DC STEP: Healthy Infants and Mothers Program

Infants 0-12 Months Abstraction Form

Affix Subject ID Label Here

THIS FORM IS TO BE COMPLETED BY THE RECORD ABSTRACTOR USING INFORMATION FROM THE INFANT'S MEDICAL RECORDS. COMPLETE THIS FORM FOR EACH SITE/PROVIDER WHERE THE INFANT RECEIVED SERVICES BETWEEN BIRTH AND 12 MONTHS. IF ANY PORTION OF INFORMATION, SUCH AS A DATE, WEIGHT, ETC. IS UNKNOWN/NOT MENTIONED, FILL WITH 88.

ABSTRACTION INTERVAL:

INFANT'S DOB: |___|___| - |___|___| - |___|___| THROUGH **12 MONTHS OLD**:|___|___| - |___|___| - |___|___|
Month Day Year Month Day Year

SECTION A. PROVIDER INFORMATION

Clinic/ER/Hospital Name: _____

1. Clinic or Institution Code: |___|___|___|
(Use Clinic/Institution Code List)

Clinic/ER/Hospital Address: _____

_____

_____

Phone Number: (_____)_____

2. Type of provider:

ER 1
Hospital In-Patient.....2
Hospital Out-Patient.....3
Public Clinic.....4
Private Clinic 5
Private Practice .....6 → **2a. SPECIFY**: _____
HMO 7

Infant's Medical Record Number: _____

BLACK OUT THE MEDICAL RECORD NUMBER BEFORE SENDING THE FORM TO RTI FOR DATA ENTRY.

3. Did the child see the same provider at all visits or different providers?

Same provider.....1

Different providers.....2

4. Abstraction Date: |___|___| - |___|___| - |___|___|___|___|
Month Day Year

Abstractor's Name:_____

5. Abstractor's Code: |___|___|___|

Editor's Name: _____

6. Editor's Code: |___|___|___|

SECTION B. GENERAL INFANT INFORMATION

Information for this section should be abstracted from the infant's record.

1. Infant's Date of Birth: |___|___| - |___|___| - |___|___| ☐ -1 DNR
Mo Day Yr

|2. Infant's Gender:.....☐ -1 DNR

Male.....1 Female 2

3. Circle All Insurance Providers for Infant ☐ -1 DNR

Medicaid.....1
Medicaid Chartered.....2
Managed Care 3
Private insurance 4
Self pay 5
None 6
Other 7
3a. Specify_____

ANTHROPORMORPHIC MEASURES (FROM LAST VISIT ONLY WHERE INDICATED IN CHART)

Please identify the last visit to this provider either prior to the infant's 12-month birth date or within 3 months after the infant's birth date.

4. Reason for visit: (**CIRCLE ALL THAT APPLY**) ☐ -1 DNR

Well child care/routine check up.....1
Illness 2
Injury.....3
Re-Check or Follow-Up.....4
Blood Work/Other test 5
Immunization(s) 6
Other 7
4a. Specify_____

5. Date of Visit: |___|___| - |___|___| - |___|___|___|___|
Month Day Year

6. Record the baby's weight

|___|___| pounds |___|___| ounces or |___|___|.|___|___| kg ☐ -1 DNR

7. Record the baby's length (in inches)

|___|___| . |___|___| inches ☐ -1 DNR

8. Record the baby's head circumference

|___|___| . |___|___| inches or |___|___|.|___| cms ☐ -1 DNR

9. Blood pressure:

Systolic |___|___| . |___|___| ☐ -1 DNR

Diastolic |___|___| . |___|___| ☐ -1 DNR

SECTION B. GENERAL INFANT INFORMATION (cont'd)

10. On the first line, indicate what, if any, chronic medical conditions the infant has. Review the infant's entire chart for this information. If no Chronic Conditions, check the "No Chronic Conditions" box. If a condition exists, use the Chronic Medical Conditions List & add the List Code (# and alphanumeric subcategory). If a condition is identified in the chart that is not listed on the Chronic Medical Conditions List and does not have an associated List Code, use the "Other" list code = 10. Add additional comments in the far right column, entitled "Comments" to provide further details describing the nature of all chronic conditions identified in the chart.

