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

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Intensive Care Society of Ireland

hpsc

Patient Details

CIDR Event ID (Official Use Only)

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 ☐ | PIMS-TS[1] ☐

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** ☐

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 PaO^2 / FiO^2 * ___ . ___ kPa OR ___ mmHg

	Yes	No
Intubation	☐	☐
Headbox	☐	☐

PIM Score | PIM2 Score

*As recorded at the time of the above PaO^2 sample

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 ☐

Does the patient require ECMO? **Yes** ☐ **No** ☐ **Unknown** ☐

Comments

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

Signature

Date

PTO

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

MRN | Initials | DOB

Underlying Medical Conditions in Children

Does the case have any underlying medical conditions? Yes ☐ No ☐

	Yes	No	Unknown
Chronic Respiratory Disease	☐	☐	☐
Bronchiectasis	☐	☐	☐
Cystic Fybrosis	☐	☐	☐
Asthma (requiring medication)	☐	☐	☐
Mild to moderate ☐			
Severe (uncontrolled despite proper medication and treatment) ☐			
Cardiovascular condition/treatment for Congenital Heart Disease	☐	☐	☐
Chronic Renal Disease	☐	☐	☐
Nephrotic syndrome	☐	☐	☐
Congenital Renal Disease	☐	☐	☐
Diabetes mellitus	☐	☐	☐
Type of Diabetes: Type I ☐ Type II ☐			
Hypothyroidism	☐	☐	☐
Immunodeficiency/Immunosuppression	☐	☐	☐
Due to HIV	☐	☐	☐
Due to Organ Transplantation	☐	☐	☐
Due to Therapy (chemotherapy, radiotherapy, high dose steroids, immunomodulators, anti-TNF agents, etc.)	☐	☐	☐
Chronic Liver Disease	☐	☐	☐
Long term asprin therapy	☐	☐	☐
Chronic Neurological Disease	☐	☐	☐
Seizure Disorder	☐	☐	☐
Cerebral Palsy	☐	☐	☐
Spina Bifida	☐	☐	☐
Myotonic and Muscular Dystrophy	☐	☐	☐

Other underlying medical conditions, please specify:

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

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

Intensive Care Society of Ireland

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
Primary viral pneumonia	☐	☐
Secondary bacterial pneumonia	☐	☐
Acute respiratory distress syndrome*	☐	☐
Pressor dependence at any time during ICU stay	☐	☐
Acute Kidney Injury	☐	☐
CRRT/IHD	☐	☐
Tracheostomy	☐	☐

	Yes	No
Myocarditis	☐	☐
Encephalitis	☐	☐
Sepsis Or Multi-Organ Failure	☐	☐
Meningitis	☐	☐

If other complication, please specify:

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	☐	☐	Duration CPAP ventilation (days) ___
BiPAP/NIV ventilation	☐	☐	Duration BiPAP ventilation (days) ___

Invasive mechanical ventilation

	Yes	No	
Conventional (including lung protective) mechanical ventilation	☐	☐	Duration conventional MV (days) ___
HFOV ventilation	☐	☐	Duration HFOV ventilation (days) ___
ECMO	☐	☐	Duration ECMO (days) ___

	Yes	No	
Hemofiltration/Plasmapheresis	☐	☐	Duration O^2 (days) ___
			Home on O^2 Yes ☐ No ☐

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: _____

	Yes	No	Unknown	Not applicable
Is COVID-19 a likely cause of death?	☐	☐	☐	☐
Is influenza a likely cause of death?	☐	☐	☐	☐
Coroner's case	☐	☐	☐	☐

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