CCEMS COVER SHEET FOR ANCILLARY DOCUMENTS

ALL CREW MEMBERS ______________________________ ________________________________

______________________________ ________________________________

______________________________ ________________________________

CCEMS RUN # ______________________________ DATE OF SERVICE ______/______/______

Unit / Crew # ____________________ Truck # ___________________

COMPLETED REPORT FAXED TO FACILITY ON: _______________ @ __________ BY:______________________________

DATE TIME CREW MEMBER

IS PATIENT A RESIDENT OF COSHOCTON COUNTY: ☐ YES ☐ NO

- ☐ 911 EMERGENCY
  - ☐ REFUSAL OF TRANSPORT
  - ☐ TRANSPORTED TO HOSPITAL
  - ☐ OTHER ____________________________
- ☐ TRANSPORTED HOME, FACILITY
  - ESO CODE: MEDICAL TRANSPORT
  - ☐ PCS INCLUDED
- ☐ HOSPITAL TO HOSPITAL TRANSPORT
  - ESO CODE: INTERFACILITY TRANSPORT
  - ☐ PCS INCLUDED
  - ☐ IMMEDIATE TRANSPORT

    OR
  - ☐ NON-EMERGENT TRANSPORT
- ☐ FLY-OUT

  BY:_________________________

  TO: _________________________
- ☐ MUTUAL AID BY: ____________________
- ☐ FIRE DEPARTMENT STAND-BY

HIPAA OFFERED (YES) (NO)

SIGNATURE VERIFICATION

PLEASE CONFIRM

- ☐ ELECTRONIC SIGNATURE OBTAINED
- ☐ PAPER FORM INCLUDED

-ALSO VERIFY WHO SIGNED

- ☐ PATIENT SIGNED *AND* RECEIVING FACILITY

  OR
- ☐ AUTHORIZED PATIENT REP *AND* REC FACILITY

  OR
- ☐ EMS CREW *AND* RECEIVING FACILITY

QA/QI

______ ESO REVIEWED

______ PAPERWORK COMPLETE

______ DOCUMENTS ATTACHED

______ BILLED

________ REQUEST PATIENT FOLLOW-UP

Signature of crew submitting paperwork

____

Patient's Name

____