =	0-1 Low 2-6 Intermediate 7+ high

PRF TEMPLATE - Breathing difficulties

Presenting complaint: Breathing difficulties.

History of presenting complaint
Use SOCATE to formulate a structure: Symptom, onset, character, associated symptoms, timing, exacerbating and relieving factors.

Review of systems (ROS): Document a review of systems relating to the presenting complaint. Use this section to rule out/or include any associated symptoms that may be of concern. Consider the following: Cough, sputum consistency, haemoptysis, chest pain, calf pain/swelling, palpitations, hives, angioedema, dizziness, nausea or vomiting, haematemesis, melena.

On arrival: Document the situation you were presented with on arrival and the appearance/condition of your patient.

Past medical history
Insert all previous and current medical conditions.

Medications and allergies
Insert the patient's medications and any allergies they may have.

Social history
Include the following: Living conditions/arrangement, care input, mobility needs, DNR in place, DoLs, lifestyle habits (smoker, recreational drug use, alcohol consumption).

Family history
Insert any medical conditions that exist within the family.

On examination
(Note: Observations to be recorded on the specific section of the PRF).

Airway: Is the airway patent? Clear from obstruction /swelling? Stridor heard? Any facial swelling?

Breathing: Results from your respiratory assessment go here; inspect, palpate, percuss, auscultate. Any abnormalities on inspection? Is the percussion note normal, high pitched or dull? Are there added sounds present on auscultation - wheeze, crackles, pleural rub?

Circulation: Cardiac assessment and ECG findings go here: Any abnormalities on inspection? Heaves and/or thrills present? Any abnormal heart sounds? Any peripheral or sacral oedema? Document ECG findings as follows; rhythm, rate, cardiac axis, the PR, QRS and QTc intervals, ST segment, T wave.

Disability: Neurological assessment findings go here: FAST positive or negative? PEARL? Results of cranial nerve assessment, any acute vision abnormalities? Non-blanching rash? Photophobia? Neck stiffness?

Examine: Musculoskeletal/skin/abdominal assessments findings go here: Abnormal abdominal inspection? Bowel sounds heard? Any tenderness on palpation? Any guarding or rebound tenderness? If so which quadrant? Can you feel a palpable or pulsating mass? Any lower back tenderness? Note skin changes/rash/hives, any joint pain/swelling?

Working impression
Enter your preferred and differential diagnosis findings here.

Care plan
List your treatment plan here, include extrication method, drugs given and why, assessment before and after treatment, did you travel with any specific monitoring on? Pre-alert? Emergency transfer or normal road speed? Note any referrals made. If you discharged on scene provide detailed worsening advice (use symptoms of conditions to formulate your advice).

CHEST PAIN

CHEST PAIN HISTORY TAKING QUESTIONS

Site
- WHERE EXACTLY IN YOUR CHEST IS THE PAIN?

Onset
- WHEN DID IT START?
- WHAT WERE YOU DOING WHEN IT STARTED?

Character
- CAN YOU DESCRIBE THE TYPE OF PAIN YOU'RE EXPERIENCING?

Radiate
- DOES THE PAIN MOVE ANYWHERE ELSE?

Associated Symptoms
- SHORT OF BREATH?
- PALE, CLAMMY OR SWEATY SKIN?
- PALPITATIONS? DIZZINESS?
- NAUSEA OR VOMITING?
- COUGH? IS IT PRODUCTIVE? SPUTUM? BLOOD STAINED?
- ANY LOWER LIMB/LOWER BACK SWELLING? (THINK OEDEMA)
- ANY CALF/LOWER LIMB PAIN OR SWELLING? (THINK DVT)
-ABDOMINAL PAIN? (IF YES USE SOCRATES TO ELABORATE)
- RECENT LONG-HAUL FLIGHTS? RECENT SURGERY? HISTORY OF IMMOBILITY? ONGOING CHEMOTHERAPY TREATMENT? CONTRACEPTIVE MEDICATION IN USE?

Timing
- IS THE PAIN CONSTANT OR INTERMITTENT?

Exacerbating/Relieving factors
- DOES ANYTHING MAKE THE PAIN BETTER OR WORSE?

Severity
- ON A SCALE OF 1-10 WHERE WOULD YOU SCORE YOUR PAIN?

CAUSES OF CHEST PAIN

Acute Coronary Syndrome (ACS) - a constant crushing/heavy/ache-like chest pain. May radiate into arms/jawline/neck/back. Onset at rest. Associated symptoms often include SOB, nausea/vomiting, diaphoresis (excessive sweating), pale/clammy skin. ECG changes can include: ST elevation (STEMI), ST depression, pathological Q waves, symmetrical T wave inversions (note: a normal ECG can not exclude ACS).

Stable angina - chest pain described as an ache /crushing /heavy, may radiate into arms/jawline/neck/back, onset on exertion, relieved in the rested state. If ST changes are present on the ECG suspect ACS.

Pericarditis - typically described as a sharp central or left-sided chest pain, may radiate into arms or neck. The pain can worsen in the supine position and improve when leaning forward, may show signs of infection. ECG changes can show widespread PR depression and ST elevation with reciprocal ST depression and PR elevation in lead aVR.

Gastric reflux - burning epigastric abdominal pain that often radiates into the chest, worse after eating, relieved when belching. No ST abnormalities seen on the ECG.

Pleuritic chest pain - sharp isolated chest pain, exacerbated when breathing/coughing/moving, often associated with a cough and a pleural friction rub on auscultation. No ST abnormalities seen on the ECG. Some causes include chest infections, pleurisy, PE, COPD exacerbation.

Muscular chest pain - Global chest pain, exacerbated when moving/stretching, tender on palpation, associated with physical activity over the last 24-72 hours. No ECG changes suggesting ischemia.

Pulmonary Embolism - SOB (can be a sudden onset), sharp pleuritic chest pain, productive cough/blood-stained sputum. Common risk factors include associated lower limb pain and swelling suggestive of a DVT, recent long haul flight, immobility, the use of contraceptive medication, ongoing chemotherapy.

Chest auscultation: air entry is often normal, but can be reduced over the affected area. ECG changes can be normal. Sinus tachycardia is the most common abnormal finding. Deep T wave inversions and the presence of S1, Q3, T3 changes can be seen in a small percentage of patients.

Heart Failure - SOB, worse when lying flat, fatigue /lethargy, chest pain, productive cough/blood stained sputum, lower limb/back, and abdominal swelling.

Chest auscultation suggests consolidation: bibasilar crackles with dull percussion note. Associated ECG findings may include ventricular hypertrophy.

Cardiac Arrhythmia - chest pain, constant or intermittent, commonly associated with palpitations, SOB, pale, clammy and sweaty skin, dizziness, and syncope. ECG changes capturing arrhythmia (e.g SVT, fast AF, pulsed VT).

PRF TEMPLATE - Chest pain

Presenting complaint: Chest pain.

History of presenting complaint
Insert the following information relating to the pain: Site, onset, character, any radiating pain, associated symptoms, timing of pain (constant or intermittent), exacerbating and relieving factors, score out of 10.

Review of systems (ROS): Document a review of systems relating to the presenting complaint. Use this section to rule out/or include any associated symptoms that may be of concern. Consider the following: SOB, pale/clammy or sweaty skin, nausea/vomiting, abdominal pain, palpitations, cough, sputum consistency, signs of a DVT, recent travel or surgery, bowel movements, dizziness, LOC.

On arrival: Document the situation you were presented with on arrival and the appearance/condition of your patient.

Past medical history
Insert all previous and current medical conditions.

Medications and allergies
Insert the patient's medications and any allergies they may have.

Social history
Insert the following: Living conditions/arrangement, care input, mobility needs, DNR form in place, DoLs in place, lifestyle habits (smoker, recreational drug use, alcohol consumption).

