

CHART Method EMS Documentation

Patient Name: _____ Date of Incident: _____ dd / mm / yyyy

Time of Call: _____ Unit Number: _____

Provider Name: _____

C - CHIEF COMPLAINT

Chief Complaint (in patient's own words or as described by family/bystanders)

H - HISTORY OF PRESENT ILLNESS

Onset Time: _____

Mechanism of Injury or Illness Progression

Past Medical History

Medications

Allergies

Witnessed Events / Pertinent Negatives

A - ASSESSMENT

Vital Signs

General Appearance

Respiratory Effort

Cardiac Rhythm

Perfusion

Neurological Checks

Specific Injury Markers / Additional Findings

R - RESPONSE TO TREATMENT

Medications Administered (dose, route, time)

Airway Management

Oxygen Therapy

Other Interventions (splinting, defibrillation, procedures)

Vital Sign Changes / Symptom Improvement Following Interventions

T - TRANSPORT

Receiving Facility: _____

Patient Condition at Handoff

Deterioration or Changes En Route

Interventions During Transport

Alerts Passed to Receiving Staff

Provider Signature

Date: _____ dd / mm / yyyy