DAILY SCREENING FORM

Patient's initials:_____ Date of admission:_____ Time of admission:_____ Gender: M ☐ F ☐

Year of Birth:_____ Type of admission: Medical/Surgical/Postoperative (elective)

Days since admission	Date	Mechanical ventilation (circle the appropriate mode)	Lung fields on Radiology	PaO_2	FiO_2	PaO_2/FiO_2	Severe respiratory failure Criteria fulfilled?*
Day of admission		Inv. MV PEEP>5/ NIMV EPAP>5/ CPAP>5/ None of the Above	Normal/ Abnormal/ Not done				□ YES □ NO
1		Inv. MV PEEP>5/ NIMV EPAP>5/ CPAP>5/ None of the Above	Normal/ Abnormal/ Not done				□ YES □ NO
2		Inv. MV PEEP>5/ NIMV EPAP>5/ CPAP>5/ None of the Above	Normal/ Abnormal/ Not done				□ YES □ NO
3		Inv. MV PEEP>5/ NIMV EPAP>5/ CPAP>5/ None of the Above	Normal/ Abnormal/ Not done				□ YES □ NO
4		Inv. MV PEEP>5/ NIMV EPAP>5/ CPAP>5/ None of the Above	Normal/ Abnormal/ Not done				□ YES □ NO
5		Inv. MV PEEP>5/ NIMV EPAP>5/ CPAP>5/ None of the Above	Normal/ Abnormal/ Not done				□ YES □ NO
6		Inv. MV PEEP>5/ NIMV EPAP>5/ CPAP>5/ None of the Above	Normal/ Abnormal/ Not done				□ YES □ NO
7		Inv. MV PEEP>5/ NIMV EPAP>5/ CPAP>5/ None of the Above	Normal/ Abnormal/ Not done				□ YES □ NO
8		Inv. MV PEEP>5/ NIMV EPAP>5/ CPAP>5/ None of the Above	Normal/ Abnormal/ Not done				□ YES □ NO
9		Inv. MV PEEP>5/ NIMV EPAP>5/ CPAP>5/ None of the Above	Normal/ Abnormal/ Not done				□ YES □ NO
10		Inv. MV PEEP>5/ NIMV EPAP>5/ CPAP>5/ None of the Above	Normal/ Abnormal/ Not done				□ YES □ NO
11		Inv. MV PEEP>5/ NIMV EPAP>5/ CPAP>5/	Normal/ Abnormal/				□ YES □ NO

***If NIV/IV/CPAP with end expiratory pressure ≥5 cmH_2O AND abnormal lung radiology AND PaO2/FiO2<300 mmhg (or < 40kPa), please move to the "Study form", otherwise, please reevaluate the patient the next day**

		None of the Above	Not done				
12		Inv. MV PEEP>5/ NIMV EPAP>5/ CPAP>5/ None of the Above	Normal/ Abnormal/ Not done				□ YES □ NO
13		Inv. MV PEEP>5/ NIMV EPAP>5/ CPAP>5/ None of the Above	Normal/ Abnormal/ Not done				□ YES □ NO
14		Inv. MV PEEP>5/ NIMV EPAP>5/ CPAP>5/ None of the Above	Normal/ Abnormal/ Not done				□ YES □ NO
15		Inv. MV PEEP>5/ NIMV EPAP>5/ CPAP>5/ None of the Above	Normal/ Abnormal/ Not done				□ YES □ NO
16		Inv. MV PEEP>5/ NIMV EPAP>5/ CPAP>5/ None of the Above	Normal/ Abnormal/ Not done				□ YES □ NO
17		Inv. MV PEEP>5/ NIMV EPAP>5/ CPAP>5/ None of the Above	Normal/ Abnormal/ Not done				□ YES □ NO
18		Inv. MV PEEP>5/ NIMV EPAP>5/ CPAP>5/ None of the Above	Normal/ Abnormal/ Not done				□ YES □ NO
19		Inv. MV PEEP>5/ NIMV EPAP>5/ CPAP>5/ None of the Above	Normal/ Abnormal/ Not done				□ YES □ NO
20		Inv. MV PEEP>5/ NIMV EPAP>5/ CPAP>5/ None of the Above	Normal/ Abnormal/ Not done				□ YES □ NO
21		Inv. MV PEEP>5/ NIMV EPAP>5/ CPAP>5/ None of the Above	Normal/ Abnormal/ Not done				□ YES □ NO
22		Inv. MV PEEP>5/ NIMV EPAP>5/ CPAP>5/ None of the Above	Normal/ Abnormal/ Not done				□ YES □ NO
23		Inv. MV PEEP>5/ NIMV EPAP>5/ CPAP>5/ None of the Above	Normal/ Abnormal/ Not done				□ YES □ NO
24		Inv. MV PEEP>5/ NIMV EPAP>5/ CPAP>5/ None of the Above	Normal/ Abnormal/ Not done				□ YES □ NO
25		Inv. MV PEEP>5/ NIMV EPAP>5/ CPAP>5/ None of the Above	Normal/ Abnormal/ Not done				□ YES □ NO
26		Inv. MV PEEP>5/ NIMV EPAP>5/ CPAP>5/ None of the Above	Normal/ Abnormal/ Not done				□ YES □ NO
27		Inv. MV PEEP>5/ NIMV EPAP>5/ CPAP>5/ None of the Above	Normal/ Abnormal/ Not done				□ YES □ NO

***If NIV/IV/CPAP with end expiratory pressure ≥5 cmH_2O AND abnormal lung radiology AND PaO2/FiO2<300 mmhg (or < 40kPa), please move to the "Study form", otherwise, please reevaluate the patient the next day**

BASELINE DATA COLLECTION FORM - Study Day 1

Date of fulfillment of criteria for severe respiratory failure (from screening form):_____

Date of Hospital Admission: _ _ / _ _ / 201 _ _ _ : _ _ (24 h clock)

Height (first documented at ICU admission): _____ □ inch □ cm

Weight (first documented at ICU admission): _____ □ lbs □ kg

Admission Source:
□ Other hospital (ICU) □ Other hospital (Ward) □ ER/ambulance
□ Operating Room □ Study Hospital (Ward) □ Study Hospital (Other ICU)
□ Other, please specify _____

If patient transferred from another hospital and/or ICU:

What was date of Admission to that Hospital: _____

If patient transferred from external ICU, what was date of ICU Admission: _____

Reason for transfer: □ ICU Bed Unavailability □ Need for more advanced support

□ Need for specialty medical input □ Other (please be precise):_____

Co-morbidities (check all that Apply):
□ COPD
□ Diabetes Mellitus
□ Chronic Renal Failure
□ Active Neoplasm
□ Hematologic neoplasm
□ Immunosuppression
□ Heart failure: NYHA classes III-IV
□ Chronic liver failure (Child-Pugh Class C)
□ Home Ventilation

ARDS Risk Factor (check all that apply):

	Direct		**Indirect**
	Pneumonia		Non-pulmonary sepsis
	Aspiration of gastric contents		Major trauma
	Inhalational injury		Pancreatitis
	Pulmonary contusion		Severe burns
	Pulmonary vasculitis		Non-cardiogenic shock
	Drowning		Drug overdose
			Multiple transfusions/transfusion-associated acute lung injury (TRALI)
	OTHER (Specify):		

	NONE

Date of the insult: _ _ / _ _ / _ _ _ _ OR Not Known ☐

Can hypoxemia be entirely explained by cardiac failure?
☐ Yes ☐ No

Did you use any of these method to rule out the cardiac origin of the disease? (check all that apply):

	Echocardiography
	Pulmonary artery catheter
	Transpulmonary thermodilution (e.g., PiCCO)
	Other (specify):
	None:

What is/are the cause(s) of the patient's acute hypoxemic respiratory failure (check all that apply)?
☐ Pneumonia

☐ Cardiac Failure

☐ Asthma

☐ ARDS

☐ COPD

☐ Unknown

☐ Other _____

Are there new or worsening respiratory symptoms within the last week?
☐ Yes ☐ No

DAILY DATA COLLECTION FOR PATIENTS WITH SEVERE RESPIRATORY FAILURE[1]

Day_____ Date of this form_____

Is the patient in the ICU on this date? □ YES □ NO*
* If "NO" please complete the discharge/Death forms

ARTERIAL BLOOD GAS	**Units**	**Value**
pH:		
PaO_2:		
$PaCO_2$:		
FiO_2:		
Arterial blood gas not available		☐
SpO2		

