Human Parechovirus 3 (HPeV3) Investigation

Part I: Medical Chart Abstraction

Please note that this medical chart review form has 19 pages and contains four parts:

**Part A**: **demographic information** about the infant who was ill with HPeV3

**Part B**: information from the medical chart of the **mother for labor, delivery and follow up**

**Part C**: information from the medical chart of the **infant during delivery and neonatal care**

**Part D**: information from the medical chart of the infant following **admission for HPeV3 illness (most likely at Children’s Mercy Hospital)**

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: HPeV3 case-patient information** |
| First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last (Family) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY) Sex: 🞎Female 🞎Male 🞎UnknownRace: 🞎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-HispanicFirst name of parent/guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last (Family) name of parent/guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Residence address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Part B: Mother’s medical record for labor, delivery and follow up** |
| Medical record number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Hospital name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Hospital floor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hospital room number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date mother was admitted to hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)Date of discharge: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)Mother’s First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mother’s Last (Family) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mother’s date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY) OR Mother’s age (yrs) \_\_\_\_\_\_\_\_ Mother’s race: 🞎Asian 🞎Black 🞎Hawaiian/Pacific Islander  🞎Native American/Alaskan 🞎White 🞎Other (More than one box can be checked)Mother’s ethnicity: 🞎Hispanic 🞎Non-HispanicMother’s telephone number (if different to Part 1): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mother’s residence address (if different to Part 1): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mother’s type of health insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Does the mother have any pre-existing medical conditions? 🞎Yes 🞎No 🞎UnknownIf yes, please describe:Date of delivery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY) Time of delivery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Delivery ward: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mode of delivery: 🞎Vaginal delivery 🞎Caesarean Section 🞎UnknownIf vaginal, duration of membrane rupture prior to delivery (hours) \_\_\_\_\_\_\_\_\_\_\_Was a scalp monitor used during delivery? 🞎Yes 🞎No 🞎UnknownIf yes, was there evidence of its use upon physical examination? 🞎Yes 🞎No 🞎Unknown(e.g. bruising, laceration)Was the mother febrile (>38 °C) during delivery? 🞎Yes 🞎No 🞎UnknownWas the mother febrile (>38 °C) in the week before delivery? 🞎Yes 🞎No 🞎UnknownDid the mother have a rash during delivery? 🞎Yes 🞎No 🞎UnknownDid the mother have a rash in the week before delivery? 🞎Yes 🞎No 🞎UnknownIf yes to any of the above, please include a description of the rash (eg location, type {maculopapular, vesicular} etc):Please list any medications prescribed to the mother in hospital (e.g. PRN medications, oxytocin, antibiotics, anesthetics):

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| **Medication** | **Dose and route** | **Date Started (MM/DD/YYYY)** | **Date Stopped (MM/DD/YYYY)** |
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| **Medication** | **Dose and route** | **Date Started (MM/DD/YYYY)** | **Date Stopped (MM/DD/YYYY)** |
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Please list staff present before and during labor or the delivery, and also post-partum care:

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| **Name** | **Job Title** |
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Any other comments regarding labor, delivery or post-partum care: |

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| **Part C: Infant’s chart for delivery and neonatal follow up** |
| Medical record number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Hospital name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Infant’s First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ Infant’s Last (Family) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of delivery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY) Time of delivery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Length of gestation (weeks): \_\_\_\_\_\_\_\_\_ Infant’s Birth Weight (lbs): \_\_\_\_\_\_\_\_\_\_ 🞎Estimated 🞎Measured 🞎UnknownWas resuscitation required at birth? 🞎Yes 🞎No 🞎UnknownIf yes: 🞎Suction 🞎Oxygen 🞎Positive pressure ventilation (PPV) 🞎IntubationWhich nursery was the infant in after birth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How long was the infant in the nursery? \_\_\_\_\_\_\_\_ hours/days (please circle) 🞎Unknown Please list any staff who cared for the infant in the nursery:

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| **Name** | **Job Title** |
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Please list any medications prescribed to the infant during neonatal care:

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| **Medication** | **Dose and route** | **Date Started (MM/DD/YYYY)** | **Date Stopped (MM/DD/YYYY)** |
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Please describe any treatment regimens or interventions provided to the infant during neonatal care(e.g. supplemental oxygen, respiratory therapy, supplemental feeding, circumcision, PRN meds etc):*Do not include intravenous fluids*Any other comments regarding the infant’s delivery or neonatal care:Discharge date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)Status upon discharge: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

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| **Part D: Medical chart of infant’s hospitalization for HPeV3 illness** |
| Medical record number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Infant’s First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Infant’s Last (Family) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Infant’s date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)Date of testing for HPeV: ­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(MM/DD/YYYY)Test type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_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 and nursery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Transferred to:Hospital name and nursery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Please describe any patient information available from a referring facility, if applicable:Did the infant have any underlying medical conditions? 🞎Yes 🞎No 🞎UnknownIf yes, please describe:Are outpatient visits prior to becoming ill noted in the chart? 🞎Yes 🞎No 🞎UnknownIf yes, please describe:Is family history of neurologic illness, including seizures, noted in the chart? 🞎Yes 🞎No 🞎UnknownIf yes, please describe:Please list any medications prescribed to the infant **before** hospitalisation (e.g. OTC meds used by parents, medications discontinued prior to hospitalisation):

