Mater Misericordiae University Hospital

Department of Critical Care Medicine

ECMO Referral Form

Please email this completed form to ecmo@mater.ie **and contact MMUH Duty Critical Care Consultant** on **01-8032000**

REFERRAL

Date of referral:	**Time of referral:**	**Referring hospital:**	
Referring Doctor:		**Contact number:**	

PATIENT DETAILS

Name:		**Date of birth:**	**Age:**
Gender: Male	**Height:**	**Weight:**	**BMI:**
Allergies:		**Pregnancy test result:**	
Smoking history:		**Alcohol history:**	
Hospital admission date:		**ICU admission date:**	
Working diagnosis:			
Other significant background:			
Brief clinical summary:			

RESPIRATORY

Intubation date:		**Number of days intubated:**		
Oxygenation	**FiO_2:**	**PEEP:**		
Ventilation	**Tidal volume:**	**P_{peak}:**	**P_{plat}:**	**Resp rate:**
Findings On Imaging	**CXR:**		**CT thorax:**	
Adjuncts	**Prone positioning:** No		**Neuromuscular blockade:** No	
	Pulmonary vasodilators:		**Chest drains:**	
ABG	**pH:**	**P_aCO_2:**	**P_aO_2:**	**SaO_2:**
	P/F ratio:	**Base Excess:**	**Lactate:**	

CARDIOVASCULAR

HR: **BP:** **CVP:** **Cardiac output:**

Urine output: **Fluid balance:**

Vasoactive medications and doses:

Peripheral perfusion:

Details of any cardiac arrest:

IABP: No **Impella:** No

Angiography findings +/- interventions:

Echo findings:

Microbiology

Positive findings:

Current antimicrobial regime:

Temp: **WCC:** **Neutrophils:** **Lymphocytes:** **CRP:**

Infection control issues:

Other

Pupilary light reflexes: **Immunosuppression:**

Relevant CT brain imaging:

Blood results:

Hb: **Plt:** **INR:** **APTT:** **Fibrinogen:**

Urea: **Creatinine:** **Na:** **K:**

Renal replacement therapy:

Bilirubin: **Albumin:** **ALT:** **AST:** **GGT:** **Alk phos:**

Any other relevant information

For MMUH use only:

MMUH Intensivist taking referral:

Accepted: No **Requirement for ECMO retrieval:** No

Declined: No **Reason(s):**

Deferred pending further discussion:

Additional notes: