

**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<sup>6</sup>) DOL: \_\_\_\_\_ Birth weight: \_\_\_\_\_ g Current weight: \_\_\_\_\_ g  Family informed of angle tolerance test

Car seat: <input type="checkbox"/> provided by family <input type="checkbox"/> bought from UAMS <input type="checkbox"/> date paid: _____	Family-provided seat was: <input type="checkbox"/> appropriate for infant <input type="checkbox"/> not appropriate <input type="checkbox"/> waiver signed	Test conducted in: <input type="checkbox"/> infant seat WITH base <input type="checkbox"/> infant seat WITHOUT base <input type="checkbox"/> car bed <input type="checkbox"/> convertible seat
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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)		1 hour	1 hr 30 min	2 hours	2 hrs 30 min	3 hours
	In Crib	In Car Seat					
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

**(Place MR Label Here)**

MR#: \_\_\_\_\_  
Patient's Name: \_\_\_\_\_  
Patient's Address: \_\_\_\_\_

\_\_\_\_\_  
RN Signature Date/Time Physician Signature Date/Time

