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FORM **NHAMCS-100(ED)**
(10-2-2006)

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

PATIENT RECORD NO.:

PATIENT'S NAME:

NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY
2007 EMERGENCY DEPARTMENT PATIENT RECORD

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 persons engaged in and for the purpose of the survey and will not be disclosed or released to other persons or used for any other purpose without consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m).

(Provider: Detach and keep)

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

1. PATIENT INFORMATION

a. Date of visit
Month | Day | Year 2 0 0 7

b. ZIP Code

c. Date of birth
Month | Day | Year

d. Time of day
(1) Arrival __ __ : __ __ ☐ AM ☐ PM ☐ Military
(2) Time seen by physician __ __ : __ __ ☐ AM ☐ PM ☐ Military
☐ Not seen by physician
(3) ED discharge __ __ : __ __ ☐ AM ☐ PM ☐ Military
Mark (X) if ED discharge is more than 24 hours from arrival. ➜ ☐

e. Patient residence
1 ☐ Private residence
2 ☐ Nursing home
3 ☐ Other institution
4 ☐ Other residence
5 ☐ Homeless
6 ☐ Unknown

f. Sex
1 ☐ Female
2 ☐ Male

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

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

i. Mode of arrival – *Mark (X) one.*
1 ☐ Ambulance
2 ☐ Public service (nonambulance)
3 ☐ Personal transportation
4 ☐ Unknown

j. 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) Oriented X 3
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

b. Immediacy with which patient should be seen
1 ☐ Immediate
2 ☐ 1-14 minutes
3 ☐ 15-60 minutes
4 ☐ >1 hour-2 hours
5 ☐ >2 hours-24 hours
6 ☐ No triage
7 ☐ Unknown

c. Presenting level of pain
1 ☐ None
2 ☐ Mild
3 ☐ Moderate
4 ☐ Severe
5 ☐ 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

As specifically as possible, list diagnoses related to this visit including chronic conditions.
(1) Primary diagnosis:
(2) Other:
(3) Other:

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 ☐ Toxicology screen
13 ☐ Other blood test
Other tests:
14 ☐ Cardiac monitor
15 ☐ EKG/ECG
16 ☐ Pregnancy test
17 ☐ Rapid flu/Influenza test
18 ☐ Urinalysis (UA)
19 ☐ Wound culture
20 ☐ Other test/service
Imaging:
21 ☐ X-ray
22 ☐ CT scan
☐ Head
☐ Other than head
23 ☐ MRI
☐ Head
☐ Other than head
24 ☐ Ultrasound
25 ☐ 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 ☐ Laceration repair
6 ☐ Incision & drainage (I&D)
7 ☐ Wound debridement
8 ☐ Foreign body removal
9 ☐ Nebulizer therapy
10 ☐ Bladder catheter
11 ☐ NG tube/gastric suction
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 ☐ On call attending physician/Fellow/Resident
4 ☐ RN/LPN
5 ☐ Nurse practitioner
6 ☐ Physician assistant
7 ☐ EMT
8 ☐ Other

11. 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 ☐ Refer to social services
5 ☐ Left before medical screening exam
6 ☐ Left after medical screening exam
7 ☐ Left AMA
8 ☐ DOA
9 ☐ Died in ED
10 ☐ Transfer to different hospital - *Specify reason*
11 ☐ Admit to observation unit
12 ☐ Admit to hospital – *Please continue with **Item 12 - HOSPITAL ADMISSION** on the reverse side.*
13 ☐ Other

12. HOSPITAL ADMISSION

Complete if the patient was admitted to the hospital at this visit. – *Mark (X) "Data not available" 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 ☐ Cardiac catheterization lab
5 ☐ Mental health or detox unit
6 ☐ Other bed/unit
7 ☐ Data not available

b. Hospital admission date

Month		Day		Year			
				2	0	0	

1 ☐ Data not available

c. Hospital admission time

☐☐ : ☐☐

☐ AM
☐ PM
☐ Military

1 ☐ Data not available

d. Hospital discharge date

Month		Day		Year			
				2	0	0	

1 ☐ Data not available

e. Principal hospital discharge diagnosis

1 ☐ Data not available

f. Hospital discharge status/disposition

1 ☐ Alive → 1 ☐ Home/Residence; 2 ☐ Transferred; 3 ☐ Other; 4 ☐ Data not available
2 ☐ Dead
3 ☐ Unknown
4 ☐ Data not available

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