2018 CHART ABSTRACTION FORM

Patient information (remove top page following abstraction)	PATIENT ID ___ ___ ___ ___ ___

Patient's Name: _____
Last Names First Name

Date of Birth: _____/_____/_____ **Abstractor initials:** _____
MM DD YYYY

FINAL

2018 CHART ABSTRACTION FORM

PATIENT ID ___ ___ ___ ___ ___

I. Patient data

Gender: ☐ **M** ☐ **F** **Date of Birth:** _____/_____/_____ (MM DD YYYY)

Tribal community: _____ **Tribal affiliation:** _____

II. Chart abstraction info

Abstractor initials: _____ **Date of chart abstraction:** _____/_____/_____ (MM DD YYYY) **Location of primary abstraction:** _____

III. Dates of care

Not available

Date of first symptoms: _____/_____/_____ (MM DD YYYY) ☐

Symptoms at first provider visit: _____

Date of fever onset (if different): _____/_____/_____ (MM DD YYYY)

Date of first provider visit: _____/_____/_____ (MM DD YYYY) ☐

ICD-9 or ICD-10 codes used at first provider visit: _____

Tick bite or tick contact noted in first visit? ☐ Yes ☐ No ☐ Unk

Healthcare facilities visited during RMSF illness:

Name of facility	Dates of care	Type of visit (ED, outpatient, inpatient)
_____	From: _____/_____/_____ To: _____/_____/_____ (MM DD YYYY)	_____
_____	From: _____/_____/_____ To: _____/_____/_____ (MM DD YYYY)	_____
_____	From: _____/_____/_____ To: _____/_____/_____ (MM DD YYYY)	_____
_____	From: _____/_____/_____ To: _____/_____/_____ (MM DD YYYY)	_____
_____	From: _____/_____/_____ To: _____/_____/_____ (MM DD YYYY)	_____

Admitted to ICU? ☐ Yes ☐ No From: _____/_____/_____ To: _____/_____/_____ (MM DD YYYY)

Date of first RMSF mention in chart: _____/_____/_____ (MM DD YYYY) ☐

Date of first tetracycline therapy: _____/_____/_____ (MM DD YYYY) ☐

Date of fever resolution: _____/_____/_____ (MM DD YYYY) ☐

Number of ER visits: _____

Number of outpatient visits: _____

Number of general admission days : _____

Number of ICU days : _____

IV. Medical history prior to hospitalization *(check if yes)*

☐ Diabetes ☐ Hx of drug abuse ☐ Hx of alcohol abuse

V. Medical history during hospitalization *(check if yes)*

☐ Evidence of shock or use of vasopressors
☐ ARDS
☐ Multiorgan failure
☐ Renal insufficiency
☐ Cerebral edema
☐ Coma
☐ Altered mental status
☐ Digital necrosis
If yes, specify body parts involved: _____
☐ Severe thrombocytopenia(<50 10^3 uL)
If yes, list date of first result <50 10^3 uL _____/_____/_____ (MM DD YYYY)
☐ Rash and/or eschar
If yes, please describe onset (including dates), location, and evolution _____

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VI. Treatment and procedures during hospitalization

Antibiotic (including tetracycline therapy)	Start date	End date
_____	_____/_____/_____ MM DD YYYY	_____/_____/_____ MM DD YYYY
_____	_____/_____/_____ MM DD YYYY	_____/_____/_____ MM DD YYYY
_____	_____/_____/_____ MM DD YYYY	_____/_____/_____ MM DD YYYY
_____	_____/_____/_____ MM DD YYYY	_____/_____/_____ MM DD YYYY

☐ Vassopressors (which:_____)
From _____/_____/_____ (MM DD YYYY) to _____/_____/_____ (MM DD YYYY)

☐ Transfusion (products an quantity:_____)
Date1 _____/_____/_____ (MM DD YYYY) Date2 _____/_____/_____ (MM DD YYYY)

☐ Mechanical Ventilation (eg. Intubation)
From _____/_____/_____ (MM DD YYYY) to _____/_____/_____ (MM DD YYYY)

☐ Hemodialysis (e.g. CRRT)
From _____/_____/_____ (MM DD YYYY) to _____/_____/_____ (MM DD YYYY)

☐ Amputation
If yes, specify body parts involved: _____

☐ Other surgical procedures
Describe: _____

VII. Neurologic and psychiatric history prior to RMSF

Did patient have any documented neurologic impairments(including concussion or TBI, fetal alcohol syndrome, Parkinson's, etc.) prior to RMSF illness?

☐ Yes ☐ No ☐ Unknown

If yes, specify type: _____

Date of diganosis _____/_____/_____ (MM DD YYYY) ☐ Unknown

Did patient have any documented psychiatric impairments prior to RMSF illness?

☐ Yes ☐ No ☐ Unknown

If yes, specify type: _____

Date of diganosis _____/_____/_____ (MM DD YYYY) ☐ Unknown

For children <8 years, were there any previously documented developmental delays noted prior to RMSF illness?

☐ Yes ☐ No ☐ Unknown

If yes, describe: _____

VIII. Neurologic and psychiatric history at discharge

	YES	NO	Unknown
Behavioral/personality change	☐	☐	☐
Memory problems	☐	☐	☐
Anxiety	☐	☐	☐
Depression	☐	☐	☐
Confusion/disorientation/coma	☐	☐	☐
Headache	☐	☐	☐
Pain	☐	☐	☐
Dysarthria/slurred speech	☐	☐	☐
Dysphagia/difficulty swallowing	☐	☐	☐
Hearing loss	☐	☐	☐
Blindness/visual impairment	☐	☐	☐
Diplopia/ophthalmoplegia	☐	☐	☐

	YES	NO	Unknown
Numbness/paresthesias	☐	☐	☐
Myoclonus	☐	☐	☐
Seizures	☐	☐	☐
Bowel/bladder incontinence	☐	☐	☐
Weakness	☐	☐	☐
Difficulty breathing	☐	☐	☐
Tremors	☐	☐	☐
Ataxia/problems with balance	☐	☐	☐
Hyporeflexia/areflexia	☐	☐	☐
Decline in functional capacity from baseline	☐	☐	☐

If yes, describe: _____

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IX. RMSF Testing

Specimen type: _____ _____/_____/_____ (MM DD YYYY) Test: _____ Result: _____

Specimen type: _____ _____/_____/_____ (MM DD YYYY) Test: _____ Result: _____

Specimen type: _____ _____/_____/_____ (MM DD YYYY) Test: _____ Result: _____

Specimen type: _____ _____/_____/_____ (MM DD YYYY) Test: _____ Result: _____

Specimen type: _____ _____/_____/_____ (MM DD YYYY) Test: _____ Result: _____

X. Other infectious etiology testing

Was a secondary infection documented (discharge summary, chart, labs)?

☐ Yes ☐ No ☐ Unknown

If yes, please describe the nature of the infection and corroborating laboratory evidence:

_____

_____

_____

_____

XI. Lumbar puncture *(leave blank if not performed)*

Note, if multiple LPs were performed please use earliest result _____/_____/_____ (MM DD YYYY)

WBCs/mm^3 _____ Protein (mg/dL) _____ Gram stain _____

WBC diff: ___%PMN ___%Lymp ___%Eos ___%Mon Glucose (mg/dL)_____ Color (eg.xanthochromia)_____

RBCs/mm^3_____ Culture _____

XII. Neurologic and imaging studies:

	Performed	*Not performed*	*Date of finding* (MM DD YYYY)	*Impression (if unremarkable, write "normal")*
Head CT	☐	☐	_____/_____/_____	_____
				List substantial changes in subsequent series: _____
Head MRI	☐	☐	_____/_____/_____	_____
				List substantial changes in subsequent series: _____
Spinal MRI	☐	☐	_____/_____/_____	_____
Specify: _____				List substantial changes in subsequent series: _____
EEG or other neurologic study	☐	☐	_____/_____/_____	_____
Specify: _____				List substantial changes in subsequent series: _____

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XIII. Outcome

Final disposition:

☐ Died

Date of death: _____/_____/_____
MM DD YYYY

☐ Transferred to another facility

Date of transfer: _____/_____/_____
MM DD YYYY

Date of discharge, if known: _____/_____/_____
MM DD YYYY

Type of facility:

- ☐ Acute rehabilitation
- ☐ Sub-acute rehabilitation
- ☐ Skilled nursing/long term care
- ☐ Hospice
- ☐ Other: _____

Name of facility: _____

☐ Home

Date of discharge: _____/_____/_____
MM DD YYYY

Was patient referred for any of the following supportive care at discharge?

For each type of supportive care note referral status and list length of referral (days)

Physical therapy	☐ Yes	☐ No	☐ Unknown	_____ days
Occupational therapy	☐ Yes	☐ No	☐ Unknown	_____ days
Speech therapy	☐ Yes	☐ No	☐ Unknown	_____ days
Behavioral therapy	☐ Yes	☐ No	☐ Unknown	_____ days

Other, please describe _____

XIIII. Modified Rankin Scale at discharge *(based on discharge summary) use pediatric modified Rankin for children less than 8 years of age*

0 = No symptoms at all

1 = No significant disability despite symptoms; able to carry our all usual duties and activities

2 = Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance

3 = Moderate disability; requiring some help, but able to walk without assistance

4 = Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance

5 = Severe disability; bedridden, incontinent and requiring constant nursing care and attention

6 = Dead

SCORE (0 – 6): _____

Additional notes from previous sections *(please note page number, section and item continued)*

_____

_____

_____

_____

_____

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_____