

## Guidelines for completion of Clinical Assessment Form

Complete line 1, as indicated. Admitting dx is what the DRG is based upon, usually early in the orders or H&P.

H&P: Summarize the physician's H&P, as it pertains to the need for MV

Subjective: Patients mental status: alert and oriented, sedated, paralyzed, unresponsive, etc.

Objective: What was the initial indication for ventilation? i.e. hypoxic or hypercapnic respiratory failure, head injury, etc. NOT car vs ped, GSW, etc. (this is what happened, not the indication for ventilation)

Ventilator settings: mode/ $\text{FiO}_2$ / $V_T$ /set f/PEEP/PSV; or values for APRV, pressure for PCV

Secretions: color, consistency, amount, ease of suctioning

Auscultation: breath sounds

Radiograph: View the radiograph or get an interpretation from today's progress notes

Vital signs: T, P, R, B/P; obtain from the monitor, count f

Recent ABG: the most recent values

Hematology: WBC, Hb, Hct, Plt

Chemistry: NA, K, Cl,  $\text{CO}_2$ , BUN, Creat

Hemodynamics: record recent data from the CCO monitor if there's a pulmonary artery catheter or CVP

Respiratory mechanics: record or calculate available data. Record spontaneous values for  $V_T$ , rate,  $V_E$

ABG interpretation: what is the acid-base and oxygenation status?

Cardiovascular/hemodynamic status: normal, fluid overloaded, dehydrated, shock?

Waveform analysis: normal for mode, dyssynchrony? Why? How to correct?

Respiratory status: based on the radiograph, auscultation, secretions, and ABGs; stable, atelectasis, infection, in distress, tachypneic, etc.

RC plan: based on the assessment, what needs to be done?

Procedures and outcome: what did you or the RT do to the patient and how was the therapy evaluated? What was the outcome of therapy?

What procedures did physicians or others do? Why?

What changes were ordered to the patient's care and what changes were made in mechanical ventilation; why?