

Validation of Enhanced Algorithms to Identify Opioid Use and Co-Occurring Disorders in National Hospital Care Survey (NHCS)

Abstraction Form

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Use the below prepopulated information to locate the full medical record for the selected encounter in the hospital’s EHR system. Verify that the correct medical record was selected before proceeding with abstraction.

Hospital_ID	XXXXXXXXXX
Encounter_ID	XXXXXXXXXX
Medical Record Number (MRN)	XXXXXXXXXXXXXXXXXXXX
Setting	<input type="checkbox"/> Emergency Department (ED) <input type="checkbox"/> Inpatient (IP)
Encounter Start Date	DD MON YYYY
Encounter End Date	DD MON YYYY
Patient Date of Birth	DD MON YYYY
Patient Name	LAST, FIRST MI
Patient Sex	XXXXXXXXXXXX
Patient Address	XXXXXXXXXXXX

Answer all the following questions using only information found in the medical record for the above referenced encounter. Exclude encounters that occurred before or after the referenced encounter.

Question 1.	Response
Did the patient have at least one diagnosis related to past or present opioid use? (Select one)	<input type="checkbox"/> Yes <input type="checkbox"/> No (Skip to Question 2)

Question 1a.	Response	
<p>Which diagnosis related to past or present opioid use did the patient have? (Select all that apply)</p> <p><i>NOTE: Includes a diagnosis code or a diagnostic phrase, such as a label or description for a diagnosis code.</i></p>	<p><u>Opioid related disorders</u></p> <input type="checkbox"/> Opioid abuse <input type="checkbox"/> Opioid dependence <input type="checkbox"/> Opioid use	<p><u>Underdosing of:</u></p> <input type="checkbox"/> Opium <input type="checkbox"/> Other opioids <input type="checkbox"/> Methadone <input type="checkbox"/> Other synthetic narcotics <input type="checkbox"/> Unspecified narcotics <input type="checkbox"/> Other narcotics
	<p><u>Poisoning by:</u></p> <input type="checkbox"/> Opium <input type="checkbox"/> Heroin <input type="checkbox"/> Other opioids <input type="checkbox"/> Methadone <input type="checkbox"/> Other synthetic narcotics <input type="checkbox"/> Unspecified narcotics <input type="checkbox"/> Other narcotics	<p><u>Miscellaneous Opioid Use:</u></p> <input type="checkbox"/> Long term current use of opiate analgesic <input type="checkbox"/> Finding of opiate in blood <input type="checkbox"/> Newborn affected by maternal use of opiates <input type="checkbox"/> Neonatal withdrawal symptoms from maternal use of drugs of addiction <input type="checkbox"/> Other (please specify) _____
	<p><u>Adverse Effect of:</u></p> <input type="checkbox"/> Opium <input type="checkbox"/> Other opioids <input type="checkbox"/> Methadone <input type="checkbox"/> Other synthetic narcotics <input type="checkbox"/> Unspecified narcotics <input type="checkbox"/> Other narcotics	

Attachment A - Sample Abstraction Form

Question 1b.	Response	
<p>Where did you find evidence of a diagnosis related to past or present opioid use? (Select all that apply)</p>	<input type="checkbox"/> Allergies <input type="checkbox"/> Assessment & Plan <input type="checkbox"/> Chief Complaint <input type="checkbox"/> Diagnoses <input type="checkbox"/> Discharge Summary <input type="checkbox"/> EMS Report <input type="checkbox"/> Family History <input type="checkbox"/> History of Present Illness (HPI) <input type="checkbox"/> Lab/Toxicology <input type="checkbox"/> Medication List <input type="checkbox"/> Nurses Notes	<input type="checkbox"/> Past Medical History <input type="checkbox"/> Physical Examination <input type="checkbox"/> Problem List <input type="checkbox"/> Progress Note <input type="checkbox"/> Reason for Visit <input type="checkbox"/> Review of Systems <input type="checkbox"/> Services <input type="checkbox"/> Social History <input type="checkbox"/> Other (please describe): _____

Question 2.	Response
<p>Did the patient have at least one written indication of past or present opioid use stated by the patient or provider other than the diagnosis(es) indicated in question 1? (Select one)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No (Skip to Question 3)

