Westchester Regional Emergency Medical Advisory Committee

BLS CPAP QA / QI Report Form

IN THE EVENT OF EMT CPAP USE COMPLETE THE FOLLOWING - Please type or print legibly

Agency Name _____

Transport Ambulance Service (if different) _____

Call Date _____ **Call Time** _____ **Receiving Hospital** _____

PATIENT INFORMATION **Gender** *(Check one)* ☐**Female** ☐**Male** **Age** _____

INITIAL VITAL SIGNS

GCS: E ____ V ____ M ____ **Heart Rate:** _____ **Respiration:** **Rate** _____ **Quality** ☐ Shallow ☐ Normal ☐ Labored

BP _____ **SPO_2** *(if available)* _____ ☐On Room Air ☐On Oxygen *(How much?* _____*LPM)*

FINAL VITAL SIGNS

GCS: E ____ V ____ M ____ **Heart Rate:** _____ **Respiration:** **Rate** _____ **Quality** ☐ Shallow ☐ Normal ☐ Labored

BP _____ **SPO_2** *(if available)* _____ ☐On Room Air ☐On Oxygen *(How much?* _____ *LPM)*

REASON FOR CPAP: *(Check all that apply)*

- ☐COPD/Asthma
- ☐Pulmonary Edema
- ☐ Pneumonia
- ☐ Submersion/drowning
- ☐ Smoke inhalation
- ☐Other _____

What was the CPAP Setting used that achieved the desired effect? _____ mmhg

Do you feel the use of CPAP had any significant **POSITIVE** effect on the patient condition? ☐**YES** ☐**NO**

Approximately how long did patient receive CPAP therapy? _____ minutes

Did the patient receive a nebulizer treatment through the CPAP device? ☐**YES** ☐**NO**

*If YES, how many treatments?*_____

Was ALS requested? ☐**YES** ☐**NO**

Was ALS available? ☐**YES** ☐**NO**

If you did not have CPAP how would you have assisted this patient? ☐ **BVM** ☐ **NRB** ☐ **Other**_____

Send this form and a copy of the PCR to the Westchester Regional EMS Office by
FAX (914-813-4161) or EMAIL admin@wremsco.org.

Please provide any other pertinent information and/or comments regarding this event on the back of this page.
☐ Check here if the back of this sheet was used for additional comments.