

TEST-TAKING STRATEGIES

EMS instructors give multiple-choice tests to prepare students for the NREMT. Multiple-choice tests may be a relatively new form of test taking for you. If you want to practice this type of testing, you may want to study this information.

LEARNING STYLE

Advice about test-taking is available from multiple sources. This advice will not be helpful unless you can diagnose your own style of test taking and follow only the advice that is best for you.

One method of classifying learning styles is based on the Myers-Briggs Type Indicator. In this tool there are two ways of taking in information: learning through the use of the five senses and learning through the use of an intuiting process.

The sensing learner likes, or prefers, to take in information through seeing, hearing, touch, taste or smell. This is a more hands-on approach and builds knowledge from learning facts and more facts until concepts or principles are formed. Approximately 70% of EMS students are sensing learners.

The intuitive learner likes to learn a principle or generality first and then seeks facts to support the generality or principle. Facts are not particularly meaningful or easily remembered unless they can be related to some previously learned idea. About 30% of EMS students are intuitive learners.

Both methods of learning have distinct advantages. Everyone uses both methods of learning, but has a preference for one over the other. Sensing learners approach tests differently than intuitive learners.

Sensing learners approach test questions systematically, analyzing each word or phrase. No detail is missed. In fact these learners may find gaps in the information provided and automatically mentally add information. Sometimes the added information leads them to select an incorrect response. Sensing test takers usually take the entire time allowed for the test because they carefully analyze each word in the questions. Sensing learners need to learn to "mentally step back" from the question and see the overall concept being tested in the question.

Intuitive learners approach test questions more globally, reading for the general idea and quickly selecting the first response that occurs to them. Intuitive test takers often finish a test quickly, using only part of the time. Unfortunately these test-takers often miss a fact or clue that would cause them to change their answer. Intuitive learners need to learn to slow down and read each question in its entirety to be sure a key fact has not been missed.

Multiple Choice Test Taking Tips

Tips on answering multiple choice questions

- ✓ Read the question before you look at the answer.
- ✓ Come up with the answer in your head before looking at the possible answers, this way the choices given on the test won't throw you off or trick you.
- ✓ Eliminate answers you know aren't right.
- ✓ Read all the choices before choosing your answer.
- ✓ If there is no guessing penalty, always take an educated guess and select an answer.
- ✓ Don't keep on changing your answer, usually your first choice is the right one, unless you miss-read the question.
- ✓ In "All of the above" and "None of the above" choices, if you are certain one of the statements is true don't choose "None of the above" or one of the statements are false don't choose "All of the above".
- ✓ In a question with an "All of the above" choice, if you see that at least two correct statements, then "All of the above" is probably the answer.
- ✓ A positive choice is more likely to be true than a negative one.
- ✓ If there is an "All of the above" option and you know that at least two of the choices are correct select the "All of the above" choice
- ✓ Usually the correct answer is the choice with the most information.
- ✓ You have a 25% chance of getting the right answer if you have A - D options.
- ✓ Read through each statement carefully, and pay attention to the qualifiers and keywords.
- ✓ Qualifiers like "never, always, and every" mean that the statement must be true all of the time. Usually these type of qualifiers lead to a false answer.
- ✓ Qualifiers like "usually, sometimes, and generally" mean that if the statement can be considered true or false depending on the circumstances. Usually these type of qualifiers lead to an answer of true.
- ✓ If any part of the question is false, then the entire statement is false, but just because part of a statement is true doesn't necessarily make the entire statement true.

TEST-TAKING PROBLEMS

Difficulty taking tests in EMT/paramedic school generally falls into one or more of three categories: anxiety, test-taking skills, or preparation.

Anxiety Some anxiety can heighten mental acuity. A moderate level of anxiety has been found to be helpful in test taking by making you more mentally alert and in a state of readiness for the testing situation. More extreme levels of anxiety can be paralyzing. Knowing the source of your anxiety may help you conquer it.

Poor Test-Taking Skills As noted earlier, EMS students can be divided into two groups of learners. Each style of learning leads to different mistakes in interpreting test questions.

The 70% of EMS students, who have a sensing preference, like to learn in a step-by-step manner. They do a good job of learning the facts from the textbook and classroom presentations. Multiple choice test items that test for application, analysis, or synthesis are asking the student to translate these facts into a slightly different cognitive situation. The sensing student often "knows" the information required to answer the question, but "reads additional information into" the question or misinterprets the information that is there.

The remaining EMS students have a preference for intuitive learning or learning that starts with a general principle and then attaches supporting information or facts to the principle. The facts are remembered because they relate to the principle. These students often miss test questions because they failed to learn all the facts related to the principle or overlooked a fact in a test item. The intuitive learner is more likely to miss an important fact or piece of information in the question that would change the answer. The techniques that you find helpful may depend on your style.

All of us are capable of using sensing and intuition and do so on a daily basis. We may have a preference for one over the other and therefore have developed the use of the style that we prefer. For that reason students may make a combination of mistakes in test taking. As you read the suggestions given below, choose to use only those that apply to you.

Preparation Nothing can substitute for adequate preparation. Schedule your study time well in advance of the test. Learning should take place before you sit down to study for the test. Studying for a test should be reviewing the material and formulating applications of the material to the clinical setting.

Form a study group. The study group will be most effective if it includes both learning styles. You can learn from each other. One style will insist on vigorous memory work exercises. Drill and practice routines will help the information to be readily available for recall during the exam. The second style will insist that the group understand the information and view it as part of a bigger picture; that is, there is a reason for knowing the information.

To have a successful study group both styles of learning need to respect the contribution of the other, so they can benefit by learning and applying the methods of the opposite style. It can be helpful but not necessary to know your learning style and that of the group members. When you are in a conflict over how to study, often it will be because of the conflict between styles. The thing to do is stop and make an agreement to spend some time with both styles of studying. (It will pay off.)

