RESOURCE HOSPITAL
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)

Name	How Contacted (Pager, Phone, Fax)	Time Notified	Date Notified

EMS PROVIDER/ASSOCIATE & PARTICIPATING HOSPITAL
WORK SHEET
SYSTEM-WIDE CRISIS

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: _____