Central New York EMS
Intubation Confirmation Form

This for 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

Patient:

☐ Adult ☐ Pediatric (<14 yo)

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 PCR.