

# North Carolina EMS Airway Evaluation Form

**The NC EMS Airway Evaluation Form is required to be completed with all patients receiving Drug-Assisted Intubation in the Pre-hospital Environment.**

**FOR ORAL ROUTE:**  
Each Insertion of  
Blade into Oropharynx = 1 Attempt

**FOR NASAL ROUTE:**  
Pass of Tube Past the Nares =  
1 Attempt

## 1. Patient Demographic Information

Date: \_\_\_/\_\_\_/\_\_\_ Dispatch Time: \_\_\_:\_\_\_ am/pm

PCR # \_\_\_\_\_

EMS Agency Name: \_\_\_\_\_

Patient Age (yr): \_\_\_\_\_ Patient Sex:  M  F

## 2. Glasgow Coma Score (GCS) before intubation

Eye  (1)  (2)  (3)  (4)

Verbal  (1)  (2)  (3)  (4)  (5)

Motor  (1)  (2)  (3)  (4)  (5)  (6)

## 3. Was ETI successful for the overall encounter?

Yes  No  Uncertain

## 4. Was intubation attempt due to Trauma?

Yes  No

## 5. Level of training of each rescuer assisting with intubation

### Rescuer A

State ID: \_\_\_\_\_

- Paramedic
- EMT-I
- Medic Student
- Nurse
- Phys. Assist
- MD/DO
- Other: \_\_\_\_\_

### Rescuer B

State ID: \_\_\_\_\_

- Paramedic
- EMT-I
- Medic Student
- Nurse
- Phys. Assist
- MD/DO
- Other: \_\_\_\_\_

### Rescuer C

State ID: \_\_\_\_\_

- Paramedic
- EMT-I
- Medic Student
- Nurse
- Phys. Assist
- MD/DO
- Other: \_\_\_\_\_

## 6. Indicate drugs given to facilitate intubation

- Atropine \_\_\_\_\_ mg
- Etomidate \_\_\_\_\_ mg
- Lidocaine \_\_\_\_\_ mg
- Midazolam \_\_\_\_\_ mg
- Rocuronium \_\_\_\_\_ mg
- Succinylcholine \_\_\_\_\_ mg
- Vecuronium \_\_\_\_\_ mg
- Other-Specify \_\_\_\_\_ - \_\_\_\_\_ mg
- Other-Specify \_\_\_\_\_ - \_\_\_\_\_ mg

## 7. Times and Vital Signs

	Time	Heart Rate	Resp. Rate	Blood Pressure	Pulse Oximetry	ECTO <sub>2</sub>
Pre-Airway Assessment Values	:			/		
Successful Airway Obtained	:					
Post-Airway Assessment Values	:			/		

## 8. Provide information for each laryngoscopy attempt.

Attempt	ETI Method	Rescuer	Successful?
1	<input type="checkbox"/> Direct <input type="checkbox"/> Nasal <input type="checkbox"/> Video	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	<input type="checkbox"/> Direct <input type="checkbox"/> Nasal <input type="checkbox"/> Video	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	<input type="checkbox"/> Direct <input type="checkbox"/> Nasal <input type="checkbox"/> Video	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> Yes <input type="checkbox"/> No
4	<input type="checkbox"/> Direct <input type="checkbox"/> Nasal <input type="checkbox"/> Video	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> Yes <input type="checkbox"/> No

## 9. Who verified placement of ET Tube?

- Rescuer performing intubation
- Another rescuer on the same team
- Receiving helicopter/EMS crew
- Receiving hospital team
- Other: \_\_\_\_\_

## 11. Endotracheal tube confirmation

	Auscultation	ETCO <sub>2</sub>	Breath Sounds	Absent Epigastric
Placement Confirmation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tube Size	Tube Depth			
Security Method				

## 10. If all attempts FAILED, indicate secondary airway technique used (Check all that apply)

- Bag-Valve-Mask (BVM)  Combitube
- Open Cricothyroidotomy  King LTD
- LMA  Other: \_\_\_\_\_

## 12. Were pulses maintained while under agencies care?

Yes  No

## 13. Signature of Receiving Physician/Healthcare Provider (Confirming Destination/Transfer Tube Placement)

Yes  No  Uncertain

## 14. Signature of EMS Medical Director (Confirming Review of Completed Form)

Chart Review Done  Remediation Required  Approved

Date and Time: \_\_\_\_\_ : \_\_\_\_\_ am/pm

Date: \_\_\_\_\_