

PATIENT ABSTRACT – NATIONAL HOSPITAL DISCHARGE SURVEY

A. STUDY-SPECIFIC INFORMATION

1. Hospital Number _____	2. HDS Number _____	3. Sampling Stratum 1 = Observation 2 = Normal Newborn 3 = AMI 4 = End-of-Life 6 = All Non-Statified 9 = Inpatient, Other
4. Medical Record Number:		5. Discharge Date : MM ___ DD ___ YY ___

B. INFORMATION THAT IS REQUESTED ON THE UB-04 CLAIM FORM

6. Patient Name (FL08, line 2b)			
<i>Last</i> _____	<i>First</i> _____	<i>Middle Name or Initial</i> _____	
7. Patient Street Address (FL09, line 1a):			8. City (FL09, line 2b)
9. State (FL09, line 2c) _____ If in US, complete items 9 and 10, but skip item 11	10. ZIP (FL09, line 2d) _____	11. Country Code (FL09, line 2e) _____	12a. Birth Date (FL10) MM ___ DD ___ YYYY _____ (Only if DOB is unavailable from the UB-04 Medical Record Face Sheet, record age) 12b. Age : _____ Units: <input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Days
13. Sex (FL11) M = Male F = Female U = Unknown	14. Admission Date (FL12) MM ___ DD ___ YY ___ (If the complete admission date is unavailable from the UB-04, record based on the Medical Record Face Sheet.)	15. Admission Type (FL14) 1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn 5 = Trauma 6-8 = Reserved for assignment by NUBC 9 = Info Not Available	
16. Admission Point of Origin (FL15) : Select Only One			
1 = Non-Health Care Facility Point of Origin 2 = Clinic 3 = Reserved for assignment by NUBC 4 = Transfer from a hospital (different facility) 5 = Transfer from a SNF or ICF 6 = Transfer from another health care facility 7 = Emergency Room 8 = Court / Law Enforcement 9 = Information not available		A = Reserved for assignment by NUBC B = Transfer from another home health agency C = Readmission to same home health agency D = Transfer from one distinct unit of the hospital to another distinct unit of the same hospital resulting in a separate claim to pay E = Transfers from ambulatory surgery center F = Transfer from hospice and is under a hospice plan of care or enrolled in a hospice program G-Z = Reserved for assignment by NUBC	
<u>Newborn Code Structure</u> 1-4 = Reserved for assignment by NUBC 5 = Born inside this hospital 6 = Born outside this hospital 7-9 = Reserved for assignment by the NUBC			

17. Discharge Status (FL17) : Select Only One Code

- | | |
|--|--|
| 1 = Discharge to home or self care | 42 = Expired – Place Unknown |
| 2 = Discharge / transferred to short term general hosp for inpt care | 43 = Discharge / transferred to Federal Health Care Facility |
| 3 = Discharge / transferred to SNF | 44-49 = Reserved for assignment by the NUBC |
| 4 = Discharge / transferred to ICF | 50 = Hospice - home |
| 5 = Discharge / transferred to a designated Cancer Center or Children's Hospital | 51 = Hospice – Medical Facility |
| 6 = Discharge / transferred to home under care of organized home health service organization | 52-60 = Reserved for assignment by the NUBC |
| 7 = Left AMA or discontinued care | 61 = Discharge / transferred to a hospital-based Medicare Approved swing bed |
| 8 = Reserved for assignment by the NUBC | 62 = Discharge / transferred to an IRF including Rehabilitation Distinct Part Units of a Hospital |
| 9 = Admitted as an Inpt to this hospital | 63 = Discharge / transferred to a Medicare Certified LTCH |
| 10-19 = Reserved for assignment by the NUBC | 64 = Discharge / transferred to a Nursing Facility Certified under Medicaid but not Certified under Medicare |
| 20 = Expired | 65 = Discharge/ transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital |
| 21-29 = Reserved for assignment by the NUBC | 66 = Discharge/ transferred to a CAH |
| 30 = Still Patient | 67-69 = Reserved for assignment by the NUBC |
| 31-39 = Reserved for assignment by the NUBC | 70 = Discharged /transferred to another Type of Health Care Institution not Defined Elsewhere in the Code List |
| 40 = Expired at Home | 71-99 = Reserved for assignment by the NUBC |
| 41 = Expired in Medical Facility | |

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18. Units/Charges allocated to select revenue codes:

Revenue Code (FL42)	Revenue Code Description		# Days (FL46)	Total Charges (\$) (FL47)																
0170	Nursery	0=General																		
0171		1=Newborn Level 1																		
0172		2=Newborn Level 2																		
0173		3=Newborn Level 3																		
0174		4=Newborn Level 4																		
0175		5=Reserved																		
0176		6=Reserved																		
0177		7=Reserved																		
0178		8=Reserved																		
0179		9=Other nursery																		
0200	Intensive Care	0=General																		
0201		1=Surgical																		
0202		2=Medical																		
0203		3=Pediatric																		
0204		4=Psychiatric																		
0205		5=Reserved																		
0206		6=Intermediate ICU																		
0207		7=Burn Care																		
0208		8=Trauma																		
0209		9=Other Intensive Care																		
0210	Coronary Care Unit	0=General																		
0211		1=Myocardial Infarction																		
0212		2=Pulmonary Care																		
0213		3=Heart Transplant																		
0214		4=Intermediate CCU																		
0215		5=Reserved																		
0216		6=Reserved																		
0217		7=Reserved																		
0218		8=Reserved																		
0219		9=Other Coronary CCU																		
0001	Total Charges																			

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Instructions: Record up to 18 diagnoses and 4 E-Codes from the UB-04.

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Principal Diagnoses		
	19a. ICD-9-CM Code (FL67, FL67a-q)	19b. Present at Admission? (8th position of FL67 and FL67a-q)
Prin Dx		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> W
Oth Dx		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> W
Oth Dx		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> W
Oth Dx		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> W
Oth Dx		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> W
Oth Dx		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> W
Oth Dx		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> W
Oth Dx		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> W
Oth Dx		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> W
Oth Dx		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> W
Oth Dx		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> W
Oth Dx		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> W
Oth Dx		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> W
Oth Dx		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> W
Oth Dx		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> W
Oth Dx		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> W
Oth Dx		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> W
Oth Dx		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> W
20. Admitting Diagnosis (FL69) _____ ICD-9-CM		
21a. E-Code (FL72, 1a-c)		21 b. Present at Admission? (8th position of FL72, 1a-c)
<input type="checkbox"/> No E-codes		
E-Code 1		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> W
E-Code 2		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> W
E-Code 3		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> W
Instructions: Record up to 6 procedures.		
22. Principal Procedures (FL 74)		
<input type="checkbox"/> No procedures		

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	ICD-9-CM	Procedure Date
Prin Px		MM _____ DD _____ YY _____
Oth Px		MM _____ DD _____ YY _____
Oth Px		MM _____ DD _____ YY _____
Oth Px		MM _____ DD _____ YY _____
Oth Px		MM _____ DD _____ YY _____
Oth Px		MM _____ DD _____ YY _____

23. Attending Physician NPI (FL76) _____

24. Operating Physician NPI (FL77) _____

C. MEDICAL RECORD FACE SHEET INFORMATION

25. Encounter/Visit Number:

(Only ask question #26, if there is not complete data for either or both the admission or discharge dates.)

26. Length of Stay: _____ days

27. Ethnicity

- Hispanic
- Not Hispanic
- Unknown

28. Race: Please Check All That Apply

- White
- Black/African American
- Asian
- Native Hawaiian/Other Pacific Islander
- American Indian/ Alaska Native
- Other: Specify _____
- Unknown

29. Expected Source of Payment: Select Only One Per Category

Primary

Other 1

Other 2

- No source indicated
- Medicare
- Medicaid / SCHIP
- Other Gov't (e.g., CHAMPUS, Tricare, VA)
- Private / commercial insurance
- Worker's compensation
- Self-pay
- No charge
- Other: Specify _____

- No source indicated
- Medicare
- Medicaid / SCHIP
- Other Gov't (e.g., CHAMPUS, Tricare, VA)
- Private / commercial insurance
- Worker's compensation
- Self-pay
- No charge
- Other: Specify _____
- Not Applicable

- No source indicated
- Medicare
- Medicaid / SCHIP
- Other Gov't (e.g., CHAMPUS, Tricare, VA)
- Private / commercial insurance
- Worker's compensation
- Self-pay
- No charge
- Other: Specify _____
- Not Applicable

30. Medicare #

- Not Documented
- _____

D. CURRENT EPISODE/HOSPITAL STAY INFORMATION

31.

If **NEWBORN** (Per item 3 {Sampling Stratum} code 2 "normal newborn" or item 15 {Adm Type} code 5

“newborn”), skip to Question 36.

<p>32. Vital Signs Value On First Presentation on the day of admission</p> <p>Height: ___ ft ___ in OR ___ ___ cm</p> <p>Weight: ___ ___ lbs OR ___ ___ kg</p>	<p>33. Clinical Laboratory Results: Initial Results on the day of admission</p> <p>Hematocrit (Hct): ___ ___ . ___ %</p> <p>White Cell Count (WBC): ___ ___ . ___ x1000/μL</p> <p>Platelet Count (Plt): ___ ___ ___ x1000/μL</p> <p>Sodium (Na): ___ ___ ___ mmol/L</p> <p>Potassium (K): ___ ___ . ___ mmol/L</p> <p>Urea Nitrogen (BUN): ___ ___ ___ mg/dL</p> <p>Creatinine (Cr): ___ ___ . ___ mg/dL</p>
<p>34.</p>	<p>35.</p>

FOR NEWBORNS (Per item 3 {Sampling Stratum} code 2 “normal newborn” or item 15 {Adm Type} code 5 “newborn”), ☐ If not a Newborn, Skip to Question 37

E. PATIENT CLINICAL VARIABLES (Obtained From Medical Records)

36. Birth Statistics

Weight: ___ ___ lbs ___ ___ oz **OR** ___ ___ ___ gm

Time of Delivery: ___ ___ : ___ ___ AM or PM (circle one)

Maternal Date of Birth: MM ___ ___ DD ___ ___ YY ___ ___

(Only complete Maternal Age if the Maternal date of birth is not available.)

Maternal Age: ___ ___ years

37.	<p>Medications Patient Was Taking Immediately Preceding Admission (Do not Include Medications Only Given in the Emergency Department)</p>
<p><input type="checkbox"/> None <input type="checkbox"/> Not applicable (newborn) <input type="checkbox"/> Unknown</p>	
<p>List up to 20 pre-admit medications</p>	
1.	
2.	
3.	

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4.	
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17.	
18.	
19.	
20.	

38.	Medications Prescribed at Discharge
	<input type="checkbox"/> None <input type="checkbox"/> Not applicable (patient expired) <input type="checkbox"/> Unknown
1.	
2.	
3.	
4.	
5.	
6.	
7.	
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18.	
19.	

20.

F. FINANCIAL AND BILLING RECORD DATA ELEMENTS

39a. Actual Source of Payment			39c. Actual Payment Grand Total (To be generated by the system)
Primary	Other 1	Other 2	
<input type="checkbox"/> No source indicated <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid / SCHIP <input type="checkbox"/> Other Gov't (e.g., CHAMPUS, Tricare, VA) <input type="checkbox"/> Private / commercial insurance <input type="checkbox"/> Worker's compensation <input type="checkbox"/> Self-pay <input type="checkbox"/> No charge <input type="checkbox"/> Other: Specify _____	<input type="checkbox"/> No source indicated <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid / SCHIP <input type="checkbox"/> Other Gov't (e.g., CHAMPUS, Tricare, VA) <input type="checkbox"/> Private / commercial insurance <input type="checkbox"/> Worker's compensation <input type="checkbox"/> Self-pay <input type="checkbox"/> No charge <input type="checkbox"/> Other: Specify _____ <input type="checkbox"/> Not Applicable	<input type="checkbox"/> No source indicated <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid / SCHIP <input type="checkbox"/> Other Gov't (e.g., CHAMPUS, Tricare, VA) <input type="checkbox"/> Private / commercial insurance <input type="checkbox"/> Worker's compensation <input type="checkbox"/> Self-pay <input type="checkbox"/> No charge <input type="checkbox"/> Other: Specify _____ <input type="checkbox"/> Not Applicable	
39b. Actual Payment by Source			
40. Social Security Number <input type="checkbox"/> Not Available _ X X X - X X - _ _ _ _ _			

INFORMATION FROM OTHER HOSPITAL CARE WITHIN 30 DAYS

41. If the patient was treated at this hospital as an acute inpatient, up 30 days prior to this hospital stay (index admission) or 30 days following discharge, provide the following information about that (those) hospital visit(s). If the patient was seen more than three times before or after this admission, please list the three visits that were closest to this discharge.

