Resuscitation Patient Management Tool

Cardiopulmonary Arrest (CPA) EVENT

June 2020

OPTIONAL:	Local Event ID:	
Did patient receive chest compressions and/or defibrillation during this event?	○ Yes	○ No/ Not Documented (Does NOT meet inclusion criteria)
Date/Time the need for chest compressions (or defibrillation when initial rhythm was VF or Pulseless VT) was FIRST recognized:	___/___/________ __:__ (MM/DD/YYYY HH:MM)	☐ Time Not Documented

CPA 2.1 Pre-Event — *Pre-Event Tab*

OPTIONAL

Was patient discharged from an Intensive Care Unit (ICU) within 24 hours prior to this CPA event?	○ Yes	○ No
If yes, date admitted to non-ICU unit (after ICU discharge):	____/_____/___________:____	MM/DD/YYYY HH:MM
Was patient discharged from a Post Anesthesia Care Unit (PACU) within 24 hours prior to this CPA event?	○ Yes	○ No
Was patient in the ED within 24 hours prior to this CPA event?	○ Yes	○ No
Did patient receive conscious/procedural sedation or general anesthesia within 24 hours prior to this CPA event?	○ Yes	○ No
Enter vital signs taken in the 4 hours prior to the CPA event (up to 4 sets)	☐ Pre-Event VS Unknown/Not Documented	

Date / Time	Heart Rate	Systolic / Diastolic BP	Respiratory Rate	SpO2	Temp	Units
____/_____/______ ____:____	______ ❑ Not Documented	______ ❑ Not Documented	______ ❑ Not Documented	______ ❑ Not Documented	______ ❑ Not Documented	❍ C ❍ F
____/_____/______ ____:____	______ ❑ Not Documented	______ ❑ Not Documented	______ ❑ Not Documented	______ ❑ Not Documented	______ ❑ Not Documented	❍ C ❍ F
____/_____/______ ____:____	______ ❑ Not Documented	______ ❑ Not Documented	______ ❑ Not Documented	______ ❑ Not Documented	______ ❑ Not Documented	❍ C ❍ F
____/_____/______ ____:____	______ ❑ Not Documented	______ ❑ Not Documented	______ ❑ Not Documented	______ ❑ Not Documented	______ ❑ Not Documented	❍ C ❍ F

CPA 2.2 Pre-Existing Conditions — *Pre-Event Tab*

Did patient have an out-of-hospital arrest leading to this admission?	○ Yes	○ No/Not Documented

Pre-existing Conditions at Time of Event (check all that apply):

- ☐ None (review options below carefully)
- ☐ Acute CNS non-stroke event
- ☐ Acute Stroke
- ☐ Baseline depression in CNS function
- ☐ Cardiac malformation/abnormality – acyanotic (pediatric and newborn/neonate only)
- ☐ Cardiac malformation/abnormality – cyanotic (pediatric and newborn/neonate only)
- ☐ Congenital malformation/abnormality (Non-Cardiac) (pediatric and newborn/neonate only)
- ☐ Congestive heart failure (this admission)
- ☐ Congestive heart failure (prior to this admission)
- ☐ Diabetes mellitus
- ☐ Hepatic insufficiency
- ☐ Myocardial ischemia/infarction (prior to admit)
- ☐ Pneumonia
- ☐ Recently delivered or currently pregnant (if selected, maternal in-hospital cardiac arrest section is required)
- ☐ Renal Insufficiency
- ☐ Respiratory Insufficiency
- ☐ Sepsis
- ☐ **Active or suspected bacterial or viral infection at admission or during hospitalization:**
  - ❑ None
  - ❑ Bacterial Infection
  - ❑ Emerging Infectious Disease
    - ☐ SARS-COV-1
    - ☐ SARS-COV-2 (COVID-19)

☐ History of vaping or e-cigarette use in the past 12 months? ☐ Hypotension/Hypoperfusion ☐ Major trauma ☐ Metastatic or hematologic malignancy ☐ Metabolic/electrolyte abnormality ☐ Myocardial ischemia/infarction (this admission)	☐ MERS ☐ Other Emerging Infectious Disease ❑ Influenza ❑ Seasonal cold ❑ Other Viral Infection ***Additional Personal Protective Equipment (PPE) Donned by the responders?*** ❑ Yes ❑ No/ND

CPA 2.2 INTERVENTIONS ALREADY IN PLACE *Pre-Event Tab*

Interventions ALREADY IN PLACE when need for chest compressions and/or defibrillation was first recognized (check all that apply):

Part A:	☐ None
❑Non-invasive assisted ventilation ☐ Bag-Valve-Mask ☐ Mask and/or Nasal CPAP ☐ Mouth-to-Barrier Device ☐ Mouth-to-Mouth ☐ Laryngeal Mask Airway (LMA) ☐ Other Non-Invasive Ventilation: (specify) _____	❑ Invasive assisted ventilation, via an: ☐ Endotracheal Tube (ET) ☐ Tracheostomy Tube ❑ Intra-arterial catheter ❑ Conscious/procedural sedation ❑ End Tidal CO_2 ($ETCO_2$) Monitoring ❑ Supplemental oxygen (cannula, mask, hood, or tent)

Monitoring	☐ Apnea	☐ Apnea/Bradycardia	☐ ECG	☐ Pulse Oximetry
Vascular Access	○ Yes		○No/ Not Documented	
Any Vasoactive Agent in Place?	○ Yes		○No/Not Documented	

OPTIONAL

Part B:	☐ None
☐ IV/IO continuous infusion of antiarrhythmic(s) ☐ Dialysis/extracorporeal filtration therapy (ongoing)	☐ Implantable cardiac defibrillator (ICD) ☐ Extracorporeal membrane oxygenation (ECMO)

CPA 3.1 EVENT *Event Tab*

Date/Time of Birth:	_____/_____/_____ ____:____ (MM/DD/YYYY HH:MM)			
Age at Event (in yrs., months, weeks, days, hrs., or minutes):	_____	○Years ○Months ○Weeks	○Days ○Hours ○Minutes	❑ Estimated ❑ Age Unknown/Not Documented

Subject Type	○ Ambulatory/Outpatient ○ Emergency Department ○ Hospital Inpatient – (rehab, skilled nursing, mental health wards)	○ Rehab Facility Inpatient ○ Skilled Nursing Facility Inpatient ○ Mental Health Facility Inpatient ○ Visitor or Employee
Illness Category	○ Medical-Cardiac ○ Surgical-Cardiac ○ Obstetric ○ Other (Visitor/Employee)	○ Medical-Noncardiac ○ Surgical-Noncardiac ○ Trauma
Event Location (Area)	○ Ambulatory/Outpatient Area ○ Adult Coronary Care Unit (CCU) ○ Adult ICU ○ Cardiac Catheterization Lab ○ Delivery Suite ○ Diagnostic/Intervention Area (excludes Cath Lab) ○ Emergency Department (ED)	○ Operating Room (OR) ○ Pediatric ICU (PICU) ○ Pediatric Cardiac Intensive Care ○ Post-Anesthesia Recovery Room (PACU) ○ Rehab, Skilled Nursing, or Mental Health Unit/Facility ○ Same-Day Surgical Area

	○ General Inpatient Area ○ Neonatal ICU (NICU) ○ Newborn Nursery	○ Telemetry Unit or Step-Down Unit ○ Other ○ Unknown/Not Documented
Event Location (Name)	_____	
Event Witnessed?	○ Yes	○ No/Not Documented
Was a hospital-wide resuscitation response activated?	○ Yes	○ No/Not Documented

