



**SREMS
COUNCIL**

Susquehanna Regional EMS Council, Inc.

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EMS Agency Quality Improvement Form

CFR Agencies: complete section 1
BLS Agencies: complete section 1 and 2
ALS Agencies: complete section 1 – 3
All agencies complete section 4

Agency Name: _____

Month/year: _____

QI Coord. completing form: _____

Contact phone number: _____

Contact email address: _____

Section 1

Number of calls for six month period: _____

Number of PCR's reviewed:

Electronic: _____

Paper: _____

Call by type:

Airway obstruction _____
Respiratory arrest _____
Respiratory distress _____
Cardiac related (potential) _____
Cardiac arrest _____
Allergic reaction _____
Syncope _____
Stroke/CVA _____
General illness/malaise _____
Gastro-intestinal distress _____
Diabetic related (potential) _____
Pain _____
Unconscious/unresp. _____
Seizure _____
Behavioral disorder _____
Substance abuse (potential) _____
Poisoning (potential) _____

Shock _____
Head injury _____
Spinal injury _____
Fracture/disloc. _____
Amputation _____
Major trauma _____
Trauma-blunt _____
Trauma-penetrating _____
Soft tissue injury _____
Bleeding/hemorrhage _____
OB/GYN _____
Burns _____
Environmental:
Heat _____
Cold _____
HazMat _____
Obvious death _____

Agency/ambulance assistance: _____ (#) _____ (#) _____ (#)
_____ (#) _____ (#) _____ (#)
_____ (#) _____ (#) _____ (#)

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Section 2

BLS/ALS Rendevous and
Agency/ambulance assistance: _____ (#) _____ (#) _____
_____ (#) _____ (#) _____
_____ (#) _____ (#) _____

Section 3

BLS/ALS Rendevous and
Agency/ambulance assistance: _____ (#) _____ (#) _____
_____ (#) _____ (#) _____
_____ (#) _____ (#) _____

Controlled Substance/Narcotic Assists: _____

Section 4

Any safety issues?

Any patient care issues?

Any agency concerns?

New EMS providers to your agency. *(please include full name, level of care, certification #, address, phone number and email address)*

Comments or suggestions?