IO insertion Report

FMC Pre-hospital Care department

Demographic Information

Agency Name: _____ Date: ____/____/____ Run #:_____ Pt. Age: _____

Pt GCS at time of IO attempts: _____

Reason for use of IO route (check all that apply):

- □ Altered MS
- □ Hemodynamic compromise
- □ Critical trauma
- □ Cardiorespiratory arrest
- □ Other: _____

Number of peripheral IV attempts prior to IO insertion/attempt

- □ None
- □ 1
- □ 2
- □3 or more

Device used:

□ EZ IO # of Attempts___ Ultimately Successful? □ yes □ no
Placement site: □ Proximal Tibia □ Distal Tibia □ Proximal Humerus

□ Standard IO # of Attempts___ Ultimately Successful? □ yes □ 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