

# SAMPLE

## National Hospital Ambulatory Medical Care Survey 2020 EMERGENCY DEPARTMENT PATIENT RECORD

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### PATIENT INFORMATION

<b>Patient medical record number</b>				<b>ZIP Code</b>				<b>Date of birth</b>																																													
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<b>Date and time of visit</b>				<b>Patient residence</b>				<b>Sex</b>		<b>Ethnicity</b>		<b>Age</b>																																									
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<b>Arrival by ambulance</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown <i>SKIP to Expected source(s) of payment</i>				<b>Was patient transferred from another hospital or urgent care facility?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown 4 <input type="checkbox"/> Not applicable				<b>Expected source(s) of payment for THIS VISIT – Mark (X) all that apply.</b> 1 <input type="checkbox"/> Private insurance 2 <input type="checkbox"/> Medicare 3 <input type="checkbox"/> Medicaid or CHIP or other state-based program 4 <input type="checkbox"/> Workers' compensation 5 <input type="checkbox"/> Self-pay 6 <input type="checkbox"/> No charge/Charity 7 <input type="checkbox"/> Other 8 <input type="checkbox"/> Unknown																																													

### TRIAGE

<b>Initial vital signs</b>		Temperature <input style="width: 50px;" type="text"/> 1 <input type="checkbox"/> °C 2 <input type="checkbox"/> °F	Heart rate <i>Enter "998" for DOPP or DOPPLER.</i> <input style="width: 50px;" type="text"/> beats per minute	Respiratory rate <input style="width: 50px;" type="text"/> breaths per minute	<b>Triage level (1-5)</b> <i>Enter "0" if no triage. Enter "9" if unknown.</i>	<b>Pain scale (0-10)</b> <i>Enter "99" if unknown.</i>
Blood pressure Systolic <input style="width: 50px;" type="text"/> / Diastolic <input style="width: 50px;" type="text"/>	Pulse oximetry <input style="width: 50px;" type="text"/> % Percent of oxyhemoglobin saturation; value is usually between 80–100%.	<b>Was patient seen in this ED within the last 72 hours?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown		<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	

### REASON FOR VISIT

<b>List the first 5 reasons for visit (i.e., complaint(s), symptom(s), problem(s), concern(s) of the patient) in the order in which they appear. Start with the chief complaint and then move to the patient history or history of present illness (HPI) for additional reasons.</b>		<b>Episode of care</b> 1 <input type="checkbox"/> Initial visit to this ED for problem 2 <input type="checkbox"/> Follow-up visit to this ED for problem 3 <input type="checkbox"/> Unknown
(1) Most important:	<input style="width: 100%; height: 20px;" type="text"/>	
(2) Other:	<input style="width: 100%; height: 20px;" type="text"/>	
(3) Other:	<input style="width: 100%; height: 20px;" type="text"/>	
(4) Other:	<input style="width: 100%; height: 20px;" type="text"/>	
(5) Other:	<input style="width: 100%; height: 20px;" type="text"/>	

### INJURY

<b>Is this visit related to an injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment?</b> 1 <input type="checkbox"/> Yes, injury/trauma 2 <input type="checkbox"/> Yes, overdose/poisoning 3 <input type="checkbox"/> Yes, adverse effect of medical or surgical treatment or adverse effect of medicinal drug 4 <input type="checkbox"/> No 5 <input type="checkbox"/> Unknown <i>SKIP to Diagnosis</i>	<b>Did the injury/trauma, overdose/poisoning, or adverse effect occur within 72 hours prior to the date and time of this visit?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown <i>For adverse effect SKIP to Cause</i>	<b>Is this injury/trauma or overdose/poisoning intentional or unintentional?</b> 1 <input type="checkbox"/> Intentional 2 <input type="checkbox"/> Unintentional (e.g., accidental) 3 <input type="checkbox"/> Intent unclear	<b>What was the intent of the injury/trauma or overdose/poisoning?</b> 1 <input type="checkbox"/> Suicide attempt with intent to die 2 <input type="checkbox"/> Intentional self-harm without intent to die 3 <input type="checkbox"/> Unclear if suicide attempt or intentional self-harm without intent to die 4 <input type="checkbox"/> Intentional harm inflicted by another person (e.g., assault, poisoning) 5 <input type="checkbox"/> Intent unclear
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**Cause of injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment** – Describe the place and circumstances that preceded the event. Examples: **1** – Injury/trauma (e.g., patient fell while walking down stairs at home and sprained her ankle; patient was bitten by a spider); **2** – Overdose/poisoning (e.g., 4 year old child was given adult cold/cough medication and became lethargic; child swallowed large amount of liquid cleanser and began vomiting); **3** – Adverse effect (e.g., patient developed a rash on his arm 2 days after taking penicillin for an ear infection)

### DIAGNOSIS

<b>As specifically as possible, list diagnoses related to this visit including chronic conditions. List PRIMARY diagnosis first.</b>	<b>Does patient have – Mark (X) all that apply.</b>	
(1) Primary diagnosis:	1 <input type="checkbox"/> Alcohol misuse, abuse, or dependence 2 <input type="checkbox"/> Alzheimer's disease/Dementia 3 <input type="checkbox"/> Asthma 4 <input type="checkbox"/> Cancer 5 <input type="checkbox"/> Cerebrovascular disease/History of stroke (CVA) or transient ischemic attack (TIA) 6 <input type="checkbox"/> Chronic kidney disease (CKD) 7 <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD) 8 <input type="checkbox"/> Congestive heart failure (CHF) 9 <input type="checkbox"/> Coronary artery disease (CAD), ischemic heart disease (IHD) or history of myocardial infarction (MI) 10 <input type="checkbox"/> Depression	11 <input type="checkbox"/> Diabetes mellitus (DM), Type 1 12 <input type="checkbox"/> Diabetes mellitus (DM), Type 2 13 <input type="checkbox"/> Diabetes mellitus (DM), Type unspecified 14 <input type="checkbox"/> End-stage renal disease (ESRD) 15 <input type="checkbox"/> History of pulmonary embolism (PE), deep vein thrombosis (DVT), or venous thromboembolism (VTE) 16 <input type="checkbox"/> HIV infection/AIDS 17 <input type="checkbox"/> Hyperlipidemia 18 <input type="checkbox"/> Hypertension 19 <input type="checkbox"/> Obesity 20 <input type="checkbox"/> Obstructive sleep apnea (OSA) 21 <input type="checkbox"/> Osteoporosis 22 <input type="checkbox"/> Substance abuse or dependence 23 <input type="checkbox"/> None of the above
(2) Other:	<input style="width: 100%; height: 20px;" type="text"/>	
(3) Other:	<input style="width: 100%; height: 20px;" type="text"/>	
(4) Other:	<input style="width: 100%; height: 20px;" type="text"/>	
(5) Other:	<input style="width: 100%; height: 20px;" type="text"/>	

**DIAGNOSTIC SERVICES**

**Diagnostic Services – Mark (X) all Laboratory tests, Other tests, and Imaging ORDERED or PROVIDED.**

- 1  NONE
- Laboratory tests:**
- 2  Arterial blood gases (ABG)
- 3  BAC (Blood alcohol concentration)
- 4  Basic metabolic panel (BMP)
- 5  BNP (brain natriuretic peptide)
- 6  Creatinine/Renal function panel
- 7  Cardiac enzymes
- 8  CBC
- 9  Comprehensive metabolic panel (CMP)
- 10  Culture, blood
- 11  Culture, throat
- 12  Culture, urine
- 13  Culture, wound
- 14  Culture, other
- 15  D-dimer
- 16  Electrolytes
- 17  Glucose, serum
- 18  Lactate
- 19  Liver enzymes/Hepatic function panel
- 20  Prothrombin time (PT/PTT/INR)
- 21  Other blood test
- Other tests:**
- 22  Cardiac monitor
- 23  EKG/ECG
- 24  HIV test
- 25  Influenza test
- 26  Pregnancy/HCG test
- 27  Toxicology screen
- 28  Urinalysis (UA) or urine dipstick
- 29  Other test/service
- Imaging:**
- 30  X-ray
- 31  CT scan  
Was CT ordered/provided with intravenous (IV) contrast?  
1  Yes  
2  No  
3  Unknown
- 32  MRI  
Was MRI ordered/provided with intravenous (IV) contrast (also written as "with gadolinium" or "with gado")?  
1  Yes  
2  No  
3  Unknown
- 33  Ultrasound  
Who performed the ultrasound?  
1  Emergency physician  
2  Other provider
- 34  Other imaging

**MEDICATIONS & IMMUNIZATIONS**

**List up to 30 drugs given at this visit or prescribed at ED discharge. Include Rx and OTC drugs, immunizations, and anesthetics.**

	When given? Mark (X) all that apply.	
	Given in ED	Rx at discharge
<input type="checkbox"/> NONE		
(1)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(2)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(3)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(4)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(5)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
	1 <input type="checkbox"/>	2 <input type="checkbox"/>
	1 <input type="checkbox"/>	2 <input type="checkbox"/>
	1 <input type="checkbox"/>	2 <input type="checkbox"/>
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	1 <input type="checkbox"/>	2 <input type="checkbox"/>
	1 <input type="checkbox"/>	2 <input type="checkbox"/>
	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(30)	1 <input type="checkbox"/>	2 <input type="checkbox"/>

**PROCEDURES**

**Procedures – Mark (X) all PROVIDED at this visit. (Exclude medications.)**

- 1  NONE
- 2  BIPAP/CPAP
- 3  Bladder catheter
- 4  Cast, splint, wrap
- 5  Central line
- 6  CPR
- 7  Endotracheal intubation
- 8  Incision & drainage (I&D)
- 9  IV fluids
- 10  Lumbar puncture (LP)
- 11  Nebulizer therapy
- 12  Pelvic exam
- 13  Skin adhesives
- 14  Suturing/Staples
- 15  Other

**VITALS AFTER TRIAGE**

**PROVIDERS**

**DISPOSITION**

**Does the chart contain vital signs taken after triage?**

- 1  Yes
  - 2  No
- Temperature  1  °C 2  °F
- Heart rate Enter "998" for DOPP or DOPPLER.  beats per minute
- Respiratory rate  breaths per minute
- Blood pressure Systolic  Diastolic

Mark (X) all providers seen at this visit.

- 1  ED attending physician
- 2  ED resident/Intern
- 3  Consulting physician
- 4  RN/LPN
- 5  Nurse practitioner
- 6  Physician assistant
- 7  EMT
- 8  Other mental health provider
- 9  Other

Mark (X) all that apply.

- 1  No follow-up planned
- 2  Return to ED
- 3  Return/Refer to physician/clinic for FU
- 4  Left without being seen (LWBS)
- 5  Left before treatment complete (LBTC)
- 6  Left AMA
- 7  DOA
- 8  Died in ED
- 9  Return/Transfer to nursing home
- 10  Transfer to psychiatric hospital
- 11  Transfer to non-psychiatric hospital
- 12  Admit to this hospital
- 13  Admit to observation unit then hospitalized
- 14  Admit to observation unit, then discharged
- 15  Other

**OBSERVATION UNIT STAY**

**Date and time of observation unit/care initiation order**

**Date and time of observation unit/care discharge order**

Month	Day	Year	Time	a.m.	p.m.	Military
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Month	Day	Year	Time	a.m.	p.m.	Military
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**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.

**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

**Date and time of admit order**

Month	Day	Year	Time	a.m.	p.m.	Military
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Admitting physician**

- 1  Hospitalist
- 2  Not hospitalist
- 3  Unknown

**Hospital discharge date**

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

**Principal hospital discharge diagnosis**

1  Unknown

**Hospital discharge status/disposition**

- 1  Alive
- 2  Dead
- 3  Unknown
- 4  Home/Residence
- 5  Return/Transfer to nursing home
- 6  Transfer to another facility (not usual place of residence)
- 7  Other
- 8  Unknown