

FORM **NHAMCS-100(ED)**
(10-14-2009)

U.S. DEPARTMENT OF COMMERCE
Economics and Statistics Administration
U.S. CENSUS BUREAU
ACTING AS DATA COLLECTION AGENT FOR THE
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
National Center for Health Statistics

PATIENT RECORD NO.:

PATIENT'S NAME:

**NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY
2010 EMERGENCY DEPARTMENT PATIENT RECORD**

Assurance of confidentiality – All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used for statistical purposes only by NCHS staff, contractors, and agents only when required and with necessary controls, and will not be disclosed or released to other persons without the consent of the individual or establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347).

(Provider: Detach and keep)

Please keep (X) marks inside of boxes → Correct Incorrect

1. PATIENT INFORMATION

a. Date and time of visit				b. ZIP Code				c. Date of birth			
Month	Day	Year	Time	a.m.	p.m.	Military		Month	Day	Year	
(1) Arrival											
(2) MD/DO/PA/NP				d. Patient residence				e. Sex		f. Ethnicity	
Seen by				1 <input type="checkbox"/> Private residence				1 <input type="checkbox"/> Female		1 <input type="checkbox"/> Hispanic or Latino	
				2 <input type="checkbox"/> Nursing home				2 <input type="checkbox"/> Male		2 <input type="checkbox"/> Not Hispanic or Latino	
				3 <input type="checkbox"/> Homeless							
				4 <input type="checkbox"/> Other							
				5 <input type="checkbox"/> Unknown							
(3) ED discharge											
g. Race – Mark (X) one or more.				h. Arrival by ambulance				i. Expected source(s) of payment for this visit – Mark (X) all that apply.			
1 <input type="checkbox"/> White				1 <input type="checkbox"/> Yes				1 <input type="checkbox"/> Private insurance			
2 <input type="checkbox"/> Black or African American				2 <input type="checkbox"/> No				4 <input type="checkbox"/> Worker's compensation			
3 <input type="checkbox"/> Asian				3 <input type="checkbox"/> Unknown				5 <input type="checkbox"/> Self-pay			
4 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander								6 <input type="checkbox"/> No charge/Charity			
5 <input type="checkbox"/> American Indian or Alaska Native								7 <input type="checkbox"/> Other			
								8 <input type="checkbox"/> Unknown			

2. TRIAGE

a. Initial vital signs		(1) Temperature		(2) Heart rate		(3) Respiratory rate		b. Triage level (1-5)		c. Pain scale (0-10)	
		[] °C / [] °F		[] per minute		[] per minute		[]		[]	
(4) Blood pressure		(5) Pulse oximetry		(6) On oxygen		(7) Glasgow Coma Scale (3-15)		1 <input type="checkbox"/> No triage		1 <input type="checkbox"/> Unknown	
Systolic / Diastolic		[] %		1 <input type="checkbox"/> Yes 3 <input type="checkbox"/> Unknown 2 <input type="checkbox"/> No		[]		2 <input type="checkbox"/> Unknown			

3. PREVIOUS CARE

4. REASON FOR VISIT

a. Has patient been –			a. Patient's complaint(s), symptom(s), or other reason(s) for this visit			b. Episode of care		
(1) seen in this ED within the last 72 hours?			Use patient's own words.			1 <input type="checkbox"/> Initial visit for problem		
Yes No Unknown			(1) Most important:			2 <input type="checkbox"/> Follow-up visit for problem		
1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>			(2) Other:			3 <input type="checkbox"/> Unknown		
(2) discharged from any hospital within the last 7 days?			(3) Other:					
1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>								
b. How many times has patient been seen in this ED within the last 12 months?								
[] 3 <input type="checkbox"/>								

5. INJURY/POISONING/ADVERSE EFFECT

a. Is this visit related to an injury, poisoning, or adverse effect of medical treatment?		b. Is this injury/poisoning intentional?		c. Cause of injury, poisoning, or adverse effect – Describe the place and events that preceded the injury, poisoning, or adverse effect (e.g., allergy to penicillin, bee sting, pedestrian hit by car driven by drunk driver, spouse beaten with fists by spouse, heroin overdose, infected shunt, etc.).	
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – SKIP to item 6.		1 <input type="checkbox"/> Yes, self inflicted 2 <input type="checkbox"/> Yes, assault 3 <input type="checkbox"/> No, unintentional 4 <input type="checkbox"/> Unknown			

6. PROVIDER'S DIAGNOSIS FOR THIS VISIT

a. As specifically as possible, list diagnoses related to this visit including chronic conditions.		(1) Primary diagnosis:		b. Does patient have – Mark (X) all that apply.	
		(2) Other:		1 <input type="checkbox"/> Cerebrovascular disease/History of stroke	
		(3) Other:		4 <input type="checkbox"/> HIV	
				5 <input type="checkbox"/> Diabetes	
				2 <input type="checkbox"/> Congestive heart failure	
				3 <input type="checkbox"/> Condition requiring dialysis	
				6 <input type="checkbox"/> None of the above	

7. DIAGNOSTIC/SCREENING SERVICES			8. PROCEDURES			9. MEDICATIONS & IMMUNIZATIONS		
Mark (X) all ordered or provided at this visit.			Mark (X) all provided at this visit. Exclude medications.			List up to 8 drugs given at this visit or prescribed at ED discharge. Include Rx and OTC drugs, immunizations, and anesthetics.		
1 <input type="checkbox"/> NONE			1 <input type="checkbox"/> NONE			[] NONE		
2 <input type="checkbox"/> CBC			2 <input type="checkbox"/> IV fluids			Given in ED Rx at discharge		
3 <input type="checkbox"/> BUN/Creatinine			3 <input type="checkbox"/> Cast			1 <input type="checkbox"/> 2 <input type="checkbox"/>		
4 <input type="checkbox"/> Cardiac enzymes			4 <input type="checkbox"/> Splint or wrap			1 <input type="checkbox"/> 2 <input type="checkbox"/>		
5 <input type="checkbox"/> Electrolytes			5 <input type="checkbox"/> Suturing/Staples			1 <input type="checkbox"/> 2 <input type="checkbox"/>		
6 <input type="checkbox"/> Glucose			6 <input type="checkbox"/> Incision & drainage (I&D)			1 <input type="checkbox"/> 2 <input type="checkbox"/>		
7 <input type="checkbox"/> Liver function tests			7 <input type="checkbox"/> Foreign body removal			1 <input type="checkbox"/> 2 <input type="checkbox"/>		
8 <input type="checkbox"/> Arterial blood gases			8 <input type="checkbox"/> Nebulizer therapy			1 <input type="checkbox"/> 2 <input type="checkbox"/>		
9 <input type="checkbox"/> Prothrombin time/INR			9 <input type="checkbox"/> Bladder catheter			1 <input type="checkbox"/> 2 <input type="checkbox"/>		
10 <input type="checkbox"/> Blood culture			10 <input type="checkbox"/> Pelvic exam			1 <input type="checkbox"/> 2 <input type="checkbox"/>		
11 <input type="checkbox"/> BAC (blood alcohol)			11 <input type="checkbox"/> Central line			1 <input type="checkbox"/> 2 <input type="checkbox"/>		
12 <input type="checkbox"/> Other blood test			12 <input type="checkbox"/> CPR			1 <input type="checkbox"/> 2 <input type="checkbox"/>		
Other tests:			13 <input type="checkbox"/> Endotracheal intubation			1 <input type="checkbox"/> 2 <input type="checkbox"/>		
13 <input type="checkbox"/> Cardiac monitor			14 <input type="checkbox"/> Other			1 <input type="checkbox"/> 2 <input type="checkbox"/>		
14 <input type="checkbox"/> EKG/ECG								
15 <input type="checkbox"/> HIV test								

10. PROVIDERS		11. SERVICE LEVEL		12. VISIT DISPOSITION	
Mark (X) all providers seen at this visit.		(CPT code)		Mark (X) all that apply.	
1 <input type="checkbox"/> ED attending physician		1 <input type="checkbox"/> 1 (99281)		1 <input type="checkbox"/> No follow-up planned	
2 <input type="checkbox"/> ED resident/Intern		2 <input type="checkbox"/> 2 (99282)		2 <input type="checkbox"/> Return if needed, PRN/appointment	
3 <input type="checkbox"/> Consulting physician		3 <input type="checkbox"/> 3 (99283)		3 <input type="checkbox"/> Return/Refer to physician/clinic for FU	
4 <input type="checkbox"/> RN/LPN		4 <input type="checkbox"/> 4 (99284)		4 <input type="checkbox"/> Left before triage	
5 <input type="checkbox"/> Nurse practitioner		5 <input type="checkbox"/> 5 (99285)		5 <input type="checkbox"/> Left after triage	
6 <input type="checkbox"/> Physician assistant		6 <input type="checkbox"/> Critical care (99291)		6 <input type="checkbox"/> Left AMA	
7 <input type="checkbox"/> EMT		7 <input type="checkbox"/> Unknown		7 <input type="checkbox"/> DOA	
8 <input type="checkbox"/> Mental health provider				8 <input type="checkbox"/> Died in ED	
9 <input type="checkbox"/> Other				9 <input type="checkbox"/> Return/Transfer to nursing home	
				10 <input type="checkbox"/> Transfer to psychiatric hospital	
				11 <input type="checkbox"/> Transfer to other hospital	
				12 <input type="checkbox"/> Admit to this hospital	
				13 <input type="checkbox"/> Admit to observation unit then hospitalized	
				14 <input type="checkbox"/> Admit to observation unit, then discharged – Continue with Item 14 on reverse side.	
				15 <input type="checkbox"/> Other	

13. HOSPITAL ADMISSION

Complete if the patient was admitted to this hospital at this ED visit. – Mark (X) "Unknown" in each item, if efforts have been exhausted to collect the data.

a. Admitted to:

- 1 Critical care unit
- 2 Stepdown unit
- 3 Operating room
- 4 Mental health or detox unit
- 5 Cardiac catheterization lab
- 6 Other bed/unit
- 7 Unknown

c. Date and time bed was requested for hospital admission

Month	Day	Year	Time	a.m.	p.m.	Military
[] []	[] []	[] [] []	[] [] : [] []	[]	[]	[]

1 Unknown

d. Date and time patient actually left the ED or observation unit

Month	Day	Year	Time	a.m.	p.m.	Military
[] []	[] []	[] [] []	[] [] : [] []	[]	[]	[]

1 Unknown

b. Admitting physician

- 1 Hospitalist
- 2 Not hospitalist
- 3 Unknown

e. Hospital discharge date

Month	Day	Year
[] []	[] []	[] [] []

1 Unknown

f. Principal hospital discharge diagnosis

1 Unknown

g. Hospital discharge status/disposition

- | | | |
|------------------------------------|---|--|
| 1 <input type="checkbox"/> Alive | } | 1 <input type="checkbox"/> Home/Residence |
| 2 <input type="checkbox"/> Dead | | 2 <input type="checkbox"/> Return/Transfer to nursing home |
| 3 <input type="checkbox"/> Unknown | | 3 <input type="checkbox"/> Transfer to another facility (not usual place of residence) |
| | | 4 <input type="checkbox"/> Other |
| | | 5 <input type="checkbox"/> Unknown |

▶ If this information is not available at time of abstraction, then complete the Hospital Admission Log.

14. OBSERVATION UNIT STAY

a. Date and time of observation unit discharge

Month	Day	Year	Time	a.m.	p.m.	Military
[] []	[] []	[] [] []	[] [] : [] []	[]	[]	[]

1 Unknown