

COUNTY OF SAN DIEGO OFFICE OF EMERGENCY MEDICAL SERVICES

ATTACHMENT A

Report of ALS Services Provided without Base Hospital Contact: In accordance with Health & Safety Code, Division 2.5 Section 1798, any incident wherein advanced life support was rendered in the absence of direct communication with a Base Hospital must be verbally reported to the Base Hospital Physician or MICN immediately upon ability to make voice contact, and the following report must be completed; if more than one patient was treated, a separate form must be completed for each patient. Complete reports must be submitted to a Base Hospital Physician at the hospital to which you are regularly assigned within twenty-four (24) hours of the incident.

Date of incident: _____ PM Agency: _____ Unit: _____

Paramedics - (Patient Care): _____ (Radio): _____

Base Hospital (if contact made): _____ Run Number: _____

Assigned Base Hospital: _____ EMS Form Number: _____ (Copy must be attached)

Completely describe the nature of the communication problem including suspected cause, exact geographic location, remedial actions taken, alternate modes attempted:

Detail the conditions and patient assessment that led you to believe the patient was in jeopardy of losing his/her life without ALS Treatment:

What specific ALS treatment was given without medical control?

What was the patient's condition on arrival at the hospital?

List witnesses at scene (first responders, other medical personnel)

Receiving RN

MD Name:

Hospital receiving patient:

Incident Reported	Date:	Time:	Agency:	Person reported to:
Verbal report(s)				

Written report:

We, the above paramedics affirm that the statements made on the report are complete and true to the best of our knowledge.

Signature: Cert #: Date:

Signature: Cert #: Date:

Written report received by:(signature)

Date & Time received:

Base Hospital:

Base Hospital Physician Review:

P-405 "Communications Failure"
Attachment A
Page 3 of 5

Signature:

M.D. Date:

Please attach copies of the following when submitting this report to the Division of Emergency Medical Services.

- A. All documentation provided by service provider agency and paramedics**
- B. Copy of the MICN report form and copy of paramedic tape (if contact was made).**
- C. Copy of EMS Prehospital Patient Record**

Forward copies of all documentation with 72 hours to:

EMS Medical Director, County of San Diego
Emergency Medical Services Branch
6255 Mission Gorge Road
San Diego, CA 92120

COUNTY OF SAN DIEGO EMERGENCY MEDICAL SERVICES

For Office Use Only

Date and time report received:

Date: Time:

Report received by:

- EMS Medical Director
- EMS Chief
- EMS Paramedic Coordinator

Reviewer's Comments:

Recommended Action:

- A. Receive and file - no further action required ()
- B. Forward summary of communication problems to County Communications for review and recommendations ()
- C. Return to Base Hospital for further information () Detail:

D. Return to Base Hospital for the following recommended action(s): ()

E. Forward to service provider agency for review ()

F. Other: ()

Signature of Reviewer:

Date: Title:

Medical Director Review:

