

REMO Airway Quality Improvement Form

Please Fax Completed Forms to REMO: (518) 464-5099

PCR# _____ REMAC# _____ Pt. Wt. _____ Pt. Age: _____ Date: ____/____/____

(1) Medic REMO # _____ Agency _____ Receiving Hospital# _____

(2) Medic REMO # _____ Agency _____ Intercept? No Yes Requesting Agency _____

Call Times: Initial Incident _____ Medic (1) Patient Contact: _____ Medic (2) Patient Contact: _____ To Destination: _____ At Destination: _____

Care Prior To Arrival	Airway Status on Arrival	Indication for Intubation	Neurologic Status	Medications Used/Dose
<input type="checkbox"/> CPR (Effective) <input type="checkbox"/> BVM / Mouth to Mask <input type="checkbox"/> Oral / Nasal Airway <input type="checkbox"/> Manual Management <input type="checkbox"/> ETT <input type="checkbox"/> Combitube <input type="checkbox"/> LMA <input type="checkbox"/> NONE	<input type="checkbox"/> Airway Not Open <input type="checkbox"/> Open - Pt Ventilating Well <input type="checkbox"/> Open - Not Ventilating Well <input type="checkbox"/> Open in Respiratory Arrest <input type="checkbox"/> Foreign Body Obstruction <input type="checkbox"/> Vomitus / Blood in Airway <input type="checkbox"/> Facial / Tracheal Trauma <input type="checkbox"/> Misplaced Airway Device	<input type="checkbox"/> Asthma / COPD <input type="checkbox"/> Cardiac Arrest / Apnea <input type="checkbox"/> CHF - CPAP Ineffective <input type="checkbox"/> CHF - CPAP Not Used <input type="checkbox"/> Multi Trauma <input type="checkbox"/> Stroke / Neurologic <input type="checkbox"/> Isolated Head Injury <input type="checkbox"/> Other _____	<input type="checkbox"/> GCS - Eyes (1-4) <input type="checkbox"/> GCS - Verbal (1-5) <input type="checkbox"/> GCS - Motor (1-6) <input type="checkbox"/> A x O (0-3) <input type="checkbox"/> Combative <input type="checkbox"/> Unresponsive <input type="checkbox"/> Suspected Drug/Acohol Use	<input type="checkbox"/> NONE <input type="checkbox"/> Vecuronium _____ <input type="checkbox"/> Lidocaine _____ <input type="checkbox"/> Etomidate _____ <input type="checkbox"/> Succinylcholine _____ <input type="checkbox"/> Versed _____ <input type="checkbox"/> Other _____

Attempt 1	Type of Intubation	Initial Confirmation	Pulse Oxygenation	Capnography	Complications
Tek #:	<input type="checkbox"/> Nasal <input type="checkbox"/> Oral <input type="checkbox"/> Rescue Device	<input type="checkbox"/> ETT visualized through cords <input type="checkbox"/> Unable to visualize <input type="checkbox"/> Tube fogging <input type="checkbox"/> Epigastric sounds absent <input type="checkbox"/> Lung sounds present	<input type="checkbox"/> Before attempt <input type="checkbox"/> Lowest <input type="checkbox"/> After attempt If not available, why?	Initial reading _____ End reading _____ Adequate waveform? <input type="checkbox"/> No <input type="checkbox"/> Yes If not available, why?	<input type="checkbox"/> NONE <input type="checkbox"/> Vomiting and/or Aspiration <input type="checkbox"/> Esophageal Placement <input type="checkbox"/> HR ↑ / ↓ <input type="checkbox"/> Other _____

Attempt 2	Type of Intubation	Initial Confirmation	Pulse Oxygenation	Capnography	Complications
Tek #:	<input type="checkbox"/> Nasal <input type="checkbox"/> Oral <input type="checkbox"/> Rescue Device	<input type="checkbox"/> ETT visualized through cords <input type="checkbox"/> Unable to visualize <input type="checkbox"/> Tube fogging <input type="checkbox"/> Epigastric sounds absent <input type="checkbox"/> Lung sounds present	<input type="checkbox"/> Before attempt <input type="checkbox"/> Lowest <input type="checkbox"/> After attempt If not available, why?	Initial reading _____ End reading _____ Adequate waveform? <input type="checkbox"/> No <input type="checkbox"/> Yes If not available, why?	<input type="checkbox"/> NONE <input type="checkbox"/> Vomiting and/or Aspiration <input type="checkbox"/> Esophageal Placement <input type="checkbox"/> HR ↑ / ↓ <input type="checkbox"/> Other _____

Attempt 3	Type of Intubation	Initial Confirmation	Pulse Oxygenation	Capnography	Complications
Tek #:	<input type="checkbox"/> Nasal <input type="checkbox"/> Oral <input type="checkbox"/> Rescue Device	<input type="checkbox"/> ETT visualized through cords <input type="checkbox"/> Unable to visualize <input type="checkbox"/> Tube fogging <input type="checkbox"/> Epigastric sounds absent <input type="checkbox"/> Lung sounds present	<input type="checkbox"/> Before attempt <input type="checkbox"/> Lowest <input type="checkbox"/> After attempt If not available, why?	Initial reading _____ End reading _____ Adequate waveform? <input type="checkbox"/> No <input type="checkbox"/> Yes If not available, why?	<input type="checkbox"/> NONE <input type="checkbox"/> Vomiting and /or Aspiration <input type="checkbox"/> Esophageal Placement <input type="checkbox"/> HR ↑ / ↓ <input type="checkbox"/> Other _____

Rescue Device	Complications	Comments
<input type="checkbox"/> Combi- Tube Placed <input type="checkbox"/> LMA Placed <input type="checkbox"/> OPA or NPA With BVM <input type="checkbox"/> Surgical Airway	<input type="checkbox"/> Desaturation below 90% <input type="checkbox"/> HR < 50 <input type="checkbox"/> Airway trauma <input type="checkbox"/> Patient demise	_____ _____ _____ Airway Coordinator Contacted: Date: ____/____/____ Time: _____

REMAC 3/06

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