

# Attachment R: Emergency Department Patient Record form

## Ambulatory Component, National Hospital Care Survey

OMB No. 0920-0212 Exp. Date: XX/XX/XXXX

**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).

**Notice** – Public reporting burden for this collection of information is estimated to average 0 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 (0920-0212).

Forms Answer Navigate Options Help

1 First 2 Prev 3 Next 4 Last 5 Add 6 Delete 7 Exit 8 UB04 List

AU FAQ Exit/F10 Patient Info 1 Patient Info 2 Triage Reason Injury Drugs Diagnosis Services and Procedures Medications & Immunizations Providers and Disposition

♦ Enter the patient's name

♦ Is the patient's Social Security Number documented?

♦ Enter the patient's Social Security Number

? [F1] ♦ Is the patient's Control Number documented?

♦ Enter the patient's Control Number

♦ Is the patient's address documented?

♦ What is the patient's address?  
Enter the number and street.

♦ Enter the second line of the address

♦ Enter the city

♦ Enter the state

? [F1] ♦ Is the patient's Medical Record Number documented?

♦ Enter the patient's Medical Record Number.

? [F1] ♦ Is the patient's Medicare Health Insurance Benefit/Claim Number documented?

♦ Enter the patient's Medicare Health Insurance Benefit/Claim Number.

? [F1] ♦ Is the National Provider Identifier - Attending documented?

♦ Enter the National Provider Identifier - Attending.

? [F1] ♦ Is the National Provider Identifier - Operating documented?

♦ Enter the National Provider Identifier - Operating.

# Attachment R: Emergency Department Patient Record form

Forms Answer Navigate Options Help

1 First 2 Prev 3 Next 4 Last 5 Add 6 Delete 7 Exit 8 UB04 List

AU FAQ Exit/F10 Patient Info 1 Patient Info 2 Triage Reason Injury Drugs Diagnosis Services and Procedures Medications & Immunizations Providers and Disposition

**2 of 3 PRF's MRN: CDC-100(ED) PATIENT INFORMATION**

**Date and time of visit**

	Date	Time	
(1) Arrival	<input type="text"/>	<input type="text"/>	Enter HH:MM AM/PM/ML
(2) Seen by MD/DO/PA/NP ? [F1]	<input type="text"/>	<input type="text"/>	Enter HH:MM AM/PM/ML
(3) ED departure ? [F1]	<input type="text"/>	<input type="text"/>	Enter HH:MM AM/PM/ML

? [F1]

♦ **Patient Residence**

1. Private residence  5. Unknown

2. Institution

3. Homeless/ Homeless Shelter

4. Other

♦ **Patient's 5-digit zip code. (Enter "1" if homeless)**

♦ **Date of birth. Enter mmdyyy.**

♦ **Age**

♦ **Enter time period**

1. Years  3. Days

2. Months

♦ **Sex**

1. Female

2. Male

? [F1] ♦ **Ethnicity**

1. Hispanic or Latino

2. Not Hispanic or Latino

? [F1] ♦ **Race**

Enter all that apply, separate with commas

1. White  4. Native Hawaiian or Other Pacific Islander

2. Black or African American  5. American Indian or Alaska Native

3. Asian

? [F1] ♦ **Mode of arrival**

1. Ambulance

2. Police transport

3. Other

4. Unknown

? [F1] ♦ **Expected source(s) of payment for THIS VISIT.**

Enter all that apply, separate with commas

1. Private Insurance  4. Medicaid or CHIP

2. Tricare  5. Worker's compensation

3. Medicare  6. Self-pay

## Payment sources 6-9.

? [F1] ♦ **Mode of arrival**

1. Ambulance

2. Police transport

3. Other

4. Unknown

? [F1] ♦ **Expected source(s) of payment for THIS VISIT.**

Enter all that apply, separate with commas

6. Self-pay  9. Unknown

7. No charge /Charity

8. Other

Not shown (not new):

For "Patient Residence" checkbox 2 "Institution", the subcategories are Nursing home, Supportive housing/Group home, Jail/Prison, and Other.

# Attachment R: Emergency Department Patient Record form

Forms Answer Navigate Options Help																																							
1 First		2 Prev		3 Next		4 Last		5 Add		6 Delete		7 Exit		8 UB04 List																									
AU		FAQ		Exit/F10		Patient Info 1		Patient Info 2		Triage		Reason		Injury		Drugs		Diagnosis		Services and Procedures		Medications & Immunizations		Providers and Disposition															
2 of 3 PRF's MRN: CDC-100(ED) Triage																																							
♦ Temperature <input type="text"/>										<input type="radio"/> 1. Celsius <input type="radio"/> 2. Fahrenheit										♦ Heart rate, Enter 998 for DOPP or DOPPLER (beats per minute) <input type="text"/>										♦ Respiratory rate (breaths per minute) <input type="text"/>									
♦ Blood Pressure - SYSTOLIC refers to the top number of the blood pressure measurement. <input type="text"/>																																							
♦ Blood pressure - DIASTOLIC refers to the bottom number of the blood pressure measurement. Enter 998 for P, PALP, DOPP, or DOPPLER <input type="text"/>																																							
♦ Pulse oximetry (percent of oxyhemoglobin saturation; value is usually between 80-100%) <input type="text"/>														♦ On oxygen at arrival <input type="text"/>																									
														<input type="radio"/> 1. Yes <input type="radio"/> 2. No <input type="radio"/> 3. Unknown																									
? [F1] ♦ Triage level (1-5) Enter 0 for no triage and 9 if unknown <input type="text"/>														? [F1] ♦ Pain scale (0-10) Enter 99 if unknown <input type="text"/>																									
? [F1] ♦ Was patient seen in this ED within the last 72 hours and discharged? <input type="text"/>																																							
<input type="radio"/> 1. Yes <input type="radio"/> 2. No <input type="radio"/> 3. Unknown																																							

Initial vital signs

New:

Vital signs on ED discharge - Temperature, Heart rate, Respiratory rate, Blood pressure - systolic and diastolic

# Attachment R: Emergency Department Patient Record form

Forms Answer Navigate Options Help															
1 First		2 Prev		3 Next		4 Last		5 Add		6 Delete		7 Exit		8 UB04 List	
AU	FAQ	Exit/F10	Patient Info 1	Patient Info 2	Triage	Reason	Injury	Drugs	Diagnosis	Services and Procedures	Medications & Immunizations	Providers and Disposition			
<b>2 of 3 PRF's      MRN:      CDC-100(ED) Reason</b>															
? [F1] <ul style="list-style-type: none"> <li>Enter the patient's complaint(s), symptom(s), or other reason(s) for this visit in the patient's own words. Enter the "most important" complaint/symptom/reason first. (Enter 0 for None/No more) Press any key or double-click in the input box for the reason for visit look up.</li> <li>Enter XXX if reason cannot be found. NEC is "not elsewhere classified", NOS is "not otherwise specified".</li> </ul>															
Most Important <input type="text"/>															
Look-Up 1 <input type="text"/>															
What is the source of the most important reason for visit? <input type="checkbox"/> <input type="radio"/> 1. In patient's own words <input type="radio"/> 2. Other <input type="radio"/> 3. Unknown															
Other: 1. <input type="text"/>															
Look-Up 2 <input type="text"/>															
Other: 2. <input type="text"/>															
Look-Up 3 <input type="text"/>															
Episode of care. <input type="checkbox"/> <input type="radio"/> 1. Initial visit to this ED for problem <input type="radio"/> 2. Follow-up visit to this ED for problem <input type="radio"/> 3. Unknown															
Press Enter to Continue.															
Includes:															
Excludes:															

Revised: This question was moved from the SUBSTANCES INVOLVED item and will come after REASON FOR VISIT. It was also modified.

