



Peninsulas EMS Council, Inc., PO Box 2348 Gloucester, Virginia 23061
(804) 693-6234, Fax (804) 693-6277

CRITICAL INCIDENT STRESS TEAM SERVICE REPORT

Contact Date _____ Approximate Time _____

Incident Date _____ Incident Time _____

Contact Person _____ Contact Number _____

Nature of Incident / Request _____

Agency Liaison (if Different from Contact Person) _____

Liaison Phone number _____

Action Plan (check one)

| | |
|--|--|
| <input type="checkbox"/> On Site | <input type="checkbox"/> Consultation |
| <input type="checkbox"/> Defusing | <input type="checkbox"/> Educational Session |
| <input type="checkbox"/> Debriefing | <input type="checkbox"/> Meeting |
| <input type="checkbox"/> Individual Intervention | <input type="checkbox"/> Follow Up |
| <input type="checkbox"/> Stress Meeting/Referral | <input type="checkbox"/> Other (specify) |

Intervention Location _____ Date _____

Start Time _____ Finish Time _____

Team Members Participating:

Mental Health _____,

Peers _____,

PEMS CISM Team Intervention Report
Page 2 of 2

Providers Participating (include Numbers)

| EMS | Fire | Law | Hosp | Comm | Other (Specify) |
|-----|------|-----|------|------|-----------------|
| | | | | | |

Did the service/intervention differ from that planned? If so, describe how.

Give a brief description of the service provided. Use the back of this form if necessary.

Does a follow up need to be planned and what is recommended?

Submitted by _____

Date _____