

REMS REGIONAL QI COMMITTEE
AGENCY QUARTERLY QUALITY MANAGEMENT REPORT



Agency Number:

Agency Name:

Reporting Period Year:

JUL-SEPT (Q1)

OCT-DEC (Q2)

JAN-MAR (Q3)

APR-JUN (Q4)

REQUIRED DATA (Please complete all sections of this form and submit with additional QI Indicator Forms)

COMMENDATIONS:

<u>Provider</u>	<u>Cert #</u>	<u>Brief Description</u>
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RECOMMENDATION(S) FOR IMPROVEMENT:

Total Number of Patient Care Reports *Filed* This Period:

Total Number of Patient Care Reports *Reviewed* This Period:

Level of Care Provided:

ALS

BLS

N/A*

TOTAL

**Unknown, Cancelled, No Patient, No Tx Required*

Incident Disposition:

Treated, Transported by EMS

Treated, Transferred

Treated, Transported by Private

Treated, Released

No Treatment Required

Patient Refused Care

Dead on Scene

Cancelled

No Patient Found

Not Applicable

Unknown

TOTAL

Submitted by:

E-mail Address:

Date:

Contact Phone #:

**FAX COMPLETED FORMS TO REMS COUNCIL AT 540-373-0536
OR E-MAIL TO REMS@VAEMS.ORG**