SHARP

ECMO REFERRAL INTAKE FORM

VV ECMO _____ VA ECMO_____

1. **Referring Physician: _____PHONE#_____**
2. **Referring Hospital: _____UNIT #_____**
3. **Patient Name: _____ AGE: _____ DOB: _____**

   HT (cm): _____WT (kg): _____BMI: _____DATE OF ADMISSION: _____

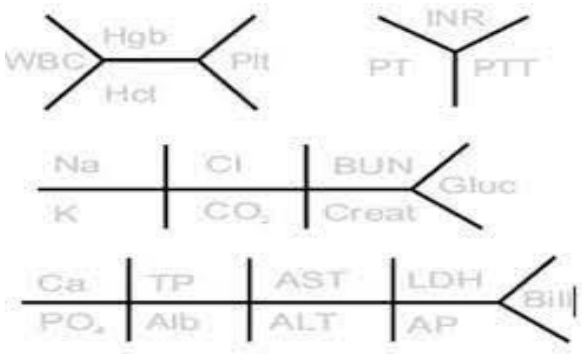
4. **Chronic conditions: _____**
5. **Admitting Diagnosis/Presenting factors: _____**

   _____
6. **Date of Intubation: _____**
7. **Last ABG Date/Time: _____PH: _____PaCO2: _____PaO2: _____HCO3: _____BE: ____**
8. **LACTATE: _____ Prone: Yes____No_____Nitric Oxide: Yes___No_____**
9. **Ventilator settings: MODE: _____FIO2: ____% VT: _____Rate: _____Peep: ____P/F ratio:____**
10. **Vasopressors/doses: _____**
11. **Inotropes/doses: _____**
12. **Mechanical circulatory support: IABP: _____IMPELLA: CP_____5.5_____**
13. **IV Access: _____**

DIAGNOSTICS:

1. **Cardiac Echo: EF%_____**
2. **CT head: _____**

Latest Laboratory values: Date/Time: _____



Troponin: _____

*** Faxed information MUST be accompanied with a phone call to Sharp Transfer Center Transfer Center: (855)995-5005 Transfer Center Right FAX:(858)303-9022**