

**WISCONSIN ADVANCED AIRWAY CONTINUOUS QUALITY IMPROVEMENT DATA RECORD**

This form is to be completed and kept on file with the emergency medical service provider under the authority of 146.52(5)(c). This form is to be used for quality assurance activities regarding the use of advanced airways and may be required to be submitted to the department for review.

**Provider Name:** \_\_\_\_\_

**Provider Run No:** \_\_\_\_\_ **Date of Incident:** \_\_\_\_\_

**Provider Level:** (Check one)  First Responder  EMT-Basic  Intermediate Technician  
 EMT-Intermediate  EMT-Paramedic

**Patient Age:** \_\_\_\_\_ **Patient Sex:** (Check one)  M  F

**Chief Complaint:** \_\_\_\_\_

**Pulse:** (Check one)  Present  Absent **Spontaneous Respirations:** (Check one)  Present  Absent

**Advanced Airway Used:** (Check one)  ETT  Non-visualized \_\_\_\_\_ **Used As:** (Check One)  Primary Device  Rescue Device  
(List type)

Attempt No.	Ease of Air Entry:	Equal Chest Rise:	Equal Breath Sounds:	Absent Sounds Over Stomach:	Difficulty of Insertion:	Other Complications:
#1	<input type="checkbox"/> Easy <input type="checkbox"/> Average <input type="checkbox"/> Difficult	<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"/> Very Easy <input type="checkbox"/> Easy <input type="checkbox"/> Average <input type="checkbox"/> Difficult <input type="checkbox"/> Very Difficult	<input type="checkbox"/> Yes <input type="checkbox"/> No
#2	<input type="checkbox"/> Easy <input type="checkbox"/> Average <input type="checkbox"/> Difficult	<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"/> Very Easy <input type="checkbox"/> Easy <input type="checkbox"/> Average <input type="checkbox"/> Difficult <input type="checkbox"/> Very Difficult	<input type="checkbox"/> Yes <input type="checkbox"/> No
#3 or more	<input type="checkbox"/> Easy <input type="checkbox"/> Average <input type="checkbox"/> Difficult	<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"/> Very Easy <input type="checkbox"/> Easy <input type="checkbox"/> Average <input type="checkbox"/> Difficult <input type="checkbox"/> Very Difficult	<input type="checkbox"/> Yes <input type="checkbox"/> No

If "other complications" marked "yes" explain: \_\_\_\_\_

**Was device removed in field?** (Check one)  
 No  
 Yes – ineffective ventilation  
 Yes – need for tracheal medications  
 Yes – patient awoke  
 Yes – return of gag reflex  
 Yes – other, see note below

**Airway confirmed by receiving physician?** (Check one)  
 Not evaluated by physician  
 Airway confirmed in place  
 Airway found out of place

**Report reviewed by service medical director?** (Check one)  
 Yes  
 No

**Comments/notes:** \_\_\_\_\_

**Signature of person completing form:** \_\_\_\_\_