## **IO insertion Report**

## FMC Pre-hospital Care department

Demographic Information					
Agency Name:	Date:	//_	Rı	un #:	Pt. Age:
Pt GCS at time of IO attempts:	_				
Reason for use of IO route (check all the	nat apply):				
☐ Altered MS					
☐ Hemodynamic compromise					
☐ Critical trauma					
☐ Cardiorespiratory arrest					
☐ Other:					
Number of peripheral IV attempts prio	r to IO inco	rtion/atta	nnt		
None □ None	i to io ilise	atter	прі		
$\begin{array}{ c c c c c c c c c c c c c c c c c c c$					
$\square$ 3 or more					
13 of more					
Device used:					
☐ EZ IO # of Attempts	Ultin	nately Suc	cessful? □ yes	□ no	
Placement site: ☐ Proximal Tibia				al Humerus	
	Ultin	nately Suc	cessful? □ yes	$\square$ no	
(e.g., Jamshidi)					
Complications (check all that apply)					
☐ Device failure* Please explain:					
☐ Fluid extravasation					
☐ Fluids would not flow					
☐ Device dislodgement					
☐ Other:					

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. May be faxed to: 928-773-2461

Revised 02/12/2010