Form Approved
OMB No. 0923-0051
Exp. Date 03/31/2018

Medical Chart Abstraction Form

Reviewer Name: ______________________ Date of Review: ___ / ___ / ____ Data entered: ___ / ___ / ____
Facility: ____ ID: __________

Patient Name: ____

Address: Street: _________________________ City: _________________ State: _____ Zip: ____________
Telephone (Home) _____________(Cell) _____________(Work) _____________(Other) _____________

Patient Demographics

DOB: ____ / ____ / _______ (MM DD YYYY) **Sex:** ☐ Male ☐ Female ☐ N/A **Ethnicity:** ☐ Hispanic ☐ Not Hispanic

Insurance:
☐ Private ☐ Medicare/Medicaid/Government program
☐ None ☐ N/A ☐ Other: __________________

Race: (check all that apply)
☐ American Indian/ Alaskan Native ☐ Asian ☐ Black
☐ Native Hawaiian/ Pacific Islander ☐ White

Visit Information

Date of Visit: ____ / ____ / ______ (MM DD YYYY) Time of arrival: ____:____ ☐ am ☐ pm

Chief Complaint: ____

Mode of arrival:
☐ Helicopter
☐ Ambulance
☐ POV
☐ Public transportation (bus, taxi, etc.)
☐ On foot
☐ Other: _______________________

Was the patient admitted? ☐ Y ☐ N
If yes,
☐ Admitted to monitored ward or ICU
Days: ______
☐ Admitted to unmonitored ward
Days: ______

Initial Vital Signs: Height: _________ ☐ cm ☐ in Weight: ________ ☐ kg ☐ lb

Temp (°F): ________ Heart Rate: _______ Respiratory Rate: _______ BP (mmHg): ______ / _______

O_2 sat: ________ Supplemental O_2? ☐ Y ☐ N ☐ N/A If yes, delivery method: ___________________

Medical History (check all that apply)

☐ Asthma
☐ COPD
☐ Depression
☐ Diabetes
☐ GERD (Reflux)
☐ Hypertension
☐ Malignancy
☐ Myocardial infarction
☐ Congestive heart failure
☐ Breastfeeding
☐ Pregnant
☐ Tobacco use
☐ Other: ____________________

Medications:
____
____
____
____

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS E-11 Atlanta, Georgia 30333; ATTN: PRA (0923-0015)

Signs and Symptoms

Check box if sign or symptom is present in the medical record (for this encounter). If date of onset is different from date of presentation, indicate in date column.

Sign/Symptom	Date
General	
☐ Chills	___ / ___ / ____
☐ Fever (>100.4 °F)	___ / ___ / ____
☐ Fatigue/Malaise	___ / ___ / ____
☐ Hypothermia (<95.0 °F)	___ / ___ / ____
☐ Other: ________________	___ / ___ / ____
☐ Other: ________________	___ / ___ / ____
☐ Other: ________________	___ / ___ / ____
Eye	
☐ Corneal abrasion	___ / ___ / ____
☐ Increased tearing	___ / ___ / ____
☐ Irritation/Pain	___ / ___ / ____
☐ Itching/Pruritis	___ / ___ / ____
☐ Miosis	___ / ___ / ____
☐ Mydriasis	___ / ___ / ____
☐ Visual changes	___ / ___ / ____
☐ Other: ________________	___ / ___ / ____
Cardiovascular	
☐ Bradycardia	___ / ___ / ____
☐ Cardiac arrest	___ / ___ / ____
☐ Chest pain	___ / ___ / ____
☐ Hypertension	___ / ___ / ____
☐ Hypotension	___ / ___ / ____
☐ Palpitations	___ / ___ / ____
☐ Tachycardia	___ / ___ / ____
☐ Other: ________________	___ / ___ / ____
Respiratory	
☐ Chest tightness	___ / ___ / ____
☐ Cough	___ / ___ / ____
☐ Cyanosis	___ / ___ / ____
☐ Dyspnea/ SOB	___ / ___ / ____
☐ Hyperventilation/Tachypnea	___ / ___ / ____
☐ Lower airway pain/irritation	___ / ___ / ____
☐ Nose bleed	___ / ___ / ____
☐ Pleuritic chest pain	___ / ___ / ____
☐ Phlegm/Congestion	___ / ___ / ____
☐ Runny nose	___ / ___ / ____
☐ Stridor	___ / ___ / ____
☐ Upper airway pain/irritation	___ / ___ / ____
☐ Wheezing	___ / ___ / ____
☐ Other: ________________	___ / ___ / ____

Sign/Symptom	Date
Gastrointestinal	
☐ Abdominal pain	___ / ___ / ____
☐ Anorexia	___ / ___ / ____
☐ Constipation	___ / ___ / ____
☐ Diarrhea	___ / ___ / ____
☐ Nausea	___ / ___ / ____
☐ Vomiting	___ / ___ / ____
Nervous System	
☐ Ataxia	___ / ___ / ____
☐ Confusion	___ / ___ / ____
☐ Dizzy/Vertigo	___ / ___ / ____
☐ Fainting	___ / ___ / ____
☐ Fasciculations	___ / ___ / ____
☐ Headache	___ / ___ / ____
☐ Hyperactive/anxiety/irritable	___ / ___ / ____
☐ Lightheaded	___ / ___ / ____
☐ Loss of balance	___ / ___ / ____
☐ Memory loss	___ / ___ / ____
☐ Muscle pain	___ / ___ / ____
☐ Muscle rigidity	___ / ___ / ____
☐ Muscle weakness	___ / ___ / ____
☐ Paralysis	___ / ___ / ____
☐ Peripheral neuropathy	___ / ___ / ____
☐ Salivation	___ / ___ / ____
☐ Tingling/Numbness	___ / ___ / ____
☐ Other: ________________	___ / ___ / ____
Skin	
☐ Burns	___ / ___ / ____
☐ Edema/Swelling	___ / ___ / ____
☐ Erythema/Redness/Flushing	___ / ___ / ____
☐ Hives/Welts	___ / ___ / ____
☐ Irritation/Pain	___ / ___ / ____
☐ Itching/Pruritis	___ / ___ / ____
☐ Rash	___ / ___ / ____
☐ Other: ________________	___ / ___ / ___

Decontamination

Was the patient decontaminated? ☐ Yes ☐ No ☐ N/A

If yes, where was the patient decontaminated?

- ☐ In the field/At site
- ☐ At hospital
- ☐ Both
- ☐ N/A
- ☐ Other: ______________________________

How was the patient decontaminated? (check all that apply)

- ☐ Clothing removed
- ☐ Water
- ☐ Soap and water
- ☐ N/A
- ☐ Other: ______________________________________

Imaging

Date	Type of Imaging	Location	Contrast	Acute Findings	Description of Acute Findings
___ / ___ / ____	☐ X-ray ☐ CT ☐ MRI ☐ Other: ______________________		☐ Y ☐ N	☐ Y ☐ N	
___ / ___ / ____	☐ X-ray ☐ CT ☐ MRI ☐ Other: ______________________		☐ Y ☐ N	☐ Y ☐ N	
___ / ___ / ____	☐ X-ray ☐ CT ☐ MRI ☐ Other: ______________________		☐ Y ☐ N	☐ Y ☐ N	
___ / ___ / ____	☐ X-ray ☐ CT ☐ MRI ☐ Other: ______________________		☐ Y ☐ N	☐ Y ☐ N	

EKG

Date	Findings	Description of EKG Findings
___ / ___ / ____	☐ WNL ☐ Abnl, consistent ☐ Abnl, new	
___ / ___ / ____	☐ WNL ☐ Abnl, consistent ☐ Abnl, new	

WNL- within normal limits

Abnl, consistent- Abnormal finding, consistent with medical history or previous disease

Abnl, new- Abnormal finding, may indicate the presence of new disease

Lab Values (See key below for check box explanations)
(Only record actual value if it is initially abnormal or becomes abnormal. Do not record normal values.)

Lab		Repeat Lab Values (if necessary)
Na ________	☐ WNL ☐ Abnl, CI ☐ Abnl, C Dz ☐ Abnl, exposure ☐ Abnl, other	Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________ Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________
K ________	☐ WNL ☐ Abnl, CI ☐ Abnl, C Dz ☐ Abnl, exposure ☐ Abnl, other	Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________ Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________
Cl ________	☐ WNL ☐ Abnl, CI ☐ Abnl, C Dz ☐ Abnl, exposure ☐ Abnl, other	Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________ Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________
HCO_3^- ________	☐ WNL ☐ Abnl, CI ☐ Abnl, C Dz ☐ Abnl, exposure ☐ Abnl, other	Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________ Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________
BUN ________	☐ WNL ☐ Abnl, CI ☐ Abnl, C Dz ☐ Abnl, exposure ☐ Abnl, other	Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________ Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________
Cr ________	☐ WNL ☐ Abnl, CI ☐ Abnl, C Dz ☐ Abnl, exposure ☐ Abnl, other	Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________ Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________
Glu ________	☐ WNL ☐ Abnl, CI ☐ Abnl, C Dz ☐ Abnl, exposure ☐ Abnl, other	Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________ Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________
Hgb ________	☐ WNL ☐ Abnl, CI ☐ Abnl, C Dz ☐ Abnl, exposure ☐ Abnl, other	Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________ Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________
Hct ________	☐ WNL ☐ Abnl, CI ☐ Abnl, C Dz ☐ Abnl, exposure ☐ Abnl, other	Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________ Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________

WBC ________	☐ WNL ☐ Abnl, CI ☐ Abnl, C Dz ☐ Abnl, exposure ☐ Abnl, other	Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________ Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________
Plts ________	☐ WNL ☐ Abnl, CI ☐ Abnl, C Dz ☐ Abnl, exposure ☐ Abnl, other	Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________ Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________
Ca^{2+} ________	☐ WNL ☐ Abnl, CI ☐ Abnl, C Dz ☐ Abnl, exposure ☐ Abnl, other	Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________ Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________
AST ________	☐ WNL ☐ Abnl, CI ☐ Abnl, C Dz ☐ Abnl, exposure ☐ Abnl, other	Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________ Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________
ALT ________	☐ WNL ☐ Abnl, CI ☐ Abnl, C Dz ☐ Abnl, exposure ☐ Abnl, other	Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________ Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________
Total Bili ________	☐ WNL ☐ Abnl, CI ☐ Abnl, C Dz ☐ Abnl, exposure ☐ Abnl, other	Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________ Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________
Alk Phos ________	☐ WNL ☐ Abnl, CI ☐ Abnl, C Dz ☐ Abnl, exposure ☐ Abnl, other	Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________ Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________
Other: ________	☐ WNL ☐ Abnl, CI ☐ Abnl, C Dz ☐ Abnl, exposure ☐ Abnl, other	Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________ Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________
Other: ________	☐ WNL ☐ Abnl, CI ☐ Abnl, C Dz ☐ Abnl, exposure ☐ Abnl, other	Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________ Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________
Other: ________	☐ WNL ☐ Abnl, CI ☐ Abnl, C Dz ☐ Abnl, exposure ☐ Abnl, other	Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________ Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ________________

Urinalysis

	Date: ___ / ___ / ____	Repeat Lab Values (if necessary)
pH	☐ WNL ☐ Abnl, CI ☐ Abnl, C Dz ☐ Abnl, exposure ☐ Abnl, other	Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ______________ Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ______________
Specific Gravity	☐ WNL ☐ Abnl, CI ☐ Abnl, C Dz ☐ Abnl, exposure ☐ Abnl, other	Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ______________ Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ______________
Protein	☐ WNL ☐ Abnl, CI ☐ Abnl, C Dz ☐ Abnl, exposure ☐ Abnl, other	Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ______________ Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ______________
Glucose	☐ WNL ☐ Abnl, CI ☐ Abnl, C Dz ☐ Abnl, exposure ☐ Abnl, other	Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ______________ Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ______________
Ketones	☐ WNL ☐ Abnl, CI ☐ Abnl, C Dz ☐ Abnl, exposure ☐ Abnl, other	Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ______________ Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ______________
WBC	☐ WNL ☐ Abnl, CI ☐ Abnl, C Dz ☐ Abnl, exposure ☐ Abnl, other	Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ______________ Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ______________
RBC	☐ WNL ☐ Abnl, CI ☐ Abnl, C Dz ☐ Abnl, exposure ☐ Abnl, other	Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ______________ Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ______________
Bilirubin	☐ WNL ☐ Abnl, CI ☐ Abnl, C Dz ☐ Abnl, exposure ☐ Abnl, other	Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ______________ Date: ___ / ___ / ___ Time: ____:____ ☐ am ☐ pm ______________

WNL- Within normal limits
Abnl, CI- Abnormal, Clinically insignificant (To be determined with NCEH Toxicologists)
Abnl, C Dz- Abnormal finding, consistent with documented chronic disease
Abnl, exposure- Abnormal finding, potentially associated with the exposure
Abnl, other- Clinically significant abnormality, related to other disease process

Pulmonary Function Tests

	Predicted Value	Measured Value	% Predicted
Forced Vital Capacity			
Forced Expiratory Volume (FEV_1)			
FEV_1/FVC			
Peak Expiratory Flow Rate			
Forced Inspiratory Vital Capacity			
Forced Expiratory Flow			

Arterial Blood Gas (ABG) Flow Sheet

Date	Date	Date	Date
Time	Time	Time	Time
pH	pH	pH	pH
pO_2	pO_2	pO_2	pO_2
pCO_2	pCO_2	pCO_2	pCO_2
HCO_3^-	HCO_3^-	HCO_3^-	HCO_3^-
O_2 sat	O_2 sat	O_2 sat	O_2 sat
Supplemental O_2 ☐ Y ☐ N ☐ N/A If Yes, ☐ NC/FM ☐ NRB ☐ CPAP ☐ Mechanical Vent.	Supplemental O_2 ☐ Y ☐ N ☐ N/A If Yes, ☐ NC/FM ☐ NRB ☐ CPAP ☐ Mechanical Vent.	Supplemental O_2 ☐ Y ☐ N ☐ N/A If Yes, ☐ NC/FM ☐ NRB ☐ CPAP ☐ Mechanical Vent.	Supplemental O_2 ☐ Y ☐ N ☐ N/A If Yes, ☐ NC/FM ☐ NRB ☐ CPAP ☐ Mechanical Vent.

Medications (new medications that were initiated or prescribed during this visit/admission)

Name	Indication	Given during this visit?	Continued after discharge?

Consults

☐ Cardiology: ____

____

☐ Dermatology: ____

____

☐ ENT: ____

____

☐ Ophthalmology: ____

____

□ Pulmonary: ____

____

□ Poison Control: ____

____

□ Psychiatry: ____

____

□ Social Work: ____

____

□ Surgery: ____

____

□ Other: ____

____

Outcomes

Primary Diagnosis: ____

Secondary Diagnosis: ____

ICD-9 Codes

1. ____________________ 2. __________________ 3. _____________________

4. ____________________ 5. __________________ 6. _____________________

Discharge

□ LWBS □ Discharged from ED: Date: ___ / ___ /____ Time: ____: _____ □ am □ pm

□ Admitted: ___ / ___ /____ Discharge information: Date: ___ / ___ /____ Time: ____: _____ □ am □ pm

□ Died: ___ / ___ /____ Cause of death: ____

□ Other: ________________________________

LWBS- Left without being seen