

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 |
|------------|-----------|-------|-------|-------------|-----------|
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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.

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 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> |
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Page number: _____

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Page number: _____

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

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

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

- Actual (ABW)
- Adjusted average ((ABW + IBW) x 0.5)
- Adjusted by 25% (ABW x 0.25 + IBW)
- Adjusted by 40% (ABW x 0.4 + IBW)
- Ideal (IBW) based on Hamwi formula
- Ideal (IBW) based on BMI 20-25 kg/m²
- No weight used in calculation
- No assessment completed
- Other (specify): _____

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

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

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)

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

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

- Initiate EN: start at low rate and progress to hourly goal rate
- Initiate EN: start at hourly rate determined by 24 hour volume goal
- Initiate EN: start at hourly goal rate
- Initiate EN: keep a low rate (trophic feeds: no progression)
- Initiate EN: bolus feeds
- Keep Nil Per Os (NPO)

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

- Bowel perforation
- Bowel obstruction
- Proximal high output fistula
- Other (specify): _____

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 |
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Filled out daily for each patient.

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: (Select one option) | | | | | | | | | | | | |
| 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 (Select all that apply) | | | | | | | | | | | | |
| 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.

Patient Number:

 ICU Name:

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 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.

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.

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