RESOURCE HOSPITAL
SYSTEM-WIDE CRISIS FORM

Date: ________________________  Time: ________________

________________________________________  __________________________________________
Name of Resource Hospital                  Name of Person Filling
                                            In Report/Title
                                        Telephone Number

Names of Associate Hospitals/Participating Hospitals Requesting Bypass or Who Have Seen an Increase in E.D. Visits:

________________________________________

Common Signs/Symptoms of Patients Who are Coming to the Emergency Department:

________________________________________

Name(s) of Provider(s) in the Area Who Have Seen an Increase in Runs:

________________________________________

Name and Time of EMS Coordinator or EMS Medical Director Notification:

________________________________________

Date/Time/Name of Person Notified at the State (i.e., Chief of EMS)

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<th>Name</th>
<th>How Contacted (Pager, Phone, Fax)</th>
<th>Time Notified</th>
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EMS PROVIDER/ASSOCIATE & PARTICIPATING HOSPITAL WORK SHEET
SYSTEM-WIDE CRISIS

Name of Hospital/Provider                  Date                   Time

Name of Person Reporting

HOSPITALS ONLY

Number of Patients with Same/Like Symptoms Seen in Last Six (6) Hours

PROVIDERS ONLY

Number of Patients Transported to Emergency Departments by All Ambulances in Our Service with Same/Like Symptoms

Any Increase in Response Time:  ● ●  ● ●
Yes
No

HOSPITALS AND PROVIDERS

Common Like Complaints by Patients:


ANY OTHER PERTINENT INFORMATION: