Westchester **R**egional **E**mergency **M**edical **A**dvisory **C**ommittee

Epinephrine Auto-Injector (EAI) Use Report Form

To be completed by the EMS Provider in-charge (whether a patient was assisted with his/her own EAI OR the EMS agency's).
Submit to Regional EMS Office:

- **Ambulance Services:** Attach copy of the PCR, including the PCR Continuation form, or a printout of the complete ePCR.
- **BLSFR Agencies:** Attach copy of the BLSFR PCR, or other NYSDOH approved medical report.

Agency Code: _____ **Agency Name:** _____

Date of Event: _____ **Location Code:** _____ **Dispatch Info:** _____

1. **Patient has a history of *(Please check all that apply)*:**
   - ☐ Anaphylaxis *(SEVERE allergic reaction)*
   - ☐ Recent exposure to possible allergen or inciting agent
   - ☐ Other Allergic Reactions
   - ☐ None of the above
2. **Indications *(Please check all that apply)*:**
   - ☐ Severe Respiratory Distress
   - ☐ Signs of Hypoperfusion *(Shock)*
   - ☐ Patient has a prescription for an EAI
   - ☐ None of the above
3. **Oxygen Administration:**
   - ☐ Nasal Cannula (Flow rate: _____ LPM)
   - ☐ Non-Rebreather (Flow rate: _____LPM)
   - ☐ Bag Valve Mask (BVM) (Flow rate:_____LPM)

   For ILS Services ONLY:
   - ☐ Advanced Airway *(e.g. ETT, King, Combi-tube)*
4. **EAI Administration:**
   - ☐ Used Patient's EAI
   - ☐ Used EMS Agency's EAI

   *Total # of EAI's administered:*_____ *Time administered: 1st EAI:*_____ *2nd EAI:*_____
5. **On-Line Medical Control (OLMC) Contact:**
   - ☐ No
   - ☐ Yes

   If YES, please complete Hospital / Physician information

   *Hospital:*_____ *Physician Name:*_____
6. **Reason for OLMC Contact:**
   - ☐ Authorization to administer EAI to patient without a prescription
   - ☐ Authorization to administer a second EAI to the patient
   - ☐ Other: _____
7. **Patient Disposition:**
   - ☐ Refused Medical Assistance/Transport (RMA/T)
   - ☐ Other EMS (e.g. BLS ambulance service, ALS ambulance service)
   - ☐ Hospital *(Facility Name:* _____ *Disposition Code:* _____*)*

Report completed: *(Please print legibly)*

Name: _____ **EMT/AEMT#:** _____ **Date:** _____