

2012 ED



Form Approved: OMB No. 0920-0278; Expiration date 08/31/2012



PRETEST

National Hospital Ambulatory Medical Care Survey

2012 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		Mon.	Tues.	Wed.	Thur.	Fri.	Sat.	Sun.	Total	
WEEK 1									WEEK 3									
Dates									Dates									
No. of patient visits									No. of patient visits									
No. of records filled									No. of records filled									
WEEK 2									WEEK 4									
Dates									Dates									
No. of patient visits									No. of patient visits									
No. of records filled									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) (4-19-2011)



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**); 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, review 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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PATIENT RECORD NO.:

PATIENT'S NAME:

**NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY
2012 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

a. Date and time of visit				b. ZIP Code				c. Date of birth				
Month	Day	Year	Time	a.m.	p.m.	Military		Month	Day	Year		
		1										
(1) Arrival												
Seen by (2) MD/DO/PA/NP				d. Patient residence				e. Sex		f. Ethnicity		
				1 <input type="checkbox"/> Private residence 2 <input type="checkbox"/> Nursing home 3 <input type="checkbox"/> Homeless 4 <input type="checkbox"/> Other 5 <input type="checkbox"/> Unknown				1 <input type="checkbox"/> Female 2 <input type="checkbox"/> Male		1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino		
(3) ED discharge												
g. Race – Mark (X) one or more.					h. Arrival by ambulance			i. Expected source(s) of payment for this visit – Mark (X) all that apply.				
1 <input type="checkbox"/> White 2 <input type="checkbox"/> Black or African American 3 <input type="checkbox"/> Asian 4 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 5 <input type="checkbox"/> American Indian or Alaska Native					1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown			1 <input type="checkbox"/> Private insurance 2 <input type="checkbox"/> Medicare 3 <input type="checkbox"/> Medicaid or CHIP 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

a. Initial vital signs	(1) Temperature	(2) Heart rate	(3) Respiratory rate	b. Triage level (1-5)	c. Pain scale (0-10)
		per minute	per minute		
(4) Blood pressure	(5) Pulse oximetry		(6) On oxygen on arrival		
Systolic / Diastolic	%		1 <input type="checkbox"/> Yes 3 <input type="checkbox"/> Unknown 2 <input type="checkbox"/> No		
			1 <input type="checkbox"/> No triage 2 <input type="checkbox"/> Unknown		1 <input type="checkbox"/> Unknown

3. PREVIOUS CARE

4. REASON FOR VISIT

a. Has patient been –	Yes	No	Unknown	a. Patient's complaint(s), symptom(s), or other reason(s) for this visit Use patient's own words.	b. Episode of care	
(1) seen in this ED within the last 72 hours and discharged?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>			1 <input type="checkbox"/> Initial visit to this ED for problem
(2) discharged from any hospital within the last 30 days?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>			2 <input type="checkbox"/> Follow-up visit to this ED for problem
b. How many times has patient been seen in this ED within the last 12 months?			3 <input type="checkbox"/>	3 <input type="checkbox"/> Unknown		

5. INJURY/POISONING/ADVERSE EFFECT

a. Is this visit related to an injury, poisoning, or adverse effect of medical treatment? Mark (X) all that apply.	b. Is this injury/poisoning intentional?	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.).
1 <input type="checkbox"/> Yes, injury/trauma 2 <input type="checkbox"/> Yes, poisoning 3 <input type="checkbox"/> Yes, adverse effect of medical treatment – SKIP to 5c 4 <input type="checkbox"/> No 5 <input type="checkbox"/> Unknown } 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

a. As specifically as possible, list diagnoses related to this visit including chronic conditions.	(1) Primary diagnosis:	b. Does patient have – Mark (X) all that apply.
	(2) Other:	1 <input type="checkbox"/> Cancer 2 <input type="checkbox"/> Cerebrovascular disease/History of stroke or transient ischemic attack (TIA) 3 <input type="checkbox"/> Chronic lung disease 4 <input type="checkbox"/> Congestive heart failure 5 <input type="checkbox"/> Condition requiring dialysis 6 <input type="checkbox"/> Current medications includes Coumadin (warfarin) 7 <input type="checkbox"/> Dementia 8 <input type="checkbox"/> Diabetes 9 <input type="checkbox"/> History of heart attack 10 <input type="checkbox"/> History of pulmonary embolism or deep vein thrombosis (DVT) 11 <input type="checkbox"/> HIV 12 <input type="checkbox"/> None of the above
	(3) Other:	

7. DIAGNOSTIC SERVICES

8. PROCEDURES

9. MEDICATIONS & IMMUNIZATIONS

<p>Mark (X) all ordered or provided at this visit.</p> <p>1 <input type="checkbox"/> NONE</p> <p>Blood tests:</p> <p>2 <input type="checkbox"/> Arterial blood gases</p> <p>3 <input type="checkbox"/> BAC (blood alcohol concentration)</p> <p>4 <input type="checkbox"/> Blood culture</p> <p>5 <input type="checkbox"/> BNP (brain natriuretic peptide)</p> <p>6 <input type="checkbox"/> BUN/Creatinine</p> <p>7 <input type="checkbox"/> Cardiac enzymes</p> <p>8 <input type="checkbox"/> CBC</p> <p>9 <input type="checkbox"/> D-dimer</p> <p>10 <input type="checkbox"/> Electrolytes</p> <p>11 <input type="checkbox"/> Glucose</p> <p>12 <input type="checkbox"/> Lactate</p> <p>13 <input type="checkbox"/> Liver function tests</p> <p>14 <input type="checkbox"/> Prothrombin time/INR</p> <p>15 <input type="checkbox"/> Other blood test</p> <p>Other tests:</p> <p>16 <input type="checkbox"/> Cardiac monitor</p> <p>17 <input type="checkbox"/> EKG/ECG</p> <p>18 <input type="checkbox"/> HIV test</p> <p>19 <input type="checkbox"/> Influenza test</p> <p>20 <input type="checkbox"/> Pregnancy/HCG test</p> <p>21 <input type="checkbox"/> Toxicology screen</p> <p>22 <input type="checkbox"/> Urinalysis (UA)</p> <p>23 <input type="checkbox"/> Wound culture</p> <p>24 <input type="checkbox"/> Urine culture</p> <p>25 <input type="checkbox"/> Other test/service</p> <p>Imaging:</p> <p>26 <input type="checkbox"/> X-ray</p> <p>27 <input type="checkbox"/> Intravenous contrast</p> <p>28 <input type="checkbox"/> CT scan</p> <p>29 <input type="checkbox"/> MRI</p> <p>30 <input type="checkbox"/> Ultrasound</p> <p>31 <input type="checkbox"/> Other imaging</p> <p>Performed by: <input type="checkbox"/> Emergency physician <input type="checkbox"/> Radiologist</p>	<p>Mark (X) all provided at this visit. Exclude medications.</p> <p>1 <input type="checkbox"/> NONE</p> <p>2 <input type="checkbox"/> BiPAP/CPAP</p> <p>3 <input type="checkbox"/> Bladder catheter</p> <p>4 <input type="checkbox"/> Cast, splint, wrap</p> <p>5 <input type="checkbox"/> Central line</p> <p>6 <input type="checkbox"/> CPR</p> <p>7 <input type="checkbox"/> Endotracheal intubation</p> <p>8 <input type="checkbox"/> Incision & drainage (I&D)</p> <p>9 <input type="checkbox"/> IV fluids</p> <p>10 <input type="checkbox"/> Lumbar puncture</p> <p>11 <input type="checkbox"/> Nebulizer therapy</p> <p>12 <input type="checkbox"/> Pelvic exam</p> <p>13 <input type="checkbox"/> Suturing/Staples</p> <p>14 <input type="checkbox"/> Skin adhesives</p> <p>15 <input type="checkbox"/> Other</p>	<p>List up to 8 drugs given at this visit or prescribed at ED discharge. Include Rx and OTC drugs, immunizations, and anesthetics.</p> <p><input type="checkbox"/> NONE</p> <table border="1"> <thead> <tr> <th></th> <th>Given in ED</th> <th>Rx at discharge</th> </tr> </thead> <tbody> <tr> <td>(1)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(2)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(3)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(4)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(5)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(6)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(7)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> <tr> <td>(8)</td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> </tbody> </table>		Given in ED	Rx at discharge	(1)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(2)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(3)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(4)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(5)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(6)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(7)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(8)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
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(5)	1 <input type="checkbox"/>	2 <input type="checkbox"/>																											
(6)	1 <input type="checkbox"/>	2 <input type="checkbox"/>																											
(7)	1 <input type="checkbox"/>	2 <input type="checkbox"/>																											
(8)	1 <input type="checkbox"/>	2 <input type="checkbox"/>																											

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. VISIT DISPOSITION

Mark (X) all that apply.

- 1 No follow-up planned
 - 2 Return to ED
 - 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
 - 14 Admit to observation unit, then discharged – SKIP to **Item 13**
 - 15 Other
- } Continue with **Item 12**

12. 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 or transfer

Month	Day	Year	Time	a.m.	p.m.	Military
		1				

1 Unknown

d. Date and time patient actually left the ED or observation unit

Month	Day	Year	Time	a.m.	p.m.	Military
		1				

1 Unknown

b. Admitting physician

- 1 Hospitalist
- 2 Not hospitalist
- 3 Unknown

e. Hospital discharge date

Month	Day	Year
		1

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.

13. OBSERVATION UNIT STAY

a. Date and time of observation unit discharge

Month	Day	Year	Time	a.m.	p.m.	Military
		1				

1 Unknown