Appendix I: Medical Chart Abstraction

Please note that this medical chart review form has 13 pages and contains two parts:

**Part A**: **demographic information** about the child who was ill with neurological signs following respiratory illness

**Part B**: medical information from the hospital chart of the child following **admission for neurological signs**

Date of chart abstraction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)

Name of person completing form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and address of institution where this form was completed:

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| **Part A: Demographic information for case-patient admitted with neurological signs following respiratory illness** |
| First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last (Family) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY) Sex: 🞎Female 🞎Male 🞎Unknown  Race: 🞎Asian 🞎Black or African American 🞎Native Hawaiian or Other Pacific Islander 🞎American Indian or Alaska Native 🞎White  (More than one box can be checked)  Ethnicity: 🞎Hispanic 🞎Non-Hispanic  First name of parent/guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last (Family) name of parent/guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Residence address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Part B: Medical chart of case-patient admitted with neurological signs following respiratory illness** |
| Medical record number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient’s First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient’s Last (Family) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient’s date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)  Admission date to hospital of initial presentation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)  Transfer date from hospital of initial presentation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)  Admission date to secondary facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)  Transferred from:  Hospital name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Transferred to:  Hospital name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please describe any patient information available from a referring facility, if applicable:  Did the patient have any underlying medical conditions? 🞎Yes 🞎No 🞎Unknown  If yes, please describe:  Are outpatient visits prior to becoming ill noted in the chart? 🞎Yes 🞎No 🞎Unknown  If yes, please describe:  Is family history of neurologic illness, including seizures, noted in the chart? 🞎Yes 🞎No 🞎Unknown  If yes, please describe:  Please list any medications prescribed to the patient **before** hospitalisation (e.g. OTC meds used by parents, medications discontinued prior to hospitalisation):   |  |  |  |  | | --- | --- | --- | --- | | **Medication** | **Dose and route** | **Date Started (MM/DD/YYYY)** | **Place of administration** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  |   Signs and Symptoms  Date of first clinical symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)  As part of this illness, does the patient have or has the patient had any of the following:  **Fever**  Fever (>38 °C)………………………………………………………….. 🞎Yes 🞎No 🞎Unknown  If yes, what was the highest temperature? \_\_\_\_\_\_\_ °C  Temperature <35 °C…….………………………………………….. 🞎Yes 🞎No 🞎Unknown  If yes, what was the lowest temperature? \_\_\_\_\_\_\_ °C  **Rash**  Skin rash……..………………………………………………………….. 🞎Yes 🞎No 🞎Unknown  If yes, please describe (eg. Location, type {maculopapular, vesicular} etc):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Redness on feet or hands ………………………………………… 🞎Yes 🞎No 🞎Unknown  Ulcers or lesions in mouth……………………………………….. 🞎Yes 🞎No 🞎Unknown  **Neurologic**  Focal seizures/convulsions…….……………………………. 🞎Yes 🞎No 🞎Unknown  Generalized seizures/convulsions…….…………………….. 🞎Yes 🞎No 🞎Unknown  Intractable seizures/convulsions…….…………………..….. 🞎Yes 🞎No 🞎Unknown  Myoclonic jerk..………………………………………………………. 🞎Yes 🞎No 🞎Unknown  Tremors.…………………………………………………………………. 🞎Yes 🞎No 🞎Unknown  Limb weakness/monoparesis………………………………….. 🞎Yes 🞎No 🞎Unknown  Stiff neck..……………………………………………………………….. 🞎Yes 🞎No 🞎Unknown  Bulging fontanelle (if infant).………………………………………………….. 🞎Yes 🞎No 🞎Unknown  Lethargy………………………………………………………………….. 🞎Yes 🞎No 🞎Unknown  Irritability.……………………………………………………………….. 🞎Yes 🞎No 🞎Unknown  Inconsolable crying…………………………………………………. 🞎Yes 🞎No 🞎Unknown  Cranial nerve palsy………………………………………………….. 🞎Yes 🞎No 🞎Unknown  **Respiratory**  Cough (dry, productive).….…………..………………………….. 🞎Yes 🞎No 🞎Unknown  Secretions……………………………………………………………….. 🞎Yes 🞎No 🞎Unknown  Runny nose.…………………………………………………………….. 🞎Yes 🞎No 🞎Unknown  Sneezing………………………………………………………………….. 🞎Yes 🞎No 🞎Unknown  Difficulty breathing………………………………………………….. 🞎Yes 🞎No 🞎Unknown  Wheezing.……………………………………………………………….. 🞎Yes 🞎No 🞎Unknown  Rales/crackles/crepitations.…………………………………….. 🞎Yes 🞎No 🞎Unknown  Tachypnea (as assessed and recorded by provider)… 🞎Yes 🞎No 🞎Unknown  If yes, please indicate rate \_\_\_\_\_\_\_\_\_\_\_ (RR/min)  Frothy secretions from mouth..……………………………….. 🞎Yes 🞎No 🞎Unknown  Hemoptysis.