CRITICAL CARE · 1 PATIENT

ICU Brain Sheet

DATE _____ SHIFT ☐ Day ☐ Night UNIT _____

ROOM _____ PATIENT (INITIALS) _____ AGE / SEX _____ CODE STATUS _____ ALLERGIES _____ ISOLATION _____

ADMIT DATE / ICU DAY # _____ DIAGNOSIS / REASON FOR ICU _____ INTENSIVIST / CONSULTS _____

NEURO

GCS E _____ V _____ M _____

RASS _____ CAM-ICU _____

Pupils L _____ R _____

Sedation / analgesia _____

CARDIOVASCULAR

Rhythm _____

MAP goal _____ Pacer _____

Pulses / edema _____

RESPIRATORY

ABG ___:___

Mode _____ FiO_2 _____

PEEP _____ Vt _____

RR set _____ RR total _____

ETT size _____ @ lip _____

pH _____ $PaCO_2$ _____

PaO_2 _____ HCO_3 _____

DRIPS

DRUG	CONC.	DOSE	ML/H	TITRATE TO

LINES & DEVICES

Art line _____ day _____

Central line _____ day _____

Foley _____ day _____

OG / NG _____ cm _____

Chest tube _____ output _____

Other _____

GI / GU / RENAL

Diet / tube feed / rate _____

Last BM _____

UOP / CRRT _____

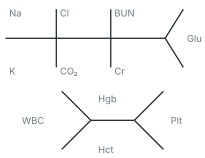
SKIN / MOBILITY

Braden _____

Wounds / pressure areas _____

Turned _____

LABS



MORE LABS

Lactate _____ K _____

Mg _____ Phos _____

iCa _____ Glu _____

INR _____ PTT _____

Trop _____ Hgb _____

HOURLY VITALS & I/O

Top: day hour, below: night hour

	0700 1900	0800 2000	0900 2100	1000 2200	1100 2300	1200 0000	1300 0100	1400 0200	1500 0300	1600 0400	1700 0500	1800 0600
Rhythm												
HR												
BP												
MAP												
SpO_2												
RR												
Temp												
CVP												
Pain												
RASS												
Glucose												
Turned												
Intake												
Output												

BUNDLE CHECKS

☐ HOB ≥ 30° ☐ Oral care ☐ SAT / SBT

☐ Line still needed? ☐ Foley still needed? ☐ Turn q2h

☐ VTE prophylaxis ☐ GI prophylaxis ☐ Glucose control

☐ Family updated

TO DO

☐ _____

☐ _____

☐ _____

☐ _____

FOR HANDOVER

_____

_____

_____

Keep identifiers to the minimum your unit allows. Never take this sheet off the unit. Shred it at the end of your shift.

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