Flagstaff Medical Center CPAP Report Form

Agency:_____ Date:_____
Time of call:_____ Arrival at hospital:_____
Pt. age:_____ Sex:_____

Indication:
- □ Pulmonary Edema/CHF
- □ Asthma/COPD
- □ Pneumonia
- □ Submersion/Drowning
- □ Smoke Inhalation

And 2 or more of the following criteria:
- □ RR >24
- □ Notable increased work of breathing
- □ SPO2 < 92%
- □ Abnormal breath sounds/frothy sputum
- □ Skin- mottling, pallor, cyanosis suggesting hypoxia

Absolute contraindications:
- □ Unconscious
- □ SBP < 90
- □ Tracheostomy
- □ Recent facial or gastric surgery
- □ Respiratory Arrest/Agonal Respirations
- □ Blunt/penetrating chest trauma/suspected pneumothorax
- □ High risk of aspiration/active vomiting
- □ Facial trauma/deformity/burns inhibiting proper mask fit

DNR/DNI Orders Present: □ Y □ N □ Unknown

Medications administered before or in conjunction with CPAP:
- □ Albuterol/Atrovent # of Doses:_____
- □ Epinephrine 1:1,000 IM
- □ Methylprednisolone
- □ Lasix
- □ NTG

CPAP continued to transfer:
- □ Yes
- □ No

CPAP discontinued for:
- □ Intolerance
- □ Hypotension
- □ Respiratory Failure/Arrest
- □ Other:_____
- □ Altered Mental Status
- □ Suspected pneumothorax

Time of patient contact to CPAP therapy:_____ min

Initial PEEP:_____
V/S before CPAP:
Time_____
BP_____/_____
P_____
R_____
SpO2_____%
Breath Sounds_____

Final PEEP:_____
Final V/S:
Time_____
BP_____/_____
P_____
R_____
SpO2_____%
Breath Sounds_____

Pt. final response: _____
Comments:_____
CPAP available in ED on arrival: □ Y □ 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.