103a Guidelines for Medical Record Abstraction and Record Requests

<table>
<thead>
<tr>
<th>Review Committee: Data</th>
<th>Effective Date: 10/01/2019</th>
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<tbody>
<tr>
<td>Attachments: FAX Cover Sheet Examples</td>
<td>Revised Date: 06/24/2019</td>
</tr>
<tr>
<td>Forms: None</td>
<td>Reviewed Date: 06/24/2019</td>
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Introduction:
Form I data collection includes abstraction of certain variables from the participant’s medical record. In order to access these records from outside facilities, data collectors need to request them from these facilities after obtaining a signed release of information from the participant or legally authorized representative.

Purpose:
To provide general guidelines for the collection of medical records in order to code TBI Model Systems variables. Each Model Systems center should ensure that their site procedures for collecting this data are approved by their local IRB.

Scope:
Current TBIMS centers which are identifying and enrolling subjects into the NDB.

Responsibilities:
TBIMS staff responsible for Form I medical record request and abstraction of Form I data.

Procedural steps:
1. Identification of Facilities to Request Records From
   a. There is no rigid rule regarding when to begin the medical record request (and coding) process. Sites may choose to begin the process upon consenting the participant. At minimum, the process should begin within 1-2 weeks of the start of a new quarter (1/01, 4/01, 7/01, 10/01) to ensure adequate time for receiving and reviewing the records, coding the variables, and entering the data on the NDSC website prior the data upload deadline (3/31, 6/30, 9/30, and 1/15).
b. Prior to requesting records from the acute stay, it may be advantageous to first abstract all items available from the rehabilitation record. If there are gaps, additional records can be requested as needed.

c. Identify which acute facilities participant was treated at following the TBI prior to rehab admission (this can typically be found in the History and Physical, transfer notes or copies of outside records, including but not limited to:

- Emergency department visits
- Acute hospitalization (civilian or military)
- Long-term acute care (LTAC) hospitalization

d. If the participant was transferred to a non-TBIMS facility prior to rehab admission, they would be considered to NOT be continuously hospitalized and therefore not eligible. Discontinue data collection and do not include this person in your TBIMS.

2. Request and Collect Medical Records

a. Contact each facility’s medical records department to determine their process for requesting records. Most centers will require a copy of the consent form for each participant and/or a signed release of information form (ROI). The facility may choose to send the record by one a variety of methods including but not limited to;

- Mailing a CD or paper copy of the record
- Emailing a PDF of the record
- Authorizing access to view the record at the facility
- Authorizing remote access to view the record online.

b. If the facility will be sending copies of the record, the specific records needed to complete Form I abstraction should be included in this request (ED Records, EMS Transport records, ICD-10 Final Diagnosis Codes, Trauma Intake, History and Physical, Head CT, Neurosurgery Consult, Discharge Summary, Neuro Checks, Flowsheets and Progress Notes).

- For persons who are following commands at rehab admission, but are not yet oriented, progress notes from the acute facilities are necessary to determine date the participant was able to follow commands.

- For persons who did not regain command following until rehab admission, progress notes from the acute care setting are still necessary to confirm that the participant had not regained but then lost command following ability while in acute care.

c. Send record request with the required paperwork (consent and/or ROI) to each facility. (see attached FAX cover sheet examples)

- Acute hospital (initial)
- Acute hospital (progress notes only)
- LTAC (initial)
- LTAC (progress notes only)
3. **Problem Solving**

This section details some common problems encountered when attempting to obtain outside medical records, and suggested strategies:

<table>
<thead>
<tr>
<th>Problem</th>
<th>Suggested Solution(s)</th>
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</table>
| Medical record just says person was transferred from an OSH (outside hospital) | • Look elsewhere in the medical record.  
• Ask the participant (or health care proxy) for the name and location of the prior hospital.  
• Ask the physiatrist, social worker, nurse manager, or neuropsychologist on the unit where the participant was hospitalized. |
| The named hospital has multiple locations (e.g., St. Joe’s North, St. Joe’s South). Not sure which one the participant was hospitalized. | • Ask the participant (or health care proxy) for the location of the prior hospital (the street name or what part of town it was located).  
• Ask the physiatrist, social worker, nurse manager, or neuropsychologist on the unit which hospital the participant was hospitalized prior to rehabilitation admission. |
| The participant was hospitalized at multiple locations prior to Rehab admission. What should I do? | • Look in the medical record for the names of each hospital prior to rehab admission.  
• Ask the participant (or health care proxy) for the name and location of each prior hospital.  
• Ask the physiatrist, social worker, nurse manager, or neuropsychologist on the unit where the participant was hospitalized, for each prior hospitalization.  
• If you have an H&P and/or Discharge Summary from one or more of the prior hospitals, often they name the hospital to/from which the patient was transferred. |
| Some but not all records I requested were sent. | • Review received records and code the medical record abstraction form to the degree possible. If there are variables un-coded due to lack of information (usually TFC and PTA because no (or limited) progress notes were sent), re-request records that will likely contain the missing items (e.g. progress notes). Follow up with a phone call to be sure the fax was received. |
| Facility indicated that no patient by that name was seen at that hospital. | • Check to verify that the spelling of the patient’s name and date of birth on the ROI are correct. Also check to ensure the time frame of hospitalization is |
correct. If the patient is known by a different name (e.g., patient’s name changed due to marriage), be sure both the maiden name and the married name are listed on the ROI. If the hospital system that the ROI was sent is a system with multiple hospital locations, verify that the ROI was sent to the hospital at which the patient was treated.

4. Storage of Outside Records
   a. Each TBIMS center should ensure that their site procedures for storing research records are approved by their local IRB.
   b. Options for storage may include the following:
      • Hard copies in a research chart with the TBIMS ID#
      • Records scanned into a secure drive on the center’s local network
      • Records scanned to a CD or secure media and stored in the research chart with the TBIMS ID#

Training requirements: None

Compliance: All

References: None

History:
1. Draft created 10/2018

Review schedule: At least every 5 years
**Medical Records Request**

<table>
<thead>
<tr>
<th>Patient’s Name:</th>
<th>Record including:</th>
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<tbody>
<tr>
<td></td>
<td>• Emergency Dept Intake (ER Records)</td>
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<tr>
<td></td>
<td>• Trauma Intake</td>
</tr>
<tr>
<td></td>
<td>• History and Physical</td>
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<tr>
<td></td>
<td>• Discharge Summary</td>
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<tr>
<td></td>
<td>• Neurology Consult</td>
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<tr>
<td></td>
<td>• Neurosurgery Consult</td>
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<tr>
<td></td>
<td>• Psychology Consult</td>
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<tr>
<td></td>
<td>• Psychiatry Consult</td>
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<tr>
<td></td>
<td>• Neuropsychology Consult</td>
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<tr>
<td></td>
<td>• Social Work Consult Note</td>
</tr>
<tr>
<td></td>
<td>• Head CT Radiology Reports</td>
</tr>
</tbody>
</table>

*Do NOT need labs/chemistry.
*Head/Brain CT reports only. Do NOT need radiology reports for cervical spine or other body areas.

Please **fax** records to

Attention: Dr. X [PI’s Name]

Contact:

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<table>
<thead>
<tr>
<th>Patient’s Name:</th>
<th>Record including:</th>
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<tbody>
<tr>
<td></td>
<td>• Physician’s Progress Notes</td>
</tr>
<tr>
<td></td>
<td>• Attending’s Progress Notes</td>
</tr>
<tr>
<td></td>
<td>• Trauma Progress Notes</td>
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</tbody>
</table>

[Also include the following if they also received rehabilitation services during the acute care hospitalization]

- Speech Language Therapy Consult/Evaluation
- Speech Language Therapy Progress Notes
- Occupational Therapy Consult/Evaluation
- Occupational Therapy Progress Notes
- Physical Therapy Consult/Evaluation
- Physical Therapy Progress Notes

Please **fax** records to

Attention:

Contact:
**Date:**

**To:** [name of LTAC]

**FAX#:**

**From:** Dr. X [PI's Name]

**Attention:** Release of Medical Records

**RE:** Patient’s Medical Records

**No. of pages including cover:** 2

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### Medical Records Request

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<tr>
<td></td>
<td>- History and Physical</td>
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<td></td>
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<td>- Neurology Consult</td>
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*Do NOT need labs/chemistry.*

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**Contact:**

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<tbody>
<tr>
<td>DoB:</td>
<td>• Physician’s Progress Notes</td>
</tr>
<tr>
<td>Date(s) of Interest:</td>
<td>• Attending’s Progress Notes</td>
</tr>
</tbody>
</table>

[Also include the following if they also received rehabilitation services during the acute care hospitalization]

• Speech Language Therapy Consult/Evaluation
• Speech Language Therapy Progress Notes
• Occupational Therapy Consult/Evaluation
• Occupational Therapy Progress Notes
• Physical Therapy Consult/Evaluation
• Physical Therapy Progress Notes

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Attention:

Contact:

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**FAX**

**FROM:**

**Date:**

To: [name of SNF or other non-hospital]

FAX#:

From: Dr. X [PI's Name]

Attention: Release of Medical Records

RE: Patient’s Medical Records

No. of pages *including cover:* 2

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<tbody>
<tr>
<td></td>
<td>• Intake / Admission</td>
</tr>
<tr>
<td></td>
<td>• History and Physical</td>
</tr>
<tr>
<td></td>
<td>• Discharge Summary</td>
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<tr>
<td></td>
<td>• Progress Notes [include this if you suspect the person may have begun following commands or emerged from PTA]</td>
</tr>
</tbody>
</table>

**DoB:**

**Date(s) of Interest:**
[date of admission to date of discharge]

Please **fax** records to

Attention:

Contact:

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