

Name of Service: _____

Head/Chief of Service: _____

Mailing Address: _____

Phone: _____ Fax: _____

Email: _____

Name & Title of Person Completing Survey: _____



THE ANNUAL SOUTHERN REGION EMS SURVEY

Reporting Period: January 1 - December 31, 2011

This EMS survey will provide basic data about the EMS system within the Region. The data will be used for local, regional, and statewide planning and evaluation; improving training; injury prevention efforts and funding requests. Both ground ambulance and first responder services are included in the survey.

The State of Alaska now has the electronic web-based data reporting system, AURORA, which is free to all services. Jane Schultz is the Regional Technical Expert/Trainer for AURORA. Her contact information is 283-9322 or jschultz@sremsc.org. We are very excited about the project and look forward to working with you as your service transitions into this system.

"If you are currently collecting prehospital data electronically,
simply attach a summary report which contains the requested information to this form."

Thank you for taking the time to complete this important survey. If you have any questions, please call Sue Hecks, Executive Director at Southern Region 562-6449 or shecks@sremsc.org.

To submit the survey:

Email Address: rmorrison@sremsc.org - Subject "Survey"

Mailing Address: 6130 Tuttle Place, Anchorage, AK 99507

Please return this survey to our office by May 1, 2012.

Eligibility for mini-grants, Code Blue/Capital Equipment & other grants is dependent on this survey being submitted by the May 1, 2012 deadline.

Service Information

- Does your agency routinely receive information on patient outcomes? _____ Yes _____ No
- Does your service need training in AURORA? _____ Yes _____ No
- Does your agency have access to the internet? _____ Yes _____ No

If yes, list location (EMS Bldg., Fire Hall, Clinic, Community Center): _____

Internet Access Type: _____ Satellite _____ Cable _____ DSL _____ Dial-up

Access Speed, if known: _____ Upload _____ Download

- Does your agency fill out an EMS patient care report for every patient you see? ____ Yes ____ No
- List the numbers of personnel you have in your service, their provider level, and if they are paid or volunteer.

	# Career/ Salaried			# Volunteer			Turn-out Pay/Stipend Amount		
	1	2	3	1	2	3	1	2	3
EMTs									
ETTs									
Other (Describe Other)									

First Responder Services:

- How often does your First Responder group meet for training? _____
- Please list all means of patient transportation you have in your community:

Patient Encounters

- How many times did your service respond to an EMS call, including patient care, standbys, false alarms, or cancelled runs, between January 1, 2011 & December 31, 2011? _____
- How many EMS patients were evaluated, treated or transported by your service during 2011? _____
- Did your service submit data to AURORA for the full 2011 calendar year? _____ Yes _____ No
(If yes, you do not need to fill out questions 4 & 5.) If you are currently collecting prehospital data electronically, simply attach a summary report which contains the requested information to this form.

Patient Encounters (continued)

4. List the number of patient contacts by the patient's primary medical problem or injury below.

<p>_____ Altered Level of Consciousness</p> <p>_____ Abdominal Pain/problems</p> <p>_____ Allergic Reaction</p> <p>_____ Back Pain (non-traumatic)</p> <p>_____ Behavioral/Psychiatric Disorder</p> <p>_____ Burns</p> <p>_____ Cardiac</p> <p style="padding-left: 20px;">_____ Arrest</p> <p style="padding-left: 20px;">_____ Chest Pain/Discomfort</p> <p style="padding-left: 20px;">_____ Cardiac Rhythm</p> <p style="padding-left: 40px;">Disturbance</p> <p style="padding-left: 20px;">_____ Cardiac - other</p> <p>_____ Diabetic</p> <p>_____ Drowning/Near Drowning</p> <p>_____ Drug/Substance Abuse</p> <p>_____ ETOH/Alcohol Abuse</p> <p>_____ Frostbite</p> <p>_____ Hypothermia</p> <p>_____ Hypovolemia/Shock</p> <p>_____ OB</p> <p>_____ Obvious death</p> <p>_____ Poisoning/Drug Ingestion</p>	<p>Respiratory</p> <p>_____ Airway Obstruction</p> <p>_____ Arrest</p> <p>_____ Asthma</p> <p>_____ COPD/Emphysema/ Chronic Bronchitis</p> <p>_____ Respiratory Distress</p> <p>_____ Smoke Inhalation</p> <p>Respiratory Other: _____</p> <p>_____ Seizure</p> <p>_____ Stroke</p> <p>_____ Trauma</p> <p>_____ Unconscious</p> <p>_____ Other - Please list: _____</p> <p>_____</p> <p>_____</p> <p>_____ TOTAL (Should match the number of patient contacts listed in #2 in Patient Encounters.)</p>
--	---

Communications

The FCC requires that all communication systems be narrow banded by January 1, 2013. (If using ALMR – this system is already compliant)

1. Have you updated your FCC radio license to meet new FCC requirements?

Yes _____ No _____ Date planned to do so _____

2. Do you have the funding to bring your system up to narrow band compliance?

Yes _____ No _____

3. Do you have a plan in place to meet the narrow banding requirements by the deadline date?

Yes _____ No _____

4. Please check all types of communications used for emergency response in your service:

_____ Cell Phone	_____ Telephone	_____ Marine VHF
_____ VHF	_____ ALMR	_____ Satellite Phone
Other - Please list: _____		

5. What is your emergency number in your community?

_____ 911 Other - please list _____