

SAMPLE

National Hospital Ambulatory Medical Care Survey 2021 EMERGENCY DEPARTMENT PATIENT RECORD

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PATIENT INFORMATION

Patient medical record number				ZIP Code				Date of birth		
								Month	Day	Year
Date and time of visit										
Arrival										
Month	Day	Year	Time	a.m.	p.m.	Military				
		202								
First provider (physician/APRN/PA) contact										
Month	Day	Year	Time	a.m.	p.m.	Military				
		202								
ED departure										
Month	Day	Year	Time	a.m.	p.m.	Military				
		202								
Arrival by ambulance				Was patient transferred from another hospital or urgent care facility?				Expected source(s) of payment for THIS VISIT – Mark (X) all that apply.		
1 <input type="checkbox"/> Yes				1 <input type="checkbox"/> Yes				1 <input type="checkbox"/> Private insurance		
2 <input type="checkbox"/> No				2 <input type="checkbox"/> No				4 <input type="checkbox"/> Workers' compensation		
3 <input type="checkbox"/> Unknown				3 <input type="checkbox"/> Unknown				5 <input type="checkbox"/> Self-pay		
				4 <input type="checkbox"/> Not applicable				6 <input type="checkbox"/> No charge/Charity		
								7 <input type="checkbox"/> Other		
								8 <input type="checkbox"/> Unknown		

TRIAGE

Initial vital signs		Temperature	Heart rate	Respiratory rate	Triage level (1-5)	Pain scale (0-10)
		1 <input type="checkbox"/> °C	Enter "998" for DOPP or DOPPLER.	breaths per minute	Enter "0" if no triage.	Enter "99" if unknown.
		2 <input type="checkbox"/> °F	beats per minute		Enter "9" if unknown.	
Blood pressure	Pulse oximetry	Was patient seen in this ED within the last 72 hours?				
Systolic / Diastolic	%	1 <input type="checkbox"/> Yes	2 <input type="checkbox"/> No	3 <input type="checkbox"/> Unknown		
	Percent of oxyhemoglobin saturation; value is usually between 80–100%.					

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 or history of present illness (HPI) for additional reasons.		Episode of care
(1) Most important:		1 <input type="checkbox"/> Initial visit to this ED for problem
(2) Other:		2 <input type="checkbox"/> Follow-up visit to this ED for problem
(3) Other:		3 <input type="checkbox"/> Unknown
(4) Other:		
(5) Other:		

INJURY

Is this visit related to an injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment?	Did the injury/trauma, overdose/poisoning, or adverse effect occur within 72 hours prior to the date and time of this visit?	Is this injury/trauma or overdose/poisoning intentional or unintentional?	What was the intent of the injury/trauma or overdose/poisoning?
1 <input type="checkbox"/> Yes, injury/trauma	1 <input type="checkbox"/> Yes	1 <input type="checkbox"/> Intentional	1 <input type="checkbox"/> Suicide attempt with intent to die
2 <input type="checkbox"/> Yes, overdose/poisoning	2 <input type="checkbox"/> No	2 <input type="checkbox"/> Unintentional (e.g., accidental)	2 <input type="checkbox"/> Intentional self-harm without intent to die
3 <input type="checkbox"/> Yes, adverse effect of medical or surgical treatment or adverse effect of medicinal drug	3 <input type="checkbox"/> Unknown	3 <input type="checkbox"/> Intent unclear	3 <input type="checkbox"/> Unclear if suicide attempt or intentional self-harm without intent to die
4 <input type="checkbox"/> No			4 <input type="checkbox"/> Intentional harm inflicted by another person (e.g., assault, poisoning)
5 <input type="checkbox"/> Unknown			5 <input type="checkbox"/> Intent unclear

Cause of injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment – Describe the place and circumstances that preceded the event. Examples: **1** – Injury/trauma (e.g., patient fell while walking down stairs at home and sprained her ankle; patient was bitten by a spider); **2** – Overdose/poisoning (e.g., 4 year old child was given adult cold/cough medication and became lethargic; child swallowed large amount of liquid cleanser and began vomiting); **3** – Adverse effect (e.g., patient developed a rash on his arm 2 days after taking penicillin for an ear infection)

DIAGNOSIS

As specifically as possible, list diagnoses related to this visit including chronic conditions. List PRIMARY diagnosis first.	Does patient have – Mark (X) all that apply.
(1) Primary diagnosis:	1 <input type="checkbox"/> Alcohol misuse, abuse, or dependence
(2) Other:	11 <input type="checkbox"/> Diabetes mellitus (DM), Type 1
(3) Other:	12 <input type="checkbox"/> Diabetes mellitus (DM), Type 2
(4) Other:	13 <input type="checkbox"/> Diabetes mellitus (DM), Type unspecified
(5) Other:	14 <input type="checkbox"/> End-stage renal disease (ESRD)
	15 <input type="checkbox"/> History of pulmonary embolism (PE), deep vein thrombosis (DVT), or venous thromboembolism (VTE)
	16 <input type="checkbox"/> HIV infection/AIDS
	17 <input type="checkbox"/> Hyperlipidemia
	18 <input type="checkbox"/> Hypertension
	19 <input type="checkbox"/> Obesity
	20 <input type="checkbox"/> Obstructive sleep apnea (OSA)
	21 <input type="checkbox"/> Osteoporosis
	22 <input type="checkbox"/> Substance abuse or dependence
	23 <input type="checkbox"/> None of the above
	2 <input type="checkbox"/> Alzheimer's disease/Dementia
	3 <input type="checkbox"/> Asthma
	4 <input type="checkbox"/> Cancer
	5 <input type="checkbox"/> Cerebrovascular disease/History of stroke (CVA) or transient ischemic attack (TIA)
	6 <input type="checkbox"/> Chronic kidney disease (CKD)
	7 <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD)
	8 <input type="checkbox"/> Congestive heart failure (CHF)
	9 <input type="checkbox"/> Coronary artery disease (CAD), ischemic heart disease (IHD) or history of myocardial infarction (MI)
	10 <input type="checkbox"/> Depression

DIAGNOSTIC SERVICES

Diagnostic Services – Mark (X) all Laboratory tests, Other tests, and Imaging ORDERED or PROVIDED.

- 1 NONE
Laboratory tests:
2 Arterial blood gases (ABG)
3 BAC (Blood alcohol concentration)
4 Basic metabolic panel (BMP)
5 BNP (brain natriuretic peptide)
6 Creatinine/Renal function panel
7 Cardiac enzymes
8 CBC
9 Comprehensive metabolic panel (CMP)
10 Culture, blood
11 Culture, throat
12 Culture, urine
13 Culture, wound
14 Culture, other
15 D-dimer
16 Electrolytes
17 Glucose, serum
18 Lactate
19 Liver enzymes/Hepatic function panel
20 Prothrombin time (PT/PTT/INR)
21 Other blood test
Other tests:
22 Cardiac monitor
23 EKG/ECG
24 HIV test
25 Influenza test
26 Pregnancy/HCG test
27 Toxicology screen
28 Urinalysis (UA) or urine dipstick
29 Other test/service
Imaging:
30 X-ray
31 CT scan
32 MRI
33 Ultrasound
34 Other imaging

PROCEDURES

Procedures – Mark (X) all PROVIDED at this visit. (Exclude medications.)

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

MEDICATIONS & IMMUNIZATIONS

List up to 30 drugs given at this visit or prescribed at ED discharge. Include Rx and OTC drugs, immunizations, and anesthetics.

Table with columns for drug name, 'Given in ED', and 'Rx at discharge'. Includes a 'When given?' section with checkboxes for 'Given in ED' and 'Rx at discharge'.

VITALS AFTER TRIAGE

Does the chart contain vital signs taken after triage?

- 1 Yes
2 No
Temperature
Heart rate
Respiratory rate
Blood pressure

PROVIDERS

Mark (X) all providers seen at this visit.

- 1 ED attending physician
2 ED resident/Intern
3 Consulting physician
4 RN/LPN
5 Nurse practitioner
6 Physician assistant
7 EMT
8 Other mental health provider
9 Other

DISPOSITION

Mark (X) all that apply.

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

OBSERVATION UNIT STAY

Date and time of observation unit/care initiation order

Date and time of observation unit/care discharge order

Form for date and time of observation unit/care initiation order with fields for Month, Day, Year, and Time.

Form for date and time of observation unit/care discharge order with fields for Month, Day, Year, and Time.

HOSPITAL ADMISSION

Complete if the patient was admitted to this hospital at this ED visit. – Mark (X) "Unknown" in each item, if efforts have been exhausted to collect the data.

Admitted to:

- 1 Critical care unit
2 Stepdown unit
3 Operating room
4 Mental health or detox unit
5 Cardiac catheterization lab
6 Other bed/unit
7 Unknown

Date and time of admit order

Form for date and time of admit order with fields for Month, Day, Year, and Time.

Admitting physician

- 1 Hospitalist
2 Not hospitalist
3 Unknown

Hospital discharge date

Form for hospital discharge date with fields for Month, Day, Year.

Principal hospital discharge diagnosis

Large text area for principal hospital discharge diagnosis.

Hospital discharge status/disposition

- 1 Alive
2 Dead
3 Unknown
4 Home/Residence
5 Return/Transfer to nursing home
6 Transfer to another facility (not usual place of residence)
7 Other
8 Unknown