Rick Hansen Institute
Institut Rick Hansen | RHSCIR

VISIT DETAILS

Acute

CHART ABSTRACTION

Visit Details

1. Facility Name: _____

2. Level of Care:
(provided to participant by health care facility)

☐ Emergency & Acute
☐ Acute

3. Facility Arrival Date:
(Record the earliest documented date. If participant arrived 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). 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.

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

☐ Unknown

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

Visit Details - continued

6. **a) Was the participant admitted to a Special Care Unit at any time during their stay?** (including any Intensive Care or Step-Down Unit)

☐ Yes

☐ No

b) If YES,

	Type of SCU: (ICU or Step-Down Unit [SDU])	Admission Date: Enter as much of the date as is known.	Discharge Date: Enter as much of the date as is known.
1st Special Care Unit visit:	☐ ICU ☐ SDU	YYYY-MM-DD	YYYY-MM-DD
2nd Special Care Unit visit:	☐ ICU ☐ SDU	YYYY-MM-DD	YYYY-MM-DD
3rd Special Care Unit visit:	☐ ICU ☐ SDU	YYYY-MM-DD	YYYY-MM-DD
4th Special Care Unit visit:	☐ ICU ☐ SDU	YYYY-MM-DD	YYYY-MM-DD
5th Special Care Unit visit:	☐ ICU ☐ SDU	YYYY-MM-DD	YYYY-MM-DD

7. **Facility Discharge Date:** (if participant transferred to rehab at the same facility, please enter date of transfer to rehab)

☐☐☐☐ / ☐☐ / ☐☐
YYYY   MM   DD

Enter as much of the date as is known.

8. **Facility Discharge Time:** (if participant transferred to rehab at the same facility, please enter time of transfer to rehab)

☐☐ : ☐☐   24 hour clock
HH   MM

☐ Unknown

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

Visit Details - continued

9. a) Discharge Destination:
(if participant transferred to rehab at the same facility, please choose hospital and enter "Rehab" Level of Care)

☐ Hospital (Rehabilitation hospital for ongoing SCI-related care as well as mental hospital or other acute care hospital for management of continuing medical issues after spinal cord injury-related care and/or rehabilitation is completed. This does not include long-term care within a hospital setting.)

Name of Hospital:_____

b) Level of Care: (check ONE response only)

☐ Acute (skip to Question 10 on page 4)

☐ Rehab (go to Question 9c)

☐ Transitional Care (skip to Question 10 on page 4)

☐ Other (specify): _____
(skip to Question 10 on page 4)

☐ Unknown (skip to Question 10 on page 4)

☐ Private residence (includes house, condominium, mobile home, apartment, or houseboat)

☐ Assisted living residence (semi-independent housing, a middle option between home support and residential care)

☐ Nursing home/Long-term care in a hospital setting (includes skilled nursing facilities and institutions providing long-term, custodial, chronic disease care, and extended care)

☐ Group living arrangement (includes transitional living facility or any residence shared by non-family members)

☐ Hotel/motel (includes short or long-term living arrangements, single room occupancy, etc.)

☐ Correctional institute (includes prison, penitentiary, jail, correctional centre, etc.)

☐ Homeless (includes cave, car, tent, street, etc.)

☐ Morgue

☐ Other (specify):_____

Skip to Question 10 on page 4

c) Date of Rehab Referral:

☐☐☐☐ / ☐☐ / ☐☐
YYYY   MM   DD

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

☐ Unknown (please also complete Question 9d, then skip to Question 10 on page 4)

☐ N/A – automatic referral process (enter date below, then skip to Question 10 on page 4)

If automatic referral, Date of 1st physiatry assessment:

☐☐☐☐ / ☐☐ / ☐☐
YYYY   MM   DD

Enter as much of the date as is known.

d) Date initial physiatry consult completed:

☐☐☐☐ / ☐☐ / ☐☐
YYYY   MM   DD

Enter as much of the date as is known.

CHART ABSTRACTION

Visit Details - continued

e) If there were > 7 days between the rehab referral and the completion of the initial physiatry consult, and a reason for the delay is documented in the physiatry consult, enter reason for delay:

☐ Deterioration in medical status

☐ Not clinically appropriate

☐ Other (specify): _____

☐ Reason unknown

10. Physician Most Responsible for Acute Care:

(physician [not resident or fellow] who performed spinal operative procedure or provided overall direction of care)

_____

Provide last name, first initial (and second initial if available).

Data Collection Details

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

Version: 08Nov2013