Hudson Valley Mohawk REMO
Albuterol Administration Quality Improvement

This form is to be completed by the EMT/AEMT-I who has administered Albuterol to a patient using the REMO Albuterol protocol. This form should be returned, along with a copy of the completed PCR. These should be returned with the yellow copies of the PCRs by the 15th of the next month.

Agency: ________________________________________________

PCR Date: ___________ PCR#:__________________________

Transporting Ambulance:_____________________________________

Hospital Destination (if a transporting agency):________________________

Level of care administering Albuterol treatment: EMT ☐ AEMT-I ☐

Name of EMT/AEMT-I administering Albuterol treatment:________________________

1. Was the patient between 1 and 65 years of age? Yes ☐ / No ☐

2. Was the patient experiencing respiratory distress? Yes ☐ / No ☐

3. Did the patient have a past medical history of asthma? Yes ☐ / No ☐

4. Was Albuterol administered to this patient? Yes ☐ / No ☐

5. Was the Albuterol treatment repeated? Yes ☐ / No ☐

6. Were vital signs obtained/documented before and after each Albuterol treatment? Yes ☐ / No ☐

7. Were the times for each Albuterol treatment documented? Yes ☐ / No ☐

8. Was the patients’ past medical history documented? Yes ☐ / No ☐

9. Was ALS notified for this patient? Yes ☐ / No ☐

10. Did the patient report relief after the Albuterol treatment(s)? Yes ☐ / No ☐

Please provide any pertinent information / comments about this patient.