McLAREN FLINT
FLINT, MICHIGAN

PULMONARY/CRITICAL CARE PROGRESS NOTE
MEDICAL INTENSIVE CARE UNIT

Date ___/____/____ Time __________

Pulmonary/Critical Care Concurrence and additional comments

Patient Name ________________________________

Subject Patient Course Past 24 hours: ____________________________________ |______________________________

____ |______________________________

____ |______________________________

____ |______________________________

Vitals: Temp _____/T_{max} ______ Pulse Range ____-____ Respiration Range ____-____ Blood Pressure ______ /______

Oxygen Support: $Fi0_2$ _________________ Oxygen Saturation ______%

(If Patient + Swan Ganz Catheter): [Serial] PCW: ___ ___ ___ ___ CI: ___ ___ ___ ___ SVRI: ___ ___ ___ ___

(If Patient Mechanical Vent Support): AC IMV CPAP Rate _____ Pressure Support (if on) ______ PEEP _____

OBJECTIVE EXAMINATION:

(Check in box indicates concurrence in exam by Pulm/Crit Care Specialist)

Pulmonary/Critical Care Additional Comments

- ☐ HEENT ______________________________ |______________________________
- ☐ Lungs: ______________________________ |______________________________
  ______________________________ |______________________________
- ☐ Heart: ______________________________ |______________________________
  ______________________________ |______________________________
- ☐ GI/GU: ______________________________ |______________________________
- ☐ Abdomen: ______________________________ |______________________________
- ☐ Extremity: ______________________________ |______________________________
  ______________________________ |______________________________
- ☐ Neurologic: ______________________________ |______________________________
  ______________________________ |______________________________

LABS:

PROBLEM LIST	**MANAGEMENT**
☐ ______________________________	☐ ______________________________
☐ ______________________________	☐ ______________________________
☐ ______________________________	☐ ______________________________
☐ ______________________________	☐ ______________________________
☐ ______________________________	☐ ______________________________

(Check in box of problem list and/or management indicates concurrence by Pulm/Crit Care Specialist Attending)

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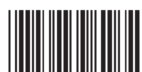
______________________________ Resident/Senior Resident Signature

______________________________ Pulmonary/Crtical Care Attending Signature

☐ -- If Checked, Patient Evaluated by Pulmonary/Critical Care Services Throughout Day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PT.

MR.#/RM.

DR.

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