

Appendix F: Medical Chart Abstraction Form

SAMPLE

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): _____ / _____

O₂ sat: _____ Supplemental O₂? 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
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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
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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 ₃ ⁻ _____	<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 ²⁺ _____	<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 ₁)			
FEV ₁ /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 ₂	pO ₂	pO ₂	pO ₂
pCO ₂	pCO ₂	pCO ₂	pCO ₂
HCO ₃ ⁻	HCO ₃ ⁻	HCO ₃ ⁻	HCO ₃ ⁻
O ₂ sat	O ₂ sat	O ₂ sat	O ₂ sat
Supplemental O ₂ <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 ₂ <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 ₂ <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 ₂ <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