CPA 4.1 INITIAL CONDITION	***Initial Condition/Defibrillation/Ventilation Tab***	
Condition that best describes this event:	○ Patient was PULSELESS when need for chest compressions and/or need for defibrillation of initial rhythm VF/Pulseless VT was first identified ○ Patient had a pulse (poor perfusion) requiring chest compressions PRIOR to becoming pulseless ○ Patient had a pulse (poor perfusion) requiring chest compressions, but did NOT become pulseless at any time during this event	
Did patient receive chest compressions (includes open cardiac massage)?	○ Yes ○ No/Not Documented ○ No, Per Advance Directive	
Compression Method(s) used (check all that apply):	☐ Standard Manual Compression ☐ Open chest CPR (direct [internal] cardiac compression) ☐ IAC-CPR (interposed abdominal compression cardiopulmonary resuscitation) ☐ Automatic Compressor ☐ Unknown/Not documented	
Date/Time compression started	___/___/_____ ___:___ (MM/DD/YYYY HH:MM)	☐ Time Not Documented
If compressions provided while pulse present: Rhythm when patient with pulse FIRST received chest compressions during event:	○ Accelerated idioventricular rhythm (AIVR) ○ Bradycardia ○ Pacemaker ○ Sinus (including Sinus Tachycardia)	○ Supraventricular Tachyarrhythmia (SVTarrhy) ○ Ventricular Tachycardia (VT) with a pulse ○ Unknown/Not Documented
If pulseless at ANY time during event: Date/Time pulselessness first identified:	____/____/_____ ____:____ (MM/DD/YYYY HH:MM)	☐ Time Not Documented
First documented pulseless rhythm:	○ Asystole ○ Pulseless Electrical Activity (PEA) ○ Pulseless Ventricular Tachycardia	○ Ventricular Fibrillation ○ Unknown/Not Documented

CPA 4.2 AED AND VF/PULSELESS VT	***Initial Condition/Defibrillation/Ventilation Tab***		
Was automated external defibrillator (AED) applied or manual defibrillator in AED/Shock Advisory mode applied?	○ Yes	○ No/Not Documented	○ Not Applicable (not used by facility)
Date/Time AED or manual defibrillator in AED/Shock Advisory mode applied?	___/___/_____ ___:___ (MM/DD/YYYY HH:MM)		☐ Time Not Documented
Did the patient have Ventricular Fibrillation (VF) OR Pulseless Ventricular Tachycardia ANY time during this event?	○ Yes		○ No/Not Documented
Date/Time of Ventricular Fibrillation (VF) OR Pulseless Ventricular Tachycardia?	___/___/_____ ___:___ (MM/DD/YYYY HH:MM)		☐ Time Not Documented
Was Defibrillation shock provided for Ventricular Fibrillation (VF) OR Pulseless Ventricular Tachycardia?	○ Yes	○ No/Not Documented	○ No, Per Advance Directive
Total # of Shocks	_____	☐ Unknown/Not Documented	

Date/Time	____/____/_____ ___:___ (MM/DD/YYYY HH:MM)	☐ Not Documented
Energy (Joules)	_____	☐ Not Documented

Details of Each Shock (maximum of 4):

Date/Time	Energy (joules)
____/____/_____ ____:____ ❑ Not Documented	_____ ❑ Not Documented
____/____/_____ ____:____ ❑ Not Documented	_____ ❑ Not Documented
____/____/_____ ____:____ ❑ Not Documented	_____ ❑ Not Documented
____/____/_____ ____:____ ❑ Not Documented	_____ ❑ Not Documented

Documented reason (s) (patient, medical, hospital related or other) for not providing defibrillation shock for Ventricular Fibrillation (VF) or Pulseless Ventricular Tachycardia (VT) in first two minutes?	○ Yes	○ No

Patient Reason(s):	☐ Initial Refusal (e.g. family refused)
Medical Reason(s)	☐ ICD in place which shocked patient within first 2 minutes of identification of VF or Pulseless VT ☐ LVAD or BIVAD in place ☐ Rhythm change to non-shockable rhythm within 2 minutes of identification of VF or Pulseless VT ☐ Spontaneous Return of Circulation within first 2 minutes of identification of VF or Pulseless VT
Hospital Related or Other Reason(s)	☐ Equipment related delay (e.g., defibrillator not available, pad not attached) ☐ In-hospital time delay (e.g. code team delays, personnel not familiar with protocol or equipment, unable to locate hospital defibrillator) ☐ Other → (Please Specify) _____

CPA 4.3 VENTILATION ***Initial Condition/Defibrillation/Ventilation Tab***

Types of Ventilation/Airways used	☐ None	☐ Unknown/Not Documented
Ventilation/Airways Used (Select all that apply)	☐ Bag-Valve-Mask ☐ Mask and/or Nasal CPAP/BiPAP ☐ Mouth-to-Barrier Device ☐ Mouth-to-Mouth	☐ Laryngeal Mask Airway (LMA) ☐ Endotracheal Tube (ET) ☐ Tracheostomy Tube ☐ Other Non-Invasive Ventilation, Specify_____

Was Bag-Valve-Mask ventilation initiated during the event?	○ Yes	○ No	○ Not Documented
Date/Time	____/____/_____ ___:___ (MM/DD/YYYY HH:MM)		☐ Time Not Documented
Was any Endotracheal Tube (ET) or Tracheostomy Tube inserted/re-inserted during event?	○ Yes		○ No
Date/Time Endotracheal Tube (ET) or Tracheostomy Tube inserted if not already in place and/or re-inserted during event:	____/____/_____ ___:___ (MM/DD/YYYY HH:MM)		☐ Time Not Documented
Method(s) of confirmation used to ensure Endotracheal Tube (ET) or Tracheostomy Tube placement in trachea (check all that apply):	☐ Waveform capnography (waveform ETCO2) ☐ Capnometry (numeric ETCO2) ☐ Exhaled CO2 colorimetric monitor (ETCO2 by color change) ☐ Esophageal detection devices		☐ Revisualization with direct laryngoscopy ☐ None of the above ☐ Not Documented

CPA 5.1 EPINEPHRINE ***Other Interventions Tab***

Was IV/IO Epinephrine BOLUS administered?	○ Yes	○ No	○ Not Documented
Date/Time	____/____/_____ ____:____ (MM/DD/YYYY HH:MM)		☐ Time Not Documented
Total Number of Doses	_____		☐ Unknown/Not Documented

If IV/IO Epinephrine was not administered within the first five minutes of the event, was there a documented patient, medical, hospital related or other reason for not providing Epinephrine bolus?	○ Yes	○ No

Patient Reason(s)	❑ Initial Refusal (e.g. family refused)
Medical Reason(s)	❑ Patient already receiving vasopressor (e.g. Epinephrine) as a continuous IV infusion prior to and during arrest ❑ Spontaneous Return of Circulation within first 5 minutes of the date/time pulselessness was first identified (or the need for chest compressions was first recognized (pediatric only)) ❑ Medication allergy
Hospital Related or Other Reason(s)	❑ In-hospital time delay (e.g., delay in locating medication) ❑ No route to deliver medication (e.g. no IV/IO access) ❑ Other → (Please Specify) _____

CPA 5.2 Other Drug Interventions — *Other Interventions Tab*

Select all either initiated, or if already in place immediately prior to, continued during event.

❑ **None** (select only after careful review of options below) ❑ **Antiarrhythmic medication(s):** ☐ Adenosine/Adenocard ☐ Amiodarone/Cordarone ☐ Lidocaine ☐ Procainamide ☐ Other antiarrhythmics: _____	❑ **Vasopressor(s) other than epinephrine bolus:** ☐ Dobutamine ☐ Dopamine > 3mcg/kg/min ☐ Epinephrine, IV/IO continuous infusion ☐ Norepinephrine ☐ Phenylephrine ☐ Other Vasopressors: _____	❑ Atropine ❑ Calcium Chloride/Calcium Gluconate ❑ Dextrose Bolus ❑ Magnesium Sulfate ❑ Reversal agent (e.g., naloxone/Narcan, flumazenil/Romazicon, neostigmine/Prostigim) ❑ Sodium Bicarbonate ❑ Other Drug Interventions: _____

CPA 5.3 Non-Drug Interventions — *Other Interventions Tab*

Select each intervention that was employed during the resuscitation event.

❑ None (review options below carefully) ❑ Cardiopulmonary bypass / extracorporeal CPR (ECPR) ❑ Chest tube(s) inserted ❑ Needle thoracostomy	❑ Pacemaker, transcutaneous ❑ Pacemaker, transvenous or epicardial ❑ Pericardiocentesis ❑ Other non-drug interventions _____

CPA 6.1 Event Outcome — *Event Outcome Tab*

Was ANY documented return of adequate circulation [ROC] (in the absence of ongoing chest compressions return of adequate pulse/heart rate by palpation, auscultation, Doppler, arterial blood pressure waveform, or documented blood pressure) achieved during the event?		○ Yes ○ No/Not Documented
Date/Time of FIRST adequate return of circulation (ROC):	____/____/_____ ___:___ (MM/DD/YYYY HH:MM)	☐ Time Not Documented
Reason resuscitation ended	○ Survived – ROC	○ Died – Efforts terminated, no sustained ROC
Date and time sustained ROC ***began lasting > 20 min*** OR resuscitation efforts were terminated (End of event)	____/____/_____ ___:___ (MM/DD/YYYY HH:MM)	☐ Time Not Documented

