

Multi-County Ambulance Advanced Life Support Checklist:

Ventilation Equipment:

- Chest Decompression: Commercial__ Self Kit__
- Angiocath: 10g __ Other: _____
- Cricothyrotomy Tray: Commercial__ or Self-Kit__
- _____
- Laryngoscope and Blades, straight and/or curved sizes: Straight: 0, 1, 2, 3, 4, Curved: 0, 1, 2, 3, 4
- Endotracheal Tubes (2 of each)
- Uncuffed: __ 2.5 __ 3 __ 3.5 __ 4 __ 4.5 __ 5 __ 5.5
- Cuffed: __ 6 __ 6.5 __ 7 __ 7.5 __ 8 __ 8.5 __ 9__
- Stylets
- End Tidal CO₂ detector or alternative device, FDA approved to determine endotracheal tube placemnt
- Endotracheal Tube Holder
- Curved Forceps __ adult __ pediatric
- Nebulizer adult __ pediatric __
- Nasogastric Tube (optional) Size 16 __ Size 18 __

IV Fluids and Equipment:

- Soluset _____
- D5W or NaCL, 50 ml bags
- NaCL or LR, 1,000 ml bags
- D5W 250 ml bags

Medications:

- Medical Director selected and approved list (attached).
- Denver Metro Paramedic Protocols, Section VI

Other Comments: _____

Patient Assessment Equipment:

- Monitor/Defibrillator Operational Check:
- Make and Model: _____
 - Monitor Serial No. _____
 - Defibrillator Serial No. _____
 - Patient Cables:
 - Lead 1 (white/black)
 - Lead 2 (white/red)
 - Lead 3 (black/red)
 - 12 –AED, PACE, CV, Defib. Pulse OX, BP, ET-CO₂ (optional)
 - Adult Paddles or Combi-Pads
 - Pediatric Paddles or Combi-Pads
 - Presentation
 - Recorder and Paper
 - Date of last service: _____
 - Output: __ 360 ws (338-382)
 - __ 300 ws (282-318)
 - __ 200 ws (188-212)
 - __ 100 ws (94-106)
 - __ 50 ws (47-93)
 - __ 20 ws (18-22)
 - Pulse Oximeter
 - Electronic Glucose measuring device

Miscellaneous Equipment:

- Compartmentalized Pneumatic Trousers (optional) _____
- Pediatric “length-based” device for sizing drug dosage calculation and sizing equipment
- Type: _____ date: _____

<input type="checkbox"/> Approved ALS <input type="checkbox"/> Approved BLS with ALS capabilities Inspection Expires: _____	<input type="checkbox"/> Not Approved. Re-inspection required. Date of Re-inspection: _____
Please print Ambulance Service Representative’s Name: _____	
Ambulance Service Representative’s Signature _____	Date _____
Stanley Howell, Multi-County Ambulance Inspector	Date _____

Denver Metro Paramedic Protocols, Section VI.

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Other: _____

Medical Director: _____ Date: _____

Medical Facility: _____