Metabolic Acidosis Assessment Form

PATIENT INFORMATION:

Full Name: _____ Date of Birth: _____ dd / mm / yyyy

Medical Record Number (MRN): _____ Contact Number: _____

Address: _____

PHYSICIAN INFORMATION:

Full Name: _____ Specialty: _____

Contact Number: _____ Email Address: _____

CLINICAL ASSESSMENT:

Presenting Complaints: (tick all that apply)

- [ ] Rapid breathing
- [ ] Fatigue
- [ ] Confusion
- [ ] Headache
- [ ] Lethargy

Others

History of Present Illness: (Duration, progression, associated symptoms)

MEDICAL HISTORY:

Known chronic diseases (e.g., diabetes, kidney disease)

Medications currently being taken

Recent illnesses or infections

PHYSICAL EXAMINATION:

Vital Signs:

Blood Pressure _____ mmHg: _____ Heart Rate _____ bpm: _____

Respiratory Rate _____ breaths/min: _____ Temperature _____ °C or °F: _____

Findings: (e.g., signs of dehydration, altered mental status)

LABORATORY TESTS CONDUCTED:

Arterial Blood Gas (ABG) Analysis:

pH: _____

$PaCO_2$ (Partial Pressure of Carbon Dioxide) _____ mmHg:

HCO_3^- (Bicarbonate) _____ mEq/L: _____

PaO_2 (Partial Pressure of Oxygen) _____ mmHg:

Serum Electrolytes:

Sodium _____ mEq/L: _____ Potassium _____ mEq/L: _____

Chloride _____ mEq/L: _____

BUN (Blood Urea Nitrogen) _____ mg/dL:

Creatinine _____ mg/dL: _____

Other Relevant Tests: (e.g., lactate levels, urine analysis)

INTERPRETATION AND RECOMMENDATIONS:

Primary Diagnosis: (e.g., Lactic Acidosis, Ketoacidosis)

Possible Secondary or Mixed Disorders

Recommended Treatment Plan

Follow-up Recommendations

Physician's Signature

Date: _____ dd / mm / yyyy