



# Common Hospital Information

FORM CODE: 

C	H	I
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VERSION: A 11/16/2006

ID NUMBER: 

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CONTACT YEAR: 

--	--

LAST NAME: 

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INITIALS: 

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**General Instructions:**  
The Common Hospital Information Form is completed for any hospital record abstraction for CHD or HF.  
Q. 1 - 10 are common to both the HRA and the HFA forms.

0. a. Hospital code number 

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0. b. Medical Record Number:  

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0. c. Date of discharge (for nonfatal case) or death:  

		-			-				
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**SECTION I: DISCHARGE CODES, TRANSFER STATUS, DEMOGRAPHIC DATA**

1.a. Primary admission diagnosis:

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[Specify if diagnosis is not ICD coded]

1.b. Primary discharge diagnosis:

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[Specify if diagnosis is not ICD coded]

2. Record the ICD9-CM diagnoses and procedure codes from the hospital discharge index (or Eligibility Form):

a.	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							<table border="1"><tr><td></td><td></td></tr></table>		
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c.	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							<table border="1"><tr><td></td><td></td></tr></table>		
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3. Sex:

M.....Male  
F..... Female

4. What is your race?:

White ..... W  
 Black or African American ..... B  
 Native Hawaiian or Other Pacific Islander ... P  
 Other ..... O  
 (if other, specify)

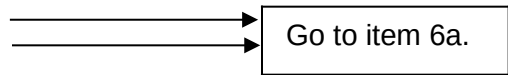
American Indian or Alaskan Native ..... I  
 Asian ..... A  
 Unknown/ not recorded ..... U

4.a. What is your ethnicity?

Hispanic or Latino..... Y  
 Not Hispanic or Latino..... N  
 Unk..... U

5.a. Does this person have health insurance?

Yes..... Y  
 No..... N  
 Unk..... U



b. Indicate type of insurance recorded:

Yes    No    Unknown

1. Prepaid insurance or health plan (BC/BS, HMO)

2. Medicare

3. Medicaid

4. Other

6.a. Date of arrival at this hospital (mm-dd-yyyy)

-   -

b. Arrival time at this hospital (24-hr clock)

:

7. Did an emergency medical service unit transport the patient to this hospital?

Yes..... Y  
 No..... N  
 Unk..... U

**Transfer information**

8.a. Was the patient transferred from or to another acute care hospital? Yes.....Y

No..... N

Unk..... U

Go to item 9.

8.b. Was this an in-catchment hospital? Yes.....Y

No..... N

b.1. Hospital Code:  If 96 - 99, specify: →

Hospital Name: \_\_\_\_\_

City and State: \_\_\_\_\_

8.c. Date of admission to that hospital (mm-dd-yyyy):

<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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c.1. Was the patient transferred a second time? Yes  No

Go to item 9.

8.d. Was this an in-catchment hospital? Yes.....Y

No..... N

d. Hospital Code:  If 96 - 99, specify: →

Hospital Name: \_\_\_\_\_

City and State: \_\_\_\_\_

8.e. Date of admission to that hospital (mm-dd-yyyy):

<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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9. List the hospital discharge diagnosis and procedure codes exactly as they appear on the front sheet of the medical record and/or on the discharge summary:

a.

b.

c.

d.

e.

f.

g.

h.

i.

j.

k.

l.

m.

n.

o.

p.

q.

r.

s.

t.

u.

v.

w.

x.

y.

z.



**SECTION II: ADMINISTRATIVE INFORMATION**

11. Abstractor number:

12. Date abstract completed (mm-dd-yyyy) --

13. Source of information abstracted:

- Medical Record (Paper chart)..... P
- Medical Record (Electronic chart) .....E
- Medical Record (Both paper and electronic chart)..... B