1997 NHAMCS INSTRUCTIONS FOR COMPLETING PATIENT RECORD FORM

Item 1 - DATE OF VISIT

Record the month, day, and year of this visit in figures. For example, enter 5/15/97 for May 15, 1997.

Item 2 (OPD) Item 3 (ED) - DATE OF BIRTH

Record the month, day, and year of the patient's birth in figures (in the same fashion as DATE OF VISIT above). In the rare event the date of birth is unknown, estimate the year of birth as closely as possible.

Item 2 (ED) - TIME OF VISIT

Record the hour and minute in figures. For example, enter 01:15 for 1:15 A.M. or 1:15 P.M. Also, check the appropriate box (Military, AM or PM). Enter the first time appearing in the medical record (i.e., arrival/registration/triage).

Item 3 (OPD) Item 5 (ED) - SEX

Place an "X" in the appropriate category. If "Female" is checked, please answer the sub-question "Is patient pregnant?"

Item 4 (ED) - MODE OF ARRIVAL

Mode	Definition
1 Ambulance	The patient arrives in an ambulance, either air or ground. This includes private and public ambulances that have either Advanced Life Support (includes both non-invasive and invasive emergency patient care, such as defibrillation and endotracheal intubation) or Basic Life Support (includes non-invasive emergency patient care, such as CPR, controlling bleeding, splinting, and bandaging).

2 Public service	The patient arrives in a vehicle, such as a police car, a social service vehicle, beach patrol, etc. or is escorted or carried by a public service official.
3 Walk-in	The patient arrives by car, taxi, bus, or on foot.
4 Unknown	The mode of arrival is unknown.

If two modes of arrival are shown, check the highest level box--Ambulance/Public service/Walk-in.

Item 4 (OPD) Item 6 (ED)- RACE

Record based on observation or your knowledge of the patient. You are not expected to ask the patient for this information.

If the patient's race is not known or not obvious, mark the box which in your judgment is most appropriate. The definitions of the categories are listed below.

Race	**Definition**
1 White	A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.
2 Black	A person having origins in any of the black racial groups of Africa.
3 Asian/Pacific Islander	A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or Pacific Islands. This area includes, for example, China, India, Japan, Korea, the Philippine Islands, and Samoa.
4 American Indian/Eskimo/ Aleut	A person having origins in any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.

Item 5 (OPD) Item (7) - ETHNICITY

Ethnicity relates to belonging to an ethnic group - that is a person's national or cultural group. NHAMCS has two categories for ethnicity, Hispanic or Not Hispanic.

Mark the appropriate category according to your hospital's usual practices. You are not expected to ask the patient for this information. If the patient's ethnicity is not known or not obvious, mark the box which in your judgment is most appropriate. The definition of the categories are listed below.

Ethnicity	Definition
1 Hispanic Origin	A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, **regardless of race**.
2 Not Hispanic	All other persons.

Item 6 (OPD) - WAS PATIENT REFERRED BY ANOTHER PHYSICIAN OR BY A HEALTH PLAN FOR THIS VISIT?

This item provides an idea of the "flow" of ambulatory patients from one physician to another. Mark the "Yes," "No" or "Unknown" category, as appropriate.

Notice that this item concerns referrals to the sample clinic by a physician different from the one that the patient is seeing at this visit. The sample clinic may or may not be affiliated with the same health care plan as the referring physician (or referring health plan.) The interest is in referrals for *this* visit and not in referrals for any prior visit

Referrals are any visits that are made because of the advice or direction of a physician (or health plan) other than the one being visited.

Item 7 (OPD) - WAS AUTHORIZATION REQUIRED FOR CARE?

Authorization is defined as permission sought or obtained prior to medical treatment from a third party payer. Mark "Yes" if authorization for care was required. Mark "No" if authorization was not required or "Unknown" if it is not known.

Item 8 (OPD) - ARE YOU THE PATIENT'S PRIMARY CARE PHYSICIAN?

The primary care physician plans and provides the comprehensive primary health care of the patient. Check "Yes" if the health care provided to the patient during this visit was from his/her primary care physician. If the physician was substituting for the patient's primary care physician, then check "Yes." Check "No" if care was not from the primary care physician and "Unknown" if it is not known.

Item 9 (OPD) Item 8 (ED) - PRIMARY EXPECTED SOURCE OF PAYMENT FOR THIS VISIT

Mark the **primary** expected source of payment that will pay for *this visit*. This information may be in the patient's file, however, in large hospitals, the billing information may be kept in the business office.

Mark *only one* Primary Expected Source of Payment.

Primary Expected Source of Payment	Definition
1 Private insurance	Charges paid in-part or in-full by a private insurer (e.g., Blue Cross or Blue Shield) either directly to the hospital or reimbursed to the patient. Include charges covered under a private insurance sponsored prepaid plan.
2 Medicare	Charges paid in-part or in-full by a Medicare plan. Includes payments directly to the hospital and payments reimbursed to the patient. Include charges covered under a Medicare sponsored prepaid plan.
3 Medicaid	Charges paid in-part or in-full by a Medicaid plan. Includes payments made directly to the hospital and payments reimbursed to the patient. Include charges covered under a Medicaid sponsored prepaid plan.
4 Workers Compensation	A program designed to enable employees injured on the job to receive financial compensation regardless of fault.
5 Self-pay	Charges to be paid by the patient or patient's family, which will not be reimbursed by a third party. DO NOT include co-payments or deductibles. Includes visits for which the patient is expected to be ultimately responsible for most of the bill, not whether the patient actually pays the bill.
6 No Charge	Visits for which no fee is charged, e.g., charity, special research or teaching. Do not include visits paid for as part of a total care package, e.g., prepaid plan visits, postoperative visits included in a surgical fee, and pregnancy visits included in a flat fee charged for the entire pregnancy. Check the box that shows how the services were originally paid.

| 7 Other | Any other sources of payment not covered by the above categories, such as CHAMPUS, state and local governments, private charitable organizations, and other liability insurance, e.g., automobile collision policy coverage. |
| 8 Unknown | The primary source of payment is not known. |

Item 10 (OPD) Item 9 (ED) - DOES PATIENT BELONG TO AN HMO?

HMO is defined as a health care delivery system that offers comprehensive health services provided by an established panel or network of providers to a voluntarily
enrolled population for a prepaid fixed fee and whose members are required to utilize services within the panel of contracted providers. Mark "Yes" if the patient belongs to an HMO. Mark "No" if the patient does not belong to an HMO and "Unknown" if it is not known.

Item 11 (OPD) - IS THIS A CAPITATED VISIT?

Capitation is a method of payment for health services in which an individual or institutional provider is paid a fixed amount for each person served, without regard to the actual number or nature of services provided to each person in a set period of time. Capitation is the characteristic payment method in certain health maintenance organizations (HMOs). Mark "Yes" if the payment for this visit is capitated. Mark "No" if the payment is not capitated and "Unknown" if it is not known.

Item 10 (ED) -IMMEDIACY WITH WHICH PATIENT SHOULD BE SEEN

Mark the box that best meets the clinical judgement made by the practitioner (e.g., triage nurse) about the patient's need for immediacy of evaluation and/or treatment. Level is assigned upon arrival at the ED.

At the time you train the ED data abstractor, determine how the hospital's triage categories correspond to those on the PRF. Use the terms that describe each of the "immediacy" levels listed below to help you link the hospital's triage system with that of the NHAMCS. Leave an index card with the ED data abstractor which indicates how the hospital's triage categories correspond to those on the PRF. If the hospital has categories
which are not listed below, please contact your supervisor.

1 Unknown/no triage	No mention of immediacy rating or triage level in medical record or hospital does not perform triage or patient arrived DOA.
2 Less than 15 minutes	(Emergent, Stat, Severe, Immediate, Expectant, Major trauma, Major medicine) Severe illness (e.g., heart attack) or injury (e.g., spinal cord injury) requiring immediate care to combat danger to life or limb and where any delay would likely result in deterioration.
3 15-60 minutes	(Urgent, ASAP) Illness (e.g., acute asthma attack) or injury (e.g., broken leg) requiring treatment within 60 minutes. The patient is not in severe pain, and poses no threat to self or others.
4 >1 - 2 hours	(Semi-urgent, Moderate, Delayed) Illness (e.g., diarrhea) or injury (e.g., laceration) requiring treatment within 60-120 minutes.
5 > 2 - 24 hours	(Non-urgent, Minimal, Minor trauma, Minor medicine) Condition (e.g., sprained ankle) where delay of up to 24 hours would make no appreciable difference to the clinical condition, and where subsequent referral may be made to the appropriate alternative specialty.

