

A.C.H.A.R.T.E. FORMAT

CLINICAL DOCUMENTATION TRAINING

ARRIVAL

Presentation of the patient

Describe any scene or call information not clearly documented in other elements of the PCR

[Ex: How the patient was found, bystander care]

COMPLAINT

Further detail of the chief complaint, if necessary

If the EPCR event log allows for adequate content and detail to be provided, “as above” would be acceptable

HISTORY OF PRESENT ILLNESS (EVENTS LEADING UP TO COMPLAINT/REASON FOR TRANSPORT)

Describe any part of the events leading to the problem that are not clear in the Arrival or Complaint section and any pre-arrival interventions that the patient has attempted.

Ex: “Patient states that they attempted to control pain with Motrin and heat application for several hours before calling 911.”

If applicable, include: SAMPLE, OPQRST (of complaint), MOI/NOI

ASSESSMENT

Findings from the head-to-toe assessment

Focus on organ system/injury/illness pertinent to the patient

Rx

What treatment was initiated, and why was it required

If a protocol indicated treatment was omitted, document the reason(s) for withheld treatment

TRANSPORT

How was the patient transferred to the stretcher? Did they walk? Were they carried by EMS?

Safety measures taken

Destination determination

EVENTS

Results of treatment

Who was care transferred to?

How was the patient moved off the stretcher at the destination?