



GWTG-Resuscitation Case Record Form (CRF)

Active Form Groups: Acute Respiratory Compromise (ARC)

February 2026

EVENT DATE/TIME Pre-Event (Common) Tab

Date/Time need for emergency assisted ventilation first recognized:	___/___/___ __:___ MM DD YYYY HH MM	<input type="checkbox"/> Time Not Documented
System Entry Date:	___/___/___ __:___ MM DD YYYY HH MM	<input type="checkbox"/> Time Not Documented

PRE-EVENT Pre-Event (Common) Tab

Did patient have an out-of-hospital arrest leading to this admission?	<input type="radio"/> Yes	<input type="radio"/> No/Not Documented
Was patient discharged from an Intensive Care Unit (ICU) within 24 hours prior to this event?	<input type="radio"/> Yes	<input type="radio"/> No
Enter admission date to unit after ICU Discharge? ___/___/___ MM DD YYYY		
Was patient discharged from a Post Anesthesia Care Unit (PACU) within 24 hrs prior to this event?	<input type="radio"/> Yes	<input type="radio"/> No
Was patient in the Emergency Department (ED) 24 hours prior to this event?	<input type="radio"/> Yes	<input type="radio"/> No
Did patient receive conscious/procedural sedation or general anesthesia within 24 hrs prior to this event?	<input type="radio"/> Yes	<input type="radio"/> No

VITAL SIGNS Pre-Event (Common) Tab

OPTIONAL: Enter vital signs taken in the 4hrs prior to the event (up to 4 sets).	<input type="checkbox"/> Pre-Event VS Unknown/Not Documented
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Date/Time	Heart Rate	Systolic BP/ Diastolic BP	Respiratory Rate	SpO2	O2 Type	Temp	Units
___/___/___ __:__	_____ <input type="checkbox"/> ND	_____ <input type="checkbox"/> ND	_____ <input type="checkbox"/> ND	_____ <input type="checkbox"/> ND	<input type="radio"/> Room Air <input type="radio"/> Supplemental O2 <input type="radio"/> ND	_____ <input type="checkbox"/> ND	C   F
___/___/___ __:__	_____ <input type="checkbox"/> ND	_____ <input type="checkbox"/> ND	_____ <input type="checkbox"/> ND	_____ <input type="checkbox"/> ND	<input type="radio"/> Room Air <input type="radio"/> Supplemental O2 <input type="radio"/> ND	_____ <input type="checkbox"/> ND	C   F
___/___/___ __:__	_____ <input type="checkbox"/> ND	_____ <input type="checkbox"/> ND	_____ <input type="checkbox"/> ND	_____ <input type="checkbox"/> ND	<input type="radio"/> Room Air <input type="radio"/> Supplemental O2 <input type="radio"/> ND	_____ <input type="checkbox"/> ND	C   F
___/___/___ __:__	_____ <input type="checkbox"/> ND	_____ <input type="checkbox"/> ND	_____ <input type="checkbox"/> ND	_____ <input type="checkbox"/> ND	<input type="radio"/> Room Air <input type="radio"/> Supplemental O2 <input type="radio"/> ND	_____ <input type="checkbox"/> ND	C   F

PRE-EXISTING CONDITIONS Pre-Event (Common) Tab

Pre-existing Conditions at Time of Event (check all that apply)	
<input type="checkbox"/> None (review options below carefully)	<input type="checkbox"/> Metastatic or hematologic malignancy
<input type="checkbox"/> Acute Stroke	<input type="checkbox"/> Myocardial ischemia/infarction (this admission)
<input type="checkbox"/> Cardiac malformation/abnormality- acyanotic	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Congenital malformation/abnormality (Non-Cardiac)	<input type="checkbox"/> Respiratory insufficiency



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<input type="checkbox"/> DVT	<input type="checkbox"/> Acute CNS non-stroke event
<input type="checkbox"/> Heart failure (this admission)	<input type="checkbox"/> Baseline Depression in CNS function
<input type="checkbox"/> Diabetes mellitus	<input type="checkbox"/> Cardiac malformation/abnormality- cyanotic
<input type="checkbox"/> History of vaping or e-cigarette use in past 12 months	<input type="checkbox"/> Coronary Artery Disease
<input type="checkbox"/> Major Trauma	<input type="checkbox"/> Heart failure (prior to this admission)
<input type="checkbox"/> Metabolic/electrolyte abnormality	<input type="checkbox"/> Hepatic insufficiency
<input type="checkbox"/> Myocardial infarction or prior proven coronary artery disease (e.g., percutaneous coronary angioplasty/stent) (prior to this admission)	<input type="checkbox"/> Hypotension/hypoperfusion
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Metastatic or hematologic malignancy
<input type="checkbox"/> Renal insufficiency	<input type="checkbox"/> Out of hospital arrest leading to this admission
<input type="checkbox"/> Sepsis	<input type="checkbox"/> Pulmonary Embolism
	<input type="checkbox"/> Recently delivered or currently pregnant (if selected, maternal in-hospital cardiac arrest section is required)
	<input type="checkbox"/> Respiratory insufficiency

