



## State of Nebraska Trauma Consultation/Designation Evaluation Form

**Hospital**

**Date**

**Your Name**

**Review Date**

**Title**

### **Administrative Process**

1-Poor 2=Fair 3=Satisfactory 4=Good 5=Excellent

Ease of Scheduling Visit

Ease of Completing Pre-Review Questionnaire

Information Provided Prior to Visit by EMS/Trauma Office

Information Provided Prior to Visit by Regional TNC

Overall Ease of Communication with Lead Reviewer

Comments:

### **Site Visit**

1-Poor 2=Fair 3=Satisfactory 4=Good 5=Excellent

Professionalism of Reviewers

Impartiality of Reviewers

Helpfulness of comments by Reviewers

Criteria Deficiencies were Clearly Identified

Recommendations were Clearly Explained

Questions Clearly Answered

Overall Satisfaction with Review Team

Overall Satisfaction with Site Visit

Comments:

**Written Report**

1-Poor 2=Fair 3=Satisfactory 4=Good 5=Excellent

Report was Factual

Report was Thorough

Report was Clearly Written

Report was Timely

Questions Clearly Answered

Comments:

**Additional Comments:**

**Submit to:** Sherri Wren  
Trauma Program Manager  
Nebraska Dept. of Health & Human Services  
EMS/Trauma Program  
301 Centennial Mall South  
P.O. Box 95026  
Lincoln, NE 68509-5026  
[sherri.wren@nebraska.gov](mailto:sherri.wren@nebraska.gov)

**To send electronically: complete and then save the form and attach to an e-mail to Sherri.**