Study ID Number

CADDRE

PEDIATRIC CHART

ABSTRACTION FORM

(11/16/2005)

Study ID Number

A. IDENTIFYING INFORMATION

1. Name (Last, First, Middle)	2. AKA	
3. Date of Birth _ _ /_ _/_ _ _ _	4. Child's SSN	5. Father's Name (Last, First)
6. Mother's Name (Last, First)	7. Maiden Name	8. Mother's SSN

CHILD'S ADDRESS HISTORY

9. Date _ _ /_ _/_ _ _ _	10. Child's Street Address		
11. City		12. State	13. Zip Code
14. Date _ _ /_ _/_ _ _ _	15. Child's Street Address		
16. City		17. State	18. Zip Code
19. Date _ _ /_ _/_ _ _ _	20. Child's Street Address		
21. City		22. State	23. Zip Code
24. Date _ _ /_ _/_ _ _ _	25. Child's Street Address		
26. City		27. State	28. Zip Code
29. Date _ _ /_ _/_ _ _ _	30. Child's Street Address		
31. City		32. State	33. Zip Code
34. Date _ _ /_ _/_ _ _ _	35. Child's Street Address		
36. City		37. State	38. Zip Code
39. Date _ _ /_ _/_ _ _ _	40. Child's Street Address		
41. City		42. State	43. Zip Code

Study ID Number

CLINIC INFORMATION			
44. Clinic Name	45. Child's Medical Record #		
46. Clinic Street Address	47. City	48. State	49. Zip Code
50. Provider's Name (Last, First, Degree)	51. Comments		
52. Date Abstracted __ __/__ __/__ __ __ __	53. Abstractor		
54. Start Time __ __ : __ __	55. Stop Time __ __ : __ __		

56. Clinic Name	57. Child's Medical Record #		
58. Clinic Street Address	59. City	60. State	61. Zip Code
62. Provider's Name (Last, First, Degree)	63. Comments		
64. Date Abstracted __ __/__ __/__ __ __ __	65. Abstractor		
66. Start Time __ __ : __ __	67. Stop Time __ __ : __ __		

68. Clinic Name	69. Child's Medical Record #		
70. Clinic Street Address	71. City	72. State	73. Zip Code
74. Provider's Name (Last, First, Degree)	75. Comments		
76. Date Abstracted __ __/__ __/__ __ __ __	77. Abstractor		
78. Start Time __ __ : __ __	79. Stop Time __ __ : __ __		

Study ID Number ☐

B. GROWTH AND ANTHROPOMETRIC MEASUREMENTS

1. Date of Exam	Weight	Height/Length	Head Circumference	**Birth Measurements**
_ _/_ _/_ _ _ _	1☐ Lbs _____ 2☐ Kg _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	
Comments/Referrals:				

2. Date of Exam	Weight	Height/Length	Head Circumference	Type of Exam
_ _/_ _/_ _ _ _	1☐ Lbs _____ 2☐ Kg _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ Well Care 2☐ Acute 3☐ Chronic 4☐ Dev/Psy 5☐ Other *(specify)* _____
Comments/Referrals:				

3. Date of Exam	Weight	Height/Length	Head Circumference	Type of Exam
_ _/_ _/_ _ _ _	1☐ Lbs _____ 2☐ Kg _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ Well Care 2☐ Acute 3☐ Chronic 4☐ Dev/Psy 5☐ Other *(specify)* _____
Comments/Referrals:				

4. Date of Exam	Weight	Height/Length	Head Circumference	Type of Exam
_ _/_ _/_ _ _ _	1☐ Lbs _____ 2☐ Kg _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ Well Care 2☐ Acute 3☐ Chronic 4☐ Dev/Psy 5☐ Other *(specify)* _____
Comments/Referrals:				

5. Date of Exam	Weight	Height/Length	Head Circumference	Type of Exam
_ _/_ _/_ _ _ _	1☐ Lbs _____ 2☐ Kg _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ Well Care 2☐ Acute 3☐ Chronic 4☐ Dev/Psy 5☐ Other *(specify)* _____
Comments/Referrals:				

6. Date of Exam	Weight	Height/Length	Head Circumference	Type of Exam
_ _/_ _/_ _ _ _	1☐ Lbs _____ 2☐ Kg _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ Well Care 2☐ Acute 3☐ Chronic 4☐ Dev/Psy 5☐ Other *(specify)* _____
Comments/Referrals:				

7. Date of Exam	Weight	Height/Length	Head Circumference	Type of Exam
_ _/_ _/_ _ _ _	1☐ Lbs _____ 2☐ Kg _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ Well Care 2☐ Acute 3☐ Chronic 4☐ Dev/Psy 5☐ Other *(specify)* _____
Comments/Referrals:				

Study ID Number _____

B. GROWTH AND ANTHROPOMETRIC MEASUREMENTS (cont'd)

8. Date of Exam _ _/_ _/_ _ _ _	Weight 1☐ Lbs _____ 2☐ Kg _____ 3☐ %ile	Height/Length 1☐ in _____ 2☐ cm _____ 3☐ %ile	Head Circumference 1☐ in _____ 2☐ cm _____ 3☐ %ile	Type of Exam 1☐ Well Care 2☐ Acute 3☐ Chronic 4☐ Dev/Psy 5☐ Other *(specify)* _____
Comments/Referrals:				
9. Date of Exam _ _/_ _/_ _ _ _	Weight 1☐ Lbs _____ 2☐ Kg _____ 3☐ %ile	Height/Length 1☐ in _____ 2☐ cm _____ 3☐ %ile	Head Circumference 1☐ in _____ 2☐ cm _____ 3☐ %ile	Type of Exam 1☐ Well Care 2☐ Acute 3☐ Chronic 4☐ Dev/Psy 5☐ Other *(specify)* _____
Comments/Referrals:				
10. Date of Exam _ _/_ _/_ _ _ _	Weight 1☐ Lbs _____ 2☐ Kg _____ 3☐ %ile	Height/Length 1☐ in _____ 2☐ cm _____ 3☐ %ile	Head Circumference 1☐ in _____ 2☐ cm _____ 3☐ %ile	Type of Exam 1☐ Well Care 2☐ Acute 3☐ Chronic 4☐ Dev/Psy 5☐ Other *(specify)* _____
Comments/Referrals:				
11. Date of Exam _ _/_ _/_ _ _ _	Weight 1☐ Lbs _____ 2☐ Kg _____ 3☐ %ile	Height/Length 1☐ in _____ 2☐ cm _____ 3☐ %ile	Head Circumference 1☐ in _____ 2☐ cm _____ 3☐ %ile	Type of Exam 1☐ Well Care 2☐ Acute 3☐ Chronic 4☐ Dev/Psy 5☐ Other *(specify)* _____
Comments/Referrals:				
12. Date of Exam _ _/_ _/_ _ _ _	Weight 1☐ Lbs _____ 2☐ Kg _____ 3☐ %ile	Height/Length 1☐ in _____ 2☐ cm _____ 3☐ %ile	Head Circumference 1☐ in _____ 2☐ cm _____ 3☐ %ile	Type of Exam 1☐ Well Care 2☐ Acute 3☐ Chronic 4☐ Dev/Psy 5☐ Other *(specify)* _____
Comments/Referrals:				
13. Date of Exam _ _/_ _/_ _ _ _	Weight 1☐ Lbs _____ 2☐ Kg _____ 3☐ %ile	Height/Length 1☐ in _____ 2☐ cm _____ 3☐ %ile	Head Circumference 1☐ in _____ 2☐ cm _____ 3☐ %ile	Type of Exam 1☐ Well Care 2☐ Acute 3☐ Chronic 4☐ Dev/Psy 5☐ Other *(specify)* _____
Comments/Referrals:				
14. Date of Exam _ _/_ _/_ _ _ _	Weight 1☐ Lbs _____ 2☐ Kg _____ 3☐ %ile	Height/Length 1☐ in _____ 2☐ cm _____ 3☐ %ile	Head Circumference 1☐ in _____ 2☐ cm _____ 3☐ %ile	Type of Exam 1☐ Well Care 2☐ Acute 3☐ Chronic 4☐ Dev/Psy 5☐ Other *(specify)* _____
Comments/Referrals:				

B. GROWTH AND ANTHROPOMETRIC MEASUREMENTS (cont'd)

15. Date of Exam	Weight	Height/Length	Head Circumference	Type of Exam
_ _/_ _/_ _ _ _	1☐ Lbs _____ 2☐ Kg _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ Well Care 2☐ Acute 3☐ Chronic 4☐ Dev/Psy 5☐ Other *(specify)* _____
Comments/Referrals:				
16. Date of Exam	Weight	Height/Length	Head Circumference	Type of Exam
_ _/_ _/_ _ _ _	1☐ Lbs _____ 2☐ Kg _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ Well Care 2☐ Acute 3☐ Chronic 4☐ Dev/Psy 5☐ Other *(specify)* _____
Comments/Referrals:				
17. Date of Exam	Weight	Height/Length	Head Circumference	Type of Exam
_ _/_ _/_ _ _ _	1☐ Lbs _____ 2☐ Kg _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ Well Care 2☐ Acute 3☐ Chronic 4☐ Dev/Psy 5☐ Other *(specify)* _____
Comments/Referrals:				
18. Date of Exam	Weight	Height/Length	Head Circumference	Type of Exam
_ _/_ _/_ _ _ _	1☐ Lbs _____ 2☐ Kg _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ Well Care 2☐ Acute 3☐ Chronic 4☐ Dev/Psy 5☐ Other *(specify)* _____
Comments/Referrals:				
19. Date of Exam	Weight	Height/Length	Head Circumference	Type of Exam
_ _/_ _/_ _ _ _	1☐ Lbs _____ 2☐ Kg _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ Well Care 2☐ Acute 3☐ Chronic 4☐ Dev/Psy 5☐ Other *(specify)* _____
Comments/Referrals:				
20. Date of Exam	Weight	Height/Length	Head Circumference	Type of Exam
_ _/_ _/_ _ _ _	1☐ Lbs _____ 2☐ Kg _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ Well Care 2☐ Acute 3☐ Chronic 4☐ Dev/Psy 5☐ Other *(specify)* _____
Comments/Referrals:				
21. Date of Exam	Weight	Height/Length	Head Circumference	Type of Exam
_ _/_ _/_ _ _ _	1☐ Lbs _____ 2☐ Kg _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ Well Care 2☐ Acute 3☐ Chronic 4☐ Dev/Psy 5☐ Other *(specify)* _____
Comments/Referrals:				

Study ID Number

B. GROWTH AND ANTHROPOMETRIC MEASUREMENTS (cont'd)

22. Date of Exam	Weight	Height/Length	Head Circumference	Type of Exam
_ _/_ _/_ _ _ _	1☐ Lbs _____ 2☐ Kg _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ Well Care 2☐ Acute 3☐ Chronic 4☐ Dev/Psy 5☐ Other *(specify)* _____
Comments/Referrals:				
23. Date of Exam	Weight	Height/Length	Head Circumference	Type of Exam
_ _/_ _/_ _ _ _	1☐ Lbs _____ 2☐ Kg _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ Well Care 2☐ Acute 3☐ Chronic 4☐ Dev/Psy 5☐ Other *(specify)* _____
Comments/Referrals:				
24. Date of Exam	Weight	Height/Length	Head Circumference	Type of Exam
_ _/_ _/_ _ _ _	1☐ Lbs _____ 2☐ Kg _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ Well Care 2☐ Acute 3☐ Chronic 4☐ Dev/Psy 5☐ Other *(specify)* _____
Comments/Referrals:				
25. Date of Exam	Weight	Height/Length	Head Circumference	Type of Exam
_ _/_ _/_ _ _ _	1☐ Lbs _____ 2☐ Kg _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ Well Care 2☐ Acute 3☐ Chronic 4☐ Dev/Psy 5☐ Other *(specify)* _____
Comments/Referrals:				
26. Date of Exam	Weight	Height/Length	Head Circumference	Type of Exam
_ _/_ _/_ _ _ _	1☐ Lbs _____ 2☐ Kg _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ Well Care 2☐ Acute 3☐ Chronic 4☐ Dev/Psy 5☐ Other *(specify)* _____
Comments/Referrals:				
27. Date of Exam	Weight	Height/Length	Head Circumference	Type of Exam
_ _/_ _/_ _ _ _	1☐ Lbs _____ 2☐ Kg _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ Well Care 2☐ Acute 3☐ Chronic 4☐ Dev/Psy 5☐ Other *(specify)* _____
Comments/Referrals:				
28. Date of Exam	Weight	Height/Length	Head Circumference	Type of Exam
_ _/_ _/_ _ _ _	1☐ Lbs _____ 2☐ Kg _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ in _____ 2☐ cm _____ 3☐ %ile	1☐ Well Care 2☐ Acute 3☐ Chronic 4☐ Dev/Psy 5☐ Other *(specify)* _____
Comments/Referrals:				

Study ID Number

C. MEDICAL HISTORY ☐ NO INFO

Medical Problem Codes: See Medical Problem List

Precision Codes: 1= Possible, 2= Probable, 3= R/O, 4= Definite, 9= Unknown

Specialty Codes: 1=Pediatrician, 2=Physician Asst., 3=Nurse, 4=Family Physician, 5=Developmental Pediatrician, 6=Geneticist, 7= Neurologist, 8=Immunologist, 9=Gastroenterologist, 10=MD, Not specified, 88=Other *(specify)*, 99=Unknown

If 'yes' is indicated for Medications Given then fill out Section I.

No.	Problem Code	Precision Code	Specialty Code	Date Diagnosed	Meds Give	Referral Given
1.				_ _/_ _/_ _ _ _ 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
2.				_ _/_ _/_ _ _ _ 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
3.				_ _/_ _/_ _ _ _ 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
4.				_ _/_ _/_ _ _ _ 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
5.				_ _/_ _/_ _ _ _ 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
6.				_ _/_ _/_ _ _ _ 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
7.				_ _/_ _/_ _ _ _ 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
8.				_ _/_ _/_ _ _ _ 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
9.				_ _/_ _/_ _ _ _ 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
10.				_ _/_ _/_ _ _ _ 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐	1 ☐ Yes 2 ☐ No 9 ☐ Unknown

Comments

Study ID Number _____

D. INFECTION HISTORY ☐ NO INFO

Infection Codes: see infection code sheet

If 'yes' is indicated for Medications then fill out Section I. If 'yes' is indicated for Fever then fill out Section H.

If a culture was performed then fill out Section E. If child was hospitalized then fill out Section F.

