Hospital____________________

# User and Site Registration (Form A)

## Part A.

**Before completing the site registration process, please answer a few questions about yourself:**

1. **First Name** _________________________ **Last Name** _________________________

2. **Address** ___________________________________________________________________

**City** _________________________________ **State/Province/County** ___________________

**Country** ___________________________

**Telephone:** ________________________ **Fax:** ____________________________

**Email:** ____________________________

3. **What is your role in the ICU?**

- Dietitian ☐
- Registered Nurse ☐
- Research Co-ordinator ☐
- Doctor ☐
- Pharmacist ☐
- Other, please specify ____________________

4. **What is your gender?** Male ☐ Female ☐

5. **What is your age?**

- 18-24 years ☐
- 25-34 years ☐
- 35 -44 years ☐
- 45-54 years ☐
- 55-64 years ☐
- 65 years and over ☐

Hospital____________________

**6. How did you hear about the study?**

Professional Society ☐ Please specify ________________

Internet ☐

Conference ☐ Please specify _________________

Colleague ☐

Other, Please specify _________________________

**7. Did you require ethics approval to participate in this survey? Yes ☐ No ☐**

if yes, please specify:

expedited review without patient consent ☐

expedited review with patient consent ☐

full review without patient consent ☐

full review with patient consent ☐

## Part B.
**To register your site, please provide the following information.**

***You may need to ask your ICU Medical Or Nursing Director to help you with some responses***

1. **Hospital Name:** __________________

2. **Does your hospital have multiple ICUs?** **Yes** ☐ **No** ☐

   If yes, name of your individual ICU_________________

3. **City:** _____________________

4. **Country:** _________________

5. **Type of Hospital:** **Teaching** ☐ **Non-Teaching** ☐

6. **Size of hospital (number of beds):** ___________________

7. **ICU Sructure:**
   **Open** (Attending physician remains in charge, ICU physician consults) ☐
   **Closed** (Care transferred or shared with ICU physician) ☐
   **Other** please specify__________________________

8. **Case Mix: (check all that apply)**

| | | | |
|---|---|---|---|
| medical | ☐ | neurological | ☐ |
| surgical | ☐ | neurosurgical | ☐ |
| trauma | ☐ | cardiac surgery | ☐ |
| pediatrics | ☐ | burns | ☐ |

   other (specify)_____________

9. **Presence of designated ICU Medical Director?** **Yes** ☐ **No** ☐

10. **Number of beds in ICU:** ______________

11. **Do you have a Dietitian working in the ICU?** **Yes** ☐ **No** ☐

    If yes, amount of FTE (full time equivalent) dietitian __________

Hospital____________________

**12. Do you use a bedside feeding protocol/algorithm that allows the nurse to advance or withhold tube feedings as specified by the protocol/algorithm?** **Yes** ☐ **No** ☐

If yes, please answer the following:

**a) Do you use a gastric residual volume threshold to adjust feeds? Yes** ☐ **No** ☐

If yes, what gastric residual volume threshold do you use? _________ mls

**b) Does your feeding protocol include an algorithm for: (please check ALL that apply)**

Motility agents ☐

Small Bowel Feeding ☐

Withholding for procedures ☐

Head Of Bed elevation ☐

Other (Please Specify):_______________________

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

*(for the average ICU patient and NOT for those with Diabetic Ketoacidosis (DKA) or hyperosmolar non-ketotic coma)*

**Yes** ☐ **No** ☐

If yes, what range of blood glucose do you target? **Lower:______ Upper:_______mmol/L**