

SAMPLE

NATIONAL HOSPITAL CARE SURVEY – AMBULATORY PRETEST EMERGENCY DEPARTMENT PATIENT RECORD

OMB No. 0920-094; Expiration date 12/31/2013

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).

PATIENT INFORMATION

Patient's name		Patient's SS#		Patient's Control #						
Patient's residential address: Street			City		State					
Patient's medical record number		Medicare health insurance benefit/claim number								
National Provider Identifier (NPI) – Attending			National Provider Identifier (NPI) – Operating							
Arrival	Date of Visit		Time		a.m.	p.m.	Mil.	Ethnicity		Sex
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino	1 <input type="checkbox"/> Female 2 <input type="checkbox"/> Male	
Seen by MD/DO/PA/NP	<input type="text"/>		<input type="text"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mode of arrival 1 <input type="checkbox"/> Ambulance 2 <input type="checkbox"/> Police transport 3 <input type="checkbox"/> Other 4 <input type="checkbox"/> Unknown		
ED Departure, if released or transferred (i.e., patients who do not have a disposition of admit to hospital or admit to observation unit)	<input type="text"/>		<input type="text"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Zip Code		Patient Residence			Race			Expected source(s) of payment for this visit. Mark (X) all that apply.		
<input type="text"/>		1 <input type="checkbox"/> Private residence 2 <input type="checkbox"/> Institution <input type="checkbox"/> Nursing home <input type="checkbox"/> Supportive housing/ Group home <input type="checkbox"/> Jail/Prison <input type="checkbox"/> Other 3 <input type="checkbox"/> Homeless/Homeless shelter 4 <input type="checkbox"/> Other 5 <input type="checkbox"/> Unknown			1 <input type="checkbox"/> White 2 <input type="checkbox"/> Black or African American 3 <input type="checkbox"/> Asian 4 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 5 <input type="checkbox"/> American Indian or Alaska Native			<input type="checkbox"/> Private insurance <input type="checkbox"/> TRICARE <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid or CHIP <input type="checkbox"/> Worker's compensation <input type="checkbox"/> Self-pay <input type="checkbox"/> No charge/charity <input type="checkbox"/> Other <input type="checkbox"/> Unknown		
Date of Birth		Age			Date of Birth			Age		
Month	Day									
<input type="text"/>		<input type="text"/>			<input type="text"/>			<input type="text"/>		

TRIAGE

PREVIOUS CARE

Initial vital signs				Was patient seen in <i>this</i> ED in the last 72 hours and discharged? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown
Temperature <input type="text"/> Celsius <input type="text"/> Fahrenheit	Heart rate/Pulse <input type="text"/> beats per minute 998= P, PALP, DOPP, DOPPLER	Respiratory rate <input type="text"/> breaths per minute	Blood pressure <input type="text"/> Systolic <input type="text"/> Diastolic 998= P, PALP, DOPP, DOPPLER	
Pulse oximetry <input type="text"/> Percent	On oxygen on arrival 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown	Triage level (1-5) <input type="text"/> <input type="checkbox"/> No triage <input type="checkbox"/> Unknown	Pain scale (0-10) <input type="text"/> <input type="checkbox"/> Unknown	

REASON FOR VISIT

<p>Enter the patient's presenting complaint(s), symptom(s), or other reason(s) for this visit in the patient's own words. Enter the source of "most important" complaint/symptom/reason first.</p> <p>(1) Most important: _____</p> <p>Source of most important reason for visit <input type="checkbox"/> In patient's own words <input type="checkbox"/> Other <input type="checkbox"/> Unknown</p> <p>(2) Other: _____</p> <p>(3) Other: _____</p> <p>(4) Other: _____</p>	<p>Episode of care</p> <p>1 <input type="checkbox"/> Initial visit to this ED for problem</p> <p>2 <input type="checkbox"/> Follow-up visit to this ED for problem</p> <p>3 <input type="checkbox"/> Unknown</p>
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INJURY/OVERDOSE/POISONING/ADVERSE EFFECT

Is this visit related to an injury, overdose, poisoning, or adverse effect of medical or surgical treatment?

- 1 No, SKIP to SUBSTANCES INVOLVED
- 2 Yes, injury/trauma
- 3 Yes, poisoning (non-drug toxic substance)
- 4 Yes, poisoning (drug-induced overdose)
 - a. Medication
 - b. Illicit substance
 - c. Unknown
- 5 Yes, adverse effect of medical or surgical treatment
 - a. Medication involved
SKIP to CAUSE OF INJURY
 - b. No medication involved
SKIP to CAUSE OF INJURY
- 6 Unknown
SKIP to SUBSTANCES INVOLVED

Is this injury/overdose/poisoning intentional?

- 1 Yes, intentional
 - a. Self-inflicted
 - Suicide attempt
 - Self-harm or suicide gesture
 - b. Intentional harm by another person
- 2 No, unintentional (e.g., accidental)
- 3 Unknown intent

Cause of injury, poisoning by drug or non-drug toxin, drug-induced illness, or adverse effect – Describe the place and events that preceded the injury (e.g., pedestrian struck by car driven on highway by drunk driver - for motor vehicle crash, indicate if it occurred on the street or highway versus a driveway or parking lot); poisoning by drug (e.g., injected heroin at nightclub restroom and overdosed) or non-drug toxin (e.g., child swallowed bleach at home); or adverse effect (e.g., developed swelling of the throat after taking Celebrex). Enter the primary cause on the first line, followed by the contributing causes. Up to 5 causes may be entered.

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

SUBSTANCES INVOLVED/ROUTE OF ADMINISTRATION

Did any substance(s) (e.g., illicit drugs, inhalants, prescription or OTC medications, dietary supplement) cause or contribute to this visit? OR The patient is under 21 and alcohol is the only drug related to the visit.

- 1 Yes
- 2 No, SKIP to DIAGNOSIS
- 3 Unknown/Not documented
SKIP to DIAGNOSIS

Enter all substances that caused or contributed to the ED visit. Record substances as specifically as possible (i.e., brand [trade] name preferred over generic name preferred over chemical name, etc.). Do not record the same substance by two different names. Do not record current medications unrelated to the visit. Up to 16 substances may be entered.

(1) _____

(2) _____

(3) _____

Was alcohol involved?

- 1 Yes
- 2 No
- 3 Not documented

For each substance listed, mark if confirmed by toxicology report.

- 1 Yes
- 2 No
- 3 Not documented

For each substance listed, mark the route of administration.

- 1 Oral
- 2 Injected
- 3 Inhaled, sniffed, snorted
- 4 Smoked
- 5 Transdermal
- 6 Other
- 7 Not documented

Patient took:

Mark (X) all that apply:

- 1 Own prescription/OTC medication or dietary supplement
- 2 Prescription medication not prescribed for patient
- 3 Prescription/OTC medication as prescribed or according to directions
- 4 Too much of a prescription/OTC medication or dietary supplement
- 5 Illicit drug(s)
- 6 Alcohol only, under 21 (SKIP TO DIAGNOSIS)
- 7 Not documented

DIAGNOSIS

As specifically as possible, enter up to 20 diagnoses related to this visit, including chronic conditions.

(1) Primary diagnosis: _____

(2) Other: _____

(3) Other: _____

(4) Other: _____

(5) Other: _____

(6) Other: _____

(7) Other: _____

(8) Other: _____

(9) Other: _____

(10) Other: _____

Does patient have:

Mark (X) all that apply.

- 1 Cancer
- 2 Cerebrovascular disease/History of stroke or transient ischemic attack (TIA)
- 3 Chronic obstructive pulmonary disease (COPD)
- 4 Conditions requiring dialysis
- 5 Congestive heart failure (CHF)
- 6 Dementia
- 7 Diabetes
- 8 History of heart attack or myocardial infarction (MI)
- 9 History of pulmonary embolism (PE) or deep vein thrombosis (DVT)
- 10 HIV infection/AIDS
- 11 Mental illness or episode
 - Bipolar disorder/Manic depression
 - Depression, excluding manic depression
 - Schizophrenia
 - Suicidal ideation
 - Other
- 12 Substance abuse, misuse, or dependence
- 13 None of the above
- 14 Not documented

SERVICES			PROCEDURES	
Mark all ORDERED or PROVIDED at this visit.			Mark all procedures PROVIDED at this visit. Exclude medications.	
1 <input type="checkbox"/> NONE Blood tests: 2 <input type="checkbox"/> ABG (arterial blood gases) 3 <input type="checkbox"/> BAC (blood alcohol concentration) _____ % 4 <input type="checkbox"/> Blood culture 5 <input type="checkbox"/> BNP (brain natriuretic peptide) 6 <input type="checkbox"/> BUN/Creatinine 7 <input type="checkbox"/> Cardiac enzymes (CE) 8 <input type="checkbox"/> CBC (complete blood count) 9 <input type="checkbox"/> D-dimer 10 <input type="checkbox"/> Electrolytes 11 <input type="checkbox"/> Glucose 12 <input type="checkbox"/> Lactate 13 <input type="checkbox"/> Liver function tests (LFT) 14 <input type="checkbox"/> Prothrombin time/INR 15 <input type="checkbox"/> Other blood test	Other tests: 16 <input type="checkbox"/> Cardiac monitor 17 <input type="checkbox"/> EKG/ECG 18 <input type="checkbox"/> HIV test 19 <input type="checkbox"/> Influenza test 20 <input type="checkbox"/> Pregnancy/HCG test 21 <input type="checkbox"/> Toxicology screen 22 <input type="checkbox"/> Urinalysis (UA) or urine dipstick 23 <input type="checkbox"/> Urine culture 24 <input type="checkbox"/> Wound culture 25 <input type="checkbox"/> Other test/service	Imaging: 26 <input type="checkbox"/> X-ray 27 <input type="checkbox"/> Intravenous contrast 28 <input type="checkbox"/> CT scan <input type="checkbox"/> Abdomen/pelvis <input type="checkbox"/> Chest <input type="checkbox"/> Head <input type="checkbox"/> Other 29 <input type="checkbox"/> MRI 30 <input type="checkbox"/> Ultrasound Performed by: <input type="checkbox"/> Emergency physician <input type="checkbox"/> Other <input type="checkbox"/> Unknown 31 <input type="checkbox"/> Other Imaging	1 <input type="checkbox"/> NONE 2 <input type="checkbox"/> BIPAP/CPAP 3 <input type="checkbox"/> Bladder catheter 4 <input type="checkbox"/> Cast, splint, or wrap 5 <input type="checkbox"/> Central line 6 <input type="checkbox"/> CPR 7 <input type="checkbox"/> Endotracheal intubation 8 <input type="checkbox"/> Incision & drainage (I&D) 9 <input type="checkbox"/> IV fluids 10 <input type="checkbox"/> Lumbar puncture 11 <input type="checkbox"/> Nebulizer therapy 12 <input type="checkbox"/> Pelvic exam 13 <input type="checkbox"/> Physical restraint 14 <input type="checkbox"/> Psychiatry/Psychology/ Substance abuse consult 15 <input type="checkbox"/> Skin adhesives 16 <input type="checkbox"/> Suturing/Staples 17 <input type="checkbox"/> Other	
MEDICATIONS & IMMUNIZATIONS			PROVIDERS	
Enter drugs given at this visit or prescribed at ED discharge. Include Rx and OTC drugs, immunizations, and anesthetics.			Mark (X) all providers seen at this visit.	
<input type="checkbox"/> NONE (1) _____ (2) _____ (3) _____ (4) _____ (5) _____ (6) _____ (7) _____ (8) _____ (9) _____ (10) _____ (11) _____ (12) _____	Given in ED	Rx at discharge	1 <input type="checkbox"/> ED attending physician 2 <input type="checkbox"/> ED resident or Intern 3 <input type="checkbox"/> Consulting physician → Specialty of consulting physician 4 <input type="checkbox"/> RN/LPN 5 <input type="checkbox"/> Nurse practitioner 6 <input type="checkbox"/> Physician assistant 7 <input type="checkbox"/> EMT 8 <input type="checkbox"/> Psychologist 9 <input type="checkbox"/> Social worker 10 <input type="checkbox"/> Other mental health provider 11 <input type="checkbox"/> Other provider 1 <input type="checkbox"/> Anesthesia 2 <input type="checkbox"/> Critical care 3 <input type="checkbox"/> ENT (Otolaryngology) 4 <input type="checkbox"/> Hematology/Oncology 5 <input type="checkbox"/> Palliative care 6 <input type="checkbox"/> Psychiatry 7 <input type="checkbox"/> Other specialty 8 <input type="checkbox"/> Unknown	
VISIT DISPOSITION				
Mark (X) all that apply. 1 <input type="checkbox"/> No follow-up planned 2 <input type="checkbox"/> Return to ED 3 <input type="checkbox"/> Return/Refer to physician/clinic for <input type="checkbox"/> Outpatient mental health treatment <input type="checkbox"/> Substance abuse treatment <input type="checkbox"/> Other follow-up 4 <input type="checkbox"/> Left before triage 5 <input type="checkbox"/> Left after triage 6 <input type="checkbox"/> Left AMA 7 <input type="checkbox"/> DOA 8 <input type="checkbox"/> Died in ED 9 <input type="checkbox"/> Return/Transfer to nursing home	10 <input type="checkbox"/> Return/Transfer to jail/prison 11 <input type="checkbox"/> Transfer to acute 24-hour behavioral health care facility a. <input type="checkbox"/> Psychiatric inpatient treatment <input type="checkbox"/> Involuntary status <input type="checkbox"/> Voluntary status <input type="checkbox"/> Not documented b. <input type="checkbox"/> Substance abuse treatment facility 12 <input type="checkbox"/> Transfer to other non-psychiatric hospital → 13 <input type="checkbox"/> Admit to this hospital 14 <input type="checkbox"/> Admit to observation unit then hospitalized 15 <input type="checkbox"/> Admit to observation unit then discharged 16 <input type="checkbox"/> Other		Reason for transfer 1 <input type="checkbox"/> Continuity of care/Request by patient, family, or physician 2 <input type="checkbox"/> Higher level or specialized care needed 3 <input type="checkbox"/> Pediatric hospital needed 4 <input type="checkbox"/> Insurance requirement/request 5 <input type="checkbox"/> Other/Insufficient information available	

HOSPITAL ADMISSION

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 bed was requested for hospital admission or transfer

Month	Day	Year	Time	a.m.	p.m.	Military
□	□	□	□ □ : □ □	□	□	□

Date and time patient actually left the ED or observation unit

Month	Day	Year	Time	a.m.	p.m.	Military
□	□	□	□ □ : □ □	□	□	□

Admitting physician:

- 1 Hospitalist
- 2 Not hospitalist
- 3 Unknown

Hospital discharge date

Month	Day	Year	Time	a.m.	p.m.	Military
□	□	□	□ □ : □ □	□	□	□

Hospital discharge diagnosis

(1) Principal

(2) Secondary

Hospital discharge status/disposition

- | | |
|---|--|
| <ul style="list-style-type: none"> 1 <input type="checkbox"/> Alive 2 <input type="checkbox"/> Dead 3 <input type="checkbox"/> Unknown | <ul style="list-style-type: none"> 1 <input type="checkbox"/> Home/Residence 2 <input type="checkbox"/> Return/Transfer to nursing home 3 <input type="checkbox"/> Return/Transfer to jail/prison 4 <input type="checkbox"/> Transfer to another facility (not usual place of residence) 5 <input type="checkbox"/> Other 6 <input type="checkbox"/> Unknown |
|---|--|

OBSERVATION UNIT STAY

Date and time of ED discharge

Month	Day	Year	Time	a.m.	p.m.	Military
□	□	□	□ □ : □ □	□	□	□

 1 Unknown

Date and time of observation unit discharge

Month	Day	Year	Time	a.m.	p.m.	Military
□	□	□	□ □ : □ □	□	□	□

 1 Unknown