



**2017 ANNUAL INTERIOR REGION EMS SURVEY**  
**Reporting Period: January 1 - December 31, 2016**

**YOU WILL BE REQUIRED TO COMPLETE THIS FORM IF YOU RECEIVED A MINI-GRANT FOR FISCAL YEAR 2017 (July 1, 2016 - June 30, 2017) OR SUBMIT A REQUEST FOR CODE BLUE FUNDS**

**Deadline for Reporting: July 30, 2017 or with the Code Blue Grant Request for Phase 17 or the FY18 Mini-Grant Request.**

*Eligibility for mini-grants, Code Blue/Capital Equipment & other grants is dependent on this survey being submitted by the deadline.*

Name of Service: \_\_\_\_\_

Chief / Head of Service: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Physical Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Name & Title of Person Completing Survey: \_\_\_\_\_

This form is available online at [www.iremsc.org](http://www.iremsc.org)

This EMS survey will provide basic data about the EMS systems within the Interior Region. The data will be used for local, regional and statewide planning and evaluation; grant applications; improving training; other EMS pro- gram related aspects and funding requests. Both ground ambulance and first responder services are included in this survey.

This survey is particularly important to help capture data from services who are not yet reporting to the state's AURORA electronic data system, and to include first responder service data into our regional EMS response statistics. If you have any questions about AURORA, please contact: Wilma Vinton at 907 456-3978.

**If your service is currently collecting prehospital data electronically, you may attach a summary report in place of the *Patient Encounters* page which contains the requested information from that page.**

*Thank you for taking the time to complete this important survey. If you have any questions, please call Dan Johnson at 907 456 3978*

*To submit the Survey:*

*Email Address: [djohnson@interioremscouncil.org](mailto:djohnson@interioremscouncil.org) with the subject I R E M S C "EMS Survey"*

*Mailing Address:  
2503 18<sup>th</sup> Avenue  
Fairbanks, AK 99709*

## Service Information

Are you an Alaska Certified EMS Service? Yes No

List the numbers of personnel you have in your service, their provider level, and if they are paid or volunteer. For "other" list all other personnel such as drivers, assistants, trained ETT and First Responders, etc.

Type of Provider	Number That are Paid with Salary or Wage	Number that are Volunteer	Per Run Pay or Stipend if Applicable for Volunteers
ETT			
EMT 1			
EMT 2			
EMT 3			
Paramedic			
Other (describe)			

- Please check all types of communications used for emergency response by your service:

Cell Phone \_\_\_\_\_ Telephone \_\_\_\_\_ Marine VHF \_\_\_\_\_ VHF \_\_\_\_\_

ALMR \_\_\_\_\_ Satellite Phone \_\_\_\_\_ Sat phone number: \_\_\_\_\_

HAM radio: \_\_\_\_\_ Other – Please list:

- Does your agency have access to the internet? Yes No

If yes, PLEASE list the following information about your primary internet access:

Location: \_\_\_\_\_ (e.g. EMS station, fire station, clinic, community center, squad member's home, etc.).

Internet Access Type: \_\_\_\_\_ Satellite \_\_\_\_\_ Cable \_\_\_\_\_ DSL \_\_\_\_\_ Dial-up

Access Speed, (answer "?" for unknown): \_\_\_\_\_ Upload \_\_\_\_\_ Download

- Does your service fill out a pre-hospital patient care report (run sheet/PCR) for every patient you treat? Yes No
- Do you provide a completed run sheet / PCR to the receiving provider or facility (clinic, hospital, medevac team)? Yes No
- If using electronic run sheet /PCR, what software are you using? AURORA   
Other : Please list: \_\_\_\_\_
- Do you plan to participate in the AURORA EMS data system? Yes No
  - Do you need training in the AURORA EMS Data system? Yes No
  - Does your agency routinely receive information on patient outcomes? Yes No

• Does your service do run reviews? Yes No If yes how often: \_\_\_\_\_

• What is the emergency contact number or system in your community?

911 \_\_\_\_\_ Other- please list \_\_\_\_\_

• How do you call out your responders? \_\_\_\_\_

• Does your service / group meet for EMS training? Yes No

• How often does your service / group meet for training? \_\_\_\_\_

• Do you maintain responder training records? Yes No

• What training does your service have difficulty obtaining?

CPR \_\_\_\_ ETT \_\_\_\_ ETT-EMT-1 Bridge \_\_ EMT-1 \_\_\_\_ EMT-2 \_\_\_\_ EMT-3 \_\_\_\_

EMT Refresher \_\_\_\_ Pediatric \_\_\_\_ Continuing medical education/ CME \_\_\_\_

\_\_\_\_ Other – please list: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Patient Encounters/ Patient Statistics

1. Did your service submit data to AURORA for the full **2016** Calendar year? Yes No  
*If yes, you do not need to fill out questions 2 - 4 however, you must attach a summary report which contains the following information:*
  - Number of EMS Responses, including standbys, false alarms or cancelled calls
  - Number of Patients evaluated, treated, and/or transported
  - *Age range of patients : < 1 year; 1-14 years; 15 and up*
  - Chief Complaint information on patients include above.
  
2. How many times did your service respond to an EMS call, including patient care standbys, false alarms, refusals or cancelled runs, between **January 1, 2016- December 31, 2016**?  
 Total number of responses \_\_\_\_\_
  
3. How many EMS patients were evaluated, treated or transported by your service during **2016**? Total number of patients: \_\_\_\_\_  
 Number of patients: Less than one year \_\_\_\_; 1 – 14 years \_\_\_\_; 15 and up \_\_\_\_
  
4. List the number of patient contacts by the patient's primary medical problem or injury below.  
 List at least one per patient.

- Altered Level of Consciousness
- Abdominal Pain/problems
- Allergic Reaction Type if known
- Burns

Cardiac

- Cardiac Arrest
- Chest Pain/Discomfort
- Cardiac – Other Please list:  
\_\_\_\_\_

- Diabetic
- Drowning
- Suspected Drug/Substance use
- Suspected Alcohol use
- Frostbite
- Hypothermia
- OB
- Deceased – no treatment
- Suspected Poisoning

Respiratory

- Respiratory Arrest
- Respiratory Distress
- Smoke Inhalation
- Respiratory Other Please list:  
\_\_\_\_\_

- Seizure
- Stroke
- Trauma
- General Illness
- Other – please list:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_