

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

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| --- | --- | --- | --- | --- | --- |
| 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. |

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| 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. |

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| **Comments:** click or tap here to enter text. |
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**Underlying Medical Conditions in Adults**

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| --- | --- | --- |
| **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 [[ ] ]  |[ ] [ ] [ ]
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| --- |
| **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. |

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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 [ ]  |

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| **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** **Fax:01-8561299**

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