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?