SAMPLE
NATIONAL HOSPITAL CARE SURVEY – AMBULATORY COMPONENT

EMERGENCY DEPARTMENT PATIENT RECORD

2016

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

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| **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.** | **Mode of arrival ARRIVE**1 [ ]  Ambulance2 [ ]  Police transport3 [ ]  Other4 [ ]  Unknown**Was patient transferred from another hospital or freestanding emergency/urgent care facility? AMBTRANSFER**1 [ ]  Yes2 [ ]  No3 [ ]  Unknown**Expected source(s) of payment for this visit. Mark (X) all that apply. PAY\_SOURCE1-7**1 **[ ]** Private insurance2 **[ ]** TRICARE3 **[ ]** Medicare4 **[ ]** Medicaid or CHIP or other state-based program5 **[ ]** Workers’ compensation6 **[ ]** Self-pay7 **[ ]** No charge/charity8 **[ ]** Other9 **[ ]** Unknown |
| Arrival | **[ ] [ ]  - [ ] [ ]  - [ ] [ ]**  **Mm VDATE dd yy** | **[ ]  [ ]**  : **[ ]  [ ]  A\_TIME** | **[ ]**  | **[ ]**  | **[ ]**  |
| Provider (physician/APRN/PA) contact | **[ ] [ ]  - [ ] [ ]  - [ ] [ ]**  **mmTSDATEdd yy** | **[ ]  [ ]**  : **[ ]  [ ]  TS\_TIME** | **[ ]**  | **[ ]**  | **[ ]**  |
| ED Departure | **[ ] [ ]  - [ ] [ ]  -** **[ ] [ ]**  **mmEDDATEdd yy** | **[ ]  [ ]**  : **[ ]  [ ]  ED\_TIME** | **[ ]**  | **[ ]**  | **[ ]**  |
| **Patient Residence RESIDNCE**1 [ ]  Private residence2 [ ]  Institution **Indicate the type of**  **institution REST\_INST**  1 [ ]  Nursing home 2 [ ]  Supportive housing/ Group home 3 [ ]  Jail/Prison 4 [ ]  Other3 [ ]  Homeless/Homeless shelter4 [ ]  Other5 [ ]  Unknown | **Date of Birth BDATE**

|  |  |  |
| --- | --- | --- |
| Month | Day | Year |
|  |  |  |  |  |  |  |  |

**Age AGE / AGET**

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|  |

**Sex SEX**1 [ ]  Female2[ ]  Male | **Ethnicity ETHNIC**1 [ ]  Hispanic or Latino2 [ ]  Not Hispanic or Latino**Race –** *Mark (X) all that apply*.1 [ ]  White **MULTIRACE1-5**2 [ ]  Black or African American3 [ ]  Asian4 [ ]  Native Hawaiian or Other Pacific Islander5 [ ]  American Indian or Alaska Native |
| TRIAGE | PREVIOUS CARE |
| **Initial vital signs** |  |  |  | **Was patient seen in *this* ED in the last 72 hours and discharged? SEEN72**1 [ ]  Yes2 [ ]  No3 [ ]  Unknown |
| **Temperature**

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| --- |
| **TEMP** |

 | **Heart rate/Pulse**

|  |
| --- |
| **PULSE** |

beats per minute998 = DOPP, DOPPLER | **Respiratory rate**

|  |
| --- |
| **RESPR** |

breaths per minute | **Blood pressure** |
|  | **BPSYS** | Systolic |
|  |  |  |
|  | **BPDIAS** | Diastolic |
| 998= P, PALP, DOPP, DOPPLER |
| **Pulse oximetry**

|  |
| --- |
| **POPCT** |
| Percent |

 | **Triage level (1-5)**

|  |
| --- |
| **IMMED** |

 Enter 0 if No triage Enter 99 if Unknown | **Pain scale (0-10)**

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| **PAIN** |

 Enter 99 if 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** | **Did alcohol cause or contribute to this visit? Alcohol6***Mark (X) all that apply*.1 [ ]  Yes, patient’s own use2 [ ]  Yes, other person’s use3 [ ]  No4 [ ]  Unknown |
|  |  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** |  |
|  |  |  |
| **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** | **Episode of care EPISODE**1 [ ]  Initial visit to this ED for problem2 [ ]  Follow-up visit to this ED for problem3 [ ]  Unknown |
| 1 [ ]  Yes, alcohol abuse/misuse/dependence **ALCOHOL\_TYPE**1. [ ]  History of alcohol abuse/misuse/dependence2. [ ]  Currently abusing alcohol 2 [ ]  Yes, other substance abuse/misuse/dependence1. [ ]  History of other substance **OTHSUB\_TYPE** abuse/misuse/dependence 2. [ ]  Other substance seeking behavior3. [ ]  Currently abusing other substance(s) | 3 [ ]  Yes, other specify **SUBETHOH\_SP** 4 [ ]  No5 [ ]  Unknown |

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| 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 INVOLVED2 [ ]  Yes, injury/trauma3 [ ]  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. [ ]  Unknown5 [ ]  Yes, adverse effect of medical/surgical treatment or adverse effect of a medicinal drug **Was medication involved? ADVERSE** 1. [ ]  Yes Skip to Cause of injury/overdose/poisoning/adverse effect 2. [ ]  No  3. [ ]  Unknown6. [ ]  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 [ ]  Yes2 [ ]  No3 [ ]  Unknown | **Is this injury/trauma or overdose/poisoning intentional? INTENT**1 [ ]  Yes, intentional - suicide attempt2 [ ]  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 [ ]  Yes2 [ ]  No, SKIP to DIAGNOSIS3 [ ]  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 [ ]  Yes2 [ ]  No3 [ ]  Unknown/Not documented | **For each substance listed, mark the route of administration**. **ROUTE\_ADMINISTRATION1-16**1 [ ]  Oral2 [ ]  Injected 3 [ ]  Inhaled, sniffed, snorted4 [ ]  Smoked5 [ ]  Transdermal6 [ ]  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 directions4 [ ]  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 substances8 [ ]  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 diagnosis: | **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** |  |
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| **Regardless of the diagnoses previously entered, does the patient now have:** Mark (X) all that apply. **PAT\_HAVE1-23** |
| 1 [ ]  Alcohol abuse, misuse, or dependence2 [ ]  Alzheimer’s disease/Dementia3 [ ]  Asthma4 [ ]  Cancer5 [ ]  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 I11[ ]  Diabetes mellitus (DM) – Type II12[ ]  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/AIDS16 [ ]  Hyperlipidemia17 [ ]  Hypertension18 [ ]  Mental illness or episode **Indicate the mental illness of episode MENTAL1-6***Mark (X) all that apply* 1. [ ]  Bipolar disorder/Manic depression2. [ ]  Depression, excluding manic depression3. [ ]  Post-traumatic stress disorder (PTSD)4. [ ]  Schizophrenia5. [ ]  Suicidal ideation6. [ ]  Other19 [ ]  Obesity20 [ ]  Obstructive sleep apnea (OSA)21 [ ]  Osteoporosis22 [ ]  Substance abuse, misuse, or dependence23 [ ]  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, blood11 [ ]  D-dimer 12 [ ]  Electrolytes 13 [ ]  Glucose, serum 14 [ ]  LDH (Lactate  dehydrogenase) | 15 [ ]  Liver enzymes/Hepatic function panel16 [ ]  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, other22 [ ]  Cardiac monitor23 [ ]  EKG/ECG24 [ ]  HIV test25 [ ]  Influenza test26 [ ]  Pregnancy/HCG test27 [ ]  Toxicology screen28 [ ]  Urinalysis (UA) or urine dipstick29 [ ]  Other test/service | **Imaging:**30 [ ]  X-ray31 [ ]  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. [ ]  Yes2. [ ]  No3. [ ]  Unknown | 32 [ ]  MRI**Was MRI ordered or provided with intravenous (IV) contrast (also written as “with gadolinium” or “with gado”)? MRI\_IV**1. [ ]  Yes2. [ ]  No3. [ ]  Unknown33 [ ]  Ultrasound**Who performed the ultrasound? ULTRASOUND**1. [ ] Emergency  physician 2. [ ]  Other3. [ ]  Unknown34 [ ]  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 [ ]  |
|  |  |  |  |  |

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| LAST VITAL SIGNS TAKEN |
| **Does the chart contain vital signs taken after triage? 1.** [ ]  Yes 2. [ ]  No → Skip to Providers **VitalsD** |  |
| **Temperature**

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| --- |
| **TempD** |

 | **Heart rate/Pulse**

|  |
| --- |
| **PulseD** |

beats per minute998= DOPP, DOPPLER | **Respiratory rate**

|  |
| --- |
| **ResprD** |

breaths per minute | **Blood pressure** |
|  | **BPSysD** | Systolic |
|  |  |  |
|  | **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 | 1 [ ]  Cardiology |  8 [ ]  Obstetrics-Gynecology |
| 6 | [ ]  | Nurse practitioner (NP) | 2 [ ]  ENT (Otolaryngology) |  9 [ ]  Ophthalmology |
| 7 | [ ]  | Physician assistant (PA) | 3 [ ]  Gastroenterology |  10 [ ]  Orthopedic Surgery |
| 8 | [ ]  | EMT | 4 [ ]  General/Trauma Surgery | 11 [ ]  Psychiatry |
| 9 | [ ]  | Psychologist  | 5 [ ]  Geriatrics | 12 [ ]  Other specialty |
| 10 | [ ]  | Social worker | 6 [ ]  Neurology | 13 [ ]  Unknown |
| 11 | [ ]  | Substance abuse services provider | 7 [ ]  Neurosurgery |  |
| 12 | [ ]  | Other mental health provider |  |  |
| 13 | [ ]  | Other provider |  |  |
| VISIT DISPOSITION |
| Mark (X) all that apply. **VISIT\_DISP1-15** |
| 1 [ ]  No follow-up planned2 [ ]  Return to ED3 [ ]  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-up4 [ ]  Left without being seen (LWBS)5 [ ]  Left before treatment complete (LBTC) 1. [ ]  Left AMA **LEFT\_AMA**6 [ ]  DOA7 [ ]  Died in ED8 [ ]  Return/Transfer to nursing home9 [ ]  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 documented2. [ ]  Substance abuse treatment facility3. [ ]  Unknown11 [ ]  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 hospital13 [ ]  Admit to observation unit then hospitalized14 [ ]  Admit to observation unit then discharged15 [ ]  Other |
| HOSPITAL ADMISSION |
| **Admitted to: ADMIT**1 [ ]  Critical care unit2 [ ]  Stepdown unit3 [ ]  Operating room4 [ ]  Mental health or detox unit5 [ ]  Cardiac catheterization lab6 [ ]  Other bed/unit7 [ ]  Unknown | **Admit order**  |
|  | Month | Day | Year | Time | a.m. | p.m. | Military |
|  | **BRDATE** | **1** |  |  [ ] [ ] :[ ] [ ]  **BR\_TIME** [ ]  | [ ]  | [ ]  |
|  |  |
| **Admitting physician: ADMITPHYS**1 [ ]  Hospitalist2 [ ]  Not hospitalist3 [ ]  Unknown |  |  |
| **Hospital discharge date** |
|  | Month | Day | Year |  |  |  |  |
|  | **DDATE** | **1** |  |  |  |  |  |
| **Hospital discharge diagnosis** |
| (1) Principal | **VHDDIAG** |
| (2) Secondary | **VHDDIAG2** |
|  |
| **Hospital discharge status****HDSTAT** | **Hospital discharge disposition ADISP** |
| 1 [ ]  Alive2 [ ]  Dead 3 [ ]  Unknown | 1 [ ]  Home/Residence2 [ ]  Return/Transfer to nursing home3 [ ]  Return/Transfer to jail/prison/law enforcement | 4 [ ]  Transfer to another facility (not usual place of residence)5 [ ]  Other6 [ ]  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** [ ]  | [ ]  | [ ]  |  |
|  |  |  |