ATTACHMENT
OCEMS P/P 710.00

EMT-D REPORT

INCIDENT NUMBER	DEPARTMENT	EMT-D-UNIT / PARAMEDIC UNIT

AGE	SEX	WITNESS ARREST?	BH YEAR MONTH DAY RUN PT
	M F	Y N	

ESTIMATED TIME OF COLLAPSE	BYSTANDER CPR?	RECEIVING CENTER
HRS	Y N	

COMMENTS/DETAILS

EQUIPMENT MALFUNCTION (DESCRIBE)

BELOW COMPLETED BY DEPARTMENT QUALITY ASSURANCE COORDINATOR

_____HRS ESTIMATED TIME OF COLLAPSE
_____HRS DISPATCH TIME
_____HRS ON-SCENE TIME
_____HRS PATIENT CONTACT TIME

90 SECOND GOAL

_____HRS TIME OF FIRST DEFIBRILLATION
_____HRS PARAMEDIC CONTACT TIME

COMMENTS: _____

_____

REVIEWED BY QA COORDINATOR AND
SENT TO BASE HOSPITAL OR EMS AGENCY _____DATE_____

INTIAL RHYTHM _____

SHOCKABLE RHYTHM: ☐S NO☐

RHYTHM SHOCK (S) _____

ED DISPOSTION: ☐MITTED EX☐ED

DISCHARGED ALIVE: ☐S NO☐

COMMENTS: _____

_____

_____

EDUCATIONAL OPPORTUNITY IDENTIFIED: ☐YES ☐

REVIEWED BY BASE HOSPITAL OR EMS AGENCY _____DATE_____

SEND THIS COMPLETED FORM AND ATTACHED REPORTS TO:

Orange County Emergency Medical Services
405 W. Fifth Street Suite 301A
SANTA ANA, CA 92701

ksh:11/6/03