ADVOCATE ILLINOIS MASONIC MEDICAL CENTER
JOHN H. STROGER JR. HOSPITAL OF COOK COUNTY
NORTHWESTERN MEMORIAL HOSPITAL
UNIVERSITY OF CHICAGO MEDICAL CENTER

REGION 11 CHICAGO EMS SYSTEM
REQUEST FOR CLARIFICATION FORM

(THIS IS A CONFIDENTIAL QUALITY IMPROVEMENT DOCUMENT. DO NOT COPY OR MAKE REFERENCE TO ITS COMPLETION IN THE MEDICAL RECORD/PATIENT CARE REPORT/JOURNAL.)

Date & Time of Occurrence:____

Ambulance Service/Unit:____

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Event or Run #:____

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Hospital Log#:____

Patient Name: ____

EMS Personnel Name:____

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Summary of Events:____

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Signature(s) of Person(s) Initiating Report:____________________________

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Report Submitted To:____

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FOLLOW UP REPORT (FOR RESOURCE HOSPITAL USE ONLY):___________________

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EMS System Coordinator:____

EMS Medical Director:____

CONFIDENTIAL