2013 West Fertilizer Plant Explosion Investigation

Non-fatal Injury Medical Record Abstraction Form

Facility Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of abstraction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(mm/dd/yyyy)

Reviewer name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT INFORMATION

Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary contact information Secondary contact information**

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ZIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alt phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alt phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth:\_\_\_\_\_\_\_\_\_\_\_\_\_(mm/dd/yyyy)

If date of birth is unknown, approximate age in years:\_\_\_\_\_\_\_\_\_\_\_\_

Sex: \_\_Male \_\_ Female \_\_\_Unknown

Race (check all that apply)

\_\_\_ White

\_\_\_ American Indian/Alaska Native

\_\_\_ Asian

\_\_\_Black or African-american

\_\_\_ Native Hawaiian/Other Pacific Islander

\_\_\_Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Unknown (if Hispanic listed as race, select unknown for race)

Hispanic or Latino? \_\_\_Yes \_\_No \_\_\_\_\_\_Unknown

Marital Status

\_\_\_Single

\_\_\_Married

\_\_\_Divorced

\_\_\_Widowed

\_\_\_Separated

\_\_\_Unknown

Employment Status (choose all that apply):

\_\_\_Employed

\_\_\_Unemployed

\_\_\_Full time student

\_\_\_Retired

\_\_\_Unknown

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance: (Check all that apply)

\_\_\_Private Insurance

\_\_\_Self Pay

\_\_\_Workers Comp

\_\_\_Medicare

\_\_\_Medicaid/State Assistance

\_\_\_Unknown

\_\_\_Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Identified as responder or rescue worker? \_\_\_Yes \_\_No \_\_\_\_\_\_Unknown

INITIAL STATUS AT FACILITY

Mode of arrival at facility:

\_\_\_ Walk in / personal vehicle

\_\_\_ Ground ambulance

\_\_\_ Air / helicopter

\_\_\_ Police / law enforcement

\_\_\_ Transferred from acute care facility

 Where from?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Unknown

\_\_\_ Other (specify):\_\_\_\_\_\_\_\_\_\_\_

Arrived at triage:

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_(mm/dd/yyyy)

Time:\_\_\_\_\_\_\_\_\_\_\_\_\_AM / PM (hh:mm)

Seen by initial provider:

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_(mm/dd/yyyy)

Time:\_\_\_\_\_\_\_\_\_\_\_\_\_AM / PM (hh:mm)

Initial provider was (check one)

\_\_\_ Physician

\_\_\_ Nurse Practitioner

\_\_\_ Physician’s assistant

\_\_\_ Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Triage level – condition upon arrival (check one)

\_\_\_ Emergent (life / limb threatening condition

\_\_\_ Urgent (requiring treatment within 2 hours)

\_\_\_ Non-urgent

Admission systolic blood pressure (check one)

\_\_\_ 90mm Hg or more

\_\_\_ less than 90 mm Hg

Initial Disposition from Emergency Department or Urgent Care Facility? (check all that apply)

\_\_\_ Treated and released

\_\_\_ Left without evaluation

\_\_\_ left against medical advice

\_\_\_Admitted to:

 \_\_\_Operating room

 \_\_\_ Intensive care unit

\_\_\_ Burn unit

\_\_\_ Hospital floor / inpatient ward

\_\_\_ Unknown

\_\_\_Transferred:

 To where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Died

 \_\_\_ Dead on arrival

 \_\_\_ In emergency department

\_\_\_ after admission

\_\_\_Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DESCRIPTION OF INJURIES (check all that apply)

\_\_ Eye injury

\_\_ Tympanic membrane rupture

\_\_ Traumatic brain injury / concussion

\_\_ Inhalation injury

\_\_ Blast lung / pulmonary contusion

\_\_ Pneumothorax / hemothorax

\_\_ Blast abdomen / acute abdomen

\_\_ Tinnitus / hearing problem

\_\_ Psychological problems post-bombing

\_\_ Unknown

\_\_ Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | Head / neck | Thorax / abdomen | Upper extremity | Lower extremity | Unknown |
|  | Fracture / dislocation |  |  |  |  |  |
|  | Sprain / strain |  |  |  |  |  |
|  | Abrasion |  |  |  |  |  |
|  | Contusion |  |  |  |  |  |
|  | Laceration / penetrating trauma |  |  |  |  |  |
|  | Crush syndrome |  |  |  |  |  |
|  | Amputation |  |  |  |  |  |
|  | Burn |  |  |  |  |  |

CIRCUMSTANCES OF INJURY

Location of patient during explosion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Explain what happened:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mechanism of injury (check all that apply)

\_\_ Cut / pierced / struck by

 \_\_ fragments

 \_\_ other debris

 \_\_ unknown

\_\_ Struck fixed object (pushed or knocked against object)

\_\_ Crushed (caught between two objects)

\_\_ burned by

 \_\_ explosion

 \_\_ secondary fire

 \_\_ chemical

 \_\_ unknown

\_\_ Inhaled

 \_\_ toxic gas / fumes

 \_\_ particulate matter

 \_\_ unknown

\_\_ Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COMORBIDITIES (check all that apply)

\_\_\_Alcoholism (291.0-291.3, 291.5, 291.81, 291.89, 291.9, 303.00-303.93, 305.00-305.03, V11.3)

\_\_\_ Drug use history including prescription medication

\_\_\_ Chemotherapy for cancer within 30 days (V58.1, V58.11)

\_\_\_ Congestive Heart Failure (398.91, 402.01, 402.11, 402.91, 404.93, 425.0-425.9, 428.0)

\_\_\_ Current Smoker

\_\_\_ Currently on dialysis

\_\_\_ History of myocardial infarction in past 6 months

\_\_\_ Obesity (278.00-278.01)

\_\_\_ Respiratory Disease (COPD) (277.00, 490-493.92)

\_\_\_Psychiatric Diagnose (290-319)

\_\_\_ Diabetes

\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ None

PROCEDURES AND RESOURCES

Medical Resources (check all that apply)

\_\_\_ Blood products

\_\_\_ Endotracheal intubation

\_\_\_ Imaging studies

 \_\_\_ X-ray

 \_\_\_ CT

 \_\_\_ Ultrasound

 \_\_\_ MRI

\_\_\_Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical procedures (check all that apply)

\_\_\_ Casting

\_\_\_ Suturing (stitches)

\_\_\_ Abdominal surgery (e.g., exploratory laparotomy)

\_\_\_ Splenectomy

\_\_\_ Liver repair

\_\_\_ Neurosurgery (brain surgery)

\_\_\_ Cardiovascular (heart) surgery

\_\_\_ Pulmonary (lung) surgery

\_\_\_ Orthopedic (bone) surgery

\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tetanus immunization given? \_\_\_Yes \_\_No \_\_\_\_\_\_Unknown

Specialists (check all that apply)

\_\_\_ General / trauma surgeon

\_\_\_ Neurosurgeon

\_\_\_ ENT surgeon

\_\_\_ Thoracic surgeon

\_\_\_ Orthopedic surgeon

\_\_\_ Urologist

\_\_\_ Unknown

\_\_\_ Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FINAL DISPOSITION FROM FACILITY

\_\_\_ Home

\_\_\_Transferred to acute care hospital:

 To where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Skilled nursing facility

\_\_\_ Rehab facility

\_\_\_Died

 \_\_\_ Dead on arrival

 \_\_\_ In emergency department

\_\_\_ after admission

\_\_\_Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ABSTRACTOR IMPRESSION

Is this case fertilizer plant explosion related?

\_\_\_ Definite (clearly stated in narrative)

\_\_\_ Probable (not explicitly stated, but timing and type of injury consistent with blast injury)

\_\_\_ Possible (unable to exclude blast injury)

\_\_\_ Not Related

ADDITIONAL NOTES:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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