LFEMSC Quality Improvement Template

Shortness of Breath

Date and Time of Incident ________________________

Incident Number ________________________

Provider Name/Level of Certification ________________________

Nature of Call/Incident Type ________________________

Documentation	Chief complaint	☐ Yes	☐ No
	Vital Signs including O2 Sat	☐Yes	☐ No
	Breath Sounds documented	☐ Yes	☐ No
	Care appropriate/Protocols Followed.	☐ Yes	☐ No

If Not Why______

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Action Needed: ☐ No

☐ Yes ______________

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Referred to OMD for review ☐ No

☐ Yes Date______

Oct. 2005)