

INSTRUCTIONS FOR COMPLETING THE POST IND MORBIDITY SURVIELENCE FORM

SECTION 1: MEDICAL FACILITY INFORMATION

1. Reporting hospital or medical facility name.
2. Name of the individual completing the form.
3. City in which the facility is located.
4. Five-digit ZIP Code.
5. Two-letter state postal code abbreviation.

SECTION 2: PATIENT INFORMATION

6. Medical record number.
7. Other ID number: If patient was transferred to your facility through the National Disaster Medical System (NDMS) include their JPATS # or if a state issued patient tracking # was issued.
8. Last name of the patient.
9. First name of the patient.
10. One-letter abbreviation for the patient's middle name.
11. Patient's age in years, if they are less than one year use the months field.
12. Patient's sex, if female provide information for questions 12a and 12b.
13. Patient's race/ethnicity.

SECTION 3: RADIATION EXPOSURE AND CONTAMINATION ASSESSMENT

14. Provide a detailed location where the patient was at the time of blast, specify an address or major landmark.
15. Indicate if the patient was inside or outside at the time of the blast.
16. Indicate the primary location the person sheltered during the first 24hrs.
17. Indicate if the person was outside or in a car during the first 4 hours after the blast. If, yes include an estimate on the number of hours spent outside/in a car.
18. Indicate if patient the patient started vomiting after the detonation.
19. Indicate the frequency the patient was vomiting per day.

20. Indicate if the patient had diarrhea, if so provide a frequency.
21. Indicate if the patient has an unexplained fever.
22. Indicate if the patient has been experiencing headaches.
23. Indicate if the patient has radiation burns.
24. Indicate if the patient has wounds/burns that are contaminated.
- 24a. If a yes answer was provided for question 24 indicate if the wounds/burns were decontaminated.
25. Indicate if internal contamination is suspected.
26. Indicate if a dose estimation was calculated for the patient.
- 26a. If a yes answer was provided for question 26 identify the method used for estimating the dose. If the method does not appear as one of the choices use the blank space provided to write in the method used.
- 26b. If a yes answer was provided for question 26 enter the dose estimation in the field provided.

SECTION 4: MEDICAL HISTORY AND TREATMENT INFORMATION

27. Select comorbidities identified for the patient. The 3 blank lines in the right column may be used to record comorbidities not in the list.
28. Indicate if the patient is being treated as an inpatient, outpatient, or no follow-up required. If inpatient is selected select one of the 6 bed types identified below that best matches the type of bed the patient was admitted to.
29. Indicate if the patient has traumatic injuries. If yes, identify all the regions that apply:

Head/neck: injuries to the brain or cervical spine, skull or cervical spine fractures and asphyxia/suffocation

Face: injuries involving mouth, ears, nose, and facial bones.

Chest: injuries internal organs, drowning and inhalation injury. Also includes those to the diaphragm, rib cage, and thoracic spine.

Abdomen/pelvis: injuries to internal organs. Lumbar spine lesions are included in the abdominal or pelvic region.

Extremities: include sprains, fractures, dislocations, and amputations.

External: injuries including lacerations, contusions, abrasions, and burns, independent of their location on the body surface, except amputation burns that are assigned to the appropriate body region. Other traumatic events assigned to this ISS body region are: electrical injury, frostbite, hypothermia and whole body (explosion-type) injury

If known, provide the Injury Severity Score (ISS) in the field available. The following resource can be used to assist in calculating the ISS score

<https://www.mdcalc.com/injury-severity-score-iss>

30. Indicate if the patient has thermal burns. If yes, identify the burn type(s) and surface area.
31. Identify any infection complications the patient has had during treatment. If, needed additional complications can be added in the blank field.
32. Indicate if the patient has neutropenia.
33. Indicate if the patient has gastrointestinal bleeding.
34. Indicate if the patient has cutaneous radiation injuries.

35. If CBC lab tests have been completed provide lab values along with date and time the tests were conducted

36. Indicate if the patient was diagnosed with Acute Radiation Syndrome (ARS). If yes, list the specific sub-syndrome below or make unknown.

37. Indicate any colony stimulating factors / cytokines that have been administered to the patient. Include the start/stop dates as well as the dose given. The blank space may be used to list a medication not listed. Common brand names are listed below:

Filgrastim – Neupogen, Nivestim, Neukine

Pegfilgrastim – Neulasta, Udenyca

Sargramostim - Leukine

Romiplostim – Nplate, Romiplate

38. If colony stimulating factors have been administered indicate any complications the patient has experienced. Multiple complications can be checked.

39. Indicate any blood products the patient has received.

40. List medications being administered to the patient along with the dates. If a medication is still being used leave the stop field blank. Codes 20-24 can be used to add additional medications not listed.

SECTION 5: PATIENT OUTCOME

41. Indicate the status of the patient and the appropriate ICD-10 codes if known.