GENERAL PRINCIPLES FOR TEST TAKING

Immediately Before the Test

Sleep well. Get to bed at your usual time and get your usual amount of sleep. Your body and mind will function best when your circadian rhythms are synchronized with your need for activity.

Do not take mind-altering drugs. This is not the time to start a new antidepressant, borrow a Valium from your neighbor, or try a different antihistamine. Any of these drugs can make you drowsy or produce a feeling of jitteriness. Do not believe anyone who tells you that you can learn more by relaxing with any drug whether it be prescription or street drugs.

Eat well. You should not have a heavy meal right before the test, but you should eat a balanced meal that will maintain your energy level throughout the test. Some sources recommend a high-carbohydrate, low-fat meal.

Avoid negative people. If you have a friend who gets test anxiety, don't spend time with him or her right before the test. Anxiety can be contagious. Have confidence that you have studied well and know the material. One test does not generally make or break the academic career of a student.

During the Test

Pace yourself. Teachers generally allow a minute to a minute and a half for a multiple-choice question. You can actually read and answer the question in about half that time. Plan to leave yourself some time at the end to review the questions where you were not certain of the answers.

Answer all of the questions. Teachers usually do not give a penalty for guessing as some standardized tests do. With four possible answers, you have a 25% chance of getting the right answer by random guessing. You can often increase that to 50% by intelligent guessing.

Read each question carefully.

Read it a second time.

Read all the options.

Read them a second time.

You want to be concentrating while you read. Don't let your mind jump ahead to the answers. Intuitive learners are less likely to read the questions carefully. They get an overview of it and make a leap to the answers, missing some detail that made a difference. When students leave the test 20-30 minutes into the examination period, they are usually intuitive learners. Just a little more care in reading can make a difference.

Do not "compulse" or "read into" (add information) the questions. Avoid asking "what if?" The correct answer is based only on the information given not the client you had yesterday at the hospital, or the example given in class. Use only the information that is presented to you in the question. Usually the students who need this advice are sensing learners, and they are the last to leave the room. That's OK when they are using their time well.

Sensing learners also need some practice in using intuition on a test. If you don't find the answer, then mentally step back from the question and try to get an overall sense of the question. This exercise may help you see what principle is being tested.

Note key words. Two answers may be correct, but one is a better answer for some reason. The reason is often simpler than you think: logical, obvious, or even common sense.

Key words in the question may help you distinguish between two apparently correct answers.

"Most important"—This phrase is asking you to establish a priority of some kind. Often that priority is safety. For example, if the question asks which step of the procedure is most important, the answer is probably one that if you leave it out the situation is not safe for the client.

"Best"—You may be able to substitute another phrase for best. For example, if the question asks "Which is the best definition?" you might substitute "Which is the most complete definition?" or "Best" might also be asking you to establish a priority for care.

"Except"; "Not true"—Many teachers try to avoid these kinds of questions, but you will probably find a few on any test. If more than one answer seems correct, go back and make sure you did not miss one of these words.

Be Sure You Realize What Is Being Asked students sometimes make difficult questions out of easy ones. For example, if the question asks which is a symptom, there may be four assessment findings (signs) that are correct for the situation, but only one is a symptom.

General Hints. Some questions are factual, with only one correct answer. It is easy to get overly involved with test-taking skills and try to make a "trick" question out of a straightforward question.

If you can narrow the options down to two, go with your "gut" response. You have a 50% chance of guessing the right answer at this point.

Sometimes you read the question and know the right answer. You read the answers, and the "right" answer is not there. Think about the question in a different way (called reframing) and choose the best response that is there.

Accept unanswered questions. Move on. Getting upset will cause you to lose your concentration. You can come back when you have finished the test, and the answer may seem obvious at that time.

Do not get angry at questions. There is a way to answer the question, based on the information given. Getting angry will not help you see the answer.

There are no questions designed to "trick" students. You will not believe that, but it is true. Your EMS instructor is a nice person who wants you to be successful. The questions are designed to test your ability to think and apply the information.

Do not "yes, but" the questions. That's what I mean by reading into questions. Saying "yes, but if the patient ... then..." is a particular temptation for students who have really studied and know more than is on the test.

Sometimes a "true-false technique" will help. Treat each response as a true-false question. You can often eliminate some responses.

*Establishing Priorities. **Safety comes first !.***

Order of Activities. The steps of the EMS assessment /intervention process are:

Scene safety

C spine control – determine if medical/trauma

General Impression

LOC

Airway - intervene

Breathing - intervene

Circulation- intervene

Major bleeding – intervene

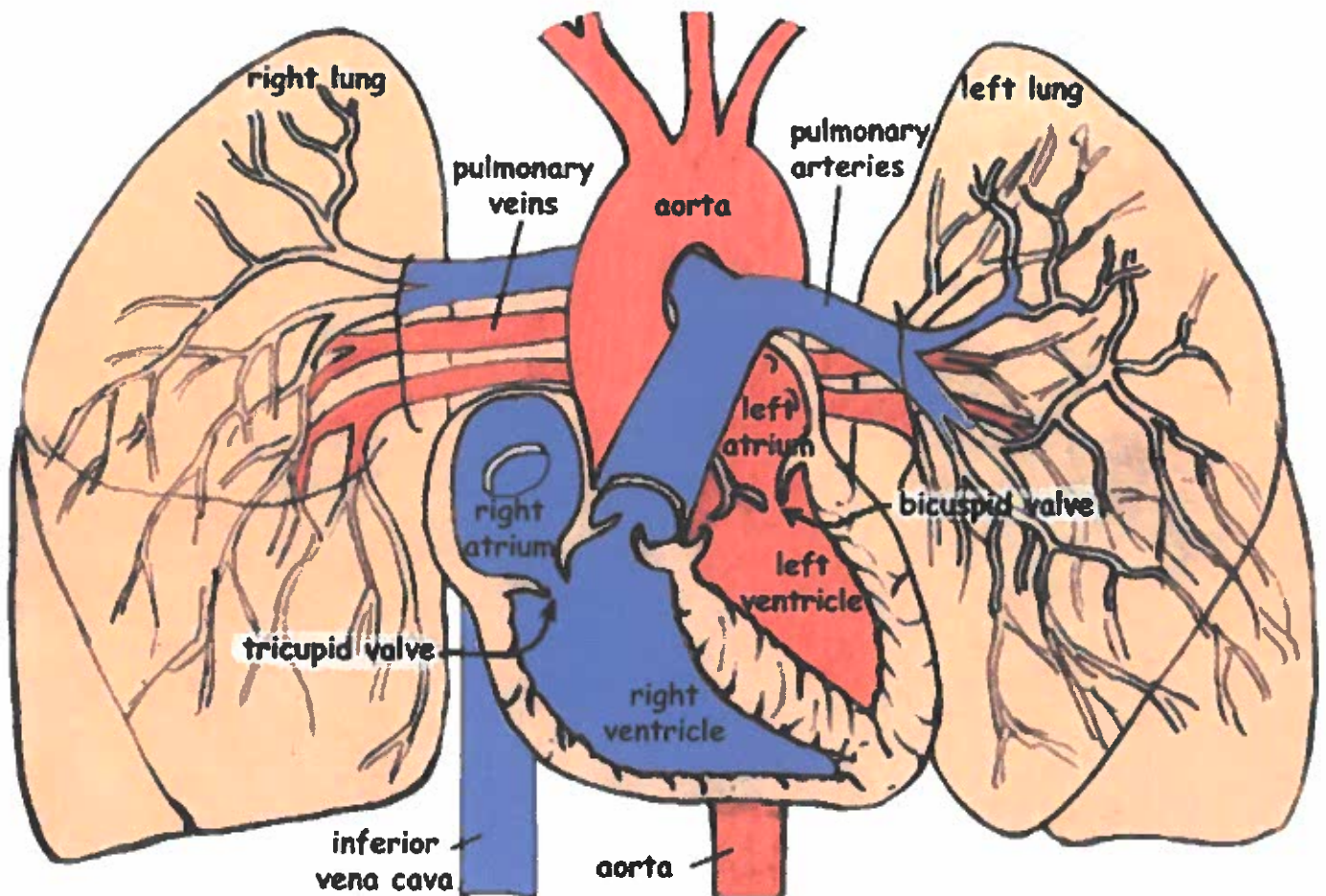
Assess and treat other problems as needed

Blood Pathway

Trace a drop of blood from the body, into and through the heart, and back out the aorta. Name the structures it passes through on the way.

- 1) c) inferior vena cava
- 2) i) right atrium
- 3) k) tricuspid valve
- 4) j) right ventricle
- 5) g) pulmonary arteries
- 6) f) lungs
- 7) h) pulmonary veins
- 8) d) left atrium
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- 11) a) aorta

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- f) lungs
- g) pulmonary arteries
- h) pulmonary veins
- i) right atrium
- j) right ventricle
- k) tricuspid valve



IMPORTANT MEDICAL ABBREVIATIONS

NTG	Nitroglycerin
O2	Oxygen
PE	Pulmonary embolism
PO	Orally, by mouth
Pt	Patient
Q	Every
QID	Four times a day
R/O	Rule out
Rx	Prescription
s/s	Signs and symptoms
SIDS	Sudden infant death syndrome
SL	Sublingual
SOB	Shortness of breath
stat	Immediately
Sx	Symptoms
TIA	Transient ischemic attack
TID	Three times a day
TKO	To keep open
Tx	Treatment
X	Times
y/o	Year old
CC	Chief complaint
c/o	Complains of
DOB	Date of birth
Hx	History
VS	Vital Signs
Wt	Weight
Abd	Abdomen
CNS	Central nervous system
ENT	Ear, nose and throat
GI	Gastrointestinal
GU	Genitourinary
GYN	Gynecological
HEENT	Head, ears, eyes, nose, and throat
OB	Obstetrical
PNS	Peripheral nervous system
Resp	Respiratory
CP	Chest pain
GSW	Gunshot wound
H/A	Headache
n/v	Nausea and vomiting
AAA	Abdominal aortic aneurysm
AMI	Acute myocardial infarction (heart attack)

ARDS	Adult respiratory distress syndrome
ETOH	Alcohol
COPD	Chronic obstructive pulmonary disease
CRF	Chronic renal failure
CHF	Congestive heart failure
CABG	Coronary artery bypass graft
CAD	Coronary artery disease
CF	Cystic fibrosis
DOA	Dead on arrival
DTs	Delirium tremors
DVT	Deep vein thrombosis
DM	Diabetes mellitus
FBO	Foreign body obstruction
HTN	Hypertension (high blood pressure)
IDDM	Insulin-dependent diabetes mellitus
ICP	Intracranial pressure
MCI	Mass casualty incident
MVC	Motor vehicle crash (or collision)
NIDDM	Non-insulin-dependent diabetes mellitus
OD	Overdose
G/P	Gravida (pregnancies) & Para (births)
STD	Sexually transmitted disease
STEMI	ST elevated myocardial infarction
TB	Tuberculosis
URI	Upper respiratory infection
UTI	Urinary tract infection
WPW	Wolff-Parkinson-White syndrome
ASA	Aspirin
NSAID	Nonsteroidal ant-inflammatory agent (Ex. Motrin)
PCN	Penicillin
Ca+	Calcium
Cl-	Chloride
K+	Potassium
Na+	Sodium
NaCl	Sodium Chloride
NS	Normal saline
LLL	Left lower lobe
LUL	Left upper lobe
LLQ	Left lower quadrant
LUQ	Left upper quadrant
RLL	Right lower lobe
RUL	Right upper lobe
RML	Right middle lobe
RLQ	Right lower quadrant