NO CHRONIC CONDITIONS..... ☐ -7 ☐ -1 DNR

	a. Name of Chronic Condition	b. List Code (NUM=NUMBER; A=ALPHA)	c. Date of Diagnosis	d. Comments
#1	_____	|___|___| - |___| NUM A	|___|___| - |___|___| |___|___| DD MM YY	_____
	_____			_____
#2	_____	|___|___| - |___| NUM A	|___|___| - |___|___| |___|___| DD MM YY	_____
	_____			_____
#3	_____	|___|___| - |___| NUM A	|___|___| - |___|___| |___|___| DD MM YY	_____
	_____			_____
#4	_____	|___|___| - |___| NUM A	|___|___| - |___|___| |___|___| DD MM YY	_____
	_____			_____
#5	_____	|___|___| - |___| NUM A	|___|___| - |___|___| |___|___| DD MM YY	_____
	_____			_____

12. Total number of visits to this facility/provider between baby's birth and 12 months: |____|____|

13. Total number of visits to this facility/provider between 12 months & 15 months: |____|____|

COMPLETE THE REMAINING SECTIONS OF THIS FORM FOR EACH VISIT TO THIS SITE/PROVIDER BETWEEN BABY'S BIRTH AND 12 MONTHS OF AGE. IF MORE THAN 3 VISITS ATTACH A SUPPLEMENTAL FORM

SECTION C. GENERAL VISIT INFORMATION	Visit #1	Visit #2	Visit #3
1. Date of Visit	☐ -1 DNR |___|___|-|___|___|-|___|___| MO DAY YR	☐ -1 DNR |___|___|-|___|___|-|___|___| MO DAY YR	☐ -1 DNR |___|___|-|___|___|-|___|___| MO DAY YR
2. Reason for Visit: **(CIRCLE ALL THAT APPLY)**	☐ -1 DNR	☐ -1 DNR	☐ -1 DNR
Well child care/routine checkup	1	1	1
Illness	2	2	2
Injury	3	3	3
Re-check or follow-up to previous visit	4	4	4
Blood work/other test	5	5	5
Immunization(s)	6	6	6
Other (SPECIFY)	7 _____	7 _____	7 _____
Other (SPECIFY)	8_____	8_____	8_____
Other (SPECIFY)	9_____	9_____	9_____
3. Was this an outpatient/inpatient visit, an ER visit or hospitalization?	☐ -1 DNR	☐ -1 DNR	☐ -1 DNR
Outpatient visit	1 → **SKIP TO Q.10**	1 → **SKIP TO Q.10**	1 → **SKIP TO Q.10**
Inpatient visit	2 → **SKIP TO Q.10**	2 → **SKIP TO Q.10**	2 → **SKIP TO Q.10**
ER visit	3	3	3
Hospitalization	4→ **SKIP TO Q.7**	4→ **SKIP TO Q.7**	4→ **SKIP TO Q.7**
Other (SPECIFY)	5 → 3a._____ ↓ **SKIP TO Q. 10**	5 → 3a._____ ↓ **SKIP TO Q. 10**	5 → 3a._____ ↓ **SKIP TO Q. 10**
4. Was the baby referred to the ER by a health care provider?	☐ -1 DNR	☐ -1 DNR	☐ -1 DNR
Yes	1	1	1
No	2 → **Skip to Q. 4b**	2 → **Skip to Q. 4b**	2 → **Skip to Q. 4b**
4a. Name/place of health care provider that referred the baby:	☐ -1 DNR	☐ -1 DNR	☐ -1 DNR
4b. Why was child brought to ER?	☐ -1 DNR	☐ -1 DNR	☐ -1 DNR
Severity of illness/injury	1	1	1
After regular provider's hours of business	2	2	2
Other reason (SPECIFY)	3 _____	3 _____	3 _____

SECTION C. GENERAL VISIT INFORMATION (cont'd)	Visit #1	Visit #2	Visit #3
5. Date and time of admission to ER:	**(1) Date:** ☐ -1 DNR |__|__|-|__|__|-|__|__| Mo Day Yr **(2)Time:** (Military Time) ☐ -1 DNR |__|__|__|__|	**(1) Date:** ☐ -1 DNR |__|__|-|__|__|-|__|__| Mo Day Yr **(2)Time:** (Military Time) ☐ -1 DNR |__|__|__|__|	**(1) Date:** ☐ -1 DNR |__|__|-|__|__|-|__|__| Mo Day Yr **(2)Time:** (Military Time) ☐ -1 DNR |__|__|__|__|
5a. Date and time of discharge from ER:	**(1) Date:** ☐ -1 DNR |__|__|-|__|__|-|__|__| Mo Day Yr **(2)Time:** (Military Time) ☐ -1 DNR |__|__|__|__|	**(1) Date:** ☐ -1 DNR |__|__|-|__|__|-|__|__| Mo Day Yr **(2)Time:** (Military Time) ☐ -1 DNR |__|__|__|__|	**(1) Date:** ☐ -1 DNR |__|__|-|__|__|-|__|__| Mo Day Yr **(2)Time:** (Military Time) ☐ -1 DNR |__|__|__|__|
6. Did the ER visit result in a hospitalization? Yes..... No	☐ -1 DNR 1 2 → **Skip to Q. 9**	☐ -1 DNR 1 2 → **Skip to Q. 9**	☐ -1 DNR 1 2 → **Skip to Q. 9**
7. To what hospital unit(s) was the baby admitted? (CIRCLE ALL THAT APPLY) Neonatal Intensive Care..... Pediatric Intensive Care Unit..... Cardiac Care Unit..... Other **(Specify)**	☐ -1 DNR 1 2 3 4_____	☐ -1 DNR 1 2 3 4_____	☐ -1 DNR 1 2 3 4_____
8. Date and time of admission to hospital:	**(1) Date:** ☐ -1 DNR |__|__|-|__|__|-|__|__| Mo Day Yr **(2)Time:** (Military Time) ☐ -1 DNR |__|__|__|__|	**(1) Date:** ☐ -1 DNR |__|__|-|__|__|-|__|__| Mo Day Yr **(2)Time:** (Military Time) ☐ -1 DNR |__|__|__|__|	**(1) Date:** ☐ -1 DNR |__|__|-|__|__|-|__|__| Mo Day Yr **(2)Time:** (Military Time) ☐ -1 DNR |__|__|__|__|
8a. Date and time of discharge from hospital:	**(1) Date:** ☐ -1 DNR |__|__|-|__|__|-|__|__| Mo Day Yr **(2)Time:** (Military Time) ☐ -1 DNR |__|__|__|__|	**(1) Date:** ☐ -1 DNR |__|__|-|__|__|-|__|__| Mo Day Yr **(2)Time:** (Military Time) ☐ -1 DNR |__|__|__|__|	**(1) Date:** ☐ -1 DNR |__|__|-|__|__|-|__|__| Mo Day Yr **(2)Time:** (Military Time) ☐ -1 DNR |__|__|__|__|

9. Describe any additional details about the ER visit or hospitalization (in Q.4-8) by visit # as needed:

Visit #1: _____ ☐ -1 DNR

_____

Visit #2: _____ ☐ -1 DNR

_____

Visit #3: _____ ☐ -1 DNR

_____

SECTION C. GENERAL VISIT INFORMATION (cont'd)	Visit #1	Visit #2	Visit #3
10. What types of routine exams, assessments, or screening procedures were completed at this visit? (CIRCLE ALL THAT APPLY)	NONE ☐-7	NONE ☐-7	NONE ☐-7
History taking—initial	1	1	1
History taking–interval	2	2	2
Physical examination	3	3	3
Dental screening or exam	4	4	4
Developmental or behavioral assessment	5	5	5
Other (SPECIFY)	6_____	6_____	6_____
Other (SPECIFY)	7_____	7_____	7_____
Other (SPECIFY)	8_____	8_____	8_____

10a. Provide any comments regarding the procedures listed in Q.10. Be sure to write comments on the line next to the correct Visit #.

Visit #1: _____ ☐ -1 DNR

_____

Visit #2: _____ ☐ -1 DNR

_____

Visit #3: _____ ☐ -1 DNR

_____

SECTION C. GENERAL VISIT INFORMATION (cont'd.)	Visit #1	Visit #2	Visit #3
11. What types of immunization shots or vaccinations were given at this visit? (CIRCLE ALL THAT APPLY)	NONE ☐-7	NONE ☐-7	NONE ☐-7
Diphtheria & tetanus toxoids & acellular pertussis vaccine (DTP/DTaP).....	1	1	1
Haemophilus influenzae type b conjugate vaccine (Hib).....	2	2	2
Hepatitis A vaccine (HepA)	3	3	3
Hepatitis B vaccine (HepB)	4	4	4
Influenza vaccine or Trivalent Inactivated Influenza Vaccine (TIV).....	5	5	5
Inactivated Poliovirus IPV	6	6	6
Measles, mumps, and rubella vaccine (MMR)....			
Oral Polio Vaccine OPV	7	7	7
Pneumococcal Conjugate Vaccine (PCV)	8	8	8
Rotavirus vaccine (Rota).....	9	9	9
Tetramune (DTP/HIB)	10	10	10
Varicella vaccine	11	11	11
Other (SPECIFY).....	12 _____	12_____	12 _____
Other (SPECIFY).....	13_____	13_____	13_____
11a. Did the chart notes indicate that the immunization shots were up-to-date at this visit?	☐ -1 DNR	☐ -1 DNR	☐ -1 DNR
Yes, up-to-date.....	1	1	1
Not up-to-date	2	2	2

11b. Provide any comments regarding the immunizations listed in Q.11. Be sure to write comments on the line next to the correct Visit #.

