Pilot i-gel Reporting Form

This reporting form must be completed for every patient that receives a BLS prehospital i-gel Supraglottic airway. The information provided will be used to evaluate the effectiveness, safety and care of use in our department. Please complete this audit form, email and drop it in the 2nd assistant Chiefs' mailbox within 24 hours. Pre settings are arranged on the printer located in the meeting room. Please go to email, phone book, and select chief.32@medfordambulance.org.

Agency Name: Medford Volunteer Ambulance, Inc

Provider Name: _____ Date: ___/___/___

i-gel Size Used: 3 / 4 / 5. Successful: Yes / No. Was ALS activated: Yes / No.

If no: Why: _____ If yes: ALS provider _____ Level CC / P

Patient Information

Age: _____ Male / Female Witnessed Arrest: Yes / No

Vital Signs

Prior to i-gel insertion: (*use n/a if exam finding not present)*

B/P: _____/_____ Pulse: _____ Spo2% _____% Respiratory Rate: _____

GCS: _____ Mental Status: A&O x _____ Conscious? Yes / No

Airway device used prior to i-gel: NPA / OPA / None

Assisted ventilation: Yes / No. Device _____

After i-gel insertion (or attempt): *(use n/a if exam finding not present)*

Successful: Yes / No. If successful: Spo2: _____%

Initial ETCO2 _____% Ending ETCO2 ___%

Other pertinent information:

_____

_____

_____

Was the ePCR Airway Confirmation signature completed?: Yes / No

If no, why:_____. By who: DR / PA / NP / ALS

ePCR# (Run Number): _____

Cabinet seal number: Current_____ New_____

Provider Signature: _____ EMT#: _____ Unit: _____