

CADDRE

PEDIATRIC CHART

ABSTRACTION FORM

(11/16/2005)

Study ID
Number

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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 ____ : ____		

B. GROWTH AND ANTHROPOMETRIC MEASUREMENTS				
1. Date of Exam _ / _ / _	Weight _____ 1 <input type="checkbox"/> Lbs _____ 2 <input type="checkbox"/> Kg _____ 3 <input type="checkbox"/> %ile	Height/Length _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Head Circumference _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Birth Measurements
Comments/Referrals:				
2. Date of Exam _ / _ / _	Weight _____ 1 <input type="checkbox"/> Lbs _____ 2 <input type="checkbox"/> Kg _____ 3 <input type="checkbox"/> %ile	Height/Length _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Head Circumference _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Type of Exam 1 <input type="checkbox"/> Well Care 2 <input type="checkbox"/> Acute 3 <input type="checkbox"/> Chronic 4 <input type="checkbox"/> Dev/Psy 5 <input type="checkbox"/> Other (<i>specify</i>) _____
Comments/Referrals:				
3. Date of Exam _ / _ / _	Weight _____ 1 <input type="checkbox"/> Lbs _____ 2 <input type="checkbox"/> Kg _____ 3 <input type="checkbox"/> %ile	Height/Length _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Head Circumference _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Type of Exam 1 <input type="checkbox"/> Well Care 2 <input type="checkbox"/> Acute 3 <input type="checkbox"/> Chronic 4 <input type="checkbox"/> Dev/Psy 5 <input type="checkbox"/> Other (<i>specify</i>) _____
Comments/Referrals:				
4. Date of Exam _ / _ / _	Weight _____ 1 <input type="checkbox"/> Lbs _____ 2 <input type="checkbox"/> Kg _____ 3 <input type="checkbox"/> %ile	Height/Length _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Head Circumference _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Type of Exam 1 <input type="checkbox"/> Well Care 2 <input type="checkbox"/> Acute 3 <input type="checkbox"/> Chronic 4 <input type="checkbox"/> Dev/Psy 5 <input type="checkbox"/> Other (<i>specify</i>) _____
Comments/Referrals:				
5. Date of Exam _ / _ / _	Weight _____ 1 <input type="checkbox"/> Lbs _____ 2 <input type="checkbox"/> Kg _____ 3 <input type="checkbox"/> %ile	Height/Length _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Head Circumference _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Type of Exam 1 <input type="checkbox"/> Well Care 2 <input type="checkbox"/> Acute 3 <input type="checkbox"/> Chronic 4 <input type="checkbox"/> Dev/Psy 5 <input type="checkbox"/> Other (<i>specify</i>) _____
Comments/Referrals:				
6. Date of Exam _ / _ / _	Weight _____ 1 <input type="checkbox"/> Lbs _____ 2 <input type="checkbox"/> Kg _____ 3 <input type="checkbox"/> %ile	Height/Length _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Head Circumference _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Type of Exam 1 <input type="checkbox"/> Well Care 2 <input type="checkbox"/> Acute 3 <input type="checkbox"/> Chronic 4 <input type="checkbox"/> Dev/Psy 5 <input type="checkbox"/> Other (<i>specify</i>) _____
Comments/Referrals:				
7. Date of Exam _ / _ / _	Weight _____ 1 <input type="checkbox"/> Lbs _____ 2 <input type="checkbox"/> Kg _____ 3 <input type="checkbox"/> %ile	Height/Length _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Head Circumference _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Type of Exam 1 <input type="checkbox"/> Well Care 2 <input type="checkbox"/> Acute 3 <input type="checkbox"/> Chronic 4 <input type="checkbox"/> Dev/Psy 5 <input type="checkbox"/> Other (<i>specify</i>) _____
Comments/Referrals:				

B. GROWTH AND ANTHROPOMETRIC MEASUREMENTS (cont'd)

8. Date of Exam _ / _ / _ _	Weight _____ 1 <input type="checkbox"/> Lbs _____ 2 <input type="checkbox"/> Kg _____ 3 <input type="checkbox"/> %ile	Height/Length _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Head Circumference _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Type of Exam 1 <input type="checkbox"/> Well Care 2 <input type="checkbox"/> Acute 3 <input type="checkbox"/> Chronic 4 <input type="checkbox"/> Dev/Psy 5 <input type="checkbox"/> Other (<i>specify</i>) _____
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Comments/Referrals: _____

9. Date of Exam _ / _ / _ _	Weight _____ 1 <input type="checkbox"/> Lbs _____ 2 <input type="checkbox"/> Kg _____ 3 <input type="checkbox"/> %ile	Height/Length _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Head Circumference _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Type of Exam 1 <input type="checkbox"/> Well Care 2 <input type="checkbox"/> Acute 3 <input type="checkbox"/> Chronic 4 <input type="checkbox"/> Dev/Psy 5 <input type="checkbox"/> Other (<i>specify</i>) _____
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Comments/Referrals: _____

10. Date of Exam _ / _ / _ _	Weight _____ 1 <input type="checkbox"/> Lbs _____ 2 <input type="checkbox"/> Kg _____ 3 <input type="checkbox"/> %ile	Height/Length _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Head Circumference _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Type of Exam 1 <input type="checkbox"/> Well Care 2 <input type="checkbox"/> Acute 3 <input type="checkbox"/> Chronic 4 <input type="checkbox"/> Dev/Psy 5 <input type="checkbox"/> Other (<i>specify</i>) _____
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Comments/Referrals: _____

11. Date of Exam _ / _ / _ _	Weight _____ 1 <input type="checkbox"/> Lbs _____ 2 <input type="checkbox"/> Kg _____ 3 <input type="checkbox"/> %ile	Height/Length _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Head Circumference _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Type of Exam 1 <input type="checkbox"/> Well Care 2 <input type="checkbox"/> Acute 3 <input type="checkbox"/> Chronic 4 <input type="checkbox"/> Dev/Psy 5 <input type="checkbox"/> Other (<i>specify</i>) _____
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Comments/Referrals: _____

12. Date of Exam _ / _ / _ _	Weight _____ 1 <input type="checkbox"/> Lbs _____ 2 <input type="checkbox"/> Kg _____ 3 <input type="checkbox"/> %ile	Height/Length _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Head Circumference _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Type of Exam 1 <input type="checkbox"/> Well Care 2 <input type="checkbox"/> Acute 3 <input type="checkbox"/> Chronic 4 <input type="checkbox"/> Dev/Psy 5 <input type="checkbox"/> Other (<i>specify</i>) _____
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Comments/Referrals: _____

13. Date of Exam _ / _ / _ _	Weight _____ 1 <input type="checkbox"/> Lbs _____ 2 <input type="checkbox"/> Kg _____ 3 <input type="checkbox"/> %ile	Height/Length _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Head Circumference _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Type of Exam 1 <input type="checkbox"/> Well Care 2 <input type="checkbox"/> Acute 3 <input type="checkbox"/> Chronic 4 <input type="checkbox"/> Dev/Psy 5 <input type="checkbox"/> Other (<i>specify</i>) _____
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Comments/Referrals: _____

14. Date of Exam _ / _ / _ _	Weight _____ 1 <input type="checkbox"/> Lbs _____ 2 <input type="checkbox"/> Kg _____ 3 <input type="checkbox"/> %ile	Height/Length _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Head Circumference _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Type of Exam 1 <input type="checkbox"/> Well Care 2 <input type="checkbox"/> Acute 3 <input type="checkbox"/> Chronic 4 <input type="checkbox"/> Dev/Psy 5 <input type="checkbox"/> Other (<i>specify</i>) _____
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Comments/Referrals: _____

B. GROWTH AND ANTHROPOMETRIC MEASUREMENTS (cont'd)				
15. Date of Exam -- / -- / --	Weight _____ 1 <input type="checkbox"/> Lbs _____ 2 <input type="checkbox"/> Kg _____ 3 <input type="checkbox"/> %ile	Height/Length _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Head Circumference _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Type of Exam 1 <input type="checkbox"/> Well Care 2 <input type="checkbox"/> Acute 3 <input type="checkbox"/> Chronic 4 <input type="checkbox"/> Dev/Psy 5 <input type="checkbox"/> Other (<i>specify</i>) _____
Comments/Referrals:				
16. Date of Exam -- / -- / --	Weight _____ 1 <input type="checkbox"/> Lbs _____ 2 <input type="checkbox"/> Kg _____ 3 <input type="checkbox"/> %ile	Height/Length _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Head Circumference _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Type of Exam 1 <input type="checkbox"/> Well Care 2 <input type="checkbox"/> Acute 3 <input type="checkbox"/> Chronic 4 <input type="checkbox"/> Dev/Psy 5 <input type="checkbox"/> Other (<i>specify</i>) _____
Comments/Referrals:				
17. Date of Exam -- / -- / --	Weight _____ 1 <input type="checkbox"/> Lbs _____ 2 <input type="checkbox"/> Kg _____ 3 <input type="checkbox"/> %ile	Height/Length _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Head Circumference _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Type of Exam 1 <input type="checkbox"/> Well Care 2 <input type="checkbox"/> Acute 3 <input type="checkbox"/> Chronic 4 <input type="checkbox"/> Dev/Psy 5 <input type="checkbox"/> Other (<i>specify</i>) _____
Comments/Referrals:				
18. Date of Exam -- / -- / --	Weight _____ 1 <input type="checkbox"/> Lbs _____ 2 <input type="checkbox"/> Kg _____ 3 <input type="checkbox"/> %ile	Height/Length _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Head Circumference _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Type of Exam 1 <input type="checkbox"/> Well Care 2 <input type="checkbox"/> Acute 3 <input type="checkbox"/> Chronic 4 <input type="checkbox"/> Dev/Psy 5 <input type="checkbox"/> Other (<i>specify</i>) _____
Comments/Referrals:				
19. Date of Exam -- / -- / --	Weight _____ 1 <input type="checkbox"/> Lbs _____ 2 <input type="checkbox"/> Kg _____ 3 <input type="checkbox"/> %ile	Height/Length _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Head Circumference _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Type of Exam 1 <input type="checkbox"/> Well Care 2 <input type="checkbox"/> Acute 3 <input type="checkbox"/> Chronic 4 <input type="checkbox"/> Dev/Psy 5 <input type="checkbox"/> Other (<i>specify</i>) _____
Comments/Referrals:				
20. Date of Exam -- / -- / --	Weight _____ 1 <input type="checkbox"/> Lbs _____ 2 <input type="checkbox"/> Kg _____ 3 <input type="checkbox"/> %ile	Height/Length _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Head Circumference _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Type of Exam 1 <input type="checkbox"/> Well Care 2 <input type="checkbox"/> Acute 3 <input type="checkbox"/> Chronic 4 <input type="checkbox"/> Dev/Psy 5 <input type="checkbox"/> Other (<i>specify</i>) _____
Comments/Referrals:				
21. Date of Exam -- / -- / --	Weight _____ 1 <input type="checkbox"/> Lbs _____ 2 <input type="checkbox"/> Kg _____ 3 <input type="checkbox"/> %ile	Height/Length _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Head Circumference _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Type of Exam 1 <input type="checkbox"/> Well Care 2 <input type="checkbox"/> Acute 3 <input type="checkbox"/> Chronic 4 <input type="checkbox"/> Dev/Psy 5 <input type="checkbox"/> Other (<i>specify</i>) _____
Comments/Referrals:				

B. GROWTH AND ANTHROPOMETRIC MEASUREMENTS (cont'd)

22. Date of Exam _ / _ / _ _	Weight _____ 1 <input type="checkbox"/> Lbs _____ 2 <input type="checkbox"/> Kg _____ 3 <input type="checkbox"/> %ile	Height/Length _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Head Circumference _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Type of Exam 1 <input type="checkbox"/> Well Care 2 <input type="checkbox"/> Acute 3 <input type="checkbox"/> Chronic 4 <input type="checkbox"/> Dev/Psy 5 <input type="checkbox"/> Other (<i>specify</i>) _____
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Comments/Referrals:

23. Date of Exam _ / _ / _ _	Weight _____ 1 <input type="checkbox"/> Lbs _____ 2 <input type="checkbox"/> Kg _____ 3 <input type="checkbox"/> %ile	Height/Length _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Head Circumference _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Type of Exam 1 <input type="checkbox"/> Well Care 2 <input type="checkbox"/> Acute 3 <input type="checkbox"/> Chronic 4 <input type="checkbox"/> Dev/Psy 5 <input type="checkbox"/> Other (<i>specify</i>) _____
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Comments/Referrals:

24. Date of Exam _ / _ / _ _	Weight _____ 1 <input type="checkbox"/> Lbs _____ 2 <input type="checkbox"/> Kg _____ 3 <input type="checkbox"/> %ile	Height/Length _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Head Circumference _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Type of Exam 1 <input type="checkbox"/> Well Care 2 <input type="checkbox"/> Acute 3 <input type="checkbox"/> Chronic 4 <input type="checkbox"/> Dev/Psy 5 <input type="checkbox"/> Other (<i>specify</i>) _____
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Comments/Referrals:

25. Date of Exam _ / _ / _ _	Weight _____ 1 <input type="checkbox"/> Lbs _____ 2 <input type="checkbox"/> Kg _____ 3 <input type="checkbox"/> %ile	Height/Length _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Head Circumference _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Type of Exam 1 <input type="checkbox"/> Well Care 2 <input type="checkbox"/> Acute 3 <input type="checkbox"/> Chronic 4 <input type="checkbox"/> Dev/Psy 5 <input type="checkbox"/> Other (<i>specify</i>) _____
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Comments/Referrals:

26. Date of Exam _ / _ / _ _	Weight _____ 1 <input type="checkbox"/> Lbs _____ 2 <input type="checkbox"/> Kg _____ 3 <input type="checkbox"/> %ile	Height/Length _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Head Circumference _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Type of Exam 1 <input type="checkbox"/> Well Care 2 <input type="checkbox"/> Acute 3 <input type="checkbox"/> Chronic 4 <input type="checkbox"/> Dev/Psy 5 <input type="checkbox"/> Other (<i>specify</i>) _____
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Comments/Referrals:

27. Date of Exam _ / _ / _ _	Weight _____ 1 <input type="checkbox"/> Lbs _____ 2 <input type="checkbox"/> Kg _____ 3 <input type="checkbox"/> %ile	Height/Length _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Head Circumference _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Type of Exam 1 <input type="checkbox"/> Well Care 2 <input type="checkbox"/> Acute 3 <input type="checkbox"/> Chronic 4 <input type="checkbox"/> Dev/Psy 5 <input type="checkbox"/> Other (<i>specify</i>) _____
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Comments/Referrals:

28. Date of Exam _ / _ / _ _	Weight _____ 1 <input type="checkbox"/> Lbs _____ 2 <input type="checkbox"/> Kg _____ 3 <input type="checkbox"/> %ile	Height/Length _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Head Circumference _____ 1 <input type="checkbox"/> in _____ 2 <input type="checkbox"/> cm _____ 3 <input type="checkbox"/> %ile	Type of Exam 1 <input type="checkbox"/> Well Care 2 <input type="checkbox"/> Acute 3 <input type="checkbox"/> Chronic 4 <input type="checkbox"/> Dev/Psy 5 <input type="checkbox"/> Other (<i>specify</i>) _____
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Comments/Referrals:

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 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Yes S 2 <input type="checkbox"/> No 9 <input type="checkbox"/>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
2.				_ _ / _ / _ _ _ _ 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Yes S 2 <input type="checkbox"/> No 9 <input type="checkbox"/>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
3.				_ _ / _ / _ _ _ _ 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Yes S 2 <input type="checkbox"/> No 9 <input type="checkbox"/>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
4.				_ _ / _ / _ _ _ _ 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Yes S 2 <input type="checkbox"/> No 9 <input type="checkbox"/>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
5.				_ _ / _ / _ _ _ _ 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Yes S 2 <input type="checkbox"/> No 9 <input type="checkbox"/>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
6.				_ _ / _ / _ _ _ _ 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Yes S 2 <input type="checkbox"/> No 9 <input type="checkbox"/>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
7.				_ _ / _ / _ _ _ _ 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Yes S 2 <input type="checkbox"/> No 9 <input type="checkbox"/>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
8.				_ _ / _ / _ _ _ _ 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Yes S 2 <input type="checkbox"/> No 9 <input type="checkbox"/>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
9.				_ _ / _ / _ _ _ _ 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Yes S 2 <input type="checkbox"/> No 9 <input type="checkbox"/>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
10.				_ _ / _ / _ _ _ _ 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Yes S 2 <input type="checkbox"/> No 9 <input type="checkbox"/>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown

Comments

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 <input type="checkbox"/> Unknown	1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	____ days 9 <input type="checkbox"/> Unknown	°C ____ °F ____ 1. • No temp 999. • Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk
2.		____/____/____ 9 <input type="checkbox"/> Unknown	1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	____ days 9 <input type="checkbox"/> Unknown	°C ____ °F ____ 1. • No temp 999. • Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk
3.		____/____/____ 9 <input type="checkbox"/> Unknown	1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	____ days 9 <input type="checkbox"/> Unknown	°C ____ °F ____ 1. • No temp 999. • Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk
4.		____/____/____ 9 <input type="checkbox"/> Unknown	1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	____ days 9 <input type="checkbox"/> Unknown	°C ____ °F ____ 1. • No temp 999. • Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk
5.		____/____/____ 9 <input type="checkbox"/> Unknown	1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	____ days 9 <input type="checkbox"/> Unknown	°C ____ °F ____ 1. • No temp 999. • Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk
6.		____/____/____ 9 <input type="checkbox"/> Unknown	1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	____ days 9 <input type="checkbox"/> Unknown	°C ____ °F ____ 1. • No temp 999. • Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk
7.		____/____/____ 9 <input type="checkbox"/> Unknown	1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	____ days 9 <input type="checkbox"/> Unknown	°C ____ °F ____ 1. • No temp 999. • Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk

Comments

E. CULTURES					<input type="checkbox"/> 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 <input type="checkbox"/> Unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. • Positive 5. • Growth noted, not specified 99. • Unknown	
2.		_ _ / _ _ / _ _ _ _ 9 <input type="checkbox"/> Unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. • Positive 5. • Growth noted, not specified 99. • Unknown	
3.		_ _ / _ _ / _ _ _ _ 9 <input type="checkbox"/> Unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. • Positive 5. • Growth noted, not specified 99. • Unknown	
4.		_ _ / _ _ / _ _ _ _ 9 <input type="checkbox"/> Unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. • Positive 5. • Growth noted, not specified 99. • Unknown	
5.		_ _ / _ _ / _ _ _ _ 9 <input type="checkbox"/> Unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. • Positive 5. • Growth noted, not specified 99. • Unknown	
6.		_ _ / _ _ / _ _ _ _ 9 <input type="checkbox"/> Unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. • Positive 5. • Growth noted, not specified 99. • Unknown	
7.		_ _ / _ _ / _ _ _ _ 9 <input type="checkbox"/> Unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. • Positive 5. • Growth noted, not specified 99. • Unknown	
8.		_ _ / _ _ / _ _ _ _ 9 <input type="checkbox"/> Unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. • Positive 5. • Growth noted, not specified 99. • Unknown	
9.		_ _ / _ _ / _ _ _ _ 9 <input type="checkbox"/> Unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. • Positive 5. • Growth noted, not specified 99. • Unknown	
10.		_ _ / _ _ / _ _ _ _ 9 <input type="checkbox"/> Unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. • Positive 5. • Growth noted, not specified 99. • Unknown	
11.		_ _ / _ _ / _ _ _ _ 9 <input type="checkbox"/> Unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. • Positive 5. • Growth noted, not specified 99. • Unknown	
12.		_ _ / _ _ / _ _ _ _ 9 <input type="checkbox"/> Unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. • Positive 5. • Growth noted, not specified 99. • Unknown	
13.		_ _ / _ _ / _ _ _ _ 9 <input type="checkbox"/> Unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. • Positive 5. • Growth noted, not specified 99. • Unknown	
14.		_ _ / _ _ / _ _ _ _ 9 <input type="checkbox"/> 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						<input type="checkbox"/> 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 <input type="checkbox"/> ER Observe 3 <input type="checkbox"/> ER Admit 2 <input type="checkbox"/> ER Only 4 <input type="checkbox"/> Elective 8 <input type="checkbox"/> Other (<i>specify</i>) _____		Admit Date _ / _ / _ _ _ _	Discharge Date _ / _ / _ _ _ _						
Dx1	ICD9 or CPT Code _____ Name	Dx2	ICD9 or CPT Code _____ Name	Dx3	ICD9 or CPT Code _____ Name	Dx4	ICD9 or CPT Code _____ Name	Dx5	ICD9 or CPT Code _____ Name	Dx6	ICD9 or CPT Code _____ Name
Problem/Infxn Code		Problem/Infxn Code		Problem/Infxn Code		Problem/Infxn Code		Problem/Infxn Code		Problem/Infxn Code	
Cultures 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		Fever 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		Medications Given 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		Injury 1 <input type="checkbox"/> Yes (<i>specify below</i>) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		Surgery 1 <input type="checkbox"/> Yes (<i>specify below</i>) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			
Injury Comments:				Surgery Details 1 <input type="checkbox"/> Radiology 2 <input type="checkbox"/> Other Procedure(s) (<i>specify below</i>) Comments:							
Hospital/Facility Name		Type of Visit 1 <input type="checkbox"/> ER Observe 3 <input type="checkbox"/> ER Admit 2 <input type="checkbox"/> ER Only 4 <input type="checkbox"/> Elective 8 <input type="checkbox"/> Other (<i>specify</i>) _____		Admit Date _ / _ / _ _ _ _	Discharge Date _ / _ / _ _ _ _						
Dx1	ICD9 or CPT Code _____ Name	Dx2	ICD9 or CPT Code _____ Name	Dx3	ICD9 or CPT Code _____ Name	Dx4	ICD9 or CPT Code _____ Name	Dx5	ICD9 or CPT Code _____ Name	Dx6	ICD9 or CPT Code _____ Name
Problem/Infxn Code		Problem/Infxn Code		Problem/Infxn Code		Problem/Infxn Code		Problem/Infxn Code		Problem/Infxn Code	
Cultures 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		Fever 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		Medications Given 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		Injury 1 <input type="checkbox"/> Yes (<i>specify below</i>) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		Surgery 1 <input type="checkbox"/> Yes (<i>specify below</i>) 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			
Injury Comments:				Surgery Details 1 <input type="checkbox"/> Radiology 2 <input type="checkbox"/> Other Procedure(s) (<i>specify below</i>) Comments:							

**Study ID
Number**

Study ID Number

G. IMMUNIZATIONS																			
Vaccine codes					Manufacturer codes														
1. DtaP 2. Hib 3. HepA 4. HepB 5. MMR 6. Polio IPV					7. Varicella Zoster 8. PCV 9. PPV 88. Other (<i>specify</i>) 99. Unknown					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 (<i>specify</i>) 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.	-- / -- / --					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	-- / -- / -- <input type="checkbox"/> Phone/E-mail <input type="checkbox"/> Visit	<input type="checkbox"/> Rash <input type="checkbox"/> Fever	<input type="checkbox"/> Seizures <input type="checkbox"/> Other (<i>specify</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown									
2.	-- / -- / --					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	-- / -- / -- <input type="checkbox"/> Phone/E-mail <input type="checkbox"/> Visit	<input type="checkbox"/> Rash <input type="checkbox"/> Fever	<input type="checkbox"/> Seizures <input type="checkbox"/> Other (<i>specify</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown									
3.	-- / -- / --					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	-- / -- / -- <input type="checkbox"/> Phone/E-mail <input type="checkbox"/> Visit	<input type="checkbox"/> Rash <input type="checkbox"/> Fever	<input type="checkbox"/> Seizures <input type="checkbox"/> Other (<i>specify</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown									
4.	-- / -- / --					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	-- / -- / -- <input type="checkbox"/> Phone/E-mail <input type="checkbox"/> Visit	<input type="checkbox"/> Rash <input type="checkbox"/> Fever	<input type="checkbox"/> Seizures <input type="checkbox"/> Other (<i>specify</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown									
5.	-- / -- / --					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	-- / -- / -- <input type="checkbox"/> Phone/E-mail <input type="checkbox"/> Visit	<input type="checkbox"/> Rash <input type="checkbox"/> Fever	<input type="checkbox"/> Seizures <input type="checkbox"/> Other (<i>specify</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown									
6.	-- / -- / --					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	-- / -- / -- <input type="checkbox"/> Phone/E-mail <input type="checkbox"/> Visit	<input type="checkbox"/> Rash <input type="checkbox"/> Fever	<input type="checkbox"/> Seizures <input type="checkbox"/> Other (<i>specify</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown									
7.	-- / -- / --					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	-- / -- / -- <input type="checkbox"/> Phone/E-mail <input type="checkbox"/> Visit	<input type="checkbox"/> Rash <input type="checkbox"/> Fever	<input type="checkbox"/> Seizures <input type="checkbox"/> Other (<i>specify</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown									

Study ID Number

H. FEVER <input type="checkbox"/> NO INFO							
<p>Children \leq 8 weeks of age: Axillary Temps: Record temperatures \geq 36.9°C (98.4°F) Rectal Temps: Record temperatures \geq 38.0°C (100.4°F)</p> <p>Children $>$ 8 weeks of age: Oral Temps: Record temperatures \geq 38.6°C (101.5°F) Axillary Temps: Record temperatures \geq 38.1°C (100.5°F) Rectal Temps: Record temperatures \geq 39.2°C (102.5°F)</p> <p>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.</p>							
1	Refer No. _____ 9 <input type="checkbox"/> NA	Date __/__/____	Duration ____ hours ____ days 9 <input type="checkbox"/> Unk	Highest temp _____ 1 <input type="checkbox"/> °C 2 <input type="checkbox"/> °F	Mode 1 <input type="checkbox"/> Oral 2 <input type="checkbox"/> Axillary 3 <input type="checkbox"/> Rectal 9 <input type="checkbox"/> Unknown	Medication Given 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	Comments
2	Refer No. _____ 9 <input type="checkbox"/> NA	Date __/__/____	Duration ____ hours ____ days 9 <input type="checkbox"/> Unk	Highest temp _____ 1 <input type="checkbox"/> °C 2 <input type="checkbox"/> °F	Mode 1 <input type="checkbox"/> Oral 2 <input type="checkbox"/> Axillary 3 <input type="checkbox"/> Rectal 9 <input type="checkbox"/> Unknown	Medication Given 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	Comments
3	Refer No. _____ 9 <input type="checkbox"/> NA	Date __/__/____	Duration ____ hours ____ days 9 <input type="checkbox"/> Unk	Highest temp _____ 1 <input type="checkbox"/> °C 2 <input type="checkbox"/> °F	Mode 1 <input type="checkbox"/> Oral 2 <input type="checkbox"/> Axillary 3 <input type="checkbox"/> Rectal 9 <input type="checkbox"/> Unknown	Medication Given 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	Comments
4	Refer No. _____ 9 <input type="checkbox"/> NA	Date __/__/____	Duration ____ hours ____ days 9 <input type="checkbox"/> Unk	Highest temp _____ 1 <input type="checkbox"/> °C 2 <input type="checkbox"/> °F	Mode 1 <input type="checkbox"/> Oral 2 <input type="checkbox"/> Axillary 3 <input type="checkbox"/> Rectal 9 <input type="checkbox"/> Unknown	Medication Given 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	Comments
5	Refer No. _____ 9 <input type="checkbox"/> NA	Date __/__/____	Duration ____ hours ____ days 9 <input type="checkbox"/> Unk	Highest temp _____ 1 <input type="checkbox"/> °C 2 <input type="checkbox"/> °F	Mode 1 <input type="checkbox"/> Oral 2 <input type="checkbox"/> Axillary 3 <input type="checkbox"/> Rectal 9 <input type="checkbox"/> Unknown	Medication Given 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	Comments
6	Refer No. _____ 9 <input type="checkbox"/> NA	Date __/__/____	Duration ____ hours ____ days 9 <input type="checkbox"/> Unk	Highest temp _____ 1 <input type="checkbox"/> °C 2 <input type="checkbox"/> °F	Mode 1 <input type="checkbox"/> Oral 2 <input type="checkbox"/> Axillary 3 <input type="checkbox"/> Rectal 9 <input type="checkbox"/> Unknown	Medication Given 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	Comments
7	Refer No. _____ 9 <input type="checkbox"/> NA	Date __/__/____	Duration ____ hours ____ days 9 <input type="checkbox"/> Unk	Highest temp _____ 1 <input type="checkbox"/> °C 2 <input type="checkbox"/> °F	Mode 1 <input type="checkbox"/> Oral 2 <input type="checkbox"/> Axillary 3 <input type="checkbox"/> Rectal 9 <input type="checkbox"/> Unknown	Medication Given 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	Comments
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					___ / ___ / ___ <input type="checkbox"/> Unknown	_____	_____ <input type="checkbox"/> Variable	<input type="checkbox"/> gm <input type="checkbox"/> mg <input type="checkbox"/> mcg <input type="checkbox"/> mU <input type="checkbox"/> cc/ml <input type="checkbox"/> other	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID <input type="checkbox"/> PRN <input type="checkbox"/> Every ___ hrs <input type="checkbox"/> Per week <input type="checkbox"/> Total Dose <input type="checkbox"/> No Info
2					___ / ___ / ___ <input type="checkbox"/> Unknown	_____	_____ <input type="checkbox"/> Variable	<input type="checkbox"/> gm <input type="checkbox"/> mg <input type="checkbox"/> mcg <input type="checkbox"/> mU <input type="checkbox"/> cc/ml <input type="checkbox"/> other	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID <input type="checkbox"/> PRN <input type="checkbox"/> Every ___ hrs <input type="checkbox"/> Per week <input type="checkbox"/> Total Dose <input type="checkbox"/> No Info

Study ID Number

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

Study ID
Number

I. MEDICATIONS								<input type="checkbox"/> NO INFO	
6					____ / ____ / ____ <input type="checkbox"/> Unknown	_____ <input type="checkbox"/> Variable	<input type="checkbox"/> gm <input type="checkbox"/> mg <input type="checkbox"/> mcg <input type="checkbox"/> mU <input type="checkbox"/> cc/ml <input type="checkbox"/> other	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID <input type="checkbox"/> PRN <input type="checkbox"/> Every ____ hrs <input type="checkbox"/> Per week <input type="checkbox"/> Total Dose <input type="checkbox"/> No Info	
7					____ / ____ / ____ <input type="checkbox"/> Unknown	_____ <input type="checkbox"/> Variable	<input type="checkbox"/> gm <input type="checkbox"/> mg <input type="checkbox"/> mcg <input type="checkbox"/> mU <input type="checkbox"/> cc/ml <input type="checkbox"/> other	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID <input type="checkbox"/> PRN <input type="checkbox"/> Every ____ hrs <input type="checkbox"/> Per week <input type="checkbox"/> Total Dose <input type="checkbox"/> No Info	
8					____ / ____ / ____ <input type="checkbox"/> Unknown	_____ <input type="checkbox"/> Variable	<input type="checkbox"/> gm <input type="checkbox"/> mg <input type="checkbox"/> mcg <input type="checkbox"/> mU <input type="checkbox"/> cc/ml <input type="checkbox"/> other	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID <input type="checkbox"/> PRN <input type="checkbox"/> Every ____ hrs <input type="checkbox"/> Per week <input type="checkbox"/> Total Dose <input type="checkbox"/> No Info	

