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BLS Administration of Nebulized Albuterol Quality Improvement Report

To be completed by the EMT who has administered Albuterol
According to the Collaborative Protocol

Upon completion of this report, please attach to the YELLOW copy of the PCR and Submit to the HVREMS office along with the monthly PCR submissions.

How bad is the Patient's Shortness of Breath? (Prior to Treatment)

0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐
None	***Slight***		***Moderate***			***Moderately-Severe***				***Severe***

0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐

Shortness of Breath Post Treatment

BLS Administration of Nebulized Albuterol

Date of Incident:_____ PCR #:_____ Agency Code:_____ EMT #:_____

Patient's Age:_____ Sex(M/F):_____ Time Patient Contact Began:_____ Time Patient Contact Ended : _____

Patient Had History of Asthma?(Y/N):_____ Patient Had Cardiac History?(Y/N): _____

Was Patient Able to Perform Peak Flow Test? (Y/N):_____ If So, what was the Reading? _____

Was Patient Able to give a Self Assessment (Borg Scale)?(Y/N):_____ If So, what was the rating? (0-10) _____

Time of Asthma Onset (If Known)?_____ Time of Albuterol Administration? 1st_____ 2nd _____

Did the Patient Show Improvement in Their Respiratory Status? (Y/N):_____ If So, How?_____

_____

Did the Patient's Respiratory Status Worsen? (Y/N):_____ If So, How?_____

_____

Was ALS Available? (Y/N):_____ If Not, Why?_____

Was Medical Control Contacted? (Y/N)::_____ If So, Name of Medical Control Physician?_____

Name of Transporting Ambulance Service?_____

Name of Receiving Hospital?_____

Level of Care Patient was Turned Over to? (Please Check): AEMT ☐ EMT-CC ☐ EMT-P ☐ RN ☐ MD ☐