

SAMPLE

NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY 2014 EMERGENCY DEPARTMENT PATIENT RECORD

Form Approved: OMB No. 0920-0278; Expiration date 12/31/2014

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 medical record number						ZIP Code <small>Enter "1" if homeless</small>			Date of birth																																						
Date and time of visit						Patient residence			Sex		Ethnicity																																				
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REASON FOR VISIT																																															
List the first 5 reasons for visit (i.e., symptoms, problems, issues, concerns of the patient) in the order in which they appear. Start with the chief complaint and then move to the patient history for additional reasons.										Episode of care																																					
(1) Most important: _____ (2) Other: _____ (3) Other: _____ (4) Other: _____ (5) Other: _____										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																																					
INJURY																																															
Is this visit related to an injury/trauma, overdose, poisoning, or adverse effect of medical treatment? 1 <input type="checkbox"/> Yes, injury/trauma 2 <input type="checkbox"/> Yes, poisoning 3 <input type="checkbox"/> Yes, adverse effect of medical treatment 4 <input type="checkbox"/> No 5 <input type="checkbox"/> Unknown } SKIP to →			Did the injury/trauma, overdose, or poisoning occur within 72 hours prior to the date and time of this visit? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown 4 <input type="checkbox"/> Not applicable			Is this injury/overdose/poisoning intentional? 1 <input type="checkbox"/> Yes, self inflicted 2 <input type="checkbox"/> Yes, assault 3 <input type="checkbox"/> No, unintentional (e.g., accidental) 4 <input type="checkbox"/> Intent unclear			Cause of injury/trauma, overdose, poisoning, or adverse effect – Describe the place and circumstances that preceded the event. Examples: 1 – Injury (e.g., patient fell while walking down stairs at home and sprained her ankle; patient was bitten by a spider); 2 – 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). _____ _____ _____																																						
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As specifically as possible, list diagnoses related to this visit including chronic conditions.						Does patient have – Mark (X) all that apply.																																									
(1) Primary diagnosis: _____ (2) Other: _____ (3) Other: _____ (4) Other: _____ (5) Other: _____						<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">1 <input type="checkbox"/> Alcohol abuse</td> <td style="width: 33%;">11 <input type="checkbox"/> Diabetes mellitus (DM)-Type I</td> <td style="width: 33%;">23 <input type="checkbox"/> None of the above</td> </tr> <tr> <td>2 <input type="checkbox"/> Alzheimer's disease/Dementia</td> <td>12 <input type="checkbox"/> Diabetes mellitus (DM)-Type II</td> <td></td> </tr> <tr> <td>3 <input type="checkbox"/> Asthma</td> <td>13 <input type="checkbox"/> Diabetes mellitus (DM)-Type unspecified</td> <td></td> </tr> <tr> <td>4 <input type="checkbox"/> Cancer</td> <td>14 <input type="checkbox"/> End-stage renal disease (ESRD)</td> <td></td> </tr> <tr> <td>5 <input type="checkbox"/> Cerebrovascular disease/ stroke (CVA) or transient ischemic attack (TIA)</td> <td>15 <input type="checkbox"/> History of pulmonary embolism (PE) or deep vein thrombosis (DVT)</td> <td></td> </tr> <tr> <td>6 <input type="checkbox"/> Chronic kidney disease (CKD)</td> <td>16 <input type="checkbox"/> HIV infection/AIDS</td> <td></td> </tr> <tr> <td>7 <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD)</td> <td>17 <input type="checkbox"/> Hyperlipidemia</td> <td></td> </tr> <tr> <td>8 <input type="checkbox"/> Congestive heart failure (CHF)</td> <td>18 <input type="checkbox"/> Hypertension</td> <td></td> </tr> <tr> <td>9 <input type="checkbox"/> Coronary artery disease (CAD), ischemic heart disease (IHD) or history of myocardial infarction (MI)</td> <td>19 <input type="checkbox"/> Obesity</td> <td></td> </tr> <tr> <td>10 <input type="checkbox"/> Depression</td> <td>20 <input type="checkbox"/> Obstructive sleep apnea (OSA)</td> <td></td> </tr> <tr> <td></td> <td>21 <input type="checkbox"/> Osteoporosis</td> <td></td> </tr> <tr> <td></td> <td>22 <input type="checkbox"/> Substance abuse</td> <td></td> </tr> </table>						1 <input type="checkbox"/> Alcohol abuse	11 <input type="checkbox"/> Diabetes mellitus (DM)-Type I	23 <input type="checkbox"/> None of the above	2 <input type="checkbox"/> Alzheimer's disease/Dementia	12 <input type="checkbox"/> Diabetes mellitus (DM)-Type II		3 <input type="checkbox"/> Asthma	13 <input type="checkbox"/> Diabetes mellitus (DM)-Type unspecified		4 <input type="checkbox"/> Cancer	14 <input type="checkbox"/> End-stage renal disease (ESRD)		5 <input type="checkbox"/> Cerebrovascular disease/ stroke (CVA) or transient ischemic attack (TIA)	15 <input type="checkbox"/> History of pulmonary embolism (PE) or deep vein thrombosis (DVT)		6 <input type="checkbox"/> Chronic kidney disease (CKD)	16 <input type="checkbox"/> HIV infection/AIDS		7 <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD)	17 <input type="checkbox"/> Hyperlipidemia		8 <input type="checkbox"/> Congestive heart failure (CHF)	18 <input type="checkbox"/> Hypertension		9 <input type="checkbox"/> Coronary artery disease (CAD), ischemic heart disease (IHD) or history of myocardial infarction (MI)	19 <input type="checkbox"/> Obesity		10 <input type="checkbox"/> Depression	20 <input type="checkbox"/> Obstructive sleep apnea (OSA)			21 <input type="checkbox"/> Osteoporosis			22 <input type="checkbox"/> Substance abuse	
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DIAGNOSTIC SERVICES	PROCEDURES	MEDICATIONS & IMMUNIZATIONS																																																			
<p>Mark (X) all ordered or provided at this visit.</p> <p>1 <input type="checkbox"/> NONE</p> <p>Blood tests:</p> <p>2 <input type="checkbox"/> Arterial blood gases</p> <p>3 <input type="checkbox"/> BAC (blood alcohol concentration)</p> <p>4 <input type="checkbox"/> Blood culture</p> <p>5 <input type="checkbox"/> BNP (brain natriuretic peptide)</p> <p>6 <input type="checkbox"/> BUN/Creatinine</p> <p>7 <input type="checkbox"/> Cardiac enzymes</p> <p>8 <input type="checkbox"/> CBC</p> <p>9 <input type="checkbox"/> D-dimer</p> <p>10 <input type="checkbox"/> Electrolytes</p> <p>11 <input type="checkbox"/> Glucose</p> <p>12 <input type="checkbox"/> Lactate</p> <p>13 <input type="checkbox"/> Liver function tests</p> <p>14 <input type="checkbox"/> Prothrombin time/INR</p> <p>15 <input type="checkbox"/> Other blood test</p> <p>Other tests:</p> <p>16 <input type="checkbox"/> Cardiac monitor</p> <p>17 <input type="checkbox"/> EKG/ECG</p> <p>18 <input type="checkbox"/> HIV test</p> <p>19 <input type="checkbox"/> Influenza test</p> <p>20 <input type="checkbox"/> Pregnancy/HCG test</p> <p>21 <input type="checkbox"/> Toxicology screen</p> <p>22 <input type="checkbox"/> Urinalysis (UA)</p> <p>23 <input type="checkbox"/> Urine culture</p> <p>24 <input type="checkbox"/> Wound culture</p> <p>25 <input type="checkbox"/> Other test/service</p> <p>Imaging:</p> <p>26 <input type="checkbox"/> X-ray</p> <p>27 <input type="checkbox"/> CT scan</p> <p><input type="checkbox"/> Abdomen/Pelvis</p> <p><input type="checkbox"/> Chest</p> <p><input type="checkbox"/> Head</p> <p><input type="checkbox"/> Other</p> <p>Was CT ordered/provided with intravenous (IV) contrast?</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Unknown</p> <p>28 <input type="checkbox"/> MRI</p> <p>Was MRI ordered/provided with intravenous (IV) contrast (also written as "with gadolinium" or "with gado")?</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Unknown</p> <p>29 <input type="checkbox"/> Ultrasound</p> <p>Who performed the ultrasound?</p> <p>1 <input type="checkbox"/> Emergency physician</p> <p>2 <input type="checkbox"/> Other provider</p> <p>30 <input type="checkbox"/> Other imaging</p>	<p>Mark (X) all provided at this visit. Exclude medications.</p> <p>1 <input type="checkbox"/> NONE</p> <p>2 <input type="checkbox"/> BPAP/CPAP</p> <p>3 <input type="checkbox"/> Bladder catheter</p> <p>4 <input type="checkbox"/> Cast, splint, wrap</p> <p>5 <input type="checkbox"/> Central line</p> <p>6 <input type="checkbox"/> CPR</p> <p>7 <input type="checkbox"/> Endotracheal intubation</p> <p>8 <input type="checkbox"/> Incision & drainage (I&D)</p> <p>9 <input type="checkbox"/> IV fluids</p> <p>10 <input type="checkbox"/> Lumbar puncture</p> <p>11 <input type="checkbox"/> Nebulizer therapy</p> <p>12 <input type="checkbox"/> Pelvic exam</p> <p>13 <input type="checkbox"/> Skin adhesives</p> <p>14 <input type="checkbox"/> Suturing/Staples</p> <p>15 <input type="checkbox"/> Other</p>	<p>List up to 30 drugs given at this visit or prescribed at ED discharge. Include Rx and OTC drugs, immunizations, and anesthetics.</p> <p><input type="checkbox"/> NONE</p> <table border="1"> <thead> <tr> <th></th> <th>Given in ED</th> <th>Rx at discharge</th> </tr> </thead> <tbody> <tr><td>(1)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>(2)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>(3)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>(4)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>(5)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>(6)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>(7)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>(8)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>(9)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>(10)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>(11)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>(12)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>(13)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>(14)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>(15)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>(16)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table>		Given in ED	Rx at discharge	(1)	<input type="checkbox"/>	<input type="checkbox"/>	(2)	<input type="checkbox"/>	<input type="checkbox"/>	(3)	<input type="checkbox"/>	<input type="checkbox"/>	(4)	<input type="checkbox"/>	<input type="checkbox"/>	(5)	<input type="checkbox"/>	<input type="checkbox"/>	(6)	<input type="checkbox"/>	<input type="checkbox"/>	(7)	<input type="checkbox"/>	<input type="checkbox"/>	(8)	<input type="checkbox"/>	<input type="checkbox"/>	(9)	<input type="checkbox"/>	<input type="checkbox"/>	(10)	<input type="checkbox"/>	<input type="checkbox"/>	(11)	<input type="checkbox"/>	<input type="checkbox"/>	(12)	<input type="checkbox"/>	<input type="checkbox"/>	(13)	<input type="checkbox"/>	<input type="checkbox"/>	(14)	<input type="checkbox"/>	<input type="checkbox"/>	(15)	<input type="checkbox"/>	<input type="checkbox"/>	(16)	<input type="checkbox"/>	<input type="checkbox"/>
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(15)	<input type="checkbox"/>	<input type="checkbox"/>																																																			
(16)	<input type="checkbox"/>	<input type="checkbox"/>																																																			

VITALS DISCHARGE	DISPOSITION
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<p>Were vitals taken at discharge?</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>Temperature <input type="text"/> °C / <input type="text"/> °F</p> <p>Heart rate <input type="text"/> beats per minute</p> <p>Respiratory rate <input type="text"/> breaths per minute</p> <p>Blood pressure Systolic <input type="text"/> / Diastolic <input type="text"/></p>	<p>Mark (X) all providers seen at this visit.</p> <p>1 <input type="checkbox"/> ED attending physician</p> <p>2 <input type="checkbox"/> ED resident/Intern</p> <p>3 <input type="checkbox"/> Consulting physician</p> <p>4 <input type="checkbox"/> RN/LPN</p> <p>5 <input type="checkbox"/> Nurse practitioner</p> <p>6 <input type="checkbox"/> Physician assistant</p> <p>7 <input type="checkbox"/> EMT</p> <p>8 <input type="checkbox"/> Other mental health provider</p> <p>9 <input type="checkbox"/> Other</p>	<p>Mark (X) all that apply.</p> <p>1 <input type="checkbox"/> No follow-up planned</p> <p>2 <input type="checkbox"/> Return to ED</p> <p>3 <input type="checkbox"/> Return/Refer to physician/clinic for FU</p> <p>4 <input type="checkbox"/> Left before triage</p> <p>5 <input type="checkbox"/> Left after triage</p> <p>6 <input type="checkbox"/> Left AMA</p> <p>7 <input type="checkbox"/> DOA</p> <p>8 <input type="checkbox"/> Died in ED</p> <p>9 <input type="checkbox"/> Return/Transfer to nursing home</p> <p>10 <input type="checkbox"/> Transfer to psychiatric hospital</p> <p>11 <input type="checkbox"/> Transfer to other hospital</p> <p>12 <input type="checkbox"/> Admit to this hospital</p> <p>13 <input type="checkbox"/> Admit to observation unit then hospitalized</p> <p>14 <input type="checkbox"/> Admit to observation unit, then discharged</p> <p>15 <input type="checkbox"/> Other</p>
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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.

<p>Admitted to:</p> <p>1 <input type="checkbox"/> Critical care unit</p> <p>2 <input type="checkbox"/> Stepdown unit</p> <p>3 <input type="checkbox"/> Operating room</p> <p>4 <input type="checkbox"/> Mental health or detox unit</p> <p>5 <input type="checkbox"/> Cardiac catheterization lab</p> <p>6 <input type="checkbox"/> Other bed/unit</p> <p>7 <input type="checkbox"/> Unknown</p>	<p>Date and time bed was requested for hospital admission or transfer</p> <p>Month <input type="text"/> Day <input type="text"/> Year <input type="text"/> Time <input type="text"/> : <input type="text"/> a.m. p.m. Military <input type="checkbox"/></p> <p>1 <input type="checkbox"/> Unknown</p>
	<p>Date and time patient actually left the ED or observation unit</p> <p>Month <input type="text"/> Day <input type="text"/> Year <input type="text"/> Time <input type="text"/> : <input type="text"/> a.m. p.m. Military <input type="checkbox"/></p> <p>1 <input type="checkbox"/> Unknown</p>
<p>Admitting physician</p> <p>1 <input type="checkbox"/> Hospitalist</p> <p>2 <input type="checkbox"/> Not hospitalist</p> <p>3 <input type="checkbox"/> Unknown</p>	<p>Hospital discharge date</p> <p>Month <input type="text"/> Day <input type="text"/> Year <input type="text"/></p> <p>1 <input type="checkbox"/> Unknown</p>

Principal hospital discharge diagnosis

1 Unknown

Hospital discharge status/disposition

1 Alive

2 Dead

3 Unknown

1 Home/Residence

2 Return/Transfer to nursing home

3 Transfer to another facility (not usual place of residence)

4 Other

5 Unknown

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

OBSERVATION UNIT STAY

Date and time of observation unit discharge

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

1 Unknown