Quality Assurance Data

Consult Audit Tool

Audit: Time_____ Date_____ Name of Auditor:_____

Consult: Time_____ Date_____

Name consulting Physician:_____ Name consulting RN_____

EMS Jurisdiction/medic#: _____ Mode of transport: ___Ground _____Air

Other hospital on Line? ____Yes _____No Name of hospital: _____

Poison Center on line _____Yes

Patient Data:

Priority Level: 1 2 3 4 Age: _____Years/Months M_____ F____

Chief Complaint :_____

Vital Signs : _____

EMS/DNR _____Yes _____No

IVs _____FSBS_____O2_____ Nasal Trumpet _____ Intubated_____ CPAP_____

Meds given_____

Quality of Radio Transmission : _____ Poor _____Partial Audible _____Clear

Content of Consult:

1- Purpose of call: ____Notification only/ patient information

_____Requesting advice/ medical direction

_____Requesting destination direction

2- Did staff identify themselves clearly on the radio _____Yes _____No
3- The staff member communicating on the radio was (were) _____MD _____RN _____Both
4- Was the consult conducted in a respectful, professional manner? _____Yes _____No
5- Did the staff demonstrate a clear understanding of EMS protocols? _____Yes _____No
(If no, explain_____)
6- Staff asked questions to guide EMS provider in decision making? _____Yes _____No
7- Staff asked or relayed orders to EMS provider _____Yes _____No
8- Physician ordered a treatment outside EMS protocol? _____Yes _____No
(action taken _____)
9- Did the field provider give an adequate report? _____Yes _____No
10- Was the chief complaint clear? _____Yes _____No
11- Did the provider request appropriate orders? _____Yes _____No

Patient Disposition/ Final Destination appropriate based on Protocol : _____Yes _____No

____The closest ED

____The closet Trauma Center

____Specialty (Burns, Eye, Hand, Pediatric Trauma)

Other
recommendations:_____
_____
_____