

Advanced Procedure Reporting Form

Wyoming Office of Emergency Medical Services



Begin Using January 1, 2007

Return completed forms by the 10th day of the following month.

This form must be completed by all EMS Agencies when: "Defibrillation" "Intraosseous"
"MLLA", "Oral or Nasal Intubation" or "Chest Decompression" is performed in the pre-hospital setting.

Agency Name:	Agency City:	Incident Date: ____/____/200____
Patient Info: Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Age: _____ <input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Days <input type="checkbox"/> Hours Lowest GCS: _____ (Glasgow Coma Score)	_____ Minutes from Notified to Enroute _____ Minutes Enroute Scene or Arrived at Patient _____ Minutes on Scene _____ Minutes to Hospital	

Background Information (Check appropriate boxes)

Procedure Performed by: <input type="checkbox"/> EMT B (report AED shocks only) <input type="checkbox"/> EMT Intermediate <input type="checkbox"/> EMT Paramedic Injury Present? (Check 1 Only): <input type="checkbox"/> No (medical etiology) <input type="checkbox"/> Yes (trauma etiology)	If Cardiac Arrest Present: <input type="checkbox"/> Yes, Prior to EMS Arrival <input type="checkbox"/> Yes, After EMS Arrival Was CPR Started Before Your Arrival <input type="checkbox"/> No <input type="checkbox"/> Yes _____ minutes estimated down time without CPR or Ventilations	If Cardiac Arrest Present: (Check 1 Only): Cardiac Arrest Etiology <input type="checkbox"/> Presumed Cardiac <input type="checkbox"/> Drowning <input type="checkbox"/> Respiratory <input type="checkbox"/> Trauma <input type="checkbox"/> Electrocutation / Lightning <input type="checkbox"/> Other Medical Event Type: _____
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Check For Pre-Hospital Procedure(s) Performed & Complete Information Listed

Defibrillation <input type="checkbox"/> AED <input type="checkbox"/> Manual	<input type="checkbox"/> Intraosseous	Endo Tracheal Intubation <input type="checkbox"/> Oral <input type="checkbox"/> Nasal	<input type="checkbox"/> Chest Decompression
_____ #of AED Shock(s) _____ #of Manual Shock(s)	IV Attempted Prior to IO: <input type="checkbox"/> No <input type="checkbox"/> Yes #of: _____ IO Attempts <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 or > IO Successful: <input type="checkbox"/> No <input type="checkbox"/> Yes Meds Given Through IO: <input type="checkbox"/> No <input type="checkbox"/> Yes Puncture Site: <input type="checkbox"/> Proximal Tibia <input type="checkbox"/> Sternum <input type="checkbox"/> Other: _____ Dislodgement Occurred: <input type="checkbox"/> No <input type="checkbox"/> Yes	Attempts: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 or > more Successful: <input type="checkbox"/> No <input type="checkbox"/> Yes Placement Confirmed by: <input type="checkbox"/> Visualized Vocal Chords <input type="checkbox"/> Chest Rise & Fall <input type="checkbox"/> BAAM Airway Monitor <input type="checkbox"/> Breath Sound Verification <input type="checkbox"/> End Tidal CO2 Detector <input type="checkbox"/> Esophageal Detector Device <input type="checkbox"/> Tube Fogging Meds Given Through ET <input type="checkbox"/> No <input type="checkbox"/> Yes Dislodgement Occurred: <input type="checkbox"/> No <input type="checkbox"/> Yes	Insertion Location: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both Indications with MOI: <input type="checkbox"/> Blunt Chest <input type="checkbox"/> Penetrating Chest <input type="checkbox"/> Blast <input type="checkbox"/> Medical Air Rush Audible <input type="checkbox"/> No <input type="checkbox"/> Yes If yes: Lung sounds initially present <input type="checkbox"/> Yes <input type="checkbox"/> No, if No: Did lung sounds return <input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Multi Lumen Lower Airway MLLA Attempts: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 or > Successful: <input type="checkbox"/> No <input type="checkbox"/> Yes Dislodgement Occurred: <input type="checkbox"/> No <input type="checkbox"/> Yes			

Cardiac (select one): <input type="checkbox"/> Never Achieved Return of Spontaneous Circulation <input type="checkbox"/> Return of Spontaneous Circulation <input type="checkbox"/> Never Lost Spontaneous Circulation	Respiratory (select one): <input type="checkbox"/> Never Achieved Return of Spontaneous Respirations <input type="checkbox"/> Return of Spontaneous Respirations <input type="checkbox"/> Never Lost Spontaneous Respirations	Efforts Ceased (select one): <input type="checkbox"/> Expired in Field <input type="checkbox"/> Expired in ED If Admitted to ICU/Hospital: <input type="checkbox"/> Expired in Hospital Within 24 Hours <input type="checkbox"/> Expired after 24 Hours <input type="checkbox"/> Discharged Alive
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Comments: _____

Completed by: _____ Medical Director's Signature: _____