

Peoria Area MICU Review and Comment Report

Reason for Report:

- | | | |
|---|---|---|
| <input type="checkbox"/> Constructive
below) | <input type="checkbox"/> Hospital Direction Related | <input type="checkbox"/> Other (Explained |
| <input type="checkbox"/> Complimentary | <input type="checkbox"/> Patient Related | <input type="checkbox"/> EMT-P Related |

Occurrence Date: ____/____/____ Occurrence Time: ____ a.m./p.m. ALS/MICU Run#

Patient Name: _____ Hospital # _____

Name of Ambulance Service: _____

Ambulance Team Members: _____

Hospital: _____ Nurse: _____

Physician (Hospital): _____ Other(s): _____

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Description of occurrence or events (use additional paper if necessary)

Follow-up/Corrective Action:

Person initiating report: _____ Date Submitted: ____/____/____

Supervisor reviewing report: _____ Date Submitted: ____/____/____