

## Endotracheal Intubation

Date: < \_\_\_ >

Time: < \_\_\_ >

Indication: Respiratory Distress / (other indication – specify)

Resident: < \_\_\_ >

Attending: < \_\_\_ >

Pre-oxygenation was provided with (specify [e.g., non-rebreathing mask, other interface]). Induction was provided with (specify each drug, dose and route). Orotracheal intubation was performed using (specify if direct laryngoscopy or video laryngoscopy; specify any adjuncts used [e.g., bougie]) with (specify the size of endotracheal tube [e.g., 7.5]) and with (specify view of vocal cords [grade of view is acceptable]). Endotracheal tube position was confirmed by capnography. The endotracheal tube was secured at (specify figure in centimeters) at upper incisors. Proper intratracheal position of the endotracheal tube was verified on portable chest -x-ray (alternatively, describe tube adjustment and any other procedure-related changes). <Attending/Resident> was present for the entire procedure.

The patient tolerated the procedure well and there were no complications (alternatively, specify briefly, peri-procedural adverse events).

## Central Venous Catheter Placement

Date: < \_\_\_ >

Time: < \_\_\_ >

Indication: Hemodynamic monitoring/Intravenous access/other indication (specify)

Resident: < \_\_\_ >

Attending: < \_\_\_ >

A time-out was completed verifying correct patient, procedure, and site. Skin sterilization was performed with chlorhexidine. Maximal barrier technique was used throughout the procedure. Local anesthesia was provided with lidocaine 1% (specify, as applicable other medications with doses and routes used to facilitate the procedure). A triple/4-lumen central venous catheter was placed in the (specify site and side) using Seldinger's technique under real-time ultrasound guidance. Adequate blood aspiration was confirmed for all ports and ports were flushed with normal saline. The central venous catheter was secured with (specify suture type and size). The position of the central venous catheter was confirmed on a portable chest -x-ray (specify if malposition was found and the actions taken to adjust position). (specify if any complications were noted of the chest x-rays and, any action taken, as applicable). <Attending/Resident> was present for the entire procedure.

Estimated Blood Loss: (estimate in ml)

The patient tolerated the procedure well and there were no complications (delete the preceding text if this is incorrect and enter a progress note specifying the complications, actions taken, patient's response to interventions and latest patient's condition).