Endotracheal Intubation

Audit Form

Please complete this form with each endotracheal intubation (oral or nasal) or intubation attempt. This form should be returned to the System Quality Assurance Coordinator within 48 hours of the call. You may fax this form to 856-6209. Please attach a copy of the $ETCO_2$ waveform strip to the form.

EMS Run Number: ______________

Date:_____________

Patient Age_______ (please circle) Years or Months

Patient Condition (please circle) Medical Trauma

Route of Intubation (please circle) Oral Nasal If intubation failed, was LMA placed? Yes No

County ID number for each person who attempts intubation and number of attempts by each person:

ID Number	Visualizations*	Attempts**	Successful

*Visualization is defined as a blade insertion and a "look" without an attempt to pass a tube

**Attempt is defined as the tip of the tube passing the teeth

Was it necessary to reintubate the patient due to an accidental or intentional dislodgement of the tube? (please circle) Yes No

If an attempt to reintubate a patient was made, please complete a second form

Protocol Used_____________________

ET Tube Size _________ Centimeter mark on tube:__________

Method(s) used to confirm placement (circle all that apply)

Breath Sounds Colorimetric CO_2 Ambu Check Condensation in tube

ET CO_2: Initial Reading______ Enroute to ED_______ At ED Arrival_______

Was ET tube/ LMA still inserted on arrival at the ED? (circle) Yes No

Was ET tube/ LMA in trachea/properly seated on arrival at the ED? (circle) Yes No

Who confirmed placement at the ED? Please print name and title____________________

Signature of person verifying placement of ET _________________________________

Signature and ID number of person completing this form__________________________