` Form Approved
OMB No. 0920-1011
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# 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:

_____

_____

**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: _____

_____

**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** |
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## 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 ℃)…… ☐Yes ☐No ☐Unknown

If yes, what was the highest temperature? _____ ℃

Temperature <35 ℃…… ☐Yes ☐No ☐Unknown

If yes, what was the lowest temperature? _____ ℃

**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 | |

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|---|---|---|---|
| | 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 | | | |
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## 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 | |
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## 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)** |
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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