

Appendix G

SPONSOR HOSPITAL COUNCIL of GREATER BRIDGEPORT



The following information is provided to another entity pursuant to 45 CFR Section 164.506c(4i), and is confidential and protected as peer review under CGS 19a-17b

This form is intended to formalize the internal QA process performed at your respective EMS agencies with SHCGB. After an inquiry is initiated by either EMS Coordinator and an internal discussion is completed, please return this form with any supporting documentation. Please retain a copy for your records. Please note that the employee is required to comment on the discussion and sign the form where indicated. Signing the form does not indicate agreement with the findings. The employee has the right to request further discussion with medical control. Similarly, filing of this form does not indicate case closure. Medical control reserves the right to request a meeting with the provider as needed to complete the review process.

Status/Disposition:		Organization/EMS Agency:			
Hospital Transported to:		Other agencies (if applicable):			
Provider:		Referred by:	Hospital	Internal QA	Provider
Case Number:		Date Entered:		Date Occurred:	
Reason for Call Review (Circle those that apply)					
Tier 1			Tier 2		
Cardiac Arrest			Over Triage		
PAMI Alert			Under Triage		
Stroke Alert			Documentation Issue		
Trauma Alert			Spinal Motion Restriction		
Electrical Therapy			Scene times		
Medication Error			Notification Times		
RSI/Intubation			Other clinical		
Safety Issue			Other non-clinical		
Tourniquet Application					
Findings:					
Service Findings:					
Conclusions:					
Recommendations:					
Provider Comments:					
QA/PI Officer Signature:			Provider Signature:		

