

**Appendix 7: Veterinary Chart Abstraction Form**

SAMPLE

# Veterinary Chart Abstraction Form

Reviewer Name: \_\_\_\_\_ Date of Review: \_\_\_ / \_\_\_ / \_\_\_ Data entered: \_\_\_ / \_\_\_ / \_\_\_

Veterinary Hospital: \_\_\_\_\_ Pet ID: \_\_\_\_\_

Pet Name: \_\_\_\_\_ Owner's Name: \_\_\_\_\_

Address: Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_ (Other) \_\_\_\_\_

## Patient Demographics

Age: \_\_\_  Years  Months Sex:  Male  Female  Neutered/SpayedSpecies:  Dog  Cat  Other \_\_\_\_\_ Breed: \_\_\_\_\_Hair Length:  Short  Medium  Long  Hairless  N/A Body Condition Score: \_\_\_\_\_

## Visit Information

Date of Visit: \_\_\_ / \_\_\_ / \_\_\_ Time of arrival: \_\_\_:\_\_\_  am  pm  
MM DD YYYY

Chief Complaint: \_\_\_\_\_

Was the pet admitted?  Y  N If yes, # Days: \_\_\_\_\_Initial Vital Signs: Weight: \_\_\_\_\_  kg  lbTemp (°F): \_\_\_\_\_ Heart Rate: \_\_\_\_\_ Respiratory Rate: \_\_\_\_\_ O<sub>2</sub> sat: \_\_\_\_\_

## Medical History

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Medications: Heartworm prevention  Y  N

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## Decontamination

Was the patient decontaminated?  Yes  No  N/A

If yes, where was the patient decontaminated?

- In the field/At site  
 At veterinary hospital  
 Both  
 Other: \_\_\_\_\_

How was the patient decontaminated?

- Water  
 Soap and water  
 Other: \_\_\_\_\_

## Clinical Signs

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

Sign Date

### General

- Fever (>103.0 °F)\* \_\_\_/\_\_\_/\_\_\_
- Hypothermia (<98.0 °F)\* \_\_\_/\_\_\_/\_\_\_
- Lethargy \_\_\_/\_\_\_/\_\_\_
- Other: \_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_
- Other: \_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_

### Eye

- Corneal abrasion \_\_\_/\_\_\_/\_\_\_
- Increased tearing \_\_\_/\_\_\_/\_\_\_
- Irritation/Pain \_\_\_/\_\_\_/\_\_\_
- Itching/Pruritis \_\_\_/\_\_\_/\_\_\_
- Miosis \_\_\_/\_\_\_/\_\_\_
- Mydriasis \_\_\_/\_\_\_/\_\_\_
- Other: \_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_

### Cardiovascular

- Bradycardia\* \_\_\_/\_\_\_/\_\_\_
- Cardiac arrest \_\_\_/\_\_\_/\_\_\_
- Hypertension \_\_\_/\_\_\_/\_\_\_
- Hypotension \_\_\_/\_\_\_/\_\_\_
- Tachycardia\* \_\_\_/\_\_\_/\_\_\_
- Other: \_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_

### Respiratory

- Cough \_\_\_/\_\_\_/\_\_\_
- Cyanosis \_\_\_/\_\_\_/\_\_\_
- Dyspnea \_\_\_/\_\_\_/\_\_\_
- Hyperventilation/Tachypnea \_\_\_/\_\_\_/\_\_\_
- Nose bleed \_\_\_/\_\_\_/\_\_\_
- Phlegm/Congestion \_\_\_/\_\_\_/\_\_\_
- Runny nose \_\_\_/\_\_\_/\_\_\_
- Stridor \_\_\_/\_\_\_/\_\_\_
- Wheezing \_\_\_/\_\_\_/\_\_\_
- Other: \_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_

### Gastrointestinal

- Abdominal pain \_\_\_/\_\_\_/\_\_\_
- Anorexia \_\_\_/\_\_\_/\_\_\_
- Constipation \_\_\_/\_\_\_/\_\_\_
- Diarrhea \_\_\_/\_\_\_/\_\_\_
- Nausea \_\_\_/\_\_\_/\_\_\_
- Vomiting \_\_\_/\_\_\_/\_\_\_
- Other: \_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_

