PROTOCOL DEVIATION FORM

Agency Name: ____________________________________

Incident Number: ______________________

Date: ________________________________

Time: ________________________________

Type of Deviation:

☐ Procedure

☐ Medication

☐ Destination

☐ Other: ______________________

HOSPITAL/PHYSICIAN INFORMATION

Where was the patient transported? ____

Was the Physician contacted prior to the protocol deviation? ☐ Yes ☐ No

Physician Name: ________________________________

Method of Contact: ☐ Radio ☐ Telephone

CREW INFORMATION

Name: ____

SNHD EMS Number: ____________

Certification Level: ______________

Name: ____

SNHD EMS Number: ____________

Certification Level: ______________

Specific Details:

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