North Country Regional Emergency Medical Advisory Committee

"Serving Jefferson, Lewis & St. Lawrence Counties"

www.ncemsprogramagency.org

BLS CPAP Therapy Screen

This regional screen should be completed for every patient that receives pre-hospital BLS CPAP therapy. The information you provide will be used to evaluate the effectiveness, safety, and frequency of use in our region. This **screen must be sent** to the Program Agency office with the PCR research copies by the 15th of the following month the PCR's are dated for or can be faxed/emailed to the Program Agency.

DATE ____/____/____ ______________________ (EMT IN CHARGE) __ __ __ __ __ __ (EMT NUMBER)

AGENCY NAME ______________________ **AGENCY CODE** __ __ __ __

Patient Information

Age: _____ ☐ **Male** ☐ **Female** **Respiratory Distress:** ☐ Moderate ☐ Severe

Vital Signs

Prior to treatment: Resp. _____ Pulse _____ BP ____/____ Room Air O²Sat _____%

Arrival at Hospital: Resp. _____ Pulse _____ BP ____/____ On CPAP O²Sat _____%

Reason for CPAP use?

☐ COPD/Asthma ☐ Pulmonary Edema ☐ Other: (Explain) ______________

☐ Pneumonia ☐ Submersion/drowning or smoke inhalation

Do you feel the use of CPAP had any significant effect on the patient condition?

☐ Improved ☐ Worsened ☐ No Obvious Change

Approximately how long did patient receive CPAP therapy? ______ Minutes

Did the patient receive a nebulizer treatment through the CPAP device? ☐ Yes ☐ No

Did you interface with ALS yes /no If no why not___________

If you did not have CPAP how would you have assisted this patient?

☐ BVM ☐ NRB ☐ Other______________

Approved – 9/21/15 AMS