

**ADVANCED AIRWAY MANEUVER FORM Version 3.0**

~Instructions on the Back~

**PART I: TO BE COMPLETED BY EACH PARAMEDIC/RN WHO ATTEMPTS AN ADVANCED AIRWAY MANEUVER:**

Date: _____ Incident #: _____ Receiving Hospital: _____		
Medic/RN/Intern/ # _____ Time since last ET _____ Years as Paramedic _____		
Agency: _____ Base Hospital :(for field-termination): _____		
Patient: <input type="checkbox"/> M <input type="checkbox"/> F Age: _____ Weight: _____ Height: _____	<u>O2 Saturation /CO2</u> Initial: _____ / _____ Lowest: _____ / _____ Highest: _____ / _____ Not registering: _____ / _____	<u>Indication for Intubation:</u> <input type="checkbox"/> Medical Cardiac Arrest <input type="checkbox"/> Traumatic Arrest <input type="checkbox"/> Respiratory Arrest/Hypoventilation <input type="checkbox"/> Airway Protection <input type="checkbox"/> Airway Injury/Obstruction
<u>1<sup>st</sup> Attempt Made</u> Tube Inserted: <input type="checkbox"/> Yes <input type="checkbox"/> No Tube Type: <input type="checkbox"/> ET Size: _____ Depth: _____ cm <b>Pt. Location:</b> Floor <input type="checkbox"/> Gurney <input type="checkbox"/> Other: _____ Blade: Mac <input type="checkbox"/> Miller <input type="checkbox"/> G.View <input type="checkbox"/> Adjuncts: Bougie <input type="checkbox"/> Video Assist <input type="checkbox"/> Suction <input type="checkbox"/> RSI <input type="checkbox"/> Cric. Press. <input type="checkbox"/> Other _____	<u>2nd Attempt Made</u> Tube Inserted: <input type="checkbox"/> Yes <input type="checkbox"/> No Tube Type: <input type="checkbox"/> ET Size: _____ Depth: _____ cm <b>Pt. Location:</b> Floor <input type="checkbox"/> Gurney <input type="checkbox"/> Other: _____ Blade: Mac <input type="checkbox"/> Miller <input type="checkbox"/> G.View <input type="checkbox"/> Adjuncts: Bougie <input type="checkbox"/> Video Assist <input type="checkbox"/> Suction <input type="checkbox"/> RSI <input type="checkbox"/> Cric. Press. <input type="checkbox"/> Other _____	<u>3rd Attempt Made</u> Tube Inserted: <input type="checkbox"/> Yes <input type="checkbox"/> No Tube Type: <input type="checkbox"/> ET Size: _____ Depth: _____ cm <b>Pt. Location:</b> Floor <input type="checkbox"/> Gurney <input type="checkbox"/> Other: _____ Blade: Mac <input type="checkbox"/> Miller <input type="checkbox"/> G.View <input type="checkbox"/> Adjuncts: Bougie <input type="checkbox"/> Video Assist <input type="checkbox"/> Suction <input type="checkbox"/> RSI <input type="checkbox"/> Cric. Press. <input type="checkbox"/> Other _____
<b>If ET was not placed, indicate alternative airway management technique(s) used &amp; complete comments section below:</b> <input type="checkbox"/> BVM <input type="checkbox"/> OPA <input type="checkbox"/> NPA <input type="checkbox"/> High Flow O2 <input type="checkbox"/> Needle Cric		
<u>Airway Confirmation Method(s) Used:</u> <input type="checkbox"/> End-Tidal CO2/Wave Form Capnography <input type="checkbox"/> End-Tidal CO2 Detector Device (colorimetric) <input type="checkbox"/> Air Aspiration Esophageal Detector <input type="checkbox"/> Stethoscope-Lung Sounds <input type="checkbox"/> Stethoscope-Epigastric Sounds <input type="checkbox"/> Other: _____		
<u>Result(s):</u> <input type="checkbox"/> Peak Value: Initial: _____ ED Arrival: _____ <input type="checkbox"/> Yellow/Tan <input type="checkbox"/> Purple <input type="checkbox"/> Air Return <input type="checkbox"/> No Air Return <input type="checkbox"/> Equal/Bilat <input type="checkbox"/> R / L Side <input type="checkbox"/> Absent <input type="checkbox"/> No <input type="checkbox"/> Yes		
Medic Comments: (Explanation of confounding factors) _____ _____		

**PART II: TO BE COMPLETED BY BASE HOSPITAL PHYSICIAN OR SECOND PARAMEDIC/RN (For Field-Terminated Patients Only):**

\*complete Part II

<u>ET Placement:</u> <input type="checkbox"/> Trachea <input type="checkbox"/> Mainstem Bronchus <input type="checkbox"/> Esophagus <input type="checkbox"/> Oropharynx	<u>Confirmation By:</u> <input type="checkbox"/> Auscultation <input type="checkbox"/> Direct Visualization <input type="checkbox"/> Pulse Oximetry <input type="checkbox"/> Capnography	<u>Outcome:</u> <input type="checkbox"/> Stabilized <input type="checkbox"/> Deceased/Terminated: <input type="checkbox"/> Field <input type="checkbox"/> ED <input type="checkbox"/> ED Disposition: _____
Physician / Paramedic Comments: <p style="text-align: center; font-size: 2em; font-weight: bold; color: gray;">DO NOT PLACE IN PATIENT CHART!</p> Physician / Paramedic Signature: _____		

- Forward completed form to provider agency's EMS Coordinator.
- Do not place this form in patient chart!

**ADVANCED AIRWAY MANEUVER FORM**

~Instructions~

- To be completed by **every Paramedic or RN who attempts** an advanced airway maneuver (ET tube or needle cricothyrotomy). Clearly note certification #. One form per Medic/RN.
- Record time interval since last intubation (months, weeks, etc) and record number of years certified as a paramedic.
- **“Attempt”** is an interruption of ventilation with insertion of endotracheal tube into the mouth. **Make a note in comment section when oral visualization made and suction required prior to attempt.**
- Record patient location when attempt is made –floor, gurney, back of pick-up. Etc
- **NEW:** Indicate blade type used (**added Grandview**) and adjuncts used (**added Bougie and King Vision or other video assist device**), stylet, suction. RSI, cricoid pressure, etc), REMOVED NT and references to it.
- Note method of placement verification. Use ETCO2 when available.
- Write confounding reasons for airway attempt failure/difficulties in the comments section. May use the space below for additional comments (if used, please remember to fax back side as well).
- Have the ED physician verify and sign for placement on all patients arriving at ED
- Disposition to be provided from Base Station Liaison to EMSA for patients admitted to hospital
- Send completed Advanced Airway Maneuver Form to your agency's EMS Coordinator. Provider EMS Coordinators will then collect Forms and related PCRs, review for completeness and forward to the EMSA each month.
- **Do not** place this form into patient chart!
- Reminder: Follow your provider agency's HIPAA policy when using or distributing this document and the corresponding Patient Care Report.
- "Why do I have to fill out this form?" Data collected from the previous study demonstrated that monitoring of performance is still necessary. The information will be used to determine if the enhanced training and performance requirements improve success rates and influence patient outcome.
- This form should also be used with training or elective intubation procedures (other than manikins)

Additional Comments for PART I: PARAMEDIC / RN

<b>DO NOT PLACE IN PATIENT CHART!</b>

Additional Comments for PART II: BASE HOSPITAL PHYSICIAN OR SECOND PARAMEDIC / RN

<b>DO NOT PLACE IN PATIENT CHART!</b>