What is the Definition of a “Patient”?

With the advent of cell phones and the increased number of requests for emergency medical care by individuals other than patient themselves (e.g., passer-by that calls 9-1-1 for a motor vehicle crash where there are no injuries, complaints, or indication of injury and EMS is dispatched to the scene), it is necessary to define a patient. Why? Because anyone that fits the definition of a patient must be properly evaluated and/or appropriate treatment options taken (including informed refusal if the competent patient absolutely does not wish medical care or transport despite our suggestions that they do). Similarly, anyone that does not fit the definition of a patient as defined here does not require an evaluation or completion of a Patient Care Record. If there is any doubt, an individual should be deemed a patient and appropriate evaluation should take place. It is important to remember that the definition of patient requires the input of both the individual and the healthcare provider, and an assessment of the circumstances that led to the 9-1-1 call. The definition of a patient is a separate question from whether or not the patient gets evaluated and/or treated. The definition of a patient is any human being that:

- Has a complaint suggestive of potential illness or injury;
- Requests evaluation for potential illness or injury;
- Has obvious evidence of illness or injury;
- Has experienced an acute event that could reasonably lead to illness or injury; OR
- Is in a circumstance or situation that could reasonably lead to illness or injury.

All individuals meeting any of the above criteria are considered “patients” under this protocol. These criteria are intended to be considered in the widest sense. If there are any questions or doubts, the individual should be considered a patient.

The patient assessment is a problem-oriented evaluation of patient and establishment of priorities based on existing and potential life-threats.

Components of the patient assessment include:

- Scene Size-Up
- Initial Assessment
- Focused History and Physical Exam
  - Using the OPQRSTI, SAMPLE and DCAPBTLS acronyms as applicable:
    - Onset
    - Provokes
    - Quality
    - Radiates
    - Severity
    - Time
    - Interventions
    - Signs & symptoms
    - Allergies
    - Medications
    - Pertinent medical history
    - Last oral intake
    - Events leading to presentation
    - Deformities
    - Contusions
    - Abrasions
    - Punctures
    - Burns
    - Tenderness
    - Lacerations
    - Swelling

- Ongoing Assessment
- Detailed Physical Exam
To ensure consistency in the assessment and treatment of patients, the following guidelines should apply:

**Patient Age**

A. Remember that in determining which age group a particular patient may fit into, several factors must be considered. They include:
   1. Legal issues
   2. Transport guidelines
   3. Patient care procedures, including medication delivery
B. It is the EMT’s responsibility to take all these factors into consideration when determining what is best for the patient.
C. General guidelines for hospital designation:
   1. Neonate – birth to one month
   2. Infant – one month to one year
   3. Child – 1 year through 8 years old
   4. Adolescent – 9 years through 16 years old (Ohio’s Trauma Triage rules dictate that trauma patient < 16 years of age be transported to a pediatric trauma center)
   5. Adult – age 17 years and older*
   
   *Exception is **Behavioral Emergencies**
   1. Pregnant psychiatric patients of any age shall be transported to an obstetrics-capable hospital.
   2. Non-pregnant pediatric (under 18 years) psychiatric patients shall be transported to a pediatric psychiatric capable hospital (i.e. Akron Children’s Hospital)
   3. If exceptions need to be made consult online medical control.

**Adult Patient Assessment**

A. Tachycardia – resting heart rate greater than 100 bpm
B. Bradycardia – resting heart rate less than 60 bpm
C. Hypertension – consistent resting blood pressure > 140/90 mmHg
D. Hypotension – consistent resting blood pressure < 100/60 mmHg with associated signs and symptoms of hypoperfusion
E. Glasgow Coma Scale

<table>
<thead>
<tr>
<th>Eye Opening</th>
<th>Spontaneously</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To verbal command</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>To pain</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>No response</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Best Motor Response</th>
<th>Obeys verbal command</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Purposeful movement to pain (localization of pain)</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Withdraws from pain</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Decorticate position</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Decerebrate position</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>No response</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Best Verbal Response</th>
<th>Oriented &amp; converses</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Disoriented &amp; converses</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Inappropriate words</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Incomprehensible sounds</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>No response</td>
<td>1</td>
</tr>
</tbody>
</table>
Pediatric Patient Assessment

A. Heart rate (per minute)

<table>
<thead>
<tr>
<th>Age</th>
<th>Awake Rate</th>
<th>Mean</th>
<th>Sleeping Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn – 3 months</td>
<td>85 – 205</td>
<td>140</td>
<td>80 – 160</td>
</tr>
<tr>
<td>3 months – 2 years</td>
<td>100 – 190</td>
<td>130</td>
<td>75 – 160</td>
</tr>
<tr>
<td>2 – 10 years</td>
<td>60 – 140</td>
<td>80</td>
<td>60 – 90</td>
</tr>
<tr>
<td>&gt; 10 years</td>
<td>60 – 100</td>
<td>75</td>
<td>50 – 90</td>
</tr>
</tbody>
</table>

B. Respiratory Rate (breaths/minute)

<table>
<thead>
<tr>
<th>Age</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant</td>
<td>30 – 60</td>
</tr>
<tr>
<td>Toddler</td>
<td>24 – 40</td>
</tr>
<tr>
<td>Preschooler</td>
<td>22 – 34</td>
</tr>
<tr>
<td>School-aged Child</td>
<td>18 – 30</td>
</tr>
<tr>
<td>Adolescent</td>
<td>12 - 16</td>
</tr>
</tbody>
</table>

C. Blood Pressure

- Typical systolic BP for 1 to 10 years of age: $90 + (\text{age in years} \times 2)$ mmHg
- Lower limits of systolic BP for 1 to 10 years of age: $70 + (\text{age in years} \times 2)$ mmHg
- Lower range of normal systolic BP of >10 years of age: approximately 90 mmHg

D. Glasgow Coma Scale

<table>
<thead>
<tr>
<th>Eye Opening</th>
<th>Less than 1 year</th>
<th>Greater than 1 year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spontaneously</td>
<td></td>
<td>Spontaneously</td>
</tr>
<tr>
<td>To shout</td>
<td></td>
<td>To verbal command</td>
</tr>
<tr>
<td>To pain</td>
<td></td>
<td>To pain</td>
</tr>
<tr>
<td>No response</td>
<td></td>
<td>No response</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Best Motor Response</th>
<th>0-23 months</th>
<th>2-5 years</th>
<th>&gt; 5 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Localizes pain</td>
<td>Obeys verbal command</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Withdraws from pain</td>
<td>Localizes pain</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Decorticate position</td>
<td>Withdraws from pain</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Decerebrate position</td>
<td>Decorticate position</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>No response</td>
<td>No response</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Best Verbal Response</th>
<th>0-23 months</th>
<th>2-5 years</th>
<th>&gt; 5 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriate, smiles, coos</td>
<td>Appropriate words &amp; phrases</td>
<td>Oriented &amp; converses</td>
<td>5</td>
</tr>
<tr>
<td>Cries</td>
<td>Inappropriate words</td>
<td>Disoriented &amp; converses</td>
<td>4</td>
</tr>
<tr>
<td>Inappropriate cry / scream</td>
<td>Cries and/or screams</td>
<td>Inappropriate words</td>
<td>3</td>
</tr>
<tr>
<td>Grunts</td>
<td>Grunts</td>
<td>Incomprehensible sounds</td>
<td>2</td>
</tr>
<tr>
<td>No response</td>
<td>No response</td>
<td>No response</td>
<td>1</td>
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</table>
**PATIENT ASSESSMENT**

**SCENE SIZE-UP**
- Body substance isolation
- If necessary control scene
  - Move the patient/s
  - Correct the hazard

**INITIAL ASSESSMENT**
- General impression
- Mental status
- Airway
- Breathing
- Circulation
- Identify transport priority

**TRAUMA PATIENT**
- Evaluate mechanism of injury
- Perform rapid head to toe assessment or focused trauma assessment when indicated.
- Obtain baseline vital signs
- Obtain sample history
- Treat per appropriate protocol

**MEDICAL PATIENT**
- Evaluate responsiveness
- Perform rapid assessment or focused medical assessment when indicated.
- Obtain baseline vital signs
- Obtain sample history
- Treat per appropriate protocol

**TRANSPORT & ONGOING ASSESSMENT**
- Reassess initial assessment
- Reassess interventions
- Perform detailed assessment
- Communication and documentation

**SAMPLE HISTORY**
- Signs and symptoms
- Allergies
- Medications
- Past medical history
- Last oral intake
- Events leading up to event

**DCAPBTLSS**
- Deformities
- Contusions
- Abrasions
- Penetrations
- Bruising
- Tenderness
- Lacerations
- Swelling

**OPQRSTI**
- Onset
- Provocation
- Quality
- Radiation
- Severity
- Time
- Interventions