



A NOTE FROM THE AUTHOR

This guide exists because I kept getting told my documentation needed work, and never once got an example of what “good” looked like. Not a template, not a standard, not a single annotated chart. Just a correction and a shrug.

I got tired of waiting for someone to hand it to me, so I wrote it.

Nothing in here replaces county policy or your protocols. It is the “how” underneath the county's “what,” built from Policy #124 and from a lot of charts that could have been better, including plenty of mine.

You already do the hard part. You make the calls, you work the problem, and you carry it. All I am asking is that the chart show it. The patient's next provider, a reviewer, and someday maybe an attorney are going to read your work without ever having been on that call. Give them something that holds up.

Use it. Argue with it. Make it better and tell me where I got it wrong.

Thomas Moore, EMT-P



PREHOSPITAL CARE DOCUMENTATION • 911 EMERGENCY RESPONSE

THE G.O.L.D. STANDARD

GATHER • OBSERVE • LINK • DO & DOCUMENT

A Field Guide to Defensible PCR Documentation

911 Emergency Response Edition

For Paramedics, EMTs & Interns • A Bearamedics Field Guide

Built to the standard of SLOEMSA Policy #124: Documentation of Prehospital Care

Version 1.1 • Revised October 2, 2026

Prepared by Thomas Moore, EMT-P

"If it isn't written, it wasn't done. If it isn't defensible, it isn't finished."

Why This Exists

SLOEMSA Policy #124 tells you what fields the county requires. It does not tell you what “good” looks like. That gap is where providers get burned, not because they left something out on purpose, but because no one ever handed them a standard to write to. This guide is that standard.

Two things are true at once about every PCR you write: it is a clinical record, and it is a legal document. The patient's next provider reads it to understand what happened. A jury, an attorney, a QI reviewer, or a billing auditor reads it to decide whether what you did was reasonable, necessary, and actually documented. Write for both readers, every time.

This is not a replacement for Policy #124. It is the “how” underneath the county's “what.” Know both.

The Governing Principle

If it isn't written, it wasn't done. If it's written but vague, it's indefensible. Every sentence in your narrative should survive one question: “How do you know that?” If the honest answer is “I observed it” or “the patient told me,” write it that way. If the honest answer is “I assumed it,” don't write it at all.

Objective vs. Subjective: Never Let the Line Blur

- Objective: what you saw, heard, felt, measured, or were told, in plain terms. “SpO2 94% on room air.” “Patient states pain is 8/10, sharp, non-radiating.”
- Subjective conclusions belong to you as a clinician, and only after you show your work. “Given diaphoresis, substernal pressure, and 12-lead findings, primary impression of ACS” is defensible. “Patient was having a heart attack” as a bare statement is not; you didn't diagnose an MI in the field, you recognized a pattern and treated it. Say it that way.
- Never chart a diagnosis you didn't make, a fact you didn't confirm, or another provider's care you didn't witness. “Reportedly given 4mg Zofran by first responders”, not “patient was given 4mg Zofran.”
- Never editorialize about the patient, family, or another crew in the narrative. If behavior is clinically relevant (capacity, mechanism, safety), describe the behavior objectively, not your opinion of it.

The G.O.L.D. Standard

Policy #124.H requires seven elements in every narrative: patient description, chief complaint, general observations, history of the present event/pertinent findings, provider impression, treatments/care rendered, and disposition. That same clause prohibits auto-narrative generation: you write your own narrative, every call, in your own words.

Seven items is a checklist, and checklists don't survive fatigue. At 3am with eight charts backed up, working memory reliably holds three or four chunks, not seven; the moment a call gets hard, a 7-item list is the first thing that gets skipped, not because you didn't know it, but because your brain can't hold it under stress. G.O.L.D. regroups those same seven elements into four, without dropping a single one. It isn't SOAP, it isn't a shortcut, and it isn't replacing Policy #124; it's the same requirement translated into a form you can actually recall when it's 3am and you're slammed.

How the Seven Map to the Four

Policy #124.H Element	G.O.L.D. Letter
1. Patient description	G: Gather
2. Chief complaint	G: Gather
3. General observations	O: Observe
4. History of present event / pertinent findings	G: Gather
5. Provider impression	L: Link
6. Treatments/care rendered	D: Do & Document
7. Disposition	D: Do & Document

Nothing in Policy #124 is dropped, relabeled to mean something different, or left to interpretation; it's the same seven requirements, organized around how you'll actually remember them mid-shift. Here's each letter in practice:

G GATHER	• Dispatch & scene: how you were dispatched, what you found on arrival (scene safety, patient position, environment). • Patient & chief complaint: age, sex, patient's own words for why they called, in quotes when possible. • History / HPI / pertinent findings: OPQRST or the equivalent for the complaint type; pertinent negatives matter as much as positives.
O OBSERVE	• Focused exam findings by system, tied to the chief complaint. • Vitals, cardiac monitor, 12-lead, and any other diagnostics. • Objective only here: what you saw, heard, felt, or measured, not what you think it means yet.
L LINK	• Primary (and secondary, if applicable) impression, stated as clinical reasoning that connects back to what you gathered and observed, not a diagnosis pulled from nowhere. • This is the letter that gets skipped when you're slammed, and it's the one that makes a chart defensible. One sentence minimum: given X and Y, impression of Z.
D DO & DOCUMENT	• Treatment/response: every intervention, the time, the response, and any reassessment. • Transport/disposition: mode of movement to the unit (see Liability Language below), position, monitoring en route, condition changes. • Transfer of care: who you gave report to at destination and their title.

Liability-Conscious Language

These are the specific patterns that turn a routine call into an unwitnessed gap in your documentation, and the phrasing that closes it.

Patient Movement: The Single Biggest Liability Gap in EMS Charting

A patient never simply “walked,” “was moved,” or “got on the gurney.” Passive, vague movement language is exactly what a plaintiff’s attorney looks for after a fall. Document who assisted, how, and what you assessed before you let a patient move at all.

Avoid	Use Instead / Why
<i>Patient walked to the gurney.</i>	Patient ambulated to gurney with stand-by assist x2 crew, gait steady, no distress noted.
<i>Pt was placed on the gurney.</i>	Patient assisted to gurney via [draw sheet / stand-and-pivot / stair chair] by crew x2, secured with all straps prior to movement.
<i>Pt got up on their own.</i>	Prior to ambulation, patient assessed for orthostatic symptoms and gait stability; crew stood by within arm’s reach throughout transfer to gurney.
<i>Moved patient to the stretcher.</i>	Patient transferred to gurney via [method], crew maintained [number]-point contact throughout, straps applied x5 prior to movement.

If a patient declines assistance or insists on moving independently, document that explicitly, including that risks were explained: “Patient declined assistance to gurney against crew recommendation; risks of fall explained and verbalized understood by patient; patient ambulated independently, crew within arm’s reach.” That single sentence is the difference between a defensible record and a deposition.

Falls, lift assists, and “refused everything” calls

- Document a functional and neuro baseline before and after any fall, even a “simple” lift assist; you cannot know it was mechanical until you’ve ruled out syncope, stroke, and cardiac causes.
- “Pt denies loss of consciousness, denies head strike, denies chest pain, ambulatory at baseline per patient/caregiver” closes far more liability than “pt fell, no injury noted.”
- If you leave a patient on scene (lift assist, no transport), document the full refusal process below; a lift assist with no documented capacity assessment is one of the most common QI findings in EMS.

Refusals and AMA: Required Elements, Every Time

☐	Decision-making capacity assessed and documented (A&Ox4, no evidence of impairment from injury, illness, EtOH, drugs, or psychiatric crisis)
☐	The specific medical concern and recommendation explained in plain language
☐	Risks of refusing explicitly listed (including, where applicable, worsening condition, permanent injury, or death) and documented as explained
☐	Alternatives offered (transport by family/POV, follow-up with PMD, calling back if symptoms worsen) and documented
☐	Patient’s own words indicating understanding, quoted if possible
☐	Signature obtained; if refused, document who witnessed and that refusal-to-sign was explained
☐	Any involvement of family, law enforcement, or online medical control documented with names/times

Restraint, behavioral, and use-of-force documentation

- Document the specific behavior that necessitated restraint (objective actions, not “patient was combative” alone): what did the patient do.
- Document less-restrictive measures attempted or considered first, the type of restraint used, and continuous reassessment of circulation, airway, and mental status at a stated interval.
- Document medical control contact/orders if your protocol requires it, and who else was present (law enforcement, additional crew).

Procedures, Medications, and Airway: Show Your Reassessment

- Every medication: dose, route, time, and the reassessment that followed, not just that it was given, but what changed.
- Every procedure attempt, successful or not: number of attempts, who performed it, complications, and confirmation method (for airway: waveform capnography value charted, not just “confirmed”).
- If a skill fails or is aborted, document why and what you did next; an incomplete procedure with no explanation reads as an unrecognized complication.

Signatures: Who Signs, and When They Can’t

Missing or poorly explained signatures are one of the most common reasons a claim is rejected, and the fix happens at the bedside, not in the office.

☐	Patient signs if physically and mentally able to. This is the default on every transport, including 911.
☐	“Unable to sign” is not a reason. State the specific reason in observed terms: unable to sign due to altered mental status at the time of transport, or unable to hold a pen due to bilateral wrist immobilization.
☐	Match the signature to the chart. If the patient was A&Ox4 and conversant at transfer of care, “unable to sign / implied consent” contradicts your own narrative and will be questioned.
☐	The ePCR’s automated checks are not authoritative on capacity. Capacity to sign is your clinical judgment, documented in your words. A software prompt is not a determination.
☐	Authorized representative. If the patient cannot sign, a family member, legal guardian, or POA may sign. Document their name and relationship.
☐	Receiving signature on every transport. Name, title, and time. It is your proof of transfer of care.
☐	Crew signatures. All crew who provided care authenticate the report. Signing attests that you were on the crew and that the report is accurate to your knowledge.

Times in the Narrative

Most times do not belong in the narrative. CAD owns dispatch, en route, on scene, at patient, and clear. The monitor owns what the monitor did. The medication and procedure fields own their own timestamps. Those systems are the authoritative record, and restating their times in prose creates a second version that can contradict the first.

Write a time in the narrative in only two situations:

- The event has no structured field. Time last seen normal, symptom onset, time a family member produced a DNR or POLST, time a document was verified, time resuscitation was terminated, time of determination of death, time a deputy or coroner assumed custody. If no field captures it, the narrative is the only place it exists.

- The relationship between two events is the point. When sequence is what makes the call defensible, state the sequence, and prefer the interval over the clock: “resuscitation continued without interruption throughout review and verification, terminated approximately 4 minutes after initiation” proves more than three separate timestamps do.

Everything else is already timestamped by a system that is harder to dispute than your memory. Leave it there.

ImageTrend-Specific Practices

- For every specialty patient (STEMI, stroke, trauma, cardiac arrest), the Primary or Secondary Impression fields (eSituation.11/.12) must reflect that alert; a correct narrative with the wrong structured field still fails county QI and CEMSIS validation.
- Attach every 12-lead / rhythm strip to the PCR, either transferred directly from the monitor or photographed from a printed strip, before you upload.
- Don't restate a time a structured field already owns. CAD, the Times tab, the monitor, and the medication and procedure fields are the authoritative record for their own timestamps; retyping them into the narrative buys nothing and creates a second version that can contradict the first.
- Know your upload clock: 60 minutes after transfer of care for Step 1/2 trauma, cardiac arrest/ROSC, STEMI, stroke alerts, and any code 3 transport; 2 hours for everything else; 12 hours (or end of shift) for non-transports.
- Complete abbreviations only from the county-approved list (Policy #124 Attachment A); an unapproved abbreviation that a reviewer can't confidently interpret is treated as missing information.

Interfacility Transfer (IFT) Documentation: Overview

IFT charting carries a burden the 911 side doesn't: every transport has to independently justify itself for billing and medical necessity, separate from whether the crew did good clinical work. A clinically perfect IFT PCR can still get the claim denied if it doesn't answer the payer's questions. These are the non-negotiables on every IFT chart:

Medical Necessity: The Core Question Every IFT Narrative Must Answer

Medicare and most payers require documentation showing the patient could not have been safely transported by any other means (wheelchair van, private vehicle, taxi). “Bed confined” is a legal/billing term with a specific meaning: don't use it unless it's true and you document why: unable to ambulate, unable to sit in a chair safely, and unable to be transported safely by other means, all three.

☐	Reason patient cannot sit upright / be transported by wheelchair van, stated specifically (not just “bed confined” as a label)
☐	Monitoring or intervention actually required en route (O2, cardiac monitor, IV maintenance, positioning) that only an ambulance crew can provide
☐	Patient's baseline functional/mobility status, in your own observed words
☐	Any condition change, intervention, or reassessment during transport; a transfer with zero documented reassessment reads as “transport that didn't need a medic”
☐	Level of service actually matches what was documented; don't bill/chart ALS if nothing ALS-level was needed or performed
☐	Mode (code 2 vs code 3) justified by the patient's condition, not convenience or scheduling
☐	Transferring facility paperwork reconciled: PCS (Physician Certification Statement) present and consistent with your narrative, receiving facility and accepting provider documented

If your narrative and the sending facility's PCS disagree about why the patient needs an ambulance, that mismatch, not your clinical care, is what gets the claim kicked back. Read the PCS before you chart, not after.

Common Pitfalls That Get Charts Flagged

Avoid	Use Instead / Why
<i>Copy-pasting vitals or narrative language from a prior call.</i>	Every set of vitals and every narrative sentence reflects this patient, this call, checked in real time.
<i>Leaving pertinent negatives out because “nothing happened.”</i>	State what you ruled out: “denies chest pain, denies SOB” is information, not filler.
<i>Writing the impression before the findings that support it.</i>	Findings first, impression second; the narrative should read like your reasoning, not your conclusion followed by backfill.
<i>“Patient refused further evaluation” with nothing else.</i>	Full refusal documentation per the checklist above: capacity, risks, alternatives, understanding.
<i>Retyping CAD and monitor times into the narrative.</i>	Let the structured fields own those. Chart only the times no field captures, and the intervals that prove sequence.
<i>Blank or minimal exam sections “because the complaint was minor.”</i>	Chart the negative exam; a reviewer needs to see that you looked, not just that nothing was found.

Quick Reference: Before You Submit

G: Gather

☐	Narrative is written in my own words
☐	Every subjective claim is attributed (patient states / bystander reports / per prior documentation)
☐	Pertinent negatives are documented, not just positives

O: Observe

☐	Focused exam documented by system, including normal findings
☐	Narrative-only times captured (nothing restated from CAD or monitor)
☐	12-lead/rhythm strips attached

L: Link

☐	Impression is stated as reasoning from the findings above, not dropped in from nowhere
☐	Primary/Secondary Impression fields match any specialty alert called (STEMI/stroke/trauma/arrest)

D: Do & Document

☐	Every patient movement is documented with method and assist level, no passive “walked/moved” language
☐	Refusal, restraint, or IFT-specific checklist completed if applicable to this call
☐	Transfer-of-care statement includes receiving provider's name/title
☐	Uploaded within the required window for this call type (60 min / 2 hr / 12 hr)

Example Narratives: Weak vs. Gold Standard

These four are general-population medical, trauma, and cardiac arrest calls, built to show the structure and liability language above applied end to end.

Scenario: Medical, Chest Pain, STEMI Alert

WEAK

Pt c/o chest pain. Vitals stable. 12-lead done, showed STEMI. Gave aspirin. Transported to hospital. Report given to RN.

GOLD STANDARD

G: Gather. 58 y/o M found seated in kitchen chair, alert, diaphoretic, and mildly pale on arrival. Pt states, “my chest has felt like an elephant is sitting on it since about twenty minutes ago,” onset sudden while at rest, describes pain as pressure, 8/10, substernal, radiating to left arm and jaw, denies relief with rest. Denies prior cardiac history, denies similar pain before.

O: Observe. Skin diaphoretic and pale, lungs clear and equal bilaterally, no JVD, no peripheral edema, radial pulses equal and strong bilaterally. Initial vitals BP 124/76, HR 88, RR 18, SpO2 98% on room air. 12-lead obtained on scene showing 3mm ST elevation in leads II, III, and aVF; repeat 12-lead unchanged. Given inferior involvement, right-sided 12-lead (V4R) obtained to assess for RV infarction; no ST elevation noted in V4R, right ventricular involvement not suspected.

L: Link. Primary impression: STEMI, inferior wall.

D: Do & Document. STEMI alert called to [receiving facility] from scene, cath lab activated. 324mg ASA (4 x 81mg chewable) given PO, no allergy or contraindication. Nitroglycerin withheld given inferior wall involvement and preload-dependent physiology; no nitrates administered in the field. 18ga IV established RT AC on first attempt, no complications, saline lock, BP monitored closely for any drop suggestive of RV involvement, reassessed at 122/74 and 120/78 en route; no hypotension noted at any point. Continuous cardiac monitoring throughout transport, no ectopy or rhythm change noted, SpO2 maintained 97-99% on room air. Transported code 3 to [receiving facility] cath lab per STEMI activation protocol, patient remained A&Ox4 throughout with pain steady at 6/10 on arrival, no analgesia given in the field per protocol/medical control. Transfer of care, 12-lead, and V4R given verbally and via ePCR to [receiving RN name], cath lab team present on arrival.

PEARL: *Inferior STEMI always earns a right-sided 12-lead (V4R). State it either way: whether RV involvement was ruled in or out decides whether nitrates are safe, and the chart should show that reasoning, not just the result.*

Scenario: Trauma, Motor Vehicle Collision, Restrained Driver

WEAK

Pt was driver in car accident. C/o neck pain. Placed in collar, moved to backboard, transported. No other injuries found.

GOLD STANDARD

G: Gather. 34 y/o F, restrained driver of single-vehicle collision into a roadside barrier at reported ~35mph, moderate front-end intrusion noted on scene, airbag deployed, windshield intact with no starring. Found seated in vehicle, seatbelt on, alert and oriented, extricated by patient herself prior to crew arrival and found standing beside vehicle on crew arrival. Pt states, “I think I just tweaked my neck,” denies loss of consciousness, denies striking head, denies chest or abdominal pain, states she was looking at her phone briefly before the collision.

O: Observe. C-spine tenderness noted on palpation at midline C5-C6 without step-off or deformity, no other spinal tenderness noted thoracic or lumbar. Exam otherwise unremarkable: PERRL, no facial or scalp trauma, trachea midline, chest wall stable and non-tender, abdomen soft and non-tender, pelvis stable to compression, all four extremities with equal strength and sensation, no gross deformity. Vitals WNL throughout, GCS 15.

L: Link. Given mechanism (front-end intrusion, reported 35mph), midline C-spine tenderness, and distracting-injury/reliability concerns given phone use immediately pre-collision, full spinal precautions indicated per protocol; trauma criteria met per eInjury.04 (mechanism/vehicular intrusion).

D: Do & Document. Patient placed in cervical collar and moved to gurney via [technique], crew x3 assisting movement, secured with straps x5 prior to any movement of gurney. Reassessed en route, neuro status and vitals unchanged, pain in neck reported steady at 4/10, no new complaints. Transported code 2 to [receiving facility], trauma criteria documented accordingly. Transfer of care given verbally to [receiving RN/MD name], including mechanism details and exam findings.

PEARL: “Distracting injury” is a judgment call, not a magic phrase. Name the actual distraction (pain level, mechanism, a reliability concern) rather than writing the label alone; a bare “distracting injury noted” gives a reviewer nothing to evaluate.

Scenario: Cardiac Arrest with ROSC

WEAK

55 y/o M found down by wife, CPR started. AED applied, shocked. Crew continued CPR, defibrillated again, gave epi and amiodarone. Patient got pulse back. Transported to hospital. Vitals stable en route.

GOLD STANDARD

G: Gather. 55 y/o M found supine on kitchen floor by wife, who reports patient collapsed suddenly while eating dinner, denies any prior complaints of chest pain, SOB, or dizziness that evening. Wife called 911 and began CPR per dispatcher instructions immediately, compressions ongoing on crew arrival, estimated downtime prior to bystander CPR less than 1 minute.

O: Observe. On arrival, patient unresponsive, apneic, pulseless. Bystander-applied AED had delivered one shock per AED prompt prior to crew arrival. Cardiac monitor applied on arrival, rhythm identified as coarse ventricular fibrillation.

L: Link. Primary impression: cardiac arrest, ventricular fibrillation.

D: Do & Document. Crew assumed resuscitation immediately: high-quality CPR continued with minimal interruptions (under 10 sec for rhythm/pulse checks), compression rate 100-120/min, depth confirmed via feedback device, full chest recoil allowed, compressors rotated every 2 minutes to prevent fatigue-related decay. Defibrillated at 200J biphasic, CPR resumed immediately without pulse check delay. Supraglottic airway placed on first attempt, placement confirmed via waveform capnography with good square-wave morphology, continuous EtCO₂ monitoring initiated and trending 16-20 mmHg during compressions, consistent with effective CPR. IV access established LT AC on first attempt, 1mg epinephrine IV given and repeated at 4-minute intervals per protocol. Rhythm check showed persistent VF, defibrillated again at 200J, 300mg amiodarone IV given for refractory VF. Sudden rise in EtCO₂ to 44 mmHg noted, palpable carotid pulse confirmed on rhythm/pulse check, organized rhythm (sinus tachycardia, rate 118) on monitor, ROSC achieved at 1856, approximately 10 minutes into crew-directed resuscitation (15 minutes total including bystander CPR prior to crew arrival), after 2 crew-delivered defibrillations (3 total including the bystander AED shock). Post-ROSC vitals: BP 88/54, HR 118, SpO₂ 93% on supraglottic airway with 100% FiO₂, EtCO₂ 38 mmHg. 12-lead obtained post-ROSC, no acute ST elevation noted, no STEMI alert indicated. Post-ROSC care initiated per protocol: FiO₂ titrated down to maintain SpO₂ 94-98% and avoid hyperoxia, ventilations titrated to maintain EtCO₂ 35-40 mmHg, 500mL normal saline bolus given for post-ROSC hypotension with BP improving to 102/64 on reassessment en route, reversible causes considered (H's and T's); no evidence of trauma, hemorrhage, or airway obstruction found on exam, downtime and history not suggestive of hypoxic or metabolic cause. Patient remained with palpable pulse and organized rhythm throughout transport, continuously reassessed, no repeat arrest en route. Wife updated on patient status and resuscitation summary by crew prior to transport and given information on receiving facility. Transported code 3 to [receiving facility], a cardiac arrest receiving center, given post-ROSC status. Transfer of care given verbally and via ePCR to [receiving RN/MD name], including total downtime, rhythm history, number of shocks, medications given, and post-ROSC 12-lead findings.

PEARL: State downtime as two numbers, bystander and crew-directed, and account for every shock, bystander AED included. “2 shocks” that was actually 3 is exactly the kind of mismatch that erodes credibility on review.

Scenario: Cardiac Arrest, Resuscitation Terminated on a Valid DNR

WEAK

93 y/o M cardiac arrest. CPR started. Family produced DNR so we stopped. Time of death 1302. Scene turned over to law enforcement.

GOLD STANDARD

G: Gather. Dispatched code 3 to a private residence for reported cardiac arrest. 93 y/o M found supine on the living room floor. Patient's son reports sudden collapse approximately 5 minutes prior to crew arrival with brief generalized stiffening and jerking lasting under a minute. Son denies the patient voiced any complaint of chest pain, shortness of breath, or other symptoms earlier in the day. Son states he called 911 immediately but was physically unable to perform CPR; no bystander CPR performed prior to crew arrival. History per family: [conditions]. Not enrolled in hospice.

O: Observe. Unresponsive and apneic on arrival. Pulselessness confirmed at both carotid and femoral arteries. No signs of trauma. No dependent lividity, no rigor mortis, no injuries incompatible with life. Pupils fixed and dilated bilaterally. Skin cool and mottled. Cardiac monitor applied, initial rhythm pulseless electrical activity.

L: Link. Primary impression: cardiac arrest, non-traumatic. Organized electrical activity without palpable pulses at two sites, with no criteria for obvious death present on exam; resuscitation therefore indicated and initiated. Following verification of the POLST described below, the order met all operative criteria under SLOEMSA Policy #125: Section A DNR, signed by both patient and physician, fully executed, and physically present with the patient. Termination of resuscitation therefore indicated.

D: Do & Document. Resuscitation assumed immediately upon patient contact: high-quality chest compressions with BVM ventilations on room air. During the initial cycle of CPR, family produced a California POLST form. Compressions continued without interruption while the crew reviewed and verified the document: name and date of birth confirmed against the patient as identified by family, Section A reading "Do Not Attempt Resuscitation/DNR (Allow Natural Death)," patient signature dated [date], physician signature dated [date], form fully executed. All resuscitative efforts terminated on verification, approximately 4 minutes after initiation. No ALS interventions performed at any point: no IV or IO access, no medications administered, no advanced airway placed, no defibrillation attempted. Determination of death on scene at 1302. Family updated on cessation of efforts by crew and remained with the patient. Engine company notified the Sheriff's Office via dispatch of a confirmed coroner's case. Deputies arrived and assumed scene and patient custody along with coroner notification; deputy name and badge not obtained. POLST photographed and attached to this report.

PEARL: Resuscitate until the document is verified, and chart that you did. "Family said he's a DNR" is not an order. Document the POLST the way you would a 12-lead: section, signatures, dates, and attached to the chart. Then state why the order was operative, not just that you stopped. This is also a call where times belong in the narrative: nothing in CAD or the monitor records when the document appeared, when it was verified, or when efforts stopped. Get the deputy's name and badge before you clear. If you can't, chart the agency, the officer's last name, or the law enforcement incident number, so custody transfer is still traceable.

The Standard, Restated

Gather what happened. Observe what you found. Link your reasoning between the two. Do the work, and Document it. Write every chart as if it will be read by three people who weren't there: the next clinician, a QI reviewer, and an attorney. If G.O.L.D. gives all three what they need, what you saw, what you did, why you did it, and what happened after, you've met the standard. That's the whole test.



SECTION 02

BLS Interfacility Transport



PREHOSPITAL CARE DOCUMENTATION • BLS INTERFACILITY TRANSPORT

THE G.O.L.D. STANDARD

GATHER • OBSERVE • LINK • DO & DOCUMENT

A Field Guide to Billable, Defensible IFT Documentation

BLS Interfacility Edition

For EMTs Assigned to BLS Interfacility Transport • A Bearamedics Field Guide
Built to SLOEMSA Policy #124 and Medicare and Medi-Cal non-emergency ambulance requirements

Version 1.1 • Revised October 2, 2026

Prepared by Thomas Moore, EMT-P

"If it isn't written, it wasn't done. If it doesn't prove necessity, it won't get paid."

Why This Edition Exists

The original G.O.L.D. Standard was written for the 911 side. On a 911 call, the emergency itself goes a long way toward explaining why an ambulance showed up. On an IFT, nobody called 911. The transport was scheduled, which means every single chart has to prove, on its own, that this patient needed an ambulance and could not have gone by wheelchair van, private car, or taxi.

That gives every IFT chart a third reader. The 911 guide says to write for the next clinician and for the QI reviewer or attorney. On IFT you also write for the **payer**: Medicare, Medi-Cal, a Medicare Advantage plan, or a commercial insurer. That reviewer was not there, has never met the patient, and will decide from your narrative alone whether the transport was covered. A clinically perfect IFT chart can still be denied if it does not answer the payer's questions.

Our billing office can only bill what you document. They cannot add facts, they cannot call the patient's condition back into existence three weeks later, and they cannot fix a narrative that says "transported without incident" and nothing else. When a claim is denied, San Luis Ambulance absorbs the cost, or worse, a patient receives a bill they should never have gotten. And payment is not final when the check clears: Medicare can review and take money back long after the transport, and non-emergency ambulance transports are among the most closely audited services in all of EMS.

This packet is the standalone "how" for the BLS IFT side. SLOEMSA Policy #124 still applies to every IFT PCR you write. This guide shows you how to meet it in a way that also satisfies the people who pay for the transport.

It is built around what SLA BLS IFT actually runs: **hospital discharges** to skilled nursing facilities, care homes, and private residences; **hospice discharges**; and **MRI wait-and-returns**. Every pickup is at a hospital, and every transport is pre-planned.

The Governing Principle

Every IFT narrative has to answer one question in plain, observed terms:

THE IFT QUESTION

Why could this patient not safely go by wheelchair van, car, or taxi, today?

Then apply the same test as the 911 guide: "How do you know that?" If the honest answer is "I observed it" or "the sending nurse told me," write it that way and attribute it. If the honest answer is "the paperwork said so" or "that's what we always write for this patient," you have not answered the question yet.

Notice the word **today**. Payers judge the patient's condition at the time of transport, not their diagnosis list, not their condition last month, and not what the facility checked on a form. A patient with a stroke history who sat in a wheelchair at the nurses' station this morning is a very different chart from a patient with the same history who cannot hold their head up in bed.

Billable Means Accurate, Never Embellished

Read this section twice. "Billable language" in this guide means precise, specific, observed language that shows the necessity that actually exists. It never means making a patient sound sicker than they are.

THE INTEGRITY LINE

Never chart a finding you did not observe or confirm, copy the facility's PCS wording in as if it were your own assessment, or use "bed confined" or "non-ambulatory" as a label because it gets paid.

Never change a completed PCR because billing says the claim will not pay. If billing asks a question, answer it truthfully. If you genuinely left out something you observed, add it as a clearly labeled, dated late entry per SLA policy, never by rewriting the original.

Documenting necessity that did not exist is false billing. Under the federal False Claims Act that exposure is personal, not just corporate. No transport is worth your certification.

If the patient did not need an ambulance, **chart that truthfully and transport the patient anyway**. Your job is to write what is true. Deciding what is billable, and to whom, is billing's job.

The good news: most IFT patients who ride on our gurneys genuinely need to. Denials usually happen not because the need was not there, but because the chart never described it. That is the gap this guide closes.

Medical Necessity: What the Payer Is Looking For

The Medicare Standard

Medicare covers non-emergency ambulance transport only when all three of these are true (42 CFR 410.40):

- **The patient's condition** is such that any other means of transportation would put their health at risk.
- **Both the ambulance and the level of service** (for us, BLS) were medically necessary.
- **The destination** is a covered one, and the trip is for (or returning from) a Medicare-covered service. See Destinations below.

Medi-Cal and most commercial plans follow the same basic logic: other transport has to be inappropriate because of the patient's physical or mental condition. Medicare Advantage plans often add prior authorization on top. If you chart to the Medicare standard, you will satisfy nearly every payer.

"Bed Confined" Is a Term With a Legal Definition

"Bed confined" is a billing term, not a description. It is only true when **all three** of these apply:

☐	Unable to get up from bed without assistance, AND
☐	Unable to ambulate, AND
☐	Unable to sit in a chair or wheelchair.

If even one of the three is false, the patient is not bed confined, and writing it anyway is a false statement. Bed confinement is also **not** the only path to necessity. A patient who can sit may still need an ambulance because of a specific condition (for example, needing continuous monitoring, positioning, or immobilization). Either way, the rule is the same: **describe the condition, do not just name the label**.

What Does Not Establish Necessity

None of these, on their own, justify an ambulance. They may be true, and you can chart them, but they will not carry the claim:

- Convenience, scheduling, or "no wheelchair van was available."
- Family cannot drive the patient, or the patient has no car.
- Facility policy, facility request, or "per facility" with no clinical reason.
- A diagnosis by itself ("hx CVA," "dementia," "ESRD") with no description of what it does to the patient today.
- Vague descriptors by themselves: "weak," "fall risk," "elderly," "frail," "deconditioned."
- Patient or family preference.

What Can Establish Necessity (When True and Described)

These are examples of conditions that can support ambulance transport. None of them work as one-word labels. Each has to be described in what you saw, what staff reported, or what the orders say.

Condition	Describe it like this
Unable to maintain sitting balance	Slumps or falls to the side when sat upright on the edge of bed, requires two-person support to stay upright, unable to hold head up.
Contractures or deformity	Bilateral hip and knee flexion contractures, unable to straighten legs or bend at the hips to sit in a wheelchair.
Positioning orders	Physician order for HOB no higher than 30 degrees, or flat/log-roll precautions, or non-weight-bearing with inability to transfer.
Pressure injury requiring offloading	Stage IV sacral pressure injury with dressing intact; sitting places direct pressure on the wound; transported side-lying/offloaded per wound care orders.
Severe pain with movement	Pain 8/10 with any repositioning of the left leg; suspected fracture requiring immobilization and supine transport.
Continuous oxygen that needs monitoring	O2 at 3 LPM via NC per orders, SpO2 88% on room air at facility, patient unable to manage own O2 due to confusion.
Cognitive or behavioral risk	Oriented to self only, repeatedly attempts to stand and pull at lines despite redirection; unsafe to transport seated without an attendant. Describe the behavior, not just the diagnosis.
Airway or secretion management	Requires oral suctioning roughly every 10 to 15 minutes per sending RN; unable to clear own secretions.
Bariatric or equipment needs	Patient unable to sit or transfer safely due to body habitus and weakness; bariatric stretcher and four-person lift required. Describe the functional limit, not the weight alone.

Vague vs. Billable Language

Vague	Billable (because it's specific)
<i>Pt is bed confined.</i>	Pt unable to get up from bed without two-person assist, unable to bear weight or ambulate, and unable to sit upright in a chair due to [specific reason], per crew observation and sending RN [name].
<i>Pt is non-ambulatory.</i>	Pt unable to stand or bear weight on either leg; attempted assisted stand not performed per NWB orders. [Or: pt unable to stand even with two-person assist.]
<i>Pt is weak.</i>	Pt unable to lift either arm against gravity or hold head upright without support; requires full assist for all repositioning.
<i>Pt is a fall risk.</i>	Pt attempted to stand x3 during assessment without awareness of deficits, unable to follow safety instructions; requires continuous attendant supervision.
<i>Transported per facility request.</i>	Transported for [covered service: hospital discharge to SNF for skilled rehab / hospice discharge home / MRI not available at sending hospital] at [facility name, facility type].
<i>Pt stable.</i>	Vitals within normal limits at pickup and on reassessment at [time]: [values]. No change in mental status from baseline.
<i>Transported without incident.</i>	Entire narrative still required. "Without incident" is a conclusion, not documentation. Describe the positioning, care, reassessment, and condition on arrival.

Level of Service and Mode

- BLS IFT is almost always a **BLS non-emergency** transport. The level billed has to match the level of care the patient needed and received. You do not need to know the billing codes; you need a chart that matches reality.
- If the patient's condition requires more than BLS (see When It Isn't a BLS Transport), the answer is not a BLS chart with ALS problems in it. The answer is to escalate.
- If a transport becomes emergent (lights and siren, diversion), document exactly what changed, when, and who you notified. The mode has to be justified by the patient's condition at that moment, never by schedule pressure.

Destinations and Facility Types

Covered Destinations

Medicare generally covers non-emergency ambulance trips between a hospital and a skilled nursing facility or the patient's residence, which is exactly what most of our discharges are. For Medicare, a residence includes a private home and residential care settings like board and care or assisted living. Freestanding outpatient imaging centers and physician offices are often **not** covered as destinations on their own; MRI wait-and-returns have their own rules (see Wait-and-Return Transports). If you are sent somewhere unusual, chart it accurately and flag it to billing; never change the destination in the chart.

Medi-Cal managed care plans generally cover non-emergency ambulance transport facility to facility or facility to home. In SLO County that is most often CenCal Health, which may require authorization before the trip.

Why This Destination

- Payers expect the patient to go to the nearest facility that can provide the care they need. On discharges, placement is usually arranged by case management based on bed availability, level of care, or patient and family choice. Document which: "SNF placement arranged by hospital case management [name]," or "residence per patient and family choice."
- On MRI wait-and-returns, state why the study can't be done at the sending hospital: "MRI not available at [hospital]," "[hospital] MRI unit out of service per sending RN." "For imaging" is not enough.

Name the Facility Type Exactly

Every IFT claim carries an origin and destination code, and those codes come from what you chart. A skilled nursing facility, an assisted living facility, a board and care, and a private residence are four different codes, and some of them change whether the trip is covered at all. Never write "the facility" or "the home."

Avoid	Use Instead / Why
<i>Picked up from hospital.</i>	Picked up from [hospital], 3 West, Room 314, inpatient discharge.
<i>To SNF.</i>	To [name], a skilled nursing facility, for skilled rehabilitation per discharge orders.
<i>Transported home.</i>	Transported to patient's private residence at [address], husband and hospice RN [name] present to receive.
<i>Pt going to a home in Arroyo Grande.</i>	To [name], a residential care facility for the elderly (board and care), Room 4.
<i>To imaging.</i>	To [name] outpatient imaging center, MRI suite, for MRI thoracic spine not available at [hospital]; wait-and-return.

The Paperwork: What You Pick Up at the Bedside

Read the paperwork **before** you chart, not after. Your narrative and the hospital's paperwork will be read side by side by the payer. Before you leave the sending hospital, confirm you have or have verified:

☐	Face sheet: demographics, primary and secondary insurance, and the patient's status (inpatient, observation, or outpatient). Status matters most on wait-and-returns, where it can change who pays.
☐	Physician Certification Statement (PCS): signed, dated, and consistent with what you are seeing. See PCS below.
☐	DNR / POLST: an operative document per SLOEMSA Policy #125, verified and traveling with the patient. See the DNR section; this is where discharges home go wrong.
☐	Discharge orders / transfer summary / med list: including positioning orders, weight-bearing status, O2 orders, IV orders, isolation status.
☐	Destination contact: accepting nurse or unit at the SNF or care home, or the family member or hospice nurse meeting you at a residence.
☐	Hospice status: hospice agency name and whether hospice services begin with this discharge. Hospice status often changes who pays for the trip.
☐	Authorization number if the payer requires one.
☐	Sending staff member's name and title who gave you report.

The Physician Certification Statement (PCS)

The PCS is the sending physician's (or qualified staff member's) certification that the patient needs an ambulance. It is required for most non-emergency transports, but **the PCS does not prove necessity on its own**. Payers review the PCS together with your PCR, and your chart has to support it with your own observations.

- **Discharges and wait-and-returns** are non-repetitive transports under Medicare. The PCS may be obtained up to 48 hours after the transport, and may be signed by a physician, PA, NP, clinical nurse specialist, RN, or discharge planner employed by the hospital and familiar with the patient's condition. In practice, a PCS collected at the bedside is by far the easiest one to get.
- **Medi-Cal: California requires a PCS form for non-emergency medical transportation (NEMT). In Medi-Cal terms, NEMT means transport by ambulance, litter van, or wheelchair van; non-medical transportation (NMT) means car, taxi, or public transit. They are different benefits with different paperwork, so use the right term, and plan forms are typically valid for up to one year from signature.**
- If there is no PCS, do not delay the transport. Document that it was not available and call the on-duty field supervisor.
- SLA BLS does not currently run scheduled repetitive transports (such as dialysis). If that changes, Medicare applies stricter rules to those trips, including a physician-signed PCS within 60 days and prior authorization, and this guide will be updated.

WHEN THE PCS AND THE PATIENT DON'T MATCH

If the PCS says "bed confined" and you find the patient dressed and sitting in a chair by the window, **chart what you see**. Do not argue with the hospital, do not refuse the transport, and do not write the PCS's version as your own. Document your observations objectively, call the on-duty field supervisor, and transport. A mismatch between the PCS and the PCR is exactly what gets a claim denied, and a PCR that silently echoes a false PCS is exactly what turns a denial into a fraud finding.

Signatures: Who Signs, and What If They Can't

Medicare requires the beneficiary's signature (or a valid substitute) to submit a claim. Missing or improperly explained signatures are one of the most common reasons claims are rejected, and the fix happens at the bedside, not in the office.

☐	Patient signs if they are physically and mentally able to.
☐	If the patient cannot sign, document why in specific terms (for example: "unable to sign due to cognitive impairment, oriented to self only" or "unable to hold a pen due to bilateral hand contractures"). "Unable to sign" alone is not a reason.
☐	If the patient cannot sign, an authorized representative may sign (family member, legal guardian, POA). Document their name and relationship.
☐	If neither is available, the crew member signs the patient-unable-to-sign statement at the time of transport, and you obtain the name, title, and signature of the receiving facility representative, with date and time.
☐	Receiving signature on every transport , regardless. It is your proof of delivery and transfer of care. Signature requirements are the same as on any other call.
☐	Drop-offs at a residence with no healthcare provider to hand off to: a family member or other witness present may sign for receipt. Document their name and relationship to the patient.

The G.O.L.D. Standard for IFT

Policy #124.H requires the same seven narrative elements on an IFT that it requires on a 911 call, and it still prohibits auto-generated narratives: you write your own narrative, every trip, in your own words. G.O.L.D. regroups the seven into four you can actually remember. What changes on IFT is what each letter has to accomplish.

Policy #124.H Element	G.O.L.D. Letter (IFT Focus)
1. Patient description	G: Gather
2. Chief complaint (on IFT: reason for transport)	G: Gather
3. General observations	O: Observe
4. History of present event / pertinent findings	G: Gather
5. Provider impression	L: Link
6. Treatments / care rendered	D: Do & Document
7. Disposition	D: Do & Document

G GATHER	• The transfer: who requested it, origin (name and facility type), destination (name and facility type), and the covered service the patient is going for (discharge to SNF for rehab, hospice discharge home, MRI not available at the sending hospital). • The report: diagnosis and pertinent history, baseline mental and functional status, attributed to the staff member by name and title. • The paperwork: PCS present and reviewed, DNR/POLST verified as operative, positioning or weight-bearing orders, O2 and IV orders, isolation, patient status (inpatient, observation, outpatient).
O OBSERVE	• Your own bedside assessment: position found, mental status compared to reported baseline, vitals, skin (including any pressure injury location, stage if known, and dressing status). • Devices: O2 and flow rate, Foley, G-tube, ostomy, PICC or peripheral IV, wound vac, and their status. • Functional observations that matter for necessity: can the patient sit up, hold their head up, bear weight, follow instructions? What happens when they try? Contractures, pain with movement.
L LINK	• The medical necessity statement. One sentence minimum, connecting what you observed to why an ambulance was required: "Due to [observed findings], pt is unable to [sit upright / bear weight / be safely transported seated] and requires [stretcher transport, positioning, O2 monitoring, attendant supervision]." • This is the letter billing lives or dies on, and the one most often skipped on IFT. Also state your provider impression as usual (for IFT, usually the condition driving the transport).
D DO & DOCUMENT	• Movement: method, number of crew, facility staff assisting (by name or title), straps and rails. • Care en route: positioning, O2, suctioning, reassessments with times and vitals, any condition change and what you did. • Arrival and handoff: condition on arrival (including skin), transfer of care to named staff with title, paperwork and belongings handed off, signatures obtained, loaded miles recorded.

Liability-Conscious Language for IFT

Patient Movement: Still the Biggest Liability Gap

IFT patients are moved more times per trip than almost any 911 patient: bed to gurney, gurney to ambulance, ambulance to gurney, gurney to bed, and on a wait-and-return, all of it twice. Every move is a fall opportunity, and every move needs to be documented with who, how, and how many.

Avoid	Use Instead / Why
<i>Pt moved to gurney.</i>	Pt transferred bed to gurney via draw sheet slide, crew x2 and hospital CNA x1 assisting, bed and gurney locked and level, straps x5 and rails up prior to any movement.
<i>Pt placed in bed at destination.</i>	Pt transferred gurney to bed via draw sheet, crew x2 and receiving RN [name] assisting, bed rails raised and call light within reach before crew departed.
<i>Staff helped.</i>	Hospital CNA [name] assisted with transfer. (Name them. "Staff helped" cannot be verified later.)
<i>Pt ambulated to gurney.</i>	Pt stood and pivoted to gurney with crew x2 contact guard, gait unsteady, one knee buckled briefly and was supported by crew, no fall. (If this happened, it matters for necessity too.)

Skin: Document It at Pickup and at Delivery

Pressure injuries, skin tears, and bruises found at the receiving facility get blamed on whoever touched the patient last. A skin check at pickup and a brief check at delivery protects you, and it is also often the strongest necessity evidence in the chart.

- "Stage IV sacral pressure injury with dressing clean, dry, and intact noted at pickup, reported present on admission per sending RN [name]. Dressing unchanged at delivery."
- "Scattered bruising to bilateral forearms noted at pickup, reported chronic per sending RN. No new skin findings at delivery."

Belongings, Devices, and Medications

- Document what traveled with the patient and who received it: dentures, glasses, hearing aids, phone, wallet, discharge medications, paperwork packet. Lost dentures and hearing aids are a real and recurring complaint.
- Document device status at handoff: "Foley draining clear yellow urine, bag emptied by sending RN prior to transport," "G-tube clamped, feeding paused by sending RN [name] at 1310."

Scope of Practice on BLS IFT

Per current SLA BLS policy, a BLS IFT crew may manage exactly two things beyond basic care:

☐	IV fluids: normal saline only, running by gravity. No other fluids, no pumps, and nothing added to the bag or line.
☐	Oxygen: by nasal cannula or non-rebreather mask, at 15 LPM or less.

- Chart what you took over: "18g PIV L forearm, site clean and dry without infiltration, NS running by gravity at KVO as set by sending RN [name], approximately 600 mL remaining at pickup, 550 mL at arrival." "O2 2 LPM via NC continued from hospital per discharge orders, SpO2 95-97% throughout."
- Any other IV fluid, a pump, an infusing medication, or an oxygen requirement beyond 15 LPM by NC or NRB means this is **not a BLS transport**. See When It Isn't a BLS Transport.

If Something Unplanned Happens

BLS IFT transports are pre-planned, so a patient refusing, a destination that isn't ready, or missing paperwork should be rare. When something does come up, the answer is the same every time: **call the on-duty field supervisor**, and chart the call.

☐	What came up (refusal, destination unable to accept, missing PCS or POLST, PCS mismatch, a question about the patient's condition), in objective terms
☐	The on-duty field supervisor's name, the time of the call, and the decision or instructions given
☐	Who else was notified (sending RN, charge RN, case manager, family), with names and times
☐	For a refusal: capacity assessed in specific terms, risks explained, patient's own words quoted, and signature or witnessed refusal to sign
☐	What happened next: transport completed, delayed, cancelled, or patient returned to the unit and care given to [RN name]

Wait-and-Return Transports (MRI)

On a wait-and-return, the crew takes a hospital patient to an outside imaging site, waits during the study, and brings the patient back. It feels like one call. For documentation and billing, **it is two transports, and it gets two complete, separate reports.**

Two Reports, Each One Standalone

- **Report 1 (outbound):** hospital to imaging. Pickup assessment, necessity statement, care en route, handoff to imaging staff, loaded miles for that leg, signatures.
- **Report 2 (return):** imaging back to the hospital. A fresh reassessment when you resume care after the study, a necessity statement for this leg, care en route, handoff to the hospital RN, loaded miles for that leg, signatures.
- Never write "see previous report" or copy the outbound narrative into the return. Each report must stand on its own, because each leg is billed and reviewed on its own.

During the Wait

- Document who was responsible for the patient: "Care transferred to MRI technologist [name] at 1015 for study; crew remained on site. Crew resumed care at 1112 at completion of study."
- Reassess before the return leg. Note anything given or done during the study that you were told about (for example, contrast), and compare mental status and vitals to the outbound baseline. If the patient received sedation or is no longer at baseline, that may no longer be a BLS patient; call the on-duty field supervisor.

MRI Safety

- Oxygen cylinders, the gurney, and anything ferromagnetic stay out of the MRI scanner area. Imaging staff will switch the patient to their MRI-safe equipment. Chart the handoff and return of O2: "O2 switched from crew NC at 2 LPM to MRI suite O2 by technologist [name] at 1016; returned to crew O2 2 LPM NC at 1112."
- Imaging staff manage the IV during the study. Recheck the site, fluid, and rate when you resume care.

Billing Notes

- Chart the patient's status from the face sheet (inpatient, observation, or outpatient). For hospital inpatients, the hospital is usually responsible for paying for a round trip to get a service it can't provide, rather than the patient's insurance directly. You don't need to decide who pays; billing does, but only if your chart tells them the status.
- Each leg still needs its own necessity statement. "For MRI" explains why the patient went, not why they needed an ambulance to get there.

DNR, POLST, and Advance Directives

Hospice and end-of-life discharges put this section front and center. Everything below follows SLOEMSA Policy #125 (Prehospital Determination of Death / DNR / End of Life Care). Know it, and know that one document you can't honor is not a technicality: if that patient arrests en route, you will be starting CPR on someone who didn't want it.

What DNR Means, and What It Doesn't

- A DNR withholds **resuscitation only**: chest compressions, assisted ventilations, advanced airways, defibrillation, and cardiotoxic drugs.
- **DNR does not mean do not treat**. Oxygen, suctioning, positioning, bleeding control, comfort care, and any artificial nutrition or hydration all continue.

What Counts as a Valid (Operative) DNR in SLO County

Document	Valid when
POLST with Section A "Do Not Attempt Resuscitation/DNR" checked	Signed and dated by a physician, NP, or PA, and by the patient or their legally recognized decision maker. No witness needed. Copies are acceptable. Any section left blank means full treatment for that section.
EMSA/CMA Prehospital DNR Form	Completed and signed per the form.
DNR medallion or bracelet	From an EMSA-approved manufacturer, worn by the patient, imprinted "Do Not Resuscitate-EMS," "Do Not Resuscitate," or "POLST."
Written DNR order in the medical record	Only for a patient in a licensed health care facility, or being transferred between licensed health care facilities. Must say "Do Not Resuscitate," "No Code," or "No CPR." You must read it yourself, and a staff witness from the facility must verbally confirm it is authentic (chart their name).
Durable Power of Attorney for Health Care / AHCD naming an agent	Only when the named health care agent is physically present and requests that resuscitation not be done.
Natural Death Act Declaration	Fully executed.

What Does NOT Count

- Family members saying "she's DNR" when they are not the named agent, or with no document present.
- An Advance Health Care Directive, living will, or DPAHC in the paperwork **without the named agent physically present**.
- A hospital chart DNR order on a discharge **home or to a board and care**. That order only covers patients in, or moving between, licensed health care facilities. A private residence is not one, and a residential care home (board and care, assisted living) generally is not either.
- A POLST with Section A blank, or one missing the provider's or patient's signature.
- Hospice enrollment by itself. Being on hospice is not a DNR.

THE DISCHARGE HOME RULE

Before you leave the hospital with a patient going home or to a care home who wants no resuscitation, **confirm an operative document is traveling with them, usually a signed POLST**. The hospital chart order stays at the hospital; it does not ride in the ambulance.

If the only DNR is the chart order, ask the discharging RN or case manager for a POLST before departure. If one can't be completed, call the on-duty field supervisor before you transport, and chart the conversation.

Using It Correctly

- **Confirm identity:** the patient is the person named on the document (ID band, staff confirmation).
- **POLST Section B** (Full Treatment, Selective Treatment, Comfort-Focused Treatment) guides care for a patient who still has a pulse. Provide care consistent with it, within BLS scope.
- **A conscious patient who asks for resuscitation overrides the document.** If you have real doubt about validity or identity, start resuscitation and sort it out after.
- **If a patient with a valid DNR dies during transport:** pull over, contact MedCom, and have the coroner rendezvous with the unit to take custody of the deceased. Do not continue to the destination or return to the hospital with the deceased.
- Document the time you found the patient pulseless and apneic, the operative DNR document, the time MedCom was contacted, the rendezvous location, and the name of the coroner representative who took custody, with the time.

Documenting It

☐	Which document it is, and where it was found
☐	What it says: "POLST Section A: DNR; Section B: Comfort-Focused Treatment"
☐	Signed by whom (provider name and title; patient or decision maker) and dated
☐	How identity was confirmed
☐	That it traveled with the patient, and to whom it was handed at the destination
☐	For a chart order at a facility: that you read it, and the name and title of the staff witness who confirmed it

When It Isn't a BLS Transport

Sometimes the patient in front of you is not the patient in the report. A BLS crew that transports an unstable patient as a routine discharge has a clinical problem, a liability problem, and a billing problem, all at once. The right move is to stop and escalate.

Stop and Escalate If

- The patient is not hemodynamically stable, judged by the trend in their vital signs and presentation compared to the baseline the hospital reported, not by a single number. A worsening trend (rising heart rate, falling blood pressure, rising respiratory rate, falling SpO2, declining mental status) is a reason to stop. **[Future revision: SLA to provide defined BLS IFT vital sign parameters; this guidance will be replaced when they are issued]**
- The patient has new symptoms: chest pain, new shortness of breath, new altered mental status, active bleeding.
- The patient needs anything outside BLS scope: IV fluid other than NS by gravity, a pump, an infusing medication, oxygen beyond 15 LPM by NC or NRB, or cardiac monitoring.
- The report and the patient do not match in a way that affects safety.

If It Happens En Route

☐	Inside SLO County: divert to the nearest hospital.
☐	Outside SLO County: call 911 for an ALS intercept.
☐	Either way, notify the on-duty field supervisor once the patient is safe, and document the change, the decision, and every time.

What to Do and Document

☐	Findings that triggered the concern, with times and vital signs
☐	At the hospital: sending RN and charge RN notified by name, title, and time; the hospital physician's response (discharge held, patient re-evaluated)
☐	On-duty field supervisor called, with name, time, and decision
☐	What happened next: transport held or cancelled, care remaining with [RN name]
☐	If deterioration occurs en route: what changed, when, what you did, where you diverted or who you called, and who you notified, with times

Common Pitfalls That Get IFT Claims Denied

Avoid	Use Instead / Why
<i>One report for a wait-and-return, or the outbound narrative copied into the return.</i>	Two complete reports. The return leg starts with a fresh reassessment after the study.
<i>"Bed confined" as a label, or checked in a box with no narrative support.</i>	All three criteria described, or a specific condition described instead.
<i>Necessity explained as "per facility" or "per PCS."</i>	Your own observations, with staff reports attributed. The PCS supports your chart; it doesn't replace it.
<i>Facility type missing or wrong ("the facility," "home").</i>	Name and type: hospital unit, SNF, assisted living, board and care, private residence, outpatient imaging center.
<i>"Pt unable to sign" with no reason.</i>	The specific reason, plus authorized representative or facility representative signature.
<i>"DNR per chart" on a discharge home.</i>	The operative document named (usually POLST Section A), verified, and traveling with the patient. A chart order does not follow a patient home.
<i>MRI trip with no stated reason for going outside.</i>	"MRI not available at [hospital]" or the specific reason the study could not be done there.
<i>Guessed or rounded mileage.</i>	Loaded miles from pickup to destination per odometer or GPS, recorded to the tenth of a mile.
<i>Times that don't match CAD.</i>	Reconcile at patient, depart, arrive, and transfer of care times before you finalize.
<i>"Transported without incident" as the whole D section.</i>	Positioning, care, reassessments, condition on arrival, and named transfer of care.

Quick Reference: Before You Submit

G: Gather

☐	Origin and destination named, with facility type
☐	Reason for transport stated as the service the patient is going for
☐	Report attributed to sending staff by name and title
☐	PCS and orders reviewed and documented
☐	DNR/POLST verified as operative under Policy #125, identity confirmed, document traveling with patient
☐	Patient status (inpatient, observation, outpatient) noted from face sheet

O: Observe

☐	Bedside assessment in my own words, compared to reported baseline
☐	Skin documented at pickup (and at delivery if relevant)
☐	Devices, IV (NS by gravity only), and O2 (NC or NRB, 15 LPM or less) documented with status and flow
☐	Functional observations documented: sitting, standing, weight bearing, following instructions

L: Link

☐	Medical necessity statement connects observed findings to why other transport was unsafe
☐	"Bed confined" used only if all three criteria are true and described
☐	Narrative is consistent with the PCS, or the mismatch is documented and reported

D: Do & Document

☐	Every transfer documented with method, number of crew, and facility staff assisting
☐	Reassessments en route documented with times
☐	Transfer of care to named staff with title; belongings and paperwork handed off
☐	Signatures complete, with specific reason if patient unable to sign
☐	Loaded mileage recorded to the tenth; times reconciled with CAD
☐	Narrative written fresh for this trip, not copied forward
☐	Wait-and-return: two complete, separate reports, with care handoff during the study documented
☐	Anything unplanned: on-duty field supervisor call documented with name, time, and decision

Example Narratives: Weak vs. Gold Standard

These five scenarios cover what BLS IFT actually runs (discharge to a SNF, hospice discharge home, and an MRI wait-and-return), plus the two that trip up crews most: the patient who doesn't meet necessity, and the patient who isn't a BLS patient anymore. Bracketed items are placeholders.

Scenario 1: Hospital Discharge to SNF

WEAK

Pt picked up from hospital for transfer to SNF. Hx CVA. Pt is bed confined. Vitals stable. Transported without incident. Report given to RN.

GOLD STANDARD

G: Gather. BLS non-emergency transport of 78 y/o M from [hospital], Room 314, to [name], a skilled nursing facility, for skilled rehabilitation following discharge; placement arranged by case management [name]. Per sending RN [name], pt admitted 6 days ago for acute right MCA stroke with residual left-sided hemiplegia and dysphagia; baseline since admission is alert, oriented x3, left side flaccid, requires two-person assist for all repositioning, aspiration precautions with HOB at least 30 degrees. PCS reviewed, signed by attending physician [name], consistent with crew findings. POLST reviewed: Section A Attempt Resuscitation/CPR, Section B Full Treatment, copy traveling with pt.

O: Observe. Pt found supine in bed with HOB at 30 degrees, alert, oriented x3, speech mildly dysarthric but understandable. Left arm and leg without movement, right side 5/5. When assisted to sit at edge of bed, pt unable to maintain trunk balance and leaned to the left, requiring two-person support to remain upright. Skin warm, dry, intact, no pressure injuries noted on sacrum or heels at pickup. Vitals at 1405: BP 142/84, HR 78, RR 16, SpO2 96% RA.

L: Link. Due to left hemiplegia with inability to maintain sitting balance, and aspiration precautions requiring HOB elevation, pt is unable to be safely transported seated in a wheelchair van and requires stretcher transport with positioning and attendant monitoring. Impression: s/p CVA with left hemiplegia.

D: Do & Document. Pt transferred bed to gurney via draw sheet slide, crew x2 and hospital CNA [name] assisting, bed and gurney locked and level, straps x5 and rails up prior to movement. Positioned semi-Fowler's at 30 degrees, left arm supported on pillow. Pt remained alert and oriented en route, no respiratory distress, no coughing or choking. Reassessment at 1432: BP 138/82, HR 76, RR 16, SpO2 96% RA. On arrival pt transferred gurney to bed via draw sheet, crew x2 and SNF CNA [name] assisting, rails up, call light within reach. Skin unchanged, no new findings. Report, discharge packet, POLST, glasses, and phone handed to receiving RN [name]. Pt signed with right hand. Loaded miles: [x.x].

PEARL: "Hx CVA" doesn't pay. "Leaned to the left and required two-person support to remain upright" does. The diagnosis explains the patient; the observed functional limit is what proves the ambulance.

Scenario 2: Hospice Discharge Home

WEAK

Pt discharged home on hospice. Pt is DNR per chart. Pt on O2. Transported home without incident. Family signed.

GOLD STANDARD

G: Gather. BLS non-emergency transport of 72 y/o F from [hospital], Room 210, to her private residence at [address] for home hospice care with [hospice agency], hospice services beginning with this discharge per case manager [name]. Per sending RN [name], pt has metastatic pancreatic cancer with spinal metastases; baseline since admission is drowsy but arousable, oriented to person and place, bed level, O2 2 LPM via NC. Pain medication given by RN at 1310 prior to departure. PCS reviewed, signed by attending physician [name]. POLST reviewed: Section A Do Not Attempt Resuscitation/DNR, Section B Comfort-Focused Treatment, signed and dated by Dr. [name] and by pt; pt identity confirmed by ID band and sending RN. Original POLST traveling with pt.

O: Observe. Pt found supine in bed, eyes open to voice, oriented to person and place, speech soft but clear. Pt reports lower back pain 4/10 at rest, increasing to 8/10 with attempted elevation of HOB above 30 degrees. Skin warm, dry, pale; small reddened, blanchable area to sacrum, intact. O2 2 LPM via NC. Vitals at 1335: BP 104/62, HR 92, RR 18, SpO2 94% on 2 LPM NC.

L: Link. Due to severe pain with any upright positioning from spinal metastases, pt is unable to sit in a wheelchair or vehicle seat and requires supine stretcher transport with continuous O2 and attendant monitoring. Impression: end-stage metastatic cancer, comfort-focused care.

D: Do & Document. Pt transferred bed to gurney via draw sheet, crew x2 and hospital CNA [name] assisting, pillows supporting lower back and knees, straps x5, rails up, HOB at 20 degrees for comfort. O2 2 LPM via NC continued from hospital. Pt rested with eyes closed en route, easily aroused, pain reported 4/10, no distress. Reassessed at 1402: BP 102/60, HR 90, RR 18, SpO2 94%. On arrival, husband [name] and hospice RN [name] present; pt transferred gurney to home hospital bed in living room via draw sheet with crew x2 and hospice RN assisting, rails up. Report and original POLST handed to hospice RN [name]. Pt unable to sign due to drowsiness and inability to hold a pen; husband [name] signed as authorized representative. Loaded miles: [x.x].

PEARL: *The hospital's DNR order stays at the hospital. For a patient going home, only a document that travels (usually a signed POLST) protects their wishes if they arrest in your ambulance. Verify it before you leave the room.*

Scenario 3: MRI Wait-and-Return (Two Reports)

WEAK

Pt transported to outside MRI and back to hospital. Pt waited during MRI. Tolerated well. Returned to room. (Single report for both legs.)

GOLD STANDARD: REPORT 1 (OUTBOUND)

G: Gather. BLS non-emergency transport of 58 y/o F, hospital inpatient per face sheet, from [hospital], Room 402, to [name] outpatient imaging center for MRI thoracic spine, wait-and-return; MRI not available at [hospital] per sending RN [name]. Pt admitted after a fall 2 days ago with T8 compression fracture; spinal precautions ordered (flat, log roll only). PCS signed by [name/title] reviewed, consistent with findings. POLST: Full Code, Full Treatment.

