

**Suffolk Regional Emergency Medical Advisory Committee  
ET Placement Verification Form**

**Agency Name:** \_\_\_\_\_ **Date of Call:** \_\_\_\_\_

**Provider Name:** \_\_\_\_\_

<b>Level</b> <input type="checkbox"/> EMT-CC <input type="checkbox"/> EMT-P	<b>Patient Age</b> <table border="1"> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td>yr</td> <td><input type="text"/></td> <td>wk</td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td>mo</td> <td><input type="text"/></td> <td>day</td> </tr> </table>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	yr	<input type="text"/>	wk	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	mo	<input type="text"/>	day	<b>Patient Sex</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	yr	<input type="text"/>	wk										
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	mo	<input type="text"/>	day										

<b>ET Tube Placement</b> <input type="checkbox"/> Oral Pharyngeal <input type="checkbox"/> Existing Trach <input type="checkbox"/> Surgical Airway
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**OR**

<b>Combitube Placement</b> <input type="checkbox"/> Trachea White Port <input type="checkbox"/> Esophagus Blue Port
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<b>Medication (s) Used To Facilitate Intubation</b> <input type="checkbox"/> None <input type="checkbox"/> Etomidate <input type="checkbox"/> Diazepam	<input type="checkbox"/> Lorazepam <input type="checkbox"/> Morphine
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<b>Verification Method(s) Used Prehospital</b> <input type="checkbox"/> Auscultation <input type="checkbox"/> Initial ETCO2 Numerical Reading _____ <input type="checkbox"/> CO2 Detector / Capnometry (If Combitube is used) <input type="checkbox"/> Disposable CO2 Detector (Only should be used if Capnography Unit malfunctions)	<input type="checkbox"/> Visualization <input type="checkbox"/> ETCO2 Waveform Present
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<b>ET Tube Placement Verification At Hospital</b> <input type="checkbox"/> Trachea <input type="checkbox"/> Oral Pharyngeal Cavity	<input type="checkbox"/> Esophagus <input type="checkbox"/> Rt. Main Stem
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**OR**

<b>Combitube Placement Verification At Hospital</b> <input type="checkbox"/> Trachea <input type="checkbox"/> Unknown	<input type="checkbox"/> Esophagus
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<b>Verification Method(s) Used In Hospital</b> <input type="checkbox"/> Auscultation <input type="checkbox"/> Visualization <input type="checkbox"/> CO2 Detector / Capnometry <input type="checkbox"/> Initial ETCO2 Numerical Reading _____	<input type="checkbox"/> Esophageal Detector Device <input type="checkbox"/> Chest X-Ray <input type="checkbox"/> ETCO2 Wave Form Present
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<b>Is surgical airway successfully done?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
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**Verifying MD**

**Name (print):** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Mail copy of completed form, PCR and Capnogram, if available, to:**

**S.C. Department of Health Services  
Div. of Emergency Medical Services  
P.O. Box 6100  
Hauppauge, NY 11788-0099  
Attn: Tom Lateulere**