



2009 ED

Form Approved: OMB No. 0920-0278



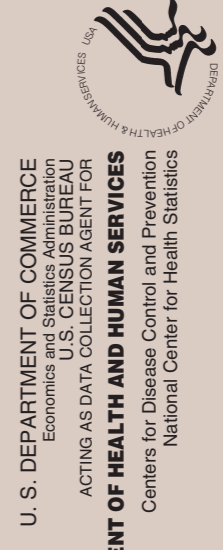
# National Hospital Ambulatory Medical Care Survey

## 2009 Emergency Department Patient Record Folio

Hospital ID	Month	Day	Month	Day
Ambulatory Unit Number	FROM:	TO	Patient.	Patient.
Start with the REPORTING PERIOD. Take every 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	
Dates		Dates		Dates		Dates		Dates		Dates		Dates		Total	
WEEK 1	No. of patient visits	No. of records filled	WEEK 2	No. of patient visits	No. of records filled	WEEK 3	No. of patient visits	No. of records filled	WEEK 4	No. of patient visits	No. of records filled	Total		Total	

**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).



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 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) (6-5-2008)

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

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U.S. Department of Health and Human Services  
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National Center for Health Statistics

**PATIENT RECORD NO.:**

**PATIENT'S NAME:**

**NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY  
2009 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).

(Provider: Detach and keep)

Please keep (X) marks inside of boxes →  Correct  Incorrect

**1. PATIENT INFORMATION**

<b>a. Date and time of visit</b>			<b>b. ZIP Code</b>			<b>c. Date of birth</b>			
Month	Day	Time	a.m.	p.m.	Military		Month	Day	Year
(1) Arrival									
Seen by (2) MD/DO/PA/NP						<b>d. Patient residence</b> 1 <input type="checkbox"/> Private residence 2 <input type="checkbox"/> Nursing home 3 <input type="checkbox"/> Homeless 4 <input type="checkbox"/> Other 5 <input type="checkbox"/> Unknown	<b>e. Sex</b> 1 <input type="checkbox"/> Female 2 <input type="checkbox"/> Male	<b>f. Ethnicity</b> 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino	
(3) ED discharge									
<b>g. Race – Mark (X) one or more.</b> 1 <input type="checkbox"/> White 2 <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian 4 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 5 <input type="checkbox"/> American Indian or Alaska Native			<b>h. Arrival by ambulance</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown			<b>i. 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/SCHIP 4 <input type="checkbox"/> Worker's compensation 5 <input type="checkbox"/> Self-pay 6 <input type="checkbox"/> No charge/Charity 7 <input type="checkbox"/> Other 8 <input type="checkbox"/> Unknown			

**2. TRIAGE**

<b>a. Initial vital signs</b>	<b>(1) Temperature</b> _____ °C _____ °F	<b>(2) Heart rate</b> _____ per minute	<b>(3) Respiratory rate</b> _____ per minute	<b>b. Immediacy with which patient should be seen</b> 1 <input type="checkbox"/> Immediate 2 <input type="checkbox"/> 1-14 minutes 3 <input type="checkbox"/> 15-60 minutes 4 <input type="checkbox"/> >1 hour-2 hours 5 <input type="checkbox"/> >2 hours-24 hours 6 <input type="checkbox"/> No triage 7 <input type="checkbox"/> Unknown	<b>c. Presenting level of pain</b> 1 <input type="checkbox"/> None 2 <input type="checkbox"/> Mild 3 <input type="checkbox"/> Moderate 4 <input type="checkbox"/> Severe 5 <input type="checkbox"/> Unknown
<b>(4) Blood pressure</b> Systolic / Diastolic _____ / _____	<b>(5) Pulse oximetry</b> _____ %	<b>(6) On Oz</b> 1 <input type="checkbox"/> Yes 3 <input type="checkbox"/> Oz (two) 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown	<b>(7) Glasgow Coma scale</b> _____		

**3. PREVIOUS CARE**

**4. REASON FOR VISIT**

<b>a. Has patient been –</b>	Yes	No	Unknown	<b>a. Patient's complaint(s), symptom(s), or other reason(s) for this visit</b> <i>Use patient's own words.</i> (1) Most important: _____ (2) Other: _____ (3) Other: _____	<b>b. Episode of care</b> 1 <input type="checkbox"/> Initial visit for problem 2 <input type="checkbox"/> Follow-up visit for problem 3 <input type="checkbox"/> Unknown
<b>(1) seen in this ED within the last 72 hours?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>		
<b>(2) discharged from any hospital within the last 7 days?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>		
<b>b. How many times has patient been seen in this ED within the last 12 months?</b>	_____				

**5. INJURY/POISONING/ADVERSE EFFECT**

<b>a. Is this visit related to an injury, poisoning, or adverse effect of medical treatment?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – SKIP to item 6.	<b>b. Is this injury/poisoning intentional?</b> 1 <input type="checkbox"/> Yes, self inflicted 2 <input type="checkbox"/> Yes, assault 3 <input type="checkbox"/> No, unintentional 4 <input type="checkbox"/> Unknown	<b>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.).</b> _____ _____
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**6. PROVIDER'S DIAGNOSIS FOR THIS VISIT**

<b>a. As specifically as possible, list diagnoses related to this visit including chronic conditions.</b>	<b>(1) Primary diagnosis:</b> _____ <b>(2) Other:</b> _____ <b>(3) Other:</b> _____	<b>b. Does patient now have – Mark (X) all that apply.</b> 1 <input type="checkbox"/> Cerebrovascular disease 2 <input type="checkbox"/> Congestive heart failure 3 <input type="checkbox"/> Chronic renal failure 4 <input type="checkbox"/> HIV 5 <input type="checkbox"/> Diabetes 6 <input type="checkbox"/> None of the above
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**7. DIAGNOSTIC/SCREENING SERVICES**

**8. PROCEDURES**

**9. MEDICATIONS & IMMUNIZATIONS**

<b>Mark (X) all ordered or provided at this visit.</b> <b>Blood tests:</b> 1 <input type="checkbox"/> NONE 2 <input type="checkbox"/> CBC 3 <input type="checkbox"/> BUN/Creatinine 4 <input type="checkbox"/> Cardiac enzymes 5 <input type="checkbox"/> Electrolytes 6 <input type="checkbox"/> Glucose 7 <input type="checkbox"/> Liver function tests 8 <input type="checkbox"/> Arterial blood gases 9 <input type="checkbox"/> Prothrombin time/INR 10 <input type="checkbox"/> Blood culture 11 <input type="checkbox"/> BAC (blood alcohol) 12 <input type="checkbox"/> Other blood test <b>Other tests:</b> 13 <input type="checkbox"/> Cardiac monitor 14 <input type="checkbox"/> EKG/ECG 15 <input type="checkbox"/> HIV test 16 <input type="checkbox"/> Influenza test 17 <input type="checkbox"/> Pregnancy test 18 <input type="checkbox"/> Toxicology screen 19 <input type="checkbox"/> Urinalysis (UA) 20 <input type="checkbox"/> Wound culture 21 <input type="checkbox"/> Other test/service <b>Imaging:</b> 22 <input type="checkbox"/> X-ray 23 <input type="checkbox"/> CT scan <input type="checkbox"/> Head <input type="checkbox"/> Other than head 24 <input type="checkbox"/> MRI 25 <input type="checkbox"/> Ultrasound 26 <input type="checkbox"/> Other imaging	<b>Mark (X) all provided at this visit. Exclude medications.</b> 1 <input type="checkbox"/> NONE 2 <input type="checkbox"/> IV fluids 3 <input type="checkbox"/> Cast 4 <input type="checkbox"/> Splint or wrap 5 <input type="checkbox"/> Suturing 6 <input type="checkbox"/> Incision & drainage (I&D) 7 <input type="checkbox"/> Foreign body removal 8 <input type="checkbox"/> Nebulizer therapy 9 <input type="checkbox"/> Bladder catheter 10 <input type="checkbox"/> Pelvic exam 11 <input type="checkbox"/> Central line 12 <input type="checkbox"/> CPR 13 <input type="checkbox"/> Endotracheal intubation 14 <input type="checkbox"/> Other	<b>List up to 8 drugs given at this visit or prescribed at ED discharge. Include Rx and OTC drugs, immunizations, and anesthetics.</b> <input type="checkbox"/> NONE <table border="1"> <tr> <td>(1)</td> <td>Given in ED</td> <td>Rx at discharge</td> </tr> <tr> <td>(2)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(3)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(4)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(5)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(6)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(7)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(8)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> </table>	(1)	Given in ED	Rx at discharge	(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"/>	(6)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(7)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(8)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
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(6)	1 <input type="checkbox"/>	2 <input type="checkbox"/>																								
(7)	1 <input type="checkbox"/>	2 <input type="checkbox"/>																								
(8)	1 <input type="checkbox"/>	2 <input type="checkbox"/>																								

**10. PROVIDERS**

**11. LEVEL SERVICE**

**12. VISIT DISPOSITION**

<b>Mark (X) all providers seen at this visit.</b> 1 <input type="checkbox"/> ED attending physician 2 <input type="checkbox"/> ED resident/Intern 3 <input type="checkbox"/> 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"/> Mental health provider 9 <input type="checkbox"/> Other	<b>Mark (X) all that apply.</b> CPT code 1 <input type="checkbox"/> 1 (99282) 2 <input type="checkbox"/> 2 (99283) 3 <input type="checkbox"/> 3 (99284) 4 <input type="checkbox"/> 4 (99285) 5 <input type="checkbox"/> 5 (99291) 6 <input type="checkbox"/> Critical care (99281) 7 <input type="checkbox"/> Unknown	<b>Mark (X) all that apply.</b> 1 <input type="checkbox"/> No follow-up planned 2 <input type="checkbox"/> Return if needed, PRN/appointment 3 <input type="checkbox"/> Return/Refer to physician/clinic for FU 4 <input type="checkbox"/> Left before medical screening exam 5 <input type="checkbox"/> Left after medical screening exam 6 <input type="checkbox"/> Left AMA 7 <input type="checkbox"/> DOA 8 <input type="checkbox"/> Died in ED 9 <input type="checkbox"/> Transfer to psychiatric hospital 10 <input type="checkbox"/> Transfer to other hospital 11 <input type="checkbox"/> Admit to observation unit, then discharged 12 <input type="checkbox"/> Admit to observation unit then hospitalized 13 <input type="checkbox"/> Admit to hospital 14 <input type="checkbox"/> Other
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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

**c. Date and time bed was requested for hospital admission**

Month	Day	Year	Time	
		20		

1  Unknown  a.m.  
 p.m.  
 Military

**d. Date and time of hospital admission**

Month	Day	Year	Time	
		20		

1  Unknown  a.m.  
 p.m.  
 Military

**f. Principal hospital discharge diagnosis**


**b. Admitting physician**

- 1  Hospitalist
- 2  Not hospitalist
- 3  Unknown

**e. Hospital discharge date**

Month	Day	Year	
		20	

1  Unknown

**g. Hospital discharge status/disposition**

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>1 <input type="checkbox"/> Alive</li> <li>2 <input type="checkbox"/> Dead</li> <li>3 <input type="checkbox"/> Unknown</li> </ul> | <div style="font-size: 2em; vertical-align: middle;">}</div> <ul style="list-style-type: none"> <li>1 <input type="checkbox"/> Home/Residence</li> <li>2 <input type="checkbox"/> Transferred</li> <li>3 <input type="checkbox"/> Other</li> <li>4 <input type="checkbox"/> Unknown</li> </ul> |
|---|--|

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