

**St. Antonys PreHospital Services  
King Airway QA form**

**Agency:** \_\_\_\_\_

**Alarm/PCR #:** \_\_\_\_\_

**Device:**

**King: size** \_\_\_\_\_

**Certification Level of user:**

**BLS**

**ALS**

**Patient Gender:**

**Male**

**Female**

**Age:** \_\_\_\_\_

**Indication:**

**Arrest – Primary airway**

**Arrest – Rescue Airway**

**Other** \_\_\_\_\_

**Were ventilations adequate with King airway?**

**Yes**

**No**

**Was intubation attempted prior to King airway use?**

**Yes** Number \_\_\_\_\_

**No**

**Methods used for confirmation?**

**Breath Sounds**

**Chest Rise**

**ETCO2**

**Capnometry (Color Change Device)**

**Complications / comments**

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**Please return to the QI coordinator within 48 hours and include patient care document.**