

V. Medical Record Abstraction

Please use the patient's medical record to abstract the information requested below for their visit related to this specific outbreak. *If you are interested in specific risk factors that might make people more susceptible you can add additional questions to this form. For example, you might ask about chronic medical conditions, mental health, substance abuse, etc.*

Date of abstraction: ____/____/____

(Include the format you want the date in, MM/DD/YYYY)

Name of abstractor: _____

Last

First

MI

General Information Questions:

1. First Name: _____
2. Last Name: _____
3. Medical Record #: _____
4. Phone Number: _____
5. Address / House description: _____
6. Village/District/Province: _____
7. Sex (*check one*): _____ Male _____ Female
8. Age: _____ (years) if less than 1 year of age _____ (months)
9. What was the date and time of the patient's **initial** evaluation in the field or in a medical facility?
Date: ____/____/____ Time: (*use 24-hour clock*) ____:____
10. What were the patient's vital signs at the time of this initial evaluation either in the field or in a medical facility? *Include relevant units for your setting F/C for temperature, etc.*

HR ____ beats/minute	☐ Not available
Respiration ____ breaths/minute	☐ Not available
BP ____/____ mmHg	☐ Not available
Temperature ____ degrees	☐ Not available
Oxygen Saturation ____ %	☐ Not available
11. Name of health facility: _____
☐ Hospital ☐ Health Clinic ☐ Other

12. From the patient's medical record, please check and/or describe in the table below the complaints (signs/symptoms) the patient reported during his/her evaluation? Check all that apply.
Modify this table as needed to add or remove signs and symptoms based on what is relevant for your investigation. Only include signs/symptoms that you are most interested in and plan to analyze.

Gastrointestinal	Neurological	Respiratory	
☐ Abdominal pain	☐ Agitation	☐ Wheezing	
☐ Nausea	☐ Confusion	☐ Cough/choke	
☐ Vomiting	☐ Headache	☐ Dyspnea	
☐ Diarrhea	☐ Dizziness	☐ Cyanosis	
☐ Oral/esophageal/gastric burns	☐ Lethargy	☐ Other (<i>specify</i>)	
☐ GI bleed	☐ Syncope		
☐ Other (<i>specify</i>)	☐ Weakness		
	☐ Seizures		
	☐ Hallucinations		
Ocular	☐ Numbness	Other Signs and Symptoms (<i>please describe</i>)	
☐ Blurred vision	☐ Tremor		
☐ Irritation/pain	☐ Paresthesia		
☐ Lacrimation	☐ Other (<i>specify</i>)		
☐ Conjunctivitis			
☐ Other (<i>specify</i>)	Cardiovascular		
	☐ Chest Pain		
	☐ Palpitations		
Dermal	☐ Racing heart		
☐ Blisters	☐ Swelling of the legs, feet or ankles		
☐ Burns			
☐ Redness	☐ Other (<i>specify</i>)		
☐ Hives/welts			
☐ Rash (<i>please describe</i>)			
☐ Other (<i>specify</i>)			

Participant ID#:

13. From the patient's medical record, please check and/or describe in the table below all the patient's pertinent physical findings, as found on evaluation. Check all that apply.
(Modify this table to include or removed physical findings specific to your investigation.)

<i>Gastrointestinal</i>	<i>Neurological</i>	<i>Respiratory</i>
☐ Oral burns	☐ Agitation	☐ Wheezing
☐ Abdominal tenderness	☐ Confusion	☐ Rales
☐ Other (<i>specify</i>)	☐ Lethargy	☐ Dyspnea
	☐ Fasciculations	☐ Cyanosis
	☐ Weakness	☐ Apneic
<i>Ocular</i>	☐ Seizures	☐ Other (<i>specify</i>)
☐ Lacrimation	☐ Hallucinations	
☐ Conjunctivitis	☐ Numbness	
☐ Miosis	☐ Tremor	<i>Other Signs and Symptoms</i> (<i>please describe</i>)
☐ Mydriasis	☐ Comatose	
☐ Other (<i>specify</i>)	☐ Other (<i>specify</i>)	
<i>Dermal</i>	<i>Cardiovascular</i> (<i>please describe</i>)	
☐ Blisters		
☐ Burns (degree? _____)		
☐ Redness		
☐ Hives/welts		
☐ Rash (<i>please describe</i>)		
☐ Other (<i>specify</i>)		

14. Did the patient have any of the following abnormal vital signs during his/her time in this medical facility?

Only include the vital signs you are interested specifically in for your investigation, you may have different thresholds that what are included here? If the values are important to your investigation you can ask for the values to be recorded here as well. The definition of abnormal vital signs are different for children, so if you are collecting information on children include those definitions as well.

