

Epinephrine Auto-Injector
Incident Report



Name of Organization _____

Date of Incident _____ Time of Incident _____

Patient's Age _____ Patient's Sex: Male _____ Female _____

Estimated time from incident to administration (in minutes) _____

Patient's condition prior to administration _____

Patient's condition after administration _____

Name of transporting service _____

Name of hospital transported to _____

Other pertinent information/Comments _____

Please complete and mail this form to:
Central New York Emergency Services, Inc.
Jefferson Tower, Suite LL1
50 Presidential Plaza
Syracuse, NY 13202

Epinephrine Auto-Injector
Incident Report



Name of Organization _____

Date of Incident _____ Time of Incident _____

Patient's Age _____ Patient's Sex: Male _____ Female _____

Estimated time from incident to administration (in minutes) _____

Patient's condition prior to administration _____

Patient's condition after administration _____

Name of transporting service _____

Name of hospital transported to _____

Other pertinent information/Comments _____

Please complete and mail this form to:
Central New York Emergency Services, Inc.
Jefferson Tower, Suite LL1
50 Presidential Plaza
Syracuse, NY 13202