Excited Delirium CQI Data Form -
Ketamine Administration

Please return within 24 hours to:
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814-337-5380

Incident Information

Date: _____ **Agency:** _____ **PCR#:** _____

Provider 1: _____ **Cert Level:** _____ **Ketamine Trained?** ◯ Y ◯ N

Provider 2: _____ **Cert Level:** _____ **Ketamine Trained?** ◯ Y ◯ N

Patient Information

Patient Age: _____ **Gender:** ◯ M ◯ F **Patient Weight:** _____ **(kg)**

CC / Provider Impression: _____

Provider considers the following: substance abuse, mania, psychiatric illness, and metabolic abnormalities

Pre-Administration Vital Signs

Heart Rate: _____ **Respirations:** _____ **Blood Pressure (if available):**_____

Post-administration Vital Signs

Heart Rate: _____ **Respirations:** _____ **Blood Pressure:** _____ **SPO2:** _____

End Tidal CO2: _____ **ECG Rhythm:** _____ **BGL:** _____

Medication Administration

Presenting IMCRASS: _____ **Ketamine Dose:** _____ **(mg)** **Route:** ◯ **IM** ◯ **IV** ◯ **IO**

Approximate time until effective sedation perceived by provider: _____

Post-Administration IMCRASS: _____ **Did patient require intubation:** ◯ **Y** ◯ **N**

Additional sedation required? ◯ **Y** ◯ **N**

Drug: _____ **Dose:** _____ **Route:** ◯ **IM** ◯ **IV** ◯ **IO**

Final Outcome: ◯ **Sedated** ◯ **Unable to Sedate**

Arrival Information

Destination Hospital: _____ **Upon Arrival**

Medical Command Physician: _____ **ED IMCRASS**

Attachments: EMS PCR EtCO2 Strips EKG Strips ED Chart (if available)

Last Revised 09/13/22
Adapted from
Montogomery Co.