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FORM **NHAMCS-100(ED)** (10-6-2000)

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
2001/2002 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 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).

1. PATIENT INFORMATION

a. Date of visit — Month | Day | Year

b. ZIP code

c. Date of birth — Month | Day | Year

d. Time of day
(1) Arrival ___ ___ : ___ ___ ☐ Military ☐ AM ☐ PM
(2) Discharge ___ ___ : ___ ___ ☐ Military ☐ AM ☐ PM
Mark (X) if discharge is more than 24 hours from arrival. ☐

e. Does patient reside in a nursing home or other institution?
1 ☐ Yes
2 ☐ No
3 ☐ 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. Primary expected source of payment for this visit – *Mark (X) one.*
1 ☐ Private insurance
2 ☐ Medicare
3 ☐ Medicaid/SCHIP
4 ☐ Worker's Compensation
5 ☐ Self-pay
6 ☐ No charge/Charity
7 ☐ Other
8 ☐ Unknown

2. 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. Is this visit related to alcohol use?
1 ☐ Yes, patient's use
2 ☐ Yes, other person's use
3 ☐ No
4 ☐ Unknown

3. CONTINUITY OF CARE

a. Has patient been seen in this ED within the last 72 hours?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

b. Immediacy with which patient should be seen
1 ☐ Unknown/ no triage
2 ☐ Less than 15 minutes
3 ☐ 15–60 minutes
4 ☐ >1 hour-2 hours
5 ☐ >2 hours-24 hours

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

4. INJURY/POISONING/ADVERSE EFFECT

a. Is this visit related to an injury, or poisoning, or adverse effect of medical treatment?
1 ☐ Yes
2 ☐ No – *SKIP to item 5.*

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

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

d. Is this visit related to an adverse drug event?
1 ☐ Yes – *List name(s) of drug(s)* →
2 ☐ No
3 ☐ Unknown

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

5. INITIAL VITAL SIGNS

a. Temperature:
b. Pulse: ____ beats per minute
c. Blood pressure: ___ / ___

6. PHYSICIAN'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

Examinations/Tests:
2 ☐ Medical screening exam
3 ☐ Mental status exam
4 ☐ EKG/ECG (electrocardiogram)
5 ☐ Cardiac monitor
6 ☐ EEG (electroencephalogram)
7 ☐ Pulse oximetry
8 ☐ Pregnancy test
9 ☐ Urinalysis (UA)

Imaging:
10 ☐ Chest X-ray
11 ☐ Extremity X-ray
12 ☐ Other X-ray
13 ☐ Ultrasound
14 ☐ MRI/CAT scan
15 ☐ Other imaging

Blood tests:
16 ☐ CBC (complete blood count)
17 ☐ BUN (blood urea nitrogen)
18 ☐ Creatinine
19 ☐ Cholesterol
20 ☐ Glucose
21 ☐ HgbA1C (glycohemoglobin)
22 ☐ Other blood chemistry
23 ☐ BAC (blood alcohol)
24 ☐ HIV serology

Cultures:
25 ☐ Blood
26 ☐ Cervical/Urethral
27 ☐ Stool
28 ☐ Throat/Rapid strep test
29 ☐ Urine

30 ☐ OTHER LAB TEST

8. PROCEDURES

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

1 ☐ NONE
2 ☐ Bladder catheter
3 ☐ CPR
4 ☐ Endotracheal intubation
5 ☐ Eye/ENT care
6 ☐ IV fluids
7 ☐ NG tube/ gastric lavage
8 ☐ OB/GYN care
9 ☐ Orthopedic care
10 ☐ Thrombolytic therapy
11 ☐ Wound care
12 ☐ Other

9. MEDICATIONS & INJECTIONS

a. What is the total number of drugs prescribed or provided at this visit? →
Include Rx and OTC medications, immunizations, allergy shots, anesthetics, and dietary supplements that were ordered, supplied, administered or continued during this visit.

b. List up to six medication/injection names below.
(1)
(2)
(3)
(4)
(5)
(6)

10. VISIT DISPOSITION

Mark (X) all that apply.

1 ☐ No follow-up planned
2 ☐ Return if needed, PRN/appointment
3 ☐ Return to referring physician
4 ☐ Refer to other physician/clinic for FU
5 ☐ Refer out from triage without treatment
6 ☐ Refer to alcohol or drug treatment program
7 ☐ Return to non-physician treatment or support service
8 ☐ Left before being seen
9 ☐ Left AMA
10 ☐ Admit for 23 hour observation
11 ☐ Admit to hospital
12 ☐ Admit to ICU/CCU
13 ☐ Transfer to other facility
14 ☐ DOA/died in ED
15 ☐ Other

11. PROVIDERS SEEN

Mark (X) all that apply.

1 ☐ Staff physician
2 ☐ Resident/Intern
3 ☐ Other physician
4 ☐ RN
5 ☐ LPN
6 ☐ Nurse practitioner
7 ☐ Physician assistant
8 ☐ EMT
9 ☐ Other technician
10 ☐ Other