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 apply)

- ☐ Rapid breathing
- ☐ Fatigue
- ☐ Confusion
- ☐ Headache
- ☐ Lethargy
- ☐ Others: ______________________________

History of Present Illness: (Duration, progression, associated symptoms)

Medical History:

Known chronic diseases (e.g., diabetes, 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: ________
- $PaCO_2$ (Partial Pressure of Carbon Dioxide): ________ mmHg
- HCO_3^- (Bicarbonate): ________ mEq/L
- PaO_2 (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: