

Documentation

- Avel eCare EMS does not maintain a legal patient record, this remains with the local EMS Agency.
- The Avel eCare team documents patient care within proprietary software which is then shared via fax to a designated local fax machine. The documentation is processed via local EMS Agency policy.
- Avel eCare physician orders and notes are part of the permanent medical record, therefore are required to remain with the EMS agency documentation.
- Please keep in mind that the Avel eCare team can only document what is seen and heard. The final product is the local EMS agency's responsibility; therefore, the attending ambulance personnel is required to review notes for accuracy and completeness prior to signing documentation.
- The following pages are Avel eCare EMS documentation samples for review including Fax Cover Sheet, Critical Care Flow Sheet, Critical Care Medication, Trauma Record, Code Blue Flow Sheet, Medication Orders, Physician Documentation, and Satisfaction Survey.



Confidential Facsimile - Cover Sheet

Date : _____ Time : _____

To: EMS Agency Name and Address

Telephone: _____ Fax: _____

From: EMS Services

Telephone: (605) 606-0430 ext-____ Fax: (605) 910-5020

Callback Number _____

Thank you for using Avel eCARE EMS Services and for allowing us to assist you. Please take a moment to fill out the survey to let us know how we are doing and what improvements can be made. Please fax back at your convenience.

~Thank you, Avel eCARE EMS Services Staff

Other Comments :

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EMS Services
Critical Care Flow
Sheet RN Notes

Patient Name:		DOB:	
Facility:	EMS Agency Name	Facility MD:	EMS Provider
Emergency Encounter:		Encounter ID:	

Time	TEMP (°F/°C)	Source	HR (bpm)	RR (bpm)	BP(mmHg)	Source	SpO2(%)	Source	ETCO2	PAIN (0-10)
11:42										
11:42	EMS call activated by EMS personnel. This clinician is scribing via Telemedicine. All cares and assessments per ambulance staff. EMS report they are with a patient complaining of crushing chest pain for the past 2 hours. Patient denies cardiac history. Patient appears diaphoretic. Clinician Name									
11:44			98	18	168 90 (116)	RT Arm	99	Room Air		
11:44	12-lead completed and transmitted to eER for review. Clinician Name									
11:46										
11:46	eER physician arrives on camera to review EKG (see physician documentation) Clinician Name									
11:47										
11:47	IV access established with an 18g in the left AC. Blood glucose level 97 Clinician Name									
11:49			103	18	136 72 (93)	RT Arm	98	Room Air		
11:49	EMS begin transport Clinician Name									
11:50										
11:50	eER paramedic calling report to receiving facility Clinician Name									
11:51										
11:51	Patient begins complaining of nausea. EMS administering IV Zofran Clinician Name									
11:52										
11:52	eER paramedic called report, receiving facility will have a room on arrival. EMS staff notified Clinician Name									
11:56			101	16						
11:56	EMS arriving at receiving facility Clinician Name									
11:59										
11:59	No further assistance needed, eER Telemedicine call logged off. Clinician Name									

eCARE EMS Clinical Staff Signatures

RN Signature

Date: _____ **Signature:** Clinician Name

EMS Agency Name - EMS Staff Signatures

Date: _____ **RN Signature:** _____

Date: _____ **Provider Signature:** _____



EMS Services
Critical Care Flow
Sheet RN Notes

Patient Name:		DOB:	
Facility:	EMS Agency Name	Facility MD:	EMS Provider
Emergency Encounter:		Encounter ID:	

eCARE EMS Clinical Staff Signatures

RN Signature

Date: **Signature:** Clinician Name

EMS Agency Name - EMS Staff Signatures

Date: **RN Signature:**

Date: **Provider Signature:**





EMS Services
Critical Care
Medication

Patient Name:		DOB:	
Facility:	EMS Agency Name	Facility MD:	EMS Provider
Emergency Encounter:		Encounter ID:	

START TIME	MEDICATION / INFUSION	DOSE / VOLUME	RATE	ROUTE	SITE	STOP TIME
11:44	Aspirin	324mg		PO	Oral	11:44
11:44	<i>Clinician Name</i>					
11:45	Nitroglycerin	0.4mg		PO	Oral	11:45
11:45	<i>Clinician Name</i>					
11:50	Nitroglycerin	0.4mg		PO	Oral	11:50
11:50	<i>Clinician Name</i>					
11:51	Zofran	4mg	IVP	IV	L AC	11:51
11:51	<i>Clinician Name</i>					
11:55	Nitroglycerin	0.4mg		PO	Oral	11:55
11:55	<i>Clinician Name</i>					

eCARE EMS Clinical Staff Signatures

RN Signature

Date: **Signature:** Clinician Name

EMS Agency Name - EMS Staff Signatures

Date: **RN Signature:**

Date: **Provider Signature:**



EMS Services
Notice of Privacy
Record

Patient Name:		DOB:	
Facility:	EMS Agency Name	Facility MD:	EMS Provider
Emergency Encounter:		Encounter ID:	

Avel eCare Notice of Privacy Practices provided to EMS personnel for distribution and acknowledgement by patient. The acknowledged notice will remain with patient's record of care.



**EMS Services
Trauma Record**

Patient Name:		DOB:	
Facility:	EMS Agency Name	Facility MD:	EMS Provider
Emergency Encounter:		Encounter ID:	

CIRCULATION

Pulse present Absent CPR in progress
 Uncontrolled bleeding
 Cardiac rhythm Sinus Tachycardia

Skin:

Warm Cool Dry Moist
 Pale Cyanotic Mottled Normal
 Flushed

Procedures:

Time	Device	Site
------	--------	------

DISABILITY

Alert Oriented :
 Responds to verbal Responds to pain Unresponsive
 Pupils L 3 R 3 PERRL

GLASGOW COMA SCORE

Date and Time	E	V	M	Total
04/28/2026 11:56	2	2	4	8
04/28/2026 12:11	2	2	4	8

SECONDARY ASSESSMENT

HEAD No evident trauma
Evident trauma : Laceration above left eye

NECK No evident trauma
 Tracheal deviation
Evident trauma : C-collar placed

THORAX No evident trauma
 Paradoxical movements Retraction
 Seatbelt marking
Evident trauma:

Breath sounds: Clear and equal bilaterally

ABDOMEN No evident trauma
 Distended Rigid Tender Soft
Bowel sounds: Present Absent
Evident trauma: URQ bruising

PERINEUM/PELVIS No evident trauma
Blood at meatus: Yes No
Evident trauma:

EXTREMITIES No evident trauma
 Moves all extremities X 4
Exception:
Distal pulses/cap refill: Distal pulses present
Evident trauma:

SPINAL/BACK No evident trauma
Evident trauma:

GLASGOW COMA SCORE LEGEND

E: Eye opening 4-Spontaneous 3-To speech(shout) 2-To pain 1-No response	V: Verbal response 5-Oriented (coos, babbles) 4-Confused (consolable, cry) 3-Inappropriate words (persistant cries, screams) 2-Incomprehensible words (grunts, restless) 1-No response	M: Motor 6-Obeys (spontaneous) 5-Localized pain 4-Withdrawal to pain 3-Flexion to pain (decorticate) 2-Extension to pain 1-No response to pain
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eCARE EMS Clinical Staff Signatures

RN Signature

Date: **Signature:** Clinician Name

EMS Agency Name - EMS Staff Signatures

Date: **RN Signature:**

Date: **Provider Signature:**





**EMS Services
Trauma Record**

Patient Name:		DOB:	
Facility:	EMS Agency Name	Facility MD:	EMS Provider
Emergency Encounter:		Encounter ID:	

DIAGNOSTICS

	Time Ordered	Time Done		Time Ordered	Time Done
C-Spine X-ray			Chest X-ray		
Pelvis X-ray			Other X-ray		
CT head			CT C-Spine		
CT chest			CT abdomen		
CT pelvis					

LABS

Time drawn:

<input type="checkbox"/> CBC	<input type="checkbox"/> BMP/CMP	<input type="checkbox"/> HCG
<input type="checkbox"/> PT/PTT	<input type="checkbox"/> Tox	<input type="checkbox"/> ABG
<input type="checkbox"/> Blood alcohol	<input type="checkbox"/> UA	<input type="checkbox"/> Type & Cross

