Date/Time Event Recognized _____ **Location**_____ **Witnessed:** ☐ Yes ☐ No

Age _____**Weight**_____ **Height** _____ **Hospital-wide response activated?** ☐ Yes ☐ No

Illness Category: ☐ Medical Cardiac ☐ Medical Noncardiac ☐ Newborn ☐ Obstetric ☐ Surgical Cardiac ☐ Surgical Noncardiac ☐ Trauma ☐ Other _____

Condition when need for compressions/defibrillation was identified? ☐ Pulseless ☐ Pulse (poor perfusion)

Did the patient with a pulse requiring compressions become pulseless? ☐ Yes ☐ No

Conscious at Onset? ☐ Yes ☐ No **Monitoring at Onset:** ☐ ECG ☐ Pulse Oximeter ☐ Apnea

Patient Label or Addressograph

Patient Name_____ MR #_____

Airway/ Ventilation

Breathing ☐Spontaneous ☐Apneic ☐Agonal ☐Assisted

Time of First Assisted Ventilation: _____

Ventilation: ☐ Bag-Valve-Mask ☐ Endotracheal Tube ☐ Tracheostomy ☐ Other:_____

Intubation: Time:_____ **Size** :_____

By Whom: _____

Confirmation: ☐ Auscultation ☐ Exhaled CO_2 ☐ Other _____

Circulation

1st Rhythm Requiring Compressions: _____

1st PULSELESS Rhythm: _____

Compressions: ☐ None ☐ Manual ☐ Device:_____

Time Chest Compressions Started: _____

Impedence Threshold Device Used? ☐ Yes ☐ No

AED Applied: ☐ Yes ☐ No ➔ **Time:**_____

Defibrillator Type(s): _____

Pacemaker On: ☐ Yes ☐ No

Time Resuscitation Event Ended: _____

Reason Resuscitation Ended:

☐ Survived – Return of Circulation (ROC) >20 min
☐ Died – Efforts Terminated (No Sustained ROC)
☐ Died – Medical Futility
☐ Died – Advance Directives
☐ Died – Restrictions by Family

Bolus Dose / Route **Infusions Dose / cc per hr**

Time	Breathing: Spontaneous	Breathing: Assisted (✓)	Pulse: Spontaneous	Pulse: Assisted (✓)	BP	Rhythm	Defibrillator Type 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	Comments: i.e.: Peripheral/Central Line Placement, IO, Chest tube, Vital Signs, Response to Interventions

Recorder Signature _____ **ID#**_____ **Provider Printed Name** _____ **ID#**_____

ICU/Code Team Nurse Signature _____**ID#**_____ **Provider Signature** _____