|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Details MRN** 000000For 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 | Yrs.  Mo. | | | | | |
| Weight (kg) | | | 000 | Height (cm) | | 000 | | BMI | **!Zero Divide** | Right click and select **‘Update Field’** to calculate BMI | | | | | | | | |
| Gestational age at time of birth (weeks) | | | | | | | 00 | | | | Sex | choose an item. | | | | | | | |
| 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. | | | | |
| Nationality | | click or tap here to enter text. | | | | | | | | | Ethnicity | | | Choose an item. | | | | | |
| GP name | | click or tap here to enter text. | | | | | | | | | GP Number | | | 000000000 | | | | | |
| 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 non-ICU | | | | | Name of other hospital | | | click or tap here to enter text. | | |

***Clinical Detail*** *please select organism that apply*

**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  Co-infected with Group A Step (iGAS) choose an item. Co-infected with RSV 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 | | | | choose an item. | | |
|  |  | |  | |  | | |  | | | |
| **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. | | | |

|  |  |
| --- | --- |
| State first measurements recorded during the first hour after admission to your unit: | |
| Systolic Blood Pressure | 00000 |
| Base Excess (arterial/capillary) | 00000 |
| Pupil reaction | Choose an item. |
| *Did the child receive any of the following during the first hour after admission to your unit?* | |
| Non-invasive mechanical ventilation (CPAP or BiPAP)? choose an item. | |
| Invasive mechanical ventilation? choose an item. | |
| Does the patient require ECMO? choose an item. | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PIM/PIM2 Physiology** | | | | |  | |  |  |  | |  |  |  |  |  |
| Blood gas in first hour  Arterial PaO2  FiO2  Intubation  Headbox | | Yes  No  0000  0000  Yes  No  Yes  No | | KPa OR | | |  |  |  | | --- | --- | --- | |  |  |  |   0000 | | | | mmHg | | | | | |
| PIM Score | 0000 | PIM2 score | 0000 | |  | |  |  |  | |  |  |  |  |  |

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

|  |
| --- |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| MRN: | 000000 | Initials: | click or tap here to enter text. | DOB: | click or tap to enter a date. |

**Underlying Medical Conditions in Children**

|  |  |  |  |
| --- | --- | --- | --- |
| Does the case have any underlying medical conditions? | Yes [] | No [] | Unknow [] |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | | | | **Yes** | **No** | **Unknown** |
| **Cardiovascular condition/treatment for Congenital Heart Disease** | | | | [] | [] | [] |
| **Chronic renal disease** | | | | [] | [] | [] |
| Nephrotic syndrome | | | | [] | [] | [] |
| Congenital Renal Disease | | | | [] | [] | [] |
| **Chronic liver disease** | | | | [] | [] | [] |
| Long term aspirin therapy | | | | [] | [] | [] |
| **Hypothyroidism** | | | | [] | [] | [] |
| **Cancer/malignancy** including haematological1 | | | | [] | [] | [] |
| **Immunodeficiency/Immunosuppression** | | | | [] | [] | [] |
| Due to HIV | | | | [] | [] | [] |
| Due to Solid Organ Transplantation | | | | [] | [] | [] |
| Due to Haematopoietic Stem Cell Transplant (HSCT) | | | | [] | [] | [] |
| 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:** | | | | [] | [] | [] |
| Bronchiectasis | | | | [] | [] | [] |
| Cystic fibrosis | | | | [] | [] | [] |
| Asthma (requiring medication) | | | | [] | [] | [] |
| Mild to Moderate | | | | [] | [] | [] |
| Severe (uncontrolled despite proper medication and treatment) | | | | [] | [] | [] |
| **Chronic Neurological Disease** | | | | [] | [] | [] |
| Seizure Disorder | | | | [] | [] | [] |
| Cerebral Palsy | | | | [] | [] | [] |
| Spina Bifida | | | | [] | [] | [] |
| Myotonic and Muscular Dystrophy | | | | [] | [] | [] |
| **Diabetes mellitus** | | | | [] | [] | [] |
| Type of Diabetes: | Type I [] | Type II [] |  | | | |
| Other | | | | [] | [] | [] |

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

|  |
| --- |
| **Other underlying medical conditions, please specify:** click or tap here to enter text. |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **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**



**Definitions**

|  |  |
| --- | --- |
| Timing | Within 1 week of a known clinical insult or new/worsening respiratory symptoms |
| Chest Imaging\* | Bilateral opacities not fully explained by effusion, lobar/lung collapse or nodules |
| Origin of oedema | Respiratory failure not fully explained by cardiac failure of fluid overload  Needs objective assessment (e.g echocardiography) to exclude hydrostatic oedema if no risk factor present |
| Oxygenation | Mild -26.6kPa < Pa02 /FiO2 ≤ 39.9 kPa  Moderate -13.3kPa < Pa02 / FiO2 ≤ 26.6 kPa  Severe - Pa02 /Fi02 ≤ 13.3 kPa  PEEP or CPAP ≥ 5cmH2 all above |

\*chest radiograph or CT ref. table modified from BJA Education, Vol 17 Number 5 2017

**Acute Kidney Injury** Use AKIN classification

|  |  |  |  |
| --- | --- | --- | --- |
| Stage | Creatinine Criteria | Urine output criteria | |
| 1 | Cr. x 1.5–2 from baseline | or | <0.5 ml/kg/hr for 6 hours |
| 2 | Cr. x 2-3 from baseline | or | <0.5 ml/kg/hr for 12 hours |
| 3 | Cr. x 3 from baseline  Or  Cr ≥ 354 umol/l with an acute rise > 44 umol/l or need RRT | or | < 0.3 ml/kg/hr for 24 hours  or anuria for 12 hours or need for RRT |

**Immunodeficiency/Immunosuppression**

|  |  |
| --- | --- |
| Due to Therapy | The following doses of prednisolone (or equivalent dose of other glucocorticoid) are likely to be immunosuppressive. Adults and children =10kg: = 40 mg/day for more than 1 week, or=20 mg/day for 2 weeks or longer; Children < 10 kg:2mg/kg/day for 2 weeks or longer.  Azathioprine, cyclophosphamide, cyclosporine, hydroxychloroquine, leflunomide, methotrexate, mycophenolic acid preparations, sirolimus and tacrolimus, in addition to biologics, such as TNFα blocking agents (adalimumab, etanercept, infliximab), and others including abatacept, anakinra, eculizumab, rituximab and tocilizumab. |
| Due to primary immunodeficiency | Ataxia Telangiectasia; Bruton agammaglobulinaemia (X linked agammlobulinaemia, XLA), Chronic/cyclic neutropoenia, Chronic granulomatous disease (CGD), Chronic mucocutaneous candidiasis (APECED syndrome), Complement deficiency, Common variable immunodeficiency (CVID) & other immunoglobulin deficiencies, DiGeorge syndrome, Down syndrome, Fanconi’s anaemia, Wiskott Aldrich Syndrome, Severe combined immunodeficiency syndrome (SCID) |