Squad___________________ QA Audit/ Review Worksheet QA.Person/Persons_________________________________

Month/Year________________ Page________ of _________

ACR #																																								
Chief Complaint																																								
Narrative																																								
Vital Signs & Times																																								
MD/MICN/EMT signatures																																								
No Transport																																								
Nursing/ Clinic transport																																								
Scene Time > 20 min.																																								
Appropriate BLS																																								
Appropriate ALS																																								
Code/ DOA/ DNR																																								
CVA/ Seizures																																								
Trauma																																								
Cardiac																																								
Respiratory																																								
Substance abuse/overdose																																								
Other calls																																								
IV (S or U)																																								
Medication, doses & times																																								
Intubation (S or U)																																								
Orders denied or varied																																								
Restrains/ commitment																																								
Second call or standby																																								

** Comments on Back Please. Total # ACR's_____ Total # of ALS calls _____ Revision Date: 7/1/98