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 <input type="checkbox"/> Normal 3 <input type="checkbox"/> Equivocal 2 <input type="checkbox"/> Abnormal 9 <input type="checkbox"/> Unknown	Final Impression	Comments
2. Date __/__/____	Code	Results 1 <input type="checkbox"/> Normal 3 <input type="checkbox"/> Equivocal 2 <input type="checkbox"/> Abnormal 9 <input type="checkbox"/> Unknown	Final Impression	Comments
3. Date __/__/____	Code	Results 1 <input type="checkbox"/> Normal 3 <input type="checkbox"/> Equivocal 2 <input type="checkbox"/> Abnormal 9 <input type="checkbox"/> Unknown	Final Impression	Comments

CRANIAL ULTRASOUNDS

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

1. Date __/__/____	Results 1 <input type="checkbox"/> Normal 2 <input type="checkbox"/> 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 <input type="checkbox"/> Normal 2 <input type="checkbox"/> 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 <input type="checkbox"/> Normal 2 <input type="checkbox"/> 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					
	Echoluency					
	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 <input type="checkbox"/> Normal 2 <input type="checkbox"/> 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					
	Echoluency					
	IVH grade ____					
	Germinal matrix bleed (Grade I IVH)					
	Other bleed					
	PVL/cavitation/white matter necrosis					
	Malformation					
	Subarachnoid hemorrhage/blood					
	Other findings, specify.					

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			<input type="checkbox"/> NO INFO
<input checked="" type="checkbox"/> Check the box in front of the test if it was performed, and complete the results.			
Biotinidase Date: ___/___/___ Results: 1 <input type="checkbox"/> Normal 2 <input type="checkbox"/> Abnormal 9 <input type="checkbox"/> Unknown	Homocystinuria Date: ___/___/___ Results: 1 <input type="checkbox"/> Normal 2 <input type="checkbox"/> Abnormal 9 <input type="checkbox"/> Unknown	Toxoplasmosis Date: ___/___/___ Results: 1 <input type="checkbox"/> Normal 2 <input type="checkbox"/> Abnormal 9 <input type="checkbox"/> Unknown	
Congenital Adrenal Hyperplasia (CAH) Date: ___/___/___ Results: 1 <input type="checkbox"/> Normal 2 <input type="checkbox"/> Abnormal 9 <input type="checkbox"/> Unknown	Hypothyroidism Date: ___/___/___ Results: 1 <input type="checkbox"/> Normal 2 <input type="checkbox"/> Abnormal 9 <input type="checkbox"/> Unknown	Tyrosinemia Date: ___/___/___ Results: 1 <input type="checkbox"/> Normal 2 <input type="checkbox"/> Abnormal 9 <input type="checkbox"/> Unknown	
Cystic Fibrosis Date: ___/___/___ Results: 1 <input type="checkbox"/> Normal 2 <input type="checkbox"/> Abnormal 9 <input type="checkbox"/> Unknown	Maple Syrup Urine Disease Date: ___/___/___ Results: 1 <input type="checkbox"/> Normal 2 <input type="checkbox"/> Abnormal 9 <input type="checkbox"/> Unknown	Glucose-6-dehydrogenase Date: ___/___/___ Results: 1 <input type="checkbox"/> Normal 2 <input type="checkbox"/> Abnormal 9 <input type="checkbox"/> Unknown	
Galactosemia Date: ___/___/___ Results: 1 <input type="checkbox"/> Normal 2 <input type="checkbox"/> Abnormal 9 <input type="checkbox"/> Unknown	Phenylketonuria/PKU Date: ___/___/___ Results: 1 <input type="checkbox"/> Normal 2 <input type="checkbox"/> Abnormal 9 <input type="checkbox"/> Unknown	Sickle Cell Anemia Date: ___/___/___ Results: 1 <input type="checkbox"/> Normal 2 <input type="checkbox"/> Abnormal 9 <input type="checkbox"/> Unknown	
Other (specify) Date: ___/___/___ Results: 1 <input type="checkbox"/> Normal 2 <input type="checkbox"/> Abnormal 9 <input type="checkbox"/> Unknown	Other (specify) Date: ___/___/___ Results: 1 <input type="checkbox"/> Normal 2 <input type="checkbox"/> Abnormal 9 <input type="checkbox"/> Unknown	Other (specify) Date: ___/___/___ Results: 1 <input type="checkbox"/> Normal 2 <input type="checkbox"/> Abnormal 9 <input type="checkbox"/> Unknown	