Patient ID _____

Form Approved
OMB No. 0923-0051
Exp. Date 10/31/2024

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): _____ / _____

Patient ID _____

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 ___/___/____
- □ Nausea ___/___/____
- □ Vomiting ___/___/____

Patient ID _____

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: _____	___ / ___ / ___

Patient ID _____

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

Patient ID _____

(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 _____

Patient ID ______________________

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 □ Abnl, other	Date: ___ / ___ / ___ Time: ____:____ □ am □ pm ________________ Date: ___ / ___ / ___ Time: ____:____ □ am □ pm ________________

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 _____

Patient ID _____

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