MCI FEEDBACK/REPORTING FORM

REPORTING ENTITY	
Reporting Agency:	Reporting Person:
Telephone:	Email Address:

INCIDENT INFORMATION (COMPLETE AS APPLICABLE TO YOUR AGENCY'S ROLE)	
Incident Date:	Incident Name:
Incident Location:	
Dispatch Time:	First Unit On Scene Time:
First Transport Unit On Scene Time:	Supervisor On Scene Time:
Incident End Time:	

NUMBER & TYPE OF PREHOSPITAL EMS RESOURCES		
First Responder Agencies Utilized:		
Ground Amb. Providers Utilized:		
# of Ground Amb. Requested:		# of Ground Amb. Utilized
HEMS Providers Utilized:		
# of HEMS Aircraft Requested:		# of HEMS Aircraft Utilized:
Other Transport Resources:		
Incident Commander:		Transportation Unit Leader:
Triage Unit Leader:		Med. Communications Coord.:
Treatment Unit Leader:		Were MCI ID Vests Used? ☐ Yes ☐ No
Were Triage Tags Used? ☐ Yes ☐ No		Were Pt. Tracking Sheets Used? ☐ Yes ☐ No

NUMBER & TYPE OF PATIENTS

IMMEDIATE:	DELAYED:	MINIMAL:	EXPECTANT	DECEASED:

# Of Adult Pts:	# Of Pediatric Pts:
# Of Pts Transported by EMS:	# Of Pts Refusing Transport:

HOSPITAL INFORMATION

CF Representative Name:	Initial CF Contact Time:
Initial MCI Notification Received From	
Number of CF Staff Assigned:	CF Pt Dispersal Officer:
Receiving Facilities Utilized:	

FEEDBACK AND SUGGESTIONS