



Interventions

1. ~~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

~~b) If YES, enter clinical trial name:~~

☐ Unknown

2. ~~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
☐ Respiriology
☐ 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

CHART ABSTRACTION

CI-Rehab
Page 2 of 4**Interventions—continued****3. Assistive Equipment—Orthosis****Use:** (check ALL that apply on day of discharge from Rehab 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.)**4.1.a) Tracheostomy Performed:** (at any point during their rehab stay)☐ Yes☐ No☐ Unknown (skip to Question 5)**b) Tracheostomy Date:**

				/			/		
YYYY					MM			DD	

Enter as much of the date as is known.

Complications**5.****Was the participant diagnosed with delirium during their stay?** (A

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 (skip to Question 6)**b) If YES, date of first delirium diagnosis:**

				/			/		
YYYY					MM			DD	

Enter as much of the date as is known.

2. 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 (skip to Question 7 on page 3)☐ Unknown**6.****PAIN****3. 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.)

CHART ABSTRACTION

CI-Rehab
Page 3 of 4

- ☐ Yes
☐ No
☐ Unknown

4. Did the participant have neuropathic pain (whether treated or untreated during their stay) at time of discharge? (Suggested to check discharge note/summary)

- ☐ Yes
☐ No
☐ Unknown

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

/ /
 YYYY MM DD

Enter as much of the date as is known.

Respiratory

7.5. Pulmonary complications and conditions diagnosed after the spinal cord lesion, during the rehab stay:

- ☐ None (skip to Data Collection Details)
- ☐ **Pneumonia:** (clinically documented [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)

Number of episodes of pneumonia treated with antibiotics: _____

Number of episodes of pneumonia resulting in hospitalization: (episodes that result in acute care hospitalization only) _____

Date of first pneumonia diagnosis: (date antibiotic treatment started)

/ /
 YYYY MM DD

Enter as much of the date as is known.

- ☐ 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
☐ Surgery (e.g., Uvulopalatopharyngoplasty, Radiofrequency Ablation [RFA], Nasal Surgery, etc.)

CHART ABSTRACTION	CI-Rehab
	Page 4 of 4

<input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown type <input type="checkbox"/> Other Respiratory Conditions (specify): _____
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Data Collection Details					
Collected by: (please print name)		Initial Here:		Date Abstraction Completed:	YYYY-MM-DD