

SAMPLE

NATIONAL HOSPITAL CARE SURVEY – AMBULATORY COMPONENT EMERGENCY DEPARTMENT PATIENT RECORD 2016

OMB No. 0920-0212; Expiration date XX/XX/20XX

Assurance of confidentiality – All information which would permit identification of an individual, a practice, or an establishment will be held confidential; will be used for statistical purposes only by NCHS staff, contractors, and agents only when required and with necessary controls; and will not be disclosed or released to other persons without the consent of the individual or establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347).

PATIENT INFORMATION										
Patient's name: PATIENT_NAME		Patient's SSN		PATIENT_SSN/ENTER_SSN		Patient's Control #		PTCTRLNUM, ENTER_PTCTRLNUM		
Patient's address RESIDENCE:Street			PT_STRET, PT_STRET2		City		PT_CITY		State	
Patient's medical record #		PTMEDRECNUM/ENTER_PTMEDRECNUM			Medicare health insurance benefit/claim #			MEDHLTHINSBEN /ENTER_MEDHLTHINSBEN		
NPI-Attending		NPI_ATTEND / ENTER_NPI_ATTEND			NPI-Operating		NPI_OPERATING / ENTER_NPI_OPERATING			
Arrival		Date of Visit □□ - □□ - □□ Mm VDATE dd yy			Time □□ : □□ □□ A_TIME		a.m.	p.m.	Mil.	
Provider (physician/APRN/PA) contact		□□ - □□ - □□ mmtSDATEdd yy			□□ : □□ □□ TS_TIME		□	□	□	
ED Departure		□□ - □□ - □□ mmedDATEdd yy			□□ : □□ □□ ED_TIME		□	□	□	
Patient Residence RESIDENCE 1 <input type="checkbox"/> Private residence 2 <input type="checkbox"/> Institution Indicate the type of institution REST_INST 1 <input type="checkbox"/> Nursing home 2 <input type="checkbox"/> Supportive housing/ Group home 3 <input type="checkbox"/> Jail/Prison 4 <input type="checkbox"/> Other 3 <input type="checkbox"/> Homeless/Homeless shelter 4 <input type="checkbox"/> Other 5 <input type="checkbox"/> Unknown		Date of Birth BDATE Month Day Year 			Ethnicity ETHNIC 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino		Race – Mark (X) all that apply. 1 <input type="checkbox"/> White MULTIRACE1-5 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		Mode of arrival ARRIVE 1 <input type="checkbox"/> Ambulance 2 <input type="checkbox"/> Police transport 3 <input type="checkbox"/> Other 4 <input type="checkbox"/> Unknown	
Was patient transferred from another hospital or freestanding emergency/urgent care facility? AMBTRANSFER 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown		Expected source(s) of payment for this visit. Mark (X) all that apply. PAY_SOURCE1-7 1 <input type="checkbox"/> Private insurance 2 <input type="checkbox"/> TRICARE 3 <input type="checkbox"/> Medicare 4 <input type="checkbox"/> Medicaid or CHIP or other state-based program 5 <input type="checkbox"/> Workers' compensation 6 <input type="checkbox"/> Self-pay 7 <input type="checkbox"/> No charge/charity 8 <input type="checkbox"/> Other 9 <input type="checkbox"/> Unknown								
TRIAGE								PREVIOUS CARE		
Initial vital signs Temperature: TEMP Heart rate/Pulse: PULSE (beats per minute, 998 = DOPP, DOPPLER) Respiratory rate: RESPR (breaths per minute) Blood pressure: BPSYS Systolic, BPDIAS Diastolic (998 = P, PALP, DOPP, DOPPLER) Pulse oximetry: POPCT (Percent) Triage level (1-5): IMMED (Enter 0 if No triage, Enter 99 if Unknown) Pain scale (0-10): PAIN (Enter 99 if Unknown)								Was patient seen in this ED in the last 72 hours and discharged? SEEN72 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown		
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 for additional reasons. (Enter 0 for None/No more.) For each reason, use the lookup list to code the entry. (1) Most important: VRFV1/ _____ Source of first complaint, symptom, reason for visit. Mark (X) all that apply SOURCE RFV 1 <input type="checkbox"/> Patient 2 <input type="checkbox"/> Other 3 <input type="checkbox"/> Unknown (2) Other VRFV2/ VRFV_LKUP2 _____ (3) Other VRFV3/ VRFV_LKUP3 _____ (4) Other VRFV4/ VRFV_LKUP4 _____ (5) Other VRFV5/ VRFV_LKUP5 _____							Did alcohol cause or contribute to this visit? Alcohol6 Mark (X) all that apply. 1 <input type="checkbox"/> Yes, patient's own use 2 <input type="checkbox"/> Yes, other person's use 3 <input type="checkbox"/> No 4 <input type="checkbox"/> Unknown			
Was alcohol or other substance abuse/misuse/dependence documented in the medical record for this visit? Other substances include illicit drugs, inhalants, prescription or OTC medications, or dietary supplements. Mark (X) all that apply SUBETOH 1 <input type="checkbox"/> Yes, alcohol abuse/misuse/dependence 3 <input type="checkbox"/> Yes, other specify SUBETHOH_SP _____ 4 <input type="checkbox"/> No 5 <input type="checkbox"/> Unknown ALCOHOL_TYPE 1. <input type="checkbox"/> History of alcohol abuse/misuse/dependence							Episode of care EPISODE 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			

2. Currently abusing alcohol
 2 Yes, other substance abuse/misuse/dependence
 1. History of other substance abuse/misuse/dependence **OTHSUB_TYPE**
 2. Other substance seeking behavior
 3. Currently abusing other substance(s)

INJURY/TRAUMA/OVERDOSE/POISONING/ADVERSE EFFECT

<p>Is this visit related to an injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment? INJURY</p> <p>1 <input type="checkbox"/> No, SKIP to SUBSTANCES INVOLVED 2 <input type="checkbox"/> Yes, injury/trauma 3 <input type="checkbox"/> Yes, poisoning (non-drug toxic substance) 4 <input type="checkbox"/> Yes, poisoning (drug-induced overdose)</p> <p>Indicate the kind of drug(s) involved: POISON</p> <p>1. <input type="checkbox"/> Medication 2. <input type="checkbox"/> Illicit substance 3. <input type="checkbox"/> Both medication and illicit substance 4. <input type="checkbox"/> Unknown</p> <p>5 <input type="checkbox"/> Yes, adverse effect of medical/surgical treatment or adverse effect of a medicinal drug</p> <p>Was medication involved? ADVERSE</p> <p>1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 3. <input type="checkbox"/> Unknown</p> <p>6. <input type="checkbox"/> Unknown (skip to substances involved)</p>	<p>Did the injury/trauma or overdose/ poisoning occur within 72 hours prior to the date and time of this visit?</p> <p>INJURY72</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown</p>	<p>Is this injury/trauma or overdose/poisoning intentional? INTENT</p> <p>1 <input type="checkbox"/> Yes, intentional - suicide attempt 2 <input type="checkbox"/> Yes, intentional - self-harm (intentional self-directed harm without intent to die) 3 <input type="checkbox"/> Yes, intentional – unclear if suicide attempt or self-harm 4 <input type="checkbox"/> Yes, intentional harm by another person (e.g., assault, poisoning) 5 <input type="checkbox"/> No, unintentional (e.g., accidental) 6 <input type="checkbox"/> Unclear if intentional or unintentional</p>
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Cause of injury/trauma; overdose/poisoning by drug or non-drug toxic substance; or adverse effect of medical/surgical treatment – Describe the place and circumstances that preceded the injury/trauma, overdose/poisoning, or adverse effect. The following are examples of each: injury (e.g., pedestrian struck by car driven on a highway by drunk driver— indicate location of occurrence, e.g., street, highway, driveway, parking lot); overdose/poisoning by drug (e.g., patient injected heroin in nightclub restroom and overdosed); non-drug toxic substance (e.g., child swallowed bleach at home); adverse effect (e.g., patient developed swelling of the throat after taking their medication). Enter the primary cause on the first line, followed by the contributing causes. Up to 5 causes may be entered.

(1) **VCAUSE / VCAUSEDROPDOWN / TRANSLOC**

(2) **VCAUSE2 / VCAUSEDROPDOWN2 / TRANSLOC2**

(3) **VCAUSE3 / VCAUSEDROPDOWN3 / TRANSLOC3**

(4) **VCAUSE4 / VCAUSEDROPDOWN4 / TRANSLOC4**

(5) **VCAUSE5 / VCAUSEDROPDOWN5 / TRANSLOC5**

SUBSTANCES INVOLVED

Did any substance(s) (e.g., illicit drugs, inhalants, prescription or OTC medications, dietary supplement) cause or contribute to this visit? OR The patient is under 21 and alcohol is the only drug related to the visit. DRUGS_CONTRIBUTED

1 Yes
 2 No, SKIP to DIAGNOSIS
 3 Unknown, SKIP to DIAGNOSIS

Enter substances that caused or contributed to the ED visit. Type in the substance name exactly as you see in the patient's chart. Enter all substances that caused or contributed to the ED visit. Record substances as specifically as possible. The brand name is preferred over generic name preferred over chemical name. Do not record the same substance by two different names unless it was administered/taken in two different ways. Do not record current medications unrelated to the visit. Up to 16 substances may be entered.

(1) **Drug_Name1 / Drug_List1**

(2) **Drug_Name2 / Drug_List2**

(3-16) **Drug_Name3-16 / Drug_List3-16**

<p>For each substance listed, mark if confirmed by toxicology or blood test report. CONFIRMEDBYTOXD1-16</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown/Not documented</p>	<p>For each substance listed, mark the route of administration. ROUTE_ADMINISTRATION1-16</p> <p>1 <input type="checkbox"/> Oral 2 <input type="checkbox"/> Injected 3 <input type="checkbox"/> Inhaled, sniffed, snorted 4 <input type="checkbox"/> Smoked 5 <input type="checkbox"/> Transdermal 6 <input type="checkbox"/> Other 7 <input type="checkbox"/> Not documented</p>	<p>Patient took: PT_TOOK1-16 Mark (X) all that apply:</p> <p>1 <input type="checkbox"/> Own prescription/OTC medication or dietary supplement 2 <input type="checkbox"/> Prescription medication not prescribed for patient 3 <input type="checkbox"/> Prescription/OTC medication as prescribed or according to directions 4 <input type="checkbox"/> Too much of a prescription/OTC medication or dietary supplement 5 <input type="checkbox"/> Illicit drug(s) 6 <input type="checkbox"/> Alcohol only, under 21 7 <input type="checkbox"/> Alcohol in combination with other substances 8 <input type="checkbox"/> Not documented</p>
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DIAGNOSIS

As specifically as possible, list all diagnoses related to this visit, including chronic conditions.
 List primary diagnosis first.

		ICD-9-CM Code			ICD-10-CM Code
(1) Primary	VDIAG1 / VDIA1G_LKUP	VDIAG1_Code	●		● VDIAG1_Code10
(2) Other:	VDIAG2 / VDIAG2_LKUP	VDIAG2_Code	●		● VDIAG2_Code10
(3) Other:	VDIAG3 / VDIAG3_LKUP	VDIAG3_Code	●		● VDIAG3_Code10
(4) Other:	VDIAG4 / VDIAG4_LKUP	VDIAG4_Code	●		● VDIAG4_Code10
(5) Other:	VDIAG5 / VDIAG5_LKUP	VDIAG5_Code	●		● VDIAG5_Code10
(6) Other:	VDIAG6 / VDIAG6_LKUP	VDIAG6_Code	●		● VDIAG6_Code10
(7) Other:	VDIAG7 / VDIAG7_LKUP	VDIAG7_Code	●		● VDIAG7_Code10
(8) Other:	VDIAG8 / VDIAG8_LKUP	VDIAG8_Code	●		● VDIAG8_Code10

