

PAEMS

Must be faxed to 655-2090 within 48hrs

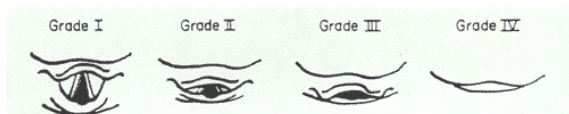
AIRWAY MANAGEMENT DATA COLLECTION FORM

Please answer ALL of the following questions (circle/check/fill-in) for ANY patient requiring airway management.

1. Trauma Medical Unsure 2. Age: _____ yrs / months (if < 1 y/o) 3. Sex M F
4. Cervical spine immobilized: Yes No If Yes: Before intubation After intubation
5. Intubation attempted (blade inserted): Yes No If No, why? Difficult Airway Other _____
6. Reason for airway management: GCS < 9 Respiratory distress Arrest Airway trauma Medical problem Other _____
7. Pre-Oxygenation: Yes No 8. Bag Valve Mask: Yes No

ETT

- 9a. Number of times blade inserted: 1 2 3 N/A
- 10a. Number of times attempted to pass ETT: 1 2 3 N/A
- 11a. Laryngoscope Grade (Check): 1 2 3 4



- 12a. Intubation successful: Yes No
- 13a. If No, Why? Inadequate relaxation _____
- Blood/vomit/secretions in airway Cords not visualized
- Epiglottis not visualized Other / explanation: _____
- 14a. Method: Orotracheal Reverse Orotracheal (face to face)

King Airway

- 9b. Number of attempts _____
- 10b Size _____
- 11b OG tube used _____
- 12b Successful ___ Yes ___ No
- 13b If No, Why? Resistance ___ Emesis ___
- Trauma ___ Other ___ Explain: _____
- 14a Inflation ml _____

15. Airway eventually controlled successfully? Yes No
16. Tube secured with: Tape Commercial Device Other: _____
17. Auscultation bilaterally at axilla with good air exchange? Yes No Air sounds in epigastrium? Yes No
18. Continuous capnography monitoring device used? Yes No If not, why not? _____
- If used: Good wave form Yes No **AND** ETCO2 reading post intubation: _____ mm/Hg;
19. Was ETCO₂ monitored? Yes How? Colorimetric other _____ No Why not? _____
20. SPO₂ pre-intubation: _____% Lowest SPO₂ during intubation _____% SPO₂ post-intubation: _____% Unavailable Not Used
21. Complications: emesis/aspiration O₂ sat fall Arrest Arrhythmia Bradycardia (pulse < 60 or decrease by = 20 bpm)
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. Verification of ET placement by MD/RN/RT/EMT-P (check one): Good placement Tube misplaced upon transfer of care

Patient not transported or care not transferred - Please explain: _____

. Name of verifying provider (print): _____ Signature of verifying provider: _____

Name of destination hospital: _____ Date: / / Time of Day: _____

EMS Service Name: _____ Primary Medical Control Hospital Name: _____

. Name of EMS Provider (Print): _____

PLEASE WRITE ADDITIONAL COMMENTS ON THE BACK OF THIS FORM