Patient Contact Instructions

Patient contacts must be obtained *prior to* Academy Week

- **Goal = 10 real patient contacts**
- Minimum = 5 real patient contacts + 5 simulated patient contacts
    - *Note: if you are unable to obtain 10 real patient contacts and have to complete any simulated patient contacts during academy week, expect to spend extra time during academy week completing patient contact forms.*

Clinical Training Record shows an overview of where and when **each contact** was obtained.

- Name of rescue squad or ambulance transport company during call (or hospital/clinic)
- Date and time the patient contact was obtained
- **Your preceptor's signature from that call (this is the *only* document they sign)**
- Once all contacts are completed, you'll sign at the bottom then upload to the Student Portal for us to sign. You must also bring the physical copy to turn in at Academy Week.

Example:

Foxville County Station 2	12/2/2025	0830 AM	Preceptor Signature

- Note: if no patient contact was obtained during your shift, do not include that shift in the clinical training record. This only tracks your actual patient contacts obtained.
- So, if you have 7 real patient contacts, you will have 7 rows filled out in the Training Record

Patient Contact Form - this mimics a patient care report (PCR) and Narrative

- Make sure to include the date, time and run # (911 call #) at the top of the report sheet
- Be precise with all information, mention **everything** about the patient and everything you assessed/did. Do not submit forms with only a handful of words.
    - Even if your patient only had an upset stomach and no medications were administered and minimal care was performed, you still need a complete PCR (in real-life and with these patient contact forms).
    - Every patient needs SAMPLE documented (even if they have no medical history, this proves that you assessed for it), every patient needs ABCs documented (even if they are stable, this proves that you assessed it), & V/S obtained
- Do not submit forms where *you* did nothing
    - You personally must, at a minimum, perform an assessment and/or obtain vitals to count that patient as a contact
- You'll sign at the bottom, then upload to the Student Portal for us to review/sign
- Bring *all* physical copies with you to turn in at Academy Week

Example Patient: 24 year old female with dizziness

Demographics	24 YOF
Chief Complaint	Dizziness
History	The Pt stated she woke up this morning feeling weak. While cleaning the house the pt then noticed her vision became blurry and she was unsteady on her feet. The Pt lowered herself onto the ground, no fall was sustained and no injury noted. The Pt did not lose consciousness at any point. A - no allergies reported M - multivitamins P - pt has no history of dizziness; kidney stones 3 months ago L - breakfast with water 2 hours ago E - cleaning the house
Assessment & Findings	The pt was found by EMS sitting on her couch. GCS 15, A/Ox4 A - airway open and maintained by Pt B - adequate depth and rate of breathing, SpO2 98% on room air, lungs clear and equal, no difficulty breathing reported by Pt C - pulse strong and regular, skin flushed and clammy, warm V/S - BP 138/88, HR 106, RR 16, Temp 98.8 F
Interventions	Pt transported to Bloomington Hospital ER in a position of comfort - semi-fowlers position. Pt taken to ER room 2 where report was given to Sarah, RN and EMS care relinquished.

This is a full story and would be considered a complete Patient Contact Form. Even though minimal EMS care was provided for this patient, an assessment was still performed and thorough documentation is required for every patient. Use these patient contact forms as practice for the field later!

As always, reach out to us if you have any questions or concerns during your ride alongs and/or with documentation.