



North Country EMS Program Agency

“Serving Jefferson, Lewis & St. Lawrence Counties”

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CPAP Therapy Screen

This regional screen should be completed for every patient that receives pre-hospital CPAP therapy prior to August, 2008. The information you provide will be used to evaluate the effectiveness, safety, and frequency of use in our region. This **screen must be sent** to the Program Agency office with the PCR yellow copies by the 15th of the following month the PCR's are dated for.

DATE / / _____ (EMT IN CHARGE) _____ (EMT NUMBER)

AGENCY NAME _____ AGENCY CODE _____

Patient Information

Age: _____ Male Female Respiratory Distress: Moderate Severe

Vital Signs

Prior to treatment: Resp. _____ Pulse _____ BP _____ / _____ Room Air O²Sat _____ %

Arrival at Hospital: Resp. _____ Pulse _____ BP _____ / _____ On CPAP O²Sat _____ %

Reason for CPAP use?

COPD Pulmonary Edema Other: (Explain) _____

Do you feel the use of CPAP had any significant effect on the patient condition?

Improved Worsened No Obvious Change

Approximately how long did patient receive CPAP therapy? _____ Minutes

Did the patient receive a nebulizer treatment through the CPAP device? Yes No

If you did not have CPAP how would you have assisted this patient?

Intubation BVM NRB

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