RUQ	Right upper quadrant
BGL	Blood glucose level
BS	Breath sounds
CSF	Cerebrospinal fluid
HR	Heart rate
JVD	Jugular vein distention
lac	Laceration
LOC	Level of consciousness
Palp	Palpation
Pearl	Pupils equal and reactive to light
A/O	Alert and oriented
Prn	As needed
PTA	Prior to arrival
W/D	Warm and dry
WNL	Within normal limits
ACLS	Advanced cardiac life support
AMA	Against medical advice
AED	Automated external defibrillator
BVM	Bag-valve mask
BLS	Basic life support
CPR	Cardiopulmonary resuscitation
CPAP	Continuous positive airway pressure
DNR	Do not resuscitate
ETA	Estimated time of arrival
NC	Nasal cannula
NG	Nasogastric
NPA	Nasopharyngeal airway
NRB	Non-rebreather (Oxygen mask)
NPO	Nothing by mouth
OPA	Oropharyngeal airway
TOT	Turned over to
VO	Verbal order
cm	Centimeter
Gtt or gtts	Drop or drops
gm	Gram
hr	Hour
pH	Hydrogen-ion concentration
IM	Intramuscular
IO	Intraosseous
IV	Intravenous
j	Joules
KVO	Keep vein open
kg	Kilogram
L	Liter
LPM	Liters per minute

mcg	Microgram
mg	Milligram
mL	Milliliter
mmHg	Millimeters of mercury
SQ	Subcutaneous
AF	Atrial fibrillation
VF	Ventricular fibrillation
VT	Ventricular tachycardia

PATIENT ASSESSMENT DEFINITIONS

Scene Size-up	Steps taken by EMS providers when approaching the scene of an emergency call; determining scene safety, taking BSI precautions, noting the mechanism of injury or patient's nature of illness, determining the number of patients, and deciding what, if any additional resources are needed including Advanced Life Support.
Initial Assessment	The process used to identify and treat life-threatening problems, concentrating on Level of Consciousness, Cervical Spinal Stabilization, Airway, Breathing, and Circulation. You will also be forming a General Impression of the patient to determine the priority of care based on your immediate assessment and determining if the patient is a medical or trauma patient. The components of the initial assessment may be altered based on the patient presentation.
Focused History and Physical Exam	In this step you will reconsider the mechanism of injury, determine if a Rapid Trauma Assessment or a Focused Assessment is needed, assess the patient's chief complaint, assess medical patients complaints and signs and symptoms using OPQRST, obtain a baseline set of vital signs, and perform a SAMPLE history. The components of this step may be altered based on the patient's presentation.
Rapid Trauma Assessment	This is performed on patients with significant mechanism of injury to determine potential life threatening injuries. In the conscious patient, symptoms should be sought before and during the Rapid Trauma assessment. You will estimate the severity of the injuries, re-consider your transport decision, reconsider Advanced Life Support, consider the platinum 10 minutes and the Golden Hour, rapidly assess the patient from head to toe using DCAP-BTLS, obtain a baseline set of vital signs, and perform a SAMPLE history.
Rapid Medical Assessment	This is performed on medical patients who are unconscious, confused, or unable to adequately relate their chief complaint. This assessment is used to quickly identify existing or potentially life-threatening conditions. You will perform a head to toe rapid assessment using DACP-BTLS, obtain a baseline set of vital signs, and perform a SAMPLE history.
Focused History and Physical Exam – Trauma	This is used for patients, with no significant mechanism of injury, that have been determined to have no life-threatening injuries. This assessment would be used in place of your Rapid Trauma Assessment. You should focus on the patient's chief complaint. An example of a patient requiring this assessment would be a patient who has sustained a fractured arm with no other injuries and no life threatening conditions.
Focused History and Physical Exam – Medical	This is used for patients with a medical complaint who are conscious, able to adequately relate their chief complaint to you, and have no life-threatening conditions. This assessment would be used in place of your Rapid Medical Assessment. You should focus on the patient's chief complaint using OPQRST, obtain a baseline set of vital signs, and perform a SAMPLE history.

**Detailed
Physical Exam**

This is a more in-depth assessment that builds on the Focused Physical Exam. Many of your patients may not require a Detailed Physical Exam because it is either irrelevant or there is not enough time to complete it. This assessment will only be performed while enroute to the hospital or if there is time on-scene while waiting for an ambulance to arrive. Patients who will have this assessment completed are patients with significant mechanism of injury, unconscious, confused, or unable to adequately relate their chief complaint. In the Detailed Physical Exam you will perform a head to toe assessment using DCAP-BTLS to find isolated and non-life-threatening problems that were not found in the Rapid Assessment and also to further explore what you learned during the Rapid Assessment.

**Ongoing
Assessment**

This assessment is performed during transport on all patients. The Ongoing Assessment will be repeated every 15 minutes for the stable patient and every 5 minutes for the unstable patient. This assessment is used to answer the following questions:

- 1 *Is the treatment improving the patient's condition?*
- 2 *Are any known problems getting better or worse?*
- 3 *What is the nature of any newly identified problems?*

You will continue to reassess mental status, ABCs, re-establish patient priorities, reassess vital signs, repeat the focused assessment, and continually recheck your interventions.

[A Guide to Radio Reports](#)

June 2, 2011 By [Sean Eddy](#) 3 Comments

Radio reports or “call ins” can be a bit of an art. Finding that happy-medium between too much and too little information can be difficult. People starting out in EMS often have trouble adapting to formal lines of communication like radio systems as getting the most information out with the least amount of words is an acquired skill. If you have never worked in a setting that utilizes formal radio traffic then naturally, you want to speak just like you would in any other conversation. But in the name of formality and time savings, you have to learn to kick proper English to the curb. In this article, I will go over some tricks that I have learned over my years in EMS and hopefully break the barrier that many of us have when it comes to giving reports over the air.

Time

Different systems may require different amounts of information, but the expectation that your report will be short and thorough typically remains the same. A good rule of thumb for a desired length is less than 30 seconds. If done correctly, that should be ample time to deliver a good report.

