

Attachment F: Emergency Department Patient Record

SAMPLE

NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY 2016 EMERGENCY DEPARTMENT PATIENT RECORD

OMB No. 0920-0278; Expiration date 02/28/2018

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PATIENT INFORMATION

Patient medical record number	PATIENT_NUMBER		Zip Code		PATZIP
Arrival	Date of Visit <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> Mm VDATE dd yy		Time <input type="checkbox"/> <input type="checkbox"/> : <input type="checkbox"/> <input type="checkbox"/> A_TIME		a.m. <input type="checkbox"/>
First provider (physician/APRN/PA) contact	<input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> mmTSDATE dd yy		<input type="checkbox"/> <input type="checkbox"/> : <input type="checkbox"/> <input type="checkbox"/> TS_TIME		p.m. <input type="checkbox"/>
ED Departure	<input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> mmEDDATE dd yy		<input type="checkbox"/> <input type="checkbox"/> : <input type="checkbox"/> <input type="checkbox"/> ED_TIME		Mil. <input type="checkbox"/>
Patient Residence RESIDENCE 1 <input type="checkbox"/> Private residence 2 <input type="checkbox"/> Nursing home 3 <input type="checkbox"/> Homeless/Homeless shelter 4 <input type="checkbox"/> Other 5 <input type="checkbox"/> Unknown	Sex SEX 1 <input type="checkbox"/> Female 2 <input type="checkbox"/> Male	Arrival by ambulance ARRIVE 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown	Expected source(s) of payment for this visit. Mark (X) all that apply. PAY_SOURCE 1 <input type="checkbox"/> Private insurance 2 <input type="checkbox"/> Medicare 3 <input type="checkbox"/> Medicaid or CHIP or other state-based program 4 <input type="checkbox"/> Workers' compensation 5 <input type="checkbox"/> Self-pay 6 <input type="checkbox"/> No charge/charity 7 <input type="checkbox"/> Other 8 <input type="checkbox"/> Unknown		
Date of Birth BDATE Month Day Year <input type="text"/> <input type="text"/> <input type="text"/>	Ethnicity ETHNIC 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino	Was patient transferred from another hospital or freestanding emergency/urgent care facility? AMBTRANSFER 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown			
Age AGE / AGET <input type="text"/> 1 <input type="checkbox"/> Years 2 <input type="checkbox"/> Months 3 <input type="checkbox"/> Days	Race – Mark (X) all that apply. MULTIRACE 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				

TRIAGE

PREVIOUS CARE

Initial vital signs					
Temperature <input type="text"/> TEMP	Heart rate/Pulse <input type="text"/> PULSE beats per minute 998 = DOPP, DOPPLER	Respiratory rate <input type="text"/> RESPR breaths per minute	Blood Pressure Systolic Diastolic <input type="text"/> BPSYS / <input type="text"/> BPDIAS		Was patient seen in this ED in the last 72 hours? SEEN72 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown
Pulse oximetry <input type="text"/> POPCT		Triage level (1-5) <input type="text"/> IMMED		Pain scale (0-10) <input type="text"/> PAIN	

(%)	Enter 0 if No triage Enter 99 if Unknown	Enter 99 if Unknown
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REASON FOR VISIT

<p>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 or history of present illness (HPI) for additional reasons. (Enter 0 for None/No more.) For each reason, use the lookup list to code the entry.</p>	<p>Episode of care EPISODE</p> <p>1 <input type="checkbox"/> Initial visit to this ED for problem</p> <p>2 <input type="checkbox"/> Follow-up visit to this ED for problem</p> <p>3 <input type="checkbox"/> Unknown</p>
<p>(1) Most important: <input style="width: 100%;" type="text" value="VRFV1/VRFV1_LKUP"/></p> <p>(2) Other: <input style="width: 100%;" type="text" value="VRFV1/VRFV1_LKUP"/></p> <p>(3) Other: <input style="width: 100%;" type="text" value="VRFV1/VRFV1_LKUP"/></p> <p>(4) Other: <input style="width: 100%;" type="text" value="VRFV1/VRFV1_LKUP"/></p> <p>(5) Other: <input style="width: 100%;" type="text" value="VRFV1/VRFV1_LKUP"/></p>	

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 Yes, injury/trauma

2 Yes, poisoning/overdose

3 Yes, adverse effect of medical or surgical treatment or adverse effect of medicinal drug

4 No

5 Unknown

<p>Did the injury/trauma or overdose/poisoning or adverse effect occur within 72 hours prior to the date and time of this visit?</p> <p>INJURY72</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Unknown</p>	<p>Is this injury/trauma or overdose/poisoning intentional or unintentional?</p> <p>INTENTO</p> <p>1 <input type="checkbox"/> Intentional</p> <p>2 <input type="checkbox"/> Unintentional (e.g., accidental)</p> <p>3 <input type="checkbox"/> Intent unclear</p>
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What was the intent of the injury/trauma or overdose/poisoning?

