

# SAMPLE

## NATIONAL HOSPITAL CARE SURVEY – AMBULATORY COMPONENT EMERGENCY DEPARTMENT PATIENT RECORD 2016

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: <b>PATIENT_NAME</b>		Patient's SSN: <b>PATIENT_SSN/ ENTER_SSN</b>		Patient's Control #: <b>PTCTRLNUM, ENTER_PTCTRLNUM</b>						
Patient's address <b>RESIDENCE:Street</b>			City: <b>PT_CITY</b>		State: <b>PT_ST</b>		Zip Code: <b>PATZIP</b>			
Patient's medical record #: <b>PTMEDRECNUM/ENTER_PTMEDRECNUM</b>		Medicare health insurance benefit/claim #:			<b>MEDHLTHINSBEN /ENTER_MEDHLTHINSBEN</b>					
NPI-Attending: <b>NPI_ATTEND / ENTER_NPI_ATTEND</b>		NPI-Operating: <b>NPI_OPERATING / ENTER_NPI_OPERATING</b>								
Arrival		Date of Visit Mm <b>VDATE</b> dd yy		Time <b>A_TIME</b>		a.m.	p.m.	Mil.	Mode of arrival <b>ARRIVE</b>	
Provider (physician/APRN/PA) contact		mmtSDATE dd yy		<b>TS_TIME</b>					1 <input type="checkbox"/> Ambulance 2 <input type="checkbox"/> Police transport 3 <input type="checkbox"/> Other 4 <input type="checkbox"/> Unknown	
ED Departure		mmEDATE dd yy		<b>ED_TIME</b>					Was patient transferred from another hospital or freestanding emergency/urgent care facility? <b>AMBTRANSFER</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown	
<b>Patient Residence RESIDENCE</b> 1 <input type="checkbox"/> Private residence 2 <input type="checkbox"/> Institution Indicate the type of institution <b>REST_INST</b> 1 <input type="checkbox"/> Nursing home 2 <input type="checkbox"/> Supportive housing/ Group home 3 <input type="checkbox"/> Jail/Prison 4 <input type="checkbox"/> Other 3 <input type="checkbox"/> Homeless/Homeless shelter 4 <input type="checkbox"/> Other 5 <input type="checkbox"/> Unknown		<b>Date of Birth BDATE</b> Month   Day   Year             <b>Age AGE / AGET</b> 		<b>Ethnicity ETHNIC</b> 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino <b>Race – Mark (X) all that apply.</b> 1 <input type="checkbox"/> White <b>MULTIRACE1-5</b> 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		<b>Expected source(s) of payment for this visit. Mark (X) all that apply. PAY_SOURCE1-7</b> 1 <input type="checkbox"/> Private insurance 2 <input type="checkbox"/> TRICARE 3 <input type="checkbox"/> Medicare 4 <input type="checkbox"/> Medicaid or CHIP or other state-based program 5 <input type="checkbox"/> Workers' compensation 6 <input type="checkbox"/> Self-pay 7 <input type="checkbox"/> No charge/charity 8 <input type="checkbox"/> Other 9 <input type="checkbox"/> Unknown				
TRIAGE								PREVIOUS CARE		
<b>Initial vital signs</b> Temperature: <b>TEMP</b> Heart rate/Pulse: <b>PULSE</b> (beats per minute, 998 = DOPP, DOPPLER) Respiratory rate: <b>RESPR</b> (breaths per minute) Blood pressure: <b>BPSYS</b> Systolic, <b>BPDIAS</b> Diastolic (998 = P, PALP, DOPP, DOPPLER) Pulse oximetry: <b>POPCT</b> (Percent) Triage level (1-5): <b>IMMED</b> (Enter 0 if No triage, Enter 99 if Unknown) Pain scale (0-10): <b>PAIN</b> (Enter 99 if Unknown)								<b>Was patient seen in this ED in the last 72 hours and discharged? SEEN72</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> 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: <b>VRFV1/</b> _____ Source of first complaint, symptom, reason for visit. Mark (X) all that apply <b>SOURCE_RFV</b> 1 <input type="checkbox"/> Patient    2 <input type="checkbox"/> Other    3 <input type="checkbox"/> Unknown (2) Other: <b>VRFV2/ VRFV_LKUP2</b> (3) Other: <b>VRFV3/ VRFV_LKUP3</b> (4) Other: <b>VRFV4/ VRFV_LKUP4</b> (5) Other: <b>VRFV5/ VRFV_LKUP5</b>							<b>Did alcohol cause or contribute to this visit? Alcohol6</b> Mark (X) all that apply. 1 <input type="checkbox"/> Yes, patient's own use 2 <input type="checkbox"/> Yes, other person's use 3 <input type="checkbox"/> No 4 <input type="checkbox"/> Unknown			
<b>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</b> 1 <input type="checkbox"/> Yes, alcohol abuse/misuse/dependence <b>ALCOHOL_TYPE</b> 1. <input type="checkbox"/> History of alcohol abuse/misuse/dependence 2. <input type="checkbox"/> Currently abusing alcohol 2 <input type="checkbox"/> Yes, other substance abuse/misuse/dependence 3 <input type="checkbox"/> Yes, other specify <b>SUBETHOH_SP</b> _____ 4 <input type="checkbox"/> No 5 <input type="checkbox"/> Unknown							<b>Episode of care EPISODE</b> 1 <input type="checkbox"/> Initial visit to this ED for problem 2 <input type="checkbox"/> Follow-up visit to this ED for problem 3 <input type="checkbox"/> Unknown			

1. <input type="checkbox"/> History of other substance abuse/misuse/dependence <b>OTHSUB_TYPE</b> 2. <input type="checkbox"/> Other substance seeking behavior 3. <input type="checkbox"/> Currently abusing other substance(s)	
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**INJURY/TRAUMA/OVERDOSE/POISONING/ADVERSE EFFECT**

<p><b>Is this visit related to an injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment? INJURY</b></p> <p>1 <input type="checkbox"/> No, SKIP to SUBSTANCES INVOLVED</p> <p>2 <input type="checkbox"/> Yes, injury/trauma</p> <p>3 <input type="checkbox"/> Yes, poisoning (non-drug toxic substance)</p> <p>4 <input type="checkbox"/> Yes, poisoning (drug-induced overdose)</p> <p><b>Indicate the kind of drug(s) involved: POISON</b></p> <p>1. <input type="checkbox"/> Medication</p> <p>2. <input type="checkbox"/> Illicit substance</p> <p>3. <input type="checkbox"/> Both medication and illicit substance</p> <p>4. <input type="checkbox"/> Unknown</p> <p>5 <input type="checkbox"/> Yes, adverse effect of medical/surgical treatment or adverse effect of a medicinal drug</p> <p><b>Was medication involved? ADVERSE</b></p> <p>1. <input type="checkbox"/> Yes</p> <p>2. <input type="checkbox"/> No</p> <p>3. <input type="checkbox"/> Unknown</p> <p>6. <input type="checkbox"/> Unknown (skip to substances involved)</p>	<p><b>Did the injury/trauma or overdose/ poisoning occur within 72 hours prior to the date and time of this visit?</b></p> <p><b>INJURY72</b></p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Unknown</p>	<p><b>Is this injury/trauma or overdose/poisoning intentional? INTENT</b></p> <p>1 <input type="checkbox"/> Yes, intentional - suicide attempt</p> <p>2 <input type="checkbox"/> Yes, intentional - self-harm (intentional self-directed harm without intent to die)</p> <p>3 <input type="checkbox"/> Yes, intentional – unclear if suicide attempt or self-harm</p> <p>4 <input type="checkbox"/> Yes, intentional harm by another person (e.g., assault, poisoning)</p> <p>5 <input type="checkbox"/> No, unintentional (e.g., accidental)</p> <p>6 <input type="checkbox"/> Unclear if intentional or unintentional</p>
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**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) <b>VCAUSE / VCAUSEDROPDOWN / TRANSLOC</b>
(2) <b>VCAUSE2 / VCAUSEDROPDOWN2 / TRANSLOC2</b>
(3) <b>VCAUSE3 / VCAUSEDROPDOWN3 / TRANSLOC3</b>
(4) <b>VCAUSE4 / VCAUSEDROPDOWN4 / TRANSLOC4</b>
(5) <b>VCAUSE5 / VCAUSEDROPDOWN5 / TRANSLOC5</b>

**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) <b>Drug_Name1 / Drug_List1</b>
(2) <b>Drug_Name2 / Drug_List2</b>
(3-16) <b>Drug_Name3-16 / Drug_List3-16</b>

<p><b>For each substance listed, mark if confirmed by toxicology or blood test report. CONFIRMEDBYTOXD1-16</b></p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Unknown/Not documented</p>	<p><b>For each substance listed, mark the route of administration. ROUTE_ADMINISTRATION1-16</b></p> <p>1 <input type="checkbox"/> Oral</p> <p>2 <input type="checkbox"/> Injected</p> <p>3 <input type="checkbox"/> Inhaled, sniffed, snorted</p> <p>4 <input type="checkbox"/> Smoked</p> <p>5 <input type="checkbox"/> Transdermal</p> <p>6 <input type="checkbox"/> Other</p> <p>7 <input type="checkbox"/> Not documented</p>	<p><b>Patient took: PT_TOOK1-16</b></p> <p>Mark (X) all that apply:</p> <p>1 <input type="checkbox"/> Own prescription/OTC medication or dietary supplement</p> <p>2 <input type="checkbox"/> Prescription medication not prescribed for patient</p> <p>3 <input type="checkbox"/> Prescription/OTC medication as prescribed or according to directions</p> <p>4 <input type="checkbox"/> Too much of a prescription/OTC medication or dietary supplement</p> <p>5 <input type="checkbox"/> Illicit drug(s)</p> <p>6 <input type="checkbox"/> Alcohol only, under 21</p> <p>7 <input type="checkbox"/> Alcohol in combination with other substances</p> <p>8 <input type="checkbox"/> Not documented</p>
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**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	<b>VDIAG1 / VDIA1G_LKUP</b>	<b>VDIAG1_Code</b> ●
(2) Other:	<b>VDIAG2 / VDIAG2_LKUP</b>	<b>VDIAG2_Code</b> ●
(3) Other:	<b>VDIAG3 / VDIAG3_LKUP</b>	<b>VDIAG3_Code</b> ●
(4) Other:	<b>VDIAG4 / VDIAG4_LKUP</b>	<b>VDIAG4_Code</b> ●
(5) Other:	<b>VDIAG5 / VDIAG5_LKUP</b>	<b>VDIAG5_Code</b> ●
(6) Other:	<b>VDIAG6 / VDIAG6_LKUP</b>	<b>VDIAG6_Code</b> ●
(7) Other:	<b>VDIAG7 / VDIAG7_LKUP</b>	<b>VDIAG7_Code</b> ●
(8) Other:	<b>VDIAG8 / VDIAG8_LKUP</b>	<b>VDIAG8_Code</b> ●
(9) Other:	<b>VDIAG9 / VDIAG9_LKUP</b>	<b>VDIAG9_Code</b> ●
(10-20) Other:	<b>VDIAG10-20 / VDIAG10-20_LKUP</b>	<b>VDIAG10-20_Code</b> ●

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
- 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**
- 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

**Other tests:**

**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 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(2)	VMED2 VMEDOTH2 GPMED2 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(3)	VMED3 VMEDOTH3 GPMED3 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(4)	VMED4 VMEDOTH4 GPMED4 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(5)	VMED5 VMEDOTH5 GPMED5 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(6)	VMED6 VMEDOTH6 GPMED6 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(7)	VMED7 VMEDOTH7 GPMED7 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(8)	VMED8 VMEDOTH8 GPMED8 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(9)	VMED9 VMEDOTH9 GPMED9 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(10)	VMED10 VMEDOTH10 GPMED10 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(11)	VMED11 VMEDOTH11 GPMED11 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(12-30)	VMED12-30 VMEDOTH12 GPMED12 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

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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**

<p><b>Temperature</b></p> <div style="border: 1px solid black; width: 100%; height: 20px; margin: 5px 0; text-align: center; color: red; font-weight: bold;">TempD</div>	<p><b>Heart rate/Pulse</b></p> <div style="border: 1px solid black; width: 100%; height: 20px; margin: 5px 0; text-align: center; color: red; font-weight: bold;">PulseD</div> <p style="font-size: small; text-align: center;">beats per minute 998= DOPP, DOPPLER</p>	<p><b>Respiratory rate</b></p> <div style="border: 1px solid black; width: 100%; height: 20px; margin: 5px 0; text-align: center; color: red; font-weight: bold;">ResprD</div> <p style="font-size: small; text-align: center;">breaths per minute</p>	<p><b>Blood pressure</b></p> <div style="border: 1px solid black; width: 100%; height: 20px; margin: 5px 0; text-align: center; color: red; font-weight: bold;">BPSysD</div> Systolic  <div style="border: 1px solid black; width: 100%; height: 20px; margin: 5px 0; text-align: center; color: red; font-weight: bold;">BPDiasD</div> Diastolic  <p style="font-size: x-small;">998= P, PALP, DOPP, DOPPLER</p>
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**PROVIDERS**

Mark (X) all providers seen at this visit. **PROV\_SEEN1-11**

- |  |   |  |
|--|---|--|
| <ul style="list-style-type: none"> <li>1 <input type="checkbox"/> NONE</li> <li>2 <input type="checkbox"/> ED attending physician</li> <li>3 <input type="checkbox"/> ED resident or Intern</li> <li>4 <input type="checkbox"/> Consulting physician</li> <li>5 <input type="checkbox"/> RN/LPN</li> <li>6 <input type="checkbox"/> Nurse practitioner (NP)</li> <li>7 <input type="checkbox"/> Physician assistant (PA)</li> <li>8 <input type="checkbox"/> EMT</li> <li>9 <input type="checkbox"/> Psychologist</li> <li>10 <input type="checkbox"/> Social worker</li> <li>11 <input type="checkbox"/> Substance abuse services provider</li> <li>12 <input type="checkbox"/> Other mental health provider</li> <li>13 <input type="checkbox"/> Other provider</li> </ul> | <p>Specialty of consulting physician <b>SPEC_CONPHYS1-12</b></p> <ul style="list-style-type: none"> <li>1 <input type="checkbox"/> Cardiology</li> <li>2 <input type="checkbox"/> ENT (Otolaryngology)</li> <li>3 <input type="checkbox"/> Gastroenterology</li> <li>4 <input type="checkbox"/> General/Trauma Surgery</li> <li>5 <input type="checkbox"/> Geriatrics</li> <li>6 <input type="checkbox"/> Neurology</li> <li>7 <input type="checkbox"/> Neurosurgery</li> <li>8 <input type="checkbox"/> Obstetrics-Gynecology</li> <li>9 <input type="checkbox"/> Ophthalmology</li> <li>10 <input type="checkbox"/> Orthopedic Surgery</li> <li>11 <input type="checkbox"/> Psychiatry</li> <li>12 <input type="checkbox"/> Other specialty</li> <li>13 <input type="checkbox"/> Unknown</li> </ul> |  |
|--|---|--|

**VISIT DISPOSITION**

Mark (X) all that apply. **VISIT\_DISP1-15**

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>1 <input type="checkbox"/> No follow-up planned</li> <li>2 <input type="checkbox"/> Return to ED</li> <li>3 <input type="checkbox"/> Return/Refer to physician/clinic for<br/><b>Specify the type of follow-up FOLLOWUP1-3</b> <ul style="list-style-type: none"> <li>1. <input type="checkbox"/> Outpatient mental health treatment</li> <li>2. <input type="checkbox"/> Substance abuse treatment</li> <li>3. <input type="checkbox"/> Other follow-up</li> </ul> </li> <li>4 <input type="checkbox"/> Left without being seen (LWBS)</li> <li>5 <input type="checkbox"/> Left before treatment complete (LBTC)             <ul style="list-style-type: none"> <li>1. <input type="checkbox"/> Left AMA <b>LEFT_AMA</b></li> </ul> </li> <li>6 <input type="checkbox"/> DOA</li> <li>7 <input type="checkbox"/> Died in ED</li> <li>8 <input type="checkbox"/> Return/Transfer to nursing home</li> <li>9 <input type="checkbox"/> Return/Transfer to jail/prison/law enforcement</li> </ul> | <ul style="list-style-type: none"> <li>10 <input type="checkbox"/> Transfer to inpatient behavioral health care facility</li> <li>11 <input type="checkbox"/> Transfer to other non-psychiatric hospital</li> </ul> <p><b>Was the patient transferred psychiatric inpatient treatment or a substance abuse treatment facility? BHEALTH</b></p> <ul style="list-style-type: none"> <li>1. <input type="checkbox"/> Psychiatric inpatient treatment</li> </ul> <p><b>Enter the status of the transfer PSYCH_INP</b></p> <ul style="list-style-type: none"> <li>1. <input type="checkbox"/> Involuntary status</li> <li>2. <input type="checkbox"/> Voluntary status</li> <li>3. <input type="checkbox"/> Not documented</li> <li>2. <input type="checkbox"/> Substance abuse treatment facility</li> <li>3. <input type="checkbox"/> Unknown</li> </ul> <p><b>Indicate the reason for transfer TRANSFER1-5</b><br/><i>Mark (X) all that apply</i></p> <ul style="list-style-type: none"> <li>1. <input type="checkbox"/> Continuity of care/Request by patient, family, or physician</li> <li>2. <input type="checkbox"/> Higher level or specialized care needed</li> <li>3. <input type="checkbox"/> Pediatric hospital needed</li> <li>4. <input type="checkbox"/> Insurance requirement/request</li> <li>5. <input type="checkbox"/> Other/Insufficient information available</li> </ul> | <ul style="list-style-type: none"> <li>12 <input type="checkbox"/> Admit to this hospital</li> <li>13 <input type="checkbox"/> Admit to observation unit then hospitalized</li> <li>14 <input type="checkbox"/> Admit to observation unit then discharged</li> <li>15 <input type="checkbox"/> Other</li> </ul> |
|---|--|---|

**HOSPITAL ADMISSION**

<p><b>Admitted to: ADMIT</b></p> <ul style="list-style-type: none"> <li>1 <input type="checkbox"/> Critical care unit</li> <li>2 <input type="checkbox"/> Stepdown unit</li> <li>3 <input type="checkbox"/> Operating room</li> <li>4 <input type="checkbox"/> Mental health or detox unit</li> <li>5 <input type="checkbox"/> Cardiac catheterization lab</li> <li>6 <input type="checkbox"/> Other bed/unit</li> <li>7 <input type="checkbox"/> Unknown</li> </ul>	<p><b>Admit order</b></p> <table style="width:100%; border-collapse: collapse; font-size: small;"> <tr> <th style="width:10%;">Month</th> <th style="width:10%;">Day</th> <th style="width:10%;">Year</th> <th style="width:20%;">Time</th> <th style="width:10%;">a.m.</th> <th style="width:10%;">p.m.</th> <th style="width:10%;">Military</th> </tr> <tr> <td align="center"><b>BRDATE</b></td> <td align="center"><b>1</b></td> <td></td> <td align="center">□□:□□</td> <td align="center"><b>BR_TIME</b></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> </table>	Month	Day	Year	Time	a.m.	p.m.	Military	<b>BRDATE</b>	<b>1</b>		□□:□□	<b>BR_TIME</b>	<input type="checkbox"/>	<input type="checkbox"/>
Month	Day	Year	Time	a.m.	p.m.	Military									
<b>BRDATE</b>	<b>1</b>		□□:□□	<b>BR_TIME</b>	<input type="checkbox"/>	<input type="checkbox"/>									
<p><b>Admitting physician: ADMITPHYS</b></p> <ul style="list-style-type: none"> <li>1 <input type="checkbox"/> Hospitalist</li> <li>2 <input type="checkbox"/> Not hospitalist</li> <li>3 <input type="checkbox"/> Unknown</li> </ul>	<p><b>Hospital discharge date</b></p> <table style="width:100%; border-collapse: collapse; font-size: small;"> <tr> <th style="width:10%;">Month</th> <th style="width:10%;">Day</th> <th style="width:10%;">Year</th> </tr> <tr> <td align="center"><b>DDATE</b></td> <td align="center"><b>1</b></td> <td></td> </tr> </table>	Month	Day	Year	<b>DDATE</b>	<b>1</b>									
Month	Day	Year													
<b>DDATE</b>	<b>1</b>														

**Hospital discharge diagnosis**

(1) Principal **VHDDIAG**

(2) Secondary **VHDDIAG2**

<p><b>Hospital discharge status HDSTAT</b></p> <ul style="list-style-type: none"> <li>1 <input type="checkbox"/> Alive</li> <li>2 <input type="checkbox"/> Dead</li> <li>3 <input type="checkbox"/> Unknown</li> </ul>	<p><b>Hospital discharge disposition ADISP</b></p> <ul style="list-style-type: none"> <li>1 <input type="checkbox"/> Home/Residence</li> <li>2 <input type="checkbox"/> Return/Transfer to nursing home</li> <li>3 <input type="checkbox"/> Return/Transfer to jail/prison/law enforcement</li> <li>4 <input type="checkbox"/> Transfer to another facility (not usual place of residence)</li> <li>5 <input type="checkbox"/> Other</li> <li>6 <input type="checkbox"/> Unknown</li> </ul>
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**OBSERVATION UNIT STAY**

**Observation unit/care initiation order**

Month	Day	Year	Time	a.m.	p.m.	Military
<b>EDDISDATE</b>	<b>1</b>		□□:□□	<b>EDDISTIME</b>	<input type="checkbox"/>	<input type="checkbox"/>

**Observation unit/care discharge order**

Month	Day	Year	Time	a.m.	p.m.	Military
<b>OBDATE</b>	<b>1</b>		□□:□□	<b>OB_TIME</b>	<input type="checkbox"/>	<input type="checkbox"/>