

Austin / Travis County EMS System Advanced Care & Supplemental Form

Provider completing narrative: Name/ ID # /Organization _____ Unit ID _____ Incident Date _____ Incident # _____

Patient Name: _____ Patient Age: _____ Patient D.O.B. _____

Stemi Alert
 Stroke Alert
 Cardiac Arrest
 Advanced Airway

Stemi Alert

ST elevation ≥ 1 mm in two contiguous limb leads
 New or presumed new left bundle branch block (LBBB)
 ST elevation ≥ 1 mm in two or more adjacent Precordial leads (V1 - V6) with reciprocal depression
 Symptoms suggestive of myocardial ischemia and an abnormal non-diagnostic ECG
 Prominent R waves with ST segment depression ≥ 1 mm in V1 and/or V2.
 Stemi Alert declared to communications Yes No

Pain scale *0-10*
 Patient contact _____ ED arrival _____

EtCO2
 Patient contact _____ ED arrival _____

SaO2
 Patient contact _____ ED arrival _____

Scene time until initial 12 lead acquisition _____

Stroke Alert

Pt. presentation and hx (including presumed T.I.A.) suggestive of stroke
 Symptoms less than or equal to 8 hours
 Stroke Alert declared to communications Yes No

Facial Droop
 Normal : Both sides of face move equally
 Abnormal: One side of face does not move at all

Arm Drift
 Normal: Both arms move equally or not at all
 Abnormal: One arm drifts compared to the other

Speech
 Normal: Patient uses correct words with no slurring
 Abnormal: Slurred or inappropriate words or mute

Onset of symptoms: < 1 hour 1-2 hours 2-3 hours
 3-4 hours 4-5 hours 5-6 hours 6-7 hours 7-8 hours

Cardiac Arrest

Witnessed? Yes No Unknown If Yes, Witnessed By _____ Bystander CPR? Yes No
 Resuscitation Attempted Yes No If not why: Valid DNR Obvious DOS
 AED Applied? Yes No AED Applied by Layperson (PAD)? Yes No AED Shocks Delivered? Yes No # _____
 First Arrest Rhythm Observed by ALS Providers Asystole PEA VF VT
 Did a pulse (ROSC) return at any time? Yes No Pulses present at ED arrival? Yes No Code Summary attached to PCR? Yes No

Rhythm at ED arrival _____ Rhythm at Pronouncement _____

Advanced Airway

Pre-Initial Procedure AVPU _____ GCS _____ EtCO2 _____ SaO2 _____ OPA / NPA used Yes No Size _____
 Able to adequately oxygenate / ventilate with BLS maneuvers Yes N Ventilations assisted with BVM Yes No

Intubation types OTI NTI Combitude (CT) LMA Needle Cric. (NC) Surgical Cric. (SC)
 Complications List A. Cough / gag reflex B. Blood or vomit C. Clenched teeth (trismus) D. Obstruction E. Unable to visualize

<i>Attempt 1:</i> Provider Name / ID # / Organization	Successful	Type/Size	BURP Used	Bougie Used	Suction	Complications
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Post Procedure GCS _____ EtCO2 _____ (post 6 vent.) SaO2 _____ C-Collar Placed Yes No Nasal Gastric Tube placed Yes No

<i>Attempt 2:</i> Provider Name / ID # / Organization	Successful	Type/Size	BURP Used	Bougie Used	Suction	Complications
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Post Procedure GCS _____ EtCO2 _____ (post 6 vent.) SaO2 _____ C-Collar Placed Yes No Nasal Gastric Tube placed Yes No

<i>Attempt 3:</i> Provider Name / ID # / Organization	Successful	Type/Size	BURP Used	Bougie Used	Suction	Complications
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Post Procedure GCS _____ EtCO2 _____ (post 6 vent.) SaO2 _____ C-Collar Placed Yes No Nasal Gastric Tube placed Yes No

<i>Attempt 4:</i> Provider Name / ID # / Organization	Successful	Type/Size	BURP Used	Bougie Used	Suction	Complications
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Post Procedure GCS _____ EtCO2 _____ (post 6 vent.) SaO2 _____ C-Collar Placed Yes No Nasal Gastric Tube placed Yes No

EtCO2 wave form printed at receiving facility / or at pronouncement <input type="checkbox"/> Yes <input type="checkbox"/> No and attached to PCR.	Final EtCO2 at facility/ or at pronouncement _____ Final SaO2 at facility/ or at pronouncement _____
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 Physician / RT / RN Verification of Advanced Airway Placement-Signature and printed name