### Did alcohol cause or contribute to this visit?

- Yes, patient's own use
- Yes, other person's use
- No
- Unknown

# Attachment R: Emergency Department Patient Record form

Forms Answer Navigate Options Help															
1 First		2 Prev		3 Next		4 Last		5 Add		6 Delete		7 Exit		8 UB04 List	
AU	FAQ	Exit/F10	Patient Info 1	Patient Info 2	Triage	Reason	Injury	Drugs	Diagnosis	Services and Procedures	Medications & Immunizations	Providers and Disposition			
2 of 3 PRF's MRN: CDC-100(ED) Injury															
? [F1]															
♦ Is this visit related to an injury, overdose, poisoning, or adverse effect of medical or surgical treatment?															
				<input type="radio"/> 1. No <input type="radio"/> 2. Yes, injury/trauma <input type="radio"/> 3. Yes, poisoning (non-drug toxic substance)				<input type="radio"/> 4. Yes, poisoning (drug-induced overdose) <input type="radio"/> 5. Yes, adverse effect of medical or surgical treatment <input type="radio"/> 6. Unknown							
<input type="checkbox"/>															
? [F1]															
♦ Poisoning (drug-induced overdose):															
Indicate the kind of drug(s) involved.															
				<input type="radio"/> 1. Medication <input type="radio"/> 2. Illicit substance <input type="radio"/> 3. Both medication and illicit substance <input type="radio"/> 4. Unknown											
<input type="checkbox"/>															
? [F1]															
♦ Is this injury/overdose/poisoning intentional?															
				<input type="radio"/> 1. Yes, self inflicted <input type="radio"/> 2. No, unintentional <input type="radio"/> 3. Unknown											
<input type="checkbox"/>															
? [F1]															
♦ Was the injury/overdose/poisoning self-inflicted or was it intentional harm by another person?															
				<input type="radio"/> 1. Self-inflicted <input type="radio"/> 2. Intentional harm by another person											
<input type="checkbox"/>															
? [F1]															
♦ Was the self-inflicted injury/overdose/poisoning a suicide attempt or selfharm/suicide gesture?															
				<input type="radio"/> 1. Suicide attempt <input type="radio"/> 2. Self-harm or suicide gesture											
<input type="checkbox"/>															

For “Is this injury/overdose/poisoning intentional?” the first checkbox “Yes, self-inflicted” should be replaced with “Yes, intentional (e.g., accidental).”

# Attachment R: Emergency Department Patient Record form

Blaise 4.8 Data Entry - C:\Users\Garage\_K\Desktop\NHCS\_Test\AU\_Main\AU

Forms Answer Navigate Options Help

1 First 2 Prev 3 Next 4 Last 5 Add 6 Delete 7 Exit 8 UB04 List

AU FAQ Ext/F10 Patient Info 1 Patient Info 2 Triage Reason Injury Drugs Diagnosis Services and Procedures Medications & Immunizations Providers and Disposition

• Adverse effect of medical or surgical treatment:

Was medication involved?  1. Yes  2. No  3. Unknown

? [F1]

• Cause of injury, poisoning by drug or non-drug toxin, drug-induced illness, or adverse effect- Describe the place and events that preceded the injury (e.g., pedestrian struck by car driven on a highway by drunk driver- for motor vehicle crash, indicate if it occurred on the street or highway versus a driveway or parking lot); poisoning by drug (e.g., injected heroin at nightclub restroom and overdosed) or non drug toxin (e.g., child swallowed bleach at home); or adverse effect (e.g., developed swelling of the throat after taking Celebrex).

Enter the primary cause on the first line, followed by the contributing causes. Up to 5 causes may be entered. After entering each cause, choose a cause from the drop down list that best matches the verbatim cause. Enter 0 when done entering causes; here or at any of the cause inputs.

Drop Down

Transportation

Cause 2

Drop Down2

Transportation

Cause 3

Drop Down3

Transportation

Cause 4

Drop Down4

Transportation

Cause 5

00020001 ADVERSE 1:50:47 PM 11-29-2012 2/3 Reporting Period: February 1 - March 31 Start With: 57 Take Every: 0 Form Approved: OMB No. 0920-0944; Expiration date: 12/31/2013

Forms Answer Navigate Options Help

1 First 2 Prev 3 Next 4 Last 5 Add 6 Delete 7 Exit 8 UB04 List

AU FAQ Ext/F10 Patient Info 1 Patient Info 2 Triage Reason Injury Drugs Diagnosis Services and Procedures Medications & Immunizations Providers and Disposition

? [F1]

• Did any substance(s) (e.g., illicit drugs, inhalants, prescription or OTC medication, dietary supplements) cause or contribute to this visit?

OR The patient is under 21 and alcohol is the only drug related to the visit.

Enter all substance(s) that caused or contributed to the ED visit. Record substance as specifically as possible (i.e. brand [trade] name preferred over generic name preferred over chemical name, etc.). Do not record the same substance by two different names. Do not record current medications unrelated to the visit.

1. Yes  2. No  3. Unknown

2 of 3 PRF's

The 3<sup>rd</sup> checkbox should read "Unknown/Not documented."

## Attachment R: Emergency Department Patient Record form

? [F1] ♦ Pick a drug from the dropdown menu. (DAWN DRV) Type 0 when done adding substances that caused or contributed to this visit.				
Drugs Lookup	Toxicology Confirmation	Route	Types of Drugs	
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
? [F1] ♦ Mark if confirmed by toxicology report.				
<input checked="" type="radio"/> 1. Yes <input type="radio"/> 2. No				
For "toxicology report" there should be a 3 <sup>rd</sup> checkbox "Not documented."				
? [F1] ♦ Route of Administration:				
<input type="radio"/> 1. Oral <input type="radio"/> 2. Injected <input type="radio"/> 3. Inhaled, sniffed, snorted <input type="radio"/> 4. Smoked <input type="radio"/> 5. Transdermal <input type="radio"/> 6. Other <input type="radio"/> 7. Not Documented				
? [F1] ♦ Enter all that apply; patient took:				
<input type="checkbox"/> 1. Own prescription/OTC medication or dietary supplement <input type="checkbox"/> 2. Prescription medication not prescribed for patient <input type="checkbox"/> 3. Prescription/OTC medication as prescribed or according to directions <input type="checkbox"/> 4. Too much of a prescription/OTC medication or dietary supplement <input type="checkbox"/> 5. Illicit drug(s) <input type="checkbox"/> 6. Alcohol only, under 21 <input type="checkbox"/> 7. Not documented				
? [F1] ♦ Was alcohol involved in this visit?				
<input type="radio"/> 1. Yes <input type="radio"/> 2. No/Not documented				
Alcohol Involved <input type="checkbox"/>				

This question was moved to come after REASON FOR VISIT and was modified:  
 Was alcohol involved in this visit?

# Attachment R: Emergency Department Patient Record form

Forms Answer Navigate Options Help

1 First 2 Prev 3 Next 4 Last 5 Add 6 Delete 7 Exit 8 UB04 List

AU FAQ Ext/F10 Patient Info 1 Patient Info 2 Triage Reason Injury Drugs **Diagnosis** Services and Procedures Medications & Immunizations Providers and Disposition

**2 of 3 PRF's MRN: CDC-100(ED) Diagnosis**

? [F1]  
 ♦ As specifically as possible, list diagnoses related to this visit including chronic conditions.  
 List PRIMARY diagnosis first

Primary:

Enter "XXX" if diagnosis cannot be found. Enter 0 when done.  
 NEC is "not elsewhere classified", NOS is "not otherwise specified".  
 Press any key or double click in the input box for the diagnosis look up.

\*Enter the ICD Code.  
 Enter 0 if None.

Look-Up Diag.

Other 2

Look-Up Diag.

ICD9 Code

Other 3

Look-Up Diag.

ICD9 Code

Other 4

Look-Up Diag.

ICD9 Code

Other 5

Look-Up Diag.

ICD9 Code

Other 6

? [F1]  
 ♦ Does patient have:  
 (Enter all that apply, separate with commas)

<input type="checkbox"/> 1. Cancer	<input type="checkbox"/> 3. Chronic obstructive pulmonary disease (COPD)	<input type="checkbox"/> 7. Diabetes	<input type="checkbox"/> 10. HIV infection/AIDS
<input type="checkbox"/> 2. Cerebrovascular disease/History of stroke or transient ischemic attack (TIA)	<input type="checkbox"/> 4. Condition requiring dialysis	<input type="checkbox"/> 8. History of heart attack or myocardial infarction (MI)	<input type="checkbox"/> 11. Mental illness or episode
<input type="checkbox"/> 5. Congestive heart failure (CHF)	<input type="checkbox"/> 6. Dementia	<input type="checkbox"/> 9. History of pulmonary embolism (PE) or deep vein thrombosis (DVT)	<input type="checkbox"/> 12. Substance abuse, misuse, or dependence
			<input type="checkbox"/> 13. None of the above
			<input type="checkbox"/> 14. Not documented

Not shown (not new except for PTSD):

Under checkbox 11 – Mental illness or episode are checkboxes for Bipolar disorder/Manic depression; Depression, excluding manic depression; Post-traumatic stress disorder (PTSD); Schizophrenia; Suicidal ideation; and Other.



# Attachment R: Emergency Department Patient Record form

Forms Answer Navigate Options Help

1 First 2 Prev 3 Next 4 Last 5 Add 6 Delete 7 Exit 8 UB04 List

AU FAQ Exit/F10 Patient Info 1 Patient Info 2 Triage Reason Injury Drugs Diagnosis Services and Procedures Medications & Immunizations Providers and Disposition

**2 of 3 PRF's MRN: CDC-100(ED) SERVICES AND PROCEDURES**

? [F1]

♦ **Diagnostic Services**  
Enter all ORDERED or PROVIDED at this visit, separate with commas

<input type="checkbox"/> 1. NONE	<input type="checkbox"/> 11. Glucose	<input type="checkbox"/> 23. Urine culture
<b>Blood tests:</b>	<input type="checkbox"/> 12. Lactate	<input type="checkbox"/> 24. Wound culture
<input type="checkbox"/> 2. ABG (Arterial blood gases)	<input type="checkbox"/> 13. LFT (Liver function tests)	<input type="checkbox"/> 25. Other test/service
<input type="checkbox"/> 3. BAC (blood alcohol concentration)	<input type="checkbox"/> 14. Prothrombin time/INR	<b>Imaging:</b>
<input type="checkbox"/> 4. Blood culture	<input type="checkbox"/> 15. Other blood test	<input type="checkbox"/> 26. X-ray
<input type="checkbox"/> 5. BNP (brain natriuretic peptide)	<b>Other tests:</b>	<input type="checkbox"/> 27. Intravenous contrast
<input type="checkbox"/> 6. BUN/Creatinine	<input type="checkbox"/> 16. Cardiac monitor	<input type="checkbox"/> 28. CT scan
<input type="checkbox"/> 7. CE (Cardiac enzymes)	<input type="checkbox"/> 17. EKG/ECG	<input type="checkbox"/> 29. MRI
<input type="checkbox"/> 8. CBC (Complete blood count)	<input type="checkbox"/> 18. HIV test	<input type="checkbox"/> 30. Ultrasound
<input type="checkbox"/> 9. D-dimer	<input type="checkbox"/> 19. Influenza test	<input type="checkbox"/> 31. Other imaging
<input type="checkbox"/> 10. Electrolytes	<input type="checkbox"/> 20. Pregnancy/HCG test	
	<input type="checkbox"/> 21. Toxicology screen	
	<input type="checkbox"/> 22. UA (Urinalysis) or urine dipstick	

---

♦ **What body site was scanned during the CT scan?**  
Enter all that apply, separate with commas

1. Abdomen/  2. Chest  4. Other  
Pelvis  3. Head

♦ **Who performed the ultrasound?**

1. Emergency physician  2. Other  3. Unknown

---

? [F1]

♦ **Enter all procedures PROVIDED at this visit, separate with commas. Exclude medications.**

<input type="checkbox"/> 1. NONE	<input type="checkbox"/> 12. Pelvic exam
<input type="checkbox"/> 2. BiPAP/CPAP	<input type="checkbox"/> 13. Physical restraint
<input type="checkbox"/> 3. Bladder catheter	<input type="checkbox"/> 14. Psychiatry/Psychology/Substance abuse consult
<input type="checkbox"/> 4. Cast, splint, wrap	<input type="checkbox"/> 15. Skin adhesives
<input type="checkbox"/> 5. Central line	<input type="checkbox"/> 16. Suturing/Staples
<input type="checkbox"/> 6. CPR	<input type="checkbox"/> 17. Other
<input type="checkbox"/> 7. Endotracheal intubation	
<input type="checkbox"/> 8. Incision and drainage	
<input type="checkbox"/> 9. IV fluids	
<input type="checkbox"/> 10. Lumbar puncture	
<input type="checkbox"/> 11. Nebulizer therapy	

Not shown (not new):

Blood tests, checkbox 3 – BAC result will be entered.

New (revision):

Blood tests, checkbox 14 – “Prothrombin time/PTT/INR.”

# Attachment R: Emergency Department Patient Record form

Forms   Answer   Navigate   Options   Help																									
1 First		2 Prev		3 Next		4 Last		5 Add		6 Delete		7 Exit		8 UB04 List											
AU		FAQ		Ext/F10		Patient Info 1		Patient Info 2		Triage		Reason		Injury		Drugs		Diagnosis		Services and Procedures		Medications & Immunizations		Providers and Disposition	
<p>? [F1]</p> <p>♦ Enter drugs given at this visit or prescribed at ED discharge. Include Rx and OTC drugs, immunizations, and anesthetics.</p> <p>Enter XXX if medication cannot be found Enter 0 for None/No more</p>																									
Drug												Drug Lookup										When given			
[1]																									
[2]																									
[3]																									
[4]																									
[5]																									
[6]																									
[7]																									
[8]																									
[9]																									
[10]																									
[11]																									
[12]																									
<p>♦ When was this drug given?</p>																									
<input type="radio"/> 1. Given in ED													<input type="radio"/> 3. Both given in ED and Rx at discharge												
<input type="radio"/> 2. Rx at discharge																									

# Attachment R: Emergency Department Patient Record form

Forms Answer Navigate Options Help															
1 First		2 Prev		3 Next		4 Last		5 Add		6 Delete		7 Exit		8 UB04 List	
AU	FAQ	Exit/F10	Patient Info 1	Patient Info 2	Triage	Reason	Injury	Drugs	Diagnosis	Services and Procedures	Medications & Immunizations	Providers and Disposition			
2 of 3 PRF's      MRN:      CDC-100(ED) DISPOSITION															
? [F1]   ♦ Enter all providers seen at this visit, separate with commas			<input type="checkbox"/> 1. ED attending physician			<input type="checkbox"/> 5. Nurse practitioner			<input type="checkbox"/> 9. Social worker						
<input type="text"/>			<input type="checkbox"/> 2. ED resident/Intern			<input type="checkbox"/> 6. Physician assistant			<input type="checkbox"/> 10. Other mental health provider						
			<input type="checkbox"/> 3. Consulting physician			<input type="checkbox"/> 7. EMT			<input type="checkbox"/> 11. Other provider						
			<input type="checkbox"/> 4. RN/LPN			<input type="checkbox"/> 8. Psychologist									
? [F1]   ♦ Speciality of consulting physician			<input type="checkbox"/> 1. Anesthesia			<input type="checkbox"/> 5. Palliative Care									
<input type="text"/>			<input type="checkbox"/> 2. Critical Care			<input type="checkbox"/> 6. Psychiatry									
			<input type="checkbox"/> 3. ENT (Otolaryngology)			<input type="checkbox"/> 7. Other Specialty									
			<input type="checkbox"/> 4. Hematology/Oncology			<input type="checkbox"/> 8. Unknown									
? [F1]   ♦ Visit Disposition (Enter all that apply, separate with commas)			<input type="checkbox"/> 1. No follow-up planned			<input type="checkbox"/> 8. Died in ED			<input type="checkbox"/> 13. Admit to this hospital						
<input type="text"/>			<input type="checkbox"/> 2. Return to ED			<input type="checkbox"/> 9. Return/Transfer to nursing home			<input type="checkbox"/> 14. Admit to observation unit then hospitalized						
			<input type="checkbox"/> 3. Return/Refer to physician/clinic for follow-up			<input type="checkbox"/> 10. Return/Transfer to jail/prison			<input type="checkbox"/> 15. Admit to observation unit, then discharged						
			<input type="checkbox"/> 4. Left before triage			<input type="checkbox"/> 11. Transfer to acute 24-hour behavioral health care facility			<input type="checkbox"/> 16. Other						
			<input type="checkbox"/> 5. Left after triage			<input type="checkbox"/> 12. Transfer to other non-psychiatric hospital									
			<input type="checkbox"/> 6. Left AMA												
			<input type="checkbox"/> 7. DOA												
? [F1]   ♦ Specify the type of follow-up. Return/Refer to physician/clinic for:			<input type="radio"/> 1. Outpatient mental health treatment			<input type="radio"/> 2. Substance abuse treatment									
<input type="text"/>						<input type="radio"/> 3. Other follow-up									
♦ Was the patient transferred to psychiatric inpatient treatment or a substance abuse facility?			<input type="radio"/> 1. Psychiatric inpatient treatment			<input type="radio"/> 2. Substance abuse treatment facility									
<input type="text"/>															
? [F1]   ♦ Indicate the reason(s) for transfer. Mark all that apply.			<input type="checkbox"/> 1. Continuity of care/Request by patient, family, or physician												
<input type="text"/>			<input type="checkbox"/> 2. Higher level or specialized care needed												
			<input type="checkbox"/> 3. Pediatric hospital needed												
			<input type="checkbox"/> 4. Insurance requirement/request												
			<input type="checkbox"/> 5. Other/Insufficient information available												

New:

For "Specialty of consulting physician" – add checkbox "General/Trauma Surgery"

New: (revision)

For "Visit disposition" checkbox 10 should read "Return/Transfer to jail/prison/law enforcement."

## Attachment R: Emergency Department Patient Record form

Forms Answer Navigate Options Help	
1 First 2 Prev 3 Next 4 Last 5 Add 6 Delete 7 Exit 8 UB04 List	
Patient Info 1 Patient Info 2 Triage Reason Injury Drugs Diagnosis Services and Procedures Medications & Immunizations Providers and Disposition Hospital	
<b>2 of 3 PRF's MRN: CDC-100(ED) HOSPITAL ADMISSION</b>	
<input type="checkbox"/> [F1] ♦ Admitted to <input type="radio"/> 1. Critical care unit <input type="radio"/> 2. Stepdown unit <input type="radio"/> 3. Operating room <input type="radio"/> 4. Mental health or detox unit <input type="radio"/> 5. Cardiac catheterization lab <input type="radio"/> 6. Other bed/unit <input type="radio"/> 7. Unknown	
<input type="checkbox"/> [F1] ♦ Admitting physician <input type="radio"/> 1. Hospitalist <input type="radio"/> 2. Not hospitalist <input type="radio"/> 3. Unknown	
<input type="checkbox"/> ♦ Date bed was requested for hospital admission or transfer	<input type="checkbox"/> ♦ Time bed was requested for hospital admission or transfer Enter HH:MM AM/PM/ML
<input type="checkbox"/> [F1] ♦ Date patient actually left the ED or observation unit	<input type="checkbox"/> [F1] ♦ Time patient actually left the ED or observation unit Enter HH:MM AM/PM/ML
<input type="checkbox"/> ♦ Hospital discharge date	
<input type="checkbox"/> ♦ Principal hospital discharge diagnosis	
<input type="checkbox"/> ♦ Hospital discharge status/disposition <input type="radio"/> 1. Alive <input type="radio"/> 2. Dead <input type="radio"/> 3. Unknown	
<input type="checkbox"/> [F1] ♦ Hospital discharge disposition <input type="radio"/> 1. Home/Residence <input type="radio"/> 2. Return/Transfer to nursing home <input type="radio"/> 3. Transfer to another facility (not usual place of residence) <input type="radio"/> 4. Return/Transfer to jail/prison <input type="radio"/> 5. Other <input type="radio"/> 6. Unknown	
<input type="checkbox"/> ♦ Date of ED discharge	<input type="checkbox"/> ♦ Time of ED discharge Enter HH:MM AM/PM/ML
<input type="checkbox"/> [F1] ♦ Date of observation unit discharge	<input type="checkbox"/> [F1] ♦ Time of observation unit discharge Enter HH:MM AM/PM/ML

(Not shown - not new)

Under "Principal hospital discharge diagnosis" the second hospital discharge diagnosis will be collected.