HEMS Medical Control Authority Epi-Kit Usage Form

June 13, 2019                                    Section 15-12

This form **MUST** be completed with every MFR/BLS Epi-Kit use. It **MUST** be attached to the run report *and sent* to HEMS for tracking purposes.

Phone: 734 727-7280       Fax: 734 727-7281       Email: mail@hems.org

AGENCY/UNIT: _______________________________________________ / ______________

DATE: _______________________               INCIDENT NUMBER: _____________________

EMS CREW (NAMES) ______________________________________________ ________

Receiving Hospital:  __________________________________________ ____________

Patient Chief Complaint:  _____________________________________ _________________

Were you confident in your ability to draw up and administer the required initial dose of Epinephrine?

**YES** ☐  **NO** ☐

Please explain: _______________________________________________ _____________
______________________________________________________________________________

Did the Epinephrine (EPI) improve the patient’s condition?

**YES** ☐  **NO** ☐

Please explain: _______________________________________________ _____________
______________________________________________________________________________

Did the patient require a second dose of Epinephrine?

**YES** ☐  **NO** ☐

Please explain: _______________________________________________ _____________
______________________________________________________________________________