SECTION 9
PATIENT CARE RECORD
DOCUMENTATION GUIDELINES

Introduction Patient Care Record Documentation

Medavie HealthEd recognizes the need for students to provide detailed and accurate Patient Care Record Documentation. It is important for the student, school staff and preceptors to recognize the value of documenting patient care, in that it serves as a safety mechanism for the patient, as well as the practitioner. To that end, students, school staff and preceptors must develop the student's ability to document all aspects of the patient care they provide.

Documentation provides a written record between practitioners of the assessment and treatment they have provided. This establishes greater patient safety and the smooth transition of patient care from one provider to another.

In regard to the student and practitioner, accurate and detailed information on the Patient Care Record will serve as the primary record in any litigation that may be brought forward by a patient or their family. **If information is not on the record it did not happen.**

While in school, the Patient Care Record also serves as the formal document to validate the competencies a student has obtained. The schools staff must be able to clearly identify any competency a student has been signed off on, in the written documentation of the Patient Care Report. If designated school staff cannot clear identify a competency as being performed, based on the students documentation, and even if it is signed off by a preceptor/facilitator it will not be validated. This then requires the student to obtain that competency again.

The following pages contain general guidelines for completing the narrative portion of your Patient Record. The student will complete documentation on all patients they encounter in the clinical and practicum settings. As we all know, accurate and complete documentation is vital for a paramedic in order to convey the patient's condition to other practitioners. Upon arrival at a hospital, any given patient's condition is often very different from what it was upon our arrival at their house or bedside. Other practitioners rely on our verbal and written reports to "paint a picture" of how the patient looked or felt when we arrived, and how they responded to any treatments or interventions we may have initiated.

Important Note to Students and Preceptors:

Please ensure you take the time to review this document in full and that you understand the requirements to evaluate the Schools students. If at any point you have a question, please feel free to contact the school at 1-888-798-3888, and ask the administrative staff for assistance. Generally you will be put in contact with the Coordinator of Clinical and Practicum Placement, an instructor, or another member of our staff who will assist you.

When to Complete a Patient Care Record

A PCR must be filled out on all patient contacts, during clinical and practicum time. Complete a PCR on all patients with whom you have contact and whom you assess.

A separate PCR must be completed for each patient transported or treated. E.g., if a baby is delivered at home and no other resources are available, separate PCRs are required for mom and baby.

PCR's must also be completed for inter-facility transfers and assessments must be completed on those patients as well.

Why use a Patient Care Record

A patient record, regardless of the health care setting, is intended to be a complete and accurate reflection of that patient's condition and care provided by the student. It is meant to be a communication tool used among health care providers to ensure the consistent and proper care is provided to the patient.

Furthermore it allows, the school to accurately assess and determine if you the student have obtained the competencies you preceptor has scored you on. To receive credit for the competency, you must accurately document information on the PCR to show us that you did perform that competency.

How to complete the Patient Care Record

You should be **gathering information through the entire call**. The PCR should be completed as soon as possible after patient care has been turned over to the receiving facility; so complete as much of, if not all of the PCR prior to clearing from the hospital. This is common practice and now is the time to get use to doing so.

Legibility is a very important when completing your PCR; sloppy, illegible handwriting creates confusion and can result in improper patient care at the receiving facility (be it a nursing home, hospital or patients home). Moreover, injury to the patient may result if crucial information is misunderstood or not communicated because of illegible handwriting. Simple solutions to this problem include, printing instead of writing, use of proper grammar/spelling, and the use of recognized abbreviations.

The PCR you complete will become a **legal document** showing what you did on the call you participated in and the care you provided. Therefore, reports should be completed as soon as possible with as much clarity and detail as possible.

And it can never be emphasized enough that **confidential patient information is required to be held in the strictest confidence**: divulging any information has severe legal repercussions.

