



Emergency Medicine Ambulance Trip Report Quality Assurance / Follow Up

Date: ____/____/____

Patient Record ID Number: _____

(EMMA: EMS Form # / EMS Charts: PRID #)

Scene time:

Time = _____ < 10 minutes for Trauma **OR** < 20 Minutes for Medical

- If No: Extrication
 Additional Medical Assistance
 Other _____

Advanced Airway:

Intubation: Successful? Yes No # of attempts: _____

Tube placement verification documented? Yes No

Verification Method(s) Capnography CO2 Detector Bamm Bulb

Needle Decompression: Successful? Yes No Properly Indicated Yes No

Cricothyroidotomy: Successful? Yes No Properly Indicated Yes No

IV Access: Successful? Yes No # of attempts: _____ # successful: _____

Cardiac Arrest: Rhythm? _____ Followed Protocol: Yes No D.O.A. Yes No

Air Transport: Trauma: Medical Properly Indicated Yes No

Comments of reviewer: _____

Necessary actions:

- No action necessary, care appropriate **CLOSED**
- Further investigation (see comments)
- Education (see comments)
- Comments: _____

Name of Reviewer Date

Medical Director Date