Appendix 6: Medical Chart Abstraction Form

Form Approved
OMB No. 0923-XXXX
Exp. Date XX/XX/20XX

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: ____ / ____ / _____ **Sex:** □ Male □ Female □ N/A **Ethnicity:** □ Hispanic □ Not Hispanic
MM DD YYYY

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: ____ / ____ / _____ Time of arrival: ____:____ □ am □ pm
MM DD YYYY

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:
_____
_____
_____
_____

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.

General

Sign/Symptom	Date
◻ Chills	___ / ___ / ____
◻ Fever (>100.4 °F)	___ / ___ / ____
◻ Fatigue/Malaise	___ / ___ / ____
◻ Hypothermia (<95.0 °F)	___ / ___ / ____
◻ Other: _____	___ / ___ / ____
◻ Other: _____	___ / ___ / ____
◻ Other: _____	___ / ___ / ____

Eye

Sign/Symptom	Date
◻ Corneal abrasion	___ / ___ / ____
◻ Increased tearing	___ / ___ / ____
◻ Irritation/Pain	___ / ___ / ____
◻ Itching/Pruritis	___ / ___ / ____
◻ Miosis	___ / ___ / ____
◻ Mydriasis	___ / ___ / ____
◻ Visual changes	___ / ___ / ____
◻ Other: _____	___ / ___ / ____

Cardiovascular

Sign/Symptom	Date
◻ Bradycardia	___ / ___ / ____
◻ Cardiac arrest	___ / ___ / ____
◻ Chest pain	___ / ___ / ____
◻ Hypertension	___ / ___ / ____
◻ Hypotension	___ / ___ / ____
◻ Palpitations	___ / ___ / ____
◻ Tachycardia	___ / ___ / ____
◻ Other: _____	___ / ___ / ____

Respiratory

Sign/Symptom	Date
◻ 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: _____	___ / ___ / ____

Gastrointestinal

Sign/Symptom	Date
◻ Abdominal pain	___ / ___ / ____
◻ Anorexia	___ / ___ / ____
◻ Constipation	___ / ___ / ____
◻ Diarrhea	___ / ___ / ____
◻ Nausea	___ / ___ / ____
◻ Vomiting	___ / ___ / ____

Nervous System

Sign/Symptom	Date
◻ 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

Sign/Symptom	Date
◻ 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