CENTRAL CALIFORNIA
EMERGENCY MEDICAL SERVICES

A Division of the Fresno County Department of Public Health

Manual	Emergency Medical Services Administrative Policies and Procedures	Policy Number 811 Page 1 of 4
Subject	Electronic Health Record – Electronic Patient Care Report (ePCR)	
References	Title 22, Division 9, Chapter 3.3 of the California Code of Regulations Health and Safety Code Section 1797.227	Effective 01/01/82

I. POLICY

A. An Electronic Health Record must be filled out completely and accurately by all ground/air ambulance and ALS first responder agencies. The Electronic Patient Care Report (ePCR) is the pre-hospital version of the Electronic Health Record.

B. Each Provider Agency must use an Electronic Health Record – Electronic Patient Care Report (ePCR).

C. The ePCR must be compliant with the **CURRENT** versions of the National Emergency Medical Services Information System (NEMSIS) and the California Emergency Medical Services Information System (CEMSIS). The ePCR must also be approved for use by the Central California EMS Agency.

D. An ePCR must be completed for each patient identified on scene.

E. Responses where a call is cancelled before arrival on scene, no ePCR is required for EMS units cancelled while enroute to a call.

F. A patient is someone who was involved in, has signs/symptoms, or who has a medical complaint of injury or illness at the scene of the incident for which a medical response was requested.

1. **Person Requesting:** The individual who called 9-1-1 seeking EMS care.
2. **Person Identified:** Any person for whom the 9-1-1 system was activated by a reporting party regardless of association with that person.
3. **Person Involved:** All parties involved in the incident or accident prompting the activation of the 9-1-1 system.

G. ALS First Responder Requirements.

An ePCR must be created by the ALS First Responder for any response where they arrive on scene, which includes when arriving before, after, or at the same time as the ambulance provider. The ePCR shall include any treatment or assessment performed by the ALS first responder provider.

Approved By	**Daniel J. Lynch**	Revision
EMS Director	(Signatures on File at EMS Agency)	**03/02/2026**
	Miranda Lewis, MD	
EMS Medical Director	(Signatures on File at EMS Agency)	

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II. PROCEDURE

A. Documentation of the Electronic Health Record – Electronic Patient Care Report (ePCR)

1. All treatment administered, vital signs, and physical assessment **MUST** be documented in appropriate section of the ePCR. This includes any treatment administered prior to arrival (PTA).

a. If the patient refuses any of the above, document whatever is available, including the part(s) of the assessment that was refused.

b. Any treatment provided by BLS first responders or bystanders (i.e., CPR, the administration of naloxone, splinting, etc.) shall be documented as PTA.

c. Vital signs must be documented on the ePCR for every patient. A minimum set of vital signs includes respiratory rate and effort, lung sounds, pulse rate, blood pressure, capillary refill, pupils, skin signs, and mental status.

d. Document all advanced airway procedures (i-Gel and ET) attempted or successfully performed.

(1) End Tidal CO_2 **MUST** be used in conjunction with adequate Paramedic assessment of advanced airway placement (i-Gel and ET). Both the reading and the waveform **MUST** be attached to the ePCR.

The receiving physician **MUST** sign the ePCR in order to confirm successful placement of an advanced airway (i-Gel or ET) by the Paramedic.

(2) Advanced airways (i-Gel or ET) without a physician placement verification signature and verified End Tidal CO_2 readings will be considered an unsuccessful advanced airway placement.

(3) In situations in which the airway is removed prior to the physician confirming advanced airway (i-Gel or ET) placement, the Paramedic will still obtain a signature from the physician and document that the advanced airway (i-Gel or ET) was pulled prior to confirmation.

e. In instances in which a 12-Lead ECG was captured and/or ECG monitoring is part of the treatment protocol, electrocardiogram rhythm strips **MUST** be attached to the ePCR. In the event that the cardiac monitor detects an acute cardiac event, the 12-Lead ECG **MUST** be transmitted to the designated cardiac center.

2. The Narrative section of the ePCR shall include:

a. A record of the patient's complaint, history of present illness, signs and symptoms pertaining to the current injury or illness, and any other pertinent information that may be useful to a care team at the hospital or for later recollection of events by the provider.

b. Information from care providers, family members, or anyone involved at the scene about what they witnessed or heard as it directly pertains to the presentation of the patient at the time of 9-1-1 activation.

c. If the patient refuses any part of the assessment, document everything that is possible, including which part of the assessment was refused.

3. Special Circumstances

a. In a multi-casualty incident (MCI), every person who has signs and/or symptoms or a complaint of injury or illness must receive a patient assessment and a triage tag. An ePCR will be completed for every patient. For Refusal of Medical Care and/or Transportation (RMCT) patients, refer to EMS Policy #546.

b. Deceased patients: The ePCR must be utilized to document the circumstances related to a deceased patient (no resuscitation attempt). Documentation shall include the following:

(1) All times of arriving unit(s).

(2) Circumstances upon which the patient was found and by whom.

(3) Historical or physical findings which prompted no resuscitation efforts.

(4) The patient's past medical history (if available), including any recent complaints which may be related to the death.

(5) To whom the patient was turned over to (family, law enforcement, care team at a SNF, etc.).

B. Responsibility for ePCR Completion

1. Responses where the patient is transported.

a. All units involved in a rendezvous with another transporting unit, regardless of provider level, shall complete an appropriate ePCR for their level of care.

b. The personnel who receives the patient from a unit previously responsible for that patient's care will attempt to obtain a transfer of care signature. If no signature is obtained, document the reason in the narrative.

2. Responses where the patient is not transported (refer to EMS Policy #546 Refusal of Emergency Medical Care and/or Transportation) and document the following:

a. The assessment of the patient to the extent possible.

b. Document the Release of Responsibility section of the ePCR and have the patient sign the release.

(1) If Base Hospital contact occurred, document which base was contacted and the name of the Base Hospital Physician.

(2) Obtain the patient/guardian signature(s) or document refusal to sign.

(3) Obtain the signature of a responsible person who witnessed the patient, parent/guardian signing the ePCR or document refusal to sign. If available at the scene, the witness should be a law enforcement officer or a member of the patient's family.

3. The ePCR is to be completed and uploaded to the receiving facility **WITHIN 45 MINUTES OF**

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LEAVING THE FACILITY. Failure to submit completed ePCRs may result in a fine.

C. Retention of ePCRs.

1. Access to the ePCR shall be maintained for a minimum of seven (7) years.