

## PRE - HOSPITAL QUALITY ASSURANCE REPORT

|  |                       |  |  |
|--|-----------------------|--|--|
| 1. INCIDENT DATE   | 2. INCIDENT NUMBER    | 3. PRE-HOSPITAL PATIENT RECORD (PPR) NO. |  |
| 4. AMBULANCE NO.   | 5. BASE / STATION NO. | 6. REVIEW DATE                           | 7. NAVY MEDICAL TREATMENT FACILITY (MTF) |
| <p>8. REVIEW</p> <p>A. Is the written report legible? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>B. Are all sections complete? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>    1) Unit Number <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>    2) Crew Names <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>    3) Incident Number <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>    4) Chief Complaint <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>    5) Physical Exam / Findings <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>    6) Appropriate Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>    7) Response to Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>    8) Appropriate Destination <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>    9) Medical Control Contact, as needed <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>C. Was patient care appropriate? (Protocol adherence and / or deviation from standard practice) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>D. Is there a question regarding response or on-scene time? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>E. Other comments, if applicable:</p> |                       |  |  |
| <p>9. CORRECTIVE ACTIONS <input type="checkbox"/> Individual Training <input type="checkbox"/> Protocol Review <input type="checkbox"/> N / A</p>  |                       |  |  |
| 10. REVIEWED BY (Name and Rank / Title)  |                       | 11. REVIEWED BY (Signature)              |  |