



# North Country EMS Program Agency

“Serving Jefferson, Lewis & St. Lawrence Counties”

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## Nitronox Therapy Screen

This regional screen should be completed for every patient that receives pre-hospital Nitronox therapy. 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 15<sup>th</sup> 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 Primary Presenting Problem \_\_\_\_\_

#### Vital Signs

Prior to treatment: Resp.        Pulse        BP     /     Room Air O<sup>2</sup>Sat        %

Arrival at Hospital: Resp.        Pulse        BP     /     Ending O<sup>2</sup>Sat        %

Location/description of pain? \_\_\_\_\_

Patients pain scale rating prior to administration of Nitronox? (circle appropriate number)

1    2    3    4    5    6    7    8    9    10

Patients pain scale rating during the administration of Nitronox? (circle appropriate number)

1    2    3    4    5    6    7    8    9    10

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

Improved             Worsened             No Obvious Change

Approximately how long did patient receive Nitronox therapy? \_\_\_\_\_ Minutes

Did the patient experience any negative effects from the administration of Nitronox?  No

If Yes, explain: \_\_\_\_\_

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