

# Naval Hospital Oak Harbor

## Record of Pediatric or Adult Cardiopulmonary Arrest

Date \_\_\_\_\_ Time Event Recognized \_\_\_\_\_ Location \_\_\_\_\_ Witnessed:  Yes  No  
 Age \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Hospital-wide resuscitation response activated?  Yes  No  
 Illness Category:  Medical Cardiac  Medical Noncardiac  Obstetric  
 Surgical Cardiac  Surgical Noncardiac  Trauma  Other \_\_\_\_\_  
 Condition when need for chest compression/defibrillation was identified?  Pulseless  Pulse (poor perfusion)  
 Did the patient with a pulse requiring compressions become pulseless?  Yes  No  
 Was patient conscious at onset?  Yes  No Monitoring at onset:  ECG  Pulse Oximeter  Apnea

<p style="text-align: center;"><b>Airway/ Ventilation</b></p> Breathing at Onset: <input type="checkbox"/> Spontaneous <input type="checkbox"/> Apneic <input type="checkbox"/> Agonal <input type="checkbox"/> Assisted Time of First Assisted Ventilation: _____ Ventilation: <input type="checkbox"/> Bag-Valve-Mask <input type="checkbox"/> Endotracheal Tube <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Other: _____ Intubation: Time: _____ Size: _____ By Whom: _____ Confirmation <input type="checkbox"/> Auscultation <input type="checkbox"/> Exhaled CO <sub>2</sub> <input type="checkbox"/> Other	<p><b>First Rhythm Requiring Compressions:</b> _____</p> <p><b>First Documented PULSELESS Rhythm:</b> _____</p> <p><b>Compressions:</b> <input type="checkbox"/> None <input type="checkbox"/> Manual <input type="checkbox"/> Device: _____</p> <p><b>Time chest compressions started:</b> _____</p> <p><b>Impedance Threshold Device used?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>AED applied:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No → <b>Time applied:</b> _____</p> <p><b>Defibrillator type(s):</b> _____</p> <p><b>Pacemaker On:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Time	Breathing		Pulse		Bolus ~ Dose / Route								Infusions ~ Dose / ml per hour				Comments: i.e.: Peripheral/Central Line Placement, IO, Chest tube, Vital Signs, Response to Interventions			
	Spontaneous	Assisted (✓)	Spontaneous	Compression (✓)	BP	Rhythm	AED	Manual (✓)	Joules	Amiodarone Dose / IV or IO	Atropine Dose / IV or IO	Epinephrine Dose / IV or IO	Lidocaine Dose / IV or IO	Vasopressin Dose / IV or IO	Dopamine	Dobutamine		Epinephrine	Norepinephrine	

**Time Resuscitation Event Ended:** \_\_\_\_\_ **Status:**  Alive  Dead  
**Reason Resuscitation Ended:**  Return of Circulation (ROC) >20 min  Efforts Terminated (No Sustained ROC)  
 Medical Futility  Advance Directives  Restrictions by Family

**Recorder Signature** \_\_\_\_\_ **Provider Printed Name** \_\_\_\_\_  
**CodeTeam Nurse Signature** \_\_\_\_\_ **Provider Signature** \_\_\_\_\_

Addressograph