



CLINICAL INFORMATION

Acute

CHART ABSTRACTION

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Interventions

~~1. Oral- or Nasal- Endotracheal~~

~~Tube >24 Hours:~~ (at any point during their stay, excluding use for surgery)

~~a) Is the participant enrolled in any interventional clinical research studies/trials?~~

~~(a clinical study or trial that involves a study drug, treatment, or device)~~

☐ Yes

☐ No

☐ Unknown


~~1.~~

~~2. Tracheostomy Performed:~~ (at any

~~point during their acute stay at~~

~~facility) Tracheostomy Performed:~~

~~(at any point during their acute stay at facility)~~

☐ Yes

☐ No

☐ No

☐ Unknown

~~b) If YES,~~

~~enter~~

~~clinical trial~~

~~name:~~

☐ Unknown

~~1. Inpatient~~

~~Health~~

~~Services:~~

~~(Check ALL that apply. Include only services accessed/consulted during inpatient stay. Do not include services referred to but not accessed by the participant during their inpatient stay.)~~

☐ Assistive technology

☐ Dentistry

☐ Drivers education

☐ Drug and alcohol

☐ Ear/nose/throat (ENT)

☐ Kinesiology

☐ Neurosurgery (for associated injuries not related to SCI)

☐ Nutrition

☐ Occupational therapy (OT)

☐ Orthotics

☐ Orthopaedic surgery (for associated injuries not related to SCI)

☐ Physiatry (Rehabilitation Medicine)

☐ Physical therapy/ Physiotherapy (PT)

☐ Psychology or Psychiatry

☐ Recreational therapy

☐ Respirology

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- ☐ Respiratory Therapy (RT)
- ☐ Sexual health
- ☐ Social work (SW)
- ☐ Speech-language pathology (SLP)
- ☐ Thrombosis/Hematology
- ☐ Urology
- ☐ Vocational rehabilitation
- ☐ Wound care
- ☐ Other (specify): _____
(e.g., art therapy, music therapy)
- ☐ None

Interventions—continued**2. Assistive****Equipment—
Orthosis**

Use: (check ALL that apply on day of discharge from Acute facility)

Consult health care team if health record is unclear. Orthoses are used to maintain neutral spinal column positioning. Note: 1) Spinal precautions do not indicate orthosis use. 2) If "neck strengthening" or "may begin isometric exercises" noted, orthosis may have been discontinued.

- ☐ No orthosis used
- ☐ Cervical orthosis (e.g., Aspen collar, Philadelphia collar, etc. A soft collar is not an orthosis.)
- ☐ Thoracolumbar orthosis (e.g., Jewett brace, body cast, etc.)
- ☐ Lumbar orthosis (e.g., Harris Knight brace, Hip spica, etc.)

**3. a) Was
Vertebral
Skeletal
Traction
(Non-
Operative)
used?**

- ☐ Yes
- ☐ No (skip to Question 5)
- ☐ Not applicable, no fracture (skip to Question 5)

**b) If Yes,
traction
type:**

- ☐ Tongs

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- ☐ ~~Halo~~
- ☐ ~~Other: _____~~
- ☐ ~~Unknown type~~

e) If Yes, outcome of Attempted Manual Reduction (Non-Operative):

- ☐ ~~Successful~~
- ☐ ~~Partial~~
- ☐ ~~Not successful (skip to Question 5)~~
- ☐ ~~Unknown outcome (skip to Question 5)~~

d) Date Reduction Achieved:

/ /
YYYY MM DD

Enter as much of the date as is known. If no details available, check Unknown.

☐ ~~Unknown~~

e) Time Reduction Achieved:

:
HH MM

24 hour clock

Enter full or partial time. If no details available, check Unknown.

☐ ~~Unknown~~

4. a) Tracheostomy Performed:

(at any point during their acute stay at facility)

- ☐ ~~Yes~~
- ☐ ~~No (skip to Question 6)~~

b) Tracheostomy Date:

/ /
YYYY MM DD

Enter as much of the date as is known.

3. Oral or Nasal Endotracheal Tube > 24 Hours: (at any point during their stay, excluding use for surgery)

- ☐ ~~Yes~~
- ☐ ~~No~~

Interventions—continued

4.3. Methylprednisolone/ Corticosteroids: (at any point during their stay)

- ☐ ~~NASCIS II (Methylprednisolone or Solumedrol run as an infusion x 23 or 24 hrs)~~
- ☐ ~~NASCIS III (Methylprednisolone or Solumedrol run as an infusion x 47 or 48 hrs)~~

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clinically documented diagnosis of delirium [not merely mention of "confusion" or "disorientation" in the medical record]. This includes all diagnoses of delirium regardless of cause [e.g. includes those due to alcohol and psychoactive substance withdrawal])

☐ Yes☐ No☐ Unknown ~~No (skip to Question 10)~~**10.5.****b) If YES, date of first delirium diagnosis:**

| | | | | | | | | | |
|------|--|--|--|---|----|--|---|----|--|
| | | | | / | | | / | | |
| YYYY | | | | | MM | | | DD | |

Enter as much of the date as is known.

11.**a) Was the participant diagnosed with a urinary tract infection (UTI) during their stay?** (A clinically documented

diagnosis with a positive urine culture resulting in treatment with antibiotics [(see User Manual for a list of common antibiotics)]).

☐ Yes☐ No☐ Unknown☐ ~~No (skip to Question 11 on page 4)~~**Pain****6. Did the participant have any type (e.g. nociceptive or neuropathic) of pain at any time during their stay?** (Can be found in nursing notes, doctor's notes, etc.)

| | | | | | | | | | |
|------|--|--|--|---|----|--|---|----|--|
| | | | | / | | | / | | |
| YYYY | | | | | MM | | | DD | |

Enter as much of the date as is known.

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Unknown **b) If YES, date of first urinary tract infection (UTI) diagnosis:** (date antibiotic treatment started)

☐

7. Did the participant have neuropathic pain (whether treated or untreated) at any of time during their stay? (Suggested to check physiatry/pain consults, discharge note/summary. Must be documented by a physician)

☐ Yes☐ No☐ Unknown**Respiratory****8. Pulmonary complications and conditions diagnosed after the SCI, during the acute stay:**☐ None (skip to Data Collection Details)

☐ **Pneumonia:** (clinically [i.e., by a medical doctor] with any of clinical (e.g. increased temperature or amount of purulent secretions), radiographic (e.g. infiltrate on chest x-ray), or laboratory (e.g. positive culture & sensitivity [C&S], increased white blood cell count) supporting evidence AND resulting in treatment with antibiotics)

☐ Asthma

☐ **Chronic Obstructive Pulmonary Disease** (includes emphysema and chronic bronchitis)

☐ **Venothromboembolic Event** (including pulmonary embolus and DVT)

☐ **Sleep Disordered Breathing** (including Obstructive Sleep Apnea)

Did the participant receive any treatment?

☐ Yes☐ No (skip to Data Collection Details)☐ Unknown (skip to Data Collection Details)

If Yes, specify type of treatment: (check ALL that apply)

☐ Continuous Positive Airway Pressure (CPAP)☐ Bi-Level Positive Airway Pressure (BiPAP®)☐ Oral appliance

| | |
|--------------------------|--------------------|
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|---|
| <input type="checkbox"/> Surgery (e.g., Uvulopalatopharyngoplasty, Radiofrequency Ablation [RFA], Nasal Surgery, etc.) <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown type <input type="checkbox"/> Other Respiratory Conditions (specify): _____ <input type="checkbox"/> Unknown |
|---|

| Data Collection Details | | | | | |
|---|--|----------------------|--|------------------------------------|------------|
| Collected by: (please print name) | | Initial Here: | | Date Abstraction Completed: | YYYY-MM-DD |