

FORM DIRECTIONS

Only complete and return sections that pertain to the incident being reported. Copy additional pages as needed.

1. Please attach copies of any agency specific Incident Reports.
2. Page 2 is for general information relating to the incident only and must be completed for all reporting.
3. Section 1 must be completed if a patient is injured or dies as a result of EMS involvement.
4. Section 2 must be completed for a motor vehicle crash involving death or injury to a patient, member of the crew or other person which requires hospitalization or care by a physician.
5. Section 3 must be completed if any member of the EMS service, civilian or other emergency responder dies or is injured requiring hospitalization or care by a physician while on duty.
6. Section 4 must be completed for any equipment failure causing patient harm.
7. Section 5 must be completed if any member of the EMS agency is alleged to have responded or treated a patient while under the influence of alcohol or drugs.
8. Section 6 must be completed for all incidents.

This form does not replace any incident reporting forms required by a regional council, state or federal laws and regulation, and/or insurance policies.

This form must be completed for any injury, illness or death of an EMS provider, patient or other individual in accordance with Part 800.21(q) and 800.21(r). Each incident must be reported to the Department's area office by telephone no later than the following business day. The completed form must be submitted to the New York State Department of Health's Bureau of Emergency Medical Services within 5 business days for every incident.

EMS Service

Name _____
Name of EMS Service _____ NYS EMS Agency Code _____

Address _____
Street _____
City _____ State _____ ZIP _____ County (where incident/injury occurred) _____

Contact Person _____
Name _____ Title _____

Phone (____) _____ - _____ (____) _____ - _____
Business Other

Regional EMS Council (primary):

Your Agency Type (check only one)

- Commercial College Fire Department Independent Not for Profit
 Municipal Hospital Industrial

Incident

Location
 Residence Medical Facility Commercial Facility Ambulance EASV/ALSFR Quarters
 Roadway Other _____ Event/Standby

Date of Incident _____ **Time (24 hour)** _____ **Day of Week** _____

Unit Status at Time of Incident
 Available Responding On Scene En-route to Hospital At Destination Training

Type of Incident

- For each patient that was injured or dies as a result of EMS involvement complete Section 1
 Motor vehicle crash involving injury or death to patient, crew, civilian or other emergency personnel requiring hospitalization or care by a physician (complete Section 2)
 Any EMS Provider, Civilian or Other Emergency Provider that dies or is injured while on duty requiring hospitalization or care by a physician (complete Section 3)
 Patient equipment failure causing patient harm (complete Section 4)
 Provider suspected of treating patients or responding under the influence of alcohol or drugs while on duty (complete Section 5)

Number of Persons Injured

EMS Provider _____ Patient _____ Other Emergency Responder _____ Civilian _____

Number of Persons Deceased

EMS Provider _____ Patient _____ Other Emergency Responder _____ Civilian _____

SECTION 1 Patient Information

Complete this section for each patient that was injured or dies as a result of EMS involvement.

Age _____ Gender Male Female

Pre Event Condition

Appears Stable Appears Stable but Potentially Unstable Appears Unstable

Post Event Condition

Appears Stable Appears Stable but Potentially Unstable Appears Unstable

Pre Event Presenting Problem (check all that apply)

<input type="checkbox"/> Airway Obstruction	<input type="checkbox"/> Pain	<input type="checkbox"/> Major Trauma
<input type="checkbox"/> Respiratory Arrest	<input type="checkbox"/> Unconscious/Unresponsive	<input type="checkbox"/> Trauma-Blunt
<input type="checkbox"/> Respiratory Distress	<input type="checkbox"/> Seizure	<input type="checkbox"/> Trauma-Penetrating
<input type="checkbox"/> Cardiac Related	<input type="checkbox"/> Behavioral Disorder	<input type="checkbox"/> Soft Tissue Injury
<input type="checkbox"/> Cardiac Arrest	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Bleeding/Hemorrhage
<input type="checkbox"/> Allergic Reaction	<input type="checkbox"/> Poisoning (accidental)	<input type="checkbox"/> OB/GYN
<input type="checkbox"/> Syncope	<input type="checkbox"/> Shock	<input type="checkbox"/> Burns Environmental
<input type="checkbox"/> Stroke/CVA	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Heat
<input type="checkbox"/> General Illness	<input type="checkbox"/> Spinal Injury	<input type="checkbox"/> Cold
<input type="checkbox"/> Gastro-Intestinal Distress	<input type="checkbox"/> Fracture/Dislocation	<input type="checkbox"/> Hazardous Materials
<input type="checkbox"/> Diabetic Related	<input type="checkbox"/> Amputation	

Injury Occurred During (check all that apply)

<input type="checkbox"/> Airway Management	<input type="checkbox"/> Splinting	<input type="checkbox"/> Hemorrhage control
<input type="checkbox"/> Oxygen therapy	<input type="checkbox"/> C-spine immobilization	<input type="checkbox"/> Alleged Assault by EMS personnel
<input type="checkbox"/> Medication error	<input type="checkbox"/> Lifting/moving	<input type="checkbox"/> Alleged Abandonment by EMS personnel
<input type="checkbox"/> Monitor/defibrillation	<input type="checkbox"/> Patient dropped	<input type="checkbox"/> Motor vehicle crash (MVC)
<input type="checkbox"/> Protocol error	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Stretcher involved incident Make/Model _____		
<input type="checkbox"/> Stair Chair involved incident Make/Model _____		
<input type="checkbox"/> Reeves transfer		

Body Part Affected (check all that apply)

<input type="checkbox"/> Head	<input type="checkbox"/> Back	<input type="checkbox"/> Leg	<input type="checkbox"/> Left/	<input type="checkbox"/> Right				
<input type="checkbox"/> Neck	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Hand	<input type="checkbox"/> Left/	<input type="checkbox"/> Right				
<input type="checkbox"/> Chest	<input type="checkbox"/> Arm	<input type="checkbox"/> Left/	<input type="checkbox"/> Right	<input type="checkbox"/> Foot	<input type="checkbox"/> Left/	<input type="checkbox"/> Right		
<input type="checkbox"/> Joint	<input type="checkbox"/> Left/	<input type="checkbox"/> Right	<input type="checkbox"/> Knee	<input type="checkbox"/> Ankle	<input type="checkbox"/> Wrist	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip	<input type="checkbox"/> Shoulder
<input type="checkbox"/> Internal Organ/System _____								

Post Event Injury/Illness (check all that apply)

<input type="checkbox"/> Respiratory	<input type="checkbox"/> Deceased	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Exposure – Heat	<input type="checkbox"/> Exposure – Cold
<input type="checkbox"/> Cardiac	<input type="checkbox"/> Fracture/Dislocation	<input type="checkbox"/> Spinal Injury	<input type="checkbox"/> Laceration	<input type="checkbox"/> Sprain/Strain
<input type="checkbox"/> Cardiac Arrest	<input type="checkbox"/> Stroke	<input type="checkbox"/> Seizure	<input type="checkbox"/> Burn	<input type="checkbox"/> Amputation
<input type="checkbox"/> Hemorrhage	<input type="checkbox"/> Pathogen	<input type="checkbox"/> Exposure Hazmat	<input type="checkbox"/> Trauma –Blunt	<input type="checkbox"/> Trauma –Penetrating
<input type="checkbox"/> Other _____				

Disposition Admission

<input type="checkbox"/> Emergency Department Only	<input type="checkbox"/> Critical Care Admission	<input type="checkbox"/> Personal Physician
<input type="checkbox"/> Hospital General Admission	<input type="checkbox"/> Urgent Care	<input type="checkbox"/> Other _____

SECTION 2 Motor Vehicle Crash

Complete this section for a motor vehicle crash involving death or injury to a patient, member of the crew or other person which requires hospitalization or care by a physician. Also include copies of Section 1 or Section 3 as necessary.

EMS Vehicle Involved

Ambulance ALS-FR EASV Other

Ambulance Type

Type I Type II Type III Other

Amount of Damage

Minor Moderate Severe

Other Vehicle Involved

Car SUV Pickup Truck Motorcycle/ATV Commercial Vehicle
 Other _____

Accident Type

Backing Head-On Sideswipe 90 Degree Rear End Parked
 Vehicle/Pedestrian/Wildlife

General Information (check all that apply)

Intersection Lights in Use Sirens in Use Traffic Control Device Present
 Mechanical Failure Airbag Deployment Entrapment

Time of Day

Daylight Night Dawn/Dusk

Weather Conditions at the Time of the Incident (check all that apply)

Clear Sunny Cloudy Foggy Rain Snow Ice

Road Conditions (check all that apply)

Dry Wet Ice Snow Other _____

EMS Vehicle Driver Information

EMT Number _____ Age _____ Gender Male Female

Hours on Duty Prior to Incident _____

EVOC or Agency specific driver training Restrained Unrestrained Injured
 Non-EMS Certified Driver

Patient Location at Time of Incident

Restrained Unrestrained Stretcher Bench Seat Captain's Chair
 Patient Injury (must complete Section 1) No patient on board

Front Seat Passenger Information

Provider Civilian Restrained Unrestrained Unoccupied
 Injury (must complete Section 3)

Compartment Occupants

EMS Provider Civilian Other Agency Restrained Unrestrained Unoccupied
 Injury (must complete Section 3)

Other Vehicle Involved

Driver

Restrained Unrestrained Injury (must complete Section 3 for each injured passenger)

Passenger

Restrained Unrestrained Injury (must complete Section 3 for each injured passenger)

SECTION 3**EMS Crew Member, Civilian or Other Emergency Responder Information**

Complete this section for any on-duty member of the EMS service, civilian or other emergency responder who dies or is injured requiring hospitalization or care by a physician.

Age _____

Gender

Male Female

Level

CFR EMT AEMT EMT-CC EMT-P Civilian
 Other Emergency Provider

Status

Paid Volunteer Driver/Helper Student

Mechanism of Injury (check all that apply)

Animal Bite Fire Assault – with weapon Assault – no weapon
 Needle Stick Pathogen Electrical Injury Explosion
 Struck by Vehicle Struck by Object Structural Collapse MVC
 Hazardous Materials Exposure (specify _____)
 Lifting/Bending Slip/Fall
 Moving Patient Onto/Off Stretcher During Stretcher Transport
 Other _____

Body Part Affected (check all that apply and indicate left/right where applicable)

Head Shoulder Left Right Arm Left Right Leg Left Right
 Neck Hip Left Right Elbow Left Right Knee Left Right
 Chest Wrist Left Right Ankle Left Right
 Back Hand Left Right Foot Left Right
 Abdomen Internal Organ/System _____

Injury/Illness Description (check all that apply)

Respiratory Deceased Head Injury Exposure – Heat Exposure -Cold
 Cardiac Fracture/Dislocation Spinal Injury Laceration Sprain/Strain
 Cardiac Arrest Stroke Seizure Burn Amputation
 Hemorrhage Pathogen Exposure Hazmat Trauma –Blunt Trauma –Penetrating
 Other _____

Equipment Description (if related to injury)

Stretcher Stair Chair Backboard Reeves
 Other _____
 Make/Model _____

Disposition Admission

Emergency Department Only Critical Care Admission
 Personal Physician Urgent Care
 Hospital General Admission
 Time Lost (if known) _____ (days)

SECTION 4 Equipment Failure

Complete this section for each equipment failure that caused patient harm. Also include Section 1 or Section 3 as necessary.

Airway Equipment (check all that apply)

Make/Model _____

- O2 delivery device Suction CPAP
- Advanced airway Nebulizer O2 tank O2 Regulator
- Other _____

Lifting/Moving Equipment

Make/Model _____

- Stretcher Stair Chair Reeves
- Other _____

Splinting Equipment (check all that apply)

Make/Model _____

- Extrication Collar Backboard Short board Frac Pack Traction Splint
- Other _____

Other Patient Equipment (check all that apply)

Make/Model _____

- Monitor Pulse Oximeter Glucometer IV Supplies AED
- Automatic CPR Device
- Other _____

SECTION 5 Provider treating or responding under the influence

Complete this section for member of the EMS agency is alleged to have responded or treated a patient while under the influence of alcohol or drugs while on duty.

EMT Number _____

Age _____

Gender

Male Female

Level

CFR EMT-Basic AEMT EMT-CC EMT-P

Status

Paid Volunteer Driver/Helper Student

Substance Type

Drugs Alcohol

Allegation

Responded Patient Treatment

Details (fill out sections 1, 2 or 3 if applicable):

Injury Motor Vehicle Crash Law Enforcement Response (Agency _____)

Testing

Breath Blood Urine

Testing Completed by

Agency Hospital Police Department Lab/Clinic

Results

Positive Negative
%BAC _____ Drug Type _____

Action Taken by Agency

Suspended Terminated Pending Removed from Service Returned to Service

