Appendix H: Medical Chart Abstraction Form SAMPLE

SAMPLE

Patient ID ______________________

Form Approved
OMB No. 0923-0051
Exp. Date 02/28/2024

Medical Chart Abstraction Form

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:
☐ Private ☐ Medicare/Medicaid/Government program
☐ None ☐ N/A ☐ Other: ____________________

Race: (check all that apply)
☐ American Indian/ Alaskan Native ☐ Asian ☐ Black
☐ 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)

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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: _____________________________________

Medical History (check all that apply)

- ☐ Asthma
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ GERD (Reflux)
- ☐ Hypertension
- ☐ Malignancy
- ☐ Myocardial infarction
- ☐ Congestive heart failure
- ☐ Breastfeeding
- ☐ Pregnant
- ☐ Tobacco use
- ☐ Other: ________________________

____

____

____

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
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	___ / ___ / ____

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☐ 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: ____________________ ___ / ___ / ___

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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

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(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 ________________
HCO_3^- ________	☐ 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 ________________

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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 _________________
Ca^{2+} ________	☐ 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	Date: ____ / ____ / ____ Time: _____:_____ ☐ am ☐ pm _________________ Date: ____ / ____ / ____ Time: _____:_____ ☐ am ☐ pm _________________

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	☐ Abnl, other	

Patient ID ________________________

	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

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		________________

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 □ Y □ N □ N/A If Yes, □ NC/FM □ NRB □ CPAP □ Mechanical Vent.	Supplemental O_2 □ Y □ N □ N/A If Yes, □ NC/FM □ NRB □ CPAP □ Mechanical Vent.	Supplemental O_2 □ Y □ N □ N/A If Yes, □ NC/FM □ NRB □ CPAP □ Mechanical Vent.	Supplemental O_2 □ 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?

Patient ID ______________________

Consults

☐ Cardiology: ____

____

☐ Dermatology: ____

____

☐ ENT: ____

____

☐ Ophthalmology: ____

____

☐ Pulmonary: ____

____

☐ Poison Control: ____

____

☐ Psychiatry: ____

____

☐ Social Work: ____

____

☐ Surgery: ____

____

☐ Other: ____

____

Patient ID ______________________

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