Visit #1: _____ ☐ -1 DNR

_____

Visit #2: _____ ☐ -1 DNR

_____

Visit #3: _____ ☐ -1 DNR

_____

SECTION C. GENERAL VISIT INFORMATION (cont'd.)	Visit #1	Visit #2	Visit #3
12. What types of primary prevention or HP assessments, behavioral counseling or guidance were addressed at this visit? (CIRCLE ALL THAT APPLY)	NONE ☐-7	NONE ☐-7	NONE ☐-7
Back-to-sleep position	1	1	1
Breastfeeding	2	2	2
ETS (secondhand smoke)	3	3	3
Injury prevention (e.g., falls, burns, etc)	4	4	4
Nutrition counseling	5	5	5
Violence prevention (IPV, risk for child abuse)	6	6	6
Infant social/emotional development	7	7	7
Other (SPECIFY)	8_____	8_____	8_____
Other (SPECIFY)	9_____	9_____	9_____
Other (SPECIFY)	10_____	10_____	10_____

12a. Provide any comments regarding the issues listed in Q.12. Be sure to write comments on the line next to the correct Visit #.

Visit #1: _____ ☐ -1 DNR

_____

Visit #2: _____ ☐ -1 DNR

_____

Visit #3: _____ ☐ -1 DNR

_____

SECTION C. GENERAL VISIT INFORMATION (cont'd.)	Visit #1	Visit #2	Visit #3
13. What types of risk factors or problems, if any, were noted by the provider at this visit? (CIRCLE ALL THAT APPLY)	NONE ☐-7	NONE ☐-7	NONE ☐-7
Alcohol use by mother	1	1	1
Alcohol use by other household member	2	2	2
Drug use by mother	3	3	3
Drug use by other household member	4	4	4
Smoking by mother	5	5	5
Smoking by other household member	6	6	6
Poor Parenting Skills (infant supervision, routines, etc)	7	7	7
Developmental delay	8	8	8
Infant growth retardation	9	9	9
Child abuse	10	10	10
Child neglect	11	11	11
Intimate partner violence	12	12	12
Crowded living conditions	13	13	13
Environmental hazards in the home	14	14	14
Homelessness	15	15	15
Transient living situation	16	16	16
Other Concerns (SPECIFY)	17_____	17_____	17_____
Other Concerns (SPECIFY)	18_____	18_____	18_____
Other Concerns (SPECIFY)	19_____	19_____	19_____

13a. Provide any comments regarding the issues listed in Q.13. Be sure to write comments on the line next to the correct Visit #.

Visit #1: _____ ☐ -1 DNR

_____

Visit #2: _____ ☐ -1 DNR

_____

Visit #3: _____ ☐ -1 DNR

_____

SECTION C. GENERAL VISIT INFORMATION (cont'd.)	Visit #1		Visit #2		Visit #3	
14. What, if any, other types of treatments or services were (a) recommended and (b) delivered at this visit. (CIRCLE ALL THAT APPLY)	NONE ☐-7		NONE ☐-7		NONE ☐-7	
	(a) Recm	**(b) Delv**	**(a) Recm**	**(b) Delv**	**(a) Recm**	**(b) Delv**
Apnea monitoring	1 ☐ -1 DNR	1 ☐ -1 DNR	1 ☐ -1 DNR	1 ☐ -1 DNR	1 ☐ -1 DNR	1 ☐ -1 DNR
Arterial line/CVP line	2 ☐ -1 DNR	2 ☐ -1 DNR	2 ☐ -1 DNR	2 ☐ -1 DNR	2 ☐ -1 DNR	2 ☐ -1 DNR
Central line	3 ☐ -1 DNR	3 ☐ -1 DNR	3 ☐ -1 DNR	3 ☐ -1 DNR	3 ☐ -1 DNR	3 ☐ -1 DNR
Chest Physiotherapy	4 ☐ -1 DNR	4 ☐ -1 DNR	4 ☐ -1 DNR	4 ☐ -1 DNR	4 ☐ -1 DNR	4 ☐ -1 DNR
Intubation.....	5 ☐ -1 DNR	5 ☐ -1 DNR	5 ☐ -1 DNR	5 ☐ -1 DNR	5 ☐ -1 DNR	5 ☐ -1 DNR
Surgery.....	6 ☐ -1 DNR	6 ☐ -1 DNR	6 ☐ -1 DNR	6 ☐ -1 DNR	6 ☐ -1 DNR	6 ☐ -1 DNR
Other (SPECIFY).....	7 ☐ -1 DNR	7 ☐ -1 DNR	7 ☐ -1 DNR	7 ☐ -1 DNR	7 ☐ -1 DNR	7 ☐ -1 DNR
Other (SPECIFY).....	8 ☐ -1 DNR	8 ☐ -1 DNR	8 ☐ -1 DNR	8 ☐ -1 DNR	8 ☐ -1 DNR	8 ☐ -1 DNR
Other (SPECIFY).....	9 ☐ -1 DNR	9 ☐ -1 DNR	9 ☐ -1 DNR	9 ☐ -1 DNR	9 ☐ -1 DNR	9 ☐ -1 DNR

14a. Describe the purpose and reason for each treatment and service recommended and/or delivered in Q.14:

Visit #1: _____ ☐ -1 DNR

_____

Visit #2: _____ ☐ -1 DNR

_____

Visit #3: _____ ☐ -1 DNR

_____

SECTION C. GENERAL VISIT INFORMATION (cont'd.)	Visit #1	Visit #2	Visit #3
15. Indicate which, if any, medications were prescribed or given at this visit. (CIRCLE ALL THAT APPLY)	NONE ☐-7	NONE ☐-7	NONE ☐-7
Antibiotics	1	1	1
Furosemide	2	2	2
Ribavirin.....	3	3	3
Steroids	4	4	4
β-agonists.....	5	5	5
Other medication(SPECIFY)	6 _____	6 _____	6 _____
Other medications (SPECIFY)	7_____	7_____	7_____
Other medications (SPECIFY)	8 _____..	8 _____	8 _____

15a. Describe the purpose for each medication prescribed or given in Q.15:

Visit #1: _____ ☐ -1 DNR

_____

Visit #2: _____ ☐ -1 DNR

_____

Visit #3: _____ ☐ -1 DNR

_____

SECTION D. ILLNESSES	Visit #1	Visit #2	Visit #3
1. Were any illness symptoms or complaints reported by the mother at this visit? (CIRCLE ALL THAT APPLY)	NONE ☐-7 →**SKIP TO Q.3**	NONE ☐-7 →**SKIP TO Q.3**	NONE ☐-7 →**SKIP TO Q.3**
Breathing difficulties	1	1	1
Constipation.	2	2	2
Convulsions or seizure-like symptoms	3	3	3
Cough, wheezing, or rattling in the chest	4	4	4
Diarrhea	5	5	5
Eye irritation	6	6	6
Feeding, food sensitivity or digestion problems	7	7	7
Fever	8	8	8
Irritability, inconsolable crying, and screaming	9	9	9
Nose runny or stuffed up	10	10	10
Skin rash, including diaper rash, hives	11	11	11
Sleeping problems	12	12	12
Spitting up or regurgitating	13	13	13
Turned blue	14	14	14
Vomiting	15	15	15
Other symptoms/complaints(SPECIFY)	16_____	16_____	16_____
Other symptoms/complaints(SPECIFY)	17_____	17_____	17_____
Other symptoms/complaints(SPECIFY)	18_____	18_____	18_____
1b. Describe the severity and duration of symptoms or complaints reported.			
2. When did the symptoms first appear/occur?	**Date:** ☐ -1 DNR |__|__|-|__|__|-|__|__| Mo Day Yr **Time:** (Military Time) ☐ -1 DNR |__|__|__|__|	**Date:** ☐ -1 DNR |__|__|-|__|__|-|__|__| Mo Day Yr **Time:** (Military Time) ☐ -1 DNR |__|__|__|__|	**Date:** ☐ -1 DNR |__|__|-|__|__|-|__|__| Mo Day Yr **Time:** (Military Time) ☐ -1 DNR |__|__|__|__|
2a. Number of days or hours symptoms present prior to visit?	☐ -1 DNR |__|__|Days |__|__|Hours	☐ -1 DNR |__|__|Days |__|__|Hours	☐ -1 DNR |__|__|Days |__|__|Hours

SECTION D. ILLNESSES (cont'd)	Visit #1		Visit #2		Visit #3	
3. Using the Illness List, indicate which illnesses, if any, were <u>diagnosed</u> and add comments. If an illness was diagnosed in the chart that is not listed on the Illness List and does not have an associated ICD-9 code in the chart, specify the condition.	NONE ☐-7 ☐ -1 DNR		NONE ☐-7 ☐ -1 DNR		NONE ☐-7 ☐ -1 DNR	
	List Code	Comments/Specify	List Code	Comments/Specify	List Code	Comments/Specify
Illness #1.....	|___|___|	_____	|___|___|	_____	|___|___|	_____
Illness #2.....	|___|___|	_____	|___|___|	_____	|___|___|	_____
Illness #3.....	|___|___|	_____	|___|___|	_____	|___|___|	_____
Illness #4.....	|___|___|	_____	|___|___|	_____	|___|___|	_____
Illness #5.....	|___|___|	_____	|___|___|	_____	|___|___|	_____

3a. Describe any additional details for illnesses listed in Q.3 by Visit # and Illness # as needed:

Visit #1: _____ ☐ -1 DNR

_____

Visit #2: _____ ☐ -1 DNR

_____

Visit #3: _____ ☐ -1 DNR

_____

SECTION D. ILLNESSES (cont'd)	Visit #1	Visit #2	Visit #3
4. Was illness resolved?	☐ -1 DNR	☐ -1 DNR	☐ -1 DNR
Yes	1	1	1
No	2	2	2
5. What was the final disposition at the end of the visit? (CIRCLE ALL THAT APPLY)	☐ -1 DNR	☐ -1 DNR	☐ -1 DNR
Left without being seen	1	1	1
Resolved, follow-up as necessary	2	2	2
Resolved, follow-up required	3	3	3
Observation in ER	4	4	4
Admission to hospital	5	5	5
Transferred to another hospital.....	6	6	6
Referral.....	7	7	7
Other (SPECIFY).....	8_____	8_____	8_____
6. Total number of follow-up visits, if any, to this facility/provider for this illness/injury:	☐ -1 DNR 0.....NONE |___|___| Follow-up visits	☐ -1 DNR 0.....NONE |___|___| Follow-up visits	☐ -1 DNR 0 ..... NONE |___|___| Follow-up visits
7. Where, if at all, was the infant referred?	☐ -1 DNR	☐ -1 DNR	☐ -1 DNR
No Referral Made	-7 → **Go to Section E**	-7 → **Go to Section E**	-7 → **Go to Section E**
Usual care provider.....	1	1	1
Medical referral	2	2	2
Developmental/behavioral referral ..	3	3	3
Dental referral	4	4	4
Social service referral	5	5	5
Other (SPECIFY)	6_____	6_____	6_____
7b. Comments on types of services to be addressed by this (these) referral(s).			

SECTION E. INJURIES/ACCIDENTS	Visit #1	Visit #2	Visit #3
1. Were any injuries or accidents reported by the mother at this visit? (CIRCLE ALL THAT APPLY)	NONE ☐-7→**SKIP TO SECTION F**	NONE ☐-7→**SKIP TO SECTION F**	NONE ☐-7→**SKIP TO SECTION F**
Burn	1	1	1
Choking/suffocation.....	2	2	2
Closed wound (bruise, abrasion, etc.)	3	3	3
Fracture/dislocation.....	4	4	4
Head injury	5	5	5
Open wound (puncture, laceration, cut, etc)..	6	6	6
Poisoning.....	7	7	7
Other injuries/accidents(SPECIFY).....	8_____	8_____	8_____
Other injuries/accidents(SPECIFY).....	9_____	9_____	9_____
Other injuries/accidents(SPECIFY).....	10_____	10_____	10_____
1b. Describe the injuries/accidents reported.			
2. When did the injury or accident first occur?	**Date:** ☐ -1 DNR |__|__|-|__|__|-|__|__| Mo Day Yr **Time:** (Military Time) ☐ -1 DNR |__|__|__|__|	**Date:** ☐ -1 DNR |__|__|-|__|__|-|__|__| Mo Day Yr **Time:** (Military Time) ☐ -1 DNR |__|__|__|__|	**Date:** ☐ -1 DNR |__|__|-|__|__|-|__|__| Mo Day Yr **Time:** (Military Time) ☐ -1 DNR |__|__|__|__|
2a. Number of days or hours injury present prior to visit.	☐ -1 DNR |__|__|Days |__|__|Hours	☐ -1 DNR |__|__|Days |__|__|Hours	☐ -1 DNR |__|__|Days |__|__|Hours
2b. How severe were the injuries?	☐ -1 DNR	☐ -1 DNR	☐ -1 DNR
Minor.....	1	1	1
Significant.....	2	2	2
Severe	3	3	3
Life threatening.....	4	4	4

