2009 ED

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

Form Approved: OMB No. 0920-0278

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National Hospital Ambulatory Medical Care Survey

2009 Emergency Department Patient Record Folio

Hospital ID	REPORTING PERIOD	FROM: Month ☐☐ Day ☐☐ TO Month ☐☐ Day ☐☐
Ambulatory Unit Number	Start with the ☐☐ Patient.	Take every ☐☐ Patient.

Please return the whole Folio with both the completed and blank forms at the completion of the survey period. Thank you!

		Mon.	Tues.	Wed.	Thur.	Fri.	Sat.	Sun.	Total
WEEK 1	Dates								
	No. of patient visits								
	No. of records filled								
WEEK 2	Dates								
	No. of patient visits								
	No. of records filled								
WEEK 3	Dates								
	No. of patient visits								
	No. of records filled								
WEEK 4	Dates								
	No. of patient visits								
	No. of records filled								

Notice – Public reporting burden for this collection of information is estimated to average 6 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a current valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing burden to: CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0278).

FORM **NHAMCS-100(ED)** (6-5-2008)

USCENSUSBUREAU

U. S. DEPARTMENT OF COMMERCE
Economics and Statistics Administration
U.S. CENSUS BUREAU
ACTING AS DATA COLLECTION AGENT FOR
U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for Health Statistics

GENERAL INSTRUCTIONS

See card in pocket for instructions on how to complete Patient Record.

REPORTING DATES

Your reporting dates are:

Monday, _____ **through Sunday,** _____

PATIENT SIGN-IN SHEET

Record the name of every patient seen during the Reporting Period on a Sign-In Sheet maintained in each area of the emergency department. Record each patient in the order registered by your receptionist or seen by the provider. If two or more patients are seen during a single provider visit, the patients should be listed in the sequence registered or the sequence seen. It is important to record every patient visit including those not seen by the provider but attended to by the staff. Patients who visit more than once during the reporting period should be recorded on the Sign-In Sheet at each visit.

PATIENT RECORD

Follow the Sampling Pattern below to determine for which visit(s) a Patient Record should be completed.

START WITH: _____ **TAKE EVERY:** _____

The START WITH designates the FIRST PATIENT for whom a patient record should be completed. The TAKE EVERY designates every patient thereafter for whom a patient record should be completed. For example, for a Start With of 2 and Take Every of 3, a patient record will be completed for the second patient listed on the emergency department Sign-In Sheet and every third patient listed thereafter (e.g., 2, 5, 8, etc.). It is essential that the Take Every Number is extended each day from one Sign-In Sheet to another. For example, If your emergency department uses a new Sign-In Sheet each day, then the Take Every Number has to be extended from the last patient visit selected on Monday to the new list on Tuesday. If a single Sign-In Sheet is used the entire reporting period, then the Take Every simply needs to be extended as new patient names are added to the list.

Please refer to the NHAMCS-122 Instruction Book for more detailed information on the sampling pattern.

DEFINITIONS

For purposes of this study:

1. An *ambulatory patient* is an individual presenting for personal health services, not currently admitted to any health care institution on the premises. **Include** patients the physician sees; and patients the physician does not see but who receive care from a physician assistant, nurse, nurse practitioner, etc. **Exclude** persons who visit only for administrative reasons, such as to complete an insurance form; patients who do not seek care or services (e.g., pick up a prescription or leave a specimen); persons currently admitted as inpatients to the hospital **(nursing home patients should be included, however)**; and telephone contacts with patients.
2. A *visit* is a direct, personal exchange between an ambulatory patient and a physician or hospital staff under a physician's supervision for the purpose of seeking care and rendering personal health services.

DISPOSITION OF MATERIALS

As each Patient Record is completed, place the combined form (Patient Log and Patient Record) in the pocket of the kit. At the end of each day scan all forms to be sure they are properly completed, verify that the total number of completed Patient Records equals the number appearing on the last completed Patient Record. Check pages of the Patient Log against other record(s) (e.g., appointment book, billing records) to assure that every patient visit was recorded on the Patient Log. At the end of the period, detach patient's name, place all Patient Records and all unused materials in the postage paid envelope provided and mail to the interviewer. (DO *NOT* RETURN THE DETACHED PAGES OF THE PATIENT RECORD THAT CONTAIN THE PATIENT'S NAME).

FIELD REP

In case of questions or difficulty, please call the Field Representative collect:

Name

Phone Number

FORM NHAMCS-100(ED) (5-8-2008)

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FORM **NHAMCS-100(ED)**
(6-5-2008)

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NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY
2009 EMERGENCY DEPARTMENT PATIENT RECORD

PATIENT RECORD NO.:

PATIENT'S NAME:

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).

(Provider: Detach and keep)

Please keep (X) marks inside of boxes ➜ ☒ Correct ☒ Incorrect

1. PATIENT INFORMATION

a. Date and time of visit

	Month	Day	Time	a.m.	p.m.	Military
(1) Arrival			:	☐	☐	☐
Seen by (2) MD/DO/PA/NP			:	☐	☐	☐
(3) ED discharge			:	☐	☐	☐

b. ZIP Code

c. Date of birth — Month / Day / Year

d. Patient residence
1 ☐ Private residence
2 ☐ Nursing home
3 ☐ Homeless
4 ☐ Other
5 ☐ Unknown

e. Sex
1 ☐ Female
2 ☐ Male

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

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

h. Arrival by ambulance
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

i. 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) Heart rate ____ per minute

(3) Respiratory rate ____ per minute

(4) Blood pressure Systolic ____ / Diastolic ____

(5) Pulse oximetry ____ %

(6) On Oz
1 ☐ Yes 3 ☐ Oz (two)
2 ☐ No 3 ☐ Unknown

(7) Glasgow Coma scale ☐

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

a. Has patient been –	Yes	No	Unknown
(1) seen in this ED within the last 72 hours? . .	1 ☐	2 ☐	3 ☐
(2) discharged from any hospital within the last 7 days?	1 ☐	2 ☐	3 ☐
b. How many times has patient been seen in this ED within the last 12 months?			3 ☐

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. Episode of care
1 ☐ Initial visit for problem
2 ☐ Follow-up visit for problem
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. PROVIDER'S DIAGNOSIS FOR THIS VISIT

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

(1) Primary diagnosis:

(2) Other:

(3) Other:

b. Does patient now have – *Mark (X) all that apply.*
1 ☐ Cerebrovascular disease
2 ☐ Congestive heart failure
3 ☐ Chronic renal failure
4 ☐ HIV
5 ☐ Diabetes
6 ☐ None of the above

7. DIAGNOSTIC/SCREENING SERVICES

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

1 ☐ NONE

Blood tests:
2 ☐ CBC
3 ☐ BUN/Creatinine
4 ☐ Cardiac enzymes
5 ☐ Electrolytes
6 ☐ Glucose
7 ☐ Liver function tests
8 ☐ Arterial blood gases
9 ☐ Prothrombin time/INR
10 ☐ Blood culture
11 ☐ BAC (blood alcohol)
12 ☐ Other blood test

Other tests:
13 ☐ Cardiac monitor
14 ☐ EKG/ECG
15 ☐ HIV test
16 ☐ Influenza test
17 ☐ Pregnancy test
18 ☐ Toxicology screen
19 ☐ Urinalysis (UA)
20 ☐ Wound culture
21 ☐ Other test/service

Imaging:
22 ☐ X-ray
23 ☐ CT scan
☐ Head
☐ Other than head
24 ☐ MRI
25 ☐ Ultrasound
26 ☐ Other imaging

8. PROCEDURES

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

1 ☐ NONE
2 ☐ IV fluids
3 ☐ Cast
4 ☐ Splint or wrap
5 ☐ Suturing
6 ☐ Incision & drainage (I&D)
7 ☐ Foreign body removal
8 ☐ Nebulizer therapy
9 ☐ Bladder catheter
10 ☐ Pelvic exam
11 ☐ Central line
12 ☐ CPR
13 ☐ Endotracheal intubation
14 ☐ 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 ☐ Consulting physician
4 ☐ RN/LPN
5 ☐ Nurse practitioner
6 ☐ Physician assistant
7 ☐ EMT
8 ☐ Mental health provider
9 ☐ Other

11. LEVEL SERVICE

Mark (X) all that apply.

CPT code
1 ☐ 1 (99282)
2 ☐ 2 (99283)
3 ☐ 3 (99284)
4 ☐ 4 (99285)
5 ☐ 5 (99291)
6 ☐ Critical care (99281)
7 ☐ Unknown

12. 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 ☐ Left before medical screening exam
5 ☐ Left after medical screening exam
6 ☐ Left AMA
7 ☐ DOA
8 ☐ Died in ED
9 ☐ Transfer to psychiatric hospital
10 ☐ Transfer to other hospital
11 ☐ Admit to observation unit, then discharged
12 ☐ Admit to observation unit then hospitalized
13 ☐ Admit to hospital
14 ☐ Other

Continue with ***Item 13 - HOSPITAL ADMISSION*** *on reverse side.*

13. HOSPITAL ADMISSION

Complete if the patient was admitted to the hospital at this visit. – *Mark (X) "Unknown" in each item, if efforts have been exhausted to collect the data.*

a. Admitted to:

1 ☐ Critical care unit
2 ☐ Stepdown or telemetry unit
3 ☐ Operating room
4 ☐ Mental health or detox unit
5 ☐ Cardiac catheterization lab
6 ☐ Other bed/unit
7 ☐ Unknown

b. Admitting physician

1 ☐ Hospitalist
2 ☐ Not hospitalist
3 ☐ Unknown

c. Date and time bed was requested for hospital admission

Month	Day	Year	Time
		2 0	:

☐ a.m. ☐ p.m. ☐ Military

1 ☐ Unknown

d. Date and time of hospital admission

Month	Day	Year	Time
		2 0	:

☐ a.m. ☐ p.m. ☐ Military

e. Hospital discharge date

Month	Day	Year
		2 0

1 ☐ Unknown

f. Principal hospital discharge diagnosis

1 ☐ Unknown

g. Hospital discharge status/disposition

1 ☐ Alive → 1 ☐ Home/Residence, 2 ☐ Transferred, 3 ☐ Other, 4 ☐ Unknown
2 ☐ Dead
3 ☐ Unknown

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