
Rappahannock EMS Council
435 Hunter Street, Fredericksburg, VA 22401
EMS/TRAUMA INCIDENT REVIEW REQUEST FORM

This form should be utilized in the event of conflict or concern. Please provide as much information as possible in the requested fields. If the information is unknown, please leave the field blank. When completed, attach any available documentation (copy of PPCR with identifying patient information redacted), and forward to the EMS liaison at the hospital, or seal in an envelope marked **CONFIDENTIAL: PI COMMITTEE** and submit to the REMS council office.

Date of Incident: _____ Time of Incident: _____

Requesting Individual: _____

Organization/Affiliation: _____

Title or Certification: _____

Type of Incident: MEDICAL TRAUMA Other: _____

Location of Incident: _____

Responding EMS Agency: _____

Unit #: _____ ALS BLS Unknown

Attendant in charge: _____

Include the names of any other crew members (if known):

How were you involved with patient? _____

Reason for review request:

Signature: _____ Date: _____ Time: _____