	Admission Date	Discharge Date	Principal Diagnosis ICD-9-CM	Principal Procedure ICD-9-CM/ CPT-4*		
30 days prior to admission Check here if: <input type="checkbox"/> None <input type="checkbox"/> Not applicable (newborn) <input type="checkbox"/> Unknown						
Index Admission	___/___/___	___/___/___				
1	___/___/___	___/___/___				
2	___/___/___	___/___/___				
3	___/___/___	___/___/___				
30 days post discharge Check here if: <input type="checkbox"/> None <input type="checkbox"/> Not applicable (patient expired) <input type="checkbox"/> Unknown						
Index Discharge	___/___/___	___/___/___				
1	___/___/___	___/___/___				

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2	____/____/____	____/____/____				
3	____/____/____	____/____/____				

* Use most significant CPT procedure for previous observation status admissions.

G. ACUTE MYOCARDIAL INFARCTION SPECIFIC ITEMS (Items 42 – 46 To Be Completed Only for discharges with a sampling stratum code {Item 3} of “3” {AMI}. All others skip to item 47.)								
42. Date of First Hospital Contact MM ____ DD ____ YY ____				43. Time of First Hospital Contact ____ : ____ AM or PM (circle one)				
44. Troponin Levels <input type="checkbox"/> Check here if no Troponin Levels were obtained								
Troponin Level	Troponin Type (Check one)		Date MM/DD/YY	Time		Result	Units	ULN
	I	T		__ : __ HH:MM	AM PM Circle one			
Troponin #1			/ /	__ : __	AM PM			
Troponin #2			/ /	__ : __	AM PM			
Troponin #3			/ /	__ : __	AM PM			
45. Ischemic Pain Upon Admission <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				46. Elective (Planned) Cardiac Procedure Admission <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
H. END OF LIFE SPECIFIC ITEMS (Items 47 – 50 To Be Completed Only for discharges with a sampling stratum code {Item 3} of “4” {End-of-Life} or a discharge status {Item 17} code of “20”. All others skip to item 51.)								
47. Advanced Care Plan on Admission <input type="checkbox"/> Yes <input type="checkbox"/> No (Skip to question 49) <input type="checkbox"/> Don't Know (Skip to question 49)				48. Type of Advanced Care Plan on Admission (Check All That Apply) <input type="checkbox"/> Comfort Measures Only Order <input type="checkbox"/> Do Not Resuscitate Order <input type="checkbox"/> Do Not Intubate Order <input type="checkbox"/> Health Care Proxy / Durable Power of Attorney / Surrogate Decision Maker <input type="checkbox"/> Advanced Directive / Living Will / POLST (Physician Orders for Life Sustaining Treatment) or Other State Program <input type="checkbox"/> Other				
49. Do Not Resuscitate Order (During				50.				

<p>Hospitalization)</p> <p><input type="checkbox"/> Yes -----> Date of Order: <u> </u> / <u> </u> / <u> </u> M M / D D / Y Y</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Don't Know</p>		
<p>I. INFECTIOUS DISEASE ITEMS</p>		
<p>INFORMATION FROM THE LABORATORY RECORDS</p>		
<p>51. Did this discharge have any positive blood cultures during this inpatient stay?</p> <p><input type="checkbox"/> Yes (Skip to Item 53)</p> <p><input type="checkbox"/> No -----> Do Not Complete Items 52 - 59</p>		
<p>53. How many positive blood cultures were recorded during this stay?</p> <p>_____ Number of Positive Blood Cultures</p>	<p>54. Date of first positive culture</p> <p>_____ / _____ / _____ M M / D D / Y Y</p>	
<p>55. Name of first organism corresponding to first positive blood culture. (Select from pathogen code dictionary)</p>		
<p>Genus</p>	<p>Species</p>	<p>Organism ID Code (To be generated by the system)</p>
<p>56.</p>		
<p>INFORMATION FROM THE MEDICAL CHART</p>		
<p>57. Was a central venous catheter in place at any time from [load date of first positive culture – 2 days] through [load date of first positive culture]?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>		