1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME

DOB

AGE/SEX

MRN / PATIENT ID

DATE OF SERVICE

PROVIDER

CREDENTIALS

VISIT TYPE: CRITICAL CARE CONSULTATION / ICU FOLLOW-UP / DAILY ICU PROGRESS NOTE / RAPID RESPONSE FOLLOW-UP / POST-ICU FOLLOW-UP

CARE SETTING: ICU / MICU / SICU / CVICU / NEURO ICU / STEP-DOWN UNIT / EMERGENCY DEPARTMENT / TELE-ICU

PRIMARY TEAM

CONSULTING SERVICES

PRIMARY CARE PROVIDER, IF APPLICABLE

REFERRING PROVIDER, IF APPLICABLE

CODE STATUS

DECISION-MAKER / HEALTHCARE PROXY, IF APPLICABLE

INTERPRETER USED, IF APPLICABLE

CC CHIEF COMPLAINT

2 REASON FOR ICU MANAGEMENT

Document the primary critical care-related reason for evaluation or ICU management, including acute respiratory failure, shock, sepsis, altered mental status, cardiac arrest, severe metabolic derangement, acute kidney injury, multisystem organ failure, post-operative critical care, neurologic emergency, severe infection, hemodynamic instability, mechanical ventilation management, or ICU-level monitoring.

S SUBJECTIVE

3 INTERVAL HISTORY & ICU COURSE

Document available patient-reported symptoms, collateral history, overnight events, ICU course, family updates, and interval changes.

3a PRESENTATION & INTERVAL EVENTS

Reason for Critical Care Evaluation:

Document whether the patient is being evaluated for ICU admission, ongoing ICU management, respiratory failure, shock, sepsis, post-arrest care, post-operative critical care, neurologic deterioration, severe metabolic abnormality, organ failure, or escalation of care.

Interval Events / Overnight Events:

Document changes in respiratory status, hemodynamics, vasopressor requirements, sedation, neurologic status, fever curve, urine output, bleeding, arrhythmias, procedures, transfusions, code events, rapid response events, consult recommendations, and major nursing concerns.

History of Present Illness:

Document presenting symptoms, onset, duration, severity, progression, pre-hospital course, emergency department course, initial vital signs, major interventions, suspected source of critical illness, and reason for ICU-level care.

3b ORGAN-SYSTEM STATUS

Respiratory Status:

Document dyspnea, oxygen requirement, work of breathing, mechanical ventilation status, noninvasive ventilation use, ventilator tolerance, secretions, cough, hemoptysis, aspiration concern, and changes in oxygenation or ventilation.

Hemodynamic Status:

Document hypotension, hypertension, tachycardia, bradycardia, arrhythmias, vasopressor/inotrope use, fluid responsiveness, perfusion, lactate trend, shock type if known, and response to resuscitation.

Neurologic Status:

Document mental status, sedation level, agitation, delirium, seizure activity, focal deficits, pupillary changes, pain response, neuromuscular blockade use, and ability to follow commands.

Infectious / Sepsis History:

Document fever, chills, suspected infection source, cultures obtained, antibiotics started, source control needs, prior infections, immunosuppression, device-related infection risks, and response to antimicrobial therapy.

Cardiac History and Symptoms:

Document chest pain, palpitations, syncope, heart failure symptoms, arrhythmia history, cardiac arrest details if applicable, troponin trend, EKG changes, echocardiogram findings, and cardiac interventions.

Renal / Fluid Status:

Document urine output, acute kidney injury, chronic kidney disease, dialysis history, fluid balance, edema, electrolyte abnormalities, acid-base concerns, renal replacement therapy, and response to diuresis or fluids.

Gastrointestinal / Nutrition Status:

Document abdominal pain, nausea/vomiting, bowel movements, ileus, GI bleeding, liver dysfunction, enteral feeding status, aspiration risk, stress ulcer prophylaxis, and nutrition tolerance.

Hematology / Bleeding / Thrombosis:

Document anemia, thrombocytopenia, coagulopathy, bleeding, transfusions, anticoagulation, DVT/PE concern, disseminated intravascular coagulation concern, and VTE prophylaxis status.

