FORM: ICU BASELINE DATA

HOSPITAL ADMISSION DATE: ______/______/______ (dd/mm/yy)

ICU ADMISSION DATE: ______/______/______ (dd/mm/yy)

☐ Previous admission(s) to study ICU during current hospitalization

Apache II Admission Diagnosis Code: ___ ___ (see Appendix A)

Specify if 'Other': ____

Apache II Score: ____ (see Appendix C)

Trauma Patient: ☐ No ☐ Yes **ISS score**: ______ (see Appendix B)

INITIAL INVASIVE MV START DATE: ______/______/______(dd/mm/yy)
– ***day 1 of data collection begins at study hospital**

☐ MV started at another hospital/ICU → Start date: ______/______/______(dd/mm/yy)

REASON FOR INITIATION OF MECHANICAL VENTILATION:
(check all that apply as well as subcategory)

☐ Acute Respiratory Failure

☐ COVID-19 Pneumonia ☐ Postoperative ☐ Congestive heart failure
☐ Sepsis ☐ Trauma ☐ ARDS
☐ Aspiration ☐ Cardiac Arrest ☐ Lung Transplant
☐ Other (e.g. retained secretions, atelectasis):__________

☐ Decreased LOC – inability to protect airway

☐ Acute Respiratory Failure Complicating Chronic Pulmonary Disease
☐ COPD ☐ Asthma ☐ Cystic Fibrosis/Bronchiectasis
☐ Interstitial Lung Disease ☐ Lung Transplant ☐ Other:____________________

☐ Neuromuscular Disease (if significant e.g. Guillian-Barre Syndrome, Myasthenia Gravis, ALS, etc – should not be enrolled!)

FORM: ICU DAILY DATA - PART 1

Page: ________

DATE (calendar day; dd/mm/yr)					
ICU DAY (#)					
MURRAY/ MATTHAY SCORE					
CXR (ALVEOLAR CONSOLIDATION IN 0, 1, 2, 3, 4 QUADRANTS)					
Infiltrates bilateral? (Y/N; circle)	**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
Lowest PaO_2/FiO_2 (record values separately)	/	/	/	/	/
Peep at lowest P/F ratio **if on HFO record MAP					
AMERICAN/EUROPEAN CONSENSUS CONFERENCE DEFINITION OF ARDS **(YES/NO; circle)**					
P/F ≤ 200	**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
Acute Onset	**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
Bilateral Infiltrates on CXR	**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
No Clinical Evidence of Elevated Left Atrial Hypertension	**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
BERLIN DEFINITION OF ARDS **(YES/NO; circle)**					
Timing ≤ 1 week of known clinical insult	**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
Bilateral Opacities Not Explained by Effusion, Lobar/Lung Collapse, or Nodules	**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
Origin of Edema Not Explained by Cardiac Failure/Fluid Overload	**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
Oxygenation with PEEP/CPAP $\geq 5cmH_2O$ — **Mild** ($200 < PaO_2/FiO_2 \leq 300$)	**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
Oxygenation with PEEP/CPAP $\geq 5cmH_2O$ — **Moderate** ($100 < PaO_2/FiO_2 \leq 200$)	**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
Oxygenation with PEEP/CPAP $\geq 5cmH_2O$ — **Severe** ($PaO2/FiO2 \leq 100$)	**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**

CANCOV	Participant ID Number ____ ____ - ____ ____ ____-____ ____ ____ ____
	(Province) (Site number) (Participant Number)

FORM: ICU DAILY DATA - PART 2

Page: ________

DATE (calendar day; dd/mm/yr)						
ICU DAY (#)						
VENTILATOR SETTINGS (24hrs; 09:00 – 09:00)						
Mode of Ventilation *(select mode and enter settings)*	**Pressure Control (cmH_2O)**					
	Volume Control					
	Assist Control (cc)					
	Pressure Support					
	Volume Support (cc)					
	Airway Pressure Release Ventilation					
	Proportional Assist Ventilation-PAV (%)					
	Neurally Adjusted Ventilatory Assist-NAVA					
	PRVC & PC-PCV					
	SIMV-VC					
	SIMV-PC					
	High Frequency Oscillation (HFO)					
Non-Invasive Ventilation	**IPAP (cmH_2O)**					
	EPAP (cmH_2O)					
	CPAP (cmH_2O)					
HFNC (AIRVO; Optiflow) (enter FiO2 + LPM)						
Tavish Mask (enter LPM)						
Venturi Mask (enter LPM or FiO2)						
Nasal Prong (enter LPM or FiO2)						
Respiratory Rate	**Set**					
	Observed					
Any Triggering	**(Yes/No; circle)**	**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
PEEP (cmH_2O)						
Maximum FiO_2						
Tidal Volume on above settings (cc) **if on HFO, indicate here						
Maximum Plateau Pressure (P_{PLAT})						
Driving Pressure (P_{PLAT} – PEEP)						
Max Peak Inspiratory Pressure						
Max Minute Ventilation (VE)						