Active or suspected bacterial or viral infection at admission or during hospitalization:	<input type="checkbox"/> None/ND <input type="checkbox"/> Bacterial Infection <input type="checkbox"/> Emerging Infectious Disease <input type="checkbox"/> MERS <input type="checkbox"/> SARS-COV-1 <input type="checkbox"/> SARS-COV-2 (COVID-19) <input type="checkbox"/> Other Emerging Infectious Disease <input type="checkbox"/> Influenza <input type="checkbox"/> Seasonal Cold <input type="checkbox"/> Other Viral Infection
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<b>INTERVENTIONS ALREADY IN PLACE</b>	<i>Pre-Event (Common) Tab</i>
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Interventions already in place when need for emergency assisted ventilation was first recognized (check all that apply)	
No Airway Interventions Already in Place	<input type="checkbox"/> None
Invasive Assisted Ventilation Already in Place:	<input type="checkbox"/> Endotracheal Tube (ET) <input type="checkbox"/> Tracheostomy Tube
Non-invasive Assisted Ventilation Already in Place:	<input type="checkbox"/> Bag-Valve-Mask <input type="checkbox"/> Mask and/or CPAP <input type="checkbox"/> Mouth-to-Barrier Device <input type="checkbox"/> Laryngeal Mask Airway (LMA) <input type="checkbox"/> BiPAP <input type="checkbox"/> Other Non-Invasive Ventilation: (specify) _____
Other Interventions Already in Place:	<input type="checkbox"/> Conscious/procedural sedation <input type="checkbox"/> End Tidal CO2 (ETCO2) Monitoring <input type="checkbox"/> High Flow Nasal Cannula <input type="checkbox"/> Intra-arterial catheter <input type="checkbox"/> 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):	<input type="checkbox"/> Not Documented <input type="checkbox"/> Capnometry (numeric ETCO2) <input type="checkbox"/> Esophageal detection devices <input type="checkbox"/> Exhaled CO2 colorimetric monitor (ETCO2 by color change) <input type="checkbox"/> Revisualization with direct laryngoscopy <input type="checkbox"/> Waveform capnography (waveform ETCO2) <input type="checkbox"/> Chest X-Ray* <input type="checkbox"/> Point of Care Ultrasound* <input type="checkbox"/> None of the above
Monitoring	<input type="checkbox"/> No Monitoring Already in Place <input type="checkbox"/> Apnea <input type="checkbox"/> Apnea/bradycardia <input type="checkbox"/> ECG



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	<input type="checkbox"/> Pulse oximetry
Vascular Access:	<input type="radio"/> Yes <input type="radio"/> No/Not Documented
Any Vasoactive Agent in place?	<input type="radio"/> Yes <input type="radio"/> No/Not Documented
Hemodynamic Interventions:	<input type="checkbox"/> None <input type="checkbox"/> Dialysis/extracorporeal filtration therapy (ongoing) <input type="checkbox"/> Extracorporeal membrane oxygenation (ECNMO) <input type="checkbox"/> Implantable Cardiac Defibrillator (ICD) <input type="checkbox"/> IV/IO continuous infusion of antiarrhythmic(s)
<b>Event (Common) Tab</b>	
Event Witnessed?	<input type="radio"/> Yes <input type="radio"/> No/Not Documented
Was Patient Conscious when the Need for Emergency Assisted Ventilation was First Identified?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown/Not Documented
Was Patient Breathing when the Need for Emergency Assisted Ventilation was First Identified?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Agonal <input type="radio"/> Assisted Ventilation <input type="radio"/> Unknown/Not Documented
Rhythm when the Need for Emergency Assisted Ventilation was First Identified:	<input type="radio"/> Accelerated idioventricular rhythm (AVIR) <input type="radio"/> Bradycardia <input type="radio"/> Pace Maker <input type="radio"/> Supraventricular tachyarrhythmia (SVTarrhy) <input type="radio"/> Sinus (inc. sinus tachycardia) <input type="radio"/> Ventricular Tachycardia with a pulse <input type="radio"/> Unknown/Not Documented
Was a Hospital-wide Resuscitation Response Activated?	<input type="radio"/> Yes <input type="radio"/> No/Not Documented
Was there an Emergency Airway Team Called?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Documented
Did patient become Apneic or Respirations Agonal ANY Time During ARC Event?	<input type="radio"/> Yes <input type="radio"/> 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:	<input type="radio"/> Years <input type="radio"/> Months <input type="radio"/> Weeks <input type="radio"/> Days <input type="radio"/> Hours <input type="radio"/> Minutes
Patient Population at Event:	_____
Illness Category:	<input type="radio"/> Medical-Cardiac <input type="radio"/> Medical-Noncardiac <input type="radio"/> Obstetric <input type="radio"/> Surgical-Cardiac <input type="radio"/> Surgical-Noncardiac <input type="radio"/> Trauma <input type="radio"/> Other (Visitor/Employee)
Subject Type:	<input type="radio"/> Ambulatory/Outpatient <input type="radio"/> Emergency Department <input type="radio"/> Hospital Inpatient <input type="radio"/> Mental Health Facility Inpatient <input type="radio"/> Rehab Facility Inpatient <input type="radio"/> Skilled Nursing Facility Inpatient <input type="radio"/> Visitor or Employee
Event Location (area):	<input type="radio"/> Ambulatory/Outpatient Area <input type="radio"/> Adult Coronary Unit (CCU) <input type="radio"/> Adult ICU <input type="radio"/> Cardiac Catheterization Lab <input type="radio"/> Delivery Suite <input type="radio"/> Diagnostic/Intervention Area (excludes Cath Lab) <input type="radio"/> Emergency Department (ED) <input type="radio"/> General Inpatient Area <input type="radio"/> Neonatal ICU (NICU)



