

# 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  American Indian/ Alaskan Native  Asian  Black  
 None  N/A  Other: \_\_\_\_\_  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<sub>2</sub> sat: \_\_\_\_\_ Supplemental O<sub>2</sub>?  Y  N  N/A If yes, delivery method: \_\_\_\_\_

## Medical History (check all that apply)

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

### 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.

### 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
___/___/___	<input type="checkbox"/> X-ray <input type="checkbox"/> CT <input type="checkbox"/> MRI <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"/> CT <input type="checkbox"/> MRI <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"/> CT <input type="checkbox"/> MRI <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"/> CT <input type="checkbox"/> MRI <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

### Pulmonary Function Tests

	Predicted Value	Measured Value	% Predicted
Forced Vital Capacity			
Forced Expiratory Volume (FEV <sub>1</sub> )			
FEV <sub>1</sub> /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 <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 If Yes, <input type="checkbox"/> NC/FM <input type="checkbox"/> NRB <input type="checkbox"/> CPAP <input type="checkbox"/> Mechanical Vent.	Supplemental O <sub>2</sub> <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A If Yes, <input type="checkbox"/> NC/FM <input type="checkbox"/> NRB <input type="checkbox"/> CPAP <input type="checkbox"/> Mechanical Vent.	Supplemental O <sub>2</sub> <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A If Yes, <input type="checkbox"/> NC/FM <input type="checkbox"/> NRB <input type="checkbox"/> CPAP <input type="checkbox"/> Mechanical Vent.	Supplemental O <sub>2</sub> <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A If Yes, <input type="checkbox"/> NC/FM <input type="checkbox"/> NRB <input type="checkbox"/> CPAP <input type="checkbox"/> 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