In an effort to assist you in developing the most appropriate reports, the following rules can be applied:

1. **Record at the time of occurrence.** Information obtained or actions taken should be recorded at the time or as shortly as possible thereafter. Do not rely on your memory, as it has a tendency to become distorted. The document will be less accurate the longer you take to record your information. Make notes during the call (e.g. vitals, history, etc.) and start recording this information on a PCR as soon as you can (e.g. during transport to the hospital).

2. **Record only what you saw, did or heard.** Never take responsibility for what someone else did if you did not see or participate in it. Record the actions your preceptor took on the call just as much as you record what you did on the call.

3. **Record in chronological order**. This allows for accuracy in the document.

4. **Record in a concise, factual and clear manner.**

5. **Record frequently**. The frequency of the documentation will be determined by the condition of the patient. The more critical the patient, the more extensive the documentation must be. However, it is with these patients that the least amount of time will be available to document and you will have the most information to remember. So it is imperative that the documentation be completed as soon as practical after transferring patient care to the receiving facility.

6. **Record Corrections Clearly.** To make a correction, write a line through the error and initial it. Then record the correct information. Never completely scratch out or black out wording; it could indicate you are trying to hide something.

7. **Record Accurately**. Accuracy of the PCR is important as paramedic students you are expected to be honest and truthful in your documentation. Falsifying a PCR or call evaluation form constitutes misconduct, and could result in dismissal from the program.

Approaches to Documentation

The areas that seem to cause students the most difficulty is the section about assessment and treatment. To that end, we have included some possible suggestions to help you in that area, which include the system by system analysis (using CHART or SOAP) and by body region (using CHART or SOAP).

System by System Approach

The system by system approach allows you to separate pertinent positive and negative findings by body system, and lends itself better to medical calls than trauma calls. It is not necessary to comment on all of the signs/symptoms for a particular body system, just the ones that seem appropriate for the call and the patient's chief complaint. By commenting on the presence or absence of any of the noted signs or symptoms, your PCR will indicate definitively that you did indeed assess that particular system.

For example, a typical cardiac chest pain patient may be complaining of chest heaviness, SOB, N/V, dizziness. Commenting on the presence of the chest pain (and radiation/quality/severity etc)

proves that you assessed the cardiovascular system. The presence of SOB (air entry, adventitia, AMU) proves you assessed the respiratory system. Stating that there was an absence of N/V indicates an assessment of the GI system, and if there was no headache or dizziness would prove an assessment of the neurological system. You could conceivably be scored at 3 or 4 for assessing these systems (4.3c, 4.3d, 4.3e, 4.3g).

When it comes to treatment for this patient you would probably provide ASA, Ntg, and O2. You could conceivably be scored at 3 or 4 for treating a cardiovascular patient and a respiratory patient (6.1a, 6.1c). You would not be scored as having treated a GI patient (6.1e) or a Neuro patient (6.1b) because those systems didn't require treatment. If the patient had nausea and gravol was administered then you could be scored as having treated the GI system as well.

Ultimately, for you to receive credit for having completed the NOCP requirements in the practicum setting (that is what the 'P' is for in your practicum manuals) your PCR's must indicate clearly that each skill was completed. That goes for simple things like your vital signs and less obvious things like your systems assessments and treatments. You can't claim to have completed a palpated blood pressure for a particular call, when the vital signs column indicates only auscultated blood pressures. Likewise, if you are claiming credit for doing a blood glucometer, the PCR must indicate a blood glucose level. **If it isn't written down, it didn't happen.**

Body Region Approach

The second format is done by body region, and separates pertinent negative and positives by region rather than body system. This format lends itself better to trauma calls than medical calls. As with the previous method, not all body regions need to be commented on for every call, just the primary ones involved. The patient mentioned above would have the same information documented, just in a different order and format. And, you would receive credit for the NOCP under the same criteria. **If it isn't written down, it didn't happen.**

Gathering information using CHART format (System by System)

C/C: chief complaint as indicated by the patient or observed by the paramedic.

H: History of present illness/injury; include what happened, where it happened or where the pain is, when it happened, how it happened (Mechanism of Injury). Also ensure you include any pertinent past medical history, positive findings from a past medical history may help you in your decision making process on how to treat the patient.

A: Assessment findings;
Cardiovascular: presence/absence of; chest pain, palpitations, bleeding, bruising, JVD, etc.

Respiratory: presence/absence of; SOB, adventitious lung sounds, AMU, tracheal deviation, etc.

Neurological: presence/absence of; headache, dizziness, vision/auditory changes, grip strengths, paralysis/parasthesia, facial droop, CSF, battle signs, raccoon eyes, etc.

Gastrointestinal: presence/absence of; nausea/vomiting, diarrhea, melena, foul breath odours, bowel sounds, localized abdominal pain, recent eating habits, etc.

Genitourinary: presence/absence of; flank pain, foul smelling urine, colour of urine (straw, blood tinged, cloudy/clear), pain on urination, ability to urinate, amount of urine output, last menstruation, etc.

Integumentary: presence/absence of; abrasions, lacerations, avulsions, burns, blisters, rashes, etc.

Musculoskeletal: presence/absence of; obvious fractures, deformity, angulation, internal/external rotation, shortening, inability to move a joint, crepitus, etc.

Immune: presence/absence of; flu-like symptoms, recent history of fever/infection, etc.

Obstetrical: presence/absence of; crowning, urge to push/defecate, contraction frequency/duration, etc.

Rx: any treatment or interventions you performed; IV, O2, dressing/bandaging, splinting/immobilizing, medication administration, CPR, BVM, ECG/12 Lead, etc. **Treatment could be a simple thing such as comforting and positioning the patient appropriately.**

T: transport; any change in patient condition during transport, and any additional treatment provided during transport.

Gathering Information using CHART format (Body region)

C/C: chief complaint as indicated by the patient or observed by the paramedic.

H: History of present illness/injury; include what happened, where it happened or where the pain is, when it happened, how it happened (Mechanism of Injury)

A: Assessment findings;
HEENT (Head, Eyes, Ears, Nose, Throat): presence/absence of; headache/dizziness, blurred vision, auditory changes, facial droop, blood CSF (ears/nose), battle signs, raccoon eyes, tracheal deviation, JVD, AMU, foul breath odours, DCAP/BLS, etc.

Chest/back: presence/absence of; adventitious lung sounds, symmetrical chest movement, quality of air entry, pain (location/radiation etc), DCAP/BLS, etc.

Abdomen: presence/absence of; pain, tenderness, bowel sounds, nausea/vomiting/diarrhea, urinary changes, recent eating habits/appetite, pulsatile masses, DCAP/BLS, etc.

Extremities: presence/absence of; pain, CMS, grip strength/movement, edema, range of motion, DCAP/BLS, shortening, rotation, etc.

Rx: any treatment or interventions you performed; IV, O2, dressing/bandaging, splinting/immobilizing, medication administration, CPR, BVM, ECG/12 Lead, etc. **Treatment could be a simple thing such as comforting and positioning the patient appropriately.**

T: transport; any change in patient condition during transport, and any additional treatment provided during transport.

Narrative using the CHART format

C – 62 yr o pt. complaining of chest pain X 2 hours.

H – Patient states pain onset while walking up stairs. Pt. sat down and realized moderate relief, took 3 ntg as prescribed, never became pain free. Past medical history of angina, htn. Meds include ntg, procardia. NKA. MFR and Police on scene. Attending MFR states they just arrived on scene and had no opportunity to initiate care.