Family history
Insert any relevant medical conditions that exist within the family.

On examination
(Note: Observations to be recorded in the appropriate section of the PRF).

Airway: Is the airway patent? Clear from obstruction/swelling? Stridor heard?

Breathing: Results from your respiratory assessment go here; inspect, palpate, percuss, auscultate. Any abnormalities on inspection? Is the percussion note normal - high pitched or dull? Are there added sounds present on auscultation - wheeze, crackles, or Pleural rub?

Circulation: Cardiac assessment and ECG findings go here: Any abnormalities on inspection? Heaves and/or thrills present? Any abnormal heart sounds? Any peripheral or sacral oedema? Document ECG findings in the following order: Rhythm, rate, cardiac axis, the PR, QRS and QTc intervals, ST segment, T waves.

Disability: Neurological assessment findings go here: FAST positive or negative? PEARL? Results of your cranial nerve assessment, any acute vision abnormalities? Non-blanching rash? Photophobia? Neck stiffness?

Examine: Musculoskeletal/skin/abdominal assessments findings go here: Abnormal abdominal inspection? Bowel sounds heard? Any tenderness on palpation? Any guarding or rebound tenderness? If so which quadrant? Can you feel a palpable or pulsating mass? Any lower back tenderness? Note skin changes/rash/hives, any joint pain/swelling?

Working impression
Enter your preferred and differential diagnosis here.

Care plan
List your treatment plan here. Include extrication method, drugs given and why, assessment before and after treatment, did you travel with any specific monitoring on? Pre-alert call made? Emergency transfer or normal road speed? Any referrals made? If you discharged on scene provide detailed worsening advice (use symptoms of conditions to formulate your advice).

ABDOMINAL PAIN

ABDOMINAL PAIN HISTORY TAKING QUESTIONS

Site

- WHERE EXACTLY IN YOUR ABDOMEN IS THE PAIN?

Onset

- WHEN DID IT START?
- WHAT WERE YOU DOING WHEN IT STARTED?

Character

- CAN YOU DESCRIBE THE TYPE OF PAIN YOU'RE EXPERIENCING?

Radiate

- DOES THE PAIN MOVE ANYWHERE ELSE?

Associated Symptoms

- ANY NAUSEA OR VOMITING?
- CONSISTENCY OF VOMIT? BILE? FOOD? HAEMATEMESIS?
- BOWEL MOVEMENTS NORMAL? LOOSE? DIARRHEA? MELAENA? CONSTIPATION? FLATULENCE?
- URINARY SYMPTOMS: FREQUENCY, VOLUME, PAIN, HAEMATURIA, INCREASED URGE, COLOUR, ODOUR.
- LOWER BACK PAIN OR DISCOMFORT?
- SOB? NSAID MEDICATION USE? (THINK ULCERS/GI BLEED)
- SYNCOPE? LOC? DIZZY OR LIGHTHEADED?

GYNAECOLOGICAL:
PV BLEED/DISCHARGE? CHANCE OF PREGNANCY? SEXUALLY ACTIVE? LMP DATE, LMP NORMAL? CONTRACEPTIVE USE? PELVIS PAIN? SHOULDER TIP PAIN?

Timing

-IS THE PAIN CONSTANT OR INTERMITTENT?

Exacerbating/Relieving factors

-DOES ANYTHING MAKE THE PAIN BETTER OR WORSE?

Severity

- ON A SCALE OF 1-10, WHERE WOULD YOU RATE YOUR PAIN?

CAUSES OF ABDOMINAL PAIN

Appendicitis - generalised or umbilical abdominal pain that radiates into the right lower quadrant. Associated symptoms can include nausea/vomiting, fever, constipation or diarrhea. An abdominal assessment can reveal right lower quadrant tenderness, rebound tenderness, positive McBurney's and Aaron's sign.

Gastritis/Peptic Ulcers – pain typically felt in the epigastric /umbilical abdominal region, described as burning or sharp. Associated symptoms can include; nausea/vomiting, feeling bloated. Risk factors include long-term NSAID use, recreational drug use, chronic smoker. complications can lead to gastrointestinal (GI) bleeding.

GI bleed - fatigue, pale skin, SOB, dizziness/lightheadedness. melaena, haematemesis, abdominal pain.

Cholecystitis - right upper quadrant or central abdominal pain, often described as sharp or cramping which can radiate into the right shoulder or back. Associated symptoms can include nausea/vomiting, fever. An abdominal assessment can reveal right upper quadrant and epigastric tenderness, positive Murphy's sign, guarding.

Pancreatitis - dull central/upper abdominal pain, can radiate into the back, fever, nausea/vomiting, can be acute or chronic, often related to chronic alcohol consumption. An abdominal assessment can reveal a blue-tinged right flank region on inspection, and tenderness on palpation.

Diverticulitis - chronic, often diagnosed condition, pain typically constant and isolated to the lower left quadrant. Associated symptoms can include PR bleeding, altered bowel movements, distended abdomen.

Crohn's Disease/Ulcerative Colitis - chronic, often diagnosed condition, typically presents as global abdominal pain, PR bleeding, mouth sores, pain when opening bowels.

Urinary tract infection (UTI) – hypogastric abdominal pain, lower back pain/tenderness, burning/stinging when urinating, increased frequency to urinate with reduced output, confusion, fever. Abdominal assessment can reveal suprapubic abdominal tenderness, lower back tenderness.

Bowel Obstruction - absent bowel sounds, global abdominal pain, bloated abdomen, constipation leading to diarrhea/ faecal vomiting.

Peritonitis - Global abdominal pain and tenderness, distended abdomen, reduced urine output, lethargy/fatigue, fever, nausea/vomiting, altered bowel habits, confusion, thirst. Can be secondary to abdominal trauma or other infections within the abdominal region, e.g appendicitis.

Ectopic Pregnancy - Sharp waves of global abdominal pain, history of pelvic inflammatory disease, PV bleeding/discharge, syncope, shoulder tip pain.

Pelvic Inflammatory Disease - hypogastric abdominal and/or pelvic pain, pain whilst urinating, vaginal discharge with an unpleasant odour.

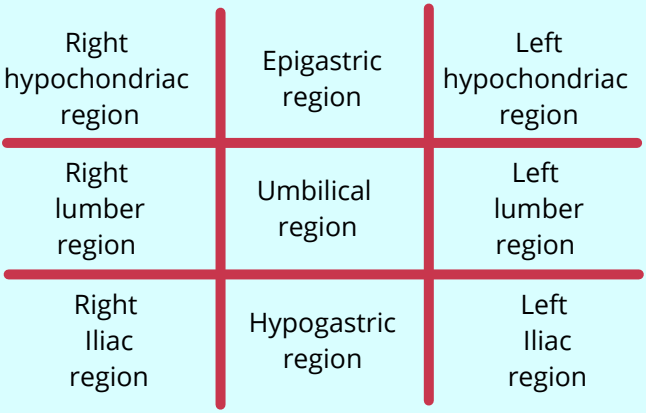
Endometriosis – Long and painful periods, lower back pain during period, pain during intercourse, PV bleeding, pain during bowel movement, and/or urination.

Ovarian Cysts – PV bleeding, pelvic pain, dull ache in the lower back and thighs, unable to completely empty bladder or bowels, breast tenderness.

Abdominal Aortic Aneurysm - Severe abdominal pain which can radiate into the lower back. Associated symptoms often include dizziness, pale, clammy, and sweaty skin, nausea/vomiting, syncope, hypotension. Abdominal assessment may reveal a pulsating mass in the abdomen.

Gastroenteritis - intermittent cramping epigastric abdominal pain, D and V, fever.

