**Supplemental Figure 1**: Emergency Physician Data Collection Form.

***Frailty in Emergency Department Infection***

Physician Data Form

**Patient MRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician completing form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: *(yyyy/mm/dd)*** \_\_ \_\_ \_\_ \_\_/\_\_ \_\_/\_\_ \_\_

**Glasgow Coma Scale (3-15):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Suspected Source of Infection:** ****Pulmonary ****Urinary ****GI ****Skin ****Other \_\_\_\_\_\_\_\_\_ ****Unknown

**BRIEF FRAILTY SCALE:** *(Please complete* ***all*** *questions)*

|  |  |  |
| --- | --- | --- |
| Does the patient have bladder incontinence? | **** YES | **** NO |
| Does the patient have bowel incontinence? | **** YES | **** NO |
| Does the patient need assistance with mobility? (not including walking aids) | **** YES | **** NO |
| Does the patient need assistance with activities of daily living? (eating, dressing, bathing) | **** YES | **** NO |
| Does the patient have cognitive impairment at baseline? | **** YES | **** NO |
| If YES to above, does the patient have an existing diagnosis of dementia? | **** YES | **** NO |

**CLINICAL FRAILTY SCALE:** *(Please circle the* ***1 category*** *that most appropriately describes the patient):*

