SAINT FRANCIS EMS SYSTEM
INCIDENT REPORT FORM
PROTECTED CONFIDENTIAL DOCUMENT

PURPOSE: To report an occurrence which is not consistent with the routine operation of prehospital care, or the routine prehospital care of a particular patient, which is serious in nature.

Date of Incident ____________________ Time ___________ Run Report # __________

** Attach a copy of the ambulance run report form to this report.

Personnel (hospital and/or provider) involved in incident:

________________________________________________________________________

DESCRIPTION OF INCIDENT BY PERSON INVOLVED OR AS WITNESSED:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

(Use reverse side if needed)

Receiving Hospital or Provider: ________________________________

Incident Reported to: ________________________________ Time __________

If incident involved a patient, the Emergency Physician in charge of the patient’s treatment must sign the report. If a provider is completing this report, the Fire Chief or CEO must be informed.

Physician Signature (if necessary): ________________________________

Date Report Completed: ________________________________

Signature of Person Completing Report: ________________________________

Name & Title

FOLLOW-UP BY ST. FRANCIS HOSPITAL, RESOURCE HOSPITAL:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

EMS System Coordinator Signature: ________________________________

EMS Medical Director Signature: ________________________________