Minimizing the amount of time your report takes helps to ensure that you aren't tying up the base-station radio for other crews that may need orders or have a critical patient to call in. It also frees up time for patient care and you don't lose the attention of the staff on the radio. As silly as it may seem, try practicing reports with a timer. You will find that it doesn't take long to improve your technique and shorten your reports.

Content

You are the eyes and ears of the ER staff until you arrive at the hospital, so it is your job to paint the best picture you can of the patient's current condition. Now this doesn't mean that you have to tell a long winded story of what led up to this event. All that does is lose the attention of the ER staff. Remember, all of that information can be relayed once you arrive at the hospital. The staff is pretty much looking to either give orders or assign a priority to your patient, so you really only need to give them the information necessary to achieve those tasks.

Here is a list of essential information that should be included in your report:

- **Age**
- **Sex**
- **GCS**
- **Chief Complaint**
- **Pertinent Positives or Negatives**
-Example: Shortness of breath associated with chest pain.

- **OPQRST (if applicable)**
-Example: This can be used to clearly paint a picture of chest pain being cardiac vs non-cardiac, or to paint the picture of a patient with abdominal pain having probable appendicitis.
- **Vital signs (including skin color and lung sounds)**
- **History, Allergies or Medications (if pertinent to the chief complaint)**
- **Any treatment or interventions along with response.**
- **Any other information that may help paint a clear picture of the patient's condition.**

There are always exceptions to these guidelines. You may be required to provide certain information in order to activate a STEMI, Trauma Code, or Stroke protocol. I typically prefer to add this information to the end of my report under "other information". Do what works best for you.

Gathering Information

In order to provide an adequate amount of information, you must first gather that information. In order to do this, I find it best to maintain an organized system of writing down information that I will use during my call-ins. Some people write on their gloves, some people carry a notepad and some people are talented enough to go completely off memory.

When you are going through your questioning, assessment, etc, try writing down your findings in the order that you give your radio report. For example, if you are writing on a notepad, write the age, sex, GCS on the top line, the chief complaint on the second line and so-forth. This way you can essentially read right off your notepad from top to bottom when you do your call-in. This helps to avoid long pauses, repeating yourself or leaving out information.

To help facilitate gathering information in an organized fashion, I created a simple document that you can print on any 3x5 card. I typically clip a bunch of these together and carry them in my shirt pocket. When I call in my reports, I read from left to right, top to bottom. This way my reports are consistent and I minimize the chance of leaving anything out.

County Hospital, Medic 325, Paramedic Eddy en route to your facility with a 57 year-old male with a GCS of 15. The patient states that he started complaining of chest pain this afternoon. He also states that he is short of breath and nauseous. He was seen at Dr. Smith's office today and is now being transported at the request of the physician to rule out a possible MI.

In the above example, I told the hospital that the patient is being transported from a physician's office with a complaint of chest pain with associated shortness of breath and nausea. While this does help to paint the picture of a cardiac event, it can be done in much less time with fewer words. The following example delivers the same message with less than half of the words:

County Hospital, Medic 325, Paramedic Eddy en route to your facility from Dr. Smith's office with a 57 year-old male complaining of chest pain, shortness of breath and nausea. Physician on scene requesting transport to rule out MI.

On a chest pain call like this, it would be wise to include the OPQRST, as that information can be useful to the base facility to differentiate between cardiac and non-cardiac chest pain. Here is an example of how you can deliver that information in a brief and effective manner:

County Hospital, Medic 325, Paramedic Eddy en route to your facility from Dr. Smith's office with a 57 year-old male complaining of chest pain, shortness of breath and nausea. Physician on scene requesting transport to rule out MI. Patient's pain is with a gradual onset, non-provoked, dull in nature, non-radiating, 7/10, times 2 hours.

In the above example, we have told the base hospital everything they need to know about the chief complaint and we can now move on to the vital signs. Any other information in regards to the complaint itself can be relayed once we arrive at the hospital. At this point we are about half way done with our report and have probably only taken up about 10-13 seconds. All that's left to cover is the vital signs, treatment and ETA. Here is an example of the complete report:

County Hospital, Medic 325, Paramedic Eddy en route to your facility from Dr. Smith's office with a 57 year-old male complaining of chest pain, shortness of breath and nausea. Physician on scene requesting transport to rule out MI. Patient's pain is with a gradual onset, non-provoked, dull in nature, non-radiating, 7/10, times 2 hours. Blood Pressure is 146/82 with a strong radial pulse of 90, non-labored respirations of 16, satting 98% on 2 liters, and sinus on the monitor with no ectopy. Skins signs pink, warm and dry, lung sounds clear. History, allergies and meds on arrival. Pt has received 1 aspirin and 2 nitros with no relief. IV is established and our ETA is 10 minutes. Any questions or orders?

This example is actually on the longer end of the spectrum as far as radio reports go. For calls that don't involve pain, you can skip past the OPQRST and probably come in

around 20 seconds for the entire report. Chest pain, vehicle collisions, and others that require special protocols (STEMI, Stroke) are going to be the longer reports, while most other medical complaints will be rather short.

When it comes to radio reports just remember; short, sweet and to the point.

Examples:

Here are a few examples of some radio reports for different types of calls:

Trauma

County Hospital, Medic 325, Paramedic Eddy en route with a 25 year-old male involved in a 2 vehicle collision. Pt was a restrained driver of a small-sized sedan traveling approximately 30mph when striking another vehicle from behind. No LOC, passenger space intrusion, or airbag deployment noted. Pt complains of lower back pain with no obvious deformities. Blood pressure is 126/74 with a strong radial pulse of 80 and non-labored respirations of 18. Skin signs pink, warm and dry. Lung sounds clear. History, allergies, meds on arrival. Pt is in c-spine and we are utilizing BLS interventions only. ETA is 5 minutes. Any questions or orders?

-Note: Trauma is the only time that I skip straight to MOI prior to the chief complaint. I know of several paramedics that prefer to leave it at the end. Do what works best for you.

Respiratory

County hospital, Medic 325, Paramedic Eddy en route with a 36 year-old female GCS of 15 complaining of difficulty breathing x 2 hours. Pt presents with labored respirations, retractions and speaks in 1-2 word sentences. Blood pressure is 146/82 with a strong radial pulse of 120, labored respirations of 26, satting 93% on 15 liters and is sinus tach on the monitor. Skin signs pink, warm and dry. Lung sounds reveal wheezing in all fields. History of Asthma, further history, allergies and meds on arrival. Pt has significant breathing improvement post 2 Albuterol treatments and .3mg sub-q Epi. IV is established and our ETA is 8 minutes. Any questions or orders?

Cardiac Arrest

County hospital, Medic 325, Paramedic Eddy en route with a 58 year old male GCS of 3. Pt found pulseless and apenic, downtime of approximately 5 minutes prior to EMS arrival. Pt has sustained asystole post 3 rounds of Epi and Atropine. Pt is intubated and an IV is established. Continuing ACLS protocol en route. ETA is 10 minutes. Any questions or orders?

-Note: The hospital will be busy getting a bed ready for your arrival. The faster you get the report done, the faster you can get back to working and the hospital can start working.

Conclusion

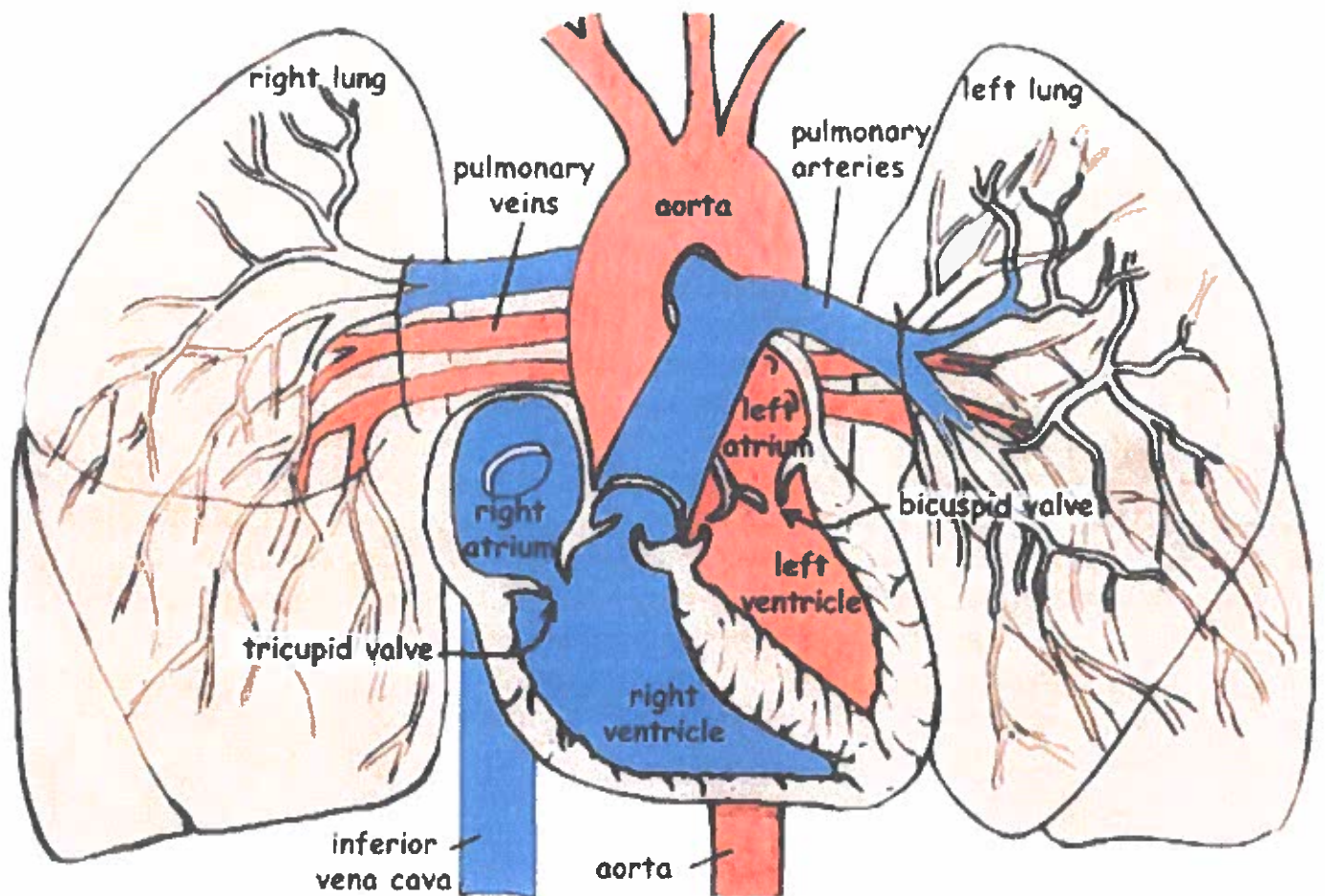
These guidelines have worked well for me during my career as a paramedic. These guidelines are meant to be flexible and should work on pretty much any type of call. If you have a format that works well for you, I would love to hear from you and try it out.

Blood Pathway

Trace a drop of blood from the body, into and through the heart, and back out the aorta. Name the structures it passes through on the way.