No.	Infection Code	Date Diagnosed	Certainty of Dx	Duration	Highest Temp	Cultures	Medication
1.		_ _/_ _/_ _ _ _ 9 ☐ Unknown	1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	__ __ __ days 9 ☐ Unknown	°C_____ °F_____ 1. • No temp 999. • Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unk	1 ☐ Yes 2 ☐ No 9 ☐ Unk
2.		_ _/_ _/_ _ _ _ 9 ☐ Unknown	1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	__ __ __ days 9 ☐ Unknown	°C_____ °F_____ 1. • No temp 999. • Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unk	1 ☐ Yes 2 ☐ No 9 ☐ Unk
3.		_ _/_ _/_ _ _ _ 9 ☐ Unknown	1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	__ __ __ days 9 ☐ Unknown	°C_____ °F_____ 1. • No temp 999. • Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unk	1 ☐ Yes 2 ☐ No 9 ☐ Unk
4.		_ _/_ _/_ _ _ _ 9 ☐ Unknown	1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	__ __ __ days 9 ☐ Unknown	°C_____ °F_____ 1. • No temp 999. • Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unk	1 ☐ Yes 2 ☐ No 9 ☐ Unk
5.		_ _/_ _/_ _ _ _ 9 ☐ Unknown	1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	__ __ __ days 9 ☐ Unknown	°C_____ °F_____ 1. • No temp 999. • Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unk	1 ☐ Yes 2 ☐ No 9 ☐ Unk
6.		_ _/_ _/_ _ _ _ 9 ☐ Unknown	1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	__ __ __ days 9 ☐ Unknown	°C_____ °F_____ 1. • No temp 999. • Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unk	1 ☐ Yes 2 ☐ No 9 ☐ Unk
7.		_ _/_ _/_ _ _ _ 9 ☐ Unknown	1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	__ __ __ days 9 ☐ Unknown	°C_____ °F_____ 1. • No temp 999. • Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unk	1 ☐ Yes 2 ☐ No 9 ☐ Unk

Comments

Study ID Number ☐

E. CULTURES ☐ NO INFO

Source: 1 = urine, 2 = blood, 3 = sputum, 4 = stool, 5 = cerebral spinal fluid, 8= other, 9= unknown
Refer: Use event number from Section E for Refer number (i.e. E1).

No.	Refer	Date Cultured	Source	Results	Description (organisms, etc.)
1.		__ __/__ __/__ __ __ __ 9 ☐ Unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specified 99. • Unknown	
2.		__ __/__ __/__ __ __ __ 9 ☐ Unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specified 99. • Unknown	
3.		__ __/__ __/__ __ __ __ 9 ☐ Unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specified 99. • Unknown	
4.		__ __/__ __/__ __ __ __ 9 ☐ Unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specified 99. • Unknown	
5.		__ __/__ __/__ __ __ __ 9 ☐ Unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specified 99. • Unknown	
6.		__ __/__ __/__ __ __ __ 9 ☐ Unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specified 99. • Unknown	
7.		__ __/__ __/__ __ __ __ 9 ☐ Unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specified 99. • Unknown	
8.		__ __/__ __/__ __ __ __ 9 ☐ Unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specified 99. • Unknown	
9.		__ __/__ __/__ __ __ __ 9 ☐ Unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specified 99. • Unknown	
10.		__ __/__ __/__ __ __ __ 9 ☐ Unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specified 99. • Unknown	
11.		__ __/__ __/__ __ __ __ 9 ☐ Unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specified 99. • Unknown	
12.		__ __/__ __/__ __ __ __ 9 ☐ Unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specified 99. • Unknown	
13.		__ __/__ __/__ __ __ __ 9 ☐ Unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specified 99. • Unknown	
14.		__ __/__ __/__ __ __ __ 9 ☐ Unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specified 99. • Unknown	

Comments

Study ID Number _____

F. HOSPITALIZATIONS ☐ NO INFO

Problem/Infection Code: See Appendix A for list of codes.

*** If 'yes' is checked for Culture, Fever, or Medications, then complete the respective sections (E, H, I).**

Hospital/Facility Name	Type of Visit 1 ☐ ER Observe 3 ☐ ER Admit 2 ☐ ER Only 4 ☐ Elective 8 ☐ Other *(specify)* _____	Admit Date _ _/_ _/_ _ _ _	Discharge Date _ _/_ _/_ _ _ _

	Dx1	Dx2	Dx3	Dx4	Dx5	Dx6
ICD9 or CPT Code						
Name						
Problem/Infxn Code						

Cultures	Fever	Medications Given	Injury	Surgery
1 ☐ Yes	1 ☐ Yes	1 ☐ Yes	1 ☐ Yes *(specify below)*	1 ☐ Yes *(specify below)*
2 ☐ No	2 ☐ No	2 ☐ No	2 ☐ No	2 ☐ No
9 ☐ Unknown	9 ☐ Unknown	9 ☐ Unknown	9 ☐ Unknown	9 ☐ Unknown

Injury Comments:	Surgery Details 1 ☐ Radiology 2 ☐ Other Procedure(s) *(specify below)* Comments:

Hospital/Facility Name	Type of Visit 1 ☐ ER Observe 3 ☐ ER Admit 2 ☐ ER Only 4 ☐ Elective 8 ☐ Other *(specify)* _____	Admit Date _ _/_ _/_ _ _ _	Discharge Date _ _/_ _/_ _ _ _

	Dx1	Dx2	Dx3	Dx4	Dx5	Dx6
ICD9 or CPT Code						
Name						
Problem/Infxn Code						

Cultures	Fever	Medications Given	Injury	Surgery
1 ☐ Yes	1 ☐ Yes	1 ☐ Yes	1 ☐ Yes *(specify below)*	1 ☐ Yes *(specify below)*
2 ☐ No	2 ☐ No	2 ☐ No	2 ☐ No	2 ☐ No
9 ☐ Unknown	9 ☐ Unknown	9 ☐ Unknown	9 ☐ Unknown	9 ☐ Unknown

Injury Comments:	Surgery Details 1 ☐ Radiology 2 ☐ Other Procedure(s) *(specify below)* Comments:

Study ID Number _____

G. IMMUNIZATIONS

Vaccine codes

1. DtaP
2. Hib
3. HepA
4. HepB
5. MMR
6. Polio IPV
7. Varicella Zoster
8. PCV
9. PPV
88. Other *(specify)*
99. Unknown

Manufacturer codes

1. AVP (Aventis Pasteur)
2. CHI (Chiron)
3. CONN (Connetics)
4. GSK (GlaxoSmithKline)
5. LED (Lederle)
6. MER (Merck)
7. SKB (SmithKlineBeecham)
8. WYE (Wyeth Ayerst)
88. Other *(specify)*
99. Unknown

Vaccine Information							Adverse Reaction Information		
No.	**Date**	**Vaccine Code**	**Manufacturer Code**	**Lot Number**	**Dose**	**Adverse Reaction**	**Date & Type of Contact**	**Describe Reaction (check all that apply)**	**Medications Given For Reaction***
1.	_ _/_ _/_ _ _ _					1☐ Yes 2 ☐ No 9 ☐ Unknown	_ _/_ _/_ _ _ _ 1☐ Phone/E-mail 2☐ Visit	1☐ Rash 3☐ Seizures 2☐ Fever 8☐ Other *(specify)* _____	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
2.	_ _/_ _/_ _ _ _					1☐ Yes 2 ☐ No 9 ☐ Unknown	_ _/_ _/_ _ _ _ 1☐ Phone/E-mail 2☐ Visit	1☐ Rash 3☐ Seizures 2☐ Fever 8☐ Other *(specify)* _____	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
3.	_ _/_ _/_ _ _ _					1☐ Yes 2 ☐ No 9 ☐ Unknown	_ _/_ _/_ _ _ _ 1☐ Phone/E-mail 2☐ Visit	1☐ Rash 3☐ Seizures 2☐ Fever 8☐ Other *(specify)* _____	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
4.	_ _/_ _/_ _ _ _					1☐ Yes 2 ☐ No 9 ☐ Unknown	_ _/_ _/_ _ _ _ 1☐ Phone/E-mail 2☐ Visit	1☐ Rash 3☐ Seizures 2☐ Fever 8☐ Other *(specify)* _____	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
5.	_ _/_ _/_ _ _ _					1☐ Yes 2 ☐ No 9 ☐ Unknown	_ _/_ _/_ _ _ _ 1☐ Phone/E-mail 2☐ Visit	1☐ Rash 3☐ Seizures 2☐ Fever 8☐ Other *(specify)* _____	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
6.	_ _/_ _/_ _ _ _					1☐ Yes 2 ☐ No 9 ☐ Unknown	_ _/_ _/_ _ _ _ 1☐ Phone/E-mail 2☐ Visit	1☐ Rash 3☐ Seizures 2☐ Fever 8☐ Other *(specify)* _____	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
7.	_ _/_ _/_ _ _ _					1☐ Yes 2 ☐ No 9 ☐ Unknown	_ _/_ _/_ _ _ _ 1☐ Phone/E-mail 2☐ Visit	1☐ Rash 3☐ Seizures 2☐ Fever 8☐ Other *(specify)* _____	1 ☐ Yes 2 ☐ No 9 ☐ Unknown

Study ID Number

H. FEVER ☐ NO INFO

Children ≤ 8 weeks of age: Axillary Temps: Record temperatures ≥ 36.9ºC (98.4ºF)
Rectal Temps: Record temperatures ≥ 38.0ºC (100.4ºF)

Children > 8 weeks of age: Oral Temps: Record temperatures ≥ 38.6ºC (101.5ºF)
Axillary Temps: Record temperatures ≥ 38.1ºC (100.5ºF)
Rectal Temps: Record temperatures ≥ 39.2ºC (102.5ºF)

Indicate the event number from the appropriate Section for Refer No. (i.e. I3).
If 'yes' is indicated for Medications Given, please fill out Section I.

	Refer No.	Date	Duration	Highest temp	Mode	Medication Given	Comments
1	_____ 9 ☐ NA	_ _/_ _/_ _ _ _	_____ hours _____ days 9 ☐ Unk	_____ 1 ☐ ºC 2 ☐ ºF	1 ☐ Oral 2 ☐ Axillary 3 ☐ Rectal 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	
2	_____ 9 ☐ NA	_ _/_ _/_ _ _ _	_____ hours _____ days 9 ☐ Unk	_____ 1 ☐ ºC 2 ☐ ºF	1 ☐ Oral 2 ☐ Axillary 3 ☐ Rectal 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	
3	_____ 9 ☐ NA	_ _/_ _/_ _ _ _	_____ hours _____ days 9 ☐ Unk	_____ 1 ☐ ºC 2 ☐ ºF	1 ☐ Oral 2 ☐ Axillary 3 ☐ Rectal 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	
4	_____ 9 ☐ NA	_ _/_ _/_ _ _ _	_____ hours _____ days 9 ☐ Unk	_____ 1 ☐ ºC 2 ☐ ºF	1 ☐ Oral 2 ☐ Axillary 3 ☐ Rectal 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	
5	_____ 9 ☐ NA	_ _/_ _/_ _ _ _	_____ hours _____ days 9 ☐ Unk	_____ 1 ☐ ºC 2 ☐ ºF	1 ☐ Oral 2 ☐ Axillary 3 ☐ Rectal 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	
6	_____ 9 ☐ NA	_ _/_ _/_ _ _ _	_____ hours _____ days 9 ☐ Unk	_____ 1 ☐ ºC 2 ☐ ºF	1 ☐ Oral 2 ☐ Axillary 3 ☐ Rectal 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	
7	_____ 9 ☐ NA	_ _/_ _/_ _ _ _	_____ hours _____ days 9 ☐ Unk	_____ 1 ☐ ºC 2 ☐ ºF	1 ☐ Oral 2 ☐ Axillary 3 ☐ Rectal 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	

Comments

Study ID Number ☐

I. MEDICATIONS ☐ NO INFO

Refer No.: Please indicate the event number from the appropriate section for Refer No., otherwise enter the reason from medical chart.

Drug codes: 9= steroids (lung maturity) 10= antidiabetics, 11= steroids (other), 12= hormones, 13= thyroid, 14= antibiotics, 15= antifungals, 16= antivirals, 17= anesthetics, 18= anticonvulsants, 19= analgesics/hypnotics/sedatives/antipsychotics, 20 = antihypertensives/diuretics, 21= cardiovascular, 22= narcotic antagonists, 23= ergotrate, 24=antidepressants, 25= prenatal vitamins, 26= asthma, 27= preterm labor prevention,88= other (specify), 99= unknown

Reason: Specify

	Refer No.	Code	Drug Name	Reason	Start Date/Time	Duration (in days)	Dose	Unit	Frequency
1					_ _ /_ _ /_ _ _ _ 9 ☐ Unknown	_____	_____ ☐ Variable	1 ☐ gm 2 ☐ mg 3 ☐ mcg 4 ☐ mU 5 ☐ cc/ml 8 ☐ other	1 ☐ QD 2 ☐ BID 3 ☐ TID 4 ☐ QID 5 ☐ PRN 6 Every ___ hrs 7 ☐ Per week 8 ☐ Total Dose 9 ☐ No Info
2					_ _ /_ _ /_ _ _ _ 9 ☐ Unknown	_____	_____ ☐ Variable	1 ☐ gm 2 ☐ mg 3 ☐ mcg 4 ☐ mU 5 ☐ cc/ml 8 ☐ other	1 ☐ QD 2 ☐ BID 3 ☐ TID 4 ☐ QID 5 ☐ PRN 6 Every ___ hrs 7 ☐ Per week 8 ☐ Total Dose 9 ☐ No Info

Study ID Number

I. MEDICATIONS									☐ **NO INFO**
3					_ _ /_ _ /_ _ _ _ 9 ☐ Unknown	_____	_____ ☐ Variable	1 ☐ gm 2 ☐ mg 3 ☐ mcg 4 ☐ mU 5 ☐ cc/ml 8 ☐ other	1 ☐ QD 2 ☐ BID 3 ☐ TID 4 ☐ QID 5 ☐ PRN 6 Every ___ hrs 7 ☐ Per week 8 ☐ Total Dose 9 ☐ No Info
4					_ _ /_ _ /_ _ _ _ 9 ☐ Unknown	_____	_____ ☐ Variable	1 ☐ gm 2 ☐ mg 3 ☐ mcg 4 ☐ mU 5 ☐ cc/ml 8 ☐ other	1 ☐ QD 2 ☐ BID 3 ☐ TID 4 ☐ QID 5 ☐ PRN 6 Every ___ hrs 7 ☐ Per week 8 ☐ Total Dose 9 ☐ No Info
5					_ _ /_ _ /_ _ _ _ 9 ☐ Unknown	_____	_____ ☐ Variable	1 ☐ gm 2 ☐ mg 3 ☐ mcg 4 ☐ mU 5 ☐ cc/ml 8 ☐ other	1 ☐ QD 2 ☐ BID 3 ☐ TID 4 ☐ QID 5 ☐ PRN 6 Every ___ hrs 7 ☐ Per week 8 ☐ Total Dose 9 ☐ No Info

