COUNTY OF SUFFOLK

STEVEN BELLONE
SUFFOLK COUNTY EXECUTIVE

DEPARTMENT OF HEALTH SERVICES

JAMES L. TOMARKEN, MD, MPH, MBA, MSW
Commissioner

CPAP Audit Form

This audit form must be completed for every patient that receives pre-hospital CPAP therapy. The information you provide will be used to evaluate the effectiveness, safety and frequency of use in our region. This **audit form must be sent** to the Suffolk County Division of Emergency Medical Services with a copy of the PCR by fax (631-853-8307) or via email to tom.lateulere@suffolkcountyny.gov.

Date ________________ **Name** ______________________________________ **Level:** _____ **EMT-CC** _____ **EMT-P**

EMT # ______________ **Agency Name** ____

Type of CPAP device used: ____

Patient Information

Age: _______ ☐ **Male** ☐ **Female** **Respiratory Distress:** ☐ Moderate ☐ Severe

Vital Signs

Prior to treatment: Resp. _____ Pulse ______ BP ____/_____ O^2Sat _____% ETC02 _______ (If available)

ECG interpretation______________

Arrival at Hospital: Resp. _____ Pulse ______ BP ____/_____ On CPAP O^2Sat _____% ETC02 _______ (If available)

ECG interpretation______________ **ETC02** **1st** ________ **2nd** _________

Reason for CPAP use?

☐ Pulmonary Edema (S/O) ☐ Other: (Medical Control) ____________________________

Do you feel the use of CPAP had any significant effect on the patient condition?

☐ Improved ☐ Worsened ☐ No Obvious Change

Presumptive pre-hospital clinical impression? ________________________________

Approximately how long did patient receive CPAP therapy? ______ Minutes

Any complications with application or discontinuance? **Yes** ☐ **No** ☐

What/Why ____

If you did not have CPAP how would you have assisted this patient?

☐ Intubation ☐ BVM ☐ NRB

DIVISION OF EMERGENCY MEDICAL SERVICES
P.O. Box 6100, Hauppauge, NY 11788-0099 (631) 853-5800 Fax (631) 853-8307