

# Carroll County CPAP Quality Assurance Review Form

Date: \_\_\_\_\_ Carroll County Incident # \_\_\_\_\_  
EMAIS # \_\_\_\_\_ Provider initiating CPAP \_\_\_\_\_ Company: \_\_\_\_\_

**Demographics:** Patient Age: \_\_\_\_ Sex: \_\_\_\_ Resp. History: CHF \_\_\_\_  
COPD \_\_\_\_  
Other \_\_\_\_

**Patient Condition:**  
\_\_\_\_ Asthma / COPD \_\_\_\_ CHF / Pulmonary Edema Other \_\_\_\_\_

**Initial Assessment:**  
SPO2 \_\_\_\_\_ GCS \_\_\_\_\_ Vitals: B/P \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_  
Respiratory effort: Retractive \_\_\_\_ Non-retractive \_\_\_\_ Accessory Muscle Y or N

<b>CPAP Used ?</b>	<b>Intubated ?</b>
____ Indicated & used	No _____
____ Indicated and not used	Yes, by EMS _____
____ Contraindicated	Yes, in ER _____

<b>Patient Dyspnea Level:</b> (prior to CPAP)	none 1	2	3	4	severe 5
<b>Ease of Application</b>	easy 1	2	3	4	difficult 5
<b>Patient Tolerance</b>	poor 1	2	3	4	fully tolerated 5
<b>Patient Dyspnea Level</b> (after CPAP)	none 1	2	3	4	severe 5

**Final Assessment:**  
SPO2 \_\_\_\_\_ GCS \_\_\_\_\_ Vitals: B/P \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_  
Respiratory effort: Retractive \_\_\_\_ Non-retractive \_\_\_\_ Accessory Muscle Y or N

CPAP Continues at Hospital ?    yes    no

Comments: \_\_\_\_\_

Hospital Comments (if any) \_\_\_\_\_

*Place form in Grey Box or download form from  
CCVESA website and email to priorityone@CCVESA .org*

