

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				Patient residence		Sex		Ethnicity		Age	
Month Day Year Time a.m. p.m. Military Arrival 202 : : a.m. p.m. Military				1 <input type="checkbox"/> Private residence 2 <input type="checkbox"/> Nursing home 3 <input type="checkbox"/> Homeless/ Homeless shelter 4 <input type="checkbox"/> Other 5 <input type="checkbox"/> Unknown		1 <input type="checkbox"/> Female 2 <input type="checkbox"/> Male		1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino		1 <input type="checkbox"/> Years 2 <input type="checkbox"/> Months 3 <input type="checkbox"/> Days	
First provider (physician/APRN/PA) contact 202 : : a.m. p.m. Military				1 <input type="checkbox"/> White 2 <input type="checkbox"/> Black or African American 3 <input type="checkbox"/> Asian		4 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 5 <input type="checkbox"/> American Indian or Alaska Native					
ED departure 202 : : a.m. p.m. Military				Expected source(s) of payment for THIS VISIT – Mark (X) all that apply.							
Arrival by ambulance 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown				Was patient transferred from another hospital or urgent care facility? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown 4 <input type="checkbox"/> Not applicable		1 <input type="checkbox"/> Private insurance 2 <input type="checkbox"/> Medicare 3 <input type="checkbox"/> Medicaid or CHIP or other state-based program		4 <input type="checkbox"/> Workers' compensation 5 <input type="checkbox"/> Self-pay 6 <input type="checkbox"/> No charge/Charity		7 <input type="checkbox"/> Other 8 <input type="checkbox"/> Unknown	

TRIAGE

Initial vital signs		Temperature <input type="text"/> 1 <input type="checkbox"/> °C 2 <input type="checkbox"/> °F	Heart rate <input type="text"/> Enter "998" for DOPP or DOPPLER. beats per minute	Respiratory rate <input type="text"/> breaths per minute	Triage level (1-5) Enter "0" if no triage. Enter "9" if unknown. <input type="text"/>	Pain scale (0-10) Enter "99" if unknown. <input type="text"/>
Blood pressure Systolic / Diastolic <input type="text"/> / <input type="text"/>	Pulse oximetry <input type="text"/> %	Was patient seen in this ED within the last 72 hours? 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 <input type="checkbox"/> Initial visit to this ED for problem 2 <input type="checkbox"/> Follow-up visit to this ED for problem 3 <input type="checkbox"/> Unknown
(1) Most important:	<input type="text"/>	
(2) Other:	<input type="text"/>	
(3) Other:	<input type="text"/>	
(4) Other:	<input type="text"/>	
(5) Other:	<input type="text"/>	

INJURY

Is this visit related to an injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment? 1 <input type="checkbox"/> Yes, injury/trauma 2 <input type="checkbox"/> Yes, overdose/poisoning 3 <input type="checkbox"/> Yes, adverse effect of medical or surgical treatment or adverse effect of medicinal drug 4 <input type="checkbox"/> No 5 <input type="checkbox"/> Unknown } SKIP to Diagnosis	Did the injury/trauma, overdose/poisoning, or adverse effect occur within 72 hours prior to the date and time of this visit? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown For adverse effect SKIP to Cause	Is this injury/trauma or overdose/poisoning intentional or unintentional? 1 <input type="checkbox"/> Intentional 2 <input type="checkbox"/> Unintentional (e.g., accidental) 3 <input type="checkbox"/> Intent unclear	What was the intent of the injury/trauma or overdose/poisoning? 1 <input type="checkbox"/> Suicide attempt with intent to die 2 <input type="checkbox"/> Intentional self-harm without intent to die 3 <input type="checkbox"/> Unclear if suicide attempt or intentional self-harm without intent to die 4 <input type="checkbox"/> Intentional harm inflicted by another person (e.g., assault, poisoning) 5 <input type="checkbox"/> 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="text"/> (2) Other: <input type="text"/> (3) Other: <input type="text"/> (4) Other: <input type="text"/> (5) Other: <input type="text"/>	1 <input type="checkbox"/> Alcohol misuse, abuse, or dependence 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 11 <input type="checkbox"/> Diabetes mellitus (DM), Type 1 12 <input type="checkbox"/> Diabetes mellitus (DM), Type 2 13 <input type="checkbox"/> Diabetes mellitus (DM), Type unspecified 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

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: NONE, Given in ED, Rx at discharge. Rows (1) through (30) for listing medications.

VITALS AFTER TRIAGE

PROVIDERS

DISPOSITION

Does the chart contain vital signs taken after triage?

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

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

Date and time of observation unit/care discharge order

Date and time input fields for initiation order (Month, Day, Year, Time).

Date and time input fields for discharge order (Month, Day, Year, 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

Date and time input fields for admit order (Month, Day, Year, Time).

Admitting physician

- 1 Hospitalist
2 Not hospitalist
3 Unknown

Hospital discharge date

Date input fields for hospital discharge date (Month, Day, Year).

Principal hospital discharge diagnosis

Large text box for principal hospital discharge diagnosis.

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