COUNTY OF SUFFOLK

STEVEN BELLONE
SUFFOLK COUNTY EXECUTIVE

DEPARTMENT OF HEALTH SERVICES

GREGSON H. PIGOTT, MD, MPH
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 (631-852-5028) or via email to william-michael.masterton@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 ____/____ O²Sat _____% ETC02 _____ (If available)

ECG interpretation_____

Arrival at Hospital: Resp. _____ Pulse _____ BP ____/____ On CPAP O²Sat _____% 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

Public Health
Prevent. Promote. Protect.

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