



## 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  
☐ Respiriology  
☐ 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

## CHART ABSTRACTION

CI-Rehab  
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## Interventions - continued

**3. Assistive Equipment – Orthosis****Use:** (check ALL that apply on day of discharge from Rehab 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) Tracheostomy Performed:** (at any point during their rehab stay)☐ Yes☐ No (skip to Question 5)**b) Tracheostomy Date:**

				/			/		
YYYY					MM			DD	

Enter as much of the date as is known.

## Complications

**5. 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 6)**b) If YES, date of first delirium diagnosis:**

				/			/		
YYYY					MM			DD	

Enter as much of the date as is known.

**6. 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 7 on page 3)**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.

## CHART ABSTRACTION

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## Respiratory

**7. Pulmonary complications and conditions diagnosed after the spinal cord lesion, during the rehab stay:**☐ None (skip to Data Collection Details)☐ **Pneumonia:** (clinically documented [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: \_\_\_\_\_

Number of episodes of pneumonia resulting in hospitalization: (episodes that result in acute care hospitalization only) \_\_\_\_\_

Date of first pneumonia diagnosis: (date antibiotic treatment started)

				/			/		
YYYY					MM			DD	

Enter as much of the date as is known.

☐ 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): \_\_\_\_\_

## Data Collection Details

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