Regional Emergency Medical Organization

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Hudson Valley Mohawk REMO

CPAP Quality Improvement

This form is to be completed by the EMT/AEMT who has applied CPAP to a patient using the REMO CPAP 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 applying CPAP: EMT AEMT

Name and EMT# of EMT/AEMT applying CPAP:_____ # _____

1. Age of patient _____
2. Was the patient experiencing respiratory distress? Yes No
3. Did the patient have a past medical history of CHF/respiratory distress Yes No
4. Was CPAP applied to this patient? Yes No
5. Was CPAP continued? Yes No
6. Were vital signs obtained/documented before and after application? Yes No
7. Was the time for initiating CPAP treatment documented? Yes No
8. Was the patient's past medical history documented? Yes No
9. Was ALS notified for this patient? Yes No
10. Did the patient report relief after CPAP ainitiation)? Yes No
11. Were medications administered by ALS to this patient? Yes No Unknown

Please provide any pertinent information / comments about this patient.