**Appendix H: Medical Chart Abstraction Form SAMPLE**

Medical Chart Abstraction Form

Form Approved

OMB No. 0923-0051

Exp. Date 02/28/2024

Reviewer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Review Date: \_\_\_ / \_\_\_ / \_\_\_\_ Start Time \_\_:\_\_\_ □am □pm

Facility (list names of facilities here for reviewer to pick one)

□ □

□ □

□ □

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Address: Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_

Telephone (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_(Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_(Work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_(Other) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Demographics**

**DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_ Age \_\_\_\_\_\_ years **Sex:**  □ Male □ Female □ other/unknown

 MM DD YYYY

**Ethnicity:** □ Hispanic/Latina □ Not Hispanic/Latina \_\_\_□Unknown Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□unknown

**Insurance:** **Race:** (check all that apply)

□ Private □ Medicare/Medicaid/Government program □ American Indian/ Alaskan Native □ Asian □ Black

□ None □ N/A □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ Native Hawaiian/ Pacific Islander □ White □ Other

**Visit Information**

**Date of Visit:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_ Time of arrival: \_\_\_\_:\_\_\_\_ □ am □ pm

 MM DD YYYY

**Chief Complaint \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Description of what happened\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Location when became injured/ill** □ **home** □**work** □**commute** □**other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mode of arrival:** □ Helicopter □ Ambulance □POV □ Public transportation □ On foot □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_o

If applicable: Did vehicle need to be decontaminated? □Yes □No

**Initial Vital Signs:** Height: \_\_\_\_\_\_\_\_\_ □ cm □ in Weight: \_\_\_\_\_\_\_\_ □ kg □ lb

Temp (°F): \_\_\_\_\_\_\_\_ Heart Rate: \_\_\_\_\_\_\_ Respiratory Rate: \_\_\_\_\_\_\_ BP (mmHg): \_\_\_\_\_\_ / \_\_\_\_\_\_\_

This information is collected under the authority Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (CERCLA), commonly known as the "Superfund" Act, as amended by the Superfund Amendments and Reauthorization Act (SARA) of 1986 and the Public Health Service Act (42 USC Sec. 301 [241]). ATSDR estimates the average public reporting burden of this collection of information as 30 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 Information Collection Review Office; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0923-0051)

**Decontamination**

Was the patient decontaminated? □ Yes □ No □ N/A How was the patient decontaminated? (check all that apply)

If yes, where was the patient decontaminated? □ Clothing removed

□ In the field/At site □ Water

□ At hospital □ Soap and water

□ Both □ N/A

□ N/A □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History** (check all that apply)

□ Asthma □ Congestive heart failure **Medications:**

□ COPD □ Breastfeeding \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Depression □ Pregnant

□ Diabetes □ Tobacco use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ GERD (Reflux) □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Hypertension \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Malignancy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Myocardial infarction \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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

**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

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ / \_\_\_ / \_\_\_

**Imaging**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date | Type of Imaging | Location | Contrast | Acute Findings | Description of Acute Findings |
| \_\_\_ / \_\_\_ / \_\_\_\_ | □ X-ray□ CT □ MRI □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | □ Y□ N | □ Y□ N |  |
| \_\_\_ / \_\_\_ / \_\_\_\_ | □ X-ray□ CT □ MRI □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | □ Y□ N | □ Y□ N |  |
| \_\_\_ / \_\_\_ / \_\_\_\_ | □ X-ray□ CT □ MRI □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | □ Y□ N | □ Y□ N |  |
| \_\_\_ / \_\_\_ / \_\_\_\_ | □ X-ray□ CT □ MRI □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | □ Y□ N | □ Y□ N |  |

**EKG**

|  |  |  |
| --- | --- | --- |
| Date | Findings | Description of EKG Findings |
| \_\_\_ / \_\_\_ / \_\_\_\_ | □ WNL□ Abnl, consistent□ Abnl, new |  |
| \_\_\_ / \_\_\_ / \_\_\_\_ | □ WNL□ Abnl, consistent□ 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

**e 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\_\_\_\_\_\_\_ | □ WNL□ Abnl, CI □ Abnl, C Dz□ Abnl, exposure□ Abnl, other | Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| K\_\_\_\_\_\_\_ | □ WNL□ Abnl, CI □ Abnl, C Dz□ Abnl, exposure□ Abnl, other  | Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Cl\_\_\_\_\_\_\_ | □ WNL□ Abnl, CI □ Abnl, C Dz□ Abnl, exposure□ Abnl, other | Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| HCO3-\_\_\_\_\_\_\_ | □ WNL□ Abnl, CI □ Abnl, C Dz□ Abnl, exposure□ Abnl, other  | Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| BUN\_\_\_\_\_\_\_ | □ WNL□ Abnl, CI □ Abnl, C Dz□ Abnl, exposure□ Abnl, other | Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Cr\_\_\_\_\_\_\_ | □ WNL□ Abnl, CI □ Abnl, C Dz□ Abnl, exposure□ Abnl, other  | Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Glu\_\_\_\_\_\_\_ | □ WNL□ Abnl, CI □ Abnl, C Dz□ Abnl, exposure□ Abnl, other | Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Hgb\_\_\_\_\_\_\_ | □ WNL□ Abnl, CI □ Abnl, C Dz□ Abnl, exposure□ Abnl, other  | Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Hct\_\_\_\_\_\_\_ | □ WNL□ Abnl, CI □ Abnl, C Dz□ Abnl, exposure□ Abnl, other | Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |
| --- | --- | --- |
| WBC\_\_\_\_\_\_\_ | □ WNL□ Abnl, CI □ Abnl, C Dz□ Abnl, exposure□ Abnl, other  | Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Plts\_\_\_\_\_\_\_ | □ WNL□ Abnl, CI □ Abnl, C Dz□ Abnl, exposure□ Abnl, other | Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Ca2+\_\_\_\_\_\_\_ | □ WNL□ Abnl, CI □ Abnl, C Dz□ Abnl, exposure□ Abnl, other | Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| AST\_\_\_\_\_\_\_ | □ WNL□ Abnl, CI □ Abnl, C Dz□ Abnl, exposure□ Abnl, other  | Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ALT\_\_\_\_\_\_\_ | □ WNL□ Abnl, CI □ Abnl, C Dz□ Abnl, exposure□ Abnl, other | Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Total Bili\_\_\_\_\_\_\_ | □ WNL□ Abnl, CI □ Abnl, C Dz□ Abnl, exposure□ Abnl, other  | Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Alk Phos\_\_\_\_\_\_\_ | □ WNL□ Abnl, CI □ Abnl, C Dz□ Abnl, exposure□ Abnl, other | Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other:\_\_\_\_\_\_\_ | □ WNL□ Abnl, CI □ Abnl, C Dz□ Abnl, exposure□ Abnl, other  | Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other:\_\_\_\_\_\_\_ | □ WNL□ Abnl, CI □ Abnl, C Dz□ Abnl, exposure□ Abnl, other | Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other:\_\_\_\_\_\_\_ | □ WNL□ Abnl, CI □ Abnl, C Dz□ Abnl, exposure□ Abnl, other  | Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Urinalysis**

|  |  |  |
| --- | --- | --- |
|  | Date: \_\_\_ / \_\_\_ / \_\_\_\_ | Repeat Lab Values (if necessary) |
| pH | □ WNL□ Abnl, CI □ Abnl, C Dz□ Abnl, exposure□ Abnl, other | Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Specific Gravity | □ WNL□ Abnl, CI □ Abnl, C Dz□ Abnl, exposure□ Abnl, other | Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Protein | □ WNL□ Abnl, CI □ Abnl, C Dz□ Abnl, exposure□ Abnl, other  | Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Glucose | □ WNL□ Abnl, CI □ Abnl, C Dz□ Abnl, exposure□ Abnl, other | Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Ketones | □ WNL□ Abnl, CI □ Abnl, C Dz□ Abnl, exposure□ Abnl, other  | Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| WBC | □ WNL□ Abnl, CI □ Abnl, C Dz□ Abnl, exposure□ Abnl, other | Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| RBC | □ WNL□ Abnl, CI □ Abnl, C Dz□ Abnl, exposure□ Abnl, other  | Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Bilirubin | □ WNL□ Abnl, CI □ Abnl, C Dz□ Abnl, exposure□ Abnl, other | Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ pm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_\_:\_\_\_\_ □ am □ 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 (FEV1) |  |  |  |
| FEV1/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 |
| pO2 | pO2 | pO2 | pO2 |
| pCO2 | pCO2 | pCO2 | pCO2 |
| HCO3- | HCO3- | HCO3- | HCO3- |
| O2 sat | O2 sat | O2 sat | O2 sat |
| Supplemental O2 □ Y □ N □ N/A If Yes, □ NC/FM □ NRB □ CPAP □ Mechanical Vent. | Supplemental O2 □ Y □ N □ N/A If Yes, □ NC/FM □ NRB □ CPAP □ Mechanical Vent. | Supplemental O2 □ Y □ N □ N/A If Yes, □ NC/FM □ NRB □ CPAP □ Mechanical Vent. | Supplemental O2 □ Y □ N □ N/A If Yes, □ NC/FM □ NRB □ CPAP □ 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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□ Dermatology: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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□ ENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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□ Ophthalmology: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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□ Pulmonary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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□ Poison Control: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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□ Psychiatry: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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□ Social Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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□ Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Outcomes**

Primary Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD-9 Codes

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did any staff or other patients get ill from this patient (secondary exposure? □ Yes □No □Unknown

If yes, explain what happened\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Discharge**

**Was the patient admitted?** □ Y □ N if yes, Where to □ICU #days \_\_□ floor #days\_\_\_\_\_\_\_\_□ observation # days\_\_\_\_

Discharge information: Date: \_\_\_ / \_\_\_ /\_\_\_\_ Time: \_\_\_\_: \_\_\_\_\_ □ am □ pm □ □LWBS- Left without being seen

□ Died: \_\_\_ / \_\_\_ /\_\_\_\_ Cause of death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Discharge instructions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

End of chart review Date\_\_\_/\_\_\_/\_\_\_ Time \_\_:\_\_\_ □ am □ pm

Secondary reviewer Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_/\_\_\_/\_\_\_ Time \_\_:\_\_\_ □ am □ pm