UAMS MEDICAL CENTER
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

UAMS Safe from the Start Child Passenger Safety Program
Angle Tolerance Test Flow Sheet

Test Criteria:
- √ <37 weeks gestation at birth
- √ <2268 g (5 lbs)
- √ Obvious respiratory compromise
- √ To be discharged on oxygen/monitor

Use 2 Monitors for Angle Tolerance Test:
Cardiorespiratory monitor AND pulse ox monitor

MONITOR SETTINGS:
- √ Cardio respiratory heart rate low alarm 80 BPM
- √ Pulse oximeter low alarm limit 90%
- √ Apnea limit 20 sec

Date of test: _____

Baby from [ ] **NICU** [ ] **5A** [ ] **5E** Manufacturer: _____ Model# / Name: _____ Date of Mfr: _____

Est. gest. age at birth: _____ **(i.e.35^6)** **DOL:** _____ **Birth weight:** _____**g** **Current weight:** _____**g** [ ] **Family informed** of angle tolerance test

Car seat: [ ] provided by family [ ] bought from UAMS [ ] date paid: _____	**Family-provided seat was:** [ ] appropriate for infant [ ] not appropriate [ ] waiver signed	**Test conducted in:** [ ] infant seat WITH base [ ] infant seat WITHOUT base [ ] car bed [ ] convertible seat

Name of staff member who positioned infant in CSS for test: [ ] CPS Advocate: _____ CPS Technician: _____

If tested on **vehicle seat**: CPS Tech installed CSS prior to test: [ ] Yes [ ] No Name: _____ If no, why? _____

If tested on **floor**: CSS angle/infant position confirmed by CPS Tech prior to test? [ ] Yes Name: _____ If no, why? _____

TEST#: _____	**Baseline Vitals (Record Both)**						
	In Crib	**In Car Seat**	**1 hour**	**1 hr 30 min**	**2 hours**	**2 hrs 30 min**	**3 hours**
Patient parameter	Time:	Time:	Time:	Time:	Time:	Time:	Time:
Heart rate							
Respiratory rate							
Pulse oximetry							
Color P=Pink D=Dusky							

Results of Angle Tolerance Test:

[ ] Pass [ ] Fail Discontinued at: _____ (i.e. 13:30)

[ ] **Apnea** > 20 sec. [ ] **Bradycardia** ≤80 BPM > 10 sec. [ ] **Desaturation** < 90% > 30 sec. [ ] **Color change**

Summary / Details: _____

Followup needed: [ ] Retest _____ [ ] Car bed recommended

_____ RN Signature _____ Date/Time _____ Physician Signature _____ Date/Time

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Address:

Med Rec 2624 (02/08)
Neonatal Angle Tolerance Test