Specialist Clinical Assessment Form for Critical Illness

Patient Details

Name

Date of Birth

Patient ID / MRN

Contact Number

Date of Assessment

Referring Physician Details

Referring Physician Name

Phone / Contact

Clinical Assessment

Presenting Complaint

Summary of Clinical Findings

Diagnosis

Critical Illness Criteria

Please select the criteria met (tick all that apply):

- [ ] Life-threatening condition
- [ ] Requires Intensive Care / Organ Support
- [ ] High risk of mortality

☐ Other (specify below)

If other, specify...

Management Plan

Summary of Planned Management

Specialist Details & Declaration

Name

Specialty

Registration No.

Signature

Date