

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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Were Triage Tags Used?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Were Pt. Tracking Sheets Used? <input type="checkbox"/> Yes <input type="checkbox"/> 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				