MIEMSS Quality Assurance Consult Audit Form

Audit Date: _____ Name of Auditor: _____

Consult Date: _____ **Consult Time:** _____

Name of RN: _____ Name of Consulting Physician: _____

EMS Jurisdiction/Commercial Company Name: _____ **Ambulance/ Unit #:** _____

Other Hospital/Poison Control on-line? Yes No Name(s): _____

Quality of Radio Transmission? Poor Partially Audible Clear

PATIENT DATA:

Priority Level: 1 2 3 4 Age: _____ Years/Months Sex: Male Female Unknown

Chief Complaint: _____

Vital Signs: Complete Set? Yes No Missing? _____

Code Status/ DNR: Full A1 A2 B Unknown

Procedures Performed: _____

Medications Administered: _____

CONTENT OF CONSULT:

Purpose of Call: Notification Only/ Patient Information Medical Direction Destination Direction

Did staff identify themselves clearly on the radio? Yes No

The staff member(s) communication on the radio was (were)? RN MD BOTH

Did staff ask questions to prompt EMS clinicians in decision-making? Yes No NA

Were physician orders appropriate per protocol? Yes No NA

Did the physician provide orders outside of the EMS protocols? Yes No NA

If Yes, Action Taken: _____

Did the EMS clinician give an adequate report? Yes No

Did the EMS clinician request appropriate orders? Yes No NA

PATIENT DISPOSITION/FOLLOW-UP/CONCERNS:

Patient Disposition/Final Disposition was appropriate based on protocols? Yes No

Patient Disposition: Closest ED Specialty Center: □Adult Trauma □Pediatric Trauma □Burn □Hand □CIC Stroke

Other Comments/Concerns: _____

_____

_____

Forwarded to EMS for review/action: Yes No

If Yes, Response Received? Yes No

Bolded fields are mandatory, all others are optional - Revised December 2021