Central New York Emergency Medical Services Program
Epinephrine Auto-Injector Quality Improvement

Name of Organization____

Date of incident______________________ Time of incident______________________

Patients Age___________________ Patients sex Male Female

Estimated time from incident to administration in minutes _______________________

Patients condition prior to administration__________________________________

Patients condition after administration ___________________________________

Name of transporting service ____

Name of hospital transported to ____

Other pertinent information ____

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Please complete and mail this form, using the address below,
promptly after each auto-injector use.
Thank you for your cooperation.

Central New York Emergency Medical Services, Inc.
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