Endocrine / Metabolic Status:

Document glucose control, diabetic ketoacidosis, hyperosmolar state, adrenal insufficiency concern, thyroid emergency, sodium/potassium abnormalities, acid-base disorders, temperature dysregulation, and endocrine medications.

Pain, Sedation, and Delirium:

Document pain control, sedation regimen, RASS goal, delirium screening, agitation, withdrawal risk, sleep disruption, analgesic response, and adverse effects of sedatives or opioids.

Lines, Tubes, Drains, and Devices:

Document endotracheal tube, tracheostomy, central venous catheter, arterial line, Foley catheter, chest tube, drains, feeding tube, dialysis catheter, pacer wires, mechanical circulatory support, and device-related concerns.

3c MEDICATIONS & BACKGROUND

Medication and Infusion History:

Document vasopressors, inotropes, sedatives, analgesics, antibiotics, anticoagulants, steroids, insulin infusions, diuretics, antiarrhythmics, paralytics, home medications held or continued, and medication adverse effects.

Past Medical History:

Include cardiopulmonary disease, renal disease, liver disease, diabetes, immunosuppression, cancer, neurologic disease, thromboembolic disease, substance use disorder, prior ICU admission, prior intubation, and baseline functional status.

Goals of Care / Family Communication:

Document code status, healthcare proxy, advance directives, family discussions, patient preferences if known, prognosis discussion, palliative care involvement, and limitations of treatment if applicable.

Pertinent Negatives:

Document denial or absence of key critical symptoms when clinically relevant, including chest pain, severe dyspnea, new neurologic deficit, active bleeding, seizure, worsening shock, fever, oliguria, abdominal rigidity, or rapidly worsening organ dysfunction.

ROS CRITICAL CARE REVIEW OF SYSTEMS

4 FROM NURSING, CHART & OBSERVATION

Document pertinent positives and negatives when obtainable from patient, family, nursing staff, chart review, or clinical observation:

Dyspnea, cough, sputum, hypoxemia, ventilator intolerance, or increased work of breathing

Chest pain, palpitations, syncope, edema, hypotension, or arrhythmia symptoms

Fever, chills, infection symptoms, wounds, device-related symptoms, or sepsis concern

Altered mental status, agitation, delirium, seizure activity, weakness, or focal neurologic deficits

Abdominal pain, vomiting, diarrhea, ileus, GI bleeding, jaundice, or nutrition intolerance

Oliguria, anuria, edema, electrolyte symptoms, or dialysis-related concerns

Bleeding, bruising, thrombosis symptoms, transfusion reactions, or anticoagulation concerns

Pain, anxiety, sedation effects, withdrawal symptoms, or sleep disturbance

O OBJECTIVE

5 MONITORING & ORGAN-SYSTEM EXAMINATION

Document objective critical care findings, organ-system examination, monitoring data, and device status.

5a VITALS AND MONITORING

TEMPERATURE	BLOOD PRESSURE	MEAN ARTERIAL PRESSURE
HEART RATE	RESPIRATORY RATE	OXYGEN SATURATION
OXYGEN DELIVERY / VENTILATOR MODE	FIO2	PEEP
VASOPRESSOR / INOTROPE SUPPORT	INTAKE / OUTPUT	NET FLUID BALANCE
URINE OUTPUT	WEIGHT	PAIN SCORE, IF APPLICABLE
RASS SCORE, IF APPLICABLE	CAM-ICU, IF APPLICABLE	

5b EXAMINATION

General Appearance:

Document alertness, distress level, intubation status, sedation level, agitation, work of breathing, perfusion, body habitus, positioning, and overall acuity.

Neurologic:

Document mental status, GCS, orientation, pupils, cranial nerve findings, strength, sensation, reflexes, focal deficits, seizure activity, sedation response, delirium findings, and neuromuscular blockade status.

Cardiovascular:

Document rate, rhythm, murmurs, pulses, perfusion, capillary refill, edema, JVD, extremity temperature, arterial waveform quality, hemodynamic support, and shock findings.

