YOUR HOSPITAL	Emergency Department QualChart®	Page 1 of 1
PROCEDURE NOTE / AIRWAY / CARDIOPULMONARY		

Time:	PROCEDURE (Refer to Attached Order Sheet)	Time:	CLINICAL RESPONSE / RE-EVALUATION
	AIRWAY MANAGEMENT:		
	Noninvasive Ventilation Bag-Valve-Mask 100% NRB		Pulse Ox Post-Procedure:
	CPAP / BiPAP O2 Content _____ l/min		NL Hypoxic _____ % on RA or O2 @ _____ l/min
	Inspiratory Pressure _____ cc/H2O *(Range 4-12)*		
	Expiratory Pressure _____ cc/H2O *(Range 0-8)*		
	Endotracheal Intubation **Pediatric ETT Size (mm) = Age (years) + 16 / 4 — Always Use Cuffed Tube**		Procedure Successful / _____
	Size: _____ mm		Tube Placement Confirmed by:
	Attempts x _____		CO2 Detector / Equal Breath Sounds / CXR / _____
	Orotracheal / Nasotracheal / LMA / _____		No Complications / _____
	Surgical Airway		Procedure Successful / _____
	Location: Cricothyroid / Trachea / _____		Breath Sounds Equal / _____
	Device / Method: Percutaneous / _____		No Complications / _____
	Ventilator Management		
	Rate: _____ Tidal Volu		Compensated / Uncomp
	Rate: _____ Tidal Volu		HCO3_____ Sat._____%
			HCO3_____ Sat._____%
	CHEST TUBE / NEEDLE DECOMPRESSION:		Procedure Successful / _____
	Indication: Pneumothorax: Simple / Tension / Open		Tube Placement Confirmed by:
	Hemothorax / Penetrating Chest Trauma		Equal Breath Sounds / CXR / _____
	Needle: _____ Gauge Right / Left Anterior 2nd ICS / _____		Results: Air / Blood / Pus / _____ _____ ml
	Tube: _____ French Right / Left Axillary 5th ICS / _____		No Complications / _____
	Anesthesia: Lidocaine _____ ml		
	Technique: Sterile / _____		
	CENTRAL LINES:		Procedure Successful / _____
	Type: Introducer / Single Lumen / Triple Lumen / Intraosseous / _____		Breath Sounds Equal / _____
	Location: Right / Left Internal / External Jugular / Subclavian /		Good Blood Return / _____
	Femoral / _____		Post CXR: Line Placement Adequate / _____
	Sterile Technique / _____		No Complications / _____
	Method: Seldinger / US-Guided / _____		
	CARDIAC PACING: External Transvenous Rate: _____ _____ mAmps		No Electric Capture / Electric Capture: w/Pulse w/o Pulse
	CARDIOVERSION: Energy: 50 / 100 / 200 / 300 / 360 Joules x 1 2 3		No Change / Sinus / _____
	Energy: 50 / 100 / 200 / 300 / 360 Joules x 1 2 3		No Change / Sinus / _____
	DEFIBRILLATION: Energy: 50 / 100 / 200 / 300 / 360 Joules x 1 2 3		No Change / Sinus / _____
	Energy: 50 / 100 / 200 / 300 / 360 Joules x 1 2 3		No Change / Sinus / _____

SAMPLE
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POST PROCEDURE RE-EVALUATION: Time: _____ a.m. / p.m.

VSS except: _____ **Pain:** _____ (0-10)

Appearance: NAD / _____

Lungs: Clear / _____

Skin: Warm & Dry / _____

Neuro: A & O x 3 / _____

CV: R R R / _____

SIGNATURE: All Procedures Performed/Supervised by Signatory

Disposition Time: _____ a.m. / p.m.

_____ MD/DO

_____ MD/DO

_____ PA / NP / Resident

This form is to assist the physician's documentation of clinical care and treatment.
It is not intended to supplant that judgement or create a standard of care.
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06/17/08 10:58 am