Region 2 EMS System Policy
SYSTEM-WIDE CRISIS FORM

Date: ___________________________  Time: ___________________________

Name of Resource Hospital ___________________________  Name of Person Filling In Report/Title ___________________________

Telephone Number ___________________________

Names of Associate Hospitals/Participating Hospitals Requesting Bypass or Who Have Seen an Increase in E.D. Visits:

________________________________________________________________________________________

________________________________________________________________________________________

Common Signs/Symptoms of Patients Who are Coming to the Emergency Department:

________________________________________________________________________________________

________________________________________________________________________________________

Name(s) of Provider(s) in the Area Who Have Seen an Increase in Runs:

________________________________________________________________________________________

________________________________________________________________________________________

Name and Time of EMS Coordinator or EMS Medical Director Notification:

________________________________________________________________________________________

Date/Time/Name of Person Notified at the State (i.e., Chief of EMS)

<table>
<thead>
<tr>
<th>Name</th>
<th>How Contacted (Pager, Phone, Fax)</th>
<th>Time Notified</th>
<th>Date Notified</th>
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Region 2 EMS System Policy
SYSTEM-WIDE CRISIS FORM

Name of Hospital/Provider ____________________  Date ____________________  Time ____________________

Name of Person Reporting ____________________

HOSPITALS ONLY

Number of Patients with Same/Like Symptoms Seen in Last Six (6) Hours: _________________

PROVIDERS ONLY

Number of Patients transported to Emergency Departments by All Ambulances in Our Service with Same/Like Symptoms: _________________

Any Increase In Response Time:  ☐ Yes  ☐ No

HOSPITALS AND PROVIDERS

Common/Like Complaints by Patients: __________________________________________________________

Any Other Pertinent Information: ____________________________________________________________

Resource Hospital Contacted:  ☐ Yes  ☐ No

Person Contacted at Resource Hospital: ______________________________________________________

How was Information Reported:  Phone ☐  Fax ☐  Page ☐  Dedicated Phone Line ☐  Person to Person ☐  Other ☐

Names/Organizations and/or Titles of Other Persons Contacted: __________________________________

Name ___________  Title ___________