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.

Department of Health and Human Services
Public Health Service
Centers for Disease Control and Prevention
National Center for Health Statistics

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NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY
1995-96 EMERGENCY DEPARTMENT PATIENT RECORD

1. DATE OF VISIT
___/___/___
Month Day Year

2. TIME OF VISIT:
☐ Military
__:__ ☐ AM
☐ PM

3. DATE OF BIRTH
___/___/___
Month Day Year

4. ZIP CODE
_____
Patient's

5. RACE
1 ☐ White
2 ☐ Black
3 ☐ Asian / Pacific Islander
4 ☐ American Indian / Eskimo / Aleut

6. SEX
1 ☐ Female
2 ☐ Male

7. ETHNICITY
1 ☐ Hispanic origin
2 ☐ Not Hispanic

8. DOES PATIENT SMOKE CIGARETTES ?
1 ☐ Yes 2 ☐ No
3 ☐ Unknown

9. EXPECTED SOURCE(S) OF PAYMENT FOR THIS VISIT

a. Type of payment *Check one.*
1 ☐ Preferred provider option
2 ☐ Insured, fee-for-service
3 ☐ HMO / other prepaid
If checked, answer **b.**
4 ☐ Self-pay
5 ☐ No charge
6 ☐ Other
If checked, skip **b.**

b. Expected sources of insurance *Check all that apply.*
1 ☐ Blue Cross / Blue Shield
2 ☐ Other private insurance
3 ☐ Medicare
4 ☐ Medicaid
5 ☐ Worker's Compensation
6 ☐ Other
7 ☐ Unknown

10. PATIENT'S COMPLAINT(S), SYMPTOM(S), OR OTHER REASON(S) FOR THIS VISIT *Use patient's own words.*
Most
a. Important: _____
b. Other: _____
c. Other: _____

11. IS THIS VISIT INJURY RELATED ?
1 ☐ Yes *(Answer a through e.)* 2 ☐ No *(Skip to Item 12.)*

a. Cause of Injury *Describe events that preceded injury, e.g., reaction to penicillin, wasp sting, driver in motor vehicle traffic accident involving collision with parked car, etc.*
_____
_____
_____

b. Place of occurrence
1 ☐ Home
2 ☐ School
3 ☐ Sports or athletics area
4 ☐ Street or highway
5 ☐ Other: _____
6 ☐ Unknown

c. Is this injury work related ?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

d. Did a firearm produce the injury ?
1 ☐ Yes
2 ☐ No

e. Is this injury violence related ?
1 ☐ No 3 ☐ Yes *(Suicide / suicide attempt)*
2 ☐ Yes *(Interpersonal violence / assault)*
If interpersonal violence / assault, person who caused the injury is the patient's:
1 ☐ Spouse
2 ☐ Other intimate partner
3 ☐ Parent
4 ☐ Other family
5 ☐ Caretaker
6 ☐ Friend /acquaintance
7 ☐ Stranger
8 ☐ Unknown
9 ☐ Other: _____

12. PHYSICIAN'S DIAGNOSES *As specifically as possible, list up to 3 current diagnoses. Include those unrelated to this visit.*
a. Principal diagnosis or problem associated with Item 10a: _____
b. Other: _____
c. Other: _____

13. IS THIS VISIT ALCOHOL OR DRUG RELATED ?
1 ☐ Neither
2 ☐ Alcohol
3 ☐ Drug
4 ☐ Both
5 ☐ Unknown

14. DOES PATIENT HAVE: *Check all that apply regardless of entry in Item 12.*
1 ☐ Depression
2 ☐ HIV / AIDS
3 ☐ None of the above

15. URGENCY OF THIS VISIT *Check one.*
1 ☐ Urgent / emergent
2 ☐ Non-urgent

16. DIAGNOSTIC / SCREENING SERVICES *Check all ordered or provided at this visit.*
1 ☐ NONE
2 ☐ Mental status exam
3 ☐ Blood pressure
4 ☐ EKG
5 ☐ Cardiac monitor
6 ☐ Pulse oximetry
7 ☐ Urinalysis
8 ☐ Pregnancy test
9 ☐ HIV serology
10 ☐ Blood alcohol concentration
11 ☐ Other blood test
12 ☐ Other: _____
IMAGING:
13 ☐ Chest X-Ray
14 ☐ Extremity X-Ray
15 ☐ Other X-Ray
16 ☐ CAT scan
17 ☐ MRI
18 ☐ Ultrasound
19 ☐ Other diagnostic imaging

17. PROCEDURES *Check all provided at this visit.*
1 ☐ NONE
2 ☐ Endotracheal intubation
3 ☐ CPR
4 ☐ IV fluids
5 ☐ NG tube/gastric lavage
6 ☐ Lumbar puncture
7 ☐ Bladder catheter
8 ☐ Wound care
9 ☐ Eye/ENT care
10 ☐ Orthopedic care
11 ☐ OB / GYN care
12 ☐ Other: _____

18. MEDICATIONS / INJECTIONS *List names of up to 6 medications that were ordered, supplied, or administered during this visit. Include new medications, continuing medications (with or without new orders), R_X and OTC medications, immunizations, allergy shots, and anesthetics.*
☐ NONE
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

19. VISIT DISPOSITION *Check all that apply.*
1 ☐ No followup planned
2 ☐ Return to ED, P.R.N./ appointment
3 ☐ Return to referring physician
4 ☐ Return to other physician / clinic
5 ☐ Left before being seen
6 ☐ Admit to hospital
7 ☐ Admit to ICU / CCU
8 ☐ Transfer to other facility
9 ☐ DOA / died in ED
10 ☐ Other: _____

20. PROVIDERS SEEN THIS VISIT *Check all that apply.*
1 ☐ Resident / intern
2 ☐ Staff physician
3 ☐ Other physician
4 ☐ Physician assistant
5 ☐ Nurse practitioner
6 ☐ RN
7 ☐ LPN
8 ☐ Medical assistant
9 ☐ Other: _____

Figure 1. Patient Record form