

Date of call:	Incident #:
Primary Agency:	
Medical control hospital:	Receiving hospital if different:
Lead patient care provider:	

Tiered response

ALS tiered response:	ALS service:
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Type of Arrest

EMS: <input type="checkbox"/> CPR <input type="checkbox"/> CCR <input type="checkbox"/> No resuscitation attempted in the field

Airway CQI

Advanced airway: <input type="checkbox"/> King <input type="checkbox"/> I gel <input type="checkbox"/> ET tube <input type="checkbox"/> LMA Other _____
What size advanced airway:
Successfully Inserted: Number of insertion attempts:
Initial EtCO2 with advanced airway-
RSA - <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Problems/Challenge encountered:
General Airway Feedback?
ROSC: <input type="checkbox"/> Yes <input type="checkbox"/> No

Please send completed form to Dane County EMS - meier.carrie@countyofdane.com
or fax to 608-266-4500