Question 2a.	Response
<p>Describe the written indication of past or present opioid use, copy verbatim from chart when possible. (Enter up to three)</p> <p><i>NOTE: Excludes diagnosis(es) indicated in Question 1. Include information regarding the intent of the opioid use if documented in the record (e.g., unintentional/accidental, suicide attempt & intentional self-harm, assault).</i></p>	<input type="checkbox"/> Written indication 1 _____ <input type="checkbox"/> Written indication 2 _____ <input type="checkbox"/> Written indication 3 _____

Question 2b.	Response	
<p>Where did you find evidence of the written indication of past or present opioid use? (Select all that apply)</p>	<input type="checkbox"/> Allergies <input type="checkbox"/> Assessment & Plan <input type="checkbox"/> Chief Complaint <input type="checkbox"/> Diagnoses <input type="checkbox"/> Discharge Summary <input type="checkbox"/> EMS Report <input type="checkbox"/> Family History <input type="checkbox"/> History of Present Illness (HPI) <input type="checkbox"/> Lab/Toxicology <input type="checkbox"/> Medication List <input type="checkbox"/> Nurses Notes	<input type="checkbox"/> Past Medical History <input type="checkbox"/> Physical Examination <input type="checkbox"/> Problem List <input type="checkbox"/> Progress Note <input type="checkbox"/> Reason for Visit <input type="checkbox"/> Review of Systems <input type="checkbox"/> Services <input type="checkbox"/> Social History <input type="checkbox"/> Other (please describe): _____

Attachment A - Sample Abstraction Form

Question 3.	Response
Was any drug testing performed during the encounter? (Select one)	<input type="checkbox"/> Yes <input type="checkbox"/> No (Skip to Question 4)

Question 3a.	Response
Were any drug tests positive? (Select one)	<input type="checkbox"/> Yes <input type="checkbox"/> No, negative for all tested substance (Skip to 3c) <input type="checkbox"/> Don't know/No results provided (Skip to 4)

Question 3b.	Response	
Which substance(s) had positive test results? (Select all that apply)	<input type="checkbox"/> Amphetamines <input type="checkbox"/> Barbiturates <input type="checkbox"/> Benzodiazepines <input type="checkbox"/> Buprenorphine/ Norbuprenorphine <input type="checkbox"/> Cannabis/Marijuana (THC) <input type="checkbox"/> Cocaine <input type="checkbox"/> Codeine <input type="checkbox"/> Ethanol/Alcohol <input type="checkbox"/> Fentanyl/Fentanyl Analogs <input type="checkbox"/> Heroin (6-AM & 6-MAM) <input type="checkbox"/> Hydrocodone <input type="checkbox"/> Hydromorphone <input type="checkbox"/> Levorphanol	<input type="checkbox"/> Methadone <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Mitragynine (Kratom) <input type="checkbox"/> Morphine <input type="checkbox"/> Naloxone <input type="checkbox"/> Naltrexone <input type="checkbox"/> Opiates <input type="checkbox"/> Oxycodone <input type="checkbox"/> Oxymorphone <input type="checkbox"/> Phencyclidine (PCP) <input type="checkbox"/> Tramadol <input type="checkbox"/> Tricyclic antidepressants (TCA) <input type="checkbox"/> Other (please describe) <hr/>

Question 3c.	Response	
Where did you find evidence of drug testing? (Select all that apply)	<input type="checkbox"/> Allergies <input type="checkbox"/> Assessment & Plan <input type="checkbox"/> Chief Complaint <input type="checkbox"/> Diagnoses <input type="checkbox"/> Discharge Summary <input type="checkbox"/> EMS Report <input type="checkbox"/> Family History <input type="checkbox"/> History of Present Illness (HPI) <input type="checkbox"/> Lab/Toxicology <input type="checkbox"/> Medication List <input type="checkbox"/> Nurses Notes	<input type="checkbox"/> Past Medical History <input type="checkbox"/> Physical Examination <input type="checkbox"/> Problem List <input type="checkbox"/> Progress Note <input type="checkbox"/> Reason for Visit <input type="checkbox"/> Review of Systems <input type="checkbox"/> Services <input type="checkbox"/> Social History <input type="checkbox"/> Other (please describe): <hr/>

Question 4.	Response
Was at least one prescription opioid administered and/or prescribed to the patient during the encounter or listed on Past or Current Medication Lists? (Select one)	<input type="checkbox"/> Yes <input type="checkbox"/> No (Skip to Question 5)

Attachment A - Sample Abstraction Form

Question 4a.	Response	
Which prescription opioid(s) was administered and/or prescribed to the patient? (Select all that apply)	<input type="checkbox"/> Buprenorphine <input type="checkbox"/> Codeine <input type="checkbox"/> Fentanyl <input type="checkbox"/> Hydrocodone <input type="checkbox"/> Hydromorphone <input type="checkbox"/> Levorphanol <input type="checkbox"/> Meperidine	<input type="checkbox"/> Methadone <input type="checkbox"/> Morphine <input type="checkbox"/> Oxycodone <input type="checkbox"/> Oxymorphone <input type="checkbox"/> Tramadol <input type="checkbox"/> Other (please describe): _____

Question 4b.	Opioid	Response		
		Prior to Encounter	Given during Encounter	Prescribed upon Discharge
When was the prescription opioid(s) administered and/or prescribed to the patient? (Select all that apply) <i>NOTE: Opioids administered prior to encounter include those listed on Past and Current Medication Lists</i>	Buprenorphine		<input type="checkbox"/>	<input type="checkbox"/>
	Codeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Fentanyl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hydrocodone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hydromorphone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Methadone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Morphine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Oxycodone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Oxymorphone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Tramadol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Other (please describe): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Question 4c.	Response	
Where did you find evidence of opioid(s) administered and/or prescribed to the patient? (Select all that apply)	<input type="checkbox"/> Allergies <input type="checkbox"/> Assessment & Plan <input type="checkbox"/> Chief Complaint <input type="checkbox"/> Diagnoses <input type="checkbox"/> Discharge Summary <input type="checkbox"/> EMS Report <input type="checkbox"/> Family History <input type="checkbox"/> History of Present Illness (HPI) <input type="checkbox"/> Lab/Toxicology <input type="checkbox"/> Medication List <input type="checkbox"/> Nurses Notes	<input type="checkbox"/> Past Medical History <input type="checkbox"/> Physical Examination <input type="checkbox"/> Problem List <input type="checkbox"/> Progress Note <input type="checkbox"/> Reason for Visit <input type="checkbox"/> Review of Systems <input type="checkbox"/> Services <input type="checkbox"/> Social History <input type="checkbox"/> Other (please describe): _____

Question 5.	Response
Was naloxone (Narcan) administered to the patient either during the encounter or shortly before arrival? (Select one)	<input type="checkbox"/> Yes <input type="checkbox"/> No (Skip to Question 6) <input type="checkbox"/> Unknown (Skip to Question 6)

Attachment A - Sample Abstraction Form

Question 5a.	Response
Who administered naloxone (Narcan)? (Select all that apply)	<input type="checkbox"/> EMS <input type="checkbox"/> Firefighter <input type="checkbox"/> Law enforcement <input type="checkbox"/> Hospital provider <input type="checkbox"/> Family/friend/bystander <input type="checkbox"/> Other <input type="checkbox"/> Unknown

Question 5b.	Response
How many doses of naloxone (Narcan) were administered? (Select one)	<input type="checkbox"/> Single <input type="checkbox"/> Multiple <input type="checkbox"/> Unknown

Question 5c.	Response
Did naloxone (Narcan) administration result in a positive response (e.g., increased respiration and/or increased alertness)? (Select one)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Question 5d.	Response	
Where did you find evidence of naloxone (Narcan) administration? (Select all that apply)	<input type="checkbox"/> Allergies <input type="checkbox"/> Assessment & Plan <input type="checkbox"/> Chief Complaint <input type="checkbox"/> Diagnoses <input type="checkbox"/> Discharge Summary <input type="checkbox"/> EMS Report <input type="checkbox"/> Family History <input type="checkbox"/> History of Present Illness (HPI) <input type="checkbox"/> Lab/Toxicology <input type="checkbox"/> Medication List <input type="checkbox"/> Nurses Notes	<input type="checkbox"/> Past Medical History <input type="checkbox"/> Physical Examination <input type="checkbox"/> Problem List <input type="checkbox"/> Progress Note <input type="checkbox"/> Reason for Visit <input type="checkbox"/> Review of Systems <input type="checkbox"/> Services <input type="checkbox"/> Social History <input type="checkbox"/> Other (please describe): _____

Question 6.	Response
Did the patient have at least one diagnosis related to a past or present substance use disorder? (Select one) <i>NOTE: Includes a diagnosis code or a diagnostic phrase, such as a label or description for a diagnosis code.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No (Skip to Question 7)

