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Resuscitation

GWTG-Resuscitation Case Record Form (CRF)

Active Form Groups: Admit/ Discharge October 2026

Patient ID:	
System Entry Date:	_____/_____/_____ _____:_____
DEMOGRAPHICS	*Demographics Tab*
Sex	○ Male ○ Female ○ Unknown
Patient Gender Identity:	○ Male ○ Female ○ Female-to-Male (FTM)/Transgender Male/Trans Man ○ Male-to-Female (MTF)/Transgender Female/Trans Woman ○ Genderqueer, neither exclusively male nor female ○ Additional gender category or other: _____ ○ Did not disclose
Patient-Identified Sexual Orientation:	○ Straight or heterosexual ○ Lesbian or gay ○ Bisexual ○ Queer, pansexual, and/or questioning ○ Something else, please specify: _____ ○ Don't know ○ Declined to answer
Date of Birth:	_____/_____/_____ ____:____ ☐ Unknown
Unknown DOB:	○ Confirm Adult Patient Population ○ Patient Population Unconfirmed
Age:	_____ Age Unit: ○ Years ○ Months ○ Weeks ○ Days ○ Hours ○ Minutes
Patient Population:	_____
Patient Zip Code:	_____ ☐ Homeless
Payment Source	☐ Medicare Title 18 ☐ Medicaid – Private/ HMO/ PPO/ Other ☐ Self Pay/ No Insurance ☐ Medicaid Title 19 ☐ Private/ HMO/ PPO/ Other ☐ Other/ Not Documented/ UTD ☐ Medicare – Private/ HMO/ PPO/ Other ☐ VA/ CHAMPVA/ Tricare
RACE AND ETHNICITY	*Demographics Tab*
Race	☐ American Indian/Alaska Native ☐ Asian [if Asian selected] ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Black or African American ☐ Hispanic or Latino [Select Hispanic Origin Group(s)] ☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Another Hispanic, Latino, or Spanish Origin ☐ Middle Eastern or North African ☐ Native Hawaiian or Pacific Islander [if Native Hawaiian or Pacific Islander selected] ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan

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	☐ Other Pacific Islander ☐ White ☐ UTD
ADMISSION DATA	*Admission Tab*
Born this admission (or transferred from birth hospital)?	○ Yes ○ No
Birth Weight (patients <30 days old only)	____ Units ○ Pounds ○ Kilograms ○ Grams ☐ Birth Weight Unknown/Not Documented ☐ Weight same as birth weight
Weight (required for pediatric and newborn/neonate patients only):	____ Units ○ Pounds ○ Kilograms ○ Grams ☐ Weight Unknown/Not Documented
Length (patients <30 days old only):	____ Units ○ Inches ○ Centimeters ☐ Length Unknown/Not Documented
Head Circumference (patients <30 days old only):	____ Units ○ Inches ○ Centimeters ☐ Circumference Unknown/Not Documented
Admission Adult Cerebral Performance Categories/CPC Scale:	○ 1 Good cerebral performance ○ 2 Moderate cerebral disability ○ 3 Severe cerebral disability ○ 4 Coma or vegetative state ○ 5 Brain death ☐ Unknown/Not Documented/Not Applicable
Admission Pediatric/Neonate Cerebral Performance Categories/PCPC Scale:	○ 1 Normal ○ 2 Mild cerebral disability ○ 3 Moderate cerebral disability ○ 4 Severe cerebral disability ○ 5 Coma or vegetative state ○ 6 Brain death ☐ Unknown/Not Documented/Not Applicable
COVID-19 Vaccination:	○ COVID-19 vaccine was given during this hospitalization ○ COVID-19 vaccine was received prior to admission, not during this hospitalization ○ Documentation of patient's refusal of COVID-19 vaccine ○ Allergy/sensitivity to COVID-19 vaccine or if medically contraindicated ○ Vaccine not available ○ None of the above/Not documented/UTD
COVID-19 Vaccination date:	_____/_____/_____ ○ Unknown
COVID-19 Vaccination Manufacturer:	○ AstraZeneca ○ Johnson & Johnson's / Janssen ○ Moderna ○ Novavax ○ Pfizer ○ Other ○ Not Documented
Did the patient receive both doses of vaccine? (if applicable)	○ Yes ○ No ○ Not Applicable
Is there documentation that this patient was included in a COVID-19 vaccine trial?	○ Yes ○ No
Influenza Vaccination:	○ Influenza vaccine was given during this hospitalization during the current flu season ○ Influenza vaccine was received prior to admission during the current flu season, not during this hospitalization ○ Documentation of patient's refusal of influenza vaccine ○ Allergy/sensitivity to influenza vaccine or if medically contraindicated ○ Vaccine not available ○ None of the above/Not documented/UTD
Physician:	

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NEWBORN/NEONATE	*Newborn/Neonate Tab*
Did mother receive prenatal care?	○ Yes ○ No ○ Not Documented
Maternal Conditions (check all that apply):	☐ Not Documented ☐ Alcohol Use ☐ Cocaine/Crack use ☐ Eclampsia ☐ Magnesium Exposure ☐ Maternal Group B Strep (Positive) ☐ Methamphetamine/ICE use ☐ Narcotics addiction and/or on methadone maintenance ☐ Polyhydramnios ☐ Prior Cesarean ☐ Urinary Tract Infection (UTI) ☐ None ☐ Chorioamnionitis ☐ Diabetes ☐ GHTN (Pregnancy induced / Gestational Hypertension) ☐ Major Trauma ☐ Maternal infection ☐ Narcotic given to mother within 4 hrs of delivery ☐ Oligohydramnios ☐ Pre-eclampsia ☐ Sexually Transmitted Infection (STI/STD), Specify: _____ ☐ Other, Specify: _____
Delivery Details:	Fetal Monitoring ☐ None ☐ External ☐ Internal ☐ Performed, method unknown ☐ Unknown/Not documented Delivery Mode ○ C-Section/emergent ○ Vaginal/operative ○ VBAC ○ C-section/ Scheduled ○ Vaginal/spontaneous ○ Unknown/Not Documented Fetal Delivery Presentation ○ Cephalic ○ Breech ○ Unknown/Not Documented
Apgar Scores:	1 min: _____ ☐ Unknown/Not Assigned 5 min: _____ ☐ Unknown/Not Assigned 10 min: _____ ☐ Unknown/Not Assigned 15 min: _____ ☐ Unknown/Not Assigned 20 min: _____ ☐ Unknown/Not Assigned
Cord pH:	_____ ☐ Unknown/Not Documented
Sample Location:	○ Arterial ○ Venous ○ Unknown/Not Documented
Best Estimate of gestational age (weeks):	_____ ☐ Unknown/Not Documented
Special Circumstances Recognized at Birth (select all that apply):	☐ None ☐ Cord Prolapse ☐ Meconium Aspiration ☐ Nuchal Cord ☐ Placenta Abruption ☐ Placenta Previa ☐ Shoulder Dystocia ☐ Other, Specify _____ ☐ Abdominal Wall Defects ○ Prenatal Dx ○ Postnatal Dx ☐ Congenital Cystic Adenomatoid Malformation/Congenital Pulmonary Airway Malformation ○ Prenatal Dx ○ Postnatal Dx ☐ Congenital Diaphragmatic Hernia ○ Prenatal Dx ○ Postnatal Dx ☐ Cardiac Malformation / Abnormality - Acyanotic ○ Prenatal Dx ○ Postnatal Dx ☐ Cardiac Malformation / Abnormality - Cyanotic ○ Prenatal Dx ○ Postnatal Dx ☐ Congenital Malformation / Abnormality (Non-cardiac) ○ Prenatal Dx ○ Postnatal Dx ☐ Decelerations ○ Prenatal Dx ○ Postnatal Dx ☐ Fetal Hydrops ○ Prenatal Dx ○ Postnatal Dx
DISCHARGE DATA	*Discharge Tab*

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Was induced hypothermia initiated after return of circulation (ROC) achieved?	○ Yes ○ No/Not Documented ○ N/A
Discharge Status:	○ Dead ○ Alive ○ Disposition Pending
During this admission, was a standardized health related social needs form or assessment completed?	○ Yes ○ No/ND
If unmet social need(s) identified, were resources provided	○ Yes ○ No
If yes, identify the areas of unmet social need. (select all that apply):	☐ None ☐ Education ☐ Employment ☐ Financial Strain ☐ Food ☐ Living Situation/Housing ☐ Mental Health ☐ Personal Safety ☐ Substance Abuse ☐ Transportation Barriers ☐ Utilities ☐ Other _____
If unmet social need(s) identified, were resources provided to the patient?	○ Yes ○ No
If yes, what resources were provided?	☐ Access to a Community Health Worker ☐ Access to a Social Worker ☐ Access to another Case Worker/Support Specialist ☐ Resources for a digital-based community platform (e.g., findhelp.org) ☐ Other _____
Was there Active or Suspected COVID-19 diagnosis in the 2 weeks prior to admission or during this hospitalization?	○ Yes, prior to admission ○ Yes, during hospitalization ○ No ○ Unknown/ND
Method of Diagnosis:	○ COVID-19 confirmed by a lab test ○ Clinical diagnosis assigned by hospital-specific criteria (suspected) ○ Unknown/ND
Date/Time of Diagnosis:	_____/_____/_____ ____:_____ ☐ Unknown
Discharge Disposition:	○ 1 Home ○ 2 Hospice – Home ○ 3 Hospice - Health Care Facility ○ 4 Acute Care Facility ○ 5 Other Healthcare Facility ○ 6 Expired ○ 7 Left Against Medical Advice ○ 8 Not Documented or UTD
Facility patient was transferred to:	
If Acute Care Facility, Reason(s) for transfer (select all that apply):	☐ Administrative ☐ Patient/family request ☐ Procedure/Service not available at this hospital ☐ Other advanced care ☐ Unknown/Not Documented ☐ Other (specify) _____
If Other Healthcare Facility:	○ Skilled Nursing Facility (SNF) ○ Inpatient Rehabilitation Facility (IRF) ○ Long Term Care Hospital (LTCH) ○ Intermediate Care Facility (ICF) ○ Other
Date/Time of Hospital Discharge/Death:	_____/_____/_____ ____:_____ ○ Unknown
DNAR during this admission?	○ Yes ○ No
If yes, Date/Time of DNAR order:	_____/_____/_____ ____:_____ ○ Unknown
If patient died:	Was Life Support Withdrawn? ○ Yes ○ No Were organs recovered? ○ Yes ○ No

OUTCOMES		DISCHARGE TAB
If patient survives to discharge	Discharge Adult Cerebral Performance Categories/CPC Scale:	○ 1 Good cerebral performance ○ 2 Moderate cerebral disability ○ 3 Severe cerebral disability ○ 4 Coma or vegetative state ○ 5 Brain death ☐ Unknown/Not Documented/Not Applicable

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	Discharge Pediatric/Neonate Cerebral Performance Categories/PCPC Scale:	○ 1 Normal ○ 2 Mild cerebral disability ○ 3 Moderate cerebral disability ○ 4 Severe cerebral disability ○ 5 Coma or vegetative state ○ 6 Brain death ☐ Unknown/Not Documented/Not Applicable
Discharge Modified Rankin Scale:	○ 0 – No symptoms at all ○ 1 – No significant disability symptoms: ability to carry out all usual activities ○ 2 – Slight disability ○ 3 – Moderate disability: Requiring some help but able to walk without assistance ○ 4 – Moderate to severe disability: Unable to walk without assistance and unable to attend to own bodily needs without assistance ○ 5 – Severe disability: Bedridden, incontinent and requiring constant nursing care and attention ○ 6 - Death	
Discharge Modified Rankin Score:	_____ ☐ Not Documented	
Comments		

END OF ADMISSION & DISCHARGE FORM

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