Ambulatory Component, National Hospital Care Survey

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

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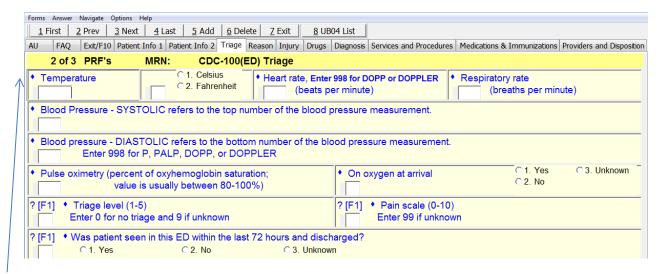
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Forms Answer Navigate Options Help		
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AU FAQ Exit/F10 Patient Info 1 Patient Info 2 Triag	ge Reason Injury Drugs Diagnosis Services and Procedu	res Medications & Immunizations Providers and Disposition
	Is the patient's address documented?	? [F1] * Is the patient's Medicare Health Insurance Benefit/Claim Number documented?
Enter the patient's name Is the patient's Social Security Number	• Enter the second line of the address	Enter the patient's Medicare Health Insurance Benefit/Claim Number.
documented? C 1. Yes C 2. No • Enter the patient's Social Security Number	• Enter the city	? [F1] Is the National Provider Identifier - Attending documented?
? [F1] * Is the patient's Control Number documented?	• Enter the state ? [F1] • Is the patient's Medical Record	Enter the National Provider Identifier - Attending.
↑ Enter the patient's Control Number	Number documented? C 1. Yes C 2. No • Enter the patient's Medical Record Number.	? [F1] * Is the National Provider Identifier - Operating documented?
		Enter the National Provider Identifier - Operating.

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			
AU FAQ Ext/F10 Patient Info 1 Patient Info 2 Triage Reason Injury Drugs 2 of 3 PRF's MRN: CDC-100(ED) PATIENT INFOR			
Date and time of visit (1) Arrival (2) Seen by MD/DO/PA/NP ? [F1] (3) ED departure ? [F1]	Time Enter HH:MM AM/PM/ML Enter HH:MM AM/PM/ML Enter HH:MM AM/PM/ML		
? [F1] Patient C 1. Private residence C 5. Unknown Residence C 2. Institution C 3. Homeless/ Homeless Shelter C 4. Other			
Patient's 5-digit zip code. (Enter "1" if homeless)			
◆ Age	• Enter time period C 1. Years C 3. Days C 2. Months		
Property Sex C1. Female C2. Male Remarks and Remarks	? [F1] ◆ Race □ 1. White □ 4. Native Hawaiian or Other Pacific apply, separate with commas □ 1. White □ 4. Native Hawaiian or Other Pacific Islander □ 3. Asian □ 5. American Indian or Alaska Native		
? [F1] • Mode of arrival C 1. Ambulance C 2. Police transport C 3. Other C 4. Unknown	? [F1] • Expected source(s) of payment for THIS VISIT. 1. Private Insurance		
Payment sources 6-9.			
? [F1] * Mode of arrival C 1. Ambulance C 2. Police transport C 3. Other C 4. Unknown	? [F1] • Expected source(s) of payment for THIS VISIT.		

Not shown (not new):

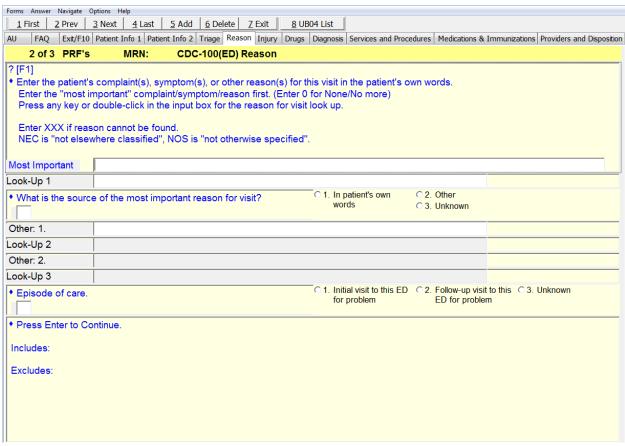
For "Patient Residence" checkbox 2 "Institution", the subcategories are Nursing home, Supportive housing/Group home, Jail/Prison, and Other.



Initial vital signs

New:

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



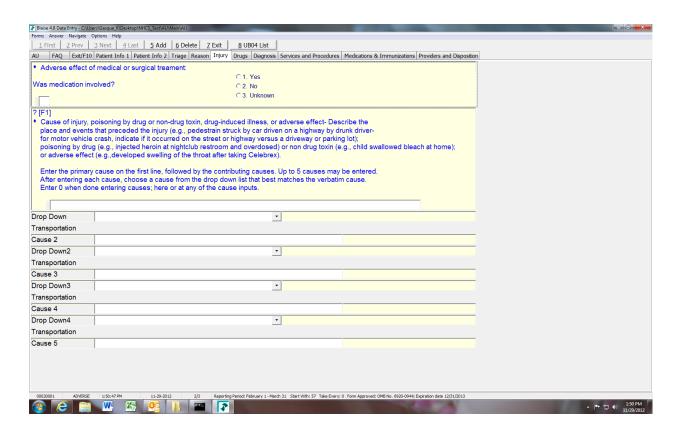
Revised: This question was moved from the SUBSTANCES INVOLVED item and will come after REASON FOR VISIT. It was also modified.

Did alcohol cause or contribute to this visit?

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

Forms Answer Navigate Options Help	
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AU FAQ Exit/F10 Patient Info 1 Patient Info 2 Triage Reason Injury	Orugs Diagnosis Services and Procedures Medications & Immunizations Providers and Disposition
2 of 3 PRF's MRN: CDC-100(ED) Injury	
? [F1]	
	C 1. No C 4. Yes, poisoning C 5. Yes, adverse effect of
or adverse effect of medical or surgical treatment?	C 2. Yes, injury/trauma (drug-induced medical or surgical overdose) treatment
	O 3. Yes, poisoning
	(non-drug toxic Unknown substance)
	Substantody
? [F1]	
Poisoning (drug-induced overdose):	C 1. Medication
Indicate the kind of dwg(a) involved	C 2. Illicit substance
indicate the kind of drug(s) invoved.	C 3. Both medication and illicit substance
	C 4. Unknown
? [F1] • Is this injury/overdose/poisoning intentional?	O.A. Was as Kindishad
	C 1. Yes, self inflicted C 2. No, unintentional
	C 3. Unknown
	C 3. OHNIOWII
? [F1]	
◆ Was the injury/overdose/poisoning self-inflicted or was it	
intentional harm by another person?	C 1. Self-inflicted
	C 2. Intentional harm by
	another person
	CA Collisian attenuat
[?[F1]	C 1. Suicide attempt
Was the self-inflicted injury/overdose/poisoning a suicide attern	opt or selfharm/suicide gesture?

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

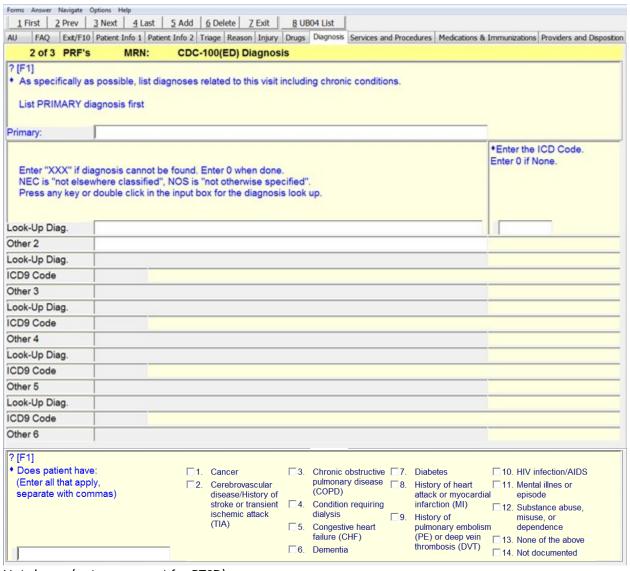


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AU FAQ Exit/F10 Patient Info 1 Patient Info 2 Triage Reason Injury Drugs Diagnosis Services and Procedures Medications & Immunizations Providers and Disposition		
? [F1]		
• Did any substance(s) (e.g., illicit drugs, inhalants, prescription or OTC 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.		
CA Vo		
C 1. Yes		
C 3. Unknown		
2 of 3 PRF's		

∥ The 3rd checkbox should read "Unknown/Not documented."

? [F1] • Pick a drug from the dropdown menu. (DA Type 0 when done adding substances that c		to this visit.		
Drugs Lookup	Tayloo	logy Confirmation Po	uto Typos of Drugo	
Drugs Lookup	TOXICO	logy Confirmation Ro	Types of Drugs	
? [F1] • Mark if confirmed by toxicology report.				
© 1. Yes C 2. No				
For "toxicology report" there shou	ld be a 3 rd chec	kbox "Not docu	ımented."	
? [F1] • Route of Administration:				
C 1. Oral	C 4. Smoked		○ 7. Not Docum	nented
C 2. Injected	○ 5. Transdermal			
C 3. Inhaled, sniffed, snorted	C 6. Other			
? [F1] • Enter all that apply; patient took:				
1. Own prescription/OTC medication or dietary supplement	3. Prescription/OTC according to direct	medication as prescribe		
Supplement 2. Prescription medication not prescribed for patien	-	escription/OTC medication	on or 7. Not docum	
? [F1] • Was alcohol involved in this visit?				
C 1. Yes C 2. No/Not documented				
Alcohol Involved				

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



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.

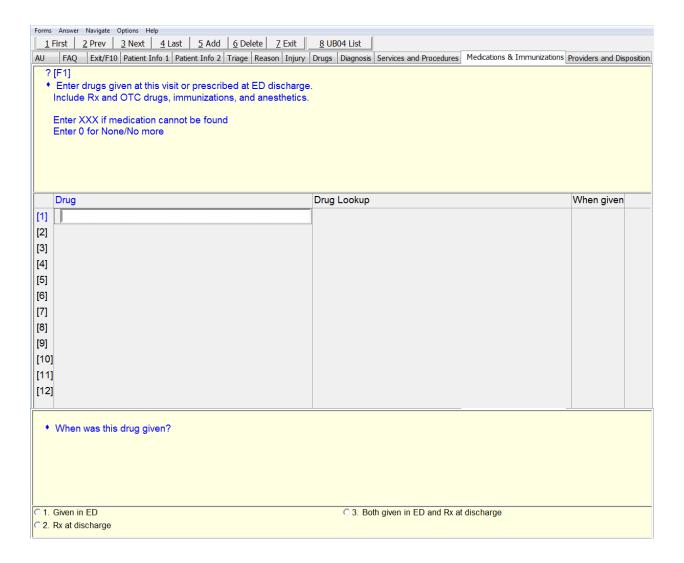
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AU FAQ Exit/F10 Patient Info 1 Patient Info 2 Triage R	eason Injury Drugs Diagnosis Services and P	Procedures Medications & Immunizations Providers and Disposition
2 of 3 PRF's MRN: CDC-100(ED) SERVICES AND PROCEDURES	
Pelvis Parks MRN: CDC-100(ED 2) 2 of 3 PRF's MRN: CDC-100(ED 2) Possible Provided	1. NONE	catate
? [F1] • Enter all procedures PROVIDED at this visit, separate with commas. Exclude medications.	1. NONE 2. BiPAP/CPAP 3. Bladder catheter 4. Cast, splint, wrap 5. Central line 6. CPR 7. Endotracheal intubation Incision and drainage 9. IV fluids 10. Lumbar puncture 11. Nebulizer therapy	☐ 12. Pelvic exam ☐ 13. Physical restraint ☐ 14. Psychiatry/Psychology/Substance abuse consult ☐ 15. Skin adhesives ☐ 16. Suturing/Staples ☐ 17. Other

Not shown (not new):

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

New (revision):

Blood tests, checkbox 14 - "Prothrombin time/PTT/INR."



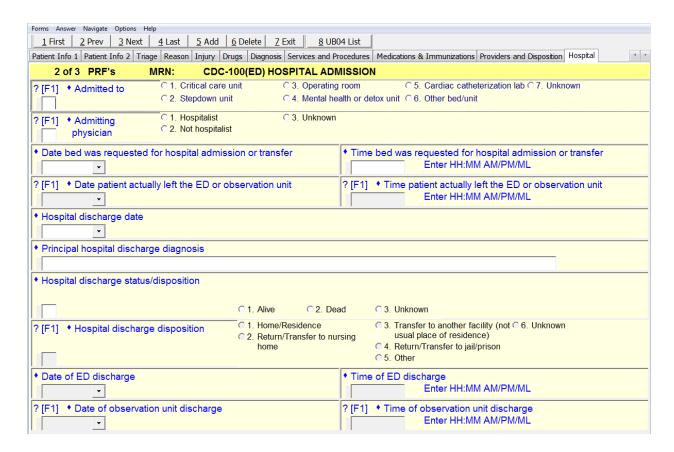
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AU FAQ Exit/F10 Patient Info 1 Patient Info 2 Tr	iage Reason Injury Drugs Diagnosis	s Services and Procedures Medications & Immunizations Providers and Disposition
2 of 3 PRF's MRN: CDC-1	00(ED) DISPOSITION	
? [F1] * Enter all providers seen at this visit, separate with commas	 □ 1. ED attending physician □ 2. ED resident/Intern □ 3. Consulting physician □ 4. RN/LPN 	 □ 5. Nurse practitioner □ 6. Physician assistant □ 7. EMT □ 10. Other mental health provider □ 11. Other provider □ 8. Psychologist
? [F1] • Speciality of consulting physician	☐ 1. Anesthesia☐ 2. Critical Care☐ 3. ENT (Otalaryngology)☐ 4. Hematology/Oncology	☐ 5. Palliative Care ☐ 6. Psychiatry ☐ 7. Other Specialty ☐ 8. Uknown
? [F1] • Visit Disposition (Enter all that apply, separate with commas)	 1. No follow-up planned 2. Return to ED 3. Return/Refer to physician/clinic for follow-up 4. Left before triage 5. Left after triage 6. Left AMA 7. DOA 	 ■ 8. Died in ED ■ 13. Admit to this hospital ■ 9. Return/Transfer to nursing home ■ 10. Return/Transfer to jail/prison ■ 11. Transfer to acute 24-hour behavioral health care facility ■ 12. Transfer to other non-psychiatric hospital
? [F1] * Specify the type of follow-up. Return/Refer to physician/clinic for:	C 1. Outpatient mental health treatment	C 2. Substance abuse treatment C 3. Other follow-up
Was the patient transferred to psychiatric input	eatient treatment or a substance 1. Pysychiatric inpatient treatment	abuse facility? C 2. Substance abuse treatment facility
? [F1] • Indicate the reason(s) for transfer. Mark all that apply.	 1. Continuity of care/Request by patient, family, or physcian 2. Higher level or specialized care needed 3. Pediatric hospital needed 4. Insurance requirement/reques 5. Other/Insuffcient 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."



(Not shown - not new)

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