Region One EMS Quality Assurance Committee
Provider Intubation Report

Date	County Incident #	Patient Name	Age	Sex
Provider Name			CRT	EMT-P

Receiving Hospital: *Check One*

☐ WMHS/CMH ☐ WMHS/SHH ☐ GCMH ☐ PVH ☐ Ruby Memorial

☐ Meyersdale ☐ Washington County Hospital ☐ Other:

Procedure Information

Time Arrived On Scene _____ Time ET Tube Placed: _____

Intubation Route:

☐ Visualized Ortotracheal w/ Laryngoscpe ☐ Blind Digital Orotracheal

☐ Nasotracheal

Size Tube Placed: _____ Depth of Placement: _____ * Number of Attempts: _____

**If more than one attempt was needed, please explain on back of form.*

Was the patient successfully intubated?	YES	_____	NO**	_____
Were bilateral breath sounds present?	YES	_____	NO**	_____
Were epigastric sounds absent?	YES	_____	NO**	_____
Was pulse oximetry used?	YES	_____	NO	_____
Was an End Tidal CO2 detector used?	YES	_____	NO	_____
Was a gastric tube placed?	YES	_____	NO	_____

**Further explanation required on back of form

ED Physician Verification

Tube Placement: ☐ Adequate ☐ Not Adequate

Verification Method: ☐ Ascultation ☐ Laryngoscope Visualization

☐ Chest X-Ray ☐ End-Tidal CO2 Monitor

☐ Aspiration Devise ☐ Other: _____

Verifying Physician: _____ Date: _____

Additional Information on back of form.

Provider Comment Area

Physician Comment Area

Return Completed Forms to:

Bill Hardy, Prehospital Care Coordinator
WMHS – Memorial Campus
600 Memorial Avenue
Cumberland, Maryland 21502
FAX: 301-723-4045