Department of Emergency Medicine Non-Intubation Checklist

[patient label]

Date: _____

Requesting physician: _____

Reason for requesting intubation (tick box)

Airway not protected	☐	Impending respiratory failure	☐	Seizures	☐
Airway not maintained	☐	Shock management	☐	Combative / agitated	☐
Airway threatened (eg. burn)	☐	Neuroprotection	☐	To facilitate safe transfer	☐
Oxygenation not adequate	☐	Fluctuating or decreasing LOC	☐	Humanitarian	☐
Ventilation not adequate	☐				

I, _____, am declining to intubate the above patient and am satisfied that the criteria in box A OR box B apply:

Box A

- patient can maintain airway patency without assistance ☐
- airway protective reflexes are intact ☐
- oxygenation is adequate ☐
- ventilation is adequate and pCO2 acceptable for clinical presentation ☐
- work of breathing is not excessive and is not likely to lead to deterioration from exhaustion ☐
- cardiovascular failure can be satisfactorily managed without intubation ☐
- conscious level is not declining or fluctuating in a way that is likely to threaten airway or breathing ☐
- status epilepticus, if present, has been fully controlled ☐
- the patient can be safely transferred (eg. to CT) without threat to airway or CO2 regulation ☐

Box B

- There is sufficient, thoroughly evaluated history (not purely based on age) and a diagnosis to confidently consider palliation to be the most appropriate course and this has been discussed with the patient's family / next of kin ☐
- I understand that in the post cardiac arrest patient, no clinical signs, including unreactive pupils, can reliably prognosticate at this stage and that declining intubation will deny such patients the opportunity to receive maximal critical care and therapeutic hypothermia. ☐

I acknowledge that I am declining a requested clinical intervention from the resuscitation team leader and confirm that this is purely due to a disagreement on the clinical need following a thorough examination of the patient. I affirm that service pressures and ICU bed availability or the anticipated need for interhospital transfer have not compromised clinical care.

I am a consultant or have discussed this case with my consultant, whose name is _____.

Contact number for family consultation / explanation to next of kin _____

Signed _____

Please document any emergency medicine qualifications: FCEM ☐ FACEM ☐ FESEM ☐ FRCPC ☐ US board cert ☐ Other_____ ABSOLUTELY NONE ☐

Original to be affixed to patient notes. First copy to emergency medicine director. Second copy to Risk Management Office.