CPA 6.2 Post-ROC Care — *Event Outcome Tab*

Highest patient temperatures during first 24 hrs. after ROC: Temperature	○ _____ **C**		○ _____ **F**		☐ Temperature Not Documented
Site	○Axillary ○Bladder	○Blood ○Brain	○Oral ○Rectal	○Surface (skin, temporal) ○Other	○Unknown ○Tympanic
Date/Time Recorded:	___/___/_____ ___:___ (MM/DD/YYYY HH:MM)		☐ Time Not Documented		

CPA 7.1 CPR QUALITY *CPR Quality Tab*

Was performance of CPR monitored or guided using any of the following? (Check all that apply)	☐ None ☐ Waveform Capnography/End Tidal CO2 (ETCO2) ☐ Arterial Wave Form/Diastolic Pressure ☐ CPR mechanics device (e.g. accelerometer, force transducer, TFI device)	☐ CPR Quality Coach ☐ Metronome ☐ Other, Specify: _____

If CPR mechanics device (e.g. accelerometer, force transducer, TFI device) used:

Average Compression Rate	_____ (Per Minute)		☐ Not Documented	
Average Compression Depth	○ _____ mm	○ _____ cm	○ _____ inches	☐ Not Documented
Compression Fraction	_____ (Enter number between 0 and 1)			☐ Not Documented
Percent of chest compressions with complete release	_____ (%)			☐ Not Documented
Average Ventilation Rate	_____ (Per Minute)			☐ Not Documented
Longest Pre-shock pause	_____ (Seconds)			☐ Not Documented
Was a team debriefing on the quality of CPR provided completed after the event?	○ Yes	○ No		○ Not Documented

CPA 7.2 RESUSCITATION-RELATED EVENTS AND ISSUES *CPR Quality Tab*

OPTIONAL: ☐ No/Not Documented

Universal Precautions	☐ Not followed by all team members (specify in comments section)	
Documentation	☐ Signature of code team leader not on code sheet ☐ Missing other signatures ☐ Initial ECG rhythm not documented	☐ Medication route(s) not documented ☐ Incomplete documentation ☐ Other (specify in comments section)
Alerting Hospital-Wide Resuscitation Response	☐ Delay ☐ Pager Issues	☐ Other (specify in comments section)
Airway	☐ Aspiration related to provision of airway ☐ Delay ☐ Delayed recognition of airway misplacement/displacement ☐ Intubation attempted, not achieved	☐ Multiple intubation attempts → Number of Attempts _____ ☐ Unknown/ Not Documented ☐ Other (specify in comments section)
Vascular Access	☐ Delay ☐ Inadvertent arterial cannulation	☐ Infiltration/Disconnection ☐ Other (specify in comments section)
Chest Compression	☐ Delay ☐ No back board	☐ Other (specify in comments section)
Defibrillations	☐ Energy level lower/higher than recommended ☐ Initial delay, personnel not available to operate defibrillator ☐ Initial delay, issues with defibrillator access to patient	☐ Initial delay, issue with paddle placement ☐ Equipment Malfunction ☐ Given, not indicated ☐ Indicated, not given ☐ Other (specify in comments section)
Medications	☐ Delay	☐ Selection

	☐ Route ☐ Dose		☐ Other (specify in comments section)
Leadership	☐ Delay in identifying leader ☐ Knowledge of equipment ☐ Knowledge of medications/protocols ☐ Knowledge of roles		☐ Team oversight ☐ Too many team members ☐ Other (specify in comments section)
Protocol Derivation	☐ ACLS/PALS	☐ NRP	☐ Other (specify in comments section)
Equipment	☐ Availability	☐ Function	☐ Other (specify in comments section)
Comments			
Was this cardiac arrest event the patient's index (first) event?	○ Yes		○ No

Comments & Optional Fields: *Do not enter any Personal Health Information/Protected Health Information into this section.*

