

CONFIDENTIAL FOR QI ONLY

QUALITY IMPROVEMENT
INCIDENT INFORMATION REQUEST FORM

Type of Incident: _____ Radio Communications _____ Protocols/Policies
_____ Interagency Cooperation _____ Professional Decorum
_____ Meds/Drug Bag _____ Other _____

Date of Incident _____ Tag Number _____ IR# (office use only) _____

Personnel _____ Agency _____

Description of the problem, including the event surrounding this incident and any contributing factors.

How did this incident affect patient care? _____

Please note patient diagnosis, in-Hospital testing and treatment, patient disposition: _____

Possible solutions to this problem: _____

IF DRUG BAG INCIDENT;

Destination Hospital _____
Box Serial # _____
Last Pharmacy Inspection:
Date _____ Hospital _____
Personnel Initials _____

PLEASE ATTACH DRUG BAG LABEL BELOW:

Name of person completing report (print) _____ Date _____

Signature _____

Phone number _____ Department/Agency Name _____

Please attach copy of **EMS Run Form** or other helpful information and return to NCMCA chairman at above address.

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Newaygo County Medical Control Authority

