

**Fauquier County
Pre-hospital Patient Care Report
Review Form**

This form will be filled out and attached to document every PPCR requiring review by the QA/QI Committee. Patients' names will be blacked out / blocked prior to making the copy.

Type of Call _____ ALS BLS

AIC _____ ALS BLS

Department _____

Incident # _____ Date of Call ____/____/____

Reviewed by _____ ALS BLS

Reason for Review:

- | | |
|--|---|
| <input type="checkbox"/> Cardiac Arrest | <input type="checkbox"/> Needle Stick Exposure |
| <input type="checkbox"/> Severe Trauma | <input type="checkbox"/> Complaint Received |
| <input type="checkbox"/> Respiratory Arrest | <input type="checkbox"/> Review requested by Provider |
| <input type="checkbox"/> Fatality | <input type="checkbox"/> Review Requested by ER Staff |
| <input type="checkbox"/> Fly out | <input type="checkbox"/> Medical Practice Violation |
| <input type="checkbox"/> Prolonged Extrication | <input type="checkbox"/> Recurrent Provider Problems |
| <input type="checkbox"/> Serious Equipment Failure | <input type="checkbox"/> Other |

Comments:
