EMS REPORT FORM INSTRUCTION MANUAL

Los Angeles County

Emergency Medical Services Agency

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INCIDENT INFORMATION

SEQUENCE NUMBER

Definition

Unique, alphanumeric EMS record number found pre-printed at the top right corner of EMS Report Form hard copies or electronically assigned to ePCRs by the EMS provider's electronic capture device

Field Values

- Consists of two letters and six digits on pre-printed EMS Report Forms; or two letters, ten digits if an approved ePCR provider

Additional Information

- **REQUIRED** for all records
- This is a unique number to the EMS Agency and must be provided to create a unique record ID within the EMS Database

Uses

- Unique patient identifier
- Essential link between other EMS Agency databases

Data Source Hierarchy

- EMS Report Form
- Auto-generated by the EMS provider's electronic capture device

ORIG. SEQ. #

Definition

Unique, alphanumeric EMS record number found pre-printed at the top right corner of EMS Report Form hard copies or electronically assigned to ePCRs by the EMS provider's electronic capture device utilized by the originating provider

Field Values

- Consists of two letters and six digits on pre-printed EMS Report Forms or two letters, ten digits if an approved ePCR provider

Additional Information

- Utilized when there is more than one provider and more than one EMS Report Form is started. This sequence number is to be utilized for all communications, e.g. Base Hospital contact

Uses

- Unique patient identifier
- Essential link between other EMS Agency databases

Data Source Hierarchy

- EMS Report Form
- Auto-generated by the EMS provider's electronic capture device

DATE

Definition

Date provider was notified of the incident

Field Values

- Collected as MMDDYYYY

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- 9-1-1 or Dispatch Center
- EMS provider

INC #

Definition

The incident number assigned by the 911 or Dispatch Center

Field Values

- Free text

Additional Information

- Numeric values only

Uses

- Allows for data sorting and incident tracking

Data Source Hierarchy

- 9-1-1 or Dispatch Center

JUR STA

Definition

The fire station in whose jurisdiction the incident occurred

Field Values

- Up to three-digit numeric value

Uses

- Incident tracking
- Epidemiological statistics

Data Source Hierarchy

- 9-1-1 or Dispatch Center
- EMS Provider

PD & UNIT #

Definition

The abbreviation and unit number/designation of the law enforcement agency on scene

Field Values

- Free text

Additional Information

- If multiple police departments/units are on scene, document the police department/unit in charge
- Law enforcement agencies are not considered EMS providers and therefore do not have a two-letter provider code. Please do not attempt to list them as a provider.

Uses

- System evaluation and monitoring

Data Source Hierarchy

- EMS Provider

MCI?

Definition

Field indicating whether or not the incident involved three or more patients

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- Field is autofilled with “N” unless changed by user to “Y”

Uses

- System evaluation and monitoring

Data Source Hierarchy

- EMS Provider

RUN TYPE

Definition

Checkbox indicating the level of service required of the provider

Field Values

- **R**egular Run: Incident where patient contact is made- excludes IFTs, Public Assist, and DOAs
- **N**o Patient: Includes when the unit has a false alarm, is canceled in route, or situations where no patient is found
- **C**x at Scene: Responding unit is canceled upon arrival by provider already on scene, no patient contact is made
- Pu**B**lic Assist: Response to a request for lifting assistance (bed to chair, chair to bed, car to home, etc.) where patient has no evidence of an illness or injury
- **I**FT: Incident where patient is transferred via ALS from one acute care facility to another
- **D**OA: Patient is determined to be dead per Los Angeles County Prehospital Care Manual Reference 814
- **F**ireLine: Incident where patient contact is made during FireLine Paramedic (FEMP), FireLine EMT (FEMT), or strike team assessment unit deployment

Additional Information

- If Run Type is **R** then the following data elements are **REQUIRED**:
    - Complaint
    - Team Member ID
    - Patient Last Name
- If Run Type is **D** then the following data elements are **REQUIRED**:
    - Complaint**= DO**
    - Time of 814 death
    - Exact 814 criteria the patient met

Uses

- System evaluation and monitoring
- Establishes system participants' roles and responsibilities

Data Source Hierarchy

- EMS Provider
- Auto-generated by the EMS Provider's software

PG 2

Definition

Checkbox indicating that a Page 2 Advanced Life Support Continuation Form was needed to complete the EMS report for the patient

Field Values

- **Y** Yes
- **N** No

Additional Information

- The ALS Continuation Form is **REQUIRED** when an advanced airway is attempted, when resuscitation is initiated, or when a patient is pronounced dead by the base hospital physician
- May also be used when additional space is needed to clearly document care
- Must be securely attached to the EMS Report Form and copies distributed in accordance with Los Angeles County Prehospital Care Manual, References 607and 610

Uses

- System evaluation and monitoring

Data Source Hierarchy

- EMS Provider
- Auto-generated by the EMS Provider's software

STREET NUMBER

Definition

The street number of the incident location

Field Values

- Free text

Uses

- Incident tracking
- Epidemiological statistics

Additional Information

- **Required** for every response
- For freeway incidents give the freeway number, direction, and nearest on/off ramp

Data Source Hierarchy

- 9-1-1 or Dispatch Center

STREET

Definition

The name of the street where the incident occurred

Field Values

- Free text

Uses

- Incident tracking
- Epidemiological statistics

Additional Information

- **Required** for every response

Data Source Hierarchy

- 9-1-1 or Dispatch Center

APT #

Definition

The apartment number of the incident location

Field Values

- Free text

Uses

- Incident tracking
- Epidemiological statistics

Additional Information

- **Required** for every response

Data Source Hierarchy

- 9-1-1 or Dispatch Center

CITY

Definition

The city code of the incident location

Field Values

AA	Arleta	**BT**	Bassett	**DO**	Downey
AC	Acton	**BU**	Burbank	**DS**	Del Sur
AD	Altadena	**BV**	Beverly Glen	**DU**	Duarte
AE	Arlington Heights	**BX**	Box Canyon	**DZ**	Dominguez
AG	Agua Dulce	**BW**	Brentwood	**EL**	East Los Angeles
AH	Agoura Hills	**BY**	Boyle Heights	**EM**	El Monte
AL	Alhambra	**BZ**	Byzantine-Latino Quarter	**EN**	Encino
AN	Athens	**CA**	Carson	**EO**	El Sereno
AO	Avocado Heights	**CB**	Calabasas	**EP**	Echo Park
AR	Arcadia	**CC**	Culver City	**ER**	Eagle Rock
AT	Artesia	**CE**	Cerritos	**ES**	El Segundo
AV	Avalon	**CH**	Chatsworth	**EV**	Elysian Valley
AW	Atwater Village	**CI**	Chinatown	**EZ**	East Rancho Dominguez
AZ	Azusa	**CK**	Charter Oak	**FA**	Fairmont
BA	Bel Air Estates	**CL**	Claremont	**FL**	Florence County
BC	Bell Canyon	**CM**	Compton	**FO**	Fair Oaks Ranch
BE	Bellflower	**CN**	Canyon Country	**GA**	Gardena
BG	Bell Gardens	**CO**	Commerce	**GF**	Griffith Park
BH	Beverly Hills	**CP**	Canoga Park	**GH**	Granada Hills
BK	Bixby Knolls	**CR**	Crenshaw	**GK**	Glenoaks
BL	Bell	**CS**	Castaic	**GL**	Glendale
BN	Baldwin Hills	**CT**	Century City	**GO**	Gorman
BO	Bouquet Canyon	**CU**	Cudahy	**GP**	Glassell Park
BP	Baldwin Park	**CV**	Covina	**GR**	Green Valley
BR	Bradbury	**CY**	Cypress Park	**GV**	Glenview
BS	Belmont Shore	**DB**	Diamond Bar	**GW**	Glendora

HA	Hawthorne	**LO**	Lomita	**NE**	Newhall
HB	Hermosa Beach	**LP**	La Puente	**NH**	North Hollywood
HC	Hacienda Heights	**LQ**	LAX	**NN**	Neenach
HE	Harvard Heights	**LR**	La Crescenta	**NO**	Norwalk
HG	Hawaiian Gardens	**LS**	Los Nietos	**NR**	Northridge
HH	Hidden Hills	**LT**	Lancaster	**NT**	North Hills
HI	Highland Park	**LU**	Lake Hughes	**OP**	Ocean Park
HK	Holly Park	**LV**	La Verne	**OT**	Other
HO	Hollywood	**LW**	Lake View Terrace	**PA**	Pasadena
HP	Huntington Park	**LX**	Lennox	**PB**	Pearblossom
HR	Harbor City	**LY**	Lynwood	**PC**	Pacoima
HV	Hi Vista	**LZ**	Lake Elizabeth	**PD**	Palmdale
HY	Hyde Park	**MA**	Malibu	**PE**	Pacific Palisades
IG	Inglewood	**MB**	Manhattan Beach	**PH**	Pacific Highlands
IN	City of Industry	**MC**	Malibu Beach	**PI**	Phillips Ranch
IR	Irwindale	**MD**	Marina Del Rey	**PL**	Playa Vista
JH	Juniper Hills	**ME**	Monte Nido	**PM**	Paramount
JP	Jefferson Park	**MG**	Montecito Heights	**PN**	Panorama City
KG	Kagel Canyon	**MH**	Mission Hills	**PO**	Pomona
KO	Koreatown	**MI**	Mint Canyon	**PP**	Palos Verdes Peninsula
LA	Los Angeles	**ML**	Malibu Lake	**PR**	Pico Rivera
LB	Long Beach	**MM**	Miracle Mile	**PS**	Palms
LC	La Canada Flintridge	**MN**	Montrose	**PT**	Porter Ranch
LD	Ladera Heights	**MO**	Montebello	**PV**	Palos Verdes Estates
LE	Leona Valley	**MP**	Monterey Park	**PY**	Playa Del Rey
LF	Los Feliz	**MR**	Mar Vista	**QH**	Quartz Hill
LG	Lake Hughes	**MS**	Mount Wilson	**RB**	Redondo Beach
LH	La Habra Heights	**MT**	Montclair	**RC**	Roosevelt Corner
LI	Little Rock	**MU**	Mount Olympus	**RD**	Rancho Dominguez
LK	Lakewood	**MV**	Monrovia	**RE**	Rolling Hills Estates
LL	Lake Los Angeles	**MW**	Maywood	**RH**	Rolling Hills
LM	La Mirada	**MY**	Metler Valley	**RK**	Rancho Park
LN	Lawndale	**NA**	Naples	**RM**	Rosemead

RO	Rowland Heights	**SU**	Sunland	**VL**	Valinda
RP	Rancho Palos Verdes	**SV**	Stevenson Ranch	**VN**	Van Nuys
RS	Reseda	**SW**	Sawtelle	**VV**	Val Verde
RV	Rampart Village	**SX**	South Central County	**VW**	View Park
RW	Rosewood	**SY**	Sylmar	**VY**	Valyermo
SA	Saugus	**SZ**	Studio City	**WA**	Walnut
SB	Sandberg	**TA**	Tarzana	**WB**	Willowbrook
SC	Santa Clara	**TC**	Temple City	**WC**	West Covina
SD	San Dimas	**TD**	Tropico	**WE**	West Hills
SE	South El Monte	**TE**	Topanga State Park	**WG**	Wilsona Gardens
SF	San Fernando	**TH**	Thousand Oaks	**WH**	West Hollywood
SG	San Gabriel	**TI**	Terminal Island	**WI**	Whittier
SH	Signal Hill	**TJ**	Tujunga	**WK**	Winnetka
SI	Sierra Madre	**TL**	Toluca Lake	**WL**	Woodland Hills
SJ	Silver Lake	**TO**	Torrance	**WM**	Wilmington
SK	Sherman Oaks	**TP**	Topanga	**WN**	Windsor Hills
SL	Sun Valley	**TR**	Three Points	**WO**	Westlake
SM	Santa Monica	**TT**	Toluca Terrace	**WP**	Walnut Park
SN	San Marino	**UC**	Universal City	**WR**	Westchester
SO	South Gate	**UP**	University Park	**WS**	Windsor Square
SP	South Pasadena	**VA**	Valencia	**WT**	Watts
SQ	Sleepy Valley	**VC**	Venice	**WV**	Westlake Village
SR	San Pedro	**VE**	Vernon	**WW**	Westwood
SS	Santa Fe Springs	**VG**	Valley Glen		
ST	Santa Clarita	**VI**	Valley Village		

Uses

- Incident tracking
- Epidemiological statistics
- System evaluation and monitoring

Additional Information

- **Required** for every response
- City codes are found on the back of the yellow copy

Data Source Hierarchy

- 9-1-1 or Dispatch Center

- EMS Provider

INCIDENT ZIP CODE

Definition

The zip code of the incident location

Field Values

- Five-digit numeric value

Uses

- Incident tracking
- Epidemiological statistics
- System monitoring

Additional Information

- **Required** for every response

Data Source Hierarchy

- 9-1-1 or Dispatch Center

PROV

Definition

Two-letter provider code of the agency (or agencies) responding to the incident

Field Values

AA	American Professional Ambulance Corp.	**ES**	El Segundo Fire	**PT**	Priority One
AC	Americare Ambulance Service	**EX**	Explorer 1 Ambulance & Medical Services	**RB**	Redondo Beach Fire
AD	AmeriPride Ambulance	**FS**	U.S. Forest Service	**RE**	REACH Air Medical Service
AE	Aegis Ambulance Service	**GC**	Gentle Care Transport	**RO**	Rescue One Ambulance
AF	Arcadia Fire	**GL**	Glendale Fire	**RR**	Rescue Services (Medic-1)
AH	Alhambra Fire	**GR**	Gentle Ride Ambulance	**RY**	Royalty Ambulance
AM	Adult Medical Transportation	**GU**	Guardian Ambulance Service	**SA**	San Marino Fire
AN	Antelope Ambulance Service	**HB**	Hermosa Beach Fire	**SB**	San Bernardino County Provider
AR	American Medical Response	**IA**	Impulse Ambulance	**SC**	Schaefer Ambulance
AT	All Town Ambulance, LLC	**LB**	Long Beach Fire	**SG**	San Gabriel Fire
AU	AmbuServe Ambulance	**LH**	La Habra Heights Fire	**SI**	Sierra Madre Fire
AV	Avalon Fire	**LT**	Liberty Ambulance	**SM**	Santa Monica Fire
AW	AMWest Ambulance	**LV**	La Verne Fire	**SP**	South Pasadena Fire
BA	Burbank Airport Fire	**MA**	Mauran Ambulance	**SS**	Santa Fe Springs Fire
BF	Burbank Fire	**MB**	Manhattan Beach Fire	**SY**	Symons Ambulance
BH	Beverly Hills Fire			**TF**	Torrance Fire
BO	Bowers Companies, Inc.	**MF**	Monrovia Fire	**TL**	TransLife, Inc.
CA	CARE Ambulance	**MI**	MedResponse, Inc.	**TR**	Trinity Ambulance
CB	LA County Beaches	**ML**	Med-Life Ambulance Service, Inc.	**UC**	UCLA Emergency Services
CC	Culver City Fire	**MO**	Montebello Fire	**UF**	Upland Fire
CF	LA County Fire	**MP**	Monterey Park Fire	**VE**	Ventura County Fire
CG	US Coast Guard	**MR**	MedReach Ambulance	**VF**	Vernon Fire
CI	LA City Fire	**MS**	Medi-Star Transport	**WC**	West Covina Fire
CM	Compton Fire	**MT**	MedCoast Ambulance	**WE**	Westcoast Ambulance
CS	LA County Sheriff	**MY**	Mercy Air	**WM**	West Med/McCormick Ambulance Service
DF	Downey Fire	**OC**	Orange County Provider	**OT**	Other Provider
EA	Emergency Ambulance	**PF**	Pasadena Fire		
EL	Elite Ambulance	**PN**	PRN Ambulance, Inc.		

Additional Information

- Law enforcement agencies are not considered EMS providers and therefore do not have a two-letter provider code. Please do not attempt to list them as a provider.
- Ambulance company codes are found on the back of the yellow copy

Uses

- System evaluation and monitoring

Data Source Hierarchy

- EMS Provider
- Auto-generated by the EMS Provider's software

A/B/H

Definition

The highest capability of care for the responding provider unit

Field Values

- **A**: ALS
- **B**: BLS
- **H**: Helicopter

Uses

- System evaluation and monitoring

Data Source Hierarchy

- EMS Provider
- Auto-generated by the EMS Provider's software

UNIT

Definition

The unit letter and number designation for the responding provider unit

Field Values

- Free text

Additional Information

- Suggested unit prefixes:
  - AU: Assessment Unit
  - AT: Assessment Truck
  - AE: Assessment Engine
  - BK: Bike
  - BT: Boat
  - CT: Cart
  - HE: Helicopter
  - PE: Paramedic Engine
  - PT: Paramedic Truck
  - SQ: Squad (no transport capability)
  - RA: Rescue (can transport)

Uses

- System evaluation and monitoring

Data Source Hierarchy

- EMS Provider
- Auto-generated by the EMS Provider's software

DISP

Definition

Time of day the provider was notified by dispatch of the incident

Field Values

- Collected as HHMM
- Use 24-hour clock

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- 9-1-1 or Dispatch Center
- EMS provider

ARRIVAL

Definition

Time of day the responding unit arrived at the incident location

Field Values

- Collected as HHMM
- Use 24-hour clock

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- 9-1-1 or Dispatch Center
- EMS provider

AT PT

Definition

Time of day provider reached the patient at the incident location

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- May differ from arrival at scene time
- Document in the Comments section the reason for an extended delay from arrival at scene to at patient times

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- 9-1-1 or Dispatch Center
- EMS provider

LEFT

Definition

Time of day provider left the incident location with the patient

Field Values

- Collected as HHMM
- Use 24-hour clock

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- 9-1-1 or Dispatch Center
- EMS provider

AT FAC

Definition

Time of day the provider arrived at the receiving facility with the patient

Field Values

- Collected as HHMM
- Use 24-hour clock

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- 9-1-1 or Dispatch Center
- EMS provider

FAC EQUIP

Definition

Time of day the provider transferred the patient to hospital equipment

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- Field is used to calculate wall time, which is defined as the time from arrival in the ED to when patient is removed from the EMS gurney and placed on hospital equipment
- Hospital equipment may include a chair or gurney in triage or a treatment area
- Hospital equipment **does not** include using the hospital's vital sign machine to check the patient's vitals

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- EMS provider

AVAIL

Definition

Time of day the provider is available to return to service

Field Values

- Collected as HHMM
- Use 24-hour clock

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- 9-1-1 or Dispatch Center
- EMS provider

TEAM MEMBER ID

Definition

The identification number of personnel involved in the patient's care

Field Values

- Free text

Additional Information

- The format used for Paramedics is "P" followed by the L.A. County issued accreditation number– example P1234
- The format used for EMTs is "E" followed by the CA certification number– example E12345

Uses

- System evaluation and monitoring

Data Source Hierarchy

- EMS Provider

PATIENT ASSESSMENT

PATIENT NUMBER

Definition

Number identifying the patient amongst the total number of patients involved in an incident

Field Values

- Up to two-digit numeric value

Additional Information

- If there is only one patient write “Pt.# 1 of 1”
- If there are two patients, and the patient is identified by the paramedics as the second patient, write “Pt.# 2 of 2”
- Patients who are not transported, such as DOAs and those who refuse transport, should also be assigned a number

Uses

- Assists with patient identification and tracking
- Identifies multiple-patient incidents
- System evaluation and monitoring

Data Source Hierarchy

- EMS Provider

TOTAL PATIENT NUMBER

Definition

The total number of patients involved in the incident

Field Values

- Up to a two-digit numeric value

Additional Information

- If there is only one patient write “Pt.# 1 of 1”
- If there are two patients, and the patient is identified by the paramedics as the second patient, write “Pt.# 2 of 2”
- Patients who are not transported, such as DOAs and those who refuse transport, should also be assigned a number

Uses

- Assists with patient identification and tracking
- Identifies multiple-patient incidents
- System evaluation and monitoring

Data Source Hierarchy

- EMS Provider

 # PTS TRANSPORTED

Definition

The total number of patients transported from an incident

Field Values

- Up to two-digit numeric value

Uses

- Assists with patient identification and tracking
- Identifies multiple-patient incidents
- System evaluation and monitoring

Data Source Hierarchy

- EMS Provider

AGE

Definition

Numeric value for the age (actual or best approximation) of the patient

Field Values

- Up to three-digit numeric age value

Additional Information

- **Required** for all patient contacts
- Must also indicate a unit of age
- If the age is estimated, mark the “Est.” checkbox

Uses

- Allows for data sorting and tracking by age
- Assists with patient identification
- Epidemiological statistics

Data Source Hierarchy

- EMS Provider
- Auto-generated by the EMS Provider’s software

AGE UNIT

Definition

Checkboxes indicating units of measurement used to report the age of the patient

Field Values

- **Y**rs: Years – used for patients 2 years old or older
- **M**os: Months – used for patients 1 month to 23 months old
- **W**ks: Weeks – used for patients whose age is reported in weeks instead of months
- **D**ays: Days – used for patients 1 to 29 days old
- **H**rs: Hours – used for patients who are newborn and up to 23 hours old

Additional Information

- **Required** for all patient contacts
- If the age is estimated, mark the “Est.” checkbox

Uses

- Allows for data sorting and tracking by age
- Assists with patient identification
- Epidemiological statistics

Data Source Hierarchy

- EMS Provider

GENDER

Definition

Checkbox indicating the gender of the patient

Field Values

- **M:** Male
- **F:** Female

Additional Information

- Patients who are undergoing or have undergone a hormonal and/or surgical sex reassignment should be coded using their stated preference
- Patients unable to state their preference should be coded according to paramedic observation/judgment

Uses

- Assists with patient identification
- Epidemiological statistics
- System evaluation and monitoring

Data Source Hierarchy

- EMS Provider

WEIGHT

Definition

Numeric value of the weight of the patient (either as stated or best approximation)

Field Values

- Up to three-digit numeric value

Additional Information

- **Required** for all patient contacts
- Must also indicate a unit of weight
- For pediatric patients, document the measured weight in kilograms obtained from the length-based pediatric resuscitation tape, if applicable
- If the pediatric patient is taller than the length-based pediatric resuscitation tape, mark the “Too Tall” checkbox, and obtain weight in estimated kilograms

Uses

- Assists with determination of appropriate treatment
- Epidemiological statistics

Data Source Hierarchy

- Patient
- Family member
- Caretaker
- EMS Provider

WEIGHT UNITS

Definition

Checkboxes indicating units of measurement used to report patient's weight

Field Values

- **L**bs: Pounds
- **K**g: Kilograms

Additional Information

- **Required** for all patient contacts
- For pediatric patients, document the measured weight in kilograms obtained from the length-based pediatric resuscitation tape, if applicable
- If the pediatric patient is taller than the length-based pediatric resuscitation tape, mark the "Too Tall" checkbox, and obtain weight in estimated kilograms

Uses

- Assists with determination of appropriate treatment
- Epidemiological statistics

Data Source Hierarchy

- Patient
- Family member
- Caretaker
- EMS Provider

PEDS COLOR CODE

Definition

Color that corresponds with the length of an infant or child as measured on a length-based pediatric resuscitation tape

Field Values

- Grey: **3**, **4**, or **5** kg (newborn infants)
- P**I**nk: 6-7 kg (~3 -6 mos)
- **R**ed: 8-9 kg (~7-10 mos)
- P**U**rple: 10-11 kg (~12-18 mos)
- **Y**ellow: 12-14 kg (~19-35 mos)
- **W**hite: 15-18 kg (~3-4 yrs)
- **B**lue: 19-22 kg (~5-6 yrs)
- **O**range: 24-28 kg (~7-9 yrs)
- Gr**E**en: 30-36 kg, or about 80 lbs (~10-12 yrs)
- **T**oo Tall: patient is longer than tape

Additional Information

- **Required** for all pediatric ALS patients
- Document the measured weight in kilograms obtained from the length-based pediatric resuscitation tape, if applicable
- If the pediatric patient is taller than the length-based pediatric resuscitation tape, mark the “Too Tall” checkbox, and obtain weight in estimated kilograms

Uses

- Assists with determination of appropriate treatment
- Epidemiological statistics
- System evaluation and monitoring

DISTRESS LEVEL

Definition

Checkboxes indicating the EMS providers' impression of the level of discomfort or severity of illness of the patient, based on assessment of signs, symptoms, and complaints

Field Values

- **N**one: The patient appears well and has no acute signs or symptoms related to the incident. Advanced life support techniques and transportation may not be necessary
- Mil**D**: Indicates that the patient does not have a life-threatening problem. Advanced life support techniques and transportation may not be necessary
- **M**oderate: Patient may have a life-threatening problem, or the degree of patient discomfort is high. Advanced life support techniques, base hospital contact, and patient transportation are usually necessary
- **S**evere: Refers to a life-threatening condition. Advanced life support techniques, base hospital contact, and patient transportation are generally necessary

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS Provider

COMPLAINT

Definition

Two-letter code(s) representing the patient's most significant medical or trauma complaints

Field Values- Trauma Codes

- **N**o **A**pparent Injury (**NA**): No complaint, or signs or symptoms of injury following a traumatic event
- **BU**rns/Elec. Shock (**BU**): Thermal or chemical burn, or electric shock
- SBP <**90** (<70 if under 1y) (**90**): Systolic blood pressure less than 90mmHg in a patient greater than one year of age (or systolic blood pressure less than 70mmHg in a patient less than one year of age) following a traumatic event
- **RR** <10/>29 (<20 if <1y) (**RR**): A sustained respiratory rate greater than 29 breaths/minute, or respiratory rate of less than 10 breaths/minute (or less than 20 breaths/minute in a patient less than one year of age), following a traumatic event
- **S**usp. Pelvic F**X** (**SX**): Suspected pelvic fracture, excluding isolated hip fractures from a ground level fall
- **S**pinal **C**ord Injury (**SC**): Suspected spinal cord injury, or presence of weakness/paralysis/parasthesia following a traumatic event
- **I**npatient **T**rauma (**IT**): Interfacility transfer (IFT) of an admitted, injured patient from one facility to an inpatient bed at another facility, excluding ER to ER transfers
- Minor **L**acerations (**BL** or **PL**): Superficial or non-serious lacerations, abrasions, or contusions involving the skin or subcutaneous tissue, due to blunt or penetrating force
- **T**rauma Arrest (**BT** or **PT**): Cessation of cardiac output and effective circulation due to blunt or penetrating force
- **H**ead (**BH** or **PH**): Injury to the head or skull in the area from above the eyebrows to behind the ears, due to blunt or penetrating force. This code can also be applied in association with facial injuries when it is likely that the brain is involved
- GCS ≤**14** (**14**): Blunt force head injury associated with a Glasgow Coma Scale score of less than or equal to 14. Code may also be used when a strong index of suspicion for blunt head injury exists due to mechanism of injury and/or signs or symptoms such as seizures, unequal pupils, or focal neurological deficits
- **F**ace/mouth (**BF** or **PF**): Injury to the anterior aspect of the face, mouth, or skull, from and including the eyebrows, down to and including the angle of the jaw and the ears, due to blunt or penetrating force
- **N**eck (**BN** or **PN**): Injury or pain to the area between the angle of the jaw and clavicles (including probable cervical spine injuries) due to blunt or penetrating force
- **B**ack (**BB** or **PB**): Injury to the area from the shoulders to the buttocks (but not including the buttocks) due to blunt or penetrating force
- **C**hest (**BC** or **PC**): Injury to the anterior chest in the area between the clavicle and the xyphoid process, bordered on either side by the posterior axillary line, due to blunt or penetrating force
- **F**lail **C**hest (**FC**): Blunt force injury to the chest wall resulting in an unstable chest wall, characterized by paradoxical chest wall movement with respirations
- Tension **P**neum (**BP** or **PP**): Air enters the pleural space due to blunt or penetrating force, and creates pressure on chest organs. Signs and symptoms can include: SOB, tachypnea, decreased or absent lung sounds on one side, shock, neck vein distention, and/or tracheal deviation
- **A**bdomen (**BA** or **PA**): Injury to any of the abdominal quadrants, flanks, or pelvis due to blunt or penetrating force

- **D**iffuse Abd. Tender. (**BD**): Blunt force injury to the abdomen resulting in tenderness in two or more quadrants
- **G**enitals/Buttoc**K**s (**BG**, **BK**, **PG** or **PK**): Injury to the external reproductive structures or buttocks due to blunt or penetrating force
- **E**xtremities (**BE** or **PE**): Injury or pain to the shoulders, arms, hands, legs, or feet due to blunt or penetrating force
- E**X**tr ↑ knee/elbow (**PX**): Penetrating force injury to an extremity, proximal to (above) the knee or elbow
- F**R**actures ≥ 2 long bones (**BR**): Blunt force injury resulting in apparent fracture of 2 or more proximal long bones (humerus, femur)
- Amputat**I**on ↑ wrist/ankle (**BI** or **PI**): Amputation proximal to (above) the wrist or ankle due to blunt or penetrating force
- Neur/**V**asc/Mangled (**BV** or **PV**): Injury to an extremity with neurological and/or vascular compromise, or that is crushed, degloved, or mangled due to blunt or penetrating force

Field Values – Medical Codes

- **A**gitated **D**elirium (**AD**): Acute onset of extreme agitation and combative or bizarre behavior that may be accompanied by paranoid delusions, hallucinations, aggression with unusual increase in human strength, and hyperthermia
- **A**bd/**P**elvic Pain (**AP**): Pain or discomfort in the abdomen or pelvic region not associated with trauma
- **A**llergic **R**eaction (**AR**): Acute onset of rash, hives, itching, redness of the skin, runny nose, facial and/or airway swelling, wheezing, shortness of breath, and/or abdominal pain in apparent reaction to ingestion or contact with a substance The patient may have been in contact with a known allergen (shellfish, milk products, etc.)
- **A**ltered **L**OC (**AL**): Any state of arousal other than normal, such as confusion, lethargy, combativeness, coma, etc., not associated with trauma
- **A**pneic **E**pisode (**AE**): Episode of cessation of respiration for a brief or prolonged period of time
- Apparent Life **T**hreatening **E**vent (**TE**): Also known as "ALTE" – any combination of transient apnea, color change, marked change in muscle tone, and choking and/or gagging in children less than 1yr of age, that is frightening to the observer
- B**EH**avioral (**EH**): Abnormal behavior of apparent mental or emotional origin
- Bleeding **O**ther **S**ite (**OS**): Bleeding from a site not elsewhere listed that is not associated with trauma (e.g. dialysis shunt)
- **C**ardiac **A**rrest (**CA**): Sudden cessation of cardiac output and effective circulation not associated with trauma
- **C**hest **P**ain (**CP**): Pain in the anterior chest occurring anywhere from the clavicles to the lower costal margins not associated with trauma
- **CH**oking/Airway Obstruction (**CH**): Acute onset of apnea, choking and/or difficulty breathing due to apparent partial or complete obstruction of the airway
- **C**ough/**C**ongestion (**CC**): Cough and/or congestion in the chest, nasal passages, or throat
- **D**evice **C**omplaint (**DC**): Any complaint associated with a patient's existing medical device (e.g. G-tube, AICD, ventilator, etc.)
- **DI**zzy (**DI**): The patient complains of sensation of spinning or feeling off-balance. If associated with complaint of weakness, code both complaints
- **DO**A (**DO**): Patient is determined to be dead upon arrival of EMS, as per the Prehospital Care Manual
- **DY**srhythmia (**DY**): Cardiac monitor indicates an abnormal cardiac rhythm (SVT, VT, etc.)

- **FE**ver (**FE**): Patient exhibits or complains of an elevated body temperature
- **F**oreign **B**ody (**FB**): Patient complains of a foreign body anywhere in the body
- **GI** Bleed (**GI**): Signs or symptoms of gastrointestinal bleeding such as vomiting blood, coffee-ground emesis, melena, rectal bleeding, etc.
- **H**ead **P**ain (**HP**): Headache or any other type of head pain not associated with trauma
- **HY**poglycemia (**HY**): Patient is symptomatic and has a measured blood glucose level that is below normal
- **I**npatient **M**edical (**IM**): Interfacility transfer (IFT) of an admitted, ill (not injured) patient from one facility to an inpatient bed at another facility
- **LA**bor (**LA**): Patient is greater than 20 weeks pregnant, and experiencing signs or symptoms of labor such as uterine contractions, vaginal bleeding, spontaneous rupture of membranes, crowning, etc.
- **L**ocal **N**euro Signs (**LN**): Weakness, numbness, or paralysis of a body part or region – including slurred speech, facial droop, and/or expressive aphasia
- **N**ausea/**V**omiting (**NV**): Patient is vomiting, or complains of nausea and/or vomiting
- **N**ear **D**rowning (**ND**): Submersion causing water inhalation, unconsciousness, or death
- **N**eck/**B**ack Pain (**NB**): Pain in any area from base of skull and the shoulders to the buttocks not associated with trauma
- **NeW**born (**NW**): Newborn infant delivered out of the hospital setting
- **N**o Medical **C**omplaint (**NC**): No complaint, or signs or symptoms of illness in a patient not involved in a traumatic event
- **NO**sebleed (**NO**): Bleeding from the nose, not associated with trauma
- **OB**stetrics (**OB**): Any complaints, signs, or symptoms which may be related to a known pregnancy (e.g., bleeding, abdominal pain/cramping, high blood pressure, edema, convulsions, severe headaches)
- **O**ther **P**ain (**OP**): Complaint of pain at a site not listed, and which is not associated with trauma (e.g. toothache, ear pain, etc.)
- **O**ver**D**ose (**OD**): Ingestion of or contact with a drug or other substance in quantities greater than recommended or generally practiced
- **PO**isoning (**PO**): Ingestion of or contact with a toxic substance
- **P**alpitation**S** (**PS**): Sensation that the heartbeat is irregular or fast
- **R**espiratory **A**rrest (**RA**): Sudden cessation of breathing not associated with trauma
- **SE**izure (**SE**): Convulsions or involuntary body movements or gaze (not associated with trauma), or signs, symptoms, or history of recent seizure
- **S**hortness of **B**reath (**SB**): Sensation of not being able to catch one's breath, and/or signs or symptoms of difficulty breathing such as gasping, wheezing, rapid respiratory rate, cyanosis, retractions, use of accessory muscles, etc.
- **SY**ncope (**SY**): Transient loss of consciousness, including sensation of "near syncope" when other associated symptoms such as weakness/dizziness do not apply
- **VA**ginal Bleeding (**VA**): Abnormal vaginal bleeding
- **WE**akness (**WE**): Patient complains of feeling weak, or exhibits signs or symptoms of decreased strength and/or muscle tone
- **OT**her (**OT**): Signs or symptoms not listed above, that are not associated with trauma

Additional Information

- OT (Other) is **never** the first complaint if there is a defined complaint
- If the patient has multiple complaints, enter in order of significance

- Patient's with a mechanism of injury documented must also have a trauma chief complaint code documented – and vice versa
- Medical complaints should not be documented with trauma complaints, unless it is suspected that a medical complaint preceded/caused the injury, or vice versa (e.g., chest pain/dizziness that caused an MVA, or seizure activity following a blow to the head.) Do not document a medical complaint such as "HP" (head pain) if the pain is due to a gunshot wound to the head – instead use only the trauma code of "PH."

Uses

- System evaluation and monitoring
- Epidemiological statistics

Data Source Hierarchy

- EMS Provider

MECHANISM OF INJURY

Definition

Checkboxes indicating how the patient was injured

Field Values

- Protective Devices – **H**e**L**met (**HL**): The patient riding on an unenclosed motorized vehicle/bicycle was wearing a helmet at the time of impact
- Protective Devices – **S**eat **B**elt (**SB**): Patient was wearing a seat belt at the time of impact
- Protective Devices – **A**ir**B**ag (**AB**): Airbag deployed at the time of impact and directly protected the patient
- Protective Devices – **C**ar **S**eat/Booster (**CS**): The patient was riding in a car seat or booster at the time of impact
- **E**nclosed **V**eh. (**EV**): Patient involved in collision while in an enclosed vehicle, such as a an automobile, bus, or other enclosed motorized vehicle
- **Ej**ected (**EJ**): Patient was fully or partially thrown from a vehicle, including convertibles and trucks. Does **NOT** include motorcycles
- **EX**tricated @ (**EX**): Time of day that the patient was removed from the vehicle when use of a pneumatic tool was required
- **P**assenger **S**pace Intrusion (**PS**): Intrusion of greater than 12 inches into an occupied passenger space of a motor vehicle, or greater than 18 inches into an unoccupied passenger space – check this box if amount of intrusion is not known or not specified by paramedics
- **12**: Intrusion of greater than 12 inches into an occupied passenger space of a motor vehicle – check this box when amount of intrusion is specified by paramedics
- **18** : Intrusion of greater than 18 inches into an unoccupied passenger space – check this box when amount of intrusion is specified by paramedics
- **S**urvived **F**atal Accident (**SF**): The patient survived a collision where another person **in the same vehicle** was fatally injured
- Impact > **20**mph unenclosed (**20**): An unenclosed transport crash (e.g., skateboard, bicycle, horse, etc.) with an estimated impact greater than 20mph
- Ped/Bike **R**un Over/**T**hrown/>20mph (**RT**): Pedestrian, bicyclist, or motorcyclist struck by an automobile and is thrown, run over, or has an estimated impact of greater than 20mph
- **P**ed/**B**ike < 20mph (**PB**): A bicyclist or pedestrian is hit by a motorized vehicle with less than 20mph estimated impact
- **M**otorcycle/**M**oped (**MM**): The patient was riding on a motorcycle or moped at the time of impact
- **SP**orts/Rec (**SP**): Any injury that occurs during a sporting or recreational athletic activity, such as aerobics, football, jogging, etc.
- **AS**sault (**AS**): Patient was physically assaulted (kicked, punched, strangled, etc.) by means other than stabbing or shooting
- **ST**abbing (**ST**): A sharp or piercing instrument (e.g. knife, broken glass, ice pick, etc.) caused an injury which penetrated the skin
- **GS**W (**GS**): Gunshot Wound - injury was caused by discharge of a gun (accidental or intentional)
- **AN**imal Bite (**AN**): The teeth of a human, reptile, dog, cat, or other animal inflicted an injury, whether or not the skin was punctured. Insect bites and bee stings are not considered animal bites, and should be coded as “Other”
- **CR**ush (**CR**): Injury sustained as the result of external pressure being placed on body parts between two opposing forces

- **S**pecial **C**onsidierations (**SC**): Injured patient meets Special Considerations of age greater than 55 years, pregnancy > 20 weeks, or age greater than 65 years with a systolic BP of less than 110mmHg
- **A**nti**C**oagulants (**AC**): Injured patient is on anticoagulant medication other than aspirin (excludes minor extremity injury)
- **T**elemetry **D**ata (**TD**): Vehicle telemetry data is encountered that is consistent with high risk of serious injury
- **FA**ll (**FA**): Any injury resulting from a fall from any height
- **>15** ft. (>10 ft. Peds) (**15**): A vertical, uninterrupted fall of greater than 15 feet for an adult or greater than 10 feet or 3 times the height of the child for a pediatric patient. This mechanism is a subcategory of "Fall." This does not include falling down stairs or rolling down a sloping cliff.
- **S**elf-Inflict'd/**A**ccid. (**SA**): The injury appears to have been accidentally caused by the patient
- **S**elf-Inflict'd/**I**ntent. (**SI**): The injury appears to have been intentionally caused by the patient
- **E**lectrical **S**hock (**ES**): Passage of an electrical current through body tissue as a result of contact with an electrical source
- **T**hermal **B**urn (**TB**): Burn caused by heat
- **H**azmat **E**xposure (**HE**): The patient was exposed to toxic or poisonous agents, such as liquids, gases, powders, foams, or radioactive material
- **W**ork- **R**elated (**WR**): Injury occurred while patient was working, and may be covered by Worker's Compensation
- **UN**known (**UN**): The cause or mechanism of injury is unknown
- **OT**her (**OT**): A cause of injury that does not fall into any of the existing categories

Additional Information

- Patients with a mechanism of injury documented must also have a trauma chief complaint code documented – and vice versa
- If the patient has multiple mechanisms of injury, enter in order of significance
- Check all that apply
- Mechanisms of injury listed in **red** meet trauma triage criteria for transport to the nearest available trauma center
- Mechanisms of injury listed in **blue** meet trauma guidelines for transport to the nearest available trauma center - strong consideration should be given to a trauma center destination

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS Provider

TIME EXTRICATED

Definition

Time of day that the patient was removed from the vehicle when use of a pneumatic tool was required

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- Required if MOI= EX

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

GCS/mLAPSS/LAMS

GLASGOW COMA SCALE- TIME

Definition

Time of day when the patient's initial, and subsequent if applicable, Glasgow Coma Scale was performed

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- **Required** on all patients who are one year of age and older

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

EYE

Definition

The Glasgow Coma Scale numerical value that corresponds to the patient's initial and subsequent, if applicable, eye opening response to stimuli

Field Values

- **4**: Spontaneous – opens eyes spontaneously, no stimuli required
- **3**: To Verbal – opens eyes only when spoken to or asked
- **2**: To Pain – opens eyes only in response to noxious stimuli such as sternal rub or nail bed pressure
- **1**: None – patient does not open eyes in response to noxious stimuli

Additional Information

- **Required** on all patients who are one year of age and older
- Adult and pediatric Glasgow Coma Scales are found on the back of the red copy

Uses

- Element necessary to calculate the overall GCS score
- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

VERBAL

Definition

The Glasgow Coma Scale numerical value that corresponds to the patient's initial and subsequent, if applicable, verbal response to stimuli

Field Values – Adult and Verbal Pediatric Patients

- **5**: Oriented x 3 – patient is oriented to person, time, and place
- **4**: Confused – patient may respond to questions coherently, but is disoriented or confused
- **3**: Inappropriate – random words or speech unrelated to questions or conversation
- **2**: Incomprehensible – makes incoherent sounds or moans only
- **1**: None – patient has no verbal response to noxious stimuli

Field Values – Infants and Toddlers

- **5**: Smiles and tracks objects, speech appropriate for age
- **4**: Cries but consolable, or confused
- **3**: Inconsistently consolable, or random words
- **2**: Moaning, incoherent sounds only
- **1**: No verbal response to noxious stimuli

Additional Information

- **Required** on all patients who are one year of age and older
- Adult and pediatric Glasgow Coma Scales are found on the back of the red copy

Uses

- Element necessary to calculate the overall GCS score
- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

MOTOR

Definition

The Glasgow Coma Scale numerical value that corresponds to the patient's initial and subsequent, if applicable, motor response to stimuli

Field Values

- **6**: Obedient – obeys verbal commands / spontaneous purposeful movement
- **5**: Purposeful – purposeful movement is made in response to noxious stimuli (e.g., attempts to push away or grab source of stimuli
- **4**: Withdrawal – withdraws body part from source of noxious stimuli
- **3**: Flexion –extremities move towards body core in response to noxious stimuli (decorticate posturing)
- **2**: Extension – extremities move away from body core in response to noxious stimuli (decerebrate posturing)
- **1**: None – patient has no motor response to noxious stimuli

Additional Information

- **Required** on all patients who are one year of age and older
- Adult and pediatric Glasgow Coma Scales are found on the back of the red copy

Uses

- Element necessary to calculate the overall GCS score
- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

GCS TOTAL

Definition

Sum of the three numerical values documented for each element of the patient's initial and subsequent, if applicable, Glasgow Coma Scale score(s)

Field Values

- One- or two-digit numeric value between 3 and 15

Additional Information

- Maximum total score is 15, which is considered normal. Minimum score possible is 3, which may indicate severe or fatal brain injury
    - 3 to 8 may indicate severe brain injury
    - 9 to 13 may indicate moderate brain injury
    - 14 or 15 may indicate mild or no brain injury

Additional Information

- **Required** on all patients who are one year of age and older
- Adult and pediatric Glasgow Coma Scales are found on the back of the red copy

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

NORMAL FOR PATIENT/AGE

Definition

Patient's behavior, although not typical of most patients, is reported by family, caregivers, etc., to be the same as it was before the incident

Field Values

- **Y:** Yes
- **N:** No

Additional Information

- Can be used on patients who suffer from mental illness, dementia, developmental delays, etc. and on infants and children who are age appropriate

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Family member
- Caregiver
- EMS provider

mLAPSS?

Definition

Checkbox indicating whether or not patient met all Modified Los Angeles Prehospital Stroke Screen (mLAPSS) criteria as defined in Reference 521 – Stroke Patient Destination

Field Values

- **M**: Met
- **N**: Not met

Additional Information

- mLAPSS criteria include:
    - Symptom duration of less than 6 hours
    - No history of seizures or epilepsy
    - Age ≥ 40
    - At baseline, patient is not wheel-chair bound or bedridden
    - Blood glucose value between 60 and 400mg/dL
    - Obvious asymmetry or unilateral weakness is observed in one or more of the following:
        - Facial Smile/Grimace
        - Grip
        - Arm Strength
- **Required** for all patients with a chief complaint of "LN" or with a destination of a Primary Stroke Center
- If mLAPSS performed, blood glucose value must also be documented
- Patients who meet mLAPSS criteria should have a LAMS performed. If the LAMS score is < 4, patient should be transported to the nearest available primary stroke center. If the LAMS score is ≥ 4, the patient should be transported to the nearest available comprehensive stroke center

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

LAST KNOWN WELL DATE

Definition

Date when the patient was last known to be well, symptom-free, at baseline, or usual state of health

Field Values

- Collected as MMDDYYYY

Additional Information

- **Required** for all patients with a “Y” value for “mLAPSS Met,” or with a destination of a primary or comprehensive stroke center for suspected stroke

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Patient
- Family member
- Caregiver
- EMS provider

LAST KNOWN WELL TIME

Definition

Time of day when the patient was last known to be well, symptom-free, at baseline, or usual state of health

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- Mandatory field for all patients with a "Y" value for "mLAPSS Met," or with a destination of a primary or comprehensive stroke center for suspected stroke

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Patient
- Family member
- Caregiver
- EMS provider

LAST KNOW WELL DATE AND TIME UNKNOWN

Definition

The date and/or time the patient was last known to be well, symptom-free, at baseline, or usual state of health is not known

Field Values

- **U** Unknown

Additional Information

- Should be reported as valid field value or Not Applicable only

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Patient
- Family member
- Caregiver
- EMS provider

FACIAL DROOP

Definition

The numerical value that corresponds to the presence, or absence, of a facial droop in a suspected stroke patient

Field Values

- **0**: Absent
- **1**: Present

Additional Information

- **Required** on all suspected stroke patients with a positive mLAPSS
- LAMS components are found on the back of the red copy

Uses

- Element necessary to calculate the overall LAMS score
- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

ARM DRIFT

Definition

The numerical value that corresponds to the presence, or absence, of an arm drift in a suspected stroke patient

Field Values

- **0**: Absent
- **1**: Drifts down
- **2**: Falls rapidly

Additional Information

- **Required** on all suspected stroke patients with a positive mLAPSS
- If patient is unable to lift their arms, lift arms for the patient and observe either a slow drift down or a rapid fall
- LAMS components are found on the back of the red copy

Uses

- Element necessary to calculate the overall LAMS score
- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

GRIP STRENGTH

Definition

The numerical value that corresponds to the quality of the grip strength in a suspected stroke patient

Field Values

- **0**: Normal
- **1**: Weak grip
- **2**: No grip

Additional Information

- **Required** on all suspected stroke patients with a positive mLAPSS
- LAMS components are found on the back of the red copy

Uses

- Element necessary to calculate the overall LAMS score
- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

TOTAL SCORE

Definition

Sum of the three numerical values documented for facial droop, arm drift, and grip strength in a suspected stroke patient

Field Values

- One-digit numeric value between 0 and 5

Additional Information

- A large vessel occlusion should be suspected in patients with a score of ≥ 4, therefore these patients should be transported to the closest comprehensive stroke center
- Patients with a score < 4 should be transported to the closest primary stroke center

Additional Information

- **Required** on all suspected stroke patients with a positive mLAPSS
- LAMS components are found on the back of the red copy

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

THERAPIES

THERAPIES

Definition

Checkbox indicating what procedure(s) were performed on the patient

Field Values

- **B**ack **B**lows/Thrust: Performed for suspected foreign body obstruction
- **B**V**M**: Respirations are assisted with bag-valve-mask device
- CO2: Numeric value indicating the concentration of carbon dioxide measure by the capnometer during bag-valve-mask ventilation
- **B**reath **S**ounds: Assessment performed to determine efficacy of bag-valve-mask ventilation
- **C**hest **R**ise: Assessment performed to determine efficacy of bag-valve-mask ventilation
- **E**xisting **T**rach: Reason why bag-valve-mask ventilation is performed
- OP/**N**P **A**irway: An airway adjunct was placed; circle which adjunct was used
- **C**ooling **M**easures: Cooling measures performed by removing clothing, applying cool, damp cloths, fanning patient, etc.
- **DR**essings: Dressing was applied to the patient by EMS personnel
- **I**ce **P**ack: An ice pack was applied to the patient by EMS personnel
- **T**ourni**Q**uet: A device for stopping the flow of blood through a vein or artery was applied to the patient by EMS personnel
- **H**emostatic **D**ressing: A hemostatic dressing was applied to the patient by EMS personnel; for use by approved providers only
- **OX**_lpm: Oxygen was delivered to the patient, specify the numeric value of the number of liters per minute in the space provided
- **N**C: Oxygen was delivered to the patient via nasal cannula
- **M**ask: Oxygen was delivered to the patient via oxygen mask
- **RE**straints: Restraints were applied to the patient and/or monitored by EMS personnel
- **D**istal CMS **I**ntact: Circulation, motor function, and sensation of extremities were intact after restraint application or splinting
- **S**pinal Mot**I**on Restriction: Patient was placed in spinal motion restriction
    - **C-C**ollar: Patient was placed in a c-collar
    - **B**ackboar**D**: Patient was placed on a backboard
- CMS **I**ntact – **B**efore: Circulation, motor function, and sensation were intact in all extremities prior to spinal immobilization
- CMS **I**ntact – **A**fter: Circulation, motor function, and sensation were intact in all extremities after spinal immobilization
- **SP**lint: A splint was applied to the patient by EMS personnel
- **T**raction **S**plint: A traction splint device was applied to the patient by EMS personnel
- **SU**ction: The patient's airway was suctioned by EMS personnel
- **BL**d Gluc #1_ #2: The patient's initial, and subsequent if applicable, blood glucose measurement
- CP**AP** __cm H20, Time:__: Continuous positive airway pressure device was used to deliver oxygen to the patient; document beginning pressure (measured in cm H20) and time applied
- **FB** Removal: A foreign body was removed from the patient's airway via visualization and Magill

forceps

- **IV**__g __site: IV access was established; document the gauge and site on the lines provided
- **IO**__g __length: IO access was established; document the gauge and length on the lines provided
- Needle **TH**oracostomy: A needle thoracostomy was performed on the patient
- **V**agal **M**aneuver: Technique performed in an attempt to slow down the patient's heart rate
- **TC** Pacing __mA, __bpm, Time__: Transcutaneous pacing was initiated on the patient; document mA, rate (bpm), and time started on the lines provided
- **OT**her: EMS personnel perform a therapy that is not listed above

Additional Information

- If the patient is in restraints, use the Comments section to document location of restraints, patient position, and quality of circulation distal to restraints
- Use the Comments section of the form to document the patient's response to therapies administered, any pressure adjustments made during CPAP administration, and the location of the placement of dressings, tourniquets, hemostatic dressings, and splints

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

TM #

Definition

The team member number of the personnel who performed or attempted the procedure

Field Values

- Numeric values only

Additional Information

- If more than one team member performs the therapy, enter the number of the team member who initiated the therapy

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS Provider

TRANSPORT

BASE

Definition

The three-letter-code for the base hospital contacted

Field Values

AMH	Methodist Hospital of Southern California	**PIH**	Presbyterian Intercommunity Hospital
AVH	Antelope Valley Medical Center	**PVC**	Pomona Valley Hospital Medical Center
CAL	California Hospital Medical Center	**QVH**	Citrus Valley Medical Center Queen of the Valley Campus
CSM	Cedars Sinai Medical Center	**SFM**	Saint Francis Medical Center
GWT	Glendale Adventist Medical Center	**SJS**	Providence Saint Joseph Medical Center
HCH	Providence Holy Cross Medical Center	**SMM**	Saint Mary Medical Center
HGH	Harbor UCLA Medical Center	**TOR**	Torrance Memorial Medical Center
HMH	Huntington Hospital	**UCL**	Ronald Reagan UCLA Medical Center
HMN	Henry Mayo Newhall Hospital	**USC**	LAC + USC Medical Center
LBM	Long Beach Memorial Medical Center	**CNA**	Contact Not Attempted
LCM	Providence Little Company of Mary Hospital Torrance	**MAC**	Medical Alert Center
NRH	Northridge Hospital Medical Center	**PRO**	Protocol

Additional Information

- Includes if base contact is made for medical control, destination decision, or notification of patient in route
- If base contact is not attempted, enter the three-letter code CNA
- If a Standing Field Treatment Protocol (SFTP) is used, enter the three-letter code PRO

Uses

- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

PROTOCOL

Definition

The four-digit numeric code of the SFTP used to treat the patient

Field Values

General Advanced Life Support			
1202	General ALS		
Dysrhythmias			
1210	Non-Traumatic Cardiac Arrest (Adult)		
Medical			
1243	Altered Level of Consciousness	1249	Respiratory Distress
1244	Chest Pain	1250	Seizure (Adult)
1247	Overdose/Poisoning (Suspected)	1251	Stroke/Acute Neurological Deficits
1248	Pain Management	1252	Syncope
Pediatrics/Childbirth			
1261	Emergency Childbirth - Mother	1264	Pediatric Seizure
1262	Emergency Childbirth – Newborn		
Trauma			
1271	Burns	1277	Traumatic Arrest
1275	General Trauma		

Community Paramedicine Pilot Project			
1400	Meets Inclusion Criteria & Transported to an UCC	1404	Meets Inclusion Criteria But Patient Refused UCC
1401	Meets Inclusion Criteria But Not Transported to an UCC Due to Geography or Time Constraints	1405	Meets Inclusion Criteria But Outside the Normal UCC Operating Hours
1402	Meets Inclusion Criteria But the UCC is Closed Due to Saturation	1406	Patients Requiring Emergent Transfer From the UCC to an Acute-Care Facility
1403	Meets Inclusion Criteria But Refused by UCC MD		

Additional Information

- Only approved providers may use Standing Field Treatment Protocols (SFTPs)
- More than one protocol can be used
- Protocol identified must match the patient's chief complaint

Uses

- Allows for data sorting and tracking by protocol
- System evaluation and monitoring

- Epidemiological statistics

Data Source Hierarchy

- EMS provider

REC FAC

Definition

The three letter code of the facility to which the patient was transported

Field Values

ACH	Alhambra Hospital Medical Center	**GAR**	Garfield Medical Center
AHM	Catalina Island Medical Center	**GEM**	Greater El Monte Community Hospital
AMH	Methodist Hospital of Southern California	**GMH**	Glendale Memorial Hospital and Health Center
ANH	Anaheim Memorial Medical Center	**GSH**	Good Samaritan Hospital
ARM	Arrowhead Regional Medical Center (S. B. County)	**GWT**	Glendale Adventist Medical Center
AVH	Antelope Valley Hospital	**HBC**	Hyperbaric Chamber (NON-BASIC)
BEV	Beverly Hospital	**HCH**	Providence Holy Cross Medical Center
BMC	Brotman Medical Center	**HEV**	Glendora Community Hospital
CAL	California Hospital Medical Center	**HGH**	LAC Harbor-UCLA Medical Center
CHH	Children's Hospital Los Angeles	**HMH**	Huntington Hospital
CHI	Chino Valley Medical Center (San Bernardino County)	**HMN**	Henry Mayo Newhall Hospital
CHO	Children’s Hospital of Orange County (Orange Co.)	**HWH**	West Hills Hospital and Medical Center
CHP	Community Hospital of Huntington Park	**ICH**	Citrus Valley Medical Center Intercommunity Campus
CNT	Centinela Hospital Medical Center	**KFA**	Kaiser Foundation - Baldwin Park
CPM	Coast Plaza Doctors Hospital	**KFB**	Kaiser Permanente Downey Medical Center
CSM	Cedars-Sinai Medical Center	**KFF**	Kaiser Foundation Hospital – Fontana (S.B. Co.)
DCH	PIH Health Hospital - Downey	**KFH**	Kaiser Permanente South Bay Medical Center
DFM	Marina Del Rey Hospital	**KFI**	Kaiser Permanente Irvine Medical Center
DHL	Lakewood Regional Medical Center	**KFL**	Kaiser Permanente Los Angeles Medical Center
DHM	Doctor's Hospital of Montclair (San Bernardino County)	**KFN**	Kaiser Foundation Ontario (S.B. Co.)
ELA	East Los Angeles Doctors Hospital	**KFO**	Kaiser Permanente Woodland Hills Medical Center
ENH	Encino Hospital Medical Center	**KFP**	Kaiser Permanente Panorama City Medical Center

FHP	Fountain Valley Hospital (Orange County)	**KFW**	Kaiser Permanente West LA Medical Center
FHR	Friendly Hills Regional Medical Center (Orange County)	**KHA**	Kaiser Foundation Hospital -Anaheim (Orange County)
FPH	Foothill Presbyterian Hospital	**LAG**	Los Alamitos Medical Center (Orange County)
LBC	Community Hospital of Long Beach	**SDC**	San Dimas Community Hospital
LBM	Long Beach Memorial Medical Center	**SFM**	Saint Francis Medical Center
LBV	Long Beach Veteran Administration (NON-BASIC)	**SGC**	San Gabriel Valley Medical Center
LCH	Lancaster Community Hospital	**SIM**	Simi Valley Hospital (Ventura County)
LCM	Providence Little Company of Mary Torrance	**SJD**	Saint Jude Medical Center (Orange County)
LLU	Loma Linda University Medical Center (San Bernardino County)	**SJH**	Providence Saint John's Health Center
LPI	La Palma Intercommunity Hospital (Orange County)	**SJO**	Saint John Regional Medical Center (Ventura County)
LRR	Los Robles Hospital and Medical Center (Ventura County)	**SJS**	Providence Saint Joseph Medical Center
MCP	Mission Community Hospital	**SMH**	UCLA Medical Center, Santa Monica
MHG	Memorial Hospital Gardena	**SMM**	Saint Mary Medical Center
MID	Olympia Medical Center	**SOC**	Sherman Oaks Hospital
MLK	Martin Luther King Jr. Community Hosptial	**SPP**	Providence Little Company of Mary San Pedro
MPH	Monterey Park Hospital	**SVH**	St. Vincent Medical Center
NOR	Norwalk Community Hospital	**TOR**	Torrance Memorial Medical Center
NRH	Northridge Hospital Medical Center Roscoe Campus	**TRI**	Tri-City Regional Medical Center
OTH	Other (FACILITY NOT LISTED)	**TRM**	Providence Tarzana Medical Center Tarzana Campus
OVM	LAC Olive View Medical Center	**UCI**	University of California Irvine (Orange County)
PAC	Pacifica Hospital of the Valley	**UCL**	Ronald Reagan UCLA Medical Center
PIH	Presbyterian Intercommunity Hospital	**USC**	LAC + USC Medical Center
PLB	Pacific Hospital of Long Beach	**VHH**	Verdugo Hills Hospital
PLH	Placentia Linda Hospital (Orange County)	**VPH**	Valley Presbyterian Hospital
PVC	Pomona Valley Hospital Medical Center	**WHH**	Whittier Hospital Medical Center
QOA	Hollywood Presbyterian Medical Center	**WMC**	Western Medical Center Santa Ana (Orange County)
QVH	Citrus Valley Medical Center Queen of the Valley Campus	**WMH**	White Memorial Medical Center
RCC	Ridgecrest Regional Hospital (Kern County)	**WVA**	Veterans Administration Hospital of West Los

			Angeles (NON-BASIC)
SAC	San Antonio Community Hospital (S.B. Co.)		

DISASTER RECEIVING FACILITIES ONLY			
BRH	Barlow Respiratory Hospital	**NCH**	USC Kenneth Norris Jr. Cancer Center
COA	Silver Lake Medical Center	**PAM**	Pacific Alliance Medical Center
COH	City of Hope National Medical Center	**RLA**	LAC-Rancho Los Amigos
LAC	Los Angeles Community Hospital – Olympic	**TEM**	Temple Community Hospital
HOL	Southern California Hospital at Hollywood	**USH**	Keck Hospital of USC
KMC	Kern Medical Center		

Additional Information

- Receiving facility codes are found on the back of the yellow copy

Uses

- System evaluation and monitoring
- Epidemiological statistics

Data Source Hierarchy

- EMS provider

VIA

Definition

Checkbox indicating the type of transport unit used

Field Values

- **A**LS: An Advanced Life Support Transport unit in which patient was accompanied by at least one paramedic
- **B**LS: Basic Life Support Transport unit in which patient was accompanied by EMTs only
- **O**ther: Type of transport not listed above
- **H**elicopter ETA: Helicopter transport requested – indicate ETA of helicopter to scene
- **N**o Transport: Patient was not transported (must indicate reason for no transport in the Comments Section)

Additional Information

- If field value is “A”, “B”, or “H” then a receiving facility and destination (“Trans To”) must be documented
- If the patient signed out AMA, the “AMA” box should also be checked

Uses

- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

TRANS TO

Definition

Checkbox indicating the actual destination of the patient

Field Values

- **M**AR: Most Accessible Receiving facility (licensed basic emergency department) that can be reached in the shortest amount of time. Depending on traffic and geography, this may not necessarily be the closest facility. Must be documented for all patients regardless of actual destination
- **E**DAP: Most accessible Emergency Department Approved for Pediatrics approved to receive patients of less than or equal to 14 years of age
- **T**C: Most accessible Trauma Center approved to receive critically injured patients
- PT**C**: Most accessible Pediatric Trauma Center approved to receive critically injured pediatric patients of less than or equal to 14 years of age
- **P**MC: Most accessible Pediatric Medical Center approved to receive critically ill pediatric patients of less than or equal to 14 years of age.
- **S**TEMI: Most accessible ST-Elevation Myocardial Infarction (STEMI) Receiving Center approved to receive patients with a suspected STEMI, or who have Return of Spontaneous Circulation (ROSC) following a non-traumatic cardiac arrest.
- Prim**A**ry Stroke Center: Most accessible Primary Stroke Center approved to receive suspected stroke patients or patients with a positive mLAPSS exam.
- Comprehensive Stro**K**e Center: Most accessible Comprehensive Stroke Center approved to receive patients with a positive mLAPSS exam and a LAMS score ≥ 4.
- Peri**N**atal: Most accessible Perinatal Center approved to receive patients greater than or equal to 20 weeks pregnant.
- SA**R**T: Most accessible Sexual Assault Response Team facility approved to receive actual or suspected victims of sexual assault/abuse.
- **O**ther: Licensed basic emergency department that may also appropriately receive the patient in addition to those listed above. Most frequently used when the closest facility is inaccessible (e.g., is requesting diversion.) The reason for using “Other” as a destination must be documented in the “Reason” section.

Additional Information

- If patient was transported then a ‘Via’ and receiving facility value must be documented

Uses

- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

REASON

Definition

Checkboxes indicating the reason that the patient was transported to a facility other than the most accessible receiving facility or specialty center

Field Values

- **N**o SC Required: Patient does not meet criteria, requirements, or guidelines for transport to a specialty center
- **C**riteria/Required: Patient meets criteria or requirements for transport to a specialty center (EDAP, TC/PTC, or SRC)
- **G**uidelines: Patient meets guidelines for transport to a specialty center (TC/PTC, Perinatal, PMC, ASC, CSC, or SART)
- **J**udgment (Provider/Base): Patient does not meet specialty center criteria, requirements, or guidelines, but is transported to a specialty center based on Base or the Provider judgment; or, meets, but is not transported to a specialty center
- E**X**tremis: Patient is transported to the most accessible receiving facility because the severity of the injury/illness precludes transport to a specialty center (e.g. unmanageable airways, cardiopulmonary arrest (excluding traumatic penetrating torso injuries), etc.)
- **E**D Saturation: Most accessible receiving facility or EDAP has requested diversion due to emergency department saturation
- No SC **A**ccess: Specialty center not accessible due to transport time constraints or geography
- **R**equest by: Patient is transported to a facility other than the most accessible receiving facility or specialty center by request from the patient, a family member, patient's private medical doctor (PMD), or other authorized person

Uses

- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

AMA?

Definition

Checkbox indicating whether the patient refused transport and signed out against medical advice

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- A patient refusing treatment or transport must sign the release on the back of the first page of the EMS Report Form; this release is not to be signed if the patient's condition does not warrant treatment or transportation

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

CODE 3?

