Apnea Testing Form

Patient Sticker
DOB:
ADM DT:

Date: _____ Unit: _____
Name of Respiratory Therapist: _____
Name of Physician present**:** _____
Name of R.N. present**:** _____

Ventilator Settings Pre-Test:

Mode_____ FiO_2_____ Rate_____ Vt_____ PEEP_____

Pressure Control/P High_____ Pressure Support (Hi/Low if needed)_____

Pre-testing Arterial Blood Gas (ABG): Time ABG performed (Must be within the last 15 minutes)

pH_____ CO_2_____ PaO_2_____ HCO_3_____ BD/BE_____

Time placed on 1.00 FiO_2 for pre-test (minimum of 10 minutes): _____

Place on Aerosol T-Piece 100% for test

Monitor Vital Signs at each Minute for the duration of the test (10 minutes)

Time	**Heart Rate**	**Blood Pressure**	**SpO_2**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Reason test terminated. Check all below that apply.

Spontaneous Respirations ____
Arrhythmias ___
SpO2≤ 92 for CORE pts ____
Hypotension ___
Physician Decision ___
Time Test Stopped _____
_____
_____

Post-testing ABG (ABG is to be obtained prior to placing patient back to pre-test ventilator settings): Time of ABG _____

pH_____ CO_2_____ PaO_2_____ HCO_3_____ BD/BE_____

Ventilator Settings Post-Testing:

Mode_____ FiO_2_____ Rate_____ Vt_____ PEEP_____

Pressure Control/P High_____ Pressure Support (Hi/Low if needed)_____

Signature_____ Title_____ Date_____

NOTE: This form is now available in Merlin.

Last Update 01/04/2010