Field 1	Field 2
Field 3	Field 4
Field 5	Field 6
Field 7	Field 8
Field 9	Field 10
Field 11	Field 12
Field 13 ____/____/_____ ____:____	Field 14 ____/____/_____ ____:____

MATERNAL IN-HOSPITAL CARDIAC ARREST *Research Tab*

If Recently delivered or currently pregnant was selected under Pre-existing conditions, please select one of the following:	____/____/_____ ____:____ (MM/DD/YYYY HH:MM)		☐ Not Documented
○ Patient recently delivered fetus	If patient recently delivered a fetus, select delivery date: ____/____/_____ ____:____ (MM/DD/YYYY HH:MM)		☐ Not Documented
○ Patient is currently pregnant	If patient is currently pregnant, enter EDC/Due Date: ____/____/_____ (MM/DD/YYYY)	☐ Not Documented	Gestational Age ___
Select Number of Fetuses (Single Select)	○ Single ○ Multiple		○ Unknown ○ Not Documented
The patient had the following delivery or pregnancy complications	☐ Not Documented ☐ None ☐ Alcohol Use ☐ Chorioamnionitis ☐ Cocaine/Crack use ☐ Gestational Diabetes ☐ Diabetes ☐ Eclampsia ☐ GHTN (Pregnancy induced/gestational hypertension) ☐ Hypertensive Disease ☐ Magnesium Exposure ☐ Major Trauma		☐ Maternal Group B Strep (Positive) ☐ Maternal Infection ☐ Methamphetamine/ICE use ☐ Narcotic given to mother within 4 hours of delivery ☐ Narcotics addiction and/or on methadone maintenance ☐ Obstetrical hemorrhage ☐ Pre-eclampsia ☐ Prior Cesarean ☐ Urinary Tract Infection (UTI) ☐ Other (specify) _____
Total # of pregnancies (gravida)	_____ (Integer Field)		☐ Unknown/Not Documented
Total # of deliveries (parity)	_____ (Integer Field)		☐ Unknown/Not Documented

Delivery Mode (Single Select):	○ Vaginal/Spontaneous ○ Vaginal/Operative	○ VBAC ○ C-Section/Scheduled	○ C-Section/Emergent ○ Unknown/Not Documented
Left Lateral Uterine Displacement:	☐Yes ☐Unknown/Not Documented Time recognized ___:___	Select Method(s) (select all that apply)	☐ Manual Uterine Displacement ☐ Left Lateral Tilt ☐ Unknown/Not Documented
Neonatal Outcome (Single Select)	○ Delivered (**If delivered, enter Apgar Scores**): ☐Enter 1 min. Apgar score (integer field range: 0-10) _____ ☐Enter 5 min Apgar score (integer field range: 0-10) _____ ☐Unknown/Not Documented		○ Undelivered ○IUFD (intrauterine fetal death) ○Viable ○Unknown/Not Documented
Was a CPA event completed for the newborn?	○ Yes	○ No	○ Unknown/ Not Documented

CPA 5.3 Other Drug Interventions

Select each intervention that was employed during the resuscitation event:	❑ **None** (review options below carefully)	❑ Cardiopulmonary bypass / ECMO or extracorporeal CPR (ECPR)	
Was ECPR process activated?	❑ ECMO/ECPR activated		
Is there an ELSO record for this patient?	○ Yes	○ No	○ Unknown/ND
If yes, enter ELSO Patient Record Number (**optional**)	_____		
Was cannulation attempted?	○ Yes	○ No	○ Unknown/ND
Was cannulation successful?	○ Yes ○ No	○ Unknown/Not Documented ○ Cannulation initiated but not completed	
Date/Time ECMO started ____/____/_____ ____:____		Date/Time ECMO ended ____/____/_____ ____:____	
Initial Extracorporeal Life Support Mode (check all that apply)	❑ Venoarterial ECMO ❑ Venovenous ECMO ❑ Veno-Venoarterial ECMO ❑ AVECCO2R	❑ VVECCO2R ❑ Other _____ ❑ Unknown/ND	

Cannulation Anatomical Site (check all that apply)

❑ RCCA – Percutaneous?	○ Yes	○ No	❑ Aorta	❑ LA	❑ PA	❑ RA
❑ LCCA – Percutaneous?	○ Yes	○ No	❑ LSA – Percutaneous?		○ Yes	○ No
❑ RIJV – Percutaneous?	○ Yes	○ No	❑ LSV – Percutaneous?		○ Yes	○ No
❑ RIJVC – Percutaneous?	○ Yes	○ No	❑ RSA – Percutaneous?		○ Yes	○ No
❑ RFA – Percutaneous?	○ Yes	○ No	❑ RSV – Percutaneous?		○ Yes	○ No
❑ LFA – Percutaneous?	○ Yes	○ No	❑ Other – Percutaneous?		○ Yes	○ No
❑ RFV – Percutaneous?	○ Yes	○ No	❑ Unknown/ND			
❑ LFV – Percutaneous	○ Yes	○ No				

ECMO Cannulation Location (area)

○ Ambulatory/Outpatient Area	○ Emergency Department (ED)	○ Post-Anesthesia Recovery Unit (PACU)
○ Adult Coronary Care Unit (CCU)	○ Inpatient Area	○ Rehab, Skilled Nursing, or Mental Health Unit/Facility
○ Adult ICU	○ Neonatal ICU (NICU)	○ Same-day Surgical Area
○ Cardiac Catheterization Lab	○ Newborn Nursery	○ Telemetry unit or Step-down unit
○ Delivery Suite	○ Operating Room (OR)	○ Other (Specify) _____
○ Diagnostic/Intervention. Area (excludes Cath Lab)	○ Pediatric ICU (PICU)	○ Unknown/Not Documented
	○ Pediatric Intensive Care Unit	

Team Member(s) Performing ECMO Cannulation:	❑ Anesthesiologist ❑ Intensivist ❑ Surgeon	❑ Other (Specify) _____ ❑ Unknown/Not Documented
ECMO circuit priming (select all that apply):	❑ Crystalloid ○Saline ○Plasma-Lyte ○Other Crystalloid _____ ❑ 5% or 25% Albumin	❑ Plasma ❑ RBC ❑ Whole Blood ❑ Other (Specify) _____ ❑ Unknown/Not Documented

Date/Time: ____/____/_____ ____:____	Blood flow _____(mL/minute) at 4 hours after cannulation	❑ ND
Date/Time: ____/____/_____ ____:____	Blood flow _____(mL/minute) 24 hours after cannulation	❑ ND
Date/Time: ____/____/_____ ____:____	FsO2 _____at 4 hours after cannulation	❑ ND
Date/Time: ____/____/_____ ____:____	FsO2 _____24 hours after cannulation	❑ ND

Head CT performed?	○ Yes	○ No	○ Unknown/Not Documented
If Yes, enter Date/Time CT Performed (for first CT post-cannulation if multiple CTs were performed):		Date/Time:	____/____/_____ ____:____
Cerebral MRI performed?	○ Yes	○ No	○ Unknown/Not Documented
If Yes, Date/Time Cerebral MRI performed (for first MRI post-decannulation if multiple MRIs were performed):		Date/Time:	____/____/_____ ____:____

Neurologic injury or events detected during ECMO or after ECMO (Less than 6 weeks after separation from ECMO or by Hospital Discharge, which ever one comes first). (check all that apply):

❑ None/Not Documented		
❑ Anoxic Brain Injury	Date/Time detected: ____/____/_____ ____:____	❑ Date/Time Unknown/ND
❑ Brain Death	Date/Time detected: ____/____/_____ ____:____	❑ Date/Time Unknown/ND
❑ Cerebral Microbleeds	Date/Time detected: ____/____/_____ ____:____	❑ End Date/Time Unknown/ND
❑ Intracranial Hemorrhage	Date/Time detected: ____/____/_____ ____:____	❑ Date/Time Unknown/ND
❑ Ischemic Stroke	Date/Time detected: ____/____/_____ ____:____	❑ Date/Time Unknown/ND
❑ New Clinical Seizure(s)	Date/Time detected: ____/____/_____ ____:____	❑ Date/Time Unknown/ND

EEG performed within in first 24 hours post-ROC?	○ Yes	○ No	○ Unknown/Not Documented
If EEG was performed, was there an indication of electrographic seizure activity?	○ Yes	○ No	○ Unknown/Not Documented
If EEG was performed, was an antiepileptic administered?	○ Yes	○ No	○ Unknown/Not Documented

END OF FORM