Region 2 EMS System Policy
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 and increase in emergency department visits:

_____

_____

_____

Common signs / symptoms of patients who are coming to the emergency department:

_____

_____

Name(s) of EMS provider(s) in the are who have seen and increase in ambulance calls:

_____

Name and time of EMS Coordinator or EMS Medical Director notification:

_____
Name Time / Date

Date / Time / Name of person notified at Illinois Department of Public Health (i.e., Chief of EMS)

_____ _____ _____ _____

Name | How Contacted (Pager, Fax, Phone) | Time | Date

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_____ _____ _____

Name of hospital / Provider | Date | Time

_____

Name of person reporting

Hospitals Only

Number of patient with same / like symptoms seen in last (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: _____

_____

_____

Resource Hospital Contacted: YES NO

Person contacted at Resource Hospital: _____ _____

Name | Title

How was information reported: PHONE FAX PAGE PERSON to PERSON OTHER

Names / Organizations and / or titles of other persons contacted:

_____

_____

_____