



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

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.

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