

**Region 2 EMS System Policy
SYSTEM-WIDE CRISIS FORM**

Date: _____

Time: _____

Name of Resource Hospital

Name of Person Filling In Report/Title

Telephone Number

Names of Associate Hospitals/Participating Hospitals Requesting Bypass or Who Have Seen an Increase in E.D. Visits:

Common Signs/Symptoms of Patients Who are Coming to the Emergency Department:

Name(s) of Provider(s) in the Area Who Have Seen an Increase in Runs:

Name and Time of EMS Coordinator or EMS Medical Director Notification:

Date/Time/Name of Person Notified at the Sate (i.e., Chief of EMS)

Name

How Contacted
(Pager, Phone, Fax)

Time Notified

Date Notified