INTENTYP

1 Suicide attempt with intent to die

2 Intentional self-harm without intent to die

3 Unclear if suicide attempt or intentional self-harm without intent to die

4 Intentional harm inflicted by another person (e.g., assault, poisoning)

5 Intent unclear

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)

DIAGNOSIS

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

	ICD-9-CM Code	
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(1) Primary diagnosis:	VDIAG1 / VDIAG1_LKUP	DIAG1	●
(2) Other:	VDIAG2 / VDIAG2_LKUP	DIAG2	●
(3) Other:	VDIAG3 / VDIAG3_LKUP	DIAG3	●
(4) Other:	VDIAG4 / VDIAG4_LKUP	DIAG4	●
(5) Other:	VDIAG5 / VDIAG5_LKUP	DIAG5	●

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

PAT_HAVE

- | | |
|--|---|
| 1 <input type="checkbox"/> Alcohol abuse, misuse, or dependence | 13 <input type="checkbox"/> Diabetes mellitus (DM) – Type unspecified |
| 2 <input type="checkbox"/> Alzheimer’s disease/Dementia | 14 <input type="checkbox"/> End-stage renal disease (ESRD) |
| 3 <input type="checkbox"/> Asthma | 15 <input type="checkbox"/> History of pulmonary embolism (PE), deep vein thrombosis (DVT), or venous thromboembolism (VTE) |
| 4 <input type="checkbox"/> Cancer | 16 <input type="checkbox"/> HIV infection/AIDS |
| 5 <input type="checkbox"/> Cerebrovascular disease/History of stroke (CVA) or transient ischemic attack (TIA) | 17 <input type="checkbox"/> Hyperlipidemia |
| 6 <input type="checkbox"/> Chronic kidney disease (CKD) | 18 <input type="checkbox"/> Hypertension |
| 7 <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD) | 19 <input type="checkbox"/> Obesity |
| 8 <input type="checkbox"/> Congestive heart failure (CHF) | 20 <input type="checkbox"/> Obstructive sleep apnea (OSA) |
| 9 <input type="checkbox"/> Coronary artery disease (CAD), ischemic heart disease (IHD), or history of myocardial infarction (MI) | 21 <input type="checkbox"/> Osteoporosis |
| 10 <input type="checkbox"/> Depression | 22 <input type="checkbox"/> Substance abuse or dependence |
| 11 <input type="checkbox"/> Diabetes mellitus (DM) – Type I | 23 <input type="checkbox"/> None of the above |
| 12 <input type="checkbox"/> Diabetes mellitus (DM) – Type II | |

DIAGNOSTIC SERVICES

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

- | | | | |
|--|--|---|---|
| 1 <input type="checkbox"/> NONE | 14 <input type="checkbox"/> Culture, other | Imaging: | 32 <input type="checkbox"/> MRI |
| Laboratory tests: | 15 <input type="checkbox"/> D-dimer | 30 <input type="checkbox"/> X-ray | Was MRI ordered or provided with intravenous (IV) contrast (also written as “with gadolinium” or “with gado”)? |
| 2 <input type="checkbox"/> ABG (Arterial blood gases) | 16 <input type="checkbox"/> Electrolytes | 31 <input type="checkbox"/> CT scan | MRI |
| 3 <input type="checkbox"/> BAC (Blood alcohol concentration) | 17 <input type="checkbox"/> Glucose, serum | What body site was scanned during the CT scan? CT_SCAN | 1. <input type="checkbox"/> Yes |
| 4 <input type="checkbox"/> BMP (Basic metabolic panel) | 18 <input type="checkbox"/> Lactate | <i>Mark (X) all that apply</i> | 2. <input type="checkbox"/> No |
| 5 <input type="checkbox"/> BNP (Brain natriuretic peptide) | 19 <input type="checkbox"/> Liver enzymes / Hepatic function panel | 1. <input type="checkbox"/> Abdomen/Pelvis | 3. <input type="checkbox"/> Unknown |
| 6 <input type="checkbox"/> CBC (Complete blood count) | 20 <input type="checkbox"/> Prothrombin time (PT/PTT/INR) | 2. <input type="checkbox"/> Chest | 33 <input type="checkbox"/> Ultrasound |
| 7 <input type="checkbox"/> CE (Cardiac enzymes) | 21 <input type="checkbox"/> Other blood test | 3. <input type="checkbox"/> Head | Who performed the ultrasound? ULTRASOUND |
| 8 <input type="checkbox"/> CMP (Comprehensive metabolic panel) | Other tests: | 4. <input type="checkbox"/> Other | 1. <input type="checkbox"/> Emergency physician |
| 9 <input type="checkbox"/> Creatinine/Renal function panel | 22 <input type="checkbox"/> Cardiac monitor | Was CT ordered or provided with intravenous (IV) contrast? CT_SCANIV | 2. <input type="checkbox"/> Other |
| 10 <input type="checkbox"/> Culture, blood | 23 <input type="checkbox"/> EKG/ECG | 1. <input type="checkbox"/> Yes | 3. <input type="checkbox"/> Unknown |
| 11 <input type="checkbox"/> Culture, throat | 24 <input type="checkbox"/> HIV test | 2. <input type="checkbox"/> No | 34 <input type="checkbox"/> Other Imaging |
| 12 <input type="checkbox"/> Culture, urine | 25 <input type="checkbox"/> Influenza test | 3. <input type="checkbox"/> Unknown | |
| 13 <input type="checkbox"/> Culture, wound | 26 <input type="checkbox"/> Pregnancy/HCG test | | |
| | 27 <input type="checkbox"/> Toxicology screen | | |
| | 28 <input type="checkbox"/> Urinalysis (UA) or urine dipstick | | |
| | 29 <input type="checkbox"/> Other test/service | | |

PROCEDURES

Mark (X) all procedures PROVIDED at this visit. Exclude medications. **PROC_PROV**

- | | | |
|--|--|---|
| 1 <input type="checkbox"/> NONE | 6 <input type="checkbox"/> CPR | 11 <input type="checkbox"/> Nebulizer therapy |
| 2 <input type="checkbox"/> BiPAP/CPAP | 7 <input type="checkbox"/> Endotracheal intubation | 12 <input type="checkbox"/> Pelvic exam |
| 3 <input type="checkbox"/> Bladder catheter | 8 <input type="checkbox"/> Incision & drainage (I&D) | 13 <input type="checkbox"/> Skin adhesives |
| 4 <input type="checkbox"/> Cast, splint, or wrap | 9 <input type="checkbox"/> IV fluids | 14 <input type="checkbox"/> Suturing/Staples |
| 5 <input type="checkbox"/> Central line | 10 <input type="checkbox"/> Lumbar puncture (LP) | 15 <input type="checkbox"/> Other |

MEDICATION(S) & IMMUNIZATION(S)

Enter drugs given at this visit or prescribed at ED discharge. Include Rx and OTC drugs, immunizations, and anesthetics.			Given in ED	Rx at discharge	Both given in ED and Rx at discharge
(1)	VMED1 VMEDOTH1	GP MED1 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(2)	VMED2 VMEDOTH2	GP MED2 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(3)	VMED3 VMEDOTH3	GP MED3 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(4)	VMED4 VMEDOTH4	GP MED4 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(5)	VMED5 VMEDOTH5	GP MED5 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(6)	VMED6 VMEDOTH6	GP MED6 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(7)	VMED7 VMEDOTH7	GP MED7 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(8)	VMED8 VMEDOTH8	GP MED8 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(9)	VMED9 VMEDOTH9	GP MED9 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(10)	VMED10 VMEDOTH10	GP MED10 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(...)	...		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(30)	VMED30 VMEDOTH30	GP MED30 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

LAST VITAL SIGNS TAKEN

Does the e chart contain vital signs taken after triage

1. Yes
2. No
3. Unknown **VITALS2**

Temperature <div style="border: 1px solid black; padding: 5px; width: 80px; margin: 0 auto;">Temp2</div>	Heart rate/Pulse <div style="border: 1px solid black; padding: 5px; width: 80px; margin: 0 auto;">Pulse2</div> <p style="font-size: small;">beats per minute 998= DOPP, DOPPLER</p>	Respiratory rate <div style="border: 1px solid black; padding: 5px; width: 80px; margin: 0 auto;">Respr2</div> <p style="font-size: small;">breaths per minute</p>	Blood Pressure <div style="display: flex; justify-content: space-around; font-size: small;"> Systolic Diastolic </div> <div style="display: flex; justify-content: center; align-items: center; gap: 10px;"> <div style="border: 1px solid black; padding: 5px; width: 60px;">BPSYS2</div> / <div style="border: 1px solid black; padding: 5px; width: 60px;">BPDIAS2</div> </div>
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PROVIDERS

Mark (X) all providers seen at this visit. **PROV_SEEN**

- | | | |
|---|---|---|
| 1 <input type="checkbox"/> ED attending physician | 4 <input type="checkbox"/> RN/LPN | 7 <input type="checkbox"/> EMT |
| 2 <input type="checkbox"/> ED resident/Intern | 5 <input type="checkbox"/> Nurse practitioner (NP) | 8 <input type="checkbox"/> Other mental health provider |
| 3 <input type="checkbox"/> Consulting physician | 6 <input type="checkbox"/> Physician assistant (PA) | 9 <input type="checkbox"/> Other provider |

VISIT DISPOSITION

Mark (X) all that apply. **VISIT_DISP**

- | | | |
|--|--|---|
| 1 <input type="checkbox"/> No follow-up planned | 7 <input type="checkbox"/> DOA | 12 <input type="checkbox"/> Admit to this hospital |
| 2 <input type="checkbox"/> Return to ED | 8 <input type="checkbox"/> Died in ED | 13 <input type="checkbox"/> Admit to observation unit then hospitalized |
| 3 <input type="checkbox"/> Return/Refer to physician/clinic for FU | 9 <input type="checkbox"/> Return/Transfer to nursing home | 14 <input type="checkbox"/> Admit to observation unit then discharged |
| 4 <input type="checkbox"/> Left without being seen (LWBS) | 10 <input type="checkbox"/> Transfer to psychiatric hospital | 15 <input type="checkbox"/> Other |
| 5 <input type="checkbox"/> Left before treatment complete (LBTC) | 11 <input type="checkbox"/> Transfer to other non-psychiatric hospital | |
| 6 <input type="checkbox"/> Left AMA | | |

HOSPITAL ADMISSION

Admitted to: ADMIT 1 <input type="checkbox"/> Critical care unit 2 <input type="checkbox"/> Stepdown unit 3 <input type="checkbox"/> Operating room	Date and time of admit order						
	Month	Day	Year	Time	a.m.	p.m.	Military
	ADMDATE	2	0	1		<input type="checkbox"/>	<input type="checkbox"/>

4 <input type="checkbox"/> Mental health or detox unit 5 <input type="checkbox"/> Cardiac catheterization lab 6 <input type="checkbox"/> Other bed/unit 7 <input type="checkbox"/> Unknown	Date and time of hospital discharge							
	Month	Day	Year		Time	a.m.	p.m.	Military
	DDATE	2	0	1		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Admitting physician: ADMTPHYS 1 <input type="checkbox"/> Hospitalist 2 <input type="checkbox"/> Not hospitalist 3 <input type="checkbox"/> Unknown	Hospital discharge status HDSTAT 1 <input type="checkbox"/> Alive 2 <input type="checkbox"/> Dead 3 <input type="checkbox"/> Unknown
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OBSERVATION UNIT STAY

Hospital discharge disposition ADISP 1 <input type="checkbox"/> Home/Residence 2 <input type="checkbox"/> Return/Transfer to nursing home 3 <input type="checkbox"/> Return/Transfer to jail/prison/law enforcement 4 <input type="checkbox"/> Transfer to another facility (not usual place of residence) 5 <input type="checkbox"/> Other 6 <input type="checkbox"/> Unknown	Date and time of observation unit/ care initiation order							
	Month	Day	Year		Time	a.m.	p.m.	Military
	OBINDATE	2	0	1		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Date and time of observation unit/ care discharge order							
	Month	Day	Year		Time	a.m.	p.m.	Military
OBINDATE	2	0	1		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	