Form Approved: OMB No. 0920-0278

FORM **NHAMCS-100(ED)**
(9-18-2008)

U.S. DEPARTMENT OF COMMERCE
Economics and Statistics Administration
U.S. CENSUS BUREAU
ACTING AS DATA COLLECTION AGENT FOR THE
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
National Center for Health Statistics

NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY
2009 EMERGENCY DEPARTMENT PATIENT RECORD

PATIENT RECORD NO.:

PATIENT'S NAME:

Assurance of confidentiality – All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used 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).

(Provider: Detach and keep)

Please keep (X) marks inside of boxes ➜ ☒ Correct ☒ Incorrect

1. PATIENT INFORMATION

a. Date and time of visit

	Month	Day	Year	Time	a.m.	p.m.	Military
(1) Arrival			0	:	☐	☐	☐
Seen by **(2)** MD/DO/PA/NP			0	:	☐	☐	☐
(3) ED discharge			0	:	☐	☐	☐

b. ZIP Code

c. Date of birth

Month | Day | Year

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

e. Sex
1 ☐ Female
2 ☐ Male

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

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

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

i. Expected source(s) of payment for this visit – *Mark (X) all that apply.*
1 ☐ Private insurance
2 ☐ Medicare
3 ☐ Medicaid/SCHIP
4 ☐ Worker's compensation
5 ☐ Self-pay
6 ☐ No charge/Charity
7 ☐ Other
8 ☐ Unknown

2. TRIAGE

a. Initial vital signs

(1) Temperature ☐°C ☐°F

(2) Heart rate per minute

(3) Respiratory rate per minute

(4) Blood pressure Systolic / Diastolic

(5) Pulse oximetry %

(6) On oxygen
1 ☐ Yes 3 ☐ Unknown
2 ☐ No

(7) Glasgow Coma Scale (3–15)

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

c. Pain scale (0–10)
1 ☐ Unknown

3. PREVIOUS CARE

a. Has patient been –	Yes	No	Unknown
(1) seen in this ED within the last 72 hours? . .	1 ☐	2 ☐	3 ☐
(2) discharged from any hospital within the last 7 days?	1 ☐	2 ☐	3 ☐
b. How many times has patient been seen in this ED within the last 12 months?			3 ☐

4. REASON FOR VISIT

a. Patient's complaint(s), symptom(s), or other reason(s) for this visit *Use patient's own words.*

(1) Most important:

(2) Other:

(3) Other:

b. Episode of care
1 ☐ Initial visit for problem
2 ☐ Follow-up visit for problem
3 ☐ Unknown

5. INJURY/POISONING/ADVERSE EFFECT

a. Is this visit related to an injury, poisoning, or adverse effect of medical treatment?
1 ☐ Yes
2 ☐ No – *SKIP to item 6.*

b. Is this injury/ poisoning intentional?
1 ☐ Yes, self inflicted
2 ☐ Yes, assault
3 ☐ No, unintentional
4 ☐ Unknown

c. Cause of injury, poisoning, or adverse effect – *Describe the place and events that preceded the injury, poisoning, or adverse effect (e.g., allergy to penicillin, bee sting, pedestrian hit by car driven by drunk driver, spouse beaten with fists by spouse, heroin overdose, infected shunt, etc.).*

6. PROVIDER'S DIAGNOSIS FOR THIS VISIT

a. *As specifically as possible, list diagnoses related to this visit including chronic conditions.*

(1) Primary diagnosis:

(2) Other:

(3) Other:

b. Does patient have – *Mark (X) all that apply.*
1 ☐ Cerebrovascular disease/ History of stroke
2 ☐ Congestive heart failure
3 ☐ Condition requiring dialysis
4 ☐ HIV
5 ☐ Diabetes
6 ☐ None of the above

7. DIAGNOSTIC/SCREENING SERVICES

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

1 ☐ NONE

Blood tests:
2 ☐ CBC
3 ☐ BUN/Creatinine
4 ☐ Cardiac enzymes
5 ☐ Electrolytes
6 ☐ Glucose
7 ☐ Liver function tests
8 ☐ Arterial blood gases
9 ☐ Prothrombin time/INR
10 ☐ Blood culture
11 ☐ BAC (blood alcohol)
12 ☐ Other blood test

Other tests:
13 ☐ Cardiac monitor
14 ☐ EKG/ECG
15 ☐ HIV test
16 ☐ Influenza test
17 ☐ Pregnancy test
18 ☐ Toxicology screen
19 ☐ Urinalysis (UA)
20 ☐ Wound culture
21 ☐ Other test/service

Imaging:
22 ☐ X-ray
23 ☐ CT scan
☐ Head
☐ Other than head
24 ☐ MRI
25 ☐ Ultrasound
26 ☐ Other imaging

8. PROCEDURES

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

1 ☐ NONE
2 ☐ IV fluids
3 ☐ Cast
4 ☐ Splint or wrap
5 ☐ Suturing/Staples
6 ☐ Incision & drainage (I&D)
7 ☐ Foreign body removal
8 ☐ Nebulizer therapy
9 ☐ Bladder catheter
10 ☐ Pelvic exam
11 ☐ Central line
12 ☐ CPR
13 ☐ Endotracheal intubation
14 ☐ Other

9. MEDICATIONS & IMMUNIZATIONS

List up to 8 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 ☐

10. 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 ☐ Mental health provider
9 ☐ Other

11. SERVICE LEVEL

Mark (X) all that apply.

(CPT code)

1 ☐ 1 (99281)
2 ☐ 2 (99282)
3 ☐ 3 (99283)
4 ☐ 4 (99284)
5 ☐ 5 (99285)
6 ☐ Critical care (99291)
7 ☐ Unknown

12. VISIT DISPOSITION

Mark (X) all that apply.

1 ☐ No follow-up planned
2 ☐ Return if needed, PRN/appointment
3 ☐ Return/Refer to physician/clinic for FU
4 ☐ Left before medical screening exam
5 ☐ Left after medical screening exam
6 ☐ Left AMA
7 ☐ DOA
8 ☐ Died in ED
9 ☐ Transfer to psychiatric hospital
10 ☐ Transfer to other hospital
11 ☐ Admit to this hospital
12 ☐ Admit to observation unit then hospitalized
Continue with ***Item 13*** *on reverse side.*
13 ☐ Admit to observation unit, then discharged – *Continue with* ***Item 14*** *on reverse side.*
14 ☐ Other

13. 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.*

a. Admitted to:

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

c. Date and time bed was requested for hospital admission

Month	Day	Year	Time	a.m.	p.m.	Military
		0	:	☐	☐	☐

1 ☐ Unknown

d. Date and time patient actually left the ED

Month	Day	Year	Time	a.m.	p.m.	Military
		0	:	☐	☐	☐

1 ☐ Unknown

b. Admitting physician

1 ☐ Hospitalist
2 ☐ Not hospitalist
3 ☐ Unknown

e. Hospital discharge date

Month	Day	Year

1 ☐ Unknown

f. Principal hospital discharge diagnosis

1 ☐ Unknown

g. Hospital discharge status/disposition

1 ☐ Alive → 1 ☐ Home/Residence; 2 ☐ Transferred; 3 ☐ Other; 4 ☐ Unknown
2 ☐ Dead
3 ☐ Unknown

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

14. OBSERVATION UNIT STAY

a. Date and time of observation unit discharge

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

1 ☐ Unknown