OFFICIAL USE ONLY

CQI #________________________

DATE RCVD: __________________

☐ Emergent ☐ Non-Emergent

CENTRAL CALIFORNIA EMERGENCY MEDICAL SERVICES

COUNTY INVOLVED:

☐ FRESNO ☐ KINGS ☐ MADERA ☐ TULARE

OTHER________________________

CONFIDENTIAL

(In Accordance with California Civil Code Section 56, et seq, California Evidence Code Section 1040 and Section 1157, et seq, and California Code of Regulations, Title 22, Division 9)

QUALITY IMPROVEMENT REPORT

(Information for Attorneys representing the Central California EMS Agency)

Incident Logistics

Call Location:____ EMS Disp. #:___________________

Date:__________________________________ Time:_______________ Location: ☐ On Scene ☐ Enroute ☐ At Hospital ☐ Other

Patient Name:_____________________________________ Med. Record # or DOB:_____________________

Personnel Involved	Agency	Discussed with Individual
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Author Information

Name: _______________________________________ Date: _______________________________

Accreditation #: _______________________________ Agency/Facility: ______________________

(Utilize the back of this form to elaborate your concerns & resolution)

Documentation Area

Issue(s):

- ☐ Airway
- ☐ Call-In
- ☐ Destination
- ☐ Dispatch
- ☐ Documentation
- ☐ Equipment
- ☐ Hospital Diversion
- ☐ Interpersonal/Conduct
- ☐ Job Well Done
- ☐ Resource Utilization
- ☐ MCI
- ☐ Medical Control
- ☐ Medication Error
- ☐ Patient Assessment
- ☐ Patient Transfer
- ☐ Patient Treatment
- ☐ Patient Turnover
- ☐ Physician Issue(s)
- ☐ Policy/Protocol
- ☐ Scope of Practice
- ☐ Other: ______________

Select primary issue from dropdown

____

____ Initial: _______________

Account of Incident:

____
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____
____

Initial: _______________

Proposed Resolution: (Author Must Complete)

- ☐ Critique/Paramedic Education
- ☐ Educational Feedback
  - ☐ Written ☐ Meeting
- ☐ Formal Education
- ☐ No Action
- ☐ Policy Review
- ☐ Policy Revision
- ☐ Protocol Review
- ☐ Protocol Revision
- ☐ Other: _______________

____
____
____

Initial: _______________

(Final completed form will be forwarded to County Counsel from the EMS Agency)