

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)

- | | |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

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.

- Tachycardia _____/_____/_____
- Other: _____/_____/_____

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 _____/_____/_____

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 _____/_____/_____

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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
___/___/___ _____	<input type="checkbox"/> X-ray <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> Other: _____		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
___/___/___ _____	<input type="checkbox"/> X-ray <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> Other: _____		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
___/___/___ _____	<input type="checkbox"/> X-ray <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> Other: _____		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
___/___/___ _____	<input type="checkbox"/> X-ray <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> Other: _____		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

EKG

Date	Findings	Description of EKG Findings
___/___/___	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, consistent <input type="checkbox"/> Abnl, new	
___/___/___	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, consistent <input type="checkbox"/> 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 _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
K _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Cl _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
HCO ₃ ⁻ _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
BUN _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Cr _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Glu _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Hgb _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Hct _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____

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WBC _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Plts _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Ca ²⁺ _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
AST _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
ALT _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Total Bili _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Alk Phos _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Other: _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Other: _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Other: _____	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____

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	Date: ___ / ___ / ___	Repeat Lab Values (if necessary)
pH	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Specific Gravity	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Protein	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Glucose	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Ketones	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
WBC	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
RBC	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____
Bilirubin	<input type="checkbox"/> WNL <input type="checkbox"/> Abnl, CI <input type="checkbox"/> Abnl, C Dz <input type="checkbox"/> Abnl, exposure <input type="checkbox"/> Abnl, other	Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> pm _____ Date: ___ / ___ / ___ Time: ___:___ <input type="checkbox"/> am <input type="checkbox"/> 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 <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A If Yes, <input type="checkbox"/> NC/FM <input type="checkbox"/> NRB <input type="checkbox"/> CPAP <input type="checkbox"/> Mechanical Vent.	Supplemental O ₂ <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A If Yes, <input type="checkbox"/> NC/FM <input type="checkbox"/> NRB <input type="checkbox"/> CPAP <input type="checkbox"/> Mechanical Vent.	Supplemental O ₂ <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A If Yes, <input type="checkbox"/> NC/FM <input type="checkbox"/> NRB <input type="checkbox"/> CPAP <input type="checkbox"/> Mechanical Vent.	Supplemental O ₂ <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A If Yes, <input type="checkbox"/> NC/FM <input type="checkbox"/> NRB <input type="checkbox"/> CPAP <input type="checkbox"/> 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