PROCEDURES

<input type="checkbox"/> Bair hugger <input type="checkbox"/> Warm blankets <input checked="" type="checkbox"/> C-Collar <input type="checkbox"/> Rm. temp increased <input type="checkbox"/> Direct pressure site Site: <input type="checkbox"/> C-Spine cleared <input type="checkbox"/> Yes <input type="checkbox"/> No By Whom: <input type="checkbox"/> Backboard removed Time: <input type="checkbox"/> Pelvic Binder Time	<input type="checkbox"/> Warm fluids <input type="checkbox"/> Cardiac monitor <input type="checkbox"/> NG <input type="checkbox"/> OG <input type="checkbox"/> EKG <input type="checkbox"/> TQT <input type="checkbox"/> Foley <input type="checkbox"/> Other	Start: <input type="checkbox"/> Splints	Stop:
--	--	---	----------------------

INTAKE

Start Time	Medication/Infusion	Dose	Rate	Route	Site	Stop Time	Total Infused
12:07	Normal Saline	1000mL	Pressure bag	IV	L AC		
12:07	Clinician Name						
12:11	TXA	1g		IV	R Forearm	12:21	
12:11	Given over 10 minutes - Clinician Name						
						TOTAL(ml)	

eCARE EMS Clinical Staff Signatures

RN Signature

Date: _____ **Signature:** Clinician Name

EMS Agency Name - EMS Staff Signatures

Date: _____ **RN Signature:** _____

Date: _____ **Provider Signature:** _____





**EMS Services
Trauma Record**

Patient Name:		DOB:	
Facility:	EMS Agency Name	Facility MD:	EMS Provider
Emergency Encounter:		Encounter ID:	

OUTPUT						
Time	Void	Foley Cath	NG/OG	Chest Tube	Emesis	EBL
SUB TOTAL(ml)						
TOTAL(ml)						0

eCARE EMS Clinical Staff Signatures

RN Signature

Date: _____ **Signature:** Clinician Name

EMS Agency Name - EMS Staff Signatures

Date: _____ **RN Signature:** _____ **Date:** _____ **Provider Signature:** _____





EMS Services
Trauma Record

Patient Name:		DOB:	
Facility:	EMS Agency Name	Facility MD:	EMS Provider
Emergency Encounter:		Encounter ID:	

NURSE NOTES										
Time	TEMP (°F/°C)	Source	HR(bpm)	RR(bpm)	BP(mmHg)	Source	SpO2(%)	Source	ETCO2	PAIN (0-10)
11:45										
11:45	EMS call activated by EMS personnel. This clinician is scribing via Telemedicine. All cares and assessments per ambulance staff. EMS report they are en route to a single vehicle rollover accident. ETA of 3 minutes. - Clinician Name									
11:48										
11:48	EMS arriving on scene. Fire is attempting to extricate the patient upon EMS arrival - Clinician Name									
11:56										
11:56	EMS in ambulance with patient. Pt was found in the driver's seat of a vehicle in the ditch. Pt was restrained and airbags did deploy. Pt is moaning incomprehensibly and does not respond to questions. EMS report pt has a GCS of 8. Pt has a C-collar applied and is on a backboard. - Clinician Name									
11:57			126	16	92 66 (75)	RT Arm	92	NRB		
11:57	Cardiac monitor applied. Pt placed on 15L/min O2 via NRB - Clinician Name									
11:59										
11:59	16g IV established in the right forearm. - Clinician Name									
12:00			130	16	96 68 (77)	RT Arm	93	NRB		
12:00	EMS performing full body assessment: Pt is pale, cool, and clammy 3cm laceration above the left eye with controlled bleeding Lungs are clear and equal bilaterally Bruising is noted to the upper right quadrant of the abdomen, rigid with palpation Pelvis is stable No injuries noted to extremities. Distal pulses are intact and pt moves all extremities - Clinician Name									
12:02										
12:02	TXA infusion started - Clinician Name									
12:03										
12:03	eER paramedic calling receiving facility for report - Clinician Name									
12:06			136	18	84 60 (68)					
12:06	eER paramedic called report, receiving facility will have a room ready. EMS notified - Clinician Name									
12:07										
12:07	18g IV established in the left AC. Normal saline started with pressure bag - Clinician Name									
12:11										
12:11	EMS arriving at receiving facility - Clinician Name									
12:15										
12:15	No further assistance needed, eER Telemedicine call logged off. - Clinician Name									

eCARE EMS Clinical Staff Signatures

RN Signature

Date: _____ Signature: Clinician Name
 _____ EMS Agency Name - EMS Staff Signatures

Date: _____ RN Signature: _____ Date: _____ Provider Signature: _____





**EMS Services
Trauma Record**

Patient Name:		DOB:	
Facility:	EMS Agency Name	Facility MD:	EMS Provider
Emergency Encounter:		Encounter ID:	

Patient Disposition

TRANSFER	ADMIT	DEATH
Accepting Facility: Accepting MD: Mode: <input type="checkbox"/> ALS <input type="checkbox"/> BLS <input type="checkbox"/> AIR <input type="checkbox"/> POV Time Initiated: Discharge time: Items sent: <input type="checkbox"/> Records/trauma flow sheet <input type="checkbox"/> Labs <input type="checkbox"/> X-Rays/CT scans and reports <input type="checkbox"/> Prehospital records <input type="checkbox"/> Other	Date / Time: Room #: Admitting MD:	Date / Time: Room #: Provider:
	DISCHARGE	MISCELLANEOUS
	Date / Time: Follow-up with #: D/C instructions given: <input type="checkbox"/> Yes <input type="checkbox"/> No Accompanied by: D/C to:	Date / Time: Follow-up with #: D/C instructions given: <input type="checkbox"/> Yes <input type="checkbox"/> No Accompanied by: D/C to:

eCARE EMS Clinical Staff Signatures

RN Signature

Date: **Signature:** Clinician Name

EMS Agency Name - EMS Staff Signatures

Date: **RN Signature:**

Date:

Provider Signature:





EMS Services
Notice of Privacy
Record

Patient Name:		DOB:	
Facility:	EMS Agency Name	Facility MD:	EMS Provider
Emergency Encounter:		Encounter ID:	

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**EMS Services
Code Blue Flow
Sheet**

Patient Name:		DOB:	
Facility:	EMS Agency Name	Facility MD:	EMS Provider
Emergency Encounter:		Encounter ID:	

Time	Vital Signs					Bolus Dose IV					Infusion			
	Spontaneous Resp	Spontaneous Pulse	BP	ETCO2	Rhythm	Defib/ Cardio joules	Amiodarone (mg)	Atropine (mg)	Epinephrine (rounds)	Narcan	Bicarb	Dopamine mcg/kg/min	Levophed mcg/min OR mcg/kg/min	Epinephrine mcg/min
12:30						Total	300	0	1	0	0			
12:30	IO established in the left tibia. Normal saline started with a pressure bag. Size 4 i-gel is placed with ETCO2 monitoring <i>Clinician Name</i>													
12:31					V-fib	200			1					
12:31	CPR paused for a pulse/rhythm check. Pt is in v-fib. Pt is defibrillated and CPR is resumed. 1mg Epinephrine is administered IO. <i>Clinician Name</i>													
12:33				22	V-fib	300	300							
12:33	CPR paused for a pulse/rhythm check. Pt is in v-fib. Pt is defibrillated and CPR is resumed. 300mg amiodarone is administered IO. <i>Clinician Name</i>													
12:35			118 60 (79)	56	S-Tach									
12:35	CPR paused for a pulse/rhythm check. Strong pulse is palpated. Vitals are obtained and a 12 lead is completed. See critical care flowsheet <i>Clinician Name</i>													

Code Blue Medication

START TIME	MEDICATION / INFUSION	DOSE / VOLUME	RATE	ROUTE	SITE	STOP TIME
12:30	Normal Saline	1000mL	Pressure bag	IO	L Tibia	
12:30	<i>Clinician Name</i>					
12:31	Epinephrine	1mg		IO	L Tibia	12:31
12:31	<i>Clinician Name</i>					
12:33	Amiodarone	300mg		IO	L Tibia	12:33
12:33	<i>Clinician Name</i>					

eCARE EMS Clinical Staff Signatures

RN Signature

Date: _____ **Signature:** _____ Clinician Name

EMS Agency Name - EMS Staff Signatures

Date: _____ **RN Signature:** _____ **Date:** _____ **Provider Signature:** _____





**EMS Services
Code Blue Flow
Sheet**

Patient Name:		DOB:
Facility:	EMS Agency Name	Facility MD: EMS Provider
Emergency Encounter:		Encounter ID:

End of Resuscitation Information

Time resuscitation event ended: Status: Alive Dead

Reason resuscitation ended:

