



S-SV EMS Prehospital Provider Incident Tracking Form

**Policy #
927-A**

CONFIDENTIAL

(In accordance with California Civil Code Section 56, et seq, California Evidence Code Section 1040 and section 1157. Et seq, and California Code of Regulations, Title 22, Division 9)

Reporting Entity Information:

Name of Reporting Party:	
Phone Number:	Email Address:
Date Received:	Receipt Acknowledgement Date:

Incident Logistics:

County: <input type="checkbox"/> Colusa <input type="checkbox"/> Butte <input type="checkbox"/> Nevada <input type="checkbox"/> Placer <input type="checkbox"/> Shasta <input type="checkbox"/> Siskiyou <input type="checkbox"/> Sutter <input type="checkbox"/> Tehama <input type="checkbox"/> Yuba		
Date Investigation Opened:		Date Investigation Closed:
Incident Date:	Incident Time:	Run #:
Incident Location:		
Prehospital Agencies Involved:		
Hospitals Involved:		
Personnel Involved:		

Type of Reportable Incident(s):

<input type="checkbox"/> Sentinel Event	<input type="checkbox"/> Breach of the Standard of Care
<input type="checkbox"/> Medication Error	<input type="checkbox"/> Treatment Error
<input type="checkbox"/> Key Equipment Failure Related to Patient Care	<input type="checkbox"/> Care Beyond the Appropriate Scope of Practice
<input type="checkbox"/> Failure to Follow S-SV EMS Policy/Protocol	<input type="checkbox"/> Suspected Violation of H&S Code 1798.200
<input type="checkbox"/> Alleged or Known Injury to a Patient as a Result of Actions by EMS Personnel	
<input type="checkbox"/> Other	

Specific Issue(s):

<input type="checkbox"/> Airway	<input type="checkbox"/> Inappropriate Behavior	<input type="checkbox"/> MICN Issues
<input type="checkbox"/> AMA/RAS	<input type="checkbox"/> Interpersonal	<input type="checkbox"/> Patient Assessment
<input type="checkbox"/> Base/Modified Base Contact	<input type="checkbox"/> Manpower/Resource Utilization	<input type="checkbox"/> Patient Transfer
<input type="checkbox"/> Destination	<input type="checkbox"/> MCI	<input type="checkbox"/> Patient Turnover
<input type="checkbox"/> Dispatch	<input type="checkbox"/> Medical Control	<input type="checkbox"/> Physician Issues
<input type="checkbox"/> Documentation	<input type="checkbox"/> Medication Broken/Missing	<input type="checkbox"/> Policy Clarification
<input type="checkbox"/> Equipment Failure	<input type="checkbox"/> Medication Error	<input type="checkbox"/> Scope of Practice
<input type="checkbox"/> Equipment Utilization	<input type="checkbox"/> Other:	



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Description of Incident (attach additional documentation if necessary):

Incident Investigation Checklist (items used/reviewed during the incident investigation):

<input type="checkbox"/> Base Hosp. Audio Files	<input type="checkbox"/> Dispatch Audio Files	<input type="checkbox"/> PCR
<input type="checkbox"/> Base Hosp. Documentation	<input type="checkbox"/> Dispatch Logs	<input type="checkbox"/> RAS/AMA Forms
<input type="checkbox"/> Cardiac Monitor/AED Reports	<input type="checkbox"/> Incident Reports	<input type="checkbox"/> S-SV EMS Policy/Protocol
<input type="checkbox"/> Prehospital Personnel Interview(s):		
<input type="checkbox"/> Interviews/Discussions With Other Personnel:		
<input type="checkbox"/> Other:		



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Comments (attach additional documentation if necessary):

Resolution(s):

<input type="checkbox"/> No Action Required	<input type="checkbox"/> Remedial Education	<input type="checkbox"/> Disciplinary Action
<input type="checkbox"/> Referral to S-SV EMS and/or the California EMS Authority for Potential Certification/Licensure Action		
<input type="checkbox"/> Referral to S-SV EMS for Possible Case Review and/or Policy/Protocol Revision		
<input type="checkbox"/> Other:		
S-SV EMS Agency Referral Date:		
Date Notification of Resolution Provided to Reporting Party:		

Investigator Information

Name/Title of Person Completing Investigation: