Blue Ridge Emergency Medical Services Council, Inc.

i-Gel™ Supraglottic Airway
Quality Control Form

Date: _____ Incident #: _____

Provider Name and Certification #: _____
Provider Level: _____

Patient Info: Age: _____ Sex: Male ☐ Female ☐ Race: _____

Approx. Weight: _____ kg Ideal Weight: _____ kg Actual Height (in inches) _____

Indication for Use:

- ☐ Cardiac Arrest
- ☐ Respiratory Arrest

Airway Control Prior to i-Gel	☐ **BVM**	☐ **OPA**	☐ **NPA**
Supraglottic i-Gel™ Airway Size	☐ 3	☐ 4	☐ 5
Did the i-Gel™ remain in place for the duration of the event?	☐ Yes		☐ No

Complication(s)

- ☐ Unable to insert
- ☐ Other:
- ☐ Inadequate Seal