



**Pre-Hospital Services  
Continuous Quality Improvement  
Variance Report Form**

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|--|---------------------------------|
| <input type="checkbox"/> Patient Care (Unusual Issues) | <input type="checkbox"/> Delay  |
| <input type="checkbox"/> Communications                | <input type="checkbox"/> Safety |
| <input type="checkbox"/> Equipment                     | <input type="checkbox"/> Other  |
| <input type="checkbox"/> Public Relations              |                                 |

Complete this form if you have identified a potential risk or issue regarding patient care. Please notify the EMS Coordinator if any issue requires immediate attention. Otherwise, when completed, return this form to the appropriate EMS Coordinator.

**Identify/Describe what occurred or what was observed:**

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**What is your concern about what occurred or what you observed?**

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**How do you think that this issue should be resolved?**

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**Check Appropriate Response Desired:**

Immediate:       Next Day:       Near Future:

**Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**E-Mail:** \_\_\_\_\_

**For Office Use Only:**

Review Date: \_\_\_\_\_ Action Plan: \_\_\_\_\_

Responsible Staff Member: \_\_\_\_\_

Follow -Up Plan: \_\_\_\_\_

Outcome: \_\_\_\_\_

Date of Completion: \_\_\_\_ / \_\_\_\_ / \_\_\_\_