American Heart Association.
Get With The Guidelines.
Resuscitation

GWTG-Resuscitation Case Record Form (CRF)

Active Form Groups: Acute Respiratory Compromise (ARC) October 2025

EVENT DATE/TIME	*Pre-Event (Common) Tab*
Date/Time need for emergency assisted ventilation first recognized:	____/____/______ ____:____ MM DD YYYY HH MM ☐ Time Not Documented
System Entry Date:	____/____/______ ____:____ MM DD YYYY HH MM ☐ Time Not Documented

PRE-EVENT		*Pre-Event (Common) Tab*
Did patient have an out-of-hospital arrest leading to this admission?	O Yes	O No/Not Documented
Was patient discharged from an Intensive Care Unit (ICU) within 24 hours prior to this event?	O Yes Enter admission date to unit after ICU Discharge? ____/____/______ MM DD YYYY	O No
Was patient discharged from a Post Anesthesia Care Unit (PACU) within 24 hrs prior to this event?	O Yes	O No
Was patient in the Emergency Department (ED) 24 hours prior to this event?	O Yes	O No
Did patient receive conscious/procedural sedation or general anesthesia within 24 hrs prior to this event?	O Yes	O No

VITAL SIGNS	*Pre-Event (Common) Tab*
OPTIONAL: Enter vital signs taken in the 4hrs prior to the event (up to 4 sets).	☐ Pre-Event VS Unknown/Not Documented

Date/ Time	Heart Rate	Systolic BP/ Diastolic BP	Respiratory Rate	SpO2	O2 Type	Temp	Units
__/__/__ ___:___	______ ☐ND	______ ☐ND	______ ☐ND	______ ☐ND	O Room Air O Supplemental O2 O ND	______ ☐ND	C | F
__/__/__ ___:___	______ ☐ND	______ ☐ND	______ ☐ND	______ ☐ND	O Room Air O Supplemental O2 O ND	______ ☐ND	C | F
__/__/__ ___:___	______ ☐ND	______ ☐ND	______ ☐ND	______ ☐ND	O Room Air O Supplemental O2 O ND	______ ☐ND	C | F
__/__/__ ___:___	______ ☐ND	______ ☐ND	______ ☐ND	______ ☐ND	O Room Air O Supplemental O2 O ND	______ ☐ND	C | F

PRE-EXISTING CONDITIONS	*Pre-Event (Common) Tab*
Pre-existing Conditions at Time of Event (check all that apply)	
☐ None (review options below carefully)	☐ Metastatic or hematologic malignancy
☐ Acute Stroke	☐ Myocardial ischemia/infarction (this admission)
☐ Cardiac malformation/abnormality- acyanotic	☐ Pneumonia
☐ Congenital malformation/abnormality (Non-Cardiac)	☐ Respiratory insufficiency

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☐ DVT ☐ Heart failure (this admission) ☐ Diabetes mellitus ☐ History of vaping or e-cigarette use in past 12 months ☐ Major Trauma ☐ Metabolic/electrolyte abnormality ☐ Myocardial infarction or prior proven coronary artery disease (e.g., percutaneous coronary angioplasty/stent) (prior to this admission) ☐ Pneumonia ☐ Renal insufficiency ☐ Sepsis	☐ Acute CNS non-stroke event ☐ Baseline Depression in CNS function ☐ Cardiac malformation/abnormality- cyanotic ☐ Coronary Artery Disease ☐ Heart failure (prior to this admission) ☐ Hepatic insufficiency ☐ Hypotension/hypoperfusion ☐ Metastatic or hematologic malignancy ☐ Out of hospital arrest leading to this admission ☐ Pulmonary Embolism ☐ Recently delivered or currently pregnant (if selected, maternal in-hospital cardiac arrest section is required) ☐ Respiratory insufficiency
Active or suspected bacterial or viral infection at admission or during hospitalization:	☐ None/ND ☐ Bacterial Infection ☐ Emerging Infectious Disease ☐ MERS ☐ SARS-COV-1 ☐ SARS-COV-2 (COVID-19) ☐ Other Emerging Infectious Disease ☐ Influenza ☐ Seasonal Cold ☐ Other Viral Infection

INTERVENTIONS ALREADY IN PLACE *Pre-Event (Common) Tab*

Interventions already in place when need for emergency assisted ventilation was first recognized (check all that apply)

No Airway Interventions Already in Place	☐ None
Invasive Assisted Ventilation Already in Place:	☐ Endotracheal Tube (ET) ☐ Tracheostomy Tube
Non-invasive Assisted Ventilation Already in Place:	☐ Bag-Valve-Mask ☐ Mask and/or CPAP ☐ Mouth-to-Barrier Device ☐ Laryngeal Mask Airway (LMA) ☐ BiPAP ☐ Other Non-Invasive Ventilation: (specify) _____
Other Interventions Already in Place:	☐ Conscious/procedural sedation ☐ End Tidal CO2 (ETCO2) Monitoring ☐ High Flow Nasal Cannula ☐ Intra-arterial catheter ☐ Supplemental oxygen (cannula, mask, hood, or tent)
Method(s) of confirmation of endotracheal tube (ET) or tracheostomy tube placement in trachea during this event (check all that apply):	☐ Not Documented ☐ Capnometry (numeric ETCO2) ☐ Esophageal detection devices ☐ Exhaled CO2 colorimetric monitor (ETCO2 by color change) ☐ Revisualization with direct laryngoscopy ☐ Waveform capnography (waveform ETCO2) ☐ Chest X-Ray* ☐ Point of Care Ultrasound* ☐ None of the above
Monitoring	☐ No Monitoring Already in Place ☐ Apnea ☐ Apnea/bradycardia ☐ ECG