● ●
● ●

(9) Other:	VDIAG9 / VDIAG9_LKUP	VDIAG9_Code					VDIAG9_Code10
(10-20) Other:	VDIAG10-20 / VDIAG10-20_LKUP	VDIAG10-20_Code					VDIAG10-20_Code10

Regardless of the diagnoses previously entered, does the patient now have: Mark (X) all that apply.

PAT_HAVE1-23

1 <input type="checkbox"/> Alcohol abuse, misuse, or dependence	15 <input type="checkbox"/> HIV infection/AIDS
2 <input type="checkbox"/> Alzheimer's disease/Dementia	16 <input type="checkbox"/> Hyperlipidemia
3 <input type="checkbox"/> Asthma	17 <input type="checkbox"/> Hypertension
4 <input type="checkbox"/> Cancer	18 <input type="checkbox"/> Mental illness or episode
5 <input type="checkbox"/> Cerebrovascular disease/History of stroke (CVA) or transient ischemic attack (TIA)	Indicate the mental illness of episode MENTAL1-6 <i>Mark (X) all that apply</i>
6 <input type="checkbox"/> Chronic kidney disease (CKD)	1. <input type="checkbox"/> Bipolar disorder/Manic depression
7 <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD)	2. <input type="checkbox"/> Depression, excluding manic depression
8 <input type="checkbox"/> Congestive heart failure (CHF)	3. <input type="checkbox"/> Post-traumatic stress disorder (PTSD)
9 <input type="checkbox"/> Coronary artery disease (CAD), ischemic heart disease (IHD), or history of myocardial infarction (MI)	4. <input type="checkbox"/> Schizophrenia
10 <input type="checkbox"/> Diabetes mellitus (DM) – Type I	5. <input type="checkbox"/> Suicidal ideation
11 <input type="checkbox"/> Diabetes mellitus (DM) – Type II	6. <input type="checkbox"/> Other
12 <input type="checkbox"/> Diabetes mellitus (DM) – Type unspecified	19 <input type="checkbox"/> Obesity
13 <input type="checkbox"/> End-stage renal disease (ESRD)	20 <input type="checkbox"/> Obstructive sleep apnea (OSA)
14 <input type="checkbox"/> History of pulmonary embolism (PE), deep vein thrombosis (DVT), or venous thromboembolism (VTE)	21 <input type="checkbox"/> Osteoporosis
	22 <input type="checkbox"/> Substance abuse, misuse, or dependence
	23 <input type="checkbox"/> None of the above

DIAGNOSTICS

Mark (X) all ORDERED or PROVIDED at this visit. **DIAG_SERVICES1-34**

1 <input type="checkbox"/> NONE	15 <input type="checkbox"/> Liver enzymes/Hepatic function panel	Imaging:	32 <input type="checkbox"/> MRI
Blood tests:	16 <input type="checkbox"/> Prothrombin time (PT/PTT/INR)	30 <input type="checkbox"/> X-ray	Was MRI ordered or provided with intravenous (IV) contrast (also written as "with gadolinium" or "with gado")? MRI_IV
2 <input type="checkbox"/> ABG (Arterial blood gases)	17 <input type="checkbox"/> Other blood test	31 <input type="checkbox"/> CT scan	1. <input type="checkbox"/> Yes
3 <input type="checkbox"/> BAC (Blood alcohol concentration)	Enter other blood tests as written: OTHDIAGSERV	What body site was scanned during the CT scan? CT_SCAN1-4	2. <input type="checkbox"/> No
Enter BAC <u> BAC </u> %	Other tests:	Mark (X) all that apply	3. <input type="checkbox"/> Unknown
4 <input type="checkbox"/> BMP (Basic metabolic panel)	18 <input type="checkbox"/> Culture, throat	1. <input type="checkbox"/> Abdomen/pelvis	33 <input type="checkbox"/> Ultrasound
5 <input type="checkbox"/> BNP (Brain natriuretic peptide)	19 <input type="checkbox"/> Culture, urine	2. <input type="checkbox"/> Chest	Who performed the ultrasound? ULTRASOUND
6 <input type="checkbox"/> CE (Cardiac enzymes)	20 <input type="checkbox"/> Culture, wound	3. <input type="checkbox"/> Head	1. <input type="checkbox"/> Emergency physician
7 <input type="checkbox"/> CBC (Complete blood count)	21 <input type="checkbox"/> Culture, other	4. <input type="checkbox"/> Other	2. <input type="checkbox"/> Other
8 <input type="checkbox"/> CMP (Comprehensive Metabolic panel)	22 <input type="checkbox"/> Cardiac monitor	Was CT ordered or provided with intravenous (IV) contrast? CT_IV	3. <input type="checkbox"/> Unknown
9 <input type="checkbox"/> Creatinine/renal function panel	23 <input type="checkbox"/> EKG/ECG	1. <input type="checkbox"/> Yes	34 <input type="checkbox"/> Other Imaging
10 <input type="checkbox"/> Culture, blood	24 <input type="checkbox"/> HIV test	2. <input type="checkbox"/> No	
11 <input type="checkbox"/> D-dimer	25 <input type="checkbox"/> Influenza test	3. <input type="checkbox"/> Unknown	
12 <input type="checkbox"/> Electrolytes	26 <input type="checkbox"/> Pregnancy/HCG test		
13 <input type="checkbox"/> Glucose, serum	27 <input type="checkbox"/> Toxicology screen		
14 <input type="checkbox"/> LDH (Lactate dehydrogenase)	28 <input type="checkbox"/> Urinalysis (UA) or urine dipstick		
	29 <input type="checkbox"/> Other test/service		

PROCEDURES

Mark all procedures PROVIDED at this visit. Exclude medications. **PROCEDURES1-17**

1 <input type="checkbox"/> NONE	7 <input type="checkbox"/> Endotracheal tube (ETT)	13 <input type="checkbox"/> Physical restraint
2 <input type="checkbox"/> BiPAP/CPAP	8 <input type="checkbox"/> Incision & drainage (I&D)	14 <input type="checkbox"/> Psychiatry/psychology/ substance abuse consult
3 <input type="checkbox"/> Bladder catheter	9 <input type="checkbox"/> IV	15 <input type="checkbox"/> Skin adhesives
4 <input type="checkbox"/> Cast, splint, or wrap	10 <input type="checkbox"/> Lumbar puncture (LP)	16 <input type="checkbox"/> Suturing/Staples
5 <input type="checkbox"/> Central line	11 <input type="checkbox"/> Nebulizer therapy	17 <input type="checkbox"/> Other
6 <input type="checkbox"/> CPR	12 <input type="checkbox"/> Pelvic exam	

MEDICATIONS & IMMUNIZATIONS

NOMED=Were any prescription or non-prescription medications given at this visit or prescribed at ED discharge? 1-Yes 2-No Include Rx and OTC medications, immunizations, oxygen, and anesthetics. Enter XXX if medication cannot be found. Enter 0 for No more.

	Given in ED	Rx at discharge	Both given in ED and Rx at discharge
(1) VMED VMEDOTH GPMED →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(2) VMED2 VMEDOTH2 GPMED2 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(3) VMED3 VMEDOTH3 GPMED3 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(4) VMED4 VMEDOTH4 GPMED4 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(5) VMED5 VMEDOTH5 GPMED5 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(6) VMED6 VMEDOTH6 GPMED6 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(7) VMED7 VMEDOTH7 GPMED7 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(8) VMED8 VMEDOTH8 GPMED8 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(9) VMED9 VMEDOTH9 GPMED9 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

(10)	VMED10	VMEDOTH10	GP MED10 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(11)	VMED11	VMEDOTH11	GP MED11 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(12-30)	VMED12-30	VMEDOTH12	GP MED12 →	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

LAST VITAL SIGNS TAKEN

Does the chart contain vital signs taken after triage? 1. Yes 2. No → Skip to Providers **VitalsD**

Temperature <div style="border: 1px solid black; padding: 2px; width: 80px; margin: 0 auto;">TempD</div>	Heart rate/Pulse <div style="border: 1px solid black; padding: 2px; width: 80px; margin: 0 auto;">PulseD</div> beats per minute 998= DOPP, DOPPLER	Respiratory rate <div style="border: 1px solid black; padding: 2px; width: 80px; margin: 0 auto;">ResprD</div> breaths per minute	Blood pressure <div style="border: 1px solid black; padding: 2px; width: 80px; margin: 0 auto;">BPSysD</div> Systolic <div style="border: 1px solid black; padding: 2px; width: 80px; margin: 0 auto;">BPDiasD</div> Diastolic 998= P, PALP, DOPP, DOPPLER
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PROVIDERS

Mark (X) all providers seen at this visit. **PROV_SEEN1-11**

1 <input type="checkbox"/> NONE 2 <input type="checkbox"/> ED attending physician 3 <input type="checkbox"/> ED resident or Intern 4 <input type="checkbox"/> Consulting physician 5 <input type="checkbox"/> RN/LPN 6 <input type="checkbox"/> Nurse practitioner (NP) 7 <input type="checkbox"/> Physician assistant (PA) 8 <input type="checkbox"/> EMT 9 <input type="checkbox"/> Psychologist 10 <input type="checkbox"/> Social worker 11 <input type="checkbox"/> Substance abuse services provider 12 <input type="checkbox"/> Other mental health provider 13 <input type="checkbox"/> Other provider	Specialty of consulting physician SPEC_CONPHYS1-12 1 <input type="checkbox"/> Cardiology 2 <input type="checkbox"/> ENT (Otolaryngology) 3 <input type="checkbox"/> Gastroenterology 4 <input type="checkbox"/> General/Trauma Surgery 5 <input type="checkbox"/> Geriatrics 6 <input type="checkbox"/> Neurology 7 <input type="checkbox"/> Neurosurgery	8 <input type="checkbox"/> Obstetrics-Gynecology 9 <input type="checkbox"/> Ophthalmology 10 <input type="checkbox"/> Orthopedic Surgery 11 <input type="checkbox"/> Psychiatry 12 <input type="checkbox"/> Other specialty 13 <input type="checkbox"/> Unknown
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VISIT DISPOSITION

Mark (X) all that apply. **VISIT_DISP1-15**

1 <input type="checkbox"/> No follow-up planned 2 <input type="checkbox"/> Return to ED 3 <input type="checkbox"/> Return/Refer to physician/clinic for Specify the type of follow-up FOLLOWUP1-3 1. <input type="checkbox"/> Outpatient mental health treatment 2. <input type="checkbox"/> Substance abuse treatment 3. <input type="checkbox"/> Other follow-up 4 <input type="checkbox"/> Left without being seen (LWBS) 5 <input type="checkbox"/> Left before treatment complete (LBTC) 1. <input type="checkbox"/> Left AMA LEFT_AMA 6 <input type="checkbox"/> DOA 7 <input type="checkbox"/> Died in ED 8 <input type="checkbox"/> Return/Transfer to nursing home 9 <input type="checkbox"/> Return/Transfer to jail/prison/law enforcement	10 <input type="checkbox"/> Transfer to inpatient behavioral health care facility Was the patient transferred psychiatric inpatient treatment or a substance abuse treatment facility? BHEALTH 1. <input type="checkbox"/> Psychiatric inpatient treatment Enter the status of the transfer PSYCH_INP 1. <input type="checkbox"/> Involuntary status 2. <input type="checkbox"/> Voluntary status 3. <input type="checkbox"/> Not documented 2. <input type="checkbox"/> Substance abuse treatment facility 3. <input type="checkbox"/> Unknown 11 <input type="checkbox"/> Transfer to other non-psychiatric hospital Indicate the reason for transfer TRANSFER1-5 Mark (X) all that apply 1. <input type="checkbox"/> Continuity of care/Request by patient, family, or physician 2. <input type="checkbox"/> Higher level or specialized care needed 3. <input type="checkbox"/> Pediatric hospital needed 4. <input type="checkbox"/> Insurance requirement/request 5. <input type="checkbox"/> Other/Insufficient information available	12 <input type="checkbox"/> Admit to this hospital 13 <input type="checkbox"/> Admit to observation unit then hospitalized 14 <input type="checkbox"/> Admit to observation unit then discharged 15 <input type="checkbox"/> Other
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HOSPITAL ADMISSION

Admitted to: ADMIT 1 <input type="checkbox"/> Critical care unit 2 <input type="checkbox"/> Stepdown unit 3 <input type="checkbox"/> Operating room 4 <input type="checkbox"/> Mental health or detox unit 5 <input type="checkbox"/> Cardiac catheterization lab 6 <input type="checkbox"/> Other bed/unit 7 <input type="checkbox"/> Unknown	Admit order <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:12.5%;">Month</th> <th style="width:12.5%;">Day</th> <th style="width:12.5%;">Year</th> <th style="width:25%;">Time</th> <th style="width:12.5%;">a.m.</th> <th style="width:12.5%;">p.m.</th> <th style="width:12.5%;">Military</th> </tr> <tr> <td align="center">BRDATE</td> <td align="center">1</td> <td></td> <td align="center">□□:□□</td> <td align="center">BR_TIME</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> </table>	Month	Day	Year	Time	a.m.	p.m.	Military	BRDATE	1		□□:□□	BR_TIME	<input type="checkbox"/>	<input type="checkbox"/>
Month	Day	Year	Time	a.m.	p.m.	Military									
BRDATE	1		□□:□□	BR_TIME	<input type="checkbox"/>	<input type="checkbox"/>									
Admitting physician: ADMITPHYS 1 <input type="checkbox"/> Hospitalist 2 <input type="checkbox"/> Not hospitalist 3 <input type="checkbox"/> Unknown	Hospital discharge date <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:12.5%;">Month</th> <th style="width:12.5%;">Day</th> <th style="width:12.5%;">Year</th> </tr> <tr> <td align="center">DDATE</td> <td align="center">1</td> <td></td> </tr> </table>	Month	Day	Year	DDATE	1									
Month	Day	Year													
DDATE	1														

Hospital discharge diagnosis

(1) Principal **VHDDIAG**

(2) Secondary **VHDDIAG2**

Hospital discharge status HDSTAT 1 <input type="checkbox"/> Alive 2 <input type="checkbox"/> Dead 3 <input type="checkbox"/> Unknown	Hospital discharge disposition ADISP 1 <input type="checkbox"/> Home/Residence 2 <input type="checkbox"/> Return/Transfer to nursing home 3 <input type="checkbox"/> Return/Transfer to jail/prison/law enforcement 4 <input type="checkbox"/> Transfer to another facility (not usual place of residence) 5 <input type="checkbox"/> Other 6 <input type="checkbox"/> Unknown
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OBSERVATION UNIT STAY

Observation unit/care initiation order

Month	Day	Year	Time	a.m.	p.m.	Military
EDDISDATE	1		□□:□□	EDDISTIME	<input type="checkbox"/>	<input type="checkbox"/>

Observation unit/care discharge order

Month	Day	Year	Time	a.m.	p.m.	Military
OBDATE	1		□□:□□	OB_TIME	<input type="checkbox"/>	<input type="checkbox"/>