



CPAP Assessment

This form is to be completed in its entirety by prehospital/hospital personnel and is to follow the patient through the hospital stay to discharge

Patient's Name:			Date of Service:
Date of Birth:	Age:	Gender:	Social Security No.:
Transporting Agency:			
Name/Certification number of Attendant:			
Patient Care Report No:		Destination:	Transport Duration:

Past Medical History

<input type="checkbox"/> Hypertension	<input type="checkbox"/> Pulmonary Edema	<input type="checkbox"/> COPD	<input type="checkbox"/> Seizures	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> CVA	<input type="checkbox"/> Renal	<input type="checkbox"/> Other (list)		

Inclusion Criteria

The patient presents with signs and symptoms consistent with one of the following:

<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Pulmonary edema	<input type="checkbox"/> Asthma	<input type="checkbox"/> COPD	<input type="checkbox"/> Pneumonia
AND at least two of the following:	<input type="checkbox"/> Accessory muscle use/retractions	<input type="checkbox"/> O2 saturation <92%	<input type="checkbox"/> Respiratory rate >24	
	<input type="checkbox"/> Inability to speak in full sentences			

Prehospital Treatment

Oxygen @ ____LPM	<input type="checkbox"/> Cannula	<input type="checkbox"/> NRB	<input type="checkbox"/> Mask	<input type="checkbox"/> Other (list):	
<input type="checkbox"/> Albuterol 2.5mg	<input type="checkbox"/> Atrovent 500mcg	<input type="checkbox"/> Furosemide ____ mg	<input type="checkbox"/> Nitroglycerin .04mg/SL	<input type="checkbox"/> Morphine ____ mg	
<input type="checkbox"/> CPAP CMH20	Did patient tolerate CPAP?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Intubation required?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Perception of condition after CPAP:

Was CPAP discontinued prior to ER arrival?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, why?
Any procedural complications or technical problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what?

Time:	RR:	HR:	B/P:	SPO2:	CO2:	Cardiac Rhythm:
Time:	RR:	HR:	B/P:	SPO2:	CO2:	Cardiac Rhythm:
Time:	RR:	HR:	B/P:	SPO2:	CO2:	Cardiac Rhythm:
Time:	RR:	HR:	B/P:	SPO2:	CO2:	Cardiac Rhythm:

Comments:

Hospital Follow-Up

Condition of patient upon admission to ER:						
Did patient require intubation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> If yes, by whom?	<input type="checkbox"/> ED personnel	<input type="checkbox"/> ICU	<input type="checkbox"/> Floor	
Patient disposition:	<input type="checkbox"/> Admitted	<input type="checkbox"/> ICU	<input type="checkbox"/> CCU	<input type="checkbox"/> Floor	<input type="checkbox"/> Transferred to: _____	
Admission diagnosis:	<input type="checkbox"/> CHF	<input type="checkbox"/> COPD	<input type="checkbox"/> Asthma	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Other (list): _____	
Was patient discharged from ER to home or extended care facility? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Was CPAP indicated and/or used correctly? <input type="checkbox"/> Yes <input type="checkbox"/> No						

Unit/Floor Follow-Up

(Comment on patient condition during admittance to floor/unit)

Notes:

Length of stay:			
Patient discharged to:	<input type="checkbox"/> Home	<input type="checkbox"/> Extended Care Facility	<input type="checkbox"/> Other (list):

Return completed form to: Dr. Wayne Cayton
Region V EMS Medical Director
Route 2, Box 400
Washington, WV 26181