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| **Medication** | **Dose and route** | **Date Started (MM/DD/YYYY)** | **Place of administration** |
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Signs and SymptomsDate of first clinical symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)As part of this illness, does the infant have or has the infant had any of the following:**Fever**Fever (>38 °C)………………………………………………………….. 🞎Yes 🞎No 🞎UnknownIf yes, what was the highest temperature? \_\_\_\_\_\_\_ °CTemperature <35 °C…….………………………………………….. 🞎Yes 🞎No 🞎UnknownIf yes, what was the lowest temperature? \_\_\_\_\_\_\_ °C**Rash**Skin rash……..………………………………………………………….. 🞎Yes 🞎No 🞎UnknownIf yes, please describe (eg. Location, type {maculopapular, vesicular} etc):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Redness on feet or hands ………………………………………… 🞎Yes 🞎No 🞎UnknownUlcers or lesions in mouth……………………………………….. 🞎Yes 🞎No 🞎Unknown**Neurologic**Focal seizures/convulsions…….……………………………. 🞎Yes 🞎No 🞎UnknownGeneralized seizures/convulsions…….…………………….. 🞎Yes 🞎No 🞎UnknownIntractable seizures/convulsions…….…………………..….. 🞎Yes 🞎No 🞎UnknownMyoclonic jerk..………………………………………………………. 🞎Yes 🞎No 🞎UnknownTremors.…………………………………………………………………. 🞎Yes 🞎No 🞎UnknownLimb weakness/monoparesis………………………………….. 🞎Yes 🞎No 🞎UnknownStiff neck..……………………………………………………………….. 🞎Yes 🞎No 🞎UnknownBulging fontanelle.………………………………………………….. 🞎Yes 🞎No 🞎UnknownLethargy………………………………………………………………….. 🞎Yes 🞎No 🞎UnknownIrritability.……………………………………………………………….. 🞎Yes 🞎No 🞎UnknownInconsolable crying…………………………………………………. 🞎Yes 🞎No 🞎UnknownCranial nerve palsy………………………………………………….. 🞎Yes 🞎No 🞎Unknown**Respiratory**Cough (dry, productive).….…………..………………………….. 🞎Yes 🞎No 🞎UnknownSecretions……………………………………………………………….. 🞎Yes 🞎No 🞎UnknownRunny nose.…………………………………………………………….. 🞎Yes 🞎No 🞎UnknownSneezing………………………………………………………………….. 🞎Yes 🞎No 🞎UnknownDifficulty breathing………………………………………………….. 🞎Yes 🞎No 🞎UnknownWheezing.……………………………………………………………….. 🞎Yes 🞎No 🞎UnknownRales/crackles/crepitations.…………………………………….. 🞎Yes 🞎No 🞎UnknownTachypnea (as assessed and recorded by provider)… 🞎Yes 🞎No 🞎UnknownIf yes, please indicate rate \_\_\_\_\_\_\_\_\_\_\_ (RR/min)Frothy secretions from mouth..……………………………….. 🞎Yes 🞎No 🞎UnknownHemoptysis.…………………………………………………………….. 🞎Yes 🞎No 🞎UnknownRespiratory failure.………………………………………………….. 🞎Yes 🞎No 🞎UnknownOxygen given.………………………………………………………….. 🞎Yes 🞎No 🞎UnknownIf yes, how was it administered? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Intubation……………………………………………………………….. 🞎Yes 🞎No 🞎UnknownRetractions, nasal flaring..……………………………………….. 🞎Yes 🞎No 🞎Unknown**Cardiovascular**Bradycardia (as assessed and recorded by provider).. 🞎Yes 🞎No 🞎UnknownIf yes, please indicate rate \_\_\_\_\_\_\_\_\_\_\_ (HR/min)Tachycardia (as assessed and recorded by provider).. 🞎Yes 🞎No 🞎UnknownIf yes, please indicate rate \_\_\_\_\_\_\_\_\_\_\_ (HR/min)Variable heart rate (tachy/brady)……………………………. 🞎Yes 🞎No 🞎UnknownCyanosis………………………………………………………………….. 🞎Yes 🞎No 🞎UnknownMottled skin……………………………………………………………. 🞎Yes 🞎No 🞎UnknownArrhythmia.…………………………………………………….……….. 🞎Yes 🞎No 🞎UnknownAbnormal heart sounds.………………………………………….. 🞎Yes 🞎No 🞎UnknownIf yes, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Hypotension/shock………………………………………………….. 🞎Yes 🞎No 🞎Unknown**Gastrointestinal**Vomiting………………………………………………………………….. 🞎Yes 🞎No 🞎UnknownWatery stools………………………………………………………….. 🞎Yes 🞎No 🞎UnknownConstipation..………………………………………………………….. 🞎Yes 🞎No 🞎UnknownAbdominal distention.…………………………………………….. 🞎Yes 🞎No 🞎UnknownAbdominal pain……………………………………………………….. 🞎Yes 🞎No 🞎UnknownJaundice………………………………………………………………….. 🞎Yes 🞎No 🞎UnknownPoor feeding………………………………………………………… .. 🞎Yes 🞎No 🞎Unknown**Others**Conjunctivitis.………………………………………………………….. 🞎Yes 🞎No 🞎UnknownBleeding.………………………………………………………………….. 🞎Yes 🞎No 🞎UnknownPersistent crying………………………………………………………. 🞎Yes 🞎No 🞎UnknownLymphadenopathy.………………………………………………….. 🞎Yes 🞎No 🞎UnknownPlease describe any other symptoms not listed above, or any of note:Laboratory ExamsPlease list here all laboratory findings from admission:

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| **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 |
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Radiologic ExamsPlease describe here all radiological exams requested:

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| **Exam date****(MM/DD/YYYY)** | **Test type** | **Results** |
|  | CXR |  |
|  | CT |  |
|  | MRI |  |
|  | Echocardiography |  |
|  | Ultrasound |  |
|  | EEG |  |
|  | Plain abdominal radiographs |  |
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Medication and TreatmentWas the infant placed in the neonatal intensive care unit (NICU)? 🞎Yes 🞎No 🞎UnknownIf yes, admission date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Discharge date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)Was the infant placed in the pediatric intensive care unit (PICU)? 🞎Yes 🞎No 🞎UnknownIf yes, admission date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Discharge date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)Please list any medications prescribed to the infant in hospital:

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| --- | --- | --- | --- |
| **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 infant in hospital(e.g. supplemental oxygen, respiratory therapy, supplemental feedings, PRN meds etc):*Do not include intravenous fluids* DischargeIs infant 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 informationPlease describe here any other information that you feel may be important or unusual, with regard to the infant’s stay in hospital: |

End of medical chart abstraction form