PROTOCOL DEVIATION FORM

Agency Name: _____

Incident Number: _____

Date: _____

Time: _____

Type of Deviation:

☐ Procedure

☐ Medication

☐ Other: _____

HOSPITAL/PHYSICIAN INFORMATION

Where was the patient transported? _____

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

Physician Name: _____

CREW INFORMATION

Name: _____

SNHD EMS Number: _____

Certification Level: _____

Name: _____

SNHD EMS Number: _____

Certification Level: _____

What is the specific deviation? (Do not describe why, simply state what it was.)

_____

_____

Why did this occur?

_____

_____

_____

_____

Attach a separate sheet of paper if more space is needed.