Adirondack-Appalachian Regional Emergency Medical Services Council, Inc.
REGIONAL MEDICAL ADVISORY COMMITTEE

BLS CPAP USE REPORTING FORM

Date of CPAP Use	Agency Name		
PCR No.	Time Call Received	Time Enroute	Time On Scene
ALS Intercept Agency	ALS Provider	CC/P #	Time on Scene

Crew (List EMT/s providing CPAP care first) ☑ *Indicates CPAP provider*

_____ EMT/AEMT # _____ ☐
_____ EMT/AEMT # _____ ☐
_____ # _____ ☐CFR ☐EMT ☐AEMT
_____ # _____ ☐CFR ☐EMT ☐AEMT

Patient Age	☐ Male ☐ Female	

Past Medical History ☐Hypertension ☐Asthma ☐COPD ☐Diabetes
☐Cardiac(CHF/PE) ☐Cardiac (Other) _____
☐Other
☐Previous CPAP Use

Time Arrived on Scene	Time oxygen delivery started _____ Device/Liter Flow

Was any improvement observed with oxygen delivery? ☐Yes ☐No
Yes? Explain

Time CPAP started	Was End-Tidal CO2 Applied? ☐Yes ☐No
Pt. assisted with MDI? ☐Yes ☐No Time	Nebulized Albuterol Administered ☐Yes ☐No Time Started

Was any improvement observed with bronchodilator delivery? ☐Yes ☐No ☐ N/A
Yes? Explain

Patient Assessment - Initial	Time	Skin	Frothy Sputum? ☐Yes ☐No
Pulse	Resp	BP	SpO_2	Borg Scale
Lung Sounds	Peripheral Edema	
Ability to speak	Accessory Muscles/Retractions	Pursed Lip Breathing

Was CPAP application successful? ☐Yes ☐No
No? Explain problem

Total length of treatment (in minutes)

Patient Assessment following CPAP	Time	Skin	Frothy Sputum? ☐Yes ☐No
Pulse	Resp	BP	SpO_2	Borg Scale
Lung Sounds			

Improvement in Work of Breathing? ☐Yes ☐No ☐Related by Patient ☐Observed
Improvement observed in:

Comments (Explain any problems/complications or other unusual occurrences)

Was medical control consulted at any time? Physician:
Reason/Result

This form must be completed and returned to the AAREMS Regional Office, PO Box 212, Speculator, NY 12164 within 48 hours of CPAP application or your agency participation in the project will be reevaluated and may be suspended.