SwedishAmerican Hospital
Emergency Medical Services System

CPAP - QI Form

This Form will be completed whenever CPAP is utilized by an EMS Provider. Form to be submitted to the SwedishAmerican Hospital EMS System with a copy of the run sheet attached.

Patient Name: _____

Date: _____

Ambulance / Rescue Agency: _____ Run #: _____

	Time	BP	P	R	Pulse Ox	LOC
Before CPAP						
After CPAP						

Indications: _____

Contraindications: _____

Any complication encountered _____

Outcome of Patient _____

Additional Comments: _____

_____

_____

Name of EMS Provider administering CPAP: _____

Send this completed form to EMS Coordinator, SwedishAmerican EMS, 1401 East State Street, Rockford, IL 61104