Sign Date

### Nervous System

- Ataxia \_\_\_/\_\_\_/\_\_\_
- Fasciculations \_\_\_/\_\_\_/\_\_\_
- Hyperactive/anxiety/irritable \_\_\_/\_\_\_/\_\_\_
- Muscle pain \_\_\_/\_\_\_/\_\_\_
- Muscle rigidity \_\_\_/\_\_\_/\_\_\_
- Muscle weakness \_\_\_/\_\_\_/\_\_\_
- Paralysis \_\_\_/\_\_\_/\_\_\_
- Peripheral neuropathy \_\_\_/\_\_\_/\_\_\_
- Salivation \_\_\_/\_\_\_/\_\_\_
- Other: \_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_

### Skin

- Burns \_\_\_/\_\_\_/\_\_\_
- Edema/Swelling \_\_\_/\_\_\_/\_\_\_
- Erythema/Redness/Flushing \_\_\_/\_\_\_/\_\_\_
- Hives/Welts \_\_\_/\_\_\_/\_\_\_
- Irritation/Pain \_\_\_/\_\_\_/\_\_\_
- Itching/Pruritis \_\_\_/\_\_\_/\_\_\_
- Rash \_\_\_/\_\_\_/\_\_\_
- Other: \_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_

\*Normal value varies by species

### Imaging

Date	Type of Imaging	Location	Contrast	Acute Findings	Description of Acute Findings
___ / ___ / ___	<input type="checkbox"/> X-ray <input type="checkbox"/> Ultrasound <input type="checkbox"/> Other: _____		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
___ / ___ / ___	<input type="checkbox"/> X-ray <input type="checkbox"/> Ultrasound <input type="checkbox"/> Other: _____		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
___ / ___ / ___	<input type="checkbox"/> X-ray <input type="checkbox"/> Ultrasound <input type="checkbox"/> Other: _____		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
___ / ___ / ___	<input type="checkbox"/> X-ray <input type="checkbox"/> Ultrasound <input type="checkbox"/> Other: _____		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

### EKG

Date	Findings	Description of EKG Findings
___ / ___ / ___	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, consistent <input type="checkbox"/> Abnl, new	
___ / ___ / ___	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, consistent <input type="checkbox"/> 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 _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
K _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Cl _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
HCO <sub>3</sub> <sup>-</sup> _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
BUN _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Cr _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Glu _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Hgb _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Hct _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____

WBC _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
_____		Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Plts _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
_____		Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Ca <sup>2+</sup> _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
_____		Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
AST _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
_____		Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
ALT _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
_____		Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Total Bili _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
_____		Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Alk Phos _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
_____		Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Other: _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
_____		Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Other: _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
_____		Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Other: _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
_____		Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____

## Urinalysis

	Date: ___ / ___ / ____	Repeat Lab Values (if necessary)
pH	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ____:____ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ____:____ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Specific Gravity	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ____:____ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ____:____ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Protein	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ____:____ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ____:____ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Glucose	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ____:____ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ____:____ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Ketones	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ____:____ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ____:____ <input type="checkbox"/> am <input type="checkbox"/> pm _____
WBC	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ____:____ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ____:____ <input type="checkbox"/> am <input type="checkbox"/> pm _____
RBC	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ____:____ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ____:____ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Bilirubin	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ____:____ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ____:____ <input type="checkbox"/> am <input type="checkbox"/> 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

### Arterial Blood Gas (ABG) Flow Sheet

Date	Date	Date	Date
Time	Time	Time	Time
pH	pH	pH	pH
pO <sub>2</sub>	pO <sub>2</sub>	pO <sub>2</sub>	pO <sub>2</sub>
pCO <sub>2</sub>	pCO <sub>2</sub>	pCO <sub>2</sub>	pCO <sub>2</sub>
HCO <sub>3</sub> <sup>-</sup>	HCO <sub>3</sub> <sup>-</sup>	HCO <sub>3</sub> <sup>-</sup>	HCO <sub>3</sub> <sup>-</sup>
O <sub>2</sub> sat	O <sub>2</sub> sat	O <sub>2</sub> sat	O <sub>2</sub> sat
Supplemental O <sub>2</sub> <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A	Supplemental O <sub>2</sub> <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/Ac	Supplemental O <sub>2</sub> <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A	Supplemental O <sub>2</sub> <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A

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

Name	Indication	Given during this visit?	Continued after discharge?

### Outcomes

Diagnosis: \_\_\_\_\_

### Discharge

LWBS       Office visit

Admitted: \_\_\_ / \_\_\_ / \_\_\_ Discharge information: Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_: \_\_\_  am  pm

Died: \_\_\_ / \_\_\_ / \_\_\_ Cause of death: \_\_\_\_\_

Necropsy performed?  Yes  No

If yes, where? \_\_\_\_\_

Necropsy findings: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other: \_\_\_\_\_

LWBS- Left without being seen