

**Patient Details MRN** 000000 For HPSC use only **CIDR Event ID** 000000

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Forename | click or tap here to enter text. | | | | | | | | Surname | | | | click or tap here to enter text. | | | | |  | |  |
| DOB | click or tap to enter a date. | | | | | | | | Age | | 00 | | Sex | | choose an item. | | |  | | |
| Weight (kg) | 00000 | | Height (cm) | | 000 | BMI | **!Zero Divide** | Right click and select ‘**Update Field’** to calculate BMI | | | | | | | | | | | | |
| HSE area of Residence | | | | choose an item. | | | | | County of Residence | | | | | choose an item. | |
| Country of Residence | | | | click or tap here to enter text. | | | | | Country of birth | | | | click or tap here to enter text. | | | | | |
| Ethnicity | Choose an item. | | | | | | | | Occupation | | | click or tap here to enter text. | | | | |
| Health Care Worker (see definition pg3) | | | | | choose an item. | | | | | GP name | | click or tap here to enter text. | | | | | | |
| GP telephone | | click or tap here to enter text. | | | | | | | GP address | | | click or tap here to enter text. | | | | | |

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name Hospital | click or tap here to enter text. | | | | |
| Date of hospital admission | | | click or tap to enter a date. | | Date of admission to ICU | | click or tap to enter a date. | | |
| Source of ICU admission: | | From within this hospital | | |  | Ward | |  |
| **OR** | |  |
|  | | | | | | Emergency Department | |  |
|  | | | |
| From another hospital | | | | | ICU  OR | | |
| Name of hospital click or tap here to enter text. | | | | | Non- ICU | | |

**Clinical Details**

**Was the COVID-19 infection the primary cause of ICU admission as clinically assessed by the ICU medical team**

**Yes  No, contributory factor  No  Not applicable (if notifying influenza**)

***If the answer is ‘’no’ or ‘’no contributory factor’’, there is no requirement to complete this form.***

***Please complete the form for influenza cases***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| SARS-CoV-2 (COVID-19) | Influenza A(H3) | | | Influenza A(H1)pdm09 | | | | | | | | Influenza A (not subtyped | | | |
| Influenza B | | | Was the infection determined to hospital acquired? | | | | | | | | | | | choose an item. | |
| Date of onset of symptoms | | click or tap to enter a date. | | | | Date of diagnosis | | | click or tap to enter a date. | | | | | |
| Was the infection determined to be hospital acquired | | | | | **Yes** | | **No** | | | **Unknown** | | | | |
| **Vaccinated against Influenza** | | choose an item. | | | | Date of influenza vaccination | | | | | | | click or tap to enter a date. | | | |
| Influenza vaccine type | | Choose an item. | | | | Other (please specify) | | | | | click or tap here to enter text. | | | | | |
| **Vaccinated against COVID-19** | | choose an item. | | | | No. doses | | choose an item. | | | | | | | |
| ***\*LAIV refers to Live Attenuated Influenza Vaccine, \*\*QIV refers to Quadrivalent Influenza Vaccine*** | | | | | | | | | | | | | | | |

**SOFA score on admission to this ICU**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***Parameter*** | **0** | **1** | **2** | **3** | **4** | **Total** |
| [PaO₂kPa/FiO₂] ratio\* | > 40 | 30-39 | 20-29 | 10-19 | < 10 | 00 |
| Platelet count (106/L) | > 150 | ≤ 150 | ≤ 100 | ≤ 50 | ≤ 20 | 00 |
| Bilirublin (umol/L) | < 20 | 20-32 | 33-100 | 101-203 | > 203 | 00 |
| Hypotension | MAP >70mmHg | MAP <70mmHg | Dop ≤ 5 or equivalent | DOP >5 or Epi ≤ 0.1 or Norepi ≤ 0.1 | DOP > 5 or Epi > 0.1 or Norepi ≤ 0.1 | 00 |
| GCS | 15 | 13-14 | 10-12 | 6-9 | < 6 | 00 |
| Serum Creatine1 (umol/L) | < 106 | 107-168 | 169-300 | 301-433 | >434 | 00 |
| **Total** |  |  |  |  |  | 00 |

e.g if PaO₂ = 20 kPa and FiO₂ = 0.5 then PaO₂/ FiO₂ ratio = 20/0.5 = 40 Therefore score = 0

\* FiO₂ = inspired O2 concentration as a fraction of 1 (1 =100% O2, 0.5 = 50% O2)

