Reset Form

CODE BLUE DOCUMENTATION

State Form 26095 (R5 / 7-17)
LOGANSPORT STATE HOSPITAL

Name of patient				Date *(month, day, year)*
Time of incident	Type of incident			
Location				
Was staff who were not needed sent back to their units?				

Condition of patient when discovered *(Check Yes or No where appropriate.)*

Vital signs:	Pulse	Respiration	Blood pressure	Time
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Conscious ☐ Yes ☐ No	Cyanotic ☐ Yes ☐ No	Breathing ☐ Yes ☐ No	Pulse palpable ☐ Yes ☐ No	Pupils dilated ☐ Yes ☐ No

Name of nurse notified	Time nurse notified	Time nurse arrived
Name of physician notified	Time physician notified	Time physician arrived

Time Communication Center notified	Time Nursing Service notified	Time Emergency Medical Services (EMS) activated

Airway placed ☐ Yes ☐ No	Airway placed by:		
CPR started ☐ Yes ☐ No	Time CPR started	Time CPR stopped	CPR administered by:
Oxygen ☐ Yes ☐ No	Oxygen administered by:		
IV started ☐ Yes ☐ No	Solution	Site / catheter size	IV started by:

Automatic defibrillator placed ☐ Yes ☐ No	Time automatic defibrillator placed	Rhythm shockable ☐ Yes ☐ No	Patient defibrillated ☐ Yes ☐ No
Time defibrillated	Joules	Time defibrillated	Joules
Intubation ☐ Yes ☐ No	Time of intubation	Size	Intubation performed by:

Time of Emergency Medical Services (EMS) arrival

OUTCOME

Time patient transferred	Time patient expired	Time family notified	Time coroner notified	Time Medical Director notified

Name(s) of physician(s) present

Name(s) of nurse(s) present

Name of nurse making report

Nurse's notes:

Signature of Registered Nurse (RN)	Date signed *(month, day, year)*

DISTRIBUTION: One copy to Quality Management (QM) Nurse

COMMENTS

RECOMMENDATIONS

Signature of physician (MD) upon review	Date signed *(month, day, year)*