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).

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
National Center for Health Statistics

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501511

PATIENT'S RECORD NO.:

NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY
1999–2000 EMERGENCY DEPARTMENT RECORD

PATIENT'S NAME:

1. PATIENT'S ZIP CODE

2. DATE OF VISIT Month | Day | Year

3. TIME OF VISIT ___ : ___ ☐ Military ☐ AM ☐ PM

4. DATE OF BIRTH Month | Day | Year

5. MODE OF ARRIVAL – *Mark (X) one.*
1 ☐ Ambulance (air/ground) 2 ☐ Public service (nonambulance, e.g., police, social services) 3 ☐ Walk-in 4 ☐ Unknown

6. SEX
1 ☐ Female – **Is patient pregnant?** 1 ☐ Yes 2 ☐ No 3 ☐ Unknown
2 ☐ Male

7. ETHNICITY
1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino

8. 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

9. PRIMARY EXPECTED SOURCE OF PAYMENT FOR THIS VISIT *Mark (X) one.*
1 ☐ Private insurance
2 ☐ Medicare
3 ☐ Medicaid
4 ☐ Worker's Compensation
5 ☐ Self-pay
6 ☐ No charge
7 ☐ Other
8 ☐ Unknown

10. DOES PATIENT BELONG TO AN HMO?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

11. 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

12. PRESENTING LEVEL OF PAIN
1 ☐ Unknown
2 ☐ None
3 ☐ Mild
4 ☐ Moderate
5 ☐ Severe

13. TIME SEEN BY PHYSICIAN
___ : ___ ☐ Military ☐ AM ☐ PM
☐ Not seen by physician or unknown

14. 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: _____

15. IS THIS VISIT RELATED TO INJURY OR POISONING? *Refers to all types of injury or poisoning, including adverse drug experiences, medical misadventures, etc.*
1 ☐ Yes *(Answer a, b, c, and d.)* 2 ☐ No *(Skip to item 16.)*

a. Place of occurrence – *Mark (X) one.*
1 ☐ Residence
2 ☐ Recreation/sports area
3 ☐ Street or highway
4 ☐ School
5 ☐ Other public building
6 ☐ Industrial places
7 ☐ Other
8 ☐ Unknown

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

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

d. 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 vehicle, shot with a handgun during a brawl, heroin overdose, etc.)*

16. PHYSICIAN'S DIAGNOSES FOR THIS VISIT *As specifically as possible, list diagnoses related to this visit including chronic conditions (e.g. depression, obesity, asthma, etc.)*

1. Primary diagnosis: _____
2. Other: _____
3. Other: _____

17. DIAGNOSTIC/SCREENING SERVICES – *Mark (X) 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 ☐ Other STD test
11 ☐ Blood alcohol concentration
12 ☐ CBC
13 ☐ Other blood test
14 ☐ Other – *Specify* _____

IMAGING:
15 ☐ Chest X-Ray
16 ☐ Extremity X-Ray
17 ☐ Other X-Ray
18 ☐ MRI
19 ☐ Ultrasound
20 ☐ CAT scan
21 ☐ Other diagnostic imaging

18. PROCEDURES – *Mark (X) 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 – *Specify* _____

19. MEDICATIONS/INJECTIONS *List names of up to 6 medications that were **ordered, supplied, administered** or **continued** during this visit. Include R_x and OTC medications, immunizations, allergy shots, and anesthetics.*
☐ None
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

20. PROVIDERS SEEN THIS VISIT – *Mark (X) all that apply.*
1 ☐ Staff physician
2 ☐ Resident/intern
3 ☐ Other physician
4 ☐ Physician assistant
5 ☐ Nurse practitioner
6 ☐ R.N.
7 ☐ L.P.N.
8 ☐ Medical/nursing assistant
9 ☐ E.M.T.
10 ☐ Other

21. VISIT DISPOSITION – *Mark (X) all that apply.*
1 ☐ No followup planned
2 ☐ Return to ED, P.R.N./appointment
3 ☐ Returned to referring physician
4 ☐ Referred out from triage without treatment
5 ☐ Referred to other physician/clinic for followup
6 ☐ Left before being seen
7 ☐ Admitted to hospital
8 ☐ Admitted to ICU/CCU
9 ☐ Transferred to other facility
10 ☐ DOA/died in ED
11 ☐ Referred to social service
12 ☐ Other – *Specify* _____

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FORM NHAMCS-100(ED) (8-19-98)