INLAND COUNTIES EMERGENCY MEDICAL AGENCY
Serving San Bernardino, Inyo and Mono Counties
1425 SOUTH "D" STREET
SAN BERNARDINO, CA 92415-0060
909-388-5823 FAX: 909-388-5825

RADIO COMMUNICATION FAILURE NOTIFICATION FORM

This form is to be completed whenever Base Station radio or telephone contact cannot be established or maintained. A verbal report must be made to the MICN or Base Station Physician immediately upon voice contact.

Report initiated by _____ Title/Cert# _____ Unit# _____

Employer _____ Address _____

Phone _____ Date of Report _____ Date of RCF _____

Prior to contact skills performed: ☐ Yes ☐ No

List RCF procedures performed: _____

Number of Contact Attempts: _____ Duration of time waiting for response: _____

Summary of situation, patient assessment and treatment: (Use additional pages if needed)

Relative to what patient care protocol? _____

Type of Radio: _____ Base Station: _____

Receiving Hospital: _____ Patient report given to: _____

Probable cause of failure: _____

Signature: _____

A photocopy of the completed **PATIENT CARE RECORD MUST ACCOMPANY THIS FORM**, and both submitted to the Base Station within twenty-four (24) hours following Communication Failure for review by the Base Station Physician. A copy of the Patient Care Record and RCF form may be required by your Agency's Paramedic Coordinator for review. Consult your employer regarding patient confidentiality.

*****DO NOT PLACE IN PATIENT RECORD*****

*****REVIEWER'S USE ONLY*****

Reviewed by: Date:
BS Physician: _____ _____
PLN: _____ _____
PC: _____ _____
Review completed: _____ _____