Predicted Body Weight (kg) Males: 50.0 + 2.3(Ht in inches - 60) Females: 45.5 + 2.3(Ht in inches - 60)					

CANCOV	Participant ID Number ___ ___ - ___ ___ ___-___ ___ ___ ___
	(Province) (Site number) (Participant Number)

FORM: ICU DAILY DATA - PART 3

Page: ________

DATE (calendar day; dd/mm/yr)						
ICU DAY (#)						
PRONING (09:00- 09:00)						
Yes/No (circle)		**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
Number of Hours of Proning in 24h Cycle (h). E,g, 5 hours						
Lowest P/F before Proning						
Highest P/F after Proning						
Complications Yes/No (circle)	**Accidental Extubation**	**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
	New/Worsening Hypotension Requiring ↑ Pressor Use	**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
	New/Worsening Desaturation <88%	**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
	Skin/Pressure Complications (specify site)	**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
INHALED NITRIC OXIDE						
Yes/No (circle)		**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
Concentration (ppm)						
Duration of hours of the therapy (hrs/24h cycle) E.g. 5 hours						
EPO-PROSTENOL						
Inhaled		**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
IV		**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
Duration of hours of the therapy (hrs/24h cycle) E.g. 5 hours						
ARTERIAL BLOOD GAS – ABG **(each day closest to and before 09:00)** If no ABG available, then select "No".						
ABG		**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**

PO_2 (mmHg)					
PCO_2 (mmHg) **pH** **Bicarb (nmol/L)**					

FORM: ICU DAILY DATA - PART 4

Page: ________

DATE (calendar day; dd/mm/yr)						
ICU DAY (#)						
EXTRACORPOREAL LIFE SUPPORT – ECLS						
Yes or No (circle)		**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
Configuration	**V-V**					
	V-A					
	Other (specify)					
Maximum Support in 24hrs (09:00-09:00)	**Sweep Gas Flow (L/min)**					
	RPM					
	Blood Flow (L/min)					
Complications (Yes/No; circle)	**Hemorrhage at Cannula Site**	**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
	Intracranial hemorrhage/Stroke	**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
	Other (specify):					
SPONTANEOUS BREATHING TRIAL – SBT						
SBT Initiated (Yes/No; circle)		**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
Failed SBT (Yes/No; circle) If "YES" specify reasons (check all that apply): ↑ Work of Breathing; Respiratory Muscle Weakness; Secretions; Desaturation; Hypercapnia; Hemodynamic Instability; ↓ Level of Consciousness.		**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
Planned Extubation (Yes/No; circle)		**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
Completed Extubation (Yes/No; circle) If yes, specify modality patient was extubated to: NP, VM, Optiflow, BIPAP, Other		**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
Self Extubation (Yes/No; circle) Specify if reintubated within 48 hours (Yes/No)		**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**

CANCOV	Participant ID Number ___ ___ - ___ ___ ___-___ ___ ___ ___
	(Province) (Site number) (Participant Number)

FORM: ICU DAILY DATA - PART 5
Page: ________

DATE (calendar day; dd/mm/yr)						
ICU DAY (#)						
BLOOD WORK (for all values – except lactate – use only formal lab validated values. If value unavailable, leave blank)						
CBC (closest to and before 09:00)	**Hb g/L**					
	WBC 10^9/L					
	Platelets 10^9/L					
PT (s)						
PTT (s)						
D-Dimer (ng/mL DDU)						
Fibrinogen (g/L)						
Troponin (µg/L)						
Albumin (g/L)						
Creatinine (mmol/day)						
Lactate (mmol/L) use only formal lab validated values						
REHAB						
Receipt of any Physiotherapy (Yes/No; circle)		**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
CNS and PAIN MEDICATIONS **(specify: N = No B = Bolus CI = Continuous Infusion)** (majority of treatment time between 09:00-09:00)						
Paralytic		**N / B / CI**	**N / B / CI**	**N / B / CI**	**N / B / CI**	**N / B / CI**
Sedation	**Midazolam**	**N / B / CI**	**N / B / CI**	**N / B / CI**	**N / B / CI**	**N / B / CI**
	Clonazepam	**N / B / CI**	**N / B / CI**	**N / B / CI**	**N / B / CI**	**N / B / CI**
	Propofol	**N / B / CI**	**N / B / CI**	**N / B / CI**	**N / B / CI**	**N / B / CI**
Narcotics	**Fentanyl**	**N / B / CI**	**N / B / CI**	**N / B / CI**	**N / B / CI**	**N / B / CI**
	Morphine	**N / B / CI**	**N / B / CI**	**N / B / CI**	**N / B / CI**	**N / B / CI**

