

**COMMUNICATION FAILURE REPORT**

**Directions:** Complete and submit original to provider's EMS/QI Coordinator within twenty-four (24) hours of the occurrence.

**INCIDENT #:** \_\_\_\_\_ **INCIDENT DATE:** \_\_\_\_\_ **INCIDENT TIME:** \_\_\_\_\_

**INCIDENT LOCATION:** \_\_\_\_\_

**PROVIDER AGENCY:** \_\_\_\_\_ **UNIT #:** \_\_\_\_\_

**COUNTY PARAMEDIC #:** \_\_\_\_\_ **PARAMEDIC:** \_\_\_\_\_

**RECEIVING HOSPITAL:** \_\_\_\_\_

**BASE HOSPITAL:** \_\_\_\_\_ **MICN#:** \_\_\_\_\_ **PHYSICIAN:** \_\_\_\_\_

**IDENTIFY CAUSE:**

- No Radio       No Phone       No Service       No Answer at Hospital
- Equipment Failure       Other: \_\_\_\_\_

**Communication Device:** \_\_\_\_\_ **Number of Attempts:** \_\_\_\_\_

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**EXPLANATION (No Patient Information):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PARAMEDIC SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_