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

UNUSUAL OCCURANCE/CONFIDENTIAL CASE REVIEW REQUEST FORM

(When complete, send via e-mail only to ICEMADutyOfficer@cao.sbcounty.gov)

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 Hospital: ______________________ Receiving Hospital: ______________________

Persons Involved:

	Notified of Report:	Employer Notified:
______________________	☐ Yes ☐ No	☐ Yes ☐ No
______________________	☐ Yes ☐ No	☐ Yes ☐ No
______________________	☐ Yes ☐ No	☐ Yes ☐ No

If yes, name of person notified: ______________________________________

Brief description of incident/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

Explanation: ____
____
____

Referred Case Review Request to: ______________________________ Date: ____________

REVIEWER'S USE ONLY

Name: ______________________ Title: ________________ Date: ____________

Employer: ______________________ Address ______________________________

Phone: ______________________ Incident Number#: ____________

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