Patient Information Form (ECMO Referral)

- Patient location (Hospital, City, State, Unit/Bed #):
- Requesting provider:
- Call back phone number:
- Is family aware of potential for ECMO? Yes/No (circle one)
- Consent/assent obtained, by whom?
- Admission diagnosis:
- Mode of ECMO Support:
- Brief patient history (working diagnosis, past medical history, reason for ECMO, etc.):

_____
_____
_____

Date/Time:
Patient Name:
Patient Health Number:
DOB:
Admission date:

Flu positive? Yes/No (circle one)
Viral panel:
COVID-19? Yes/No (circle one)

Current and admission weight:
Height:
Chronic renal failure? Yes/No (circle one)
Dialysis? Yes/No (circle one)
Acute renal failure? Yes/No (circle one)
Active bleeding? Yes/No (circle one) If yes, where?
Requiring transfusion Yes/No (circle one)
Current continuous medications:
Current neurological status:

Cardiac arrest this admission? Yes/No (circle one)
Trauma? Yes/No (circle one)
Surgery/type/date:

Latest laboratory results

WBC:	Na:	ALT:	INR:
HGB:	K:	AST:	PT:
Platelets:	Urea	Total bilirubin:	APTT:
Fibrinogen:	Creatinine:	Albumin:	Glucose:
Lactate:	HCO_3:	LDH:	Pregnancy test:
Procalcitonin:	Blood type:	*(please have 2 units PRBC available.)*	

Latest ABG

pH:
pCO_2:
pO_2:
Base excess:

Chest X-Ray

Findings:

Latest Vitals
HR:
ABP:
Resp:
SpO_2:
Temp:

Ventilator settings
Date of intubation:
Mode:
FiO_2:
PEEP:
When was the FiO_2 last < 60%?

I/O status
Last 24 hours
Since admission:
Nutrition:

ECHO

Ejection fraction:
Aortic Valve status: Mitral Valve status: Pericardial effusion? Yes/No (circle one)
CT Head: CT Chest/Abdomen: