



VISIT DETAILS & CLINICAL INFORMATION

Non-Participating Facility

CHART ABSTRACTION

VD&CI-NP

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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

☐ Unknown

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

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

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

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

- ☐ Unknown

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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):**

		:		
HH			MM	

24 hour clock

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

☐ Unknown

Data Collection Details

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