



CYCLE RCT #142

Plate #021

Study
DayPatient ID 1
(site #) (patient #)Coded Patient Initials
F LTherapist(s) Initials
F M L F M LDate 2 0
(dd/mm/yyyy)

PT THERAPY: WORKSHEET (Form 5)

Day of week
M Tu W Th F Sa Su

1. Was routine PT/ rehab done today?

- ☐ Yes (submit Form 5R)
☐ No (check one of a, b, c, or d and specify where necessary)
- a) ☐ Patient discharged from ICU before 1200pm
b) ☐ Temporary exemption criteria met (check ALL; if #10 specify)

- ☐ 1. Increase in inotropes/vasopressors (2h)
☐ 2. Active MI, or unstable/uncontrolled arrhythmia per ICU team
☐ 3. MAP <60 or >110 (2h) or out of range for this patient per ICU team
☐ 4. HR <40 or >140 (2h)
☐ 5. SpO₂ <88% (2h) or out of range for this patient per ICU team
☐ 6. Neuromuscular blocker (4h)
☐ 7. Severe agitation RASS >2 or SAS >6 or equivalent (2h)
☐ 8. Uncontrolled pain
☐ 9. Changes in goals to palliative care
☐ 10. Other concern [e.g., active haemorrhage, acute peritonitis, new pelvic, groin, or extremity wound precluding routine PT/ rehab, new known or suspected muscle inflammation (specify below)]

c) ☐ Other reasons routine PT/ rehab not received (check all that apply)

Refusals

- ☐ Tired ☐ Non-verbal behaviours indicating disinterest
☐ Having a bad day ☐ Other reason patient declined (specify)
☐ Family declined

Other activity prioritized by therapist

- ☐ Cycling ☐ Other (specify) _____
☐ Patient not scheduled for therapy

Therapist not available

- ☐ Workload ☐ Other (specify) _____

Patient not available

- ☐ Out of ICU ☐ While in ICU (procedure, test, etc.)
☐ Other (specify) _____

d) ☐ Other reason (specify) _____

2. Was cycling done today?

- ☐ N/A, patient not randomized to cycling
☐ Yes (submit Form 5C)
☐ No (check one of a, b, c, d, or e and specify where necessary)
- a) ☐ Patient discharged from ICU before 1200pm
b) ☐ Patient marched on the spot for 2 consecutive days
c) ☐ Temporary exemption criteria met (check ALL; if #10 specify)

- ☐ 1. Increase in inotropes/vasopressors (2h)
☐ 2. Active MI, or unstable/uncontrolled arrhythmia per ICU team
☐ 3. MAP <60 or >110 (2h) or out of range for this patient per ICU team
☐ 4. HR <40 or >140 (2h)
☐ 5. SpO₂ <88% (2h) or out of range for this patient per ICU team
☐ 6. Neuromuscular blocker (4h)
☐ 7. Severe agitation RASS >2 or SAS >6 or equivalent (2h)
☐ 8. Uncontrolled pain
☐ 9. Changes in goals to palliative care
☐ 10. Other concern [e.g., active haemorrhage, acute peritonitis, new pelvic, groin, or extremity wound precluding cycling, new known or suspected muscle inflammation (specify below)]

d) ☐ Other reasons cycling not received (check all that apply)

Refusals

- ☐ Tired ☐ Non-verbal behaviours indicating disinterest
☐ Having a bad day ☐ Other reason patient declined (specify)
☐ Family declined

Other activity prioritized by therapist

- ☐ Other (specify) _____

Therapist not available

- ☐ Workload ☐ Other (specify) _____
☐ No CYCLE-trained therapist available

Patient not available

- ☐ Out of ICU ☐ While in ICU (procedure, test, etc.)
☐ Other (specify) _____

e) ☐ Other reason (specify) _____

3. Total # of screening attempts for cycling today?

☐ N/A ☐ (#)

4A. Therapy session duration (min)

- ☐ No PT/ rehab Session 1 (min)
☐ N/A Session 2 (min)
☐ N/A Session 3 (min)

4B. Therapy type(s) received

- ☐ Routine PT/ rehab ☐ Cycling
☐ Routine PT/ rehab ☐ Cycling
☐ Routine PT/ rehab ☐ Cycling

4C. Safety Events reported

- ☐ No ☐ Yes (complete Form 5S)
☐ No ☐ Yes (complete Form 5S)
☐ No ☐ Yes (complete Form 5S)

5. Patient highest level of activity from ALL rehabilitation/therapy sessions (includes Forms 5R, 5C, applicable S&F ax's)

☐ No PT/ rehab

SCORE

 /5 (0-11)

- 0 - Passively moved by staff (includes passive cycling only)
1 - Any activity in bed, but not moving out of or over edge of bed (includes cycling)
2 - Passively moved to chair (no standing or sitting at edge of bed)
3 - Actively sitting over side of bed with some trunk control (may be assisted)
4 - Standing
5 - Transferring from bed to chair
6 - Marching on the spot (at bedside; ≥ 2 steps/foot)
7 - Walking with assistance of 2 or more people (≥ 5m)
8 - Walking with assistance of 1 person (≥ 5m)
9 - Walking independently with gait aid (≥ 5m)
10 - Walking independently without gait aid (≥ 5m)
11 - Walking up and down stairs

6. Cognitive screening for ICU Awakening Ax: Strength and Function (Ask the patient to perform all 5 commands; check ALL successful commands)

☐ No PT/ rehab

Successful Commands

- SCORE /5
☐ Open your eyes
☐ Look at me
☐ Open your mouth and stick out your tongue
☐ Nod your head
☐ Raise your eyebrows when I count to 5

- ☐ Not done, patient unable to follow commands
☐ No, score ≤ 2/5 (continue screening)
☐ Yes, score ≥ 3/5 + not appropriate for PT ICU Awakening Ax (continue screening)
☐ Yes, score ≥ 3/5 + appropriate for PT ICU Awakening Ax (initiate assessment)
☐ Not done, PT ICU awakening Ax in progress/ complete



CYCLE RCT #142

Plate #025

Study
DayPatient ID 1
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F LTherapist(s) Initials
F M L F M LDate 2 0
(dd/mm/yyyy)

PT THERAPY: ROUTINE PT/ REHAB (Form 5R)

Complete form if patient receives any routine therapy (incl. therapy received while cycling)

Day of week
M Tu W Th F Sa Su

1. Pre-routine therapy assessments SAS / VAMASS → RASS Conversion Chart

1. RASS (-) (0 - 5)
☐ Not done ☐ (+)

SAS	1	2	X	3	X	4	5	6	7	X
RASS	-5	-4	-3	-2	-1	0	1	2	3	4
VAMASS	0	X	1	2	X	3	4	5	6	X

2. CAM-ICU ☐ Negative
☐ Positive
☐ Unable to Ax (RASS = -4 or -5)
*Scores ≥ 4 on Intensive Care Delirium Screening Checklist / ICDSC = CAM-ICU "Positive"2. Vitals: highest O₂ % received [21% (room air) - 100%]
Session 1: (%) ☐ N/A
Session 2: (%) ☐ N/A
Session 3: (%) ☐ N/A

3. ALL advanced life support strategies received DURING ANY ROUTINE PT/REHAB today (check ALL that apply)

1. Airway Access ☐ No ☐ Yes → ☐ ETT ☐ Tracheostomy
2. Mechanical Ventilation (MV) ☐ No → None/Spontaneous (e.g. t-mask, venti-mask, nasal prongs)
☐ Yes → ☐ Invasive MV (e.g. pressure assist control, volume assist control, pressure support)
☐ Non-Invasive MV (e.g. BIPAP, CPAP by mask not ETT or trach, e.g., nocturnal)
3. Other Ventilation Strategy ☐ No ☐ Yes → ☐ ECMO/ECLS ☐ Nitric oxide ☐ High-flow nasal cannula ☐ Other (specify) (e.g. AIRVO, Optiflow)
4. Vasopressor / Inotrope ☐ No ☐ Yes
infusions (e.g., dopamine, norepinephrine, phenylephrine, epinephrine, milrinone, vasopressin)
5. Dialysis ☐ No ☐ Yes → ☐ Intermittent (IHD) ☐ Continuous (CRRT) ☐ Peritoneal ☐ Sustained low efficiency (SLED) ☐ Other (specify)
6. Femoral Catheter in Situ ☐ No ☐ Yes → ☐ Venous ☐ Arterial ☐ Other (specify)

4. Routine PT (usual care) rehabilitation activities (check ALL received)

1. Target: Independent airway clearance

Complete? (Yes = complete row)	Physical Assistance				Instructions	Repetition	Feedback	Cues	Encouragement	Equipment (specify)
Respiratory Interventions <input type="checkbox"/> No <input type="checkbox"/> Yes →	Percussion	Vibration	Rib springs	Suctioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Target: Increase active ROM of limbs

Complete? (Yes = complete row)	Phys. Assist. (PROM, AAROM)		Instructions	Repetition	Feedback	Cues	Encouragement	Motivation	Equipment (specify)
Arms <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legs <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Target: Increase muscle strength

Complete? (Yes = complete row)	Physical Resistance			Instructions	Repetition	Feedback	Cues	Encouragement	Motivation	Equipment (specify)
	Therapist	Bands	Weights							
Arms <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legs <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Target: Independent transfers

Complete? (Yes = complete row)	Physical Assistance (People)				Instructions	Repetition	Feedback	Cues	Encouragement	Motivation	Equipment (specify)
	None	Ax1	Ax2	>Ax2							
Rolling <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lie to sit <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sit at EOB <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sit to stand <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bed to chair <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Target: Walking

Complete? (Yes = complete row)	Physical Assistance (People)				Instructions	Repetition	Feedback	Cues	Encouragement	Motivation	Equipment (specify)
	None	Ax1	Ax2	>Ax2							
Marching <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stairs <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Any safety events during routine PT/ rehab?

**stop session if any of these events occur: suspected new unstable/ uncontrolled arrhythmia, concern for MI, cardiac arrest, unplanned extubation, fall to knees

☐ No ☐ Yes (complete Safety Events Form 5S)

Comments



CYCLE RCT #142

Plate #030

Study
DayPatient ID 1
(site #) (patient #)Coded Patient Initials
F LTherapist(s) Initials
F M L F M LDate 2 0
(dd/mm/yyyy)

RT 300 ID

RT 300 PIN

PT THERAPY: CYCLING (Form 5C)

Day of
week
M Tu W Th F Sa Su

1. Cycling session start time (equipment prepped and enter room)

 : (24h-hr:min)

2. Pre-cycling therapy assessments

SAS / VAMASS → RASS Conversion Chart

1. RASS (-) (0 - 5)
☐ Not done ☐ (+)

SAS	1	2	X	3	X	4	5	6	7	X
RASS	-5	-4	-3	-2	-1	0	1	2	3	4
VAMASS	0	X	1	2	X	3	4	5	6	X

2. CAM-ICU

☐ Not done☐ Negative☐ Positive☐ Unable to Ax (RASS = -4 or -5)

*Scores ≥ 4 on Intensive Care Delirium Screening Checklist / ICDSC = CAM-ICU "Positive"

3. Vitals: Highest O₂ % received

[21% (room air) - 100%]

 (%)

4. ALL advanced life support strategies received DURING CYCLING today (check ALL that apply)

1. Airway Access ☐ No ☐ Yes → ☐ ETT ☐ Tracheostomy
2. Mechanical Ventilation (MV) ☐ No → None/Spontaneous (e.g. t-mask, venti-mask, nasal prongs)
☐ Yes → ☐ Invasive MV (e.g. pressure assist control, volume assist control, pressure support)
☐ Non-Invasive MV (e.g. BIPAP, CPAP by mask not ETT or trach, e.g., nocturnal)
3. Other Ventilation Strategy ☐ No ☐ Yes → ☐ ECMO/ECLS ☐ Nitric oxide ☐ High-flow nasal cannula ☐ Other (specify) (e.g. AIRVO, Optiflow)
4. Vasopressor / Inotrope ☐ No ☐ Yes
infusions (e.g., dopamine, norepinephrine, phenylephrine, epinephrine, milrinone, vasopressin)
5. Dialysis ☐ No ☐ Yes → ☐ Intermittent (IHD) ☐ Continuous (CRRT) ☐ Peritoneal ☐ Sustained low efficiency (SLED) ☐ Other (specify)
6. Femoral Catheter in Situ ☐ No ☐ Yes → ☐ Venous ☐ Arterial ☐ Other (specify)

5. CYCLING THERAPY

Session Duration (MIN, tablet; check all that apply)	Mode (Active, Passive)	Pedal Spd. (RPM)	Power (Watts)	Any active cycling	<input type="checkbox"/> Yes <input type="checkbox"/> No
5 <input type="checkbox"/> >0 and ≤5 mins	<input type="checkbox"/> A <input type="checkbox"/> P	<input type="text"/>	<input type="text"/>	Distance travelled (Bike Tablet)	<input type="text"/> (km)
10 <input type="checkbox"/> >5 and ≤10 mins	<input type="checkbox"/> A <input type="checkbox"/> P	<input type="text"/>	<input type="text"/>	Total therapy time (Bike Tablet)	<input type="text"/> (min:sec)
20 <input type="checkbox"/> >10 and ≤20 mins	<input type="checkbox"/> A <input type="checkbox"/> P	<input type="text"/>	<input type="text"/>	Time active (off motor) (Bike Tablet)	<input type="checkbox"/> N/A <input type="text"/> (min:sec)
				Time passive (on motor) (Bike Tablet)	<input type="checkbox"/> N/A <input type="text"/> (min:sec)

6. Did cycling finish before 30 minutes? ☐ No ☐ Yes (check ALL that apply)

- Patient's request ☐ Tired ☐ Other (specify) _____
- Therapist stopped session ☐ Agitation ☐ Cardiovascular (specify) _____ ☐ Respiratory (specify) _____ ☐ Other (specify) _____
- Physician stopped session ☐ (specify) _____
- Other ☐ (specify) _____

7. Any safety events during cycling therapy?

**stop session if any of these events occur: suspected new unstable/ uncontrolled arrhythmia, concern for MI, cardiac arrest, unplanned extubation

☐ No ☐ Yes (complete Safety Events Form 5S)

8. Cycling session end time (bike take down complete and end of cycling therapy portion of therapy session)

 : (24h-hr:min)

Comments _____



CYCLE RCT #142

Plate #035

Study
Day

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Patient ID

		1		
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(site #) (patient #)Coded Patient Initials

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F LDate

				2	0		
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(dd/mm/yyyy)**SAFETY EVENTS (Form 5S)****Complete this form if any safety events occurred during cycling or routine PT/ rehab****Cycling therapy safety events** - Did any of the following occur during cycling therapy? (check ALL that apply)

** = stop session if any of these events occur

1. ☐ **Suspected new unstable/ uncontrolled arrhythmia
2. ☐ **Concern for myocardial ischaemia
3. ☐ **Cardiac Arrest
4. ☐ **Unplanned extubation
5. ☐ Bleeding at femoral catheter site attributed to in-bed cycling
6. ☐ New bruising at femoral catheter site attributed to in-bed cycling
7. ☐ Sustained O₂ desaturation below baseline and clinical deterioration attributed to in-bed cycling
8. ☐ Sustained symptomatic bradycardia (<40 bpm) or tachycardia (>140 bpm) and clinical deterioration attributed to in-bed cycling
9. ☐ Sustained hypertension (mean arterial pressure >120 mmHg) and clinical deterioration attributed to in-bed cycling
10. ☐ Removal or dysfunction of intravascular catheter (e.g., central venous catheter, arterial line, dialysis catheter) attributed to in-bed cycling
11. ☐ Other (specify) _____
12. What were the consequences of the safety event(s)?
☐ None
☐ Cycling therapy stopped
☐ Other (specify) _____

Routine PT/rehab safety events - Did any of the following occur during routine PT/ rehab? (check ALL that apply)

** = stop session if any of these events occur

1. ☐ **Suspected new unstable/ uncontrolled arrhythmia
2. ☐ **Concern for myocardial ischaemia
3. ☐ **Cardiac Arrest
4. ☐ **Unplanned extubation
5. ☐ **Fall to knees
6. ☐ Bleeding at femoral catheter site attributed to routine PT/ rehab activities
7. ☐ New bruising at femoral catheter site attributed to routine PT/ rehab activities
8. ☐ Sustained O₂ desaturation below baseline and clinical deterioration attributed to routine PT/ rehab activities
9. ☐ Sustained symptomatic bradycardia (<40 bpm) or tachycardia (>140 bpm) and clinical deterioration attributed to routine PT/ rehab activities
10. ☐ Sustained hypertension (mean arterial pressure >120 mmHg) and clinical deterioration attributed to routine PT/ rehab activities
11. ☐ Removal or dysfunction of intravascular catheter (e.g., central venous catheter, arterial line, dialysis catheter) attributed to routine PT/ rehab activities
12. ☐ Other (specify) _____
13. What were the consequences of the safety event(s)?
☐ None
☐ Routine PT/ rehab stopped
☐ Other (specify) _____