

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

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NUMBER & TYPE OF PATIENTS

IMMEDIATE:	DELAYED:	MINIMAL:	EXPECTANT	DECEASED:
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# Of Adult Pts:	# Of Pediatric Pts:
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# Of Pts Transported by EMS:	# Of Pts Refusing Transport:
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HOSPITAL INFORMATION

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

FEEDBACK AND SUGGESTIONS

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