Suffolk Regional Emergency Medical Advisory Committee
ET Placement Verification Form

Agency Name: ____ **Date of Call:** ____________________

Provider Name: ____

Level	**Patient Age**			**Patient Sex**
☐ EMT-CC	☐☐☐	☐ yr	☐ wk	☐ Male
☐ EMT-P		☐ mo	☐ day	☐ Female

ET Tube Placement

Size ____________________

☐ Oral Pharyngeal

☐ Existing Trach

OR

Combitube Placement

Size ____________________

☐ Trachea White Port

☐ Esophagus Blue Port

OR

King Airway

Size ________________

Medication(s) Used To Facilitate Intubation

Etomidate ________ mg Midazolam _________ mg

Adjunct (s) Used To Facilitate Intubation

☐ Video Laryngoscope ☐ Bougie Device

Verification Method(s) Used Prehospital

☐ Auscultation ☐ Visualization ☐ ETCO2 Waveform Present

Pre-intubation pulse oximetry reading ______ Post-intubation pulse oximetry reading ______

☐ Initial ETCO2 Numerical Reading ________________________________

☐ Final at Hospital ETCO2 Numerical Reading _________________________

ET Tube Placement Verification at Hospital

☐ Trachea ☐ Esophagus

☐ Oral Pharyngeal Cavity ☐ Rt. Main Stem

OR

Combitube Placement Verification at Hospital

☐ Trachea ☐ Esophagus

☐ Unknown

OR

King Airway Placement Verification at Hospital

Visible Chest Wall Expansion

Yes ________ **No** _________

Verification Method(s) Used In Hospital

☐ Auscultation ☐ Esophageal Detector Device

☐ Visualization ☐ Chest X-Ray

☐ CO2 Detector / Capnometry ☐ ETCO2 Wave Form Present

☐ Initial ETCO2 Numerical Reading ______________________

Is Needle Cricothyrotomy successfully done?

☐ Yes ☐ No

Verifying MD

Name (print): ________________________________ **Signature:** ___________________________________

Mail or Fax (631-852-5028) copy of completed form, PCR and Capnogram, to:

S.C. Department of Health Services
Div. of Emergency Medical Services
360 Yaphank Ave., Suite 1B
Yaphank, NY 11980 Attn: W. M. Masterton

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