A. HEALTHCARE FACILITY - ADMINISTRATIVE

A1. CDC FACILITY CODE |__|__|__|__|

A2. FACILITY NAME: _____

A3. FACILITY PATIENT MEDICAL RECORD NUMBER: |__|__|__|__|__|__|__|__|__|__|

B. PATIENT INFORMATION

B1. DATE OF BIRTH: |___|___| - |___|___| - |___|___|___|___|
M M D D Y Y Y Y

IF BIRTHDATE IS UNKNOWN, APPROXIMATE AGE IN YEARS: _____

(CHECK ONE)

B2. SEX ..... ☐ MALE ☐ FEMALE

B3. IDENTIFIED AS RESPONDER OR RESCUE WORKER ... ☐ YES ☐ NO

B4. IDENTIFIED AS SUSPECTED TERRORIST..... ☐ YES ☐ NO

C. ARRIVAL STATUS

C1. MODE OF ARRIVAL AT FACILITY (CHECK ONE)

☐ WALK IN / PERSONAL VEHICLE ☐ GROUND AMBULANCE

☐ AIR/HELICOPTER ☐ POLICE / LAW ENFORCEMENT

☐ UNKNOWN OTHER (TEXT):

_____

DATES & TIMES:

	MONTH	DAY	YEAR	MILITARY TIME
C2. ARRIVED AT TRIAGE:	|__|__| - |__|__| - |__|__|__|__|			|__|__|__|__|
C3. SEEN BY INITIAL PROVIDER:	|__|__| - |__|__| - |__|__|__|__|			|__|__|__|__|

C4. INITIAL PROVIDER WAS (CHECK ONE): ☐ PHYSICIAN ☐ NURSE PRACTITIONER

☐ PHYSICIAN'S ASSISTANT ☐ OTHER: (TEXT) _____

C5. TRIAGE LEVEL (CONDITION UPON ARRIVAL) (CHECK ONE)

☐ EMERGENT (LIFE / LIMB THREATENING INJURY)

☐ URGENT (REQUIRING TREATMENT WITHIN 2 HOURS)

☐ NON-URGENT

C6. ADMISSION SYSTOLIC BLOOD PRESSURE (CHECK ONE)

☐ 90 MM HG OR MORE ☐ LESS THAN 90 MM HG

D. INCIDENT CIRCUMSTANCES: GENERAL (CHECK *ALL* THAT APPLY)

D1. TYPE BOMBING: ☐ CONFINED SPACE (BUS, TRAIN, BUILDING) ☐ OPEN AIR ☐ STRUCTURAL COLLAPSE

D2. DISPERSIVES: ☐ RADIOLOGICAL ☐ CHEMICAL ☐ BIOLOGICAL ☐ NONE ☐ UNKNOWN

E. INCIDENT CIRCUMSTANCES: PATIENT-SPECIFIC

E1. LOCATION / PROXIMITY OF PATIENT DURING INCIDENT (TEXT):

_____

E2. EXPLAIN WHAT HAPPENED (TEXT): _____

E3. 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

☐ RADIATION EXPOSURE ☐ UNKNOWN

☐ OTHER (TEXT): _____

F. 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 PROBLEMS

☐ PSYCHOLOGICAL PROBLEMS POST-BOMBING

HN=HEAD / NECK UE=UPPER EXTREMITY
TA=THORAX /ABDOMEN LE=LOWER EXTREMITY

	HN	TA	UE	LE	UNKNOWN
☐ FRACTURE/DISLOCATION.. >	☐	☐	☐	☐	☐
☐ SPRAIN / STRAIN..... >	☐	☐	☐	☐	☐
☐ ABRASION..... >	☐	☐	☐	☐	☐
☐ CONTUSION..... >	☐	☐	☐	☐	☐
☐ LACERATION / PENETRATING TRAUMA..... >	☐	☐	☐	☐	☐
☐ CRUSH SYNDROME..... >	☐	☐	☐	☐	☐
☐ AMPUTATION..... >	☐	☐	☐	☐	☐
☐ BURN..... >	☐	☐	☐	☐	☐

☐ UNKNOWN ☐ OTHER (TEXT): _____

G. INITIAL DISPOSITION AND RESOURCES

G1. DISPOSITION (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

☐ OTHER (TEXT) :

_____

☐ TRANSFERRED: EXPLAIN "WHERE / WHY" (TEXT):

_____

DIED: ☐ DEAD ON ARRIVAL ☐ IN EMERGENCY DEPARTMENT

☐ AFTER ADMISSION ☐ UNKNOWN

☐ OTHER (TEXT): _____

G2. MEDICAL RESOURCES: (CHECK *ALL* THAT APPLY)

☐ BLOOD PRODUCTS

☐ ENDOTRACHEAL INTUBATION

☐ IMAGING STUDIES: ☐ X-RAY ☐ CT ☐ ULTRASOUND

☐ OTHER (TEXT): _____

_____

G3. SPECIALISTS: (CHECK *ALL* THAT APPLY)

☐ GENERAL / TRAUMA SURGEON ☐ THORACIC SURGEON

☐ NEUROSURGEON ☐ ORTHOPEDIC SURGEON

☐ ENT SURGEON ☐ UROLOGIST

☐ UNKNOWN

☐ OTHER (TEXT): _____

ED MEDICAL RECORD ABSTRACTION FORM FOR DOMESTIC BOMBING EVENTS

CDC RECORD# __|__|__|__| CDC EVENT CODE |__|__|__|__|

FORM COMPLETED BY : _____ (INITIALS) DATE COMPLETED: _____/_____/_____ (MONTH DAY YEAR)

General Directions for Completion of Medical Record Abstraction Form for Bomb Victims:

HEADER:

CDC Record # : a unique identifier assigned by CDC (1 through N) for this patient record.
CDC EVENT CODE: - A four digit code assigned to the bombing event
COMPLETED BY: 3 initials of the person abstracting the record; if no middle initial, leave middle blank.
DATE: mm-dd-yy format of the day record is abstracted (example: November 27, 2007 = 11 – 2 7 – 0 8)

A. HEALTHCARE FACILITY:

A1. CDC FACILITY CODE: 4-digit code assigned to the facility for event (example: 0104)
A2. NAME of FACILITY
A3. FACILITY PATIENT MEDICAL RECORD NUMBER: record number assigned/maintained by facility (example: 001023947)

B. PATIENT INFORMATION:

B1. DATE OF BIRTH: mm-dd-yyyy format (example: August 23, 1981 = 0 8 – 2 3 – 1 9 8 1)
If DATE OF BIRTH is UNKNOWN, complete approximate AGE IN YEARS in the text field
B2. SEX: Check MALE OR FEMALE
B3. IDENTIFIED AS RESPONDER OR RESCUE WORKER: Check "Yes" or "No" as appropriate
B4. IDENTIFIED AS SUSPECTED TERRORIST: Check "Yes" or "No" as appropriate

C. ARRIVAL STATUS:

C1. Check one correct answer
C2 and C3. For Dates: mm-dd-yyyy format (example:, August 23, 1981 = 0 8 – 2 3 – 1 9 8 1)
For Time: use military time (example: 2PM = 14:00)
C4. INITIAL PROVIDER: Check box for Physician, Nurse Practitioner, or Physician's Assistant, or text field for Other type
C5. and C6. Check one correct answer

D. INCIDENT CIRCUMSTANCES: General

D1. TYPE BOMBING: Indicate environment of bombing if known, or thought to be known
D2. DISPERSIVES: Indicate dispersives known, or thought to be known, in the bombing

E. INCIDENT CIRCUMSTANCES: Patient-Specific

E1. LOCATION/PROXIMITY: Patient's description of his/her location during the bombing
E2. EXPLAIN WHAT HAPPENED: Patient's description of what the patient says happened to them
E3. MECHANISM OF INJURY: The primary mechanisms begin with a slightly larger letter (example: BURNED) and appear at the left margin of the column. Second level information about mechanism is indented and preceded by an arrow (example: "→ ☐ BY EXPLOSION"). A text field is also available for "OTHER" information.

F. BLAST INJURIES:

F1. Check all boxes in E1 that apply.
F2. Check the type of injury in boxes along the left side of the column.
For injuries followed by a "→" the location of the injury can be indicated by checking (to the right) one or body locations (i.e., for HEAD/NECK, THORAX/ABDOMEN, UPPER EXTREMITY, LOWER EXTREMITY, OR RARELY, UNKNOWN)

G. INITIAL DISPOSITION AND RESOURCES:

G1. Check DISPOSITION along the left side of the column. If ADMITTED TO is selected, indicate initial accepting unit.
G2. Check any of the MEDICAL RESOURCES listed if used. If "IMAGING STUDIES is checked, check one or more boxes to indicate the specific type of imaging (X-ray, CT, Ultrasound). If the other resources are used, explain in text.
G3. Check boxes for all SPECIALISTS consulted after initial triage.
If NOT listed, provide type in text field (example: pediatrician).

Begin Data Collection on Following Page →