Assurance of confidentiality – All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used only by persons engaged in and for the purpose of the survey and will not be disclosed or released to other persons or used for any other purpose without consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m).

Department of Health and Human Services
Public Health Service
Centers for Disease Control and Prevention
National Center for Health Statistics

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PATIENT'S RECORD NO.:

NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY
1997–98 EMERGENCY DEPARTMENT RECORD

PATIENT'S NAME:

1. DATE OF VISIT
____/____/____
Month Day Year

2. TIME OF VISIT
___ : ___ ☐ Military ☐ AM ☐ PM

3. DATE OF BIRTH
____/____/____
Month Day Year

4. MODE OF ARRIVAL *Check one.*
1 ☐ Ambulance (air/ground)
2 ☐ Public service (nonambulance, e.g., police, social services)
3 ☐ Walk-in
4 ☐ Unknown

5. SEX
1 ☐ Female 2 ☐ Male
↓
Is patient pregnant?
1 ☐ Yes 2 ☐ No 3 ☐ Unknown

6. RACE
1 ☐ White
2 ☐ Black
3 ☐ Asian/Pacific Islander
4 ☐ American Indian/ Eskimo/Aleut

7. ETHNICITY
1 ☐ Hispanic origin
2 ☐ Not Hispanic

8. PRIMARY EXPECTED SOURCE OF PAYMENT FOR THIS VISIT *Check one.*
1 ☐ Private insurance
2 ☐ Medicare
3 ☐ Medicaid
4 ☐ Worker's Compensation
5 ☐ Self-pay
6 ☐ No charge
7 ☐ Other
8 ☐ Unknown

9. DOES PATIENT BELONG TO AN HMO?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

10. IMMEDIACY WITH WHICH PATIENT SHOULD BE SEEN
1 ☐ Unknown/no triage
2 ☐ Less than 15 minutes
3 ☐ 15 – 60 minutes
4 ☐ > 1 hour – 2 hours
5 ☐ > 2 hours – 24 hours

11. PRESENTING LEVEL OF PAIN
1 ☐ Unknown
2 ☐ None
3 ☐ Mild
4 ☐ Moderate
5 ☐ Severe

12. TIME SEEN BY PHYSICIAN
___ : ___ ☐ Military ☐ AM ☐ PM
☐ Not seen by physician or unknown

13. PATIENT'S COMPLAINT(S), SYMPTOM(S), OR OTHER REASON(S) FOR THIS VISIT *Use patient's own words*

1. Most important: _____
2. Other: _____
3. Other: _____

14. IS THIS VISIT RELATED TO INJURY OR POISONING? *Refers to all types of injury or poisoning, including adverse drug experiences, medical misadventures, etc.*

1 ☐ Yes *(Answer a, b, c, and d.)* 2 ☐ No *(Skip to item 15.)*

a. Place of occurrence *Check one*
1 ☐ Residence
2 ☐ Recreation/sports area
3 ☐ Street or highway
4 ☐ School
5 ☐ Other public building
6 ☐ Industrial places
7 ☐ Other
8 ☐ Unknown

b. Is this injury intentional?
1 ☐ Yes (self-inflicted)
2 ☐ Yes (assault)
3 ☐ No, unintentional
4 ☐ Unknown

c. Is this injury work related?
1 ☐ Yes 2 ☐ No 3 ☐ Unknown

d. Cause of injury *Describe events that preceded injury (e.g. reaction to penicillin, wasp sting, driver in motor vehicle traffic accident involving collision with parked vehicle, shot with a handgun during a brawl, etc.)*

15. PHYSICIAN'S DIAGNOSES FOR THIS VISIT *As specifically as possible, list diagnoses related to this visit including chronic conditions (e.g. depression, obesity, asthma, etc.)*

1. Primary diagnosis: _____
2. Other: _____
3. Other: _____

16. DIAGNOSTIC/SCREENING SERVICES *Check all **ordered** or **provided** at this visit.*

1 ☐ None
2 ☐ Mental status exam
3 ☐ Blood pressure
4 ☐ EKG
5 ☐ Cardiac monitor
6 ☐ Pulse oximetry
7 ☐ Urinalysis
8 ☐ Pregnancy test
9 ☐ HIV serology
10 ☐ Other STD test
11 ☐ Blood alcohol concentration
12 ☐ CBC
13 ☐ Other blood test
14 ☐ Other – *Specify* _____

IMAGING:
15 ☐ Chest X-Ray
16 ☐ Extremity X-Ray
17 ☐ Other X-Ray
18 ☐ MRI
19 ☐ Ultrasound
20 ☐ CAT scan
21 ☐ Other diagnostic imaging

17. PROCEDURES *Check all **provided** at this visit.*

1 ☐ None
2 ☐ Endotracheal intubation
3 ☐ CPR
4 ☐ IV fluids
5 ☐ NG tube/gastric lavage
6 ☐ Lumbar puncture
7 ☐ Bladder catheter
8 ☐ Wound care
9 ☐ Eye/ENT care
10 ☐ Orthopedic care
11 ☐ OB/GYN care
12 ☐ Other – *Specify* _____

18. MEDICATIONS/INJECTIONS *List names of up to 6 medications that were **ordered, supplied, administered** or **continued** during this visit. Include R_x and OTC medications, immunizations, allergy shots, and anesthetics.*

☐ None

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

19. VISIT DISPOSITION *Check all that apply.*

1 ☐ No followup planned
2 ☐ Return to ED, P.R.N./appointment
3 ☐ Returned to referring physician
4 ☐ Referred out from triage without treatment
5 ☐ Referred to other physician/ clinic for followup
6 ☐ Left before being seen
7 ☐ Admitted to hospital
8 ☐ Admitted to ICU/CCU
9 ☐ Transferred to other facility
10 ☐ DOA/died in ED
11 ☐ Referred to social service
12 ☐ Other

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20. PROVIDERS SEEN THIS VISIT *Check all that apply.*

1 ☐ Staff physician
2 ☐ Resident/intern
3 ☐ Other physician
4 ☐ Physician assistant
5 ☐ Nurse practitioner
6 ☐ R.N.
7 ☐ L.P.N.
8 ☐ Medical/nursing assistant
9 ☐ E.M.T.
10 ☐ Other