## Resuscitation

### GWTG-Resuscitation Case Record Form (CRF)

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	<input type="radio"/> Observation Unit <input type="radio"/> Pediatric Cardiac Intensive Care Unit (CICU) <input type="radio"/> Post-Anesthesia Recovery Room (PACU) <input type="radio"/> Same-Day Surgical Area <input type="radio"/> Other	<input type="radio"/> Newborn Nursery <input type="radio"/> Operating Room (OR) <input type="radio"/> Pediatric ICU (PICU) <input type="radio"/> Rehab, Skilled Nursing, or Mental Health Unit/Facility <input type="radio"/> Telemetry Unit or Step-Down Unit <input type="radio"/> Unknown/Not Documented
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Event Location (name):	_____
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<b>VENTILATION</b>	<b>Ventilation Tab</b>
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Ventilation/Airways Used (select all that apply):	<input type="checkbox"/> None <input type="checkbox"/> Bag-Valve-Mask ____/____/____ ____:____ MM DD YYYY HH : MM <input type="checkbox"/> Laryngeal Mask Airway (LMA) <input type="checkbox"/> Mouth-to-Barrier Device <input type="checkbox"/> Supraglottic Airway <input type="checkbox"/> Other Non-Invasive Ventilation, Please Specify: _____	<input type="checkbox"/> Unknown/Not Documented <input type="checkbox"/> Endotracheal Tube (ET) <input type="checkbox"/> Mask and/or Nasal CPAP/BiPAP <input type="checkbox"/> Mouth-to-Mouth <input type="checkbox"/> Tracheostomy Tube
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Date/Time First Emergency Assisted Ventilation During Event:	____/____/____ ____:____ MM DD YYYY HH MM
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Was Endotracheal Tube (ET) or Tracheostomy Tube Inserted/Re-inserted During Event?  <i>(Complete if Endotracheal Tube (ET) or Tracheostomy Tube was selected for Ventilation Airways Used)</i>	<input type="radio"/> 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):	<input type="radio"/> No
	<input type="checkbox"/> Not Documented <input type="checkbox"/> Esophageal detection devices <input type="checkbox"/> Revisualization with direct laryngoscopy <input type="checkbox"/> Chest X-Ray* <input type="checkbox"/> None of the above	<input type="checkbox"/> Capnometry (numeric ETCO2) <input type="checkbox"/> Exhaled CO2 colorimetric monitor (ETCO2 by color change) <input type="checkbox"/> Waveform capnography (waveform ETCO2) <input type="checkbox"/> Point of Care Ultrasound*

<b>OTHER INTERVENTIONS</b>	<b>Other Interventions Tab</b>
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<i>Select each intervention that was employed during the ARC event</i>	
Other Drug Interventions:	<input type="checkbox"/> None <input type="checkbox"/> Bronchodilator: Inhaled



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

ARC ARC Tab

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

Was a Team Debriefing Completed After the Event?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented
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<input type="checkbox"/> No/Not Documented <input type="checkbox"/> Universal Precautions <input type="checkbox"/> Not followed by all team members (specify in comments section)
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## Resuscitation

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- 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:
  - 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)

Number of Intubation Attempts Unknown

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

Comments:

END OF ARC FORM