A – Pt found sitting in chair in her living room. CAO X 3 (person, place, time). Airway patent. Adequate respirations, but fast and adequate circulation. Head – no trauma, PERL@4-5 mm, ENT clear. Neck – no trauma, JVC or TD. Chest – no trauma, + BS Bilat. BS X 4 Abd – soft, non-tender, non-distended. Pelvis – stable. Back – no trauma. Extremities – no Trauma. + PMS X 4, CR<=2sX4, ROM WNL X4, Skin – pale, cool, moist. Pt. states + dyspnea/nausea/chest pain, denies any vomiting/dizziness/headache. States chest pain is a "pressure" sensation, radiating to Lt shoulder and jaw, rates it as a 7/10 initially, now 4/10. Clinical impression, possible AMI.

R – Scene safe, no addition resources required. Ensured pt and bystanders understood the situation and provided/explained the following care - LOC. ABC. Secondary. O2 10 lpm. Ntg 0.04 mg sl. ASA 160 mg po. Loaded pt to stretcher. Vitals. Pain now 2/10. Loaded to ambulance. Transport code 2.

T – Second ntg 0.04 mg sl given. Vitals. Pt. now pain free. EKG shows sinus tach at 108 without ectopy. Monitored, vitals, no changes en route. Transport without incident, pt. remained pain free. Patient delivered to ER bed number 2 and report given to receiving RN. Stretcher cleaned and disinfected. Ambulance and equipment cleaned, disinfected and restocked.

Gathering information using SOAP format (System by system)

S: Subjective; what the patient tells you happened (includes c/c, pertinent recent history, bystander information)

O: Objective; what you find during your physical assessment (includes vital signs)

Cardiovascular: presence/absence of; chest pain, palpitations, bleeding, bruising, JVD, etc.

Respiratory: presence/absence of; SOB, adventitious lung sounds, AMU, tracheal deviation, etc.

Neurological: presence/absence of; headache, dizziness, vision/auditory changes, grip strengths, paralysis/parasthesia, facial droop, CSF, battle signs, raccoon eyes, etc.

Gastrointestinal: presence/absence of; nausea/vomiting, diarrhea, melena, foul breath odours, bowel sounds, localized abdominal pain, recent eating habits, etc.

Genitourinary: presence/absence of; flank pain, foul smelling urine, colour of urine (straw, blood tinged, cloudy/clear), pain on urination, ability to urinate, amount of urine output, last menstruation, etc.

Integumentary: presence/absence of; abrasions, lacerations, avulsions, burns, blisters, rashes, etc.

Musculoskeletal: presence/absence of; obvious fractures, deformity, angulation, internal/external rotation, shortening, inability to move a joint, crepitus, etc.

Immune: presence/absence of; flu-like symptoms, recent history of fever/infection, etc.

Obstetrical: presence/absence of; crowning, urge to push/defecate, contraction frequency/duration, etc.

A: Assessment; your clinical impression based upon your subjective and objective findings

P: Plan; any treatment or interventions you performed, including IV, O2, dressing/bandaging, splinting/immobilizing, medication administration, CPR, BVM, ECG/12 Lead, etc. And, any changes in patient condition. **Treatment could be a simple thing such as comforting and positioning the patient appropriately.**

Gathering information using SOAP format (Body region)

S: Subjective; what the patient tells you happened (includes c/c, pertinent recent history, bystander information)

O: Objective; what you find during your physical assessment (includes vital signs)
HEENT (Head, Eyes, Ears, Nose, Throat): presence/absence of; headache/dizziness, blurred vision, auditory changes, facial droop, blood CSF (ears/nose), battle signs, raccoon eyes, tracheal deviation, JVD, AMU, foul breath odours, DCAP/BLS, etc.

Chest/back: presence/absence of; adventitious lung sounds, symmetrical chest movement, quality of air entry, pain (location/radiation etc), DCAP/BLS, etc.

Abdomen: presence/absence of; pain, tenderness, bowel sounds, nausea/vomiting/diarrhea, urinary changes, recent eating habits/appetite, pulsatile masses, DCAP/BLS, etc.

Extremities: presence/absence of; pain, CMS, grip strength/movement, edema, range of motion, DCAP/BLS, shortening, rotation, etc.

A: Assessment; your clinical impression based upon your subjective and objective findings.

P: Plan; any treatment or interventions you performed, including IV, O2, dressing/bandaging, splinting/immobilizing, medication administration, CPR, BVM, ECG/12 Lead, etc. And, any changes in patient condition. **Treatment could be a simple thing such as comforting and positioning the patient appropriately.**

Narrative using the SOAP format

S – 48 yr o pt. involved in a single vehicle MVI (motorcycle). Patient states he was going approx. 90 km/h when he lost control of the bike, sliding into a ditch. Pt. states he dragged himself up from the ditch to roadside. Pt. denies any pertinent past medical history, states no meds or allergies. Pt. also denies any ETOH use today. Pt. complaining of pain in Lt ankle and wrist. MFR and Police on scene. Attending MFR states they just arrived on scene and had no opportunity to initiate care.

O – Upon arrival, patient found sitting on shoulder of road. CAO X 3 (person, place and time). Airway patent. Adequate respirations and circulation. Skin P-W-D Head – no trauma, ENT clear, PERL @ 4-5 mm. Neck – no trauma, JVD or TD. Chest – no trauma, + Bilat BS clear X 4. Abd – soft, non-tender, non-distended. Pelvis – stable. Back – no trauma/indications. Extremities – Lt upper, marked deformity and ecchymosis present to distal forearm; left lower, marked deformity with ecchymosis and edema to distal shin; right upper and lower, unremarkable. + PS X 4, decreased mobility Lt side. CR<=2's X 4, ROM WNL X 2, decreased Lt side.

A – Pt has possible Lt ankle and Lt wrist #, no other injuries noted.

P – Scene safe, no extra resources required. Made contact. LOC ABC. C-spine Secondary. Ensured pt and bystanders understood the situation and provided/explained the following care - Collared pt. Laid back on long board, straps X 3, head immobilized. Lifted to cot, loaded to ambulance, using proper body mechanics. Exposed and examined Lt ankle and wrist. SAM Splints applied to ankle and wrist. Pulses present before and after splinting. Transport code 2. Monitored, vitals, no changes en route. Pt. delivered to ER bed 3 without incident. Left in care of RN. Stretcher cleaned and disinfected. Ambulance and equipment cleaned, disinfected and restocked.

Illness and Injury Reference for Competency Sign Offs 4.3 and 6.1

The student and Preceptor should reference this section when determining sign offs for area's 4.3 and 6.1 of the National Occupational Competency Profile for Paramedicine as developed by the Paramedic Association of Canada. A student will have obtained a competency under area 4.3 Conduct Assessment and Interpret findings or 6.1 Provide care for patient if the injury or illness is found in this chart, or it (injury or illness) can be shown to involve the competency the student is seeking.

If the student or preceptor assess and treat a patient that does not meet the exact illnesses or injuries identified in this chart, they should contact the school for advice on selecting and approving the competency.

The various illnesses and injuries that apply to area 4.3 and 6.1 can be found under the following headings:

A. Cardiovascular System
B. Neurologic System
C. Respiratory System
D. Genitourinary/Reproductive System
E. Gastronintestinal System
F. Integumentary System
G. Musculoskeletal System
H. Immunologic Disorders
I. Endocrine System
J. Ears, Eyes, Nose and Throat
K. Toxicological Illness
L. Adverse Environment
M. Trauma
N. Psychiatric Disorders
O. Obstetrics and Neonates
P. Multisystems Diseases and Injuries

A. Cardiovascular System	
Vascular Disease	Aneurysm (intracranial, abdominal aortic) Arteriosclerosis Deep vein thrombosis Hypertension Peripheral vascular disease Thoracic aortic dissection
Inflammatory disorders	Endocarditis Myocarditis Pericarditis
Valvular Disease	Prolapsed mitral valve Regurgitation Stenosis
Acute Coronary Syndromes	Infarction ST-elevation vs non-ST-elevation) Infarction (transmural vs subendocardial) Ischemia/angina
Heart Failure	Cardiomyopathies

