SAINT FRANCIS EMS SYSTEM
REQUEST FOR CLARIFICATION

PURPOSE: To improve communication and understanding between hospital personnel and providers in the interest of better patient care.
(Confidential, peer review use only.)

Date of Occurrence ________________ Time ________________
Ambulance Run Report # ________________ Department ________________

HOSPITAL ______________________________________________________________________

Personnel (hospital and/or provider) involved and/or reporting
_________________________________________________________________________________

I request clarification of the following episode:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Signature of person preparing report _____________________________________________________________________

Date report prepared ____________________________

Submit to the EMS System Coordinator at the Resource Hospital. It will be reviewed, investigated, commented upon and returned.

Comments of EMS System Coordinator: ___________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Comments of EMS Medical Director (if indicated): ___________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

PLEASE NOTE: THE BACK OF THIS FORM MAY BE USED IF NEEDED.

REVISED: OCTOBER 1999
REVIEWED: DECEMBER 2011