Heart Rate < 60 beats/minute	☐ Yes ☐ No ☐ Unknown
Heart Rate > 100 beats/minute	☐ Yes ☐ No ☐ Unknown
Respiratory or Breathing Rate > 20 breaths/minute)	☐ Yes ☐ No ☐ Unknown
Respiratory Rate <10 breaths/minute	☐ Yes ☐ No ☐ Unknown
Systolic Blood pressure > 140 OR Diastolic blood pressure > 90 mmHG	☐ Yes ☐ No ☐ Unknown
Systolic Blood pressure ≤ 90 OR Diastolic blood pressure ≤ 60 mmHG)	☐ Yes ☐ No ☐ Unknown
Temperature > (Include threshold for your investigation)	☐ Yes ☐ No ☐ Unknown
Temperature < (Include threshold for your investigation)	☐ Yes ☐ No ☐ Unknown
Oxygen saturation < 90%	☐ Yes ☐ No ☐ Unknown

15. Since insert date of event, did this patient have any radiologic imaging performed?

☐ Yes ☐ No ☐ Unknown

15a. If yes, please indicate study type site and findings (e.g., X-ray, Chest; density in left lobe).

Date		Site	
:	_____	:	_____
Type:	_____	Finding:	_____
Date		Site	
:	_____	:	_____
Type:	_____	Finding:	_____
Date		Site	
:	_____	:	_____
Type:	_____	Finding:	_____
Date		Site	
:	_____	:	_____
Type:	_____	Finding:	_____

16. Since insert date of event, has this patient received an ECG? ☐ Yes ☐ No ☐ Unknown

16a. If yes, please provide the dates performed and describe the results below...

Date:	_____	Result:	_____
Date:	_____	Result:	_____
Date:	_____	Result:	_____
Date:	_____	Result:	_____

Participant ID#:

17. Since insert date of event, has the patient received any other diagnostic tests?

☐ Yes ☐ No ☐ Unknown

17a. If yes, please provide the test, date performed, and results below...

Date: _____ Test: _____ Result: _____

Date: _____ Test: _____ Result: _____

Date: _____ Test: _____ Result: _____

Date: _____ Test: _____ Result: _____

18. Since insert date of event, did this patient have any of the following laboratory analysis done? If yes, record the results and date test was performed.

Modify the form to label the specific laboratory tests you are interested in for your investigation (for example, hemoglobin, creatinine, specific liver function tests, etc.). Individuals may have multiple results for these tests, determine if you want the most abnormal values, initial values, both?

(Insert name of lab test #1)

Initial
result: _____ Date: _____

Most abnormal result: _____ Date: _____

(Insert name of lab test #2)

Initial
result: _____ Date: _____

Most abnormal result: _____ Date: _____

(Insert name of lab test #3)

Initial
result: _____ Date: _____

Most abnormal result: _____ Date: _____

19. What therapy did this patient receive? Include any medications prescribed.

You can modify this to include specific therapies you might be interested in (for example, atropine if you suspect organophosphate poisoning) If you have a specific list of medication you want them to ask include a column if they received this medication yes/no. You may also want to collect more specific information such as the day the medication started, ended, how often they received it. You can include options for the response to the medication such as improved, no effect, or worsened condition.

Name of therapy/medications	Dose (include unit)	Total # of doses received	Response (improved, worsened condition, no effect)

20. What was this patient's disposition following evaluation at a medical facility?

(You may include additional options like ICU admission if this is available at the facility)

- ☐ Admitted. If subsequently discharged, date of discharge _____
- ☐ Evaluated and transferred to another facility, name of facility _____
- ☐ Evaluated and discharged from Emergency Department
- ☐ Died, date of death _____ (complete #29-31)
- ☐ Unknown

20a. What was the total amount of time this patient was observed in a hospital setting?

____ _ ☐ Days ☐ Hours

Samples

21. Have vomit, urine, blood stool or other biologic material been collected?

☐ Yes ☐ No ☐ Unknown

21a. If yes, which specimens were collected *(please check all that apply)*

☐ Vomit ☐ Urine ☐ Blood ☐ Stool
☐ Pathology ☐ Other _____

21b. If yes, where are the specimens stored? _____

Participant ID#:

Deceased

22. Official cause of death: _____

23. Post-Mortem Histology findings:

24. Post-Mortem Pathology findings:
