

ICU Report Sheet

Report date: _____ Report time: _____

Healthcare provider: _____ ID: _____

Designation: _____ Facility: _____

Unit: _____ Room number: _____

Patient information

Name:

Date of birth:

Sex:

Medical ID:

Code:

VTE:

Isolation:

Admission date:

Admission diagnosis:

Allergies:

Past medical history

Tick all that apply:

DM

CHF

HTN

CAD

PCI

HLD

PVD

GERD

COPD

Asthma

CKD

ESRD

Smoker

Drug abuse

Psych

CVA

Dementia

Hypothyroid

CA

Other (specify):

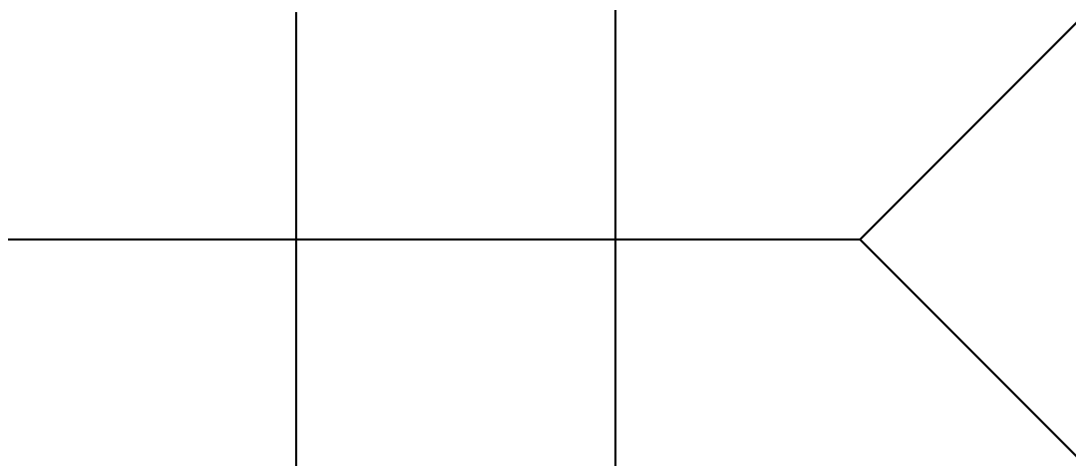
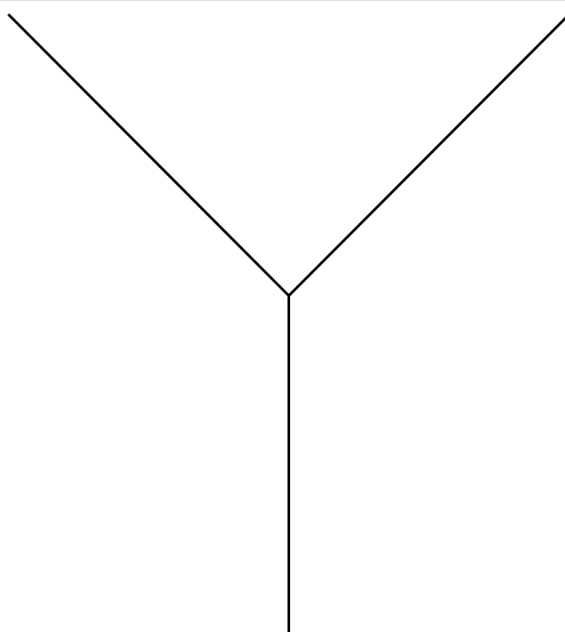
Clinical status

Heart rate:

Blood pressure:

Respiratory rate:	Temperature:
Oxygen saturation:	FiO ₂ :
Neurological status (GCS):	
Other:	
Care information	
Feeding tube:	Diet:
Lines:	
IV	Central
HD	Other:
Medications (including dosage, route and time):	
Other:	
Ventilator settings	
Yes	N/A
Mode:	Tidal volume:
Respiratory rate:	PEEP:
Other:	

Laboratory results



Other relevant results:

Procedures/interventions**Date:****Time:****Procedure:****Results:**

Scheduled procedures:

Other information & instructions