Study ID Number

I. MEDICATIONS									☐ NO INFO
6					_ _ /_ _ /_ _ _ _ 9 ☐ Unknown	_____	_____ ☐ Variable	1 ☐ gm 2 ☐ mg 3 ☐ mcg 4 ☐ mU 5 ☐ cc/ml 8 ☐ other	1 ☐ QD 2 ☐ BID 3 ☐ TID 4 ☐ QID 5 ☐ PRN 6 Every ___ hrs 7 ☐ Per week 8 ☐ Total Dose 9 ☐ No Info
7					_ _ /_ _ /_ _ _ _ 9 ☐ Unknown	_____	_____ ☐ Variable	1 ☐ gm 2 ☐ mg 3 ☐ mcg 4 ☐ mU 5 ☐ cc/ml 8 ☐ other	1 ☐ QD 2 ☐ BID 3 ☐ TID 4 ☐ QID 5 ☐ PRN 6 Every ___ hrs 7 ☐ Per week 8 ☐ Total Dose 9 ☐ No Info
8					_ _ /_ _ /_ _ _ _ 9 ☐ Unknown	_____	_____ ☐ Variable	1 ☐ gm 2 ☐ mg 3 ☐ mcg 4 ☐ mU 5 ☐ cc/ml 8 ☐ other	1 ☐ QD 2 ☐ BID 3 ☐ TID 4 ☐ QID 5 ☐ PRN 6 Every ___ hrs 7 ☐ Per week 8 ☐ Total Dose 9 ☐ No Info

Study ID Number

J. CRANIAL STUDIES (EEG, MRI AND CT SCAN) ☐ NO INFO

Please abstract all ultrasounds, unless the findings are clearly the same.
Code: 1 = EEG, 2 = Cranial MRI, 3 = CT scan, 8 = Other *(specify in comments)*

1. Date __ __/__ __/__ __ __ __	Code	Results 1☐ Normal 3☐ Equivocal 2☐ Abnormal 9☐ Unknown	Final Impression	Comments
2. Date __ __/__ __/__ __ __ __	Code	Results 1☐ Normal 3☐ Equivocal 2☐ Abnormal 9☐ Unknown	Final Impression	Comments
3. Date __ __/__ __/__ __ __ __	Code	Results 1☐ Normal 3☐ Equivocal 2☐ Abnormal 9☐ Unknown	Final Impression	Comments

CRANIAL ULTRASOUNDS

Please abstract all ultrasounds, unless the findings are clearly the same.

1. Date _ _/_ _/_ _ _ _ — Results 1☐ Normal 2☐ Abnormal

Hemisphere: *1 = Right, 2 = Left, 3 = Bilateral, 9 = NK*
Location: *1 = Anterior/Frontal, 2 = Posterior/Occipital, 3 = Parietal, 4 = Temporal, 9 = NK*
Size: *1 = Small/Mild, 2 = Medium/Moderate, 3 = Large/Severe, 9 = NK*

	Findings *(1= No, 2= Definite, 3=Suspect)*	H	L	S	Description/Comments
	Ventriculomegaly				
	Echodensity/echogenicity				
	Echolucency				
	IVH grade _____				
	Germinal matrix bleed (Grade I IVH)				
	Other bleed				
	PVL/cavitation/white matter necrosis				
	Malformation				
	Subarachnoid hemorrhage/blood				
	Other findings, specify.				

2. Date _ _/_ _/_ _ _ _ — Results 1☐ Normal 2☐ Abnormal

Hemisphere: *1 = Right, 2 = Left, 3 = Bilateral, 9 = NK*
Location: *1 = Anterior/Frontal, 2 = Posterior/Occipital, 3 = Parietal, 4 = Temporal, 9 = NK*
Size: *1 = Small/Mild, 2 = Medium/Moderate, 3 = Large/Severe, 9 = NK*

	Findings *(1= No, 2= Definite, 3=Suspect)*	H	L	S	Description/Comments
	Ventriculomegaly				
	Echodensity/echogenicity				
	Echolucency				
	IVH grade _____				
	Germinal matrix bleed (Grade I IVH)				
	Other bleed				
	PVL/cavitation/white matter necrosis				
	Malformation				
	Subarachnoid hemorrhage/blood				
	Other findings, specify.				

