SAMPLE

NATIONAL HOSPITAL CARE SURVEY – AMBULATORY COMPONENT
EMERGENCY DEPARTMENT PATIENT RECORD
2014

OMB No. 0920-0212; Expiration date XX/XX/20XX

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).

PATIENT INFORMATION

Patient's name:	PATIENT_NAME	**Patient's SSN**	PATIENT_SSN/ ENTER_SSN	**Patient's Control #**	PTCTRLNUM, ENTER_PTCTRLNUM		
Patient's address RESIDENCE:Street	PT_STRET, PT_STRET2	**City**	PT_CITY	**State**	PT_ST	**Zip Code**	PATZIP
Patient's medical record #	PTMEDRECNUM/ENTER_PTMEDRECNUM	**Medicare health insurance benefit/claim #**	MEDHLTHINSBEN /ENTER_MEDHLTHINSBEN				
NPI–Attending	NPI_ATTEND / ENTER_NPI_ATTEND	**NPI–Operating**	NPI_OPERATING / ENTER_NPI_OPERATING				

	Date of Visit	Time	a.m.	p.m.	Mil.
Arrival	☐☐ - ☐☐ - ☐☐ Mm VDATE dd yy	☐☐ : ☐☐ A_TIME	☐	☐	☐
Provider (physician/APRN/PA) contact	☐☐ - ☐☐ - ☐☐ mmTSDATEdd yy	☐☐ : ☐☐ TS_TIME	☐	☐	☐
ED Departure	☐☐ - ☐☐ - ☐☐ mmEDDATEdd yy	☐☐ : ☐☐ ED_TIME	☐	☐	☐

Mode of arrival ARRIVE
1 ☐ Ambulance
2 ☐ Police transport
3 ☐ Other
4 ☐ Unknown

Was patient transferred from another hospital or freestanding emergency/urgent care facility? AMBTRANSFER
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

Patient Residence RESIDNCE
1 ☐ Private residence
2 ☐ Institution
Indicate the type of institution REST_INST
1 ☐ Nursing home
2 ☐ Supportive housing/ Group home
3 ☐ Jail/Prison
4 ☐ Other
3 ☐ Homeless/Homeless shelter
4 ☐ Other
5 ☐ Unknown

Date of Birth BDATE
Month | Day | Year

Age AGE / AGET

Sex SEX
1 ☐ Female
2 ☐ Male

Ethnicity ETHNIC
1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino

Race – *Mark (X) all that apply*.
1 ☐ White MULTIRACE1-5
2 ☐ Black or African American
3 ☐ Asian
4 ☐ Native Hawaiian or Other Pacific Islander
5 ☐ American Indian or Alaska Native

Expected source(s) of payment for this visit. Mark (X) all that apply. PAY_SOURCE1-7
1 ☐ Private insurance
2 ☐ TRICARE
3 ☐ Medicare
4 ☐ Medicaid or CHIP or other state-based program
5 ☐ Workers' compensation
6 ☐ Self-pay
7 ☐ No charge/charity
8 ☐ Other
9 ☐ Unknown

TRIAGE

Initial vital signs

Temperature	Heart rate/Pulse	Respiratory rate	Blood pressure
TEMP	PULSE	RESPR	BPSYS Systolic / BPDIAS Diastolic
	beats per minute 998 = DOPP, DOPPLER	breaths per minute	998= P, PALP, DOPP, DOPPLER

Pulse oximetry	Triage level (1-5)	Pain scale (0-10)
POPCT	IMMED	PAIN
Percent	Enter 0 if No triage Enter 99 if Unknown	Enter 99 if Unknown

PREVIOUS CARE

Was patient seen in *this* ED in the last 72 hours and discharged? SEEN72
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

REASON FOR VISIT

List the first 5 reasons for visit (i.e., complaint(s), symptom(s), problem(s), concern(s) of the patient) in the order in which they appear. Start with the chief complaint and then move to the patient history for additional reasons. (Enter 0 for None/No more.) For each reason, use the lookup list to code the entry.

(1) Most important: VRFV1/ VRFV_LKUP1

Source of first complaint, symptom, reason for visit.
Mark (X) all that apply SOURCE_RFV
1 ☐ Patient 2 ☐ Other 3 ☐ Unknown

(2) Other VRFV2/ VRFV_LKUP2
(3) Other VRFV3/ VRFV_LKUP3
(4) Other VRFV4/ VRFV_LKUP4
(5) Other VRFV5/ VRFV_LKUP5

Did alcohol cause or contribute to this visit? Alcohol6
Mark (X) all that apply.
1 ☐ Yes, patient's own use
2 ☐ Yes, other person's use
3 ☐ No
4 ☐ Unknown

Was alcohol or other substance abuse/misuse/dependence documented in the medical record for this visit? Other substances include illicit drugs, inhalants, prescription or OTC medications, or dietary supplements.
Mark (X) all that apply SUBETOH

1 ☐ Yes, alcohol abuse/misuse/dependence
ALCOHOL_TYPE
1. ☐ History of alcohol abuse/misuse/dependence
2. ☐ Currently abusing alcohol
2 ☐ Yes, other substance abuse/misuse/dependence
3 ☐ Yes, other specify SUBETHOH_SP
4 ☐ No
5 ☐ Unknown

Episode of care EPISODE
1 ☐ Initial visit to this ED for problem
2 ☐ Follow-up visit to this ED for problem
3 ☐ Unknown

1. ☐ History of other substance abuse/misuse/dependence **OTHSUB_TYPE**
2. ☐ Other substance seeking behavior
3. ☐ Currently abusing other substance(s)

INJURY/TRAUMA/OVERDOSE/POISONING/ADVERSE EFFECT

Is this visit related to an injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment? INJURY

1 ☐ No, SKIP to SUBSTANCES INVOLVED
2 ☐ Yes, injury/trauma
3 ☐ Yes, poisoning (non-drug toxic substance)
4 ☐ Yes, poisoning (drug-induced overdose)

Indicate the kind of drug(s) involved: POISON
1. ☐ Medication
2. ☐ Illicit substance
3. ☐ Both medication and illicit substance
4. ☐ Unknown

5 ☐ Yes, adverse effect of medical/surgical treatment or adverse effect of a medicinal drug

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

} Skip to Cause of injury/overdose/poisoning/ adverse effect

6. ☐ Unknown (skip to substances involved)

Did the injury/trauma or overdose/ poisoning occur within 72 hours prior to the date and time of this visit?

INJURY72

1 ☐ Yes
2 ☐ No
3 ☐ Unknown

Is this injury/trauma or overdose/poisoning intentional? INTENT

1 ☐ Yes, intentional - suicide attempt
2 ☐ Yes, intentional - self-harm (intentional self-directed harm without intent to die)
3 ☐ Yes, intentional – unclear if suicide attempt or self-harm
4 ☐ Yes, intentional harm by another person (e.g., assault, poisoning)
5 ☐ No, unintentional (e.g., accidental)
6 ☐ Unclear if intentional or unintentional

Cause of injury/trauma; overdose/poisoning by drug or non-drug toxic substance; or adverse effect of medical/surgical treatment – Describe the place and circumstances that preceded the injury/trauma, overdose/poisoning, or adverse effect. The following are examples of each: injury (e.g., pedestrian struck by car driven on a highway by drunk driver— indicate location of occurrence, e.g., street, highway, driveway, parking lot);overdose/poisoning by drug (e.g., patient injected heroin in nightclub restroom and overdosed); non-drug toxic substance (e.g., child swallowed bleach at home); adverse effect (e.g., patient developed swelling of the throat after taking their medication). Enter the primary cause on the first line, followed by the contributing causes. Up to 5 causes may be entered.

(1) **VCAUSE / VCAUSEDROPDOWN / TRANSLOC**
(2) **VCAUSE2 / VCAUSEDROPDOWN2 / TRANSLOC2**
(3) **VCAUSE3 / VCAUSEDROPDOWN3 / TRANSLOC3**
(4) **VCAUSE4 / VCAUSEDROPDOWN4 / TRANSLOC4**
(5) **VCAUSE5 / VCAUSEDROPDOWN5 / TRANSLOC5**

SUBSTANCES INVOLVED

Did any substance(s) (e.g., illicit drugs, inhalants, prescription or OTC medications, dietary supplement) cause or contribute to this visit? OR The patient is under 21 and alcohol is the only drug related to the visit. DRUGS_CONTRIBUTED

1 ☐ Yes
2 ☐ No, SKIP to DIAGNOSIS
3 ☐ Unknown, SKIP to DIAGNOSIS

Enter substances that caused or contributed to the ED visit. Type in the substance name exactly as you see in the patient's chart. Enter all substances that caused or contributed to the ED visit. Record substances as specifically as possible. The brand name is preferred over generic name preferred over chemical name. Do not record the same substance by two different names unless it was administered/taken in two different ways. Do not record current medications unrelated to the visit. Up to 16 substances may be entered.

(1) **Drug_Name1 / Drug_List1**
(2) **Drug_Name2 / Drug_List2**
(3-16) **Drug_Name3-16 / Drug_List3-16**

For each substance listed, mark if confirmed by toxicology or blood test report. CONFIRMEDBYTOXD1-16

1 ☐ Yes
2 ☐ No
3 ☐ Unknown/Not documented

For each substance listed, mark the route of administration. ROUTE_ADMINISTRATION1-16

1 ☐ Oral
2 ☐ Injected
3 ☐ Inhaled, sniffed, snorted
4 ☐ Smoked
5 ☐ Transdermal
6 ☐ Other
7 ☐ Not documented

Patient took: PT_TOOK1-16
Mark (X) all that apply:

1 ☐ Own prescription/OTC medication or dietary supplement
2 ☐ Prescription medication not prescribed for patient
3 ☐ Prescription/OTC medication as prescribed or according to directions
4 ☐ Too much of a prescription/OTC medication or dietary supplement
5 ☐ Illicit drug(s)
6 ☐ Alcohol only, under 21
7 ☐ Alcohol in combination with other substances
8 ☐ Not documented

DIAGNOSIS

As specifically as possible, list all diagnoses related to this visit, including chronic conditions.
List primary diagnosis first.

			ICD-9-CM Code	ICD-10-CM Code
(1)	Primary	**VDIAG1 / VDIA1G_LKUP**	**VDIAG1_Code**	**VDIAG1_Code10**
(2)	Other:	**VDIAG2 / VDIAG2_LKUP**	**VDIAG2_Code**	**VDIAG2_Code10**
(3)	Other:	**VDIAG3 / VDIAG3_LKUP**	**VDIAG3_Code**	**VDIAG3_Code10**
(4)	Other:	**VDIAG4 / VDIAG4_LKUP**	**VDIAG4_Code**	**VDIAG4_Code10**
(5)	Other:	**VDIAG5 / VDIAG5_LKUP**	**VDIAG5_Code**	**VDIAG5_Code10**
(6)	Other:	**VDIAG6 / VDIAG6_LKUP**	**VDIAG6_Code**	**VDIAG6_Code10**
(7)	Other:	**VDIAG7 / VDIAG7_LKUP**	**VDIAG7_Code**	**VDIAG7_Code10**
(8)	Other:	**VDIAG8 / VDIAG8_LKUP**	**VDIAG8_Code**	**VDIAG8_Code10**
(9)	Other:	**VDIAG9 / VDIAG9_LKUP**	**VDIAG9_Code**	**VDIAG9_Code10**
(10-20)	Other:	**VDIAG10-20 / VDIAG10-20_LKUP**	**VDIAG10-20_Code**	**VDIAG10-20_Code10**

Regardless of the diagnoses previously entered, does the patient now have: Mark (X) all that apply.
PAT_HAVE1-23

1 ☐ Alcohol abuse, misuse, or dependence
2 ☐ Alzheimer's disease/Dementia
3 ☐ Asthma
4 ☐ Cancer
5 ☐ Cerebrovascular disease/History of stroke (CVA) or transient ischemic attack (TIA)
6 ☐ Chronic kidney disease (CKD)
7 ☐ Chronic obstructive pulmonary disease (COPD)
8 ☐ Congestive heart failure (CHF)
9 ☐ Coronary artery disease (CAD), ischemic heart disease (IHD), or history of myocardial infarction (MI)
10 ☐ Diabetes mellitus (DM) – Type I
11 ☐ Diabetes mellitus (DM) – Type II
12 ☐ Diabetes mellitus (DM) – Type unspecified
13 ☐ End-stage renal disease (ESRD)
14 ☐ History of pulmonary embolism (PE), deep vein thrombosis (DVT), or venous thromboembolism (VTE)
15 ☐ HIV infection/AIDS
16 ☐ Hyperlipidemia
17 ☐ Hypertension
18 ☐ Mental illness or episode

Indicate the mental illness of episode MENTAL1-6
Mark (X) all that apply
1. ☐ Bipolar disorder/Manic depression
2. ☐ Depression, excluding manic depression
3. ☐ Post-traumatic stress disorder (PTSD)
4. ☐ Schizophrenia
5. ☐ Suicidal ideation
6. ☐ Other

19 ☐ Obesity
20 ☐ Obstructive sleep apnea (OSA)
21 ☐ Osteoporosis
22 ☐ Substance abuse, misuse, or dependence
23 ☐ None of the above

DIAGNOSTICS

Mark (X) all ORDERED or PROVIDED at this visit. DIAG_SERVICES1-34

1 ☐ NONE

Blood tests:

2 ☐ ABG (Arterial blood gases)
3 ☐ BAC (Blood alcohol concentration)
Enter BAC _BAC_ %
4 ☐ BMP (Basic metabolic panel)
5 ☐ BNP (Brain natriuretic peptide)
6 ☐ CE (Cardiac enzymes)
7 ☐ CBC (Complete blood count)
8 ☐ CMP (Comprehensive Metabolic panel)
9 ☐ Creatinine/renal function panel
10 ☐ Culture, blood
11 ☐ D-dimer
12 ☐ Electrolytes
13 ☐ Glucose, serum
14 ☐ LDH (Lactate dehydrogenase)
15 ☐ Liver enzymes/Hepatic function panel
16 ☐ Prothrombin time (PT/PTT/INR)
17 ☐ Other blood test

Enter other blood tests as written: OTHDIAGSERV

Other tests:

18 ☐ Culture, throat
19 ☐ Culture, urine
20 ☐ Culture, wound
21 ☐ Culture, other
22 ☐ Cardiac monitor
23 ☐ EKG/ECG
24 ☐ HIV test
25 ☐ Influenza test
26 ☐ Pregnancy/HCG test
27 ☐ Toxicology screen
28 ☐ Urinalysis (UA) or urine dipstick
29 ☐ Other test/service

Imaging:

30 ☐ X-ray
31 ☐ CT scan

What body site was scanned during the CT scan? CT_SCAN1-4
Mark (X) all that apply
1. ☐ Abdomen/pelvis
2. ☐ Chest
3. ☐ Head
4. ☐ Other

Was CT ordered or provided with intravenous (IV) contrast? CT_IV
1. ☐ Yes
2. ☐ No
3. ☐ Unknown

32 ☐ MRI

Was MRI ordered or provided with intravenous (IV) contrast (also written as "with gadolinium" or "with gado")? MRI_IV
1. ☐ Yes
2. ☐ No
3. ☐ Unknown

33 ☐ Ultrasound

Who performed the ultrasound? ULTRASOUND
1. ☐ Emergency physician
2. ☐ Other
3. ☐ Unknown

34 ☐ Other Imaging

PROCEDURES

Mark all procedures PROVIDED at this visit. Exclude medications. PROCEDURES1-17

1 ☐ NONE
2 ☐ BiPAP/CPAP
3 ☐ Bladder catheter
4 ☐ Cast, splint, or wrap
5 ☐ Central line
6 ☐ CPR
7 ☐ Endotracheal tube (ETT)
8 ☐ Incision & drainage (I&D)
9 ☐ IV
10 ☐ Lumbar puncture (LP)
11 ☐ Nebulizer therapy
12 ☐ Pelvic exam
13 ☐ Physical restraint
14 ☐ Psychiatry/psychology/substance abuse consult
15 ☐ Skin adhesives
16 ☐ Suturing/Staples
17 ☐ Other

MEDICATIONS & IMMUNIZATIONS

NOMED=Were any prescription or non-prescription medications given at this visit or prescribed at ED discharge? 1-Yes 2-No Include Rx and OTC medications, immunizations, oxygen, and anesthetics. Enter XXX if medication cannot be found. Enter 0 for No more.

				Given in ED	Rx at discharge	Both given in ED and Rx at discharge
(1)	VMED	VMEDOTH	GPMED →	1 ☐	2 ☐	3 ☐
(2)	VMED2	VMEDOTH2	GPMED2 →	1 ☐	2 ☐	3 ☐
(3)	VMED3	VMEDOTH3	GPMED3 →	1 ☐	2 ☐	3 ☐
(4)	VMED4	VMEDOTH4	GPMED4 →	1 ☐	2 ☐	3 ☐
(5)	VMED5	VMEDOTH5	GPMED5 →	1 ☐	2 ☐	3 ☐
(6)	VMED6	VMEDOTH6	GPMED6 →	1 ☐	2 ☐	3 ☐
(7)	VMED7	VMEDOTH7	GPMED7 →	1 ☐	2 ☐	3 ☐
(8)	VMED8	VMEDOTH8	GPMED8 →	1 ☐	2 ☐	3 ☐
(9)	VMED9	VMEDOTH9	GPMED9 →	1 ☐	2 ☐	3 ☐
(10)	VMED10	VMEDOTH10	GPMED10 →	1 ☐	2 ☐	3 ☐
(11)	VMED11	VMEDOTH11	GPMED11 →	1 ☐	2 ☐	3 ☐
(12-30)	VMED12-30	VMEDOTH12	GPMED12 →	1 ☐	2 ☐	3 ☐

LAST VITAL SIGNS TAKEN

Does the chart contain vital signs taken after triage? 1. ☐ Yes 2. ☐ No → Skip to Providers **VitalsD**

Temperature	Heart rate/Pulse	Respiratory rate	Blood pressure
TempD	**PulseD**	**ResprD**	**BPSysD** Systolic
	beats per minute 998= DOPP, DOPPLER	breaths per minute	**BPDiasD** Diastolic 998= P, PALP, DOPP, DOPPLER

PROVIDERS

Mark (X) all providers seen at this visit. **PROV_SEEN1-11**

1 ☐ NONE
2 ☐ ED attending physician
3 ☐ ED resident or Intern
4 ☐ Consulting physician → Specialty of consulting physician **SPEC_CONPHYS1-12**
5 ☐ RN/LPN
6 ☐ Nurse practitioner (NP)
7 ☐ Physician assistant (PA)
8 ☐ EMT
9 ☐ Psychologist
10 ☐ Social worker
11 ☐ Substance abuse services provider
12 ☐ Other mental health provider
13 ☐ Other provider

Specialty of consulting physician **SPEC_CONPHYS1-12**

1 ☐ Cardiology
2 ☐ ENT (Otolaryngology)
3 ☐ Gastroenterology
4 ☐ General/Trauma Surgery
5 ☐ Geriatrics
6 ☐ Neurology
7 ☐ Neurosurgery
8 ☐ Obstetrics-Gynecology
9 ☐ Ophthalmology
10 ☐ Orthopedic Surgery
11 ☐ Psychiatry
12 ☐ Other specialty
13 ☐ Unknown

VISIT DISPOSITION

Mark (X) all that apply. **VISIT_DISP1-15**

1 ☐ No follow-up planned
2 ☐ Return to ED
3 ☐ Return/Refer to physician/clinic for
Specify the type of follow-up **FOLLOWUP1-3**
1. ☐ Outpatient mental health treatment
2. ☐ Substance abuse treatment
3. ☐ Other follow-up
4 ☐ Left without being seen (LWBS)
5 ☐ Left before treatment complete (LBTC)
1. ☐ Left AMA **LEFT_AMA**
6 ☐ DOA
7 ☐ Died in ED
8 ☐ Return/Transfer to nursing home
9 ☐ Return/Transfer to jail/prison/law enforcement
10 ☐ Transfer to inpatient behavioral health care facility
Was the patient transferred psychiatric inpatient treatment or a substance abuse treatment facility? **BHEALTH**
1. ☐ Psychiatric inpatient treatment
Enter the status of the transfer **PSYCH_INP**
1. ☐ Involuntary status
2. ☐ Voluntary status
3. ☐ Not documented
2. ☐ Substance abuse treatment facility
3. ☐ Unknown
11 ☐ Transfer to other non-psychiatric hospital
Indicate the reason for transfer **TRANSFER1-5**
Mark (X) all that apply
1. ☐ Continuity of care/Request by patient, family, or physician
2. ☐ Higher level or specialized care needed
3. ☐ Pediatric hospital needed
4. ☐ Insurance requirement/request
5. ☐ Other/Insufficient information available
12 ☐ Admit to this hospital
13 ☐ Admit to observation unit then hospitalized
14 ☐ Admit to observation unit then discharged
15 ☐ Other

HOSPITAL ADMISSION

Admitted to: **ADMIT**

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

Admit order

Month	Day	Year	Time	a.m.	p.m.	Military
BRDATE	**1**		☐☐:☐☐ **BR_TIME** ☐		☐	☐

Admitting physician: **ADMITPHYS**

1 ☐ Hospitalist
2 ☐ Not hospitalist
3 ☐ Unknown

Hospital discharge date

Month	Day	Year
DDATE	**1**	

Hospital discharge diagnosis

(1) Principal **VHDDIAG**
(2) Secondary **VHDDIAG2**

Hospital discharge status **HDSTAT**

1 ☐ Alive
2 ☐ Dead
3 ☐ Unknown

Hospital discharge disposition **ADISP**

1 ☐ Home/Residence
2 ☐ Return/Transfer to nursing home
3 ☐ Return/Transfer to jail/prison/law enforcement
4 ☐ Transfer to another facility (not usual place of residence)
5 ☐ Other
6 ☐ Unknown

OBSERVATION UNIT STAY

Observation unit/care initiation order

Month	Day	Year	Time	a.m.	p.m.	Military
EDDISDATE	**1**		☐☐:☐☐ **EDDISTIME** ☐		☐	☐

Observation unit/care discharge order

Month	Day	Year	Time	a.m.	p.m.	Military
OBDATE	**1**		☐☐:☐☐ **OB_TIME** ☐		☐	☐