

2010 ED



# National Hospital Ambulatory Medical Care Survey

## 2010 Emergency Department Patient Record Folio

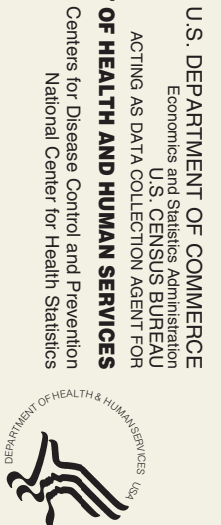
Hospital ID	REPORTING PERIOD	FROM:	Month	Day	Month	Day
Ambulatory Unit Number			<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		TO:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Start with the Patient. Take every _____ Patient.				

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

WEEKLY PERIOD	No. of records filled							Total
	Mon.	Tues.	Wed.	Thur.	Fri.	Sat.	Sun.	
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**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: PPA (0920-0278).

FORM **NHAMCS-100(ED)** (4-13-2009)  
U.S. DEPARTMENT OF COMMERCE  
ECONOMIC AND STATISTICS 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:   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 \_\_\_\_\_

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

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(4-13-2009)

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  
2010 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 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**

<b>a. Date and time of visit</b>				<b>b. ZIP Code</b>				<b>c. Date of birth</b>			
Month	Day	Year	Time	a.m.	p.m.	Military		Month	Day	Year	
(1) Arrival											
<b>(2) MD/DO/PA/NP</b>				<b>d. Patient residence</b>				<b>e. Sex</b>		<b>f. Ethnicity</b>	
Seen by				1 <input type="checkbox"/> Private residence				1 <input type="checkbox"/> Female		1 <input type="checkbox"/> Hispanic or Latino	
				2 <input type="checkbox"/> Nursing home				2 <input type="checkbox"/> Male		2 <input type="checkbox"/> Not Hispanic or Latino	
				3 <input type="checkbox"/> Homeless							
				4 <input type="checkbox"/> Other							
				5 <input type="checkbox"/> Unknown							
<b>(3) ED discharge</b>				<b>g. Race – Mark (X) one or more.</b>				<b>h. Arrival by ambulance</b>			
				1 <input type="checkbox"/> White				1 <input type="checkbox"/> Yes			
				2 <input type="checkbox"/> Black or African American				2 <input type="checkbox"/> No			
				3 <input type="checkbox"/> Asian				3 <input type="checkbox"/> Unknown			
				4 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander				<b>i. Expected source(s) of payment for this visit – Mark (X) all that apply.</b>			
				5 <input type="checkbox"/> American Indian or Alaska Native				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>		<b>(2) Heart rate</b>		<b>(3) Respiratory rate</b>		<b>b. Triage level (1-5)</b>		<b>c. Pain scale (0-10)</b>	
		[ ] °C [ ] °F		[ ] per minute		[ ] per minute		[ ]		[ ]	
<b>(4) Blood pressure</b>		<b>(5) Pulse oximetry</b>		<b>(6) On oxygen</b>		<b>(7) Glasgow Coma Scale (3-15)</b>		1 <input type="checkbox"/> No triage		1 <input type="checkbox"/> Unknown	
Systolic / Diastolic		[ ] %		1 <input type="checkbox"/> Yes 3 <input type="checkbox"/> Unknown 2 <input type="checkbox"/> No		[ ]		2 <input type="checkbox"/> Unknown			

**3. PREVIOUS CARE**

<b>a. Has patient been –</b>			<b>a. Patient's complaint(s), symptom(s), or other reason(s) for this visit</b>			<b>b. Episode of care</b>		
<b>(1) seen in this ED within the last 72 hours?</b>			Use patient's own words.			1 <input type="checkbox"/> Initial visit for problem		
Yes	No	Unknown	(1) Most important:			2 <input type="checkbox"/> Follow-up visit for problem		
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	(2) Other:			3 <input type="checkbox"/> Unknown		
<b>(2) discharged from any hospital within the last 7 days?</b>			(3) Other:					
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>		<b>b. Is this injury/poisoning intentional?</b>		<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>	
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – SKIP to item 6.		1 <input type="checkbox"/> Yes, self inflicted 2 <input type="checkbox"/> Yes, assault 3 <input type="checkbox"/> No, unintentional 4 <input type="checkbox"/> Unknown			

**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>b. Does patient have – Mark (X) all that apply.</b>	
		(2) Other:		1 <input type="checkbox"/> Cerebrovascular disease/History of stroke	
		(3) Other:		2 <input type="checkbox"/> Congestive heart failure	
				3 <input type="checkbox"/> Condition requiring dialysis	
				4 <input type="checkbox"/> HIV	
				5 <input type="checkbox"/> Diabetes	
				6 <input type="checkbox"/> None of the above	

<b>7. DIAGNOSTIC/SCREENING SERVICES</b>			<b>8. PROCEDURES</b>			<b>9. MEDICATIONS &amp; IMMUNIZATIONS</b>		
Mark (X) all ordered or provided at this visit.			Mark (X) all provided at this visit. Exclude medications.			List up to 8 drugs given at this visit or prescribed at ED discharge. Include Rx and OTC drugs, immunizations, and anesthetics.		
1 <input type="checkbox"/> NONE			1 <input type="checkbox"/> NONE			[ ] NONE		
2 <input type="checkbox"/> CBC			2 <input type="checkbox"/> IV fluids			Given in ED   Rx at discharge		
3 <input type="checkbox"/> BUN/Creatinine			3 <input type="checkbox"/> Cast			(1) [ ]   [ ]		
4 <input type="checkbox"/> Cardiac enzymes			4 <input type="checkbox"/> Splint or wrap			(2) [ ]   [ ]		
5 <input type="checkbox"/> Electrolytes			5 <input type="checkbox"/> Suturing/Staples			(3) [ ]   [ ]		
6 <input type="checkbox"/> Glucose			6 <input type="checkbox"/> Incision & drainage (I&D)			(4) [ ]   [ ]		
7 <input type="checkbox"/> Liver function tests			7 <input type="checkbox"/> Foreign body removal			(5) [ ]   [ ]		
8 <input type="checkbox"/> Arterial blood gases			8 <input type="checkbox"/> Nebulizer therapy			(6) [ ]   [ ]		
9 <input type="checkbox"/> Prothrombin time/INR			9 <input type="checkbox"/> Bladder catheter			(7) [ ]   [ ]		
10 <input type="checkbox"/> Blood culture			10 <input type="checkbox"/> Pelvic exam			(8) [ ]   [ ]		
11 <input type="checkbox"/> BAC (blood alcohol)			11 <input type="checkbox"/> Central line					
12 <input type="checkbox"/> Other blood test			12 <input type="checkbox"/> CPR					
<b>Other tests:</b>			13 <input type="checkbox"/> Endotracheal intubation					
13 <input type="checkbox"/> Cardiac monitor			14 <input type="checkbox"/> Other					
14 <input type="checkbox"/> EKG/ECG								
15 <input type="checkbox"/> HIV test								

<b>10. PROVIDERS</b>		<b>11. SERVICE LEVEL</b>		<b>12. VISIT DISPOSITION</b>	
Mark (X) all providers seen at this visit.		Mark (X) all that apply. (CPT code)		Mark (X) all that apply.	
1 <input type="checkbox"/> ED attending physician		1 <input type="checkbox"/> 1 (99281)		1 <input type="checkbox"/> No follow-up planned	
2 <input type="checkbox"/> ED resident/Intern		2 <input type="checkbox"/> 2 (99282)		2 <input type="checkbox"/> Return if needed, PRN/appointment	
3 <input type="checkbox"/> Consulting physician		3 <input type="checkbox"/> 3 (99283)		3 <input type="checkbox"/> Return/Refer to physician/clinic for FU	
4 <input type="checkbox"/> RN/LPN		4 <input type="checkbox"/> 4 (99284)		4 <input type="checkbox"/> Left before triage	
5 <input type="checkbox"/> Nurse practitioner		5 <input type="checkbox"/> 5 (99285)		5 <input type="checkbox"/> Left after triage	
6 <input type="checkbox"/> Physician assistant		6 <input type="checkbox"/> Critical care (99291)		6 <input type="checkbox"/> Left AMA	
7 <input type="checkbox"/> EMT		7 <input type="checkbox"/> Unknown		7 <input type="checkbox"/> DOA	
8 <input type="checkbox"/> Mental health provider				8 <input type="checkbox"/> Died in ED	
9 <input type="checkbox"/> Other				9 <input type="checkbox"/> Return/Transfer to nursing home	
				10 <input type="checkbox"/> Transfer to psychiatric hospital	
				11 <input type="checkbox"/> Transfer to other hospital	
				12 <input type="checkbox"/> Admit to this hospital	
				13 <input type="checkbox"/> Admit to observation unit then hospitalized	
				14 <input type="checkbox"/> Admit to observation unit, then discharged – Continue with Item 14 on reverse side.	
				15 <input type="checkbox"/> 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
_	_	_ _	_  :  _ _	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1 <input type="checkbox"/> Unknown						

**d. Date and time patient actually left the ED**

Month	Day	Year	Time	a.m.	p.m.	Military
_	_	_ _	_  :  _ _	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1 <input type="checkbox"/> Unknown						

**b. Admitting physician**

- 1  Hospitalist
- 2  Not hospitalist
- 3  Unknown

**e. Hospital discharge date**

Month	Day	Year
_	_	_ _
1 <input type="checkbox"/> Unknown		

**f. Principal hospital discharge diagnosis**

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> | } | <ul style="list-style-type: none"> <li>1 <input type="checkbox"/> Home/Residence</li> <li>2 <input type="checkbox"/> Return/Transfer to nursing home</li> <li>3 <input type="checkbox"/> Transfer to another facility (not usual place of residence)</li> <li>4 <input type="checkbox"/> Other</li> <li>5 <input type="checkbox"/> Unknown</li> </ul> |
|---|---|---|

► **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
_	_	_ _	_  :  _ _	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1 <input type="checkbox"/> Unknown						