ABDOMINAL REGIONS



CONDITIONS ASSOCIATED WITH THE ABDOMINAL REGIONS

Cholecystitis Stomach ulcer Pancreatitis Liver cirrhosis	Heartburn Stomach ulcer Pancreatitis Epigastric hernia Gastroenteritis	Duodenal ulcer Stomach ulcer Biliary colic Pancreatitis
Kidney stones UTI Constipation Lumber hernia	Pancreatitis Early appendicitis stomach ulcer Inflammatory bowel umbilical hernia	Kidney stones Diverticular disease Constipation Inflammatory bowel
Appendicitis Pelvic pain Constipation Inguinal hernia	UTI Appendicitis Diverticular disease Inflammatory disease pelvic pain	Diverticular disease Inguinal hernia pelvic pain

PRF TEMPLATE - Abdominal Pain

Presenting complaint: Abdominal pain.

History of presenting complaint
Insert the following information relating to the pain: Site, onset, character, any radiating pain, associated symptoms, timing of pain (constant or intermittent), exacerbating and relieving factors, score out of 10.

Review of systems (ROS): Document a review of systems relating to the presenting complaint. Use this section to rule out/or include any associated symptoms that may be of concern. Consider the following: Haematemesis, bowel movement/ melaena, PR bleed, urinary symptoms, haematuria, back pain, dizziness, chest pain, SOB, LOC, fluid intake. Gynaecological considerations: PV bleed/discharge, LMP, chance of pregnancy, shoulder tip pain, pelvis pain.

On arrival: Document the situation you were presented with on arrival and the appearance/condition of your patient.

Past medical history
Insert all previous and current medical conditions.

Medications and allergies
Insert the patient's medications and any allergies they may have.

Social history
Insert the following: Living conditions/arrangement, care input, mobility needs, DNR form in place, DoLs in place, lifestyle habits (smoker, recreational drug use, alcohol consumption).

Family history
Insert any relevant medical conditions that exist within the family.

On examination
(Note: Observations to be recorded in the appropriate section of the PRF).

Airway: Is the airway patent? Clear from obstruction/swelling? Stridor heard?

Breathing: Results from your respiratory assessment go here; inspect, palpate, percuss, auscultate. Any abnormalities on inspection? Is the percussion note normal - high pitched or dull? Are there added sounds present on auscultation - wheeze, crackles, or pleural rub?

Circulation: Cardiac assessment and ECG findings go here: Any abnormalities on inspection? Heaves and/or thrills present? Any abnormal heart sounds? Any peripheral or sacral oedema? Document ECG findings in the following order: Rhythm, rate, cardiac axis, the PR, QRS and QTc intervals, ST segment, T waves.

Disability: Neurological assessment findings go here: FAST positive or negative? PEARL? Results of your cranial nerve assessment, any acute vision abnormalities? Non-blanching rash? Photophobia? Neck stiffness?

Examine: Musculoskeletal/skin/abdominal assessments findings go here: Abnormal abdominal inspection? Bowel sounds heard? Any tenderness on palpation? Any guarding or rebound tenderness? If so which quadrant? Can you feel a palpable or pulsating mass? Any lower back tenderness? Note skin changes/rash/hives, any joint pain/swelling?

Working impression
Enter your preferred and differential diagnosis here.

Care plan
List your treatment plan here. Include extrication method, drugs given and why, assessment before and after treatment, did you travel with any specific monitoring on? Pre-alert call made? Emergency transfer or normal road speed? Any referrals made? If you discharged on scene provide detailed worsening advice (use symptoms of conditions to formulate your advice).

BACK PAIN

BACK PAIN HISTORY TAKING QUESTIONS

Site
- WHERE EXACTLY IS THE PAIN IN YOUR BACK?

Onset
- WHEN DID IT START?
- WHAT WERE YOU DOING WHEN IT STARTED?

Character
- CAN YOU DESCRIBE THE TYPE OF PAIN YOU'RE EXPERIENCING?

Radiate
- DOES THE PAIN MOVE ANYWHERE?

Associated Symptoms
- ANY PAIN/NUMBNESS/ALTERED SENSATION IN YOUR LOWER LIMBS?
- ANY BOWEL OR URINARY INCONTINENCE?
- ANY SADDLE ANAESTHESIA? (THE LOSS OF SENSATION IN THE BUTTOCKS, PERINEUM, AND INNER SURFACES OF THE THIGHS)
- ANY HISTORY OF TRAUMA?
- ABDOMINAL PAIN? (IF YES USE SOCRATES TO ELABORATE)
- DIZZINESS? SOB? SYNCOPE?
- URINARY SYMPTOMS: FREQUENCY, VOLUME, PAINFUL TO PASS, HAEMATURIA, INCREASED URGE, COLOUR, ODOUR.

Timing
- IS THE PAIN CONSTANT OR INTERMITTENT?

Exacerbating/ Relieving factors
- DOES ANYTHING MAKE THE PAIN BETTER OR WORSE?

Severity
- ON A SCALE OF 1-10, WHERE WOULD YOU SCORE YOUR PAIN?

CAUSES OF BACK PAIN

Cauda Equina - lower back and or leg pain, saddle anaesthesia, lower limb weakness/ numbness/ altered sensation, bladder and/or bowel incontinence.

Sciatica - sharp lower back or buttocks pain shooting down one or both legs. Pain worse in buttocks, feet or toes. May cause weakness/ numbness in lower limbs.

Muscular - intermittent spasm, worse on movement, cramping in nature.

UTI - suprapubic pain, lower back pain/tenderness, burning/stinging urination, increased frequency of urine with reduced output, confusion, fever.

Spinal Stenosis - lower back pain when standing/walking, numbness in buttocks/ legs, loss of balance.

Abdominal Aortic Aneurysm - severe abdominal pain which can radiate into the lower back. Associated symptoms often include dizziness, pale, clammy, sweaty skin, nausea/vomiting, syncope, hypotension. Abdominal assessment may reveal a pulsating mass in the abdomen.

PRF TEMPLATE - Back Pain

Presenting complaint: Back pain.

History of presenting complaint
Insert the following information relating to the pain: Site, onset, character, any radiating pain, associated symptoms, timing of pain (constant or intermittent), exacerbating and relieving factors, score out of 10.

Review of systems (ROS): Document a review of systems relating to the presenting complaint. Use this section to rule out/or include any associated symptoms that may be of concern. Consider the following: Saddle anaesthesia, lower limb weakness/altered sensation, abdominal pain, bowel/urinary incontinence, dizziness, SOB, LOC, urinary symptoms, pale/clammy or sweaty skin.

On arrival: Document the situation you were presented with on arrival and the appearance/condition of your patient.

Past medical history
Insert all previous and current medical conditions.

Medications and allergies
Insert the patient's medications and any allergies they may have.

Social history
Insert the following: Living conditions/arrangement, care input, mobility needs, DNR form in place, DoLs in place, lifestyle habits (smoker, recreational drug use, alcohol consumption).

Family history
Insert any relevant medical conditions that exist within the family.

On examination
(Note: Observations to be recorded in the appropriate section of the PRF).

Airway: Is the airway patent? Clear from obstruction/swelling? Stridor heard?

Breathing: Results from your respiratory assessment go here; inspect, palpate, percuss, auscultate. Any abnormalities on inspection? Is the percussion note normal - high pitched or dull? Are there added sounds present on auscultation - wheeze, crackles, or pleural rub?

Circulation: Cardiac assessment and ECG findings go here: Any abnormalities on inspection? Heaves and/or thrills present? Any abnormal heart sounds? Any peripheral or sacral oedema? Document ECG findings in the following order: Rhythm, rate, cardiac axis, the PR, QRS and QTc intervals, ST segment, T waves.

Disability: Neurological assessment findings go here: FAST positive or negative? PEARL? Results of your cranial nerve assessment, any acute vision abnormalities? Non-blanching rash? Photophobia? Neck stiffness?

Examine: Musculoskeletal/skin/abdominal assessments findings go here: Abnormal abdominal inspection? Bowel sounds heard? Any tenderness on palpation? Any guarding or rebound tenderness? If so which quadrant? Can you feel a palpable or pulsating mass? Any lower back tenderness? Note skin changes/rash/hives, any joint pain/swelling?

Working impression
Enter your preferred and differential diagnosis here.

Care plan
List your treatment plan here. Include extrication method, drugs given and why, assessment before and after treatment, did you travel with any specific monitoring on? Pre-alert call made? Emergency transfer or normal road speed? Any referrals made? If you discharged on scene provide detailed worsening advice (use symptoms of conditions to formulate your advice).

DIABETES

DIABETIC HISTORY TAKING QUESTIONS

- HOW LONG HAVE THEY HAD DIABETES?

- ARE THEY INSULIN-DEPENDENT?

-WHEN WAS THEIR LAST INSULIN INJECTION?

-HAVE THEY MADE ANY CHANGES TO THEIR DIET?

-WHEN WAS THEIR LAST MEAL CONTAINING CARBOHYDRATES?

- HAVE THEY BEEN MORE ACTIVE THAN THEY WOULD NORMALLY BE?

- EXCESSIVE THIRST? (POLYDIPSIA)
- EXCESSIVE HUNGER? (POLYPHAGIA)
- EXCESSIVE URINE OUTPUT? (POLYURIA)
- INCREASED URGE TO URINATE? (POLYURIA)

- IS THEIR DIABETES WELL MANAGED? PREVIOUS HYPOGLYCAEMIA OR HYPERGLYCAEMIA EPISODES?

- PREVIOUS HOSPITAL ADMISSION RELATING TO DIABETES?

- ANY RECENT INFECTIONS?

- WHEN WAS THEIR LAST DIABETIC REVIEW WITH THEIR GP/NURSE?

CONDITIONS ASSOCIATED WITH DIABETES

Diabetic ketoacidosis (DKA) - symptoms include hyperglycaemia, polydipsia (increased thirst), polyuria (increased urine output), polyphagia (increased appetite), kussmaul breathing (deep and rapid breathing effort), diarrhea and vomiting.

Hyperosmolar hyperglycaemic nonketotic state - presents similar to DKA, with the absence of kussmaul breathing.

Hypoglycaemia - symptoms may include confusion, blurred vision, difficulty concentrating, unusual behaviour, slurred speech, clumsiness, reduced GCS, seizures.

Consider other factors influencing blood glucose levels:

Sepsis - signs of recent infection?

Addisonian crisis - signs and symptoms can include hypoglycaemia, hypotension, hyponatremia, hyperpigmentation on palms, D and V. Risk factors: Long term steroid use, TB infection.

PRF TEMPLATE - Diabetic emergencies

Presenting complaint: Diabetic emergencies.

History of presenting complaint
Use SOCATE to formulate your structure: Symptom, onset, character, associated symptoms, timing, exacerbating and relieving factors. Note the events leading up to their symptoms.

Diabetic specific: Follow this up with some diabetic-specific information; how do they manage their diabetes - diet controlled? Medication? Insulin-dependant? Note the time of last insulin injection, time of last meal and its contents. Note any previous hospital admission related to diabetes, any history of DKA, coma?

Review of systems: Document a review of systems relating to the presenting complaint. Use this section to rule out/or include any associated symptoms that may be of concern. Consider the following: Polydipsia, polyurea, polyphagia, Kussmaul breathing, recent infection/illness, D&V.

On arrival: Document the situation you were presented with on arrival and the appearance/condition of your patient.

Past medical history
Insert all previous and current medical conditions.

Medications and allergies
Insert the patient's medications and any allergies they may have.

Social history
Include the following: Living conditions/arrangement, care input, mobility needs, DNR, DoLs, lifestyle habits (smoker, recreational drug use, alcohol consumption).

Family history
Insert any medical conditions that exist within the family.

On examination
(Note: Observations to be recorded in the specific section of the PRF).

Airway: Is the airway patent? Clear from obstruction/swelling? Stridor heard? Any facial swelling?

Breathing: Results from your respiratory assessment go here; inspect, palpate, percuss, auscultate. Any abnormalities on inspection? Rate and depth? Kussmaul breathing? Is the percussion note normal, high pitched, or dull? Are there any added sounds present on auscultation - wheeze, crackles, pleural rub?

Circulation: Cardiac assessment and ECG findings go here: Any abnormalities on inspection? Heaves and/or thrills present? Any abnormal heart sounds? Any peripheral or sacral oedema? Document ECG findings as follows; rhythm, rate, cardiac axis, the PR, QRS and QTc intervals, ST segment, T wave.

Disability: Neurological assessment findings go here: FAST positive or negative? PEARL? Results of cranial nerve assessment, any acute vision abnormalities? Non-blanching rash? Photophobia? Neck stiffness?

Examine: Musculoskeletal/skin/abdominal assessments findings go here: Abnormal abdominal inspection? Bowel sounds heard? Any tenderness on palpation? Any guarding or rebound tenderness? If so which quadrant? Can you feel a palpable or pulsating mass? Any lower back tenderness? Note skin changes/rash/hives, any joint pain/swelling.

Working impression
Enter your preferred and differential diagnosis findings here.

Care plan
List your treatment plan here, include extrication method, drugs given and why, assessment before and after treatment, did you travel with any specific monitoring on? Pre-alert? Emergency transfer or normal road speed? Any referrals made. If you discharged on scene provide detailed worsening advice (use symptoms of conditions to formulate your advice).

MATERNITY

MATERNITY: PREGNANCY HISTORY

(USE THE TECP MNEMONIC TO GATHER A HISTORY)

T: TRIMESTER - HOW MANY WEEKS PREGNANT ARE THEY?

E: EXPECTED DELIVERY DATE/LAST MENSTRUAL CYCLE - DUE DATE? LAST MENSTRUAL CYCLE? (THE LATTER IS ONLY RELEVANT WHEN BIRTH IS NOT IMMINENT AND IN EARLY PREGNANCY)

C: COMPLICATIONS - ASK ABOUT THE RESULTS OF THE LAST SCAN, LAST TIME THE FOETUS WAS FELT, THE BABY'S POSITIONING, ANY HEALTH CONCERNS WITH THE MOTHER; ECLAMPSIA? PRE-ECLAMPSIA? GESTATIONAL DIABETES?

P: PREVIOUS -HOW MANY PREVIOUS BIRTHS (PARITY) AND PREVIOUS PREGNANCIES (GRAVIDA)? ANY ABNORMAL DELIVERIES, QUICK BIRTHS, MISCARRIAGES, OR ECTOPIC PREGNANCIES?

PROGRESSION OF BIRTH

CONTRACTIONS - NOTE TIME STARTED, DURATION, AND LENGTH APART.

SHOW (A VAGINAL DISCHARGE KNOWN AS A PLUG OF MUCUS THAT IS EXPELLED IMMEDIATELY PRIOR TO LABOUR) - NOTE THE TIME OCCURRED AND CONSISTENCY.

WATERS - NOTE THE TIME BROKEN AND THE CONSISTENCY OF THE FLUID.

***BIRTH IS LIKELY IMMINENT IF THE FOLLOWING OCCURS*:**
- REGULAR CONTRACTIONS AT 1-2 MINUTE INTERVALS
- AN URGE TO PUSH
- BABY CROWNING
- BABY'S HEAD VISIBLE AT THE VULVA

BABY BORN?
- TIME OF BIRTH
- COMPLICATIONS ENCOUNTERED
-MECONIUM PRESENT DURING BIRTH?
- BLOOD LOSS?
- DELIVERY TIME OF PLACENTA
- PLACENTA INTACT?

PREGNANCY COMPLICATIONS

Gestational diabetes - the development of diabetes during pregnancy.

Pre-Eclampsia - pregnant patients who are found to have high blood pressure and protein in their urine.

