

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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Agency OMD: \_\_\_\_\_

Signature of person completing this form: \_\_\_\_\_

For QA Committee use only	Date received:	Action taken:
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