	Left sided Pericardial tamponade Right sided
Cardiac Conduction Disorder	Benign arrhythmias Lethal arrhythmias Life threatening arrhythmias
Congenital Abnormalities	Atrial septal defect Patent ductus arteriosus Transposition Ventricular septal defect
Traumatic Injuries	Aortic disruption Myocardial contusion Peripheral vascular disruption
B. Neurologic System	
Convulsive Disorders	Febrile seizures Generalized seizures Partial seizures (focal)
Headache and Facial Pain	Infection Intracranial hemorrhage Migraine Tension
Cerebrovascular Disorders	Ischemic stroke (thrombotic vs embolic) Hemorrhagic stroke Transient ischemic attack
Altered Metal Status	Metabolic Structural
Chronic Neurologic Disorders	Alzheimers Amyotrophic lateral sclerosis (ALS) Bell's Palsy Cerebral palsy Multiple sclerosis Muscular dystrophy Parkinson's disease Poliomyelitis
Infectious Disorders	Encephalitis Guillian Barre syndrome Meningitis
Tumors	Structural Vascular
Traumatic Injuries	Head injury Focal (Hematoma, epidural, subdural, subarachnoid) Diffuse Axonal injury

	Spinal cord injury
Pediatric	Downs Syndrome Hydrocephalus Spina bifida
C. Respiratory System	
Medical Illness	Acute respiratory failure Adult respiratory disease syndrome Aspiration Chronic obstructive pulmonary disorder Hyperventilation Syndrome Pleural effusion Pneumonia/bronchitis Pulmonary edema Pulmonary embolism Reactive airways disease/asthma Severe Acute Respiratory Syndrome (SARS) Antibiotic resistant strains
Traumatic Injuries	Aspirated foreign body Burns Diaphragmatic injuries Flail chest Hemothorax Penetrating injury Pneumothorox (simple, tension) Pulmonary contusion Toxic inhalation Tracheobronchial disruption
Pediatric Illness	Acute respiratory failure Bronchiolitis Croup Cystic fibrosis Epiglottitis Sudden infant death syndrome
D. Genitourinary System	
Reproductive Disorders	Bleeding/discharge Infection Ovarian cyst Testicular torsion
Renal/Bladder	Colic/calculi Infection Obstruction Renal failure Traumatic injuries
E. Gastrointestinal System	
Esophagus/ Stomach	Esophageal varices Esophagitis Gastritis

	Gastroesophageal reflux
	Obstruction
	Peptic ulcer disease
	Upper gastrointestinal bleed
Liver/Gall Bladder	Cholecystitis/biliary colic
	Cirrhosis
	Hepatitis
Pancreas	Pancreatitis
Small/Large Bowel	Appendicitis
	Diverticulitis
	Gastroenteritis
	Inflammatory bowel disease
	Lower gastroinintestional bleed
	Obstruction
Traumatic Injuries	Abdominal injuries - penetrating / blunt
	Esophageal disruption
	Evisceration
F. Integumentary System	
Traumatic Injuries	Burns
	Laceration/avulsions/abrasions
Infectious and inflammatory Illness	Allergy/urticaria
	Infections
	Infestations
G. Musculoskeletal System	
Soft Tissue Disorders	Amputations
	Compartment syndrome
	Contusions
	Dislocations
	Muscular dystrophies
	Myopathies
	Necrotizing fascitis
	Sprain
	Strains
	Subluxations
Skeletal Fractures	Appendicular
	Axial
	Open/closed
Inflammatory Disorders	Arthritis
	Gout
	Osteomyelitis
	Osteoporosis
H. Immunologic Disorders	
Anaphylaxis	Anaphylaxis/anaphylactoid reactions
	Autoimmune disorders
I. Endocrine System	
	Acid-base disturbances

	Addison's disease
	Cushing's disease
	Diabetes mellitus
	Electrolyte imbalances
	Thyroid disease
J. Ears, Eyes, Nose and Throat	
Eyes - Traumatic Injuries	Burns/chemical exposure
	Corneal injuries
	Hyphema
	Penetrating injury
Eyes - Medical Illness	Cataracts
	Central rentinal artery occlusion
	Glaucoma
	Infection
	Retinal detachment
External, Middle and Inner Ear Disorders	Otitis externa
	Otitis media
	Traumatic ear injuries
	Vertigo
Face and Jaw Disorders	Dental abscess
	Trauma injury
	Trismus
Nasal and Sinus Disorders	Epistaxis
	Sinusitis
	Trauma injury
Oral and Dental Disorders	Dental fractures
	Penetrating injury
Neck and Upper Airway Disorder	Epiglottitis
	Obstruction
	Peritonsilar abscess
	Retropharygneal abscess
	Tonsillitis
	Tracheotomies
	Trauma injury-blunt/penetrating
K. Toxicologic Illness	
	Prescription medication
	Non-prescription medication
	Recreational
	Poisons (absorption, inhalation, ingestion)
	Acids and alkalis
	Hydrocarbons
	Asphyxiants
	Cyanide
	Cholinergics
	Anti-cholinergics
	Sympathomimetics
	Alcohols

	Food poisoning
	Vesicants (Blister agents)
	Crowd management agents
Alcohol related	Chronic alcoholism
	Delerium tremens
	Korsakov's psychosis
	Wernicke's encephalopathy
L. Adverse Environments	
	Barotrauma
	Hyperthermal injuries
	Hypothermal injuries
	Air embolism
	Decompression sickness
	Descent, ascent barotrauma
	Heat cramps
	Heat exhaustion
	Heat stroke
	High altitude cerebral edema
	High altitude pulmonary edema
	Local cold injuries
	Near drowning and drowning
	Radiation exposure
	Stings and bites
	Systemic hypothermia
M. Trauma	
	Assault
	Blast injuries
	Crush injuries
	Falls
	Rapid deceleration injuries
N. Psychiatric Disorders	
Anxiety Disorders	Acute stress disorder
	Generalized anxiety disorder
	Panic disorder
	Post-traumatic stress disorder
	Situational disturbances
Childhood Psychiatric Disorders	Attention-deficit disorder
	Autistic disorder
Cognitive Disorders	Delirium
Eating Disorders	Anorexia nervosa
	Bulimia nervosa
Affective Disorders	Bipolar disorder
	Depressive disorders
	Suicidal ideation
Psychotic Disorders	Delusional disorder
	Homicidal ideation
	Schizophrenia

Psychosocial disorders	Antisocial disorder
O. Obstetrics and Neonates	
Pregnancy complications	Abruptio placenta Eclampsia Ectopic pregnancy First trimester bleeding Placenta previa Pre-eclampsia Third trimester bleeding Uterine rupture
Childbirth complications	Abnormal presentations Postpartum complications Postpartum hemorrhage Prolapsed cord Uterine inversion
Neonatal complications	Premature Cardiovascular insufficiency Meconium aspiration Respiratory insufficiency Cold Stress
P. Multisystem Diseases and Injuries	
Cancer	Malignancy
Hematologic Disorders	Anemia Bleeding disorders Leukemia Lymphomas (Hodgkins, non-Hodgkins) Multiple myeloma Sickle cell disease
Infectious Diseases	Acquired immune deficiency syndrome Antibiotic resistant infection CBRNE related bacterial agents CBRNE related viral agents Influenza virus Malaria Meningococcemia/bacteremia Tetanus Toxic shock syndrome Tuberculosis Varicella Rubella West Nile Virus
Shock syndromes	Anaphylactic Cardiogenic Hypovolemic Neurogenic Obstructive Septic