

ICU Report Sheet

PATIENT INFORMATION

Name: _____ Medical Record Number: _____
Age: _____ Admission Diagnosis: _____
Allergies: _____

VITAL SIGNS

Heart Rate: _____ Blood Pressure: _____
Respiratory Rate: _____ Temperature: _____
Neurological Status (GCS): _____

OXYGENATION

Oxygen Saturation: _____ FiO2: _____

VENTILATOR SETTINGS

Mode: _____ Tidal Volume: _____
Respiratory Rate (Ventilator): _____ PEEP: _____

MEDICATIONS

Medication Name: _____ Dose: _____
Route: _____ Frequency: _____

LABORATORY RESULTS

Hemoglobin: _____ White Blood Cell Count: _____
Platelet Count: _____

Other Relevant Results

Procedures/Interventions

SPECIAL CONSIDERATIONS

Allergies/Precautions

Specific Care Requirements

Upcoming Events/Plans