PROTOCOL DEVIATION FORM

Agency Name: ________________________________

Incident Number: _______________ Type of Deviation: □ Procedure
Date: ___________________________ □ Medication
Time: ___________________________ □ 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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