SECTION E. INJURIES/ACCIDENTS (cont'd)	Visit #1		Visit #2		Visit #3	
3. Using the Injury Cause List, indicate the causes of the injuries noted in the chart and add comments. If an injury cause is identified in the chart that is not listed on the Injury Cause List or does not have an associated ICD-9 code, specify the cause.	NONE ☐-7	☐ -1 DNR	NONE ☐-7	☐ -1 DNR	NONE ☐-7	☐ -1 DNR
	List Code	Comments/Specify	List Code	Comments/Specify	List Code	Comments/Specify
Illness #1.....	|___|___|	_____	|___|___|	_____	|___|___|	_____
Illness #2.....	|___|___|	_____	|___|___|	_____	|___|___|	_____
Illness #3.....	|___|___|	_____	|___|___|	_____	|___|___|	_____
Illness #4.....	|___|___|	_____	|___|___|	_____	|___|___|	_____
Illness #5.....	|___|___|	_____	|___|___|	_____	|___|___|	_____

3a. Describe any additional details for injuries/accidents listed in Q.3 by Visit # and Injury # as needed:

Visit #1: _____ ☐ -1 DNR

_____

Visit #2: _____ ☐ -1 DNR

_____

Visit #3: _____ ☐ -1 DNR

_____

SECTION E. INJURIES/ACCIDENTS (cont'd)	Visit #1	Visit #2	Visit #3
4. Was injury/accident resolved?	☐ -1 DNR	☐ -1 DNR	☐ -1 DNR
Yes	1	1	1
No	2	2	2
5. What was the final disposition at the end of the visit? (CIRCLE ALL THAT APPLY)	☐ -1 DNR	☐ -1 DNR	☐ -1 DNR
Left without being seen	1	1	1
Resolved, follow-up as necessary	2	2	2
Resolved, follow-up required	3	3	3
Observation in ER	4	4	4
Admission to hospital	5	5	5
Transferred to another hospital.....	6	6	6
Referral.....	7	7	7
Other (SPECIFY).....	8_____	8_____	8_____
6. Total number of follow-up visits, if any, to this facility/provider for this injury/accident:	☐ -1 DNR 0.....NONE |___|___| Follow-up visits	☐ -1 DNR 0.....NONE |___|___| Follow-up visits	☐ -1 DNR 0 ..... NONE |___|___| Follow-up visits
7. Where, if at all, was the infant referred?	☐ -1 DNR	☐ -1 DNR	☐ -1 DNR
No Referral Made	-7 → **Go to Section F**	-7 → **Go to Section F**	-7 → **Go to Section F**
Usual care provider.....	1	1	1
Medical referral	2	2	2
Developmental/behavioral referral ..	3	3	3
Dental referral	4	4	4
Social service referral	5	5	5
Other (SPECIFY)	6_____	6_____	6_____
7b. Comments on types of services to be addressed by this (these) referral(s).			

SECTION F. LABORATORY AND DIAGNOSTIC TESTS	Visit #1		Visit #2		Visit #3	
1. Indicate whether the following laboratory and diagnostic tests were ordered at this visit and the results.	**a. ORDERED** **YES** **NO**	**b. RESULTS** Positive = condition present Negative/normal = condition absent	**a. ORDERED** **YES** **NO**	**b. RESULTS** Positive = condition present Negative/normal = condition absent	**a. ORDERED** **YES** **NO**	**b. RESULTS** Positive = condition present Negative/normal = condition absent
(1) Chest X-Ray (CXR)	□ -1 DNR 1 2	□ -1 DNR Positive ..... 1 Negative ..... 2 Normal..... 3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____
(2) Chest Radiography	□ -1 DNR 1 2	□ -1 DNR Positive ..... 1 Negative ..... 2 Normal..... 3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____
(3) Respiratory Syncytial Virus (RSV) Test	□ -1 DNR 1 2	□ -1 DNR Positive ..... 1 Negative ..... 2 Normal..... 3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____
(4) Ultrasound	□ -1 DNR 1 2	□ -1 DNR Positive ..... 1 Negative ..... 2 Normal..... 3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____
(5) White Blood Cells (WBC)	□ -1 DNR 1 2	□ -1 DNR Positive ..... 1 Negative ..... 2 Normal..... 3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____

SECTION F. LABORATORY AND DIAGNOSTIC TESTS (cont'd)	Visit #1		Visit #2		Visit #3	
1. Indicate whether the following laboratory and diagnostic tests were ordered at this visit and the results.	**a. ORDERED** **YES** **NO**	**b. RESULTS** Positive = condition present Negative/normal = condition absent	**a. ORDERED** **YES** **NO**	**b. RESULTS** Positive = condition present Negative/normal = condition absent	**a. ORDERED** **YES** **NO**	**b. RESULTS** Positive = condition present Negative/normal = condition absent
(6) Other Test (Specify)	☐ -1 DNR 1 2	☐ -1 DNR Positive ..... 1 Negative ..... 2 Normal..... 3 Other .....4↓ Specify _____	☐ -1 DNR 1 2	☐ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____	☐ -1 DNR 1 2	☐ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____
(7) Other Test (Specify)	☐ -1 DNR 1 2	☐ -1 DNR Positive ..... 1 Negative ..... 2 Normal..... 3 Other .....4↓ Specify _____	☐ -1 DNR 1 2	☐ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____	☐ -1 DNR 1 2	☐ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____
(8) Other Test (Specify)	☐ -1 DNR 1 2	☐ -1 DNR Positive ..... 1 Negative ..... 2 Normal..... 3 Other .....4↓ Specify _____	☐ -1 DNR 1 2	☐ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____	☐ -1 DNR 1 2	☐ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____

1a. Describe any additional details about laboratory and diagnostic tests marked in Q.1 by Visit # and test as needed:

Visit #1: _____ ☐ -1 DNR

_____

Visit #2: _____ ☐ -1 DNR

_____

Visit #3: _____ ☐ -1 DNR

SECTION G. SCREENING TESTS	Visit #1		Visit #2		Visit #3	
1. Indicate whether the following screening tests were ordered at this visit and the results.	**a. ORDERED** **YES** **NO**	**b. RESULTS** Positive = condition present Negative/normal = condition absent	**a. ORDERED** **YES** **NO**	**b. RESULTS** Positive = condition present Negative/normal = condition absent	**a. ORDERED** **YES** **NO**	**b. RESULTS** Positive = condition present Negative/normal = condition absent
(1) Genetic Screening	□ -1 DNR 1 2	□ -1 DNR Positive ..... 1 Negative ..... 2 Normal..... 3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____
(2) Hematocrit or Hemoglobin for Anemia (Hct/Hgb)	□ -1 DNR 1 2	□ -1 DNR Positive ..... 1 Negative ..... 2 Normal..... 3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____
(3) Hearing Screen	□ -1 DNR 1 2	□ -1 DNR Positive ..... 1 Negative ..... 2 Normal..... 3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____
(4) Heredity Screening	□ -1 DNR 1 2	□ -1 DNR Positive ..... 1 Negative ..... 2 Normal..... 3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____
(5) Lead Screening	□ -1 DNR 1 2	□ -1 DNR Positive ..... 1 Negative ..... 2 Normal..... 3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____

SECTION G. SCREENING TESTS (cont'd)	Visit #1		Visit #2		Visit #3	
1. Indicate whether the following screening tests were ordered at this visit and the results.	**a. ORDERED** **YES** **NO**	**b. RESULTS** Positive = condition present Negative/normal = condition absent	**a. ORDERED** **YES** **NO**	**b. RESULTS** Positive = condition present Negative/normal = condition absent	**a. ORDERED** **YES** **NO**	**b. RESULTS** Positive = condition present Negative/normal = condition absent
(6) Metabolic Screen (PKU)	□ -1 DNR 1 2	□ -1 DNR Positive ..... 1 Negative ..... 2 Normal..... 3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____
(7) Vision Screening	□ -1 DNR 1 2	□ -1 DNR Positive ..... 1 Negative ..... 2 Normal..... 3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____
(8) Other Test (Specify)	□ -1 DNR 1 2	□ -1 DNR Positive ..... 1 Negative ..... 2 Normal..... 3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____
(9) Other Test (Specify)	□ -1 DNR 1 2	□ -1 DNR Positive ..... 1 Negative ..... 2 Normal..... 3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____
(10) Other Test (Specify)	□ -1 DNR 1 2	□ -1 DNR Positive ..... 1 Negative ..... 2 Normal..... 3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____	□ -1 DNR 1 2	□ -1 DNR Positive .....1 Negative.....2 Normal .....3 Other .....4↓ Specify _____

1a. Describe any additional details about screening tests marked in Q.1 by Visit # and test as needed:

Visit #1: _____ ☐ -1 DNR

_____

Visit #2: _____ ☐ -1 DNR

_____

Visit #3: _____ ☐ -1 DNR

_____

SECTION H. FINAL CHART NOTES	Visit #1	Visit #2	Visit #3
1. In general, how easy or difficult was it to decipher the information contained in the medical record(s)?			
Very easy.....	1	1	1
Somewhat easy.....	2	2	2
Some information easy/some difficult	3	3	3
Somewhat difficult	4	4	4
Very difficult	5	5	5
2. Describe any special problems in completing the abstraction.			