



CARDIOPULMONARY RESUSCITATION RECORD

DATE / /	LOCATION	SERVICE
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WITNESSED ARREST RESPIRATORY ARREST
 UNWITNESSED ARREST CARDIAC ARREST

CODE CHRONOLOGY: Time code event recognized: _____ Time CPR started: _____ Code team called: Yes / No Time: _____

PRESENTING HISTORY RELATED TO CODE (i.e., what triggered event, significant patient history, meds, signs/symptoms): _____
 On cardiac monitor prior to arrest? Yes / No Time team called: _____ Time code team arrived: _____

Admitting Dx: _____

Glasgow Coma Scale: _____ Spinal Cord Injury Motor Exam Codes: 5 4 3 2 1 0 Pupil Gauge: 3 4 5 6 7 8 (mm) _____ Eyes Open: 4 3 2 1 C Pupils: Equal reac _____ Fixed/no reac _____ One pupil dilated/no reac _____ Best Motor Response: 6 5 4 3 2 1 Best Verbal Response: 5 4 3 2 1 Total: _____

RESPIRATORY ASSESSMENT/INTERVENTIONS: Intubated Prior? Yes No AED time _____ Code Status _____ # of shocks _____

Intubated during code Yes* No *Intubated by: _____ Time of intubation: _____ Tube placement: _____ cm @ teeth/gum/nares
 Spontaneous ventilation Yes No Size of ETT: Oral Nasal Bilateral breath sounds: Yes No* (If no,
 Airway: ETT LMA MLT Number of intubation _____ when was auscultated?)
 Attempts: _____
 Ambu bag with 100% O2 Yes No Comments: _____

IV STATUS: Prior IV access <input type="checkbox"/> Yes <input type="checkbox"/> No IO access <input type="checkbox"/> Yes <input type="checkbox"/> No Site: _____	IV STATUS: Initiated *Time: _____ Gauge: _____ Site: _____	EXTERNAL PACEMAKER USED: <input type="checkbox"/> Yes* <input type="checkbox"/> No *Time placed: _____ Rate: _____ MA's _____ Response: _____	PEDS CODE SHEET: <input type="checkbox"/> Yes <input type="checkbox"/> No WT _____ Kgs
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Time	Rhythm	Joules	Meds/Dose Route	Response	Pulse/BP/Spo ₂			Fluid Volume	Comments

ABG's	TIME	SITE	PT. FiO ₂	pH	PaCO ₂	PaO ₂	HCO ₃	%SAT	ΔBASE	OTHER LABS

Post Arrest Status		ECG (Strips Posted on Back)			
Survived <input type="checkbox"/> Family Notified <input type="checkbox"/>	Expired <input type="checkbox"/>	Time: _____	By: _____		
VS: _____	Family Notified	(Name): _____	<input type="checkbox"/> No	<input type="checkbox"/> N/A By: _____	
Rhythm: _____	OMI Notified:	<input type="checkbox"/> Yes	Time: _____	<input type="checkbox"/> N/A	
LOC: _____	Autopsy Requested:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A By: _____	
Transferred to: _____ Time: _____	Donor Services Notified:	<input type="checkbox"/> Yes	Time: _____		

PRINT NAME	SIGNATURE
RECORDER:	
MEDS BY:	
RN LEADER:	
MD LEADER:	
RT:	

Pt. Sticker

SAME AS 1

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