

2018 CHART ABSTRACTION FORM

Patient information (remove top page following abstraction)

PATIENT ID _____

Patient's Name:

Last Names

First Name

Date of Birth:

____/____/____

MM

DD

YYYY

Abstructor initials:

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

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

Date of first provider visit: ____/____/____
MM DD YYYY

Symptoms at first provider visit:

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 MM DD YYYY	_____
_____	From: ____/____/____ To: ____/____/____ MM DD YYYY MM DD YYYY	_____
_____	From: ____/____/____ To: ____/____/____ MM DD YYYY MM DD YYYY	_____
_____	From: ____/____/____ To: ____/____/____ MM DD YYYY MM DD YYYY	_____
_____	From: ____/____/____ To: ____/____/____ MM DD YYYY MM DD YYYY	_____

Admitted to ICU? Yes No From: ____/____/____ To: ____/____/____
MM DD YYYY 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)

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

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VI. Treatment and procedures during hospitalization

Antibiotic (including tetracycline therapy) _____ _____ _____ _____	Start date ____/____/____ <small>MM DD YYYY</small> ____/____/____ <small>MM DD YYYY</small> ____/____/____ <small>MM DD YYYY</small> ____/____/____ <small>MM DD YYYY</small>	End date ____/____/____ <small>MM DD YYYY</small> ____/____/____ <small>MM DD YYYY</small> ____/____/____ <small>MM DD YYYY</small> ____/____/____ <small>MM DD YYYY</small>
<input type="checkbox"/> Vassopressors (which: _____) From ____/____/____ to ____/____/____ <small>MM DD YYYY MM DD YYYY</small>	<input type="checkbox"/> Transfusion (products an quantity: _____) Date1 ____/____/____ Date2 ____/____/____ <small>MM DD YYYY MM DD YYYY</small>	
<input type="checkbox"/> Mechanical Ventilation (eg. Intubation) From ____/____/____ to ____/____/____ <small>MM DD YYYY MM DD YYYY</small>	<input type="checkbox"/> Hemodialysis (e.g. CRRT) From ____/____/____ to ____/____/____ <small>MM DD YYYY MM DD YYYY</small>	
<input type="checkbox"/> Amputation If yes, specify body parts involved: _____	<input type="checkbox"/> 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 diagnosis ____/____/____ Unknown
MM DD YYYY

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

Yes No Unknown

If yes, specify type: _____

Date of diagnosis ____/____/____ Unknown
MM DD YYYY

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		YES	NO	Unknown
Behavioral/personality change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/paresthesias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Myoclonus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bowel/bladder incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Confusion/disorientation/coma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dysarthria/slurred speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ataxia/problems with balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dysphagia/difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyporeflexia/areflexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Decline in functional capacity from baseline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blindness/visual impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, describe: _____			
Diplopia/ophthalmoplegia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			

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IX. RMSF Testing

Specimen type: _____	_____ / _____ / _____ <small>MM DD YYYY</small>	Test: _____	Result: _____
Specimen type: _____	_____ / _____ / _____ <small>MM DD YYYY</small>	Test: _____	Result: _____
Specimen type: _____	_____ / _____ / _____ <small>MM DD YYYY</small>	Test: _____	Result: _____
Specimen type: _____	_____ / _____ / _____ <small>MM DD YYYY</small>	Test: _____	Result: _____
Specimen type: _____	_____ / _____ / _____ <small>MM DD YYYY</small>	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 ___%Lymph ___%Eos ___%Mon	Glucose (mg/dL) _____	Color (eg.xanthochromia) _____
RBCs/mm ³ _____	Culture _____	

XII. Neurologic and imaging studies:

	<i>Performed</i>	<i>Not performed</i>	<i>Date of finding</i>	
Head CT	<input type="checkbox"/>	<input type="checkbox"/>	_____ / _____ / _____ <small>MM DD YYYY</small>	<i>Impression (if unremarkable, write "normal")</i> _____ _____ List substantial changes in subsequent series: _____ _____
Head MRI	<input type="checkbox"/>	<input type="checkbox"/>	_____ / _____ / _____ <small>MM DD YYYY</small>	_____ _____ List substantial changes in subsequent series: _____ _____
Spinal MRI	<input type="checkbox"/>	<input type="checkbox"/>	_____ / _____ / _____ <small>MM DD YYYY</small>	_____ _____ List substantial changes in subsequent series: _____ _____
EEG or other neurologic study	<input type="checkbox"/>	<input type="checkbox"/>	_____ / _____ / _____ <small>MM DD YYYY</small>	_____ _____ 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: _____

Name of facility: _____

Acute rehabilitation

Sub-acute rehabilitation

Skilled nursing/long term care

Hospice

Other: _____

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 _____

XIII. 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 out 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)

