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Standardization of Documentation in Prehospital Psychiatric Emergencies: Analysis of a Specific form Implemented for the Psychiatric Ambulance in the City of Buenos Aires

Martín Mazzoglio Y. Nabar[1,2], Diego Slipak[3], Daniel Algieri[2], Sandra Álvarez[1], María Amelia Proyetti[1]

[1]Emergency Department, Torcuato de Alvear Psychiatric Emergency Hospital, Buenos Aires, Argentina
[2]Center for Interdisciplinary Forensic Research (CIDIF), National Academy of Sciences, Buenos Aires, Argentina
[3]SAME (Emergency Medical Care System), Buenos Aires, Argentina
Email: mazzoglioynabar@yahoo.com.ar

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Abstract

Introduction: Traditional ambulance report forms are primarily designed for medical and surgical emergencies and do not adequately address the semiological, contextual, and medico-legal particularities of psychiatric emergencies. **Objective**: To conceptually analyze the clinical, operational, and managerial relevance of a specific documentation form designed for psychiatric emergencies and implemented in the psychiatric ambulance operated by the Emergency Service of the Torcuato de Alvear Psychiatric Emergency Hospital in the City of Buenos Aires. **Methods**: A descriptive-analytical study of the documentation instrument implemented in the psychiatric mobile unit was conducted. Its structural dimensions were examined, including socio-demographic data collection, structured psychiatric examination using a checklist methodology, prehospital triage categorization, and documentation of clinical decision-making. The instrument was further analyzed in light of international recommendations for mental health crisis care. **Results**: The analyzed form integrates structured clinical assessment, risk stratification, and medico-legal traceability within a single instrument. The checklist format reduces the likelihood of semiological omissions under urgent conditions, while prehospital triage facilitates resource prioritization and continuity of care with the receiving hospital setting. **Conclusions**: The implementation of a psychiatric-specific form in the prehospital emergency setting enhances clinical standard-

ization, strengthens legal safeguards, and provides strategic value for healthcare system management.

Keywords

Psychiatric Emergency, Emergency Care, Prehospital Care, Triage, Healthcare Management

1. Introduction

Prehospital emergency medical systems have historically been organized under a biomedical paradigm centered on acute medical and surgical events such as trauma, acute coronary syndrome, respiratory failure, or shock. Within this model, initial assessment, resource prioritization, and clinical documentation are structured around objectively measurable physiological variables and technical procedures aimed at somatic stabilization. Documentation tools used in general ambulances reflect this logic: they prioritize hemodynamic parameters, organic medical history, invasive interventions, and operational timelines. This approach is appropriate and efficient for acute medical pathology; however, it demonstrates limitations when the activation of emergency services is triggered by a psychiatric crisis or by the predominance of psychopathological symptoms.

Over recent decades, the burden of mental health crisis care within emergency systems has steadily increased in major urban centers. Calls related to suicidal ideation, heteroaggressive behavior, acute psychotic episodes, self-harm-related intoxications, and severe affective decompensation account for a significant proportion of prehospital activations. Unlike somatic conditions, clinical decision-making in these situations is not based exclusively on physiological parameters, but rather on mental status assessment, behavioral risk estimation, and analysis of the psychosocial context [1] [2].

Psychiatric emergencies have specific characteristics that require a differentiated approach. These include impaired judgment of reality, suicidal or heteroaggressive ideation, behavioral disorganization, altered levels of consciousness, concomitant substance use, and the need to assess the patient's capacity to consent to or refuse interventions [3]. Furthermore, prehospital mental health interventions often occur in complex environments—private residences with family conflict, public spaces, or community settings—and frequently involve law enforcement or potential judicial notification [4]. These particularities introduce ethical and medico-legal dimensions that extend beyond routine emergency medical practice.

The absence of psychiatric-specific documentation instruments in the prehospital setting generates multiple challenges. First, it hinders the standardization of mental status examination under temporal and environmental pressure. Second, it increases the risk of omitting variables critical to estimating suicidal or violent risk. Finally, it may compromise the medico-legal traceability of clinical

actions, particularly in jurisdictions where mental health regulations strictly govern involuntary interventions and require explicit documentation of certain and imminent risk.

In the Autonomous City of Buenos Aires, the Emergency Medical Care System (SAME) operates a psychiatric ambulance based at the Torcuato de Alvear Psychiatric Emergency Hospital. This mobile unit is staffed by a driver and a board-certified psychiatrist, enabling a specialized response to mental health crises. Within this operational framework, the *Prehospital Ambulance Care Form of the Emergency Department of the Torcuato de Alvear Psychiatric Emergency Hospital* was implemented. The form was designed to structure clinical assessment, systematically record socio-demographic variables, categorize risk through psychiatric triage, and explicitly document the adopted course of action.

The objective of this study is to conceptually analyze the relevance of this instrument as a tool for clinical standardization, enhancement of patient safety, and optimization of management in prehospital psychiatric emergencies. The underlying hypothesis is that specialization of the mobile emergency resource requires an equivalent specialization of its documentation tools, capable of integrating clinical, contextual, and legal dimensions into a single operational instrument.

2. Methods

A descriptive analytical-conceptual study was conducted to examine the structural characteristics of the documentation instrument used in the psychiatric ambulance (**Figure 1**). The methodological design is framed within structural document analysis applied to clinical-operational tools and was carried out by the attending emergency department chiefs on duty. The purpose was not to evaluate quantitative clinical outcomes, but to examine the internal coherence (logical, structural, and semantic connections among components), conceptual foundation, and functional adequacy (the degree to which the instrument fulfills its intended purpose by ensuring accurate, complete, and appropriate data capture) of the tool in relation to its field of application.

From an epistemological standpoint, the study adopts a qualitative analytical approach based on the premise that documentation instruments are not merely administrative supports, but organizational devices that structure clinical processes. In prehospital psychiatric emergencies, the architecture of the form influences the sequence of assessment, prioritization of variables, and real-time decision-making. Therefore, its analysis required consideration of both its formal structure and its alignment with clinical and regulatory standards.

The analytical process involved identifying and categorizing the structural components of the instrument, defining four central domains for evaluation:

- Integration of socio-demographic variables relevant to contextual risk estimation;
- A structured psychiatric examination using a checklist methodology aimed at

systematizing semiological exploration under urgent conditions;

- Incorporation of a prehospital psychiatric triage system for initial behavioral risk stratification;
- Explicit documentation of the adopted clinical course of action and issued recommendations, considering their clinical and medico-legal implications.

Each domain was analyzed in terms of internal coherence, operational applicability in high-pressure emergency scenarios, and concordance with international recommendations for mental health crisis care. The analytical framework was contextualized using guidance from the Substance Abuse and Mental Health Services Administration [5], the World Health Organization [6] [7], and policy statements from the American College of Emergency Physicians [1].

This approach allowed the instrument to be examined not merely as an administrative form, but as an organizational technology aimed at structuring clinical practice and strengthening governance in prehospital psychiatric emergencies.

3. Results

The analyzed instrument (**Figure 1**) demonstrates an integrated architecture that systematically articulates clinical, contextual, and legal dimensions within a single documentation framework. From the perspective of emergency medicine, this integration represents not merely an administrative improvement, but a restructuring of the decision-making process in prehospital mental health care.

First, the structured incorporation of socio-demographic variables into the initial assessment expands the traditional prehospital evaluation model, which is typically centered on biomedical parameters. In psychiatric emergencies, risk cannot be estimated solely on the basis of observed mental status at a specific moment; it must be integrated with dynamic contextual factors. Social support networks, cohabitation status, the presence of a responsible companion, continuity of psychiatric treatment, and adherence to psychopharmacological regimens significantly influence the probability of imminent harm.

Operationally, embedding these variables within the instrument prevents their omission under conditions of acute time pressure. In crisis environments—particularly in public settings or conflictual households—clinicians may naturally focus on the most overt behavioral manifestations. The structured format compels systematic integration of contextual information, promoting a more ecologically valid risk assessment aligned with mental health regulations.

Second, the structured psychiatric examination using a checklist methodology constitutes the organizational core of the instrument. In emergency medicine, checklists function as cognitive tools for error reduction. The mental status examination is organized into classical semiological domains—consciousness, orientation, attention, thought processes, perception, affect, judgment, and impulse control—presented in a sequenced and categorized format. This reduces inter-observer variability and decreases the likelihood of critical omissions.

Prehospital Ambulance Care Form

Emergency Department, Torcuato de Alvear Psychiatric Emergency Hospital

Assistance No.:			Home evaluation		Transfer		Triage	
Date:	/ /		Hospital interconsultation		Official request			RED
			Public-space emergency		Tother			YELLOW
Start Time:		End Time:						GREEN

Socio-demographic data

Patient information

Full name: _____ Date of Birth / / Age

Address _____ ID Document:

Family / Companion / Witness

Full name: _____ ID Document:

Relationship: _____ Cohabitant: Yes No

Police intervention

Police station: _____ Officer name: _____ Badge No.:

Requesting court: _____

Mental status examination

General appearance	Normal		Depressed		Clouded			
	Excited		Indifferent					
Orientation	Autopsychic				Allopsychic			
Awareness of situation		Full		Partial		Absent		
Insight		Full		Partial		Absent		
Attention	Normal		Hyperprosexia		Aprosexia			
	Hypoprosexia		Paraprosexia					
Perception	No alterations		Hallicinations		Auditory			
	Illusions				Visual			
					Other			
Thought content	Normal		Delusional		Other			
Association of ideas	Coherent		Incoherent					
Thought process	Normal		Accelerated		Retarded			
	Disorganized		Intercepted		Incoherent			
Memory	Normal		Hypomnesia		Alterations	Anterograde		
			Hypermnesia			Retrograde		
Level of consciousness	Normal		Clouded		Other			
Affect	Normal		Labile		Ambivalent			
	Elevated		Depressed		Other			
Activity	Normal		Hypobulia		Hyperbulia			
Judgment	Adequate		Suspended		Weakened			
	Insufficient		Deviated					

Sphincter control	Normal		Altered		
Walks	Yes		No		
Pupils	Isocoric		Anisocoric		
	s/p		Midriasis		Miosis

Family support	Yes		No	
Psychoterapeutic support	Yes		No	
Ongoing psychiatric treatment	Yes		No	

Presumptive diagnosis

Orders / Requests

Police custody				
Fingerprint record				
Laboratory tests				
Clinical evaluation / interconsultation				
Psychopharmacological plan	1.		3.	
	2.		4.	
Warning signs	A.			
	B.			
	C.			

Clinical decision

Resolved at home		time	:
Resolved at hospital		time	:
Transfer to hospital (specification)		time	:

Comments:

Physician Signature (Ambulance) Receiving Physician Signature

Figure 1. Prehospital care form of the emergency department of the torcuato de alvear psychiatric emergency hospital.

Under cognitive overload, decision-making may be influenced by attentional bias and prioritization of highly visible behavioral stimuli. The structured examination mitigates these effects by systematically prompting assessment of variables that may not be immediately apparent. This aligns with evidence demonstrating that checklist-based approaches improve adherence to evaluative standards and reduce clinical errors in high-pressure environments.

A third key finding is the explicit incorporation of a color-coded prehospital psychiatric triage system (red, yellow, green), corresponding to graduated levels of behavioral risk. The integration of triage within the same form does not merely classify the patient; it directly informs immediate clinical conduct. "Certain and imminent risk" (red) mandates highest priority and urgent transport; "certain but non-imminent risk" (yellow) allows moderated intervention; and "no identifiable risk" (green) supports resolution on scene with follow-up recommendations [8].

From an emergency management standpoint, early risk stratification facilitates rational resource allocation, enhances coordination with receiving hospitals, and reduces operational uncertainty. Importantly, prehospital triage is dynamic and requires reassessment upon hospital arrival, strengthening continuity of care and patient safety.

Finally, explicit documentation of the adopted course of action constitutes a critical element of medico-legal traceability [9]. In psychiatric emergencies, decisions involving involuntary transport or restrictive measures require documented clinical justification. The structured "clinical decision" section compels explicit articulation of proportionality relative to assessed risk. Institutionally, such traceability reduces legal vulnerability and enhances transparency. The operational sequence structured by the instrument is summarized in Figure 2.

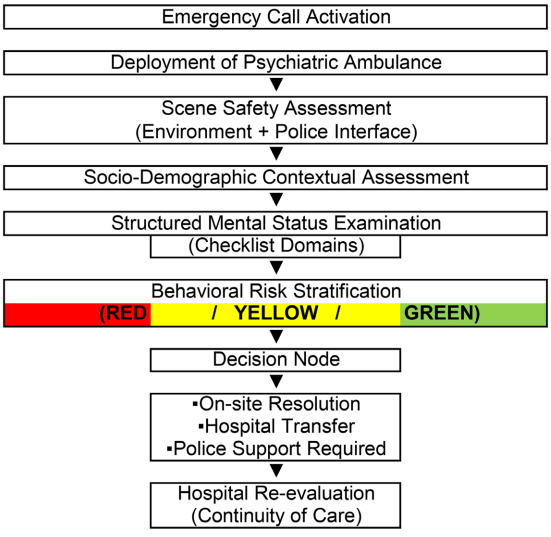

Figure 2. Operational sequence.