Item 11 (ED) PRESENTING PAIN LEVEL

Mark the box that indicates the level of the patient's pain as recorded in the medical record. Assessment of pain level should be based on the Clinical Practice Guidelines published by the Agency for Health Care Policy and Research which provide a numerical pain intensity scale.

1 Unknown	Unable to determine level of pain
2 None	Numerical rating of 0
3 Mild	Numerical rating of 1-3
4 Moderate	Numerical rating of 4-6
5 Severe	Numerical rating of 7-10

Item 12 (ED) - TIME SEEN BY PHYSICIAN

Record the time (i.e., the hour and minute) when the physician began seeing the patient in figures. For example, enter 01:15 for 1:15 AM or 1:15 PM. Also check the appropriate box (Military, AM or PM).

If the patient was not seen by a physician or the time that the patient was seen is unknown, check the appropriate box.

It is very important that this item be recorded correctly. Please pay special attention the military, AM or PM boxes.

Item 12(OPD) - HAS PATIENT BEEN SEEN IN THIS CLINIC BEFORE?

"Seen" means "provided care for" at any time in the past. Mark "Yes, established patient" if the patient was seen before by another physician or staff member in the clinic. Mark "No, new patient" if the patient has not been seen in the clinic before.

Item 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

This is one of the most important items on the form. No similar national data on outpatient department visits are available anywhere and there is a tremendous interest in the findings. Please take the time to be sure you understand what is wanted - most importantly the following three points:

✦ Record the patient's principal complaint(s), symptom(s) or other reason for this visit **as stated by the patient.** The physician may recognize right away, or may find out after examination, that the real problem is something entirely different, but here we are interested in how the patient defines the reason for the visit.

✦ The item refers to the patient's complaint, symptom or other reason for **this visit**. Conceivably, the patient may be undergoing a course of treatment for a serious illness, but if his/her principal reason for this visit is a cut finger or a twisted ankle, that is the information we want.

✦ The complaint or symptom should be described in the **patient's own words**. We will obtain the physician's diagnosis in Item 16 (OPD) and in Item 15 (ED). Here we want the patient's description of the problem: "pain in the chest," "cramps after eating.

Space has been allocated for both the "most important" and two "other" complaints, symptoms, and reasons mentioned by the patient. Enter the most important in (a) and the other(s) in (b) and (c). By "most important" we mean the problem or symptom which in the physician's judgment was most responsible for the patient making this visit.

Since we are interested only in the patient's **most important complaint(s)/symptom(s)/reason(s),** it will seldom be necessary to record more than three.

There will, of course, be visits by patients for reasons other than some complaint or symptom. Examples might be :

 an annual checkup,
 routine prenatal or
 postnatal care.

In such cases, simply record the *reason for the visit.*

NOTE: Remember that if the reason for the patient's visit was only to pay a bill or ask the hospital staff to complete an insurance form or drop off a specimen, the patient is not recorded on the log and no Patient Record Form should be completed.

Item 14 (OPD) - MAJOR REASON FOR THIS VISIT?

Mark the major reason for the patient's present visit. Check only one of the following "Major Reasons."

Major Reason	**Definition**
1 Acute Problem	A condition, illness, or injury having a relatively sudden or recent onset (within three months of this visit). For injury, only include the initial visit for treatment of the injury.
2 Chronic Problem, Routine	A visit primarily to receive care or examination for a pre-existing chronic condition, illness, or injury (onset of condition was three months or more before this visit).
3 Chronic Problem, Flare-up	A visit primarily due to sudden exacerbation of a pre-existing chronic condition.
4 Pre-or Post Surgery/Injury Followup	A visit scheduled primarily for followup of a previous visit to any health care provider for treatment of the injury or for care required prior to or following surgery (e.g., pre-surgery tests, removing sutures). Include followup for treatment of injuries occurring within the last three months (e.g., removing casts). Do not include visits to determine if surgery is needed.

5 Non-Illness Care	General health maintenance examinations and routine periodic examinations of presumably healthy persons, both children and adults. Includes prenatal and postnatal care, annual physicals, well-child exams and insurance examinations.

Item 15 (OPD) Item 14 (ED) - IS THIS RELATED TO VISIT INJURY OR POISONING?

Mark the "Yes" or "No" box to indicate whether the patient's visit was due to any type of injury or poisoning. The injury/poisoning does not need to be recent. It also includes those visits for follow-up of previously treated injuries and visits for flare-ups of problems due to old injuries. Medical misadventures and adverse drug experiences are also included in this item.

If this visit is injury/poison-related, complete parts *a* through d as follows:

a) Indicate where the injury/poisoning occurred.

Place of occurrence	**Definition**
1 Residence	apartment, boarding house, farm house, house (residential), home including -- private driveway, garage, garden, walk, yard and swimming pool, noninstitution place of residence.
	exclude home under construction but not yet occupied and institutional places of residence.
2 Recreation/ sports area	all sports areas including -- baseball field, basketball court, cricket ground, fives court, football field, golf course, gymnasium, hockey field, school gymnasium or sports field, race course, riding school, rifle range, sports ground, sports palace, stadium, tennis court, swimming pool (public) amusement park, beach resort, lake resort, mountain resort, seashore, vacation resort, holiday camp, playground, public park, ice palace, skating rink.
	exclude those areas that are in a private house or garden.
3 Street or highway	freeway, motor way, pavement, road, sidewalk.

4 School	include all private, public or state schools, university, kindergarten.
	exclude recreation and sports areas located on school premises.
5 Other public building	building (including adjacent grounds) used by the general public. Includes -- airport, garage building (for car storage), station (bus or railway), bank, cafe, restaurant, casino, church, cinema, theater, opera house, dance hall, music hall, movie house, radio broadcasting station, nightclub, public hall, clubhouse market (grocery or other commodity), shop (commercial), store, courthouse, post office, hotel, office, office building.
	exclude home garage and industrial buildings.
6 Industrial places	building under construction, dockyard, dry dock, factory building or premises, industrial yard, loading platform, industrial plant, railway yard, warehouse.
7 Other	mine and quarry, including, gravel pit, sand pit, and tunnel under construction.
	residential institutions: children's home, hospital, jail, senior citizen's home, orphanage, prison, reform school.
	farm (buildings, land under cultivation, ranch).
	farmhouse and home premises of farm should be included under "Residence."

Check the "Unknown" box if the place of injury is not known.

b) Indicate whether the injury was intentional (self-inflicted or assault), unintentional, or unknown.

c) Indicate whether the injury is work related or not. Consider available information with regard to location and activity at time of injury (i.e. if location is farm, suspect work related and evaluate per criteria).

Criteria for work-related injuries:

1 On employer premises
-Engaged in work activity, apprentice, vocational training
-On break, in hallways, restroom, cafeteria, storage area
-In employer parking lot while working, arriving, or leaving

2 Off employer premises
-Working for pay or compensation, including at home
-Working as a volunteer firefighter, law enforcement officer or EMT.
-Working in family business, including family farm. Activity should be clearly
  related to a profit-oriented business
-Traveling on business, including to and from customer/business contacts
-Engaged in work activity where vehicle is considered the work environment (e.g., taxi
  driver, truck driver, etc.)

 Criteria for non work-related injuries:

 1 On employer premises

-Engaged in recreational activities on employer controlled facilities (games, etc) for
  personal enjoyment
-As a visitor for non-work purposes, not on official business

2 Off employer premises

-Homemaker working at homemaking activities
-Working for self-non profit, i.e., mowing lawn, repairing own roof, hobby, or
  recreation activities
-Student engaged in school activities
-Operating vehicle (personal or commercial) for non-work purposes
-Commuting to or from work site

d)   Describe in detail the circumstances that caused the injury (e.g. fell off monkey bars, motor
     vehicle involving collision with another car). Also, include information on the role of the
     patient associated with the injury (e.g. bicyclist, pedestrian, unrestrained driver or passenger
     in a motor vehicle, horseback rider), the specific place of occurrence (e.g., lake), and the
     activity in which the patient was engaged at the time of the injury (e.g., swimming, boating).

     Also include what happened to the patient and identify the proximate cause of the injury or
     injuries for which the patient sought treatment. The proximate cause of injury is the
     mechanism of injury that is temporarily or immediately responsible for the injury. An
     example is a laceration caused by a broken piece of glass. Include, in addition, the
     underlying or precipitating cause of injury: the event, mechanism, or external cause of injury
     that initiated and led to the proximate cause of injury. An example is a house fire that
     caused a person to jump out of the window. Both the precipitating or underlying cause
     (house fire) and the proximate cause (fall from window) would be important to record. It's
     especially important to record as much detail about falls and motor vehicle accidents as
     possible. For each, indicate what the fall was from and where the patient landed. NCHS
     will use the information collected to classify the cause of the injury using the International
     Classification of Diseases, Supplementary Classification of External Causes of Injury and
     Poisoning codes (ICD-9-CM E-Codes).

In addition to the usual types of injury-related visits for falls, laceration, burns, etc., other injury-related visits include, but are not limited to: visits for unintentional poisoning by drugs, medicinal substances, biological, other solid and liquid substances, gases, and vapors; adverse reaction to drugs, medicinal substances, biologicals; complications of surgical and medical procedures; and insect and animal bites.

Item 16 (OPD) Item 15 (ED) - PHYSICIAN'S DIAGNOSES FOR THIS VISIT

1. **Primary diagnosis**
2. **Other**
3. **Other**

This is one of the most important items on the Patient Record Form. Item 16-1 (OPD) and 15-1 (ED) refer to the physician's primary diagnosis for this visit. While the diagnosis may be tentative, provisional or definitive, it should represent the physician's best judgement at this time, expressed in acceptable medical terminology including "problem" terms. If the patient was not seen by a physician, then the diagnosis by the main medical provider should be recorded.

If a patient appears for *postoperative* care (follow-up visit after surgery), record the postoperative diagnosis and any other. The postoperative diagnosis should be shown with the letters (P.O.).

Space has been allotted for two "other" diagnoses. In Items 16-2 and 16-3 (OPD) and in 15-2 and 15-3 (ED), list the *other conditions related to this visit or related to the choice of treatment or medications ordered or provided for the patient at this time.* Include chronic conditions (e.g., hypertension, depression, etc.), if related to this visit.

Item 17 (OPD) Item 16 (ED) - DIAGNOSTIC/SCREENING SERVICES

Mark all services that were ordered or provided during *this* visit for the purpose of screening (i.e., early detection of health problems in asymptomatic individuals) or diagnosis (i.e., identification of health problems causing individuals to be symptomatic). During a visit for complete physical exam, several services may be ordered or provided. **EACH SERVICE SHOULD BE MARKED.**

If services were ordered or provided but not listed, mark the "All other" box and specify the type of diagnostic tests in the space(s) provided.

Mark the "None" box, if no Examinations, Tests and Measurements, or Imaging were ordered or provided.

Item 18 (OPD) - THERAPEUTIC AND PREVENTIVE SERVICES

Counseling/Education   Mark all appropriate boxes for any of the following types of counseling, advice, education, instructions, or recommendations to the patient that were ordered or provided during the visit:

Diet/nutrition - any topic related to the foods and/or beverages consumed by the patient. Examples include general dietary guidelines for health promotion and disease prevention, dietary restrictions to treat or control a specific medical problem or condition, and dietary instructions related to medications.

Includes referrals to other health professionals, for example, dietitians and nutritionists.

Exercise - any topics related to the patient's physical conditioning or fitness. Examples include information aimed at general health promotion and disease prevention and information given to treat or control a specific medical condition. Includes referrals to other health and fitness professionals. Does not include referrals for physiotherapy. Physiotherapy ordered or provided at the visit is listed as a separate checkbox under "Other Therapy."

HIV/STD transmission - information intended to help the patient understand how HIV (human immunodeficiency virus) or STDs (sexually transmitted diseases) are transmitted. Includes topics such as "safe sex," IV drug use, and exchange of bodily fluids.

Family planning/contraception - information given to the patient to assist in conception or intended to help the patient understand how to prevent conception.

Prenatal instructions - information given to the mother during her entire pregnancy on the growth and development of the fetus and its chances for survival and good health after birth. Includes information about the mother's dietary intake, her weight, other factors affecting the fetus such as alcohol and certain drugs taken by the mother during pregnancy, and diseases that increase the risk of obstetrical complications such as diabetes, heart disease, hypertension, kidney disease, and anemia.

Breast self-exam - information given to the patient instructing her when and how to perform a simple self-examination of the breast.

Tobacco use/exposure - information given to the patient on issues related to tobacco use in any form, including cigarettes, cigars, snuff, and chewing tobacco, and on the exposure to tobacco in the form of "secondhand smoke." Includes information on

smoking cessation as well as prevention of tobacco use. Includes referrals to other health professionals for smoking cessation programs.

Growth/development - any topics related to human growth and development.

Mental health - general advice or counseling about mental health issues; education about mental disorders. Includes referrals to other mental health professionals for mental health counseling.

Stress management - information intended to help patient reduce stress through exercise, biofeedback, yoga, etc. Includes referrals to other health professionals for the purpose of health stress coping mechanisms.

Skin cancer prevention - information intended to help the patient understand strategies for reducing exposure to the sun and its effects. Includes information on sunbathing and the use of sunscreens.

Injury prevention - any topic aimed at minimizing the chances of injury in one's daily life. May include issues as diverse as drinking and driving, child safety; avoidance of injury through proper techniques for various physical activities, etc.

Other Therapy   Mark all appropriate boxes for therapeutic services (excluding medication) ordered or provided. Examples include:

Psychotherapy - All *treatments* involving the intentional use of verbal techniques to explore or alter the patient's emotional life in order to effect symptom reduction or behavior change.

Psycho-pharmacotherapy - All *treatments* involving the intentional use of medicinal techniques to explore or alter the patient's emotional life in order to effect symptom reduction or behavior change.

Physiotherapy - Any form of physical therapy including treatments using heat, light, sound, or physical pressure or movement. For example: ultrasonic, ultraviolet, infrared, whirlpool, diathermy, cold and manipulative therapy.

All specific forms of medication are excluded because that information is collected in Item 20 (OPD) and Item 18 (ED).

If services were ordered or provided, but not listed, mark the "All other" box and specify in the space(s) provided.

Mark the "None" box, if no services were ordered or provided.

Item 19 (OPD) - AMBULATORY SURGICAL PROCEDURES

Record the specific name of up to two ambulatory surgical procedures *actually performed* at the visit. Routine surgical procedures (e.g. wound care) as well as more complex procedures (e.g., cataract extraction, vasectomy, hernia repair, growth removal, etc.) should be reported. Any procedure designated in the ICD-9-CM Volume 3 as a surgical procedure may be recorded. Diagnostic surgical procedures such as biopsy should also be recorded.

Mark the "None" box, if no surgical procedures were performed.

Item 17 (ED) - PROCEDURES

Mark all procedures provided on *this visit*.

1   NONE - No procedures were ordered or provided this visit.

2   ENDOTRACHEAL INTUBATION - Insertion of a laryngoscope into the mouth followed by a tube into the trachea.

3   CPR - Cardiopulmonary resuscitation.

4   IV FLUIDS - Administration of intravenous fluids.

5   NG TUBE - Insertion of a nasogastric (NG) tube through the nose, down the esophagus and into the stomach.

GASTRIC LAVAGE - Passage of a solution through the inflow tube into the nose, down the esophagus and into the stomach where the gastric contents are irrigated and returned through an outflow tube.

6   LUMBAR PUNCTURE - Insertion of a needle into the lumbar spine to extract spinal fluid for laboratory examination.

7   BLADDER CATHETER - Any type of catheter used to catheterize the bladder, for example, Foley.

8   WOUND CARE - Includes cleaning, debridement, and dressing of burns; repair of lacerations with skin tape or sutures; removal of foreign bodies; excisions; and incision and drainage of wounds.

9   EYE/ENT CARE - Care provided to the eyes, ears, nose, and throat; includes measurement of intraocular pressure in the eyes, removal of ear wax, removal of foreign bodies, nasal packing, and laryngoscopy.

10   ORTHOPEDIC CARE - Treatment of orthopedic injuries or conditions; includes casting, wrapping, splinting, and aspiration of fluid from joints.

11   OB/GYN CARE - Treatment of obstetric or gynecologic conditions, including routine care.

12   OTHER - Record all other diagnostic and/or treatment procedures provided this visit. Up to three procedures may be entered.

Mark the "Other" box and specify the type of procedure in the space provided if procedures were provided but not listed.

Mark the "None" box, if no procedures were provided.

Item 20 (OPD) Item 18 (ED) - MEDICATIONS/INJECTIONS

List up to 6 medications that were ordered, supplied, administered, or continued during this visit, using either brand or generic names.

Medication, broadly defined, includes the specific name of any:

♦ prescription *and* non-prescription medication;
♦ injections;
♦ topical preparations;
♦ suppositories
♦ allergy shots;
♦ immunizations;
♦ hormones;
♦ vitamins;
♦ anesthetics;
♦ drugs and medications that the physician ordered or provided *prior to this visit and instructs or expects* the patient to continue taking regardless of whether a "refill" is provided at the time of visit.

Record the exact drug name (brand or generic) written on any prescription or in the patient's medical record.

Do not enter broad drug classes, such as "laxative," "cough preparation," "analgesic," "birth control pills," or "antibiotics." The one exception is "allergy shot."

Limit entries to **drug name only**. Additional information such as dosage strength or regimen is **not** required. For example, the medication might be in the forms of pills, injections, salves or ointments, drops, suppositories, powders, or skin patch, but this information should not be entered on the Patient Record Form.

Mark the "None" box, if no medications were prescribed or provided during this visit.

Item 19(ED) - VISIT DISPOSITION

Mark all categories that apply to where the patient went after he/she left the emergency department.

1 No follow-up planned	No return visit or telephone contact was scheduled or planned for the patient's problem.
2 Return to ED, P.R.N/appointment	The patient was instructed to return to the ED as needed; or the patient was told to schedule an appointment or was given an appointment to return to the ED at a particular time.
3 Returned to referring physician	The patient was referred to the ED by his/her personal physician or some other physician and is now instructed to consult again with the physician who made the referral.
4 Referred out from triage without treatment	The patient was screened but his/her condition did not warrant ED evaluation or treatment. The patient was referred to another health care provider for diagnostic evaluation and treatment.
5 Referred to other physician/clinic for follow-up	The patient was screened, evaluated, stabilized and then referred to another clinic for followup physician or clinic for followup.
6 Left before being seen	The patient left the hospital after being triaged, but before receiving any medical care.
7 Admitted to hospital	The patient or person accompanying the patient was instructed that further care or treatment will be provided as an inpatient in the hospital.
8 Admitted to ICU/CCU	The patient was admitted to the Intensive Care Unit, Critical Care Unit or Coronary Care Unit of the hospital.
9 Transferred to other facility	The patient was transferred to a facility other than a facility operated under the auspices of this hospital (e.g., jail, drug or alcohol detoxification, another hospital).

10 DOA/died in ED	If the patient was dead on arrival (DOA) or died in the ED, this patient is still included in the sample if listed on the arrival log.
11 Referred to social services	The patient was referred to social services. Include both social services provided by the hospital as well as services provided in the community.
12 Other	Any other disposition of the case not included in the categories above. For example, a patient who was instructed to telephone the ED to report on his/her progress.

Mark "Other" if none of the eleven boxes apply and specify the type of disposition.

Item 21(OPD) Item 20 (ED) - PROVIDERS SEEN THIS VISIT

Mark all providers seen during this visit. Mark the "Other" box if care was provided, at least in part, by a person not represented in the nine categories.

Item 22(OPD) - TIME SPENT WITH PHYSICIAN

Include here the length of time the physician spent with the patient. DO NOT include time the patient spent waiting to see the physician or receiving care from someone other than the physician. For example, DO NOT include the time the nurse spent giving the patient an inoculation or the time a technician spent administering an electrocardiogram. It is entirely possible that for visits such as these, the patient would not see the doctor at all. In that case, "0" minutes should be recorded. DO NOT include time spent <u>on</u> the patient, but not <u>with</u> the patient, such as time spent reviewing the patient's medical records or test results <u>before</u> seeing the patient. The intent of this item is to get the total time spent in face-to-face contact with the *physician*.

If more than one patient is seen by the doctor at the same time, apply the following rule:

If the doctor can easily separate the time spent with each (e.g., 3 minutes with one and 27 minutes with the other), he/she should record that on the Patient Record Forms. If the doctor cannot easily estimate how much time was spent with each, he/she should divide the total time equally among the patients seen together.