Eclampsia - pregnant patients who develop seizures or enter a coma after previously being diagnosed with pre-eclampsia.

Consider the following causes when a PV bleed occurs under 24 weeks gestation:

- **Ectopic Pregnancy** – sharp waves of pain in the abdomen, pelvis, shoulder or neck, PV bleeding, syncope episodes, dizziness and shoulder tip pain.

- **Miscarriage** – vaginal bleeding which can vary from mild spotting to heavy bleeding, often associated with cramping abdominal pain radiating into the lower back.

Consider the following causes when a PV bleed occurs after 24 weeks gestation (known as antepartum haemorrhage):

Placenta Abruption - abdominal pain with or without vaginal bleeding, back pain, uterine contractions, and rigidity of the abdomen.

Placenta Previa - painless vaginal bleeding of ranging severity with associated uterine contractions in some cases.

BIRTH COMPLICATIONS

Postpartum Haemorrhage - the loss of more than 500ml of blood within the first 24 hours following childbirth.

Cord Prolapse - a birth complication where the umbilical cord drops through the open cervix into the vagina, ahead of the baby.

Shoulder Dystocia - when the head has been born but one of the shoulders becomes stuck behind the mother's pubic bone.

Breech Birth - when the buttocks or feet are closest to the cervix.

PRF TEMPLATE -Maternity

Presenting complaint: Maternity.

History of presenting complaint
History of events specific to the call out, use SOCRATES to document any pain, use SOCATE for non pain-related symptoms. Document any blood loss by noting volume, colour, and evidence of clot formation. Any recent trauma?

Pregnancy history: Document history of pregnancy using the **TECP** framework: **T**rimester (weeks pregnant). **E**xpected delivery date and last menstrual period. **C**omplications (if any) with the pregnancy? Include results of last scan, last time the foetus was felt, and any health concerns with the mother during pregnancy. **P**revious pregnancies and births, any history of miscarriage/ectopic pregnancies?

Patient in labour?
Document the following: **Contractions**: Time started, duration, and length apart. **Show**: Time and consistency. **Waters**: Time broken and consistency (clear fluid?).

Baby born?
Note the time from baby crowning to birth, time of birth, complications encountered; meconium? Breached/shoulder dystocia etc. Initial assessment of baby; crying straight away? Tone, RR, HR, and interventions performed (neonatal resus required?). Document delivery time of placenta, and note its condition (fully intact?). Record mother's blood loss and umbilical cord management (time cut, reason left).

Past medical history
Insert all previous and current medical conditions.

Medications and allergies
Insert the patient's medications and any allergies they may have.

Social history
Include the following: Living conditions/arrangement, care input, mobility needs, DNR, DoLs, lifestyle habits (smoker, recreational drug use, alcohol consumption), any safeguarding concerns.

Family history
Insert any medical conditions that exist within the family.

On examination (Mother)
(Note: Observations to be recorded in the specific section of the PRF, document both mother and baby).

Catastrophic haemorrhage: Document any significant blood loss/how it was managed.

Airway: Is the airway patent? Clear from obstruction/swelling? Stridor, snoring or gurgling heard? Any facial swelling?

Breathing: Document respiratory rate and effort, inspection, palpation, percussion and auscultation findings, any recent SOB? Cough?

Circulation: Radial pulse findings, cap refill, skin colour and temperature, document results of abdominal inspection/assessment (any tenderness, guarding, rigidity suggesting internal bleeding?

Disability: GCS, posture, evidence of seizure activity?

Examine: Inspect vaginal opening (document consent gained), document any bleeding, signs of baby, crowning? Waters consistency, visual birth complications/breach/cord prolapse/shoulder dystocia etc.

Fundus: Estimate and document fundal height: A fundus at the level of the umbilicus equates to a gestation of around 22 weeks.

On examination (Newborn - note: Observations recorded in the appropriate section on the PRF).

Initail assessment - Document colour, tone, resp rate, heart rate, and if resuscitation interventions have been required. If time permits, document APGAR score. Include steps taken to stimulate/dry/provide warmth to newborn, as well as documenting the time of first feed.

Working impression
Enter your preferred and differential diagnosis findings here.

Care plan
List your treatment here, birth management, time backup called, your extrication method, drugs given and why, assessment before and after treatment, non-conveyed or transported? Any referrals made? Pre-alert calls made to maternity and/or ED? Did you travel with any specific monitoring on? Did you provide an emergency transfer?

PAEDIATRIC

PAEDIATRIC HISTORY BY ASSESSMENT

(A BLEND OF HISTORY TAKING AND ASSESSMENT)

AIRWAY – SECRETIONS? FOREIGN BODY? CROUP? DROOLING? INFLAMED TONSILS?

BREATHING – RESPIRATORY RATE? RESPIRATORY RECESSION? ADDITIONAL MUSCLE USE? EQUAL CHEST RISE AND FALL? STRIDOR? WHEEZE? CRACKLES? PLEURAL RUB? NASAL FLARING?

CIRCULATION – PULSE RATE? CAPILLARY REFILL? O_2 SATURATIONS? COLOUR? TEMPERATURE OF PERIPHERIES? MOTTLED SKIN?

DISABILITY – CRYING APPROPRIATELY? MUSCLE TONE? PEARL? AVPU? PHOTOPHOBIA? NECK STIFFNESS? NON-BLANCHING RASH? BRUDZINSKI'S OR KERNIG'S SIGN? MASTOIDITIS?

EXAMINATION – ABDOMEN SOFT AND NON-TENDER? NAUSEA OR VOMITING? FEEDING HISTORY? WET NAPPIES? BOWEL MOVEMENTS NORMAL? TEMPERATURE? BM?

ADDITIONAL HISTORY: NORMAL BIRTH? FULL TERM? VACCINATION HISTORY, ANY SAFEGUARDING CONCERNS?

COMMON CONDITIONS ASSOCIATED WITH PAEDIATRIC PATIENTS

Epiglottitis - rapid onset, breathing difficulties, difficulty swallowing resulting in excessive drooling, a hoarse voice, fever.

Croup - barking cough, stridor, hoarse voice, fever, breathing difficulties.

Bronchiolitis -productive cough, cold-like symptoms, rapid/shallow breathing. Respiratory assessment can reveal a wheeze, crackles, and an increased respiratory rate with signs of respiratory distress.

Pneumonia - SOB, productive cough/haemoptysis, sharp pleuritic chest pain, lethargy, fever, nausea /vomiting, abdominal pain. Chest auscultation suggests consolidation: bibasilar crackles, dull percussion note.

Febrile Convulsion - fever, history of infection, seizure activity.

Meningitis/Encephalitis – headache, photophobia, neck stiffness, fever, seizures (late sign). A non-blanching rash is typically associated with meningococcal septicaemia.

Intussusception - severe right upper quadrant cramping abdominal pain, often causing legs to draw up to the chest, mass on abdominal palpation, red jelly-like stools, vomiting.

Pyloric Stenosis - projectile vomiting, cramping abdominal pain, weight loss, altered bowel movements.

PRF TEMPLATE - Paediatric

Presenting complaint: Insert specific problem relating to paediatric patient, e.g breathing difficulties.

History of presenting complaint
Use SOCATE: Symptom, Onset, Character, Associated symptoms, Timing, Exacerbating and relieving factors. Or SOCRATES: Site, Onset, Character, Associated symptoms, Timing, Exacerbating/relieving factors, Severity - as a template.

Review of systems: Document a review of systems relating to the presenting complaint. For example, if a patient presents with breathing difficulties, use this section to rule out/or include any associated symptoms that may be of concern. In paediatric patients, consider: Urine output, recent feeding history, bowel movements, nausea/vomiting? Any cold-like symptoms? Cough? Irritability? Any drowsiness? Responding appropriately for age? Neck stiffness? Photophobia? Rash?

On arrival: Document the situation you were presented with on arrival and the appearance of your patient.

Past medical history/Birth history
Insert all previous and current medical conditions. Include birth history; full term? Normal delivery? Any complications?

Medications & Allergies
Insert the patient's medications, vaccination history, and allergies.

Social history
Include the following: Living conditions/arrangement, mother and father's details, school/nursery details, any safeguarding concerns.

Family history
Insert any medical conditions that exist within the family and any recent household illness.

On examination
(Note: Observations recorded in the appropriate section of the PRF).

Airway: Clear/patent? Secretions? Foreign body? Croup like cough? Drooling?

Breathing: Respiratory rate and depth, nasal flaring? Tracheal tug? Additional muscle use? Respiratory recession? Bi lateral air entry? Any added sounds on auscultation?

Circulation: Skin colour and temperature? Mottled skin? Heart rate, cap refill (central and peripheral), oxygen saturations, blood pressure.

Disability: AVPU/GCS, pupil assessment, crying appropriately? Muscle tone, Budzinski's and/or Kernig's sign present?

Examine: Musculoskeletal/skin/abdominal assessments findings go here: Abnormal abdominal inspection? Bowel sounds heard? Any tenderness on palpation? Any guarding or rebound tenderness? If so which quadrant? Can you feel a palpable mass? Note skin changes /rash/ hives/mottled.

Working impression
Enter preferred and differential diagnosis here.

Care plan
Document any treatment given. Was the patient transferred to hospital? Non-conveyed? Any referrals made (e.g GP, safeguarding). If you discharged on scene provide detailed worsening advice (use symptoms of conditions to formulate your advice).

MENTAL HEALTH

MENTAL HEALTH HISTORY TAKING QUESTIONS

GENERAL QUESTIONS

- HOW CAN WE HELP YOU TODAY?
- WHAT'S HAPPENED?
- ARE THERE ANY RECENT EVENTS THAT MAY HAVE AFFECTED HOW YOU'RE FEELING?
- WHAT SUPPORT DO YOU HAVE IN PLACE AT THE MOMENT? (FAMILY, FRIENDS, MENTAL HEALTH TEAMS, GP INPUT)
- HAVE YOU BEEN DIAGNOSED WITH ANY MENTAL HEALTH CONDITIONS?
- DO YOU TAKE MEDICATION? IF SO, HAVE YOU BEEN COMPLIANT?
- HAVE YOU TAKEN ANY MEDICATION IN EXCESS? OR SELF-HARMED TODAY?
- DO YOU HAVE ANY THOUGHTS OF SUICIDE?

***IF THEY'VE SELF HARMED*:**
- HOW HAVE THEY SELF HARMED?
- WHAT LED THEM TO MAKE THIS DECISION?
- WHAT WERE THEIR INTENTIONS/OBJECTIVE?
- HAVE THEY DONE THIS IN THE PAST?

***IF THEY'VE TAKEN A DRUG OVERDOSE*:**
- WHICH MEDICATION HAVE THEY TAKEN?
- DOSAGE AND TIME OF INGESTION?
- WAS IT ACCIDENTAL OR INTENTIONAL?
- WHAT LED THEM TO MAKE THIS DECISION?
- WHAT WERE THEIR INTENTIONS/OBJECTIVES?
- HAVE THEY VOMITED SINCE INGESTION?
- HAVE THEY DONE THIS BEFORE?

***IF THEY'RE SUICIDAL*:**
- HOW LONG HAVE THEY FELT LIKE THIS?
- HAVE ANY RECENT EVENTS OCCURRED THAT MAY HAVE CONTRIBUTED TO THEIR CURRENT STATE OF MIND?
-HAVE THEY PLANNED A METHOD TO END THEIR LIFE?
- HAVE THEY ACTED ON ANY PART OF THIS PLAN? IF YES UP TO WHICH STAGE, AND WHAT STOPPED THEM FROM CONTINUING?
- HAVE THEY ATTEMPTED SUICIDE IN THE PAST?

COMMON MENTAL HEALTH CONDITIONS

Bipolar Disorder - episodes of deep depression coupled with episodes of mania (feeling very high and overactive).

Personality Disorder - thinks, feels, behaves or relates to others very differently from the average person. Behaves impulsively, has problems controlling emotions and may think in a disturbing way.

Psychosis - delusions, hallucinations, suspiciousness, anxiety, disorganised speech.

Schizophrenia - relapsing episodes of psychosis. Symptoms include; hearing voices, seeing things, believing something is real when it's not, feeling disconnected from their emotions, lack of motivation.

Depression - described as feelings of sadness, loss, or anger that interfere with a person's everyday activities.

PRF TEMPLATE - Mental Health

Presenting complaint: Mental health.

History of presenting complaint
Document reason for call, current mental state; Psychosis? Low mood? Anxious? Any triggering factors that have influenced their mental state? Mental health history, what their intentions are today e.g. to end life/self-harm. Any history of self-harm/suicidal tendencies?

If they've self-harmed: Document injuries sustained, weapon used, their intentions.

If they've taken a drug overdose: Document time of O/D, drug name, and dose consumed, was it intentional or accidental? Their desired outcome? Have they vomited since ingestion?

If they're suicidal: Have they planned a method? Have they acted on their plan? If so up to what stage? What are the reasons they haven't gone through with it? Have they attempted suicide in the past?

Past medical history
Insert all previous and current medical conditions, include any mental health diagnosis.

Medications
Insert the patient's medications, include information regarding compliance.

Social history
Include the following: Living conditions/arrangement, mental health teams input, social worker information, care input, DNR, DoLs, lifestyle habits (smoker, recreational drug use, alcohol consumption/dependency). Any safeguarding concerns.

Family history
Insert any medical conditions that exist within the family.

On examination
(Observations to be recorded in the appropriate section of the PRF. The following information should be documented alongside your physical assessment findings).

Appearance: Include a description of clothing, hygiene, immediate surroundings.

Behaviour: Are they agitated? Any delusional thoughts? Do they appear relaxed? Paranoid? Upset? Aggressive?

Communication: Report eye contact, tone of voice, have they demonstrated an appropriate understanding of questions asked? Appropriate answers to questions? Report any non-verbal cues.

Disability: Record result of capacity test and details of how capacity has been demonstrated/not demonstrated.

Working impression
Enter your preferred and differential diagnosis and any triggering factors that may have exacerbated/or caused a mental health crisis today.

Care plan
Document any treatment given. Was the patient transferred to hospital? Non-conveyed? Any referrals made (e.g mental health or safeguarding). If you discharged on scene provide detailed worsening advice (use symptoms of conditions to formulate your advice).

EPISTAXIS/PR/PV BLEED

Epistaxis/PR/PV bleed

(Questions that can be applied to bleeding problems)

- When did it start?
- Spontaneous onset or trauma related?
- Estimated blood loss?
- Still actively bleeding?
- Blood consistency; any clots?
- Is the blood bright or dark?
- Any antiplatelet or anticoagulant medications used?
- Has this happened before?
- Any abdominal pain? (PV, PR)
- Any back pain? (PV, PR)
- Bowel movements normal? (PR)
- Any urinary symptoms? (PR, PV)
- Any nausea/vomiting blood? (PR)
- Bleeding from both nostrils or just one? (epistaxis)

Gynaecological:
PV bleed/discharge? Chance of pregnancy? Sexually active? LMP date, LMP normal? Contraceptive use? Pelvis pain? Shoulder tip pain?

PRF TEMPLATE - Bleeding complaints

Presenting complaint: Bleeding (epistaxis/PR/PV bleeding)

History of presenting complaint
Use SOCATE to formulate a structure: Symptom (site of bleeding), onset (spontaneous? Trauma-related?), character (blood colour, volume, and consistency), associated symptoms, timing, exacerbating and relieving factors.

Review of systems (ROS): Document a review of systems relating to the presenting complaint. Use this section to rule out/or include any associated symptoms that may be of concern. Consider the following: Anticoagulant medication use? Abdominal pain, back pain, bowel movements/melaena, urinary symptoms, haematemesis, prolonged NSAID use. Gynaecological considerations: LMP, chance of pregnancy, shoulder tip pain, pelvis pain.

On arrival: Document the situation you were presented with on arrival and the appearance/condition of your patient.

Past medical history
Insert all previous and current medical conditions.

Medications and allergies
Insert the patient's medications and any allergies they may have.

Social history
Insert the following: Living conditions/arrangement, care input, mobility needs, DNR form in place, DoLs in place, lifestyle habits (smoker, recreational drug use, alcohol consumption).

Family history
Insert any relevant medical conditions that exist within the family.

On examination
(Note: Observations to be recorded in the appropriate section of the PRF).

Airway: Is the airway patent? Clear from obstruction/swelling? Stridor heard?

Breathing: Results from your respiratory assessment go here; inspect, palpate, percuss, auscultate. Any abnormalities on inspection? Is the percussion note normal - high pitched or dull? Are there added sounds present on auscultation - wheeze, crackles, or pleural rub?

Circulation: Cardiac assessment and ECG findings go here: Any abnormalities on inspection? Heaves and/or thrills present? Any abnormal heart sounds? Any peripheral or sacral oedema? Document ECG findings in the following order: Rhythm, rate, cardiac axis, the PR, QRS and QTc intervals, ST segment, T waves.

Disability: Neurological assessment findings go here: FAST positive or negative? PEARL? Results of your cranial nerve assessment, any acute vision abnormalities? Non-blanching rash? Photophobia? Neck stiffness?

Examine: Musculoskeletal/skin/abdominal assessments findings go here: Abnormal abdominal inspection? Bowel sounds heard? Any tenderness on palpation? Any guarding or rebound tenderness? If so which quadrant? Can you feel a palpable or pulsating mass? Any lower back tenderness? Note skin changes/rash/hives, any joint pain/swelling?

Working impression
Enter your preferred and differential diagnosis here.

Care plan
List your treatment plan here. Include extrication method, drugs given and why, assessment before and after treatment, did you travel with any specific monitoring on? Pre-alert call made? Emergency transfer or normal road speed? Any referrals made? If you discharged on scene provide detailed worsening advice (use symptoms of conditions to formulate your advice).

CARDIAC ARREST

CARDIAC ARREST (DRSID)

(DRSID IS A MNEMONIC THAT CAN BE USED TO HELP RECORD/KEEP TRACK OF THE EVENTS THAT OCCUR IN A CARDIAC ARREST)

D – DOWNTIME – LENGTH OF TIME THE PATIENT HAS BEEN IN CARDIAC ARREST.

ROSC - R - RHYTHM – R HAS TWO MEANINGS; THE INITIAL CARDIAC ARREST RHYTHM, ALONG WITH SUBSEQUENT RHYTHM CHANGES AND TIME OF ROSC (IF APPLICABLE).

S – SHOCKS – THE NUMBER OF SHOCKS THAT HAVE BEEN DELIVERED.

I – INTUBATION/I-GEL AND IV/IO - THE TIME AT WHICH AN ADVANCED AIRWAY AND A CANNULA ARE INSERTED.

D – DRUGS GIVEN – A RECORD OF DRUGS GIVEN THROUGHOUT.

FURTHER HISTORY - EVENTS LEADING UP TO THE CARDIAC ARREST? WITNESSED ARREST? CPR PRIOR TO ARRIVAL? PATIENTS PMHX AND MEDICATIONS?

REVERSIBLE CAUSES CHECKLIST

(USE THIS SECTION AS A CHECKLIST TO ENSURE YOU CONSIDER ALL OF THE REVERSIBLE CAUSES OF A CARDIAC ARREST)

HYPOXIA - SECURE AIRWAY, ENSURE CAPNOGRAPHY READING, HIGH FLOW OXYGEN.

HYPOVOLAEMIA - TRAUMA? SEPSIS? DEHYDRATION? DROWNING? CONSIDER 2 LITRES OF IV SALINE AND TXA.

HYPO/HYPERKALAEMIA - DOES THE HISTORY SUGGEST HYPER OR HYPOKALAEMIA? E.G DIALYSIS PATIENT? DKA LIKELY? DRUG-INDUCED HYPERKALAEMIA?

HYPO/HYPERTHERMIA - TEMPERATURE? WARM OR COOL THE PATIENT, ALWAYS TRANSPORT IF HYPOTHERMIA IS THE CAUSE.

TOXINS - HISTORY OR EVIDENCE OF DRUG USE ON SCENE? ALL PATIENTS SHOULD BE TRANSPORTED IF THIS IS SUSPECTED. CONSIDER NALOXONE.

TENSION PNEUMOTHORAX - IS THERE BVM RESISTANCE? NO CHEST RISE AND FALL? SURGICAL EMPHYSEMA PRESENT? TRAUMA, ASTHMA OR ANAPHYLAXIS THE LIKELY CAUSE? CONSIDER NEEDLE CHEST DECOMPRESSION.

THROMBOSIS - CONSIDER THE HISTORY, COULD IT SUGGEST A CORONARY OR PULMONARY THROMBOSIS?

CARDIAC TAMPONADE - CONSIDERATION SHOULD BE GIVEN IN TRAUMATIC CARDIAC ARRESTS AND DECOMPRESSED BY AN APPROPRIATE CLINICIAN IF AVAILABLE.

SPECIAL CIRCUMSTANCES

(SPECIAL CONSIDERATIONS THAT NEED TO BE MADE IN CERTAIN CARDIAC ARREST SITUATIONS)

PREGNANCY - HYPOXIA, HYPOVOLEMIA, PE, AND SEPSIS ARE LIKELY CAUSES. DISPLACE THE UTERUS TO THE LEFT AT 22 WEEKS GESTATION OR ABOVE. ALWAYS TRANSPORT.

DROWNING - CONSIDER HYPOXIA, HYPOVOLAEMIA, AND HYPOTHERMIA. MAINTAIN HORIZONTAL POSITIONING OF THE PATIENT IN THE WATER WHERE POSSIBLE, 5 INITIAL VENTILATIONS TAKE PRIORITY, CONSIDER HEAD AND NECK INJURY.

PAEDIATRICS - CONSIDER THE FOLLOWING:

- SHOCK JOULES = 4 X WEIGHT IN KG
- WEIGHT = AGE + 4 X 2
- ADRENALINE 1:10000 DOSE = 10MCG PER KG
- AMIODARONE DOSE = 5MG PER KG
- 5 INITIAL VENTILATIONS TAKE PRIORITY
- 15 COMPRESSIONS TO 2 BREATHS (3:1 IN NEWBORNS)

ASTHMA - CONSIDER HYPOXIA AND TENSION PNEUMOTHORAX AS CAUSES. CONSIDER EARLY IM ADRENALINE 1:1000, EARLY INTUBATION, AND NEEDLE CHEST DECOMPRESSION.

TRAUMA - USE THE HOTT APPROACH (SEE NEXT PAGE)

THE HOTT APPROACH

THE HOTT APPROACH HIGHLIGHTS THE LIKELY CAUSES OF A TRAUMATIC CARDIAC ARREST AND THE INTERVENTIONS REQUIRED TO REVERSE THESE CAUSES.

HYPOVOLAEMIA	- CONTROL HAEMORRHAGE -PELVIC/LONG BONE SPLINT -IV FLUIDS/TXA
OXYGEN	-SECURE AIRWAY -HIGH FLOW OXYGEN
TENSION PNEUMOTHORAX	-NEEDLE CHEST DECOMPRESSION
TAMPONADE	- CONSIDER SUITABILITY AND AVAILABILITY FOR THORACOTOMY

PRF TEMPLATE - Cardiac arrest

Presenting complaint: Cardiac arrest.

History of presenting complaint
Document the history leading up to the cardiac arrest, the appearance of the scene on arrival, CPR in progress? Time bystander CPR commenced? Note how long the patient has been in cardiac arrest (downtime), initial and subsequent rhythms, how many shocks were performed (if any), time of advanced airway insertion, time of cannulation/IO, time BLS and ALS commenced, the length of time ALS was carried out. Drugs given with timings. Document how each reversible cause has been considered and addressed where appropriate, note time of ROSC if applicable.

Past medical history
Insert all previous and current medical conditions.

Medications
Insert the patient's medications.

Social history
Include the following: Living conditions/arrangement, care input, mobility needs, DNR, DoLs, lifestyle habits (smoker, recreational drug use, alcohol consumption), any safeguarding concerns (if applicable).

Family history
Insert any medical conditions that exist within the family.

On examination

Initial Primary survey:

Airway: Is the airway clear? Obstructed?

Breathing: Is the patient breathing?

Circulation: Corotid pulse present?

Disability: GCS?

Cardiac arrest confirmed?
Detail step by step actions taken to manage cardiac arrest. If ROSC is achieved, detail your post ROSC assessment here too.

E.g. compressions started, pads attached; VF arrest, charge and shocked, CPR continued, I-Gel inserted with end-tidal CO2, catheter mount, filter and BVM. 15L O2 attached to BVM. Rhythm checks every 2 minutes, subsequent rhythms VF and pulseless VT, IO access gained, Adrenaline and Amiodarone administered (see drug section of PRF for times/dose).

Reversible causes addressed: Document each reversible cause and how it's been considered/reversed.

(note: The above information can be documented in the History of presenting complaint section, the on examination section, or in the care plan, it's purely personal preference, and situation dependant).

Working impression
Enter the most likely cause of the cardiac arrest.

Care plan
List the treatment carried out here. Patient transferred? Note the management throughout the journey. Document actions taken post-incident: Non conveyed - deceased? ROLE form completed? Police/coroner requested/on scene, bereavement advice given? NOK informed?

TRAUMA/BURNS

TRAUMA ASSESSMENT

Catastrophic Haemorrhage	- Assess and manage any catastrophic bleeding
Airway and C-spine	- Assess and maintain patient airway whilst ensuring neutral C-spine alignment
Breathing	Respiratory rate and depth Check specifically for **(TWELVE)**: -Tracheal deviation - Wounds/bleeding/bruising - Emphysema (surgical) - Laryngeal Crepitus - Venous engorgement - Exclude Pneumothorax, Hemothorax and flail chest
Circulation	- Reassess any catastrophic bleeding - Assess peripheral and central pulses - Blood pressure - SPO2 - Any blood on the floor or four more; chest, abdomen, pelvis, long bones. - High flow oxygen - Gain access and consider TXA and Sodium chloride
Disability	- Obtain a GCS - Assess pupils - Assess for a head injury
Examine/expose	- Consider Analgesia and antiemetics - Complete full secondary survey (only on route if appropriate)

Trauma Centre decision tool

Sustained respiratory rate ↓10 or ↑29	YES	NO
Systolic BP ↓90mmHg or absent radial pulse	YES	NO
Sustained tachycardia ↑120bpm or tourniquet applied	YES	NO
GCS motor score of 4 or less	YES	NO
Open pneumothorax or flail chest	YES	NO
Crushed, de-gloved or mangled limb or extreme fracture	YES	NO
Suspected major pelvic fracture	YES	NO
Neck or back injury with paralysis	YES	NO
Amputated limb proximal to wrist or ankle	YES	NO
Suspected open or depressed skull fracture	YES	NO

If yes to any of the criteria move to section 2
(If no, transport to nearest suitable hospital)

Section 2
Does the patient fit the following safety criteria?

Can the airway or any catastrophic bleeding be controlled?	YES	NO
Can the major trauma centre be reached within 60 minutes?	YES	NO

If YES, consider transporting to a trauma centre
(always cross reference with local pathways)

BURNS - THE HATT APPROACH

- **H**OW WAS THE PATIENT BURNED?
- **A**REA OF THE BURN (SPECIFIC AREAS AND TOTAL BODY SURFACE AREA)
- **T**IME THAT THE BURN OCCURRED AND LENGTH OF EXPOSURE
- **T**EMPERATURE OF THE BURN SOURCE

CONSIDERATIONS:

- AIRWAY COMPROMISE
- HYPOTHERMIA
- CIRCULATION
- DEHYDRATION/ELECTROLYTE IMBALANCE
- INFECTION

TIME CRITICAL FEATURES INCLUDE:

- HOT AIR/GAS INHALATION
- FACIAL BURNS
- FULL CIRCUMFERENTIAL BURNS
- BURNS OVER 15%

PRF TEMPLATE - Trauma

Presenting complaint: Trauma.

History of presenting complaint
Insert a description of the traumatic event. Use **ATMIST** to structure your paperwork: **A**ge, **T**ime, **M**echanism of injury: Include estimated height if fallen, estimate speed of vehicles, damage to vehicles/helmets. Note if airbags were deployed. Blunt/penetrating trauma? Crush injury? Time crushed? **I**njuries sustained; LOC? Location of injuries/pain.
(note not all of the ATMIST information is seen here, you do not have to repeat information if it will be included in other sections of the PRF).

On arrival: Document the situation you were presented with on arrival, the appearance of your patient, how many patients, and which resources you requested.

Past medical history
Insert all previous and current medical conditions.

Medications and allergies
Insert the patient's medications and any allergies they may have.

Social history
Include the following: Living conditions/arrangement, care input, mobility needs, DNR, DoLs, lifestyle habits (smoker, recreational drug use, alcohol consumption).

Family history
Insert any medical conditions that exist within the family.

On examination
(Note: Observations to be recorded in the specific section of the PRF).

Catastrophic haemorrhage: Details and action taken.

Airway: Is the airway patent? Clear? Any max fax injuries?

C-spine: Insert the results of your spinal assessment here.

Breathing: Include results from your respiratory assessment, use **TWELVE** as a guide: **T**rachea central? **W**ounds /bruising/lacerations on inspection? **E**mphysema (surgical) present? **L**aryngeal crepitus? **V**enous engorgement? **E**xclude pneumothorax/haemothorax, results of auscultation and percussion assessment.

Circulation: Catastrophic haemorrhage management still effective? Document your pelvis, long bone, and abdominal assessment here, alongside any external bleeding, and your manual radial/carotid pulse findings.

Disability: Neurological assessment findings go here: Head injury? Boggy mass? GCS? LOC? FAST positive or negative? Pupil check, cranial nerve assessment findings. Any acute vision abnormalities? CSF fluid present?

Examine: Detailed record of your secondary survey, record distal pulse and cap refill if injury found.

Working impression
Document the injuries your patient sustained here.

Care plan
List your treatment plan here, include extrication method, drugs given and why, assessment before and after treatment, did you travel with any specific monitoring on? Pre-alert call made? Did you provide an emergency transfer? Normal road speed? Did you liaise with the major trauma team? Did you travel to a major trauma centre?

HOSPITAL HANDOVERS

ATMIST

Trauma handover template

AGE:

TIME:

MECHANISM OF INJURY:

INJURIES SUSTAINED:

SIGNS & SYMPTOMS:

HR:

RR:

BP:

SATS:

GCS:

TREATMENT:

SBAR

Medical handover template

SITUATION:

BACKGROUND:

ASSESSMENT:

HR:

RR:

SATS:

BP:

TEMP:

BM:

GCS:

RESPS:

ECG:

NEURO:

ABDO:

RECOMMENDATION: