

# Case Report Form

Unique patient ID number: \_\_\_\_\_

## Demographics

a) Age:  years old

b) Sex:  Male  
 Female

c) Height:  cm

d) Weight at ICU admission:  kg

## Pre Intensive Care Unit (ICU) Information

a) Hospital admit date (current hospitalization):      
Y Y M M D D

b) What was the category of hospital admitting diagnosis for this patient:

- Respiratory
- Cardiovascular
- Gastrointestinal
- Neurological (including eyes)
- Trauma
- Poisoning
- Genito-urinary
- Endocrine, Metabolic, Thermoregulation and Poisoning
- Haematological/Immunological
- Musculoskeletal
- Dermatological
- Psychiatric

<p><b>c) What was the specific diagnosis?</b></p>	<p>_____</p> <p>_____</p> <p>_____</p>
<p><b>d) Location before ICU admission:</b></p>	<p><input type="checkbox"/> Emergency Department (ED)</p> <p><input type="checkbox"/> High dependency unit/step down (intermediate care) unit</p> <p><input type="checkbox"/> OR/Recovery</p> <p><input type="checkbox"/> Ward</p> <p><input type="checkbox"/> Other hospital (any location in another hospital)</p> <p><input type="checkbox"/> Other ICU (within this hospital)</p> <p><input type="checkbox"/> Other</p> <p> If other, please specify:</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p><b>e) Did this patient receive surgery (during this hospital admission) prior to ICU admission?</b></p>	<p><input type="checkbox"/> No surgery</p> <p><input type="checkbox"/> Elective surgery</p> <p><input type="checkbox"/> Emergency surgery</p>
<p><b>f) Was this patient admitted to the ICU after resuscitation from cardiopulmonary arrest (ie. code)?</b></p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
<p><b>g) Was this patient admitted to the ICU after Medical Emergency Team (MET) activation?</b></p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
<p><b>h) Was this patient previously admitted to an ICU during this current hospital stay?</b></p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
<p><b>i) If yes, what was the discharge date from the previous ICU admission?</b></p>	<p><input type="text"/> <input type="text"/>    <input type="text"/> <input type="text"/>    <input type="text"/> <input type="text"/></p> <p style="text-align: center;">Y Y        M M        D D</p>

**Current ICU Admission**

a) ICU admit date:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Y	Y	M	M	D	D

b) What was the category of hospital admitting diagnosis for this patient:

- Respiratory
- Cardiovascular
- Gastrointestinal
- Neurological (including eyes)
- Trauma
- Poisoning
- Genito-urinary
- Endocrine, Metabolic, Thermoregulation and Poisoning
- Haematological/Immunological
- Musculoskeletal
- Dermatological
- Psychiatric

c) What was the specific diagnosis?

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d) Was this a scheduled or unscheduled admission to the ICU?

- Scheduled (ie. planned admission, post surgery or procedure)
- Unscheduled (ie. not planned in advance)

e) SOFA score at ICU admission:

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f) Glasgow Coma Scale (GCS) at ICU admission:

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g) APACHE II score at ICU admission:

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**Comorbidities**

a) Pre-existing comorbidities(ie. prior to hospitalization):

- Alcohol abuse
- Anemia
- Cerebrovascular disease
- Chronic pulmonary disease
- Coagulopathy
- Congestive heart failure
- Connective tissue disease
- Dementia
- Depression
- Diabetes (without end-organ damage)
- Diabetes (with end-organ damage)
- Drug abuse
- Fluid/electrolyte disorder
- Hemiplegia
- HIV/AIDS
- Hypertension
- Liver disease (mild; without portal hypertension, includes chronic hepatitis)
- Leukemia
- Lymphoma
- Metastatic solid tumor
- Myocardial infarction
- Obesity
- Peptic ulcer disease (no bleed)
- Peripheral vascular disease
- Renal Disease (moderate to severe)
- Thrombophilia
- Tumor (without metastasis (exclude if diagnosis made >5 years ago))
- Other(s)

Please list all other major comorbidities:

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**Advanced Respiratory Support During ICU Stay**

a) During this patient's ICU stay was the patient mechanically ventilated? Please select all that apply. (If no, please move onto next section - 'Advanced Cardiac Support During ICU Stay')

- Invasive mechanical ventilation
- Non-invasive mechanical ventilation
- No mechanical ventilation

b) If this patient was mechanically ventilated (invasive or non-invasive), what was the first date and time of mechanical ventilation?

Y Y M M D D

Time (H:M) \_\_\_\_\_ AM or PM

c) Please provide the date and time of final liberation from mechanical ventilation:

Y Y M M D D

Time (H:M) \_\_\_\_\_ AM or PM

d) What is the total number of calendar days (or portion of calendar days) that the patient received mechanical ventilation?

Days

e) In the ICU, did the patient need to be re-intubated?

Yes  
 No

f) Did the patient receive a tracheostomy while he/she was in the ICU?

Yes  
 No

**Advanced Cardiac Support During ICU Stay**

a) While this patient was in ICU, were vasopressors or inotropes used? (If no, please move onto next section - 'Advanced Kidney Support During ICU Stay')

Yes  
 No

<p>b) What was the first date and time that vasopressors or inotropes were administered for this patient:</p>	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center; border: 1px solid black; width: 30px; height: 20px;"> </td> <td style="text-align: center; border: 1px solid black; width: 30px; height: 20px;"> </td> <td style="text-align: center; border: 1px solid black; width: 30px; height: 20px;"> </td> <td style="text-align: center; border: 1px solid black; width: 30px; height: 20px;"> </td> <td style="text-align: center; border: 1px solid black; width: 30px; height: 20px;"> </td> <td style="text-align: center; border: 1px solid black; width: 30px; height: 20px;"> </td> </tr> <tr> <td style="text-align: center;">Y</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">M</td> <td style="text-align: center;">M</td> <td style="text-align: center;">D</td> <td style="text-align: center;">D</td> </tr> </table> <p style="text-align: right;">Time (H:M) _____ AM or PM</p>							Y	Y	M	M	D	D		
Y	Y	M	M	D	D										
<p>c) What was the last date and time that vasopressors or inotropes were administered for this patient:</p>	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center; border: 1px solid black; width: 30px; height: 20px;"> </td> <td style="text-align: center; border: 1px solid black; width: 30px; height: 20px;"> </td> <td style="text-align: center; border: 1px solid black; width: 30px; height: 20px;"> </td> <td style="text-align: center; border: 1px solid black; width: 30px; height: 20px;"> </td> <td style="text-align: center; border: 1px solid black; width: 30px; height: 20px;"> </td> <td style="text-align: center; border: 1px solid black; width: 30px; height: 20px;"> </td> </tr> <tr> <td style="text-align: center;">Y</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">M</td> <td style="text-align: center;">M</td> <td style="text-align: center;">D</td> <td style="text-align: center;">D</td> </tr> </table> <p style="text-align: right;">Time (H:M) _____ AM or PM</p>							Y	Y	M	M	D	D		
Y	Y	M	M	D	D										
<p>d) What is the total number of calendar days (or portion of calendar days) that vasopressors or inotropes were administered for this patient?</p>	<table style="width: 100%; border: none;"> <tr> <td style="border: 1px solid black; width: 60px; height: 20px; text-align: center;"> </td> <td style="padding-left: 10px;">days</td> </tr> </table>		days												
	days														
<p>e) Please indicate the type of vasopressors or inotropes administered to this patient:</p>	<table style="width: 100%; border: none;"> <tr><td style="border: 1px solid black; width: 20px; height: 15px;"> </td><td>Norepinephrine</td></tr> <tr><td style="border: 1px solid black; width: 20px; height: 15px;"> </td><td>Epinephrine</td></tr> <tr><td style="border: 1px solid black; width: 20px; height: 15px;"> </td><td>Vasopressin</td></tr> <tr><td style="border: 1px solid black; width: 20px; height: 15px;"> </td><td>Phenylephrine</td></tr> <tr><td style="border: 1px solid black; width: 20px; height: 15px;"> </td><td>Dopamine</td></tr> <tr><td style="border: 1px solid black; width: 20px; height: 15px;"> </td><td>Dobutamine</td></tr> <tr><td style="border: 1px solid black; width: 20px; height: 15px;"> </td><td>Milrinone</td></tr> </table>		Norepinephrine		Epinephrine		Vasopressin		Phenylephrine		Dopamine		Dobutamine		Milrinone
	Norepinephrine														
	Epinephrine														
	Vasopressin														
	Phenylephrine														
	Dopamine														
	Dobutamine														
	Milrinone														
<b>Advanced Kidney Support During ICU Stay</b>															
<p>a) While this patient was in ICU, did he/she have Acute Renal Failure (ARF)?</p>	<table style="width: 100%; border: none;"> <tr><td style="border: 1px solid black; width: 20px; height: 15px;"> </td><td>Yes</td></tr> <tr><td style="border: 1px solid black; width: 20px; height: 15px;"> </td><td>No</td></tr> </table>		Yes		No										
	Yes														
	No														
<p>b) Did the patient receive any form of renal replacement therapy while in ICU? (If no, please move onto next section - 'Delirium')</p>	<table style="width: 100%; border: none;"> <tr><td style="border: 1px solid black; width: 20px; height: 15px;"> </td><td>Yes</td></tr> <tr><td style="border: 1px solid black; width: 20px; height: 15px;"> </td><td>No</td></tr> </table>		Yes		No										
	Yes														
	No														
<p>c) Was the patient a pre-existing dialysis patient?</p>	<table style="width: 100%; border: none;"> <tr><td style="border: 1px solid black; width: 20px; height: 15px;"> </td><td>Yes</td></tr> <tr><td style="border: 1px solid black; width: 20px; height: 15px;"> </td><td>No</td></tr> </table>		Yes		No										
	Yes														
	No														

<p>d) Type of dialysis received (please select all that apply):</p>	<p><input type="checkbox"/> Intermittent Hemodialysis  <input type="checkbox"/> Peritoneal Dialysis  <input type="checkbox"/> Continuous Renal Replacement Therapy</p>
<p>e) On which date was dialysis first received in the ICU?</p>	<p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>  Y Y M M D D</p>
<p>f) Was the patient still being prescribed dialysis after he/she left the ICU?</p>	<p><input type="checkbox"/> Yes  <input type="checkbox"/> No</p>
<p><b>Delirium</b></p>	
<p>a) Was this patient diagnosed with delirium during his/her ICU stay?</p>	<p><input type="checkbox"/> Yes  <input type="checkbox"/> No</p>
<p><b>Code Status</b></p>	
<p>a) On the day of transfer from ICU to the hospital ward, what was the Level of Care (Code Status) for this patient?</p>	<p><input type="checkbox"/> Resuscitation - patient eligible to receive resuscitation in the event of cardiac arrest  <input type="checkbox"/> ICU Care - patient eligible to be readmitted to ICU and receive ICU level care but not resuscitation in the event of cardiac arrest  <input type="checkbox"/> Medical Care - patient eligible to receive medical/surgical care, but not admission to ICU  <input type="checkbox"/> Comfort Care - patient eligible to receive care focused on comfort and dignity at the end of life  <input type="checkbox"/> Not recorded</p>
<p>b) Is there documentation in this patients chart that the Level of Care (Code Status) for this patient was reviewed with the patient/family while the patient was in the ICU?</p>	<p><input type="checkbox"/> Yes  <input type="checkbox"/> No</p>

c) If yes, what was the date when the Level of Care (Code Status) was documented to have been reviewed with the patient/family while the patient was in the ICU?

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Y	Y	M	M	D	D

Time (H:M) \_\_\_\_\_ AM or PM

### Family Meetings

a) Is there documentation in this patients chart that a family consultation (ie. family meeting) occurred while the patient was in the ICU?

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No

b) If yes, what was the date and time of the last documented family consult while the patient was in the ICU?

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Y	Y	M	M	D	D

Time (H:M) \_\_\_\_\_ AM or PM

### Transfer from ICU to Hospital Ward

a) Date and time patient was put up for transfer from ICU to hospital ward (ie. transfer of care request by the ICU team to a hospital ward team):

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Y	Y	M	M	D	D

Time (H:M) \_\_\_\_\_ AM or PM

b) Date and time of actual ICU discharge to hospital ward (ie. when patient left ICU):

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Y	Y	M	M	D	D

\_\_\_\_\_ AM or PM

c) Date and time transfer orders were written:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Y	Y	M	M	D	D

Time (H:M) \_\_\_\_\_ AM or PM



<p>d) What was the date and time that the ICU discharge summary or transfer note was recorded in the patient's chart (paper or electronic)?</p>	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center; border: 1px solid black; width: 30px; height: 20px;"></td> <td style="text-align: center; border: 1px solid black; width: 30px; height: 20px;"></td> <td style="text-align: center; border: 1px solid black; width: 30px; height: 20px;"></td> <td style="text-align: center; border: 1px solid black; width: 30px; height: 20px;"></td> <td style="text-align: center; border: 1px solid black; width: 30px; height: 20px;"></td> <td style="text-align: center; border: 1px solid black; width: 30px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">Y</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">M</td> <td style="text-align: center;">M</td> <td style="text-align: center;">D</td> <td style="text-align: center;">D</td> </tr> </table> <p style="margin-top: 10px;">Time (H:M) _____ AM or PM</p>							Y	Y	M	M	D	D
Y	Y	M	M	D	D								
<p>e) At 9AM on the day this patient was transferred from ICU to the hospital ward, how many beds were occupied in this ICU?</p>	<div style="border: 1px solid black; width: 60px; height: 20px; display: inline-block;"></div> Beds												
<p>f) SOFA score at time of transfer from ICU to hospital ward</p>	<hr style="border: 0; border-top: 1px solid black; width: 100%;"/>												
<p>g) APACHE II score at time of transfer from ICU to hospital ward:</p>	<hr style="border: 0; border-top: 1px solid black; width: 100%;"/>												
<p>h) Is the ward (bed) this patient was transferred to a high dependency or step-down (intermediate care) ward (bed)?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No												
<p>i) Are there any tools in the chart that relate to the transfer of this patient from ICU to the hospital ward? (examples below)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No												
<p>j) If yes, which of the following tools are in the chart that were used to transfer this patient from ICU to the hospital ward?</p>	<input type="checkbox"/> Checklist <input type="checkbox"/> Discharge/Transfer Summary <input type="checkbox"/> Medication Reconciliation Tool <input type="checkbox"/> Patient and/or family information brochure/sheet <input type="checkbox"/> Risk Stratification Tool (calculates risk of re-admission or death post transfer) <input type="checkbox"/> Other												
<p>If other tools were used, please specify:</p>	<hr style="border: 0; border-top: 1px solid black; width: 100%;"/> <hr style="border: 0; border-top: 1px solid black; width: 100%;"/> <hr style="border: 0; border-top: 1px solid black; width: 100%;"/> <hr style="border: 0; border-top: 1px solid black; width: 100%;"/>												

**Outcomes**

a) Patient status at time of hospital discharge:

Alive  
 Dead

b) Location of patient following hospital discharge (if alive):

Home  
 Assisted Living  
 Long Term Care Home (LTCH)  
 Rehab  
 Other

If other, please specify:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c) Did the patient have a MET activation after ICU discharge?

Yes  
 No

d) If yes, what was the date of the first MET activation?

Y Y M M D D

e) Did the patient have cardiac arrest (code) after ICU discharge?

Yes  
 No

f) If yes, what was the date of the first cardiac arrest?

Y Y M M D D

g) Was the patient readmitted to the ICU after ICU discharge?

Yes  
 No

h) If yes, please provide the date of readmission (first readmission if more than one) to the ICU during the same hospital stay:

Y Y M M D D

i) Please provide the date of hospital discharge:

Y Y M M D D

## APACHE SCORE AT ICU ADMISSION

Physiologic Variable		Actual Score	Acute Physiologic Score (APS)							APS Score		
			High Abnormal Range			Normal		Low Abnormal Range				
			+4	+3	+2	+1	0	+1	+2	+3	+4	
Temperature (Rectal/Core) Oral: add 0.5°C Axilla: add 1.0°C			≥ 41	39-40.9		38.5-38.9	36-38.4	34-35.9	32-33.9	30-31.9	≤ 29.9	
Mean Arterial Pressure (mmHg)			≥ 160	130-159	110-129		70-109		50-69		≤ 49	
Heart Rate			≥ 180	140-179	110-139		70-109		55-69	40-54	≤ 39	
Respiratory Rate (Ventilated or non-ventilated)			≥ 50	35-49		25-34	12-24	10-11	6-9		≤ 5	
Oxygenation			≥ 500	350-499	200-349		< 200	AaDO <sub>2</sub> : [FiO <sub>2</sub> x 713] - [PaCO <sub>2</sub> /0.8] - PaO <sub>2</sub>				
a) FiO <sub>2</sub> ≥ .5, record AaDO <sub>2</sub>							> 70	61-70		55-60	< 55	
b) FiO <sub>2</sub> < .5, record only PaO <sub>2</sub>			≥ 7.7	7.6-7.69		7.5-7.59	7.33-7.49		7.25-7.32	7.15-7.24	< 7.15	
Arterial pH			≥ 180	160-179	155-159	150-154	130-149		120-129	111-119	< 110	
Serum Sodium (mmol/L)			≥ 7	6-6.9		5.5-5.9	3.5-5.4	3-3.4	2.5-2.9		< 2.5	
Serum Potassium (mmol/L)			≥ 309	177-308	132-176		53-131		< 53			*
Serum Creatinine (μmol/L)			*DOUBLE SCORE FOR ARF									
Hematocrit (%)			≥ 60		50-59.9	46-49.9	30-45.9		20-29.9		< 20	
WBC			≥ 40		20-39.9	15-19.9	3-14.9		1-2.9		< 1	
GCS (Score = 15 minus actual GCS)			Enter Actual GCS here _____									
*HCO <sub>3</sub> (Venous mMol/L) (*Only if no ABG)			≥ 52	41-51.9		32-40.9	22-31.9		18-21.9	15-17.9	< 15	
AGE POINTS (circle)			TOTAL ACUTE									
AGE	POINTS	PHYSIOLOGIC SCORE (APS)										
< 45	0	AGE POINTS										
45-54	2	TOTAL APACHE SCORE										
55-64	3											
65-74	5											
> 74	6											

## Sequential Organ Failure Assessment (SOFA) Score Worksheet at ICU Admission

Unique Patient ID Number: \_\_\_\_\_

ORGAN SYSTEM	Actual Score	SOFA SCORE				
		0	1	2	3	4
<b>Respiratory:</b> PaO <sub>2</sub> /FIO <sub>2</sub> (mmHg) with Respiratory Support	—	> 400	301 - 400	201 - 300	101 - 200	≤ 100
<b>Respiratory:</b> PaO <sub>2</sub> /FIO <sub>2</sub> (mmHg) without Respiratory Support		> 400	301 - 400	≤ 300		
<b>Coagulation:</b> Platelets (x 10 <sup>9</sup> /mm <sup>3</sup> )		> 150	101 - 150	51 - 100	21 - 50	≤ 20
<b>Liver:</b> Bilirubin (mmol/L)		> 20	20 - 32	33 - 101	102 - 204	> 204
<b>Cardiovascular:</b> Hypotension		No hypotension	MAP < 70 mmHg	dopamine ≤ 5.0 or any dose dobutamine or any dose milrinone	dopamine > 5.0 or epinephrine ≤ 0.1 or norepinephrine ≤ 0.1 or any dose vasopressin or any dose phenylephrine	dopamine > 15.0 or epinephrine > 0.1 or norepinephrine > 0.1
<b>Renal:</b> Creatinine (mmol/L) OR urine output	—	< 110	110 - 170	171 - 299	300 - 440 < 500 ml/day	> 440 < 200 ml/day
<b>Neurologic:</b> Glasgow Coma Scale		15	13 - 14	10 - 12	6 - 9	< 6
<b>TOTAL SOFA SCORE =</b>						

(doses are expressed in mcg/kg/min)

## APACHE SCORE AT ICU TRANSFER TO HOSPITAL WARD

Physiologic Variable		Actual Score	High Abnormal Range							Normal				Low Abnormal Range				APS Score
			+4	+3	+2	+1	0	+1	+2	+3	+4	+1	+2	+3	+4			
Temperature (Rectal/Core) Oral: add 0.5°C Axilla: add 1.0°C			≥ 41	39-40.9		38.5-38.9	36-38.4	34-35.9	32-33.9	30-31.9	≤ 29.9							
Mean Arterial Pressure (mmHg)			≥ 160	130-159	110-129		70-109	70-109	50-69	40-54	≤ 49							
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a) FiO <sub>2</sub> ≥ .5, record AaDO <sub>2</sub>							> 70	61-70		55-60	< 55							
b) FiO <sub>2</sub> < .5, record only PaO <sub>2</sub>			≥ 7.7	7.6-7.69		7.5-7.59	7.33-7.49		7.25-7.32	7.15-7.24	< 7.15							
Arterial pH			≥ 180	160-179	155-159	150-154	130-149		120-129	111-119	< 110							
Serum Sodium (mmol/L)			≥ 7	6-6.9		5.5-5.9	3.5-5.4	3-3.4	2.5-2.9	< 2.5								
Serum Potassium (mmol/L)			≥ 309	177-308	132-176		53-131		< 53								*	
Serum Creatinine (μmol/L)			*DOUBLE SCORE FOR ARF															
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WBC			≥ 40	20-39.9	15-19.9	3-14.9	1-2.9		1-2.9		< 1							
GCS (Score = 15 minus actual GCS)			Enter Actual GCS here _____															
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> 74	6	TOTAL APACHE SCORE																

## Sequential Organ Failure Assessment (SOFA) Score Worksheet at ICU Transfer to Hospital Ward

Unique Patient ID Number: \_\_\_\_\_

ORGAN SYSTEM	Actual Score	0	1	2	3	4	SOFA SCORE
<b>Respiratory:</b> PaO <sub>2</sub> /FIO <sub>2</sub> (mmHg) with Respiratory Support		> 400	301 - 400	201 - 300	101 - 200	≤ 100	
		> 400	301 - 400	≤ 300			
<b>Respiratory:</b> PaO <sub>2</sub> /FIO <sub>2</sub> (mmHg) without Respiratory Support		> 150	101 - 150	51 - 100	21 - 50	≤ 20	
		> 20	20 - 32	33 - 101	102 - 204	> 204	
<b>Cardiovascular:</b> Hypotension		No hypotension	MAP < 70 mmHg	dopamine ≤ 5.0 or any dose dobutamine or any dose milrinone	dopamine > 5.0 or epinephrine ≤ 0.1 or norepinephrine ≤ 0.1 or any dose vasopressin or any dose phenylephrine	dopamine > 15.0 or epinephrine > 0.1 or norepinephrine > 0.1	
				(doses are expressed in mcg/kg/min)			
<b>Renal:</b> Creatinine (mmol/L) OR urine output		< 110	110 - 170	171 - 299	300 - 440 < 500 ml/day	> 440 < 200 ml/day	
<b>Neurologic:</b> Glasgow Coma Scale		15	13 - 14	10 - 12	6 - 9	< 6	
<b>TOTAL SOFA SCORE =</b>							