



Blue Ridge Emergency Medical Services Council, Inc.

Atrial Fibrillation Quality Control Form

Date: _____

Incident #: _____

Agency: _____

Provider Certification #: _____

Patient Info: Age: _____ Sex: Male Female Race: _____ Weight: _____ lbs kg

Indication for Use (check):

- Chest pain
- Altered mental status
- Hypertension
- Rapid ventricular rate (associated with Atrial Fibrillation/Flutter)
- Other: _____

Measures Used Prior/After Cardizem (check):

- 12 Lead Prior: Rhythm/Rate: _____
- 12 Lead After Rhythm/Rate: _____
- Cardioversion Quantity: _____ Joules: _____
- Other: _____

Medications:

Cardizem Dose: _____ mg Route: IV IO

Repeat Dose: _____ mg

Blood Pressure Pre: _____ mmHg During: _____ mmHg Post: _____ mmHg

Heart Rate: Pre: _____ BPM During: _____ BPM Post: _____ BPM

Complications (check):

- Hypotension Bradycardia Heart Block
- Asystole Headache Nausea/Vomiting