Metabolic Acidosis Assessment Form

Patient Information:	
Full Name:	Date of Birth:
Medical Record Number (MRN):	Contact Number:
Address:	
Physician Information:	
Full Name:	Specialty:
Contact Number:	Email Address:
Clinical Assessment:	
Presenting Complaints: (tick all that ap	oply)
☐ Rapid breathing	
☐ Fatigue	
☐ Confusion	
☐ Headache	
☐ Lethargy	
Others:	
History of Present Illness: (Duration	, progression, associated symptoms)
Medical History:	
Known chronic diseases (e.g., diabete	es, kidney disease):
Medications currently being taken:	
Recent illnesses or infections:	

Physical Examination: Vital Signs: Blood Pressure: ____ mmHg Heart Rate: _____ bpm Respiratory Rate: _____ breaths/min • Temperature: _____ °C or °F Findings: (e.g., signs of dehydration, altered mental status) **Laboratory Tests Conducted:** Arterial Blood Gas (ABG) Analysis: • pH: _____ • PaCO₂ (Partial Pressure of Carbon Dioxide): _____ mmHg • HCO (Bicarbonate): ____ mEq/L • PaO₂ (Partial Pressure of Oxygen): _____ mmHg **Serum Electrolytes:** • Sodium: _____ mEq/L • Potassium: _____ mEq/L Chloride: _____ mEq/L BUN (Blood Urea Nitrogen): _____ mg/dL Creatinine: ____ mg/dL Other Relevant Tests: (e.g., lactate levels, urine analysis)

Interpretation and Recommendations:

- Primary Diagnosis: (e.g., Lactic Acidosis, Ketoacidosis)
- Possible Secondary or Mixed Disorders:

Recommended Treatment Plan:		
Follow-up Recommendations:		
Physician's Signature:	Date:	