

## GENERAL PATIENT INFORMATION

Hotline: +45 35 45 69 49

The registration below is based on information from the first day in ICU.

#	Question	Answer	Info	Validation and limits	Further comments for data manager
G1	Date of birth	_ _ - _ _ - _ _ _ _	Format: dd-mm-yyyy	Required	
G2	Male sex	<input type="checkbox"/> YES <input type="checkbox"/> NO	Yes, if the patient is male	Required	
G3	Hospital admission date	_ _ - _ _ - _ _ _ _	Format: dd-mm-yyyy	Required	
G4	ICU admission date	_ _ - _ _ - _ _ _ _	Format: dd-mm-yyyy	Required	ICU admission must be after or on the same day as hospital admission
G5	ICU admission time	_ _ - _ _	Format: 24 hours, hh:mm	Required	
<b>Admission diagnose</b>					
G6	Sepsis?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Yes, if the patient has proven or suspected infection <b>AND</b> a change in SOFA Score $\geq 2$ .	Required	
G7	Trauma	<input type="checkbox"/> YES <input type="checkbox"/> NO	YES, if the patient is classified as a trauma patient.	Required	
G8	Surgery?	<input type="checkbox"/> Emergency surgery <input type="checkbox"/> Elective surgery <input type="checkbox"/> None	Did the patient have <b>emergency surgery</b> OR <b>elective surgery</b> during this hospital admission or was transferred from another hospital and had emergency surgery there, but before this ICU admission.	Required	

## Risk factors for delirium prior to hospital/ICU admission

G9	Treatment with haloperidol before ICU admission?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Defined as: Received one or more dose, oral or IV, before admitted to the ICU. Only for this hospitalization.	Required	
G10	Smoking?	<input type="checkbox"/> YES <input type="checkbox"/> NO	YES, if the patient smokes every day. If pack years are mention in the patient journal and the patient still smokes, answer 'YES'.	Required	
G11	Alcohol abuse?	<input type="checkbox"/> YES <input type="checkbox"/> NO	YES, if the patient drinks more than 3 units of alcohol per day (1 unit is defined as 12g of alcohol).	Required	
G12	Substance abuse?	<input type="checkbox"/> YES <input type="checkbox"/> NO	YES, if the patient has daily use of <b>morphine, benzodiazepines or barbiturates</b> not prescribed by a physician. Or any other use of illegal substances.	Required	
G13	Benzodiazepine use?	<input type="checkbox"/> YES <input type="checkbox"/> NO	YES, if the patient is being treated with <b>benzodiazepines (N05BA) (N05CD08) at admission or before admission to ICU</b> , such as; <ul style="list-style-type: none"> <li>Diazepam, Oxazepam, Lorazepam, Bromazepam, Cloxazolam, Midazolam.</li> </ul>	Required	
G14	Is the patient's vision impaired?	<input type="checkbox"/> YES <input type="checkbox"/> NO	YES, if the patient uses glasses? Data from patient file or ask the next of kin.	Required	
G15	Is the patient's hearing impaired?	<input type="checkbox"/> YES <input type="checkbox"/> NO	YES, if the patient uses a hearing aid. Data from patient file or ask the next of kin.	Required	