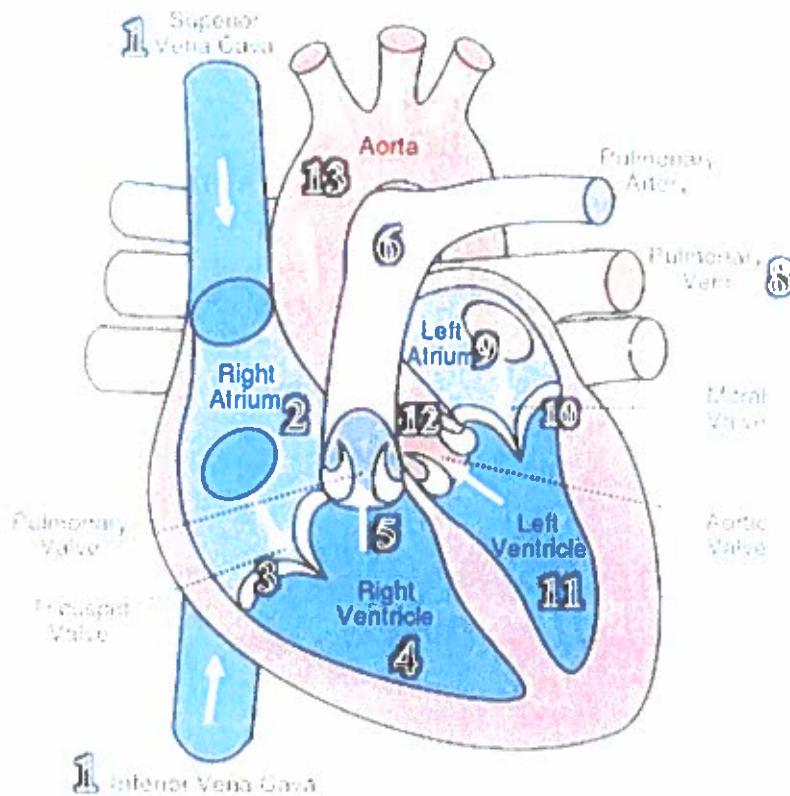
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- k) tricuspid valve



Blood flow through the heart

- 1 Oxygen poor blood travels through the inferior or superior vena cava to a coronary sinus (secondary blood circulation)
- 2 Deoxygenated blood enters the right atrium
- 3 Blood passes through the tricuspid valve
- 4 Blood enters right ventricle
- 5 Blood moves through the pulmonary valve
- 6 Blood enters the pulmonary trunk and arteries where the blood is carried to the lungs
- 7 Blood loses CO₂ and gains O₂ in the pulmonary capillaries
- 8 The oxygenated blood enters the pulmonary veins
- 9 Blood enters the left atrium
- 10 Blood travels through the mitral/bicuspid valve
- 11 Blood enters the left ventricle
- 12 Blood moves through the aortic valve
- 13 Blood travels through the aorta and systemic arteries
- 14 Blood loses O₂ and gains CO₂ in the systemic capillaries



A Guide to Radio Reports

June 2, 2011 By [Sean Eddy](#) [3 Comments](#)

Radio reports or “call ins” can be a bit of an art. Finding that happy-medium between too much and too little information can be difficult. People starting out in EMS often have trouble adapting to formal lines of communication like radio systems as getting the most information out with the least amount of words is an acquired skill. If you have never worked in a setting that utilizes formal radio traffic then naturally, you want to speak just like you would in any other conversation. But in the name of formality and time savings, you have to learn to kick proper English to the curb. In this article, I will go over some tricks that I have learned over my years in EMS and hopefully break the barrier that many of us have when it comes to giving reports over the air.

Time

Different systems may require different amounts of information, but the expectation that your report will be short and thorough typically remains the same. A good rule of thumb for a desired length is less than 30 seconds. If done correctly, that should be ample time to deliver a good report.

Minimizing the amount of time your report takes helps to ensure that you aren't tying up the base-station radio for other crews that may need orders or have a critical patient to call in. It also frees up time for patient care and you don't lose the attention of the staff on the radio. As silly as it may seem, try practicing reports with a timer. You will find that it doesn't take long to improve your technique and shorten your reports.

Content

You are the eyes and ears of the ER staff until you arrive at the hospital, so it is your job to paint the best picture you can of the patient's current condition. Now this doesn't mean that you have to tell a long winded story of what led up to this event. All that does is lose the attention of the ER staff. Remember, all of that information can be relayed once you arrive at the hospital. The staff is pretty much looking to either give orders or assign a priority to your patient, so you really only need to give them the information necessary to achieve those tasks.

Here is a list of essential information that should be included in your report:

- **Age**
- **Sex**
- **GCS**
- **Chief Complaint**
- **Pertinent Positives or Negatives**
-Example: Shortness of breath associated with chest pain.

- **OPQRST (if applicable)**
-Example: This can be used to clearly paint a picture of chest pain being cardiac vs non-cardiac, or to paint the picture of a patient with abdominal pain having probable appendicitis.
- **Vital signs (including skin color and lung sounds)**
- **History, Allergies or Medications (if pertinent to the chief complaint)**
- **Any treatment or interventions along with response.**
- **Any other information that may help paint a clear picture of the patient's condition.**

There are always exceptions to these guidelines. You may be required to provide certain information in order to activate a STEMI, Trauma Code, or Stroke protocol. I typically prefer to add this information to the end of my report under "other information". Do what works best for you.

Gathering Information

In order to provide an adequate amount of information, you must first gather that information. In order to do this, I find it best to maintain an organized system of writing down information that I will use during my call-ins. Some people write on their gloves, some people carry a notepad and some people are talented enough to go completely off memory.

When you are going through your questioning, assessment, etc, try writing down your findings in the order that you give your radio report. For example, if you are writing on a notepad, write the age, sex, GCS on the top line, the chief complaint on the second line and so-forth. This way you can essentially read right off your notepad from top to bottom when you do your call-in. This helps to avoid long pauses, repeating yourself or leaving out information.

To help facilitate gathering information in an organized fashion, I created a simple document that you can print on any 3x5 card. I typically clip a bunch of these together and carry them in my shirt pocket. When I call in my reports, I read from left to right, top to bottom. This way my reports are consistent and I minimize the chance of leaving anything out.

Below is a blank view of my 3x5 report card:

Age	Sex	DOB	Trip#
CC			
O		BP	
P		P	
Q		R	
R		SpO2	
S		ECG	
T		BCG	
Skin		Lungs	
HX			
A			
M			
TX/Other			

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When I use this format, I fill in all of the pertinent information prior to making my call-in. Any information that I don't plan to pass along over the radio is skipped over. For example; A patient complaining of chest pain would most likely require every field to be completed while a complaint of general weakness would not require the OPQRST.

The medical history, allergies and current medications are generally skipped over during the call-in, but written down to reference for documentation and the formal report given at the bedside.

The "TX/Other" section is utilized for treatment, response to treatment, mechanism of injury (for trauma calls) and anything else that might be needed to paint a clear picture.

This card is available for free download on this site.

Calling in the Report:

This is the part that requires some time and repetition to get right. This is where you need to learn to minimize the amount of words that you use in an effort to keep your report brief and formal. Remember, it should only take 30 seconds or less to deliver a brief but thorough report.

When reporting a chief complaint, stick to only the necessary information. Rambling on about things like the patient's last doctors visit will eat up that 30 seconds and lose the attention of the staff on the other end of the radio. Here is an common example of "rambling" on the chief complaint:

County Hospital, Medic 325, Paramedic Eddy en route to your facility with a 57 year-old male with a GCS of 15. The patient states that he started complaining of chest pain this afternoon. He also states that he is short of breath and nauseous. He was seen at Dr. Smith's office today and is now being transported at the request of the physician to rule out a possible MI.

In the above example, I told the hospital that the patient is being transported from a physician's office with a complaint of chest pain with associated shortness of breath and nausea. While this does help to paint the picture of a cardiac event, it can be done in much less time with fewer words. The following example delivers the same message with less than half of the words:

County Hospital, Medic 325, Paramedic Eddy en route to your facility from Dr. Smith's office with a 57 year-old male complaining of chest pain, shortness of breath and nausea. Physician on scene requesting transport to rule out MI.

On a chest pain call like this, it would be wise to include the OPQRST, as that information can be useful to the base facility to differentiate between cardiac and non-cardiac chest pain. Here is an example of how you can deliver that information in a brief and effective manner:

County Hospital, Medic 325, Paramedic Eddy en route to your facility from Dr. Smith's office with a 57 year-old male complaining of chest pain, shortness of breath and nausea. Physician on scene requesting transport to rule out MI. Patient's pain is with a gradual onset, non-provoked, dull in nature, non-radiating, 7/10, times 2 hours.

In the above example, we have told the base hospital everything they need to know about the chief complaint and we can now move on to the vital signs. Any other information in regards to the complaint itself can be relayed once we arrive at the hospital. At this point we are about half way done with our report and have probably only taken up about 10-13 seconds. All that's left to cover is the vital signs, treatment and ETA. Here is an example of the complete report:

County Hospital, Medic 325, Paramedic Eddy en route to your facility from Dr. Smith's office with a 57 year-old male complaining of chest pain, shortness of breath and nausea. Physician on scene requesting transport to rule out MI. Patient's pain is with a gradual onset, non-provoked, dull in nature, non-radiating, 7/10, times 2 hours. Blood Pressure is 146/82 with a strong radial pulse of 90, non-labored respirations of 16, satting 98% on 2 liters, and sinus on the monitor with no ectopy. Skins signs pink, warm and dry, lung sounds clear. History, allergies and meds on arrival. Pt has received 1 aspirin and 2 nitros with no relief. IV is established and our ETA is 10 minutes. Any questions or orders?

This example is actually on the longer end of the spectrum as far as radio reports go. For calls that don't involve pain, you can skip past the OPQRST and probably come in

around 20 seconds for the entire report. Chest pain, vehicle collisions, and others that require special protocols (STEMI, Stroke) are going to be the longer reports, while most other medical complaints will be rather short.

When it comes to radio reports just remember; short, sweet and to the point.

Examples:

Here are a few examples of some radio reports for different types of calls:

Trauma

County Hospital, Medic 325, Paramedic Eddy en route with a 25 year-old male involved in a 2 vehicle collision. Pt was a restrained driver of a small-sized sedan traveling approximately 30mph when striking another vehicle from behind. No LOC, passenger space intrusion, or airbag deployment noted. Pt complains of lower back pain with no obvious deformities. Blood pressure is 126/74 with a strong radial pulse of 80 and non-labored respirations of 18. Skin signs pink, warm and dry. Lung sounds clear. History, allergies, meds on arrival. Pt is in c-spine and we are utilizing BLS interventions only. ETA is 5 minutes. Any questions or orders?

-Note: Trauma is the only time that I skip straight to MOI prior to the chief complaint. I know of several paramedics that prefer to leave it at the end. Do what works best for you.

Respiratory

County hospital, Medic 325, Paramedic Eddy en route with a 36 year-old female GCS of 15 complaining of difficulty breathing x 2 hours. Pt presents with labored respirations, retractions and speaks in 1-2 word sentences. Blood pressure is 146/82 with a strong radial pulse of 120, labored respirations of 26, satting 93% on 15 liters and is sinus tach on the monitor. Skin signs pink, warm and dry. Lung sounds reveal wheezing in all fields. History of Asthma, further history, allergies and meds on arrival. Pt has significant breathing improvement post 2 Albuterol treatments and .3mg sub-q Epi. IV is established and our ETA is 8 minutes. Any questions or orders?

Cardiac Arrest

County hospital, Medic 325, Paramedic Eddy en route with a 58 year old male GCS of 3. Pt found pulseless and apenic, downtime of approximately 5 minutes prior to EMS arrival. Pt has sustained asystole post 3 rounds of Epi and Atropine. Pt is intubated and an IV is established. Continuing ACLS protocol en route. ETA is 10 minutes. Any questions or orders?

-Note: The hospital will be busy getting a bed ready for your arrival. The faster you get the report done, the faster you can get back to working and the hospital can start working.

Conclusion

These guidelines have worked well for me during my career as a paramedic. These guidelines are meant to be flexible and should work on pretty much any type of call. If you have a format that works well for you, I would love to hear from you and try it out.