



CHART ABSTRACTION

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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
☐ Respirology
☐ 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

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3. 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.)

4. 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
- ☐ Halo
- ☐ Other: _____
- ☐ Unknown type

c) 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

5. 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.

6. Oral- or Nasal- Endotracheal

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

- ☐ Yes
- ☐ No

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- 7. 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)
- ☐ Other (specify): _____
- ☐ None

- 8. Was spine surgery
performed?**

- ☐ Yes (if yes, please complete a Spinal Procedures Form (SPROC-MULT) for each surgery performed)
- ☐ No

Complications

- 9. a) 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 10)

- b) If YES, date of first
delirium diagnosis:**

				/			/		
YYYY					MM			DD	

Enter as much of the date
as is known.

- 10. 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 11 on page 4)

- 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.

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Respiratory

11. 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)Number of episodes of
pneumonia treated with
antibiotics: _____Date of first pneumonia
diagnosis: (date antibiotic
treatment started)

				/			/		
YYYY					MM			DD	

Enter as much of the date
as is known. If no details
available, check Unknown.☐ 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.)☐ Other (specify): _____☐ Unknown type☐ Other Respiratory Conditions (specify): _____☐ Unknown

Data Collection Details

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