



Central New York EMS Intubation Confirmation Form



This form is to be completed with each intubation attempt.
Successful intubations require a physician confirmation signature.

Date: _____ PCR or PRID #: _____

Agency: _____ Agency #: _____

Pre- Hospital Provider: _____ AEMT#: _____

Transferred Care From: Yes – FR Agency Name: _____ No

Location of Intubation:

On-Scene Enroute

Provider Level:

AEMT-I AEMT-CC AEMT-P

Number of Attempts:

1 2 3 _____

Intubation Unsuccessful – Combitube Used:

Yes No

Patient Type :

Medical Trauma Adult Pediatric (<14 yo)

Patient:

Tube Placement Confirmation (list all documented)

Visualization Auscultation Wave-Form Capnography Color-Metric CO2 EDD

Hospital Capnography Utilized: Yes No

Notes: _____

Physician Confirmation

Receiving Hospital: _____ Hospital Code: _____

Physician: _____
Signature

Tube Placement Confirmation: (list all documented)

Visualization Auscultation Wave-Form Capnography Color-Metric CO2 EDD

Notes: _____

** Return completed forms to the CNYEMS Office along with Research Copy of PCR. **