



VISIT DETAILS & CLINICAL INFORMATION

Non-Participating Facility

CHART ABSTRACTION

VD&CI-NP

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Visit Details (for visit at Non-Participating facility)

1. a) Non-Participating Facility Name: _____

b) Location of Facility:

i.) City: _____

ii.) Province: (if in Canada) _____

iii.) Country: _____

2. Level of Care:

(provided to participant by health care facility)

- ☐ Emergency
- ☐ Emergency and Acute
- ☐ Acute
- ☐ Rehab
- ☐ Acute and Rehab
- ☐ Unknown

3. a) Facility Arrival Date:

(Record the earliest documented date. If participant admitted through Emergency Dept, record Emergency Dept arrival date.)

/ /
 YYYY MM DD

Enter as much of the date as is known.

4. b) Facility

Arrival Time: (Record the earliest documented time. [If participant admitted through Emergency Dept, record Emergency Dept arrival time.](#))

: 24 hour clock Enter full or partial time.
 HH MM

5-4. If Level of Care is "Emergency and Acute", indicate:

a) Date of admission to

acute care unit: (e.g., ICU, step-down, acute. Do not include Post-Anaesthetic Recovery (PAR) room. If more than one transfer, choose first date. Note: If Unknown, please document date of first clinical assessment on acute care unit [any type of assessment, e.g., RN, physician, etc.]

/ /
 YYYY MM DD

☐ Unknown

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

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a)

Visit Details - continued

b) Time of admission to

acute care unit: (e.g., ICU, step-down, acute. Do not include Post-Anaesthetic Recovery (PAR) room. If more than one transfer, choose first time. Note: If Unknown, please document time of first clinical assessment on acute care unit [any type of assessment, e.g., RN, physician, etc.]

		:		
HH			MM	

24 hour clock

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

☐ Unknown**6. If Level of Care is "Acute and Rehab", indicate:****a) Date transferred to**

rehab unit: (If more than one transfer, choose date of first. Note: If Unknown, please document date of first clinical assessment on rehab unit [any type of assessment, e.g., RN, physician, etc.]

				/			/		
YYYY					MM			DD	

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

☐ Unknown**b) Time transferred to**

rehab unit: (If more than one transfer, choose time of first. Note: If Unknown, please document time of first clinical assessment on rehab unit [any type of assessment, e.g., RN, physician, etc.]

		:		
HH			MM	

24 hour clock

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

☐ Unknown**6. a) Facility Discharge Date:**

				/			/		
YYYY					MM			DD	

Enter as much of the date as is known.

b) Facility Discharge Time:

(emergency level of care only)

		:		
HH			MM	

24 hour clock

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

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☐ Unknown**Interventions** (performed at Non-Participating Facility)

☐ Check here if the non-participating facility provided only Rehab level of care. Then skip to Data Collection Details.

(Questions ~~7-109-13~~ below apply only if the level of care provided was 'Emergency', 'Emergency & Acute', 'Acute' or 'Acute & Rehab'.)

~~9. a) Was Vertebral Skeletal
Traction (Non-
Operative) used?~~

☐ Yes☐ No (using available documentation, able to reliably determine intervention was NOT performed—skip to Question 10)☐ Not applicable, no fracture (skip to Question 10)☐ Unknown (not recorded in transfer documentation; skip to Question 10)

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

☐ Tongs☐ Halo☐ Other (specify): _____☐ Unknown type

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

☐ Successful☐ Partial☐ Not successful (skip to Question 10)☐ Unknown outcome (skip to Question 10)

~~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:~~

: 24-hour clock
HH MM

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

☐ Unknown

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10-9.**Tracheostomy Performed?**

(at any point during their stay)

☐ Yes☐ No (using available documentation, able to reliably determine intervention was NOT performed)☐ Unknown (documentation not available or not complete, therefore unable to reliably determine if intervention was performed)**b) Tracheostomy Date:**

				/			/		
YYYY					MM			DD	

☐ Unknown

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

Interventions—continued**11-10.****Tracheal or Nasal-Endotracheal Tube > 24 Hours:** (at any point during their stay, excluding use for surgery)☐ Yes☐ No (using available documentation, able to reliably determine intervention was NOT performed)☐ Unknown (documentation not available or not complete, therefore unable to reliably determine if intervention was performed)**12-11.****Methylprednisolone/Corticosteroids:**☐ 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.)☐ Other (specify): _____☐ None (using available documentation, able to reliably determine intervention was NOT performed)☐ Unknown (documentation not available or not complete, therefore unable to reliably determine if intervention was performed)**13-12.****Spine Surgery performed at the Non-participating facility?**☐ Yes**14-13.**☐ No (using available documentation, able to reliably determine intervention was NOT performed. Skip to Data Collection Details.)☐ Unknown (documentation not available or not complete, therefore unable to reliably determine if intervention was performed)**b) If Yes, date of spine surgery:**

				/			/		
YYYY					MM			DD	

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

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(Incision):**

		:		
HH			MM	

24 hour clock

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

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