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| --- | --- | --- | --- | --- | --- |
| MRN: | 00000 | Initials: | click or tap here to enter text. | DOB: | click or tap to enter a date. |

|  |  |
| --- | --- |
| Does the Patient have Acute Respiratory Distress Syndrome on admission? | choose an item. |
| Does the patient require non-invasive mechanical ventilation (CPAP,BiPAP or HFNO) on admission? | choose an item. |
| Does the patient require invasive mechanical ventilation on admission? | choose an item. |
| Does the patient require renal replacement therapy (CRRT) on admission? | choose an item. |

|  |
| --- |
| **Comments:** click or tap here to enter text. |
|  |

**Underlying Medical Conditions in Adults**

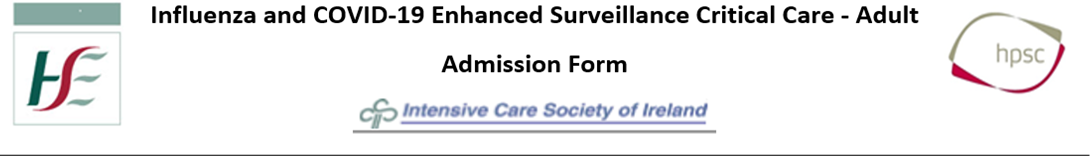
|  |  |  |  |
| --- | --- | --- | --- |
| **Does the case have any underlying medical conditions?** | Yes | No | |
|  | | | **Yes** | | **No** | **Unknown** |
| **Chronic Heart Disease** | | |  | |  |  |
| **Hypertension** | | |  | |  |  |
| **Chronic kidney disease** | | |  | |  |  |
| **Chronic liver disease** | | |  | |  |  |
| **Chronic neurological disease** | | |  | |  |  |
| **Cancer/malignancy** including haematological1 | | |  | |  |  |
| **Immunodeficiency/Immunosuppression** | | |  | |  |  |
| Due to HIV | | |  | |  |  |
| Due to Solid Organ Transplantation | | |  | |  |  |
| Due to Therapy (chemotherapy, radiotherapy, high dose steroid,  Immunomodulators, anti-TNF agents, etc (see definitions pg3) | | | [] | | [] | [] |
| Due to Primary immunodeficiency (see definitions pg3) | | |  | |  |  |
| Due to inherited metabolic disorders | | | [] | | [] | [] |
| Due to Asplenia / Splenic dysfunction | | | [] | | [] | [] |
| **Chronic respiratory disease including:** | | | [] | | [] | [] |
| Chronic obstructive pulmonary disease (COPD) (including chronic bronchitis and emphysema | | |  | |  |  |
| Bronchiectasis | | |  | |  |  |
| Cystic fibrosis | | |  | |  |  |
| Interstitial lung fibrosis | | |  | |  |  |
| Asthma (requiring medication) | | |  | |  |  |
| Mild to Moderate | | |  | |  |  |
| Severe (uncontrolled despite proper medication and treatment) | | |  | |  |  |
| Other | | |  | |  |  |
| **Pregnant** | | |  | |  |  |
| Week of gestation | | |  | |  |  |
| Is the case <= 6 weeks post partum | | | Click or tap here to enter text. | | | |
| **Obesity** BMI < 30 [] BMI 30-40 [] BMI > 40 [] Unknown [] | | |  | |  |  |
| |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Diabetes mellitus** | | | |  |  |  | | Type of Diabetes: | Type I | Type II | Gestational diabetes | | | | | **Hypothyroidism** | | | | [] | [] | [] | | **Haemoglobinopathy** | | | |  |  |  | | **Alcohol related disease** | | | |  |  |  | | **Other underlying medical conditions, please specify:** click or tap here to enter text. | | | | | | | | | | | | | |
|  | | | | | | |

1 Includes, leukaemia, lymphomas, blood dyscrasias or other malignant neoplasms affecting the bone marrow or lymphatic systems.

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| --- | --- | --- | --- |
| **Smoking Status**: Current Smoker | Never smoked | Former smoker (stopped smoking ≥ 1 year ago) | Unknown |

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature:** | click or tap here to enter text. | **Date:** | click or tap to enter a date. |
|  |  |  |  |

**Please send Critical Care Admission Form to HPSC when patient is first admitted to ICU Email:** [**hpsc-data@hpsc.ie**](mailto:hpsc-data@hpsc.ie) **Fax:01-8561299**

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