- Restoration of Circulation (ROC) > 20 min
- Efforts Terminated (No Sustained ROC)
- Medical Futility
- Advance Directives
- Request by Family

eCARE EMS Clinical Staff Signatures

RN Signature

Date: **Signature:** Clinician Name

EMS Agency Name - EMS Staff Signatures

Date: **RN Signature:** **Date:** **Provider Signature:**





EMS Services Notice of Privacy Record	Patient Name:		DOB:	
	Facility:	EMS Agency Name	Facility MD:	EMS Provider
	Emergency Encounter:		Encounter ID:	

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EMS Services
Critical Care Flow
Sheet RN Notes

Patient Name:		DOB:	
Facility:	EMS Agency Name	Facility MD:	EMS Provider
Emergency Encounter:		Encounter ID:	

Time	TEMP (°F/°C)	Source	HR (bpm)	RR (bpm)	BP(mmHg)	Source	SpO2(%)	Source	ETCO2	PAIN (0-10)
12:37										
12:37	EMS begin transport to ER. eER paramedic calling receiving facility with report <i>Clinician Name</i>									
12:40			103	12	122 74 (90)	RT Arm	96	BVM	44	
12:40	18g IV established in the left AC. eER paramedic called report, receiving facility will have a room ready. EMS notified. <i>Clinician Name</i>									
12:46			98	12	126 80 (95)	RT Arm	98	BVM	39	
12:46	EMS arriving at receiving facility <i>Clinician Name</i>									

eCARE EMS Clinical Staff Signatures

RN Signature

Date: **Signature:** Clinician Name

EMS Agency Name - EMS Staff Signatures

Date: **RN Signature:** **Date:** **Provider Signature:**





**EMS Services
Physician
Documentation**

Patient Name:		DOB:	
Facility:	EMS Agency Name	Facility MD:	EMS Provider
Emergency Encounter:		Encounter ID:	

History of Present Illness

Patient is a 68-year-old male who is being transported to local facility for chest pain. Consulted by EMS for evaluation of patient with chest pain and initial orders en route

Allergies

NKDA Unknown

Medications

Lisinopril

Past Medical History

Hypertension, coronary disease

Surgical History

Social History

Smoker Alcohol Drug

Examination

RN Vitals

Time	TEMP (°F/°C)	HR(bpm)	RR(bpm)	BP(mmHg)	SpO2(%)	ETCO2	PAIN (0-10)
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eCARE EMS Clinical Staff Signatures

Provider Signature

Date:

Signature: Avel Physician Name





**EMS Services
Physician
Documentation**

Patient Name:		DOB:	
Facility:	EMS Agency Name	Facility MD:	EMS Provider
Emergency Encounter:		Encounter ID:	

HEENT	
Neck	
CVS	
Pulm	
Abd	
Ext	
Back	
Neuro	
Derm	

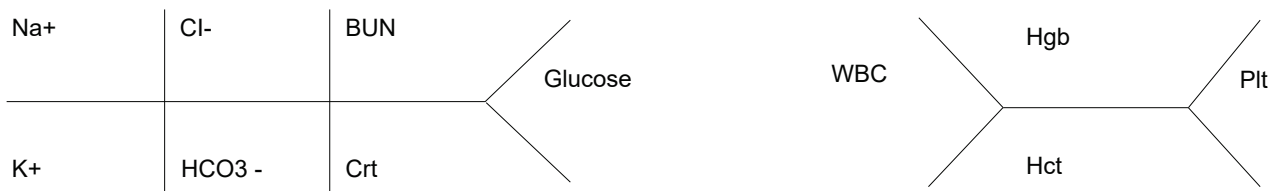
eEmergency Course

Patient is a 68-year-old male who is being transported to local facility with concerns of chest pain. Consulted by EMS for initial evaluation, EKG interpretation and medication orders. EKG as reviewed by myself showed a normal sinus rhythm without ischemic changes. No STEMI criteria noted. Vital signs including blood pressure are stable. Did order 4 baby aspirin, sublingual nitro as needed 0.4 mg x 3 doses for pain as well as 1 L of normal saline. No further assistance needed at this time, will call back if any additional help needed.

Working Diagnosis

Chest pain

Physical Exam / Lab values / EKG / Imaging



EKG interpretation - This interpretation is based solely on review of the ECG in the absence of complete clinical information required for a final clinical diagnosis or therapeutic recommendations

Normal EKG - Normal Sinus Rhythm with no ST Elevation

eCARE EMS Clinical Staff Signatures

Provider Signature

Date:

Signature: Avel Physician Name





**EMS Services
Medication
Orders**

Patient Name:		DOB:	
Facility:	EMS Agency Name	Facility MD:	EMS Provider
Emergency Encounter:		Encounter ID:	

Medication	Dose	Route	Frequency	
Cardiac				
<input type="checkbox"/> Adenosine	mg	IVP	ONCE	
<input type="checkbox"/> Amiodraone	mg	IVP	ONCE	
	450mg/250ml	IV	Titrate per facility protocol	
	900mg/500ml	IV	Titrate per facility protocol	
	300mg/250ml	IV	Titrate per facility protocol	
<input checked="" type="checkbox"/> Baby ASA (Aspirin)	324 mg	<input checked="" type="checkbox"/> PO <input type="checkbox"/> Re ctal	<input checked="" type="checkbox"/> ONCE	
<input type="checkbox"/> Diltiazem/Cardizem	mg	IVP	ONCE	
	125mg/100ml	IV	Titrate per facility protocol	
<input type="checkbox"/> Dopamine	400mg/250ml	IV	Titrate per facility protocol	
	800mg/250ml	IV	Titrate per facility protocol	
<input type="checkbox"/> Epinephrine/Adrenalin	mg	IVP	ONCE	
	1mg/250ml	IV	Titrate per facility protocol	
	4mg/250ml	IV	Titrate per facility protocol	
	5mg/250ml	IV	Titrate per facility protocol	
	8mg/250ml	IV	Titrate per facility protocol	
<input type="checkbox"/> Metoprolol/Lopressor	mg	IVP	ONCE	Q5 Minutes x3 Doses
<input checked="" type="checkbox"/> Nitroglycerin	0.4 0.4 mg	<input checked="" type="checkbox"/> SL	<input type="checkbox"/> ONCE	<input checked="" type="checkbox"/> PRN/Pain x3 Doses
	0.4mg/hr Patch	<input type="checkbox"/> TRANSDERMAL	ONCE	
	50mg/250ml	<input type="checkbox"/> IV	<input type="checkbox"/> Titrate per facility protocol	
	25mg/250ml	<input type="checkbox"/> IV	<input type="checkbox"/> Titrate per facility protocol	

Date and time of the order :

eCARE EMS Clinical Staff Signatures

Provider Signature

Date:

Signature: Avel Physician Name



**EMS Services
Medication
Orders**

Patient Name:		DOB:	
Facility:	EMS Agency Name	Facility MD:	EMS Provider
Emergency Encounter:		Encounter ID:	

<input type="checkbox"/>	Norepinephrine/Levophed	4mg/250ml	IV	Titrate per facility protocol
		8mg/250ml	IV	Titrate per facility protocol
IV Fluids				
<input type="checkbox"/>	Lactated Ringers	ml/Bolus	IV	ONCE
		ml/hr	IV	Tirtate
<input checked="" type="checkbox"/>	Normal Saline	1000 ml/Bolus	<input checked="" type="checkbox"/> IV	<input checked="" type="checkbox"/> ONCE
		0 ml/hr	<input type="checkbox"/> IV	<input type="checkbox"/> Tirtate

Date and time of the order :

eCARE EMS Clinical Staff Signatures

Provider Signature

Date:

Signature: Avel Physician Name



Avel eCARE EMS Satisfaction Survey

Date/Time of Use:

Facility/City Name:

EMS Agency Name

EMS Services Physician/Nurse:

Patient Name:

1. Did you experience any technical issues with this encounter?

Yes No

1.1. If Yes, what issues were experienced? [check all that apply]

Couldn't connect video Dropped call Dropped Video Dropped Audio Video lag/Freeze

Audio choppy Other

1.2. How would you rate the impact of the issue(s) on the effectiveness of care? ?

None 1 2 3 4 5 Severe

2. How valuable was the Avel eCare EMS service?

Poor 1 2 3 4 5 Excellent

3. How would you rate your experience with the Avel EMS Staff?

Poor 1 2 3 4 5 Excellent

4. Anything else you'd like to tell us about?

Thank you! Please fax back to (605) 910-5020

