2010 ED

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

Form Approved: OMB No. 0920-0278

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National Hospital Ambulatory Medical Care Survey

2010 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 7 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 Information Collection Review Office, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0278).

FORM **NHAMCS-100(ED)** (4-13-2009)

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 during the entire Reporting Period, then the Take Every Number 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/e-mail contacts with patients.
2. A *visit* is a direct, personal exchange between an ambulatory patient and a physician or hospital staff member 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 it in the pocket of the folio. 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. At the end of the Reporting Period, detach patient's name, return all Patient Records and all unused materials to the field representative as arranged. (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

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NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY
2010 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 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).

(Provider: Detach and keep)

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

1. PATIENT INFORMATION

a. Date and time of visit

	Month	Day	Year	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
3 ☐ 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 oxygen
1 ☐ Yes 3 ☐ Unknown
2 ☐ No

(7) Glasgow Coma Scale (3–15)

b. Triage level (1–5)
1 ☐ No triage
2 ☐ Unknown

c. Pain scale (0–10)
1 ☐ 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 have – *Mark (X) all that apply.*
1 ☐ Cerebrovascular disease/ History of stroke
2 ☐ Congestive heart failure
3 ☐ Condition requiring dialysis
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/HCG 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/Staples
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. SERVICE LEVEL

Mark (X) all that apply.

(CPT code)

1 ☐ 1 (99281)
2 ☐ 2 (99282)
3 ☐ 3 (99283)
4 ☐ 4 (99284)
5 ☐ 5 (99285)
6 ☐ Critical care (99291)
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 triage
5 ☐ Left after triage
6 ☐ Left AMA
7 ☐ DOA
8 ☐ Died in ED
9 ☐ Return/Transfer to nursing home
10 ☐ Transfer to psychiatric hospital
11 ☐ Transfer to other hospital
12 ☐ Admit to this hospital
13 ☐ Admit to observation unit then hospitalized
Continue with ***Item 13*** *on reverse side.*
14 ☐ Admit to observation unit, then discharged – *Continue with* ***Item 14*** *on reverse side.*
15 ☐ Other

13. 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.*

a. 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

c. Date and time bed was requested for hospital admission

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

1 ☐ Unknown

d. Date and time patient actually left the ED

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

1 ☐ Unknown

b. Admitting physician

1 ☐ Hospitalist
2 ☐ Not hospitalist
3 ☐ Unknown

e. Hospital discharge date

Month	Day	Year
☐☐	☐☐	☐☐

1 ☐ Unknown

f. Principal hospital discharge diagnosis

1 ☐ Unknown

g. 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.***

14. OBSERVATION UNIT STAY

a. Date and time of observation unit discharge

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

1 ☐ Unknown