

ADULT CARDIOPULMONARY RESUSCITATION REPORT

HEALTHCARE

Date: _____ Time Event Recognized: _____ Location: _____ Age: _____ Est. Wt. _____

Condition when need for Chest compression/defibrillation was identified? Pulse (poor perfusion) Pulseless

Witnessed: Yes No Indicate all monitors that were present at Onset: BCG Pulse Ox. Apnea None

Patient Conscious at Onset: Yes No Did the patient with a pulse become pulseless? Yes No

Airway/Ventilation					Circulation					Outcome				
At Onset: <input type="checkbox"/> Spontaneous <input type="checkbox"/> Apnea <input type="checkbox"/> Agonal <input type="checkbox"/> Assisted					First Documented Rhythm: _____					Resuscitation Event Ended @ _____ Disposition of Patient: <input type="checkbox"/> CCU <input type="checkbox"/> ICU <input type="checkbox"/> MORGUE <input type="checkbox"/> MS Case <input type="checkbox"/> AUTOPSY Other: _____ Attending Notified: <input type="checkbox"/> Yes <input type="checkbox"/> No Family Notified: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
Time of First Assisted Ventilation: _____					Time Chest Compressions Started: _____									
Types of Ventilation: <input type="checkbox"/> BMV <input type="checkbox"/> ETT <input type="checkbox"/> Tracheostomy <input type="checkbox"/> LMA					Patient Defibrillated: <input type="checkbox"/> Yes <input type="checkbox"/> No									
ETT Intubation: Time: _____ Size: _____					If yes, Time of First Shock: _____									
By: <input type="checkbox"/> Anesthesia <input type="checkbox"/> Resident <input type="checkbox"/> Attending <input type="checkbox"/> EMT <input type="checkbox"/> Other					Pacemaker On: <input type="checkbox"/> Yes <input type="checkbox"/> No									
Name: _____					NG Tube Inserted: <input type="checkbox"/> Yes <input type="checkbox"/> No									
Secondary Confirmation: <input type="checkbox"/> Auscultation <input type="checkbox"/> E.T. CO ₂														
Medication - Dose - IVP														
Time	Pulse		BP	Rhythm	Defibrillation	Rhythm Post Shock	Medication - Dose - IVP			Infusions - Dose			Comments: Peripheral/Central Line Placement and Site, Chest Tube Inserted, Vital Signs, Response to Interventions, ABG's	
	Spontaneous/Assisted	Spontaneous/Assisted					Atropine Dose	Epinephrine	Lidocaine Dose	Sodium Bicarb Dose	Dopamine	Thrombolysis		

Medication Nurse: _____

Physician's Printed Name: _____

Rhythm Strips to be documented in Progress Notes

Recording Nurse: _____

Physician's Signature: _____

White Sheet: Chart Copy Yellow Sheet: Nurse Manager

(Physician in charge must sign)