

# Rapid Sequence Induction (RSI) Verification Form

RSI Paramedic Name: \_\_\_\_\_

2<sup>nd</sup> RSI Paramedic Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Time: \_\_\_\_\_:

### Indication For RSI

**Head Trauma or ICH with:**

- ↓ LOC – GCS \_\_\_\_\_
- Hypoxia – SpO2 <90%
- Combativeness
- Failure to maintain airway
  - Secretions
  - Sonorous breathing
  - Emesis

**Respiratory Failure**

- Hypoxia – SpO2, 90% **with** assist
- Nasal etCO2 – >60 mmHg

**Loss of Airway Reflexes**

- Depressed level of consciousness
- Active seizure

**Anticipated Deterioration**

- Severe multi-trauma
- Major OD
- Other \_\_\_\_\_

**After indication for RSI:**

Pre-intubation pulse oximetry reading: \_\_\_\_\_

Pre-intubation nasal end-tidal CO2 reading, if available: \_\_\_\_\_

Post intubation pulse oximetry reading: \_\_\_\_\_

Post intubation end-tidal CO2 reading: \_\_\_\_\_

**Predictors of Difficult Bag-Mask Ventilation or Intubation**

- | YES                      | No                       |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <b>M</b> – Poor Mask seal predicted  |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>O</b> – Obese habitus   |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>A</b> – Advanced age  |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>N</b> – No teeth  |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>S</b> – Stiff lungs (COPD, hemo/pneumothorax, burns, etc.)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>L</b> – Look externally (short-bull neck, micrognathia, etc.)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>E</b> – Evaluate distances. “3, 3, 2” < 3 fingerbreadths for thyromental distance and between teeth; < 2 fingerbreadths for thyrohyoid distance |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>M</b> – Mallampati class 3 or 4 airway  |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>O</b> – Obstruction of airway   |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>N</b> – Neck mobility limited (e.g. suspected cervical injury)  |

**RSI Medications**

Etomidate (0.3 mg/kg) \_\_\_\_\_ mg  
 Ketamine (1-2 mg/kg) \_\_\_\_\_ mg  
 Succinylcholine (1.5 mg/kg) \_\_\_\_\_ mg  
 Rocuronium (1 mg/kg) \_\_\_\_\_ mg

**Paralysis and Sedation Post Advanced Airway**

Versed (0.05-0.1 mg) maximum single dose of 5 mg \_\_\_\_\_ mg  
 Ketamine (1-1.5 mg/kg) \_\_\_\_\_ mg  
 Fentanyl (1 mcg / kg) maximum single dose of 100 mcg \_\_\_\_\_ mcg  
 Repeat Paralytcs Order by MC \_\_\_\_\_

**Patient Characteristics**

Age: \_\_\_\_\_ years  
 Weight: \_\_\_\_\_ kilograms  
 Height: \_\_\_\_\_ feet

**If standing order, name of second ALS Provider:**

\_\_\_\_\_

## Confirmation of Proper Placement of an Advanced Airway

<b>Initial device used:</b> <input type="checkbox"/> Traditional Laryngoscope <input type="checkbox"/> King Vision <input type="checkbox"/> Glidescope <input type="checkbox"/> Other: <hr/>	<b>Number of ETT attempts:</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Other: <hr/>	<b>Additional techniques used:</b> <input type="checkbox"/> Sniffing Position <input type="checkbox"/> Head Elevated <input type="checkbox"/> Burp <input type="checkbox"/> External Laryngeal Manipulation	ETT Diameter: _____ ETT Depth: _____ Secured with: _____ <hr/> <b>Glottic Visualization</b> <input type="checkbox"/> Cormack-Lehane Grade (I-IV): _____ <input type="checkbox"/> Mallampati Score (I-IV): _____
<b>Secondary device used:</b> <input type="checkbox"/> Bougie <input type="checkbox"/> King Vision <input type="checkbox"/> Other: <hr/>	<b>Paramedic (Check all that apply.)</b> <input type="checkbox"/> Waveform capnography o _____ mmHg <input type="checkbox"/> Direct visualization of tube passing the vocal cords <input type="checkbox"/> Equal breath sounds <input type="checkbox"/> Absent epigastric sounds <input type="checkbox"/> O2 Saturation <u>sustained</u> >95% <input type="checkbox"/> Secured after confirmation  Name: _____  Signature: _____		<b>ED Physician (Check all that apply.)</b> <input type="checkbox"/> Waveform Capnography o _____ mmHg <input type="checkbox"/> Direct visualization of tube between vocal cords <input type="checkbox"/> Equal breath sounds <input type="checkbox"/> Absent epigastric sounds <input type="checkbox"/> O2 Saturation <u>sustained</u> >95% <input type="checkbox"/> Re-intubation necessary  Name: _____  Signature: _____
<b>If rescue airway was used:</b> <input type="checkbox"/> King Airway <input type="checkbox"/> Size: <hr/>	<p><b>Please affix strip(s) showing initial &amp; at the hospital pulse, SpO2 and ETCO2 waveform below:</b></p>          		

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