



INLAND COUNTIES EMERGENCY MEDICAL AGENCY
Serving San Bernardino, Inyo and Mono Counties
1425 SOUTH "D" STREET
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**UNUSUAL OCCURANCE/CONFIDENTIAL CASE REVIEW
REQUEST FORM**

SENTINEL EVENT

UNUSUAL OCCURRENCE

To be completed by person initiating case review requests:

Name: _____ Title/Cert#: _____
Employer: _____ Phone: _____
Address: _____ Today's Date: _____
Date of Occurrence: _____ Time: _____ Run#: _____
Location: _____
Base Station: _____ Receiving Hospital: _____

Persons Involved: _____

Notified of Report: Yes No
 Yes No
 Yes No
Employer Notified: Yes No
 Yes No
 Yes No
If yes, name of person notified: _____
Brief description of occurrence: _____

Notification of:
 Exceptional Performance
 Educational
 Deviation from policy/protocol
 Medication error
 Dispatch
 Deviation of Destination Guidelines
 Equipment malfunction (not communications)
 Physician on scene
 Scope of Practice
 Other (explain below)

Referred Case Review Request to: _____ Date: _____

REVIEWER'S USE ONLY

Name: _____ Title: _____ Date: _____
Employer: _____ Address: _____
Phone: _____ Run Report#: _____

*****NOT PART OF PATIENT CARE RECORD*****