O: Observe. Pt found supine and flat in bed, alert, oriented x4. Mid-back pain 5/10 at rest, 8/10 with log roll. Sensation and motor intact in all extremities. 20g PIV R forearm, site clean, NS by gravity at KVO as set by RN, about 700 mL remaining. Vitals at 0935: BP 128/76, HR 84, RR 16, SpO2 97% RA.

L: Link. Due to thoracic compression fracture with physician-ordered flat positioning and log-roll precautions, pt cannot sit upright and requires supine stretcher transport. Impression: T8 compression fracture.

D: Do & Document. Pt log rolled onto draw sheet and slid to gurney, crew x2 and RN [name] assisting, kept flat, straps x5, rails up. IV maintained en route, site unchanged. Pain 6/10 en route, no neuro change. On arrival, care transferred to MRI technologist [name] at 1015 after MRI safety screening; crew remained on site. Loaded miles: [x.x].

GOLD STANDARD: REPORT 2 (RETURN)

G: Gather. BLS non-emergency return transport of 58 y/o F, hospital inpatient, from [name] outpatient imaging center to [hospital], Room 402, following MRI thoracic spine. Per MRI technologist [name], study completed without complications, no contrast or sedation given.

O: Observe. Crew resumed care at 1112. Pt supine and flat, alert, oriented x4, mental status unchanged from pickup. Pain 5/10 at rest. Sensation and motor intact all extremities, unchanged. IV site clean and dry, NS by gravity at KVO, about 650 mL remaining. Vitals at 1114: BP 126/74, HR 82, RR 16, SpO2 97% RA.

L: Link. Pt remains on flat positioning and log-roll precautions for T8 compression fracture, unable to sit upright, requires supine stretcher transport. Impression: T8 compression fracture.

D: Do & Document. Pt log rolled to gurney via draw sheet, crew x2 and MRI tech [name] assisting, kept flat, straps x5, rails up. Condition unchanged en route; reassessed at 1135 with vitals stable, neuro status unchanged. Transferred to bed via draw sheet with crew x2 and RN [name] assisting, kept flat, rails up, call light within reach. Report to RN [name]. Pt signed. Loaded miles: [x.x].

PEARL: *Two legs, two complete reports. The return report starts with a fresh assessment, not with "see previous." And chart the inpatient status: it can decide who pays for both legs.*

Scenario 4: The Honest Chart (Necessity Not Met)

WEAK

Pt is non-ambulatory and bed confined. Transported to board and care on gurney per hospital.

GOLD STANDARD

G: Gather. BLS non-emergency transport of 74 y/o M from [hospital], Room 118, to [name], a residential care facility for the elderly (board and care), following discharge. Per sending RN [name], pt admitted for pneumonia, now resolved; stretcher transport requested because pt "gets tired easily." PCS reviewed, marked "bed confined" by [name/title].

O: Observe. Pt found dressed and sitting upright in a bedside chair, alert and oriented x4, conversant. Pt stood from chair independently and ambulated approximately 15 feet to the gurney with a front-wheeled walker and crew standby assist, gait steady. No respiratory distress, no pain, no devices. Vitals at 1010: BP 132/78, HR 72, RR 16, SpO2 97% RA.

L: Link. Crew observations do not match the PCS designation of bed confined: pt was sitting upright in a chair on arrival and ambulated with a walker and standby assist. No condition identified by crew that would prevent seated transport. Impression: discharge following resolved pneumonia, no acute complaint.

D: Do & Document. On-duty field supervisor [name] called at 1012 regarding PCS discrepancy; instructed to transport and document findings. Pt ambulated to gurney with walker and crew x2 standby assist, straps x5, rails up, positioned sitting upright at pt preference. Pt comfortable and unchanged en route. At destination, pt stood and pivoted to bed with crew x2 standby assist. Report, discharge packet, and walker given to care home staff [name]. Pt signed. Loaded miles: [x.x].

PEARL: *This chart is not a failure. The patient still got where they needed to go, and the chart tells the truth. Billing now has what they need to handle the claim correctly. The weak version, which echoes the PCS, is the one that exposes the crew.*

Scenario 5: The Escalation (Not a BLS Patient)

WEAK

Pt picked up for discharge. Pt was SOB. Told RN. Didn't transport.

GOLD STANDARD

G: Gather. Dispatched for BLS non-emergency transport of 81 y/o M from [hospital], Room 226, to [name], a skilled nursing facility, following discharge. Per sending RN [name], pt at baseline this morning, hx CHF and COPD, on 2 LPM O2 via NC at baseline.

O: Observe. Pt found sitting upright in bed, alert, speaking in 3 to 4 word sentences, accessory muscle use noted, 2+ pitting edema bilateral lower legs. Vitals at 0915: BP 178/102, HR 118, RR 30, SpO2 86% on 2 LPM NC. Pt states breathing "got worse over the last hour."

L: Link. Findings indicate acute respiratory distress with significant deterioration from reported baseline; pt is not hemodynamically or respiratorily stable and is not appropriate for BLS discharge transport. Impression: acute respiratory distress.

D: Do & Document. Transport not initiated. Pt kept sitting upright. Sending RN [name] notified at bedside at 0917 of findings; RN notified charge RN [name] and hospital physician [name], who came to bedside at 0924 and placed discharge on hold. On-duty field supervisor [name] called at 0918, advised of findings; transport cancelled. Crew remained at bedside until care was resumed by RN [name] at 0925 with verbal report of findings and times.

PEARL: *The scheduled trip is not the patient. When the patient in front of you doesn't match the job on the screen, the chart should show exactly what you found, who you told, and when. That documentation protects the patient, the crew, and San Luis Ambulance.*

The Standard, Restated

Gather the transfer and the report. Observe the patient for yourself. Link what you saw to why nothing but an ambulance would do. Do the work, and Document every move, every reassessment, and every handoff.

Every IFT chart will be read by people who weren't there: the next clinician, a QI reviewer or attorney, and a payer deciding whether the transport was necessary. If your narrative tells all three what you saw, why this patient needed a stretcher today, what you did, and who you handed them to, you've met the standard. And if the honest answer is that the patient didn't need one, write that too. **Accurate is always billable enough.**

Appendix A: Where to Find the Current Documents

Policies are revised. Printed copies are not. Nothing in this appendix is reproduced here on purpose: always work from the current version published by the issuing agency, not from a copy bound into a book.

SAN LUIS OBISPO COUNTY EMS AGENCY (SLOEMSA)

- **Policy #124, Documentation of Prehospital Care.** Narrative requirements, upload timeframes, specialty-care data fields. Attachment A is the approved abbreviations list; Attachment B is the required CEMIS values.
- **Policy #125, Do Not Resuscitate / POLST.** Which directives are operative in the prehospital setting.
- **SLO County EMS protocols and policy manual.** Published by the SLO County Public Health Department, Division: Emergency Medical Services Agency.

Verify the effective date on any policy before relying on it. Revisions were anticipated for the start of 2027 at the time this edition went to print.

Appendix B: Federal and State References

MEDICARE

- **42 CFR 410.40, Coverage of ambulance services.** Medical necessity requirements at subsection (e). Bed-confinement criteria at (e)(1). Older handouts often cite (d); the paragraph was redesignated.
- **42 CFR 410.41.** Vehicle, staff, and billing and reporting requirements.
- **Medicare Benefit Policy Manual (Pub. 100-02), Chapter 10, Ambulance Services.** Section 10.2.3 covers bed confinement.
- **Medicare Claims Processing Manual (Pub. 100-04), Chapter 15.** Billing and reporting of ambulance services.

Worth knowing: per Chapter 10, bed confinement is neither sufficient nor necessary to establish coverage. It is one factor among several. A patient who is not bed confined can still qualify when their condition contraindicates other transport, and a bed-confined patient does not automatically qualify.

MEDI-CAL

- **CCR, Title 22, Section 51323.** Medical transportation coverage. Subsection (b) requires the lowest cost type of transportation adequate for the patient's medical needs.
- **CCR, Title 22, Sections 51003 and 51303.** Prior authorization and medical necessity.
- **CCR, Title 22, Section 51476.** Records must be readily retrievable and fully disclose the type and extent of services provided.
- **Medi-Cal Provider Manual, Medical Transportation (Ground).** Coverage, codes, and documentation requirements for emergency and non-emergency ground transport.
- **DHCS 6182.** Nonemergency Medical Transportation (NEMT) Required Justification form.

Certification authority for nonemergency ambulance transport was the subject of California legislation during the 2025 to 2026 session. Confirm the current rule before relying on who may sign.

DOCUMENTATION STANDARDS

- **NEMSIS, PCR Data QuickGuide: Owning, Amending, Retaining.** Free. Covers who may amend a PCR, what an amendment must contain, and retention. Published by NEMSIS with Page, Wolfberg & Wirth.
- **NEMSIS Data Dictionary.** National definitions for the eSituation, eInjury, eVitals and related fields cited throughout this guide.