# St. Elizabeth Healthcare
# Pre-Hospital Patient Follow-Up

**Please Print:** Date:_____
**Circle**

**Hospital:** Covington Edgewood Florence Ft. Thomas Grant

Squad _____Run Date:_____

Mailing Address_____

Requested By:_____

Quality Assurance Officer:_____

Contact Number:_____

Patient Transported: ALS BLS

Patients Name:_____

SS#_____Birth Date_____

Chief Complaint:_____

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**Follow Up Report:**

Patient Diagnosis:_____

ER Treatment:_____

_____

_____

_____

Length of stay_____ Discharge Date_____

**All reports will be mailed directly to EMS Departments Quality Assurance Officer**.