



Case Report Forms and Instructions

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Methods Centre Contacts

CERU Contacts	
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All questions related to data collection procedures should be directed to the Project Assistant.

General Instructions

Completing the CRFs:

- All data requested in this CRF is to be taken from original source documents (e.g. the patient's hospital chart).
- These paper CRFs are important records. Accordingly, please ensure they are complete.
- All data collection activities will be completed on the web.
- All data fields should be completed
 - Asterisks (*) denote required fields. You will be unable to finalize a patient if any of these items on REDCap are missing, and/or if you have not provided a comment if these values are considered "out of range."

Important Notes about CRFs:

- All dates must be recorded in the format YYYY-MM-DD
- All times must be recorded using the 24 hour (military) clock (HH:MM). Midnight will be 00:00 hrs.
- Anywhere in the CRF that "Other, specify" is indicated and/or has been selected, there must be an entry on the line provided further describing what "other" means.
- Day 1 is the date of admission to ICU
- Study days are defined by the calendar clock (i.e. 00:00-23:59 hrs)
 - Day 1 may not be a full 24 hour period
 - The last day in the ICU may not be a full 24 hour period

Entering Data Online:

- The Web Based Data Capture System for the PEP uP Study can be accessed by following the REDCap login link on the www.criticalcarenutrition.com website, or directly at <https://ceru.hpcvl.queensu.ca/EDC/redcap/>
- Please see the PEP uP REDCap Instruction Manual for more information

Site and User Registration

Completion of the online user registration form will notify the Project Assistant, and the Project Assistant will assign you a username and password. Users will receive their usernames and passwords via email. This may take up to 2 business days, though every effort will be made to assign you a username as quickly as possible.

- The Clinical Evaluation Research Unit will provide a username and password only to individuals who are registered to participate in the study
- The site and user registration must be completed **once** for each ICU.
 - Please ensure only one person registers each ICU, and provides all the contact details for each individual from that ICU that needs a username and password
- If you have multiple ICUs:
 - You should register each ICU separately
 - You will receive a separate username for each ICU
- All users must log onto the website using their own username and password prior to data entry

Protocol Implementation Team	This is where you specify who is going to be involved in educating staff regarding the study and/or feeding protocol, collecting and entering study data, and coordinating the study. Each person indicated here will receive a REDCap username and password.
Hospital Name	Please specify your hospital's full name, without abbreviations, as you wish for it to appear on your Site Report. Please ensure there are no typos.
Hospital Type	A teaching hospital is a hospital that provides training to medical students and residents. If your hospital only has occasional medical students/residents, select non-teaching hospital.
City, Province/State, Country	Specify the location of your hospital
Size of Hospital	Specify the number of beds in your hospital
Multiple ICUs	Indicate whether or not your hospital has multiple ICUs. Select yes even if only one of these ICUs is participating in the study.
ICU Name	Please specify your ICU's name as you wish for it to appear on your Site Report. Please ensure there are no typos.
Participation in Previous Years	Please indicate whether or not this ICU has participated in the International Nutrition Survey in previous years. You may need to ask your colleagues if you are unsure, or contact us for assistance. If you have had multiple ICUs participate in various years, please be specific as to which ICU(s) participated in which year(s).
ICU Type	Indicate the ICU structure. Open ICUs are sites where patients are under the care of an attending physician (e.g. internist, family physician, surgeon) with intensivists (i.e. physician with training in critical care) consulted as necessary. Closed ICUs are sites in which patients are under the care of an intensivist or care is shared between the intensivist and another attending physician.
Case Types	Please indicate all case types applicable to this ICU.

User Registration 1

1. Primary REDCap Users: *(Usernames and passwords to access the online data entry system will be assigned to each of the individuals listed below.)*

First name	Last name	Email	Phone	Role in ICU	Signature

To register your site, please provide the following information. You may need to ask your ICU Medical or Nursing Director to help you with some responses.

Hospital Information

2. Hospital Name: _____

3. Hospital Type: Teaching Non-teaching

4. City: _____ 5. Province/State: _____ 6. Country: _____

7. Size of Hospital (Number of Beds): _____

8. Does your hospital have multiple ICUs? Yes No

ICU Information

9. ICU Name: _____

10. Has this ICU participated in the International Nutrition Survey in previous years? Yes No

If yes, in which year(s) did you participate? (select all that apply)

2007 2008 2009

11. ICU Type:

- Open: Attending physician remains in charge, ICU physician consults.
- Closed: Care transferred or shared with ICU physician
- Other, *Please specify:* _____

12. Case Types (select all that apply):

- | | | |
|-------------------------------------|--|--|
| <input type="checkbox"/> Medical | <input type="checkbox"/> Neurological | <input type="checkbox"/> Other, <i>Please Specify:</i> _____ |
| <input type="checkbox"/> Surgical | <input type="checkbox"/> Neurosurgical | |
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Cardiac Surgery | |
| <input type="checkbox"/> Pediatrics | <input type="checkbox"/> Burns | |

Filled out once for each ICU.

Site and User Registration

ICU Medical Director	Indicate whether or not your ICU has a Medical Director
Number of ICU Beds	Indicate how many beds your ICU contains
Dietitian in ICU	<p>This is a measure of the amount of time the dietitian is dedicated to the ICU relative to a full time position.</p> <p><u>Example:</u> A FTE of 1.0 means the dietitian works in the ICU full time and a FTE of 0.5 means the dietitian is in the ICU half time, or two and a half days a week.</p>
Feeding Protocol/ Algorithm	<p><u>Enteral feeding protocols are defined as:</u> tools designed to enable the bedside nurse to initiate, monitor, and modify the administration of EN to individual patients. Implementation of such protocols includes, but is not limited to, the use of pre-printed orders that are signed by a physician when a patient is admitted to the ICU and a bedside algorithm that provides instructions to the bedside nurse on the management of EN.</p> <p>If your ICU uses a feeding protocol to guide the initiation and progression of enteral nutrition, indicate if your protocol includes the listed components. If you have a gastric residual volume threshold, indicate this value in mL.</p>
Blood Sugar Protocol	Indicate whether or not you have a protocol or algorithm to monitor blood sugar control. If yes, enter the upper and lower value of your acceptable range, or alternatively, if your ICU targets one value, enter this value. Specify the units (mmol/L or mg/dL) for these values by checking the appropriate box.

User Registration 2

13. Is there a designated ICU Medical Director? Yes No

14. Number of beds in ICU: _____

15. Do you have a Dietitian working in the ICU? Yes No

If yes: Amount of full time equivalent (FTE) dietitian: _____

16. Do you use a bedside feeding protocol/algorithm that allows the nurse to advance or withhold tube feedings as specified by the protocol/algorithm?

Yes No

If yes:

Do you use a gastric residual volume threshold to adjust feeds? Yes: _____ mL No

Does your feeding protocol use an algorithm for: (check all that apply)

- Motility agents Other, *Please Specify:* _____
 Small bowel feeding
 Withholding for procedures
 Head of bed elevation

17. Do you use a protocol to monitor blood sugar control or the administration of insulin?

Yes No

<i>If yes:</i>	What range do you target?	-OR-	What value do you target?	<i>Units?</i>
	Lower: _____ Upper: _____		Target: _____	<input type="checkbox"/> mmol/L <input type="checkbox"/> mg/dL

Comments:

Filled out once for each ICU.

Screening

1. You will prospectively and consecutively enroll patients in the study. Beginning on the first day of data collection, record all patients admitted to your ICU on or after that day in your screening log.

Note: Study Day 1 is the date of ICU admission, regardless of when the patient is screened. *Example:* if you screen a patient on November 3, and they were admitted to ICU on November 1, you need to collect data from November 1 until November 12

Note: If charts are missing and you are unable to collect the relevant data for this patient, please exclude this patient and include the next eligible patient.

2. Screening log columns represent eligibility criteria for purposes of data collection. Place a ✓ in each column where a patient meets the eligibility criteria, or an × if the patient does not meet that criteria. You will not know if a patient is eligible until 48 hours after ICU admission (exclude patients that die within 48 hours). Collect data on all patients who meet all eligibility criteria. If the number of patients meeting inclusion criteria is <30, continue to screen daily until you have at least 30 consecutive patients.

Note: **Consecutive** means the very next patient that meets the criteria, instead of picking and choosing patients.

3. If a patient has had several admissions to the ICU, use the **most recent** admission.
 - a. If a patient you collected data on is later readmitted to the ICU, do not screen them a 2nd time.
 - b. If a patient you are collecting data on is discharged but readmitted within 48 hours consider it as if this patient never left the ICU (and continue collecting data on them)
4. Use additional pages of the screening log as necessary. Number the pages at the bottom. When the page is the last of the series, check the box:

Page number: _____

Check box if this is the last page of the screening log:

5. Record the REDCap patient number on the screening log.

Important: The patient number and screening number will **not** be the same. The patient number is automatically generated by REDCap.

6. Please keep the screening log to help track down which patient corresponds to which patient number in case we have data queries at a later date.

Enroll all patients meeting the following Eligibility Criteria:

Inclusion	Exclusion
<ul style="list-style-type: none"> ○ Adult patients (≥18 years) ○ Mechanically ventilated within 6 hours of admission to the ICU <p><i>Note:</i> Duration of mechanical ventilation does not matter. Patients already mechanically ventilated when admitted to ICU are eligible.</p>	<ul style="list-style-type: none"> ○ Enteral or parenteral nutrition initiated before ICU admission ○ Patients on mask ventilation ○ Moribund (as evidenced by death within 48 hours of admission to ICU)

Screening Log

This log is for your own reference and will not be entered online. However, you may be asked to provide the total number of patients from each column of your screening log. Please use additional copies of this page as necessary.

Screening number <i>(for your reference only)</i>	Patient initials for all patients admitted to ICU on/after first day of data collection	Patient is ≥18 years old	EN and/or PN not initiated prior to ICU admission	Patients intubated and ventilated within the first 6 hours of admission to ICU <i>(exclude mask ventilation)</i>	Patient did not die within 48 hours of ICU admission	Patient eligible?	REDCap Patient number <i>(automatically assigned online)</i>
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
TOTAL							

Page number: _____

 Check box if this is the last page of the screening log:

Screening Log

This log is for your own reference and will not be entered online. However, you may be asked to provide the total number of patients from each column of your screening log. Please use additional copies of this page as necessary.

Screening number <i>(for your reference only)</i>	Patient initials for all patients admitted to ICU on/after first day of data collection	Patient is ≥18 years old	EN and/or PN not initiated prior to ICU admission	Patients intubated and ventilated within the first 6 hours of admission to ICU <i>(exclude mask ventilation)</i>	Patient did not die within 48 hours of ICU admission	Patient eligible?	REDCap Patient number <i>(automatically assigned online)</i>
26							
27							
28							
29							
30							
31							
32							
33							
34							
35							
36							
37							
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
50							
TOTAL							

Page number: _____

Check box if this is the last page of the screening log:

Screening Log

This log is for your own reference and will not be entered online. However, you may be asked to provide the total number of patients from each column of your screening log. Please use additional copies of this page as necessary.

Screening number <i>(for your reference only)</i>	Patient initials for all patients admitted to ICU on/after first day of data collection	Patient is ≥18 years old	EN and/or PN not initiated prior to ICU admission	Patients intubated and ventilated within the first 6 hours of admission to ICU <i>(exclude mask ventilation)</i>	Patient did not die within 48 hours of ICU admission	Patient eligible?	REDCap Patient number <i>(automatically assigned online)</i>
51							
52							
53							
54							
55							
56							
57							
58							
59							
60							
61							
62							
63							
64							
65							
66							
67							
68							
69							
70							
71							
72							
73							
74							
75							
TOTAL							

Page number: _____

Check box if this is the last page of the screening log:

Screening Log

This log is for your own reference and will not be entered online. However, you may be asked to provide the total number of patients from each column of your screening log. Please use additional copies of this page as necessary.

Screening number <i>(for your reference only)</i>	Patient initials for all patients admitted to ICU on/after first day of data collection	Patient is ≥18 years old	EN and/or PN not initiated prior to ICU admission	Patients intubated and ventilated within the first 6 hours of admission to ICU <i>(exclude mask ventilation)</i>	Patient did not die within 48 hours of ICU admission	Patient eligible?	REDCap Patient number <i>(automatically assigned online)</i>
76							
77							
78							
79							
80							
81							
82							
83							
84							
85							
86							
87							
88							
89							
90							
91							
92							
93							
94							
95							
96							
97							
98							
99							
100							
TOTAL							

Page number: _____

Check box if this is the last page of the screening log:

Screening Log

This log is for your own reference and will not be entered online. However, you may be asked to provide the total number of patients from each column of your screening log. Please use additional copies of this page as necessary.

Screening number <i>(for your reference only)</i>	Patient initials for all patients admitted to ICU on/after first day of data collection	Patient is ≥18 years old	EN and/or PN not initiated prior to ICU admission	Patients intubated and ventilated within the first 6 hours of admission to ICU <i>(exclude mask ventilation)</i>	Patient did not die within 48 hours of ICU admission	Patient eligible?	REDCap Patient number <i>(automatically assigned online)</i>
101							
102							
103							
104							
105							
106							
107							
108							
109							
110							
111							
112							
113							
114							
115							
116							
117							
118							
119							
120							
121							
122							
123							
124							
125							
TOTAL							

Page number: _____

Check box if this is the last page of the screening log:

Patient Information

Sex	Place a ✓ in the appropriate box (male or female)
Age	Record patient's age at the time of screening
Hospital Admission Date/Time*	Enter the date and time the patient was admitted to the hospital. This is the time of initial presentation to the emergency department or hospital ward, whichever is the earliest. For patients transferred from another institution directly to the ICU, the ICU admission date/time is to be used for the hospital admission date/time.
ICU Admission Date/Time*	Enter the date and time the patient was admitted to the ICU in your hospital. If the patient has been admitted to your ICU multiple times, use the most recent admission. If a patient is transferred from another ICU enter the date of admission to your ICU. If the patient is admitted directly to your ICU, the ICU and hospital admission dates and times will be the same.
Mechanical Ventilation Date/Time*	Enter the date and time mechanical ventilation was started. This refers to invasive mechanical ventilation i.e. intubation with mechanical ventilation or tracheostomy with mechanical ventilation. This includes any positive pressure delivered via an endotracheal tube or a tracheostomy. This does not refer to non-invasive methods of ventilation such as BI-PAP or mask-CPAP. For the patient that is mechanically ventilated prior to admission to your hospital, check the box "Started prior to ICU admission".
Type of Admission	Place a ✓ in only one of the following categories: Medical: defined as a patient admitted to the ICU for treatment without any surgical intervention (includes patients admitted from a cardiology/radiology intervention suite) Surgical Elective: defined as a patient admitted to the ICU from the operating room directly or a recovery unit following a planned surgical procedure Surgical Emergency: defined as a patient admitted to the ICU from the operating room directly or a recovery unit following an unplanned surgical procedure. <i>Note:</i> If a surgical patient develops a medical complication and is transferred to the ICU from the ward, this would be a "medical" admission type.
Primary ICU Diagnosis	Choose the most pertinent diagnosis from the taxonomy provided that resulted in the patient's admission to ICU . Only one diagnosis can be chosen. Remember, symptoms are not an admission diagnosis (e.g. respiratory distress, hypotension, etc). <u>Example:</u> A patient was admitted to hospital for an elective cholecystectomy. Post-operatively the patient experiences a cardiac arrest on the ward and was subsequently admitted to the ICU. This patient would be classified as <i>medical</i> admission type, and <i>cardiac arrest</i> as primary ICU diagnosis. If the admission diagnosis is not present in the taxonomy, under the correct admission type (Medical, Surgical Elective or Surgical Emergency) select "other" under the appropriate body system (Respiratory, Neurologic, etc) and specify the admission diagnosis. <i>Note:</i> We are specifically interested in reporting on patients with sepsis, pancreatitis, bariatric surgery, ARDS, and burns . If a suitable diagnosis for a patient includes one of these conditions, select this condition in preference to other diagnoses. <u>Example:</u> If a patient is admitted with sepsis and pneumonia, select sepsis.

Patient Number:

Patient Information 1

 ICU Name:

 Sex: Male Female Age: _____

Hospital Admission Date (YYYY-MM-DD): _____ *Required Time (HH:MM, 24h): _____

ICU Admission Date (YYYY-MM-DD): _____ * Time (HH:MM, 24h): _____

Mechanical ventilation: *

 Started prior to ICU admission

 Started in ICU: Date (YYYY-MM-DD): _____ Time (HH:MM, 24h): _____

 Type of Admission: Medical Surgical Elective Surgical Emergency

 Primary ICU Diagnosis: (Select **one** item from the taxonomy)

Medical

Cardiovascular/Vascular

- Acute myocardial infarction
- Aortic aneurysm
- Cardiac arrest
- Cardiogenic shock
- Congestive heart failure
- Hypertension
- Peripheral vascular disease
- Rhythm disturbance
- Other CV disease (specify)

Respiratory

- Aspiration pneumonia
- Asthma
- Bacterial / Viral pneumonia
- Chronic obstructive pulmonary disease
- Mechanical airway obstruction
- Parasitic pneumonia (ie.pneumocystis carinii)
- Pulmonary edema (non-cardiogenic)
- Pulmonary embolism
- Respiratory arrest
- Respiratory neoplasm (include larynx and trachea)
- Other respiratory disease (specify)

Gastrointestinal

- GI bleeding due to diverticulosis
- GI bleeding due to ulcer/laceration
- GI bleeding due to varices
- GI inflammatory disease (ulcerative colitis, crohn's disease)
- GI perforation/obstruction
- Hepatic failure
- Pancreatitis
- Other GI disease (specify)

Neurologic

- Intracerebral hemorrhage
- Neurologic infection
- Neurologic neoplasm
- Neuromuscular disease
- Seizure
- Stroke
- Subarachnoid hemorrhage
- Other neurologic disease (specify)

Sepsis

- Sepsis (other than urinary tract)
- Sepsis of urinary tract origin

Trauma

- Head trauma (with/without multiple trauma)
- Multiple trauma (excluding head trauma)

Metabolic

- Diabetic ketoacidosis
- Drug overdose
- Metabolic coma
- Other metabolic disease (specify)

Hematologic

- Coagulopathy / neutropeniathrombocytopenia
- Other hematologic condition (specify)

Other

- Burns
- Renal disease (specify)
- Other medical disease (specify)

If you selected "other" in any of the above categories, specify here: _____

Surgical

Vascular/Cardiovascular

- CABG only
- Carotid endarterectomy
- Dissecting/ruptured aorta
- Elective abdominal aneurysm repair
- Peripheral artery bypass graft
- Peripheral vascular surgery (no bypass graft)
- Valvular heart surgery/CABG
- Valvular heart surgery only
- Other CV disease (specify)

Respiratory

- Lung neoplasm
- Respiratory infection
- Respiratory neoplasm (mouth, sinus, larynx, trachea)
- Other respiratory disease (specify)

Gastrointestinal

- GI bleeding
- GI cholecystitis / cholangitis
- GI inflammatory disease
- GI neoplasm
- GI obstruction
- GI perforation/rupture
- Liver transplant
- Pancreatitis
- Other GI disease (specify)

Neurologic

- Craniotomy for neoplasm
- Intracerebral hemorrhage
- Laminectomy/other spinal cord surgery
- Subarachnoid hemorrhage
- Subdural/epidural hematoma
- Other neurologic disease (specify)

Trauma

- Head trauma (with/without multiple trauma)
- Multiple trauma (excluding head trauma)

Renal

- Renal neoplasm
- Other renal disease (specify)

Gynecologic

- Hysterectomy

Orthopedic

- Hip or extremity fracture

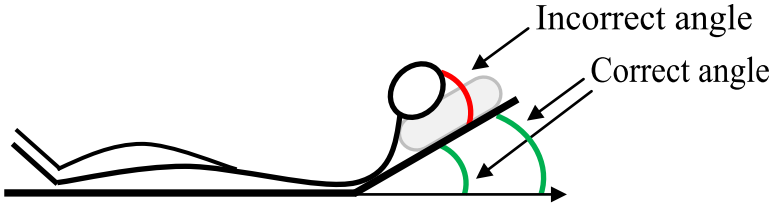
Bariatric Surgery

- Laparoscopic Banding
- Laparoscopic Gastric Bypass
- Open Gastric Bypass (Roux-en-Y)
- Vertical Banded Gastroplasty

Other surgical condition (specify)

If you selected "other" in any of the above categories, specify here: _____

Patient Information

Co-morbidities	<p>Place a ✓ beside all co-morbidities present using the taxonomy provided. Only those co-morbidities found on the taxonomy listing should be recorded.</p> <p><u>Example:</u> A patient’s primary ICU diagnosis is cardiac arrest, and the patient is asthmatic, has type II diabetes, is obese, and is hearing impaired. Under co-morbidities, select:</p> <ul style="list-style-type: none"> - Pulmonary: Asthma - Endocrine: Diabetes Type I or II - Endocrine: Obesity and/or BMI >30 - Miscellaneous: Hearing Impairment
Highest/Lowest Blood Sugar in 1 st 24 hours	<p>Indicate if blood sugar was recorded within the first 24 hours of admission to the ICU. This can be either serum or capillary. If yes, please record the highest and lowest values. Indicate what units you are reporting the values in (mmol/L or mg/dL).</p> <p>If only one blood sugar was recorded in the first 24 hours, enter the same value for the highest and lowest blood sugar.</p>
Presence of ARDS	<p>ARDS is an acute lung condition characterized by PaO₂:FiO₂ <200mmHg in the presence of bilateral alveolar infiltrates on chest x-ray. You are not expected to diagnose ARDS. You only need to review the chart for the first 72 hours from admission to the ICU for either a confirmed or suspected diagnosis of ARDS. If the chart says “? ARDS”, this is suspected ARDS, and you should select “Yes”.</p>
Head of Bed Elevation	<p>This should be observed at the time of screening (i.e. when patient is first included in survey). If head of bed elevation is not observed, please simply note it as “missing.” For determining head of bed elevation, use the device that the ICU bed is equipped with. If no such device is available, you will need to estimate the angle, and we suggest that you do this with another team member (i.e. RN, RT, etc). When you are estimating, please note if the patient has pillows under his/her head. If there are pillows make sure that you record the angle at which the patient’s trunk meets the bed instead of the angle between the head and the pillow.</p> 
APACHE II Score	<p>If routinely calculated, directly enter the score recorded in the patient’s chart.</p> <p>To calculate the score, you may use any tool you wish. We recommend the worksheet on our website or go to the following website: http://www.sfar.org/scores2/apache22.html#haut</p> <p>Record the calculated score.</p> <p><i>Remember:</i> use values from the first 24 hours of this ICU admission. If variables are not available from the first 24 hours, go outside the 24 hour window and use data closest to ICU admission.</p> <p><i>Note:</i> Ensure the units that you are using for serum sodium, potassium and white blood count correspond with the units designated in the tool you are using.</p>

Patient Number:

 ICU Name:

Patient Information 2

 Co-morbidities: *(Check all that apply)*
Myocardial

- Angina
- Arrhythmia
- Congestive heart failure (or heart disease)
- Myocardial infarction
- Valvular

Vascular

- Cerebrovascular disease (Stroke or TIA)
- Hypertension
- Peripheral vascular disease or claudication

Pulmonary

- Asthma
- Chronic obstructive pulmonary disease (COPD, emphysema)

Neurologic

- Dementia
- Hemiplegia (paraplegia)
- Neurologic illnesses (such as Multiple sclerosis or Parkinsons)

Endocrine

- Diabetes Type I or II
- Diabetes with end organ damage
- Obesity and/or BMI > 30 (weight in kg/(ht in meters)²)

Renal

- Moderate or severe renal disease

Gastrointestinal

- Gastrointestinal Disease (hernia or reflux)
- GI Bleeding
- Inflammatory bowel
- Mild liver disease
- Moderate or severe liver disease
- Peptic ulcer disease

Cancer/Immune

- AIDS
- Any Tumor
- Leukemia
- Lymphoma
- Metastatic solid tumor

Psychological

- Anxiety or Panic Disorders
- Depression

Musculoskeletal

- Arthritis (Rheumatoid or Osteoarthritis)
- Connective Tissue disease
- Degenerative Disc disease (back disease or spinal stenosis or severe chronic back pain)
- Osteoporosis

Miscellaneous

- Hearing Impairment (very hard of hearing even with hearing aids)
- Visual Impairment (cataracts, glaucoma, macular degeneration)

 Was the patient's blood sugar recorded in the 1st 24 hours after admission? Yes No

<i>If yes,</i>	Highest blood glucose in 1st 24 hours: _____	Units?
	Lowest blood glucose in 1st 24 hours: _____	<input type="checkbox"/> mmol/L
		<input type="checkbox"/> mg/dL

 Was ARDS present? Yes No

 Head of Bed Elevation: _____° Actual Estimated
 Head of Bed Elevation Not Available or Not Observed