Collectively, these findings indicate that the instrument functions not merely as retrospective documentation, but as a prospective organizer of clinical workflow.

Its architecture positively shapes evaluative sequencing, guides risk stratification, and structures real-time decision-making. In the context of prehospital psychiatric emergencies—where clinical complexity, temporal pressure, and legal exposure converge—this structural organization constitutes a central component of quality and safety.

4. Discussion

The implementation of a psychiatric-specific documentation form in the prehospital emergency setting represents a significant step toward standardizing a historically under-documented domain within emergency medical systems. As demonstrated by the findings, the instrument operates as an organizational technology in environments characterized by uncertainty, time pressure, and legal exposure.

The instrument was developed by the Chief of the Emergency Department in collaboration with a designated commission composed of two emergency department physicians from Hospital Alvear and two external emergency medicine specialists. Following its development, it was approved by the Hospital Directorate for legal implementation in the psychiatric ambulance service. It was implemented in January 2025 and is reviewed semiannually to identify potential improvements based on evolving clinical demands and case typologies.

Clinically, the structured mental status examination using a checklist methodology is particularly relevant in uncontrolled prehospital settings. Emergency medicine literature consistently demonstrates that checklist-based tools reduce errors and improve adherence to standards during critical events [10]. The semiological systematization embedded in the instrument mitigates attentional bias and diagnostic omission, enabling more comprehensive mental state evaluation under adverse conditions. The structural differences between conventional ambulance documentation and the psychiatric-specific model are outlined in **Table 1**.

Table 1. Comparative model table.

Dimension	General Ambulance Model	Psychiatric Specialized Model
Primary Focus	Hemodynamic & somatic stabilization	Behavioral risk + mental status
Risk Assessment	Physiological severity	Dynamic clinical-contextual risk
Mental Status Exam	Non-structured/narrative	Checklist-based structured exam
Triage	Somatic priority systems	Behavioral risk stratification
Legal Documentation	Limited	Explicit proporcionality & traceability
Data for Governance	Somatic indicators	Psychiatric crisis indicators

The integration of psychiatric triage aligns with international crisis response models that emphasize early risk stratification. Mobile crisis units and co-re-

sponse models underscore the importance of categorizing behavioral risk at first contact to optimize resources and reduce unnecessary hospitalization [11].

From a risk theory perspective, psychiatric emergency risk is dynamic, emerging from interactions among clinical symptoms, contextual variables, and temporal evolution. The inclusion of socio-demographic factors reflects this dynamic conception of risk. Explicit documentation of proportionality aligns with the principle of least restrictive intervention recognized in contemporary mental health legislation.

Operationally, specialized psychiatric ambulances acknowledge mental health crises as structural components of emergency demand. Documentation standardization enables generation of psychiatric-specific epidemiological indicators to inform macro-level planning and governance.

However, this study has limitations. It reflects a single-center experience within a specific urban system, limiting external generalizability. The analysis focused on structural and conceptual characteristics without formal usability testing, acceptability assessment among clinicians, or inter-rater reliability evaluation. Prospective studies are needed to evaluate performance, consistency, and impact on operational and clinical indicators.

5. Conclusions

Conventional documentation forms used in general ambulances are insufficient to address the clinical, legal, and operational demands of prehospital psychiatric crises. Behavioral risk assessment, structured mental status evaluation, and documentation of legally relevant decisions require instruments specifically designed for this context.

The Prehospital Ambulance Care Form of the Emergency Department of the Torcuato de Alvear Psychiatric Emergency Hospital represents an organized response to this structural gap. By integrating socio-demographic assessment, checklist-based mental status examination, psychiatric triage, and explicit documentation of clinical decisions, it enhances documentation quality and structures real-time clinical workflow.

From an emergency medicine perspective, this structuring reduces error under high-pressure conditions, improves continuity of care, and strengthens medico-legal traceability. It also enables the generation of psychiatric-specific indicators for health system governance.

This experience constitutes a replicable model for documentation standardization in specialized mobile psychiatric crisis units. Specialization of emergency resources requires equivalent specialization of documentation tools.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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