**D – Dispatch**

* What was the **dispatch information**?
* Nature of the call, time received, priority level.
* Who requested EMS (e.g., bystander, facility, law enforcement)?

**A – Arrival**

* Document **scene arrival time** and **conditions**.
* Describe the **scene size-up**, including location, number of patients, safety concerns, and your initial impression.
* Note **who is present** (e.g., fire, police, bystanders).

**C – Chief Complaint**

* The patient's **own words** describing why EMS was called.
* If the patient is unable to speak, document what was reported by others.

**H – History**

* History of present illness or injury (HPI): **Onset, Provocation, Quality, Radiation, Severity, Time** (OPQRST).
* Past medical history, medications, allergies.
* Any relevant **mechanism of injury** or context.

**A – Assessment**

* Primary and secondary assessments.
* **Vital signs** (initial and serial).
* General appearance, mental status, physical exam findings.

**R – Rx (Treatment)**

* Treatments **provided on scene and en route**.
* Include **timing, route, dose, response** to interventions.
* Mention any **medical control orders**, refusals, or changes in plan.

**T – Transport**

* Time of transport, **mode** (emergent/non-emergent), position of patient.
* Destination and **reason for destination choice**.
* Changes in patient condition en route.

**E – Exceptions**

* Any **deviations from protocols** or anything unusual (e.g., equipment malfunction, patient refusal, delays).
* Also document if **anything was attempted but not completed** (e.g., unsuccessful IV attempt).