ECMO/LVAD REFERRAL INTAKE FORM

Please send most recent labs, Face sheet, Progress note(s), and H & P

Date: _____ Requesting: **VV ECMO____ VA ECMO____ LVAD/Transplant_____**

Referring MD Name: _____ MD Phone #: _____

Referring Hospital: _____ Email: _____ Fax #: _____

Patient Name: _____ AGE: _____ DOB: _____HT (cm): _____

Weight (kg): _____ BMI: _____ BSA: _____ Admit Date: _____

Primary Diagnosis: _____ Active Infections: _____

Organ(s) Concern/Failure: _____

Comorbidities: _____

BiPAP date: _____ Intubation date: _____ Vent duration: _____

Current Vent settings: Mode_____ VT_____ Rate _____Peep_____ FIO2_____ Pplat _____

Prone position: ☐ Yes ☐ No Paralyzed: ☐ Yes ☐ No iNO or Folan: ☐ Yes ☐ No

Last ABG Date: _____: pH _____ PaCo2 _____ PaO2 _____ Bicarb _____ Base Excess_____

Mechanical Circulatory Support/Settings: _____

Last CT Head date and result: _____

Neuro Status (Exam/pupils, last normal, etc):_____

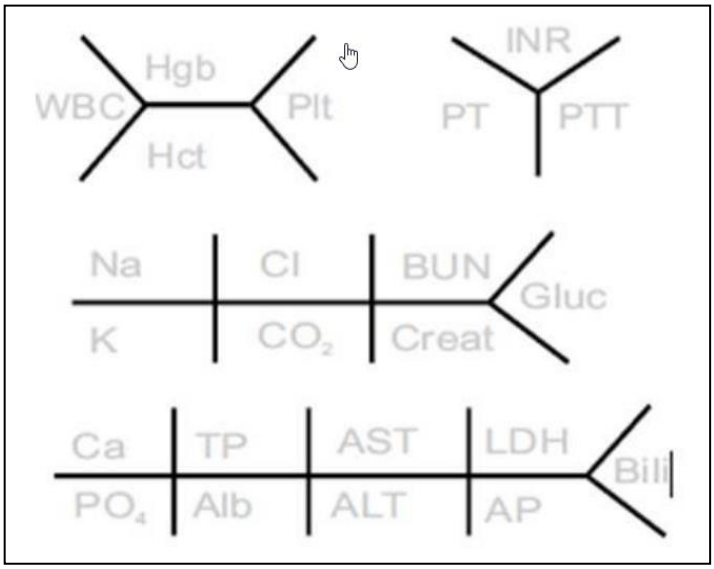
Current Drips/Doses: _____

On Anticoagulants? / Name of anticoagulants: _____

Current lines _____

Date of Most Recent Labs: _____

- Please give most recent
- If older than 24 hours, please include date



Lactate: _____ Procalcitonin: _____

CRP: _____ CKMB: _____

Troponin: _____ BNPP or BNP: _____

Faxed Info MUST be accompanied with a phone call to the Transfer Center.

Transfer Center: 855-995-5005

Transfer Center Right Fax: 858-303-9022