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FORM **HDS-1**
(3-27-2003)

U.S. DEPARTMENT OF COMMERCE
Economics and Statistics Administration
U.S. CENSUS BUREAU
ACTING AS COLLECTING AGENT FOR
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL CENTER FOR HEALTH STATISTICS

MEDICAL ABSTRACT – NATIONAL HOSPITAL DISCHARGE SURVEY

A. PATIENT IDENTIFICATION

1. Hospital number	<input type="text"/>	4. Date of admission	Month <input type="text"/>	Day <input type="text"/>	Year <input type="text"/>
2. HDS number	<input type="text"/>	5. Date of discharge	<input type="text"/>	<input type="text"/>	<input type="text"/>
3. (Item deleted)		6. Residence ZIP Code	<input type="text"/>	<input type="text"/>	<input type="text"/>

B. PATIENT CHARACTERISTICS

7. Date of birth	Month <input type="text"/>	Day <input type="text"/>	Year <input type="text"/>	11. Race – Mark all that apply
8. Age – Complete only if date of birth not given	Units <input type="text"/>	1 <input type="checkbox"/> Years	2 <input type="checkbox"/> Months	3 <input type="checkbox"/> Days
9. Sex – Mark (X) one	1 <input type="checkbox"/> Male	2 <input type="checkbox"/> Female	3 <input type="checkbox"/> Not stated	4 <input type="checkbox"/> White
10. Ethnicity – Mark (X) one	1 <input type="checkbox"/> Hispanic or Latino	2 <input type="checkbox"/> Not Hispanic or Latino	3 <input type="checkbox"/> Not stated	5 <input type="checkbox"/> Black or African American
				6 <input type="checkbox"/> American Indian or Alaska Native
				7 <input type="checkbox"/> Asian
				8 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander
				9 <input type="checkbox"/> Other – Specify <input type="text"/>
				10 <input type="checkbox"/> Not stated
				12. Marital status – Mark (X) one
				1 <input type="checkbox"/> Married
				2 <input type="checkbox"/> Single
				3 <input type="checkbox"/> Widowed
				4 <input type="checkbox"/> Divorced
				5 <input type="checkbox"/> Separated
				6 <input type="checkbox"/> Not stated

C. ADMINISTRATIVE INFORMATION

13. Type of Admission – Mark (X) one	1 <input type="checkbox"/> Emergency	2 <input type="checkbox"/> Urgent	3 <input type="checkbox"/> Elective	4 <input type="checkbox"/> Newborn	5 <input type="checkbox"/> Items not available/unknown	16. Expected source(s) of payment	Principal Mark one only	Other additional sources Mark all that apply		
14. Source of Admission – Mark (X) one	1 <input type="checkbox"/> Physician referral	2 <input type="checkbox"/> Clinical referral	3 <input type="checkbox"/> HMO referral	4 <input type="checkbox"/> Transfer from a hospital	5 <input type="checkbox"/> Transfer from SNF				6 <input type="checkbox"/> Transfer from other health facility	7 <input type="checkbox"/> Emergency room
15. Status/Disposition of patient – Mark (X) appropriate box(es)	Status	Disposition								
	1 <input type="checkbox"/> Alive	a. <input type="checkbox"/> Routine discharge/discharged home	b. <input type="checkbox"/> Left against medical advice	c. <input type="checkbox"/> Discharged, transferred to another short-term hospital	d. <input type="checkbox"/> Discharged, transferred to long-term care institution	e. <input type="checkbox"/> Other disposition/not stated	1. Worker's compensation	<input type="checkbox"/>	<input type="checkbox"/>	
	2 <input type="checkbox"/> Died						2. Medicare	<input type="checkbox"/>	<input type="checkbox"/>	
	3 <input type="checkbox"/> Status not stated						3. Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	
							4. Other government payments	<input type="checkbox"/>	<input type="checkbox"/>	
							5. Blue Cross/Blue Shield	<input type="checkbox"/>	<input type="checkbox"/>	
							6. HMO/PPO	<input type="checkbox"/>	<input type="checkbox"/>	
							7. Other private or commercial insurance	<input type="checkbox"/>	<input type="checkbox"/>	
							8. Self pay	<input type="checkbox"/>	<input type="checkbox"/>	
							9. No charge	<input type="checkbox"/>	<input type="checkbox"/>	
							10. Other – Specify <input type="text"/>			
							<input type="checkbox"/> No source of payment indicated	<input type="checkbox"/>	<input type="checkbox"/>	

D. MEDICAL INFORMATION

17. Final Diagnoses (including E-code diagnoses) (Enter ICD-9-CM codes as well as narrative if available)

Principal: _____

Other/additional: _____

18. Surgical and Diagnostic Procedures (Enter ICD-9-CM codes as well as narrative if available)

Date of procedure(s)

Principal: _____

Other/additional: _____

Month	Day		Year		

NONE

Completed by _____

Date _____