



Instructions—Concomitant Medication



Concomitant Medication Page __ of __

	ICU Admit	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10
DATE dd/mmm/yyyy										
Receive any today?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hydrocortisone	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Activated Protein C	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Motility agents	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes which ones	<input type="checkbox"/> Metoclopramide <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin	<input type="checkbox"/> Metoclopra- <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin	<input type="checkbox"/> Metoclopramide <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin	<input type="checkbox"/> Metoclopramide <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin	<input type="checkbox"/> Metoclopra- <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin	<input type="checkbox"/> Metoclopramide <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin	<input type="checkbox"/> Metoclopramide <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin	<input type="checkbox"/> Metoclopramide <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin	<input type="checkbox"/> Metoclopramide <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin	<input type="checkbox"/> Metoclopramide <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin
Insulin Total <input type="checkbox"/> units/day										



Instructions—Daily Parenteral Nutrition



Daily Parenteral Nutrition Page __ of __

	ICU Admit	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10
DATE dd/mmm/yyyy										
Parenteral Nutrition received today?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mls of Amino Acids Kcals/ml Protein/ml										
Volume received in 24 hrs										
Lipids received?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Type of Lipids										
Volume of lipids received										



Instructions - Daily Data



<Name of Study / Study # / Logo>

Daily Data Page __ of __

	ICU Admit	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10
DATE dd/mmm/yyyy										
Heart Rate Highest										
Blood Pressure Lowest										
Temperature Core										
Urine Output	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls
Diarrhea > 750 mls or > 5/day	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gastric Residual Volume										
Gastric Residual Volume Dis- cared										
Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes because of Acute Renal Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Location of feeding tube										



Instructions - Daily Enteral Nutrition



Daily Enteral Nutrition Page __ of __

	ICU Admit	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10
DATE dd/mmm/yyyy										
Enteral Nutrition received today?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Formula Collect up to 3	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Formulation Cals/ml	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Protein per ml	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Volume (mls) received in 24 hrs for each formula										
Did the patient receive propofol today?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Volume (mls) received in 24 hrs										



<Name of Study / Study # / Logo>

Instructions - Daily Laboratory Measurements



<Name of Study / Study # / Logo>

Daily Laboratory Measurements Page __ of __

	ICU admit	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10
DATE dd/mmm/yyyy										
WBC High										
WBC Low										
Platelets Low										
Blood Sugar (BS) am										
Serum Creatinine high										
Serum Urea High										
Serum Albumin high										
Serum Bilirubin high										



Instructions - Vasopressor



<Name of Study / Study # / Logo>

Vasopressor Page __ of __

	ICU Admit	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10
DATE dd/mmm/yyyy										
Received any today?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dopamine <input type="checkbox"/> ug/kg/min <input type="checkbox"/> ug/min										
Norepineph- rine <input type="checkbox"/> ug/kg/min <input type="checkbox"/> ug/min										
Epinephrine <input type="checkbox"/> ug/kg/min <input type="checkbox"/> ug/min										
Dobutamine <input type="checkbox"/> ug/kg/min <input type="checkbox"/> ug/min										
Phenylephrine <input type="checkbox"/> ug/kg/min <input type="checkbox"/> ug/min										
Milrinone <input type="checkbox"/> ug/kg/min <input type="checkbox"/> ug/min										
Vasopressin <input type="checkbox"/> units/min										



Daily Parenteral Nutrition Form Page __ of __

	Day 21	Day 22	Day 23	Day 24	Day 25	Day 26	Day 27	Day 28	Day 29	Day 30
DATE dd/mmm/yyyy										
Parenteral Nutrition received today?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mls of Amino Acids Kcals/ml Protein/ml										
Lipids Received?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Type of lipids										
Mls of Lipids Kcals/per ml	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No



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Daily Data Page __ of __

	Day11	Day 12	Day 13	Day 14	Day 15	Day 16	Day 17	Day 18	Day 19	Day 20	
DATE dd/mmm/yyyy											
Heart Rate Highest											
Blood Pressure Lowest											
Temperature Core											
Urine Output	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls
Diarrhea > 750 mls or > 5/day	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Gastric Residual Volume											
Gastric Residual Volume Dis- cared											
Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes because of Acute Renal Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Location of feeding tube											



Daily Enteral Nutrition Form Page __ of __

	Day 21	Day 22	Day 23	Day 24	Day 25	Day 26	Day 27	Day 28	Day 29	Day 30
DATE dd/mmm/yyyy										
Enteral Nutri- tion received today?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Formula Collect up to 3	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Formulation Cals/ml	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Protein per ml	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Volume (mls) received in 24 hrs for each formula	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Did the patient receive propofol today?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Volume (mls) received in 24 hrs										



Concomitant Medication Page __ of __

	Day 11	Day 12	Day 13	Day 14	Day 15	Day 16	Day 17	Day 18	Day 19	Day 20
DATE dd/mmm/yyyy										
Receive any today?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hydrocorti- sone	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Activated Protein C	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Motility agents	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes which ones	<input type="checkbox"/> Metoclopramide <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin	<input type="checkbox"/> Metoclopra- <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin	<input type="checkbox"/> Metoclopramide <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin	<input type="checkbox"/> Metoclopramide <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin	<input type="checkbox"/> Metoclopra- <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin	<input type="checkbox"/> Metoclopramide <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin	<input type="checkbox"/> Metoclopramide <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin	<input type="checkbox"/> Metoclopramide <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin	<input type="checkbox"/> Metoclopramide <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin	<input type="checkbox"/> Metoclopramide <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin
Insulin Total <input type="checkbox"/> units/day										



Daily Parenteral Nutrition Form Page __ of __

	Day 11	Day 12	Day 13	Day 14	Day 15	Day 16	Day 17	Day 18	Day 19	Day 20
DATE dd/mmm/yyyy										
Parenteral Nutrition received today?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mls of Amino Acids Kcals/ml Protein/ml										
Lipids Received?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Type of lipids										
Mls of Lipids Kcals/per ml										



Daily Enteral Nutrition Form Page __ of __

	Day 11	Day 12	Day 13	Day 14	Day 15	Day 16	Day 17	Day 18	Day 19	Day 20
DATE dd/mmm/yyyy										
Enteral Nutrition received today?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Formula Collect up to 3	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Formulation Cals/ml	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Protein per ml	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Volume (mls) received in 24 hrs for each formula	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Did the patient receive propofol today?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Volume (mls) received in 24 hrs										



Concomitant Medication Page __ of __

	Day 21	Day 22	Day 23	Day 24	Day 25	Day 26	Day 27	Day 28	Day 29	Day 30
DATE dd/mmm/yyyy										
Receive any today?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hydrocorti- sone	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Activated Protein C	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Motility agents	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes which ones	<input type="checkbox"/> Metoclopramide <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin	<input type="checkbox"/> Metoclopramide <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin	<input type="checkbox"/> Metoclopramide <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin	<input type="checkbox"/> Metoclopramide <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin	<input type="checkbox"/> Metoclopra- <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin	<input type="checkbox"/> Metoclopramide <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin	<input type="checkbox"/> Metoclopramide <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin	<input type="checkbox"/> Metoclopramide <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin	<input type="checkbox"/> Metoclopramide <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin	<input type="checkbox"/> Metoclopramide <input type="checkbox"/> Motilium <input type="checkbox"/> Erythromycin
Insulin Total <input type="checkbox"/> units/day										



Daily Data Page __ of __

	Day 21	Day 22	Day 23	Day 24	Day 25	Day 26	Day 27	Day 28	Day 29	Day 30	
DATE dd/mmm/yyyy											
Heart Rate Highest											
Blood Pressure Lowest											
Temperature Core											
Urine Output	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls	<input type="checkbox"/> 0-199 mls <input type="checkbox"/> 200-499 mls <input type="checkbox"/> ≥ 500 mls
Diarrhea > 750 mls or > 5/day	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes because of Acute Renal Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	



Daily Laboratory Measurements Page __ of __

	Day 11	Day 12	Day 13	Day 14	Day 15	Day 16	Day 17	Day 18	Day 19	Day 20
DATE dd/mmm/yyyy										
WBC High										
WBC Low										
Platelets Low										
Blood Sugar (BS) am										
Serum Creatinine high										
Serum Urea High										
Serum Albumin high										
Serum Bilirubin high										



<Name of Study / Study # / Logo>

Vasopressor Page __ of __

	Day 11	Day 12	Day 13	Day 14	Day 15	Day 16	Day 17	Day 18	Day 19	Day 20
DATE dd/mmm/yyyy										
Received any today?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dopamine <input type="checkbox"/> ug/kg/min <input type="checkbox"/> ug/min										
Norepineph- rine <input type="checkbox"/> ug/kg/min <input type="checkbox"/> ug/min										
Epinephrine <input type="checkbox"/> ug/kg/min <input type="checkbox"/> ug/min										
Dobutamine <input type="checkbox"/> ug/kg/min <input type="checkbox"/> ug/min										
Phenylephrine <input type="checkbox"/> ug/kg/min <input type="checkbox"/> ug/min										
Milrinone <input type="checkbox"/> ug/kg/min <input type="checkbox"/> ug/min										
Vasopressin <input type="checkbox"/> units/min										



<Name of Study / Study # / Logo>

Daily Laboratory Measurements Page __ of __

	Day 21	Day 22	Day 23	Day 24	Day 25	Day 26	Day 27	Day 28	Day 29	Day 30
DATE dd/mmm/yyyy										
WBC High										
WBC Low										
Platelets Low										
Blood Sugar (BS) am										
Serum Creatinine high										
Serum Urea High										
Serum Albumin high										
Serum Bilirubin high										



<Name of Study / Study # / Logo>

Vasopressor Page __ of __

	Day 21	Day 22	Day 23	Day 24	Day 25	Day 26	Day 27	Day 28	Day 29	Day 30
DATE dd/mmm/yyyy										
Received any today?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dopamine <input type="checkbox"/> ug/kg/min <input type="checkbox"/> ug/min										
Norepineph- rine <input type="checkbox"/> ug/kg/min <input type="checkbox"/> ug/min										
Epinephrine <input type="checkbox"/> ug/kg/min <input type="checkbox"/> ug/min										
Dobutamine <input type="checkbox"/> ug/kg/min <input type="checkbox"/> ug/min										
Phenylephrine <input type="checkbox"/> ug/kg/min <input type="checkbox"/> ug/min										
Milrinone <input type="checkbox"/> ug/kg/min <input type="checkbox"/> ug/min										
Vasopressin <input type="checkbox"/> units/min										