

SAMPLE

National Hospital Ambulatory Medical Care Survey 2020 EMERGENCY DEPARTMENT PATIENT RECORD

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PATIENT INFORMATION

Patient medical record number				ZIP Code				Date of birth																			
<input style="width: 100%;" type="text"/>				<input style="width: 100%;" type="text"/>				<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; padding: 2px;">Month</td> <td style="width: 33%; padding: 2px;">Day</td> <td style="width: 33%; padding: 2px;">Year</td> </tr> <tr> <td style="padding: 2px;"><input style="width: 100%;" type="text"/></td> <td style="padding: 2px;"><input style="width: 100%;" type="text"/></td> <td style="padding: 2px;"><input style="width: 100%;" type="text"/></td> </tr> </table>			Month	Day	Year	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>											
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Date and time of visit				Patient residence				Sex		Ethnicity		Age															
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Arrival by ambulance <input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 Unknown				Was patient transferred from another hospital or urgent care facility? <input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 Unknown <input type="checkbox"/> 4 Not applicable				Expected source(s) of payment for THIS VISIT – Mark (X) all that apply. <input type="checkbox"/> 1 Private insurance <input type="checkbox"/> 2 Medicare <input type="checkbox"/> 3 Medicaid or CHIP or other state-based program <input type="checkbox"/> 4 Workers' compensation <input type="checkbox"/> 5 Self-pay <input type="checkbox"/> 6 No charge/Charity <input type="checkbox"/> 7 Other <input type="checkbox"/> 8 Unknown																			

TRIAGE

Initial vital signs		Temperature <input style="width: 40px;" type="text"/> 1 <input type="checkbox"/> °C 2 <input type="checkbox"/> °F		Heart rate <input style="width: 40px;" type="text"/> beats per minute <small>Enter "998" for DOPP or DOPPLER.</small>		Respiratory rate <input style="width: 40px;" type="text"/> breaths per minute		Triage level (1-5) Enter "0" if no triage. Enter "9" if unknown. <input style="width: 40px;" type="text"/>		Pain scale (0-10) Enter "99" if unknown. <input style="width: 40px;" type="text"/>	
Blood pressure Systolic <input style="width: 40px;" type="text"/> / Diastolic <input style="width: 40px;" type="text"/>		Pulse oximetry <input style="width: 40px;" type="text"/> % <small>Percent of oxyhemoglobin saturation; value is usually between 80–100%.</small>		Was patient seen in this ED within the last 72 hours? <input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 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 or history of present illness (HPI) for additional reasons.		Episode of care <input type="checkbox"/> 1 Initial visit to this ED for problem <input type="checkbox"/> 2 Follow-up visit to this ED for problem <input type="checkbox"/> 3 Unknown	
(1) Most important:	<input style="width: 100%;" type="text"/>		
(2) Other:	<input style="width: 100%;" type="text"/>		
(3) Other:	<input style="width: 100%;" type="text"/>		
(4) Other:	<input style="width: 100%;" type="text"/>		
(5) Other:	<input style="width: 100%;" type="text"/>		

INJURY

Is this visit related to an injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment? <input type="checkbox"/> 1 Yes, injury/trauma <input type="checkbox"/> 2 Yes, overdose/poisoning <input type="checkbox"/> 3 Yes, adverse effect of medical or surgical treatment or adverse effect of medicinal drug <input type="checkbox"/> 4 No <input type="checkbox"/> 5 Unknown } <i>SKIP to Diagnosis</i>	Did the injury/trauma, overdose/poisoning, or adverse effect occur within 72 hours prior to the date and time of this visit? <input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 Unknown <i>For adverse effect SKIP to Cause</i>	Is this injury/trauma or overdose/poisoning intentional or unintentional? <input type="checkbox"/> 1 Intentional <input type="checkbox"/> 2 Unintentional (e.g., accidental) <input type="checkbox"/> 3 Intent unclear	What was the intent of the injury/trauma or overdose/poisoning? <input type="checkbox"/> 1 Suicide attempt with intent to die <input type="checkbox"/> 2 Intentional self-harm without intent to die <input type="checkbox"/> 3 Unclear if suicide attempt or intentional self-harm without intent to die <input type="checkbox"/> 4 Intentional harm inflicted by another person (e.g., assault, poisoning) <input type="checkbox"/> 5 Intent unclear
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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:	<input type="checkbox"/> 1 Alcohol misuse, abuse, or dependence	<input type="checkbox"/> 11 Diabetes mellitus (DM), Type 1
(2) Other:	<input type="checkbox"/> 2 Alzheimer's disease/Dementia	<input type="checkbox"/> 12 Diabetes mellitus (DM), Type 2
(3) Other:	<input type="checkbox"/> 3 Asthma	<input type="checkbox"/> 13 Diabetes mellitus (DM), Type unspecified
(4) Other:	<input type="checkbox"/> 4 Cancer	<input type="checkbox"/> 14 End-stage renal disease (ESRD)
(5) Other:	<input type="checkbox"/> 5 Cerebrovascular disease/History of stroke (CVA) or transient ischemic attack (TIA)	<input type="checkbox"/> 15 History of pulmonary embolism (PE), deep vein thrombosis (DVT), or venous thromboembolism (VTE)
	<input type="checkbox"/> 6 Chronic kidney disease (CKD)	<input type="checkbox"/> 16 HIV infection/AIDS
	<input type="checkbox"/> 7 Chronic obstructive pulmonary disease (COPD)	<input type="checkbox"/> 17 Hyperlipidemia
	<input type="checkbox"/> 8 Congestive heart failure (CHF)	<input type="checkbox"/> 18 Hypertension
	<input type="checkbox"/> 9 Coronary artery disease (CAD), ischemic heart disease (IHD) or history of myocardial infarction (MI)	<input type="checkbox"/> 19 Obesity
	<input type="checkbox"/> 10 Depression	<input type="checkbox"/> 20 Obstructive sleep apnea (OSA)
		<input type="checkbox"/> 21 Osteoporosis
		<input type="checkbox"/> 22 Substance abuse or dependence
		<input type="checkbox"/> 23 None of the above

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
Was CT ordered/provided with intravenous (IV) contrast?
1 Yes
2 No
3 Unknown
- 32 MRI
Was MRI ordered/provided with intravenous (IV) contrast (also written as "with gadolinium" or "with gado")?
1 Yes
2 No
3 Unknown
- 33 Ultrasound
Who performed the ultrasound?
1 Emergency physician
2 Other provider
- 34 Other imaging

MEDICATIONS & IMMUNIZATIONS

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

	When given? Mark (X) all that apply.	
	Given in ED	Rx at discharge
<input type="checkbox"/> NONE		
(1)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(2)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(3)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(4)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(5)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
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	1 <input type="checkbox"/>	2 <input type="checkbox"/>
	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(30)	1 <input type="checkbox"/>	2 <input type="checkbox"/>

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

VITALS AFTER TRIAGE

PROVIDERS

DISPOSITION

Does the chart contain vital signs taken after triage?

- 1 Yes
- 2 No
- Temperature: °C / °F
- Heart rate: Enter "998" for DOPP or DOPPLER. beats per minute
- Respiratory rate: breaths per minute
- Blood pressure: Systolic / Diastolic

- 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

- 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

Month Day Year 202 Time : a.m. p.m. Military

1 Unknown

Date and time of observation unit/care discharge order

Month Day Year 202 Time : a.m. p.m. Military

1 Unknown

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

Month Day Year 202 Time : a.m. p.m. Military

1 Unknown

- Admitting physician**
- 1 Hospitalist
 - 2 Not hospitalist
 - 3 Unknown

Hospital discharge date

Month Day Year 202

1 Unknown

Principal hospital discharge diagnosis

1 Unknown

- 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