



Fidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Influenza and COVID-19 Enhanced Surveillance Critical Care Neonatal & Paediatric (0-14 years)

Admission Form

Intensive Care Society of Ireland



CIDR Event ID (Official Use Only)

Patient Details

Forename Surname MRN

DOB: Age: Gestational age at time of birth (weeks): Sex: Female Male

HSE area of Residence County of Residence Country of Residence

Country of birth Nationality

GP Name GP Address

GP Telephone

All information completed on this form should relate to the patient's admission to THIS hospital, not referring hospital

Name hospital

Date of hospital admission Date of admission to ICU

Source of ICU admission:

From within this hospital → Ward
OR
Emergency department

From another hospital - non ICU → Name of other hospital

From another hospital - ICU → Name of other hospital

Clinical Details

Please select organisms that apply

Influenza A (H1) pdm 2009 Influenza A (not subtyped) Sars-CoV-2 (COVID-19)

Influenza A (H3) Influenza B

Date of onset of symptoms Date of diagnosis

Was the infection determined to be hospital acquired? Yes No Unknown

Does the patient have acute respiratory syndrome? Yes No Unknown

Does the patient have PIMS-TS? Yes No

Antiviral treatment

Antivirals commenced Yes No Unknown Date antiviral treatment commenced:

Influenza Vaccine Status

Vaccinated during current influenza season Yes No Unknown Date of vaccination:

PIM/PIM2 Physiology

Blood gas in first hour? Yes No

Arterial PaO₂ kPa OR mmHg

FiO₂ *

Intubation Yes No

Headbox Yes No

PIM Score PIM2 Score

*As recorded at the time of the above PaO₂ sample

Comments

State first measurements recorded during the first hour after admission to your unit:

Systolic Blood Pressure mmHg

Base Excess (arterial/capillary)

Pupil reaction Both fixed and dilated
 Other reaction
 Not known

Did the child receive any of the following during the first hour after admission to your unit?

Non-invasive mechanical ventilation (CPAP or BiPAP)? Yes No Unknown

Invasive mechanical ventilation? Yes No Unknown

¹PIMS-TS refers to Paediatric Inflammatory Multisystem Syndrome
Case definition TBD

Signature

Date

Patient Details

All information completed on this form should relate to the patient's current ICU admission

Forename Surname CIDR Event ID
 For HPSC use only

DOB MRN

Name Of Hospital

Date of discharge from ICU Length of stay in ICU (days)

Disease Course

Please tick all that apply

	Yes	No		Yes	No
Primary viral pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Myocarditis	<input type="checkbox"/>	<input type="checkbox"/>
Secondary bacterial pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Encephalitis	<input type="checkbox"/>	<input type="checkbox"/>
Acute respiratory distress syndrome*	<input type="checkbox"/>	<input type="checkbox"/>	Sepsis Or Multi-Organ Failure	<input type="checkbox"/>	<input type="checkbox"/>
Pressor dependence at any time during ICU stay	<input type="checkbox"/>	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>	<input type="checkbox"/>
Acute Kidney Injury	<input type="checkbox"/>	<input type="checkbox"/>	<u>If other complication, please specify:</u>		
CRRT/IHD	<input type="checkbox"/>	<input type="checkbox"/>			
Tracheostomy	<input type="checkbox"/>	<input type="checkbox"/>			

Mechanical ventilation *(in current PICU/NICU i.e. data should not include mechanical ventilation in other hospitals)*

Non-invasive mechanical ventilation	Yes	No		
CPAP ventilation	<input type="checkbox"/>	<input type="checkbox"/>	Duration CPAP ventilation (days)	<input type="text"/>
BiPAP/NIV ventilation	<input type="checkbox"/>	<input type="checkbox"/>	Duration BiPAP ventilation (days)	<input type="text"/>
Invasive mechanical ventilation	Yes	No		
Conventional (including lung protective) mechanical ventilation	<input type="checkbox"/>	<input type="checkbox"/>	Duration conventional MV (days)	<input type="text"/>
HFOV ventilation	<input type="checkbox"/>	<input type="checkbox"/>	Duration HFOV ventilation (days)	<input type="text"/>
ECMO	<input type="checkbox"/>	<input type="checkbox"/>	Duration ECMO (days)	<input type="text"/>
Hemofiltration/Plasmapheresis	<input type="checkbox"/>	<input type="checkbox"/>	Duration O ² (days)	<input type="text"/>
			Home on O ²	Yes <input type="checkbox"/> No <input type="checkbox"/>

Discharge Information

Transferred from ICU to: Ward HDU Other ICU ECMO abroad Died

If transferred to other ICU, please state name

If patient transferred abroad for ECMO, please state country

Deaths

If died, date of death:

Is COVID-19 a likely cause of death?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Not applicable <input type="checkbox"/>
Is influenza a likely cause of death?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Not applicable <input type="checkbox"/>
Coroner's case	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Not applicable <input type="checkbox"/>

Comments

Signature Date

Please send Critical Care Admission Form to HPSC when patient is first discharged from ICU
Email: hpsc-data@hpsc.ie Fax: 01-8561299