

Flagstaff Medical Center CPAP Report Form

Agency: _____ Time of call: _____ Pt. age: _____	Date: _____ Arrival at hospital: _____ Sex: _____
<div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> Indication: <input type="checkbox"/> Pulmonary Edema/CHF <input type="checkbox"/> Asthma/COPD <input type="checkbox"/> Pneumonia <input type="checkbox"/> Submersion/Drowning <input type="checkbox"/> Smoke Inhalation </div> <div style="width: 48%;"> And 2 or more of the following criteria: <input type="checkbox"/> RR >24 <input type="checkbox"/> Notable increased work of breathing <input type="checkbox"/> SPO2 < 92% <input type="checkbox"/> Abnormal breath sounds/frothy sputum <input type="checkbox"/> Skin- mottling, pallor, cyanosis suggesting hypoxia </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 48%;"> Absolute contraindications: <input type="checkbox"/> Unconscious <input type="checkbox"/> SBP < 90 <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Recent facial or gastric surgery </div> <div style="width: 48%;"> <input type="checkbox"/> Respiratory Arrest/Agonal Respirations <input type="checkbox"/> Blunt/penetrating chest trauma/suspected pneumothorax <input type="checkbox"/> High risk of aspiration/active vomiting <input type="checkbox"/> Facial trauma/deformity/burns inhibiting proper mask fit </div> </div>	
DNR/DNI Orders Present: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown	
Medications administered before or in conjunction with CPAP: <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> Albuterol/Atrovent <input type="checkbox"/> Methylprednisolone <input type="checkbox"/> NTG </div> <div style="width: 10%; text-align: center;"> # of Doses: _____ </div> <div style="width: 45%;"> <input type="checkbox"/> Epinephrine 1:1,000 IM <input type="checkbox"/> Lasix </div> </div>	
<div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> CPAP continued to transfer: <input type="checkbox"/> Yes <input type="checkbox"/> No </div> <div style="width: 48%;"> CPAP discontinued for: <input type="checkbox"/> Intolerance <input type="checkbox"/> Respiratory Failure/Arrest <input type="checkbox"/> Altered Mental Status <input type="checkbox"/> Suspected pneumothorax <input type="checkbox"/> Hypotension <input type="checkbox"/> Other: _____ </div> </div>	
Time of patient contact to CPAP therapy: _____ min	
<div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> Initial PEEP: _____ V/S before CPAP: Time _____ BP _____/_____ P _____ R _____ SpO2 _____% Breath Sounds _____ </div> <div style="width: 48%;"> Final PEEP: _____ Final V/S: Time _____ BP _____/_____ P _____ R _____ SpO2 _____% Breath Sounds _____ </div> </div>	
Pt. final response: _____ Comments: _____ CPAP available in ED on arrival: <input type="checkbox"/> Y <input type="checkbox"/> N	

Attach copy of First Care form with this report. Please complete and send to PHC within 24 hours of event. Thank you for your cooperation in improving pre-hospital patient care and outcomes in Northern Arizona. This form may be faxed to: 928-773-2461.