Pulmonary:

Document respiratory effort, breath sounds, wheezes, crackles, rhonchi, diminished sounds, secretions, cough strength, chest tube status, oxygen requirement, and signs of respiratory failure.

Abdomen / Gastrointestinal:

Document distension, tenderness, guarding, rebound, bowel sounds, hepatomegaly, ascites, feeding tube status, ostomy, surgical wounds, drains, and signs of ileus or intra-abdominal process.

Renal / Genitourinary:

Document Foley status, urine appearance, urine output, bladder distension, dialysis catheter status, edema, and renal replacement therapy status.

Extremities / Vascular:

Document edema, cyanosis, mottling, pulses, calf tenderness, limb ischemia signs, compartment concerns, DVT signs, pressure injury risk, and vascular access sites.

Skin / Wounds:

Document temperature, color, perfusion, rash, bruising, pressure injuries, surgical wounds, cellulitis, line sites, ulcers, drains, and infection signs.

Lines / Tubes / Drains:

Document type, location, insertion date if known, function, dressing status, infection signs, securement, output, and need for continuation or removal.

RS RESPIRATORY SUPPORT / VENTILATOR ASSESSMENT

6 VENTILATOR SETTINGS & WEANING

Document respiratory support details when applicable. Include:

OXYGEN DELIVERY DEVICE

VENTILATOR MODE AND SETTINGS

FIO2 AND PEEP

TIDAL VOLUME AND RESPIRATORY RATE

PEAK AND PLATEAU PRESSURES WHEN AVAILABLE

DRIVING PRESSURE WHEN AVAILABLE

MINUTE VENTILATION

ABG/VBG INTERPRETATION

SPONTANEOUS BREATHING TRIAL STATUS

SEDATION AND SYNCHRONY

SECRETIONS AND AIRWAY CLEARANCE

CUFF LEAK OR AIRWAY CONCERNS

PRONING STATUS IF APPLICABLE

TRACHEOSTOMY STATUS IF APPLICABLE

WEANING READINESS AND BARRIERS

EXTUBATION PLAN OR ESCALATION PLAN

HS HEMODYNAMIC / SHOCK ASSESSMENT

7 PERFUSION & RESPONSE

Document hemodynamic status and perfusion. Include:

SHOCK TYPE SUSPECTED: SEPTIC / CARDIOGENIC / HYPOVOLEMIC / OBSTRUCTIVE / DISTRIBUTIVE / MIXED

MAP GOAL

VASOPRESSOR AND INOTROPE DOSES

FLUID RESUSCITATION RECEIVED

FLUID RESPONSIVENESS ASSESSMENT

LACTATE TREND

URINE OUTPUT

EXTREMITY PERFUSION

CENTRAL VENOUS PRESSURE OR ADVANCED MONITORING IF USED

BEDSIDE ULTRASOUND OR ECHOCARDIOGRAM FINDINGS IF AVAILABLE

SOURCE CONTROL OR BLEEDING CONTROL STATUS

HEMODYNAMIC RESPONSE TO INTERVENTIONS

IB ICU BUNDLE / SAFETY ASSESSMENT

8 PREVENTION & SAFETY MEASURES

Document ICU prevention and safety measures. Include:

DVT PROPHYLAXIS

STRESS ULCER PROPHYLAXIS

VENTILATOR-ASSOCIATED PNEUMONIA PREVENTION

HEAD-OF-BED ELEVATION

ORAL CARE

SEDATION INTERRUPTION / AWAKENING TRIAL WHEN APPROPRIATE

SPONTANEOUS BREATHING TRIAL

DELIRIUM PREVENTION

EARLY MOBILITY

NUTRITION PLAN

BOWEL REGIMEN

GLYCEMIC CONTROL

PRESSURE INJURY PREVENTION

FOLEY AND CENTRAL LINE NECESSITY REVIEW

RESTRAINT NECESSITY AND ALTERNATIVES WHEN APPLICABLE

FAMILY COMMUNICATION AND GOALS-OF-CARE REVIEW

PR PROCEDURES PERFORMED, IF APPLICABLE

9 CRITICAL CARE PROCEDURES

Document critical care procedures performed during the encounter. Include procedure name, indication, consent or emergency necessity, timeout, sterile technique, ultrasound guidance if used, anesthesia/sedation, site, number of attempts, findings, confirmation method, patient tolerance, complications, post-procedure imaging if applicable, and follow-up plan. Examples may include: Endotracheal intubation · Central venous catheter placement · Arterial line placement · Thoracentesis · Paracentesis · Chest tube placement · Bronchoscopy · Lumbar puncture · Cardioversion · Transcutaneous or transvenous pacing · Point-of-care ultrasound · Dialysis catheter placement · Bedside debridement or drainage · Proning procedure documentation · Ventilator management · Code blue / resuscitation documentation

L LABORATORY AND DIAGNOSTIC RESULTS

10 REVIEWED & ORDERED

Document critical care-relevant results reviewed or ordered. Include:

Laboratory Testing:

CBC, CMP, electrolytes, renal function, liver function, lactate, ABG/VBG, coagulation studies, troponin, BNP, inflammatory markers, glucose, ketones, osmolality, ammonia, cortisol, thyroid studies, toxicology, and medication levels when relevant.

Microbiology:

Blood cultures, urine culture, sputum culture, BAL culture, wound culture, CSF studies, viral testing, fungal studies, MRSA screen, C. difficile testing, and antimicrobial sensitivities.

Imaging:

Chest X-ray, CT chest/abdomen/pelvis, CT head, CTA, MRI, ultrasound, echocardiogram, vascular duplex, abdominal imaging, and post-procedure imaging.

Cardiac Testing:

EKG, telemetry, echocardiogram, cardiac catheterization, hemodynamic monitoring, pacemaker/ICD interrogation, and rhythm strips.

Respiratory Testing:

ABG/VBG trends, ventilator mechanics, PFTs if relevant, bronchoscopy findings, sleep/oxygen testing, and capnography.

Neurologic Testing:

CT/MRI brain, EEG, lumbar puncture results, neurocritical care monitoring, and neurologic consultation findings.

Prior Records Reviewed:

ED notes, hospital records, ICU records, operative reports, medication list, prior imaging, outside hospital records, discharge summaries, consult notes, and advance directive documents.

A ASSESSMENT

11 CRITICAL CARE CLINICAL INTERPRETATION

Provide critical care-specific clinical interpretation: Primary ICU diagnosis or working diagnosis · Current severity of illness and acuity · Organ systems affected and trajectory · Respiratory failure type and ventilatory status · Shock type, perfusion status, and vasopressor needs · Sepsis source, antimicrobial status, and source control needs · Neurologic status, sedation, delirium, or seizure concerns · Renal function, fluid balance, electrolyte, and acid-base status · Cardiac rhythm, ischemia, heart failure, or circulatory support issues · Hematologic, bleeding, thrombosis, and transfusion considerations · Nutrition, GI, hepatic, endocrine, and metabolic issues · Lines, tubes, devices, and ICU safety concerns · Code status, goals-of-care considerations, and family communication needs · Need for escalation, de-escalation, procedures, consults, imaging, labs, transfer, or ongoing ICU care

P PLAN

12 MANAGEMENT BY ORGAN SYSTEM

Outline critical care management by organ system or problem. Include:

Neurologic Plan:

Sedation target, analgesia, delirium prevention, neurologic monitoring, seizure management, imaging, EEG, stroke/neurocritical care coordination, and daily awakening trial when appropriate.

Respiratory Plan:

Oxygen strategy, ventilator settings, lung-protective ventilation, ABG/VBG monitoring, bronchodilators, airway clearance, proning, SBT, extubation readiness, tracheostomy planning, and escalation or weaning plan.

Cardiovascular / Shock Plan:

MAP goal, vasopressors/inotropes, fluid strategy, diuresis if indicated, lactate monitoring, echo/cardiac testing, arrhythmia management, anticoagulation considerations, and perfusion reassessment.

Infectious Disease / Sepsis Plan:

Empiric or targeted antibiotics, culture follow-up, source control, de-escalation plan, infectious disease consultation, fever evaluation, and sepsis bundle reassessment.

