ECMO BASIC EVALUATION FORM
MASINA HEART INSTITUTE

Date/Time:
Patient Name:
Patient Health Number:
DOB:
Admission date:
Flu positive? Yes/No (circle one)
Viral panel:
COVID-19? Yes/No (circle one)

- Patient location (Hospital, City, State, Unit/Bed #):
- Name:
- 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.):____
  ____
  ____
  ____
- 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:
- Labs

Wbc:	Na:	ALT:	INR:
Hgb:	K:	AST:	PT:
Plat:	Urea:	T Bili:	APTT:
Fibrinogen:	Creat:	Alb:	HGT:
Lac:	HCO2:	LDH:	UPT:
Procal:	Blood Group:		

Latest ABG: PH PCO2 po2 Base Excess

XRC:

Latest Vitals :

HR:	ABP:	RR:	SPO2:	FEB/AFEB

Intake/ Output : RT Feeds :

Ventilator Settings :

Intubated ON:	Mode	Fio2	PEEP	

2 D ECHO

To be filled by ICCU Registar/Treating Consultant
Name : Dr
Contact No : ICCU Contact No: