Southwest Virginia EMS Council

Performance Improvement Referral/Comment Form

Your name:_____ Your title:_____

Your agency:_____ Today's Date:_____

Agency/facility/individual targeted for quality improvement: _____

EMS Incident number:_____ Patient Record number:_____

Receiving facility:_____

Date of incident:_____ Time of incident:_____

Patient age:_____ Patient date of birth:_____

Illness/Diagnosis:_____

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Purpose of Referral/Comment:

_____ Patient care _____ equipment issue _____ destination/diversion

_____ Other (describe) _____

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Attendant in charge: _____ Level of certification: _____

Attendant: _____ Level of certification: _____

Attendant: _____ Level of certification: _____

Attendant: _____ Level of certification: _____

Description of events/Comment (use back of paper if necessary): _____

_____

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_____

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Agency OMD: _____

Signature of person completing this form: _____

For QA Committee use only	Date received:	Action taken: