Appendix H: Medical Chart Abstraction Form SAMPLE

SAMPLE

Patient ID _____

Form Approved
OMB No. 0923-0051
Exp XX/XX.XXXX

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 _____, _____ ___

Last First M.I.

Patient Address: Street: _____ City: _____ State: _____ Zip: _____

Telephone (Home) _____(Cell) _____(Work) _____(Other) _____

Public reporting burden of this collection of information is estimated to average 25 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining 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 Clearance Officer, 1600 Clifton Road NE, MS H21–8, Atlanta, Georgia 30329 ATTN: PRA (0923-0051)

Patient Demographics

DOB: ____ / ____ / _____ **Age**: _____ years

MM DD YYYY

Sex (biological): □ Male □ Female □ other/unknown

Race and/or ethnicity? (*Select all that apply*)

- ❑ American Indian or Alaska Native *(For example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya, etc.)*
- ❑ Asian *(For example, Chinese, Asian Indian, Filipino, Vietnamese, Korean, Japanese, etc.)*
- ❑ Black or African American *(For example, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.)*
- ❑ Hispanic or Latino (For example, Mexican, Puerto Rican, Salvadoran, Cuban, Dominican, Guatemalan, etc.)
- ❑ Middle Eastern or North African *(For example, Lebanese, Iranian, Egyptian, Syrian, Iraqi, Israeli, etc.)*
- ❑ Native Hawaiian or Pacific Islander *(For example, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marshallese, etc.)*
- ❑ White *(For example, English, German, Irish, Italian, Polish, Scottish, etc.)*

Occupation: _____□unknown

Insurance:

□ Private □ Government/Military

□ Medicare □ Medicaid

□ No coverage □ Other: _____

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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 □ school □unknown □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 or C Heart Rate: _____ Respiratory Rate: _____ BP (mmHg): _____ / _____

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)

- □ Anxiety
- □ Asthma
- □ Breastfeeding
- □ Congestive heart failure
- □ COPD
- □ Depression
- □ Diabetes
- □ GERD (Reflux)
- □ Hypertension
- □ Malignancy
- □ Myocardial infarction
- □ Post-traumatic stress disorder

Medication 1: _____
Medication 2: _____
Medication 3: _____
Medication 4: _____

- □ Pregnant estimated due date __/__/__
- □ Sleep difficulties
- □ Tobacco use
- □ Drug/alcohol abuse_____
- □ Other _____
- □ Other _____
- □ Other _____
- □ Other _____

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	___ / ___ / ____

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□ 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: _____ ___ / ___ / ___

Disability

□ Vision difficulty (e.g. blind or having serious difficulty seeing) ___ / ___ / ____
□ Hearing difficulty (e.g. deaf or having serious difficulty hearing) ___ / ___ / ____
□ Mobility difficulty (e.g. serious difficulty walking or climbing stairs ___ / ___ / ____
□ Cognition difficulty (e.g. serious difficulty remembering or making decisions) ___ / ___ / ____
□ Self-care difficulty (e.g. serious difficulty bathing or dressing) ___ / ___ / ____
□ Independent living difficulty (e.g. serious difficulty doing errands along) ___ / ___ / ____
□ Communication (e.g. serious difficulty understanding or being understood) ___ / ___ / ____
□ Intellectual/developmental ___ / ___ / ____
□ Other: _____ ___ / ___ / ___

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Imaging

Date	Type of Imaging	Location	Contrast	Acute Findings	Description of Acute Findings
__/__/____	□ X-ray □ CT □ MRI □ Ultrasound □ Other: _____		□ Y □ N	□ Y □ N	
___ / ___ / ____	□ X-ray □ CT □ MRI □ Ultrasound □ Other: _____		□ Y □ N	□ Y □ N	
___ / ___ / ____	□ X-ray □ CT □ MRI □ Ultrasound □ Other: _____		□ Y □ N	□ Y □ N	
___ / ___ / ____	□ X-ray □ CT □ MRI □ Ultrasound □ 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 _____
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 _____

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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 _____
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
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

Lab	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	Date: ___ / ___ / ___ Time: ____:____ □ am □ pm _____

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	□ Abnl, other	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 (FEV_1)			
FEV_1/FVC			
Peak Expiratory Flow Rate			
Forced Inspiratory Vital Capacity			
Forced Expiratory Flow			

Blood Gas (ABG) Flow Sheet

Date	Date	Date	Date
Time	Time	Time	Time
□Arterial □Venous	□Arterial □Venous	□Arterial □Venous	□Arterial □Venous
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 _____

Patient ID _____

Consults

□ Cardiology: _____

_____

□ Dermatology: _____

_____

□ ENT: _____

_____

□ Gastroenterology:

_____

_____

□ Ob/Gyn: _____

_____

□ Ophthalmology: _____

_____

□ Pulmonary: _____

_____

□ Poison Control: _____

_____

□ Psychiatry/Mental health:

_____

_____

□ Social Work: _____

_____

□ Surgery: _____

_____

□ Other: _____

_____

Patient ID _____

Outcomes

Primary Diagnosis: _____

Secondary Diagnosis: _____

ICD-10 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