	Hydromorphine	N / B / CI	N / B / CI	N / B / CI	N / B / CI	N / B / CI

CANCOV	Participant ID Number ____ ____ - ____ ____ ____-____ ____ ____ ____
	(Province) (Site number) (Participant Number)

FORM: ICU DAILY DATA - PART 6

Page: ________

DATE (calendar day; dd/mm/yr)						
ICU DAY (#)						
CNS and PAIN MEDICATIONS (specify: N = No B = Bolus CI = Continuous Infusion) (majority of treatment time between 09:00-09:00)						
Antipsychotics	Haloperidol	N / B / CI	N / B / CI	N / B / CI	N / B / CI	N / B / CI
	Quetiapine	N / B / CI	N / B / CI	N / B / CI	N / B / CI	N / B / CI
	Olanzapine	N / B / CI	N / B / CI	N / B / CI	N / B / CI	N / B / CI
	Other Antipsychotics (Y/N) (specify)					
Sedative/Analgesic	Dexmedetomidine	N / B / CI	N / B / CI	N / B / CI	N / B / CI	N / B / CI
	Clonidine	N / B / CI	N / B / CI	N / B / CI	N / B / CI	N / B / CI
	Other Sedative/Analgesic? (Y/N) (specify)					
CAM + or ICDSC score≥4 (Yes/No; circle)		Y/N	Y/N	Y/N	Y/N	Y/N
Lowest SAS (+1 to +7) or RASS (+4 to -5) score in previous 24 hrs						
OTHER DRUG and THERAPIES (Yes/No; circle)						
ATB	Azithromycin	Y/N	Y/N	Y/N	Y/N	Y/N
	Ceftriaxone or other cephalosporin	Y/N	Y/N	Y/N	Y/N	Y/N
	Others, specify:					
Steroids	Prescribed before ICU admission	Y/N	Y/N	Y/N	Y/N	Y/N
	Newly prescribed during ICU admission	Y/N	Y/N	Y/N	Y/N	Y/N
Anticoagulation	DVT Prophylaxis If Yes, specify: UFH, LMWH, Other External Pneumatic Compression Devices (Y/N)	Y/N	Y/N	Y/N	Y/N	Y/N
	Full Anti-coagulation for DVT/PE	Y/N	Y/N	Y/N	Y/N	Y/N

	If Yes, specify: UFH, LMWH, Other						
	Empiric Anti-coagulation for COVID-19 **If Yes, specify: UFH, LMWH, Other** **Any deviation from usual prophylaxis at YOUR site (Y/N)**		**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
RRT **(majority of treatment time between 09:00-09:00)**	**IHD**		**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
	CRRT		**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
	Peritoneal		**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
	SLEDD	**Intermittent< 12h**	**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
		Continuous 24h	**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
	Other (specify)						

FORM: ICU DAILY DATA - PART 7

Page: ________

DATE (calendar day; dd/mm/yr)						
ICU DAY (#)						
MODIFIED MULTIPLE ORGAN DYSFUNCTION SCORE **–see Appendix D**						
RENAL (highest creatinine)						
HEPATIC (highest total bilirubin)						
HEMATOLOGIC (lowest platelet count)						
CARDIO-VASCULAR	**Highest HR:**					
	Inotropes or Vasopressors: Y/N	**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
	Lactate ≥ 5 Y/N	**Y/N**	**Y/N**	**Y/N**	**Y/N**	**Y/N**
CENTRAL NERVOUS SYSTEM (lowest GCS; use 10T method)						

DATA COLLECTION:
- Daily for one week → Every Monday and Thursday thereafter until ICU discharge or death
- Continue to collect every Monday and Thursday if patient is readmitted within 48 hours of ICU discharge

If no ABG available: Record the FiO2, PEEP, and Vt where the SpO2 is lowest and indicate “No ABG

CANCOV	Participant ID Number ____ ____ - ____ ____ ____-____ ____ ____ ____ (Province) (Site number) (Participant Number)

FORM: COURSE DURING ICU STAY - PART 1

COMPLETE FOR THE ICU STAY AT ENROLLMENT SITE

YES	NO	FORM DATE: ____/____/_____
		TRACHEOSTOMY (check all that apply) ***Date: ___/___/___ (dd/mm/yy)*** **Reason:** ☐ **Failed primary extubation** ☐ **Prolonged or anticipated prolonged ventilation, no extubation attempt** ☐ **Profound weakness/disability, no extubation attempt** ☐ **Upper airway obstruction or complication, no primary extubation attempt**
		CARDIAC (check all that apply) ☐ **New Ischemic ECG Changes** ☐ **Pericarditis** ☐ **Myocarditis** ☐ **Endocarditis → specify affected valve and organism:____________________________** ☐ **Sustained ventricular tachycardia or ventricular fibrillation** ☐ **Myocardial infarct defined by ECG changes and elevated troponin** ☐ **Cardiac arrest** ☐ **New acquired heart failure defined by ECHO in ICU >Grade III LV** ☐ **Pulmonary hypertension (PAP >25mmHg / sPA >35 or RSVP ≥35 on ECHO)**
		GI BLEED **(requires transfusion and documented in chart)** **(check all that apply)** ☐**Upper** ☐ **Lower**
		COAGULOPATHY ☐ **Platelets ≤ 50** ☐ **INR > 2x ULN**
		NEUROLOGICAL **(documented)** **(check all that apply)** ☐ **Acute Ischemic Stroke** ☐ **Intracerebral Hemorrhage** ☐ **Subarachnoid Hemorrhage** ☐ **Status Epilepticus** ☐ **Aseptic Meningitis** ☐ **Viral Encephalitis** ☐ **Acute Encephalopathy** ☐ **Coma** ☐ **Other:__________________**
		☐ **Critical Illness Polyneuropathy** **(check all that apply)** ☐ **Yes - defined by nerve conduction study** ☐ **Yes - documented clinical suspicion** Type of Polyneuropathy ☐ **Demyelinating GBS** ☐**Axonal GBS** ☐ **Miller Fisher Syndrome** ☐ **Axonal polyneuropathy** ☐ **Critical Illness Myopathy** ☐ **Yes - defined by EMG, CK or biopsy** ☐ **Yes - documented clinical suspicion**

CANCOV	Participant ID Number ____ ____ - ____ ____ ____-____ ____ ____ ____ (Province) (Site number) (Participant Number)

FORM: COURSE DURING ICU STAY - PART 2

COMPLETE FOR THE ICU STAY AT ENROLLMENT SITE

YES	NO	FORM DATE: ____/____/_____
		HEMATOLOGY (check all that apply) ☐ DVT → ☐ clinical suspicious ☐ documented by ultrasound ☐ recurrent events location_______________ date___/___/___ location_______________ date____/____/____ location_______________ date___/___/___ location_______________ date____/____/____ ☐ Pulmonary Embolism → ☐ clinical suspicious ☐ documented by CT angiography ☐ recurrent events location_______________ date___/___/___ location_______________ date____/____/____ location_______________ date___/___/___ location_______________ date____/____/____ ☐ Arterial Thrombotic Events ☐ ischemic stroke → date___/___/___ ☐ acute coronary syndrome → date___/___/___ ☐ intracranial hemorrhage → date___/___/___ ☐ other:_________________ → date___/___/___ ☐ Line-related thrombosis → date___/___/___ ☐ recurrent events Date ______
		INFECTIOUS DISEASES (check all that apply) ☐ Bacteremia organism (s)________________________________ date____/____/____ organism (s)________________________________ date____/____/____ organism (s)________________________________ date____/____/____ organism (s)________________________________ date____/____/____ organism (s)________________________________ date____/____/____ organism (s)________________________________ date____/____/____ organism (s)________________________________ date____/____/____ organism (s)________________________________ date____/____/____ ☐ Sputum/BAL organism (s)________________________________ date____/____/____ organism (s)________________________________ date____/____/____ organism (s)________________________________ date____/____/____ organism (s)________________________________ date____/____/____ organism (s)________________________________ date____/____/____ organism (s)________________________________ date____/____/____ organism (s)________________________________ date____/____/____ organism (s)________________________________ date____/____/____ ☐ Skin Pressure Ulcer Location: ______________________ date____/____/____ Location: ______________________ date____/____/____

		Location: ____________________ **date**____/____/____ **Location:** ____________________ **date**____/____/____ **Location:** ____________________ **date**____/____/____ **Location:** ____________________ **date**____/____/____

CANCOV	Participant ID Number ____ ____ - ____ ____ ____-____ ____ ____ ____
	(Province) (Site number) (Participant Number)

