OHIOHEALTH EMS FEEDBACK FORM

Submit to the EMS Coordinator or ED Manager at the Receiving OhioHealth Facility.

PURPOSE		
☐ Compliment / Complaint / Suggestion / Other ☐ Patient Follow-up Request → May also be submitted via email to **EMSOutcomes@OhioHealth.com**		
REQUESTER INFO		
Your Name:	Date Submitted:	
EMS Agency:	City	County
Station #:	Shift / Unit Day:	
Phone:	Work Email:	
EMS AGENCY INFO		
EMS Coordinator:	Title:	
Phone:	Work Email:	
PATIENT INFORMATION **Follow-Up Information Will Be Emailed To The EMS (Performance Improvement) Coordinator's Work Email Address via OhioHealth's Secure Email System.**		
Incident / Run #:	Transported By (Medic/Squad #):	
Transport Date:	Time at ED:	
Patient Name:	DOB:	☐ Male ☐ Female
Primary Complaint / Mechanism of Injury:		
ADDITIONAL INFORMATION | COMMENTS		
☐ Continued on Back		

OhioHealth