Covid

Record ID	_____

Patient Info

PLEASE MAKE SURE THIS IS A CORNELL/LMH PATIENT	
Name of Reviewer	_____
Patient MRN	_____
Patient EMPI	_____
Date of Birth (MM/DD/YYYY)	_____
Sex	◯ Male ◯ Female
Today's Date	_____
BMI (kg/m^2)	_____
Race	◯ White ◯ Black ◯ Asian ◯ Other ◯ Not Specified

Co-morbidities

CAD (Coronary Artery Disease)	◯ No ◯ Yes
Heart Failure	◯ No ◯ HFpEF ◯ HFrEF (EF< 50%) ◯ Unspecified HF
CVA (Stroke)	◯ No ◯ Yes
Diabetes Mellitus (DMI, DMII)	◯ No ◯ Yes
HTN (Hypertension)	◯ No ◯ Yes

Does the patient require non-invasive home O2 at baseline?	☐ No ☐ Nasal Cannula (oxygen tank/concentrator) ☐ CPAP ☐ BIPAP (Prior to ED presentation)
Does the patient require invasive mechanical ventilation at baseline?	◯ No ◯ Yes (Does NOT include CPAP/BIPAP)
Pulmonary Disease	☐ No ☐ COPD ☐ Asthma ☐ Interstitial Lung Disease ☐ Obstructive Sleep Apnea ☐ Other (Select all that apply)
Other:	_____
Renal Disease	☐ No ☐ CKD (Creat >2 at baseline) ☐ ESRD
Cirrhosis	◯ No ◯ Yes
Does the patient have a history of chronic Hep B or Hep C?	☐ No ☐ Hepatitis B ☐ Hepatitis C
HIV	◯ No ◯ Yes
What is the patient's HIV regimen?	◯ Not on Medication ◯ Regimen includes Protease Inhibitors ◯ Regimen does not include Protease Inhibitors ((all protease inhibitors end with "-navir"; however, please note that integrase inhibitors end with "-avir"))
What was their most recent CD4 count (cells/mm^3)?	_____
What was their most recent viral load (copies/mL)?	_____ (If "Undetected", put "0")
CD4< 200 and/or Viral Load >1,000	◯ No ◯ Yes (As documented in admission note)
Active Cancer (excluding non-melanoma skin cancer)	☐ No ☐ Solid ☐ Liquid (Receiving cancer therapy, diagnosed within 6 months, recurrent or metastatic)

Specify:	_____
History of Transplant	☐ No ☐ Bone Marrow Transplant (BMT) ☐ Kidney (DDKT, LRRT, LURT) ☐ Liver (LDLT, DDLT, OLT) ☐ Other
Other:	_____
Inflammatory Bowel Disease	◯ No ◯ Yes
Rheumatologic Disease	☐ No ☐ Rheumatoid Arthritis (RA) ☐ Lupus (SLE) ☐ Other
Other:	_____
Current Pregnancy	◯ No ◯ Yes (If male, select No)
What is the gestational age?	_____ (Round to closest week)
Other Immunosuppressed State	◯ No ◯ Yes (Chemotherapy or radiotherapy (XRT) within last 6 months; inherited immunodeficiency)
Which immunosuppressed state? (Within last 6 months for chemo/radiation)	☐ Chemotherapy ☐ Radiotherapy (XRT) ☐ Inherited immunodeficiency

Symptoms

Is there an exact date of first symptoms?	◯ No ◯ Yes
Date of First Symptoms (MM/DD/YYYY)	_____
Enter timeframe "term" used	_____ ((ie "a couple days", "last week", "2-3 weeks ago"))
Did the patient receive healthcare for their presenting symptoms before this ED presentation?	◯ No ◯ Yes (ie office visit, phone call, etc)

Within the last week, was the patient discharged from an ED or hospital for these symptoms?	◯ No ◯ Yes
Is there an exact date of first healthcare contact?	◯ No ◯ Yes
Date of First Contact with Healthcare (MM/DD/YYYY)	_____
Enter timeframe "term" used	_____ ((ie "a couple days", "last week", "2-3 weeks ago"))
Smoking Status	◯ No ◯ Active Smoker ◯ Former Smoker (Search in iNYP: tobacco, smoker, smoking)
Vaping Status	◯ No ◯ Yes
Recent Travel (within 14 days of symptom onset)	◯ No ◯ Yes, Domestic ◯ Yes, International
Location:	_____ (For Domestic: specify city and state (format: San Francisco, CA) | For International: specify country)
Did the patient have any confirmed COVID positive contacts?	◯ No ◯ Yes
Symptoms	☐ Fever ☐ Cough ☐ Dyspnea ☐ Sore throat ☐ Rhinorrhea or nasal congestion ☐ Conjunctival congestion ☐ Headache ☐ Myalgias ☐ Nausea or vomiting ☐ Diarrhea ☐ Sputum production ☐ Presyncope or Syncope ☐ Chest Pain (includes "tightness" and "pressure") ☐ Abdominal Pain ☐ Altered Mental Status (includes "confusion") ☐ Anosmia (loss of smell) ☐ Ageusia (loss of taste) ☐ Other
Other:	_____ (Please only include major symptoms)

Home Medications

Use of ACEi or ARB	◯ No ◯ Yes (ACEi: "-pril" | ARB: "-sartan")
Use of NSAIDs	◯ No ◯ Yes (aspirin, celecoxib, diclofenac, diflunisal, etodolac, ibuprofen, indomethacin, ketoprofen, ketorolac, meloxicam, nabumetone, naproxen, oxaprozin, piroxican, salsalate, sulindac, tolmetin)
Use of PPIs	◯ No ◯ Yes (Omeprazole, Pantoprazole, "-prazole")
Use of Steroids	☐ No ☐ Nasal ☐ Inhaled ☐ Oral (Prednisone, Budesonide, Fluticasone)
Use of oseltamivir (Tamiflu)	◯ No ◯ Yes
Use of Antivirals (excluding oseltamivir and HIV treatment)	◯ No ◯ Yes
Use of Statins	◯ No ◯ Yes
Use of hydroxychloroquine/Plaquenil (for treatment of RA, SLE, etc)	◯ No ◯ Yes
Use of Immunosuppressive Medication (within last 30 days)	☐ None ☐ Prednisone less than 20mg/day ☐ Prednisone at least 20mg/day ☐ TNF-alpha inhibitor ☐ Other monoclonal antibody ☐ Tacrolimus ☐ Cyclosporine ☐ MTOR inhibitor (sirolimus, everolimujs) ☐ Mycophenolate (MMF, myfortic) ☐ Azathioprine ☐ Methotrexate ☐ Other
Other:	_____
Total Count of Home Medications (excluding over-the-counter medications)	_____ (For NSAIDs, only include if prescribed (No OTC NSAIDs))

ED Course

Are they a healthcare worker?	◯ No ◯ Yes (Active healthcare worker only)
Did the patient require supplemental oxygen within the first 3 hours of arrival?	◯ No ◯ Yes
What was the highest level of supplemental oxygen required (within first 3 hours)?	◯ Nasal Cannula ◯ Venti mask ◯ High flow nasal cannula ◯ Non-rebreather ◯ NIV (BIPAP, CPAP) ◯ Mechanical Ventilation
Date of ED/Hospital Arrival (MM/DD/YYYY)	_____
Time of ED/Hospital Arrival (24 HH:MM)	_____ (Military time)
Where were they admitted from?	◯ Home ◯ Rehab/Nursing Home ◯ Other Hospital ◯ Undomiciled ◯ Prison ◯ Other
Other:	_____

Mechanical Ventilation

Did the patient require non-invasive mechanical ventilation?	◯ No ◯ Yes (ie BIPAP, CPAP, proportional assist ventilation (PAV))
Was patient intubated at any point	◯ No ◯ Yes (Please also search "intubated" and "intubation" in iNYP to double check)
Intubation Date (MM/DD/YYYY)	_____
Intubation Time (24 HH:MM)	_____ (Military time)
Was the patient intubated in the ED?	◯ No ◯ Yes ◯ Unknown

Where was the patient primarily managed while ventilated?

_____
(Format: If Cornell: G5N, B17 | If LMH: LMH2S, LMH5C |If Queens: Q5W, QMICU)

Did the patient receive a new tracheostomy during this hospitalization?

◯ No
◯ Yes

Date of tracheostomy

_____

Was the patient extubated?

◯ No
◯ Yes

Extubation Date (MM/DD/YYYY)

_____

Extubation Time (24 HH:MM)

_____
(Military time)

Was patient intubated a second time?

◯ No
◯ Yes

Second intubation date (MM/DD/YYYY)

_____

Second intubation time (24 HH:MM)

_____
(Military time)

Where was the patient primarily managed while ventilated?

_____
(Format: If Cornell: G5N, B17 | If LMH: LMH2S, LMH5C |If Queens: Q5W, QMICU)

Was the patient extubated a second time?

◯ No
◯ Yes

Second extubation date (MM/DD/YYYY)

_____

Second extubation time (24 HH:MM)

_____
(Military time)

Were there additional intubations?

◯ No
◯ Yes

ICU Stay

Admitted to ICU at any point	◯ No ◯ Yes
Date of admission to ICU (MM/DD/YYYY)	_____
Time of admission to ICU (24 HH:MM)	_____ (Military time)
Was the patient discharged from the ICU?	◯ No ◯ Yes
ICU Discharge date (MM/DD/YYYY)	_____
ICU Discharge time (24 HH:MM)	_____ (Military time)
Was patient admitted to the ICU for a second time?	◯ No ◯ Yes (After prior admission and discharge from ICU)
Second ICU Date (MM/DD/YYYY)	_____
Second ICU admission time (24 HH:MM)	_____ (Military time)
Was the patient discharged from the ICU a second time?	◯ No ◯ Yes
Second ICU Discharge date (MM/DD/YYYY)	_____
Second ICU Discharge time (24 HH:MM)	_____ (Military time)
Were there additional ICU admissions?	◯ No ◯ Yes

Discharge

Did the patient die in the hospital?	◯ No ◯ Yes
Date of death (MM/DD/YYYY)	_____

Time of death (24 HH:MM)

_____
(Military time)

Was the patient discharged from the hospital?

◯ No
◯ Yes
◯ Transfer to outside hospital (without EMR access)

Date of discharge from the hospital (MM/DD/YYYY)

_____

Time of discharge from the hospital (24 HH:MM)

_____
(Military time)

Where was the patient discharged to?

◯ Home
◯ Subacute Rehab
◯ Acute Rehab
◯ Skilled Nursing Facility
◯ Hospice
◯ Shelter
◯ Other

Other:

_____

Date of transfer from the hospital (MM/DD/YYYY)

_____

Time of transfer from the hospital (24 HH:MM)

_____
(Military time)

Where was the patient transferred to?

◯ HSS
◯ DHK
◯ NYP-Columbia
◯ MSKCC
◯ NYP-Cornell
◯ Other
(Only mark NYP-Cornell if you are a Queens reviewer)

Other:

_____

Imaging

What was the QTc (calculated QT) of the first EKG?

_____

Did the patient receive a chest x-ray?

◯ No
◯ Yes

Date of Initial Chest X-Ray (MM/DD/YYYY)

_____

Initial Chest X-ray Findings	☐ Clear ☐ Unilateral Infiltrate ☐ Bilateral Infiltrates ☐ Pleural Effusion ☐ Other
Other:	_____
Did they have a follow-up CXR?	◯ No ◯ Yes
Date of follow-up CXR (MM/DD/YYYY)	_____
Follow-up CXR findings	◯ Not Specified ◯ Improved ◯ Stable ◯ Worse
What was the finding on worsening chest X-Ray?	☐ Clear ☐ Unilateral Infiltrate ☐ Bilateral Infiltrates ☐ Pleural Effusion ☐ Other
Other:	_____
Did the patient receive a chest CT?	◯ No ◯ Yes
Chest CT 1 Date (MM/DD/YYYY)	_____
Chest CT Scan 1 Findings	☐ Clear ☐ Ground glass opacities ☐ Multi-focal or bilateral patchy consolidations/infiltrates ☐ Local, patchy shadowing ☐ Interstitial abnormalities ☐ Broncial wall thickening ☐ Centrilobular nodules
Did the patient receive a second chest CT?	◯ No ◯ Yes
Chest CT 2 Date (MM/DD/YYYY)	_____
How did the second CT compare to the first?	◯ Unspecified ◯ Improved ◯ No Change ◯ Worse

Chest CT Scan 2 Findings

- ☐ Clear
- ☐ Ground glass opacities
- ☐ Multi-focal or bilateral patchy consolidations/infiltrates
- ☐ Local, patchy shadowing
- ☐ Interstitial abnormalities
- ☐ Broncial wall thickening
- ☐ Centrilobular nodules

Disposition

Was the patient admitted?

- ◯ No
- ◯ Yes

Date of Admission (MM/DD/YYYY)

_____

Time of Admission (24 HH:MM)

_____
(Military time)

Where was the patient admitted?

- ◯ Floor
- ◯ Step Down
- ◯ ICU

Complications

Did the patient develop ARDS?

- ◯ No
- ◯ Yes

Was prone positioning performed?

- ◯ No
- ◯ Yes

Was mechanical circulatory support required?

- ◯ No
- ◯ Yes

(Balloon pump, Impella, VV-ECMO, VA-ECMO)

Type of initial mechanical circulatory support used

- ◯ Balloon pump
- ◯ Impella
- ◯ VV-ECMO
- ◯ VA-ECMO

Start date of initial mechanical circulatory support (MM/DD/YYYY)

_____

Was a second form of mechanical circulatory support used?

- ◯ No
- ◯ Yes

Type of second mechanical circulatory support used

- ◯ Balloon pump
- ◯ Impella
- ◯ VV-ECMO
- ◯ VA-ECMO

Date that second mechanical circulatory support started (MM/DD/YYYY)

_____

Was a third form of mechanical circulatory support used?	◯ No ◯ Yes
Type of third mechanical circulatory support used	◯ Balloon pump ◯ Impella ◯ VV-ECMO ◯ VA-ECMO
Date that third mechanical circulatory support started (MM/DD/YYYY)	_____
Did the patient develop a respiratory coinfection? (as confirmed by microbiology)	☐ No ☐ Yes, bacterial ☐ Yes, viral ☐ Yes, fungal ☐ Yes, unspecified
Did the patient develop a thromboemoblic event as confirmed by imaging (CT-PE, ultrasound, etc)?	☐ No ☐ DVT ☐ Pulmonary Embolism ☐ Arterial thrombosis
What was the location of the arterial thrombosis?	_____
Did the patient develop any other complications?	☐ None ☐ Myocardial Infarction ☐ Heart failure exacerbation or cardiogenic shock ☐ New onset Arrythmia ☐ DIC ☐ Rhabdomyolysis ☐ Septic Shock ☐ Acute Kidney Injury ☐ Ventilator-associated Pneumonia ☐ Other (Select all that apply)
Other:	_____
Was dialysis required at any point?	◯ No ◯ Yes (Search Dialysis, HD, PD, CRRT)

Testing

Did the patient receive a respiratory pathogen or viral panel?	◯ No ◯ Yes
Was the respiratory pathogen or viral panel positive?	◯ No ◯ Yes

What pathogens were positive?	☐ Adenovirus DNA ☐ Coronavirus 229E RNA ☐ Coronavirus HKU1 RNA ☐ Coronavirus NL63 RNA ☐ Coronavirus OC43 RNA ☐ Human Metapneumovirus RNA ☐ Human Rhinovirus/Enterovirus ☐ Influenza A H1 2009 Virus RNA ☐ Influenza B Virus RNA ☐ Parainfluenza 1 Virus RNA ☐ Parainfluenza 2 Virus RNA ☐ Parainfluenza 3 Virus RNA ☐ Parainfluenza 4 Virus RNA ☐ Respiratory Syncytial Virus RNA ☐ Bordetella pertussis DNA ☐ Chlamydia pneumoniae DNA ☐ Mycoplasma pneumoniae DNA ☐ Bordetella parapertussis DNA ☐ Other
Other:	_____
Did the patient have a blood culture?	◯ No ◯ Yes
Did the patient have a postive blood culture?	◯ No ◯ Yes
What was the date of the positive blood culture? (MM/DD/YYYY)	_____
What were the pathogen(s)?	_____
Did the patient have a second positive blood culture sample with a different pathogen?	◯ No ◯ Yes
What was the date of the second positive blood culture?	_____
What were the second pathogen(s)?	_____
Did the patient have 3 or more positive blood culture samples with a different pathogen?	◯ No ◯ Yes
Please list all other pathogens that were found	_____
Did the patient have a sputum culture?	◯ No ◯ Yes
Did the patient have a postive sputum culture?	◯ No ◯ Yes
What was the date of the positive sputum culture? (MM/DD/YYYY)	_____

What were the pathogen(s)?	_____
Did the patient have a second positive sputum sample with a different pathogen?	◯ No ◯ Yes
What was the date of the second positive sputum culture?	_____
What were the second pathogen(s)?	_____
Did the patient have 3 or more positive sputum samples with a different pathogen?	◯ No ◯ Yes
Please list all other pathogens that were found	_____
Initial COVID Test Result	◯ Not Tested ◯ Negative ◯ Positive
Initial COVID specimen type	◯ Nasopharyngeal ◯ Sputum ◯ Bronchoalveolar lavage ◯ Other
Other:	_____
Initial COVID Test Date (MM/DD/YYYY)	_____
Second COVID Test Result	◯ Not Tested ◯ Negative ◯ Positive
Second COVID Specimen Type	◯ Nasopharyngeal ◯ Sputum ◯ Bronchoalveolar lavage ◯ Other
Other:	_____
Second COVID Test Date (MM/DD/YYYY)	_____
Third COVID Test Result	◯ Not Tested ◯ Negative ◯ Positive
Third COVID Specimen Type	◯ Nasopharyngeal ◯ Sputum ◯ Bronchoalveolar lavage ◯ Other

Other:	_____
Third COVID Test Date (MM/DD/YYYY)	_____
Fourth COVID Test Result	◯ Not Tested ◯ Negative ◯ Positive
Fourth COVID Test Type	◯ Nasopharyngeal ◯ Sputum ◯ Bronchoalveolar lavage ◯ Other
Other:	_____
Fourth COVID Test Date (MM/DD/YYYY)	_____
Fifth COVID Test Result	◯ Not Tested ◯ Negative ◯ Positive
Fifth COVID Test Type	◯ Nasopharyngeal ◯ Sputum ◯ Bronchoalveolar lavage ◯ Other
Other:	_____
Fifth COVID Test Date (MM/DD/YYYY)	_____

Inpatient Medications

Was the patient treated with a statin while hospitalized?	◯ No ◯ Yes (Minimum of 2 days)
Did the patient require vasopressors at any point?	◯ No ◯ Yes (Dopamine, Epinephrine, Norepinephrine, Phenylephrine, Vasopressin)
Start date of vasopressors (MM/DD/YYYY)	_____
Date that vasopressors were permanently stopped and remained off for at least 24 hours	_____ (Must be off for at least 24 hours. PLEASE make sure to look at rate and make sure it's not listed as "0.0000" and the correct date is given.)

Did the patient require vasopressors again during the hospitalization?	◯ No ◯ Yes (If there are rates of "0.0000" for >24 hours, this would count as vasopressors being stopped and started again.)
Did the patient require inotropes at any point?	◯ No ◯ Yes (Dobutamine, Milrinone)
Start date of inotropes (MM/DD/YYYY)	_____
Date that inotropes were permanently stopped and remained off for at least 24 hours	_____ (Must be off for at least 24 hours)
Did the patient require inotropes again during the hospitalization?	◯ No ◯ Yes
Did the patient receive ACE inhibitors or ARBs?	◯ No ◯ Yes (Minimum of 2 days; ACEi: "-pril" | ARB: "-sartan")
Start date of ACEi/ARBs (MM/DD/YYYY)	_____
Stop date of ACEi/ARBs (MM/DD/YYYY)	_____
Did the patient receive diuretics?	◯ No ◯ Yes (Minimum of 2 days; furosemide, bumetanide, torsemide, ethacrynic acid, hctz, chlorthalidone, amiloride, spironolactone, eplerenone, triamterene, etc)
Start date of diuretics (MM/DD/YYYY)	_____
Stop date of diuretics (MM/DD/YYYY)	_____
Did the patient receive NSAIDs?	◯ No ◯ Yes (Minimum of 2 days; aspirin, celecoxib, diclofenac, diflunisal, etodolac, ibuprofen, indomethacin, ketoprofen, ketorolac, meloxicam, nabumetone, naproxen, oxaprozin, piroxican, salsalate, sulindac, tolmetin)
Start date of NSAIDs (MM/DD/YYYY)	_____
Stop date of NSAIDs (MM/DD/YYYY)	_____

Did the patient receive hyroxychloroquine (Plaquenil)?	◯ No ◯ Yes
What was the loading dose of hydroxychloroquine (Plaquenil) (mg/day)?	_____
What was the maintenace dose of hydroxychloroquine (Plaquenil) (mg/day)?	_____
Start date of hydroxychloroquine (Plaquenil) (MM/DD/YYYY)	_____
Stop date of hydroxychloroquine (Plaquenil) (MM/DD/YYYY)	_____ (If the patient was discharged with instructions to continue Plaquenil, put the last date of the intended course (refer to discharge med rec))
Was the patient discharged with instructions to continue Plaquenil?	◯ No ◯ Yes
If Plaquenil was discontinued before regimen completed (less than 5 days), what was the reason:	☐ Physician Discretion ☐ Renal toxicity ☐ Liver toxicity ☐ Prolonged QTc ☐ Other
Other:	_____
Did the patient receive Remdesivir?	◯ No ◯ Yes
Start date of Remdesivir (MM/DD/YYYY)	_____
Stop date of Remesivir (MM/DD/YYYY)	_____
Did the patient receive Kaletra (lopinavir/ritonavir)	◯ No ◯ Yes
Start date of Kaletra (lopinavir/ritonavir) (MM/DD/YYYY)	_____
Stop date of Kaletra (lopinavir/ritonavir) (MM/DD/YYYY)	_____
Was the patient on any other protease inhibitors (excluding their HIV regimen if applicable)	◯ No ◯ Yes
Which one?	_____
Did the patient receive Tamiflu (oseltamavir)?	◯ No ◯ Yes

Start date of Tamiflu (MM/DD/YYYY)

_____

Stop date of Tamiflu (MM/DD/YYYY)

_____

Did the patient require antibiotics for ≥ 48hs?

◯ No
◯ Yes
(Only include antibiotics given as an INPATIENT)

Which antibiotics were used for at least 48 hours?

☐ Ceftriaxone
☐ Piperacillin-tazobactam
☐ Meropenem
☐ Vancomycin
☐ Azithromycin
☐ Levofloxacin
☐ Doxycycline
☐ Other

Other:

_____

Did the patient receive steroids?

◯ No
◯ Yes

Start date of steroids (MM/DD/YYYY)

_____

Stop date of steroids (MM/DD/YYYY)

_____

Did the patient receive IVIG?

◯ No
◯ Yes

Start date of IVIG (MM/DD/YYYY)

_____

Stop date of IVIG (MM/DD/YYYY)

_____

Did the patient receive interferon beta?

◯ No
◯ Yes

Start date of interferon beta (MM/DD/YYYY)

_____

Stop date of interferon beta (MM/DD/YYYY)

_____

Did the patient receive tocilizumab (Actemra)?

◯ No
◯ Yes

Start date of tocilizumab (MM/DD/YYYY)

_____

Stop date of tocilizumab (MM/DD/YYYY)

_____

Did the patient receive an sarilumab (Kevzara)?

◯ No
◯ Yes

Start date of sarilumab (MM/DD/YYYY)

_____

Stop date of sarilumab (MM/DD/YYYY)

_____

Did the patient receive any other COVID-targeted treatments?

_____

(Please refer to latest ID note and list the treatments. Only treatments used to target COVID, not symptomatic treatments (leave blank if none))

Survey Status

Which ED did the patient present to?

◯ NYP Cornell
◯ NYP Lower Manhattan
◯ NYP Queens
◯ Brooklyn Methodist
◯ NYP Columbia
◯ Other

Other:

_____

Was the patient transferred to Cornell, LMH, or Queens?

◯ No
◯ Yes, to NYP Cornell
◯ Yes, to NYP Queens

When was the patient transferred?

_____

Was your patient last hospitalized at Cornell, LMH, or Queens?

◯ NYP Cornell
◯ NYP Lower Manhattan
◯ NYP Queens

Was the patient DNR/DNI during this hospitalization?

◯ No
◯ DNR and DNI
◯ Do Not Resuscitate (DNR) only
◯ Do Not Intubate (DNI) only

Was the patient transferred to Hospital for Special Surgery (HSS) during this hospitalization?

◯ No
◯ Yes

Date of transfer to HSS

_____

Was the patient transferred back from HSS?

◯ No
◯ Yes

Date of transfer back from HSS

_____

Is the patient still hospitalized?	◯ No ◯ Yes
Calculated Age (years) at time of ED presentation	_____ (Please use to confirm DOB)
Chart Review Last Updated (MM/DD/YYYY)	_____
Please leave any questions for further review	_____

Please save as one of the following: Complete = patient discharged and chart reviewed | Incomplete = patient in hospital and chart reviewed | Unverified = chart requires further review