COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF PUBLIC HEALTH
AMBULANCE REGULATION PROGRAM
AMBULANCE TRIP RECORDS AUDIT FORM
105 CMR 170.345
DOCUMENTATION VERIFICATION

Service name_____ **Audit date** _____
Pt. name_____ **Date of service**_____
Auditor_____

	CIRCLE ONE		
Storage of records (secured against water/fire damage unauthorized use, kept minimum 7 years)	YES	NO	N/A
Content of Trip Records			
1. EMS personnel (names, EMT #, level function)	YES	NO	N/A
2. Identification of vehicle	YES	NO	N/A
3. Date of service	YES	NO	N/A
4. Times, location of dispatch & pick-up & delivery	YES	NO	N/A
5. Other services, EFR's/!st responder agencies	YES	NO	N/A
6. Patient Information	YES	NO	N/A
7. Medical Condition at scene	YES	NO	N/A
8. Medical Condition during transport	YES	NO	N/A
9. Care provided to patient	YES	NO	N/A
10. Non transporting – trip records inc. signed refusal	YES	NO	N/A
11. Copy timely delivered to receiving institution	YES	NO	N/A
12. Compliance with Statewide Treatment Protocols	YES	NO	N/A
13. Approved medications	YES	NO	N/A
14. Treatment consistent with level of licensure	YES	NO	N/A
15. Closest appropriate medical facility	YES	NO	N/A
16. Employ techniques for which certified	YES	NO	N/A
17. Assuring continuality of ALS care	YES	NO	N/A
18. Minimum staffing levels met	YES	NO	N/A
19. Medication administration and authorization	YES	NO	N/A
20. Highest trained EMT attended when applicable	YES	NO	N/A

Comment on all NO checks:

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