

Appendix G: 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/Spayed

Species: 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 lb

Temp (°F): _____ Heart Rate: _____ Respiratory Rate: _____ O₂ sat: _____

Medical History

Medications: Heartworm prevention Y N

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 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

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	Supplemental O ₂ <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/Ac	Supplemental O ₂ <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A	Supplemental O ₂ <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