APACHE II Score: _____

Baseline Nutrition Assessment

Height*	Record height in metres . If unable to obtain “actual” value, use estimated height or height obtained from family members and check the box indicating the data was estimated. See www.criticalcarenutrition.com for a units conversion tool, if required.
Weight*	Record patient’s actual weight in kilograms . Do not enter the weight used to estimate the patients nutritional requirements if it differs from patient’s actual weight. If unable to obtain “actual” value, use estimated weight or weight obtained from family members and check the box to indicate the data was estimated. Use “dry weight” (i.e. weight in the absence of fluid retention) if fluid retention is present. See appendix or www.criticalcarenutrition.com for a units conversion tool, if required.
Weight used to determine energy requirements	Choose from the list, or if weight used is not listed, select “other” and specify. If an unadjusted estimated weight is used to calculate nutritional requirements, select “actual” body weight.
Calculation of energy requirements	Select all that apply from the list.
Prescribed Energy Intake*	Enter the total kilocalories provided by the goal regimen (i.e. maximum rate/volume determined at the initial assessment) for EN/PN according to the dietitians’ or physicians’ recommendation. Include kilocalories from protein. If a range is prescribed, indicate the midpoint of the range. If no assessment was completed, calculate prescription as 25kcal/kg <i>Note:</i> If patient is receiving both EN and PN, please record the kilocalories from the combined prescription of EN and PN. If a patient is receiving propofol, enter the prescription before adjusting for propofol.
Prescribed Protein Intake*	Enter the grams provided by the goal regimen (i.e. maximum rate/volume determined at the initial assessment) for EN/PN according to the dietitians’ or physicians’ recommendation. If a range is prescribed, indicate the midpoint of the range. If no assessment was completed, calculate prescription as 1g/kg <i>Note:</i> If patient is receiving both EN and PN, please record the protein from the combined prescription of EN and PN.
EN Initiation Date/Time*	Enter the date/time EN was initiated in the ICU. <i>Note:</i> For the PEP uP Study “EN initiated prior to ICU admission” is not an option because this is an exclusion criteria.
PN Initiation Date/Time*	Enter the date/time PN was initiated in the ICU. <i>Note:</i> For the PEP uP Study “PN initiated prior to ICU admission” is not an option because this is an exclusion criteria.
Reason PN initiated	Choose from the list, or if the reason is not listed, select “other” and specify.
EN delivery technique recommended by physician or dietitian at initial assessment	Choose one option from the list which best describes the delivery technique recommended by the physician or dietitian at the initial assessment for enteral nutrition. For this question, we are only interested in provision of EN, regardless of PN or oral feeding.

Patient Number:

Baseline Nutrition Assessment

 ICU Name:

 Height (metres):* _____ Actual Estimated Weight (kg):* _____ Actual Estimated

Weight used in calculation of nutrition prescription (select all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Actual (ABW) | <input type="checkbox"/> Ideal (IBW) based on Hamwi formula |
| <input type="checkbox"/> Adjusted average ((ABW + IBW) x 0.5) | <input type="checkbox"/> Ideal (IBW) based on BMI 20-25 kg/m ² |
| <input type="checkbox"/> Adjusted by 25% (ABW x 0.25 + IBW) | <input type="checkbox"/> No weight used in calculation |
| <input type="checkbox"/> Adjusted by 40% (ABW x 0.4 + IBW) | <input type="checkbox"/> No assessment completed |
| | <input type="checkbox"/> Other (specify): _____ |

Method(s) used to calculate energy requirements for this patient (select all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Harris Benedict Equation with no adjustment for stress and/or activity | <input type="checkbox"/> Provide 1200-1499 kcal as standard |
| <input type="checkbox"/> Harris Benedict Equation with adjustment for stress and/or activity | <input type="checkbox"/> Provide 1500-2000 kcal as standard |
| <input type="checkbox"/> Schofield Equations with no adjustment for stress and/or activity | <input type="checkbox"/> Indirect calorimetry |
| <input type="checkbox"/> Schofield Equation with adjustment for stress and/or activity | <input type="checkbox"/> No assessment completed |
| <input type="checkbox"/> Mifflin-St. Jeor Equation | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Ireton-Jones Equation | |
| <input type="checkbox"/> Penn State Equation | |
| <input type="checkbox"/> Weight based: _____ kcal/kg to _____ kcal/kg | |

Prescribed Energy intake:* (kcal/day) _____ Prescribed Protein Intake:* (g/day) _____

When was EN first initiated? *

- EN initiated in ICU: Date (YYYY-MM-DD): _____ Time (HH:MM, 24h): _____
- EN not initiated during first 12 days in ICU

When was PN first initiated? *

- PN initiated in ICU: Date (YYYY-MM-DD): _____ Time (HH:MM, 24h): _____
- PN not initiated during first 12 days in ICU

If PN initiated in ICU, specify reason PN initiated: (select only one)

- | | |
|---|---|
| <input type="checkbox"/> Bowel ischemia | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Gastrointestinal bleed | <input type="checkbox"/> Proximal bowel anastomosis |
| <input type="checkbox"/> Gastrointestinal perforation | <input type="checkbox"/> Short gut syndrome |
| <input type="checkbox"/> Gastrointestinal surgery | <input type="checkbox"/> Small bowel ileus |
| <input type="checkbox"/> Hemodynamic instability | <input type="checkbox"/> Small bowel fistulae |
| <input type="checkbox"/> Mechanical bowel obstruction | <input type="checkbox"/> No clinical reason |
| <input type="checkbox"/> No access to small bowel | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Not tolerating enteral feeding | |

What was the delivery technique recommended by the physician or dietitian at the initial assessment for enteral nutrition?

- | | |
|--|---|
| <input type="checkbox"/> Initiate EN: start at low rate and progress to hourly goal rate | <input type="checkbox"/> Initiate EN: keep a low rate (trophic feeds: no progression) |
| <input type="checkbox"/> Initiate EN: start at hourly rate determined by 24 hour volume goal | <input type="checkbox"/> Initiate EN: bolus feeds |
| <input type="checkbox"/> Initiate EN: start at hourly goal rate | <input type="checkbox"/> Keep Nil Per Os (NPO) |

If NPO, please specify reason (select only one):

- | | |
|--|---|
| <input type="checkbox"/> Bowel perforation | <input type="checkbox"/> Proximal high output fistula |
| <input type="checkbox"/> Bowel obstruction | <input type="checkbox"/> Other (specify): _____ |

Daily Nutrition Data

Study day 1 is from ICU admission until midnight on that calendar day. This may be less than 24 hours. Day 2 and subsequent days are labeled by **calendar day** (i.e. midnight to midnight), **not** according to your flowsheet.

Example: A patient is admitted May 2nd at 14:28. Day 1 begins at 14:28 and ends May 2nd at 23:59 (Day 1 is only 9hrs, 31 min. long). Day 2 begins at 00:00 (midnight), May 3rd, and ends at 23:59 on May 3rd.

Collect data daily until ICU discharge, or until day 12, whichever comes first. Once daily data is complete, proceed to the outcomes form.

You must collect data on consecutive days following ICU admission, **even if the patient does not receive nutrition**, and even when study days fall on weekends. If you do not work weekends, collect this data retrospectively when you return to work.

Type of Nutrition Received	Each study day, indicate whether the patient received EN and/or PN and/or Oral Nutrition.
Morning Blood Glucose	Record the blood sugar reading closest to 08:00hrs. This can be either serum or capillary. If no blood sugars were recorded that day, indicate "none recorded". Indicate which units (mmol/L or mg/dL) the blood sugar values are recorded in.
Hypoglycemic Event	Record any blood sugar (up to 3 episodes per day) reading <3.5mmol/L (<63mg/dL).
Insulin	Indicate yes or no to whether or not insulin was received. If yes, add up the total number of units of insulin over the 24 hour period regardless of route or type. If the patient received two types of insulin add them together to provide total units of insulin.
Supplemental Glutamine	This refers to glutamine given as a supplement over and above what would normally be present in the standard enteral or parenteral formula. Indicate yes or no to whether or not glutamine was given, and if yes, indicate the dose and route of glutamine.
Supplemental Selenium	This refers to selenium given as a supplement over and above what would normally be present in the standard enteral formula, parenteral solution, or multivitamin mineral supplement. Indicate yes or no to whether or not selenium was given, and if yes, indicate the dose and route of selenium.
Supplemental Prebiotics	This refers to prebiotics given as a supplement over and above what would normally be present in the standard enteral formula. Indicate yes or no for whether or not they were received. You do not need to indicate type or dose. <u>Prebiotics are defined as:</u> non-digestible food ingredients that stimulate the growth and/or activity of bacteria.
Supplemental Probiotics	This refers to probiotics given as a supplement over and above what would normally be present in the standard enteral formula. Indicate yes or no for whether or not they were received. You do not need to indicate type or dose. <u>Probiotics are defined as:</u> a commercial preparation of viable, defined microorganisms in sufficient numbers which alter the microflora (by implantation or colonization) in a compartment of the patient and by that may exert beneficial health effects in this patient.

Daily Nutrition Data 1

Study Day:	1 (ICU Admission)	2	3	4	5	6	7	8	9	10	11	12	
Type of Nutrition Received:	<input type="checkbox"/> EN <input type="checkbox"/> PN <input type="checkbox"/> Oral	<input type="checkbox"/> EN <input type="checkbox"/> PN <input type="checkbox"/> Oral	<input type="checkbox"/> EN <input type="checkbox"/> PN <input type="checkbox"/> Oral	<input type="checkbox"/> EN <input type="checkbox"/> PN <input type="checkbox"/> Oral	<input type="checkbox"/> EN <input type="checkbox"/> PN <input type="checkbox"/> Oral	<input type="checkbox"/> EN <input type="checkbox"/> PN <input type="checkbox"/> Oral	<input type="checkbox"/> EN <input type="checkbox"/> PN <input type="checkbox"/> Oral	<input type="checkbox"/> EN <input type="checkbox"/> PN <input type="checkbox"/> Oral	<input type="checkbox"/> EN <input type="checkbox"/> PN <input type="checkbox"/> Oral	<input type="checkbox"/> EN <input type="checkbox"/> PN <input type="checkbox"/> Oral	<input type="checkbox"/> EN <input type="checkbox"/> PN <input type="checkbox"/> Oral	<input type="checkbox"/> EN <input type="checkbox"/> PN <input type="checkbox"/> Oral	<input type="checkbox"/> EN <input type="checkbox"/> PN <input type="checkbox"/> Oral
Morning Blood Glucose: <i>Units?</i> <input type="checkbox"/> mmol/L <input type="checkbox"/> mg/dL													
Hypoglycemic event? (<3.5mmol/L or <63mg/dL) (enter up to 3)	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	
Insulin? <i>If yes:</i> Units/day:	<input type="checkbox"/> Y <input type="checkbox"/> N _____	<input type="checkbox"/> Y <input type="checkbox"/> N _____	<input type="checkbox"/> Y <input type="checkbox"/> N _____	<input type="checkbox"/> Y <input type="checkbox"/> N _____	<input type="checkbox"/> Y <input type="checkbox"/> N _____	<input type="checkbox"/> Y <input type="checkbox"/> N _____	<input type="checkbox"/> Y <input type="checkbox"/> N _____	<input type="checkbox"/> Y <input type="checkbox"/> N _____	<input type="checkbox"/> Y <input type="checkbox"/> N _____	<input type="checkbox"/> Y <input type="checkbox"/> N _____	<input type="checkbox"/> Y <input type="checkbox"/> N _____	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Supplemental Glutamine? <i>If yes:</i> Dose (g): Route:	<input type="checkbox"/> Y <input type="checkbox"/> N _____ <input type="checkbox"/> EN <input type="checkbox"/> IV	<input type="checkbox"/> Y <input type="checkbox"/> N _____ <input type="checkbox"/> EN <input type="checkbox"/> IV	<input type="checkbox"/> Y <input type="checkbox"/> N _____ <input type="checkbox"/> EN <input type="checkbox"/> IV	<input type="checkbox"/> Y <input type="checkbox"/> N _____ <input type="checkbox"/> EN <input type="checkbox"/> IV	<input type="checkbox"/> Y <input type="checkbox"/> N _____ <input type="checkbox"/> EN <input type="checkbox"/> IV	<input type="checkbox"/> Y <input type="checkbox"/> N _____ <input type="checkbox"/> EN <input type="checkbox"/> IV	<input type="checkbox"/> Y <input type="checkbox"/> N _____ <input type="checkbox"/> EN <input type="checkbox"/> IV	<input type="checkbox"/> Y <input type="checkbox"/> N _____ <input type="checkbox"/> EN <input type="checkbox"/> IV	<input type="checkbox"/> Y <input type="checkbox"/> N _____ <input type="checkbox"/> EN <input type="checkbox"/> IV	<input type="checkbox"/> Y <input type="checkbox"/> N _____ <input type="checkbox"/> EN <input type="checkbox"/> IV	<input type="checkbox"/> Y <input type="checkbox"/> N _____ <input type="checkbox"/> EN <input type="checkbox"/> IV	<input type="checkbox"/> Y <input type="checkbox"/> N _____ <input type="checkbox"/> EN <input type="checkbox"/> IV	<input type="checkbox"/> Y <input type="checkbox"/> N _____ <input type="checkbox"/> EN <input type="checkbox"/> IV
Supplemental Selenium? <i>If yes:</i> Dose (g): Route:	<input type="checkbox"/> Y <input type="checkbox"/> N _____ <input type="checkbox"/> EN <input type="checkbox"/> IV	<input type="checkbox"/> Y <input type="checkbox"/> N _____ <input type="checkbox"/> EN <input type="checkbox"/> IV	<input type="checkbox"/> Y <input type="checkbox"/> N _____ <input type="checkbox"/> EN <input type="checkbox"/> IV	<input type="checkbox"/> Y <input type="checkbox"/> N _____ <input type="checkbox"/> EN <input type="checkbox"/> IV	<input type="checkbox"/> Y <input type="checkbox"/> N _____ <input type="checkbox"/> EN <input type="checkbox"/> IV	<input type="checkbox"/> Y <input type="checkbox"/> N _____ <input type="checkbox"/> EN <input type="checkbox"/> IV	<input type="checkbox"/> Y <input type="checkbox"/> N _____ <input type="checkbox"/> EN <input type="checkbox"/> IV	<input type="checkbox"/> Y <input type="checkbox"/> N _____ <input type="checkbox"/> EN <input type="checkbox"/> IV	<input type="checkbox"/> Y <input type="checkbox"/> N _____ <input type="checkbox"/> EN <input type="checkbox"/> IV	<input type="checkbox"/> Y <input type="checkbox"/> N _____ <input type="checkbox"/> EN <input type="checkbox"/> IV	<input type="checkbox"/> Y <input type="checkbox"/> N _____ <input type="checkbox"/> EN <input type="checkbox"/> IV	<input type="checkbox"/> Y <input type="checkbox"/> N _____ <input type="checkbox"/> EN <input type="checkbox"/> IV	<input type="checkbox"/> Y <input type="checkbox"/> N _____ <input type="checkbox"/> EN <input type="checkbox"/> IV
Supplemental Probiotics?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
Supplemental Probiotics?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

Filled out daily for each patient.

Daily Nutrition Data

Propofol*	Indicate “yes” if continuous profusion ≥ 6 hours. Indicate “no” if no propofol was given, or if provided intermittently, or if continuous ≤ 6 hours. If yes, indicate the dose, and specify the units you are recording this value in (kcal or mL).
Location of Feeding Tube	Choose from the list to indicate the location of the feeding tube (refers to any oro/nasogastric tube inserted for the purpose of enterally feeding the patient), or choose “no tube in place”.
Motility agents	Choose from the list to indicate if the patient received any motility agents that day. We are not asking for route or dose. If the patient has been prescribed combination therapy, select all motility agents the patient received on that day.
Diarrhea	Indicate whether or not the patient had diarrhea today. <u>Diarrhea is defined as:</u> $>750\text{mL}$ or >5 stools per day
New Incidence of ICU acquired pneumonia	Indicate if there is a new incidence of ICU acquired pneumonia noted as a complication on this day. This is to be determined by chart review. We do not expect you to diagnose pneumonia. We are only interested in capturing pneumonia that developed after at least 48 hours in the ICU. Accordingly, this question has been blanked out on Study Days 1 and 2 of the case report form. The question will still show up on Days 1 and 2 on REDCap. Please just answer “no” for this question on those days. <i>Note:</i> If pneumonia is noted on day 3, select yes. On subsequent days pneumonia may still be present, but you will answer “no” for this question, as this is not a new incidence of pneumonia.
Macroaspiration	Indicate if macroaspiration occurred on this day. This is to be determined by reviewing nursing notes. <u>Macroaspiration is defined as:</u> inhalation of gastric or oropharyngeal contents into the lungs that are witnessed by the bedside nurse or other healthcare personnel (present in ETT secretions).

Daily Nutrition Data 2

Study Day:	1 (ICU Admission)	2	3	4	5	6	7	8	9	10	11	12
Propofol (≥ 6 hours) *	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<i>If yes:</i> Dose:												
<i>Units?</i>												
<input type="checkbox"/> kcal <input type="checkbox"/> mL	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Location of Feeding Tube: <i>(Select one option)</i>												
Gastric confirmed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastric presumed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post-pyloric duodenal confirmed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post-pyloric duodenal presumed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post-pyloric jejunal confirmed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post-pyloric jejunal presumed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No tube in place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Motility Agents <i>(Select all that apply)</i>												
Erythromycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metoclopramide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Domperidone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea? (>750 mL or > 5/day)	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
New Incidence of ICU-acquired pneumonia?			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Macroaspiration?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

Filled out daily for each patient.

Daily Enteral Nutrition Data

If the patient is on combination EN and PN, record calories/protein from EN here, and record nutrition from PN on the Daily PN Data form (i.e. do not include calories/protein from PN on the EN page)

Note: record calories/protein from formulas, protein supplements, and other supplements **separately**

EN Formula(s)	Refer to the taxonomy (see appendix) to record enteral formula(s) received. You may specify up to 3 formulas per day. If the patient received more than 3 formulas in a day, select the 3 that provided the largest volumes.
Kilocalories received from EN*	The total calories (kcal) from EN formula(s) will need to be calculated by the dietitian daily as follows: <ul style="list-style-type: none"> • Include calories from protein • Do NOT include calories from other supplements • Do NOT include calories from propofol • Do NOT include calories from IV solutions
Protein received from EN*	Total protein (g) will need to be calculated by the dietitian daily as follows: <ul style="list-style-type: none"> • Do NOT include protein from additional supplements • Do NOT include glutamine
Supplemental Protein	Indicate yes or no for whether or not a modular protein supplement was given. If yes, refer to the taxonomy (see appendix) to record what supplement was given. If more than one supplement was given, select the one that provided the largest volumes. <u>A modular protein supplement is defined as:</u> a concentrated protein source. This does not include high-protein enteral formulas. High-protein formulas (that also have lipid, carbohydrate and micronutrient components) should be specified under the EN Formula section.
Kilocalories received from Supplemental Protein*	If the patient received a modular protein supplement, indicate calories received (kcal) from the modular protein supplement. <ul style="list-style-type: none"> • Include calories from protein
Protein received from Supplemental Protein*	If the patient received a modular protein supplement, indicate the protein received (g) from the modular protein supplement. <ul style="list-style-type: none"> • Do NOT include glutamine
Other Modular Supplements	Indicate yes or no for whether or not non-protein modular supplements were given. If yes, refer to the taxonomy (see appendix) to record supplement(s) provided. If more than two supplements were given, select the two that provided the largest volumes. <u>A non-protein modular supplement is defined as:</u> single macronutrients used in addition to enteral formulas. This includes glucose polymers, and fat emulsions. Typically modular supplements do not provide a source of micronutrients.
Kilocalories from Supplements	If the patient received a non-protein modular supplement, indicate calories received (kcal) from the modular protein supplement.

Daily Nutrition: Enteral Nutrition 1

Study Day:	1 <i>ICU Admission</i>	2	3	4	5	6	7	8	9	10	11	12
Enteral formula(s): <i>(Select up to 3, see taxonomy)</i>	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.
Kilocalories received from enteral formula(s): *	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Protein (g) received from enteral formula(s): *	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Supplemental protein? Specify: <i>(see taxonomy)</i>	<input type="checkbox"/> Y <input type="checkbox"/> N _____	<input type="checkbox"/> Y <input type="checkbox"/> N _____	<input type="checkbox"/> Y <input type="checkbox"/> N _____	<input type="checkbox"/> Y <input type="checkbox"/> N _____	<input type="checkbox"/> Y <input type="checkbox"/> N _____	<input type="checkbox"/> Y <input type="checkbox"/> N _____	<input type="checkbox"/> Y <input type="checkbox"/> N _____	<input type="checkbox"/> Y <input type="checkbox"/> N _____	<input type="checkbox"/> Y <input type="checkbox"/> N _____	<input type="checkbox"/> Y <input type="checkbox"/> N _____	<input type="checkbox"/> Y <input type="checkbox"/> N _____	<input type="checkbox"/> Y <input type="checkbox"/> N _____
Kilocalories received from supplemental protein: *	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Protein (g) received from supplemental protein: *	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Other modular supplements? Specify (up to 2): <i>(see taxonomy)</i>	<input type="checkbox"/> Y <input type="checkbox"/> N 1. 2.	<input type="checkbox"/> Y <input type="checkbox"/> N 1. 2.	<input type="checkbox"/> Y <input type="checkbox"/> N 1. 2.	<input type="checkbox"/> Y <input type="checkbox"/> N 1. 2.	<input type="checkbox"/> Y <input type="checkbox"/> N 1. 2.	<input type="checkbox"/> Y <input type="checkbox"/> N 1. 2.	<input type="checkbox"/> Y <input type="checkbox"/> N 1. 2.	<input type="checkbox"/> Y <input type="checkbox"/> N 1. 2.	<input type="checkbox"/> Y <input type="checkbox"/> N 1. 2.	<input type="checkbox"/> Y <input type="checkbox"/> N 1. 2.	<input type="checkbox"/> Y <input type="checkbox"/> N 1. 2.	<input type="checkbox"/> Y <input type="checkbox"/> N 1. 2.
Kilocalories received from modular supplements: *	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

Filled out on each day this patient received enteral nutrition.

Daily Enteral Nutrition Data

<p>Goal 24 hour volume</p>	<p>Indicate what the prescribed 24 hour volume of enteral formula (mL) is today. Volume may differ depending on caloric density of EN formula.</p> <p><i>Note:</i> This may be different from the prescribed goal regimen (i.e. maximum volume) determined at the initial nutrition assessment.</p>
<p>Maximal Hourly Rate in the 24 Hour Period</p>	<p>Indicate the highest rate (mL/h) at which the EN formula was delivered today.</p>
<p>Problem(s) Associated with Maximal Hourly Rate</p>	<p>Review the chart/nursing notes and select all that apply from the list provided, and/or select “other” and specify any other additional problem(s) noted. Choose “none” if no problems occurred.</p>
<p>EN Interruptions</p>	<p>Choose “yes” or “no” for whether or not EN was interrupted today. If yes, indicate the total time (hh:mm) EN was interrupted for.</p> <p><u>An interruption is defined as:</u> EN being stopped at any point after it was initiated, with the intent that EN be restarted again. This does not include:</p> <ul style="list-style-type: none"> • Brief or transient (i.e. less than one hour) interruptions for short bedside procedures • Reduction in rate of feeds • Stopping the feeds permanently and transitioning to oral feeds <p>Select “yes” to this question if the patient received EN at some point on this calendar day, but feeds were stopped for some reason. If the patient did not receive feeds for an entire calendar day, the patient did not receive EN on this day, and you should indicate this in the “type of nutrition received” question at the beginning of the daily nutrition data section (and you do not need to complete the EN daily data form for this day).</p> <p><u>Example 1:</u> EN was initiated at 08:30 on study day 1. EN was stopped at 14:30 for a bedside procedure. EN was started again at 18:30. <i>The time from 00:00 until 08:30 does not constitute an interruption. EN was interrupted from 14:30 until 18:30, which equals 4 hours.</i></p> <p><u>Example 2:</u> EN was initiated at 08:30 on study day 1. EN was stopped at 14:30. EN was not started again until study day 3 at 04:30, and then there were no further interruptions. <i>EN was interrupted from 14:30 until the end of day 1 (midnight), which equals 9 hours and 30 minutes. On day 2, daily EN data is not completed because the patient did not receive EN. On day 3, midnight until 04:30 does not constitute an interruption, so no interruptions are recorded for day 3.</i></p> <p>If EN was interrupted, specify all reason(s) that EN was interrupted, by selecting from the list provided.</p>

Daily Nutrition: Enteral Nutrition 2

Study Day:	1 <i>ICU Admission</i>	2	3	4	5	6	7	8	9	10	11	12
Goal 24 hour Volume? (mL)												
Maximal hourly rate during the 24 hour period: (mL/h)												
Problem(s) associated with maximal hourly rate: <i>(Select all that apply)</i>												
Aspiration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Distension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emesis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Gastric Residual Volume	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Regurgitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Was EN interrupted today?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<i>If yes:</i> Total time interrupted: (hh:mm)	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Reason(s) interrupted: <i>(Select all that apply)</i>												
Fasting for endotracheal extubation or intubation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fasting for other bedside procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fasting for operating room procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fasting for radiology suite procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fasting for administration of medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intolerance to enteral feeding - high gastric residuals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intolerance to enteral feeding - increased abdominal girth or abdominal distension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intolerance to enteral feeding - vomiting/emesis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intolerance to enteral feeding - diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intolerance to enteral feeding - subjective discomfort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No enteral access available/enteral access lost, displaced or malfunctioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inotropes, vasopressor requirement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Subject deemed too sick to continue enteral feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enteral feeding formula not available	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reason for EN interruption not known	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Filled out on each day this patient received enteral nutrition.

Daily Parenteral Nutrition Data

If the patient is on combination EN and PN, record calories/protein from PN here, and record nutrition from EN on the Daily EN Data form (i.e. do not include calories/protein from EN on the PN page)

Parenteral Nutrition is typically defined as: provision of carbohydrates plus protein and/or lipid and/or micronutrients delivered directly into a vein. Infusion of dextrose alone does not constitute parenteral nutrition.

Example: If a patient only received dextrose in the absence of amino acids, you should answer “no” for whether or not the patient received parenteral nutrition, and you do not need to fill out this form.

Parenteral Solution(s)	<p>Refer to the taxonomy (see appendix) to record parenteral solution(s) provided. Specify 1 “all-in-one” solution or indicate “single bottle system” to select 1 amino acid and 1 carbohydrate and 1 lipid solution (if applicable).</p> <p><i>Note:</i> If you select “other” in the lipid or all-in-one categories, please be sure to specify what type of lipid was provided (see appendix).</p> <p><u>“Custom” PN Solutions:</u> If possible, select “single bottle system” and indicate the lipid, carbohydrate and protein components from the custom solution from the taxonomy provided. If this is not possible, select “other” all-in-one solution. If you select “other” for all-in-one solution or for the lipid component, be sure to specify what type of lipid was provided.</p>
Kilocalories from parenteral formula(s)*	<p>Total calories received (kcal) will need to be calculated by the dietitian daily as follows:</p> <ul style="list-style-type: none"> • Include calories from protein • Include calories from other supplements • Do NOT include calories from enteral formula or modular supplements • Do NOT include calories from propofol • Do NOT include calories from other IV solutions
Protein from parenteral formula(s)*	<p>Total protein will need to be calculated by the dietitian daily as follows:</p> <ul style="list-style-type: none"> • Include protein from supplements, if applicable • Do NOT include calories from enteral formula or modular supplements • Do NOT include glutamine

Patient Number:

 ICU Name:

Daily Nutrition: Parenteral Nutrition

Study Day:	1 <i>ICU Admission</i>	2	3	4	5	6	7	8	9	10	11	12
Parenteral solution(s): <i>(See taxonomy)</i>												
All-in-one solution:	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
<i>OR</i>												
Amino Acid:	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Dextrose:	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Lipid: <i>(If lipid is "other", specify lipid type)</i>	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Kilocalories received from parenteral formula(s): *	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Protein (g) received from parenteral formula(s): *	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

Filled out on each day this patient received parenteral nutrition.

Outcomes Information

This form is to be completed upon discharge from hospital or if the patient dies. You may need to wait until day 60 (from admission to ICU) to complete some of these questions.

Note: Death or hospital discharge marks the end of data collection. We are not asking you to follow up for 60 days after discharge home or transfer to another healthcare facility.

Did the patient die in ICU?*	<ul style="list-style-type: none"> • Answer yes or no • If no, provide ICU discharge date (YYYY-MM-DD) and time (hh:mm) or indicate that the patient is still in the ICU at day 60
Did the patient die in hospital?*	<ul style="list-style-type: none"> • Answer yes or no • If no, provide hospital discharge date (YYYY-MM-DD) and time (hh:mm) or indicate that the patient is still in the hospital at day 60
Death*	<ul style="list-style-type: none"> • If the patient died in hospital or ICU provide date (YYYY-MM-DD) and time (hh:mm) of death
Mechanical ventilation discontinued in ICU?*	<ul style="list-style-type: none"> • Answer yes if the patient died while mechanically ventilated • Answer yes if mechanical ventilation was discontinued in the ICU and the patient remained in the ICU, was discharged from the ICU alive, or subsequently died in the ICU • Answer no if the patient was discharged from the ICU while mechanically ventilated • If yes, the mechanical ventilation was discontinued in the ICU, indicate date (YYYY:MM:DD) and time (hh:mm) or select “same as date/time of death” <p><u>Example 1:</u> Mechanical ventilation was discontinued at 11:34 on May 5, and patient was discharged from the ICU on May 6. Choose “yes” to this question and enter May 5, 11:34 under date/time mechanical ventilation discontinued.</p> <p><u>Example 2:</u> Mechanical ventilation was discontinued at 11:34 on May 5, but the patient was discharged from the ICU on May 3. Choose “no” to this question.</p> <p><u>Example 3:</u> Patient was admitted to the ICU on May 1. Patient is still in the ICU on June 29 (day 60) and still mechanically ventilated. Choose “no” to this question.</p> <p><u>Example 4:</u> A patient died in the ICU on May 1. At time of death, the patient was still mechanically ventilated. Choose “yes” to “was mechanical ventilation discontinued in ICU”, and then choose “yes” to “same as date/time of death”</p>

Patient Number: ICU Name:

Outcomes Information

Did the patient die in the ICU? *

 Yes No ICU Discharge Date (YYYY-MM-DD): _____ Time (HH:MM, 24h): _____*OR* Patient still in ICU at day 60

Did the patient die in hospital? *

 Yes No Hospital Discharge Date (YYYY-MM-DD): _____ Time (HH:MM, 24h): _____*OR* Patient still in hospital at day 60

If patient died in hospital or ICU: *

Date of death (YYYY-MM-DD): _____ Time (HH:MM, 24h): _____

Was mechanical ventilation discontinued in the ICU? *

 Yes Date discontinued in ICU (YYYY-MM-DD): _____ Time (HH:MM, 24h): _____*OR* Same as date/time of death No

Enteral Nutrition Formulas – Sorted by Company

Abbott International

- AlitraQ
- Edanec
- Edanec HN
- Ensure
- Ensure Fibre
- Ensure HP
- Ensure Prebiotics
- Ensure Plus
- Glucerna 1.0 Cal
- Glucerna Select
- Jevity
- Jevity 1 Cal
- Jevity 1.2 Cal
- Jevity 1.5 Cal
- Jevity Plus 1.5 k/cal
- Jevity 2 with FOS
- Jevity with FOS
- Jevity HiCal
- Jevity Plus
- Jevity Promote
- Nepro
- Nepro with Carb Steady
- Osmolite
- Osmolite 1 Cal
- Osmolite 1.2 Cal
- Osmolite 1.5 Cal
- Osmolite with Fiber
- Osmolite HN
- Osmolite HN Plus
- Osmolite High Protein
- Oxepa
- Optimental
- Optimental 1.0
- Perative
- Pivot 1.5 Cal
- Promote
- Promote with Fiber
- Pulmocare
- Suplena
- Two Cal HN
- Vital 1.0 Cal
- Vital 1.5 Cal
- Vital HN
- Prosure
- Other Abbott Product (please specify)

Fresenius Kabi

- Fresubin 1000 complete
- Fresubin 1200 complete
- Fresubin 1500 complete
- Fresubin 1800 complete
- Fresubin 2250 complete
- Diben
- Fresubin Original
- Fresubin Original Fibre
- Fresubin Energy
- Fresubin Energy Fibre
- Fresubin HP Energy
- Fresubin Soya Fibre
- Fresubin HEPA
- Fresubin Diabetes
- Intestamin
- Reconvan
- Supportan
- Survimed Renal
- Survimed OPD
- Other Fresenius Kabi Product (please specify)

Nestle

- Boost 1.0 Standard
- Boost 1.5 Plus Calories
- Boost High Protein
- Crucial
- Compleat
- Diabetisource AC
- Fibersource HN
- Glutasolve
- Impact
- Impact Glutamine
- Impact with Fiber
- Impact 1.5
- Impact AR / Oral Impact
- Isosource HN
- Isosource HN with fibre
- Isosource VHN
- Isosource 1.5 Cal
- Modulen IBD
- Novasource GI Control
- Novasource GI Forte
- Novasource Renal
- Nutren 1.0
- Nutren 1.0 Fiber
- Nutren 1.5
- Nutren 2.0
- Nutren Glytrol
- Nutren Pulmonary
- Nutren Replete
- Nutren Replete Fiber
- Nutrihep
- Peptamen
- Peptamen HN
- Peptamen 1.5
- Peptamen OS
- Peptamen OS 1.5
- Peptamen with Prebio1
- Peptamen AF 1.2 with Prebio1
- Renalcal
- Resource 2.0
- Resource Diabetic
- Tolerex
- Vivonex TEN
- Vivonex Plus
- Vivonex RTF
- Resource Arginaid
- Other Nestle Product (please specify)

Nutricia

- Cubison
- Diason
- Nutrison Standard
- Nutrison Multi Fibre
- Nutrison Protein Plus Multi Fibre
- Nutrison Protein Plus
- Nutrison1000 Complete Multi Fibre
- Nutrison 1200 Complete Multi Fibre
- Nutrison Energy Multi Fibre
- Nutrison Energy
- Nutrison Soya
- Nutrison MCT
- Nutrison Low Sodium
- Nutrison Concentrated
- Nutrison Pre
- Nutrison Low Energy Multi Fibre
- Nutrisorb Low Energy
- Nutrisorb Low Energy Soy Multi Fibre
- Peptisorb
- DuoCal
- Fortimel
- Other Nutricia Product (please specify)

B. Braun

- Nutricomp Standard
- Nutricomp Standard with Fibre
- Nutricomp Standard with Fibre D
- Nutricomp
- Nutricomp Diabetes
- Nutricomp Hepa
- Nutricomp Intensive
- Nutricomp Immun
- Nutricomp MCT
- Nutricomp Peptid
- Nutricomp Energy
- Nutricomp Energy Fibre
- Other B.Braun Product (please specify)

Miscellaneous

- Baxter: Restore-X
- Mead Johnson: Portagen
- Hormel Health: Immun-Aid
- Hormel Health: Hepatic-Aid
- Hormel Health: Glutasorb
- National Nutrition: Argiment
- Victus Inc: Immunex Plus
- Wyeth: Enercal
- Wyeth: Enercal Plus
- Other (please specify)

Enteral Nutrition – Modular Protein Supplements

- Abbott: Promod
- Nestle: Beneprotein Instant Protein Powder
- Nutricia: Protifar
- Hormel Health: Propass
- National Nutrition: Argitein
- National Nutrition: Prosource liquid
- National Nutrition: Prosource powder
- Global Health: Procel
- Medical Nutrition: Pro-stat
- Other protein supplement: Please specify

Enteral Nutrition – Other Modular Supplements

- Abbott: Juven
- Abbott: Polycose powder
- Abbott: Polycose Liquid
- Fresenius Kabi: Fresubin 5kcal shot
- Nestle: Microlipid
- Nestle: MCT Oil
- Nestle: Resource Benefiber
- Nutricia: Calogen
- Nutricia: Polycal Powder / Fantomalt
- Nutricia: Polycal Liquid
- Other modular supplement: Please specify

Parenteral Nutrition Solutions

Remember: When specifying parenteral nutrition solutions you may specify:

1 Amino acid (required)
1 Glucose (required)
1 Lipid (optional)

OR

1 All-in-One Solution

Amino Acids

Baxter

- | | | |
|-----------------------------|-------------------------------|-----------------|
| • BranchAmin 4% | • Prosol 20% | • Travasol 5.5% |
| • Clinisol 15% Sulfite free | • RenAmin | • Travasol 8.5% |
| • Premasol 6% | • Synthamin 9, 5.5% / 9.1g N | • Travasol 10% |
| • Premasol 10% Sulfite free | • Synthamin 14, 8.5% / 14g N | |
| • Primene 10% | • Synthamin 17, 10% / 16.5g N | |

B. Braun

- | | | |
|------------------------|------------------------|------------------------|
| • Aminoplasmal – 5% E | • Aminoplasmal – 10% | • Aminoplasmal – 15% |
| • Aminoplasmal – 10% E | • Aminoplasmal – 15% E | • Aminoplasmal Hepa 10 |

Fresenius Kabi

- | | | |
|--------------------|--------------------------|-----------------|
| • Aminoven 5% | • Aminosteril N-HEPA 8% | • Vamin 14 |
| • Aminoven 10% | • Dipeptiven/ Dipeptamin | • Vamin 14EF |
| • Aminoven 15% | • Glamin/Glavamin | • Vamin 18EF |
| • Aminoven 3.5% GE | • Nephroprotect 10% | • Vamin Glucose |

Hospira

- | | | |
|--------------------------------------|---|--------------------|
| • Aminosyn | • Aminosyn II (dextrose injection) | • Aminosyn II 5% |
| • Aminosyn – RF 5.2% | • Aminosyn II 3.5% | • Aminosyn II 7% |
| • Aminosyn – RF 7% | • Aminosyn II 4.25% – without electrolytes | • Aminosyn – HF 8% |
| • Aminosyn – with electrolytes | • Aminosyn II 4.25% – with electrolytes & calcium | • Aminosyn II 8.5% |
| • Aminosyn – HBC 7% | | • Aminosyn II 10% |
| • Aminosyn II (amino acid injection) | | • Aminosyn II 15% |

Other

- Other (please specify)

Glucose**Baxter**

- Glucose 5%
- Glucose 10%
- Glucose 15%
- Glucose 20%
- Glucose 40%
- Glucose 50%
- Glucose 70%

B. Braun

- Glucose 10%
- Glucose 20%
- Glucose 40%
- Glucose 50%
- Glucose 70%

Hospira

- 10% Dextrose Injection USP
- 20% Dextrose Injection USP
- 30% Dextrose Injection USP
- 40% Dextrose Injection USP
- 50% Dextrose Injection USP
- 70% Dextrose Injection USP

Other

- Other (please specify)

Lipids**Baxter**

- ClinOleic 20%
- Intralipid 20% IV Emulsion
- Intralipid 30% IV Emulsion

B. Braun

- Lipidem/Lipoplus
- Lipofundin MCT/LCT 10%
- Lipofundin MCT/LCT 20%
- Lipofundin N 10%
- Lipofundin 20% N

Fresenius Kabi

- Intralipid 10%
- Intralipid 20%
- Intralipid 30%
- Lipovenoes 10% PLR
- Lipovenoes MCT 10%
- Lipovenoes MCT 20%
- Omegaven 10%
- SMOFlipid 20%
- Structolipid 20%

Hospira

- Liposyn II
- Liposyn III
- Liposyn III 30%

Other

- Other (specify lipid type)

All-in-One Solutions**Baxter**

- Clinimix 2.5/10
- Clinimix 2.75/5
- Clinimix 2.75/10
- Clinimix 4.25/5
- Clinimix 4.25/10
- Clinimix 4.25/20
- Clinimix 4.25/25
- Clinimix 5/5
- Clinimix 5/10
- Clinimix 5/15
- Clinimix 5/16.6
- Clinimix 5/20
- Clinimix 5/25
- Clinimix N9G20E dual chamber
- Clinimix N14G30E dual chamber
- Oliclinomel N4-550 E
- Oliclinomel N4-720 E
- Oliclinomel N5-800
- Oliclinomel N6-900 E
- Oliclinomel N7-1000
- Oliclinomel N7-1000 E
- Oliclinomel N8-800

B. Braun

- Nutriflex Lipid
- Aminomix 1
- Aminomix 2
- Aminomix 3
- Nutriflex

Fresenius Kabi

- Kabiven Central
- Kabiven Peripheral/PeriKabiven/Periven
- StructoKabiven
- StructoKabiven EF
- SmofKabiven
- SmofKabiven EF
- SmofKabiven Peripheral
- Aminomix 1 Novum/Aminomix/Mixamin Glucose 20 %
- Aminomix 2 Novum/Aminomix/Mixamin Glucose 12%
- Aminomix 3 Novum/Aminomix/Mixamin Glucose 12% without electrolytes

Hospira

- Nutrimix Dual Chamber TPN Delivery System

Other

- Other (please specify, and include lipid type)

If you choose "Other" for any parenteral solution which contains lipids, please specify the lipid type:

- Olive oil based
- Soybean oil based
- MCT/LCT Physical mixture
- MCT/LCT Structured Form
- Mixture of soy oil, MCTs, olive oil, and fish oil
- Fish oil based
- Other (specify)

Appendix
Height Conversion Table

One foot = 12 inches
One inch = 2.54 centimeters

Feet/Inches	Inches	Centimeters	Feet/Inches	Inches	Centimeters
4ft 6 inch	54	137	5ft 10 inch	70	178
4ft 7 inch	55	140	5ft 11 inch	71	180
4ft 8 inch	56	142	6 ft	72	183
4ft 9 inch	57	145	6ft 1 inch	73	185
4ft 10 inch	58	147	6ft 2 inch	74	188
4ft 11 inch	59	150	6ft 3 inch	75	191
4ft 12 inch	60	152	6ft 4 inch	76	193
5ft 1 inch	61	155	6ft 5 inch	77	196
5ft 2 inch	62	157	6ft 6 inch	78	198
5ft 3 inch	63	160	6ft 7 inch	79	201
5ft 4 inch	64	163	6ft 8 inch	80	203
5ft 5 inch	65	165	6ft 9 inch	81	206
5ft 6 inch	66	168	6ft 10 inch	82	208
5ft 7 inch	67	170	6ft 11 inch	83	211
5ft 8inch	68	173	7ft	84	213
5ft 9inch	69	175	7ft 1 inch	85	216