| Individual Completing Pre Intubation Airway Assessment Record: ____________________________ |
| Date of Evaluation: _______ (day)/_______ (mth)/_______ (year) |

### Patient History:
- Has the patient had a previous difficult intubation? (i.e. Fiberoptic)  
  - [ ] yes  
  - [ ] no  
  Comment: ______________________________________
- Does the patient have an unstable c-spine or previous spinal fusion?  
  Specifs: ________________________________  
  - [ ] yes  
  - [ ] no  
- Does the patient have a history of OSA with CPAP use?  
  Any treatment: _________________________________  
  - [ ] yes  
  - [ ] no  
- Does the patient have a history of burns to the head or neck?  
  Comment: ______________________________________  
  - [ ] yes  
  - [ ] no  
- Does patient have severe rheumatoid arthritis?  
  Comment: ______________________________________  
  - [ ] yes  
  - [ ] no  
- Has the patient had previous airway surgery or a previous tracheostomy?  
  Specifics: ____________________________________  
  - [ ] yes  
  - [ ] no  

### Clinical Examination – LEMON Assessment Method:

#### L – Look externally for characteristics known to cause difficult laryngoscopy (please circle all that apply)

- **Face**
  - [ ] Small jaw
  - [ ] Edema
  - [ ] Prominent Teeth
  - [ ] Disfiguring of the Jaw
  - [ ] Difficult Bag/Mask Ventilation (2 person, use of airway, inability to maintain seal)

- **Thorax / Abdomen**
  - [ ] Pregnancy
  - [ ] Bowel Obstruction
  - [ ] Massive ascities
  - [ ] Morbid obesity

#### E – Evaluate the 3-3 Rule:

- **Mouth opening – 3 finger breadths**  
  - [ ] yes  
  - [ ] no
- **Thyro-Mental distance – 3 finger breadths**  
  - [ ] yes  
  - [ ] no

#### M – Mallampati Score

- Mallampati Class: ___________

#### O – Obstruction (Is there any condition that can cause obstruction of the airway which would make laryngoscopy and ventilation difficult?)

- [ ] Tumors
- [ ] Stridor
- [ ] Congenital Defects (Down’s, Goiter, Pierre-Robin Syndrome)
- [ ] Other obvious deformity

#### N – Neck mobility

- Can the patient move their jaw forward?  
  - [ ] yes  
  - [ ] no
- Can the patient fully bend / extend the head and neck?  
  - [ ] yes  
  - [ ] no
- Is the patient in a cspine collar?  
  - [ ] yes  
  - [ ] no
VGH Intensive Care Unit

VGH Intensive Care Unit
Post Intubation
Airway Assessment Record

Individual Completing Post Intubation Airway Assessment Record: ____________________________________________

Date of Intubation: ____________________ (day)/ __________  (mth)/ ________ (year)

Level
☐ PGY (circle) 1 2 3
☐ Attending Physician
☐ Clinical Associate
☐ ICU Fellow
☐ Respiratory Therapist
☐ Other

Specialty
☐ Internal Medicine
☐ Emergency Medicine
☐ Surgery
☐ Anesthesiology
☐ Critical Care
☐ Other

Location of Intubation:
☐ ICU
☐ Pre-hospital (EHS)
☐ Ward
☐ Other Facility
☐ Emergency
☐ Other

Total Number of Intubation Attempts: _______________________

Size of OETT / EVAC placed: _______________________________

Confirmed Position at the Teeth: ____________________________

Was Anesthesia called for Assistance? ☐ YES ☐ NO
☐ YES – failed attempt ☐ YES – anticipated difficult airway

Modality Utilized for Intubation:

<table>
<thead>
<tr>
<th>Attempt</th>
<th>Performed by</th>
<th>Successful?</th>
<th>Cricoid?</th>
<th>Technique (circle all appropriate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>L GS B LW FOB LMA S</td>
</tr>
<tr>
<td>2</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>L GS B LW FOB LMA S</td>
</tr>
<tr>
<td>3</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>L GS B LW FOB LMA S</td>
</tr>
</tbody>
</table>

L = laryngoscope
B = Bougie
GS = Glidescope
LW = lightwand
FOB = fiberoptic
S = Surgical
LMA = laryngeal mask airway

Mallampati Score during Intubation: ____________

Glottic View during Intubation:

Drug Utilized during Intubation:
☐ Sedated
☐ Awake
☐ Midazolam
☐ Fentanyl
☐ Ketamine
☐ Etomidate
☐ Succinylcholine
☐ Rocuronium
☐ Vasopressors
☐ Other

Date of Tracheostomy: ____________ (day)/ __________  (mth)/ ________ (year)

Type of Tube Placed: _______________________________

Date of First Change: ____________ (day)/ __________  (mth)/ ________ (year)

Surgical Service: _______________________________

Comments/ Concerns During Airway Procedures (Intubation or Tracheostomy): _______________________________