NHAMCS-173
(2-5-2014)

SAMPLE

NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY
2014 EMERGENCY DEPARTMENT PATIENT RECORD

Form Approved: OMB No. 0920-0278; Expiration date 12/31/2014

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 medical record number

ZIP Code
Enter "1" if homeless

Date of birth
Month | Day | Year

Date and time of visit

	Month	Day	Year	Time	a.m.	p.m.	Military
Arrival			1	:	☐	☐	☐
Seen by MD/DO/PA/NP			1	:	☐	☐	☐
Date and time of ED departure, if released or transferred			1	:	☐	☐	☐

Patient residence
1 ☐ Private residence
2 ☐ Nursing home
3 ☐ Homeless
4 ☐ Other
5 ☐ Unknown

Sex
1 ☐ Female
2 ☐ Male

Ethnicity
1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino

Age
1 ☐ Years
2 ☐ Months
3 ☐ Days

Race – *Mark (X) all that apply.*
1 ☐ White
2 ☐ Black or African American
3 ☐ Asian
4 ☐ Native Hawaiian or Other Pacific Islander
5 ☐ American Indian or Alaska Native

Arrival by ambulance
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

Was patient transferred from another hospital or urgent care facility?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown
4 ☐ Not applicable

Expected source(s) of payment for THIS VISIT – *Mark (X) all that apply.*
1 ☐ Private insurance
2 ☐ Medicare
3 ☐ Medicaid or CHIP or other state-based program
4 ☐ Workers' compensation
5 ☐ Self-pay
6 ☐ No charge/Charity
7 ☐ Other
8 ☐ Unknown

TRIAGE

Initial vital signs

Temperature ☐ °C ☐ °F

Heart rate beats per minute

Respiratory rate breaths per minute

Blood pressure Systolic / Diastolic

Pulse oximetry %

Was patient seen in this ED within the last 72 hours and discharged?
1 ☐ Yes 2 ☐ No 3 ☐ Unknown

Triage level (1–5)
1 ☐ No triage
2 ☐ Unknown

Pain scale (0–10)
1 ☐ Unknown

REASON FOR VISIT

List the first 5 reasons for visit (i.e., symptoms, problems, issues, concerns 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.

(1) Most important:
(2) Other:
(3) Other:
(4) Other:
(5) Other:

Episode of care
1 ☐ Initial visit to this ED for problem
2 ☐ Follow-up visit to this ED for problem
3 ☐ Unknown

INJURY

Is this visit related to an injury/trauma, overdose, poisoning, or adverse effect of medical treatment?
1 ☐ Yes, injury/trauma
2 ☐ Yes, poisoning
3 ☐ Yes, adverse effect of medical treatment
4 ☐ No
5 ☐ Unknown
SKIP to

Did the injury/ trauma, overdose, or poisoning occur within 72 hours prior to the date and time of this visit?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown
4 ☐ Not applicable

Is this injury/overdose/poisoning intentional?
1 ☐ Yes, self inflicted
2 ☐ Yes, assault
3 ☐ No, unintentional (e.g., accidental)
4 ☐ Intent unclear

Cause of injury/trauma, overdose, poisoning, or adverse effect – *Describe the place and circumstances that preceded the event. Examples:* **1 –** *Injury (e.g., patient fell while walking down stairs at home and sprained her ankle; patient was bitten by a spider);* **2 –** *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.

(1) Primary diagnosis:
(2) Other:
(3) Other:
(4) Other:
(5) Other:

Does patient have – *Mark (X) all that apply.*
1 ☐ Alcohol abuse
2 ☐ Alzheimer's disease/Dementia
3 ☐ Asthma
4 ☐ Cancer
5 ☐ Cerebrovascular disease/ 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 ☐ Depression
11 ☐ Diabetes mellitus (DM)-Type I
12 ☐ Diabetes mellitus (DM)-Type II
13 ☐ Diabetes mellitus (DM)-Type unspecified
14 ☐ End-stage renal disease (ESRD)
15 ☐ History of pulmonary embolism (PE) or deep vein thrombosis (DVT)
16 ☐ HIV infection/AIDS
17 ☐ Hyperlipidemia
18 ☐ Hypertension
19 ☐ Obesity
20 ☐ Obstructive sleep apnea (OSA)
21 ☐ Osteoporosis
22 ☐ Substance abuse
23 ☐ None of the above

DIAGNOSTIC SERVICES

*Mark (X) all **ordered** or **provided** at this visit.*

1 ☐ NONE

Blood tests:

2 ☐ Arterial blood gases
3 ☐ BAC (blood alcohol concentration)
4 ☐ Blood culture
5 ☐ BNP (brain natriuretic peptide)
6 ☐ BUN/Creatinine
7 ☐ Cardiac enzymes
8 ☐ CBC
9 ☐ D-dimer
10 ☐ Electrolytes
11 ☐ Glucose
12 ☐ Lactate
13 ☐ Liver function tests
14 ☐ Prothrombin time/INR
15 ☐ Other blood test

Other tests:

16 ☐ Cardiac monitor
17 ☐ EKG/ECG
18 ☐ HIV test
19 ☐ Influenza test
20 ☐ Pregnancy/HCG test
21 ☐ Toxicology screen
22 ☐ Urinalysis (UA)
23 ☐ Urine culture
24 ☐ Wound culture
25 ☐ Other test/service

Imaging:

26 ☐ X-ray
27 ☐ CT scan
- ☐ Abdomen/Pelvis
- ☐ Chest
- ☐ Head
- ☐ Other

Was CT ordered/provided with intravenous (IV) contrast?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

28 ☐ MRI

Was MRI ordered/provided with intravenous (IV) contrast *(also written as "with gadolinium" or "with gado")*?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

29 ☐ Ultrasound

Who performed the ultrasound?
1 ☐ Emergency physician
2 ☐ Other provider

30 ☐ Other imaging

PROCEDURES

*Mark (X) all **provided** at this visit. Exclude medications.*

1 ☐ NONE
2 ☐ BPAP/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
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.

☐ NONE

		Given in ED	Rx at discharge
(1)		1 ☐	2 ☐
(2)		1 ☐	2 ☐
(3)		1 ☐	2 ☐
(4)		1 ☐	2 ☐
(5)		1 ☐	2 ☐
(6)		1 ☐	2 ☐
(7)		1 ☐	2 ☐
(8)		1 ☐	2 ☐
(9)		1 ☐	2 ☐
(10)		1 ☐	2 ☐
(11)		1 ☐	2 ☐
(12)		1 ☐	2 ☐
(13)		1 ☐	2 ☐
(14)		1 ☐	2 ☐
(15)		1 ☐	2 ☐
(16)		1 ☐	2 ☐

VITALS DISCHARGE

Were vitals taken at discharge?

1 ☐ Yes
2 ☐ No

Temperature ☐ °C ☐ °F

Heart rate (beats per minute)

Respiratory rate (breaths per minute)

Blood pressure Systolic / Diastolic

DISPOSITION

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 before triage
5 ☐ Left after triage
6 ☐ Left AMA
7 ☐ DOA
8 ☐ Died in ED
9 ☐ Return/Transfer to nursing home
10 ☐ Transfer to psychiatric hospital
11 ☐ Transfer to other hospital
12 ☐ Admit to this hospital
13 ☐ Admit to observation unit then hospitalized
14 ☐ Admit to observation unit, then discharged
15 ☐ Other

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 bed was requested for hospital admission or transfer

Month / Day / Year (1) / Time / a.m. p.m. Military

1 ☐ Unknown

Date and time patient actually left the ED or observation unit

Month / Day / Year (1) / Time / a.m. p.m. Military

1 ☐ Unknown

Admitting physician

1 ☐ Hospitalist
2 ☐ Not hospitalist
3 ☐ Unknown

Hospital discharge date

Month / Day / Year (1)

1 ☐ Unknown

Principal hospital discharge diagnosis

1 ☐ Unknown

Hospital discharge status/disposition

1 ☐ Alive
2 ☐ Dead
3 ☐ Unknown

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

▶ ***If this information is not available at time of abstraction, then complete the Hospital Admission Log.***

OBSERVATION UNIT STAY

Date and time of observation unit discharge

Month / Day / Year (1) / Time / a.m. p.m. Military

1 ☐ Unknown

Date and time of ED Departure

Month / Day / Year (1) / Time / a.m. p.m. Military

☐ Unknown