PATIENT ABSTRACT – NATIONAL HOSPITAL DISCHARGE SURVEY

A. STUDY-SPECIFIC INFORMATION

1. Hospital Number	2. HDS Number	3. Sampling Stratum
_____ _____ _____ _____	_____ _____ _____ _____	1 = Observation 2 = Normal Newborn 6 = All Non-Statified 3 = AMI 9 = Inpatient, Other 4 = End-of-Life
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)

_____	_____	_____
Last	*First*	*Middle Name or Initial*

7. Patient Street Address (FL09, line 1a):	8. City (FL09, line 2b)

9. State (FL09, line 2c)	10. ZIP (FL09, line 2d)	11. Country Code (FL09, line 2e)	12a. Birth Date (FL10)
__ __ If in US, complete items 9 and 10, but skip item 11	__ __ __ __ __ - __ __ __ __	__ __	MM __ __ DD__ __ YYYY __ __ __ __ (Only if DOB is unavailable from the UB-04 Medical Record Face Sheet, record age) **12b**. Age : ___ ___ ___ Units: ☐ Years ☐ Months ☐ Days

13. Sex (FL11)	14. Admission Date (FL12)	15. Admission Type (FL14)
M = Male F = Female U = Unknown	MM __ __ DD__ __ YY __ __ (If the complete admission date is unavailable from the UB-04, record based on the Medical Record Face Sheet.)	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 distin unit of the same hospital resulting in a separate claim to paye
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

Newborn Code Structure
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

2 = Discharge / transferred to short term general hosp for inpt care

3 = Discharge / transferred to SNF

4 = Discharge / transferred to ICF

5 = Discharge / transferred to a designated Cancer Center or Children's Hospital

6 = Discharge / transferred to home under care of organized home health service organization

7 = Left AMA or discontinued care

8 = Reserved for assignment by the NUBC

9 = Admitted as an Inpt to this hospital

10-19 = Reserved for assignment by the NUBC

20 = Expired

21-29 = Reserved for assignment by the NUBC

30 = Still Patient

31-39 = Reserved for assignment by the NUBC

40 = Expired at Home

41 = Expired in Medical Facility

42 = Expired – Place Unknown

43 = Discharge / transferred to Federal Health Care Facility

44-49 = Reserved for assignment by the NUBC

50 = Hospice - home

51 = Hospice – Medical Facility

52-60 = Reserved for assignment by the NUBC

61 = Discharge / transferred to a hospital-based Medicare Approved swing bed

62 = Discharge / transferred to an IRF including Rehabilitation Distinct Part Units of a Hospital

63 = Discharge / transferred to a Medicare Certified LTCH

64 = Discharge / transferred to a Nursing Facility Certified unde Medicaid but not Certified under Medicare

65 = Discharge/ transferred to a Psychiatric Hospital or Psychia Distinct Part Unit of a Hospital

66 = Discharge/ transferred to a CAH

67-69 = Reserved for assignment by the NUBC

70 = Discharged /transferred to another Type of Health Care Institution not Defined Elsewhere in the Code List

71-99 = Reserved for assignment by the NUBC

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			.

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

Principal Diagnoses		
	19a. ICD-9-CM Code (FL67, FL67a-q)	**19b. Present at Admission? (8th position of FL67 and FL67a-q)**
Prin Dx		☐Y ☐N ☐U ☐W
Oth Dx		☐Y ☐N ☐U ☐W
Oth Dx		☐Y ☐N ☐U ☐W
Oth Dx		☐Y ☐N ☐U ☐W
Oth Dx		☐Y ☐N ☐U ☐W
Oth Dx		☐Y ☐N ☐U ☐W
Oth Dx		☐Y ☐N ☐U ☐W
Oth Dx		☐Y ☐N ☐U ☐W
Oth Dx		☐Y ☐N ☐U ☐W
Oth Dx		☐Y ☐N ☐U ☐W
Oth Dx		☐Y ☐N ☐U ☐W
Oth Dx		☐Y ☐N ☐U ☐W
Oth Dx		☐Y ☐N ☐U ☐W
Oth Dx		☐Y ☐N ☐U ☐W
Oth Dx		☐Y ☐N ☐U ☐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)**
☐ No E-codes	
E-Code 1	☐Y ☐N ☐U ☐W
E-Code 2	☐Y ☐N ☐U ☐W
E-Code 3	☐Y ☐N ☐U ☐W

Instructions: Record up to 6 procedures.

22. Principal Procedures (FL 74)

☐ **No procedures**

	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 <u>NEWBORN</u> (Per item 3 {Sampling Stratum} code 2 "normal newborn" <u>or</u> item 15 {Adm Type} code 5

"newborn"), skip to Question 36.

32. Vital Signs Value On First Presentation on the day of admission

Height: ___ ft ___ ___ in **OR** ___ ___ ___ cm

Weight: ___ ___ ___ lbs **OR** ___ ___ ___ kg

33. Clinical Laboratory Results: Initial Results on th day of admission

Hematocrit (Hct): ___ ___.___%

White Cell Count (WBC): ___ ___ ___.___ x1000/µL

Platelet Count (Plt): ___ ___ ___ x1000/µL

Sodium (Na): ___ ___ ___ mmol/L

Potassium (K): ___ ___.___ mmol/L

Urea Nitrogen (BUN): ___ ___ ___ mg/dL

Creatinine (Cr): ___ ___.___ mg/dL

34.

35.

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.	Medications Patient Was Taking Immediately Preceding Admission (Do not Include Medications Only Given in the Emergency Department)
	☐ None ☐ Not applicable (newborn) ☐ Unknown
	List up to 20 pre-admit medications
1.	
2.	
3.	

4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
16.	
17.	
18.	
19.	
20.	

38.	Medications Prescribed at Discharge
	☐ None ☐ Not applicable (patient expired) ☐ Unknown
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
16.	
17.	
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**	
☐ 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	
39b. Actual Payment by Source			
.	.	.	

40. Social Security Number

☐ 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: ☐ None ☐ Not applicable (newborn) ☐ Unknown						
Index Admission	____/____/____	____/____/____				
1	____/____/____	____/____/____				
2	____/____/____	____/____/____				
3	____/____/____	____/____/____				
30 days post discharge Check here if: ☐ None ☐ Not applicable (patient expired) ☐ Unknown						
Index Discharge	____/____/____	____/____/____				
1	____/____/____	____/____/____				

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	**43. Time of First Hospital Contact**
MM ___ ___ DD ___ ___ YY ___ ___	___ ___ : ___ ___ AM or PM (circle one)

44. Troponin Levels

☐ 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	**46. Elective (Planned) Cardiac Procedure Admission**
☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ 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	**48. Type of Advanced Care Plan on Admission (Check All That Apply)**
☐ Yes ☐ No (Skip to question 49) ☐ Don't Know (Skip to question 49)	☐ Comfort Measures Only Order ☐ Do Not Resuscitate Order ☐ Do Not Intubate Order ☐ Health Care Proxy / Durable Power of Attorney / Surrogate Decision Maker ☐ Advanced Directive / Living Will / POLST (Physician Orders for Life Sustaining Treatment) or Other State Program ☐ Other
49. Do Not Resuscitate Order (During	**50.**

Hospitalization)

☐ Yes -------> Date of Order: __ __ / __ __ / __ __
M M D D Y Y

☐ No

☐ Don't Know

I. INFECTIOUS DISEASE ITEMS

INFORMATION FROM THE LABORATORY RECORDS

51. Did this discharge have any positive blood cultures during this inpatient stay?

☐ Yes (Skip to Item 53)

☐ No -------> Do Not Complete Items 52 - 59

52. How many positive blood cultures were recorded during this stay?

_____ Number of Positive Blood Cultures

53. Date of first positive culture

____ ____ / ____ ____ / ____ ____
M M D D Y Y

54. Name of first organism corresponding to first positive blood culture. (Select from pathogen code dictionary)

Genus	Species	Organism ID Code (To be generated by the system)

INFORMATION FROM THE MEDICAL CHART

55. 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]?

☐ Yes

☐ No