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FORM **NHAMCS-100(ED)**
(8-1-2005)

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
2006 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 only by persons engaged in and for the purpose of the survey and will not be disclosed or released to other persons or used for any other purpose without consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m).

1. PATIENT INFORMATION

a. Date of visit — Month / Day / Year: 2006

b. ZIP code

c. Date of birth — Month / Day / Year

d. Time of day
(1) Arrival ___ ___ : ___ ___ ☐ AM ☐ PM ☐ Military
(2) Time seen by physician ___ ___ : ___ ___ ☐ AM ☐ PM ☐ Military
☐ Not seen by physician
(3) ED discharge ___ ___ : ___ ___ ☐ AM ☐ PM ☐ Military
Mark (X) if ED discharge is more than 24 hours from arrival. →

e. Patient residence
1 ☐ Private residence
2 ☐ Nursing home
3 ☐ Other institution
4 ☐ Other residence
5 ☐ Homeless
6 ☐ Unknown

f. Mode of arrival – *Mark (X) one.*
1 ☐ Ambulance (air/ground)
2 ☐ Public service (nonambulance, e.g., police, social services)
3 ☐ Walk-in
4 ☐ Unknown

g. Sex
1 ☐ Female
2 ☐ Male

h. Ethnicity
1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino

i. Race – *Mark (X) one or more.*
1 ☐ White
2 ☐ Black/ African American
3 ☐ Asian
4 ☐ Native Hawaiian/ Other Pacific Islander
5 ☐ American Indian/ Alaska Native

j. Expected source(s) of payment for this visit – *Mark (X) all that apply.*
1 ☐ Private insurance
2 ☐ Medicare
3 ☐ Medicaid/SCHIP
4 ☐ Worker's compensation
5 ☐ Self-pay
6 ☐ No charge/Charity
7 ☐ Other
8 ☐ Unknown

2. TRIAGE

a. Initial vital signs
(1) Temperature ☐ °C ☐ °F
(2) Pulse ___ beats per minute
(3) Blood pressure ____ / ____
(4) Oriented X 3 1 ☐ Yes 2 ☐ No 3 ☐ Unknown

b. Immediacy with which patient should be seen
1 ☐ Immediate
2 ☐ 1-14 minutes
3 ☐ 15-60 minutes
4 ☐ >1 hour-2 hours
5 ☐ >2 hours-24 hours
6 ☐ No triage
7 ☐ Unknown

c. Presenting level of pain
1 ☐ None
2 ☐ Mild
3 ☐ Moderate
4 ☐ Severe
5 ☐ Unknown

3. PREVIOUS CARE

Has patient been:

a. Seen in this ED within the last 72 hours?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

b. Discharged from any hospital within the last 7 days?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

4. REASON FOR VISIT

a. 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:

b. Is this visit work related?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

5. INJURY/POISONING/ADVERSE EFFECT

a. Is this visit related to an injury, poisoning, or adverse effect of medical treatment?
1 ☐ Yes
2 ☐ No – *SKIP to item 6.*

b. Is this injury/ poisoning intentional?
1 ☐ Yes, self inflicted
2 ☐ Yes, assault
3 ☐ No, unintentional
4 ☐ Unknown

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.).*

6. PHYSICIAN'S DIAGNOSIS FOR THIS VISIT

As specifically as possible, list diagnoses related to this visit including chronic conditions.

(1) Primary diagnosis:
(2) Other:
(3) Other:

7. DIAGNOSTIC/SCREENING SERVICES

Mark (X) all ***ordered*** *or* ***provided*** *at this visit.*

1 ☐ NONE

Blood tests:
2 ☐ CBC (complete blood count)
3 ☐ BUN/Creatinine
4 ☐ Cardiac enzymes
5 ☐ Electrolytes
6 ☐ Glucose
7 ☐ Liver function tests
8 ☐ Arterial blood gases
9 ☐ BAC (blood alcohol)
10 ☐ HIV serology
11 ☐ Other blood test

Other tests:
12 ☐ EKG/ECG
13 ☐ Cardiac monitor
14 ☐ Pulse oximetry ____ %
15 ☐ Pregnancy test
16 ☐ Urinalysis (UA)
17 ☐ Other test/service

Imaging:
18 ☐ X-ray
19 ☐ Ultrasound
20 ☐ MRI
21 ☐ CT scan
22 ☐ Other imaging

8. PROCEDURES

Mark (X) all ***provided*** *at this visit. Exclude medications.*

1 ☐ NONE
2 ☐ Bladder catheter
3 ☐ CPR
4 ☐ Endotracheal intubation
5 ☐ IV fluids
6 ☐ Nebulizer therapy
7 ☐ NG tube/gastric suction
8 ☐ OB/GYN care
9 ☐ Orthopedic care
10 ☐ Thrombolytic therapy
11 ☐ Wound care
12 ☐ Other

9. MEDICATIONS & IMMUNIZATIONS

List up to 8 drugs given at this visit or prescribed at ED discharge. Include Rx and OTC drugs, immunizations, and anesthetics.

☐ NONE

	Given in ED	Rx at discharge
(1)	1 ☐	2 ☐
(2)	1 ☐	2 ☐
(3)	1 ☐	2 ☐
(4)	1 ☐	2 ☐
(5)	1 ☐	2 ☐
(6)	1 ☐	2 ☐
(7)	1 ☐	2 ☐
(8)	1 ☐	2 ☐

10. PROVIDERS

Mark (X) all providers seen at this visit.

1 ☐ ED attending physician
2 ☐ ED resident/Intern
3 ☐ On call attending physician/Fellow
4 ☐ RN/LPN
5 ☐ Nurse practitioner
6 ☐ Physician assistant
7 ☐ EMT
8 ☐ Other

11. VISIT DISPOSITION

Mark (X) all that apply.

1 ☐ No follow-up planned
2 ☐ Return if needed, PRN/ appointment
3 ☐ Return/Refer to physician/clinic for FU
4 ☐ Refer to social services
5 ☐ Left AMA
6 ☐ Left without being seen
7 ☐ DOA/died in ED
8 ☐ Transfer to different hospital - *Reason*
9 ☐ Admit to observation unit
10 ☐ **Admit to hospital**
11 ☐ Other

If "Admit to hospital" was marked, then please continue with Item 12 - HOSPITAL ADMISSION on the reverse side.

12. HOSPITAL ADMISSION

Complete if the patient was admitted to the hospital at this visit.

a. Admitted to:
1 ☐ Critical care unit
2 ☐ OR/Cath lab
3 ☐ Other bed/unit
4 ☐ Unknown

b. Hospital admission time
___ ___ : ___ ___ ☐ AM ☐ PM ☐ Military

c. Hospital discharge date

Month	Day	Year
		2 0 0

d. Principal hospital discharge diagnosis

_____

e. Hospital discharge status
1 ☐ Alive
2 ☐ Dead
3 ☐ Unknown

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