Northern Virginia Quality Assurance Report For
Emergency Department Re-Route Issues

Incident Number	Date	Ambulance/Medic Unit
Patient Name	Communications RN Name	
Hospital	Accepting RN Name	
Name of Person Submitting Report	Charge MD Name	
Arrival to Triage Time	Witness Name (If Applicable)	

If applicable, indicate below the original destination hospital, and the hospital to which the patient was diverted. Additionally, indicate each hospital's status at the time of the diversion.

Original Hospital Destination	ED Re-Route	ED Closed
Final Hospital Destination	ED Re-Route	ED Closed

Please describe the events in detail (using back of sheet if necessary). Be sure to include a brief summary of the patient's condition. You may also attach a separate sheet.

When you have completed this form, please attach a photocopy of your Patient Care Report, including any relevant documents, and forward to the appropriate EMS or Hospital ED Supervisor.

Confidential: Prepared for review by EMS Agency and Hospital Supervisors functioning primarily to review adequacy or quality of professional services.

Privileged under VA Code Ann. 8.01.581.17 NOT PART OF MEDICAL RECORD

Northern Virginia Quality Assurance Report For Emergency Department Re-Route Issues