INTRAOSSEOUS INFUSION DATA FORM

Date: ________________________________ **Incident Number:** ____________________

Unit Number: ______________________

Nature of Case:

________ Cardiac Arrest ________ Respiratory Arrest

________ Profound Hypovolemia ________ Describe

Non-traumatic _____________
Traumatic _________________

Age: _____________ **Sex:** ____________ **Weight (in kg):** _____________

Number of Attempts / Successes:

Total: _____________ Attempts: __________ Success: ___________

Anatomical Location:

Proximal Tibial Site: _________ Distal Tibial Site: __________

Proximal Humerus Site: ___________

Provider Information:

Provider Name: ________________________ Provider ID: ____________

Provider Name: ________________________ Provider ID: ____________

Fluid / Medication Infusion:

Total Volume: ____________________ cc

Medication Via IO: ____________________ ____________________
____________________ ____________________
____________________ ____________________

IO Pain management: **Yes** _____ **NO** _____ Dose: ___________mg

Email this for to jmothershed@hdgac.org OR Fax to 410-939-6665