Renal / Fluid / Electrolyte Plan:

Intake/output goals, renal function monitoring, electrolyte replacement, acid-base management, diuresis, renal replacement therapy, nephrology consult, and medication dose adjustment.

Gastrointestinal / Nutrition Plan:

Enteral or parenteral nutrition, bowel regimen, GI prophylaxis, aspiration precautions, liver monitoring, GI bleeding management, and surgical/GI consult when indicated.

Hematology / Anticoagulation Plan:

DVT prophylaxis, anticoagulation management, transfusion thresholds, coagulopathy correction, platelet management, bleeding evaluation, and thrombosis workup.

Endocrine / Metabolic Plan:

Glucose target, insulin regimen, adrenal/thyroid management, DKA/HHS protocol, temperature management, nutrition-related glucose planning, and metabolic lab monitoring.

Lines / Tubes / Devices Plan:

Necessity review, maintenance, removal or exchange plan, infection prevention, device troubleshooting, and documentation of line/tube dates when available.

Skin / Wound / Mobility Plan:

Pressure injury prevention, wound care, turning schedule, early mobility, PT/OT involvement, restraints review, and skin monitoring.

Medication Plan:

Continue, hold, initiate, adjust, or discontinue critical medications; review renal/hepatic dosing, interactions, sedation burden, antimicrobial stewardship, and home medication reconciliation.

Procedural Plan:

Indications, timing, consent, preparation, imaging guidance, post-procedure monitoring, and consultant coordination.

Goals of Care / Communication Plan:

Code status confirmation, family update, healthcare proxy communication, prognosis discussion, palliative care consult when appropriate, and documentation of shared decisions.

Disposition Plan:

ICU continuation, step-down readiness, transfer criteria, isolation status, rehabilitation needs, discharge barriers, and anticipated care needs.

F FOLLOW-UP

13 ICU REASSESSMENT

Specify follow-up timeframe and purpose, including ICU reassessment, ventilator weaning, hemodynamic monitoring, culture review, lab/imaging follow-up, procedure follow-up, consultant recommendations, family meeting, goals-of-care review, or transfer readiness.

TB TIME DOCUMENTATION & BILLING

14 CRITICAL CARE TIME DOCUMENTATION

TOTAL CRITICAL CARE TIME

TIME EXCLUDES SEPARATELY BILLABLE PROCEDURES: YES / NO

FAMILY MEETING / GOALS-OF-CARE TIME, IF APPLICABLE

PROCEDURE TIME, IF SEPARATELY DOCUMENTED

VENTILATOR MANAGEMENT TIME, IF APPLICABLE

CARE COORDINATION TIME

RECORDS REVIEW TIME, IF APPLICABLE

Document that critical care time was spent in direct management of life-threatening organ dysfunction when applicable.

14a BILLING CONSIDERATIONS — CRITICAL CARE / ICU CODING

CRITICAL CARE CODE(S): [E.G., 99291 / 99292 WHEN APPLICABLE]

E/M LEVEL, IF APPLICABLE AND NOT BILLED AS CRITICAL CARE: [E.G., 99221 / 99222 / 99223 / 99231 / 99232 / 99233]

PROCEDURE CODE(S), IF APPLICABLE

VENTILATOR MANAGEMENT CODE(S), IF APPLICABLE

CENTRAL LINE / ARTERIAL LINE / INTUBATION / CHEST TUBE CODE(S), IF APPLICABLE

BASIS FOR BILLING: [CRITICAL CARE TIME / MEDICAL DECISION MAKING / PROCEDURE-BASED / VENTILATOR MANAGEMENT / CARE COORDINATION]

ICD-10 DIAGNOSIS CODES: [PRIMARY CRITICAL CARE DIAGNOSIS CODE + DESCRIPTION]

[SECONDARY ORGAN FAILURE / SHOCK / SEPSIS / RESPIRATORY / METABOLIC DIAGNOSIS CODE(S), IF APPLICABLE]

SO SIGNATURE

15 PROVIDER SIGN-OFF

PROVIDER NAME

CREDENTIALS

SPECIALTY: CRITICAL CARE MEDICINE

DATE

TIME