Glatfelter Commercial Ambulance℠
A Division of Glatfelter Insurance Group

Airway Verification Form

Agency Name: _____ **Date of Call:** _____

Provider Name: _____ **Trip/PCR #:** _____

Level: ☐ EMT-CC ☐ EMT-P ☐ PHRN ☐ HP

Patient Age: _____ **Patient Sex:** ☐ Male ☐ Female

ET Tube Placement: Size _____ ☐ Oral Pharyngeal ☐ Existing Trach

Combitube Placement: Size _____ ☐ Trachea White Port ☐ Esophagus Blue Port

Other Blind Insertion Device: Brand _____ Size _____

Medication(s)/Adjuncts Used to Facilitate Intubation:

Lidocaine _____ mg Etomidate _____ mg Rocuronium _____ mg Vecuronium _____ mg

Fentanyl _____ mg Succinylcholine _____ mg Midazolam _____ mg

☐ Video Laryngoscope ☐ Bougie Device

Verification Method(s) Used Prehospital:

☐ Auscultation ☐ ETCO2 Waveform Present ☐ Visualization ☐ Initial ETCO2 Numerical Reading: _____

ET Tube Verification at Hospital: ☐ Yes ☐ No ☐ N/A

Combitube Placement Verification at Hospital: ☐ Yes ☐ No ☐ N/A

Was Needle Cricothyrotomy Successfully Performed?: ☐ Yes ☐ No ☐ N/A

Verification Method(s) Used in Hospital:

☐ Auscultation ☐ Esophageal Detection Device ☐ Visualization ☐ Chest X-ray ☐ ETCO2 Wave Form

☐ CO2 Detector/Capnography ☐ Initial ETCO2 Numerical Reading: _____

Other Blind Insertion Device Verification at Hospital: Visible Chest Wall Expansion: ☐ Yes ☐ No

Verifying MD signature required below:

Name (print) _____ **Signature:** _____

**Document content published with permission by Suffolk County Regional EMS Advisory Committee.*