…………………………………………………………….. 🞎Yes 🞎No 🞎Unknown  Respiratory failure.………………………………………………….. 🞎Yes 🞎No 🞎Unknown  Oxygen given.………………………………………………………….. 🞎Yes 🞎No 🞎Unknown  If yes, how was it administered? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Intubation……………………………………………………………….. 🞎Yes 🞎No 🞎Unknown  Retractions, nasal flaring..……………………………………….. 🞎Yes 🞎No 🞎Unknown  **Cardiovascular**  Bradycardia (as assessed and recorded by provider).. 🞎Yes 🞎No 🞎Unknown  If yes, please indicate rate \_\_\_\_\_\_\_\_\_\_\_ (HR/min)  Tachycardia (as assessed and recorded by provider).. 🞎Yes 🞎No 🞎Unknown  If yes, please indicate rate \_\_\_\_\_\_\_\_\_\_\_ (HR/min)  Variable heart rate (tachy/brady)……………………………. 🞎Yes 🞎No 🞎Unknown  Cyanosis………………………………………………………………….. 🞎Yes 🞎No 🞎Unknown  Mottled skin……………………………………………………………. 🞎Yes 🞎No 🞎Unknown  Arrhythmia.…………………………………………………….……….. 🞎Yes 🞎No 🞎Unknown  Abnormal heart sounds.………………………………………….. 🞎Yes 🞎No 🞎Unknown  If yes, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Hypotension/shock………………………………………………….. 🞎Yes 🞎No 🞎Unknown  **Gastrointestinal**  Vomiting………………………………………………………………….. 🞎Yes 🞎No 🞎Unknown  Watery stools………………………………………………………….. 🞎Yes 🞎No 🞎Unknown  Constipation..………………………………………………………….. 🞎Yes 🞎No 🞎Unknown  Abdominal distention.…………………………………………….. 🞎Yes 🞎No 🞎Unknown  Abdominal pain……………………………………………………….. 🞎Yes 🞎No 🞎Unknown  Jaundice………………………………………………………………….. 🞎Yes 🞎No 🞎Unknown  Poor feeding………………………………………………………… .. 🞎Yes 🞎No 🞎Unknown  **Others**  Conjunctivitis.………………………………………………………….. 🞎Yes 🞎No 🞎Unknown  Bleeding.………………………………………………………………….. 🞎Yes 🞎No 🞎Unknown  Persistent crying………………………………………………………. 🞎Yes 🞎No 🞎Unknown  Lymphadenopathy.………………………………………………….. 🞎Yes 🞎No 🞎Unknown  Please describe any other symptoms not listed above, or any of note:  Laboratory Exams  Please list here all laboratory findings from admission:   |  |  |  |  | | --- | --- | --- | --- | | **Specimen Collection Date**  **(MM/DD/YYYY)** | **Specimen type** | **Test type** | **Results (include reference range)** | |  | Serum | AST(SGOT), ALT(SGPT), GGT |  | |  | Serum | T. BILI, direct bili |  | |  | Serum | BUN, creatinine |  | |  | Serum | Glucose |  | |  | Serum | Creatinine Kinase |  | |  | Serum | Sodium |  | |  | Blood | HB/HCT |  | |  | Blood | WBC |  | |  | Blood | Neutros |  | | **Specimen Collection Date**  **(MM/DD/YYYY)** | **Specimen type** | **Test type** | **Results (include reference range)** | |  | Blood | Bands |  | |  | Blood | Lymphs |  | |  | Blood | Monos |  | |  | Blood | EOS |  | |  | Blood | PLTS |  | |  | Blood | Culture |  | |  | Blood | ANC |  | |  | Blood | LDH |  | |  | Blood | CRP |  | |  | Blood | ESR |  | |  | NP/OP/Throat | Culture |  | |  | Rectal/stool | Culture |  | |  | Eye | Culture |  | |  | Vesicle | Culture |  | |  | Urine | Culture |  | |  | Urine | UA |  | |  | CSF | Opening pressure |  | |  | CSF | RBC |  | |  | CSF | WBC |  | |  | CSF | Neutro |  | |  | CSF | Lympho |  | |  | CSF | EOS |  | | **Specimen Collection Date**  **(MM/DD/YYYY)** | **Specimen type** | **Test type** | **Results (include reference range)** | |  | CSF | Protein |  | |  | CSF | Glucose |  | |  | CSF | Gram stain |  | |  | CSF | Culture |  | |  |  | HPeV3-specific PCR |  | |  |  | Enterovirus-specific PCR |  | |  |  | HSV-specific PCR |  | |  |  | Other virus PCR |  | | Please describe below any other unusual laboratory results at admission | | | | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  |   Radiologic Exams  Please describe here all radiological exams requested:   |  |  |  | | --- | --- | --- | | **Exam date**  **(MM/DD/YYYY)** | **Test type** | **Results** | |  | CXR |  | |  | CT |  | |  | MRI |  | |  | Echocardiography |  | |  | Ultrasound |  | |  | EEG |  | |  | Plain abdominal radiographs |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  |   Medication and Treatment  Was the patient placed in the intensive care unit (ICU)? 🞎Yes 🞎No 🞎Unknown  If yes, admission date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Discharge date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)  Please list any medications prescribed to the patient in hospital:   |  |  |  |  | | --- | --- | --- | --- | | **Medication** | **Dose and route** | **Date Started (MM/DD/YYY)** | **Date Stopped (MM/DD/YYY)** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  |   Please describe any other treatment regimens or interventions provided to the patient in hospital  (e.g. supplemental oxygen, respiratory therapy, supplemental feedings, PRN meds etc):  *Do not include intravenous fluids*  Discharge  Is patient still in hospital? 🞎Yes 🞎No If no, discharge date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(MM/DD/YYYY)  Status upon discharge: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Died: 🞎Yes 🞎No 🞎Unknown If yes, date of death \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)  Discharge diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other information  Please describe here any other information that you feel may be important or unusual, with regard to the patient’s stay in hospital: |

End of medical chart abstraction form