Print Form Clear Form

CENTRAL DUPAGE HOSPITAL
EMERGENCY MEDICAL SERVICES SYSTEM

25 N. WINFIELD ROAD
WINFIELD, IL 60190

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REQUEST FOR CLARIFICATION FORM

ALL INFORMATION CONTAINED WITHIN THIS FORM IS PRIVATE AND CONFIDENTIAL PURSUANT TO THE ILLINOIS MEDICAL STUDIES ACT AND IS FOR OFFICIAL USE ONLY.

INCIDENT INFORMATION:

DATE OF REPORT: / / DATE OF INCIDENT: / / TIME OF INCIDENT: HRS

INCIDENT LOCATION:

TYPE OF INCIDENT (CHECK ALL THAT APPLY):

- ☐ MEDICATIONS
- ☐ EQUIPMENT
- ☐ COMMUNICATION
- ☐ PROCEDURE
- ☐ SOP DEVIATION
- ☐ ASSESSMENT / INTERVENTION
- ☐ INJURY TO PATIENT
- ☐ INJURY TO EMS PROVIDER
- ☐ OTHER EMS PROVIDER RELATED
- ☐ OTHER PATIENT RELATED
- ☐ E.D. STAFF RELATED

AGENCY / ORGANIZATION INVOLVED: Select EMS Agency Name

RECEIVING HOSPITAL: Select Facility Name

EMS REPORT #:

ECRN LOG #:

EMS SYSTEM PERSONNEL INVOLVED (LIST ALL):

NON-EMS SYSTEM PERSONNEL INVOLVED (LIST ALL):

REPORT INITIATED BY:

INCIDENT DESCRIPTION / DETAILS:

****STOP**** **EMS PERSONNEL DO NOT WRITE BELOW THIS LINE. FOR ADMINISTRATIVE USE ONLY!**

EMS SYSTEM REVIEW:

DISPOSITION:

☐ No Action Required ☐ Re-Education ☐ Verbal Warning ☐ Written Warning ☐ Suspension

EMS SYSTEM COORDINATOR SIGNATURE: DATE: / /

EMS MEDICAL DIRECTOR SIGNATURE: DATE: / /

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