**Critical Care Must Call List**

As patient volume increases and providers are spread thin, it is crucial to notify the critical care faculty when patients may be at risk of worsening or deteriorating. This is not a comprehensive list, but serves as a limited Must-Call list – if any of the following apply to your patient, you must notify the supervising ICU faculty. Please ensure there is closed-loop communication (i.e., a text without an acknowledgement of receipt is not sufficient). The critical care faculty are here to help. Please communicate any concerns that you have about a patient’s care, even if it is not included on this list.

### Hemodynamics
- New diagnosis of shock or hypotension
- Starting a new pressor / dual pressor
- Increasing a pressor (>0.05 increase / 6-hours)
- Increased lactate (new elevation or >0.5 above prior)

### Respiratory
- Pre-intubation: Escalating oxygen or PEEP / other support
- Vent: Increased work of breathing, non-resolving ventilator dyssynchrony; non-resolving bronchospasm; Plateau pressure >30; or an increase in driving pressure (Insp Pressure minus PEEP) to >18
- Any worsening of PF-ratio ↓50/shift or when considering turning prone
- Extubation if not discussed on rounds

### GI & Heme
- Any new acute GI Bleed or other symptomatic bleeding
- Transfusion of any blood product
- A drop in Hb >1.5 in any shift
- Any new Plt <50 or acute drop in Plt count

### Renal & Electrolytes
- Hyperkalemia >6 (start therapy and inform ICU)
- Oliguria >6 hours (< 0.5 mL/kg/hr) or any concern for need for dialysis or impending kidney problems

### Infection
- Starting new ABx (including anti-virals or anti-fungals)
- Changing Abx
- New positive culture results

### Neuro
- Any acute change in mental status, depressed mental status, or concerns for seizure

**Any procedure:**
- Central / arterial lines, lumbar puncture, intubation, regional anesthetic techniques, endoscopy (upper/lower), and so on.

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