CHEST X-RAY (CXR) / CT SCAN	
Chest x-ray (CXR) / CT scan not available	☐
Bilateral opacities on the CXR/CT scan	**Yes** ☐ **No** ☐
Number of involved quadrants:	**1**☐ 2 ☐ 3 ☐ 4☐

Mechanical Ventilation *(Please record ventilatory settings as close as possible to the ABG)***:**

☐ Invasive ☐ Non-invasive ☐ Only O_2 ☐ None

Modailty
☐ *Volume A/C*
☐ *PC/BIPAP/APRV*
☐ *SIMV*
☐ *PRVC*
☐ *PSV*
☐ *NAVA*
☐ *HFO*
☐ *CPAP*
☐ *T-Tube*
☐ Other

Ventilatory settings:	
Respiratory Rate (set)	
Respiratory Rate (Total)	

[1] Data is collected at at 10am on Days 1,2,3,5,7 inclusive, Day 10, 14, 21, 28 until ICU discharge/death.

Tidal Volume (ml)	
PEEP (cmH_2O)	
Plateau Pressure available?	**Yes ☐ No ☐**
Plateau Pressure (cmH_2O)	
Peak Inspiratory Pressure (PIP) (cmH_2O)	
Mean Airway Pressure (MAP) (cmH_2O)	
Is the patient triggering the Ventilator?	**Yes ☐ No ☐**
Oxygen flow (for t-tube or O2 therapy)	

Adjunctive Measures/Therapies (in the last 24 hours – check all that apply)

	Prone positioning *****		CT scan
	Recruitment maneuvers		Alveolar surfactant
	Extracorporeal membrane oxygenation (If yes: V-V or A-V or V-A)		Lung Ultrasound
	High dose corticosteroids		Renal Replacement Therapy
	Almitrine besylate		Tracheostomy
	Continuous Sedation		Inhaled vasodilators
	Oesophageal pressure monitoring******		Neutrophil Elastase Therapy
	Continuous Neuromuscular Blocking Agents		
	Pulmonary Artery Catheter	Mean pulmonary arterial pressure:_____	
	None of the above		

Sequential Organ Failure Assessment (SOFA) Score (worst value over last 24hrs)
(only for days 1,2, 7,10, 14, 21, 28)

SOFA Score	Units	Value	NOT AVAILABLE
Estimated Glasgow Coma Scale			□
Mean Arterial Pressure	mmHg		□
Vasopressors used? Yes/No			
Dopamine infusion			□
Dobutamine infusion			□
Noradrenaline infusion			□
Adrenaline infusion			□
Platelet Count($\times 10^3/mm^3$)			□
Total Bilirubin	µmol/L mg/dL		□
Creatinine (mg/dL)			□
OR Creatinine (µmol/L)			□
OR Urine Output (mL/day)			□

*** For Patients Receiving prone position:**

	Units	**Supine (before pronation)**	**Prone**
pH:	**--------**		
PaO_2:			
$PaCO_2$:			
PEEP	cmH_2O		
Plateau pressure	cmH_2O	☐	
Duration of the session	hours		

**** For Patients receiving Oesophageal pressure measurement:**

Why was esophageal pressure used?

☐ To measure chest wall elastance

☐ To facilitate PEEP titration

☐ To assess the Work of breathing

☐ To assess synchrony

☐ Other:_____

OUTCOME AND ICU DISCHARGE/DEATH

OUTCOMES AT ICU DISCHARGE/DEATH

ICU (or day 90) Outcome (whichever event comes first)
□ Alive □ Dead

Date of ICU discharge/Death: _ _ / _ _ / _ _ _ _

For patients without severe respiratory failure only this section is necessary

Discharged to:
□ Other ICU □ Hospital Ward □ Intermediate Care Unit □ Hospital Discharge
~~(go to Form 5)~~

Did the patient develop additional risk factors for ARDS (in addition to those indicated in the "STUDY DATA-BASELINE" form) (check all that apply):

	Direct		**Indirect**
	Pneumonia		Non-pulmonary sepsis
	Aspiration of gastric contents		Major trauma
	Inhalational injury		Pancreatitis
	Pulmonary contusion		Severe burns
	Pulmonary vasculitis		Non-cardiogenic shock
	Drowning		Drug overdose
			Multiple transfusions/transfusion-associated acute lung injury (TRALI)
	OTHER (Specify):		

Could patient hypoxemia be entirely explained by cardiac failure?
☐ Yes ☐ No

Did you use any of these method to rule out the cardiac origin of the disease? (check all that apply):

	Echocardiography
	Pulmonary artery catheter
	Transpulmonary thermodilution (e.g., PiCCO)
	Other (specify):
	None:

Did the patient have ARDS at any stage of their ICU stay?
☐ Yes ☐ No

Respiratory status at ICU Discharge (Check all that apply):
□ Tracheostomy □ Invasive ventilation □ Non-invasive ventilation □ CPAP
□ Oxygen therapy □ No oxygen therapy

Date of liberation from MV: _ _ / _ _ / _ _ _ _

If patient did not survive:
What was the most important factor leading to ICU Death (Check one)?

□ Respiratory Failure
□ Cardiovascular Failure [i.e. Unresponsive Shock]
□ Renal Failure
□ Hepatic Failure
□ Coagulation Failure
□ Neurologic Failure

Limitations in Care
Was there a decision to withhold a life sustaining measure at any time during the ICU stay? □ Yes □ No

Was there a decision to withdraw a life sustaining measure at any time during the ICU stay? □ Yes □ No

Date of decision to withhold/withdraw life sustaining measures: _ _ / _ _ / _ _ _ _

Did the patient undergo an autopsy (i.e. post mortem) examination
□ Yes □ No

If an Autopsy was performed, what did lung histology demonstrate [Check all that apply]
□ Pneumonia
□ Diffuse Alveolar Damage
□ Pulmonary Oedema
□ Atelectasis
□ Alveolar Haemorrhage
□ No lung pathology
□ Other (Specify) _____

DISCHARGE/DEATH

ADDITIONAL DISCHARGE FORM FOR PATIENT WITHOUT RISK FACTORS FOR ARDS

This form is required only for patients with "none" selected as risk factor for ARDS

Was a broncho-alveolar lavage (BAL) fluid analysis performed? ☐ Yes☐ No

If yes, please provide

- Day BAL performed*: _ _ / _ _ / _ _ _ _
- Cytological analysis:

Macroscopic aspect: ☐ normal ☐ bloody or pink ☐ lactescent

Number of cells: _ _ _ _ _ _ / mL

Macrophages: _ _ % lymphocytes: _ _ % neutrophils: _ _ %

mast cells: _ _ % eosinophils: _ _ % siderophages: _ _ % other cells: _ _ %

- Microbiological analyses performed (check all that apply):

☐ Bacterial culture

☐ *Pneumocystis jiroveci* stain or PCR

☐ Fungal analysis

☐ Viral PCRs

Positive result(s): _ _ _ _ _

*if several BAL were performed: results of the nearest to the ARDS diagnosis

Were immunological tests performed? ☐ Yes☐ No

If yes, please check if the result is positive:

☐ antinuclear antibodies

☐ Antisynthetase antibodies

☐ Anti-CCP antibody

☐ ANCA

☐ Rheumatoid factor

☐ Other: _ _ _ _

Was the patient taking pneumotoxic medications* before the development of ARDS? ☐ Yes☐ No

If yes, provide name of the drugs (check all that apply)

☐ Amiodarone

☐ Methotrexate

☐ Hydrochlorothiazide

☐ Tyrosine kinase inhibitors

☐ Chemotherapy agents: _ _ _ _ _ _ _ _ _

☐ Other: _ _ _ _ _ _ _ _ _ _

* see www.pneumotox.com for more information

Was a final etiology for ARDS obtained? ☐ Yes ☐ No

If yes, specify: _

Was a chest CT-scan performed? ☐ Yes ☐ No

If yes, day chest CT-scan performed: _ _ / _ _ / _ _ _ _

If yes, provide CT-scan patterns present (check all that apply):

☐ *Honeycombing*

☐ *Ground class attenuation*

☐ *Traction bronchiectasis*

☐ *Interlobular septal thickening*

☐ *Air space consolidation including atelectasis*

☐ *Other* Specify: _

*if several CT were performed: results of the nearest to the ARDS diagnosis

DISCHARGE/DEATH

HOSPITAL OUTCOME

Hospital (or 90 day) Outcome (whichever event occurs first)

□ Alive □ Dead

Date of hospital discharge: _ _ / _ _ / _ _ _ _