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 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 Sate (i.e., Chief of EMS)

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

Region 2 EMS System Policy
SYSTEM-WIDE CRISIS FORM

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: _____

Resource Hospital Contacted: ☐ Yes ☐ No

Person Contacted at Resource Hospital: _____ (Name) _____ (Title)

How was Information Reported:

- Phone ☐
- Fax ☐
- Page ☐
- Dedicated Phone Line ☐
- Person to Person ☐
- Other ☐

Names/Organizations and/or Titles of Other Persons Contacted: _____