Attachment A - Sample Abstraction Form

Question 6a.	Response
<p>Which diagnosis related to a past or present substance use disorder did the patient have? (Select all that apply)</p> <p><i>NOTE: Includes a diagnosis code or a diagnostic phrase, such as a label or description for a diagnosis code.</i></p>	<input type="checkbox"/> Alcohol related disorders <input type="checkbox"/> Opioid related disorders <input type="checkbox"/> Cannabis related disorders <input type="checkbox"/> Sedative, hypnotic or anxiolytic related disorders <input type="checkbox"/> Cocaine related disorders <input type="checkbox"/> Other stimulant related disorders <input type="checkbox"/> Hallucinogen related disorders <input type="checkbox"/> Nicotine dependence <input type="checkbox"/> Inhalant related disorders <input type="checkbox"/> Other psychoactive substance related disorders <input type="checkbox"/> Other (please describe): _____

Question 6b.	Response	
<p>Where did you find evidence of a diagnosis related to past or present substance use disorder? (Select all that apply)</p>	<input type="checkbox"/> Allergies <input type="checkbox"/> Assessment & Plan <input type="checkbox"/> Chief Complaint <input type="checkbox"/> Diagnoses <input type="checkbox"/> Discharge Summary <input type="checkbox"/> EMS Report <input type="checkbox"/> Family History <input type="checkbox"/> History of Present Illness (HPI) <input type="checkbox"/> Lab/Toxicology <input type="checkbox"/> Medication List <input type="checkbox"/> Nurses Notes	<input type="checkbox"/> Past Medical History <input type="checkbox"/> Physical Examination <input type="checkbox"/> Problem List <input type="checkbox"/> Progress Note <input type="checkbox"/> Reason for Visit <input type="checkbox"/> Review of Systems <input type="checkbox"/> Services <input type="checkbox"/> Social History <input type="checkbox"/> Other (please describe): _____

Question 7.	Response
<p>Was there at least one written indication of past or present substance use disorder stated by the patient or provider other than the diagnosis(es) indicated in question 6? (Select one)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No (Skip to Question 8)

Question 7a.	Response
<p>Describe the written indication of a past or present substance use disorder, copy verbatim from chart when possible. (Enter up to three)</p> <p><i>NOTE: Excludes diagnosis(es) indicated in Question 6.</i></p>	<input type="checkbox"/> Written indication 1 _____ <input type="checkbox"/> Written indication 2 _____ <input type="checkbox"/> Written indication 3 _____

Attachment A - Sample Abstraction Form

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Question 7b.	Response	
<p>Where did you find evidence of a written indication of a past or present substance use disorder? (Select all that apply)</p> <p><i>NOTE: Excludes diagnosis(es) indicated in Question 6.</i></p>	<input type="checkbox"/> Allergies <input type="checkbox"/> Assessment & Plan <input type="checkbox"/> Chief Complaint <input type="checkbox"/> Diagnoses <input type="checkbox"/> Discharge Summary <input type="checkbox"/> EMS Report <input type="checkbox"/> Family History <input type="checkbox"/> History of Present Illness (HPI) <input type="checkbox"/> Lab/Toxicology <input type="checkbox"/> Medication List <input type="checkbox"/> Nurses Notes	<input type="checkbox"/> Past Medical History <input type="checkbox"/> Physical Examination <input type="checkbox"/> Problem List <input type="checkbox"/> Progress Note <input type="checkbox"/> Reason for Visit <input type="checkbox"/> Review of Systems <input type="checkbox"/> Services <input type="checkbox"/> Social History <input type="checkbox"/> Other (please describe): _____

Question 8.	Response
<p>Did the patient have at least one diagnosis related to a past or present anxiety disorder? (Select one)</p> <p><i>NOTE: Includes a diagnosis code or a diagnostic phrase, such as a label or description for a diagnosis code.</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No (Skip to Question 9)

Question 8a.	Response
<p>Which diagnosis related to a past or present anxiety disorder did the patient have? (Select all that apply)</p> <p><i>NOTE: Includes a diagnosis code or a diagnostic phrase, such as a label or description for a diagnosis code.</i></p>	<input type="checkbox"/> Social phobias <input type="checkbox"/> Panic disorder <input type="checkbox"/> Generalized anxiety disorder <input type="checkbox"/> Other anxiety disorders <input type="checkbox"/> Obsessive-compulsive disorder <input type="checkbox"/> Acute stress reaction <input type="checkbox"/> Post-traumatic stress disorder (PTSD) <input type="checkbox"/> Other (please describe): _____