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	☐ Pulse oximetry
Vascular Access:	○ Yes ○ No/Not Documented
Any Vasoactive Agent in place?	○ Yes ○ No/Not Documented
Hemodynamic Interventions:	☐ None ☐ Dialysis/extracorporeal filtration therapy (ongoing) ☐ Extracorporeal membrane oxygenation (ECNMO) ☐ Implantable Cardiac Defibrillator (ICD) ☐ IV/IO continuous infusion of antiarrhythmic(s)

EVENT *Event (Common) Tab*

Event Witnessed?	○ Yes ○ No/Not Documented
Was Patient Conscious when the Need for Emergency Assisted Ventilation was First Identified?	○ Yes ○ No ○ Unknown/Not Documented
Was Patient Breathing when the Need for Emergency Assisted Ventilation was First Identified?	○ Yes ○ Agonal ○ Unknown/Not Documented ○ No ○ Assisted Ventilation
Rhythm when the Need for Emergency Assisted Ventilation was First Identified:	○ Accelerated idioventricular rhythm (AVIR) ○ Pace Maker ○ Sinus (inc. sinus tachycardia) ○ Unknown/Not Documented ○ Bradycardia ○ Supraventricular tachyarrhythmia (SVTarrhy) ○ Ventricular Tachycardia with a pulse
Was a Hospital-wide Resuscitation Response Activated?	○ Yes ○ No/Not Documented
Was there an Emergency Airway Team Called?	○ Yes ○ No ○ Not Documented
Did patient become Apneic or Respirations Agonal ANY Time During ARC Event?	○ Yes ○ No Date/Time Patient Became Apneic or Respirations Agonal: ____/____/_____ ____:____ MM DD YYYY HH MM
Date of Birth:	____/____/_____ ___:___ (MM/DD/YYYY HH:MM)
Age at Event:	_____
Age Units at Event:	○ Years ○ Months ○ Weeks ○ Days ○ Hours ○ Minutes
Patient Population at Event:	_____
Illness Category:	○ Medical-Cardiac ○ Obstetric ○ Surgical-Noncardiac ○ Other (Visitor/Employee) ○ Medical-Noncardiac ○ Surgical-Cardiac ○ Trauma
Subject Type:	○ Ambulatory/Outpatient ○ Hospital Inpatient ○ Rehab Facility Inpatient ○ Visitor or Employee ○ Emergency Department ○ Mental Health Facility Inpatient ○ Skilled Nursing Facility Inpatient
Event Location (area):	○ Ambulatory/Outpatient Area ○ Adult ICU ○ Delivery Suite ○ Emergency Department (ED) ○ Neonatal ICU (NICU) ○ Adult Coronary Unit (CCU) ○ Cardiac Catheterization Lab ○ Diagnostic/Intervention Area (excludes Cath Lab) ○ General Inpatient Area

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	○ Observation Unit ○ Pediatric Cardiac Intensive Care Unit (CICU) ○ Post-Anesthesia Recovery Room (PACU) ○ Same-Day Surgical Area ○ Other ○ Newborn Nursery ○ Operating Room (OR) ○ Pediatric ICU (PICU) ○ Rehab, Skilled Nursing, or Mental Health Unit/Facility ○ Telemetry Unit or Step-Down Unit ○ Unknown/Not Documented
Event Location (name):	_____

VENTILATION *Ventilation Tab*

Ventilation/Airways Used (select all that apply):	☐ None ☐ Bag-Valve-Mask ____/____/_____ ___:____ MM DD YYYY HH : MM ☐ Laryngeal Mask Airway (LMA) ☐ Mouth-to-Barrier Device ☐ Supraglottic Airway ☐ Other Non-Invasive Ventilation, Please Specify: _____	☐ Unknown/Not Documented ☐ Endotracheal Tube (ET) ☐ Mask and/or Nasal CPAP/BiPAP ☐ Mouth-to-Mouth ☐ Tracheostomy Tube
Date/Time First Emergency Assisted Ventilation During Event:	___/___/_____ ____:____ MM DD YYYY HH MM	
Was Endotracheal Tube (ET) or Tracheostomy Tube Inserted/Re-inserted During Event? (*Complete if Endotracheal Tube (ET) or Tracheostomy Tube was selected for Ventilation Airways Used)*	○ Yes Date/Time Endotracheal (ET) or Tracheostomy Tube Inserted If Not Already in Place and/or Re-inserted During Event: ____/____/_____ ____:____ MM DD YYYY HH MM Method(s) of confirmation of endotracheal tube (ET) or tracheostomy tube placement in trachea (check all that apply): ☐ Not Documented ☐ Esophageal detection devices ☐ Revisualization with direct laryngoscopy ☐ Chest X-Ray* ☐ None of the above ☐ Capnometry (numeric ETCO2) ☐ Exhaled CO2 colorimetric monitor (ETCO2 by color change) ☐ Waveform capnography (waveform ETCO2) ☐ Point of Care Ultrasound*	○ No

OTHER INTERVENTIONS *Other Interventions Tab*

Select each intervention that was employed during the ARC event

Other Drug Interventions:	☐ None ☐ Bronchodilator: Inhaled

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	☐ Bronchodilator: Sub Q or IV/IO ☐ Calcium chloride/Calcium gluconate ☐ Fluid bolus for volume expansion ☐ Magnesium sulfate ☐ Neuromuscular blocker/muscle relaxant ☐ Prostaglandin E1 (PGE) ☐ Reversal agent (e.g., naloxone/Narcan, flumazenil/Romazicon, neostigmine/Prostigin) ☐ Sedative/induction agent ☐ Other drug interventions, Specify: _____
Non-Drug Interventions:	☐ None ☐ Central venous catheter inserted ☐ Chest tube(s) inserted ☐ Needle thoracostomy ☐ Nasogastric (NG) / Orogastric (OG) tube ☐ Thoracentesis ☐ Tracheostomy / Cricothyrotomy (placed during event) ☐ Tracheostomy change/replacement ☐ Other non-drug interventions, Specify: _____

ARC *ARC Tab*

Was ANY return of Spontaneous Respiration Documented During Event (excluding agonal/gasping)?	○ Yes	○ No/Not Documented
Date/Time FIRST return of spontaneous ventilation (ROSV)	____/____/_____ ____:____ MM DD YYYY HH MM	
Reason ARC event ended:	○ Return of spontaneous ventilation (ROSV) (no further need for assisted ventilation) that was sustained for > 20 minutes. ○ Control of ventilation with assisted ventilation that is sustained for > 20 minutes either ○ Transfer of newborn out of delivery room prior to 20 min of spontaneous/controlled vent. ○ Progressed to Cardiopulmonary Arrest; or ARC interventions terminated because advanced directive.	
If progressed to CPA, does CPA portion of Event Meet GWTG-R inclusion criteria?	○ Yes	○ No, not being entered (e.g., DNAR)
Date/ Time of the BEGINNING of Sustained Return of Spontaneous Ventilation, Control of Ventilation or Need for Chest Compression and/or Defibrillation (CPA) First Identified:	____/____/_____ ____:____ MM DD YYYY HH MM	
Patient Transferred To:	○ Not Transferred (remained on unit) ○ Cardiac Catheterization Lab ○ Emergency Department ○ Intensive Care Unit Post-ARC ICU length of stay for this ICU admission (days) _____ ○ Operating Room ○ Post Cardiac Arrest Care ○ Telemetry/Step-Down ○ Other Hospital ○ Other (please specify)	

RESUSCITATION-RELATED EVENTS AND ISSUES *Events and Issues Tab*

☐ No/Not Documented
☐ Universal Precautions
  ☐ Not followed by all team members (specify in comments section)
☐ Documentation
  ☐ Incomplete documentation
  ☐ Initial ECG rhythm Not Documented
  ☐ Medication route(s) Not Documented

- ☐ Missing other signatures
- ☐ Signature of code team leader not on code sheet
- ☐ Other Documentation Issue (specify in comments section)

☐ Airway
- ☐ Aspiration related to provision or airway
- ☐ Delay
- ☐ Delayed recognition of airway misplacement/displacement
- ☐ Intubation attempted, not achieved
- ☐ Multiple intubation attempts
  Number of intubation attempts: ☐ Number of Intubation Attempts Unknown
- ☐ Other Airway Issue (specify in comments section)

☐ Vascular Access
- ☐ Delay
- ☐ Inadvertent arterial cannulation
- ☐ Infiltration/Disconnection
- ☐ Other Vascular Issue (specify in comments section)

☐ Medications
- ☐ Delay
- ☐ Dose
- ☐ Route
- ☐ Selection
- ☐ Other Medications Issue (specify in comments section)

☐ Leadership
- ☐ Delay in identifying leader
- ☐ Knowledge of equipment
- ☐ Knowledge of medications/protocols
- ☐ Knowledge of roles
- ☐ Team oversight
- ☐ Too many team members
- ☐ Other Leadership issues (specify in comments section)

☐ Protocol Deviation
- ☐ ACLS
- ☐ PALS
- ☐ NRP
- ☐ Other Protocol Issue (specify in comments section)

☐ Equipment
- ☐ Availability
- ☐ Function
- ☐ Other Equipment (specify in comments section)

NOTE: PLEASE DO NOT ENTER ANY PATIENT IDENTIFIABLE INFORMATION IN THIS FIELD:

Comments:

END OF ARC FORM