FORM: ICU OUTCOME

FORM DATE: ____/____/_____

☐ **DNR order** (date written): _____________☐ No CPR order (date written): ____________

☐ **Do not reintubate order** (date written): _______________ ☐ None

FINAL MV STOP DATE/EXTUBATION: ____/____/____ (dd/mm/yy) or ☐ N/A ☐ (death or transfer)

Time: _____ (24 hr clock) (for trached patients MV stop date is AFTER completing 48 hours of continuous T/M)

☐ Any subsequent reintubation/mechanical ventilation within 48 hours of initial extubation during this ICU stay

ICU SURVIVOR:

☐ YES → ICU Discharge Date: ______/______/______ (dd/mm/yy)

ICU Discharge Weight: ___________kg

Discharged to :

- ☐ *Home*
- ☐ *Shelters/encampment/street/outdoors/couch surfing*
- ☐ *Ward*
- ☐ *ICU (Other, specify):_____________________________________*
- ☐ *Acute Care Hospital (name):________________________________*
- ☐ *Inpatient Rehabilitation Hospital (name):_____________________*
- *Long Term Care (name): ____________________*
- ☐ *Chronic Care Hospital(name):_____________________________*
- ☐ *Prolonged Ventilation Weaning Centre (name): ______________*
- ☐ *Transitional Care (name:__________________________________*
- ☐ *Hospice/Palliative Care (name):__________________________*
- ☐ *Assisted Living ______________________________*
- ☐ *Other (specify):____*

☐ NO → Month/Year of Death: ______/______ (mm/yy) → *complete form Hospital Discharge*

☐ Died while on MV or N/A ☐

Immediate Cause of Death:

☐ Intractable Hypoxemia	☐ Multiple Organ Dysfunction ≥ 3 organ system
☐ Refractory Shock	☐ Cardiac Arrhythmias
☐ Withdrawal of life sustaining treatment	☐ Other:________________________________

CANCOV	Participant ID Number ____ ____ - ____ ____ ____-____ ____ ____ ____
	(Province) (Site number) (Participant Number)

FORM ICU RE-ADMISSION

WITHIN SAME HOSPITAL STAY

ICU RE-ADMISSION DATE: ______/______/______ (dd/mm/yy)
(If patient re-admitted within 48 hours of initial ICU discharge, continue daily data collection 1-7)

Apache II Admission Diagnosis Code: _____ _____ (see Appendix A) Specify if 'Other':_____________________

Initial Invasive MV Start Date (on the re-admission): ______/______/______ (dd/mm/yy)

Reason for Initiation of Mechanical Ventilation: (check all that apply as well as subcategory)

☐ Acute Respiratory Failure
- ☐ COVID-19 Pneumonia ☐ Postoperative ☐ Congestive heart failure
- ☐ Sepsis ☐ Trauma ☐ ARDS
- ☐ Cardiac Arrest ☐ Aspiration ☐ Other (e.g. retained secretions, atelectasis): ______________

☐ Decreased LOC – inability to protect airway

☐ Acute Respiratory Failure Complicating Chronic Pulmonary Disease
- ☐ COPD ☐ Asthma ☐ Cystic Fibrosis/Bronchiectasis
- ☐ Interstitial Lung Disease ☐ Lung Transplant ☐ Other:________________________________

☐ Neuromuscular Disease (if significant e.g. Guillian-Barre Syndrome, Myasthenia Gravis, ALS, etc – should not be enrolled!)

Final Mechanical Ventilation Stop Date: ____/____/____ (dd/mm/yy) OR ☐ **Death or Transfer**
☐ Any subsequent reintubation/MV within 48hrs of initial extubation during this ICU stay

ICU Survivor:
☐ YES → ICU Discharge Date: ____/____/____ (dd/mm/yy) ICU Discharge Weight: ______kg

Discharged to : ☐ *Home*

☐ *Ward*
☐ *ICU (Other, specify):*_______________________________________
☐ *Acute Care Hospital (name):*________________________________
☐ *Rehabilitation (name):*_____________________
☐ *Referring Hospital (name):* _______________________
☐ ☐ *Chronic Care Hospital(name):*____________________________

☐ NO Month/Year of Death → ___/___ (mm/yy) → *complete form complete form Hospital Discharge*
☐ Died while on MV
Immediate Cause of Death:
- ☐ Intractable Hypoxemia ☐ Multiple Organ Dysfunction ≥ 3 organ system
- ☐ Refractory Shock ☐ Cardiac Arrhythmias
- ☐ Withdrawal of life sustaining treatment ☐ Other:________________________________