Attachment A - Sample Abstraction Form

Question 8b.	Response	
<p>Where did you find evidence of a diagnosis related to a past or present anxiety disorder? (Select all that apply)</p>	<input type="checkbox"/> Allergies <input type="checkbox"/> Assessment & Plan <input type="checkbox"/> Chief Complaint <input type="checkbox"/> Diagnoses <input type="checkbox"/> Discharge Summary <input type="checkbox"/> EMS Report <input type="checkbox"/> Family History <input type="checkbox"/> History of Present Illness (HPI) <input type="checkbox"/> Lab/Toxicology <input type="checkbox"/> Medication List <input type="checkbox"/> Nurses Notes	<input type="checkbox"/> Past Medical History <input type="checkbox"/> Physical Examination <input type="checkbox"/> Problem List <input type="checkbox"/> Progress Note <input type="checkbox"/> Reason for Visit <input type="checkbox"/> Review of Systems <input type="checkbox"/> Services <input type="checkbox"/> Social History <input type="checkbox"/> Other (please describe): _____

Question 9.	Response
<p>Was there at least one written indication of past or present anxiety disorder stated by the patient or provider other than the diagnosis indicated in question 8? (Select one)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No (Skip to Question 10)

Question 9a.	Response
<p>Describe the written indication of a past or present anxiety disorder, copy verbatim from chart when possible. (Enter up to three)</p> <p><i>NOTE: Excludes diagnosis(es) indicated in Question 8.</i></p>	<input type="checkbox"/> Written indication 1 _____ <input type="checkbox"/> Written indication 2 _____ <input type="checkbox"/> Written indication 3 _____

Question 9b.	Response	
<p>Where did you find evidence of a written indication of a past or present anxiety disorder? (Select all that apply)</p> <p><i>NOTE: Excludes diagnosis(es) indicated in Question 8.</i></p>	<input type="checkbox"/> Allergies <input type="checkbox"/> Assessment & Plan <input type="checkbox"/> Chief Complaint <input type="checkbox"/> Diagnoses <input type="checkbox"/> Discharge Summary <input type="checkbox"/> EMS Report <input type="checkbox"/> Family History <input type="checkbox"/> History of Present Illness (HPI) <input type="checkbox"/> Lab/Toxicology <input type="checkbox"/> Medication List <input type="checkbox"/> Nurses Notes	<input type="checkbox"/> Past Medical History <input type="checkbox"/> Physical Examination <input type="checkbox"/> Problem List <input type="checkbox"/> Progress Note <input type="checkbox"/> Reason for Visit <input type="checkbox"/> Review of Systems <input type="checkbox"/> Services <input type="checkbox"/> Social History <input type="checkbox"/> Other (please describe): _____

Attachment A - Sample Abstraction Form

Question 10.	Response
<p>Was there at least one diagnosis related to a past or present depressive disorder? (Select one)</p> <p><i>NOTE: Includes a diagnosis code or a diagnostic phrase, such as a label or description for a diagnosis code.</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No (Skip to Question 11)

Question 10a.	Response
<p>Which diagnosis related to a past or present depressive disorder did the patient have? (Select all that apply)</p> <p><i>NOTE: Includes a diagnosis code or a diagnostic phrase, such as a label or description for a diagnosis code.</i></p>	<input type="checkbox"/> Major depressive disorder, single episode <input type="checkbox"/> Major depressive disorder, recurrent <input type="checkbox"/> Personal history of self-harm <input type="checkbox"/> Suicidal ideations <input type="checkbox"/> Suicide attempt <input type="checkbox"/> Other (please describe): _____

Question 10b.	Response	
<p>Where did you find evidence of a diagnosis related to a past or present depressive disorder? (Select all that apply)</p>	<input type="checkbox"/> Allergies <input type="checkbox"/> Assessment & Plan <input type="checkbox"/> Chief Complaint <input type="checkbox"/> Diagnoses <input type="checkbox"/> Discharge Summary <input type="checkbox"/> EMS Report <input type="checkbox"/> Family History <input type="checkbox"/> History of Present Illness (HPI) <input type="checkbox"/> Lab/Toxicology <input type="checkbox"/> Medication List <input type="checkbox"/> Nurses Notes	<input type="checkbox"/> Past Medical History <input type="checkbox"/> Physical Examination <input type="checkbox"/> Problem List <input type="checkbox"/> Progress Note <input type="checkbox"/> Reason for Visit <input type="checkbox"/> Review of Systems <input type="checkbox"/> Services <input type="checkbox"/> Social History <input type="checkbox"/> Other (please describe): _____

Question 11.	Response
<p>Was there at least one written indication of past or present depressive disorder as stated by the patient or provider other than the diagnosis indicated in question 10? (Select one)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No (Skip to Question 12)

Attachment A - Sample Abstraction Form

Question 11a.	Response
<p>Describe the written indication of a past or present depressive disorder, copy verbatim from chart when possible. (Enter up to three)</p> <p><i>NOTE: Excludes diagnosis(es) indicated in Question 10. For written indications of self-harm thoughts and behaviors, include whether they were related to a comorbidity of schizophrenia if documented in the record.</i></p>	<p><input type="checkbox"/> Written indication 1 _____</p> <p><input type="checkbox"/> Written indication 2 _____</p> <p><input type="checkbox"/> Written indication 3 _____</p>

Question 11b.	Response	
<p>Where did you find evidence of a written indication of a past or present depressive disorder? (Select all that apply)</p> <p><i>NOTE: Excludes diagnosis(es) indicated in Question 10.</i></p>	<p><input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> Assessment & Plan</p> <p><input type="checkbox"/> Chief Complaint</p> <p><input type="checkbox"/> Diagnoses</p> <p><input type="checkbox"/> Discharge Summary</p> <p><input type="checkbox"/> EMS Report</p> <p><input type="checkbox"/> Family History</p> <p><input type="checkbox"/> History of Present Illness (HPI)</p> <p><input type="checkbox"/> Lab/Toxicology</p> <p><input type="checkbox"/> Medication List</p> <p><input type="checkbox"/> Nurses Notes</p>	<p><input type="checkbox"/> Past Medical History</p> <p><input type="checkbox"/> Physical Examination</p> <p><input type="checkbox"/> Problem List</p> <p><input type="checkbox"/> Progress Note</p> <p><input type="checkbox"/> Reason for Visit</p> <p><input type="checkbox"/> Review of Systems</p> <p><input type="checkbox"/> Services</p> <p><input type="checkbox"/> Social History</p> <p><input type="checkbox"/> Other (please describe): _____</p>

Question 12.	Response
<p>Was any treatment initiated for the patient's substance use disorder (SUD), anxiety disorder and/or depressive disorder during this encounter? (Select one)</p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No (Skip to Question 13)</p> <p><input type="checkbox"/> N/A, patient does not have a substance use disorder, anxiety disorder or depressive disorder (Skip to 13)</p>

Question 12a.	Response	
<p>What treatment was initiated during this encounter? (Select all that apply)</p>	<p><input type="checkbox"/> Buprenorphine, Methadone or Naltrexone</p> <p><input type="checkbox"/> Admitted to a chemical dependency/detoxification unit at the hospital</p> <p><input type="checkbox"/> Psychotropic medication</p>	<p><input type="checkbox"/> Admitted to a psychiatric inpatient unit at this hospital</p> <p><input type="checkbox"/> Brief intervention counseling</p> <p><input type="checkbox"/> Transferred/referred to another facility</p> <p><input type="checkbox"/> Other (please describe): _____</p>

Attachment A - Sample Abstraction Form

Question 12b.	Response	
<p>Where did you find evidence of treatment initiated during this encounter? (Select all that apply)</p>	<input type="checkbox"/> Allergies <input type="checkbox"/> Assessment & Plan <input type="checkbox"/> Chief Complaint <input type="checkbox"/> Diagnoses <input type="checkbox"/> Discharge Summary <input type="checkbox"/> EMS Report <input type="checkbox"/> Family History <input type="checkbox"/> History of Present Illness (HPI) <input type="checkbox"/> Lab/Toxicology <input type="checkbox"/> Medication List <input type="checkbox"/> Nurses Notes	<input type="checkbox"/> Past Medical History <input type="checkbox"/> Physical Examination <input type="checkbox"/> Problem List <input type="checkbox"/> Progress Note <input type="checkbox"/> Reason for Visit <input type="checkbox"/> Review of Systems <input type="checkbox"/> Services <input type="checkbox"/> Social History <input type="checkbox"/> Other (please describe): _____

Question 13.	Response
<p>Abstractor Notes</p> <p><i>Use this space to describe any issues with abstracting information for this encounter or any other pertinent information.</i></p>	