

## Appendix I: Medical Chart Abstraction

Public reporting burden of this collection of information is estimated to average 60 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

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

**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 °C)..... Yes No Unknown

If yes, what was the highest temperature? \_\_\_\_\_ °C

Temperature <35 °C..... Yes No Unknown

If yes, what was the lowest temperature? \_\_\_\_\_ °C

**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:

<b>Specimen Collection Date (MM/DD/YYYY)</b>	<b>Specimen type</b>	<b>Test type</b>	<b>Results (include reference range)</b>
	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	
<b>Specimen Collection Date (MM/DD/YYYY)</b>	<b>Specimen type</b>	<b>Test type</b>	<b>Results (include reference range)</b>
	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	
<b>Specimen Collection Date (MM/DD/YYYY)</b>	<b>Specimen type</b>	<b>Test type</b>	<b>Results (include reference range)</b>
	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			


**Radiologic Exams**

Please describe here all radiological exams requested:

<b>Exam date (MM/DD/YYYY)</b>	<b>Test type</b>	<b>Results</b>
	CXR	
	CT	
	MRI	
	Echocardiography	
	Ultrasound	
	EEG	
	Plain abdominal radiographs	


**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:

<b>Medication</b>	<b>Dose and route</b>	<b>Date Started (MM/DD/YYYY)</b>	<b>Date Stopped (MM/DD/YYYY)</b>

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: \_\_\_\_\_

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**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