Prehospital Care/Base Station
Quality Improvement/Assurance Program
Request for Quality Improvement Review

Date of Incident: _____

Time of Incident: _____

Patient Name: _____

Medical Record # or EMS ID #_____

Ambulance or Medic Unit Number_____

Hospital Staff _____

Details of
Incident_____
_____
_____
_____
_____
_____

Name of Person Making Report:
_____

Title/position: _____

Contact information: _____
Who did you notify at [NAME HOSPITAL} of your concerns?
_____

If you wish to discuss this incident in person, please contact Prehospital Care coordinator or base station nurse manager at ######.

Prehospital Care/Base Station
Quality Improvement/Assurance Program
Occurrence Report Review

Incident Number: _____
Reporting Year: _____
Date of Incident: _____

Staff Member(s) Involved:_____

Initial Reviewer: _____

Details of
Incident:_____
_____
_____
_____
_____
_____
_____
_____
_____

Investigative
Findings:_____
_____
_____
_____
_____
_____

Disposition:
_____
_____
_____

Referred for further review to:
_____
_____