



Case Report Forms and Instructions

Patient Package

Note: This file contains all the forms and instructions required for an individual patient. It does not contain any appendices or site and user registration forms.

Version: September 30, 2010

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

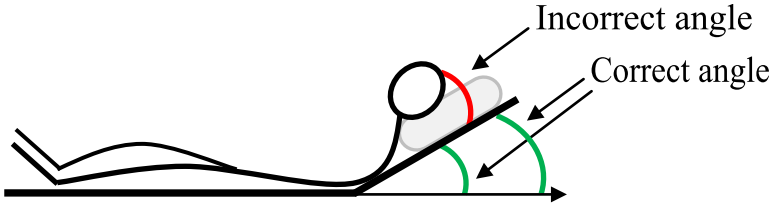
Bariatric Surgery

- 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: _____	<i>Units?</i> <input type="checkbox"/> mmol/L
	Lowest blood glucose in 1st 24 hours: _____	<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
Morning Blood Glucose: <i>Units?</i> <input type="checkbox"/> mmol/L <input type="checkbox"/> mg/dL												
Hypoglycemic event? (<3.5 mmol/L or <63 mg/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
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
Supplemental Prebiotics?	<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> >750mL 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: (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.

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>



Patient Number:

ICU Name:

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

Daily Nutrition: Parenteral Nutrition

 Patient Number:

 ICU Name:

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