

CONTINUOUS POSITIVE AIRWAY PRESSURE REPORT FORM

A copy of the PCR must be attached and submitted to the organizations QI liaison within 24 hours of the incident. The QI Liaison must submit the report to SJCEMSA with monthly CQI report. Attach additional pages if necessary.

Date: _____

Provider Agency: _____

PATIENT INFORMATION Age: _____ Sex: M F Chief Complaint: _____
Medical history: CHF COPD/Asthma Other: _____

1. Treatment Indicators for CPAP (check all that apply):

Unable to speak full sentences Accessory muscle use Abdominal breathing Altered LOC Base Hospital Order
 Other: _____

2-5. Vital signs prior to treatment:

Pulse: _____ BPM Blood pressure: _____ / _____ mmHg
Resp. Rate: _____ SaO2: _____ %

6-9. Vital signs 5 min. after treatment:

Pulse: _____ BPM Blood pressure: _____ / _____ mmHg
Resp. Rate: _____ SaO2: _____ %

10. Concurrent treatment (check all that apply):

NTG Lasix Albuterol Atrovent Other _____

11. CPAP Device Used:

Boussignac Whisper Flow Port O Vent Other

12. Pressure Used:

5 CM H₂O 7.5 CM H₂O 10 CM H₂O

13. Complications:

Unable to tolerate mask Hypotension No improvement in patient status Required BVM/ intubation
 Equipment failure

14. Provider Comments:

15. Liaison Comments: