

**NORTH COAST EMS
ESOPHAGEAL TRACHEAL AIRWAY DEVICE (ETAD) /
AUTOMATED EXTERNAL DEFIBRILLATOR (AED)
REPORTING FORM**

Provider Agency: _____

Work Phone #: _____ Date of Call: _____

Name(s) of EMT-I(s) performing procedure(s): _____

TIMES:

Call Received: _____ On Scene: _____ Patient Contact: _____

ALS Arrival: _____ Estimated Down Time: _____

PATIENT INFORMATION:

Patient Name: _____

Age: _____ Sex (circle one): Female Male

PATIENT CONDITION:

Apneic (circle one): Yes No Pulseless (circle one): Yes No

Bystander Airway Mgmt. (circle one): Yes No Bystander CPR (circle one): Yes No

If cardiac arrest, was it witnessed (seen or heard) (circle one): Yes No

Probable cause of arrest (if known): _____

AED:

Was AED placed (circle one): Yes No Name of person operating AED: _____

Shock delivered (circle one): Yes No Total number of shocks: _____

AIRWAY:

Initial Airway Management (circle): OPA NPA BVM Other: _____

ETAD Placement Time: _____ ETAD inserted successfully (circle one): Yes No

Number of Attempts: _____ ETAD Location (circle): Esophagus (ventilation tube #1)
Tracheal (ventilation tube #2)

Placement confirmed by (circle): Chest Rise Lung Sounds Epigastric Sounds

Confirmation Device: Toomey Syringe Other: _____

Did ALS crew remove ETAD (circle one): Yes No

TRANSPORT INFORMATION:

Patient Destination: _____

Transport Provider: _____

Please write any comments on the back of this form.