Peoria Area MICU Review and Comment Report

Reason for Report:

( ) Constructive ( ) Hospital Direction Related ( ) Other (Explained below)
( ) Complimentary ( ) Patient Related ( ) EMT-P Related

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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): ____________

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

Follow-up/Corrective Action:

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

Supervisor reviewing report:_______________________________Date Submitted: _____/ _____/