



Westchester REMAC

Patient Care Report QI Review Form

Call Review Type _____ Review Date _____ Date of Call _____

EMS Agency _____ PCR # _____

NYS Certification # _____ Receiving Hospital _____

	YES	NO
Call Times are within accepted parameters? <i>If No, explain deviation:</i>		
Patient Assessment was thorough and revealed a presumptive diagnosis? <i>If No, explain deviation:</i>		
Pre-Hospital Medical Care that was provided was appropriate and effective? <i>If No, explain deviation:</i>		
Patient Care was provided in compliance with existing triage, treatment, and transport protocols? <i>If No, explain deviation:</i>		
Patient transportation to an appropriate destination was performed in an acceptable manner? <i>If No, explain deviation:</i>		
Continuity of Pre-Hospital to Hospital Care was acceptable? <i>If No, explain deviation:</i>		
PCR and related documentation was complete, accurate, and legible? <i>If No, explain deviation:</i>		
Internal or External Customer Feedback? <i>If Yes, was it POSITIVE or NEGATIVE (please circle one)</i> Describe:		
Patient Disposition at Hospital (if available) reflects EMS Care was provided appropriately? Describe:		

Continue on Back of Sheet

