



# VISIT DETAILS & CLINICAL INFORMATION

## Non-Participating Facility

CHART ABSTRACTION

VD&CI-NP  
Page 1 of 4

### 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. 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. Facility Arrival Time:** (Record the earliest documented time.)

		:		
HH			MM	

24 hour clock Enter full or partial time.

**5. 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	

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

Unknown

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### 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

**7. Facility Discharge Date:**

				/			/		
YYYY					MM			DD	

Enter as much of the date as is known.

**8. Facility Discharge Time:**

		:		
HH			MM	

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

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 9-13 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

Unknown

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

**e) Time Reduction Achieved:**

:   24 hour clock  
 HH                      MM

Unknown

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

**10. a) 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. Oral- 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)

**12. 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)

**13. a) Was Spine Surgery performed at the Non-participating facility?**

- Yes
- No (using available documentation, able to reliably determine intervention was NOT performed. Skip to Data Collection Details.)

**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.

- Unknown

**c) Operative start time (Incision):**

		:			24 hour clock
HH			MM		

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

- Unknown

**Data Collection Details**

<b>Collected by:</b> <small>(please print name)</small>		<b>Initial Here:</b>		<b>Date Abstraction Completed:</b>	YYYY-MM-DD
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