Study ID Number

3. Date _ _/_ _/_ _ _ _	Results 1☐ Normal 2☐ Abnormal	***Hemisphere:*** *1 = Right, 2 = Left, 3 = Bilateral, 9 = NK* ***Location:*** *1 = Anterior/Frontal, 2 = Posterior/Occipital, 3 = Parietal, 4 = Temporal, 9 = NK* ***Size:*** *1 = Small/Mild, 2 = Medium/Moderate, 3 = Large/Severe, 9 = NK*			
Findings *(1= No, 2= Definite, 3=Suspect)*		**H**	**L**	**S**	**Description/Comments**
Ventriculomegaly					
Echodensity/echogenicity					
Echolucency					
IVH grade _____					
Germinal matrix bleed (Grade I IVH)					
Other bleed					
PVL/cavitation/white matter necrosis					
Malformation					
Subarachnoid hemorrhage/blood					
Other findings, specify.					

4. Date _ _/_ _/_ _ _ _	Results 1☐ Normal 2☐ Abnormal	***Hemisphere:*** *1 = Right, 2 = Left, 3 = Bilateral, 9 = NK* ***Location:*** *1 = Anterior/Frontal, 2 = Posterior/Occipital, 3 = Parietal, 4 = Temporal, 9 = NK* ***Size:*** *1 = Small/Mild, 2 = Medium/Moderate, 3 = Large/Severe, 9 = NK*			
Findings *(1= No, 2= Definite, 3=Suspect)*		**H**	**L**	**S**	**Description/Comments**
Ventriculomegaly					
Echodensity/echogenicity					
Echolucency					
IVH grade _____					
Germinal matrix bleed (Grade I IVH)					
Other bleed					
PVL/cavitation/white matter necrosis					
Malformation					
Subarachnoid hemorrhage/blood					
Other findings, specify.					

Study ID Number

K. OTHER PROCEDURE OR STUDY (ECG, CHEST X-RAY, GENETIC STUDY, ETC.)

☐ **NO INFO**

Refer No.: Please indicate the event number from the appropriate section (e.g. D2 – for Section D, #2), otherwise enter the reason from the chart.

		Refer No./ Reason	Type of Procedure	Date	Outcome
1.				_ _/_ _/_ _ _ _	
2.				_ _/_ _/_ _ _ _	
3.				_ _/_ _/_ _ _ _	
4.				_ _/_ _/_ _ _ _	
5.				_ _/_ _/_ _ _ _	
6.				_ _/_ _/_ _ _ _	
7.				_ _/_ _/_ _ _ _	
8.				_ _/_ _/_ _ _ _	
9.				_ _/_ _/_ _ _ _	
10.				_ _/_ _/_ _ _ _	

Study ID Number

L. NEWBORN SCREENING RESULTS ☐ NO INFO

☑ Check the box in front of the test if it was performed, and complete the results.

	Biotinidase Date: __ __/__ __/__ __ __ __ Results: 1☐ Normal 2☐ Abnormal 9 ☐ Unknown		**Homocystinuria** Date: __ __/__ __/__ __ __ __ Results: 1☐ Normal 2☐ Abnormal 9 ☐ Unknown		**Toxoplasmosis** Date: __ __/__ __/__ __ __ __ Results: 1☐ Normal 2☐ Abnormal 9 ☐ Unknown
	Congenital Adrenal Hyperplasia (CAH) Date: __ __/__ __/__ __ __ __ Results: 1☐ Normal 2☐ Abnormal 9 ☐ Unknown		**Hypothyroidism** Date: __ __/__ __/__ __ __ __ Results: 1☐ Normal 2☐ Abnormal 9 ☐ Unknown		**Tyrosinemia** Date: __ __/__ __/__ __ __ __ Results: 1☐ Normal 2☐ Abnormal 9 ☐ Unknown
	Cystic Fibrosis Date: __ __/__ __/__ __ __ __ Results: 1☐ Normal 2☐ Abnormal 9 ☐ Unknown		**Maple Syrup Urine Disease** Date: __ __/__ __/__ __ __ __ Results: 1☐ Normal 2☐ Abnormal 9 ☐ Unknown		**Glucose-6-dehydrogenase** Date: __ __/__ __/__ __ __ __ Results: 1☐ Normal 2☐ Abnormal 9 ☐ Unknown
	Galactosemia Date: __ __/__ __/__ __ __ __ Results: 1☐ Normal 2☐ Abnormal 9 ☐ Unknown		**Phenylketonuria/PKU** Date: __ __/__ __/__ __ __ __ Results: 1☐ Normal 2☐ Abnormal 9 ☐ Unknown		**Sickle Cell Anemia** Date: __ __/__ __/__ __ __ __ Results: 1☐ Normal 2☐ Abnormal 9 ☐ Unknown
	Other *(specify)* _____ Date: __ __/__ __/__ __ __ __ Results: 1☐ Normal 2☐ Abnormal 9 ☐ Unknown		**Other *(specify)*** _____ Date: __ __/__ __/__ __ __ __ Results: 1☐ Normal 2☐ Abnormal 9 ☐ Unknown		**Other *(specify)*** _____ Date: __ __/__ __/__ __ __ __ Results: 1☐ Normal 2☐ Abnormal 9 ☐ Unknown