Definition

Checkbox indicating whether the patient was transported to the receiving facility Code 3

Field Values

- **Y**: Yes
- **N**: No

Uses

- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

PATIENT INFORMATION

LAST NAME

Definition

The patient's last name

Field Values

- Free text

Additional Information

- If Run Type=R , then the patient's last name must be documented

Uses

- Patient identification
- Link between other databases

Data Source Hierarchy

- Patient
- Family member
- Caretaker

FIRST NAME

Definition

The patient's first name

Field Values

- Free text

Additional Information

- If Run Type=R , then the patient's first name must be documented

Uses

- Patient identification
- Link between other databases

Data Source Hierarchy

- Patient
- Family member
- Caretaker

MI

Definition

The first letter of the patient's middle name

Field Values

- Free text

Uses

- Patient identification
- Link between other databases

Data Source Hierarchy

- Patient
- Family member
- Caretaker

DOB

Definition

The patient's date of birth

Field Values

- Collected as MMDDYYYY

Additional Information

- Year must be after 1890

Uses

- Patient identification
- Link between other databases

Data Source Hierarchy

- Patient
- Family member
- Caretaker

PHONE

Definition

The patient's primary telephone number

Field Values

- Free text

Uses

- Patient identification

Data Source Hierarchy

- Patient
- Family member
- Caretaker

STREET NUMBER

Definition

The street number of the patient's primary residence

Field Values

- Free text

Uses

- Epidemiological statistics

Data Source Hierarchy

- Patient
- Family member
- Caretaker
- EMS Provider
- 9-1-1 or Dispatch Center

STREET NAME

Definition

The name of the street of the patient's primary residence

Field Values

- Free text

Uses

- Epidemiological statistics

Data Source Hierarchy

- Patient
- Family member
- Caretaker
- EMS Provider
- 9-1-1 or Dispatch Center

APT #

Definition

The apartment number of the patient's primary residence

Field Values

- Free text

Uses

- Epidemiological statistics

Data Source Hierarchy

- Patient
- Family member
- Caretaker
- EMS Provider
- 9-1-1 or Dispatch Center

CITY

Definition

The city code of the patient's primary residence

Field Values

AA	Arleta	**CR**	Crenshaw	**HY**	Hyde Park
AC	Acton	**CS**	Castaic	**IG**	Inglewood
AD	Altadena	**CT**	Century City	**IN**	City of Industry
AE	Arlington Heights	**CU**	Cudahy	**IR**	Irwindale
AG	Agua Dulce	**CV**	Covina	**JH**	Juniper Hills
AH	Agoura Hills	**CY**	Cypress Park	**JP**	Jefferson Park
AL	Alhambra	**DB**	Diamond Bar	**KG**	Kagel Canyon
AN	Athens	**DO**	Downey	**KO**	Koreatown
AO	Avocado Heights	**DS**	Del Sur	**LA**	Los Angeles
AR	Arcadia	**DU**	Duarte	**LB**	Long Beach
AT	Artesia	**DZ**	Dominguez	**LC**	La Canada Flintridge
AV	Avalon	**EL**	East Los Angeles	**LD**	Ladera Heights
AW	Atwater Village	**EM**	El Monte	**LE**	Leona Valley
AZ	Azusa	**EN**	Encino	**LF**	Los Feliz
BA	Bel Air Estates	**EO**	El Sereno	**LG**	Lake Hughes
BC	Bell Canyon	**EP**	Echo Park	**LH**	La Habra Heights
BE	Bellflower	**ER**	Eagle Rock	**LI**	Little Rock
BG	Bell Gardens	**ES**	El Segundo	**LK**	Lakewood
BH	Beverly Hills	**EV**	Elysian Valley	**LL**	Lake Los Angeles
BK	Bixby Knolls	**EZ**	East Rancho Dominguez	**LM**	La Mirada
BL	Bell	**FA**	Fairmont	**LN**	Lawndale
BN	Baldwin Hills	**FL**	Florence County	**LO**	Lomita
BO	Bouquet Canyon	**FO**	Fair Oaks Ranch	**LP**	La Puente
BP	Baldwin Park	**GA**	Gardena	**LQ**	LAX
BR	Bradbury	**GF**	Griffith Park	**LR**	La Crescenta
BS	Belmont Shore	**GH**	Granada Hills	**LS**	Los Nietos
BT	Bassett	**GK**	Glenoaks	**LT**	Lancaster

BU	Burbank	**GL**	Glendale	**LU**	Lake Hughes
BV	Beverly Glen	**GO**	Gorman	**LV**	La Verne
BX	Box Canyon	**GP**	Glassell Park	**LW**	Lake View Terrace
BW	Brentwood	**GR**	Green Valley	**LX**	Lennox
BY	Boyle Heights	**GV**	Glenview	**LY**	Lynwood
BZ	Byzantine-Latino Quarter	**GW**	Glendora	**LZ**	Lake Elizabeth
CA	Carson	**HA**	Hawthorne	**MA**	Malibu
CB	Calabasas	**HB**	Hermosa Beach	**MB**	Manhattan Beach
CC	Culver City	**HC**	Hacienda Heights	**MC**	Malibu Beach
CE	Cerritos	**HE**	Harvard Heights	**MD**	Marina Del Rey
CH	Chatsworth	**HG**	Hawaiian Gardens	**ME**	Monte Nido
CI	Chinatown	**HH**	Hidden Hills	**MG**	Montecito Heights
CK	Charter Oak	**HI**	Highland Park	**MH**	Mission Hills
CL	Claremont	**HK**	Holly Park	**MI**	Mint Canyon
CM	Compton	**HO**	Hollywood	**ML**	Malibu Lake
CN	Canyon Country	**HP**	Huntington Park	**MM**	Miracle Mile
CO	Commerce	**HR**	Harbor City	**MN**	Montrose
CP	Canoga Park	**HV**	Hi Vista	**MO**	Montebello

MP	Monterey Park	**RH**	Rolling Hills	**TI**	Terminal Island
MR	Mar Vista	**RK**	Rancho Park	**TJ**	Tujunga
MS	Mount Wilson	**RM**	Rosemead	**TL**	Toluca Lake
MT	Montclair	**RO**	Rowland Heights	**TO**	Torrance
MU	Mount Olympus	**RP**	Rancho Palos Verdes	**TP**	Topanga
MV	Monrovia	**RS**	Reseda	**TR**	Three Points
MW	Maywood	**RV**	Rampart Village	**TT**	Toluca Terrace
MY	Metler Valley	**RW**	Rosewood	**UC**	Universal City
NA	Naples	**SA**	Saugus	**UP**	University Park
NE	Newhall	**SB**	Sandberg	**VA**	Valencia
NH	North Hollywood	**SC**	Santa Clara	**VC**	Venice
NN	Neenach	**SD**	San Dimas	**VE**	Vernon
NO	Norwalk	**SE**	South El Monte	**VG**	Valley Glen

NR	Northridge	**SF**	San Fernando	**VI**	Valley Village
NT	North Hills	**SG**	San Gabriel	**VL**	Valinda
OP	Ocean Park	**SH**	Signal Hill	**VN**	Van Nuys
OT	Other	**SI**	Sierra Madre	**VV**	Val Verde
PA	Pasadena	**SJ**	Silver Lake	**VW**	View Park
PB	Pearblossom	**SK**	Sherman Oaks	**VY**	Valyermo
PC	Pacoima	**SL**	Sun Valley	**WA**	Walnut
PD	Palmdale	**SM**	Santa Monica	**WB**	Willowbrook
PE	Pacific Palisades	**SN**	San Marino	**WC**	West Covina
PH	Pacific Highlands	**SO**	South Gate	**WE**	West Hills
PI	Phillips Ranch	**SP**	South Pasadena	**WG**	Wilsona Gardens
PL	Playa Vista	**SQ**	Sleepy Valley	**WH**	West Hollywood
PM	Paramount	**SR**	San Pedro	**WI**	Whittier
PN	Panorama City	**SS**	Santa Fe Springs	**WK**	Winnetka
PO	Pomona	**ST**	Santa Clarita	**WL**	Woodland Hills
PP	Palos Verdes Peninsula	**SU**	Sunland	**WM**	Wilmington
PR	Pico Rivera	**SV**	Stevenson Ranch	**WN**	Windsor Hills
PS	Palms	**SW**	Sawtelle	**WO**	Westlake
PT	Porter Ranch	**SX**	South Central County	**WP**	Walnut Park
PV	Palos Verdes Estates	**SY**	Sylmar	**WR**	Westchester
PY	Playa Del Rey	**SZ**	Studio City	**WS**	Windsor Square
QH	Quartz Hill	**TA**	Tarzana	**WT**	Watts
RB	Redondo Beach	**TC**	Temple City	**WV**	Westlake Village
RC	Roosevelt Corner	**TD**	Tropico	**WW**	Westwood
RD	Rancho Dominguez	**TE**	Topanga State Park		
RE	Rolling Hills Estates	**TH**	Thousand Oaks		

Uses

- Epidemiological statistics

Data Source Hierarchy

- Patient
- Family member
- Caretaker

- EMS Provider
- 9-1-1 or Dispatch Center

PATIENT STATE

Definition

The state of the patient's primary residence

Field Values

AK	Alaska	**KS**	Kansas	**NM**	New Mexico	**WI**	Wisconsin
AL	Alabama	**KY**	Kentucky	**NV**	Nevada	**WV**	West Virginia
AR	Arkansas	**LA**	Louisiana	**NY**	New York	**WY**	Wyoming
AZ	Arizona	**MA**	Massachusetts	**OH**	Ohio	**AS**	American Samoa
CA	California	**MD**	Maryland	**OK**	Oklahoma	**FM**	Federated States of Micronesia
CO	Colorado	**ME**	Maine	**OR**	Oregon	**GU**	Guam
CT	Connecticut	**MI**	Michigan	**PA**	Pennsylvania	**MH**	Marshall Islands
DC	District of Columbia	**MN**	Minnesota	**RI**	Rhode Island	**MP**	Northern Mariana Islands
DE	Delaware	**MO**	Missouri	**SC**	South Carolina	**PR**	Puerto Rico
FL	Florida	**MS**	Mississippi	**SD**	South Dakota	**PW**	Palau
GA	Georgia	**MT**	Montana	**TN**	Tennessee	**UM**	US Minor Outlying Islands
HI	Hawaii	**NC**	North Carolina	**TX**	Texas	**VI**	Virgin Islands of the US
IA	Iowa	**NH**	New Hampshire	**UT**	Utah	**OT**	Other
ID	Idaho	**ND**	North Dakota	**VA**	Virginia		
IL	Illinois	**NE**	Nebraska	**VT**	Vermont		
IN	Indiana	**NJ**	New Jersey	**WA**	Washington		

Uses

- Epidemiological statistics

Data Source Hierarchy

- Patient
- Family member
- Caretaker
- EMS Provider

PATIENT ZIP CODE

Definition

The zip code of the patient's primary residence

Field Values

- Five-digit numeric value

Uses

- Epidemiological statistics

Data Source Hierarchy

- Patient
- Family member
- Caretaker
- EMS Provider
- 9-1-1 or Dispatch Center

MILEAGE

Definition

Total mileage traveled from the incident to the receiving facility

Field Values

- Numeric values only

Additional Information

- Document according to your Agency's policy
- For billing purposes only

Uses

- Billing purposes

Data Source Hierarchy

- Internet based mapping program
- Auto-generated by the EMS provider's electronic capture device

INSURANCE

Definition

The patient's insurance company, if applicable

Field Values

- Free text

Additional Information

- Document according to your Agency's policy
- For billing purposes only

Uses

- Billing purposes

Data Source Hierarchy

- Patient

HOSPITAL ID

Definition

The patient's medical record or hospital identification number, if applicable

Field Values

- Free text

Additional Information

- Document according to your Agency's policy

Uses

- Patient identification
- Link between other databases

Data Source Hierarchy

- ED Records
- Other hospital records

PMD NAME

Definition

The name of the patient's private medical doctor (PMD), if known

Field Values

- Free text

Additional Information

- Document according to your Agency's policy

Data Source Hierarchy

- Patient

PARTIAL SS # (LAST 4 DIGITS)

Definition

The last four digits of the patient's social security number

Field Values

- Numeric values only

Additional Information

- Document according to your Agency's policy

Uses

- Billing purposes

Data Source Hierarchy

- Patient

COMMENTS

COMMENT SECTION

Definition

Area of form used to document critical run information that is not covered in other sections of the EMS Report Form

Field Values

- Free text

Additional Information

- Write a legible, brief but thorough summary of run
- List pertinent points and findings, including all unusual circumstances that affect patient care
- Use appropriate abbreviations only
- Use to provide a complete scene description, including time needed to secure the scene, approximate speed and/or damage to the vehicle, and distance of the fall and onto what type of surface
- Use to describe why no medical intervention was needed or reasons for an incomplete report or vital signs (BP cuff too small/large for patient's arm, etc.)
- State facts, avoid conclusions or inflammatory statements
- Expand on response to treatment, change in patient status, and information concerning restraints
- Use a Page 2 for runs requiring more space for additional medications, treatments, vitals, and/or comments

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

O/P,Q,R,S,T

Definition

Acronym used as a tool to assess and document the following symptom attributes:

- O/P: Onset/Provocation
- Q: Quality
- R: Region/Radiation/Relief
- S: Severity
- T: Time

Field Values

- Free text

Uses

- Prompts thorough assessment and documentation of patient's symptoms
- Assists with determination of appropriate treatment and transport

Data Source Hierarchy

- EMS provider

HX

Definition

Space to indicate previous medical problem(s) experienced by the patient, if applicable

Field Values

- Free text

Uses

- Prompts thorough assessment and documentation of patient's symptoms
- Assists with determination of appropriate treatment and transport

Data Source Hierarchy

- Patient
- Family member
- Caretaker
- PMD

ALLERGIES

Definition

Checkbox and space to indicate patient history of adverse reactions or allergies to medications or other substances, if applicable

Field Values

- Free text

Additional Information

- Allergies to non-medication items may be listed if they are related to the current problem or potential treatments (e.g., adhesive tape, or latex)

Uses

- Patient safety

Data Source Hierarchy

- Patient
- Family member
- Caretaker
- PMD

MEDS

Definition

Space to indicate medications currently being taken by the patient, if applicable

Field Values

- Free text

Additional Information

- Indicate patient compliance, if applicable
- Include nonprescription drugs and herbal supplements

Uses

- Assists with determination of appropriate treatment and transport

Data Source Hierarchy

- Patient
- Family member
- Caretaker
- PMD

SEDs IN PAST 48 HRS

Definition

Checkboxes indicating whether or not patient has used sexually enhancing drugs (SEDs) within the past 48 hours

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- Use of SEDs must be assessed prior to ordering nitroglycerin for any patient

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Patient
- Family member
- Caretaker

PHYSICAL SIGNS

PUPILS

Definition

Checkboxes indicating the findings from assessment of the patient's initial pupillary response to light

Field Values

- **P**ERL: Pupils are equal in size and react to light
- P**I**npoint: Pupils are extremely constricted
- **S**luggish: Pupils react to light slower than normal
- **F**ixed/Dilated: Pupils are dilated and do not react to light
- **C**ataracts: Cataracts in one or both eyes interfere with pupil exam
- **U**nequal: Pupils are unequal in size
- Pt's **N**orm: Pupils are normal in size and reaction for patient

Additional Information

- If a value of "N" is documented, another value must also be entered, for example "S"

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS Provider

RESP

Definition

Checkboxes indicating findings from initial assessment of the patient's respiratory system

Field Values

- **N**ormal rate/effort: Breathing appears effortless and rate is within normal limits for patient
- **C**lear: No abnormal sounds are heard on auscultation
- **W**heezes: Coarse, whistling sound heard on auscultation, associated with inspiration and/or expiration
- R**H**onchi: Coarse, rattling or snoring sound heard on auscultation, associated with inspiration and/or expiration
- **U**nequal: Chest rise or breath sounds diminished on one side
- S**T**ridor: High-pitched, audible wheezing sound associated with inspiration and/or expiration
- **R**ales: Rattling or crackling noises heard on auscultation, associated with inspiration **S**noring: Prolonged snorting sound/soft palate vibration that is audible during inspiration
- **J**VD: Distended jugular veins are observed in the supine patient
- Accessory **M**uscle Use (AMU): Patient is using additional muscles to assist with difficulty breathing, such as those of the neck, shoulders, or abdomen
- **L**abored: Breathing appears to be difficult or requires extra effort
- **A**pnea: Patient is not breathing or stops breathing for periods of time
- Tidal Volume:
    - **N**: Normal depth of inspiration is observed
    - **+**: Increased depth of inspiration is observed
    - **-**: Decreased depth of inspiration is observed

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS Provider

SKIN

Definition

Checkboxes indicating findings from assessment of the patient's initial skin signs

Field Values

- **N**ormal: All aspects of skin assessment (color, temperature, moisture, and appearance) are normal
- **C**yanotic: Skin or lips appear blue
- **F**lushed: Skin appears red
- **H**ot: Skin feels warmer than normal or hot to touch
- Co**L**d: Skin feels cool or cold to touch
- **P**ale: Skin appears abnormally pale, ashen, or gray
- **D**iaphoretic: Skin is sweaty or moist to touch
- Cap Refill No**R**mal: Capillary refill is less than or equal to 2 seconds
- Cap Refill D**E**layed: Capillary refill is greater than 2 seconds

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS Provider

FIRST 12 LEAD TIME

Definition

Time of day the first 12-lead ECG was performed

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- **Required** for all patients on whom a 12-lead ECG is performed
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, enter the 12-lead time from the STEMI ECG in this field
- **Do not** perform another 12-lead ECG if the clinic, doctor's office, or transferring hospital already has performed a 12-lead ECG indicating STEMI

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

SOFTWARE INTERPRETATION

Definition

Checkbox indicating the software's interpretation of the first 12-lead ECG

Field Values

- **N**orma**L**: Electronic interpretation indicates ECG is normal
- **AB**normal: Electronic interpretation indicates ECG is abnormal
- STE**MI**: Electronic interpretation indicates an ST-Elevation Myocardial Infarction, or manufacturer's equivalent

Additional Information

- **Required** for all patients on whom a 12-lead ECG is performed
- If electronic interpretation indicates an ST-Elevation Myocardial Infarction (or manufacturer's equivalent) the patient should be transported to the nearest available STEMI Receiving Center (SRC)
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, check the STE**MI** box in this field

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- ECG strip

EMS INTERPRETATION

Definition

Checkbox indicating the EMS personnel's interpretation of the first 12-lead ECG

Field Values

- **N**orma**L**: EMS personnel interpretation indicates ECG is normal
- **AB**normal: EMS personnel interpretation indicates ECG is abnormal
- STE**MI**: EMS personnel interpretation indicates an ST-Elevation Myocardial Infarction, or manufacturer's equivalent

Additional Information

- **Required** for all patients on whom a 12-lead ECG is performed
- If EMS personnel interpretation indicates an ST-Elevation Myocardial Infarction (or manufacturer's equivalent) the patient should be transported to the nearest available STEMI Receiving Center (SRC)
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, **do not** repeat the 12-lead ECG
- Every 12-lead ECG should be evaluated by EMS personnel, regardless of whether the ECG was performed by a clinic, doctor's office, transferring hospital, or EMS personnel

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider
- ECG strip

ARTIFACT

Definition

Checkbox indicating whether or not artifact is observed on the first 12-lead ECG tracing

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- **Required** for all patients on whom a 12-lead ECG is performed where either the software or EMS interpretation indicates STEMI
- Electronic artifact interferes with accurate ECG interpretation and may indicate need to repeat ECG

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- ECG strip

WAVY BASELINE

Definition

Checkbox indicating whether or not baseline of the first 12-lead ECG tracing moves with respiration

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- **Required** for all patients on whom a 12-lead ECG is performed where either the software or EMS interpretation indicates STEMI
- Wavy baseline can interfere with accurate ECG interpretation and may indicate need to reposition leads and repeat ECG

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- ECG strip

PACED RHYTHM

Definition

Checkbox indicating presence of a pacemaker-generated rhythm on the first 12-lead ECG tracing

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- **Required** for all patients on whom a 12-lead ECG is performed where either the software or EMS interpretation indicates STEMI
- Pacemakers can interfere with accurate ECG interpretation and must be reported

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- ECG strip

TRANSMITTED?

Definition

Checkbox indicating whether the first 12-lead performed was transmitted to the receiving facility

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- **Required** for all patients on whom a 12-lead ECG is performed

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

SECOND 12 LEAD TIME

Definition

Time of day the second 12-lead ECG was performed, if applicable

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- **Required** for all patients on whom a 2nd 12-lead ECG is performed
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, enter the 12-lead time from the STEMI ECG in this field
- **Do not** perform another 12-lead ECG if the clinic, doctor's office, or transferring hospital already has performed a 12-lead ECG indicating STEMI

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

SOFTWARE INTERPRETATION

Definition

Checkbox indicating the software's interpretation of the second 12-lead ECG

Field Values

- **N**orma**L**: Electronic interpretation indicates ECG is normal
- **AB**normal: Electronic interpretation indicates ECG is abnormal
- STE**MI**: Electronic interpretation indicates an ST-Elevation Myocardial Infarction, or manufacturer's equivalent

Additional Information

- **Required** for all patients on whom a 2nd 12-lead ECG is performed
- If electronic interpretation indicates an ST-Elevation Myocardial Infarction (or manufacturer's equivalent) the patient should be transported to the nearest available STEMI Receiving Center (SRC)
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, check the STE**MI** box in this field

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- ECG strip

EMS INTERPRETATION

Definition

Checkbox indicating the EMS personnel's interpretation of the second 12-lead ECG

Field Values

- **N**orma**L**: EMS personnel interpretation indicates ECG is normal
- **AB**normal: EMS personnel interpretation indicates ECG is abnormal
- STE**MI**: EMS personnel interpretation indicates an ST-Elevation Myocardial Infarction, or manufacturer's equivalent

Additional Information

- **Required** for all patients on whom a 2nd 12-lead ECG is performed
- If EMS personnel interpretation indicates an ST-Elevation Myocardial Infarction (or manufacturer's equivalent) the patient should be transported to the nearest available STEMI Receiving Center (SRC)
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, **do not** repeat the 12-lead ECG
- Every 12-lead ECG should be evaluated by EMS personnel, regardless of whether the ECG was performed by a clinic, doctor's office, transferring hospital, or EMS personnel

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider
- ECG strip

ARTIFACT

Definition

Checkbox indicating whether or not artifact is observed on the second 12-lead ECG tracing

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- **Required** for all patients on whom a 2nd 12-lead ECG is performed where either the software or EMS interpretation indicates STEMI
- Electronic artifact interferes with accurate ECG interpretation and may indicate need to repeat ECG

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- ECG strip

WAVY BASELINE

Definition

Checkbox indicating whether or not baseline of the second 12-lead ECG tracing moves with respiration

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- **Required** for all patients on whom a 2nd 12-lead ECG is performed where either the software or EMS interpretation indicates STEMI
- Wavy baseline can interfere with accurate ECG interpretation and may indicate need to reposition leads and repeat ECG

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- ECG strip

PACED RHYTHM

Definition

Checkbox indicating presence of a pacemaker-generated rhythm on the second 12-lead ECG tracing

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- **Required** for all patients on whom a 2nd 12-lead ECG is performed where either the software or EMS interpretation indicates STEMI
- Pacemakers can interfere with accurate ECG interpretation and must be reported

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- ECG strip

TRANSMITTED?

Definition

Checkbox indicating whether the second 12-lead performed was transmitted to the receiving facility, if applicable

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- **Required** for all patients on whom a 2nd 12-lead ECG is performed

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

SPECIAL CIRCUMSTANCES

DNR/AHCD/POLST?

Definition

Checkbox indicating presence of a valid DNR, Advance Healthcare Directive (AHCD), or Physician Order for Life Sustaining Treatment (POLST) form for the patient

Field Values

- **Y**: Yes
- **N**: No

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Patient
- Family member
- Caregiver
- EMS provider

SUSPECTED ETOH?

Definition

Checkbox indicating that statements by the patient, family, or bystanders and/or the situation and behavior suggest the patient has ingested alcohol

Field Values

- **Y**: Yes

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Patient
- Family member
- Caregiver
- EMS provider
- Bystander

SUSPECTED DRUGS?

Definition

Checkbox indicating that statements by the patient, family, or bystanders and/or the situation and behavior suggest the patient has used drugs

Field Values

- **Y**: Yes

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Patient
- Family member
- Caregiver
- EMS provider
- Bystander

SUSPECTED ABUSE?

Definition

Checkbox indicating whether family violence, neglect or abuse is suspected

Field Values

- **Y**: Yes

Additional Information

- Must be followed up with the appropriate reports per Los Angeles County Prehospital Care Manual Reference 822, Suspected Child Abuse/Neglect Reporting Guidelines, and Reference 823, Elder Abuse and Dependent Adult Abuse Reporting Guidelines

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Patient
- Caregiver
- Family member
- EMS provider

POISON CONTROL CONTACTED?

Definition

Checkbox indicating whether poison control was contacted

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- Applies to poison control contact made by dispatch, EMS on scene, or family members prior to arrival of paramedics

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- 9-1-1 or Dispatch Center
- EMS provider
- Patient
- Family member
- Caregiver

≥ 20 WKS IUP?

Definition

Checkbox indicating whether the patient is greater than or equal to twenty weeks of intrauterine pregnancy, if applicable

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- Patients may only be able to provide the number of months, not weeks, of their pregnancy – in this case, pregnancies reported of greater than 4½ months can be assumed to be greater than 20 weeks
- Patients injured while pregnant meet trauma triage special considerations for transport to a trauma center due to risk to the fetus – not the mother

Uses

- Provides documentation of assessment
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Patient
- Family member
- Caregiver

_ *WKS*

Definition

Space indicating the number of weeks of intrauterine pregnancy, if applicable

Field Values

- Up to two-digit numeric value

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Patient
- Family member
- Caregiver

BARRIERS TO PATIENT CARE

Definition

Specific barriers that may potentially impact patient care

Field Values

- **H**: Hearing
- **P**: Physical
- **L**: Language
- **S**: Speech
- **O**: Other

Uses

- Provides documentation of assessment
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Patient
- Family member
- Caregiver
- EMS provider

CARDIAC ARREST

ARREST/ REASON FOR WITHHOLDING RESUSCITATION

Definition

The details of the cardiac arrest to include the following: the person(s) who witnessed the cardiac arrest; who performed cardiopulmonary resuscitation; EMT performed defibrillation; resuscitation efforts and advanced airway attempts are initiated; indicates if pulses are present when EMS is performing cardiopulmonary resuscitation; and reason(s) for withholding cardiopulmonary resuscitation.

Field Values

- **W**itness **C**itizen: Witnessed by a non-EMS person (e.g., law enforcement or nursing home personnel, bystanders, family, etc.)
- **W**itness **E**MS: Witnessed by EMS personnel
- **W**itness **N**one: Not witnessed
- **C**itizen **C**PR: CPR was initiated by a non-EMS person (e.g., law enforcement or nursing home personnel, bystanders, family, etc.)
- **C**itizen **A**ED: An AED was applied to the patient by a non-EMS person (e.g., law enforcement or nursing home personnel, bystanders, family, etc.)
- EMS CPR @: Time of day CPR was initiated by EMS personnel
- Arrest to CPR: Estimated time, in minutes, from the time of arrest to the time CPR is initiated
- **A**ED **A**nalyze: An AED is applied by EMS personnel and analyzed (no shocks administered)
- **A**ED **D**efibrillation: An AED is applied by EMS personnel and one or more shocks are administered
- **A**LS **R**esuscitation (use pg 2): ALS resuscitation efforts are initiated or patient is pronounced dead by the base hospital physician; attach completed ALS Continuation Form
- **DN**R/AHCD/POLST: A valid DNR, Advance Healthcare Directive (AHCD), or Physician Order for Life Sustaining Treatment (POLST) form is present
- **T.**O.**R.**: Resuscitative measures are terminated by EMS personnel
- **AS**Y > __min: Mark if patient in non-traumatic cardiac arrest is estimated to have been in asystole without CPR for at least 10 minutes per Los Angeles County Prehospital Care Manual Reference 814
- __ Time of 814 Death: Time of day patient is determined to be dead per Los Angeles County Prehospital Care Manual Reference 814
- **RI**gor: Rigor mortis is present
- **LI**vidity: Post-mortem lividity is present
- **B**lunt **T**rauma: Mark for blunt trauma patients who, based on a paramedic's thorough patient assessment, are found apneic, pulseless, and without organized ECG activity (narrow complex supraventricular rhythm) upon the arrival of EMS personnel at the scene
- **OT**her: The patient is determined dead per Reference 814 due to a reason not listed above (decapitation, incineration, decomposition, etc.)
- **FA**mily __ (signature): The signature of the family member who requested resuscitation be withheld

Additional Information

- Mark all that apply

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

VITAL SIGNS

TIME

Definition

Time of day the patient's vital signs are obtained

Field Values

- Collected as HHMM
- Use 24-hour clock

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

TM #

Definition

The number of the team member who obtained vital signs from the patient

Field Values

- Free text

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

BLOOD PRESSURE

Definition

Numeric values of the patient's systolic and/or diastolic blood pressure

Field Values

- Up to three-digit numeric value
- Documented as numeric systolic value / numeric diastolic value

Additional Information

- If the blood pressure is palpated or not reported, write "P" for the diastolic value- blood pressure should only be palpated when environmental or other extenuating factors makes it impossible to accurately auscultate

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

PULSE

Definition

Numeric value of the patient's palpated pulse rate

Field Values

- Up to three-digit numeric value

Additional Information

- Measured in beats palpated per minute
- If cardiac monitor shows a rhythm that does not produce signs of perfusion, rate is documented as "0"

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

RR

Definition

Numeric value of the patient's unassisted respiratory rate

Field Values

- Up to two-digit numeric value

Additional Information

- Measured in breaths per minute
- If patient requires mechanical assistance, then unassisted rate is documented only, not the assisted rate

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

O2 SAT

Definition

Numeric value of the patient's oxygen saturation

Field Values

- Up to three-digit percentage from 0 to 100

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

PAIN

Definition

Numeric value indicating the patient's subjective pain level

Field Values

- Up to two-digit value from 0 to 10

Additional Information

- Pain level should be assessed and recorded with each set of vital signs, whenever trauma or pain is the chief complaint, a mechanism of injury exists, and before and after administration of pain medication
- When assessing non-verbal patients the "Faces Pain Scale" may be used to obtain the corresponding numeric pain score
- The "Faces Pain Scale" assessment tool is on the back of the red copy

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

CO2

Definition

Numeric value indicating the subsequent concentration of carbon dioxide measured by the capnometer, if applicable

Field Values

- Up to three-digit value

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

MEDICATION/ DEFIBRILLATION

TIME

Definition

Time of day when medication or treatment was administered and/or when a subsequent 3-lead rhythm was read from the cardiac monitor

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- The exact time for each defibrillation/cardioversion, as well as the joules, must be noted separately

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

TM #

Definition

The number of the team member who administered medication or treatment to the patient and/or who read the subsequent 3-lead rhythm from the cardiac monitor

Field Values

- Free text

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

RHYTHM

Definition

Two- or three-letter code indicating the patient's subsequent rhythm(s) on the cardiac monitor, if applicable

Field Values

1HB First degree Heart Block	**AFI** Atrial Fibrillation
3HB Third degree Heart Block	**AGO** Agonal Rhythm
AFL Atrial Flutter	**AVR** Accelerated Ventricular Rhythm
ASY Asystole	**JR** Junctional Rhythm
IV Idioventricular Rhythm	**PAC** Premature Atrial Contraction
PAT Paroxysmal Atrial Tachycardia	**PEA** Pulseless Electrical Activity
PM Pacemaker Rhythm	**PST** Paroxysmal Supraventricular Tachycardia
PVC Premature Ventricular Contraction	**SA** Sinus Arrhythmia
SB Sinus Bradycardia	**SR** Sinus Rhythm
ST Sinus Tachycardia	**SVT** Supraventricular Tachycardia
VF Ventricular Fibrillation	**VT** Ventricular Tachycardia
2HB Second degree Heart Block	

Additional Information

- Cardiac rhythm should be assessed, and documented here any time a change is noted, or after any cardiac-related treatments
- ECG Codes are found on the back of the red copy

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

MEDS/DEFIB

Definition

The medication, defibrillation and/or cardioversion administered to the patient

Field Values

ADE Adenosine	**DEF** Defibrillation
AED AED	**DOP** Dopamine
ALB Nebulized Albuterol	**EPI** Epinephrine
AMI Amiodarone	**FEN** Fentanyl
ASA Aspirin	**GLP** Oral Glucose Paste
ATR Atropine	**GLU** Glucagon
BEN Benadryl	**IVU** I.V. Unobtainable
BIC Sodium Bicarbonate	**MID** Midazolam
CAL Calcium Chloride	**MORPHINE** Morphine Sulfate
CAR Cardioversion	**NAR** Narcan
COL Glucola	**NS** Normal Saline
D10 10% Dextrose	**NTG** Nitroglycerin Spray
D50 50% Dextrose	**OND** Ondansetron
D25 25% Dextrose	**SL** Saline Lock

Additional Information

- Each drug/defibrillation ordered should be written on a separate line so that dose and results can be clearly documented
- Medication/Defibrillation codes are found on the back of the red copy

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

DOSE

Definition

The medication dosage administered or the joules delivered during defibrillation/cardioversion

Field Values

- Free text

Additional Information

- Include dose and unit of measurement: e.g., “1mg” or “300J”

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

ROUTE

Definition

Two-letter code indicating the route of medication administration

Field Values

- **IV**: Intravenous
- **IO**: Intraosseous
- **SQ**: Subcutaneous
- **IM**: Intramuscular
- **PO**: By Mouth (per os) / oral disintegrating tablets (ODT)
- **IN**: Intranasal/Inhalation (e.g, HHN)
- **SL**: Sublingual

Additional Information

- Medication Route codes are found on the back of the red copy

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

RESULT

Definition

The effect the medication or treatment had on the patient

Field Values

- **-**: Deteriorated
- **+**: Improved
- **N**: No Change

Additional Information

- When documenting the effects of pain medication, the numeric scale (not the up/down arrows) must be used
- Any adverse effects must be noted in the Comments Section

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

TRANSFER OF CARE

CONDITION ON TRANSFER

Definition

Area of form used to document the patient's condition when care is transferred to another EMS provider or to a receiving facility

Field Values

- Free text

Additional Information

- Use this area to provide a brief summary of the patient's condition

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

MORPHINE

Definition

Amount of morphine given and wasted, if applicable

Field Values

- Given: ____mg
- Wasted: ____mg

Additional Information

- A registered nurse from the receiving facility who witnessed the wastage must print and sign their name in the space provided

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

MIDAZOLAM

Definition

Amount of midazolam given and wasted, if applicable

Field Values

- Given: ____mg
- Wasted: ____mg

Additional Information

- A registered nurse from the receiving facility who witnessed the wastage must print and sign their name in the space provided

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

FENTANYL

Definition

Amount of fentanyl given and wasted, if applicable

Field Values

- Given: ____mcg
- Wasted: ____mcg

Additional Information

- A registered nurse from the receiving facility who witnessed the wastage must print and sign their name in the space provided

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

TOTAL IV FLUIDS RECEIVED

Definition

The total amount of intravenous fluids the patient received prior to arrival at the receiving facility

Field Values

- Up to four-digit numeric value

Additional Information

- IV fluid challenge volume should also be documented here

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

CARE TRANSFERRED TO

Definition

The level of care the patient was transferred to

Field Values

- **A**LS: Care of the patient was transferred to an ALS provider
- **B**LS: Care of the patient was transferred to a BLS provider
- **H**elicopter: Care of the patient was transferred to the helicopter crew
- **F**acility: Care of the patient was transferred to the receiving facility

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

TRANSFER VS TIME

Definition

Time of day vital signs were obtained for transfer of care

Field Values

- Collected as HHMM
- Use 24-hour clock

Uses

- Establishes care intervals and incident timelines
- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

TM #

Definition

The number of the team member who transferred care of the patient

Field Values

- Free text

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

BP

Definition

Numeric values of the patient's systolic and/or diastolic blood pressure

Field Values

- Up to three-digit numeric value
- Documented as numeric systolic value / numeric diastolic value

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

PULSE

Definition

Numeric value of the patient's pulse rate at transfer of care

Field Values

- Up to three-digit numeric value

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

RR

Definition

Numeric value of the patient's unassisted respiratory rate at transfer of care

Field Values

- Up to two-digit numeric value

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

O2 SAT

Definition

Numeric value of the patient's oxygen saturation at transfer of care

Field Values

- Up to three-digit percentage from 0 to 100

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

CO2

Definition

Numeric CO2 measurement from the capnometer at transfer of care

Field Values

- Up to three-digit value

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

RHYTHM

Definition

Two- or three-letter code indicating the patient's subsequent rhythm on the cardiac monitor

Field Values

1HB First degree Heart Block	**AFI** Atrial Fibrillation
3HB Third degree Heart Block	**AGO** Agonal Rhythm
AFL Atrial Flutter	**AVR** Accelerated Ventricular Rhythm
ASY Asystole	**JR** Junctional Rhythm
IV Idioventricular Rhythm	**PAC** Premature Atrial Contraction
PAT Paroxysmal Atrial Tachycardia	**PEA** Pulseless Electrical Activity
PM Pacemaker Rhythm	**PST** Paroxysmal Supraventricular Tachycardia
PVC Premature Ventricular Contraction	**SA** Sinus Arrhythmia
SB Sinus Bradycardia	**SR** Sinus Rhythm
ST Sinus Tachycardia	**SVT** Supraventricular Tachycardia
VF Ventricular Fibrillation	**VT** Ventricular Tachycardia
2HB Second degree Heart Block	

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

CPAP PRESSURE

Definition

Numeric pressure reading from the CPAP device at transfer of care, if applicable

Field Values

- Up to three-digit value

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

GCS E

Definition

The Glasgow Coma Scale numerical value that corresponds to the patient's eye opening response to stimuli at transfer of care

Field Values

- **4**: Spontaneous – opens eyes spontaneously, no stimuli required
- **3**: To Verbal – opens eyes only when spoken to or asked
- **2**: To Pain – opens eyes only in response to noxious stimuli such as sternal rub or nail bed pressure
- **1**: None – patient does not open eyes in response to noxious stimuli

Additional Information

- **Required** on all patients who are one year of age and older
- Adult and pediatric Glasgow Coma Scales are found on the back of the red copy

Uses

- Element necessary to calculate the overall GCS score
- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

GCS V

Definition

The Glasgow Coma Scale numerical value that corresponds to the patient's verbal response to stimuli at transfer of care

Field Values – Adult and Verbal Pediatric Patients

- **5**: Oriented x 3 – patient is oriented to person, time, and place
- **4**: Confused – patient may respond to questions coherently, but is disoriented or confused
- **3**: Inappropriate – random words or speech unrelated to questions or conversation
- **2**: Incomprehensible – makes incoherent sounds or moans only
- **1**: None – patient has no verbal response to noxious stimuli

Field Values – Infants and Toddlers

- **5**: Smiles and tracks objects, speech appropriate for age
- **4**: Cries but consolable, or confused
- **3**: Inconsistently consolable, or random words
- **2**: Moaning, incoherent sounds only
- **1**: No verbal response to noxious stimuli

Additional Information

- **Required** on all patients who are one year of age and older
- Adult and pediatric Glasgow Coma Scales are found on the back of the red copy

Uses

- Element necessary to calculate the overall GCS score
- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

GCS M

Definition

The Glasgow Coma Scale numerical value that corresponds to the patient's motor response to stimuli at transfer of care

Field Values

- **6**: Obedient – obeys verbal commands / spontaneous purposeful movement
- **5**: Purposeful – purposeful movement is made in response to noxious stimuli (e.g., attempts to push away or grab source of stimuli
- **4**: Withdrawal – withdraws body part from source of noxious stimuli
- **3**: Flexion –extremities move towards body core in response to noxious stimuli (decorticate posturing)
- **2**: Extension – extremities move away from body core in response to noxious stimuli (decerebrate posturing)
- **1**: None – patient has no motor response to noxious stimuli

Additional Information

- **Required** on all patients who are one year of age and older
- Adult and pediatric Glasgow Coma Scales are found on the back of the red copy

Uses

- Element necessary to calculate the overall GCS score
- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

GCS TOTAL

Definition

Sum of the three numerical values documented for each element of the patient's Glasgow Coma Scale score at transfer of care

Field Values

- One- or two-digit numeric value between 3 and 15

Additional Information

- Maximum total score is 15, which is considered normal. Minimum score possible is 3, which may indicate severe or fatal brain injury
    - 3 to 8 may indicate severe brain injury
    - 9 to 13 may indicate moderate brain injury
    - 14 or 15 may indicate mild or no brain injury
- **Required** on all patients who are one year of age and older
- Adult and pediatric Glasgow Coma Scales are found on the back of the red copy

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

SIGNATURE TM COMPLETING FORM

Definition

Signature of the ALS team members who have primary responsibility for the patient or ALS/BLS members who have the completed the form

Field Values

- Free text

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

ADVANCED LIFE SUPPORT CONTINUATION FORM

INCIDENT INFORMATION SECTION

Definition

The top section of the ALS Continuation Form that needs to be completely filled out if an ALS Continuation Form is used

Field Values

- Date: Date of the incident, enter in MMDDYYYY format
- Provider Code: Two letter code of the provider agency responding to the incident
- Unit: Unit letter and number designation for the responding provider unit
- Seq. #: Must exactly match the original EMS Form
- Sec. Seq. #: When applicable- should only be filled in when two provider agencies have participated in the run and each has completed their own EMS Report Form
- Patient Name: The patient's first and last name
- Incident #: Incident number assigned by the 911 or Dispatch Center

Additional Information

- Complete each area accurately

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

VITAL SIGNS AND MEDICATION/DEFIB SECTION

Definition

The section of the ALS Continuation Form that needs to be completely filled out when additional vital signs are taken or medications are given

Field Values

Vital Signs:

- Time: Time of day the patient's vitals are obtained
- SBP: Numeric value of the patient's systolic blood pressure
- DBP: Numeric value of the patient's diastolic blood pressure
- P: Numeric value of the patient's pulse rate
- R: Numeric value of the patient's unassisted respiratory rate
- SpO2: Numeric value of the patient's oxygen saturation
- Pain (0-10): Numeric value indicating the patient's subjective pain level

Meds/Defib:

- Time: Time of day when medication or treatment was administered and/or when a subsequent 3-lead rhythm was read from the cardiac monitor
- TM#: The number of the team member who administered medication or treatment to the patient and/or who read the subsequent 3-lead rhythm from the cardiac monitor
- EKG: Two- or three-letter code indicating the patient's subsequent rhythm(s) on the cardiac monitor, if applicable
- Med/Defib: The medication, defibrillation, and/or cardioversion administered to the patient
- Dose: The medication dosage administered or the joules delivered during defibrillation/cardioversion
- Route: Two-letter code indicating the route of medication administration
- Result: The effect the medication or treatment had on the patient

Additional Information

- Complete this section in the same way as the Vitals and Meds/Defib sections of the EMS Report Form

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

REASON FOR ADVANCED AIRWAY

Definition

The reason(s) that the patient needs an advanced airway

Field Values

- **R**esp **A**rrest
- **C**ardiopulmonary **A**rrest
- **HY**poventilation
- **P**rofoundly **A**ltered
- **OT**her

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

PM #

Definition

The identification number of the team member who attempted endotracheal tube or King LTS-D placement on the patient

Field Values

- Free text

Additional Information

- The ALS Continuation Form has not been revised to reflect the discontinuation of the Combitube and the addition of the King LTS-D. Document the usage of the King LTS-D whenever “ETC” or “Combitube” is stated
- The format used for Paramedics is “P” followed by the L.A. County issued accreditation number– example P1234

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

SUCCESS

Definition

Checkbox indicating whether endotracheal tube or King LTS-D placement was successful

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- The ALS Continuation Form has not been revised to reflect the discontinuation of the Combitube and the addition of the King LTS-D. Document the usage of the King LTS-D whenever “ETC” or “Combitube” is stated

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

TIME ET/ETC START

Definition

Time of day endotracheal tube or King LTS-D placement attempt was started

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- The ALS Continuation Form has not been revised to reflect the discontinuation of the Combitube and the addition of the King LTS-D. Document the usage of the King LTS-D whenever “ETC” or “Combitube” is stated

Uses

- Establishes care intervals and incident timelines
- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

TIME ET/ETC SUCCESS

Definition

Time of day endotracheal tube/King LTS-D placement was successfully completed

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- The ALS Continuation Form has not been revised to reflect the discontinuation of the Combitube and the addition of the King LTS-D. Document the usage of the King LTS-D whenever “ETC” or “Combitube” is stated

Uses

- Establishes care intervals and incident timelines
- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

ETT SIZE

Definition

The size of the endotracheal tube or King LTS-D placed

Field Values

- Up to three-digit numeric value

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

DIFFICULT AIRWAY TECHNIQUES

Definition

Checkbox indicating techniques utilized to assist with endotracheal tube or King LTS-D placement

Field Values

- **F**lex **G**uide
- **C**ricoid **P**ressure
- **E**xternal **L**aryngeal Manipulation

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

TUBE PLACEMENT MARK AT TEETH

Definition

The centimeter mark at the teeth as a result of endotracheal tube or King LTS-D placement

Field Values

- Two-digit numeric value

Additional Information

- ETC Ventilating field is no longer in use

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

COMPLICATION(S) DURING TUBE PLACEMENT

Definition

Checkbox indicating complications that occurred during endotracheal tube or King airway insertion

Field Values

- **No**ne: No complications were encountered during advanced airway placement
- **E**mesis/**S**ecretions/Blood: Excess emesis or secretions hampered advanced airway placement
- **G**astric **D**istention: Gastric distention was observed
- **Cl**enching: Patient clenched down as advanced airway placement was attempted
- **An**atomy: Anatomical factors affected advanced airway placement
- **G**ag **R**eflex: Patient had a gag reflex, which hampered advanced airway placement
- **OT**her: Other complications encountered that are not listed above

Additional Information

- If “None” is marked, do not mark any other checkboxes
- If “None” is <u>not</u> marked, check all that apply

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

INITIAL ADVANCED AIRWAY PLACEMENT CONFIRMATION

Definition

Checkbox indicating the method utilized to confirm correct endotracheal tube or placement

King LTS-D

Field Values

- **B**ilateral **B**reath Sounds: Patient had bilateral breath sounds following advanced airway placement
- **B**ilateral **C**hest Rise: Bilateral chest rise is observed following advanced airway placement
- **A**bsent **G**astric Sounds: No breath sounds are auscultated over the gastric area following advanced airway placement
- EID **N**o **R**esistance: The EID is used to check advanced airway placement

Additional Information

- Mark all that apply

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

CAPNOGRAPHY MEASUREMENT

Definition

The numeric CO_2 measurement from the capnometer after endotracheal tube or placement

King LTS-D

Field Values

- Up to two-digit numeric value

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

$EtCO_2$ DETECTOR COLORIMETRIC

Definition

Checkbox indicating the color observed when the carbon dioxide colorimetric device is used after endotracheal tube or King LTS-D placement

Field Values

- **Y**ellow
- **T**an
- **P**urple

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

WAVEFORM CAPNOGRAPHY

Definition

Indicates whether or not a waveform is observed on the capnography tracing

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- Attach a printout of the waveform Capnography to the ALS Continuation Form

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

ONGOING ADVANCED AIRWAY PLACEMENT CONFIRMATION

ONGOING VERIFICATION TIME

Definition

Time of day endotracheal tube or King LTS-D placement is verified

Field Values

- Collected as HHMM
- Use 24-hour clock

Uses

- Establishes care intervals and incident timelines
- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

ONGOING VERIFICATION VALUE

Definition

Checkbox indicating the result of the ongoing verification endotracheal tube or King LTS-D placement assessment

Field Values

- **C**ontinued **C**orrect Placement: Tube placement is correct upon reassessment
- **S**uspected **D**islodgement: Tube seems to have dislodged upon patient movement

Additional Information

- If dislodgment is suspected, comment on the measures taken to correct the situation (tube removed, patient re-intubated, etc.)

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

TIME CARE TRANSFERRED

Definition

Time of day care was transferred to another provider or hospital personnel

Field Values

- Collected as HHMM
- Use 24-hour clock

Uses

- Establishes care intervals and incident timelines
- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

CO2

Definition

The numeric CO_2 measurement from the capnometer at transfer of care

Field Values

- Two-digit numeric value

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

O2 SAT

Definition

Numeric value of the patient's oxygen saturation at transfer of care

Field Values

- Up to three-digit percentage from 0 to 100

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

SPONTANEOUS RESPIRATIONS

Definition

Checkbox indicating whether or not the patient had spontaneous respirations upon transfer of care

Field Values

- **Y**: Yes
- **N**: No

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

REASON ALS AIRWAY UNABLE

REASON(S) ALS AIRWAY UNABLE

Definition

Checkboxes indicating the reason(s) an advanced ALS airway was unable to be inserted

Field Values

- Positive **G**ag Reflex
- **A**natomy
- **B**lood/Secretions
- Unable to visualize **C**ords
- Unable to visualize **E**piglottis
- Equipment **F**ailure
- **L**ogistical/Environmental Issues

Additional Information

- Mark all that apply
- Describe any logistical/environmental issues (patient access, safety hazards, etc.) encountered on the line provided
- If an advanced airway was not possible, the patient should be ventilated using a bag-mask-device

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

CARDIAC ARREST/ RESUSCITATION

PULSES WITH CPR BY EMS

Definition

Checkboxes indicating whether or not pulses are present when compressions are performed by EMS personnel

Field Values

- **Y**: Yes
- **N**: No

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

RESTORATION OF PULSE TIME

Definition

Time of day when return of spontaneous circulation (ROSC) occurred

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- Document even if the pulses are lost prior to arrival at the receiving facility
- Patients with ROSC in the field should be transported to the nearest available STEMI Receiving Center (SRC)

Uses

- Establishes care intervals and incident timelines
- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

PRONOUNCED TIME

Definition

Time of day when resuscitative measures were discontinued, either due to patient being pronounced dead by the base hospital or by EMS personnel decision to terminate resuscitation

Field Values

- Collected as HHMM
- Use 24-hour clock

Uses

- Establishes care intervals and incident timelines
- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

PRONOUNCED BY

Definition

The name of the base hospital physician that pronounced the patient dead

Field Values

- Free text

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

PRONOUNCED RHYTHM

Definition

Two- or three-letter code identifying the cardiac rhythm reported when the patient was pronounced dead or resuscitation was terminated

Field Values

AGO Agonal Rhythm	PEA Pulseless Electrical Activity
ASY Asystole	VF Ventricular Fibrillation
IV Idioventricular Rhythm	

Additional Information

- PEA is not a defined rhythm, but rather a finding that may be present at time of pronouncement where electrical activity and/or rhythm seen on the cardiac monitor does not produce a palpable pulse or auscultatable heartbeat

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

COMMENTS

Definition

Area used to describe any special or unusual circumstances that may have occurred during the attempted resuscitation

Field Values

- Free text

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

VERIFICATION OF TUBE PLACEMENT

RECEIVING FACILITY

Definition

The three letter code of the facility to which the patient was transported

Field Values

ACH	Alhambra Hospital Medical Center	**GWT**	Glendale Adventist Medical Center
AHM	Catalina Island Medical Center	**HBC**	Hyperbaric Chamber (NON-BASIC)
AMH	Methodist Hospital of Southern California	**HCH**	Providence Holy Cross Medical Center
ANH	Anaheim Memorial Medical Center	**HEV**	Glendora Community Hospital
AVH	Antelope Valley Hospital	**HGH**	LAC Harbor-UCLA Medical Center
BEV	Beverly Hospital	**HMH**	Huntington Hospital
BMC	Brotman Medical Center	**HMN**	Henry Mayo Newhall Hospital
CAL	California Hospital Medical Center	**HWH**	West Hills Hospital and Medical Center
CHH	Children's Hospital Los Angeles	**ICH**	Citrus Valley Medical Center Intercommunity
CHI	Chino Valley Medical Center (San Bernardino County)	**KFA**	Kaiser Foundation - Baldwin Park
CHP	Community Hospital of Huntington Park	**KFB**	Kaiser Permanente Downey Medical Center
CNT	Centinela Hospital Medical Center	**KFF**	Kaiser Foundation Hospital - Fontana
CPM	Coast Plaza Doctors Hospital	**KFH**	Kaiser Permanente South Bay Medical Center
CSM	Cedars-Sinai Medical Center	**KFI**	Kaiser Permanente Irvine Medical Center
DCH	PIH Health Hospital - Downey	**KFL**	Kaiser Permanente Los Angeles Medical Center
DFM	Marina Del Rey Hospital	**KFO**	Kaiser Permanente Woodland Hills Medical Center
DHL	Lakewood Regional Medical Center	**KFP**	Kaiser Permanente Panorama City Medical Center
DHM	Doctor's Hospital of Montclair (San Bernardino County)	**KFW**	Kaiser Permanente West LA Medical Center
ELA	East Los Angeles Doctors Hospital	**KHA**	Kaiser Foundation Hospital -Anaheim (Orange County)
ENH	Encino Hospital Medical Center	**LAG**	Los Alamitos Medical Center (Orange County)
FPH	Foothill Presbyterian Hospital	**LBC**	Community Hospital of Long Beach
GAR	Garfield Medical Center	**LBM**	Long Beach Memorial Medical Center
GEM	Greater El Monte Community Hospital	**LBV**	Long Beach Veteran Administration (NON-BASIC)
GMH	Glendale Memorial Hospital and Health Center	**LCH**	Lancaster Community Hospital
GSH	Good Samaritan Hospital	**LCM**	Providence Little Company of Mary Torrance

LPI	La Palma Intercommunity Hospital (Orange County)	**SGC**	San Gabriel Valley Medical Center
LRR	Los Robles Hospital and Medical Center (Ventura County)	**SIM**	Simi Valley Hospital (Ventura County)
MCP	Mission Community Hospital	**SJD**	Saint Jude Medical Center (Orange County)
MHG	Memorial Hospital Gardena	**SJH**	Providence Saint John's Health Center
MID	Olympia Medical Center	**SJO**	Saint John Regional Medical Center (Ventura County)
MLK	Martin Luther King Jr. Community Hospital	**SJS**	Providence Saint Joseph Medical Center
MPH	Monterey Park Hospital	**SMH**	UCLA Medical Center, Santa Monica
NOR	Norwalk Community Hospital	**SMM**	Saint Mary Medical Center
NRH	Northridge Hospital Medical Center Roscoe Campus	**SOC**	Sherman Oaks Hospital
OTH	Other (FACILITY NOT LISTED)	**SPP**	Providence Little Company of Mary San Pedro
OVM	LAC Olive View Medical Center	**TOR**	Torrance Memorial Medical Center
PAC	Pacifica Hospital of the Valley	**TRI**	Tri-City Regional Medical Center
PIH	Presbyterian Intercommunity Hospital	**TRM**	Providence Tarzana Medical Center Tarzana Campus
PLB	Pacific Hospital of Long Beach	**UCI**	University of California Irvine (Orange County)
PLH	Placentia Linda Hospital (Orange County)	**UCL**	Ronald Reagan UCLA Medical Center
PVC	Pomona Valley Hospital Medical Center	**USC**	LAC + USC Medical Center
QOA	Hollywood Presbyterian Medical Center	**VHH**	Verdugo Hills Hospital
QVH	Citrus Valley Medical Center Queen of the Valley Campus	**VPH**	Valley Presbyterian Hospital
RCC	Ridgecrest Regional Hospital (Kern County)	**WHH**	Whittier Hospital Medical Center
SAC	San Antonio Community Hospital (San Bernardino County)	**WMH**	White Memorial Medical Center
SDC	San Dimas Community Hospital	**WVA**	Veterans Administration Hospital of West Los Angeles (NON-BASIC)
SFM	Saint Francis Medical Center		

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

VERIFICATION TECHNIQUE(S)

Definition

Checkbox indicating the technique(s) utilized by the receiving facility physician to confirm endotracheal tube or King LTS-D placement

Field Values

- **V:** Visualization
- **A:** Auscultation
- **E:** EtCO2
- **X:** X-Ray

Additional Information

- Technique may be identified by ED physician (or designee)
- May attach a copy of the waveform Capnography printout as an alternate means of verifying tube placement (physician signature is not required if waveform is attached)

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

PATIENT DISPOSITION

Definition

Checkbox indicating the emergency department disposition of the patient

Field Values

- **E:** Expired in the Emergency Department
- **A:** Admitted or transferred to another facility

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

PLACEMENT

Definition

The receiving facility physician's determination of the anatomical position of the endotracheal tube or King LTS-D placed by EMS personnel

Field Values

- **T:** Tracheal
- **E:** Esophageal
- **R:** Right Main

Additional Information

- May attach a copy of the waveform Capnography printout as an alternate means of verifying tube placement (physician signature is not required if waveform is attached)

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

SIGNED VERIFICATION

Definition

Checkbox indicating whether or not a signed verification of endotracheal tube or placement was obtained by EMS personnel

King LTS-D

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- May attach a copy of the waveform Capnography printout as an alternate means of verifying tube placement (physician signature is not required if waveform is attached)

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

MULTIPLE CASUALTY INCIDENT (MCI) FORM

INCIDENT INFORMATION SECTION

Definition

The top section of the MCI Form that needs to be completely filled out if a MCI form is used

Field Values

- Date: Date of the incident, enter in MMDDYYYY format
- Base Contact: Three-letter code of the base hospital contacted
- Total Patients: Total number of patients at the incident
- Inc. #: Incident number assigned by the 911 or Dispatch Center
- Location: Location of the incident
- Signature(s): Signature(s) of the ALS personnel completing the form
- Juris. Station: Fire station in whose jurisdiction the incident occurred
- Zip Code: Zip code of the incident location
- Prov: Two-letter code of the provider agency responding to the incident
- ALS/BLS: The highest capability of care for the responding provider unit
- Unit: The unit letter and number designation for the responding provider unit
- Disp: Time of day the provider was notified by dispatch of the incident
- Arrival: Time of day the responding unit arrived at the incident location
- At Pt: Time of day provider reached the patient at the incident location
- Left: Time of day provider left the incident location with the patient
- Team Member ID: The identification number of personnel involved in the patient's care

Additional Information

- The first EMS provider on scene initiates the MCI form
- MCI form may be used for incidents involving three or more patients, each form should contain no less than three patient records
- Complete each area accurately
- This section **must** remain attached to all patient sections for the EMS Agency (yellow) copy. There is critical date and incident information that can only be found in this area. Detachment of the top section invalidates all patient documentation

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

PATIENT ASSESSMENT SECTION

Definition

The section of the MCI Form where the patient assessment, patient's GCS, and triage category should be documented

Field Values

- Sequence Number/Pt #: The sequence number assigned to the section of the MCI from and the patient number for the incident
- Triage Categories: Four categories which correspond to Triage Tags commonly used in LA County
- Age: The age and age units of the patient
- Gender: Checkbox indicating the patient's gender
- Triage Tag #: Number that corresponds to the printed number on the triage tag that is on the patient
- Patient Name: The patient's first and last name
- GCS: The patient's Glasgow Coma Scale
- Vital Signs: The patient's blood pressure (BP) or cap refill if using the START system, pulse, and respirations
- Chief Complaint: Two-letter code(s) representing the patient's most significant medical or trauma complaints
- Mech of Inj.: Two-letter code(s) indicating how the patient was injured
- Field Decontamination: Checkbox indicating that some form of field decontamination , such as showering, has occurred

Additional Information

- Complete each area accurately

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

TREATMENT

Definition

The section of the MCI Form that where treatments performed on the patient should be documented

Field Values

- O2: O2 was delivered to the patient
- IV: An IV was placed on the patient
- Sp. Immobil.: Patient was placed in spinal motion restriction
- Meds: Medication was given to the patient, document medication name, dose, and route on the line provided

Uses

- Assists with determination of appropriate treatment and transport
- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

AMA

Definition

Checkbox indicating that the patient signed out against medical advice

Field Values

- **Y**: Yes
- **N**: No

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provider

TRANSPORT SECTION

Definition

The section of the MCI Form where the transport information related to the patient should be documented

Field Values

- Transported By: Unit (ALS) - the number of the ALS unit that transported the patient

  Unit (BLS) - the number of the BLS unit that transported the patient

  Time: time of day the transporting unit left the scene with the patient
- Transported Via: Checkboxes indicating whether the patient was transported ALS, BLS, or not transported
- Rec Facility: Space to write in the three-letter code that corresponds to the facility to which the patient was transported
- Trans To: Checkbox indicating the destination of the patient

Uses

- Assists with determination of appropriate treatment and transport
- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS provideR

BASE HOSPITAL FORM INSTRUCTION MANUAL

Los Angeles County

Emergency Medical Services Agency

TABLE OF CONTENTS

COMMON NULL VALUES

Definition

These values are to be used with each of the data elements described in this document which have been defined to accept the Null Values

Field Values

- F6: Not Documented
- F7: Not Applicable

Additional Information

- For any collection of data to be of value and reliably represent intended information, a strong commitment must be made to ensure that data collected are complete and accurate.
- Not Documented: This null value code applies if the documentation being referenced has nothing recorded in a specific field)
- Not Applicable: This null value code applies if the data field referenced does not apply to the patient (e.g., “Reason for No Transport” if patient was transported)

GEN INFO SECTION

LOG

Definition

Number assigned by the hospital to each base contact that coincides with its numbered entry on a base contact log

Additional Information

- Mandatory field for all base hospital contacts
- Format is unique to each individual hospital

Uses

- Unique patient identifier
- Assists in locating the coinciding audio file

Data Source Hierarchy

- Base Hospital Log
- Base Hospital Form

MCI PATIENT?

Definition

Field indicating whether or not incident involved three or more patients

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- Field is autofilled with “N” unless changed by user to “Y”

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

SEQUENCE NUMBER

Definition

Unique, alphanumeric EMS record number provided by the paramedic, and found pre-printed at the top right corner of EMS report form hard copies. Electronically assigned to ePCRs from approved providers

Additional Information

- Mandatory Field for all base hospital contacts: electronic data entry cannot begin without this number
- Consists of two letters and six digits on pre-printed EMS Report Forms; or two letters, ten digits if obtained from an approved ePCR provider
- If sequence number is missing or incorrectly documented, every effort must be taken by the base hospital to obtain it – either by reviewing the audio recording, or by contacting the appropriate provider agency directly. Only after all efforts to obtain the actual sequence number have been exhausted may a request be made of the EMS Agency for assistance, or as a last resort, a 'dummy' sequence number, in a **timely** fashion

Uses

- Unique patient identifier
- Essential link between other EMS Agency databases

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- Base Hospital Log
- Audio records
- Fire Station logs
- EMS Agency

PG 2

Definition

Checkbox indicating that a Base Hospital Form supplemental page was used

Uses

- Use when space is needed for additional Drugs, ECGs, Treatments, and/or Comments

Data Source Hierarchy

- Base Hospital Form Page 2
- Base Hospital Form

DATE

Definition

Date of base hospital contact

Field Values

- Collected as MMDDYYYY

Additional Information

- Mandatory field for all base hospital contacts

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log

TIME

Definition

Time of day that base hospital contact was initiated

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- Mandatory field for all base hospital contacts

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log

LOCATION

Definition

Two-letter code indicating where the incident occurred

Field Values

AI	Airport	NH	Nursing Home
AM	Ambulance	OF	Office
BE	Beach	PA	Park
CL	Cliff/Canyon	PL	Parking Lot
DC	Dialysis Center	PV	Public Venue/Event
DO	Doctor's Office/Clinic	RE	Restaurant
FR	Freeway	RL	Religious Building
FS	Fire Station	RS	Retail/Store
HO	Home	SC	School
IN	Industrial	ST	Street
JA	Jail	OT	Other
MC	Hospital/Medical Center		

Additional Information

- Mandatory field for all base hospital contacts
- Location codes are listed on the back of pages 1 and 4 of the Base Hospital Form
- Additional details can be written on the adjacent line: e.g., the name of the facility or business, or any other useful information

Uses

- Allows for data sorting and tracking by incident location
- Epidemiological statistics

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

PROVIDER CODE

Definition

Two-letter code for the EMS provider primarily responsible for the patient's prehospital care

Field Values

PUBLIC PROVIDERS			
AF	Arcadia Fire	LV	La Verne Fire
AH	Alhambra Fire	MB	Manhattan Beach Fire
AV	Avalon Fire	MF	Monrovia Fire
BA	Burbank Airport Fire	MO	Montebello Fire
BF	Burbank Fire	MP	Monterey Park Fire
BH	Beverly Hills Fire	OT	Other Provider
CB	LA County Beaches	PF	Pasadena Fire
CC	Culver City Fire	RB	Redondo Beach Fire
CF	LA County Fire	SA	San Marino Fire
CG	US Coast Guard	SG	San Gabriel Fire
CI	LA City Fire	SI	Sierra Madre Fire
CM	Compton Fire	SM	Santa Monica Fire
CS	LA County Sheriff	SP	South Pasadena Fire
DF	Downey Fire	SS	Santa Fe Springs Fire
ES	El Segundo Fire	TF	Torrance Fire
FS	U.S. Forest Service	UF	Upland Fire
GL	Glendale Fire	VE	Ventura County Fire
HB	Hermosa Beach Fire	VF	Vernon Fire
LB	Long Beach Fire	WC	West Covina Fire
LH	La Habra Heights Fire		
PRIVATE PROVIDERS			
AA	American Professional Ambulance Corp.	IA	Impulse Ambulance
AC	Americare Ambulance Service	LT	Liberty Ambulance
AD	AmeriPride Ambulance	MI	MedResponse, Inc.
AE	Aegis Ambulance Service	ML	Med-Life Ambulance
AM	Adult Medical Transportation	MR	MedReach Ambulance
AN	Antelope Ambulance Service	MT	MedCoast Ambulance
AR	American Medical Response	MY	Mercy Air
AT	All Town Ambulance, LLC	PN	PRN Ambulance, Inc.
AU	AmbuServe Ambulance	PT	Priority One
AW	AMWest Ambulance	RE	REACH Air Medical Service
BO	Bowers Companies, Inc.	RR	Rescue Services (Medic-1)
CA	CARE Ambulance	RY	Royalty Ambulance
EA	Emergency Ambulance	SC	Schaefer Ambulance
EL	Elite Ambulance	SY	Symons Ambulance
EX	Explorer 1 Ambulance & Medical Services	TR	Trinity Ambulance
GC	Gentle Care Transport	WE	Westcoast Ambulance
GR	Gentle Ride Ambulance	WM	West Med/McCormick Ambulance Service
GU	Guardian Ambulance Service		

Additional Information

- Mandatory field for all base hospital contacts
- Refers to the EMS care provider establishing base contact – not the transport-only provider

Uses

- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form / Log
- Audio records

PROVIDER UNIT

Definition

Alphanumeric apparatus code consisting of type of vehicle + numeric vehicle identifier for the paramedic unit that establishes base contact

Field Values

- AB: Private Ambulance
- AT: Assessment Truck
- AE: Assessment Engine
- BK: Bike
- BT: Boat
- CT: Cart
- HE: Helicopter
- PE: Paramedic Engine
- PT: Paramedic Truck
- SQ: Squad
- RA: Rescue

Additional Information

- Mandatory field for all base hospital contacts
- This is a free-text field – the values above reflect those used by EMS providers

Uses

- System evaluation and monitoring

Data Hierarchy

- EMS Report Form
- Base Hospital Form
- Base Hospital Log
- Audio records

PT. # __ OF __

Definition

Number identifying the patient amongst the total number of patients involved in an incident

Additional Information

- If there is only one patient write “Pt.# 1 of 1”
- If there are two patients, and the patient is identified by the paramedics as the second patient, write “Pt.# 2 of 2”

Uses

- Assists with patient identification and tracking
- Identifies multiple-patient incidents
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Base Hospital Log
- Audio records

AGE

Definition

Numeric value for the age (actual or best approximation) of the patient

Field Values

- Enter the numeric age value

Additional Information

- Mandatory field for all base hospital contacts
- Must also indicate unit of age
- If the age is estimated, mark the “Est.” checkbox

Uses

- Allows for data sorting and tracking by age
- Assists with patient identification
- Epidemiological statistics

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Base Hospital Log
- Audio records

AGE UNITS

Definition

Checkboxes indicating units of measurement used to report the age of the patient

Field Values

- **Y**rs: Years – used for patients 2 years old or older
- **M**os: Months – used for patients 1 month to 23 months old
- **W**ks: Weeks – used for patients whose age is reported in weeks instead of months
- **D**ays: Days – used for patients 1 to 29 days old
- **H**rs: Hours – used for patients who are newborn and up to 23 hours old

Additional Information

- Mandatory field for all base hospital contacts
- If the unit of age is estimated, mark the “Est.” checkbox

Uses

- Assists with patient identification
- Epidemiological statistics
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Base Hospital Log
- Audio records

SEX

Definition

Checkbox indicating the gender of the patient

Field Values

- **M**: Male
- **F**: Female

Additional Information

- Mandatory field for all base hospital contacts
- Patients who are undergoing or have undergone a hormonal and/or surgical sex reassignment should be coded using their stated preference
- Patients unable to state their preference should be coded according to paramedic observation/judgment

Uses

- Assists with patient identification
- Epidemiological statistics
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Base Hospital Log
- Audio records

WEIGHT

Definition

Numeric value of the weight of the patient

Field Values

- Up to three-digit numeric field

Additional Information

- Mandatory field for all pediatric patients and all adult patients for whom medications are ordered
- Must also indicate a unit of weight
- For pediatric patients, document the measured weight in kilograms obtained from the length-based pediatric resuscitation tape, if applicable
- If the pediatric patient is taller than the length-based pediatric resuscitation tape, mark the “Too Tall” checkbox, and obtain weight in estimated kilograms

Uses

- Assists with determination of appropriate treatment
- Epidemiological statistics

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

WEIGHT UNITS

Definition

Checkboxes indicating units of measurement used to report patient's weight

Field Values

- **K**g: Kilograms
- **L**bs.: Pounds

Additional Information

- Mandatory field for all pediatric patients, and all adult patients for whom medications are ordered
- For pediatric patients, document the measured weight in kilograms obtained from the length-based pediatric resuscitation tape, if applicable
- If the pediatric patient is taller than the length-based pediatric resuscitation tape, mark the "Too Tall" checkbox, and obtain weight in estimated kilograms

Uses

- Assists with determination of appropriate treatment
- Epidemiological statistics

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

PEDS WEIGHT COLOR CODE

Definition

Color that corresponds with the length of an infant or child as measured on a length-based pediatric resuscitation tape

Field Values

- Grey: **3**, **4**, or **5** kg (newborn infants)
- P**I**nk: 6-7 kg (~3 -6 mos)
- **R**ed: 8-9 kg (~7-10 mos)
- P**U**rple: 10-11 kg (~12-18 mos)
- **Y**ellow: 12-14 kg (~19-35 mos)
- **W**hite: 15-18 kg (~3-4 yrs)
- **B**lue: 19-22 kg (~5-6 yrs)
- **O**range: 24-28 kg (~7-9 yrs)
- Gr**E**en: 30-36 kg, or about 80 lbs (~10-12 yrs)
- **T**oo Tall: patient is longer than tape

Additional Information

- Mandatory field for all pediatric patients
- Document the measured weight in kilograms obtained from the length-based pediatric resuscitation tape, if applicable
- If the pediatric patient is taller than the length-based pediatric resuscitation tape, mark the "Too Tall" checkbox, and obtain weight in estimated kilograms

Uses

- Assists with determination of appropriate treatment
- Epidemiological statistics
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

HOSPITAL CODE

Definition

Three-letter code for the base hospital contacted

Field Values

AMH	Methodist Hospital of Southern California	NRH	Northridge Hospital Medical Center
AVH	Antelope Valley Hospital	PVC	Pomona Valley Hospital Medical Center
CAL	California Medical Center	PIH	PIH Health Hospital- Whittier
CSM	Cedars-Sinai Medical Center	QVH	Citrus Valley- Queen of the Valley Campus
GWT	Glendale Adventist Medical Center	SFM	Saint Francis Medical Center
HCH	Providence Holy Cross Medical Center	SJS	Providence St. Joseph Medical Center
HGH	LAC Harbor-UCLA Medical Center	SMM	Saint Mary Medical Center
HMH	Huntington Hospital	TOR	Torrance Memorial Medical Center
HMN	Henry Mayo Newhall Hospital	UCL	Ronald Reagan UCLA Medical Center
LCM	Providence Little Co. of Mary Torrance	USC	LAC-USC Medical Center
LBM	Long Beach Memorial Medical Center		

Additional Information

- Mandatory field for all base hospital contacts
- Codes are also listed on the back of pages 1 and 4 of the Base Hospital Form

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log

COMMUNICATION TYPE

Definition

Checkbox indicating the device used by the paramedic to establish base hospital contact

Field Values

- **R**adio: Radio
- **P**hone: Telephone
- **V**MED28: formerly known as Hospital Emergency Administrative Radio (HEAR)

Additional Information

- Mandatory field for all base hospital contacts

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form

CALL TYPE

Definition

Checkboxes indicating the level of EMS encounter

Field Values

- **F**ull Call: Paramedics establish base contact for online medical direction based upon a complete patient report (includes Against Medical Advice calls and calls downgraded from ALS to BLS)
- **S**FTP: Paramedics working for an authorized SFTP provider agency assess, treat, and transport patients according to existing protocols. Only limited patient and destination information is exchanged with the base hospital – no medical direction is given
- **J**oint Run: Paramedics for an authorized SFTP provider agency initially utilize existing protocols, but then establish base contact when patient has an additional complaint not covered by protocol, requires treatment beyond what is covered by protocol, or when additional medical direction or consultation is needed. A full patient report is then given and medical direction is provided by the base hospital.
- **I**nfo Only: Base hospital contact is established for the purpose of documenting information only when base hospital orders are not possible or practical (i.e., patient elopes prior to establishment of base contact, or patient arrives at the receiving facility before base contact was possible)
- IF**T** (Interfacility Transfer): Patient is being transferred via ALS from one acute care facility to another

Additional Information

- Mandatory field for all base hospital contacts
- An AMA call is considered to be a Full Call – not Info Only
- If a call is both an IFT and an SFTP, check the IFT box as the protocol number will be documented elsewhere and can be used to identify SFTP calls

Uses

- System evaluation and monitoring
- Establishes system participants' roles and responsibilities

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

ASSESSMENT SECTION

CHIEF COMPLAINT CODE

Definition

Two-letter code(s) representing the patient's most significant medical or trauma complaints

Field Values – Trauma Codes

- **N**o **A**pparent Injury (**NA**): No complaint, or signs or symptoms of injury following a traumatic event
- **BU**rns/Elec. Shock (**BU**): Thermal or chemical burn, or electric shock
- SBP <**90** (<70 if under 1y) (**90**): Systolic blood pressure less than 90mmHg in a patient greater than one year of age (or systolic blood pressure less than 70mmHg in a patient less than one year of age) following a traumatic event
- **RR** <10/>29 (<20 if <1y) (**RR**): A sustained respiratory rate greater than 29 breaths/minute, or respiratory rate of less than 10 breaths/minute (or less than 20 breaths/minute in a patient less than one year of age), following a traumatic event
- **S**usp. Pelvic F**X** (**SX**): Suspected pelvic fracture, excluding isolated hip fractures from a ground level fall
- **S**pinal **C**ord Injury (**SC**): Suspected spinal cord injury, or presence of weakness/paralysis/parasthesia following a traumatic event
- **I**npatient **T**rauma (**IT**): Interfacility transfer (IFT) of an admitted, injured patient from one facility to an inpatient bed at another facility, excluding ER to ER transfers
- Minor **L**acerations (**BL** or **PL**): Superficial or non-serious lacerations, abrasions, or contusions involving the skin or subcutaneous tissue, due to blunt or penetrating force
- **T**rauma Arrest (**BT** or **PT**): Cessation of cardiac output and effective circulation due to blunt or penetrating force
- **H**ead (**BH** or **PH**): Injury to the head or skull in the area from above the eyebrows to behind the ears, due to blunt or penetrating force. This code can also be applied in association with facial injuries when it is likely that the brain is involved
- GCS ≤**14** (**14**): Blunt force head injury associated with a Glasgow Coma Scale score of less than or equal to 14. Code may also be used when a strong index of suspicion for blunt head injury exists due to mechanism of injury and/or signs or symptoms such as seizures, unequal pupils, or focal neurological deficits
- **F**ace/mouth (**BF** or **PF**): Injury to the anterior aspect of the face, mouth, or skull, from and including the eyebrows, down to and including the angle of the jaw and the ears, due to blunt or penetrating force
- **N**eck (**BN** or **PN**): Injury or pain to the area between the angle of the jaw and clavicles (including probable cervical spine injuries) due to blunt or penetrating force
- **B**ack (**BB** or **PB**): Injury to the area from the shoulders to the buttocks (but not including the buttocks) due to blunt or penetrating force
- **C**hest (**BC** or **PC**): Injury to the anterior chest in the area between the clavicle and the xyphoid process, bordered on either side by the posterior axillary line, due to blunt or penetrating force
- **F**lail **C**hest (**FC**): Blunt force injury to the chest wall resulting in an unstable chest wall, characterized by paradoxical chest wall movement with respirations

- Tension **P**neum (**BP** or **PP**): Air enters the pleural space due to blunt or penetrating force, and creates pressure on chest organs. Signs and symptoms can include: SOB, tachypnea, decreased or absent lung sounds on one side, shock, neck vein distention, and/or tracheal deviation
- **A**bdomen (**BA** or **PA**): Injury to any of the abdominal quadrants, flanks, or pelvis due to blunt or penetrating force
- **D**iffuse Abd. Tender. (**BD**): Blunt force injury to the abdomen resulting in tenderness in two or more quadrants
- **G**enitals/Buttoc**K**s (**BG**, **BK**, **PG** or **PK**): Injury to the external reproductive structures or buttocks due to blunt or penetrating force
- **E**xtremities (**BE** or **PE**): Injury or pain to the shoulders, arms, hands, legs, or feet due to blunt or penetrating force
- E**X**tr ↑ knee/elbow (**PX**): Penetrating force injury to an extremity, proximal to (above) the knee or elbow
- F**R**actures ≥ 2 long bones (**BR**): Blunt force injury resulting in apparent fracture of 2 or more proximal long bones (humerus, femur)
- Amputat**I**on ↑ wrist/ankle (**BI** or **PI**): Amputation proximal to (above) the wrist or ankle due to blunt or penetrating force
- Neur/**V**asc/Mangled (**BV** or **PV**): Injury to an extremity with neurological and/or vascular compromise, or that is crushed, degloved, or mangled due to blunt or penetrating force

Field Values – Medical Codes

- **A**gitated **D**elirium (**AD**): Acute onset of extreme agitation and combative or bizarre behavior that may be accompanied by paranoid delusions, hallucinations, aggression with unusual increase in human strength, and hyperthermia
- **A**bd/**P**elvic Pain (**AP**): Pain or discomfort in the abdomen or pelvic region not associated with trauma
- **A**llergic **R**eaction (**AR**): Acute onset of rash, hives, itching, redness of the skin, runny nose, facial and/or airway swelling, wheezing, shortness of breath, and/or abdominal pain in apparent reaction to ingestion or contact with a substance The patient may have been in contact with a known allergen (shellfish, milk products, etc.)
- **A**ltered **L**OC (**AL**): Any state of arousal other than normal, such as confusion, lethargy, combativeness, coma, etc., not associated with trauma
- **A**pneic **E**pisode (**AE**): Episode of cessation of respiration for a brief or prolonged period of time
- Apparent Life **T**hreatening **E**vent (**TE**): Also known as “ALTE” – any combination of transient apnea, color change, marked change in muscle tone, and choking and/or gagging in children less than 1yr of age, that is frightening to the observer
- B**EH**avioral (**EH**): Abnormal behavior of apparent mental or emotional origin
- Bleeding **O**ther **S**ite (**OS**): Bleeding from a site not elsewhere listed that is not associated with trauma (e.g. dialysis shunt)
- **C**ardiac **A**rrest (**CA**): Sudden cessation of cardiac output and effective circulation not associated with trauma
- **C**hest **P**ain (**CP**): Pain in the anterior chest occurring anywhere from the clavicles to the lower costal margins not associated with trauma

- **CH**oking/Airway Obstruction (**CH**): Acute onset of apnea, choking and/or difficulty breathing due to apparent partial or complete obstruction of the airway
- **C**ough/**C**ongestion (**CC**): Cough and/or congestion in the chest, nasal passages, or throat
- **D**evice **C**omplaint (**DC**): Any complaint associated with a patient's existing medical device (e.g. G-tube, AICD, ventilator, etc.)
- **DI**zzy (**DI**): The patient complains of sensation of spinning or feeling off-balance. If associated with complaint of weakness, code both complaints
- **DO**A (**DO**): Patient is determined to be dead upon arrival of EMS, as per the Prehospital Care Manual
- **DY**srhythmia (**DY**): Cardiac monitor indicates an abnormal cardiac rhythm (SVT, VT, etc.)
- **FE**ver (**FE**): Patient exhibits or complains of an elevated body temperature
- **F**oreign **B**ody (**FB**): Patient complains of a foreign body anywhere in the body
- **GI** Bleed (**GI**): Signs or symptoms of gastrointestinal bleeding such as vomiting blood, coffee-ground emesis, melena, rectal bleeding, etc.
- **H**ead **P**ain (**HP**): Headache or any other type of head pain not associated with trauma
- **HY**poglycemia (**HY**): Patient is symptomatic and has a measured blood glucose level that is below normal
- **I**npatient **M**edical (**IM**): Interfacility transfer (IFT) of an admitted, ill (not injured) patient from one facility to an inpatient bed at another facility
- **LA**bor (**LA**): Patient is greater than 20 weeks pregnant, and experiencing signs or symptoms of labor such as uterine contractions, vaginal bleeding, spontaneous rupture of membranes, crowning, etc.
- **L**ocal **N**euro Signs (**LN**): Weakness, numbness, or paralysis of a body part or region – including slurred speech, facial droop, and/or expressive aphasia
- **N**ausea/**V**omiting (**NV**): Patient is vomiting, or complains of nausea and/or vomiting
- **N**ear **D**rowning (**ND**): Submersion causing water inhalation, unconsciousness, or death
- **N**eck/**B**ack Pain (**NB**): Pain in any area from base of skull and the shoulders to the buttocks not associated with trauma
- **NeW**born (**NW**): Newborn infant delivered out of the hospital setting
- **N**o Medical **C**omplaint (**NC**): No complaint, or signs or symptoms of illness in a patient not involved in a traumatic event
- **NO**sebleed (**NO**): Bleeding from the nose, not associated with trauma
- **OB**stetrics (**OB**): Any complaints, signs, or symptoms which may be related to a known pregnancy (e.g., bleeding, abdominal pain/cramping, high blood pressure, edema, convulsions, severe headaches)
- **O**ther **P**ain (**OP**): Complaint of pain at a site not listed, and which is not associated with trauma (e.g. tootheache, ear pain, etc.)
- **O**ver**D**ose (**OD**): Ingestion of or contact with a drug or other substance in quantities greater than recommended or generally practiced
- **PO**isoning (**PO**): Ingestion of or contact with a toxic substance
- **P**alpitation**S** (**PS**): Sensation that the heartbeat is irregular or fast
- **R**espiratory **A**rrest (**RA**): Sudden cessation of breathing not associated with trauma
- **SE**izure (**SE**): Convulsions or involuntary body movements or gaze (not associated with trauma), or signs, symptoms, or history of recent seizure

- **S**hortness of **B**reath (**SB**): Sensation of not being able to catch one's breath, and/or signs or symptoms of difficulty breathing such as gasping, wheezing, rapid respiratory rate, cyanosis, retractions, use of accessory muscles, etc.
- **SY**ncope (**SY**): Transient loss of consciousness, including sensation of "near syncope" when other associated symptoms such as weakness/dizziness do not apply
- **VA**ginal Bleeding (**VA**): Abnormal vaginal bleeding
- **WE**akness (**WE**): Patient complains of feeling weak, or exhibits signs or symptoms of decreased strength and/or muscle tone
- **OT**her (**OT**): Signs or symptoms not listed above, that are not associated with trauma

Additional Information

- Mandatory field for all base hospital contacts
- If the patient has multiple complaints, enter in order of significance
- Two-letter codes for trauma can be derived from the bolded, capitalized letters in the Trauma area of the Base Hospital Form
- Medical complaint codes are found on the back of pages 1 and 4 of the Base Hospital Form
- Medical complaints should not be documented with trauma complaints, unless it is suspected that a medical complaint preceded/caused the injury, or vice versa (e.g., chest pain/dizziness that caused an MVA, or seizure activity following a blow to the head.) Do not document a medical complaint such as "HP" (head pain) if the pain is due to a gunshot wound to the head – instead use only the trauma code of "PH."

Uses

- System evaluation and monitoring
- Epidemiological statistics

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Base Hospital Log
- Audio records

SEVERITY OF DISTRESS

Definition

Checkboxes indicating paramedics' impression of the level of discomfort or severity of illness of the patient, based on assessment of signs, symptoms, and complaints

Field Values

- **N**one: The patient appears well and has no acute signs or symptoms related to the incident. Advanced life support techniques and transportation may not be necessary
- Mil**D**: Indicates that the patient does not have a life-threatening problem. Advanced life support techniques and transportation may not be necessary
- **M**oderate: Patient may have a life-threatening problem, or the degree of patient discomfort is high. Advanced life support techniques, base hospital contact, and patient transportation are usually necessary
- **S**evere: Refers to a life-threatening condition. Advanced life support techniques, base hospital contact, and patient transportation are generally necessary

Additional Information

- Mandatory field for all base hospital contacts

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

mLAPSS MET

Definition

Checkboxes indicating whether or not patient met all Modified Los Angeles Prehospital Stroke Screen (mLAPSS) criteria as defined in Reference 521 – Stroke Patient Destination

Field Values

- **Y**: Yes, patient met all mLAPSS criteria
- **N**: No, patient did not meet all mLAPSS criteria

Additional Information

- mLAPSS criteria include:
    1. Symptom duration of less than 6 hours
    2. No history of seizures or epilepsy
    3. Age ≥ 40
    4. At baseline, patient is not wheel-chair bound or bedridden
    5. Blood glucose value between 60 and 400mg/dL
    6. Obvious asymmetry or unilateral weakness is observed in one or more of the following:
        - Facial Smile/Grimace
        - Grip
        - Arm Strength
- Mandatory field for all patients with a chief complaint of “LN” or with a destination of Primary Stroke Center, “PSC”, or Comprehensive Stroke Center, “CSC”
- If mLAPSS performed, blood glucose value must also be documented
- Patients who meet mLAPSS criteria should also have a LAMS performed and be transported, at a minimum, to the nearest available PSC

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- ASC Log
- Audio records

LAST KNOWN WELL DATE

Definition

Date when the patient was last known to be well, symptom-free, or at baseline or usual state of health

Field Values

- Collected as MMDDYYYY

Additional Information

- Mandatory field for all patients with a “Y” value for “mLAPSS Met” or with a destination of “PSC” or “CSC” for suspected stroke
- If unknown, enter “Not Applicable” (F7)

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- ASC Log
- Audio records

LAST KNOWN WELL TIME

Definition

Time of day when the patient was last known to be well, symptom-free, or at baseline or usual state of health

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- Mandatory field for all patients with a “Y” value for “mLAPSS Met” or with a destination of “PSC” or “CSC” for suspected stroke
- If unknown, enter “Not Applicable” (F7)

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- ASC Log
- Audio records

LAMS SCORE

Definition

Patient's total score for the Los Angeles Motor Scale (LAMS)

Field Values

- Numeric value range from 0 to 5

Additional Information

- LAMS includes 3 components:
    1. Facial Droop
        - Absent=0
        - Present=1
    2. Arm Drift
        - Absent=0
        - Drifts Down=1
        - Falls Rapidly=2
    3. Grip Strength
        - Normal=0
        - Weak Grip=1
        - No Grip=2
- Mandatory field for all patients with a "Y" value for "mLAPSS Met"
- Patients with a LAMS score of < 4 should be transported to the nearest available PSC
- Patients with a LAMS score of ≥ 4 should be transported to the nearest available CSC

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- ASC Log
- Audio records

PROTOCOL

Definition

Four-digit numeric code of the Standing Field Treatment Protocol (SFTP) utilized by approved SFTP providers

Field Values

General Advanced Life Support			
1202	General ALS		
Dysrhythmias			
1210	Non-Traumatic Cardiac Arrest (Adult)		
Medical			
1243	Altered Level of Consciousness	1249	Respiratory Distress
1244	Chest Pain	1250	Seizure (Adult)
1247	Overdose/Poisoning (Suspected)	1251	Stroke/Acute Neurological Deficits
1248	Pain Management	1252	Syncope
Pediatrics/Childbirth			
1261	Emergency Childbirth - Mother	1264	Pediatric Seizure
1262	Emergency Childbirth – Newborn		
Trauma			
1271	Burns	1277	Traumatic Arrest
1275	General Trauma		

Community Paramedicine Pilot Project			
1400*	Meets Inclusion Criteria & Transported to an UCC	1404*	Meets Inclusion Criteria But Patient Refused UCC
1401*	Meets Inclusion Criteria But Not Transported to an UCC Due to Geography or Time Constraints	1405*	Meets Inclusion Criteria But Outside the Normal UCC Operating Hours
1402*	Meets Inclusion Criteria But the UCC is Closed Due to Saturation	1406^	Patients Requiring Emergent Transfer From the UCC to an Acute-Care Facility
1403*	Meets Inclusion Criteria But Refused by UCC MD		

Additional Information

- Mandatory field for all SFTP and Joint call types
- More than one protocol can be used
- Protocol identified must match the patient's chief complaint
- *Community Paramedicine Pilot Project protocols – REFERENCE ONLY
- ^1406 is the only Community Paramedicine Pilot Project protocol that should be entered if reported by a participating provider

Uses

- Allows for data sorting and tracking by protocol
- System evaluation and monitoring
- Epidemiological statistics

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

O/P, Q, R, S, T

Definition

Acronym used as a tool to assess and document the following symptom attributes:

- O/P: Onset/Provocation
- Q: Quality
- R: Region/Radiation/Relief
- S: Severity
- T: Time

Field Values

- Free text

Uses

- Prompts thorough assessment and documentation of patient's symptoms
- Assists with determination of appropriate treatment and transport

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

DNR/AHCD/POLST?

Definition

Checkbox indicating presence of a valid DNR, Advance Healthcare Directive (AHCD), or Physician Order for Life Sustaining Treatment (POLST) form for the patient

Field Values

- **Y**: Yes
- **N**: No
- **U**: Unknown

Additional Information

- EMS personnel need not validate authenticity of document provided – should provide base hospital with the type of document and its contents

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- DNR/AHCD/POLST
- Audio Records

MEDICAL HX

Definition

Space to indicate previous medical problem(s) experienced by the patient, if applicable

Field Values

- Free text

Uses

- Prompts thorough assessment and documentation of patient's symptoms
- Assists with determination of appropriate treatment and transport

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

MEDICATIONS

Definition

Space to indicate medications currently being taken by the patient, if applicable

Field Values

- Free text

Additional Information

- Indicate patient compliance, if applicable
- Include nonprescription drugs and herbal supplements

Uses

- Assists with determination of appropriate treatment and transport

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

ALLERGIES

Definition

Checkbox and space to indicate patient history of adverse reactions or allergies to medications or other substances, if applicable

Field Values

- Free text, or
- NKA: No known allergies checkbox

Additional Information

- If the patient has no known allergies, mark the “NKA” box
- Allergies to non-medication items may be listed if they are related to the current problem or potential treatments (e.g., adhesive tape, or latex)

Uses

- Patient safety

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

PRIOR TO BASE MEDS

Definition

Checkboxes and spaces indicating medications and dosages administered prior to base contact, if applicable

Field Values

ADE	Adenosine	NAR	Narcan
ALB	Nebulized Albuterol	NTG	Nitroglycerin
ASA	Aspirin	OND	Ondansetron
EPI	Epinephrine	Morphine	Morphine Sulfate
FEN	Fentanyl	D50/25/10	D50W/D25W/D10W
MID	Midazolam	GLU/GLP	Glucagon/ Glucose Paste

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

PRIOR TO BASE TXS

Definition

Checkboxes indicating treatments rendered prior to base contact, if applicable

Field Values

BVM	Bag Valve Mask Ventilation	**CAR**	Cardioversion
CPAP	Continuous Positive Airway Pressure	**TC**P	Transcutaneous Pacing
ETT	Endotracheal Tube Intubation	**A**ED- **A**nalyzed	AED Analyzed Rhythm
King	King Airway	**A**ED- **D**efibrillated	AED Defibrillated Patient
SMR	Spinal Motion Restriction	Needle **TH**oracost.	Needle Thoracostomy
GLucometer	Glucometer Reading	Tourniquet (**TK**)	Tourniquet
DEFibrillated X	Number of defibrillation attempts	**OT**her	Other Treatment Not Listed
King	King Airway		

Additional Information

- Checked Glucometer checkbox should be accompanied by the reading obtained
- Checked Defibrillated checkbox should be accompanied by the number of times performed

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

PHYSICAL SECTION

LOC

Definition

Checkboxes indicating the patient's initial level of consciousness

Field Values

- **A**lert: Patient is awake and responsive to the environment
- **O** X 3: Patient is oriented to person, time, and place
- **D**isoriented: Patient is not oriented to person, time, and/or place
- **C**ombative: Patient is physically resistant to interaction with on-scene personnel
- No**T** Alert: Patient is awake, but is drowsy or lethargic – may include intoxicated patients
- Nor**M**al for Patient: Patient's behavior, although not typical of most patients, is reported by family, caregivers, etc., to be the same as it was before the incident (e.g., patients who suffer from mental illness, dementia, developmental delays, etc.) Can also be used for infants and children who are age appropriate
- No **R**esponse: Patient is unresponsive to verbal and painful stimuli

Additional Information

- Mandatory field for all Full Call base hospital contacts
- Mark all that apply

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

IUP_ WKS

Definition

Checkbox and space indicating the number of weeks of intrauterine pregnancy, if applicable

Additional Information

- Patients may only be able to provide the number of months, not weeks, of their pregnancy – in this case, pregnancies reported of greater than 4½ months can be assumed to be greater than 20 weeks
- Patients injured while pregnant meet trauma triage special considerations for transport to a trauma center due to risk to the fetus – not the mother

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

SUSPECTED DRUGS/ETOH

Definition

Checkbox indicating that the situation, patient behavior, or statements made by the patient, family members or bystanders cause the paramedics to suspect that chief complaint may be related to alcohol and/or drug use

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

EYE

Definition

Checkboxes indicating the Glasgow Coma Scale numerical value that corresponds to the patient's initial eye opening response to stimuli

Field Values

- **4**: Spontaneous – opens eyes spontaneously, no stimuli required
- **3**: To Verbal – opens eyes only when spoken to or asked
- **2**: To Pain – opens eyes only in response to noxious stimuli such as sternal rub or nail bed pressure
- **1**: None – patient does not open eyes in response to noxious stimuli

Additional Information

- Mandatory field for all Full Call and General Trauma protocol base hospital contacts
- GCS eye opening values are the same for adult and pediatric patients

Uses

- Element necessary to calculate the overall GCS score
- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

VERBAL

Definition

Checkboxes indicating the Glasgow Coma Scale numerical value that corresponds to the patient's initial verbal response to stimuli

Field Values – Adult and Verbal Pediatric Patients

- **5**: Oriented x 3 – patient is oriented to person, time, and place
- **4**: Confused – patient may respond to questions coherently, but is disoriented or confused
- **3**: Inappropriate – random words or speech unrelated to questions or conversation
- **2**: Incomprehensible – makes incoherent sounds or moans only
- **1**: None – patient has no verbal response to noxious stimuli

Field Values – Infants and Toddlers

- **5**: Smiles and tracks objects, speech appropriate for age
- **4**: Cries but consolable, or confused
- **3**: Inconsistently consolable, or random words
- **2**: Moaning, incoherent sounds only
- **1**: No verbal response to noxious stimuli

Additional Information

- Mandatory field for all Full Call and General Trauma protocol base hospital contacts

Uses

- Element necessary to calculate the overall GCS score
- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

MOTOR

Definition

Checkboxes indicating the Glasgow Coma Scale numerical value that corresponds to the patient's initial motor response to stimuli

Field Values

- **6**: Obedient – obeys verbal commands / spontaneous purposeful movement
- **5**: Purposeful – purposeful movement is made in response to noxious stimuli (e.g., attempts to push away or grab source of stimuli
- **4**: Withdrawal – withdraws body part from source of noxious stimuli
- **3**: Flexion –extremities move towards body core in response to noxious stimuli (decorticate posturing)
- **2**: Extension – extremities move away from body core in response to noxious stimuli (decerebrate posturing)
- **1**: None – patient has no motor response to noxious stimuli

Additional Information

- Mandatory field for all Full Call and General Trauma protocol base hospital contacts
- GCS motor values are the same for adult and pediatric patients

Uses

- Element necessary to calculate the overall GCS score
- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

TOTAL GCS

Definition

Sum of the initial three numerical values documented for each element of the Glasgow Coma Scale.

Field Values

- One- or two-digit numeric value between 3 and 15

Additional Information

- Maximum total score is 15, which is considered normal. Minimum score possible is 3, which may indicate severe or fatal brain injury
    - 3 to 8 may indicate severe brain injury
    - 9 to 13 may indicate moderate brain injury
    - 14 or 15 may indicate mild or no brain injury
- Space is provided for documentation of a repeat GCS, if applicable

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

PUPILS

Definition

Checkboxes indicating findings from assessment of the patient's initial pupillary response to light

Field Values

- **P**ERL: Pupils are equal in size and react to light
- **U**nequal: Pupils are unequal in size
- **F**ixed/Dilated: Pupils are dilated and do not react to light
- **C**ataracts: Cataracts in one or both eyes interfere with pupil exam
- **S**luggish: Pupils react to light slower than normal

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

RESPIRATION

Definition

Checkboxes indicating findings from initial assessment of the patient's respiratory system

Field Values

- **C**lear: No abnormal sounds are heard on auscultation
- **N**ormal rate/effort: Breathing appears effortless and rate is within normal limits for patient
- **W**heezes: Coarse, whistling sound heard on auscultation, associated with inspiration and/or expiration
- **R**ales: Rattling or crackling noises heard on auscultation, associated with inspiration
- R**H**onchi: Coarse, rattling or snoring sound heard on auscultation, associated with inspiration and/or expiration
- S**T**ridor: High-pitched, audible wheezing sound associated with inspiration and/or expiration
- **S**noring: Prolonged snorting sound/soft palate vibration that is audible during inspiration
- Tidal Volume:
  - **N**: Normal depth of inspiration is observed
  - **+**: Increased depth of inspiration is observed
  - **-**: Decreased depth of inspiration is observed
- Accessory **M**uscle Use: Patient is using additional muscles to assist with difficulty breathing, such as those of the neck, shoulders, or abdomen
- **L**abored: Breathing appears to be difficult or requires extra effort
- **U**nequal: Chest rise or breath sounds diminished on one side
- **A**pnea: Patient is not breathing or stops breathing for periods of time
- **J**VD: Distended jugular veins are observed in the supine patient
- Capnography #: The initial numerical CO_2 measurement from the capnometer
- Waveform: Indicates whether or not a waveform is observed on the capnography tracing:
  - **Y**es
  - **N**o

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

ADV AIRWAY

Definition

Checkboxes indicating initial assessment of findings after placement of an advanced airway, if applicable

Field Values

- BS after ETT/King: Mark appropriate box to indicate whether or not breath sounds are auscultated after placement of an endotracheal tube or King LTs-D
  - **Y**es
  - **N**o
- $ETCO_2$: Mark appropriate box to indicate presence or absence of CO_2 detected after placement of an endotracheal tube or King LTs-D:
  - **+**: present
  - **–**: absent

Additional Information

- Mandatory field for all patients with advanced airway placement in the field

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

SKIN

Definition

Checkboxes indicating findings from assessment of the patient's initial skin signs

Field Values

- **N**ML: All aspects of skin assessment are normal (color, temperature, moisture, and appearance)
- **P**ale: Skin appears abnormally pale, ashen, or gray
- Coo**L**/Cold: Skin feels cool or cold to touch
- **D**iaphoretic: Skin is sweaty or moist to touch
- **C**yanotic: Skin or lips appear blue
- **H**ot: Skin feels warmer than normal or hot to touch
- **F**lushed: Skin appears red
- Cap Refill No**R**mal: Capillary refill is less than or equal to 2 seconds
- Cap Refill D**E**layed: Capillary refill is greater than 2 seconds

Additional Information

- Capillary refill must be completed for all pediatric patients without a documented systolic blood pressure

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

GLUCOMETER

Definition

Numeric value of the patient's blood glucose measurement, if applicable

Field Values

- Up to three-digit numeric value
- #1: The initial blood glucose level
- #2: The second blood glucose level, if applicable

Additional Information

- Mandatory field if mLAPSS is performed **OR** if Protocol 1251 is utilized
- If equipment used yields an alpha reading indicating blood sugar is "LOW," enter the number "1"
- If equipment used yields an alpha reading indicating blood sugar is "HIGH," enter the number "999"

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

ECG/ARREST

INITIAL RHYTHM

Definition

Two- or three-letter code indicating patient's initial cardiac rhythm from the cardiac monito

Field Values

1HB	1st Degree Heart Block	PEA	Pulseless Electrical Activity
2HB	2nd Degree Heart Block	PM	Pacemaker Rhythm
3HB	3rd Degree Heart Block	PST	Paroxysmal Supraventricular Tachycardia
AFI	Atrial Fibrillation	PVC	Premature Ventricular Contraction
AFL	Atrial Flutter	SA	Sinus Arrhythmia
AGO	Agonal Rhythm	SB	Sinus Bradycardia
ASY	Asystole	SR	Sinus Rhythm
AVR	Accelerated Ventricular Rhythm	ST	Sinus Tachycardia
IV	Idioventricular Rhythm	SVT	Supraventricular Tachycardia
JR	Junctional Rhythm	VF	Ventricular Fibrillation
PAC	Premature Atrial Contraction	VT	Ventricular Tachycardia
PAT	Paroxysmal Atrial Tachycardia		

Additional Information

- Mandatory field for all patients who are placed on a cardiac monitor
- ECG codes are also found on the back of pages 1 and 4 of the Base Hospital Form
- Additional cardiac rhythm information can be documented in the Assessment section

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- ECG strip
- Audio Records

12 LEAD ECG @

Definition

Time of day that a 12-lead ECG was performed, if applicable

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- Mandatory field for all base hospital contacts where either the software or EMS interpretation of the 12 lead ECG indicates STEMI
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, enter the 12-lead time from the STEMI ECG in this field

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- ECG strip
- SRC Log
- Audio records

SOFTWARE INTERPRETATION
☐ NORMAL ☐ ABNORMAL ☐ STEMI

Definition

Checkbox indicating the software's interpretation of 12-lead ECG, if applicable

Field Values

- **N**orma**L**: Electronic interpretation indicates ECG is normal
- **AB**normal: Electronic interpretation indicates ECG is abnormal
- STE**MI**: Electronic interpretation indicates an ST-Elevation Myocardial Infarction, or manufacturer's equivalent

Additional Information

- Mandatory field for all patients on whom a 12-lead ECG is performed
- If electronic interpretation indicates an ST-Elevation Myocardial Infarction (or manufacturer's equivalent) the patient should be transported to the nearest available STEMI Receiving Center (SRC)
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, enter STEMI (two-letter code **MI**) in this field

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- ECG strip
- SRC Log
- Audio records

EMS INTERPRETATION
☐ NORMAL ☐ ABNORMAL ☐ STEMI

Definition

Checkbox indicating EMS personnel's interpretation of 12-lead ECG, if applicable

Field Values

- **N**orma**L**: EMS personnel interpretation indicates ECG is normal
- **AB**normal: EMS personnel interpretation indicates ECG is abnormal
- STE**MI**: EMS personnel interpretation indicates an ST-Elevation Myocardial Infarction

Additional Information

- Mandatory field for all patients on whom a 12-lead ECG is performed
- If EMS personnel interpretation indicates an ST-Elevation Myocardial Infarction the patient should be transported to the nearest available STEMI Receiving Center (SRC)
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, enter STEMI (two-letter code **MI**) in this field

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- ECG strip
- SRC Log
- Audio records

ARTIFACT?

Definition

Checkbox indicating whether or not artifact is observed on 12-lead ECG tracing

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- Mandatory field for all base hospital contacts where either the software or EMS interpretation of the 12 lead ECG indicates STEMI
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, indicate whether artifact is present on the STEMI ECG in this field
- Electronic artifact interferes with accurate ECG interpretation, and may indicate need to repeat ECG

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- ECG strip
- Audio records

WAVY BASELINE?

Definition

Checkbox indicating whether or not baseline of 12-lead ECG tracing moves with respiration

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- Mandatory field for all base hospital contacts where either the software or EMS interpretation of the 12 lead ECG indicates STEMI
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, indicate whether wavy baseline is present on the STEMI ECG in this field
- Wavy baseline can interfere with accurate ECG interpretation, and may indicate need to reposition leads and repeat ECG

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- ECG strip
- Audio Records

PACED RHYTHM?

Definition

Checkbox indicating whether or not 12-lead ECG or electronic interpretation indicates presence of a pacemaker-generated rhythm

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- Mandatory field for all base hospital contacts where either the software or EMS interpretation of the 12 lead ECG indicates STEMI
- If an ECG indicating STEMI is obtained by a clinic, doctor's office, or transferring hospital, indicate whether a paced rhythm is present on the STEMI ECG in this field
- Pacemakers can interfere with accurate ECG interpretation, and must be reported

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- ECG strip
- Audio Records

WITNESSED BY:

Definition

Checkbox indicating witnesses to a patient's collapse due to cardiac arrest, if applicable

Field Values

- **C**itizen: Witnessed by a non-EMS person (e.g., law enforcement or nursing home personnel, bystanders, family, etc.)
- **E**MS: Witnessed by EMS personnel
- **N**one: Not witnessed

Additional Information

- Mandatory field for all Full Call base hospital contacts with a chief complaint of "CA"

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

CPR BY:

Definition

Checkbox indicating by whom CPR was performed on a patient in cardiac arrest, if applicable

Field Values

- **C**itizen: CPR was initiated by a non-EMS person (e.g., law enforcement or nursing home personnel, bystanders, family, etc.)
- **E**MS: CPR was initiated by EMS upon arrival
- **N**one: No CPR was initiated

Additional Information

- Mandatory field for all Full Call base hospital contacts with a chief complaint of “CA”

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

ARREST TO CPR

Definition

Estimated time, in minutes, from the time of arrest to the time of initiation of CPR, if applicable

Field Values

- Collected as minutes

Additional Information

- Mandatory field for all Full Call base hospital contacts with a witnessed, non-traumatic cardiac arrest/collapse
- If the arrest was unwitnessed, field will be entered as “Not Applicable” (F7 key) in TEMIS
- If arrest was witnessed, but minutes from arrest to CPR is not provided, field will be entered as “Not Documented” (F6 key) in TEMIS

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

RTN OF PULSE (ROSC)?

Definition

Checkboxes indicating whether or not return of spontaneous circulation (ROSC) – or 'sustained restoration of a spontaneous, perfusing rhythm that results in a palpable pulse, breathing (more than occasional gasp), coughing, movement, and/or a measureable blood pressure following cardiac arrest' – occurred, if applicable

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- Mandatory field for all patients with a chief complaint of "CA"
- Document even if the pulses are lost prior to arrival at the receiving facility
- Non-traumatic patients with ROSC in the field should be transported to the nearest available STEMI Receiving Center (SRC)
- Traumatic arrests should be transported according to trauma destination policies

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

RTN OF PULSE (ROSC) @

Definition

Time of day when return of spontaneous circulation (ROSC) occurs, if applicable

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- Mandatory field for all patients with ROSC in the field
- Document even if the pulses are lost prior to arrival at the receiving facility
- Patients with ROSC in the field should be transported to the nearest available STEMI Receiving Center (SRC)
- If patient has a DNR/AHCD, field will be entered as “Not Applicable” (F7 key) in TEMIS

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

RESUS D/C TIME

Definition

Time of day when resuscitative measures were terminated or patient was pronounced dead by the base hospital, if applicable

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- Mandatory field for all patients who had resuscitative measures discontinued in the field

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

RESUS D/C RHYTHM

Definition

Two- or three-letter code identifying the cardiac rhythm reported when resuscitative measures were terminated or patient was pronounced dead by the base hospital, if applicable

Field Values

AGO	Agonal	PEA	Pulseless Electrical Activity
ASY	Asystole	VF	Ventricular Fibrillation
IV	Idioventricular Rhythm		

Additional Information

- Mandatory field for all patients who had resuscitative measures discontinued in the field
- PEA is not a defined rhythm, but rather a finding that may be present at time of pronouncement where electrical activity and/or rhythm seen on the cardiac monitor does not produce a palpable pulse or auscultatable heartbeat

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

TOTAL MIN. EMS CPR:

Definition

Time in minutes from the initiation of CPR by EMS personnel, to the time when resuscitative measures were terminated or patient was pronounced dead by the base hospital, if applicable

Field Values

- Collected in minutes

Additional Information

- Mandatory field for all patients who had resuscitative measures discontinued in the field

Uses

- Assists with determination of appropriate treatment and transport
- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

VITALS & TXS SECTION

O2 @ ___ LPM

Definition

Numeric value of the number of liters per minute of oxygen delivered to the patient, if applicable

Field Values

- One- or two-digit numeric value

Additional Information

- The oxygen delivery device used must also be indicated

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

TITRATED

Definition

Checkbox indicating that the number of liters per minute of oxygen ordered by the base was given in a range, to be adjusted to desired effect, if applicable

Additional Information

- The oxygen delivery device used must also be indicated

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

VIA:

Definition

Checkboxes indicating the type of device used to deliver oxygen to the patient, if applicable

Field Values

- **N**C: Nasal Cannula
- **M**ask: Oxygen mask
- **B**VM: Bag Valve Mask
- Blo**W** By: Oxygen delivery device is used to “blow” oxygen towards patient’s face
- E**X**isting Trach.: Patient is being oxygenated/ventilated via an existing tracheostomy tube
- **E**TT: Endotracheal Tube
- **K**ing: King LTS-D (laryngeal tube suction device)
- **C**PAP: Continuous Positive Airway Pressure

Additional Information

- The number of liters per minute of oxygen delivered must also be indicated

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

IV:

Definition

Checkboxes indicating whether or not IV access was ordered for the patient, and type

Field Values

- **T**KO: To keep open – minimum drip rate necessary to keep line patent
- **W**O: Wide open – maximum drip rate possible (clamp wide open)
- **F**C: Fluid challenge –specified amount of IV fluid is ordered to be given over a specified amount of time. In the space provided, enter the number of cc's of IV fluid ordered
- **N**ot Ordered: No IV ordered
- **I**V Unable: Paramedics were not able to successfully establish an IV
- **R**efused: Patient refused to allow paramedics to establish IV access
- **S**L: Saline Lock device
- I**O**: Intraosseous device
- Pree**X**isting IV: Upon arrival of EMS personnel, the patient already had IV access established (by a clinic, urgent care, doctor's office, etc.)

Additional Information

- Mandatory field for all Full Call base hospital contacts

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

TRANSCUTANEOUS PACING @ mA:

Definition

Numeric value of the electrical current strength in milliamps (mA) required to achieve capture (as evidenced by a palpable pulse that corresponds with rhythm observed on cardiac monitor) during transcutaneous pacing, if applicable

Field Values

- Up to three-digit numeric value

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

RATE:

Definition

Numeric value of the rate of capture during transcutaneous pacing (as evidenced by a palpable pulse that corresponds with rhythm observed on cardiac monitor), if applicable

Field Values

- Up to three-digit numeric value

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

CAPTURE?

Definition

Checkboxes indicating whether or not mechanical capture (as evidenced by a palpable pulse that corresponds with rhythm observed on cardiac monitor) was achieved during transcutaneous pacing, if applicable

Field Values

- **Y**: Yes
- **N**: No

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

NEEDLE THORACOSTOMY

Definition

Checkboxes indicating whether or not a needle thoracostomy was ordered, if applicable

Field Values

- Y: Yes
- N: No

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

SPINAL MOTION RESTRICTION?

Definition

Checkboxes indicating whether or not the patient was placed in spinal motion restriction

Field Values

- Y: Yes
- N: No

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

CMS INTACT:

Definition

Checkboxes indicating whether patient's circulation, motor function, and sensation (CMS) were intact before and after spinal motion restriction, if applicable

Field Values

- **I**ntact **B**efore: CMS intact in all extremities prior to spinal immobilization
- **I**ntact **A**fter: CMS intact in all extremities after spinal immobilization

Additional Information

- CMS should always be assessed before and after spinal immobilization

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

SMR REFUSED

Definition

Checkbox indicating that spinal motion restriction was refused by the patient, if applicable

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

TOURNIQUET

Definition

Checkbox indicating that a device for stopping the flow of blood through a vein or artery was applied for bleeding control in the prehospital setting, if applicable

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

TIME

Definition

Time of day that corresponds to the adjacent vital signs, ECG, and treatments fields

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- May write “PTC” if event occurred prior to base contact – will be entered as “Not Documented” (F6 key) in TEMIS

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

B/P

Definition

Numeric values of the patient's systolic and/or diastolic blood pressure

Field Values

- Up to three-digit numeric value
- Documented as numeric systolic value / numeric diastolic value

Additional Information

- If the blood pressure is palpated or not reported, write "P" for the diastolic value – will be entered as "Not Documented" (F6 key) in TEMIS

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

PULSE

Definition

Numeric value of the patient's palpated pulse rate

Field Values

- Up to three-digit numeric value

Additional Information

- Measured in beats palpated per minute
- If cardiac monitor shows a rhythm that does not produce signs of perfusion, rate is documented as "0"

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

RR

Definition

Numeric values of the patient's initial, unassisted respiratory rate

Field Values

- Up to three-digit numeric value

Additional Information

- Measured in breaths per minute
- If patient requires mechanical assistance, then unassisted rate is documented only, not the assisted rate

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

O_2 SAT

Definition

Numeric value of the patient's percent oxygen saturation in the prehospital setting

Field Values

- Up to three-digit percentage from 0 to 100

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

PAIN

Definition

Numeric value indicating the patient's subjective pain level

Field Values

- Up to two-digit value from 0 to 10

Additional Information

- Pain level should be assessed whenever trauma or pain is the chief complaint, a mechanism of injury exists, and before and after administration of pain medication

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

CO_2

Definition

Numeric value indicating the concentration of carbon dioxide measured by the capnometer, if applicable

Field Values

- Up to three-digit value

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

ECG

Definition

Two- or three-letter code indicating the patient's subsequent rhythm(s) on cardiac monitor, if applicable

Field Values

1HB	1st Degree Heart Block	PEA	Pulseless Electrical Activity
2HB	2nd Degree Heart Block	PM	Pacemaker Rhythm
3HB	3rd Degree Heart Block	PST	Paroxysmal Supraventricular Tachycardia
AFI	Atrial Fibrillation	PVC	Premature Ventricular Contraction
AFL	Atrial Flutter	SA	Sinus Arrhythmia
AGO	Agonal Rhythm	SB	Sinus Bradycardia
ASY	Asystole	SR	Sinus Rhythm
AVR	Accelerated Ventricular Rhythm	ST	Sinus Tachycardia
IV	Idioventricular Rhythm	SVT	Supraventricular Tachycardia
JR	Junctional Rhythm	VF	Ventricular Fibrillation
PAC	Premature Atrial Contraction	VT	Ventricular Tachycardia
PAT	Paroxysmal Atrial Tachycardia		

Additional Information

- Cardiac rhythm should be assessed, and documented here any time a change is noted, or after any cardiac-related treatments

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- ECG strip
- Audio Records

DRUG/DEFIB

Definition

Space for documenting defibrillation/cardioversion and medication codes ordered by the base hospital

Field Values

ADE	Adenosine	DEF	Defibrillation
ALB	Nebulized Albuterol	DOP	Dopamine
AMI	Amiodarone	EPI	Epinephrine
ASA	Aspirin	FEN	Fentanyl
ATR	Atropine	GLP	Glucose Paste
BEN	Benadryl	GLU	Glucagon
BIC	Sodium Bicarbonate	COL	Glucola
CAL	Calcium Chloride	MID	Midazolam
CAR	Cardioversion	Morphine	Morphine Sulfate
D10	D10W	NAR	Narcan
D25	D25W	NTG	Nitroglycerin
D50	D50W	OND	Ondansetron

Additional Information

- Mandatory field for all base hospital contacts in which medications are ordered
- Each drug/defibrillation ordered should be written on a separate line so that dose and results can be clearly documented
- Mark the “PRN” box if the medication and/or defibrillation are ordered as PRN

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio records

SEDs IN PAST 48 HRS

Definition

Checkboxes indicating whether or not patient has used sexually enhancing drugs (SED) within the past 48 hours

Field Values

- **Y**: Yes
- **N**: No

Additional Information

- Use of SEDs must be assessed prior to ordering nitroglycerin for any patient

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

DOSE

Definition

Space for alphanumeric value of joules of defibrillation/cardioversion and/or dose of medication ordered by the base hospital

Field Values

- Free text

Additional Information

- Include dose and unit of measurement: e.g., “1mg” or “300J”

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

ROUTE

Definition

Two-letter code indicating the route of medication administration ordered by the base hospital, if applicable

Field Values

- **IV**: Intravenous
- **IO**: Intraosseous
- **SQ**: Subcutaneous
- **IM**: Intramuscular
- **PO**: By Mouth (per os) / oral disintegrating tablets (ODT)
- **IN**: Intranasal/Inhalation (e.g, HHN)
- **SL**: Sublingual

Additional Information

- Drug route codes are listed on the back of pages 1 and 4 of the Base Hospital Form

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

TX/RESULTS

Definition

Space for brief documentation of results of medications given or treatments rendered

Field Values

- "**-**": Deteriorated
- "**+**": Improved
- "**N**": No Change

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

TRAUMA SECTION

TRAUMA

Definition

Checkboxes indicating the nature and location of the patient's injury, if applicable

Field Values

- **N**o **A**pparent Injury (**NA**): No complaint, or signs or symptoms of injury following a traumatic event
- **BU**rns/Elec. Shock (**BU**): Thermal or chemical burn, or electric shock
- SBP <**90** (<70 if under 1y) (**90**): Systolic blood pressure less than 90mmHg in a patient greater than one year of age (or systolic blood pressure less than 70mmHg in a patient less than one year of age) following a traumatic event
- **RR** <10/>29 (<20 if <1y) (**RR**): A sustained respiratory rate greater than 29 breaths/minute, or respiratory rate of less than 10 breaths/minute (or less than 20 breaths/minute in a patient less than one year of age), following a traumatic event
- **S**usp. Pelvic F**X** (**SX**): Suspected pelvic fracture, excluding isolated hip fractures from a ground level fall
- **S**pinal **C**ord Injury (**SC**): Suspected spinal cord injury, or presence of weakness/paralysis/parasthesia following a traumatic event
- **I**npatient **T**rauma (**IT**): Interfacility transfer (IFT) of an admitted, injured patient from one facility to an inpatient bed at another facility, excluding ER to ER transfers
- Minor **L**acerations (**BL** or **PL**): Superficial or non-serious lacerations, abrasions, or contusions involving the skin or subcutaneous tissue, due to blunt or penetrating force
- **T**rauma Arrest (**BT** or **PT**): Cessation of cardiac output and effective circulation due to blunt or penetrating force
- **H**ead (**BH** or **PH**): Injury to the head or skull in the area from above the eyebrows to behind the ears, due to blunt or penetrating force. This code can also be applied in association with facial injuries when it is likely that the brain is involved
- GCS ≤**14** (**14**): Blunt force head injury associated with a Glasgow Coma Scale score of less than or equal to 14. Code may also be used when a strong index of suspicion for blunt head injury exists due to mechanism of injury and/or signs or symptoms such as seizures, unequal pupils, or focal neurological deficits
- **F**ace/mouth (**BF** or **PF**): Injury to the anterior aspect of the face, mouth, or skull, from and including the eyebrows, down to and including the angle of the jaw and the ears, due to blunt or penetrating force
- **N**eck (**BN** or **PN**): Injury or pain to the area between the angle of the jaw and clavicles (including probable cervical spine injuries) due to blunt or penetrating force
- **B**ack (**BB** or **PB**): Injury to the area from the shoulders to the buttocks (but not including the buttocks) due to blunt or penetrating force
- **C**hest (**BC** or **PC**): Injury to the anterior chest in the area between the clavicle and the xyphoid process, bordered on either side by the posterior axillary line, due to blunt or penetrating force
- **F**lail **C**hest (**FC**): Blunt force injury to the chest wall resulting in an unstable chest wall, characterized by paradoxical chest wall movement with respirations
- Tension **P**neum (**BP** or **PP**): Air enters the pleural space due to blunt or penetrating force, and creates pressure on chest organs. Signs and symptoms can include: SOB,

tachypnea, decreased or absent lung sounds on one side, shock, neck vein distention, and/or tracheal deviation

- **A**bdomen (**BA** or **PA**): Injury to any of the abdominal quadrants, flanks, or pelvis due to blunt or penetrating force
- **D**iffuse Abd. Tender. (**BD**): Blunt force injury to the abdomen resulting in tenderness in two or more quadrants
- **G**enitals/Buttoc**K**s (**BG**, **BK**, **PG** or **PK**): Injury to the external reproductive structures or buttocks due to blunt or penetrating force
- **E**xtremities (**BE** or **PE**): Injury or pain to the shoulders, arms, hands, legs, or feet due to blunt or penetrating force
- E**X**tr ↑ knee/elbow (**PX**): Penetrating force injury to an extremity, proximal to (above) the knee or elbow
- F**R**actures ≥ 2 long bones (**BR**): Blunt force injury resulting in apparent fracture of 2 or more proximal long bones (humerus, femur.
- Amputat**I**on ↑ wrist/ankle (**BI** or **PI**): Amputation proximal to (above) the wrist or ankle due to blunt or penetrating force
- Neur/**V**asc/Mangled (**BV** or **PV**): Injury to an extremity with neurological and/or vascular compromise, or that is crushed, degloved, or mangled due to blunt or penetrating force

Additional Information

- Mandatory field for all injured patients
- Check all that apply - if the patient has multiple complaints, enter Chief Complaints in order of significance
- Codes beginning with “B” or “P” indicate Blunt or Penetrating injury, respectively
- Two-letter codes can be derived from the bolded, capitalized letters of the trauma descriptions – trauma codes should be listed in order of significance in the “Chief Complaint Code” fields
- Patient’s with injuries documented must also have a mechanism of injury documented – and vice versa
- Medical complaints should not be documented with trauma complaints, unless it is suspected that a medical complaint preceded/caused the injury, or vice versa (e.g., chest pain/dizziness that caused an MVA, or seizure activity following a blow to the head.) Do not document a medical complaint such as “HP” (head pain) if the pain is due to a gunshot wound to the head – instead use only the trauma code of “PH.”
- Penetrating injuries may be inflicted by dull objects travelling at high velocity (e.g., bullets), sharp objects with a low velocity, or from a slashing or puncturing force
- Blunt injuries occur from a forces that do not typically penetrate the skin (e.g., baseball bat) though lacerations may be caused by the tearing/crushing force of a blunt object or broken bones
- Injury descriptions listed in **red** meet trauma triage criteria for transport to the nearest available trauma center

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

MECHANISM OF INJURY

Definition

Checkboxes indicating how the patient was injured

Field Values

- Protective Devices – **H**e**L**met (**HL**): The patient riding on an unenclosed motorized vehicle/bicycle was wearing a helmet at the time of impact
- Protective Devices – **S**eat **B**elt (**SB**): Patient was wearing a seat belt at the time of impact
- Protective Devices – **A**ir**B**ag (**AB**): Airbag deployed at the time of impact and directly protected the patient
- Protective Devices – **C**ar **S**eat/Booster (**CS**): The patient was riding in a car seat or booster at the time of impact
- **E**nclosed **V**eh. (**EV**): Patient involved in collision while in an enclosed vehicle, such as a an automobile, bus, or other enclosed motorized vehicle
- **Ej**ected (**EJ**): Patient was fully or partially thrown from a vehicle, including convertibles and trucks. Does **NOT** include motorcycles
- **EX**tricated @ (**EX**): Time of day that the patient was removed from the vehicle when use of a pneumatic tool was required
- **P**assenger **S**pace Intrusion (**PS**): Intrusion of greater than 12 inches into an occupied passenger space of a motor vehicle, or greater than 18 inches into an unoccupied passenger space – check this box if amount of intrusion is not known or not specified by paramedics
- **12**: Intrusion of greater than 12 inches into an occupied passenger space of a motor vehicle – check this box when amount of intrusion is specified by paramedics
- **18** : Intrusion of greater than 18 inches into an unoccupied passenger space – check this box when amount of intrusion is specified by paramedics
- **S**urvived **F**atal Accident (**SF**): The patient survived a collision where another person **in the same vehicle** was fatally injured
- Impact > **20**mph unenclosed (**20**): An unenclosed transport crash (e.g., skateboard, bicycle, horse, etc.) with an estimated impact greater than 20mph
- Ped/Bike **R**un Over/**T**hrown/>20mph (**RT**): Pedestrian, bicyclist, or motorcyclist struck by an automobile and is thrown, run over, or has an estimated impact of greater than 20mph
- **P**ed/**B**ike < 20mph (**PB**): A bicyclist or pedestrian is hit by a motorized vehicle with less than 20mph estimated impact
- **M**otorcycle/**M**oped (**MM**): The patient was riding on a motorcycle or moped at the time of impact
- **SP**orts/Rec (**SP**): Any injury that occurs during a sporting or recreational athletic activity, such as aerobics, football, jogging, etc.
- **AS**sault (**AS**): Patient was physically assaulted (kicked, punched, strangled, etc.) by means other than stabbing or shooting
- **ST**abbing (**ST**): A sharp or piercing instrument (e.g. knife, broken glass, ice pick, etc.) caused an injury which penetrated the skin
- **GS**W (**GS**): Gunshot Wound - injury was caused by discharge of a gun (accidental or intentional)

- **AN**imal Bite (**AN**): The teeth of a human, reptile, dog, cat, or other animal inflicted an injury, whether or not the skin was punctured. Insect bites and bee stings are not considered animal bites, and should be coded as "Other"
- **CR**ush (**CR**): Injury sustained as the result of external pressure being placed on body parts between two opposing forces
- **S**pecial **C**onsid. (**SC**): Injured patient meets Special Considerations of age greater than 55 years, pregnancy > 20 weeks, or age greater than 65 years with a systolic BP of less than 110mmHg
- **A**nti**C**oagulants (**AC**): Injured patient is on anticoagulant medication other than aspirin (excludes minor extremity injury)
- **T**elemetry **D**ata (**TD**): Vehicle telemetry data is encountered that is consistent with high risk of serious injury
- **FA**ll (**FA**): Any injury resulting from a fall from any height
- **>15** ft. (>10 ft. Peds) (**15**): A vertical, uninterrupted fall of greater than 15 feet for an adult or greater than 10 feet or 3 times the height of the child for a pediatric patient. This mechanism is a subcategory of "Fall." This does not include falling down stairs or rolling down a sloping cliff.
- **S**elf-Inflict'd/**A**ccid. (**SA**): The injury appears to have been accidentally caused by the patient
- **S**elf-Inflict'd/**I**ntent. (**SI**): The injury appears to have been intentionally caused by the patient
- **E**lectrical **S**hock (**ES**): Passage of an electrical current through body tissue as a result of contact with an electrical source
- **T**hermal **B**urn (**TB**): Burn caused by heat
- **H**azmat **E**xposure (**HE**): The patient was exposed to toxic or poisonous agents, such as liquids, gases, powders, foams, or radioactive material
- **W**ork- **R**elated (**WR**): Injury occurred while patient was working, and may be covered by Worker's Compensation
- **UN**known (**UN**): The cause or mechanism of injury is unknown
- **OT**her (**OT**): A cause of injury that does not fall into any of the existing categories

Additional Information

- Mandatory field for all injured patients
- Check all that apply
- Two-letter codes can be derived from the bolded, capitalized letters of the mechanisms of injury (MOI) – MOIs should be listed in order of significance in the MOI code fields
- Patient's with a mechanism of injury documented must also have a trauma code documented – and vice versa
- Mechanisms of injury listed in **red** meet trauma triage criteria for transport to the nearest available trauma center
- Mechanisms of injury listed in **blue** meet trauma guidelines for transport to the nearest available trauma center - strong consideration should be given to a trauma center destination

Uses

- Provides documentation of assessment and/or care

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio Records

TRANSPORT SECTION

CODE ALL OPTIONS

Definition

Three-letter code for each of the potential patient destination facilities

Field Values

LOS ANGELES COUNTY 9-1-1 RECEIVING			
ACH	Alhambra Hospital Medical Center	LBC	Community Hospital of Long Beach
AHM	Catalina Island Medical Center	LBM	Long Beach Memorial Medical Center
AMH	Methodist Hospital of Southern California	LCH	Palmdale Regional Medical Center
AVH	Antelope Valley Hospital	LCM	Providence Little Co. of Mary Torrance
BEL	Bellflower Medical Center	MCP	Mission Community Hospital
BEV	Beverly Hospital	MHG	Memorial Hospital of Gardena
BMC	Southern California Hospital at Culver City	MID	Olympia Medical Center
CAL	California Hospital Medical Center	MLK	Martin Luther King Jr. Community Hospital
CHH	Children's Hospital Los Angeles	MPH	Monterey Park Hospital
CHP	Community Hospital of Huntington Park	NOR	Norwalk Community Hospital
CNT	Centinela Hospital Medical Center	NRH	Northridge Hospital Medical Center
CPM	Coast Plaza Doctors Hospital	OVM	LAC Olive View Medical Center
CSM	Cedars-Sinai Medical Center	PAC	Pacifica Hospital of the Valley
DCH	PIH Health Hospital - Downey	PIH	PIH Health Hospital- Whittier
DFM	Marina Del Rey Hospital	PLB	College Medical Center
DHL	Lakewood Regional Medical Center	PVC	Pomona Valley Hospital Medical Center
ELA	East Los Angeles Doctors Hospital	QOA	Hollywood Presbyterian Medical Center
ENH	Encino Hospital Medical Center	QVH	Citrus Valley M.C. - Queen of the Valley Campus
FPH	Foothill Presbyterian Hospital	SDC	San Dimas Community Hospital
GAR	Garfield Medical Center	SFM	Saint Francis Medical Center
GEM	Greater El Monte Community Hospital	SGC	San Gabriel Valley Medical Center
GMH	Glendale Memorial Hospital and Health Center	SJH	Providence Saint John's Health Center
GSH	Good Samaritan Hospital	SJS	Providence Saint Joseph Medical Center
GWT	Glendale Adventist Medical Center	SMH	UCLA Medical Center, Santa Monica
HCH	Providence Holy Cross Medical Center	SMM	Saint Mary Medical Center
HEV	Glendora Community Hospital	SOC	Sherman Oaks Hospital
HGH	LAC Harbor-UCLA Medical Center	SPP	Providence Little Co. of Mary San Pedro
HMH	Huntington Hospital	SVH	Saint Vincent Medical Center
HMN	Henry Mayo Newhall Hospital	TOR	Torrance Memorial Med Ctr
HWH	West Hills Hospital & Medical Center	TRI	Tri-City Regional Med Ctr
ICH	Citrus Valley M.C. - Intercommunity Campus	TRM	Providence Tarzana Medical Center
KFA	Kaiser Foundation Hospital- Baldwin Park	UCL	Ronald Reagan UCLA Medical Center
KFB	Kaiser Permanente Downey Med Ctr	USC	LAC USC Medical Center
KFH	Kaiser Permanente South Bay Med Ctr	VHH	USC Verdugo Hills Hospital
KFL	Kaiser Permanente Los Angeles Med Ctr	VPH	Valley Presbyterian Hospital

KFO	Kaiser Permanente Woodland Hills M.C.	WHH	Whittier Hospital Medical Center
KFP	Kaiser Permanente Panorama City M.C.	WMH	White Memorial Medical Center
KFW	Kaiser Permanente West LA Med Ctr		

ORANGE COUNTY 9-1-1 RECEIVING			
ANH	Anaheim Memorial Medical Center	LPI	La Palma Intercommunity Hospital
CHO	Children's Hospital of Orange County	PLH	Placentia Linda Hospital
FHP	Fountain Valley Hospital	SJD	Saint Jude Medical Center
FHR	Friendly Hills Regional Medical Center	UCI	UCI Medical Center
KHA	Kaiser Foundation Hospital- Anaheim	WAM	West Anaheim Medical Center
KFI	Kaiser Permanente Irvine Medical Center	WMC	Western Medical Center Santa Ana
LAG	Los Alamitos Medical Center		
SAN BERNARDINO COUNTY 9-1-1 RECEIVING			
ARM	Arrowhead Regional Medical Center	KFN	Kaiser Foundation Ontario
CHI	Chino Valley Medical Center	LLU	Loma Linda University Medical Center
DHM	Montclair Hospital Medical Center	SAC	San Antonio Community Hospital
KFF	Kaiser Foundation Hospital- Fontana		
OTHER COUNTY 9-1-1 RECEIVING			
LRR	Los Robles Hospital & Med Ctr (Ventura)	SJO	St. John's Regional Medical Center (Ventura)
SIM	Simi Valley Hospital (Ventura)	RCC	Ridgecrest Regional Hospital (Kern)
NON-BASIC HOSPITALS			
LBV	Long Beach VA	WVA	Wadsworth Veterans Administration

Additional Information

- Mandatory field for all base hospital contacts
- A three-letter code for MAR must be documented for all patients, regardless of age
- A three-letter code for EDAP must be documented for all pediatric patients of less than or equal to 14 years of age

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

CHECK ACTUAL DESTINATION

Definition

Checkboxes indicating actual destination of patient

Field Values

- **M**AR: Most Accessible Receiving facility (licensed basic emergency department) that can be reached in the shortest amount of time. Depending on traffic and geography, this may not necessarily be the closest facility. Must be documented for all patients regardless of actual destination
- **E**DAP: Most accessible Emergency Department Approved for Pediatrics approved to receive patients of less than or equal to 14 years of age. Must be documented for all pediatric patients regardless of actual destination
- **T**C: Most accessible Trauma Center approved to receive critically injured patients. Must be documented for all adult patients that meet criteria, guidelines, or special considerations for transport to a TC, regardless of actual destination
- PT**C**: Most accessible Pediatric Trauma Center approved to receive critically injured pediatric patients of less than or equal to 14 years of age. Must be documented for all pediatric patients that meet criteria, guidelines, or special considerations for transport to a PTC, regardless of actual destination
- **P**MC: Most accessible Pediatric Medical Center approved to receive critically ill pediatric patients of less than or equal to 14 years of age. Must be documented for all pediatric patients that meet guidelines for transport to a PMC, regardless of actual destination
- **S**TEMI Receiving Center: Most accessible ST-Elevation Myocardial Infarction (STEMI) Receiving Center approved to receive patients with a suspected STEMI, or who have Return of Spontaneous Circulation (ROSC) following a non-traumatic cardiac arrest. Must be documented for all patients who meet criteria for transport to a SRC, regardless of actual destination
- Prim**A**ry Stroke Center: Most accessible Primary Stroke Center approved to receive suspected stroke patients or patients with a positive mLAPSS exam. Must be documented for all patients who meet guidelines for transport to a PSC, regardless of actual destination
- Comprehensive Stro**K**e Center: Most accessible Comprehensive Stroke Center approved to receive patients with a positive mLAPSS exam and a LAMS score ≥ 4
- Peri**N**atal: Most accessible Perinatal Center approved to receive patients greater than or equal to 20 weeks pregnant. Must be documented for all patients who meet guidelines for transport to a Perinatal Center
- SA**R**T: Most accessible Sexual Assault Response Team facility approved to receive actual or suspected victims of sexual assault/abuse. Must be documented for patients who meet guidelines for transport to a SART Center
- **O**ther: Licensed basic emergency department that may also appropriately receive the patient in addition to those listed above. Most frequently used when the closest facility is inaccessible (e.g., is requesting diversion.) The reason for using “Other” as a destination must be documented in the “Destination Rationale” section

Additional Information

- Mandatory field for all transported patients
- Check only the actual patient destination
- If more than one specialty center option applies, choose the option most applicable to the patient's presentation (e.g., pregnant pediatric patients, or sexually assaulted trauma patients)

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

ETA

Definition

Estimated time of arrival (ETA) for each of the possible destinations documented

Field Values

- Collected as minutes

Additional Information

- ETA must be provided for each possible destination

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio records

CHECK ONE

Definition

Checkboxes indicating whether or not a specialty center destination was indicated for the patient

Field Values

- **S**pecialty Center **N**ot Required: Patient does not meet guidelines or criteria for transport to a specialty center
- **S**pecialty Center **R**equired/Criteria Met: Patient meets criteria or requirements for transport to a specialty center
- **S**pecialty Center **G**uidelines Met: Patient meets guidelines for transport to a specialty center

Additional Information

- Mandatory field for all base hospital contacts
- Check one box only
- If more than one specialty center option applies, choose the option most applicable to the patient's presentation
- If patient meeting requirements, criteria, or guidelines is not transported to specialty center, must indicate reason in the "Destination Rationale" section

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio records

DESTINATION RATIONALE

Definition

Checkboxes indicating the reason that the patient was transported to a facility other than the most accessible receiving facility or specialty center, if applicable

Field Values

- **E**D Saturation: Most accessible receiving facility or EDAP has requested diversion due to emergency department saturation
- Int. **D**isaster: Most accessible receiving facility or specialty center is closed due to internal disaster such as fire, flood, etc.
- **C**T Diversion: CT scanner at the most accessible receiving facility or specialty center is non-functioning
- I**F**T: Patient is being transferred from one facility to another
- SC Diversion **T**C/PTC: Most accessible TC/PTC is closed due to encumberment of the trauma team or OR
- SC Diversion **P**MC: Most accessible PMC is closed due to lack of critical equipment
- SC Diversion STE**M**I: Most accessible SRC is closed due to Cath lab encumberment or malfunction
- SC Diversion Stro**K**e: Most accessible stroke center is closed due to a non-functioning CT scanner
- SC Diversion Cardiac Arrest (**X**): Injured patient meeting trauma criteria is in blunt traumatic cardiac arrest (BT), and is therefore transported to the MAR rather than the most accessible TC/PTC
- SC Not Accessib**L**e: Specialty center not accessible due to transport time constraints or geography
- Jud**G**ment (Provider/Base): Patient does not meet specialty center criteria, requirements, or guidelines, but is transported to a specialty center based on Base or the Provider judgment; or, meets, but is not transported to a specialty center
- Minimal In**J**uries: Patient meets trauma criteria or guidelines but is determined to have only minimal injuries which do not warrant transport to a specialty center
- **R**equested By: Patient is transported to a facility other than the most accessible receiving facility or specialty center by request from the patient, a family member, patient's private medical doctor (PMD), or other authorized person
- Shared Am**B**ulance: The patient does not meet specialty center criteria, requirements, or guidelines, but is transported to SC because they are sharing an ambulance with a patient who does meet SC criteria/guidelines/requirements
- **U**nmanageable Airway: Patient meets specialty center criteria, requirements, or guidelines, but airway cannot be adequately managed due to injury or illness, and patient's life may be jeopardized by transport to any facility but the closest
- **O**ther: Patient is transported a facility other than the most accessible receiving facility or specialty center for any reason other than those listed above (use space below to briefly document reason)

Additional Information

- Mandatory field if the patient is transported to “Other,” or, if the patient meets specialty center criteria, requirements, or guidelines but is transported to a facility other than the most accessible specialty center

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Audio records

PT TRANSPORTED VIA:

Definition

Checkboxes indicating the type of transport unit used

Field Values

- **A**LS: An Advanced Life Support Transport unit in which patient was accompanied by at least one paramedic
- **B**LS: Basic Life Support Transport unit in which patient was accompanied by EMTs only
- **O**ther: Type of transport not listed above
- **H**elicopter ETA: Helicopter transport requested – indicate ETA of helicopter to scene
- **N**o Transport: Patient was not transported (must indicate reason for no transport in the "Reason for No Transport" field)

Additional Information

- Mandatory field for all patients

Uses

- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

REASON FOR NO TRANSPORT

Definition

Checkboxes indicating reason why patient was not transported, if applicable

Field Values

- **A**MA: Patient refuses transport
- **D**OA: Patient is determined to be dead on arrival as per Prehospital Care Manual
- **U**nwarranted: Patient's condition does not require transportation to a hospital
- **T**.O.R.: Resuscitative measures are terminated by EMS personnel
- **P**ronounced by: Enter the name of the physician who pronounced the patient dead, if applicable
- **O**ther: Mark this box if the patient was not transported due a reason not listed above

Additional Information

- Mandatory field for all patients who are not transported

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- Audio records

TIME CLEAR

Definition

The time of day that paramedic contact with the base hospital ends

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- Mandatory field for all base hospital contacts
- Use one timepiece throughout call to ensure accurate time intervals

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form

TIME RECEIVING HOSPITAL NOTIFIED

Definition

The time of day that the receiving hospital was notified of an arriving patient

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- Mandatory field for all patients transported to a receiving facility other than the base hospital
- Use one timepiece throughout call to ensure accurate time intervals

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form

NAME OF PERSON NOTIFIED:

Definition

Space to document the name of the person at the receiving facility notified of an arriving patient

Field Values

- Free text

Additional Information

- Not necessary if base hospital is the receiving facility
- Document whatever name is given – e.g., “Mary” or “Dr. Jones”

Uses

- Provides documentation of communication

Data Source Hierarchy

- Base Hospital Form
- Audio records

TRANSPORT SCENARIOS

Specialty Care Center Not Required

70 y/o female, short of breath x 2 hours, speaking in full sentences, in mild/moderate distress:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☒ **M**AR	PIH	7
☐ **E**DAP (age ≤14)	| | |	
☐ **T**C	| | |	
☐ PT**C** (trauma, age ≤14)	| | |	
☐ **P**MC (medical, age ≤14)	| | |	
☐ **S**TEMI Receiving Center	| | |	
☐ Prim**A**ry Stroke Center	| | |	
☐ Comprehensive Stro**K**e Center	| | |	
☐ Peri**N**atal (≥20wks pregnancy)	| | |	
☐ SA**R**T	| | |	
☐ **O**ther	| | |	
Time Clear	| | | |	
Time Receiving Hospital Notified	| | | |	
Name of Person Notified:		

CHECK ONE:	**DESTINATION RATIONALE:**
Specialty Center: ☒ **N**ot Required ☐ **R**equired/Criteria Met ☐ **G**uidelines Met	☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Stro**K**e ☐ SC Not Accessib**L**e ☐ Cardiac Arrest (**X**) ☐ **U**nmanageable Airway ☐ Minimal In**J**uries ☐ Jud**G**ment *(Provider/Base)* ☐ Shared Am**B**ulance ☐ **R**equested by: ☐ **O**ther:
PT TRANSPORTED VIA:	**REASON FOR NO TRANSPORT:**
☒ **A**LS ☐ **B**LS ☐ **O**ther ☐ **H**elicopter - ETA: _____ ☐ **N**o Transport	☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther ☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown
☐ **I**CU ☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |__|__|__| (Hosp. code) ☐ **O**ther _____
ED Diagnosis:

- Enter hospital code for the closest MAR
- Indicate the actual destination by checking MAR
- Check Specialty Center: Not Required (SB as described meets no specialty center criteria or guidelines as per Reference No. 502)
- Destination Rationale is left blank, as there is no deviation from destination principles

Pediatric: EDAP Required

2 y/o male, febrile, witnessed tonic/clonic seizure. No signs of trauma, GCS is improving:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☐ **M**AR	LCM	5
☒ **E**DAP (age ≤14)	LCM	5
☐ **T**C	| | |	
☐ PT**C** (trauma, age ≤14)	| | |	
☐ **P**MC (medical, age ≤14)	| | |	
☐ **S**TEMI Receiving Center	| | |	
☐ Prim**A**ry Stroke Center	| | |	
☐ Comprehensive Stro**K**e Center	| | |	
☐ Peri**N**atal (≥20wks pregnancy)	| | |	
☐ SA**R**T	| | |	
☐ **O**ther	| | |	
Time Clear	| | | |	
Time Receiving Hospital Notified	| | | |	
Name of Person Notified:		

CHECK ONE:	**DESTINATION RATIONALE:**
Specialty Center: ☐ **N**ot Required ☒ **R**equired/Criteria Met ☐ **G**uidelines Met	☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Stro**K**e ☐ SC Not Accessib**L**e ☐ Cardiac Arrest (**X**) ☐ **U**nmanageable Airway ☐ Minimal In**J**uries ☐ Jud**G**ment *(Provider/Base)* ☐ Shared Am**B**ulance ☐ **R**equested by: ☐ **O**ther:
PT TRANSPORTED VIA:	**REASON FOR NO TRANSPORT:**
☒ **A**LS ☐ **B**LS ☐ **O**ther ☐ **H**elicopter - ETA: _____ ☐ **N**o Transport	☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther ☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown
☐ **I**CU ☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |__|__|__| (Hosp. code) ☐ **O**ther:_____
ED Diagnosis:

- Enter hospital codes for the closest MAR and EDAP
- Indicate the actual destination by checking EDAP
- Check Specialty Center: Required/Criteria Met (EDAP specialty center is required for patients 14yrs of age or younger, as per Reference No. 510)
- Destination Rationale is left blank, as there is no deviation from destination principles

Pediatric: PTC Criteria

5 y/o female, fell from a second story window, GCS 4-6-5. CC = BB, MOIs = FA and 15:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☐ **M**AR	KFL	4
☐ **E**DAP (age ≤14)	UCL	7
☐ **T**C	| |	
☒ PT**C** (trauma, age ≤14)	UCL	7
☐ **P**MC (medical, age ≤14)	| |	
☐ **S**TEMI Receiving Center	| |	
☐ Prim**A**ry Stroke Center	| |	
☐ Comprehensive Stro**K**e Center	| |	
☐ Peri**N**atal (≥20wks pregnancy)	| |	
☐ SA**R**T	| |	
☐ **O**ther	| |	
Time Clear	| | |	
Time Receiving Hospital Notified	| | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
- ☐ **N**ot Required
- ☒ **R**equired/Criteria Met
- ☐ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter - ETA: _____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Stro**K**e
☐ SC Not Accessib**L**e ☐ Cardiac Arrest (**X**)
☐ **U**nmanageable Airway ☐ Minimal In**J**uries
☐ Jud**G**ment *(Provider/Base)* ☐ Shared Am**B**ulance
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown
☐ **I**CU ☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |__|__|__| (Hosp. code) ☐ **O**ther:_____
ED Diagnosis:

- Enter hospital codes for the closest MAR, EDAP, and PTC
- Indicate the actual destination by checking PTC
- Check Specialty Center: Required/Criteria Met (MOI=15 is a criteria for transport to a PTC as per Reference No. 506)
- Destination Rationale is left blank, as there is no deviation from destination principles

Pediatric: PTC Guideline

7 y/o female, auto vs bicycle at less than 5mph, wearing a helmet. CC = BE, MOIs = PB and HL:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☐ **M**AR	HEV	2
☒ **E**DAP (age ≤14)	GEM	8
☐ **T**C	| |	
☐ PT**C** (trauma, age ≤14)	USC	20
☐ **P**MC (medical, age ≤14)	| |	
☐ **S**TEMI Receiving Center	| |	
☐ Prim**A**ry Stroke Center	| |	
☐ Comprehensive Stro**K**e Center	| |	
☐ Peri**N**atal (≥20wks pregnancy)	| |	
☐ SA**R**T	| |	
☐ **O**ther	| |	
Time Clear	| | |	
Time Receiving Hospital Notified	| | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
- ☐ **N**ot Required
- ☐ **R**equired/Criteria Met
- ☒ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter - ETA: _____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Stro**K**e
☐ SC Not Accessib**L**e ☐ Cardiac Arrest (**X**)
☐ **U**nmanageable Airway ☒ Minimal In**J**uries
☐ Jud**G**ment *(Provider/Base)* ☐ Shared Am**B**ulance
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown
☐ **I**CU ☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |__|__|__| (Hosp. code) ☐ **O**ther:_____
ED Diagnosis:

- Enter hospital codes for the closest MAR, EDAP, and PTC
- Indicate the actual destination by checking EDAP
- Check Specialty Center: Guidelines Met (Auto vs Ped/Bike at less than 20mph [PB] is a guideline for transport to a PTC as per Reference No. 506.) If more than one specialty center option applies, choose the option most applicable to the patient's presentation.

- Check Destination Rationale: Minimal Injuries, as this is the reason patient was not transported to the PTC

Pediatric: PMC Guideline

4 y/o male, witnessed tonic/clonic seizure. No signs of trauma, but GCS is not improving:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☐ **M**AR	SJS	8
☐ **E**DAP (age ≤14)	SJS	8
☐ **T**C	| |	
☐ PT**C** (trauma, age ≤14)	| |	
☒ **P**MC (medical, age ≤14)	CHH	15
☐ **S**TEMI Receiving Center	| |	
☐ Prim**A**ry Stroke Center	| |	
☐ Comprehensive Stro**K**e Center	| |	
☐ Peri**N**atal (≥20wks pregnancy)	| |	
☐ SA**R**T	| |	
☐ **O**ther	| |	
Time Clear	| | | |	
Time Receiving Hospital Notified	| | | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
☐ **N**ot Required
☐ **R**equired/Criteria Met
☒ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter - ETA: _____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ **I**FT
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Stro**K**e
☐ SC Not Accessib**L**e ☐ Cardiac Arrest (**X**)
☐ **U**nmanageable Airway ☐ Minimal In**J**uries
☐ Jud**G**ment *(Provider/Base)* ☐ Shared Am**B**ulance
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown
☐ **I**CU ☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |__|__|__| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR, EDAP, and PMC
- Indicate the actual destination by checking PMC
- Check Specialty Center: Guidelines Met (persistent altered mental status is a guideline for transport to a PMC, as per Reference No. 510)
- Destination Rationale is left blank, as there is no deviation from destination principles

Specialty Center Guidelines Met

50 y/o male, L facial droop x 1 hr, positive mLAPSS exam:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☐ **M**AR	SMH	5
☐ **E**DAP (age ≤14)	| |	
☐ **T**C	| |	
☐ PT**C** (trauma, age ≤14)	| |	
☐ **P**MC (medical, age ≤14)	| |	
☐ **S**TEMI Receiving Center	| |	
☒ Prim**A**ry Stroke Center	UCL	12
☐ Comprehensive Stro**K**e Center	| |	
☐ Peri**N**atal (≥20wks pregnancy)	| |	
☐ SA**R**T	| |	
☐ **O**ther	| |	
Time Clear	| | | |	
Time Receiving Hospital Notified	| | | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
☐ **N**ot Required
☐ **R**equired/Criteria Met
☒ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter - ETA: _____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ **I**FT
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Stro**K**e
☐ SC Not Accessib**L**e ☐ Cardiac Arrest (**X**)
☐ **U**nmanageable Airway ☐ Minimal In**J**uries
☐ Jud**G**ment *(Provider/Base)* ☐ Shared Am**B**ulance
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown
☐ **I**CU ☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |__|__|__| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR and PSC
- Indicate the actual destination by checking PSC
- Check Specialty Center: Guidelines Met (positive mLAPSS exam meets guidelines for transport to a PSC as per Reference No. 521)
- Destination Rationale is left blank, as there is no deviation from destination principles

Specialty Center Judgment

66 y/o male, crushing chest pain and SOB for 15min, Abnormal ECG, hx of MI, DM, HTN. MICN directs transport to SRC due to high suspicion of MI:

TRANSPORT

CODE all options, CHECK actual destination:	CODE	ETA
☐ **M**AR	CNT	5
☐ **E**DAP (age ≤14)	| |	
☐ **T**C	| |	
☐ PT**C** (trauma, age ≤14)	| |	
☐ **P**MC (medical, age ≤14)	| |	
☒ **S**TEMI Receiving Center	UCL	15
☐ Prim**A**ry Stroke Center	| |	
☐ Comprehensive Stro**K**e Center	| |	
☐ Peri**N**atal (>20wks pregnancy)	| |	
☐ SA**R**T	| |	
☐ **O**ther	| |	
Time Clear	| | | |	
Time Receiving Hospital Notified	| | | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
- ☒ **N**ot Required
- ☐ **R**equired/Criteria Met
- ☐ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter - ETA: _____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**MI** ☐ Stro**K**e
☐ SC Not Accessib**L**e ☐ Cardiac Arrest (**X**)
☐ **U**nmanageable Airway ☐ Minimal In**J**uries
☒ Jud**G**ment *(Provider/Base)* ☐ Shared Am**B**ulance
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown
☐ **I**CU ☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |__|__|__| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR and SRC
- Indicate the actual destination by checking SRC
- Check Specialty Center Not Required
- Check Destination Rationale: Judgment

9-1-1 Interfacility Transfer

66 y/o male presented by private auto to a non-SRC facility, c/o crushing chest pain and SOB for 15min, ECG in ED shows STEMI. 9-1-1 is activated for rapid transport to closest SRC:

TRANSPORT

CODE all options, CHECK actual destination:	CODE	ETA
☐ **M**AR	CNT	0
☐ **E**DAP (age ≤14)	| |	
☐ **T**C	| |	
☐ PT**C** (trauma, age ≤14)	| |	
☐ **P**MC (medical, age ≤14)	| |	
☒ **S**TEMI Receiving Center	UCL	15
☐ Prim**A**ry Stroke Center	| |	
☐ Comprehensive Stro**K**e Center	| |	
☐ Peri**N**atal (>20wks pregnancy)	| |	
☐ SA**R**T	| |	
☐ **O**ther	| |	
Time Clear	| | | |	
Time Receiving Hospital Notified	| | | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
- ☐ **N**ot Required
- ☒ **R**equired/Criteria Met
- ☐ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter - ETA: _____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**MI** ☐ Stro**K**e
☐ SC Not Accessib**L**e ☐ Cardiac Arrest (**X**)
☐ **U**nmanageable Airway ☐ Minimal In**J**uries
☐ Jud**G**ment *(Provider/Base)* ☐ Shared Am**B**ulance
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown
☐ **I**CU ☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |__|__|__| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- *(Run Type at top right of form is IFT)*
- Enter hospital codes for the closest MAR and SRC
- Indicate the actual destination by checking SRC
- Destination Rationale is left blank, as there is no deviation from destination principles

ED Saturation

55 y/o female, c/o abdominal pain x 3 days. The closest facility has requested diversion due to ED saturation:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☐ **M**AR	NRH	5
☐ **E**DAP (age ≤14)	| |	
☐ **T**C	| |	
☐ PT**C** (trauma, age ≤14)	| |	
☐ **P**MC (medical, age ≤14)	| |	
☐ **S**TEMI Receiving Center	| |	
☐ Prim**A**ry Stroke Center	| |	
☐ Comprehensive Stro**K**e Center	| |	
☐ Peri**N**atal (≥20wks pregnancy)	| |	
☐ SA**R**T	| |	
☒ **O**ther	MCP	12
Time Clear	| | | |	
Time Receiving Hospital Notified	| | | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
- ☒ **N**ot Required
- ☐ **R**equired/Criteria Met
- ☐ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter - ETA: _____
☐ **N**o Transport

DESTINATION RATIONALE:

☒ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Stro**K**e
☐ SC Not Accessib**L**e ☐ Cardiac Arrest (**X**)
☐ **U**nmanageable Airway ☐ Minimal In**J**uries
☐ Jud**G**ment *(Provider/Base)* ☐ Shared Am**B**ulance
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown
☐ **I**CU ☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |__|__|__| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital code for the closest MAR
- Indicate the actual destination by checking Other, and enter the hospital code for the actual destination
- Check Specialty Center: Not Required (AP as described meets no specialty center criteria or guidelines as per Reference No. 502)
- Destination Rationale is ED Saturation, as patient did not go to the MAR due to diversion request for ED Saturation

Specialty Center Diversion

17 y/o male, single stab wound to LUQ, CC = PA, MOI = ST. Most accessible trauma center has requested trauma diversion:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☐ **M**AR	MHG	8
☐ **E**DAP (age ≤14)	| |	
☐ **T**C	SFM	10
☐ PT**C** (trauma, age ≤14)	| |	
☐ **P**MC (medical, age ≤14)	| |	
☐ **S**TEMI Receiving Center	| |	
☐ Prim**A**ry Stroke Center	| |	
☐ Comprehensive Stro**K**e Center	| |	
☐ Peri**N**atal (≥20wks pregnancy)	| |	
☐ SA**R**T	| |	
☒ **O**ther	HGH	15
Time Clear	| | | |	
Time Receiving Hospital Notified	| | | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
- ☐ **N**ot Required
- ☒ **R**equired/Criteria Met
- ☐ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter - ETA: _____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T
SC diversion: ☒ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Stro**K**e
☐ SC Not Accessib**L**e ☐ Cardiac Arrest (**X**)
☐ **U**nmanageable Airway ☐ Minimal In**J**uries
☐ Jud**G**ment *(Provider/Base)* ☐ Shared Am**B**ulance
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown
☐ **I**CU ☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |__|__|__| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR and TC

- Indicate the actual destination by checking Other, and enter the hospital code for the actual destination
- Check Specialty Center: Required/Criteria Met (PA is a criteria for transport to a TC as per Reference No. 506)
- Destination Rationale is SC Diversion: TC/PTC, as patient was not transported to closest TC due to diversion request

Conducted Electrical Weapon (CEW, aka Taser®)

34 y/o male, status post deployment of a conducted electrical weapon (CEW, trade name Taser®) dart to chest, minor laceration to chest, no other trauma or associated signs or symptoms. CC = PL, MOI = OT:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☒ **M**AR	PLB	3
☐ **E**DAP (age ≤14)	| |	
☐ **T**C	LBM	5
☐ PT**C** (trauma, age ≤14)	| |	
☐ **P**MC (medical, age ≤14)	| |	
☐ **S**TEMI Receiving Center	| |	
☐ Prim**A**ry Stroke Center	| |	
☐ Comprehensive Stro**K**e Center	| |	
☐ Peri**N**atal (≥20wks pregnancy)	| |	
☐ SA**R**T	| |	
☐ **O**ther	| |	
Time Clear	| | | |	
Time Receiving Hospital Notified	| | | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
☒ **N**ot Required
☐ **R**equired/Criteria Met
☐ **G**uidelines Met

PT TRANSPORTED VIA:

☐ **A**LS ☒ **B**LS ☐ **O**ther
☐ **H**elicopter - ETA: _____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Stro**K**e
☐ SC Not Accessib**L**e ☐ Cardiac Arrest (**X**)
☐ **U**nmanageable Airway ☐ Minimal In**J**uries
☐ Jud**G**ment *(Provider/Base)* ☐ Shared Am**B**ulance
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown
☐ **I**CU ☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |__|__|__| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR and TC
- Indicate the actual destination by checking MAR
- Check Specialty Center: Not Required (PL is not a criteria or guideline for transport to a TC as per Reference No. 506)
- Destination Rationale is left blank, as there is no deviation from destination principles

Minimal Injuries

17 y/o male, status post leg struck by car in parking lot, minor abrasion to foot, no deformity, no other trauma or associated signs or symptoms. CC = BE, MOI = PB:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☒ **M**AR	BMC	3
☐ **E**DAP (age ≤14)	| |	
☐ **T**C	UCL	15
☐ PT**C** (trauma, age ≤14)	| |	
☐ **P**MC (medical, age ≤14)	| |	
☐ **S**TEMI Receiving Center	| |	
☐ Prim**A**ry Stroke Center	| |	
☐ Comprehensive Stro**K**e Center	| |	
☐ Peri**N**atal (≥20wks pregnancy)	| |	
☐ SA**R**T	| |	
☐ **O**ther	| |	
Time Clear	| | | |	
Time Receiving Hospital Notified	| | | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
☐ **N**ot Required
☐ **R**equired/Criteria Met
☒**G**uidelines Met

PT TRANSPORTED VIA:

☐ **A**LS ☒ **B**LS ☐ **O**ther
☐ **H**elicopter - ETA: _____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Stro**K**e
☐ SC Not Accessib**L**e ☐ Cardiac Arrest (**X**)
☐ **U**nmanageable Airway ☒ Minimal In**J**uries
☐ Jud**G**ment *(Provider/Base)* ☐ Shared Am**B**ulance
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown
☐ **I**CU ☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |__|__|__| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR and TC
- Indicate the actual destination by checking MAR
- Check Specialty Center: Guidelines Met (PB is a guideline for transport to a TC as per Reference No. 506)
- Destination Rationale is Minimal Injuries, as patient was not transported to the closest TC, due to minimal injuries

Shared Ambulance

8 y/o male, restrained rear passenger in a moderate speed MVA. Pt. c/o LLE pain only, no deformity noted. CC = BE, MOIs = EV, SB. Patient's mother was unrestrained driver and meets trauma criteria:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☐ **M**AR	DCH	3
☐ **E**DAP (age ≤14)	DCH	3
☐ **T**C	| |	
☐ PT**C** (trauma, age ≤14)	LBM	20
☐ **P**MC (medical, age ≤14)	| |	
☐ **S**TEMI Receiving Center	| |	
☐ Prim**A**ry Stroke Center	| |	
☐ Comprehensive Stro**K**e Center	| |	
☐ Peri**N**atal (≥20wks pregnancy)	| |	
☐ SA**R**T	| |	
☒ **O**ther	SFM	8
Time Clear	| | |	
Time Receiving Hospital Notified	| | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
- ☐ **N**ot Required
- ☒ **R**equired/Criteria Met
- ☐ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter - ETA: _____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Stro**K**e ☐ SC Not Accessib**L**e ☐ Cardiac Arrest (**X**)
☐ **U**nmanageable Airway ☐ Minimal In**J**uries
☐ Jud**G**ment *(Provider/Base)* ☒ Shared Am**B**ulance
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown
☐ **I**CU ☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |__|__|__| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital codes for the closest MAR, EDAP, and PTC
- Indicate the child's actual destination by checking Other (patient not transported to MAR, EDAP, or PTC) and enter the hospital code for the actual destination
- Check Specialty Center: Required/Criteria Met (EDAP, PMC or PTC is required for all pediatric patients)
- Destination Rationale is Shared Ambulance, as patient was transported to Other

Patient Request

82 y/o male, c/o cough and fever x 3 days, vital signs stable. Pt. is a Kaiser member and is requesting transport to Kaiser – which is accessible but not the MAR:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☐ **M**AR	DCH	3
☐ **E**DAP (age ≤14)	| |	
☐ **T**C	| |	
☐ PT**C** (trauma, age ≤14)	| |	
☐ **P**MC (medical, age ≤14)	| |	
☐ **S**TEMI Receiving Center	| |	
☐ Prim**A**ry Stroke Center	| |	
☐ Comprehensive Stro**K**e Center	| |	
☐ Peri**N**atal (≥20wks pregnancy)	| |	
☐ SA**R**T	| |	
☒ **O**ther	KFB	6
Time Clear	| | |	
Time Receiving Hospital Notified	| | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
- ☒ **N**ot Required
- ☐ **R**equired/Criteria Met
- ☐ **G**uidelines Met

PT TRANSPORTED VIA:

☒ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter - ETA: _____
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Stro**K**e ☐ SC Not Accessib**L**e ☐ Cardiac Arrest (**X**)
☐ **U**nmanageable Airway ☐ Minimal In**J**uries
☐ Jud**G**ment *(Provider/Base)* ☐ Shared Am**B**ulance
☒ **R**equested by: *Patient* ☐ **O**ther:

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown
☐ **I**CU ☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |__|__|__| (Hosp. code) ☐ **O**ther: _____
ED Diagnosis:

- Enter hospital code for the closest MAR
- Indicate the actual destination by checking Other, and enter the hospital code for the actual destination

- Check Specialty Center: Not Required (CC and FE, as described meet no specialty center criteria or guidelines as per Reference No. 502)
- Destination Rationale is Requested by: Patient, as patient did not go to the MAR due to patient request

AMA

36 y/o female, history of diabetes, status post altered mental status resolved with paramedic administration of D50 for blood glucose of 40. GCS now 4-6-5, no complaints, vital signs stable. The patient has decided she does not want to be transported to the hospital and wishes to sign out against the medical advice of the paramedics and MICN:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☐ **M**AR	AMH	3
☐ **E**DAP (age ≤14)	| |	
☐ **T**C	| |	
☐ PT**C** (trauma, age ≤14)	| |	
☐ **P**MC (medical, age ≤14)	| |	
☐ **S**TEMI Receiving Center	| |	
☐ Prim**A**ry Stroke Center	| |	
☐ Comprehensive Stro**K**e Center	| |	
☐ Peri**N**atal (≥20wks pregnancy)	| |	
☐ SA**R**T	| |	
☐ **O**ther	| |	
Time Clear	| | |	
Time Receiving Hospital Notified	| | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
☒ **N**ot Required
☐ **R**equired/Criteria Met
☐ **G**uidelines Met

PT TRANSPORTED VIA:

☐ **A**LS ☐ **B**LS ☐ **O**ther
☐ **H**elicopter - ETA: _____
☒ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Stro**K**e
☐ SC Not Accessib**L**e ☐ Cardiac Arrest (**X**)
☐ **U**nmanageable Airway ☐ Minimal In**J**uries
☐ Jud**G**ment *(Provider/Base)* ☐ Shared Am**B**ulance
☐ **R**equested by: ☐ **O**ther:

REASON FOR NO TRANSPORT:

☒ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown
☐ **I**CU ☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |__|__|__| (Hosp. code) ☐ **O**ther:
_____
ED Diagnosis:

- Enter hospital code for the closest MAR
- No actual destination is indicated, as patient is not transported
- Check Specialty Center Not Required (adult with status post medical ALOC does not meet Specialty Center criteria or guidelines)
- Destination Rationale is left blank, as there is no destination
- Reason for No Transport is AMA

Hyperbaric Chamber

25 y/o male, status post scuba diving accident, GCS 2-1-4, no signs of trauma, helicopter transport 5 minutes away:

TRANSPORT

CODE all options, **CHECK** actual destination:	**CODE**	**ETA**
☐ **M**AR	AHM	3
☐ **E**DAP (age ≤14)	| |	
☐ **T**C	| |	
☐ PT**C** (trauma, age ≤14)	| |	
☐ **P**MC (medical, age ≤14)	| |	
☐ **S**TEMI Receiving Center	| |	
☐ Prim**A**ry Stroke Center	| |	
☐ Comprehensive Stro**K**e Center	| |	
☐ Peri**N**atal (≥20wks pregnancy)	| |	
☐ SA**R**T	| |	
☒ **O**ther	USC	25
Time Clear	| | |	
Time Receiving Hospital Notified	| | |	
Name of Person Notified:		

CHECK ONE:

Specialty Center:
☒ **N**ot Required
☐ **R**equired/Criteria Met
☐ **G**uidelines Met

PT TRANSPORTED VIA:

☐ **A**LS ☐ **B**LS ☐ **O**ther
☒ **H**elicopter - ETA: 5
☐ **N**o Transport

DESTINATION RATIONALE:

☐ **E**D Saturation ☐ Int. **D**isaster ☐ **C**T Diversion ☐ I**F**T
SC diversion: ☐ **T**C/PTC ☐ **P**MC ☐ STE**M**I ☐ Stro**K**e
☐ SC Not Accessib**L**e ☐ Cardiac Arrest (**X**)
☐ **U**nmanageable Airway ☐ Minimal In**J**uries
☐ Jud**G**ment *(Provider/Base)* ☐ Shared Am**B**ulance
☐ **R**equested by: ☒ **O**ther: HBC

REASON FOR NO TRANSPORT:

☐ **A**MA ☐ **D**OA ☐ **U**nwarranted ☐ **O**ther
☐ **P**ronounced by: _____, MD

DISPO

If Base is receiving hospital: ☐ **D**ischarged ☐ **W**ard ☐ **S**tepdown
☐ **I**CU ☐ O**R** ☐ **C**ath Lab ☐ I**N**t'l Radiology ☐ **E**xpired in ED ☐ O**B**
Transferred to: _____ |__|__|__| (Hosp. code) ☐ **O**ther:
_____
ED Diagnosis:

- Enter hospital code for the closest MAR
- Indicate the actual destination by checking Other, and enter the hospital code for the actual destination
- Check Specialty Center Not Required (an unconscious patient status post scuba diving accident shall go immediately to a MAC-listed hyperbaric chamber, as per Reference No. 518)
- Destination Rationale is Other: HBC (hyperbaric chamber)

DISPO SECTION

IF BASE IS RECEIVING HOSPITAL

Definition

Checkboxes indicating the emergency department disposition of patients transported to the base hospital

Field Values

- **D**ischarged: Patient was discharged home from the emergency department
- **W**ard: Patient was admitted to a medical/surgical ward
- **S**tepdown: Patient was admitted to a Direct Observation Unit (DOU), Stepdown Unit, or Telemetry Unit
- **I**CU: Patient was admitted to an Intensive Care Unit or Cardiac Care Unit
- O**R**: Patient was transferred directly from the emergency department to the operating room
- **C**ath Lab: Patient was transferred directly from the emergency department to the Cardiac Catheterization Lab
- I**N**t'l Radiology: Patient was transferred directly from the emergency department to Interventional Radiology for embolization, angiography, etc.
- **E**xpired in ED: Patient died in the emergency department
- O**B**: Patient was admitted to an obstetrics department
- **T**ransferred to: Patient was transferred directly from the emergency department to another healthcare facility – document the name of the facility or the three-letter hospital code in the space provided
- **O**ther: Patient disposition other than those listed above – document disposition on the line provided
- ED Diagnosis: Emergency department diagnosis as documented by a physician – is entered into TEMIS as an ICD-9 code

Additional Information

- Mandatory field for all patients for whom the base hospital contacted is the receiving facility
- May be completed at a later time by personnel other than the MICN/MD contacted

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- ED Records
- Other hospital records

COMMENTS

Definition

Space provided for documentation of any additional information

Field Values

- Free text

Additional Information

- Base Hospital Form Page 2 can be utilized if additional space is needed for documentation

Uses

- Additional documentation, if needed

Data Source Hierarchy

- Base Hospital Form

MICN/PHYSICIAN

Definition

Signature and certification/identification number of the MICN and/or Base physician contacted

Field Values

- Free text

Additional Information

- Mandatory field for all base hospital contacts
- First initial and last name is sufficient for signature
- If **both** a MICN and a physician handle the call, or if a physician is consulted during the run, both names and numbers are documented

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Base Hospital Form
- Base Hospital Log

PATIENT NAME/NUMBER

Definition

Patient's name/hospital medical record number

Field Values

- Free text

Additional Information

- May be completed at a later time by personnel other than the MICN/MD contacted

Uses

- Patient identification
- Link between other databases

Data Source Hierarchy

- Base Hospital Form
- EMS Report Form
- ED Records
- Other hospital records

APPENDIX

MANDATORY DATA FIELDS FOR ALL FULL CALLS

Field Values

- Gen Info:
  - Log and Sequence #
  - Date and Time of Call
  - Provider Code and Unit #
  - Age, Age Units, and Sex of Patient
  - Pediatric Weight (in kilograms, from length-based tape)
  - Pediatric Weight Color Code
  - Hospital Code of base handling the run
  - Communication and Call Type
  - Location
- Assessment:
  - Chief Complaint
  - Severity of Distress
- Physical:
  - LOC/GCS
  - mLAPSS (if CC=LN, or actual destination =PSC or CSC for suspected stroke)
  - Last Known Well Date/Time (if mLAPSS met = Y, or if patient was transported to a PSC or CSC for suspected stroke)
  - LAMS Score (if mLAPSS met=Y)
  - Adv Airway (if advanced airway placed): BS after ETT/King, and CO_2 Detection, if applicable
- ECG/Arrest:
  - Initial Rhythm (for all patients placed on a cardiac monitor or on whom a 12-lead is performed)
  - Interpretation (for all patients on whom a 12-lead is performed)
  - For all 12-lead ECGs with an interpretation of “STEMI”
    - 12-lead time
    - Artifact?
    - Wavy Baseline?
    - Paced Rhythm?
  - For all patients with a chief complaint of “CA”
    - Initial Rhythm
    - Witnessed by
    - CPR by
    - Arrest to CPR (if arrest is witnessed)
    - Rtn of Pulse (ROSC)?
    - Rtn of Pulse (ROSC) @ (if patient has return of pulses)
    - Resus D/C Rhythm (if resuscitative measures are discontinued or patient is pronounced)
    - Total Min. EMS CPR (if resuscitative measures are discontinued or patient is pronounced)
    - Resuscitation D/C’d @ (if resuscitative measures are discontinued or patient is pronounced)

- Vitals/TXs:
  - Intravenous Access
  - Medications ordered (name) and PRN, if applicable
- Trauma:
  - Trauma Complaint
  - Mechanism of Injury
    - Includes PSI, 12” or 18” if applicable
- Transport:
  - Destination options (MAR, TC, etc.)
  - Actual transport destination (if patient was transported)
  - Check One
  - Pt Transported Via
  - Destination Rationale (if applicable)
  - Reason For No Transport (if patient was not transported)
- Dispo:
  - Time Clear
  - Time Receiving Hospital Notified (for all patients transported to a receiving facility other than the base hospital)
  - ED Diagnosis (if the base is the receiving facility)
  - Patient Disposition (if the base is the receiving facility)
- Signature:
  - MICN # (if MICN handled the call)
  - Physician # (if the physician handled the call or was consulted by the MICN)

MANDATORY DATA FIELDS FOR ALL SFTP CALLS

Field Values

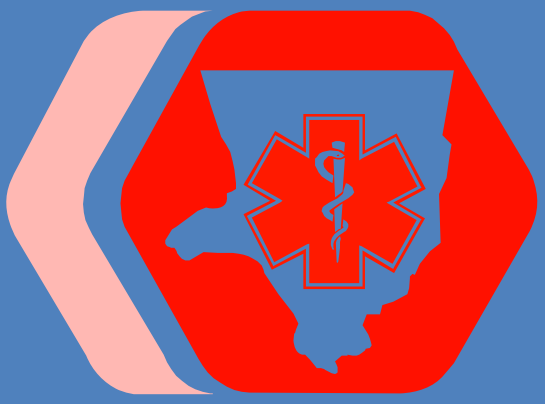
- Gen Info:
  - Log and Sequence #
  - Date and Time of Call
  - Provider Code and Unit Number
  - Age, Age Units, and Sex
  - Pediatric Weight (in kilograms, from length-based tape) and Color Code
  - Hospital Code of base handling run
  - Communication and Call Type
  - Location
- Assessment:
  - Chief Complaint
  - Severity of Distress
  - Protocol Used
- Physical:
  - GCS (for Protocol 1243)
  - mLAPSS, Last Known Well Date/Time, LAMS Score (for Protocol 1251)
- ECG/Arrest (for Protocol 1244)
  - Initial Rhythm and Interpretation
  - For all 12-lead ECGs with an interpretation of “STEMI”
    - 12-lead time
    - Artifact?
    - Wavy Baseline?
    - Paced Rhythm?
  - ROSC? and ROSC@ (for Protocol 1210, if applicable)
- Vitals/TXs:
  - Glucometer (for Protocol 1251)
- Trauma:
  - Trauma Complaint
  - Mechanism of Injury
  - If patient was transported to a trauma center for criteria/guidelines/judgment:
    - Complete vital signs
    - GCS
- Transport:
  - Actual Transport Destination (if patient was transported)
  - Check One
  - Pt Transported Via
  - Destination Rationale (if applicable)
  - Reason For No Transport (if patient was not transported)
- Dispo:
  - Time Clear
  - Time Receiving Hospital Notified (for all patients transported to a receiving facility other than the base hospital)
  - ED Diagnosis (if the base is the receiving facility)

  - Patient Disposition (if the base is the receiving facility)
- Signature
  - MICN # (if the MICN handled the call)
  - Physician # (if the physician handled the call or was consulted by the MICN)

TRAUMA CENTER DATA DICTIONARY

Los Angeles County

Emergency Medical Services Agency



Incorporating:
National Trauma Data Standards (NTDS) 2016 Admissions
Trauma Quality Improvement Program

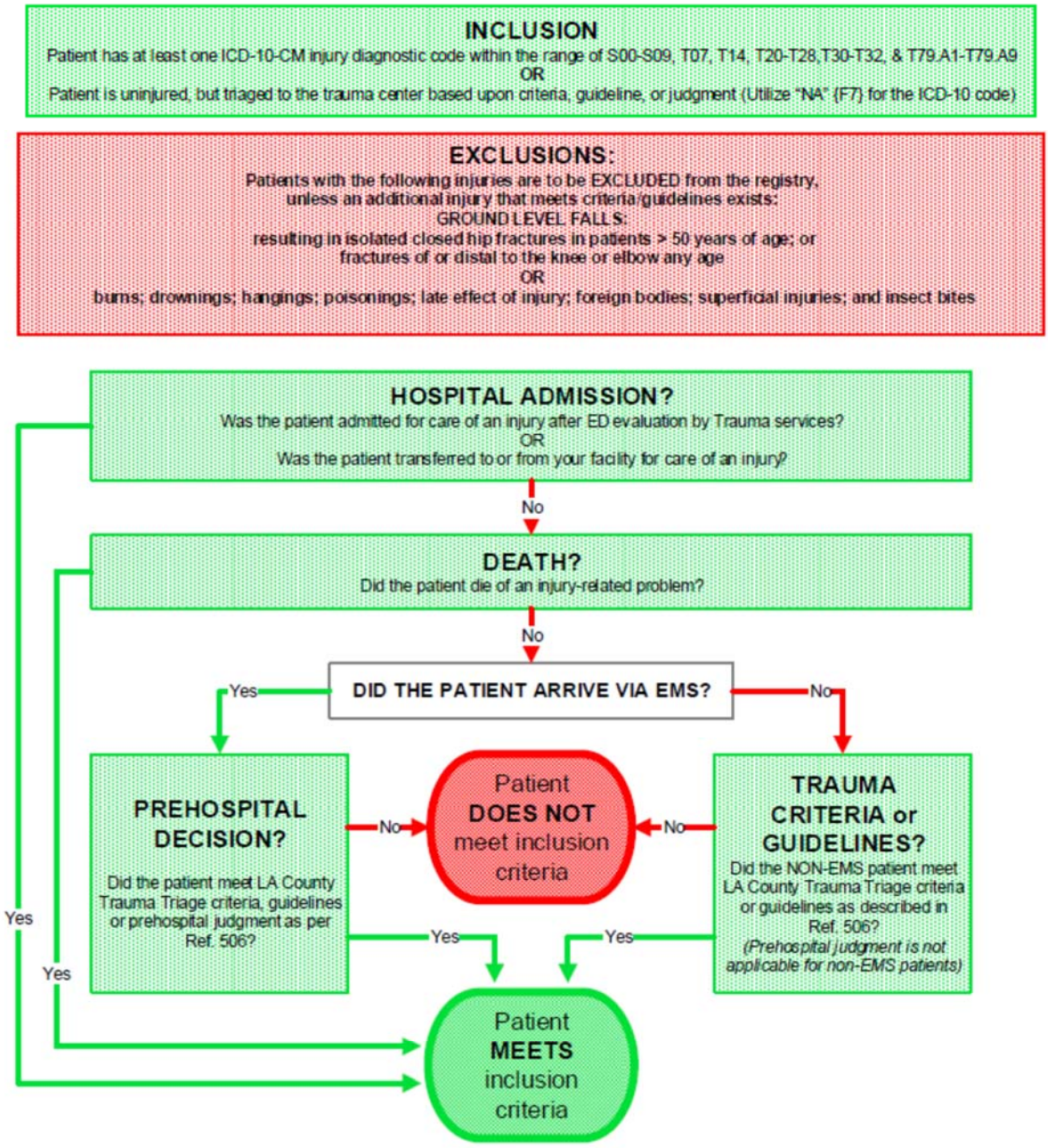
TABLE OF CONTENTS

Los Angeles County Trauma Database Patient Inclusion Criteria

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT C

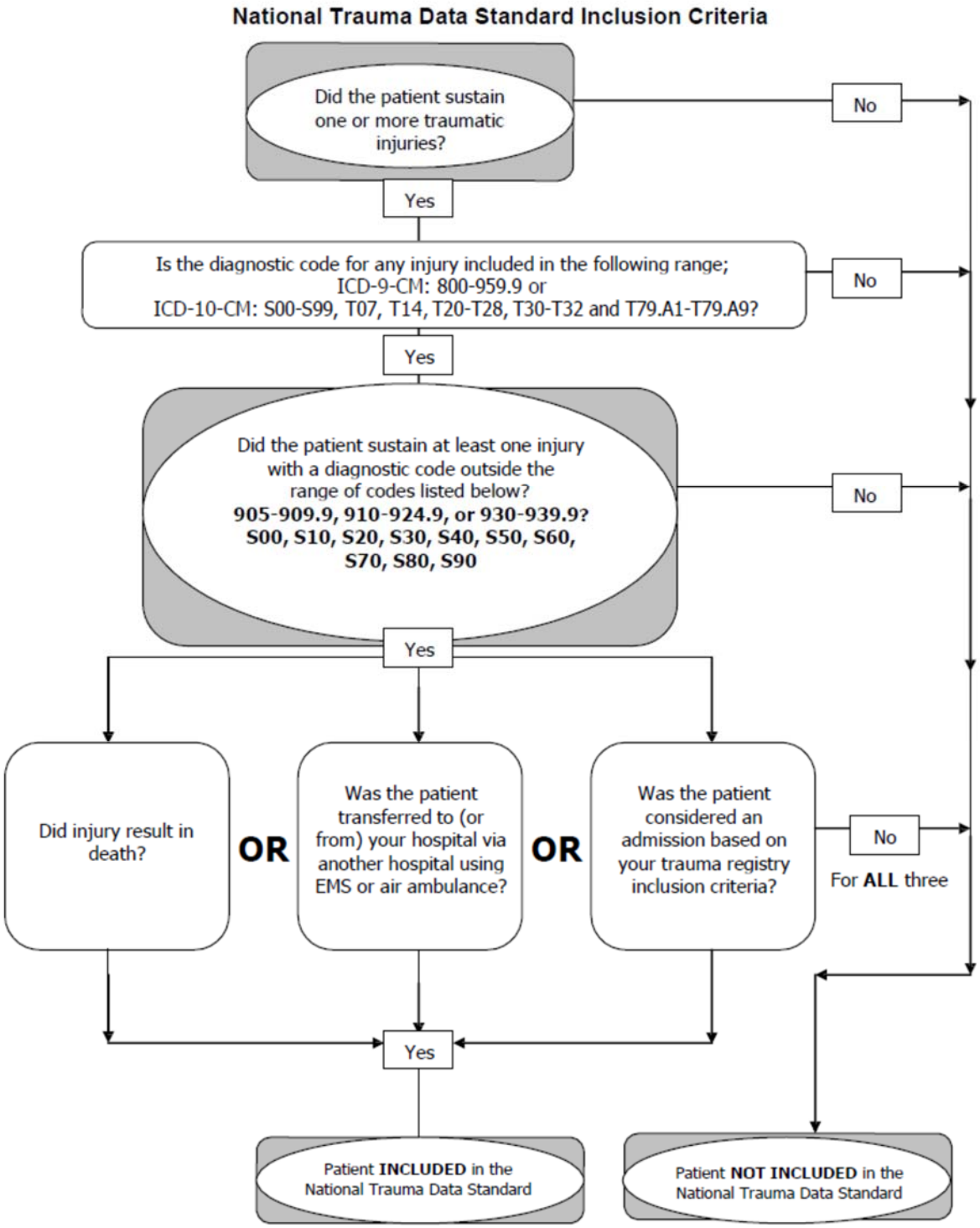
PATIENT INCLUSION IN THE TRAUMA DATA SYSTEM



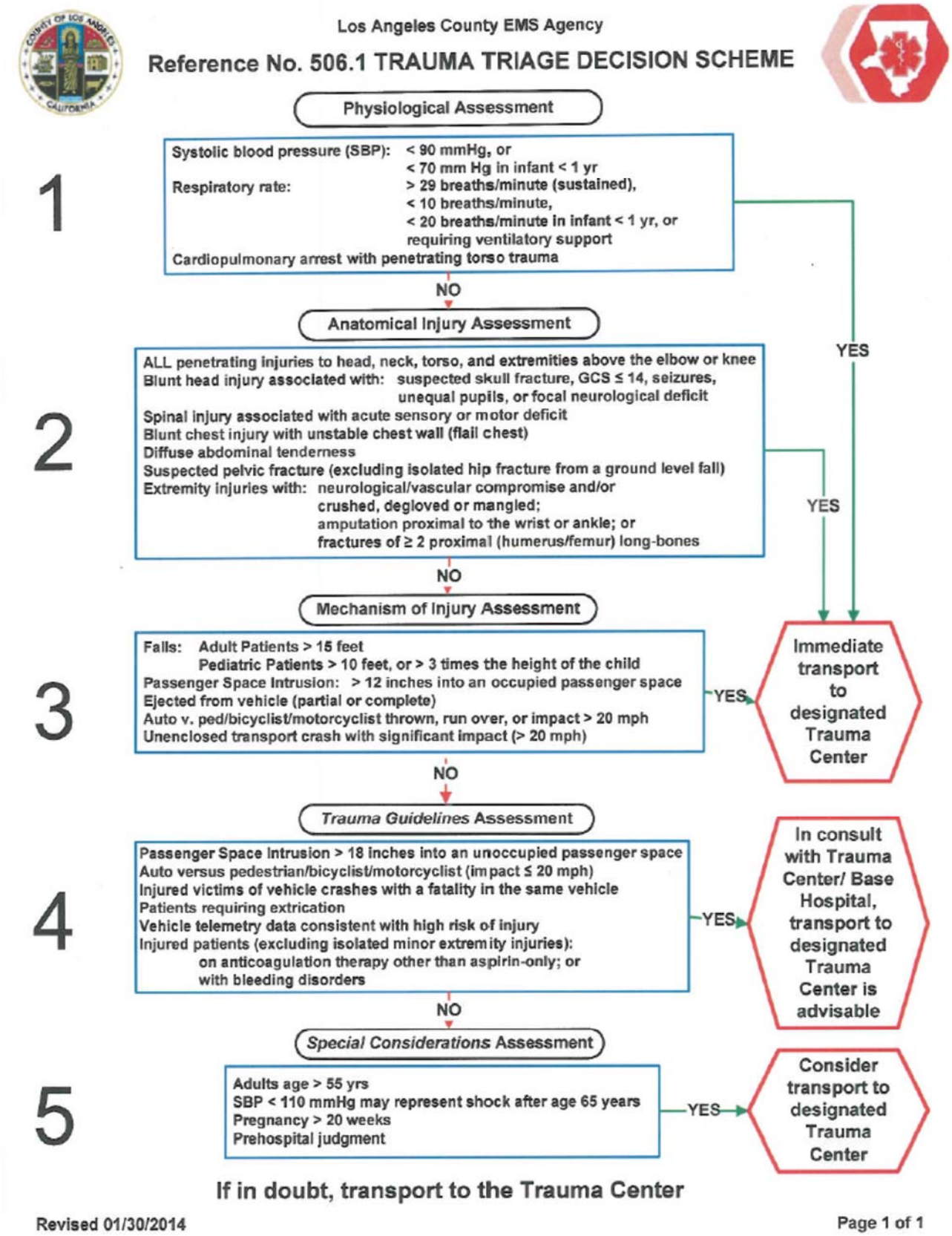
CASES ENTERED INTO THE REGISTRY THAT DO NOT MEET "EXHIBIT C" CRITERIA MUST BE IDENTIFIED AS "DHS=NO", AND HAVE THE TPS RATIONALE OF "DHS=NO" INDICATED.

January 1, 2016 (Implemented)
Valid until amended by the EMS Agency
(Replaces Exhibit C dated April 1, 2015)

2016 NATIONAL TRAUMA DATA STANDARD INCLUSION CRITERIA



Reference No. 506.1 TRAUMA TRIAGE DECISION SCHEME



TRAUMA PATIENT SUMMARY (TPS) FORM - Page 1

TRAUMA PATIENT SUMMARY (TPS) FORM – PAGE 1

GENERAL INFO

LAST NAME	FIRST NAME	INIT.	ARRIVAL DATE / /

ADDRESS: ☐ Unknown ☐ Homeless

SEX: M F | D.O.B.: / / | AGE: ☐YR ☐MO ☐DAY ☐HR ☐ESTIMATE | HT. | WT.

RACE/ETHNICITY: ☐ Asian ☐ Black ☐ Filipino ☐ Hispanic ☐ Other ☐ Native American ☐ Pacific Islander, Other/Hawaiian ☐ White ☐ Unk

EMS Form available? ☐ Y ☐ N | SEQ #

ENTRY MODE: ☐ EMS ☐ NON-EMS
TRANSFER: ☐ ED to ED ☐ Direct Admit ☐ 9-1-1 Re-triage
VIA: ☐ Ground ☐ Air ☐ Vehicle ☐ Walk-in ☐ Police ☐ Other

TRANS FROM (TF): __I__I__
TF Arrival Time ___:___
TF Exit Time ___:___

MR #

OTH #

PREHOSP / WALK-INS

INJURY DATE __/__/__
INJURY TIME ___:___
PROVIDER _____
RA / SQUAD _____
DISPATCH DATE __/__/__
DISPATCH TIME ___:___
1ST ON SCENE ___:___
TRANSPORT ARR ___:___
TRANSPORT LEFT ___:___

INJURY DESCRIPTION I I I I ☐ Blunt
MECHANISM OF INJURY I I I I ☐ Penetrating

PROTECTIVE DEVICES
☐ None ☐ Helmet
☐ Protective clothing
☐ Non-clothing gear
☐ Eye protection
☐ Personal Flotation Device

AIRBAG DEPLOYED? ☐ Y ☐ N *(front)*
☐ Side ☐ Other *(curtain, knee,etc.)*
☐ Shoulder belt ☐ Lap belt
☐ Infant seat ☐ Child car seat
☐ Booster seat
☐ Other:

1st FIELD GCS: E_____ V_____ M_____ TOTAL _____
1st FIELD VS: BP_____/_____ HR_____ RR_____ O_2 SAT____%

PRIMARY E-CODE:

OTHER E/V-CODES:

LOCATION CODES:

INJ. ZIP CODE: *If unk, must complete all known Address fields, i.e., City/County/State*

FIELD INTUBATION? ☐ Y ☐ N | PREHOSP CARDIAC ARREST? ☐ Y ☐ N

WORK RELATED? ☐ Y ☐ N: | OCCUPATION: | INDUSTRY:

EMERGENCY DEPARTMENT

ED NOTIFIED? ☐ Y ☐ N | MET CRITERIA? ☐ Y ☐ N

ED ARRIVAL TIME ___:___
ED EXIT DATE __/__/__
ED EXIT TIME ___:___
ACTIVATION? Y N
TIME: ___:___
LEVEL: _____

1st ED VS TIME ___:___ BP _____/_____ HR _____ RR _____
O_2 Sat _____% ASST? ☐ Y ☐ N On O_2? ☐ Y ☐ N
TEMP:_____ F C TIME: ____:____
GCS: E____ M_____ V____ TOTAL _____
☐ Sedated ☐ Eye obstruction ☐ Intubated
Initial Pupillary Response: ☐ Both ☐ One ☐ None

ED Disposition Order: Date ___/___/____ Time ___:___

TPS RATIONALE: ☐ Prehospital Decision ☐ Non-EMS: Criteria/Guide ☐ Admitted for care of an injury after ED eval. by the Trauma Service ☐ Transferred for care of injury ☐ Died ☐ DHS = No

ADMITTING MD: | ADMITTING SERVICE:

MD SERVICE	MD CODE	REQ TIME	STAT?	ARR TIME
EMERGENCY PHYSICIAN (EDP)		:	Y N	:
TRAUMA SURGEON (TRS)		:	Y N	:
TRAUMA RESIDENT (TRR)		:	Y N	:
NEUROSURGEON (NES)		:	Y N	:
ORTHOPEDIST (ORT)		:	Y N	:
ANESTHESIOLOGIST (ANE)		:	Y N	:
		:	Y N	:
		:	Y N	:
		:	Y N	:
		:	Y N	:

1st Antibiotic Administration: IF Blunt Open Tibial Fracture Date: / / Time: ___:___

IV FLUIDS in ED: _____ml | SIGNS OF LIFE ON ARRIVAL? ☐ Y ☐ N

DEATH IN ED: ☐ DOA (minimal/no resuscitations) ☐ <15min resuscitation ☐ Other death in ED

NEXT PHASE AFTER ED: ☐ <24hr ☐ OR ☐ ICU ☐ Ward ☐ Tele/Step ☐ Peds Ward ☐ Peds ICU ☐ Int Radiology ☐ SpecProc ☐ Posthosp

CRITERIA:
☐ BP<90/70
☐ RR<10/>29/<20
☐ Suspected Pelvic Fx
☐ Spinal Injury
Penetrating:
☐ Arrest
☐ Head
☐ Face/Mouth
☐ Neck
☐ Prox. to Knee/Elbow
Blunt:
☐ Head/GCS≤14
☐ Flail Chest
☐ Diff. Abd. Tend.
☐ ≥2 Long Bone Fxs
Extremity Injury:
☐ Neuro/Vasc. Compr.
☐ Amputation Prox. to wrist/Ankle
MOI:
☐ Ejected
☐ PSI:12
☐ Unencl. Veh. >20mph
☐ Fall >15' (10' peds)
☐ Ped/Bike vs. Auto >20mph
GUIDELINES:
☐ Extricated
☐ Ped/Bike vs. Auto <20mph
☐ PSI:18
☐ Survivor Fatal Accid.
☐ Telemetry Data
☐ Anticoags
SPECIAL:
☐ Pregnancy>20wks
☐ Age>55
☐ Age>65/SBP<110
☐ **JUDGMENT** Prehosp

TRAUMA PATIENT SUMMARY FORM (TPS) - Page 2

TRAUMA PATIENT SUMMARY (TPS) FORM – PAGE 2

NAME	ARRIVAL DATE: / /	SEQ#	MR#	OTH #

RADIOLOGY / LABORATORY

X-RAYS:

BODY PART	ICD-10	DATE	TIME	Nml/Abn
HEAD	BN00ZZZ	/	:	
NECK	BR00ZZZ	/	:	
CHEST	BW03ZZZ	/	:	
ABD	BW00ZZZ	/	:	
PELVIS	BR0CZZZ	/	:	
F.A.S.T	BW41ZZZ	/	:	
		/	:	

CT/ANGIO/MRI:

BODY PART	ICD-10	Contrast Y/N	DATE	TIME	Nml/Abn
HEAD	BN20ZZZ		/	:	
NECK	BR20ZZZ		/	:	
CHEST	BW24ZZZ		/	:	
ABD	BW20ZZZ		/	:	
PELVIS	BR2CZZZ		/	:	
			/	:	

Comments / Results:

Midline Shift? ☐ Y ☐ N ☐ Not Imaged	**TBI Inclusion?** ☐ Y ☐ N	**Highest GCS Total:**
Highest GCS Motor:	**GCS Qualifier:**	**SOLID ORGAN INJURY?** ☐ Y ☐ N

SOLID ORGAN GRADING		TIME	GRP/PANEL	Result/Tested?
LIVER	Grade:_____	:	HGB / HCT	NML ABN
SPLEEN	Grade:_____	:	TOX (BLOOD)	T NT F NF
RIGHT KIDNEY	Grade:_____	:	TOX (URINE)	T NT F NF
LEFT KIDNEY	Grade:_____	:	ETOH	T NT F NF

DRUGS OF ABUSE: ☐ Amphetamine ☐ Benzodiazepines ☐ Cannabinoids ☐ Cocaine ☐ Opiates ☐ PCP ☐ Other:

MTP Activated? ☐Y ☐ N	Blood Inclusion? ☐ Y ☐ N	Lowest Systolic B/P: W/in 1st hr. of arrival, IF PRBCs given w/in 1st 4 hrs.

BLOOD PRODUCTS:	4 HR	24 HR	HOSPITAL
PRBCs IF given w/in 1st 4 hours	_____ml	_____ml	_____ml
PLASMA IF PRBCs given w/in 1st 4 hours	_____ml	_____ml	_____ml
PLATELET IF PRBCs given w/in 1st 4 hours	_____ml	_____ml	_____ml
CRYO IF PRBCs given w/in 1st 4 hours	_____ml	_____ml	_____ml
TOTAL	_____ml	_____ml	_____ml

OPERATIONS / PROCEDURES

ENTER ALL THAT APPLY DURING HOSPITAL STAY:

PHASE	DATE	START @	END @	PROCEDURE	PHASE	DATE	START @	END @	PROCEDURE
	/	:	:	☐ ETT 0BH17EZ		/	:	:	☐ ICP 4A103BD
	/	:	:	☐ CRIC 0B110F4		/	:	:	☐ JUG BLUB ☐ EVD
	/	:	:	☐ (L) CHEST TUBE 0W9B3OZ		/	:	:	☐ IVC FILTER 06H00DZ
	/	:	:	☐ (R) CHEST TUBE 0W9930Z		/	:	:	☐ TRACH OBH10DZ
	/	:	:	☐ THORACOTOMY 02JA0ZZ		/	:	:	☐ PEG ODH63UZ
	/	:	:	☐ DPA 0W9G3ZX		/	:	:	☐ VENTILATOR
	/	:	:	☐ CENTRAL LINE 0JH60XZ	**TOTAL VENTILATORY DAYS** *(All Episodes)*				

PHASE	DATE	CUT TIME	END TIME	PROCEDURE	PROCEDURE ICD-10	SURG TYPE	MD CODE
	/	:	:				
	/	:	:				
	/	:	:				
	/	:	:				
	/	:	:				
	/	:	:				
	/	:	:				
	/	:	:				
	/	:	:				

ICP PLACED? ☐Y ☐ N	**Cerebral Monitor Type:**	**Cere. Mon. Date:** / /	**Cere. Mon. Time:** ___:___
Angiography:	**Embolization Site:**	**Angiography Date:** / /	**Angiography Time:** ___:___
Hem. Control Type:	**Hem. Control Date:** / /	**Hem. Control Time:** ___:___	

TRAUMA PATIENT SUMMARY FORM (TPS) - Page 3

TRAUMA PATIENT SUMMARY (TPS) FORM – PAGE 3

NAME	ARRIVAL DATE: / /	SEQ#	MR#	OTH #

OR

PHASE AFTER OR	ARRIVAL	EXIT
1ST VISIT _____	/ /	/ /
2ND VISIT _____	/ /	/ /
3RD VISIT _____	/ /	/ /
4TH VISIT _____	/ /	/ /
5TH VISIT _____	/ /	/ /

ICU

CONSULTS

DATE	SERVICE	MD CODE
/ /		
/ /		
/ /		
/ /		
/ /		
/ /		
/ /		
/ /		

TQIP

VTE Prophylaxis Inclusion? ☐ Y ☐ N	VTE Prophylaxis Type: _____	VTE Prophylaxis Date: / /	VTE Prophylaxis Time: ___:___
Withdrawal Of Care? ☐ Y ☐ N	Withdrawal Of Care Date: ___:___	Withdrawal Of Care Time: ___:___	

POSTHOSPITAL

HOSPITAL DISPOSITION DATE: / / **HOSPITAL DISPOSITION TIME:** ___:___

DISCHAGE DATE: / / **DISCHARGE TIME:** ___:___ **PRIOR PHASE:**

TRANSFERRED / DISCHARGED TO: ☐ Acute Care ☐ AMA/Eloped/LWBS ☐ Burn Ctr ☐ Home w/Home Hlth ☐ Home w/o ☐ Hospice ☐ Jail ☐ Morgue ☐ Rehab ☐ SNF ☐ SubAcute ☐ Trauma Ctr ☐ LTHC ☐ Psych ☐ Other

FACILITY: **VIA:** ☐ Air ☐ Ground

RATIONALE: ☐ Health Plan ☐ Financial ☐ Specialized /Higher Level Care ☐ Rehab ☐ Extended Care ☐ In Custody ☐ Other: _____

D/C CAPACITY: ☐ Pre-Injury Capacity (DC'd from ED with minimum or no injuries) ☐ Temporary Handicap (Admit for injuries) ☐ Permanent Handicap, >1yr limitations (excludes splenectomy

PHYSICAL ABUSE REPORTED? ☐ Y ☐ N **INVESTIGATION INITIATED?** ☐ Y ☐ N **CAREGIVER CHANGE?** ☐ Y ☐ N

☐ **LIVED** ☐ **DIED** **AUTOPSY UPDATE?** ☐ Y ☐ N **CORONER#** _____ ☐ N/A

ORGAN REFERRAL? ☐ Y ☐ N **ORGAN DONOR?** ☐ Y ☐ N

ORGANS DONATED: ☐ Heart ☐ Intestine ☐ Kidney (1) ☐ Kidneys (2) ☐ Liver ☐ Lung (1) ☐ Lungs (2) ☐ Pancreas

DISCHARGE DIAGNOSES	ICD-10	AIS	BODY REG	DISCHARGE DIAGNOSES	ICD-10	AIS	BODY REG

NTDS CO-MORBID CONDITIONS ☐ No NTDS Co-Morbids ☐ ADD/HD ☐ Alcoholism ☐ Angina (w/in 30d) ☐ Ascites (w/in 30d) ☐ Bleeding Disorder ☐ Chemo (currently rec'g) ☐ CHF ☐ Cirrhosis ☐ Congenital Anomalies ☐ Smoker (now) ☐ CVA/Neuro Deficit ☐ Dementia ☐ Diabetes ☐ Disseminated Cancer ☐ Drug Abuse/Depend. ☐ DNR ☐ Dialysis (needs/on) ☐ Fxn'l Dependent Hlth Status ☐ HTN (req'g meds) ☐ Impaired Sensorium ☐ Major Psych Illness ☐ MI (w/in 6mons) ☐ Obesity ☐ Prematurity ☐ Resp Disease ☐ Sz Disorder ☐ Steroid Use ☐ Revasc/Amp for Periph Vasc Disease ☐ Other:

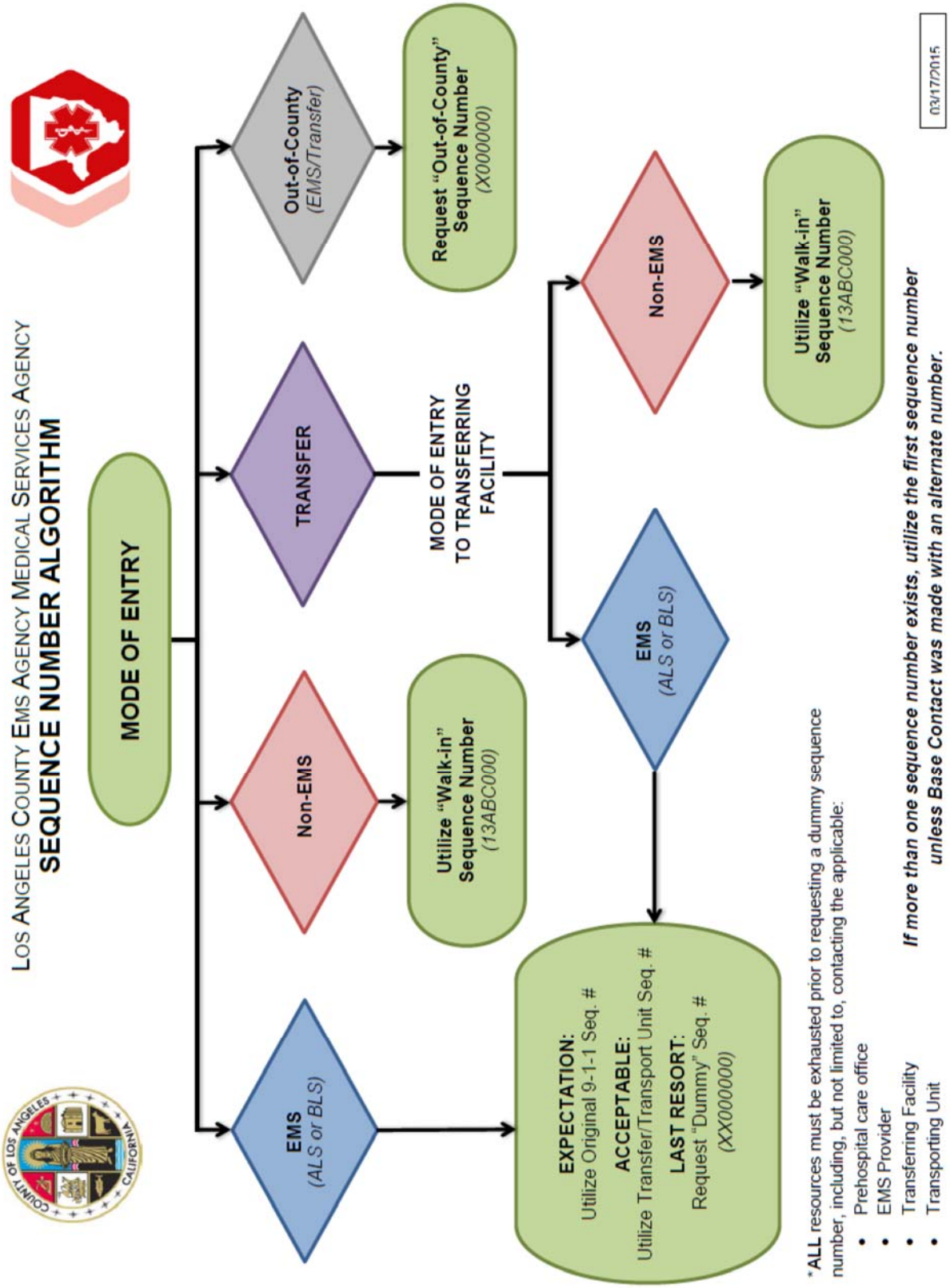
NTDS COMPLICATIONS ☐ No NTDS Complications ☐ Abd Compart Synd ☐ Abd Fascia Left Open ☐ ARDS ☐ Acute Kidney Inj w/dialysis ☐ Acute MI (w/in 30 days) ☐ Base Deficit ☐ Bleeding w/transfusion ☐ Cath.-Rel. Blood Inf ☐ Coagulopathy ☐ Coma ☐ CPR ☐ CVA ☐ Decub Ulcer ☐ Drug/ETOH Withdrawal ☐ DVT ☐ Extremity Comp. Synd ☐ Graft/Prosth/Flap Failure ☐ ↑ICP ☐ Osteomyelitis ☐ PE ☐ Pneumonia Surg Site Infection: ☐ Superficial ☐ Deep ☐ Organ/Space ☐ Sepsis ☐ Unanticipated Intub ☐ Unplanned Readmit ☐ Unplanned Rtn ICU ☐ Unplanned Rtn OR ☐ UTI ☐ Wound Disruption ☐ Wound Inf ☐ Other:

FINANCES

Pvt/Commercial Insurance:	Government:	Self:	Medicaid:
☐ HMO	☐ CCS (California Children's Services)	☐ Cash	☐ Medi-Cal
☐ Medi-Cal HMO	☐ CHIP eligible	☐ ATP w/liability	☐ Medi-Cal pending
☐ Auto Insurance	☐ Custody Funds	☐ Pre-pay	☐ Medicare/ Medicare HMO
☐ Worker's Comp.	☐ Military Insurance	**Not billed:**	
☐ Organ Donor Subsidy	☐ VOC (Victims of Crime)	☐ Charity	TOTAL CHARGES:
☐ Other private carrier:	☐ Other Government:	☐ ATP w/o liability	$

Revised 05/10/2016 #CP

SEQUENCE NUMBER ALGORITHM



COMMON NULL VALUES

LA County Element
National Element

Definition

These values are to be used with each of the data elements described in this document which have been defined to accept the Null Values

Field Values

- Not Documented (F6)
- Not Applicable (F7)

Additional Information

- For any collection of data to be of value and reliably represent what was intended, a strong commitment must be made to ensure the correct documentation of incomplete data.
- Not Documented: This null value code applies if hospital documentation or an information system has an empty field or nothing is recorded. This null value signifies that the hospital patient care record provides a “placeholder” to document the specific data element, but that no value for that element was recorded for the patient. For example, a hospital patient care record may request date of birth, but none was recorded.
- Not Applicable: This null value code applies if, at the time of patient care documentation, the information requested was “Not Applicable” to the patient, the hospitalization or the patient care event. For example, variables documenting EMS care would be “Not Applicable” if a patient self-transports to the hospital.

FUNCTION AND HOT KEYS

LA County Element
National Element

Definition

These function and hot keys can be utilized at your discretion

Field Values

FUNCTION KEYS		HOT KEYS	
F2	Enter the current date or time.	^C	Copy
F3	Enter last entered date or time.	^E	Close … (Report, Pathway, Page, etc.)
F4	Restore default value in selected field.	^I	Make new window copy.
F6	Not Documented.	^K	Run cross-checks for all fields in the current window.
F7	Not Applicable.	^L	List open windows.
F8	Calculate selected calculable field.	^M	Open note attached to selected field.
^F8	Calculate all calculable fields in the window.	^N	New … (Report, Pathway, Page, etc.)
F9	Clear selected field.	^O	Open … (Report, Pathway, Page, etc.)
F10	Set the current pathway and page to the user's defaults.	^P	Open picklist for selected field.
F11	Move to the next field group defined on the current window/page. Data Entry	^S	Save … (Report, Pathway, Page, etc.)
F11	Place non-leaf picklist item in selected field. Report/Population	^T	Display descriptive text for the code entered in the selective field. Data Entry
Shift + F11	Move to the previous field group defined on the current window/page. Data Entry	^U	Undo
F12	Return to parent.	^V	Paste
^PgUp	Go to previous page in pathway or in multiple-paged window.	^X	Cut
^PgDn	Go to next page in pathway or in in multiple-paged window.	ALT + Q	Quick exit from the system.

(^ Control Key)

SCROLLING WINDOWS COMMANDS

LA County Element
National Element

Definition

These commands can be utilized at your discretion

Field Values

COMMANDS FOR SCROLLING WINDOWS	
PGUP	Move up a window full of items at a time in scrolling window and picklists.
PGDN	Move down a window full of items at a time in scrolling window and picklists.
^UP ARROW	Move out of scrolling window to previous item.
^DOWN ARROW	Move out of scrolling window to next item.
^A	Add new row to scrolling window.
^I	Insert new row above current row in scrolling window.
^D	Delete selected row in scrolling window.
^C	Copy selected row in scrolling window to the end of the scrolling window.
ALT+F9	Copy selected field value in scrolling window to the same field in successive rows having no values.
ALT+R	Resize scrolling windows and graphic boxes with arrows. (Valid only in Reconfiguration.)
^F	Go to first row in scrolling window.
^B	Go to last row in scrolling window.
SYSTEM-WIDE	
Single Click	Selects object.
Double Click	On an entry field, brings up associated picklist. On a picklist item, selects highlighted item or opens attached subpicklist. On a title bar, minimizes the window.
Right Click	On an entry field, brings up associated picklist. On a picklist item, selects highlighted item or opens attached subpicklist.
ESC	Close open picklist, dialog window, or menu.

(^ Control Key)

General Information

DHS? YES / NO

LA County Element **GEN_01**
National Element **N/A**

Definition

The patient's TEMIS database inclusion status

Field Values

- Y (Yes)
- N (No)

Additional Information

- "Yes" indicates that patient meets Exhibit C inclusion criteria "No" indicates that patient does not meet inclusion criteria
- Edit check: if "No" is selected, TPS Rationale must be "DHS=No"

Uses

- Allows facilities to capture data on patients not meeting Exhibit C inclusion criteria for their own purposes
- "No" indicates that patient data will not be included in the LA County trauma database and will not be submitted to NTDB

Other Associated Elements

- TPS RATIONALE

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** No

TRAUMA CENTER CODE

LA County Element **GEN_02**
National Element **N/A**

Definition

Three-letter code for the trauma center submitting data

Field Values

- Relevant value for data element

Additional Information

- Auto-populated as a read-only field – no user action necessary

Uses

- Identifies the treating facility

Data Format: [character, 3] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** No

LAST NAME

LA County Element **GEN_03**
National Element **N/A**

Definition

Patient's last name

Field Values

- Relevant value for data element

Data Source Hierarchy

1. Facesheet
2. ED Nurses Notes
3. Triage Form / Trauma Flow Sheet
4. EMS Report Form
5. Billing Sheet / Medical Records Coding Summary Sheet
6. ED Admission Form

Uses

- Patient identifier

Other Associated Elements

- FIRST NAME
- INIT

Data Format: [character, 25] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

FIRST NAME

LA County Element **GEN_04**
National Element **N/A**

Definition

Patient's first name

Field Values

- Relevant value for data element

Data Source Hierarchy

1. Facesheet
2. ED Nurses Notes
3. Triage Form / Trauma Flow Sheet
4. EMS Report Form
5. Billing Sheet / Medical Records Coding Summary Sheet
6. ED Admission Form

Uses

- Patient identifier

Other Associated Elements

- INIT
- LAST NAME

Data Format: [character, 12] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

MIDDLE INITIAL

LA County Element **GEN_05**
National Element **N/A**

Definition

Patient's middle initial

Field Values

- Relevant value for data element

Data Source Hierarchy

1. Facesheet
2. ED Nurses Notes
3. Triage Form / Trauma Flow Sheet
4. EMS Report Form
5. Billing Sheet / Medical Records Coding Summary Sheet
6. ED Admission Form

Uses

- Patient identifier

Other Associated Elements

- FIRST NAME
- LAST NAME

Data Format: [character, 1] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ARRIVAL DATE

LA County Element **GEN_14**
National Element **ED_01**

Definition

The date the patient arrived in the ED or was admitted to the hospital – whichever occurred first

Field Values

- Relevant value for data element

Additional Information

- If the patient was brought to the ED, enter the date patient arrived in the ED. If patient was directly admitted to the hospital, enter date patient was admitted to the hospital
- Collected as MM-DD-YYYY

Data Source Hierarchy

1. ED Record
2. Billing Sheet / Medical Records Coding Summary Sheet
3. Hospital Discharge Summary

Uses

- Allows data to be sorted based upon total length of hospital stay
- Used to calculate Total EMS Time (elapsed time from EMS dispatch to hospital arrival) and Total Length of Hospital Stay (elapsed time from ED/Hospital Arrival to ED/Hospital Discharge)

Other Associated Elements

- ARRIVAL TIME
- DISPATCH DATE/TIME
- TRANS ARR *(TRANSPORTING EMS UNIT ARRIVAL ON SCENE DATE/TIME)*
- TRANS LEFT *(TRANSPORTING EMS UNIT LEFT SCENE DATE/TIME)*

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

SEX

LA County Element **GEN_06**
National Element **D_12**

Definition

The patient's gender

Field Values

- M (Male)
- F (Female)

Additional Information

- Patients who are undergoing or have undergone a hormonal and/or surgical sex reassignment should be coded using their stated preference

Data Source Hierarchy

1. Facesheet
2. ED Records
3. History and Physical
4. EMS Report Form

Uses

- Allows data to be sorted based upon gender

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

DATE OF BIRTH (DOB)

LA County Element **GEN_07**
National Element **D_07**

Definition

The patient's date of birth

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYXX
- If patient less than 24 hours old, complete variables: Age and; Age Units
- If "Not Recorded", or "Not Known" complete variables: Age and; Age Units

Data Source Hierarchy

1. Facesheet
2. ED Records
3. History and Physical
4. Billing Sheet / Medical Records Coding Summary Sheet
5. EMS Report Form

Uses

- Used to calculate patient age in days, months, or years

Other Associated Elements

- AGE
- AGE UNITS

Data Format: [date] single entry **Picklist:** No
Min Value: Date minus 125yrs **Max Value:** Current date **Accepts Null Value:** Yes

AGE

LA County Element **GEN_08**
National Element **D_08**

Definition

The best approximation of patient's age at the time of injury when Date of Birth is unavailable

Field Values

- Relevant value for data element

Additional Information

- Normally calculated from Date of Birth and auto-populated
- User entry required only when Date of Birth is less than 24 hours, "Not Documented", or "Not Known"
- If utilized, must also complete Age Units field

Data Source Hierarchy

1. Facesheet
2. ED Records
3. History and Physical
4. Billing Sheet / Medical Records Coding Summary Sheet
5. EMS Report Form

Uses

- Allows data to be sorted based upon age

Other Associated Elements

- DATE OF BIRTH
- AGE UNITS

Data Format: [character, 3] single entry **Picklist:** Yes, non-modifiable
Min Value: 1hr **Max Value:** 125yrs **Accepts Null Value:** Yes

AGE UNITS

LA County Element **GEN_09**
National Element **D_09**

Definition

The units used to document the best approximation of patient's Age at the time of injury when Date of Birth is unavailable

Field Values

- H (Hours)
- D (Days)
- M (Months)
- Y (Years)

Additional Information

- Normally calculated from Date of Birth and auto-populated
- User entry required only when Date of Birth is less than 24 hours, "Not Documented", or "Not Known"
- If utilized, must also complete Age field
- For patients 2 years of age or older, use "Y"
- For patients 1 to 23 months of age, use "M"
- For patients 1 to 29 days old, use "D"
- For patients up to 23 hours old, use "H"

Data Source Hierarchy

1. ED Nurses Notes
2. EMS Report Form
3. Triage Form / Trauma Flow Sheet
4. Billing Sheet / Medical Records Coding Summary Sheet
5. ED Admission Form

Uses

- Allows data to be sorted based upon age

Other Associated Elements

- DATE OF BIRTH
- AGE

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

HEIGHT (HT.)

LA County Element **GEN_28**
National Element **ED_15**

Definition

Patient's height, or the best approximation, upon ED/hospital arrival

Field Values

- Relevant value for data element

Additional Information

- Recorded in centimeters
- May be self-reported or provided by family
- Cannot exceed 244 centimeters

Data Source Hierarchy

1. ED Nurses Notes
2. EMS Report Form
3. Triage Form / Trauma Flow Sheet
4. Billing Sheet / Medical Records Coding Summary Sheet
5. ED Admission Form

Other Associated Elements

- WEIGHT

Data Format: [character, 3] single entry **Picklist:** No
Min Value: N/A **Max Value:** 244 **Accepts Null Value:** No

WEIGHT (WT.)

LA County Element **GEN_29**
National Element **ED_16**

Definition

Patient's weight, or the best approximation, upon ED/hospital arrival

Field Values

- Relevant value for data element

Additional Information

- Recorded in kilograms
- May be self-reported or provided by family
- Cannot exceed 907 kilograms

Data Source Hierarchy

1. ED Nurses Notes
2. EMS Report Form
3. Triage Form / Trauma Flow Sheet
4. Billing Sheet / Medical Records Coding Summary Sheet
5. ED Admission Form

Uses

- Allows data to be sorted based upon age

Other Associated Elements

- HEIGHT

Data Format: [character, 3] single entry **Picklist:** No
Min Value: N/A **Max Value:** 907 **Accepts Null Value:** No

RACE / ETHNICITY

LA County Element **GEN_10**
National Element **D_10,11**

Definition

The patient's race and/or ethnicity

Field Values

LA COUNTY	NTDB	
Race/Ethnicity	**Race**	**Ethnicity**
A Asian	Asian	Not Hispanic or Latino
B Black	Black or African American	Not Hispanic or Latino
F Filipino	Native Hawaiian or Oth Pacific Islander	Not Hispanic or Latino
H Hispanic	White	Hispanic or Latino
N Native American	American Indian	Not Hispanic or Latino
P Pacific Islander (Oth)/Hawaiian	Native Hawaiian or Oth Pacific Islander	Not Hispanic or Latino
U Unknown	Other Race	Not Hispanic or Latino
W White	White	Not Hispanic or Latino
O Other	Other Race	Not Hispanic or Latino

Additional Information

- Patient race/ethnicity should be based upon self-report or identified by a family member

Data Source Hierarchy

1. ED Records
2. EMS Report Form
3. History and Physical

Uses

- Allows data to be sorted based upon race

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

EMS FORM AVAILABLE?

LA County Element **GEN_12**
National Element **N/A**

Definition

Indicates whether a copy of the patient's EMS Report Form is available for abstraction

Field Values

- Y (Yes)
- N (No)

Additional Information

- If Entry Mode is EMS, entering "No" in this field will result in "Not Documented" being entered automatically in the following fields:
  - PROVIDER
  - RA/SQUAD
  - TR DISP DATE
  - TR DISP TIME
  - 1st ON SCENE
  - TR ARRIVED
  - TR UNIT LEFT
  - 1st FIELD GCS Fields
  - Field Intub?
  - 1st FIELD VS Fields
- If Entry Mode is non-EMS, entering "Not Applicable" in this field will result in "Not Applicable" being entered automatically in the following fields:
  - PROVIDER
  - RA/SQUAD
  - TR DISP DATE
  - TR DISP TIME
  - 1st ON SCENE
  - TR ARRIVED
  - TR UNIT LEFT
  - 1st FIELD GCS Fields
  - Field Intub?
  - 1st FIELD VS Fields

Data Source Hierarchy

1. EMS Report Form

Uses

- Allows data to be evaluated based on presence of an EMS Report Form

Other Associated Elements

- TRANSPORT MODE

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ENTRY MODE

LA County Element **GEN_11**
National Element **P_07, 17**

Definition

The patient's mode of transport to the treating facility

Field Values

LA COUNTY	NTDB
EMS: Ground	TRANSPORT MODE (P_07): Ground Ambulance
EMS: Air	TRANSPORT MODE (P_07): Helicopter Ambulance
NON-EMS: Vehicle/Walk-in	TRANSPORT MODE (P_07): Private/Public Vehicle/Walk-in
NON-EMS: Police	TRANSPORT MODE (P_07): Police
NON-EMS: Other	TRANSPORT MODE (P_07): Other
TRANSFERRED: 9-1-1 Re-Triage / Ground	INTER-FACILITY TRANSFER (P_17): Yes; TRANSPORT MODE (P_07): Ground Amb
TRANSFERRED: 9-1-1 Re-Triage / Air	INTER-FACILITY TRANSFER (P_17): Yes; TRANSPORT MODE (P_07): Helicopter Ambulance
TRANSFERRED: ED to ED / Ground	INTER-FACILITY TRANSFER (P_17): Yes; TRANSPORT MODE (P_07): Ground Amb
TRANSFERRED: ED to ED / Air	INTER-FACILITY TRANSFER (P_17): Yes; TRANSPORT MODE (P_07): Helicopter Ambulance
TRANSFERRED: Direct Admit / Ground	INTER-FACILITY TRANSFER (P_17): Yes; TRANSPORT MODE (P_07): Ground Amb
TRANSFERRED: Direct Admit / Air	INTER-FACILITY TRANSFER (P_17): Yes; TRANSPORT MODE (P_07): Helicopter Ambulance
(Not Applicable in LA County)	TRANSPORT MODE (P_07): Fixed Wing Ambulance

Additional Information

- "TRANSFERRED: ED to ED" is indicated when patient is both transferred from an acute care facility and has an ED phase of care at your facility (Use Default Pathway for data entry)
- "TRANSFERRED: Direct Admit" is indicated when patient is transferred from an acute care facility but has no ED phase of care at your facility. If sending facility's ED record is available, those ED vital signs may be abstracted and entered into your database. Excludes patients transferred from a private doctor's office, stand-alone ambulatory surgery center, or delivered to your hospital by a non-EMS transport
- "TRANSFERRED: 9-1-1 Re-Triage" is indicated when patient is transferred from an acute care facility emergently via 9-1-1

Data Source Hierarchy

1. EMS Report Form
2. ED Records
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be evaluated based on mode of transport and/or by presence of an inter-facility transfer

Other Associated Elements

- TRANSFERRED FROM (IF APPLICABLE)
- TRANS. FROM: Arrival Time
- TRANS. FROM: Exit Time

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

TRANSFERRED FROM:

LA County Element **GEN_13**
National Element **N/A**

Definition

Enter the EMS Agency's three-letter code for the hospital from which the patient was transferred to your facility

Field Values

- Relevant value for data element

Additional Information

- Excludes non-EMS transports and patients transferred from a private doctor's office or stand-alone ambulatory surgery center

Data Source Hierarchy

1. ED Records
2. EMS Report Form
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon transferring facility

Other Associated Elements

- ENTRY MODE
- TRANS. FROM: Arrival Time
- TRANS. FROM: Exit Time

Data Format: [character, 3] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

TRANS. FROM: Arrival Time

LA County Element **GEN_30**
National Element **N/A**

Definition

If the patient is a 9-1-1 Re-triage, enter the time the patient arrived at the facility they are being transferred from

Collection Criterion

ONLY COLLECT ON 9-1-1 RE-TRIAGE PATIENTS

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time)
- ONLY applicable for 9-1-1 Re-triage patients

Data Source Hierarchy

1. ED Records
2. EMS Report Form
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon transferring facility

Other Associated Elements

- ENTRY MODE

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

TRANS. FROM: Exit Time

LA County Element **GEN_31**
National Element **N/A**

Definition

If the patient is a 9-1-1 Re-triage, enter the time the patient exited the facility they are being transferred from

Collection Criterion

ONLY COLLECT ON 9-1-1 RE-TRIAGE PATIENTS

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time)
- ONLY applicable for 9-1-1 Re-triage patients

Data Source Hierarchy

1. ED Records
2. EMS Report Form
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon transferring facility

Other Associated Elements

- ENTRY MODE
- TRANSFERRED FROM
- TRANS. FROM: Arrival Time

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

SEQUENCE

LA County Element **GEN_15**
National Element **N/A**

Definition

The patient's Sequence Number (EMS record number), which is pre-printed on the EMS Report form

Field Values

- Relevant value for data element

Additional Information

- EMS-generated numbers follow "Mod-9" formula: 2 letters, 6 numbers
- Electronic Patient Care Record (ePCR) utilizes: provider's two-letter code, followed by the last 2- digits of the year, and an additional 8-digits
- NON-EMS patients (only valid when Entry Mode is not equal to "EMS") when a valid sequence number is not available utilize: last two digits of the current year, followed by the three-letter Trauma Center Code (of the first treating trauma facility), and the sequential non-EMS patient number, e.g. ***13USC001***
- DHS = No patients without an existing sequence number utilize: last two digits of the current year, followed by the two-letter Trauma Log Code, plus the sequential DHS = No patient number, e.g. ***13TL0001***
- Essential link between the EMS, Base and Trauma databases – **every effort should be made to collect this information from any available source**. If not obtainable by any means, a "dummy number" can be requested from the EMS Agency. Supporting documentation of collection efforts must be provided, along with other specified fields that will enable additional search for the patient's sequence number in the Base and/or EMS databases.
- For transferred patients, or patients with more than one sequence number, use the sequence number from the initial contact whenever possible
- For patients arriving from outside of LA County, contact the EMS Agency to request an "Out of County" sequence number

Data Source Hierarchy

1. EMS Report Form
2. Base Hospital form, tapes or electronic records

Uses

- Patient identifier

Other Associated Elements

- MR #
- OTHER #

Data Format: [character, 12] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

MEDICAL RECORD (MR)

LA County Element **GEN_16**
National Element **N/A**

Definition

The patient's medical (or financial) record number as assigned by the treating facility

Field Values

- Relevant value for data element

Additional Information

- 15 characters, user-defined patient record identifier

Data Source Hierarchy

1. Facesheet
2. ED Records
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Patient identifier

Data Format: [character, 15] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

OTHER

LA County Element **GEN_17**
National Element **N/A**

Definition

Other medical record number as assigned by the treating facility

Field Values

- Relevant value for data element – facility specific

Additional Information

- OPTIONAL FIELD: This field may be used at the discretion of each treating facility

Data Source Hierarchy

1. Facesheet
2. ED Records
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Patient identifier

Data Format: [character, 15] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

PATIENT'S HOME ADDRESS

LA County Element **GEN_18**
National Element **N/A**

Definition

The house or building number of the patient's primary residence

Field Values

- Relevant value for data element

Additional Information

- If the only address provided is a P.O. Box, enter in place of the Patient's Home Address

Data Source Hierarchy

1. ED Records
2. Billing Sheet / Medical Records Coding Summary Sheet
3. EMS Report Form

Uses

- Allows data to be sorted based upon the geographic location of the patient's home
- Patient identifier

Other Associated Elements

- PATIENT'S HOME STREET
- PATIENT'S HOME STREET TYPE
- PATIENT'S HOME APT #
- PATIENT'S HOME ZIP CODE
- ALTERNATE HOME RESIDENCE
- PATIENT'S HOME CITY
- PATIENT'S HOME COUNTY
- PATIENT'S HOME STATE
- PATIENT'S HOME COUNTRY

Data Format: [character, 6] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

PATIENT'S HOME STREET

LA County Element **GEN_19**
National Element **N/A**

Definition

The street name of the patient's primary residence

Field Values

- Relevant value for data element

Data Source Hierarchy

1. Facesheet
2. Billing Sheet / Medical Records Coding Summary Sheet
3. EMS Report Form

Uses

- Allows data to be sorted based upon the geographic location of the patient's home
- Patient identifier

Other Associated Elements

- PATIENT'S HOME ADDRESS
- PATIENT'S HOME STREET TYPE
- PATIENT'S HOME APT #
- PATIENT'S HOME ZIP CODE
- ALTERNATE HOME RESIDENCE
- PATIENT'S HOME CITY
- PATIENT'S HOME COUNTY
- PATIENT'S HOME STATE
- PATIENT'S HOME COUNTRY

Data Format: [character, 40] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

PATIENT'S HOME STREET TYPE

LA County Element **GEN_20**
National Element **N/A**

Definition

The two-letter code for the street type of the patient's primary residence

Field Values

AL ALLEY	FY FREEWAY	PT POINT
AV AVENUE	GD GARDEN	RD ROAD
BL BOULEVARD	GN GLEN	RT ROUTE
CE CALLE	GR GROVE	SQ SQUARE
CA CANYON	HI HEIGHTS	ST STREET
CN CENTER	HY HIGHWAY	TR TERRACE
CH CHANNEL/CANAL	LN LANE	TT TRACK/TRANSITION
CL CIRCLE	LP LOOP	TL TRAIL
CO CORNER	MT MOUNT	TK TURNPIKE
CT COURT	MY MOTORWAY	VW VIEW
CK CREEK	PK PARK	VS VISTA
CR CRESCENT	PY PARKWAY	WK WALK
CS CROSSING	PS PASEO	WY WAY
DR DRIVE	PL PLACE	OT OTHER NOT LISTED
EX EXPRESSWAY	PZ PLAZA	

Data Source Hierarchy

1. Facesheet
2. Billing Sheet / Medical Records Coding Summary Sheet
3. EMS Report Form

Uses

- Allows data to be sorted based upon the geographic location of the patient's home
- Patient identifier

Other Associated Elements

- PATIENT'S HOME ADDRESS
- PATIENT'S HOME STREET
- PATIENT'S HOME APT #
- PATIENT'S HOME ZIP CODE
- ALTERNATE HOME RESIDENCE
- PATIENT'S HOME CITY
- PATIENT'S HOME COUNTY
- PATIENT'S HOME STATE
- PATIENT'S HOME COUNTRY

Data Format: [character, 2] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

PATIENT'S HOME APT

LA County Element **GEN_21**
National Element **N/A**

Definition

The apartment number of the patient's primary residence

Field Values

- Relevant value for data element

Data Source Hierarchy

1. Facesheet
2. Billing Sheet / Medical Records Coding Summary Sheet
3. EMS Report Form

Uses

- Allows data to be sorted based upon the geographic location of the patient's home
- Patient identifier

Other Associated Elements

- PATIENT'S HOME ADDRESS
- PATIENT'S HOME STREET
- PATIENT'S HOME STREET TYPE
- PATIENT'S HOME ZIP CODE
- ALTERNATE HOME RESIDENCE
- PATIENT'S HOME CITY
- PATIENT'S HOME COUNTY
- PATIENT'S HOME STATE
- PATIENT'S HOME COUNTRY

Data Format: [character, 6] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

PATIENT'S HOME ZIP CODE

LA County Element **GEN_22**
National Element **D_01**

Definition

The patient's home ZIP code of primary residence

Field Values

- Relevant value for data element

Additional Information

- Use 5-digit code (XXXXX)
- May require adherence to HIPAA regulations
- Patients possessing an address, but which cannot be found on any document would have a ZIP code of "Not Documented."
- Patients not having a home, (or, therefore, a home address or ZIP code) the home address fields will not apply to that patient -so their home ZIP code will be "Not Applicable."
- Zip code entered as "Not Applicable" will result in "Not Applicable" being entered automatically in all address related fields.
- If the only address provided is a P.O. Box, utilize the Zip Code for the P.O. Box.

Data Source Hierarchy

1. Facesheet
2. Billing Sheet / Medical Records Coding Summary Sheet
3. EMS Report Form

Uses

- Allows data to be sorted based upon the geographic location of the patient's home
- *If zip code is "Not Applicable", e.g., homeless, foreign visitor, complete Alternate Home Residence*
- *If zip code is "Not Documented", complete Patient's Home Country, Patient's Home State, Patient's Home County, and Patient's Home City*

Other Associated Elements

- PATIENT'S HOME ADDRESS
- PATIENT'S HOME STREET
- PATIENT'S HOME STREET TYPE
- PATIENT'S HOME APT #
- ALTERNATE HOME RESIDENCE
- PATIENT'S HOME CITY
- PATIENT'S HOME COUNTY
- PATIENT'S HOME STATE
- PATIENT'S HOME COUNTRY

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 90001 (CA) **Max Value:** 96162 (CA) **Accepts Null Value:** Yes

ALTERNATE HOME RESIDENCE

LA County Element **GEN_23**
National Element **D_06**

Definition

One-letter code reason when home zip code is “Not Applicable”

Field Values

- H Homeless
- U Undocumented
- M Migrant
- F Foreign Visitor

Additional Information

- *Only completed when ZIP code is "Not Applicable"*
- Homeless is defined as a person who lacks housing. The definition also includes a person living in transitional housing or a supervised public or private facility providing temporary living quarters.
- Undocumented Citizen is defined as a national of another country who has entered or stayed in another country without permission.
- Migrant Worker is defined as a person who temporarily leaves his/her principal place of residence within a country in order to accept seasonal employment in the same country.
- Foreign Visitor is defined as any person visiting a country other than his/her usual place of residence for any reason without intending to receive earnings in the visited country

Data Source Hierarchy

1. Facesheet
2. History and Physical
3. EMS Report Form

Uses

- Allows data to be sorted based upon type of residence

Other Associated Elements

- PATIENT’S HOME ADDRESS
- PATIENT’S HOME STREET
- PATIENT’S HOME STREET TYPE
- PATIENT’S HOME APT #
- PATIENT’S HOME ZIP CODE
- PATIENT’S HOME CITY
- PATIENT’S HOME COUNTY
- PATIENT’S HOME STATE
- PATIENT’S HOME COUNTRY

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

PATIENT'S HOME CITY

LA County Element **GEN_24**
National Element **D_05**

Definition

The patient's city (or township, or village) of primary residence

Field Values

- Relevant value for data element

Additional Information

- *Only completed when ZIP code is "Not Documented" or "Not Known"*
- IF the Zip Code entered doesn't match the Patient's Home City provided, manually override the information and enter the correct "Patient's Home City". Follow-up with Lancet representatives for identification of problem Zip Codes. Internally we will work towards a resolution of the issue with the specific Zip Codes identified.
- Used to calculate FIPS code

Data Source Hierarchy

1. Facesheet
2. Billing Sheet / Medical Records Coding Summary Sheet
3. EMS Report Form

Uses

- Allows data to be sorted based upon the geographic location of the patient's home

Other Associated Elements

- PATIENT'S HOME ADDRESS
- PATIENT'S HOME STREET
- PATIENT'S HOME STREET TYPE
- PATIENT'S HOME APT #
- PATIENT'S HOME ZIP CODE
- ALTERNATE HOME ADDRESS
- PATIENT'S HOME COUNTY
- PATIENT'S HOME STATE
- PATIENT'S HOME COUNTRY

Data Format: [character, 15] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

PATIENT'S HOME COUNTY

LA County Element **GEN_25**
National Element **D_04**

Definition

The patient's county (or parish) of primary residence

Field Values

- Relevant value for data element

Additional Information

- *Only completed when ZIP code is "Not Documented" or "Not Known"*
- Used to calculate FIPS code

Data Source Hierarchy

1. Facesheet
2. Billing Sheet / Medical Records Coding Summary Sheet
3. EMS Report Form

Uses

- Allows data to be sorted based upon the geographic location of the patient's home

Other Associated Elements

- PATIENT'S HOME ADDRESS
- PATIENT'S HOME STREET
- PATIENT'S HOME STREET TYPE
- PATIENT'S HOME APT #
- PATIENT'S HOME ZIP CODE
- ALTERNATE HOME ADDRESS
- PATIENT'S HOME CITY
- PATIENT'S HOME STATE
- PATIENT'S HOME COUNTRY

Data Format: [character, 15] single entry **Picklist:** Yes, modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

PATIENT'S HOME STATE

LA County Element **GEN_26**
National Element **D_03**

Definition

The two-letter code of the patient's state (territory, province, or District of Columbia) of primary residence

Field Values

AK Alaska	LA Louisiana	OR Oregon
AL Alabama	MA Massachusetts	PA Pennsylvania
AR Arkansas	MD Maryland	PR Puerto Rico
AS American Samoa	ME Maine	PW Palau
AZ Arizona	MH Marshall Islands	RI Rhode Island
CA California	MI Michigan	SC South Carolina
CO Colorado	MN Minnesota	SD South Dakota
CT Connecticut	MO Missouri	TN Tennessee
DC District of Columbia	MP Northern Mariana Islands	TX Texas
DE Delaware	MS Mississippi	UM US Minor Outlying Islands
FL Florida	MT Montana	UT Utah
FM Federated States of Micronesia	NC North Carolina	VA Virginia
GA Georgia	ND North Dakota	VI Virgin Islands of the US
GU Guam	NE Nebraska	VT Vermont
HI Hawaii	NH New Hampshire	WA Washington
IA Iowa	NJ New Jersey	WI Wisconsin
ID Idaho	NM New Mexico	WV West Virginia
IL Illinois	NV Nevada	WY Wyoming
IN Indiana	NY New York	OT Other
KS Kansas	OH Ohio	
KY Kentucky	OK Oklahoma	

Additional Information

- *Only completed when ZIP code is "Not Documented" or "Not Known"*
- Used to calculate FIPS code

Data Source Hierarchy

1. Facesheet
2. Billing Sheet / Medical Records Coding Summary Sheet
3. EMS Report Form

Uses

- Allows data to be sorted based upon the geographic location of the patient's home

Other Associated Elements

- PATIENT'S HOME ADDRESS
- PATIENT'S HOME STREET
- PATIENT'S HOME STREET TYPE
- PATIENT'S HOME APT #
- PATIENT'S HOME ZIP CODE
- ALTERNATE HOME ADDRESS
- PATIENT'S HOME CITY
- PATIENT'S HOME COUNTY
- PATIENT'S HOME COUNTRY

Data Format: [character, 2] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

PATIENT'S HOME COUNTRY

LA County Element **GEN_27**
National Element **D_02**

Definition

The patient's country of primary residence

Field Values

- Autofilled with USA – use picklist if needed for other countries

Additional Information

- *Only completed when ZIP code is "Not Documented" or "Not Known"*
- Used to calculate FIPS code

Data Source Hierarchy

1. Facesheet
2. Billing Sheet / Medical Records Coding Summary Sheet
3. EMS Report Form

Uses

- Allows data to be sorted based upon the geographic location of the patient's home

Other Associated Elements

- PATIENT'S HOME ZIP
- PATIENT'S HOME CITY
- PATIENT'S HOME COUNTY
- PATIENT'S HOME STATE
- ALTERNATE HOME RESIDENCE

Data Format: [character, 15] single entry **Picklist:** Yes, modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

Prehospital

INJURY DATE

LA County Element **PRE_01**
National Element **I_01**

Definition

The date the injury occurred

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY
- Estimates of date of injury should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g. , 911 call time) should not be used.

Data Source Hierarchy

1. EMS Report Form
2. ED Records
3. History and Physical

Uses

- Important to identify when the injury event started to better analyze resource utilization and outcomes

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

INJURY TIME

LA County Element **PRE_02**
National Element **I_02**

Definition

The time the injury occurred

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time)
- Estimates of time of injury should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g., 911 call time) should not be used.

Data Source Hierarchy

1. EMS Report Form
2. ED Records
3. History and Physical

Uses

- Important to identify when the injury event started to better analyze resource utilization and outcomes

Data Format: [time] single entry		**Picklist:** No
Min Value: 0000	**Max Value:** 2359	**Accepts Null Value:** Yes

PROVIDER

LA County Element **PRE_03**
National Element **N/A**

Definition

The two-letter code for the EMS provider primarily responsible for the patient's prehospital care

Field Values

PUBLIC PROVIDERS					
AF	Arcadia Fire	ES	El Segundo Fire	RB	Redondo Beach Fire
AH	Alhambra Fire	FS	U.S. Forest Service	SA	San Marino Fire
AV	Avalon Fire	GL	Glendale Fire	SG	San Gabriel Fire
BF	Burbank Fire	HB	Hermosa Beach Fire	SI	Sierra Madre Fire
BH	Beverly Hills Fire	LB	Long Beach Fire	SM	Santa Monica Fire
CB	LA County Beaches	LH	La Habra Heights Fire	SP	South Pasadena Fire
CC	Culver City Fire	LV	La Verne Fire	SS	Santa Fe Springs Fire
CF	LA County Fire	MB	Manhattan Beach Fire	TF	Torrance Fire
CG	US Coast Guard	MF	Monrovia Fire	UF	Upland Fire
CI	LA City Fire	MO	Montebello Fire	VE	Ventura County Fire
CM	Compton Fire	MP	Monterey Park Fire	VF	Vernon Fire
CS	LA County Sheriff	OT	Other Provider	WC	West Covina Fire
DF	Downey Fire	PF	Pasadena Fire		
PRIVATE PROVIDERS					
AA	American Professional	EX	Explorer 1 Ambulance	PN	PRN Ambulance
AC	Americare Ambulance	GC	Gentle Care Transport	PT	Priority One
AD	AmeriPride Ambulance	GE	Gerber Ambulance	RE	REACH Air Medical Service
AE	Aegis Ambulance	GR	Gentle Ride Ambulance	RO	Rescue One Ambulance
AM	Adult Medical Transportation	GU	Guardian Ambulance	RR	Rescue Services (Medic-1)
AN	Antelope Ambulance	IA	Impulse Ambulance	RY	Royalty Ambulance
AR	American Medical Response	LT	Liberty Ambulance	SC	Schaefer Ambulance
AT	All Town Ambulance	MA	Mauran Ambulance	SY	Symons Ambulance
AU	AmbuServe Ambulance	MI	MedResponse	TL	TransLife, Inc.
AW	AMWest Ambulance	ML	Med-Life Ambulance	TR	Trinity Ambulance
BO	Bowers Companies	MR	MedReach Ambulance	UC	UCLA Emergency Services
CA	CARE Ambulance	MS	Medi-Star Transport	WE	Westcoast Ambulance
EA	Emergency Ambulance	MT	MedCoast Ambulance	WM	West Med/McCormick
EL	Elite Ambulance	MY	Mercy Air		

Additional Information

Data Source Hierarchy

1. EMS Report Form
2. Base Hospital form, tapes or electronic records
3. ED Records

Uses

- Allows data to be sorted based upon EMS Provider

Other Associated Elements

- RA/SQUAD

Data Format: [character, 2] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

RA / SQUAD

LA County Element **PRE_04**
National Element **N/A**

Definition

The alphanumeric apparatus code of the paramedic unit primarily responsible for the patient's prehospital care

Field Values

- Relevant value for data element

Additional Information

- Non-picklisted – manually enter information exactly as appears on EMS Report Form

Data Source Hierarchy

1. EMS Report Form
2. Base Hospital form, tapes or electronic records
3. ED Records

Uses

- Allows data to be sorted based upon EMS Provider and unit

Other Associated Elements

- PROVIDER

Data Format: [character, 6] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

DISPATCH DATE

LA County Element **PRE_05**
National Element **P_01**

Definition

The date the unit *transporting to your hospital* was notified by dispatch

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY

Data Source Hierarchy

1. EMS Report Form
2. Base Hospital form, tapes or electronic records
3. ED Records

Uses

- Allows data to be sorted based upon EMS agency time intervals
- Used in calculating EMS times

Other Associated Elements

- DISPATCH TIME
- TRANS ARR *(TRANSPORTING EMS UNIT ARRIVAL ON SCENE DATE/TIME)*
- TRANS LEFT *(TRANSPORTING EMS UNIT LEFT SCENE DATE/TIME)*

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

DISPATCH TIME

LA County Element **PRE_06**
National Element **P_02**

Definition

The time the unit *transporting to your hospital* was notified by dispatch

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time)

Data Source Hierarchy

1. EMS Report Form

Uses

- Allows data to be sorted based upon EMS agency time intervals
- Used in calculating EMS times

Data Collection

- 911 or Dispatch Center and electronically or verbally transmitted to the EMS agency
- EMS records or electronically through linkage with the EMS/medical record

Other Associated Elements

- DISPATCH DATE
- TRANS ARR *(TRANSPORTING EMS UNIT ARRIVAL ON SCENE DATE/TIME)*
- TRANS LEFT *(TRANSPORTING EMS UNIT LEFT SCENE DATE/TIME)*

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

1st ON SCENE

LA County Element **PRE_07**
National Element **N/A**

Definition

The time of arrival of the **first** EMS unit (ALS or BLS) on scene

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time)
- Indicates time prehospital EMS care began

Data Source Hierarchy

1. EMS Report Form

Uses

- Allows data to be sorted based upon EMS agency time intervals
- Used in calculating total EMS scene time

Data Collection

- 911 or Dispatch Center and electronically or verbally transmitted to the EMS agency
- EMS records or electronically through linkage with the EMS/medical record

Other Associated Elements

- DISPATCH DATE/TIME
- TRANS ARR *(TRANSPORTING EMS UNIT ARRIVAL ON SCENE DATE/TIME)*
- TRANS LEFT *(TRANSPORTING EMS UNIT LEFT SCENE DATE/TIME)*

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

TRANSPORT UNIT ARRIVAL DATE

LA County Element **PRE_08**
National Element **P_03**

Definition

The date the unit *transporting the patient to your hospital* arrived on scene

Field Values

- Relevant value for data element

Additional Information

- Auto-calculated based on Dispatch information – does not appear as a field on the TPS form or in the data entry program
- Reported as HHMM (military time)

Data Source Hierarchy

1. EMS Report Form

Uses

- Allows data to be sorted based upon EMS agency time intervals
- Used in calculating EMS times

Other Associated Elements

- DISPATCH DATE/TIME
- TRANS. LEFT *(TRANSPORTING EMS UNIT LEFT SCENE DATE/TIME)*

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

TRANSPORT UNIT ARRIVAL TIME

LA County Element **PRE_09**
National Element **P_04**

Definition

The time the unit *transporting the patient to your hospital* arrived on the scene

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time)

Data Source Hierarchy

1. EMS Report Form

Uses

- Allows data to be sorted based upon EMS agency time intervals
- Used in calculating EMS times

Other Associated Elements

- DISPATCH DATE/TIME
- TRANS LEFT *(TRANSPORTING EMS UNIT LEFT SCENE DATE/TIME)*

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

TRANSPORT UNIT DEPARTURE DATE

LA County Element **PRE_10**
National Element **P_05**

Definition

The date the *unit transporting the patient to your hospital* left the scene

Field Values

- Relevant value for data element

Additional Information

- Auto-calculated based on Dispatch information – does not appear as a field on the TPS form or in the data entry program
- Reported as HHMM (military time)

Data Source Hierarchy

1. EMS Report Form

Uses

- Allows data to be sorted based upon EMS agency time intervals
- Used in calculating EMS times

Other Associated Elements

- DISPATCH DATE/TIME
- TRANS. ARRIV'D *(TRANSPORTING EMS UNIT ARRIVED SCENE DATE/TIME)*

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

TRANSPORT LEFT

LA County Element **PRE_11**
National Element **P_06**

Definition

The time the unit *transporting the patient to your hospital* left the scene

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time)

Data Source Hierarchy

1. EMS Report Form

Uses

- Allows data to be sorted based upon EMS agency time intervals
- Used in calculating EMS times

Other Associated Elements

- DISPATCH DATE/TIME
- TRANS ARR (TRANSPORTING EMS UNIT ARRIVAL ON SCENE TIME)

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

INJURY DESCRIPTION

LA County Element **PRE_12**
National Element **N/A**

Definition

The LA County two-letter injury description code

Field Values

Blunt:	Penetrating:	Other:
BL Blunt Minor Lac/Cont	PL Penetrating Minor Laceration	NA No Apparent Injury
BT Blunt Trauma Arrest	PT Penetrating Trauma Arrest	BU Burns / Electric Shock
BH Blunt Head	PH Penetrating Head	90 SBP <90
14 BH with GCS ≤14		70 SBP <1yr
BF Blunt Facial/Dental	PF Penetrating Facial/Dental	RR Respiratory Rate <10/>29, <20 if <1y
BN Blunt Neck	PN Penetrating Neck	
BB Blunt Back	PB Penetrating Back	SX Suspected Pelvic Fracture
BC Blunt Chest	PC Penetrating Chest	SC Spinal Cord Injury
FC Blunt Flail Chest		
BP Blunt Tension Pneumo	PP Penetrating Tension Pneumo	
BA Blunt Abdomen	PA Penetrating Abdomen	
BD Blunt Diffuse Tenderness		
BG Blunt Genitals	PG Penetrating Genitals	**IFT (Interfacility Transfer) Inpatient:**
BK Blunt Buttocks	PK Penetrating Buttocks	IT Inpatient Trauma (Direct Admit)
BE Blunt Extremity	PE Penetrating Extremity ↓ elbow/knee	
BR Blunt Fractures ≥ 2 long bone	PX Penetrating Extremity ↑ elbow/knee	
BI Blunt Amputation ↑ wrist/ankle	PI Penetrating Amputations ↑ wrist/ankle	
BV Blunt Neuro/Vasc/Mangled	PV Penetrating Neuro/Vasc/Mangled	

Additional Information

- If the patient has multiple injuries, enter the most significant injury first (most likely to be fatal). The "Injury Description" should reflect the injury force, Blunt (MVA, Fall, Auto vs Ped) versus Penetrating (GSW or SW), selected
- If the patient has an injury that fits multiple field values, e.g., Blunt Chest (BC) and Flail Chest (FC), Blunt Head (BH) and Blunt Head with GCS ≤14 (14), use the most significant injury. Flail Chest is a more significant injury than Blunt Chest, as is Blunt Head with GCS ≤14 more significant than Blunt Head.

Data Source Hierarchy

1. EMS Report Form (preferred)
2. ED Records

Uses

- Allows data to be sorted based upon injury description

Other Associated Elements

- MECHANISM OF INJURY
- PROTECTIVE DEVICES

Data Format: [character, 2] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

MECHANISM OF INJURY

LA County Element **PRE_13**
National Element **N/A**

Definition

The LA County two-letter code describing the mechanism of the patient's injury

Field Values

EV Enclosed Vehicle	AC Anticoagulants
EJ Ejected	AN Animal Bite
EX Extricated	CR Crush
PS (12) Passenger Space Intrusion (PSI)	TD Telemetry Data
18 PSI >18 inch. into unoccupied passenger space	FA Fall
SF Survived Fatal Accident	15 Fall >15Ft. Adult / >10Ft. Child
20 Unenclosed Vehicle >20 MPH	SA Self Inflicted Accidental
RT Ped/Bike Thrown / Runover >20 MPH	SI Self Inflicted Intentional
PB Ped/Bike ≤20 MPH	ES Electrical Shock
MM Motorcycle / Moped	TB Thermal Burn
SP Sports / Recreation	HE Hazmat Exposure
AS Assault	WR Work Related
ST Stabbing	UN Unknown
GS GSW	OT Other

Additional Information

- If the patient has more than one Mechanism of Injury (MOI) use all that apply, e.g. Enclosed Vehicle (EV), Extrication Required (EX), and Passenger Space Intrusion (PS)
- Insect bites and bee stings are not considered animal bites, and should be coded as "Other" and do not meet the inclusion criteria for the trauma registry

Data Source Hierarchy

1. EMS Report Form (preferred)
2. ED Records

Uses

- Allows data to be sorted based upon mechanism of injury

Other Associated Elements

- INJURY DESCRIPTION
- PROTECTIVE DEVICES

Data Format: [character, 2] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

PROTECTIVE DEVICES

LA County Element **PRE_14**
National Element **I_13-15**

Definition

Protective devices (safety equipment) in use or worn at the time of the injury

Field Values

LA COUNTY	NTDB		
Protective Devices (PH_12)	**Protective Devices (I_13)**	**Child Specific Restraint (I_14)**	**Airbag Deployment (I_15)**
PROTECTIVE DEVICES			
NO None	None	N/A	N/A
HE Helmet	Helmet	N/A	N/A
PC Protective Clothing	Protective Clothing	N/A	N/A
PG Protective Gear (non-clothing)	Protective Non-Clothing Gear	N/A	N/A
EP Eye Protection	Eye protection	N/A	N/A
PF Personal Flotation Device	Personal Flotation Device	N/A	N/A
SB Seatbelt - Shoulder Belt	Shoulder Belt	N/A	N/A
LB Seatbelt - Lap Belt	Lap Belt	N/A	N/A
OT Other	Other	N/A	N/A
AIRBAG			
AN Airbag Not Deployed	Airbag Present	N/A	Airbag Not Deployed
AF Airbag - Front	Airbag Present	N/A	Airbag Deployed Front
AS Airbag - Side	Airbag Present	N/A	Airbag Deployed Side
AO Airbag - Other	Airbag Present	N/A	Airbag Deployed Other
CHILD RESTRAINTS			
IC Infant Car Seat (up to 1yr/20lbs)	Child Restraint	Infant Car Seat	N/A
CC Child Car Seat (>1yr/20-40lbs)	Child Restraint	Child Car seat	N/A
CB Child Booster (>40lbs/<4'9")	Child Restraint	Child Booster Seat	N/A
CARSEAT W/BELT			
CARSEAT WO/BELT			
SEAT BELT			

Additional Information

- A value of *"None"* **MUST** be entered if no protective devices are in use at the time of injury
- *If "Child Restraint" is present, complete variable "Child Specific Restraint"*
- *If "Airbag" is present, complete variable "Airbag Deployment"*
- Presence or use of protective devices may be reported or observed
- Indicate all that apply

Data Source Hierarchy

1. EMS Report Form (preferred)
2. ED Records (if above determined to be inaccurate or incomplete)

Uses

- Used to better define injury cause and characterize injury patterns

Other Associated Elements

- MECHANISM OF INJURY
- INJURY DESCRIPTION

Data Format: [character, 2] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** No

1st FIELD GCS: EYE

LA County Element **PRE_15**
National Element **P_13**

Definition

First recorded Glasgow Coma Eye Score measured at the scene of injury

Field Values

- 4 Opens eyes spontaneously
- 3 Opens eyes in response to verbal stimulation
- 2 Opens eyes in response to painful stimulation
- 1 No eye opening

Data Source Hierarchy

1. EMS Report Form

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care
- Used to calculate Overall GCS - EMS Score

Other Associated Elements

- 1st Field VS: BP (Systolic)
- 1st Field VS: BP (Diastolic)
- 1st Field VS: HR
- 1st Field VS: RR
- 1st Field VS: O_2 SAT %
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL

Data Format: [number] single entry **Picklist:** Yes, non-modifiable
Min Value: 1 **Max Value:** 4 **Accepts Null Value:** Yes

1st FIELD GCS: VERBAL

LA County Element **PRE_17**
National Element **P_14**

Definition

First recorded Glasgow Coma Verbal Score measured at the scene of injury

Field Values

	ADULT	INFANT
5	Oriented X 3	Smiling or cooing appropriately
4	Confused	Crying but consolable
3	Inappropriate words	Crying or screaming is persistent and inappropriate for the incident
2	Incomprehensible sounds	Grunts, agitated, or restless
1	No verbal response	No verbal response

Additional Information

- If the patient is intubated then the GCS Verbal score is equal to 1

Data Source Hierarchy

1. EMS Report Form

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care
- Used to calculate Overall GCS - EMS Score

Other Associated Elements

- 1st Field VS: BP (Systolic)
- 1st Field VS: BP (Diastolic)
- 1st Field VS: HR
- 1st Field VS: RR
- 1st Field VS: O_2 SAT %
- 1st Field GCS: EYE
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL

Data Format: [number, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: 1 **Max Value:** 5 **Accepts Null Value:** Yes

1st FIELD GCS: MOTOR

LA County Element **PRE_16**
National Element **P_15**

Definition

First recorded Glasgow Coma Motor Score measured at the scene of injury

Field Values

- 6 Obeys commands
- 5 Localizes pain
- 4 Withdraws from pain
- 3 Flexion (decorticate movement) to pain
- 2 Extension (decerebrate movement) to pain
- 1 No motor response

Data Source Hierarchy

1. EMS Report Form

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care
- Used to calculate Overall GCS - EMS Score

Other Associated Elements

- 1st Field VS: BP (Systolic)
- 1st Field VS: BP (Diastolic)
- 1st Field VS: HR
- 1st Field VS: RR
- 1st Field VS: O_2 SAT %
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: TOTAL

Data Format: [number] single entry **Picklist:** Yes, non-modifiable
Min Value: 1 **Max Value:** 6 **Accepts Null Value:** Yes

1st FIELD GCS: TOTAL

LA County Element **PRE_18**
National Element **P_16**

Definition

First recorded Glasgow Coma Score Total measured at the scene of injury

Field Values

- Relevant value for data element

Additional Information

- Entering values for each of the GCS component fields will result in an auto-calculated total
- Value may be hand-entered if GCS component fields are not documented
- If a patient does not have a numeric GSC recorded, but documentation related to their level of consciousness exists such as, “awake, alert, and oriented”, this may be interpreted as a GCS of 15 if no other contraindicating information exists

Data Source Hierarchy

1. EMS Report Form

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care
- Used to calculate Revised Trauma Score - EMS (adult & pediatric)

Other Associated Elements

- 1st Field VS: BP (Systolic)
- 1st Field VS: BP (Diastolic)
- 1st Field VS: HR
- 1st Field VS: RR
- 1st Field VS: O_2 SAT %
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR

Data Format: [number, 2] single entry **Picklist:** No
Min Value: 3 **Max Value:** 15 **Accepts Null Value:** Yes

1st FIELD VS: BP (Systolic)

LA County Element **PRE_19**
National Element **P_9**

Definition

First recorded systolic blood pressure measured at the scene of injury

Field Values

- Relevant value for data element

Additional Information

- For references to capillary refill, or if reported to be “unable to obtain”, utilize “Not Documented”

Data Source Hierarchy

1. EMS Report Form

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care
- Used to calculate Revised Trauma Score - EMS (adult & pediatric)

Other Associated Elements

- 1st Field VS: BP (Diastolic)
- 1st Field VS: HR
- 1st Field VS: RR
- 1st Field VS: O_2 SAT %
- 1st Field GCS: EYE
- 1st Field GCS: MOTOR
- 1st Field GCS: VERBAL
- 1st Field GCS: TOTAL

Data Format: [number, 3] single entry **Picklist:** No
Min Value: 0 **Max Value:** 300 **Accepts Null Value:** Yes

1st FIELD VS: BP (Diastolic)

LA County Element **PRE_20**
National Element **N/A**

Definition

First recorded diastolic blood pressure measured at the scene of injury

Field Values

- Relevant value for data element

Additional Information

- "Not Documented" if not measured (i.e., only palpated SYSTOLIC pressure measured)

Data Source Hierarchy

1. EMS Report Form

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care

Other Associated Elements

- 1st Field VS: BP (Systolic)
- 1st Field VS: HR
- 1st Field VS: RR
- 1st Field VS: O_2 SAT %
- 1st Field GCS: EYE
- 1st Field GCS: MOTOR
- 1st Field GCS: VERBAL
- 1st Field GCS: TOTAL

Data Format: [number, 3] single entry **Picklist:** No
Min Value: 0 **Max Value:** 300 **Accepts Null Value:** Yes

1st FIELD VS: HR

LA County Element **PRE_21**
National Element **P_10**

Definition

First recorded pulse rate measured at the scene of injury ***(palpated or auscultated ONLY – no monitor readings)***, expressed as a number per minute

Field Values

- Relevant value for data element

Data Source Hierarchy

1. EMS Report Form

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care

Other Associated Elements

- 1st Field VS: BP (Systolic)
- 1st Field VS: BP (Diastolic)
- 1st Field VS: RR
- 1st Field VS: O_2 SAT %
- 1st Field GCS: EYE
- 1st Field GCS: MOTOR
- 1st Field GCS: VERBAL
- 1st Field GCS: TOTAL

Data Format: [number, 3] single entry **Picklist:** No
Min Value: 0 **Max Value:** 300 **Accepts Null Value:** Yes

1st FIELD VS: RR

LA County Element **PRE_22**
National Element **P_11**

Definition

First recorded respiratory rate measured at the scene of injury (expressed as a number per minute)

Field Values

- Relevant value for data element

Data Source Hierarchy

1. EMS Report Form

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care
- Used to calculate Revised Trauma Score - EMS (adult & pediatric)

Other Associated Elements

- 1st Field VS: BP (Systolic)
- 1st Field VS: BP (Diastolic)
- 1st Field VS: HR
- 1st Field VS: O_2 SAT %
- 1st Field GCS: EYE
- 1st Field GCS: MOTOR
- 1st Field GCS: VERBAL
- 1st Field GCS: TOTAL

Data Format: [number, 3] single entry **Picklist:** No
Min Value: 0 **Max Value:** 100 **Accepts Null Value:** Yes

1st FIELD VS: O_2 SAT %

LA County Element **PRE_23**
National Element **P_12**

Definition

First recorded oxygen saturation measured at the scene of injury (expressed as a percentage)

Field Values

- Relevant value for data element

Data Source Hierarchy

1. EMS Report Form

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care
- Used to calculate Revised Trauma Score - EMS (adult & pediatric)

Other Associated Elements

- 1st Field VS: BP (Systolic)
- 1st Field VS: BP (Diastolic)
- 1st Field VS: HR
- 1st Field VS: RR
- 1st Field GCS: EYE
- 1st Field GCS: MOTOR
- 1st Field GCS: VERBAL
- 1st Field GCS: TOTAL

Data Format: [number, 3] single entry **Picklist:** No
Min Value: 0 **Max Value:** 100 **Accepts Null Value:** Yes

FIELD INTUBATION?

LA County Element **PRE_24**
National Element **N/A**

Definition

One-letter code indicating whether or not the patient was intubated in the prehospital setting

Field Values

- Y (Yes)
- N (No)

Data Source Hierarchy

1. EMS Report Form

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care

Other Associated Elements

- 1st Field VS: RR
- 1st Field VS: O_2 SAT %

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: **N/A** **Max Value:** N/A **Accepts Null Value:** Yes

PREHOSPITAL CARDIAC ARREST?

LA County Element **PRE_35**
National Element **I_04**

Definition

Indicates whether the patient experienced cardias arrest prior to ED/Hospital arrival

Field Values

- Y (Yes)
- N (No)

Additional Information

- A patient who experienced a sudden cessation of cardiac activity. The patient was unresponsive with no normal breathing and no signs of circulation.
- The event must have occurred outside of the hospital, prior to admission at the center in which the registry is maintained. Prehospital cardiac arrest could occur at a transferring facility
- Any component of basic and/or advanced cardiac life support must have been initiated by a health care provider

Data Source Hierarchy

1. EMS Report Form
2. ED Nurses Notes
3. History & Physical
4. Transfer Records

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care

Other Associated Elements

- Field Intubation

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

PRIMARY E-CODE

LA County Element **PRE_25**
National Element **I_06**

Definition

E-code used to describe the mechanism (or external factor) that caused the injury event

Field Values

- Relevant ICD-10-CM code value for injury event

Additional Information

- E-codes describe external causes of injury – the Primary E-code should describe the cause of the primary reason a patient is admitted to the hospital

Data Source Hierarchy

1. EMS Report Form
2. ED Records
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows injuries to be characterized by mechanism causing the injury

Other Associated Elements

- OTHER E-CODES
- LOCATION E-CODE

Data Format: [character, 6] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

OTHER E/V-CODES

LA County Element **PRE_26**
National Element **I_08**

Definition

Additional E-codes and/or V-codes used to describe circumstances involving patient's injury and need for care

Field Values

- Relevant ICD-10-CM code value for injury event

Additional Information

- E-codes describe external causes of injury, and V-codes describe factors influencing health status and contact with health services. – the Primary E-code should describe the cause of the primary reason a patient is admitted to the hospital

Data Source Hierarchy

1. EMS Report Form
2. ED Records
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows injuries to be characterized by mechanism causing the injury

Other Associated Elements

- OTHER E-CODES
- LOCATION E-CODE

Data Format: [character, 6] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

LOCATION E-CODES

LA County Element **PRE_27**
National Element **I_07**

Definition

Place of occurrence external cause code used to describe the place/site/location of the injury event (Y92.x)

Field Values

- 0 Home
- 1 Farm
- 2 Mine or Quarry
- 3 Industrial
- 4 Recreation or Sport
- 5 Street or Highway
- 6 Public building
- 7 Residential institution
- 8 Other specified place
- 9 Other unspecified place

Data Source Hierarchy

1. EMS Report Form
2. ED Records
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows injuries to be characterized by the place/site/location of the injury

Other Associated Elements

- PRIMARY E-CODE
- OTHER E-CODES

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: 0 **Max Value:** 9 **Accepts Null Value:** Yes

INJURY LOCATION ZIP CODE

LA County Element **PRE_28**
National Element **I_09**

Definition

The ZIP code of the incident location

Field Values

- Relevant value for data element

Additional Information

- Use 5 digit code (XXXXX)
- If "Not Applicable", "Not Documented", or "Not Known," must complete variables of Injury State; Injury County and Injury City in database

Data Source Hierarchy

1. EMS Report Form
2. ED Records
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon the geographic location of the injury

Other Associated Elements

- INJURY COUNTRY
- INJURY STATE
- INJURY COUNTY
- INJURY CITY
- ALTERNATE HOME RESIDENCE

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 90001 (CA) **Max Value:** 96162 (CA) **Accepts Null Value:** Yes

INJURY LOCATION CITY

LA County Element **PRE_29**
National Element **I_12**

Definition

The city (or township, or village) where the injury occurred

Field Values

Picklist contains all cities within the following counties

- Los Angeles
- Orange
- Riverside
- San Bernardino
- San Diego
- Ventura

Additional Information

- Select city from picklist, or enter non-picklisted city directly
- *Only completed when Injury ZIP code is "Not Documented" or "Not Known"*
- Used to calculate FIPS code

Data Source Hierarchy

1. EMS Report Form
2. ED Records

Uses

- Allows data to be sorted based upon the geographic location of the patient's injury

Other Associated Elements

- PATIENT'S HOME COUNTRY
- PATIENT'S HOME STATE
- PATIENT'S HOME COUNTY
- PATIENT'S HOME CITY
- ALTERNATE HOME RESIDENCE

Data Format: [character, 30] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

INJURY LOCATION COUNTY

LA County Element **PRE_30**
National Element **I_11**

Definition

The county (or parish) where the injury occurred

Field Values

- Los Angeles
- Orange
- Riverside
- San Bernardino
- San Diego
- Ventura

Additional Information

- Select county from picklist, or enter non-picklisted county directly
- *Only completed when ZIP code is "Not Documented" or "Not Known"*
- Used to calculate FIPS code

Data Source Hierarchy

1. EMS Report Form
2. ED Records

Uses

- Allows data to be sorted based upon the geographic location of the patient's injury

Other Associated Elements

- INJURY ZIP
- INJURY COUNTRY
- INJURY STATE
- INJURY CITY
- ALTERNATE HOME RESIDENCE

Data Format: [character, 30] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

INJURY LOCATION STATE

LA County Element **PRE_31**
National Element **I_10**

Definition

The two-letter code for the state (territory, province, or District of Columbia) where the injury occurred

Field Values

- Picklist contains codes for all of the United States and its territories

Additional Information

- *Only completed when ZIP code is "Not Documented" or "Not Known"*
- Used to calculate FIPS code

Data Source Hierarchy

1. EMS Report Form
2. ED Records

Uses

- Allows data to be sorted based upon the geographic location of the patient's injury

Other Associated Elements

- INJURY ZIP
- INJURY COUNTRY
- INJURY COUNTY
- INJURY CITY
- ALTERNATE HOME RESIDENCE

Data Format: [character, 2] single entry		**Picklist:** Yes, non-modifiable
Min Value: N/A	**Max Value:** N/A	**Accepts Null Value:** Yes

WORK RELATED?

LA County Element **PRE_32**
National Element **I_03**

Definition

Indication of whether the injury occurred during paid employment

Field Values

- Y (Yes)
- N (No)

Additional Information

- *If work related, two additional data fields must be completed: Patient's Occupational Industry and Patient's Occupation*

Data Source Hierarchy

1. ED Records
2. EMS Report Form

Uses

- Allows characterization of injuries associated with job environments

Other Associated Elements

- INDUSTRY
- OCCUPATION

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

OCCUPATION

LA County Element **PRE_33**
National Element **I_05**

Definition

The occupation of the patient

Field Values

ARCH/ENG	Architecture and Engineering Occupations
ARTS	Arts, Design, Entertainment, Sports, and Media
BUILD/MAINT	Building and Grounds Cleaning and Maintenance
BUS/FIN	Business and Financial Operations Occupations
COMM/SOC	Community and Social Services Occupations
COMP/MATH	Computer and Mathematical Occupations
CONSTRUCTION	Construction and Extraction Occupations
ED/TRAINING	Education, Training, and Library Occupations
FARMING	Farming, Fishing, and Forestry Occupations
FOOD	Food Preparation and Serving Related
HEALTH PRACT	Healthcare Practitioners, and Technical Occupations
HEALTH SUPPORT	Healthcare Support Occupations
INST/MAINT	Installation, Maintenance, and Repair Occupations
LEGAL	Legal Occupations
MANAGEMENT	Management Occupations
MILITARY	Military Specific Occupations
OFFICE	Office and Administrative Support Occupations
PERSONAL	Personal Care and Service Occupations
PRODUCTION	Production Occupations
PROTECTIVE	Protective Service Occupations
SALES	Sales and Related Occupations
SCIENCE	Life, Physical and Social Science Occupations
TRANSPORTATION	Transportation and Material Moving Occupations
UNEMPLOYED	Unemployed

Additional Information

- *Only completed if injury is work-related – must also complete Patient's Occupational Industry*
- Based upon 1999 US Bureau of Labor Statistics Standard Occupational Classification (SOC)

Data Source Hierarchy

1. Facesheet
2. History & Physical
3. ED Nurses Notes
4. Triage Form / Trauma Flow Sheet
5. EMS Report Form

Uses

- Can be used to better describe injuries associated with work environments

Other Associated Elements

- WORK RELATED?
- INDUSTRY

Data Format: [character, 15] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

INDUSTRY

LA County Element **PRE_34**
National Element **I_04**

Definition

The occupational industry associated with the patient's work environment

Field Values

AGRICULTURAL	Agricultural, Forestry, Fishing
CONSTRUCTION	Construction
ED/HEALTH	Education and Health
INFORMATION	Information Services
FIN/INS/REAL	Finance, Insurance, and Real Estate
GOVERNMENT	Government
LEISURE	Leisure and Hospitality
MANUFACTURING	Manufacturing
NATURAL	Natural Resources and Mining
PROFESSIONAL	Professional and Business Services
RETAIL	Retail Trade
TRANS/UTIL	Transport and Public Utilities
WHOLESALE	Wholesale Trade
OTHER	Other Services

Additional Information

- *Only completed if injury is work-related – must also complete Patient's Occupation*

Data Source Hierarchy

1. Facesheet
2. History & Physical
3. ED Nurses Notes
4. Triage Form / Trauma Flow Sheet
5. EMS Report Form

Uses

- Can be used to better describe injuries associated with work environments

Other Associated Elements

- WORK RELATED?
- OCCUPATION

Data Format: [character, 15] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

Emergency Department

ED NOTIFIED?

LA County Element **ED_31**
National Element **N/A**

Definition

Indicates whether or not the Emergency Department received notification prior to the patient's arrival

Field Values

- Y (Yes)
- N (No)

Data Source Hierarchy

1. ED Records
2. History and Physical
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Used in quality management for the evaluation of care

Other Associated Elements

- MD SERVICE
- MD CODE
- STAT?
- REQ TIME
- ARR TIME

Data Format: [character, 1] single entry		**Picklist:** Yes, non-modifiable
Min Value: N/A	**Max Value:** N/A	**Accepts Null Value:** Yes

MET CRITERIA?

LA County Element **ED_32**
National Element **N/A**

Definition

Indicates whether or not the patient met Trauma Criteria per LA County Reference No. 506

Field Values

- Y (Yes)
- N (No)

Additional Information

- Collected as HHMM (military time)
- Prehospital judgment is not applicable for non-EMS patients
- Do not include patients that meet Trauma Guidelines or Special Consideration

Data Source Hierarchy

1. EMS Report Form
2. ED Records
3. Base hospital records

Uses

- Allows data to be sorted based upon prehospital findings/judgment
- Used in quality management for the evaluation of care

Other Associated Elements

- TPS RATIONALE
- CRITERIA
- GUIDELINES MET
- JUDGMENT

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ED ARRIVAL TIME

LA County Element **ED_01**
National Element **ED_02**

Definition

The time the patient arrived to the ED/hospital

Field Values

- Relevant value for data element

Additional Information

- If the patient was brought to the ED, enter time patient arrived at ED.
- If patient was directly admitted to the hospital, enter time patient was admitted to the hospital
- Collected as HHMM (military time)
- Used to calculate Total EMS Time and Total Length of Hospital Stay

Data Source Hierarchy

1. ED Records
2. EMS Report Form

Uses

- Allows data to be sorted based upon total length of hospital stay

Other Associated Elements

- ARRIVAL DATE
- DISPATCH DATE/TIME
- 1st ON SCENE
- TRANSPORT ARRIVAL DATE/TIME

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

ED EXIT DATE

LA County Element **ED_02**
National Element **ED_19**

Definition

The date the patient was discharged from the ED

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY
- Used to calculate Total ED Time

Data Source Hierarchy

1. Physician's Progress Notes
2. Billing Sheet / Medical Records Coding Summary Sheet
3. Hospital Discharge Summary

Uses

- Allows data to be sorted based upon total length of ED stay

Other Associated Elements

- EXIT ED TIME
- NEXT PHASE AFTER ED

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

ED EXIT TIME

LA County Element **ED_03**
National Element **ED_20**

Definition

The time the patient was discharged from the ED

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time)
- Used to calculate Total ED Time

Data Source Hierarchy

1. ED Records
2. Hospital Record

Uses

- Allows data to be sorted based upon ED length of stay

Other Associated Elements

- EXIT ED DATE
- NEXT PHASE AFTER ED

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

ACTIVATION?

LA County Element **ED_04**
National Element **N/A**

Definition

Indicates whether or not the treating facility's Trauma Team was activated

Field Values

- Y (Yes)
- N (No)

Additional Information

- The responding team must include the Trauma Surgeon or a post-graduate year four (PGY4) surgical resident (minimum) – regardless of the level of trauma activation

NOTE: Requests for Trauma Consults are NOT considered Activations

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Allows data to be sorted based upon TPS Rationale and level of facility response

Other Associated Elements

- TPS RATIONALE
- TIME (OF ACTIVATION)
- LEVEL (OF ACTIVATION)

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

TIME *(OF ACTIVATION)*

LA County Element **ED_05**
National Element **N/A**

Definition

If applicable, the time that the treating facility's Trauma Team was activated

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time)

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Allows monitoring of Trauma Team response times

Other Associated Elements

- TPS RATIONALE
- ACTIVATION?
- LEVEL (OF ACTIVATION)

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

LEVEL *(OF ACTIVATION)*

LA County Element **ED_06**
National Element **N/A**

Definition

If applicable, the level of the Trauma Team's activation

Field Values

- Relevant value for data element

Additional Information

- Enter level of activation or code directly, or create facility-specific picklist

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Allows monitoring of Trauma Team response times and sorting of data based upon level of response

Other Associated Elements

- TPS RATIONALE
- ACTIVATION?
- TIME (OF ACTIVATION)

Data Format: [character, 3] single entry **Picklist:** Yes, facility-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

1st ED VS: TIME

LA County Element **ED_07**
National Element **N/A**

Definition

Time of the first recorded vital signs in the ED/hospital

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time)
- All timed values are tied to a date and time; therefore, the 1st Set of ED Vitals at the ED Receiving facility (Trauma Center) must be used, NOT the 1st Set of documented ED vitals from the ED Sending facility. Although this will result in variance in the Revised Trauma Score, vital signs that are timed prior to ED arrival at the Trauma Center will result in data validation issues.

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care

Other Associated Elements

- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: O_2 SAT / ON O_2?
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

1st ED VS: BP – SYSTOLIC

LA County Element **ED_11**
National Element **ED_03**

Definition

Numeric value of the patients first recorded systolic blood pressure in the ED/hospital

Field Values

- Up to three-digit numeric value
- Documented as numeric systolic value / diastolic value

Additional Information

- Used to calculate Revised Trauma Score - ED (adult & pediatric)

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care

Other Associated Elements

- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: O_2 Sat / ON O_2?
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [character, 3] single entry **Picklist:** No
Min Value: 0 **Max Value:** 300 **Accepts Null Value:** Yes

1st ED VS: BP – DIASTOLIC

LA County Element **ED_12**
National Element **N/A**

Definition

Numeric value of the patients first recorded diastolic blood pressure in the ED/hospital

Field Values

- Up to three-digit numeric value
- Documented as numeric systolic value / diastolic value

Additional Information

- "Not Documented" if not measured (i.e., only palpated SYSTOLIC pressure measured)

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care

Other Associated Elements

- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: O_2 Sat / ON O_2?
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [character, 3] single entry **Picklist:** No
Min Value: 0 **Max Value:** 300 **Accepts Null Value:** Yes

1st ED VS: HR

LA County Element **ED_13**
National Element **ED_04**

Definition

First recorded pulse *(palpated or auscultated ONLY – no monitor readings)* in the ED/hospital, expressed as a number per minute

Field Values

- Relevant value for data element

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care

Other Associated Elements

- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: RR / ASST?
- 1st ED VS: O_2 Sat / ON O_2?
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [character, 3] single entry **Picklist:** No
Min Value: 0 **Max Value:** 400 **Accepts Null Value:** Yes

1st ED VS: RR

LA County Element **ED_14**
National Element **ED_06**

Definition

First recorded respiratory rate in the ED/hospital, expressed as a number per minute

Field Values

- Relevant value for data element

Additional Information

- Used to calculate Revised Trauma Score - ED (adult & pediatric)
- Enter actual rate only – indicate whether or not respirations were assisted in the next field: “ASST?”

Data Source Hierarchy

1. ED Records
2. Physician’s Progress Notes

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care

Other Associated Elements

- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: RR ASST?
- 1st ED VS: O_2 Sat / ON O_2?
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [character, 3] single entry **Picklist:** No
Min Value: 0 **Max Value:** 100 **Accepts Null Value:** Yes

1st ED VS: ASST? *(RESP)*

LA County Element **ED_15**
National Element **ED_07**

Definition

Determination of respiratory assistance associated with the initial ED/hospital respiratory rate

Field Values

- Y (Yes)
- N (No)

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care

Other Associated Elements

- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: RR
- 1st ED VS: O_2 Sat / ON O_2?
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** No

1st ED VS: O_2 Sat

LA County Element **ED_16**
National Element **ED_08**

Definition

First recorded oxygen saturation in the ED/hospital, expressed as a percentage

Field Values

- Relevant value for data element

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care

Other Associated Elements

- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: RR / ASST?
- 1st ED VS: ON O_2?
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [character, 3] single entry **Picklist:** No
Min Value: 0 **Max Value:** 100 **Accepts Null Value:** Yes

1st ED VS: ON O_2? *(O_2 Sat)*

LA County Element **ED_17**
National Element **ED_07**

Definition

Determination of the presence of supplemental oxygen during assessment of initial ED/hospital oxygen saturation level

Field Values

- Y (Yes)
- N (No)

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care

Other Associated Elements

- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: RR / ASST?
- 1st ED VS: O_2 Sat
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

1st ED VS: TEMP

LA County Element **ED_08**
National Element **ED_05**

Definition

First recorded temperature in the ED/hospital

Field Values

- Relevant value for data element

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care

Other Associated Elements

- 1st ED VS: TEMP UNITS / TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: O_2 Sat / ON O_2?
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [character, 5] single entry **Picklist:** No
Min Value: 25 **Max Value:** 110 **Accepts Null Value:** Yes

F vs C *(1st TEMP UNITS)*

LA County Element **ED_09**
National Element **ED_05**

Definition

Units of measurement for first recorded temperature in the ED/hospital

Field Values

- F (Fahrenheit)
- C (Celsius)

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care

Other Associated Elements

- 1st ED VS: TEMP / TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: O_2 Sat / ON O_2?
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

TIME *(1st TEMP)*

LA County Element **ED_10**
National Element **N/A**

Definition

First recorded temperature in the ED/hospital

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time)

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care

Other Associated Elements

- 1st ED VS: TEMP / UNITS
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: O_2 Sat / ON O_2?
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

1st ED VS: GCS – EYE

LA County Element **ED_18**
National Element **ED_10**

Definition

First recorded Glasgow Coma Eye Score in the ED/hospital

Field Values

- 4 Opens eyes spontaneously
- 3 Opens eyes to verbal stimulation
- 2 Opens eyes to painful stimulation
- 1 No eye opening

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care
- Used to calculate Total GCS

Other Associated Elements

- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: RR / ASST?
- 1st ED VS: O_2 Sat / ON O_2?
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [number, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: 1 **Max Value:** 4 **Accepts Null Value:** Yes

1st ED VS: GCS – VERBAL

LA County Element **ED_20**
National Element **ED_11**

Definition

First recorded Glasgow Coma Verbal Score in the ED/hospital

Field Values

	ADULT	INFANT
5	Oriented X 3	Smiling or cooing appropriately
4	Confused	Crying but consolable
3	Inappropriate words	Crying or screaming is persistent and inappropriate for the incident
2	Incomprehensible sounds	Grunts, agitated, or restless
1	No verbal response	No verbal response

Additional Information

- If the patient is intubated then the GCS Verbal score is equal to 1

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care
- Used to calculate Total GCS

Other Associated Elements

- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: RR / ASST?
- 1st ED VS: O_2 Sat / ON O_2?
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [number, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: 1 **Max Value:** 5 **Accepts Null Value:** Yes

1st ED VS: GCS – MOTOR

LA County Element **ED_19**
National Element **ED_12**

Definition

First recorded Glasgow Coma Motor Score in the ED/hospital

Field Values

- 6 Obeys commands
- 5 Localizes pain
- 4 Withdraws from pain
- 3 Flexion (decorticate movement) to pain
- 2 Extension (decerebrate movement) to pain
- 1 No motor response

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care
- Used to calculate Total GCS

Other Associated Elements

- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: RR / ASST?
- 1st ED VS: O_2 Sat / ON O_2?
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [number, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: 1 **Max Value:** 6 **Accepts Null Value:** Yes

1st ED VS: GCS – TOTAL

LA County Element **ED_21**
National Element **ED_13**

Definition

First recorded Total Glasgow Coma Score in the ED/hospital

Field Values

- Relevant value for data element

Additional Information

- Is auto-calculated if components are entered, or total can be hand-entered if components not available
- If a patient does not have a numeric GCS recorded, but documentation related to their level of consciousness exists, i.e., AAOx3, awake alert and oriented, or patient with normal mental status, interpret this as GCS of 15, IF there is no other contraindicating documentation
- If a patient does not have a numeric GSC recorded, but documentation related to their level of consciousness exists such as, “awake, alert, and oriented”, this may be interpreted as a GCS of 15 if no other contraindicating information exists

Data Source Hierarchy

1. ED Records
2. Physician’s Progress Notes

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care
- Used to calculate Revised Trauma Score - EMS (adult & pediatric)

Other Associated Elements

- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: RR / ASST?
- 1st ED VS: O_2 Sat / ON O_2?
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [number, 2] single entry **Picklist:** No
Min Value: 3 **Max Value:** 15 **Accepts Null Value:** Yes

1st ED VS: GCS *(Modifiers)*

LA County Element **ED_22**
National Element **ED_14**

Definition

Documentation of factors potentially affecting the first assessment of GCS upon arrival in the ED/hospital

Field Values

- S Sedated
- E Eye Obstruction
- I Intubated

Additional Information

- Identified medical treatments given to the patient that may affect the first assessment of GCS. This field does not apply to self-medications the patient may have administered (i.e., ETOH, prescriptions, etc.)
- If patient was not chemically sedated, intubated, and did not have eye obstruction then code as “Not Applicable”

Data Source Hierarchy

1. ED Records
2. Physician’s Progress Notes

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care

Other Associated Elements

- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – TOTAL

Data Format: [character, 1] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

INITIAL PUPILLARY RESPONSE

LA County Element **TQIP-01**
National Element **PM_04**

Definition

Physiological response of the pupil size within 30 minutes or less of ED/hospital arrival

Collection Criterion

ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION. "Not Applicable" is used for patients that do not meet the collection criterion.

Field Values

LA COUNTY		NTDB	
2	Both Reactive	1	Both Reactive
1	One Reactive	2	One Reactive
0	None Reactive	3	Neither Reactive

Additional Information

- If a patient does not have a listed field value recorded, but there is documentation related to their pupillary response such as PERRL "Pupils Equal Round Reactive to Light" submit field value for both reactive IF there is no other contradicting documentation
- The null value "Not Known/Not Recorded" should be submitted if this information is not documented or if assessment is unable to be obtained due to facial trauma and/or foreign object in the eye
- One reactive should be reported for patients who have a prosthetic eye

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care

Data Format: [character, 1] multiple entries **Picklist:** Yes, non-modifiable
Min Value: 0 **Max Value:** 2 **Accepts Null Value:** Yes

ED DISPOSTION ORDER DATE

LA County Element **ED_39**
National Element **ED_21**

Definition

The date the order was written for the patient to be dispositioned from the ED

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY
- Used to calculate Total ED Time

Data Source Hierarchy

1. Physician's Progress Notes
2. Billing Sheet / Medical Records Coding Summary Sheet
3. Hospital Discharge Summary

Uses

- Allows data to be sorted based upon total length of ED stay

Other Associated Elements

- EXIT ED TIME
- NEXT PHASE AFTER ED
- ED DISPOSITION ORDER
- ED DISPOSITION TIME

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

ED DISPOSTION ORDER TIME

LA County Element **ED_40**
National Element **ED_22**

Definition

The time the order was written for the patient to be dispositioned from the ED

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time)
- Used to calculate Total ED Time

Data Source Hierarchy

1. ED Records
2. Hospital Record

Uses

- Allows data to be sorted based upon ED length of stay

Other Associated Elements

- EXIT ED DATE
- NEXT PHASE AFTER ED
- ED DISPOSITION ORDER
- ED DISPOSTION DATE

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

TPS RATIONALE

LA County Element **ED_23**
National Element **N/A**

Definition

The patient's primary rationale for TPS completion and inclusion in the TEMIS database

Field Values

PH	Prehospital care personnel made destination decision of Trauma Center based on criteria, guidelines, or judgment – must be documented on EMS report form
CG	Non-EMS patient met trauma criteria or guidelines (excluding Prehospital Judgment)
AD	Admitted to **your** hospital for care of an injury after Trauma service evaluation in the ED
DI	Died of an injury-related problem
TS	Transferred to or from your facility for care of an injury
NO	DHS = No – use for patients not meeting Exhibit C inclusion criteria that your facility wishes to capture in your hospital database (e.g., hangings, or patients being followed for special studies)

Additional Information

- Always use the rationale that occurs *first* in the patient's course of treatment
- Prehospital judgment is not applicable for non-EMS patients

Data Source Hierarchy

1. ED Records
2. EMS Report Form
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon TPS Rationale
- Used in quality management for the evaluation of care

Other Associated Elements

- DHS? Y N

Data Format: [character, 2] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ADMITTING MD

LA County Element **ED_24**
National Element **N/A**

Definition

The physician primarily responsible for admitting patient to the hospital, if applicable

Field Values

- Relevant value for data element

Additional Information

- Non-picklisted – free text physician's name or code at discretion of facility

Data Source Hierarchy

1. ED Admission Form
2. Billing Sheet / Medical Records Coding Summary Sheet
3. ED Records

Uses

- Allows data to be sorted based upon Admitting MD
- Used in quality management for the evaluation of care

Other Associated Elements

- ADMITTING SERVICE

Data Format: [character, 15] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ADMITTING SERVICE

LA County Element **ED_25**
National Element **N/A**

Definition

The three-letter code for physician service primarily responsible for admitting patient to the hospital, if applicable

Field Values

- Relevant value for data element

Data Source Hierarchy

1. ED Records
2. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon Admitting Service
- Used in quality management for the evaluation of care

Other Associated Elements

- ADMITTING MD

Data Format: [character, 3] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

MD SERVICE

LA County Element **ED_26**
National Element **N/A**

Definition

Trauma Team services activated to evaluate patient upon arrival

Field Values

ANE	ANESTHESIOLOGY	NEP	NEPHROLOGY	POS	PED. ORTHOPEDIC
CAR	CARDIOLOGY	NEU	NEUROLOGY	POT	PED. OTOLARYNGOLOGY
CTS	CARDIOTHOR. SURG.	NER	NEURORADIOLOGY	PEP	PED. PATHOLOGY
CCI	CRIT. CARE INTENSIVIST	NES	NEUROSURGEON	PPY	PED. PSYCHIATRIST
DEN	DENTAL	OBS	OBSTERICS	PPS	PED. PULM. SPECIALIST
DER	DERMATOLOGY	OPS	OPTHAL. SURGEON	PER	PED. RADIOLOGY
EDP	ED PHYS/ATTENDING	ORS	ORAL SURGEON	PES	PEDIATRIC SURGEON
EDR	ED RESIDENT	ORT	ORTHOPEDICS	PUR	PEDIATRIC UROLOGY
END	ENDOCRINOLOGY	ONL	OTHER NOT LISTED	PED	PEDIATRICS
FNM	FAMILY MEDICINE	OTO	OTOLARYNGOLOGY	PHY	PHYSIATRY
GAS	GASTROENTEROLOGY	PAL	PALLIATIVE CARE	PLS	PLASTIC SURGEON
GES	GENERAL SURGEON	PAT	PATHOLOGY	POD	PODIATRY
GER	GERIATRICS	PEA	PEDIATRIC ALLERGY	PTN	PRIMARY TRAUMA NURSE
GYN	GYNECOLOGY	PEC	PED. CARDIOLOGY	PSC	PSYCHOLOGY
HAS	HAND SURGEON	PCA	PED. CHILD ADVOCACY	PSY	PSYCHIATRY
HEM	HEMATOLOGY	PCS	PED. CARDIOTHOR. SURG.	PUL	PULMONARY SPECIALIST
HMO	HMO CONSULTANT	PEN	PED. ENDOCRINOLOGY	RAD	RADIOLOGY
HNS	HEAD & NECK SURG.	PEG	PED. GASTROENTEROLOGY	RHE	RHEUMATOLOGY
HBO	HYPERBARIC MEDICINE	PEH	PED. HEMATOLOGY	SPI	SPINAL
INF	INFECTIOUS MEDICINE	PEI	PEDIATRIC INTENSIVIST	TRR	TRAUMA RESIDENT
INR	INTERVENT. RADIOLOGY	PMS	PAIN MANAGE SPECIALIST	TRS	TRAUMA SURG/ATTEND
INT	INTERNAL MEDICINE	PNP	PEDIATRIC NEPHROLOGY	URO	UROLOGY
MAS	MAXILLOFACIAL SURG.	PNE	PEDIATRIC NEUROLOGY	VAS	VASCULAR SURGEON
NCC	NEURO CRITICAL CARE	PNR	PED. NEURORADIOLOGY		
NEO	NEONATOLOGY	PNS	PED. NEUROSURGEON		

Additional Information

- Trauma Team composition will vary by facility policy

Data Source Hierarchy

1. ED Records
2. History and Physical
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon physician service
- Used in quality management for the evaluation of care

Other Associated Elements

- MD CODE
- REQ TIME
- STAT?
- ARR TIME

Data Format: [character, 3] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

MD CODE

LA County Element **ED_27**
National Element **N/A**

Definition

Name or code of Trauma Team physician activated to evaluate patient upon arrival

Field Values

- Relevant value for data element

Additional Information

- Enter physician name or code directly, or create facility-specific picklist

Data Source Hierarchy

1. ED Records
2. History and Physical
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon responding physician
- Used in quality management for the evaluation of care

Other Associated Elements

- MD SERVICE
- REQ TIME
- STAT?
- ARR TIME

Data Format: [character, 5] multiple entries **Picklist:** Yes, facility-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

REQUEST TIME *(MD)*

LA County Element **ED_28**
National Element **N/A**

Definition

Time that Trauma Team physician was contacted to request evaluation of injured patient

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time)

Data Source Hierarchy

1. ED Records
2. History and Physical
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon responding physician
- Used in quality management for the evaluation of care

Other Associated Elements

- MD SERVICE
- REQ TIME
- STAT?
- ARR TIME

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

STAT? *(MD)*

LA County Element **ED_29**
National Element **N/A**

Definition

Indicates whether or not the Trauma Team physician was asked to respond immediately (responding without delay when notified) to evaluate the injured patient

Field Values

- Y (Yes)
- N (No)

Data Source Hierarchy

1. ED Records
2. History and Physical
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Used in quality management for the evaluation of care

Other Associated Elements

- MD SERVICE
- MD CODE
- REQ TIME
- ARR TIME

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ARRIVAL TIME *(MD)*

LA County Element **ED_30**
National Element **N/A**

Definition

Time that Trauma Team physician arrived at the bedside to evaluate the injured patient

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time)
- A “phone response” is NOT to be utilized as an *Arrival Time*. Physical evaluation of the patient is not possible via the phone

Data Source Hierarchy

1. ED Records
2. History and Physical
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Used in quality management for the evaluation of care

Other Associated Elements

- MD SERVICE
- MD CODE
- REQ TIME
- STAT?

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

CRITERIA MET

LA County Element **ED_33**
National Element **N/A**

Definition

Trauma Criteria, per LA County Reference No. 506, met by the patient

Field Values

LA COUNTY		NTDB Physiologic & Anatomic / Mechanism of Injury	
14	Blunt Head with GCS≤14	1	Glasgow Coma Score ≤13
15	Adult fall from heights >15 feet, or Peds from heights >10 feet, or >3 times child's height	1 2	Adult fall from heights >15 feet, or Peds from heights >10 feet, or >3 times child's height
20	Unenclosed vehicle crash impact >20 mph	8	Motorcycle crash >20 mph
70	Blood Pressure <70mmHg Systolic Infant	2	Blood Pressure <90mmHg Systolic
90	Blood Pressure <90mmHg Systolic Adult	2	Blood Pressure <90mmHg Systolic
RR	Respiratory Rate <10/>29, <20 if <1yr.	3	Respiratory Rate <10/>29, <20 if <1yr.
FC	Flail Chest	5	Chest wall instability or deformity
SX	Suspected Pelvic Fracture	9	Pelvic Fracture
SC	Spinal Cord Injury with Sensory Deficit	11	Paralysis
EJ	Ejected	4	Crash ejection (partial or complete)
PS	Passenger Space Intrusion of 12 inches into an occupied passenger space	3	Intrusion >12 in. occupant site; 18 in. any site
RT	Pedestrian/Bicyclist Thrown / Runover / Impact >20 mph	7	Pedestrian/Bicyclist Thrown / Runover / Impact >20 mph
BD	Blunt Abdomen with Diffuse Abd. Tenderness	N/A	
BR	Blunt Fractures of Two or More Long Bones (femur/humerus)	6	Two or more proximal long-bone fractures
BI	Blunt Amputation above the Wrist or Ankle	8	Amputation proximal to the wrist or ankle
BV	Blunt Extremity with Neuro / Vascular / Mangled	7	Crushed, degloved, mangled, or pulseless extremity
PT	Penetrating Full Arrest	N/A	
PH	Penetrating Head	4	Penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
PF	Penetrating Face/Mouth	4	Penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
PN	Penetrating Neck	4	Penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
PX	Penetrating Extremity above the Elbow or Knee (includes Chest / Back / Abdomen / Genitals / Buttocks)	4	Penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
PI	Penetrating Amputation above the Wrist or Ankle	8	Amputation proximal to the wrist or ankle
PV	Penetrating Extremity with Neuro / Vascular / Mangled	7	Crushed, degloved, mangled, or pulseless extremity

Data Source Hierarchy

1. EMS Report Form
2. Base Hospital Records
3. ED Records

Uses

- Allows data to be sorted based upon prehospital findings/judgment
- Used in quality management for the evaluation of care

Other Associated Elements

- TPS RATIONALE
- MET CRITERIA?

Data Format: [character, 2] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

GUIDELINES / SPEC. CONSIDER. MET

LA County Element **ED_34**
National Element **N/A**

Definition

Trauma Guidelines / Special Considerations, per LA County Reference No. 506, met by the patient

Field Values

GUIDELINES		NTDB Physiologic & Anatomic Mechanism of Injury & Other Risk Injury	
18	Passenger Space Intrusion of 18 inches into an unoccupied passenger space	3	Intrusion >12 inches occupant site
AN	Anticoagulant Medication (other than aspirin only) or with Bleeding Disorder	10	Patients on anticoagulants and bleeding disorders
EX	Extrication Required	N/A	
PB	Pedestrians/Bicyclists Impact ≤ 20 mph	N/A	
SF	Survivor of Fatal Crash (same vehicle), with Complaint of Injury	5	Crash death in same passenger compartment
TD	Telemetry Data	6	Telemetry data consistent w/ high risk injury
SPECIAL CONSIDERATIONS		**NTDB Physiologic & Anatomic Mechanism of Injury**	
55	Age greater than 55 years	N/A	
BP	Systolic B/P less than 110mmHg for patient greater than 65 years of age	9	Adults greater than 65 years of age with Systolic B/P less than 110mmHg
IU	Pregnancy greater than 20 weeks	11	Pregnancy greater than 20 weeks
PJ	Prehospital judgment that transport to Trauma Center is in the pt's best interest	12	EMS provider judgment

Additional Information

- Special consideration is not applicable for non-EMS patients
- Special consideration is not to be used if an existing criteria or guideline exists

Data Source Hierarchy

1. EMS Report Form
2. Base Hospital Records
3. ED Records

Uses

- Allows data to be sorted based upon prehospital findings/judgment
- Used in quality management for the evaluation of care

Other Associated Elements

- TPS RATIONALE
- MET CRITERIA?

Data Format: [character, 2] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

1ST ANTIBIOTIC ADMIN. DATE

LA County Element **ED_41**
National Element **N/A**

Definition

Date of 1st antibiotic administration for patients that meet the collection criteria

Collection Criterion

- **ONLY COLLECT ON PATIENTS WITH BLUNT OPEN TIBIAL FRACTURE. The null value "Not Applicable" is used for patients that do not meet the collection criteria.**

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY

Data Source Hierarchy

1. ED Records

Uses

- Allows data to be sorted based upon antibiotic administration

Other Associated Elements

- 1st ANTIBIOTIC ADMIN. TIME

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

1ST ANTIBIOTIC ADMIN. TIME

LA County Element **ED_42**
National Element **N/A**

Definition

Time of 1st antibiotic administration for patients that meet the collection criteria

Collection Criterion

- **ONLY COLLECT ON PATIENTS WITH BLUNT OPEN TIBIAL FRACTURE. The null value "Not Applicable" is used for patients that do not meet the collection criteria.**

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time)

Data Source Hierarchy

1. ED Records

Uses

- Used in quality management for the evaluation of care

Other Associated Elements

- 1st ANTIBIOTIC ADMIN. DATE

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

IV FLUIDS *(ED)*

LA County Element **ED_35**
National Element **N/A**

Definition

Total amount of all crystalloids and colloids, excluding blood products, received by the patient in the ED

Field Values

- Relevant value for data element

Additional Information

- Collected as milliliters – not liters or units. If IV fluids are documented, but amount is not, "Not Documented" is entered.

Data Source Hierarchy

1. ED Records

Uses

- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- BLOOD PROD.s *(ED)*
- AUTOTRANS. *(ED)*

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

ARRIVED WITH SIGNS OF LIFE?

LA County Element **ED_38**
National Element **ED_18**

Definition

Indication of whether the patient arrived at the ED/Hospital with signs of life

Field Values

- Y (Yes)
- N (No)

Additional Information

- A patient with no signs of life is defined as having none of the following:
  - Organized EKG activity
  - Pupillary responses
  - Spontaneous respiratory effort
- This usually implies that the patient arrived with CPR in progress
- Applicable for all patients

Data Source Hierarchy

1. ED Records

Uses

- Allows data to be sorted based upon ED phase of care
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- EXIT ED DATE/TIME
- TRANSFERRED / D/C'D TO
- PHASE PRIOR D/C

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

DEATH IN ED

LA County Element **ED_37**
National Element **ED_17**

Definition

Resuscitation details of patients who expire in the ED

Field Values

LA COUNTY	
D DOA	Death declared on arrival no invasive procedures attempt
F Failed resuscitation (<15min)	Death in ED within 15 minutes of failed resuscitation attempt
O Died in ED	Death in ED of other than failed resuscitation attempt

Data Source Hierarchy

1. ED Records

Uses

- Allows data to be sorted based upon post-ED phase of care
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- EXIT ED DATE/TIME
- TRANSFERRED / D/C'D TO
- PHASE PRIOR D/C

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

NEXT PHASE AFTER ED

LA County Element **ED_36**
National Element **ED_17**

Definition

Phase of care occurring directly after the ED phase (ED disposition)

Field Values

LA COUNTY	NTDB	
23HR OBS	2	Observation unit (provides < 24 hour stays)
ICU	8	Intensive Care Unit (ICU)
INTERVENTIONAL RADIOLOGY (IR)	8	Intensive Care Unit (ICU)
OR	7	Operating Room
PICU	8	Intensive Care Unit (ICU)
PEDSWARD	1	Floor bed (general admission, non-specialty bed)
SPECIAL PROCEDURES (anything other than IR)	8	Intensive Care Unit (ICU)
STEPDOWN	3	Telemetry/step-down unit (less acuity than ICU)
WARD	1	Floor bed (general admission, non-specialty bed)
POSTHOSP *(Uses LA County "TRANSFERRED / D/C TO:"):*		
HOME W/O	9	Home without services
HOME WITH	4	Home with services
MORGUE	5	Died
JAIL SCJ USC (Jail Ward at LAC+USC) REHAB SNF SUBACUTE CARE	6	Other (jail, institutional care, mental health, etc)
HOSPICE	4 6	Home with services, OR Other (jail, institutional care, mental health, etc)
AMA/ELOPED/LWBS	10	Left against medical advice
ACUTE CARE BURN CENTER TRAUMA CENTER	11	Transferred to another hospital
Long Term Care Hospital (LTCH)	12	Discharged Transferred to Long Term Care Hospital
Psych	13	Discharged Transferred to a psych facility or unit
OTHER	F5	

Additional Information

- Next phase begins when patient is no longer being cared for by the ED or ED personnel with the exception of Interventional Radiology and/or Special procedures

Data Source Hierarchy

1. ED Records

Uses

- Allows data to be sorted based upon post-ED phase of care
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- EXIT ED DATE/TIME
- DEATH IN ED (if applicable)
- TRANSFERRED / D/C'D TO

Data Format: [character, 8] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

Radiology / Laboratory

RADIOLOGY: Body Part/ICD-10

LA County Element **RL_01**
National Element **N/A**

Definition

Body region and radiological study performed during hospital stay, if applicable

Field Values

BODY PART	X-Ray	CT	BODY PART	X-Ray	CT
HEAD			**UPPER EXTREMITIES**		
Head / Skull	BN00ZZZ	BW28ZZZ	Right Upper Extremity	BP0EZZZ	BP2EZZZ
Brain		B020ZZZ	Right hand	BP0NZZZ	BP2NZZZ
Orbits	BN03ZZZ	BN23ZZZ	Right wrist	BP0M0ZZ	BP2LZZZ
Facial	BN05ZZZ	BN25ZZZ	Right forearm (radius / ulna)	BP0JZZZ	BP2JZZZ
Mandible	BN06ZZZ	BN26ZZZ	Right elbow	BP0GZZZ	BP2GZZZ
			Right upper arm (humerus)	BP0AZZZ	BP2AZZZ
NECK / SPINE			Right shoulder	BP08ZZZ	BP28ZZZ
Cervical spine	BR00ZZZ	BR20ZZZ	Right scapula	BP06ZZZ	BP26ZZZ
Thoracic spine	BR07ZZZ	BR27ZZZ	Left Upper Extremity	BP0FZZZ	BP2FZZZ
Lumbosacral spine	BR09ZZZ	BR29ZZZ	Left hand	BP0PZZZ	BP2PZZZ
			Left wrist	BP0MZZZ	BP2MZZZ
CHEST / ABDOMEN			Left forearm (radius / ulna)	BP0KZZZ	BP2KZZZ
Chest	BW03ZZZ		Left elbow	BP0HZZZ	BP2HZZZ
Chest & Abdomen		BW24ZZZ	Left upper arm (humerus)	BP0BZZZ	BP2BZZZ
Chest, Abdomen, Pelvis		BW25ZZZ	Left shoulder	BP09ZZZ	BP29ZZZ
Right Ribs	BP0XZZZ	BP2XZZZ	Left scapula	BP07ZZZ	BP27ZZZ
Left Ribs	BP0YZZZ	BP2YZZZ			
Sternum	BR0HZZZ	BW24ZZZ	**LOWER EXTREMITIES**		
Right Clavicle	BP04ZZZ	BW24ZZZ	Right Lower Extremity	BQ0DZZZ	BQ2DZZZ
Left Clavicle	BP05ZZZ	BW24ZZZ	Right ankle	BQ0GZZZ	BQ2GZZZ
Heart / Lung	B206ZZZ	B226ZZZ	Right foot	BQ0LZZZ	BQ2LZZZ
Abdomen / Pelvis	BW00ZZZ	BW21ZZZ	Right femur	BQ03ZZZ	BQ23ZZZ
Kidneys (KUB)	BT030ZZ	BT23ZZZ	Right tibia / fibula	BQ0DZZZ	BQ2BZZZ
Right Kidney	BT01ZZZ	BT21ZZZ	Right hip	BQ00ZZZ	BQ20ZZZ
Left Kidney	BT02ZZZ	BT22ZZZ	Left Lower Extremity	BQ0FZZZ	BQ2FZZZ
			Left ankle	BQ0HZZZ	BQ2HZZZ
OTHER			Left foot	BQ0MZZZ	BQ2MZZZ
Pelvis	BR0CZZZ	BW2GZZZ	Left femur	BQ04ZZZ	BQ24ZZZ
Sacrum	BR0FZZZ	BR2FZZZ	Left knee	BQ08ZZZ	BQ28ZZZ
Skeletal Survey	BW0LZZZ		Left tibia / fibula	BQ0FZZZ	BQ2CZZZ
F.A.S.T.	BW41ZZZ		Left hip	BQ01ZZZ	BQ21ZZZ

Additional Information

- Codes for CT's with contrast is dependent on the site, type of contrast, and enhanced versus unenhanced
- Head CT results are **NOT** considered abnormal if facial fracture(s) is / are the only abnormality identified

Data Source Hierarchy

1. Radiology Records
2. ED Records

Uses

- Allows data to be sorted based upon studies performed
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- RADIOLOGY: Date
- RADIOLOGY: Time
- RADIOLOGY: Result

Data Format: [character, 22] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

RADIOLOGY: Study

LA County Element **RL_02**
National Element **N/A**

Definition

Type of radiological study performed, if applicable

Field Values

CT ANGIO	CT Angio
CONTRAST	Contrast Studies
CT SCAN	Computerized Tomography Scan
FAST	Focused Assessment Sonography for Trauma
MRI	Magnetic Resonance Imaging
MRI ANGIO	Magnetic Resonance Imaging(MRI) Angio
PLAIN FILMS	Plain Films
RADIONUCLEOTIDE SCANS	Radionucleotide Scans
ULTRASOUND	Ultrasound
OT	Other study

Additional Information

- Operative and/or essential procedures is defined as procedures performed in the Operating Room, Emergency Department, or Intensive Care Unit that were essential to the diagnoses, stabilization, or treatment of the patient's injuries
- Repeated diagnostic procedures (e g , repeated CT scan) should not be recorded (record only the first procedure)
- Record subsequent radiology studies identifying missed injuries
- CTs and MRIs may or may not include contrast.
- If no contrast is used, use the field values of CT Scan and MRI
- If contrast is used, use the field values of CT Angio or MRI Angio.
- Interventional Angiogram (Catheter Angiogram, Formal Angiogram) involves interventional radiology (IR). IR is considered invasive; therefore, IR procedures should be coded in the procedure section not in the radiology section. A catheter is inserted into an artery or vein through a small incision, and is moved directly into the artery being studied. X-ray images can be obtained while contrast is delivered directly into the artery being studied and allows for embolization if needed.

Data Source Hierarchy

1. Radiology Records
2. ED Records

Uses

- Allows data to be sorted based upon studies performed
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- RADIOLOGY: Date
- RADIOLOGY: Time
- RADIOLOGY: Result

Data Format: [character, 25] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

RADIOLOGY: Date

LA County Element **RL_04**
National Element **HP_02**

Definition

Date that x-ray, CAT scan, and/or ultrasound studies were performed, if applicable

Field Values

- Relevant value for data element

Data Source Hierarchy

1. Radiology Records
2. ED Records

Uses

- Allows data to be sorted based upon studies performed
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- RADIOLOGY: Body Part
- RADIOLOGY: Study
- RADIOLOGY: Time
- RADIOLOGY: Result

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

RADIOLOGY: Time

LA County Element **RL_05**
National Element **HP_03**

Definition

Time that x-ray, CAT scan, and/or ultrasound studies were performed, if applicable

Field Values

- Relevant value for data element

Data Source Hierarchy

1. Radiology Records
2. ED Records

Uses

- Allows data to be sorted based upon studies performed
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- RADIOLOGY: Body Part
- RADIOLOGY: Study
- RADIOLOGY: Date
- RADIOLOGY: Result

Data Format: [time] multiple entries **Picklist:** No
Min Value: N/A **Max Value:** 2359 **Accepts Null Value:** Yes

RADIOLOGY: Comments/Results

LA County Element **RL_06**
National Element **N/A**

Definition

Results of x-ray, CAT scan, and/or ultrasound studies, if applicable

Field Values

- A Abnormal
- N Normal

Additional Information

- Head CT results are **NOT** considered abnormal if facial fracture(s) is / are the only abnormality identified

Data Source Hierarchy

1. Radiology Records
2. ED Records

Uses

- Allows data to be sorted based upon studies performed
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- RADIOLOGY: Body Part
- RADIOLOGY: Study
- RADIOLOGY: Date
- RADIOLOGY: Time

Data Format: [character, 1] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

MIDLINE SHIFT?

LA County Element **TQIP_02**
National Element **PM_05**

Definition

Indicate if a midline shift exists and its size within 24 hours after time of injury

Collection Criterion

- **ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION. The null value "Not Applicable" is used for patients that do not meet the collection criteria.**

Field Values

- Yes
- No
- Not Imaged

Data Source Hierarchy

1. Radiology Report
2. Operative Report
3. Procedure Notes
4. Neurosurgical Notes
5. ICU Records
6. Progress Notes
7. Anesthesia Records
8. Hospital Discharge Summary

Uses

- Allows data to be sorted based upon type of surgery performed
- Used in quality management for the evaluation of care

Other Associated Elements

- TBI INCLUSION?
- HIGHEST GCS TOTAL
- HIGHEST GCS MOTOR
- QUALIFIER OF HIGHEST GCS

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

TBI INCLUSION?

LA County Element **TQIP_03**
National Element **PM_**

Definition

Indicate if patient meets the TBI inclusion criteria

Collection Criterion

- **ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION. The null value "Not Applicable" is used for patients that do not meet the collection criteria.**

Field Values

- Yes
- No

Data Source Hierarchy

1. Radiology Report
2. Operative Report
3. Procedure Notes
4. Neurosurgical Notes
5. ICU Records
6. Progress Notes
7. Anesthesia Records
8. Hospital Discharge Summary

Uses

- Allows data to be sorted based upon type of surgery performed
- Used in quality management for the evaluation of care

Other Associated Elements

- MIDLINE SHIFT?
- HIGHEST GCS TOTAL
- HIGHEST GCS MOTOR
- QUALIFIER OF HIGHEST GCS

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

HIGHEST GCS TOTAL

LA County Element **TQIP_04**
National Element **PM_01**

Definition

Highest total GCS **within 24 hours** of ED/Hospital arrival

Collection Criterion

- **ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION. The null value "Not Applicable" is used for patients that do not meet the collection criteria.**

Field Values

- Relevant value for data element

Additional Information

- Requires review of all data sources to obtain the highest GCS total. In many cases, the highest GCS may occur after ED discharge
- If patient is intubated then the GCS Verbal score is equal to 1
- Best obtained when sedatives or paralytics are withheld as part of sedation holiday
- If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as "AAOx3," "awake alert and oriented," or "patient with normal mental status," interpret this as GCS of 15 IF there is no other contradicting documentation

Data Source Hierarchy

1. Neuro Assessment Flow Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Nursing Notes/Flow Sheet
4. Progress Notes

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care

Data Format: [number, 2} single entry **Picklist:** No
Min Value: 3 **Max Value:** 15 **Accepts Null Value:** Yes

HIGHEST GCS MOTOR

LA County Element **TQIP_05**
National Element **PM_02**

Definition

Highest GCS MOTOR **within 24 hours** of ED/Hospital arrival

Collection Criterion

- **ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION. The null value "Not Applicable" is used for patients that do not meet the collection criteria.**

Field Values

- 6 Obeys commands
- 5 Localizes pain
- 4 Withdraws from pain
- 3 Flexion (decorticate movement) to pain
- 2 Extension (decerebrate movement) to pain
- 1 No motor response

Additional Information

- Requires review of all data sources to obtain the highest GCS total. In many cases, the highest GCS may occur after ED discharge
- If patient is intubated then the GCS Verbal score is equal to 1
- Best obtained when sedatives or paralytics are withheld as part of sedation holiday
- If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as "AAOx3," "awake alert and oriented," or "patient with normal mental status," interpret this as GCS of 15 IF there is no other contradicting documentation

Data Source Hierarchy

1. Neuro Assessment Flow Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Nursing Notes/Flow Sheet
4. Progress Notes

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care

Data Format: [number, 1 single entry **Picklist:** Yes, non-modifiable
Min Value: 1 **Max Value:** 6 **Accepts Null Value:** Yes

QUALIFIER OF HIGHEST GCS

LA County Element **TQIP_06**
National Element **PM_03**

Definition

Documentation of factors potentially affecting the highest GCS upon arrival in the ED/hospital

Collection Criterion

- **ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION. The null value "Not Applicable" is used for patients that do not meet the collection criteria.**

Field Values

O - Obstruction Eye	TS – Intubated & Sedated / Paralyzed
S - Sedated / Paralyzed	TSO – Intubated, Sedated / Paralyzed, & Obstruction
T - Intubated	SO - Sedated / Paralyzed & Obstruction
TO – Intubated & Obstruction	L – Valid GCS, Not sedated, intubated, or obstructed

Additional Information

- Identified medical treatments given to the patient that may affect the first assessment of GCS. This field does not apply to self-medications the patient may have administered (i.e., ETOH, prescriptions, etc.)
- Requires review of all data sources to obtain the highest GCS motor score which might occur after the ED phase of care
- Must be the assessment qualifier for the Highest GCS Total
- If an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible, then the patient should be considered to have an exam that is not reflective of their neurologic status and the chemical sedation modifier should be selected
- Neuromuscular blockade is typically induced following the administration of agents like succinylcholine, mivacurium, rocuronium, (cis) atracurium, vecuronium, or pancuronium. While these are the most common agents, please review what might be typically used in your center so it can be identified in the medical record.
- Each of these agents has a slightly different duration of action, so their effect on the GCS depends on when they were given. For example, succinylcholine's effects last for only 5-10 minutes.

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care

Data Format: [character] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

SOLID ORGAN INJURY?

LA County Element **RL_30**
National Element **N/A**

Definition

Indicate if a solid organ injury exists

Field Values

Field Values

- Yes
- No

Data Source Hierarchy

1. Radiology Records
2. ED Records

Uses

- Allows data to be sorted based upon studies performed
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- RADIOLOGY: Body Region / Study
- RADIOLOGY: Date
- RADIOLOGY: Time
- RADIOLOGY: Result

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

RADIOLOGY: Organ Grading - Liver

LA County Element **RL_07**
National Element **N/A**

Definition

Results of Solid Organ Grading of the liver if applicable

Field Values

Grade I	Hematoma	Subcapsular, <10% surface area
	Laceration	Capsular tear, <1cm parenchymal depth
Grade II	Hematoma	Subcapsular, 10-50% surface area Intraparenchymal, <10cm diameter
	Laceration	1-3cm parenchymal depth, <10cm length
Grade III	Hematoma	Subcapsular, >50% surface area or expanding Ruptured subcapsular or parenchymal hematoma Intraparenchymal hematoma >10cm or expanding
	Laceration	>3cm parenchymal depth
Grade IV	Laceration	Parenchymal disruption involving 25-75% of hepatic lobe 1-3 Couinaud's segments in a single lobe
Grade V	Laceration	Parenchymal disruption involving >75% of hepatic lobe >3 Couinaud's segments within a single lobe
	Vascular	Juxtahepatic venous injuries i.e., retrohepatic vena cava/central major hepatic veins
Grade VI	Vascular	Hepatic Avulsion

Data Source Hierarchy

3. Radiology Records
4. ED Records

Uses

- Allows data to be sorted based upon studies performed
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- RADIOLOGY: Body Region / Study
- RADIOLOGY: Date
- RADIOLOGY: Time
- RADIOLOGY: Result

Data Format: [character, 1] multiple entries **Picklist:** Yes, non-modifiable
Min Value: 1 **Max Value:** 6 **Accepts Null Value:** Yes

RADIOLOGY: Organ Grading - Spleen

LA County Element **RL_08**
National Element **N/A**

Definition

Results of Solid Organ Grading of the spleen if applicable

Field Values

Grade I	Hematoma	Subcapsular, <10% surface area
	Laceration	Capsular tear, <1cm parenchymal depth
Grade II	Hematoma	Subcapsular, 10-50% surface area Intraparenchymal, <5cm diameter
	Laceration	1-3cm parenchymal depth not involving a parenchymal vessel
Grade III	Hematoma	Subcapsular, >50% surface area or expanding Ruptured subcapsular or parenchymal hematoma Intraparenchymal hematoma >5cm
	Laceration	>3cm parenchymal depth or involving trabecular vessels
Grade IV	Laceration	Laceration of segmental or hilar vessels producing major devascularization (>25% of spleen)
Grade V	Laceration	Completely shattered spleen
	Vascular	Hilar vascular injury which devascularized the spleen

Data Source Hierarchy

1. Radiology Records
2. ED Records

Uses

- Allows data to be sorted based upon studies performed
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- RADIOLOGY: Body Region / Study
- RADIOLOGY: Date
- RADIOLOGY: Time
- RADIOLOGY: Result

Data Format: [character, 1] multiple entries **Picklist:** Yes, non-modifiable
Min Value: 1 **Max Value:** 5 **Accepts Null Value:** Yes

RADIOLOGY: Organ Grading - Kidney

LA County Element **RL_09**
National Element **N/A**

Definition

Results of Solid Organ Grading of the kidney if applicable, specify right or left

Field Values

Grade I	Contusion	Microscopic or gross hematuria, urological studies normal
	Hematoma	Subcapsular, nonexpanding without parenchymal laceration
Grade II	Hematoma	Nonexpanding perirenal hematoma confined to renal retroperitoneum
	Laceration	<1cm parenchymal depth of renal cortex without urinary extravasation
Grade III	Laceration	>1cm depth of renal cortex, without collecting system rupture or urinary extravasation
Grade IV	Laceration	Parenchymal laceration extending through the renal cortex, medulla and collecting system
	Vascular	Main renal artery or vein injury with contained hemorrhage
Grade V	Laceration	Completely shattered kidney
	Vascular	Avulsion of renal hilum which devascularizes the kidney

Data Source Hierarchy

1. Radiology Records
2. ED Records

Uses

- Allows data to be sorted based upon studies performed
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- RADIOLOGY: Body Region / Study
- RADIOLOGY: Date
- RADIOLOGY: Time
- RADIOLOGY: Result

Data Format: [character, 1] multiple entries **Picklist:** Yes, non-modifiable
Min Value: 1 **Max Value:** 5 **Accepts Null Value:** Yes

LABORATORY: Time

LA County Element **RL_10**
National Element **N/A**

Definition

Time laboratory testing was performed, if applicable

Field Values

- Relevant value for data element

Additional Information

- Scrolling window fields: enter time, group/panel, description and results for each test as applicable

Data Source Hierarchy

1. Lab results
2. ED Records

Uses

- Allows data to be sorted based upon studies performed
- Provides documentation of assessment
- Used in quality management for the evaluation of care

Other Associated Elements

- LABORATORY: Group/Panel
- LABORATORY: Description *(optional)*
- LABORATORY: Result

Data Format: [time] multiple entries **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

LABORATORY: Group/Panel

LA County Element **RL_11**
National Element **N/A**

Definition

Type of laboratory testing performed, if applicable

Field Values

- 24 HOUR URINALYSIS
- BLD BNK - TYPE AND CROSS
- BLD BNK - TYPE AND HOLD
- BLOOD GAS
- CARDIAC ENZYME FRACTIONS
- CEREBROSPINAL FLUID
- CHEMISTRY
- COAGULATION STUDIES
- CULTURES
- ELECTROLYTES
- HEMATOLOGY
- PERITONEAL LAVAGE
- SEROLOGY STUDIES
- SPECIAL CHEMISTRY
- URINALYSIS

Additional Information

- Hemoglobin / Hematocrit are mandatory values if performed
- Scrolling window fields: enter time, group/panel, description and results for each test as applicable

Data Source Hierarchy

1. Lab results
2. ED Records

Uses

- Allows data to be sorted based upon studies performed
- Provides documentation of assessment
- Used in quality management for the evaluation of care

Other Associated Elements

- LABORATORY: Time
- LABORATORY: Description *(optional)*
- LABORATORY: Result

Data Format: [character, 5] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

LABORATORY: Result

LA County Element **RL_12**
National Elements **N/A**

Definition

These fields indicate results of laboratory testing performed, if applicable

Field Values

- A ABNORMAL
- N NORMAL

Additional Information

- Scrolling window fields: enter time, group/panel, description and results for each test as applicable
- Detailed laboratory test and value fields can be found by clicking on the “Other Labs” button

Data Source Hierarchy

1. Lab results
2. ED Records

Uses

- Allows data to be sorted based upon studies performed
- Provides documentation of assessment
- Used in quality management for the evaluation of care

Other Associated Elements

- LABORATORY: Time \
- LABORATORY: Group/Panel
- LABORATORY: Description *(optional)*

Data Format: [number, 1] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

LABORATORY: Description

LA County Element **RL_13**
National Element **N/A**

Definition

Comments or additional information pertaining to laboratory testing performed

Field Values

- Relevant value for data element

Additional Information

- Scrolling window fields: enter time, group/panel, description and results for each test as applicable
- OPTIONAL FIELD: This field may be used for free text comments at the discretion of each treating facility
- Detailed laboratory test and value fields can be found by clicking on the “Other Labs” button

Data Source Hierarchy

1. Lab results
2. ED Records

Uses

- Allows data to be sorted based upon studies performed
- Provides documentation of assessment
- Used in quality management for the evaluation of care

Other Associated Elements

- LABORATORY: Time
- LABORATORY: Group/Panel
- LABORATORY: Result

Data Format: [character, 50] multiple entries **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

TOX / ETOH: Time

LA County Element **RL_14**
National Element **N/A**

Definition

Time specified toxicology testing occurred, if applicable

Field Values

- Relevant value for data element

Additional Information

- Scrolling window fields: enter time, specimen source, substance, results and comments for each test as applicable

Data Source Hierarchy

1. Lab results
2. ED Records

Uses

- Allows data to be sorted based upon studies performed
- Provides documentation of assessment
- Used in quality management for the evaluation of care

Other Associated Elements

- DRUGS OF ABUSE *(optional)*

Data Format: [time] multiple entries **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

TOX / ETOH: Substance

LA County Element **RL_15**
National Element **N/A**

Definition

These fields indicate whether or not specified toxicology testing occurred, and if applicable, the times and results of the tests

Field Values

Acetaminophen (Tylenol)	Narcotics / Opioids	Chlorzoxazone Parafon Forte
Amphetamines / Methamphetamines	Codeine	Diphenhydramine Benadryl
Antipsychotics / Antidepressants	Fentanyl Sublimaze	Doxylamine Unisom
Phenothiazines	Heroin	Hydroxyzine Atarax
Other Antipsychotics	Hydrocodone Vicodin	Isopropanol Rubbing alcohol
Tricyclic Antidepressants	Hydromorphone Dilaudid	Ketamine Ketalar
MAO Inhibitor Antidepressants	Meperidine Demerol	Lidocaine Xylocaine
Other Antidepressants	Methadone	Meprobamate Equanil
Benzodiazepines	Morphine	Methanol
Clonazepam Clonipin	Oxycodone Percodan	Methapyrilene Histadyl
Flurazepam Dalmane	Propoxyphine Darvon	Methocarbamol Robaxin
Lorazepam Ativan	Other Narcotic/Opioid	Phenylpropanolal Dexatrim
Oxazepam Serax	NSAIDS (Motrin)	Phenytoin Dilatin
Prazepam Centrax	PCP	Prochlorperazin Compazine
Other Benzodiazepines	Salicylate (Aspirin)	Pyrilamine Rynatan
Barbiturates	Other toxins	Quinidine
Cannabinoids	Acetone	Theophylline
Cocaine	Caffeine NoDoz	Other Toxin
Ethanol (ETOH)	Carbamazepine Tegretol	Toxicology Screen

Additional Information

- Scrolling window fields: enter time, specimen source, substance, results and comments for each test as applicable
- Use Substance value “Toxicology Screen” with Result (see RL_15) of “Not Found” for negative toxicology screens

Data Source Hierarchy

1. Lab results
2. ED Records

Uses

- Allows data to be sorted based upon studies performed
- Provides documentation of assessment
- Used in quality management for the evaluation of care

Other Associated Elements

- DRUGS OF ABUSE *(optional)*

Data Format: [character, 20] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

TOX / ETOH: Source

LA County Element **RL_16**
National Element **N/A**

Definition

Specimen type used for toxicology testing, if applicable

Field Values

- Blood
- Urine

Additional Information

- Scrolling window fields: enter time, specimen source, substance, results and comments for each test as applicable

Data Source Hierarchy

1. Lab results
2. ED Records

Uses

- Allows data to be sorted based upon studies performed
- Provides documentation of assessment
- Used in quality management for the evaluation of care

Other Associated Elements

- DRUGS OF ABUSE *(optional)*

Data Format: [character, 5] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

TOX / ETOH: Results

LA County Element **RL_17**
National Elements **ED_15,16**

Definition

These fields indicate whether or not specified toxicology testing occurred, and if applicable, findings

Field Values

- FOUND
- NOT FOUND
- NOT TESTED

LA COUNTY	NTDB
N/A (use F6)	N/A (use null value)
ETOH Result “NOT TESTED”	ED_15 = “1 No ”
ETOH Result “NOT FOUND”--	ED_15 = “2 No (confirmed by test)”
ETOH Result “FOUND”	ED_15 = “3 Yes (confirmed by test, trace levels)”
N/A (no interpretation)	ED_15 = “4 Yes (confirmed by test, > legal limit)”
TOX (BLD) Result “NOT TESTED”	ED_16 = “1 No (by test or not suspected)”
TOX (URINE) Result “NOT TESTED”	ED_16 = “1 No (by test or not suspected)”
TOX (BLD Result “FOUND”	ED_16 = “3 Yes (confirmed by test, prescription)”
TOX (URINE Result “FOUND”	ED_16 = “3 Yes (confirmed by test, prescription)”
TOX (BLD) Result “NOT FOUND”	ED_16 = “1 No (by test or not suspected)”
TOX (URINE) Result “NOT FOUND”	ED_16 = “1 No (by test or not suspected)”
N/A (no interpretation)	ED_16 = “2 Yes (suspected)”
N/A (no interpretation)	ED_16 = “4 Yes (confirmed by test, illegal use)”

Additional Information

- Scrolling window fields: enter time, specimen source, substance, results and comments for each test as applicable
- Toxicology screens positive for substance administered during the medical care provided e.g. morphine for pain, are still entered as positive.

Data Source Hierarchy

1. Lab results
2. ED Records

Uses

- Allows data to be sorted based upon studies performed
- Provides documentation of assessment
- Used in quality management for the evaluation of care

Other Associated Elements

- DRUGS OF ABUSE *(optional)*

Data Format: [character, 10] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

TOX / ETOH: Value

LA County Element **RL_18**
National Element **N/A**

Definition

Numeric value for toxicology results, if applicable

Field Values Field Values

- Relevant value for data element

Additional Information

- Scrolling window fields: enter time, specimen source, substance, results and comments for each test as applicable

Data Source Hierarchy

1. Lab results
2. ED Records

Uses

- Allows data to be sorted based upon studies performed
- Provides documentation of assessment
- Used in quality management for the evaluation of care

Other Associated Elements

- DRUGS OF ABUSE *(optional)*

Data Format: [number, 12] multiple entries **Picklist:** No
Min Value: 0 **Max Value:** 99999999.999 **Accepts Null Value:** Yes

DRUGS OF ABUSE

LA County Element **RL_19**
National Element **ED_16**

Definition

If applicable, drugs known to be abused by patient at time of injury (on TPS form only)

Field Values

Amphetamine	Cocaine
Benzodiazepines	Opiates
Cannabinoids	PCP
Other	

Additional Information

- OPTIONAL FIELD on TPS form only – laboratory toxicological findings positive for Amphetamines, Barbiturates, PCP, Cocaine, Opiates, Cannabinoids, or Other substances are recorded on the Radiology/Laboratory screen in the ETOH/Toxicology scrolling window fields.

Data Source Hierarchy

1. Lab results
2. ED Records

Uses

- Allows data to be sorted based upon substances abused by patient at time of injury

Other Associated Elements

- TOX (BLOOD) fields
- TOX (URINE) fields

Data Format: N/A (TPS Form only) **Picklist:** N/A (TPS Form only)
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** N/A (TPS Form

MTP ACTIVATED?

LA County Element **TQIP-07**
National Element **PM_**

Definition

Indicates whether or not the Massive Transfusion Protocol (MTP) was activated during the care of the patient

Field Values

- Y (Yes)
- N (No)

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Identifies patients with active bleeding
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- PACKED CELLS *(4 HOURS)*
- PLASMA *(4 HOURS)*
- PLATELETS *(4 HOURS)*
- CRYOPRECIPITATE *(4 HOURS)*
- TOTAL PRODUCTS *(4 HOURS)*
- PACKED CELLS *(24 HOURS)*
- PLASMA *(24 HOURS)*
- PLATELETS *(24 HOURS)*
- CRYOPRECIPITATE *(24 HOURS)*
- TOTAL PRODUCTS *(24 HOURS)*
- PACKED CELLS *(HOSPITAL {includes ED})*
- PLASMA *(HOSPITAL {includes ED})*
- PLATELETS *(HOSPITAL {includes ED})*
- CRYOPRECIPITATE *(HOSPITAL {includes ED})*
- TOTAL PRODUCTS *(HOSPITAL {includes ED})*

Data Format: {character, 1} single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

BLOOD INCLUSION?

LA County Element **TQIP-08**
National Element **PM_**

Definition

Indicates whether the patient received blood during the first four hours of ED/hospital arrival

Field Values

- Yes
- No

Additional Information

- If no blood given, the Blood Inclusion is equal to “no”

Data Source Hierarchy

1. Trauma Flow Sheet
2. ED Records
3. Physician’s Progress Notes
4. Operative Report

Uses

- Identifies patients that received blood
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- MTP ACTIVATED?
- PACKED CELLS *(4 HOURS)*

Data Format: {character, 1} single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

LOWEST ED/HOSPITAL BP-SYSTOLIC

LA County Element **TQIP-09**
National Element **PM_28**

Definition

Numeric value of the patient's lowest sustained (>5min) systolic blood pressure **within the first hour** of ED/hospital arrival

Collection Criterion

COLLECT ON ALL PATIENTS WITH TRANSFUSED PACKED RED BLOOD CELLS WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL

Field Values

- Up to three-digit numeric value
- Documented as numeric systolic value / diastolic value

Additional Information

- "Not Applicable" is used for patients that do not meet the collection criterion

Data Source Hierarchy

1. Trauma Flow Sheet
2. ED Records
3. Physician's Progress Notes
4. Operative Report

Uses

- Identifies patients with active bleeding
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- MTP ACTIVATED?
- PACKED CELLS *(4 HOURS)*

Data Format: {character, 3} single entry **Picklist:** No
Min Value: 0 **Max Value:** 300 **Accepts Null Value:** Yes

PACKED CELLS *(4 HOURS)*

LA County Element **TQIP-10**
National Element **PM_12**

Definition

Total volume of packed cells received by the patient during the first **4 hours** of care

Collection Criterion

COLLECT ON ALL PATIENTS WITH TRANSFUSED PACKED RED BLOOD CELLS WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL

Field Values

- Relevant value for data element

Additional Information

- Collected as milliliters – not liters or units.
- **Packed Red Blood Cells** 1 unit is equivalent to **350mls** if the actual volume of the unit is not documented.
- If no packed red blood cells were given in the first 24 hours, then the volume is zero.
- Packed red blood cells *(24 HOURS)* volume should never be “not applicable”.

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Identifies patients with active bleeding
- Provides documentation of care
- Used in quality management for the evaluation of care
- Included in calculation of Total Blood Products

Other Associated Elements

- PLASMA *(4 HOURS)*
- PLATELETS *(4 HOURS)*
- CRYOPRECIPITATE *(4 HOURS)*
- TOTAL PRODUCTS *(4 HOURS)*

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

PLASMA *(4 HOURS)*

LA County Element **TQIP-11**
National Element **PM_16**

Definition

Total volume of fresh frozen plasma received by the patient during the first **4 hours** of care

Collection Criterion

COLLECT ON ALL PATIENTS WITH TRANSFUSED PACKED RED BLOOD CELLS WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL

Field Values

- Relevant value for data element

Additional Information

- Collected as milliliters – not liters or units.
- **Plasma** 1 unit is equivalent to **225mls** if the actual volume of the unit is not documented.
- If no plasma was given in the first 24 hours, then the volume is zero.
- Plasma *(24 HOURS)* volume should never be “not applicable”.

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Identifies treatment for presumed coagulopathy
- Provides documentation of care
- Used in quality management for the evaluation of care
- Included in calculation of Total Blood Products

Other Associated Elements

- PACKED CELLS *(4 HOURS)*
- PLATELETS *(4 HOURS)*
- CRYOPRECIPITATE *(4 HOURS)*
- TOTAL PRODUCTS *(4 HOURS)*

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

PLATELETS *(4 HOURS)*

LA County Element **TQIP-12**
National Element **PM_20**

Definition

Total volume of platelets received by the patient during the first **4 hours** of care

Collection Criterion

COLLECT ON ALL PATIENTS WITH TRANSFUSED PACKED RED BLOOD CELLS WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL

Field Values

- Relevant value for data element

Additional Information

- Collected as milliliters – not liters or units.
- **Platelets** 1 unit is equivalent to **225mls** if the actual volume of the unit is not documented.
- If no platelets were given in the first 24 hours, then the volume is zero.
- Platelets *(24 HOURS)* volume should never be “not applicable”.

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Identifies treatment for presumed coagulopathy
- Provides documentation of care
- Used in quality management for the evaluation of care
- Included in calculation of Total Blood Products

Other Associated Elements

- PACKED CELLS *(4 HOURS)*
- PLASMA *(4 HOURS)*
- CRYOPRECIPITATE *(4 HOURS)*
- TOTAL PRODUCTS *(4 HOURS)*

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

CRYOPRECIPITATE *(4 HOURS)*

LA County Element **TQIP-13**
National Element **PM_24**

Definition

Total volume of cryoprecipitate received by the patient during the first **4 hours** of care

Collection Criterion

COLLECT ON ALL PATIENTS WITH TRANSFUSED PACKED RED BLOOD CELLS WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL

Field Values

- Relevant value for data element

Additional Information

- Collected as milliliters – not liters or units.
- **Cryoprecipitate** pack is equivalent to **100mls** if the actual volume of the pack is not documented.
- If no cryoprecipitate was given in the first 24 hours, then the volume is zero.
- Cryoprecipitate *(24 HOURS)* volume should never be “not applicable”.

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Identifies treatment for presumed coagulopathy
- Provides documentation of care
- Used in quality management for the evaluation of care
- Included in calculation of Total Blood Products

Other Associated Elements

- PACKED CELLS *(4 HOURS)*
- PLASMA *(4 HOURS)*
- PLATELETS *(4 HOURS)*
- TOTAL PRODUCTS *(4 HOURS)*

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

TOTAL PRODUCTS *(4 HOURS)*

LA County Element **TQIP-14**
National Element **PM_14**

Definition

Total blood/products, packed cells, plasma, platelets, and cryoprecipitate in milliliters given to the patient during the first 4 hours of care

Field Values

- Relevant value for data element

Additional Information

- Auto-calculated using sum of PACKED CELLS *(24 HOURS)*, PLASMA *(24 HOURS)*, PLATELETS *(24 HOURS)*, and CRYOPRECIPITATE *(24 HOURS)* values.

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Provides documentation of care
- Used in quality management for the evaluation of care
- Included in calculation of Hospital Blood Totals

Other Associated Elements

- PACKED CELLS *(4 HOURS)*
- PLASMA *(4 HOURS)*
- PLATELETS *(4 HOURS)*
- CRYOPRECIPITATE *(4 HOURS)*

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

PACKED CELLS *(24 HOURS)*

LA County Element **RL_21**
National Element **PM_15**

Definition

Total volume of packed cells received by the patient during the first **24 hours** of care

Field Values

- Relevant value for data element

Additional Information

- Collected as milliliters – not liters or units.
- **Packed Red Blood Cells** 1 unit is equivalent to **350mls** if the actual volume of the unit is not documented.
- If no packed red blood cells were given in the first 24 hours, then the volume is zero.
- Packed red blood cells *(24 HOURS)* volume should never be “not applicable”.

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Identifies patients with active bleeding
- Provides documentation of care
- Used in quality management for the evaluation of care
- Included in calculation of Total Blood Products

Other Associated Elements

- PLASMA *(24 HOURS)*
- PLATELETS *(24 HOURS)*
- CRYOPRECIPITATE *(24 HOURS)*
- TOTAL PRODUCTS *(24 HOURS)*

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

PLASMA *(24 HOURS)*

LA County Element **RL_22**
National Element **PM_16**

Definition

Total volume of fresh frozen plasma received by the patient during the first **24 hours** of care

Field Values

- Relevant value for data element

Additional Information

- Collected as milliliters – not liters or units.
- **Plasma** 1 unit is equivalent to **225mls** if the actual volume of the unit is not documented.
- If no plasma was given in the first 24 hours, then the volume is zero.
- Plasma *(24 HOURS)* volume should never be “not applicable”.

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Identifies treatment for presumed coagulopathy
- Provides documentation of care
- Used in quality management for the evaluation of care
- Included in calculation of Total Blood Products

Other Associated Elements

- PACKED CELLS *(24 HOURS)*
- PLATELETS *(24 HOURS)*
- CRYOPRECIPITATE *(24 HOURS)*
- TOTAL PRODUCTS *(24 HOURS)*

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

PLATELETS *(24 HOURS)*

LA County Element **RL_23**
National Element **PM_17**

Definition

Total volume of platelets received by the patient during the first **24 hours** of care

Field Values

- Relevant value for data element

Additional Information

- Collected as milliliters – not liters or units.
- **Platelets** 1 unit is equivalent to **225mls** if the actual volume of the unit is not documented.
- If no platelets were given in the first 24 hours, then the volume is zero.
- Platelets *(24 HOURS)* volume should never be “not applicable”.

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Identifies treatment for presumed coagulopathy
- Provides documentation of care
- Used in quality management for the evaluation of care
- Included in calculation of Total Blood Products

Other Associated Elements

- PACKED CELLS *(24 HOURS)*
- PLASMA *(24 HOURS)*
- CRYOPRECIPITATE *(24 HOURS)*
- TOTAL PRODUCTS *(24 HOURS)*

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

CRYOPRECIPITATE *(24 HOURS)*

LA County Element **RL_24**
National Element **PM_18**

Definition

Total volume of cryoprecipitate received by the patient during the first **24 hours** of care

Field Values

- Relevant value for data element

Additional Information

- Collected as milliliters – not liters or units.
- **Cryoprecipitate** pack is equivalent to **100mls** if the actual volume of the pack is not documented.
- If no cryoprecipitate was given in the first 24 hours, then the volume is zero.
- Cryoprecipitate *(24 HOURS)* volume should never be “not applicable”.

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Identifies treatment for presumed coagulopathy
- Provides documentation of care
- Used in quality management for the evaluation of care
- Included in calculation of Total Blood Products

Other Associated Elements

- PACKED CELLS *(24 HOURS)*
- PLASMA *(24 HOURS)*
- PLATELETS *(24 HOURS)*
- TOTAL PRODUCTS *(24 HOURS)*

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

TOTAL PRODUCTS *(24 HOURS)*

LA County Element **RL_25**
National Element **N/A**

Definition

Total blood/products, packed cells, plasma, platelets, and cryoprecipitate in milliliters given to the patient during the first 24 hours of care

Field Values

- Relevant value for data element

Additional Information

- Auto-calculated using sum of PACKED CELLS *(24 HOURS)*, PLASMA *(24 HOURS)*, PLATELETS *(24 HOURS)*, and CRYOPRECIPITATE *(24 HOURS)* values.

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Provides documentation of care
- Used in quality management for the evaluation of care
- Included in calculation of Hospital Blood Totals

Other Associated Elements

- PACKED CELLS *(24 HOURS)*
- PLASMA *(24 HOURS)*
- PLATELETS *(24 HOURS)*
- CRYOPRECIPITATE *(24 HOURS)*

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

PACKED CELLS *(HOSPITAL)*

LA County Element **RL_26**
National Element **N/A**

Definition

Total volume of packed cells received by the patient during hospital stay – *including* 24 hour total

Field Values

- Relevant value for data element

Additional Information

- Collected as milliliters – not liters or units.
- **Packed Red Blood Cells** 1 unit is equivalent to **350mls** if the actual volume of the unit is not documented.
- If no packed red blood cells were given during the patient's hospital stay, then the volume is zero.
- Packed Red Blood Cells *(HOSPITAL)* volume should never be "not applicable".

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Provides documentation of care
- Used in quality management for the evaluation of care
- Included in calculation of Total Blood Products

Other Associated Elements

- PLASMA *(HOSPITAL)*
- PLATELETS *(HOSPITAL)*
- CRYOPRECIPITATE *(HOSPITAL)*
- TOTAL PRODUCTS *(HOSPITAL)*

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

PLASMA *(HOSPITAL)*

LA County Element **RL_27**
National Element **N/A**

Definition

Total volume of fresh frozen plasma received by the patient during hospital stay – *including* 24 hour total

Field Values

- Relevant value for data element

Additional Information

- Collected as milliliters – not liters or units.
- **Plasma** 1 unit is equivalent to **225mls** if the actual volume of the unit is not documented.
- If no plasma was given during the patient's hospital stay, then the volume is zero.
- Plasma *(HOSPITAL)* volume should never be "not applicable".

- **Data Source Hierarchy**

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Provides documentation of care
- Used in quality management for the evaluation of care
- Included in calculation of Total Blood Products

Other Associated Elements

- PACKED CELLS *(HOSPITAL)*
- PLATELETS *(HOSPITAL)*
- CRYOPRECIPITATE *(HOSPITAL)*
- TOTAL PRODUCTS *(HOSPITAL)*

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

PLATELETS *(HOSPITAL)*

LA County Element **RL_28**
National Element **N/A**

Definition

Total volume of platelets received by the patient during hospital stay – *including* 24 hour total

Field Values

- Relevant value for data element

Additional Information

- Collected as milliliters – not liters or units.
- **Platelets** 1 unit is equivalent to **225mls** if the actual volume of the unit is not documented.
- If no platelets were given during the patient's hospital stay, then the volume is zero.
- Platelets *(HOSPITAL)* volume should never be "not applicable".

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Provides documentation of care
- Used in quality management for the evaluation of care
- Included in calculation of Total Blood Products

Other Associated Elements

- PACKED CELLS *(HOSPITAL)*
- PLASMA *(HOSPITAL)*
- CRYOPRECIPITATE *(HOSPITAL)*
- TOTAL PRODUCTS *(HOSPITAL)*

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

CRYOPRECIPITATE *(HOSPITAL)*

LA County Element **RL_29**
National Element **N/A**

Definition

Total volume of cryoprecipitate received by the patient during hospital stay – *including* 24 hour total

Field Values

- Relevant value for data element

Additional Information

- Collected as milliliters – not liters or units.
- **Cryoprecipitate** pack is equivalent to **100mls** if the actual volume of the pack is not documented.
- If no cryoprecipitate was given during the patient's hospital stay, then the volume is zero.
- Cryoprecipitate *(HOSPITAL)* volume should never be "not applicable".

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Provides documentation of care
- Used in quality management for the evaluation of care
- Included in calculation of Total Blood Products

Other Associated Elements

- PACKED CELLS *(HOSPITAL)*
- PLASMA *(HOSPITAL)*
- PLATELETS *(HOSPITAL)*
- TOTAL PRODUCTS *(HOSPITAL)*

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

TOTAL PRODUCTS *(HOSPITAL)*

LA County Element **RL_30**
National Element **N/A**

Definition

Total blood/products, packed cells, plasma, platelets, and cryoprecipitate given to the patient during hospital stay – *including* 24 hour total

Field Values

- Relevant value for data element

Additional Information

- Auto-calculated using sum of PACKED CELLS *(HOSPITAL)*, PLASMA *(HOSPITAL)*, PLATELETS *(HOSPITAL)*, and CRYOPRECIPITATE *(HOSPITAL)* values.

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Provides documentation of care
- Used in quality management for the evaluation of care
- Included in calculation of Hospital Blood Totals

Other Associated Elements

- PACKED CELLS *(HOSPITAL)*
- PLASMA *(HOSPITAL)*
- PLATELETS *(HOSPITAL)*
- CRYOPRECIPITATE *(HOSPITAL)*

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

Procedures / Operations

PHASE BEGUN

LA County Element **PRO_01**
National Element **N/A**

Definition

Phase of care where operative or essential major and minor procedures conducted during hospital stay were begun

Field Values

- 23HR OBS <24 Hour Observation
- ED Emergency Department
- ICU Intensive/Critical Care Unit
- IR Interventional Radiology
- OR Operating Room
- PICU Pediatric ICU
- PEDSWARD Pediatric Ward
- READMIT
- SPECIAL PROCEDURES (e.g., Angio, Interventional Radiology, etc)
- STEPDOWN Stepdown or Telemetry Unit
- WARD Ward/Floor

Additional Information

- Operative and/or essential procedures are defined as procedures performed in the Operating Room, Emergency Department, Intensive Care Unit, or radiology department that were essential to the diagnoses, stabilization, or treatment of the patient's specific injuries or complications
- Repeated diagnostic procedures (e g , repeated CT scan) should not be recorded (record only the first procedure)
- Use "Readmit" phase of care for procedures done following readmission

Data Source Hierarchy

1. Radiology readings / Lab results
2. ED Records

Uses

- Allows data to be sorted based upon procedures performed
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- PHASE BEGUN
- START/END TIMES
- PROCEDURE
- SURG TYPE
- MD CODE

Data Format: [character, 8] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

START DATE

LA County Element **PRO_02**
National Element **HP_02**

Definition

Date when operative or essential major and minor procedures conducted during hospital stay were begun

Field Values

- Relevant value for data element

Additional Information

- Collected as YYYY-MM-DD

Data Source Hierarchy

1. OR Records
2. Radiology Records
3. ED Records
4. Progress Notes

Uses

- Allows data to be sorted based upon dates associated with procedures performed
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- PHASE BEGUN
- START/END TIMES
- PROCEDURE
- SURG TYPE
- MD CODE

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

START / CUT TIME

LA County Element **PRO_03**
National Element **HP_03**

Definition

Time when operative or essential major and minor procedures conducted during hospital stay were begun

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time)

Data Source Hierarchy

1. OR Records
2. Radiology Records
3. ED Records
4. Progress Notes

Uses

- Allows data to be sorted based upon times associated with procedures performed
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- PHASE BEGUN
- START DATE
- END TIME
- PROCEDURE

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

END TIME

LA County Element **PRO_04**
National Element **N/A**

Definition

Time when operative or essential major and minor procedures conducted during hospital stay ended (if relevant)

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time)

Data Source Hierarchy

1. Radiology readings / Lab results
2. ED Records
3. ICU Records
4. Operative Reports
5. Billing Sheet / Medical Records Coding Summary Sheet
6. Hospital Discharge Summary

Uses

- Allows data to be sorted based upon times associated with procedures performed
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- PHASE BEGUN
- PROCEDURE
- START DATE
- START TIME

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

PROCEDURES *(ICD-10 Codes)*

LA County Element **PRO_05**
National Element **HP_01**

Definition

Operative or essential major and minor procedures conducted during hospital stay

Field Values

MANDATORY PROCEDURES	ICD-10 CODES	MANDATORY PROCEDURES	ICD-10 CODES
Central Line Approach: • Chest, Open • Chest, Percutaneous **Special Note:** The ICD-10 Code for central lines varies depending on the site and the approach used for placement.	0JH60XZ 0JH63XZ	Inferior Vena Cava (IVC) Filters (temporary or permanent) Approach: • Open • Percutaneous • Percutaneous Endoscopic	06H00DZ 06H03DZ 06H04DZ
Chest Tube (left)	0W9B30Z	Interventional Angiogram (IA) **Special Note:** The ICD-10 Code for IA varies depending on the site and the approach used.	
Chest Tube (right)	0W9930Z		
Cricothyroidotomy Approach: • Open • Percutaneous • Percutaneous Endoscopic	0B110F4 0B113F4 0B114F4	Intracranial Pressure (ICP) Monitor: • Percutaneous • Via Natural or Artificial Opening	4A103BD 4A107BD
Diagnostic Peritoneal Aspirate (DPA)	0W9G3ZX	Percutaneous Endoscopic Gastrostomy (PEG) Approach: • Percutaneous • Percutaneous Endoscopic	0DH63UZ 0DH64UZ
Diagnostic Peritoneal Lavage (DPL)	3E1M38X		
Embolization: **Special Note:** The ICD-10 Code for embolization varies depending on the site embolized and the approach used.		Thoracotomy	02JA0ZZ
		Tracheostomy Approach: • Open • Percutaneous • Percutaneous Endoscopic	0BH10DZ 0BH13DZ 0BH14DZ
Endotracheal (ETT) Intubation: • Via Natural or Artificial Opening • Via Natural or Artificial Opening Endoscopic	0BH17EZ 0BH18EZ	Ventilator: • Less than 24 Consecutive Hours • 24-96 Consecutive Hours • > 96 Consecutive Hours	5A1935Z 5A1945Z 5A1955Z

Additional Information

- Operative and/or essential procedures is defined as procedures performed in the OR, ED, ICU, or radiology department that were essential to the diagnoses, stabilization, or treatment of the patient's specific injuries
- Repeated diagnostic procedures (e g , repeated CT scan) should not be recorded (record only the first procedure)
- Optional operative or essential major and minor procedures ICD-10-CM codes conducted during hospital stay include the following: Licox, Bronchoscopy, & PICC line.

Data Source Hierarchy

1. Radiology readings / Lab results
2. ED Records
3. ICU Records
4. Operative Reports
5. Billing Sheet / Medical Records
6. Hospital Discharge Summary

Uses

- Allows data to be sorted based upon procedures performed
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- START DATE
- START/END TIMES
- SURG TYPE
- MD CODE

Data Format: [character, 6] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

TOTAL VENTILATOR DAYS

LA County Element **PRO_06**
National Element **N/A**

Definition

The total number of patient days spent on a mechanical ventilator (include all episodes)

Field Values

- Relevant value for data element

Additional Information

- Recorded in full day increments with any partial day entered as one full day
- Excludes mechanical ventilation time associated with operating department procedures and the immediate recovery period
- A ventilator required for up to 6 hours post-operatively is considered routine and should not be counted as ventilator days
- Ventilator ICD-9 4th digit is determined by the duration of mechanical duration, e.g. **unspecified** (96.7**0**), **less than 96 consecutive hours** (96.7**1**), or **96 consecutive hours or greater** (96.7**2**).
- If no ventilator episodes recorded, utilize “Not Applicable” versus the numeric value of “0”
- Non-invasive means of ventilatory support (CPAP or BIPAP) should not be considered in the calculation of ventilatory days

Data Source Hierarchy

1. ED Records
2. ICU Records
3. Respiratory Therapy Records
4. Progress Notes

Uses

- Allows data to be sorted based upon days spent on mechanical ventilation
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- PROCEDURE (VENTILATOR)
- PHASE BEGUN
- START DATE
- START/END TIMES

Data Format: [number, 4] single entry		**Picklist:** No
Min Value: 0	**Max Value:** 9999	**Accepts Null Value:** Yes

SURGERY TYPE

LA County Element **PRO_09**
National Element **N/A**

Definition

Two-digit numerical code for the type of surgical procedure performed in the operating room

Field Values

- 00 Surgical Procedures done outside of the operating room
- 01 Orthopedic
- 02 Thoracic
- 03 Abdominal
- 04 Cardiovascular
- 05 Plastics
- 06 Urology
- 07 Vascular
- 08 Neurosurgical – Head
- 09 Neurosurgical – Spine
- 10 Obstetrics / Gynecology
- 11 Ophthalmology
- 99 Other

Data Source Hierarchy

1. OR Reports
2. Anesthesia Record

Uses

- Allows data to be sorted based upon type of surgery performed
- Used in quality management for the evaluation of care

Other Associated Elements

- START DATE
- START/END TIMES
- PROCEDURE
- MD CODE

Data Format: [character, 2] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

MD CODE

LA County Element **PRO_08**
National Element **O_02**

Definition

Name or code of surgeon that performed the surgical procedure in the operating room

Field Values

- Relevant value for data element

Additional Information

- Non-picklisted – free text physician name or code at discretion of facility

Data Source Hierarchy

1. OR Records

Uses

- Allows data to be sorted based upon physician performing surgical procedure
- Used in quality management for the evaluation of care

Other Associated Elements

- START DATE
- START/END TIMES
- PROCEDURE
- SURG TYPE

Data Format: [character, 15] multiple entries **Picklist:** Yes, facility-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ICP PLACED?

LA County Element **TQIP_15**
National Element **PM_**

Definition

Was an ICP monitor placed in the acute phase of care (1ST 72 Hours)?

Field Values

- Y (Yes)
- N (No)

Collection Criterion

- **ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION. The null value "Not Applicable" is used for patients that do not meet the collection criteria.**

Additional Information

- Refers to insertion of an intracranial pressure (ICP) monitor (or other measures of cerebral perfusion) for the purposes of managing severe TBI

Data Source Hierarchy

1. Neurosurgical Notes
2. ICU Records
3. Progress Notes
4. Hospital Discharge Summary

Uses

- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- TYPE OF ICP MONITOR
- IF NO ICP MONITOR, INDICATE WHY

Data Format: [character, 1] single entry		**Picklist:** Yes, non-modifiable
Min Value: N/A	**Max Value:** N/A	**Accepts Null Value:** Yes

CEREBRAL MONITOR TYPE

LA County Element **TQIP_16**
National Element **PM_06**

Definition

If an ICP monitor was placed during the acute phase of care (1ST 72 Hours) indicate the type

Collection Criterion

- **ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION. The null value "Not Applicable" is used for patients that do not meet the collection criteria.**

Field Values

- Intraparenchymal Oxygen Monitor (e.g., Licox)
- Intraparenchymal Pressure Monitor (e.g., Camino bolt, subarachnoid bolt)
- Intraventricular Drain/Catheter, draining (e.g., Ventriculostomy, External Ventricular Drain {EVD})
- Jugular Venous Bulb
- None

Data Source Hierarchy

1. Operative Report
2. Procedure Notes
3. Neurosurgical Notes
4. ICU Records
5. Progress Notes
6. Anesthesia Records
7. Hospital Discharge Summary

Uses

- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- ICP MONITOR PLACED?
- IF NO ICP MONITOR, INDICATE WHY

Data Format: [character, 2] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

CEREBRAL MONITOR DATE

LA County Element **TQIP_17**
National Element **PM_07**

Definition

The date an ICP monitor was placed

Collection Criterion

- **ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION. The null value "Not Applicable" is used for patients that do not meet the collection criteria.**

Field Values

- Relevant value for data element

Additional Information

- Collected as YYYY-MM-DD

Data Source Hierarchy

1. Operative Report
2. Procedure Notes
3. Neurosurgical Notes
4. ICU Records
5. Progress Notes
6. Anesthesia Records
7. Hospital Discharge Summary

Uses

- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- ICP MONITOR PLACED?
- IF NO ICP MONITOR, INDICATE WHY

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

CEREBRAL MONITOR TIME

LA County Element **TQIP_18**
National Element **PM_08**

Definition

If an ICP monitor was placed during the acute phase of care (1ST 72 Hours) indicate the type

Collection Criterion

- **ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION. The null value "Not Applicable" is used for patients that do not meet the collection criteria.**

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time)

Data Source Hierarchy

1. Operative Report
2. Procedure Notes
3. Neurosurgical Notes
4. ICU Records
5. Progress Notes
6. Anesthesia Records
7. Hospital Discharge Summary

Uses

- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- ICP MONITOR PLACED?
- IF NO ICP MONITOR, INDICATE WHY

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

ANGIOGRAPHY

LA County Element **TQIP_19**
National Element **PM_29**

Definition

Interventional angiogram with or without embolization within the first 24 hours of ED/Hospital arrival

Collection Criterion

COLLECT ON ALL PATIENTS WITH TRANSFUSED PACKED RED BLOOD CELLS WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL

Field Values

- None
- Angiogram Only
- Angiogram with Embolization

Additional Information

- Limit collection of angiography data to the first 24 hours following ED/hospital arrival
- “Not Applicable” is used for patients that do not meet the collection criterion
- Excludes CTA

Data Source Hierarchy

1. Radiology Report
2. Operative Report
3. Progress Notes

Uses

- Identifies patients with active bleeding
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- MTP ACTIVATED?
- PACKED CELLS *(4 HOURS)*
- EMBOLIZATION SITE
- ANGIOGRAPHY DATE
- AMGOPGRAPHY TIME

Data Format: {character, 30} single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

EMBOLIZATION SITE

LA County Element **TQIP_20**
National Element **PM_30**

Definition

Organ / site of embolization for hemorrhage control

Collection Criterion

COLLECT ON ALL PATIENTS WITH TRANSFUSED PACKED RED BLOOD CELLS WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL

Field Values

- Liver
- Spleen
- Kidneys
- Pelvic (iliac, gluteal, obturator)
- Retroperitoneum (lumbar, sacral)
- Peripheral vascular (neck, extremities)
- Aortic (thoracic, abdominal)
- Other

Additional Information

- Limit collection of embolization site to the first 24 hours following ED/hospital arrival
- “Not Applicable” is used for patients that do not meet the collection criterion and for those patients who underwent an angiography but without embolization
- Select all applicable sites

Data Source Hierarchy

1. Radiology Report
2. Operative Report
3. Progress Notes

Uses

- Identifies patients with active bleeding
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- MTP ACTIVATED?
- PACKED CELLS *(4 HOURS)*
- ANGIOGRAPHY
- ANGIOGRAPHY DATE
- ANGIOGRAPHY TIME

Data Format: {character, 30} single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ANGIOGRAPHY DATE

LA County Element **TQIP_21**
National Element **PM_31**

Definition

Date the interventional angiogram was performed with or without embolization within the first 24 hours of ED/Hospital arrival

Collection Criterion

COLLECT ON ALL PATIENTS WITH TRANSFUSED PACKED RED BLOOD CELLS WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY
- Limit collection of angiography data to the first 24 hours following ED/hospital arrival
- “Not Applicable” is used for patients that do not meet the collection criterion and for those who did not undergo an angiography

Data Source Hierarchy

1. Radiology Report
2. Operative Report
3. Progress Notes

Uses

- Identifies patients with active bleeding
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- MTP ACTIVATED?
- PACKED CELLS *(4 HOURS)*
- EMBOLIZATION SITE
- ANGIOGRAPHY TIME

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

ANGIOGRAPHY TIME

LA County Element **TQIP_22**
National Element **PM_32**

Definition

Interventional angiogram with or without embolization within the first 24 hours of ED/Hospital arrival

Collection Criterion

COLLECT ON ALL PATIENTS WITH TRANSFUSED PACKED RED BLOOD CELLS WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time)
- Limit collection of angiography data to the first 24 hours following ED/hospital arrival
- “Not Applicable” is used for patients that do not meet the collection criterion and for those who did not undergo an angiography

Data Source Hierarchy

1. Radiology Report
2. Operative Report
3. Progress Notes

Uses

- Identifies patients with active bleeding
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- MTP ACTIVATED?
- PACKED CELLS *(4 HOURS)*
- EMBOLIZATION SITE
- ANGIOGRAPHY DATE

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

HEMORRHAGE CONTROL TYPE

LA County Element **TQIP_23**
National Element **PM_33**

Definition

Type of surgery for hemorrhage control within the first 24 hours of ED/hospital arrival

Collection Criterion

COLLECT ON ALL PATIENTS WITH TRANSFUSED PACKED RED BLOOD CELLS WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL

Field Values

- None
- Laparotomy
- Thoracotomy
- Sternotomy
- Extremity (peripheral vascular)
- Neck
- Mangled extremity / traumatic amputation
- Other skin / soft tissue

Additional Information

- If unclear if surgery was for hemorrhage control, consult with the Trauma Medical Director or relevant surgeon
- “Not Applicable” is used for patients that do not meet the collection criterion
- Select all applicable values

Data Source Hierarchy

1. Radiology Report
2. Operative Report
3. Progress Notes

Uses

- Identifies patients with active bleeding
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- MTP ACTIVATED?
- PACKED CELLS *(4 HOURS)*
- HEMORRHAGE CONTROL DATE
- HEMORRHAGE CONTROL TIME

Data Format: {character, 30} single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

HEMORRHAGE CONTROL DATE

LA County Element **TQIP_24**
National Element **PM_34**

Definition

Date of surgery for hemorrhage control within the first 24 hours of ED/hospital arrival

Collection Criterion

COLLECT ON ALL PATIENTS WITH TRANSFUSED PACKED RED BLOOD CELLS WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY
- Limit collection of data to the first 24 hours following ED/hospital arrival
- “Not Applicable” is used for patients that do not meet the collection criterion and for those who did not undergo hemorrhage control surgery

Data Source Hierarchy

1. Radiology Report
2. Operative Report
3. Progress Notes

Uses

- Identifies patients with active bleeding
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- MTP ACTIVATED?
- PACKED CELLS *(4 HOURS)*
- HEMORRHAGE CONTROL TYPE
- HEMORRHAGE CONTROL TIME

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

HEMORRHAGE CONTROL TIME

LA County Element **TQIP_25**
National Element **PM_35**

Definition

Time of surgery for hemorrhage control within the first 24 hours of ED/hospital arrival

Collection Criterion

COLLECT ON ALL PATIENTS WITH TRANSFUSED PACKED RED BLOOD CELLS WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time)
- Limit collection of data to the first 24 hours following ED/hospital arrival
- “Not Applicable” is used for patients that do not meet the collection criterion and for those who did not undergo hemorrhage control surgery

Data Source Hierarchy

1. Radiology Report
2. Operative Report
3. Progress Notes

Uses

- Identifies patients with active bleeding
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- MTP ACTIVATED?
- PACKED CELLS *(4 HOURS)*
- HEMORRHAGE CONTROL TYPE
- HEMORRHAGE CONTROL DATE

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

PHASE AFTER OR

LA County Element **PRO_07**
National Element **N/A**

Definition

Phase of care occurring directly following each OR phase

Field Values

- 23HR OBS <24 Hour Observation
- ICU Intensive/Critical Care Unit
- INTERVENTIOANL RADIOLOGY
- PICU Pediatric ICU
- PEDSWARD Pediatric Ward
- SPECIAL PROCEDURES
- STEPDOWN Stepdown or Telemetry Unit
- WARD Ward/Floor
- POSTHOSPITAL

Data Source Hierarchy

1. Progress Notes
2. ICU records

Uses

- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- D/C DATE/TIME

Data Format: [character, 17] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

Intensive Care Unit

ICU: ARRIVAL DATE

LA County Element **ICU_01**
National Element **N/A**

Definition

Date patient was admitted to the Intensive Care Unit

Field Values

- Relevant value for data element

Additional Information

- Collected as YYYY-MM-DD

Data Source Hierarchy

1. ICU Records
2. ED Records
3. Progress Notes

Uses

- Allows data to be sorted based upon dates associated with ICU stays
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- ICU EXIT DATE

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

ICU: EXIT DATE

LA County Element **ICU_02**
National Element **N/A**

Definition

Date patient was discharged or transferred from the Intensive Care Unit

Field Values

- Relevant value for data element

Additional Information

- Collected as YYYY-MM-DD

Data Source Hierarchy

1. ICU Records
2. ED Records
3. Progress Notes

Uses

- Allows data to be sorted based upon dates associated with ICU stays
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- ICU ARRIVAL DATE

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

ICU: LENGTH OF STAY (LOS)

LA County Element **ICU_03**
National Element **HP_02**

Definition

The total number of patient days in any ICU (including all episodes)

Field Values

- Relevant value for data element

Additional Information

- Recorded in full day increments with any partial day listed as a full day
- Field allows for multiple admission and discharge dates and autofills with total ICU LOS

Uses

- Provides a rough estimate of severity of injury and resource utilization
- Provides documentation of care
- Used in quality management for the evaluation of care

Data Source Hierarchy

1. ICU Records
2. ED Records
3. Progress Notes

Other Associated Elements

- ICU ARRIVAL DATE
- ICU EXIT DATE

Data Format: [number, 4] auto-calculated **Picklist:** No
Min Value: 1 **Max Value:** 9999 **Accepts Null Value:** Yes

Consultations

DATE

LA County Element **CON_01**
National Element **N/A**

Definition

Date during hospital stay when physician consultation occurred

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY

Data Source Hierarchy

1. Progress Notes
2. Consultation Notes

Uses

- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- CONSULTATION – SERVICE
- CONSULTATION – MD CODE

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

SERVICE

LA County Element **CON_02**
National Element **N/A**

Definition

Service of physician consulted during hospital stay

Field Values

ANE	ANESTHESIOLOGY	NEP	NEPHROLOGY	POS	PED. ORTHOPEDIC
CAR	CARDIOLOGY	NEU	NEUROLOGY	POT	PED. OTOLARYNGOLOGY
CTS	CARDIOTHOR. SURG.	NER	NEURORADIOLOGY	PEP	PED. PATHOLOGY
CCI	CRIT. CARE INTENSIVIST	NES	NEUROSURGEON	PPY	PED. PSYCHIATRIST
DEN	DENTAL	OBS	OBSTERICS	PPS	PED. PULM. SPECIALIST
DER	DERMATOLOGY	OPS	OPTHAL. SURGEON	PER	PED. RADIOLOGY
EDP	ED PHYS/ATTENDING	ORS	ORAL SURGEON	PES	PEDIATRIC SURGEON
EDR	ED RESIDENT	ORT	ORTHOPEDICS	PUR	PEDIATRIC UROLOGY
END	ENDOCRINOLOGY	ONL	OTHER NOT LISTED	PED	PEDIATRICS
FNM	FAMILY MEDICINE	OTO	OTOLARYNGOLOGY	PHY	PHYSIATRY
GAS	GASTROENTEROLOGY	PAL	PALLIATIVE CARE	PLS	PLASTIC SURGEON
GES	GENERAL SURGEON	PAT	PATHOLOGY	POD	PODIATRY
GER	GERIATRICS	PEA	PEDIATRIC ALLERGY	PTN	PRIMARY TRAUMA NURSE
GYN	GYNECOLOGY	PEC	PED. CARDIOLOGY	PSC	PSYCHOLOGY
HAS	HAND SURGEON	PCA	PED. CHILD ADVOCACY	PSY	PSYCHIATRY
HEM	HEMATOLOGY	PCS	PED. CARDIOTHOR. SURG.	PUL	PULMONARY SPECIALIST
HMO	HMO CONSULTANT	PEN	PED. ENDOCRINOLOGY	RAD	RADIOLOGY
HNS	HEAD & NECK SURG.	PEG	PED. GASTROENTEROLOGY	RHE	RHEUMATOLOGY
HBO	HYPERBARIC MEDICINE	PEH	PED. HEMATOLOGY	SPI	SPINAL
INF	INFECTIOUS MEDICINE	PEI	PEDIATRIC INTENSIVIST	TRR	TRAUMA RESIDENT
INR	INTERVENT. RADIOLOGY	PMS	PAIN MANAGE SPECIALIST	TRS	TRAUMA SURG/ATTEND
INT	INTERNAL MEDICINE	PNP	PEDIATRIC NEPHROLOGY	URO	UROLOGY
MAS	MAXILLOFACIAL SURG.	PNE	PEDIATRIC NEUROLOGY	VAS	VASCULAR SURGEON
NCC	NEURO CRITICAL CARE	PNR	PED. NEURORADIOLOGY		
NEO	NEONATOLOGY	PNS	PED. NEUROSURGEON		

Data Source Hierarchy

1. Progress Notes
2. Consultation Notes

Uses

- Allows data to be sorted based upon physician service
- Used in quality management for the evaluation of care

Other Associated Elements

- CONSULTATION – DATE
- CONSULTATION – MD CODE

Data Format: [character, 15] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

MD CODE

LA County Element **CON_03**
National Element **N/A**

Definition

Name or code of physician consulted during hospital stay

Field Values

- Relevant value for data element

Additional Information

- Enter physician name or code directly, or create facility-specific picklist

Data Source Hierarchy

1. Progress Notes
2. Consultation Notes

Uses

- Allows data to be sorted based upon responding physician
- Used in quality management for the evaluation of care

Other Associated Elements

- CONSULTATION – DATE
- CONSULTATION – SERVICE

Data Format: [character, 15] multiple entries **Picklist:** Yes, facility-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

TRAUMA QUALITY IMPROVEMENT

VTE PROPHYLAXIS INCLUSION?

LA County Element **TQIP_26**
National Element **PM_**

Definition

Indicates if the patient received Venous Thromboembolism (VTE) prophylaxis at your facility

Collection Criterion

- **COLLECT ON ALL PATIENTS**

Field Values

- Y (Yes)
- N (No)

Data Source Hierarchy

1. Progress Notes
2. ICU records
3. Withdrawal of care order
4. Hospital Discharge Summary

Uses

- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- VTE PROPHYLAXIS TYPE
- VTE PROPHYLAXIS DATE
- VTE PROPHYLAXIS TIME

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

VTE PROPHYLAXIS TYPE

LA County Element **TQIP_27**
National Element **PM_09**

Definition

Type of Venous Thromboembolism (VTE) prophylaxis first administered to the patient at your facility

Collection Criterion

- **COLLECT ON ALL PATIENTS**

Field Values

LA COUNTY		NTDB	
1	Heparin	1	Heparin
2	LMHW (Dalteparin, Enoxaparin, etc.)	6	LMHW (Dalteparin, Enoxaparin, etc.)
3	Direct Thrombin Inhibitor (Dabigatran, etc.)	7	Direct Thrombin Inhibitor (Dabigatran, etc.)
4	Oral Xa Inhibitor (Rivaroxaban, etc.)	8	Oral Xa Inhibitor (Rivaroxaban, etc.)
5	Coumadin	9	Coumadin
6	Other	10	Other
7	None	5	None

Additional Information

- Does not accept null values

Data Source Hierarchy

1. Medication Summary
2. Nursing Notes / Flow Sheet
3. Pharmacy Record

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care

Other Associated Elements

- VTE PROPHYLAXIS DATE
- VTE PROPHYLAXIS TIME

Data Format: [number, 2] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** No

VTE PROPHYLAXIS DATE

LA County Element **TQIP_28**
National Element **PM_10**

Definition

Date VTE prophylaxis first administered to the patient at your facility

Collection Criterion

- **COLLECT ON ALL PATIENTS**

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY
- The null value "Not Applicable" is used if no Venous Thromboembolism Prophylaxis Type exists

Data Source Hierarchy

1. Medication Summary
2. Nursing Notes / Flow Sheet
3. Pharmacy Record

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care

Other Associated Elements

- VTE PROPHYLAXIS TYPE
- VTE PROPHYLAXIS TIME

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

VTE PROPHYLAXIS TIME

LA County Element **TQIP_29**
National Element **PM_11**

Definition

Time VTE prophylaxis first administered to the patient at your facility

Collection Criterion

- **COLLECT ON ALL PATIENTS**

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time)
- The null value "Not Applicable" is used if no Venous Thromboembolism Prophylaxis Type exists

Data Source Hierarchy

1. Medication Summary
2. Nursing Notes / Flow Sheet
3. Pharmacy Record

Uses

- Provides documentation of assessment and care
- Used in quality management for the evaluation of care

Other Associated Elements

- VTE PROPHYLAXIS TYPE
- VTE PROPHYLAXIS DATE

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

WITHDRAWAL OF CARE

LA County Element **PRO_10**
National Element **PM_36**

Definition

Care was withdrawn based on a decision to either remove or withhold further life sustaining intervention. This decision **MUST** be documented in the medical record and is often, but not always associated with a discussion with the legal next of kin.

Field Values

- Y (Yes)
- N (No)

Additional Information

- DNR is not a requirement.
- Withdrawal of care MUST be documented with the date and time. These interventions are limited to: ventilator support (with or without extubation), dialysis or other forms of renal support, institution of medications to support blood pressure or cardiac function, or a specific surgical, interventional or radiological procedure (e.g. decompressive craniectomy, operation for hemorrhage control, angiography). Note that this definition provides equal weight to the withdrawal of an intervention already in place (e.g. extubation) and a decision not to proceed with a life-saving intervention (e.g. intubation).
- DNR order is not the same as withdrawal of care.

Data Source Hierarchy

1. Progress Notes
2. ICU records
3. Withdrawal of care order
4. Hospital Discharge Summary

Uses

- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- WITHDRAWAL OF CARE DATE
- WITHDRAWAL OF CARE TIME

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

WITHDRAWAL OF CARE DATE

LA County Element **PRO_11**
National Element **PM_37**

Definition

The date care was withdrawn

Field Values

- Relevant value for data element

Additional Information

- Collected as YYYY-MM-DD (military time)

Data Source Hierarchy

1. Progress Notes
2. ICU records
3. Withdrawal of care order
4. Hospital Discharge Summary

Uses

- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- WITHDRAWAL OF CARE
- WITHDRAWAL OF CARE TIME

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

WITHDRAWAL OF CARE TIME

LA County Element **PRO_12**
National Element **PM_38**

Definition

The time care was withdrawn

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time)

Data Source Hierarchy

1. Progress Notes
2. ICU records
3. Withdrawal of care order
4. Hospital Discharge Summary

Uses

- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- WITHDRAWAL OF CARE
- WITHDRAWAL OF CARE DATE

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

Posthospital

HOSPITAL DISPOSITION DATE

LA County Element **POS_20**
National Element **O_03**

Definition

The date the order was written for the patient to be transferred or discharged from the hospital, or the date the patient died

Field Values

- Relevant value for data element

Additional Information

- Collected as YYYY-MM-DD
- Utilize the time the patient was pronounced brain dead in situations when care is assumed by an organ procurement agency

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Used to calculate LOS
- Allows data to be sorted based upon ED length of stay

Other Associated Elements

- ARRIVAL DATE/TIME
- D/C TIME
- PRIOR PHASE

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

HOSPITAL DISPOSITION TIME

LA County Element **POS_21**
National Element **O_04**

Definition

The time the order was written for the patient to be transferred or discharged from the hospital, or the date the patient died

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time)
- Utilize the time the patient was pronounced brain dead in situations when care is assumed by an organ procurement agency

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Used to calculate LOS
- Allows data to be sorted based upon ED length of stay

Other Associated Elements

- ARRIVAL DATE/TIME
- D/C DATE
- PRIOR PHASE

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

DISCHARGE DATE

LA County Element **POS_01**
National Element **N/A**

Definition

The date the patient died, was transferred or discharged from the hospital

Field Values

- Relevant value for data element

Additional Information

- Collected as YYYY-MM-DD
- Utilize the time the patient was pronounced brain dead in situations when care is assumed by an organ procurement agency

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Used to calculate LOS
- Allows data to be sorted based upon ED length of stay

Other Associated Elements

- ARRIVAL DATE/TIME
- D/C TIME
- PRIOR PHASE

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

DISCHARGE TIME

LA County Element **POS_02**
National Element **N/A**

Definition

The time the patient died, was transferred or discharged from the hospital

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time)
- Utilize the time the patient was pronounced brain dead in situations when care is assumed by an organ procurement agency

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Used to calculate LOS
- Allows data to be sorted based upon ED length of stay

Other Associated Elements

- ARRIVAL DATE/TIME
- D/C DATE
- PRIOR PHASE

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

PRIOR PHASE

LA County Element **POS_03**
National Element **N/A**

Definition

Phase of care occurring directly prior to hospital discharge of patient

Field Values

- 23HR OBS <24 Hour Observation
- ED Emergency Department
- ICU Intensive/Critical Care Unit
- IR Interventional Radiology
- OR Operating Room
- PICU Pediatric ICU
- PEDSWARD Pediatric Ward
- READMIT
- SPECIAL PROCEDURES (e.g., Angio, etc)
- STEPDOWN Stepdown or Telemetry Unit
- WARD Ward/Floor

Additional Information

- If the 23HR OBS is not a specific physical location at your facility, utilize Ward/Floor as the phase of care prior to discharge

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon patient's last phase of care
- Used in quality management for the evaluation of care

Other Associated Elements

- D/C DATE/TIME

Data Format: [character, 8] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

PHYSICAL ABUSE REPORTED?

LA County Element **POS_04**
National Element **O_05**

Definition

A report of suspected physical abuse was made to law enforcement and/or protective services

Field Values

- Y (Yes)
- N (No)

Additional Information

- This includes, but is not limited to, a report of child, elder, spouse or intimate partner physical abuse
- If Physical Abuse Reported? is “Yes”, then Investigation Initiated and Caregiver Change are required

Data Source Hierarchy

1. EMS Run Sheet
2. ED Records
3. History/Physical
4. Progress Notes
5. Case Manager / Social Service’s Notes
6. Hospital Discharge Summary

Uses

- Determine trauma incidents due to physical abuse
- Used in quality management for the evaluation of care

Other Associated Elements

- INVESTIGATION INITIATED?
- CAREGIVER CHANGE?

Data Format: {character, 1} single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

INVESTIGATION INITIATED?

LA County Element **POS_05**
National Element **O_05**

Definition

An investigation by law enforcement and/or protective services was initiated because of the suspected physical abuse

Field Values

- Y (Yes)
- N (No)

Additional Information

- This includes, but is not limited to, a report of child, elder, spouse or intimate partner physical abuse
- Only complete when Report of Physical Abuse is “Yes”
- If Physical Abuse Reported? is “No”, then Investigation Initiated will auto fill with “NA”

Data Source Hierarchy

1. EMS Run Sheet
2. ED Records
3. History/Physical
4. Progress Notes
5. Case Manager / Social Service’s Notes
6. Hospital Discharge Summary

Uses

- Determine trauma incidents due to physical abuse
- Used in quality management for the evaluation of care

Other Associated Elements

- PHYSICAL ABUSE REPORTED?
- CAREGIVER CHANGE?

Data Format: {character, 1} single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

CAREGIVER CHANGE?

LA County Element **POS_06**
National Element **O_05**

Definition

The patient was discharged to a caregiver different than the caregiver at admission due to suspected physical abuse

Field Values

- Y (Yes)
- N (No)

Additional Information

- Only complete when Report of Physical Abuse is “Yes”
- Excludes emancipated minors
- If Physical Abuse Reported? is “No”, then Caregiver Change will auto fill with “NA”

Data Source Hierarchy

1. EMS Run Sheet
2. ED Records
3. History/Physical
4. Progress Notes
5. Case Manager / Social Service’s Notes
6. Hospital Discharge Summary

Uses

- Determine trauma incidents due to physical abuse
- Used in quality management for the evaluation of care

Other Associated Elements

- PHYSICAL ABUSE REPORTED?
- INVESTIGATION INITIATED

Data Format: {character, 1} single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

TRANSFERRED / DISCHARGED TO

LA County Element **POS_07**
National Element **O_05**

Definition

The disposition of the patient when discharged from the hospital

Field Values

LA COUNTY		NTDB	
ACUTE	Acute Care Facility	1	Transferred to another acute care hospital using EMS
AMA	AMA/Eloped/LWBS	4	Left against medical advice
BURN	Burn Center	1	Transferred to another acute care hospital using EMS
HOME WITH	Home W/Home Hlth Srvcs	3	Discharged home under care of Home Health Agency
HOME W/O	Home Without Services	6	Discharged home with no home services
HOSPICE	Hospice	8	Discharged to hospice care
JAIL	Jail	10	Discharged/Transferred to court/law enforcement
MORGUE	Morgue	5	Expired
REHAB	Rehabilitation Center	11	Transferred to inpatient rehabilitation or designated unit
SCJ	Jail Ward at LAC+USC	10	Discharged/Transferred to court/law enforcement
SNF	Skilled Nursing Facility	7	Transferred to Skilled Nursing Facility
SUBACUTE	Subacute Care	2	Transferred to an Intermediate Care Facility
TRAUMA	Trauma Center	1	Transferred to another acute care hospital using EMS
LTCH	Long Term Care Hospital	12	Discharged/Transferred to Long Term Care Hospital (LTCH)
PSYCH	Psychiatric Facility	13	Discharged/Transferred to a psych hospital/hospital psych unit
OTHER	Other	14	Discharged/Transferred to another type of facility not defined

Additional Information

- For patients pronounced brain dead and whose care is assumed by an organ procurement agency enter “Morgue”
- Long-term care hospitals (LTCHs) are certified as acute care hospitals, but focus on patients who, on average, stay more than 25 days
- An SNF is an institution that provides skilled nursing care after a patient no longer needs the level of services that an acute care hospital provides

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon post-ED phase of care
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- D/C DATE/TIME
- PRIOR PHASE
- RATIONALE
- DISCHARGE CAPACITY

Data Format: [character, 9] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

TRANSFER RATIONALE

LA County Element **POS_08**
National Element **N/A**

Definition

The rationale for transfer, if applicable

Field Values

HP	Health Plan	Health Plan decision
FI	Financial	Decision based on financial status (i.e., cash or self-pay, uninsured)
SC	Specialized/ Higher Level Care	Patient required acute specialized care or higher level of care not available at the transferring facility, e.g., pediatrics, burns, complex pelvic fracture, reimplantation
RH	Rehab	Patient required rehabilitation
EX	Extended Care	Patient discharged from acute care setting of hospital, but required sub-acute care in the setting of a convalescent home, board-and-care, etc.
CU	In Custody	Patient discharged/transferred in custody of law enforcement
OT	Other	Transfer rationale other than above

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon post-ED phase of care
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- D/C DATE/TIME
- PRIOR PHASE
- TRANSFER / D/C TO
- D/C CAPACITY
- FACILITY

Data Format: [character, 2] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

FACILITY

LA County Element **POS_09**
National Element **N/A**

Definition

If applicable, the three-letter code for the facility to which the patient was transferred

Field Values

- See drop-down picklist for all facilities and their codes

Additional Information

- Only applicable for patients transferred (e.g. Acute Care, Burn, Trauma)
- For patients discharged to non-acute care facilities (e.g. Rehab, SNF, Subacute) use "Other"

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Provides documentation of care

Other Associated Elements

- TRANSFER / D/C TO
- RATIONALE

Data Format: [character, 3] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

TRANSFER OUT VIA AIR / GROUND

LA County Element **POS_10**
National Element **N/A**

Definition

If applicable, method used for transferring the patient

Field Values

- Air
- Ground

Additional Information

- Only applicable for patients transferred (e.g. Acute Care, Burn, Trauma)
- This field will automatically be filled with “Not Applicable” for patients Transferred / Discharged To:
  - AMA/Eloped/LWBS (Left Without Being Seen)
  - Home w/Home Hlth
  - Home w/o
  - Morgue

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Provides documentation of care

Other Associated Elements

- TRANSFER / D/C TO
- RATIONALE

Data Format: [character, 3] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

DISCHARGE CAPACITY

LA County Element **POS_11**
National Element **N/A**

Definition

Patient's gross functional capacity upon discharge from hospital

Field Values

H PERMANENT HANDICAP	Limitations from the injury expected to last more than one year
T TEMPORARY HANDICAP	Required ADMISSION to the hospital for injuries sustained
P PRE-INJURY CAPACITY	Discharged FROM THE ED with minimal or no injury

Additional Information

- "Not applicable" if patient expired
- A splenectomy in NOT considered a permanent handicap

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon functional capacity at discharge
- Used in quality management for the evaluation of care

Other Associated Elements

- PRIOR PHASE
- TRANSFER / D/C TO
- RATIONALE
- FACILITY

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

LIVED / DIED

LA County Element **POS_12**
National Element **N/A**

Definition

Indicates whether or not patient died of injuries during hospital stay

Field Values

- L Lived
- D Died

Data Source Hierarchy

1. Hospital Records
2. Hospital Discharge Summary
3. Progress Notes

Uses

- Allows data to be sorted based upon mortality
- Used in quality management for the evaluation of care

Other Associated Elements

- TRANSFER'D / D/C TO
- RATIONALE
- ORGAN DONOR?
- AUTOPSY UPDATE?
- CORONER #

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ORGAN REFERRAL?

LA County Element **POS_13**
National Element **N/A**

Definition

Indicates whether or not patient was referred for potential organ donation

Field Values

- Y (Yes)
- N (No)

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes

Uses

- Allows tracking of organ referrals

Other Associated Elements

- LIVED / DIED

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ORGAN DONOR?

LA County Element **POS_14**
National Element **N/A**

Definition
Indicates whether or not patient's organs were donated

Field Values (Organ Donor?)
- Y (Yes)
- N (No)

Data Source Hierarchy
1. Hospital Discharge Summary
2. Progress Notes

Uses
- Allows tracking of organ donation

Other Associated Elements
- LIVED / DIED

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ORGANS DONATED?

LA County Element **POS_20**
National Element **N/A**

Definition

Indicates which specific organs were donated

Field Values (Organs Donated)

- Heart
- Intestine
- Kidney (1)
- Kidneys (2)
- Liver
- Lung (1)
- Lungs (2)
- Pancreas

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes

Uses

- Allows tracking of organ donation

Other Associated Elements

- LIVED / DIED

Data Format: [character, 9] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

AUTOPSY UPDATE?

LA County Element **POS_15**
National Element **N/A**

Definition

Indicates whether or not an autopsy update was provided/obtained

Field Values

- Y (Yes)
- N (No)

Additional Information

- Enter “Yes” if a Coroner’s Report is received
- To ensure that the data accurately reflects the extent of the patient’s injuries, enter any additional injuries identified in the autopsy report in the discharge diagnoses

Data Source Hierarchy

1. Coroner Report

Uses

- Allows data to be sorted according to whether or not autopsy update was obtained

Other Associated Elements

- CORONER #

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

CORONER

LA County Element **POS_16**
National Element **N/A**

Definition

Coroner's ID number or code, if applicable

Field Values

- Relevant value for data element

Additional Information

- Non-picklisted – free text Coroner name or code at discretion of facility

Data Source Hierarchy

1. Trauma Patient Summary Form?

Uses

- Identifies the coroner that performed the autopsy, if applicable

Other Associated Elements

- LIVED / DIED
- AUTOPSY UPDATE?

Data Format: [character, 10] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

DISCHARGE DIAGNOSES

LA County Element **POS_17**
National Element **DG_02**

Definition

All identified diagnoses related to injury

Field Values

- ICD-10-CM codes

Additional Information

- Injury diagnoses as defined by ICD-10 codes range S00-S99, T07, T14, T20-T-28, and T30-T32
- ICD-10-CM codes should be listed starting with the most to least significant injury
- The primary injury resulting in the hospitalization should be listed first
- The “significance” of other injuries should be based upon severity and location
- Used to calculate Abbreviated Injury Scale and Injury Severity Score
- To ensure that the data accurately reflects the extent of the patient’s injuries, if a Coroner’s report is received enter any additional injuries identified in the autopsy report

Data Source Hierarchy

1. Hospital Discharge Summary
2. Billing Sheet / Medical Records Coding Summary Sheet
3. ER , ICU, OR Records
4. Autopsy / Medical Examiner Report

Uses

- Allows characterization of patients and hospital outcomes based upon the presence, severity and type of injury
- Allows data to be sorted based upon ICD-10-CM codes
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- CO-MORBIDITIES
- COMPLICATIONS

Data Format: [character, 6] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

NTDS CO-MORBID CONDITIONS

LA County Element **POS_18**
National Element **DG_01**

Definition

Pre-existing co-morbid factors present before patient arrival at the ED/hospital

Field Values

LA COUNTY	NTDB	
No NTDS Co-Morbidities		No NTDS Co-Morbidities are present
Advanced Directive (limiting care) (DNR status)	13	Advanced Directive (limiting care)
Alcoholism	2	Alcohol Use Disorder
Angina (within 30 days)	16	History of Angina within 30 days
Ascites (within 30 days)	3	NTDB RETIRED IN 2015
Attention Deficit Disorder/Hyperactivity Disorder (ADD/ADHD)	30	Attention Deficit Disorder/Hyperactivity Disorder (ADD/ADHD)
Bleeding Disorder	4	Bleeding Disorder
Cerebral Vascular Accident (CVA) / Residual Neuro Deficit	10	Cerebral Vascular Accident (CVA)
Chemotherapy (currently receiving)	5	Currently receiving Chemotherapy for cancer
Cirrhosis	25	Cirrhosis
Congenital Anomalies	6	Congenital Anomalies
Congestive Heart Failure (CHF)	7	Congestive Heart Failure (CHF)
Current Smoker	8	Current Smoker
Dementia	26	Dementia
Diabetes Mellitus	11	Diabetes Mellitus
Dialysis	9	Chronic Renal Failure
Disseminated Cancer	12	Disseminated Cancer
Drug Abuse or Dependence	28	Drug Use Disorder
Functionally Dependent Health Status	15	Functionally Dependent Health Status
Hypertension (requiring medication)	19	Hypertension (requiring medication)
Impaired Sensorium	20	NTDB RETIRED IN 2012
Major Psychiatric Illness	27	Major Psychiatric Illness
Myocardial Infarction (**within 6 months of injury**)	17	History of Myocardial Infarction
Obesity	22	NTDB RETIRED IN 2015
Peripheral Vascular Disease (PVD) (revascularization)	18	History of Peripheral Vascular Disease (PVD)
Prematurity	21	Prematurity
Respiratory Disease (COPD)	23	Chronic Obstructive Pulmonary Disease (COPD)
Seizure Disorder	N/A	
Steroid Use	24	Steroid Use
Other:	1	Other
*Esophageal Varices (No longer valid, LA retired in 2015)	14	NTDB RETIRED IN 2015
*Prehospital Cardiac Arrest w/ CPR (No longer valid, LA retired in 2015)	29	NTDB RETIRED IN 2015

Additional Information

- The field value “No NTDS co-morbidities” should be chosen if none of the pre-existing co-morbid factors listed above are present in the patient

Data Source Hierarchy

1. Progress/Consultation Notes
2. Hospital Nursing Notes

Uses

- Allows data to be used to characterize patients and hospital outcomes based upon the presence (and type) of co-morbid condition

Other Associated Elements

- INJURY DIAGNOSES

Data Format: [character, 22] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

COMPLICATIONS

LA County Element **POS_19**
National Element **Q_01**

Definition

Any medical complication that occurred during the patient's stay at your hospital

Field Values

LA COUNTY	NTDB	
No Listed Complications Occurred		No NTDS listed Medical Complications Occurred
Abdominal Compartment Syndrome	2	NTDB RETIRED IN 2011
Abdominal Fascia Left Open	3	NTDB RETIRED IN 2011
Acute Kidney Injury (dialysis)	4	Acute Kidney Injury
Adult Respiratory Distress Syndrome (ARDS)	5	Adult Respiratory Distress Syndrome (ARDS)
Base Deficit	6	NTDB RETIRED IN 2011
Bleeding	7	NTDB RETIRED IN 2011
Cardiac Arrest with CPR	8	Cardiac Arrest with CPR
Catheter-Related Blood Stream Infection	28	NTDB RETIRED IN 2016
Central line-associated bloodstream infection (CLABSI)	34	Central line-associated bloodstream infection (CLABSI)
Cerebral Vascular Accident (CVA) / Stroke	22	Stroke / CVA
Coagulopathy	9	NTDB RETIRED IN 2011
Coma	10	NTDB RETIRED IN 2011
Decubitus Ulcer	11	Decubitus Ulcer
Drug or ETOH Withdrawal	13	Drug or Alcohol Withdrawal Syndrome
Deep Vein Thrombosis (DVT) / Thrombophlebitis	14	Deep Vein Thrombosis (DVT)/Thrombophlebitis
Extremity Compartment Syndrome	15	Extremity Compartment Syndrome
Graft / Prosthesis / Flap Failure	16	NTDB RETIRED IN 2016
Increase Intracranial Pressure	17	NTDB RETIRED IN 2011
Myocardial Infarction (within 30 days of injury)	18	Myocardial Infarction
Osteomyelitis	29	Osteomyelitis
Pneumonia	20	NTDB RETIRED IN 2016
Pneumonia Ventilator Associated (VAP)	35	Ventilator Associated Pneumonia
Pulmonary Embolism (PE)	21	Pulmonary Embolism
Surgical Site Infection (superficial)	23	Superficial Surgical Site Infection
Surgical Site Infection (deep)	12	Deep Surgical Site Infection
Surgical Site Infection (organ/space)	19	Organ/space Surgical Site Infection
Sepsis and/or Severe Sepsis	32	Severe Sepsis
Unplanned Intubation	25	Unplanned Intubation
Unplanned Readmission	N/A	
Unplanned Return to the ICU	31	Unplanned Admission to the ICU
Unplanned Return to the OR	30	Unplanned Return to the OR
Urinary Tract Infection (UTI)	27	NTDB RETIRED IN 2016
Urinary Tract Infection Catheter Associated (CAUTI)	33	Catheter-associated Urinary Tract Infection
Wound Disruption	26	NTDB RETIRED IN 2011
Wound Infection	N/A	
Other:	1	Other
*Anastomotic leak (No longer valid, LA retired in 2015)	N/A	
*Empyema (No longer valid, LA retired in 2015)	N/A	
*Jaundice/Hepatic Failure (No longer valid, LA retired in 2015)	N/A	
*Pancreatic (No longer valid, LA retired in 2015)	N/A	

Additional Information

- The field value "No NTDS complications" should be chosen if none of the pre-existing co-morbid factors listed above are present in the patient

Data Source Hierarchy

1. Progress/Consultation Notes
2. Hospital Nursing Notes

Uses

- Allows data to be used to characterize patients and hospital outcomes based upon presence and type of hospital complication

Data Format: [character, 22] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

Readmit

READMIT DATE

LA County Element **RA_01**
National Element **N/A**

Definition

The date the patient was readmitted to the hospital following discharge, elopement, AMA, etc., or readmission post transfer for higher level of care for an unplanned readmission

Field Values

- Relevant value for data element

Additional Information

- If the patient returns to the ED, enter the date patient the patient returned to the ED. If patient was directly admitted to the hospital, enter date patient was re-admitted to the hospital.
- Only applicable if patient returns within 30 days of discharge
- Collected as YYYY-MM-DD

Data Source Hierarchy

1. ED Record
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows information to be collected on patient's that are readmitted

Other Associated Elements

- READMIT DATE/TIME
- READMIT D/C TIME
- READMIT PRIOR PHASE

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

READMIT TIME

LA County Element **RA_02**
National Element **N/A**

Definition

The time the patient was readmitted to the hospital following discharge, elopement, AMA, etc., or readmission post transfer for higher level of care for an unplanned readmission

Field Values

- Relevant value for data element

Additional Information

- If the patient was brought to the ED, enter the time the patient arrived in the ED. If patient was directly admitted to the hospital, enter the time the patient was readmitted to the hospital.
- Collected as HHMM (military time)

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Used to calculate LOS
- Allows data to be sorted based upon ED length of stay

Other Associated Elements

- READMIT DATE/TIME
- READMIT D/C DATE
- READMIT PRIOR PHASE

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

LA County Element **RA_03**
National Element **N/A**

READMIT COMMENTS

Definition

Comments related to the readmission of the patient

Field Values

- Free text

Data Source Hierarchy

1. Radiology readings / Lab results
2. ED Records
3. ICU Records
4. Operative Reports
5. Billing Sheet / Medical Records Coding Summary Sheet
6. Hospital Discharge Summary

Uses

Other Associated Elements

Data Format: [character, 6] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** Unlimited **Accepts Null Value:** Yes

LA County Element **RA_04**
National Element **N/A**

READMIT COMPLICATIONS

Definition

Any medical complication that occurred during the patient's readmission

Field Values

LA COUNTY	NTDB	
No Listed Complications Occurred		No NTDS listed Medical Complications Occurred
Abdominal Compartment Syndrome	2	NTDB RETIRED IN 2011
Abdominal Fascia Left Open	3	NTDB RETIRED IN 2011
Acute Kidney Injury (dialysis)	4	Acute Kidney Injury
Adult Respiratory Distress Syndrome (ARDS)	5	Adult Respiratory Distress Syndrome (ARDS)
Base Deficit	6	NTDB RETIRED IN 2011
Bleeding	7	NTDB RETIRED IN 2011
Cardiac Arrest with CPR	8	Cardiac Arrest with CPR
Catheter-Related Blood Stream Infection	28	NTDB RETIRED IN 2016
Central line-associated bloodstream infection (CLABSI)	34	Central line-associated bloodstream infection (CLABSI)
Cerebral Vascular Accident (CVA) / Stroke	22	Stroke / CVA
Coagulopathy	9	NTDB RETIRED IN 2011
Coma	10	NTDB RETIRED IN 2011
Decubitus Ulcer	11	Decubitus Ulcer
Drug or ETOH Withdrawal	13	Drug or Alcohol Withdrawal Syndrome
Deep Vein Thrombosis (DVT) / Thrombophlebitis	14	Deep Vein Thrombosis (DVT)/Thrombophlebitis
Extremity Compartment Syndrome	15	Extremity Compartment Syndrome
Graft / Prosthesis / Flap Failure	16	NTDB RETIRED IN 2016
Increase Intracranial Pressure	17	NTDB RETIRED IN 2011
Myocardial Infarction (within 30 days of injury)	18	Myocardial Infarction
Osteomyelitis	29	Osteomyelitis
Pneumonia	20	NTDB RETIRED IN 2016
Pneumonia Ventilator Associated (VAP)	35	Ventilator Associated Pneumonia
Pulmonary Embolism (PE)	21	Pulmonary Embolism
Surgical Site Infection (superficial)	23	Superficial Surgical Site Infection
Surgical Site Infection (deep)	12	Deep Surgical Site Infection
Surgical Site Infection (organ/space)	19	Organ/space Surgical Site Infection
Sepsis and/or Severe Sepsis	32	Severe Sepsis
Unplanned Intubation	25	Unplanned Intubation
Unplanned Readmission	N/A	
Unplanned Return to the ICU	31	Unplanned Admission to the ICU
Unplanned Return to the OR	30	Unplanned Return to the OR
Urinary Tract Infection (UTI)	27	NTDB RETIRED IN 2016
Urinary Tract Infection Catheter Associated (CAUTI)	33	Catheter-associated Urinary Tract Infection
Wound Disruption	26	NTDB RETIRED IN 2011
Wound Infection	N/A	
Other:	1	Other
*Anastomotic leak (No longer valid, LA retired in 2015)	N/A	
*Empyema (No longer valid, LA retired in 2015)	N/A	
*Jaundice/Hepatic Failure (No longer valid, LA retired in 2015)	N/A	
*Pancreatic (No longer valid, LA retired in 2015)	N/A	

Data Source Hierarchy

1. Progress/Consultation Notes
2. Hospital Nursing Notes

Uses

- Allows data to be used to characterize patients and hospital outcomes based upon presence and type of hospital complication

Data Format: [character, 22] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

READMIT DISCHARGE DATE

LA County Element **RA_05**
National Element **N/A**

Definition

The date the patient died, was transferred or discharged from the hospital following readmission

Field Values

- Relevant value for data element

Additional Information

- Collected as YYYY-MM-DD

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Used to calculate LOS
- Allows data to be sorted based upon ED length of stay

Other Associated Elements

- READMIT DATE/TIME
- READMIT D/C DATE
- READMIT PRIOR PHASE

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

READMIT DISCHARGE TIME

LA County Element **RA_06**
National Element **N/A**

Definition

The time the patient died, was transferred or discharged from the hospital following readmission

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time)
- Utilize the time the patient was pronounced brain dead in situations when care is assumed by an organ procurement agency

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Used to calculate LOS
- Allows data to be sorted based upon ED length of stay

Other Associated Elements

- READMIT DATE/TIME
- READMIT D/C DATE
- READMIT PRIOR PHASE

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

READMIT PRIOR PHASE

LA County Element **RA_07**
National Element **N/A**

Definition

Phase of care prior to discharge of the patient following readmission

Field Values

- 23HR OBS <24 Hour Observation
- ED Emergency Department
- ICU Intensive/Critical Care Unit
- IR Interventional Radiology
- OR Operating Room
- PICU Pediatric ICU
- PEDSWARD Pediatric Ward
- READMIT
- SPECIAL PROCEDURES (e.g., Angio, etc)
- STEPDOWN Stepdown or Telemetry Unit
- WARD Ward/Floor

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon patient's last phase of care
- Used in quality management for the evaluation of care

Other Associated Elements

- READMIT D/C DATE/TIME

Data Format: [character, 8] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

READMIT TRANSFERRED / D/C TO

LA County Element **RA_08**
National Element **N/A**

Definition

The disposition of the patient following readmission

Field Values

LA COUNTY	NTDB	
ACUTE Acute Care Facility	1	Transferred to another acute care hospital using EMS
AMA AMA/Eloped/LWBS	4	Left against medical advice
BURN Burn Center	1	Transferred to another acute care hospital using EMS
HOME WITH Home W/Home Hlth Srvcs	3	Discharged home under care of Home Health Agency
HOME W/O Home Without Services	6	Discharged home with no home services
HOSPICE Hospice	8	Discharged to hospice care
JAIL Jail	10	Discharged/Transferred to court/law enforcement
MORGUE Morgue	5	Expired
REHAB Rehabilitation Center	11	Transferred to inpatient rehabilitation or designated unit
SCJ Jail Ward at LAC+USC	10	Discharged/Transferred to court/law enforcement
SNF Skilled Nursing Facility	7	Transferred to Skilled Nursing Facility
SUBACUTE Subacute Care	2	Transferred to an Intermediate Care Facility
TRAUMA Trauma Center	1	Transferred to another acute care hospital using EMS
LTCH Long Term Care Hospital	12	Discharged/Transferred to Long Term Care Hospital (LTCH)
PSYCH Psychiatric Facility	13	Discharged/Transferred to a psych hospital or psych unit of a hospital
OTHER Other	14	Discharged/Transferred to another type of institution not defined

Additional Information

- Utilize morgue for patient's pronounced brain dead and care is assumed by an organ procurement agency
- Long-term care hospitals (LTCHs) are certified as acute care hospitals, but focus on patients who, on average, stay more than 25 days
- An SNF is an institution that provides skilled nursing care after a patient no longer needs the level of services that an acute care hospital provides

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Can be used to roughly characterize functional status at hospital discharge
- Allows data to be sorted based upon post-ED phase of care
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- READMIT D/C DATE/TIME
- READMIT PRIOR PHASE
- READMIT RATIONALE
- READMIT D/C CAPACITY

Data Format: [character, 9] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

READMIT RATIONALE

LA County Element **RA_09**
National Element **N/A**

Definition

The rationale for transfer following readmission, if applicable

Field Values

HP	Health Plan	Health Plan decision
FI	Financial	Decision based on financial status (i e , cash or self-pay, uninsured)
SC	Higher Level / Specialized Care	Patient required higher level of care or acute service not available at the transferring facility
RH	Rehab	Patient required rehabilitation
EX	Extended Care	Patient discharged from acute care setting of hospital, but required sub-acute care in the setting of a convalescent home, board-and-care, etc
CU	In Custody	Patient discharged/transferred in custody of law enforcement
OT	Other	Transfer rationale other than above

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Can be used to roughly characterize functional status at hospital discharge
- Allows data to be sorted based upon post-ED phase of care
- Provides documentation of care
- Used in quality management for the evaluation of care

Other Associated Elements

- READMIT D/C DATE/TIME
- READMIT PRIOR PHASE
- READMIT TRANSFER / D/C TO
- READMIT D/C CAPACITY
- READMIT FACILITY

Data Format: [character, 2] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

READMIT FACILITY

LA County Element **RA_10**
National Element **N/A**

Definition

If applicable, the three-letter code for the facility to which the patient was transferred following readmission

Field Values

- See drop-down picklist for all facilities and their codes

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Provides documentation of care

Other Associated Elements

- TRANSFER / D/C TO RATIONALE

Data Format: [character, 3] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

READMIT DISCHARGE CAPACITY

LA County Element **RA_11**
National Element **N/A**

Definition

Patient's gross functional capacity upon discharge following readmission

Field Values

H PERMANENT HANDICAP	Limitations from the injury expected to last more than one year
T TEMPORARY HANDICAP	Required ADMISSION to the hospital for injuries sustained
P PRE-INJURY CAPACITY	Discharged FROM THE ED with minimal or no injury

Additional Information

- "Not applicable" if patient expired
- A splenectomy in NOT considered a permanent handicap

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon functional capacity at discharge
- Used in quality management for the evaluation of care

Other Associated Elements

- PRIOR PHASE
- TRANSFER / D/C TO
- RATIONALE FACILITY

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

Finances

FINANCES *(Payor)*

LA County Element **FIN_01**
National Element **F_01**

Definition

Indicate primary source of payment for patient's hospital care

Field Values

LA COUNTY	NTDB	
Pvt/Commercial Insurance:		
HMO	4	Private/Commercial Insurance
Medi-Cal HMO	4	Private/Commercial Insurance
Other private carrier	4	Private/Commercial Insurance
Auto Insurance	4	Private/Commercial Insurance
Worker's Comp.	8	Workers Compensation
Other Private	10	Other
Medicaid:		
Medi-Cal	1	Medicaid
Medi-Cal pending	1	Medicaid
Medicare (including Medicare HMO)	6	Medicare
Self:		
Cash	3	Self Pay
ATP w/liability	3	Self Pay
Pre-pay	3	Self Pay
Not billed:		
Charity	2	Not Billed (for any reason)
ATP w/o liability	2	Not Billed (for any reason)
Government:		
CHIP eligible	7	Other Government
CCS (California Children's Services)	7	Other Government
Custody Funds	7	Other Government
VOC (Victims of Crime)	7	Other Government
Other Government	7	Other Government
Organ Donor Subsidy	7	Other Government
Military insurance	7	Other Government
N/A	5	No Fault Automobile

Data Source Hierarchy

1. Facesheet
2. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon payor mix

Data Format: [character, 15] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

TOTAL CHARGES

LA County Element **FIN_02**
National Element **N/A**

Definition

Indicate total of all charges for patient's hospital care

Field Values

- Relevant value for data element

Data Source Hierarchy

1. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon total charges

Other Associated Elements

- FINANCES

Data Format: [number, 12] single entry **Picklist:** No
Min Value: 0 **Max Value:** 999999999.99 **Accepts Null Value:** Yes

Appendix 1:
Glossary of Terms

CO-MORBID CONDITIONS

(SPECIAL NOTE: The use of "NA" should NOT be used for this data field. At a minimum, the field value "No NTDS co-morbidities" should be chosen if none of the NTDS' co-morbid conditions listed are present. This value will be mapped to NTDB as "Not Applicable".)

LA COUNTY	NTDB	
No NTDS Co-Morbidities		No NTDS Co-Morbidities are present
Advanced Directive (limiting care) (DNR status)	13	Advanced Directive (limiting care)
Alcoholism	2	Alcohol Use Disorder
Angina (within 30 days)	16	History of Angina within 30 days
Ascites (within 30 days)	3	NTDB RETIRED IN 2015
Attention Deficit Disorder/Hyperactivity Disorder (ADD/ADHD)	30	Attention Deficit Disorder/Hyperactivity Disorder (ADD/ADHD)
Bleeding Disorder	4	Bleeding Disorder
Cerebral Vascular Accident (CVA) / Residual Neuro Deficit	10	Cerebral Vascular Accident (CVA)
Chemotherapy (currently receiving)	5	Currently receiving Chemotherapy for cancer
Cirrhosis	25	Cirrhosis
Congenital Anomalies	6	Congenital Anomalies
Congestive Heart Failure (CHF)	7	Congestive Heart Failure (CHF)
Current Smoker	8	Current Smoker
Dementia	26	Dementia
Diabetes Mellitus	11	Diabetes Mellitus
Dialysis	9	Chronic Renal Failure
Disseminated Cancer	12	Disseminated Cancer
Drug Abuse or Dependence	28	Drug Use Disorder
Functionally Dependent Health Status	15	Functionally Dependent Health Status
Hypertension (requiring medication)	19	Hypertension (requiring medication)
Impaired Sensorium	20	NTDB RETIRED IN 2012
Major Psychiatric Illness	27	Major Psychiatric Illness
Myocardial Infarction (**in the 6 months prior to injury**)	17	Myocardial Infarction (w/in 30 days of injury
Obesity	22	NTDB RETIRED IN 2015
Peripheral Vascular Disease (PVD) (revascularization)	18	History of Peripheral Vascular Disease (PVD)
Prematurity	21	Prematurity
Respiratory Disease (COPD)	23	Chronic Obstructive Pulmonary Disease (COPD)
Seizure Disorder	N/A	
Steroid Use	24	Steroid Use
Other:	1	Other
*Esophageal Varices (No longer valid, LA retired in 2015)	14	NTDB RETIRED IN 2015
*Prehospital Cardiac Arrest with Cardiopulmonary Resuscitation (CPR) (No longer valid, LA retired in 2015)	29	NTDB RETIRED IN 2015

Advanced Directive (limiting care): The patient had a Do-Not-Resuscitate (DNR) document or similar advance directive recorded prior to injury.

Alcoholism: Evidence of chronic use, such as withdrawal episodes. Exclude isolated elevated blood alcohol level in the absence of history of abuse.

Angina (within 30 days): Pain or discomfort between the diaphragm and the mandible resulting from myocardial ischemia. Typically angina is a dull, diffuse (fist sized or larger), substernal chest discomfort precipitated by exertion or emotion and relieved by rest or nitroglycerine. Radiation often occurs to the arms and shoulders and occasionally to the neck, jaw (mandible, not maxilla), or interscapular region. For patients on anti-anginal medications, enter yes only if the patient has had angina within the last 30 days prior to admission.

Ascites (within 30 days): The presence of fluid accumulation (other than blood) in the peritoneal cavity noted on physical examination, abdominal ultrasound, or abdominal CT/MRI.

Attention Deficit Disorder / Hyperactivity Disorder (ADD/ADHD): History of a disorder involving inattention, hyperactivity, or impulsivity requiring medication for treatment.

Bleeding Disorder: Any condition that places the patient at risk for excessive bleeding due to a deficiency of blood clotting elements (e.g., vitamin K deficiency, hemophilia, thrombocytopenia, chronic anticoagulation therapy with Coumadin, Plavix, or similar medications). Do not include the patient on chronic aspirin therapy.

Cerebral Vascular Accident (CVA) / Residual Neurological Deficit: A history prior to injury of a cerebrovascular accident (embolic, thrombotic, or hemorrhagic) with persistent residual motor, sensory, or cognitive dysfunction (e.g., hemiplegia, hemiparesis, aphasia, sensory deficit, impaired memory).

Chemotherapy (currently receiving): A patient who is currently receiving any chemotherapy treatment for cancer prior to admission. Chemotherapy may include, but is not restricted to, oral and parenteral treatment with chemotherapeutic agents for malignancies such as colon, breast, lung, head and neck, and gastrointestinal solid tumors as well as lymphatic and hematopoietic malignancies such as lymphoma, leukemia, and multiple myeloma.

Cirrhosis: Documentation in the medical record of cirrhosis, which might also be referred to as end stage liver disease. If there is documentation of prior or present esophageal or gastric varices, portal hypertension, previous hepatic encephalopathy, or ascites with notation of liver disease, then cirrhosis should be considered present. Cirrhosis should also be considered present if documented by diagnostic imaging studies or a laparotomy/laparoscopy.

Congenital Anomalies: Documentation of a cardiac, pulmonary, body wall, CNS/spinal, gastrointestinal, renal, orthopedic, or metabolic congenital anomaly.

Congestive Heart Failure (CHF): Inability of the heart to pump a sufficient quantity of blood to meet the metabolic needs of the body or can do so only at an increased ventricular filling pressure. To be included, this condition must be noted in the medical record as CHF, congestive heart failure, or pulmonary edema with onset or increasing symptoms within 30 days prior to injury. Common manifestations are:

- Abnormal limitation in exercise tolerance due to dyspnea or fatigue
- Orthopnea (dyspnea on lying supine)
- Paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea)
- Increased jugular venous pressure
- Pulmonary rales on physical examination
- Cardiomegaly
- Pulmonary vascular engorgement

Current Smoker: A patient who reports smoking cigarettes every day or some days. Exclude patients who smoke cigars or pipes or use smokeless tobacco (chewing tobacco or snuff).

Dementia: Brain diseases that cause a long term and often gradual decrease in the ability to think and remember such that a person's daily functioning is affected. Pay particular attention to senile or vascular dementia (e.g., Alzheimer's).

Diabetes Mellitus: Diabetes mellitus prior to injury that required exogenous parenteral insulin or an oral hypoglycemic agent. Do not include a patient if diabetes is controlled by diet alone.

Dialysis: Renal failure prior to injury that was requiring periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration.

Disseminated Cancer: Patients who have cancer that:

- Has spread to one site or more sites in addition to the primary site

AND

- In whom the presence of multiple metastases indicates the cancer is widespread, fulminant, or near terminal. Other terms describing disseminated cancer include "diffuse," "widely metastatic," "widespread," or "carcinomatosis." Common sites of metastases include major organs (e.g., brain, lung, liver, meninges, abdomen, peritoneum, pleura, or bone).

Drug Abuse or Dependence: Maladaptive patterns of substance use that lead to significant impairment or distress, and may result in withdrawal upon cessation of drug use. Pay particular attention to opioid, sedative, amphetamine, cocaine, diazepam, alprazolam, or lorazepam dependence (excludes ADD / ADHD or chronic pain with medication use as-prescribed).

Esophageal Varices: Esophageal varices are engorged collateral veins in the esophagus which bypass a scarred liver to carry portal blood to the superior vena cava. A sustained increase in portal pressure results in esophageal varices which are most frequently demonstrated by direct visualization at esophagoscopy.

Functionally Dependent Health Status: Pre-injury functional status may be represented by the ability of the patient to complete activities of daily living (ADL) including: bathing, feeding, dressing, toileting, and walking. This item is marked YES if the patient, prior to injury, was partially dependent or completely dependent upon equipment, devices or another person to complete some or all activities of daily living. Formal definitions of dependency are listed below:

- Partially dependent: The patient requires the use of equipment or devices coupled with assistance from another person for some activities of daily living. Any patient coming from a nursing home setting who is not totally dependent would fall into this category, as would any patient who requires kidney dialysis or home ventilator support that requires chronic oxygen therapy yet maintains some independent functions.
- Totally dependent: The patient cannot perform any activities of daily living for himself/herself. This would include a patient who is totally dependent upon nursing care, or a dependent nursing home patient. All patients with psychiatric illnesses should be evaluated for their ability to function with or without assistance with ADLs just as the non-psychiatric patient.

Hypertension (requiring medication): History of a persistent elevation of systolic blood pressure >140 mm Hg and a diastolic blood pressure >90 mm Hg requiring an antihypertensive treatment (e.g., diuretics, beta blockers, angiotensin-converting enzyme (ACE) inhibitors, calcium channel blockers).

Impaired Sensorium: Patients should be noted to having an impaired sensorium if they had mental status changes, and/or delirium in the context of a current illness prior to injury. Patients with chronic or longstanding mental status changes secondary to chronic mental illness (e.g., schizophrenia) or chronic dementing illnesses (e.g., multi-infarct dementia, senile dementia of the Alzheimer's type) should also be included. Mental retardation would qualify as impaired sensorium. For pediatric populations, patients with documented behavior disturbances, attention disorders, delayed learning or delayed development should be included.

Major Psychiatric Illness: Defined as documentation of the presence of pre-injury major depressive disorder, bipolar disorder, schizophrenia, anxiety / panic disorder, borderline or antisocial personality disorder, and / or adjustment disorder / post-traumatic stress disorder.

Myocardial Infarction (in the 6 months prior to injury): The history of a non-Q wave, or a Q wave infarction in the six months prior to injury and diagnosed in the patient's medical record.

Obesity: Defined as a Body Mass Index of 30 or greater.

Peripheral Vascular Disease (PVD) (revascularization): Any type of operative (open) or interventional radiology angioplasty or revascularization procedure for atherosclerotic PVD (e.g., aorta-femoral, femoral-femoral, femoral-popliteal, balloon angioplasty, stenting, etc.). Patients, who have had amputation for trauma or resection/repair of abdominal aortic aneurysms, including Endovascular Repair of Abdominal Aortic Aneurysm (EVAR), would not be included.

Prematurity: Defined as documentation of premature birth, a history of bronchopulmonary dysplasia, or ventilator support for greater than 7 days after birth. Premature birth is defined as infants delivered before 37 weeks from the first day of the last menstrual period.

Respiratory Disease (COPD): Defined as severe chronic lung disease, chronic asthma; cystic fibrosis; or COPD (such as emphysema and /or chronic bronchitis) resulting in any one or more of the following:

- Functional disability from COPD (e.g., dyspnea, inability to perform ADLs)
- Hospitalization in the past for treatment of COPD
- Requires chronic bronchodilator therapy with oral or inhaled agents
- An FEV1 of <75% of predicted on pulmonary function testing

Do not include patients whose only pulmonary disease is *acute* asthma. Do not include patients with diffuse interstitial fibrosis or sarcoidosis.

Seizure Disorder (history of): History of a seizure disorder prior to injury that required medication to control.

Steroid Use: Patients that required the regular administration of oral or parenteral corticosteroid medications (e.g., Prednisone, Decadron) in the 30 days prior to injury for a chronic medical condition (e.g., COPD, asthma, rheumatologic disease, rheumatoid arthritis, inflammatory bowel disease). Do not include topical corticosteroids applied to the skin or corticosteroids administered by inhalation or rectally.

HOSPITAL COMPLICATIONS

(SPECIAL NOTE: The use of "NA" should NOT be used for this data field. At a minimum, the field value "No NTDS Complications" should be chosen if none of NTDS' complications listed are present. This value will be mapped to NTDB as "Not Applicable".)

LA COUNTY	NTDB	
No Listed Complications Occurred		No NTDS listed Medical Complications Occurred
Abdominal Compartment Syndrome	2	NTDB RETIRED IN 2011
Abdominal Fascia Left Open	3	NTDB RETIRED IN 2011
Acute Kidney Injury (dialysis)	4	Acute Kidney Injury
Adult Respiratory Distress Syndrome (ARDS)	5	Adult Respiratory Distress Syndrome (ARDS)
Acute Myocardial Infarction (within 30 days of injury)	18	Myocardial Infarction
Base Deficit	6	NTDB RETIRED IN 2011
Bleeding	7	NTDB RETIRED IN 2011
Cardiac Arrest with CPR	8	Cardiac Arrest with CPR
Catheter-Related Blood Stream Infection	28	NTDB RETIRED IN 2016
Central Line-Associated Bloodstream Infection (CLABSI)	34	Central line-associated bloodstream infection (CLABSI)
Cerebral Vascular Accident (CVA) / Stroke	22	Stroke / CVA
Coagulopathy	9	NTDB RETIRED IN 2011
Coma	10	NTDB RETIRED IN 2011
Decubitus Ulcer	11	Decubitus Ulcer
Drug or ETOH Withdrawal	13	Drug or Alcohol Withdrawal Syndrome
Deep Vein Thrombosis (DVT) / Thrombophlebitis	14	Deep Vein Thrombosis (DVT)/Thrombophlebitis
Extremity Compartment Syndrome	15	Extremity Compartment Syndrome
Graft / Prosthesis / Flap Failure	16	NTDB RETIRED IN 2016
Increase Intracranial Pressure	17	NTDB RETIRED IN 2011
Osteomyelitis	29	Osteomyelitis
Pneumonia	20	NTDB RETIRED IN 2016
Pneumonia Ventilator Associated (VAP)	35	Ventilator Associated Pneumonia
Pulmonary Embolism (PE)	21	Pulmonary Embolism
Surgical Site Infection (superficial)	23	Superficial Surgical Site Infection
Surgical Site Infection (deep)	12	Deep Surgical Site Infection
Surgical Site Infection (organ/space)	19	Organ/space Surgical Site Infection
Sepsis and/or Severe Sepsis	32	Severe Sepsis
Unplanned Intubation	25	Unplanned Intubation
Unplanned Readmission	N/A	
Unplanned Return to the ICU	31	Unplanned Admission to the ICU
Unplanned Return to the OR	30	Unplanned Return to the OR
Urinary Tract Infection (UTI)	27	NTDB RETIRED IN 2016
Urinary Tract Infection Catheter Associated (CAUTI)	33	Catheter-associated Urinary Tract Infection
Wound Disruption	26	NTDB RETIRED IN 2011
Wound Infection	N/A	
Other:	1	Other
*Anastomotic leak (No longer valid, LA retired in 2015)	N/A	
*Empyema (No longer valid, LA retired in 2015)	N/A	
*Jaundice/Hepatic Failure (No longer valid, LA retired in 2015)	N/A	
*Pancreatic (No longer valid, LA retired in 2015)	N/A	

Abdominal Compartment Syndrome: Sudden increase in the intra-abdominal pressure resulting in alteration in the respiratory mechanism, hemodynamic parameters, and renal perfusion. Typically patients with this syndrome are critically ill and require ventilator support and/or reoperation.

Abdominal Fascia Left Open: No primary surgical closure of the fascia or intra-abdominal packs left at conclusion of primary laparotomy (damage control).

Acute Kidney Injury (dialysis): Abrupt (within 48 hours) reduction of kidney function as defined as:

- Increase in serum creatinine of more than or equal to 3x baseline

OR

- Increase in serum creatinine to ≥4mg/dl (≥353.3µmol/l)

OR

- Patients >18 years with a decrease in $_{e}$GFR to <35 ml/min per 1.73m^2

OR

- Reduction in urine output of <0.3 ml/kg/hr for ≥24 hours

OR

- Anuria for ≥12 hours

OR

- Requiring renal replacement therapy (e.g., continuous renal replacement therapy (CRRT) or periodic peritoneal dialysis, hemodialysis, hemofiltration or hemodiafiltration).

NOTE: If the patient or family refuses treatment (e.g., dialysis) the condition is still considered to be present if a combination of oliguria and creatinine.

EXCLUDE patients with renal failure that were requiring chronic renal replacement therapy such as periodic peritoneal dialysis, hemodialysis, hemofiltration or hemodiafiltration prior to injury.

Acute Respiratory Distress Syndrome (ARDS):

Timing:	Within 1 week of known clinical insult or new or worsening respiratory symptoms.
Chest imaging:	Bilateral opacities – not fully explained by effusions, lobar/lung collage, or nodules.
Origin of edema:	Respiratory failure not fully explained by cardiac failure or fluid overload. Need objective assessment (e.g., echocardiography) to exclude hybrostatic edema if no risk factors present.
Oxygenation:	200<PaO_2/FiO_2≤300.
(at a minimum)	**AND** Peep or CPAP ≥5 cmH_2O.

Acute Myocardial Infarction (AMI): A new acute myocardial infarction occurring during hospitalization (within 30 days of injury).

Base Deficit: A blood gas value greater than 4 at any time during admission, including the ED Phase of Care. This number is reported as a component of arterial or venous blood gases. The number may be reported by the lab as Base Deficit, or as Base Excessive with a negative value.

Bleeding: Any transfusion (including autologous) of five or more units of packed red blood cells or whole blood given from the time the patient is injured up to and including 72 hours later. The blood may be given for any reason.

Cardiac Arrest with CPR: The sudden cessation of cardiac activity after hospital arrival. The patient becomes unresponsive with no normal breathing and no signs of circulation. If corrective measures are not taken rapidly, this condition progresses to sudden death.

INCLUDE patients who have had an episode of cardiac arrest evaluated by hospital personnel, and received compressions or defibrillation or cardioversion or cardiac pacing to restore circulation.

EXCLUDE patients that arrive at the hospital in full arrest.

Catheter-Related Blood Stream Infection: Organism cultured from the bloodstream that is not related to an infection at another site but is attributed to a central venous catheter. Patients must have evidence of infection including at least one of the following:

- Criterion 1: Patient has a recognized pathogen cultured from one or more blood cultures and organism cultured from blood is not related to an infection at another site.
- Criterion 2: Patient has at least one of the following signs or symptoms:
  - Fever>38°C
  - Chills
  - WBC> 10,000 or < 3000 per cubic millimeter
  - Hypotension (SBP<90) or >25% drop in systolic blood pressure
  - Signs and symptoms and positive laboratory results are not related to an infection at another site

    AND
  - Common skin contaminant (i.e., diphtheroids [Corynebacterium spp.], Bacillus [not B. anthracis] spp., Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., Micrococcus spp.) is cultured from two or more blood cultures drawn on separate occasions.
- Criterion 3: Patient < 1 year of age has at least one of the following signs or symptoms:
  - Fever (>38°C)
  - Hypothermia (<36°C),
  - Apnea, or bradycardia
  - Signs and symptoms and positive laboratory results are not related to an infection at another site and common skin contaminant (i.e., diphtheroids [Corynebacterium spp.], Bacillus [not B. anthracis] spp., Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., Micrococcus spp.) is cultured from two or more blood cultures drawn on separate occasions.

Erythema at the entry site of the central line or positive cultures on the tip of the line in the absence of positive blood cultures is not considered a CRBSI.

Central Line-Associated Bloodstream Infection: A laboratory-confirmed bloodstream infection (LCBI) where central line (CL) or umbilical catheter (UC) was in place for >2 calendar days on the date of event, with day of device placement being Day 1,
AND

A CL or UC was in place on the date of event or the day before. If a CL or UC was in place for >2 calendar days and then removed, the LCBI criteria must be fully met on the day of discontinuation or the next day. If the patient is admitted or transferred into a facility with a central line in place (e.g., tunneled or implanted central line), and that is the patient's only central line, day of first access as an inpatient is considered Day 1. "Access" is defined as line placement, infusion or withdrawal through the line.

Criterion 1: Patient has a recognized pathogen cultured from one or more blood cultures

AND

Organism cultured from blood is not related to an infection at another site

OR

Criterion 2: Patient has at least one of the following signs or symptoms:

- o fever (>38^{0}C)
- o chills
- o hypotension

AND

Positive laboratory results are not related to an infection at another site

AND

The same common commensal (i.e., diphtheroids [Corynebacterium spp. not C. diphtheriae], Bacillus spp. [not B. anthracis], Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., and Micrococcus spp.) is cultured from two or more blood cultures drawn on separate occasions. Criterion elements must occur within a timeframe that does not exceed a gap of 1 calendar day between two adjacent elements

OR

Criterion 3: Patient ≤ 1 year of age has at least one of the following signs or symptoms:

- o fever (>38^{0}C)
- o hypothermia
- o apnea
- o bradycardia

AND

Positive laboratory results are not related to an infection at another site

AND

The same common commensal (i.e., diphtheroids [Corynebacterium spp. not C. diphtheriae], Bacillus spp. [not B. anthracis], Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., Micrococcus spp.) is cultured from two or more blood cultures drawn on the same or consecutive days and separate occasions. Criterion elements must occur within a timeframe that does not exceed a gap of 1 calendar day between two adjacent elements.

Cerebral Vascular Accident (CVA) / Stroke: A focal or global neurological deficit of rapid onset and NOT present on admission. The patient must have at least one of the following symptoms:

- Change in level of consciousness
- Hemiplegia
- Hemiparesis
- Numbness or sensory loss affecting one side of the body
- Dysphasia or aphasia
- Hemianopia
- Amaurosis fugax
- Or other neurological signs or symptoms consistent with stroke

  AND
- Duration of neurological deficit ≥24 h

OR

- duration of deficit <24 h, if neuroimaging (MR, CT, or cerebral angiography) documents a new hemorrhage or infarct consistent with stroke, or therapeutic intervention(s) were performed for stroke, or the neurological deficit results in death **AND**
- No other readily identifiable nonstroke cause, e.g., progression of existing traumatic brain injury, seizure, tumor, metabolic or pharmacologic etiologies, is identified **AND**
- Diagnosis is confirmed by neurology or neurosurgical specialist or neuroimaging procedure (MR, CT, angiography) or lumbar puncture (CSF demonstrating intracranial hemorrhage that was not present on admission).

Although the neurologic deficit must not present on admission, risk factors predisposing to stroke (e.g., blunt cerebrovascular injury, dysrhythmia) may be present on admission.

Coagulopathy: Twice the upper limit of the normal range for PT or PTT in a patient without a pre-injury bleeding disorder of this magnitude.

Coma: Significantly impaired level of consciousness (exclude transient disorientation or psychosis) for greater than 24 hours. The patient should be unconscious, or postures to painful stimuli, or is unresponsive to all stimuli. Do not include drug-induced coma.

Decubitus Ulcer: Any partial or full thickness loss of dermis resulting from pressure exerted by the patient's weight against a surface. Deeper tissues may or may not be involved. Equivalent to NPUAP Stages II – IV and NPUAP "unstageable" ulcers.

EXCLUDE intact skin with nonblanching redness (NPUAP Stage I), which is considered reversible tissue injury.

Drug or Alcohol Withdrawal Syndrome: Set of symptoms that may occur when a person who has been habitually drinking too much alcohol or habitually using certain drugs (e.g. narcotics, benzodiazepine) experiences physical symptoms upon suddenly stopping consumption. Symptoms may include: activation syndrome (i.e., tremulousness, agitation, rapid heartbeat and high blood pressure), seizures, hallucinations, or delirium tremens.

Deep Vein Thrombosis (DVT)/ Thrombophlebitis: The formation, development, or existence of a blood clot or thrombus within the vascular system, which may be coupled with inflammation. This diagnosis may be confirmed by a venogram, ultrasound, or CT. The patient must be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava.

Extremity Compartment Syndrome: Condition not present at admission in which there is documentation of tense muscular compartments of an extremity through clinical assessment or direct measurement of intracompartmental pressure requiring fasciotomy. Compartment syndromes usually involve the leg but can also occur in the forearm, arm, thigh, and shoulder. Record as a complication if it is originally missed, leading to late recognition, a need for late intervention, and has threatened limb viability.

Graft / Prosthesis / Flap Failure: Mechanical failure of an extracardiac vascular graft or prosthesis including myocutaneous flaps and skin grafts requiring return to the operating room or a balloon angioplasty.

Increased Intracranial Pressure: Intracranial pressure that measures greater than 25 Torr for greater than 30 minutes.

Osteomyelitis: Existence of at least one of the following criteria:

- Organisms cultured from bone.
- Evidence of osteomyelitis on direct examination of the bone during a surgical operation or histopathologic examination.
- At least two of the following signs or symptoms with no other recognized cause:
    - fever (38°C), localized swelling, tenderness, heat, or drainage at suspected site of bone infection and at least one of the following:
        - Organisms cultured from blood
        - Positive blood antigen test (e.g., H. influenzae, S. pneumoniae)
        - Radiographic evidence of infection, e.g., abnormal findings on x-ray, CT scan, magnetic resonance imaging (MRI), radiolabel scan (gallium, technetium, etc.).

Pneumonia: Patients with evidence of pneumonia that develops during the hospitalization. Patients with pneumonia must meet at least one of the following two criteria:

- Criterion 1. Rales or dullness to percussion on physical examination of chest **AND** any of the following:
    - New onset of purulent sputum or change in character of sputum
    - Organism isolated from blood culture
    - Isolation of pathogen from specimen obtained by transtracheal aspirate, bronchial brushing, or biopsy
- Criterion 2. Chest radiographic examination shows new or progressive infiltrate, consolidation, cavitation, or pleural effusion
  AND any of the following:
    - New onset of purulent sputum or change in character of sputum
    - Organism isolated from the blood
    - Isolation of pathogen from specimen obtained by transtracheal aspirate, bronchial brushing, or biopsy
    - Isolation of virus or detection of viral antigen in respiratory secretions
    - Diagnostic single antibody titer (IgM) or fourfold increase in paired serum samples (IgG) for pathogen
    - Histopathologic evidence of pneumonia

Pneumonia Ventilator-Associated: A pneumonia where the patient is on mechanical ventilation for >2 calendar days on the date of event, with day of ventilator placement being Day 1
AND
The ventilator was in place on the date of event or the day before. If the patient is admitted or transferred into a facility on a ventilator, the day of admission is considered Day 1.

VAP ALGORITHM (PNU2 BACTERIAL OR FILAMENTOUS FUNGAL PATHOGENS):

Radiology

Two or more serial chest radiographs with at least **one** of the following:

- New or progressive **and** persistent infiltrate
- Consolidation
- Cavitation
- Pneumatoceles, in infants ≤1 year old

NOTE: In patients **without** underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** chest radiograph is acceptable.

Signs/Symptoms

At least **one** of the following:

- Fever (>38^{0}C or >100.4^{0}F)
- Leukopenia (<4000 WBC/mm^3)or leukocytosis (≥12,000WBC/mm^3)
- For adults ≥70 years old, altered mental status with no other recognized cause

AND at least two of the following:

- o New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements
- o New onset or worsening cough, or dyspnea, or tachypnea
- o Rales or bronchial breath sounds
- o Worsening gas exchange (e.g.,0_2 desaturations (e.g., PaO_2/FiO_2≤240), increased oxygen requirements, or increased ventilator demand)

Laboratory

At least **one** of the following:

- Positive growth in blood culture not related to another source of infection
- Positive growth in culture of pleural fluid
- Positive quantitative culture from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing)
- ≥5% BAL-obtained cells contain intracellular bacteria on direct microscopic exam (e.g., Gram's stain)
- Positive quantitative culture of lung tissue
- Histopathologic exam shows at least **one** of the following evidences of pneumonia:
  - o Abscess formation or foci of consolidation with intense PMN accumulation in bronchioles and alveoli
  - o Evidence of lung parenchyma invasion by fungal hyphae or pseudohyphae

VAP ALGORITHM (PNU2 VIRAL, LEGIONNELLA, AND OTHER BACTERIAL PNEUMONIAS):

Radiology

Two or more serial chest radiographs with at least **one** of the following:

- New or progressive **and** persistent infiltrate
- Consolidation
- Cavitation
- Pneumatoceles, in infants ≤1 year old

NOTE: In patients **without** underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** chest radiograph is acceptable.

Signs/Symptoms

At least **one** of the following:

- Fever (>38^{0}C or >100.4^{0}F)
- Leukopenia (<4000 WBC/mm^3) or leukocytosis (≥12,000WBC/mm^3)
- For adults ≥70 years old, altered mental status with no other recognized cause

AND at least two of the following:

- o New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements

Laboratory

At least **one** of the following:

- Positive culture of virus, Legionella or Chlamydia from respiratory secretions
- Positive non culture diagnostic laboratory test of respiratory secretions or tissue for virus,Bordetella, Chylamydia, Mycoplasma, Legionella (e.g., EIA<FAMA< shell vial assay, PCR,micro-IF)
- Fourfold rise in pared sera (IgG) for pathogen (e.g., influenza viruses, Chlamydia)
- Fourfold rise in L. pneumophila serogroup 1 antibody titer to ≥1:128in pared acute and convalescent sera by indirect IFA

- o New onset or worsening cough, or dyspnea, or tachypnea
- o Rales or bronchial breath sounds
- o Worsening gas exchange (e.g.,0_2 desaturations (e.g.,$PaO_2/FiO_2 \leq 240$), increased oxygen requirements, or increased ventilator demand)

- Detection of Legionella pneumophila serogroup 1 antigens in urine by RIA or EIA

VAP ALGORITHM ALTERNATE CRITERIA (PNU1), FOR INFANT'S ≤1 YEAR OLD:

Radiology	Signs/Symptoms
Two or more serial chest radiographs with at least **one** of the following: • New or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1year old NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** chest radiograph is acceptable	Worsening gas exchange (e.g., O_2 desaturation [e.g. pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand) **AND** at least **three** of the following: • Temperature instability • Leukopenia (<4000 WBC/mm³) **or** leukocytosis (≥15,000WBC/mm³) and left shift (≥10% band forms) • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • Apnea, tachypnea, nasal flaring with retraction of chest wall, or nasal flaring with grunting • Wheezing, rales, or rhonchi • Cough • Bradycardia (<100 beats/min) or tachycardia (>170 beats/min)

VAP ALGORITHM ALTERNATE CRITERIA (PNU1), FOR CHILDREN >1 YEAR OLD OR ≤12 YEARS OLD:

Radiology	Signs/Symptoms/Laboratory
Two or more serial chest radiographs with at least **one** of the following: • New or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1year old NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** chest radiograph is acceptable	At least **three** of the following: • Fever (>38.0^{0}C or >100.4^{0}F) or hypothermia (<36.0^{0}C or <96.8^{0}F) • Leukopenia (<4000 WBC/mm³) **or** leukocytosis (≥15,000WBC/mm³) • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, apnea, or tachypnea • Rales or bronchial breath sounds • Worsening gas exchange (e.g., O_2 desaturations [e.g., pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand

Pulmonary Embolism (PE): Lodging of a blood clot in a pulmonary artery with subsequent obstruction of blood supply to the lung parenchyma. The blood clots usually originate from the deep leg veins or the pelvic venous system. Consider the condition present if the patient

has a V-Q scan interpreted as high probability of pulmonary embolism or a positive pulmonary arteriogram or positive CT angiogram.

Surgical Site Infection (SSI) (superficial): Infection that occurs within 30 days after an operation and involves only skin or subcutaneous tissue of the incision and at least one of the following:

- Purulent drainage, with or without laboratory confirmation, from the superficial incision
- Organisms isolated from an aseptically obtained culture of fluid or tissue from the superficial incision
  OR
- At least one of the following signs or symptoms of infection:
  - pain or tenderness
  - localized swelling
  - redness, or heat
  - superficial incision deliberately opened by the surgeon, unless incision is culture-negative

  AND/OR
  - diagnosis of superficial incisional surgical site infection by the surgeon or attending physician

Do **NOT** report the following conditions as superficial surgical site infection:

- Stitch abscess (minimal inflammation and discharge confined to the points of suture penetration)
- Infected burn wound
- Incisional SSI that extends into the fascial and muscle layers (see deep surgical site infection)

Surgical Site Infection (deep): Deep incisional SSI must meet one of the following criteria:

- Infection occurs within 30 days after the operative procedure if no implant is left in place

OR

- within one year if implant is in place and the infection appears to be related to the operative procedure and involves deep soft tissues (e.g., fascial and muscle layers) of the incision **AND** patient has at least one of the following:

  - purulent drainage from the deep incision but not from the organ/space component of the surgical site
  - a deep incision spontaneously dehisces or is deliberately opened by a surgeon and is culture-positive or not cultured and the patient has at least one of the following signs or symptoms:
    - fever (>38°C), or
    - localized pain or tenderness
  - an abscess or other evidence of infection involving the deep incision is found on direct examination, during reoperation, or by histopathologic or radiologic examination
  - diagnosis of a deep incisional SSI by a surgeon or attending physician.

NOTE: There are two specific types of deep incisional SSIs:

- Deep Incisional Primary (DIP)- a deep incisional SSI that is identified in a primary incision in a patient that has had an operation with one or more incisions (e.g., C-section incision or chest incision for CBGB)

- Deep Incisional Secondary (DIS)-a deep incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (e.g., donor site [leg] incision for CBGB)

REPORTING INSTRUCTIONS: Classify infection that involves both superficial and deep incision sites as deep incisional SSI.

Surgical Site Infection (organ/space): Infection that occurs within 30 days after an operation and infection involves any part of the anatomy (e.g., organs or spaces) other than the incision, which was opened or manipulated during a procedure; and at least one of the following, including:

- Purulent drainage from a drain that is placed through a stab wound or puncture into the organ/space;
- Organisms isolated from an aseptically obtained culture of fluid or tissue in the organ/space;
- An abscess or other evidence of infection involving the organ/space that is found on direct examination, during reoperation, or by histopathologic or radiologic examination; or
- Diagnosis of an organ/space SSI by a surgeon or attending physician.

Sepsis / Severe Sepsis: Obvious source of infection with bacteremia and two or more of the following:

- Temp > 38°C or < 36°C
- White Blood Cell count > 12,000/mm³, or >20% immature (Source of Infection)
- Hypotension – (Severe Sepsis)
- Evidence of hypoperfusion: (Severe Sepsis)
    - Anion gap or lactic acidosis or
    - Oliguria, or
    - Altered mental status

Unplanned Intubation: Patient requires placement of an endotracheal tube and mechanical or assisted ventilation because of the onset of respiratory or cardiac failure manifested by severe respiratory distress, hypoxia, hypercarbia, or respiratory acidosis. In patients who were intubated in the field or Emergency Department, or those intubated for surgery, unplanned intubation occurs if they require reintubation > 24 hours after extubation.

Unplanned Readmission: Unplanned return to the hospital requiring readmission following initial discharge.

Unplanned Return (admission) to the ICU: Unplanned return to the intensive care unit after initial ICU discharge or admission to the ICU after initial transfer to the floor.

EXCLUDE patients in which the ICU care is required postoperatively for a planned surgical procedure.

Unplanned Return to the OR: Unplanned return to the operating room after initial operation management for a similar or related previous procedure.

Urinary Tract Infection: Infection anywhere along the urinary tract with clinical evidence of infection, which includes at least one of the following symptoms with no other recognized cause:

- Fever ≥38°C
- WBC> 10,000 or < 3000 per cubic millimeter
- Urgency
- Frequency
- Dysuria
- Suprapubic tenderness

AND

- positive urine culture (≥100,000 microorganisms per cm^3 of urine with no more than two species of microorganisms)

OR

At least <u>two</u> of the following signs or symptoms with no other recognized cause:

- Fever ≥38°C
- WBC> 10,000 or < 3000 per cubic millimeter
- Urgency
- Frequency
- Dysuria
- Suprapubic tenderness

AND at least <u>one</u> of the following:

- Positive dipstick for leukocyte esterase and/or nitrate
- Pyuria (urine specimen with >10 WBC/mm^3 or >3 WBC/high power field of unspun urine)
- Organisms seen on Gram stain of unspun urine
- At least two urine cultures with repeated isolation of the same uropathogen (gram-negative bacteria or S. saprophyticus) with ≥10^2 colonies/ml in nonvoided specimens
- ≤10^5 colonies/ml of a single uropathogen (gram-negative bacteria or S. saprophyticus) in a patient being treated with an effective antimicrobial agent for a urinary tract infection
- Physician diagnosis of a urinary tract infection
- Physician institutes appropriate therapy for a urinary tract infection

EXCLUDE asymptomatic bacteriuria and “other” UTIs that are more like deep space infections of the urinary tract.

Urinary Tract Infection <u>Catheter-Associated</u> (CAUTI): A UTI where an indwelling urinary catheter was in place for >2 calendar days on the date of event, with day of device placement being Day 1,

AND

An indwelling urinary catheter was in place on the date of event or the day before. If an indwelling urinary catheter was in place for >2 calendar days and then removed, the date of event for the UTI must be the day of discontinuation or the next day for the UTI to be catheter-associated.

Criterion 1:

- ***Criterion 1a:*** Patient must meet 1, 2, **and** 3 below:

1. Patient has an indwelling urinary catheter in place for the entire day on the date of event and such catheter had been in place for >2 calendar days, on that date (day of device placement = Day 1)
2. Patient has at least **one** of the following signs or symptoms:
    - •Fever (>38^{0}C)
    - Suprapubic tenderness with no other recognized cause
    - Costovertebral angle pain or tenderness with no other recognized cause
3. Patient has a urine culture with no more than two species of organisms, at least one of which is a bacteria >10^5 CFU/ml.

OR

- ***Criterion 1b:*** Patient must meet 1, 2, **and** 3 below:
    1. Patient had an indwelling urinary catheter in place for >2 calendar days which was removed on the day of, or day before the date of event
    2. Patient has at least **one** of the following signs or symptoms:
        - Fever (>38^{0}C)
        - Suprapubic tenderness with no other recognized cause
        - Costovertebral angle pain or tenderness with no other recognized cause
        - Urinary urgency with no other recognized cause
        - Urinary frequency with no other recognized cause
        - Dysuria with no other recognized cause
    3. Patient has a urine culture with no more than two species of organisms, at least one of which is a bacteria >10^5 CFU/ml

Criterion 2: Patient must meet 1, 2 **and** 3 below:

1. Patient is ≤1 year of age
2. Patient has at least **one** of the following signs or symptoms:
    - fever (>38.0^{0}C)
    - hypothermia (<36.0^{0}C)
    - apnea with no other recognized cause
    - bradycardia with no other recognized cause
    - lethargy with no other recognized cause
    - vomiting with no other recognized cause
    - suprapubic tenderness with no other recognized cause
3. Patient has a urine culture with no more than two species of organisms, at least one of which is bacteria of ≥10^5 CFU/ml.

Wound Disruption: Separation of the layers of a surgical wound, which may be partial or complete, with disruption of the fascia.

Wound Infection: Drainage of purulent material from surgical wound or active treatment of the wound, including opening a closed wound or antibiotics for the wound.

OTHER TERMS

Dead on arrival (DOA): DOA is defined as arrival at the hospital with no signs of life, but with pre-hospital CPR as indicated below:

- Age >12 years
    - Blunt trauma, more than 5 minutes pre-hospital CPR
    - Penetrating head/neck/abdomen trauma, more than 5 minutes pre-hospital CPR
    - Penetrating chest trauma, more than 15 minutes pre-hospital CPR
- Age ≤ 12 years
    - Blunt trauma, more than 15 minutes pre-hospital CPR
    - Penetrating trauma, more than 15 minutes pre-hospital CPR

Operative and/or essential procedures is defined as procedures performed in the Operating Room, Emergency Department, or Intensive Care Unit that were essential to the diagnoses, stabilization, or treatment of the patient's specific injuries. Repeated diagnostic procedures (e.g., repeated CT scan) should not be recorded (record only the first procedure).

INJURY DESCRIPTIONS

	INJURY DESCRIPTION
14	GCS ≤**14**: Blunt force head injury associated with a Glasgow Coma Scale score of less than or equal to 14. Code may also be used when a strong index of suspicion for blunt head injury exists due to mechanism of injury and/or signs or symptoms such as seizures, unequal pupils, or focal neurological deficits
90	SBP <**90** (<70 if under 1y): Systolic blood pressure less than 90mmHg in a patient greater than one year of age (or systolic blood pressure less than 70mmHg in a patient less than one year of age) following a traumatic event
BA	**B**lunt **A**bdomen: Injury to any of the abdominal quadrants, flanks, or pelvis due to blunt force
BB	**B**lunt **B**ack: Injury to the area from the shoulders to the buttocks (but not including the buttocks) due to blunt force
BC	**B**lunt **C**hest: Injury to the anterior chest in the area between the clavicle and the xyphoid process, bordered on either side by the posterior axillary line, due to blunt force
BD	**B**lunt **D**iffuse Abdominal Tenderness: Blunt force injury to the abdomen resulting in tenderness in two or more quadrants
BE	**B**lunt **E**xtremities: Injury or pain to the shoulders, arms, hands, legs, or feet due to blunt force
BF	**B**lunt **F**ace/mouth: Injury to the anterior aspect of the face, mouth, or skull, from and including the eyebrows, down to and including the angle of the jaw and the ears, due to blunt force
BG	**B**lunt **G**enitals: Injury to the external reproductive structures due to blunt force
BH	**B**lunt **H**ead: Injury to the head or skull in the area from above the eyebrows to behind the ears, due to blunt force. This code can also be applied in association with facial injuries when it is likely that the brain is involved
BI	**B**lunt Amputat**I**on: Amputation proximal to (above) the wrist or ankle due to blunt force
BK	**B**lunt Buttoc**K**s: Injury to the buttocks due to blunt force
BL	**B**lunt Minor **L**acerations: Superficial or non-serious lacerations, abrasions, or contusions involving the skin or subcutaneous tissue, due to blunt force
BN	**B**lunt **N**eck: Injury or pain to the area between the angle of the jaw and clavicles (including probable cervical spine injuries) due to blunt force
BP	**B**lunt Tension **P**neumothorax: Air enters the pleural space due to blunt force, and creates pressure on chest organs. Signs and symptoms can include: SOB, tachypnea, decreased or absent lung sounds on one side, shock, neck vein distention, and/or tracheal deviation
BR	**B**lunt F**R**acture of 2 or more long bones: Blunt force injury resulting in apparent fracture of 2 or more proximal long bones (humerus, femur)
BT	**B**lunt **T**rauma Arrest: Cessation of cardiac output and effective circulation due to blunt force
BU	**BU**rns/Elec. Shock: Thermal or chemical burn, or electric shock
BV	**B**lunt extremity injury with neurological and/or **V**ascular compromise, or one that is crushed, degloved, or mangled due to blunt force
FC	**F**lail **C**hest: Blunt force injury to the chest wall resulting in an unstable chest wall, characterized by paradoxical chest wall movement with respirations

INJURY DESCRIPTION	
IT	**I**npatient **T**rauma: Interfacility transfer (IFT) of an admitted, injured patient from one facility to an inpatient bed at another facility, excluding ER to ER transfers
NA	**N**o **A**pparent Injury: No complaint, or signs or symptoms of injury following a traumatic event
PA	**P**enetrating **A**bdomen: Injury to any of the abdominal quadrants, flanks, or pelvis due to penetrating force
PY	**P**enetrating Back: Injury to the area from the shoulders to the buttocks (but not including the buttocks) due to penetrating force
PC	**P**enetrating **C**hest: Injury to the anterior chest in the area between the clavicle and the xyphoid process, bordered on either side by the posterior axillary line, due to penetrating force
PE	**P**enetrating **E**xtremities: Injury or pain to the shoulders, arms, hands, legs, or feet due to penetrating force
PF	**P**enetrating **F**ace/mouth: Injury to the anterior aspect of the face, mouth, or skull, from and including the eyebrows, down to and including the angle of the jaw and the ears, due to penetrating force
PG	**P**enetrating **G**enitals: Injury to the external reproductive structures due to penetrating force
PH	**P**enetrating **H**ead: Injury to the head or skull in the area from above the eyebrows to behind the ears, due to penetrating force. This code can also be applied in association with facial injuries when it is likely that the brain is involved
PI	**P**enetrating Amputat**I**on: Amputation proximal to (above) the wrist or ankle due to penetrating force
PK	**P**enetrating Buttoc**K**s: Injury to the buttocks due to penetrating force
PL	**P**enetrating Minor **L**acerations (Penetrating): Superficial or non-serious lacerations, abrasions, or contusions involving the skin or subcutaneous tissue, due to penetrating force
PN	**P**enetrating **N**eck: Injury or pain to the area between the angle of the jaw and clavicles (including probable cervical spine injuries) due to penetrating force
PP	**P**enetrating Tension **P**neumothorax: Air enters the pleural space due to penetrating force, and creates pressure on chest organs. Signs and symptoms can include: SOB, tachypnea, decreased or absent lung sounds on one side, shock, neck vein distention, and/or tracheal deviation
PT	**P**enetrating **T**rauma Arrest: Cessation of cardiac output and effective circulation due to penetrating force
PV	**P**enetrating extremity injury with neurological and/or **V**ascular compromise, or one that is crushed, degloved, or mangled due to penetrating force
PX	Penetrating e**X**tremity injury proximal to (above) the knee or elbow due to penetrating force
RR	**RR** <10/>29 (<20 if <1y): A sustained respiratory rate greater than 29 breaths/minute, or respiratory rate of less than 10 breaths/minute (or less than 20 breaths/minute in a patient less than one year of age), following a traumatic event
SC	**S**pinal **C**ord Injury: Suspected spinal cord injury, or presence of weakness/paralysis/parasthesia following a traumatic event
SX	**S**uspected Pelvic Fracture: Suspected pelvic fracture, e**X**cluding isolated hip fractures from a ground level fall

MECHANISM OF INJURY

MECHANISM OF INJURY (MOI)	
15	Fall >**15** ft. (>10 ft. Peds): A vertical, uninterrupted fall of >15 feet for an adult or >10 feet or 3 times the height of the child for a pediatric patient. This mechanism is a subcategory of "Fall." This does not include falling down stairs or rolling down a sloping cliff.
18	Intrusion of >**18** inches into an unoccupied passenger space
20	An unenclosed transport crash (e.g., skateboard, bicycle, horse) with an estimated impact of >**20** mph, not involving a moving auto
AN	**AN**imal Bite: The teeth of a human, reptile, dog, cat, or other animal inflicted an injury, whether or not the skin was punctured.
AS	**AS**sault: Patient was physically assaulted (kicked, punched, strangled, etc.) by means other than stabbing or shooting
CR	**CR**ush: Injury sustained as the result of external pressure being placed on body parts between two opposing forces
EJ	**EJ**ected: Patient was fully or partially thrown from a vehicle, including convertibles and trucks. Does NOT include motorcycles
ES	**E**lectrical **S**hock: Passage of an electrical current through body tissue as a result of contact with an electrical source
EV	**E**nclosed **V**ehicle: Patient involved in collision while in an enclosed vehicle, such as a an automobile, bus, or other enclosed motorized vehicle
EX	**EX**trication: Use of a pneumatic tool was required to remove patient from the vehicle
FA	**FA**ll: Any injury resulting from a fall from any height
GS	**G**un**S**hot Wound (GSW): Injury was caused by discharge of a gun (accidental or intentional)
MM	**M**otorcycle/**M**oped: The patient was riding on a motorcycle or moped at the time of impact; code should be used whenever a motorcycle or moped is involved, other codes may apply (e.g. 20, RT, or PB)
OT	**OT**her: A cause of injury that does not fall into any of the existing categories
PB	**P**edestrian/**B**icyclist/motorcyclist is struck by a motorized vehicle who is NOT thrown or run over, and impact is estimated to be ≤20 MPH
PS	**P**assenger **S**pace Intrusion: Intrusion of >**12** inches into an occupied passenger space of a motor vehicle
RT	Moving auto vs. pedestrian/bicyclist/motorcyclist: **R**un over, **T**hrown, or with an estimated impact of >20 MPH
SA	**S**elf-Inflicted, **A**ccidental: The injury appears to have been accidentally caused by the patient
SF	**S**urvived **F**atal Accident: The patient survived a collision where another person in the same vehicle was fatally injured
SI	**S**elf-Inflicted, **I**ntentional: The injury appears to have been intentionally caused by the patient
SP	**SP**orts/Recreation: Any injury that occurs during a sporting or recreational athletic activity, such as aerobics, football, jogging, etc.
ST	**ST**abbing: A sharp or piercing instrument (e.g. knife, broken glass, ice pick, etc.) was used to cause an injury which penetrated the skin
TB	**T**hermal **B**urn: Burn caused by heat
TD	**T**elemetry **D**ata: Vehicle telemetry data that is consistent with high risk of serious injury
UN	**UN**known: The cause or mechanism of injury is unknown
WR	**W**ork-**R**elated: Injury occurred while patient was working, and may be covered by Worker's Compensation

APPENDIX 2:
Auto-calculated Variables

Abbreviated Injury Scale (six body regions)

Definition: The Abbreviated Injury Scale (AIS) is an anatomical scoring system first introduced in 1969. Since this time it has been revised and updated against survival to provide a ranking the severity of injury. AIS scores are available for six body regions; Head (or neck), Face, Chest, Abdominal, Extremities (including pelvis) and External. The AIS is monitored by a scaling committee of the Association for the Advancement of Automotive Medicine.

Calculation: Injuries are ranked on a scale of 1 to 6, with 1 being minor, 5 severe and 6 an un-survivable injury. This represents the 'threat to life' associated with an injury and is not meant to represent a comprehensive measure of severity. The AIS is not a true scale, in that the difference between any two AIS scores is not the same as the difference between another set of two scores.

FIPS code (location code)

Definition: Federal Information Processing Standards codes (FIPS codes) are a standardized set of numeric codes issued by the National Institute of Standards and Technology (NIST) to ensure uniform identification of geographic entities. The entities covered include: states, counties, cities and other statistically equivalent entities.

Calculation: An overall FIPS code is calculated by concatenating individual FIPS codes for state (2-digit FIPS code), county (3-digit FIPS code) and city (5-digit FIPS code) in that order.

Injury Severity Score

Definition: The Injury Severity Score (ISS) is an anatomical scoring system that provides an overall score for patients with multiple injuries.

Calculation: Each injury is assigned an Abbreviated Injury Scale (AIS) score and is allocated to one of six body regions (Head, Face, Chest, Abdomen, Extremities (including Pelvis) and External). The 3 most severely injured body regions have their AIS score squared and added together to produce the ISS score. Only the highest AIS score in each body region is used. The ISS score takes values from 0 to 75. If an injury is assigned an AIS of 6 (un-survivable injury), the ISS score is automatically assigned to 75.

Overall GCS - EMS score (adult and pediatric)

Definition: A scale calculated in the out-of-hospital setting which evaluates the patient's initial level of awareness, which indirectly indicates the extent of neurologic injury. The score is based upon three categories of patient responses; eye opening, verbal response, and motor response. The lowest score is 3 and is indicative of no response, the highest score is 15, indicates the patient is alert and aware of his or her surroundings.

Calculation: Initial Field GCS Eye + Initial Field GCS Verbal + Initial Field GCS Motor

Overall GCS - ED score (adult and pediatric)

Definition: A scale calculated in the emergency department (ED) or hospital setting which evaluates the patient's initial (upon arrival) level of awareness, which indirectly indicates the extent of neurologic injury. The score is based upon three categories of patient responses; eye opening, verbal response, and motor response. The lowest score is 3 and is indicative of no response, the highest score is 15, indicates the patient is alert and aware of his or her surroundings.

Calculation: Initial ED/Hospital GCS Eye + Initial ED/Hospital GCS Verbal + Initial ED/Hospital GCS Motor

Revised Trauma Score - EMS (adult and pediatric)

Definition: The Revised Trauma Score is a physiological scoring system used to predict death from injury or need for trauma center care. It is scored based upon the initial vital signs obtained from the patient in the out-of-hospital setting.

Calculation: RTS = 0.9368 (Initial Field GCS Total) + 0.7326 (Initial Field Systolic Blood Pressure) + 0.2908 (Initial Field Respiratory Rate)

Revised Trauma Score - ED (adult and pediatric)

Definition: The Revised Trauma Score is a physiological scoring system used to predict death from injury or need for trauma center care. It is scored based upon the initial vital signs obtained from the patient in the ED or hospital setting

*Calculation: RTS = 0.9368 (Initial ED/Hospital GCS Total) + 0.7326 (Initial ED/Hospi*tal Systolic Blood Pressure) + 0.2908 (Initial ED/Hospital Respiratory Rate)

Total ED Time

Definition: The total elapsed time the patient was in the emergency department (ED).

Calculation: ED Discharge Date/Time – ED/Hospital Arrival Date/Time

Total Length of Hospital Stay

Definition: The total elapsed time the patient was in the hospital.

Calculation: Hospital Discharge Date/Time – ED/Hospital Arrival Date/Time

STEMI RECEIVING CENTER DATA DICTIONARY

Los Angeles County

Emergency Medical Services Agency

TABLE OF CONTENTS

INCLUSION CRITERIA

1) STEMI patients:

- **Patients with STEMI identified in the field by:**
  - **Software** ECG interpretation of STEMI
  - **Paramedic** ECG interpretation of STEMI
- **Patients transported by 911 with an ED interpretation of STEMI**:
  - Identified by physician over-read of a prehospital ECG
  - Identified on the first ED ECG
  - Identified on a subsequent ED ECG within 1 hour of arrival
- **ED inter-facility transfer (IFT) to the SRC via 911 or other ALS transport for suspected STEMI to be evaluated for emergent PCI** (includes Nurse Critical Care Interfacility Transports)

2) Cardiac arrest patients:

- **9-1-1 ALS**, non-traumatic, adult, patients with out-of-hospital cardiac arrest (OHCA) and return of spontaneous circulation **(ROSC)** at any point in the acute phase (field, ED or cath lab).
- Patient with STEMI complicated by cardiac arrest, with or without ROSC, in the acute phase (field, ED or cath lab).

STEMI?

Definition

Patients with a STEMI identified on the field or ED ECG

Field Values

- Yes
- No

Additional Information

- **Includes**
  - **Patients with STEMI identified in the field by:**
    - **Software** ECG interpretation of STEMI
    - **Paramedic** ECG interpretation of STEMI
  - **Patients transported by 911 with an ED interpretation of STEMI**:
    - Identified by physician over-read of a prehospital ECG
    - Identified on the first ED ECG
    - Identified on a subsequent ED ECG within 1 hour of arrival
  - **ED inter-facility transfer (IFT) to the SRC via 911 or other ALS transport for suspected STEMI to be evaluated for emergent PCI** (includes Nurse Critical Care Interfacility Transports)

Uses

- Identify patients for inclusion
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- SRC Log
- ED Records

CARDIAC ARREST?

Definition

Patients who suffer a non-traumatic cardiac arrest

Field Values

- Yes
- No

Additional Information

- Includes:
  - All patients with **out-of-hospital cardiac arrest** AND **return of spontaneous circulation**, whether transient or sustained, in the acute phase (field, ED or cath lab)
  - **All STEMI patients complicated by a cardiac arrest,** with or without ROSC, in the acute phase (field, ED, cath lab)

Uses

- Identify patients for inclusion
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- SRC Log
- ED Records
- Cath Lab Records

GENERAL INFO

SEQUENCE NUMBER

Definition

Unique alphanumeric EMS record number found pre-printed at the top right corner of EMS report form hard copies, or electronically assigned to electronic patient care records (ePCRs) from approved providers

Additional Information

- Data entry cannot begin without this number
- Consists of two letters and six digits on pre-printed EMS Report Forms; or two letters, ten digits if obtained from an approved ePCR provider
- If sequence number is missing or incorrectly documented, every effort must be taken to obtain it – by reviewing the patient's medical record, or by contacting either the Prehospital Care Coordinator of the applicable base hospital, or the provider who transported the patient

Uses

- Unique patient identifier

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- Base Hospital Log
- Fire Station Logs
- SRC Log

PROVIDER

Definition

Two-letter code for the EMS provider primarily responsible for the patient's prehospital care

Field Values

PUBLIC PROVIDERS			
AF	Arcadia Fire	LV	La Verne Fire
AH	Alhambra Fire	MB	Manhattan Beach Fire
AV	Avalon Fire	MF	Monrovia Fire
BA	Burbank Airport Fire	MO	Montebello Fire
BF	Burbank Fire	MP	Monterey Park Fire
BH	Beverly Hills Fire	ND	Not Documented
CB	LA County Beaches	OT	Other Provider
CC	Culver City Fire	PF	Pasadena Fire
CF	LA County Fire	RB	Redondo Beach Fire
CG	US Coast Guard	SA	San Marino Fire
CI	LA City Fire	SG	San Gabriel Fire
CM	Compton Fire	SI	Sierra Madre Fire
CS	LA County Sheriff	SM	Santa Monica Fire
DF	Downey Fire	SP	South Pasadena Fire
ES	El Segundo Fire	SS	Santa Fe Springs Fire
FS	U.S. Forest Service	TF	Torrance Fire
GL	Glendale Fire	VE	Ventura County Fire
HB	Hermosa Beach Fire	WC	West Covina Fire
LB	Long Beach Fire	VF	Vernon Fire
LH	La Habra Heights Fire		
PRIVATE PROVIDERS			
AA	American Professional Ambulance Corp.	LT	Liberty Ambulance
AC	Americare Ambulance Service	MI	MedResponse, Inc.
AE	Aegis Ambulance Service	MR	MedReach Ambulance
AN	Antelope Ambulance Service	MS	Medi-Star Transport
AR	American Medical Response	MY	Mercy Air
AT	All Town Ambulance	PM	PRN Ambulance, Inc.
AU	AmbuServe Ambulance	PT	Priority One
AW	AMWest Ambulance	RE	REACH Air Medical Service
BO	Bowers Companies, Inc.	RR	Rescue Services International
CA	CARE Ambulance	SC	Schaefer Ambulance
EX	Explorer 1 Ambulance & Medical Services	SY	Symons Ambulance
GC	Gentle Care Transport	WE	Westcoast Ambulance
GU	Guardian Ambulance Service	WM	West Med/McCormick Amb Service
IA	Impulse Ambulance		

Uses

- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form

ALS UNIT

Definition

Number assigned to the Advanced Life Support (ALS) provider unit that transported the patient

Field Values

- Up to three-digit numeric field
- ND: Not Documented

Uses

- System evaluation and monitoring

Data Hierarchy

- EMS Report Form
- Base Hospital Form
- Base Hospital Log
- SRC Log
- ED Records

PATIENT AGE

Definition

Numeric value for the age (actual or best approximation) of the patient

Field Values

- Up to three-digit numeric value
- ND**:** Not Documented

Uses

- Allows for data sorting and tracking by age
- Assists with patient identification
- Epidemiological statistics
- System evaluation and monitoring

Data Source Hierarchy

- Facesheet
- ED Records
- History and Physical
- EMS Report Form
- Base Hospital Form
- Base Hospital Log
- Billing Sheet / Medical Records Coding Summary Sheet
- SRC Log

PATIENT GENDER

Definition

Checkbox indicating the gender of the patient

Field Values

- **F:** Female
- **M:** Male
- **U:** Unknown

Additional Information

- Transgender patients should be coded using their stated preference
- Patients unable to state their preference should be coded according to best medical judgment/observation

Uses

- Assists with patient identification
- Epidemiological statistics
- System evaluation and monitoring

Data Source Hierarchy

- Facesheet
- ED Records
- History and Physical
- EMS Report Form
- Base Hospital Form
- Base Hospital Log
- Billing Sheet / Medical Records Coding Summary Sheet
- SRC Log

RACE/ETHNICITY

Definition

Checkbox indicating the race and/or ethnicity of the patient

Field Values

- **B:** Black/African American: person having origins in any of the Black racial groups of Africa (includes Haitians)
- **A:** Asian/Non Pacific Islander: person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam
- **H:** Latino/Hispanic: person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race
- **N:** Native American/Alaska Native: person having origins in any of the original peoples of North, Central, and South America and who maintains tribal affiliation or community attachment
- **P:** Pacific Islander/Native Hawaiian: person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
- **W:** White: person having origins in any of the original peoples of Europe, the Middle East, or North Africa (e.g., Caucasian, Iranian, White)
- **O:** Other
- **ND:** Not Documented: race is unknown or not documented

Additional Information

- Patient race/ethnicity should be coded as stated by patient or family member

Uses

- Epidemiological statistics
- System evaluation and monitoring

Data Source Hierarchy

- Facesheet
- ED Records
- History and Physical
- Billing Sheet / Medical Records Coding Summary Sheet

CHIEF COMPLAINT

Definition

Two-letter code(s) representing the patient's most significant medical complaints

Field Values

AD	Agitated Delirium
AP	Abdominal/Pelvic Pain
AR	Allergic Reaction
AL	Altered Level of Consciousness
AE	Apneic Episode
EH	Behavioral (abnormal behavior of apparent mental or emotional origin)
OS	Bleeding: Other Site (NOT associated with trauma, e.g., dialysis shunt)
CA	Cardiac Arrest (NOT associated with trauma)
CP	Chest Pain (NOT associated with trauma)
CH	Choking/Airway Obstruction
CC	Cough/Congestion
DC	Device Complaint (associated with existing medical device, e.g., g-tube, AICD, ventilator, etc.)
DI	Dizzy (sensation of spinning or feeling off-balance – code weakness separately)
DY	Dysrhythmia
FE	Fever
FB	Foreign Body (anywhere In body)
GI	Gastrointestinal Bleeding
HP	Head Pain (NOT associated with trauma)
HY	Hypoglycemia
IM	Inpatient Medical Interfacility Transfer (IFT) of an admitted, ill (NOT injured) patient, from one facility to an inpatient bed at another facility, excluding ER To ER transfers
LN	Local Neuro signs (e.g., weakness, numbness, paralysis, slurred speech, facial droop, aphasia)
NV	Nausea/Vomiting
ND	Near-Drowning/Drowning (submersion causing water inhalation, unconsciousness, or death)
NB	Neck/Back Pain (NOT associated with trauma)
NC	No Medical Complaint, or signs or symptoms of illness (NOT associated with trauma)
NO	Nosebleed (NOT associated with trauma)
OB	Obstetrics (any complaint possibly related to a known pregnancy, e.g., bleeding, pain, hypertension)
OP	Other Pain (pain at site not listed, NOT associated with trauma – e.g., toothache, earache, etc.)
OD	Overdose (dose greater than recommended or generally given)
PO	Poisoning (ingestion of or contact with a toxic substance)
PS	Palpitations
RA	Respiratory Arrest (cessation of breathing NOT associated with trauma)
SE	Seizure (NOT associated with trauma)
SB	Shortness of Breath
SY	Syncope
VA	Vaginal Bleeding
WE	Weakness
OT	Other (signs or symptoms not listed above, NOT associated with trauma)
N/D	Not Documented

Additional Information

- Enter up to three complaints, if applicable, by pressing down and holding the "Control/Ctrl" key while making your selections
- Electrical shock, lightning strike, and hanging are mechanisms of injury rather than chief complaints – use "Other" and document the injury description in the comment section of the General Info tab

Uses

- System evaluation and monitoring
- Epidemiological statistics

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- Base Hospital Log
- SRC Log
- ED Records
- History and Physical

DIVERTED FROM MAR?

Definition

Checkbox indicating if the Most Accessible Receiving hospital (MAR) was bypassed to transport a patient to a STEMI Receiving Center (SRC), if applicable

Field Values

- **Y:** Yes
- **N:** No
- **ND**: Not Documented

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- SRC Log

HOSP. DISCHARGE DATE

Definition

Date the patient was discharged from the acute care unit at your facility

Field Values

- MMDDYYYY
- ND: Not Documented

Additional Information

- Applicable when the patient:
  - Expires
  - Is discharged
  - Leaves against medical advice (AMA)
  - Leaves without being seen (LWBS) or elopes
  - Is transferred to a rehabilitation, skilled nursing, or hospice unit (at your facility, or another facility)
  - Is transferred to an acute inpatient unit at another facility

Uses

- Provides documentation of care
- System evaluation and monitoring

Data Source Hierarchy

- Hospital Discharge Summary
- Progress Notes
- Billing Sheet / Medical Records Coding Summary Sheet

OUTCOME

Definition

Checkbox indicating whether the patient lived or died during their hospital stay at your facility

Field Values

- **L:** Lived
- **ED:** Died in ED
- **CL:** Died in Cath Lab
- **OT:** Died in Other
- **ND:** Not Documented

Additional Information

- If patient died in the Emergency Department (ED), ED Pronounced Time must have a value

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Hospital Discharge Summary
- ED Records
- Progress Notes
- Billing Sheet / Medical Records Coding Summary Sheet

ED PRONOUNCED TIME

Definition

Time of day patient was pronounced dead at your facility's Emergency Department, if applicable

Field Values

- HHMM
- ND: Not Documented

Uses

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- Hospital Discharge Summary
- Billing Sheet / Medical Records Coding Summary Sheet

DNR STATUS

Definition

Field indicating the patient's Do Not Resuscitate status

Field Values

- **E:** Existing (DNR order in place upon arrival)
- **NE:** New (DNR order written during hospital stay)
- **NO:** None (patient does not have a DNR order)

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- ED Records
- Other SRC Hospital Records
- Progress Notes
- Hospital Discharge Summary
- Hospital Discharge Summary

COMORBIDITIES

Definition
Field indicating whether co-morbid conditions or factors were also present (check all that apply)

Field Values

- **BM:** Body Mass Index greater than 40
- **BP:** Hypertension
- **CG:** Prior CABG
- **CH:** Congestive Heart Failure
- **CO:** Chronic Obstructive Pulmonary Disease
- **CS:** Cardiogenic Shock on presentation
- **CV:** Cerebrovascular Disease
- **DM:** Diabetes
- **ES:** End-stage Renal Disease
- **HX:** Family History of Coronary Artery Disease (CAD)
- **HL:** Hyperlipidemia
- **MI:** Prior Myocardial Infarction
- **PC:** Prior Percutaneous Coronary Intervention (PCI)
- **PV:** Peripheral Vascular Disease
- **SM:** Smoker - current/recent Tobacco (within 1 year)
- **SP:** Sepsis
- **ND:** Not Documented

Additional Information

- Enter multiple selections, if applicable, by pressing down and holding the “Control/Ctrl” key while making your selections
- Body Mass Index is calculated as weight in kg divided by height in meters-squared
- Cerebrovascular disease is defined as history of TIA or stroke
- End-stage renal disease is defined as patient receiving peritoneal or hemodialysis
- Family history of coronary artery disease is defined as a parent or sibling with history of myocardial infarction, PCI and/or CABG
- Cardiogenic shock is defined as :
    - Sustained (>30 min) episode of systolic blood pressure <90mm Hg **and/or**
    - Cardiac index <2.2L/min/m^2 determined to be secondary to cardiac dysfunction **and/or**
    - Requires parenteral inotropic or vasopressor agents **OR**
    - Requires mechanical support (from an IABP, extracorporeal circulation, ventricular assist devices, etc.) to maintain blood pressure and cardiac index above specified levels

Uses

- Provides documentation of assessment
- Assists with determination of appropriate treatment

- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- Progress Notes
- Hospital Discharge Summary
- Billing Sheet / Medical Records Coding Summary Sheet

HOSP. DISPOSITION

Definition

Checkbox indicating the patient's destination upon discharge from the acute care unit at your facility

Field Values

- **Home:** Home/Previous residence
- **SNF:** Extended Care/SNF
- **Subacute:** Sub-Acute/Transitional Care/Rehabilitation Care Facility
- **Acute:** Other Acute Care Facility
- **Morgue:** Morgue/Mortuary
- **AMA:** Left Against Medical Advice (AMA)/Eloped/Left Without Being Seen (LWBS)
- **Other:** Other
- **ND:** Not Documented

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Hospital Discharge Summary
- Progress Notes
- Billing Sheet / Medical Records Coding Summary Sheet

STEMI

EARLIEST REPORTED SYMPTOM ONSET DATE

Definition

Date when the patient first noted to have symptoms lasting longer than ten minutes

Field Values

- Collected as MMDDYYYY
- ND: Not Documented

Additional Information

- If symptoms are intermittent, symptom onset can be determined by when the symptoms became constant in quality or intensity
- Symptoms may include jaw pain, arm pain, shortness of breath, nausea, vomiting, fatigue/malaise, or other symptoms suggestive of a myocardial infarction
- If the symptom onset date is estimated, mark the “Est.” checkbox

Uses

- Establishes care intervals and incident timelines
- Provides documentation of assessment
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- Progress Notes
- EMS Report Form
- Base Hospital Form
- Physician’s Office/Clinic/Urgent Care Records

EARLIEST REPORTED SYMPTOM ONSET TIME

Definition

Time of day when the patient first noted to have symptoms lasting longer than ten minutes

Field Values

- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Additional Information

- If symptom onset time is not specified, it may be recorded as:
  - 0700 for morning
  - 1200 for lunchtime
  - 1500 for afternoon
  - 1800 for dinnertime
  - 2200 for evening
  - 0300 if awakened from sleep
- If the symptom onset time is estimated, mark the “Est.” checkbox

Uses

- Establishes care intervals and incident timelines
- Provides documentation of assessment
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- Progress Notes
- EMS Report Form
- Base Hospital Form
- Physician’s Office/Clinic/Urgent Care Records

TRANSFER?

Definition

Checkbox indicating whether the patient was transferred to the SRC from another acute care facility

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- SRC Log
- ED Records

TRANSFERRING FACILITY

Definition

Three-letter code of the facility **from which the patient was transferred**, if applicable

Field Values

LOS ANGELES COUNTY 9-1-1 RECEIVING HOSPITALS			
ACH	Alhambra Community Hospital	NOR	LA Community Hospital of Norwalk
AVH	Antelope Valley Medical Center	LAD	Los Angeles Metro Hospital
BEV	Beverly Hospital	DFM	Marina Del Rey Hospital
BMC	Southern Calif. Hospital at Culver City	MLK	Martin Luther King Jr. Community Hospital
CAL	California Medical Center	MHG	Memorial Hospital of Gardena
AHM	Catalina Island Medical Center	AMH	Methodist Hospital of Southern California
CSM	Cedars-Sinai Medical Center	MCP	Mission Community Hospital
CNT	Centinela Hospital Medical Center	MPH	Monterey Park Hospital
CHH	Children's Hospital Los Angeles	NRH	Northridge Hospital Medical Center
ICH	Citrus Valley – Intercommunity	MID	Olympia Medical Center
QVH	Citrus Valley – Queen of the Valley	PAC	Pacifica Hospital of the Valley
CPM	Coast Plaza Doctors Hospital	PLB	College Medical Center
CHP	Community Hospital of Huntington Park	PVC	Pomona Valley Hospital Medical Center
LBC	Community Hospital of Long Beach	PIH	PIH Health Hospital – Whittier
DCH	PIH Health Hospital – Downey	HCH	Providence Holy Cross Medical Center
ELA	East Los Angeles Doctors	SPP	Providence Little Co. of Mary San Pedro
HEV	East Valley Hospital	LCM	Providence Little Co. of Mary Torrance
ENH	Encino Hospital Medical Center	SJH	Providence Saint John's Health Center
FPH	Foothill Presbyterian Hospital	SJS	Providence Saint Joseph Medical Center
GAR	Garfield Medical Center	TRM	Providence Tarzana Medical Center
GWT	Glendale Adventist Medical Center	QOA	Queen of Angels/Hollywood Presbyterian
GMH	Glendale Memorial Hospital	UCL	Ronald Reagan UCLA Medical Center
GSH	Good Samaritan Hospital	SFM	Saint Francis Medical Center
GEM	Greater El Monte Community	SMM	Saint Mary Medical Center
HGH	Harbor-UCLA Medical Center	SVH	Saint Vincent Medical Center
HMN	Henry Mayo Newhall Hospital	SDC	San Dimas Community
HMH	Huntington Memorial Hospital	SGC	San Gabriel Valley Medical Center
KFA	Kaiser Permanente Baldwin Park	SMH	Santa Monica-UCLA Medical Center
KFB	Kaiser Permanente Downey Med Ctr	SOC	Sherman Oaks Community Hospital
KFL	Kaiser Permanente Los Angeles Med Ctr	TOR	Torrance Memorial Med Ctr
KFP	Kaiser Permanente Panorama City Hosp	TRI	Tri-City Regional Med Ctr
KFH	Kaiser Permanente South Bay Med Ctr	VPH	Valley Presbyterian Hospital
KFW	Kaiser Permanente West LA Med Ctr	VHH	USC Verdugo Hills Hospital
KFO	Kaiser Foundation Woodland Hills	HWH	West Hills Hospital & Medical Center
OVM	LAC Olive View Medical Center	WMH	White Memorial Medical Center
USC	LAC USC Medical Center	WHH	Whittier Hospital Medical Center
DHL	Lakewood Regional Medical Center	WVA	Wadsworth Veterans Administration
LCH	Palmdale Regional Medical Center	OT	Other
LBM	Long Beach Memorial Medical Center	ND	Not Documented

OUT OF COUNTY 9-1-1 RECEIVING HOSPITALS / OTHER			
LRR	Los Robles Hospital & Med Ctr (Ventura)	SJD	Saint Jude Medical Center (Orange)

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- SRC Log
- ED Records
- Progress Notes

SRF ED ARRIVAL DATE

Definition

Date the patient arrived at the STEMI Referral Center (SRF) ED

Field Values

- Collected as MMDDYYYY
- ND: Not Documented

Uses

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- SRF Facesheet
- SRC Records
- EMS Report Form
- SRC Log
- SRC ED Records
- Other SRC Hospital Records

SRF ED ARRIVAL TIME

Definition

Time of day the patient arrived at the SRF ED

Field Values

- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Uses

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- SRF Facesheet
- SRF Records
- EMS Report Form
- SRC Log
- SRC ED Records
- Other SRC Hospital Records

1st SRF STEMI ECG DATE

Definition

Date the first ECG performed at the SRF was interpreted as STEMI

Field Values

- Collected as MMDDYYYY
- ND: Not Documented

Uses

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- Provides documentation of care
- System evaluation and monitoring

Data Source Hierarchy

- SRF ED Records
- SRF Progress Notes
- SRF ECG Tracing
- EMS Report Form
- Base Hospital Form
- SRC Log

1st SRF STEMI ECG TIME

Definition

Time of day the first ECG performed at the SRF was interpreted as STEMI

Field Values

- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Uses

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- Provides documentation of care
- System evaluation and monitoring

Data Source Hierarchy

- SRF ED Records
- SRF Progress Notes
- SRF ECG Tracing
- EMS Report Form
- Base Hospital Form
- SRC Log

SRF ED DEPARTURE DATE

Definition

Date the patient left the SRF ED en route to the SRC ED

Field Values

- Collected as MMDDYYYY
- ND: Not Documented

Uses

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- SRF Facesheet
- SRF Records
- EMS Report Form
- SRC Log
- SRC ED Records
- Other SRC Hospital Records

SRF ED DEPARTURE TIME

Definition

Time of day the patient left the SRF en route to the SRC ED

Field Values

- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Additional Information

- If departure time is not documented by the SRF, it is acceptable to use the departure time documented by the medic on the EMS Report Form

Uses

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- SRF Facesheet
- SRF ED Records
- EMS Report Form
- SRC Log
- SRC ED Records
- Other SRC Hospital Records

DISPATCH TIME

Definition

Dispatch time of EMS as documented on the EMS Report Form

Field Values

- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Uses

- Establishes care intervals and incident timelines
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form

FIELD ECG PERFORMED?

Definition

Checkbox indicating whether an ECG was performed prior to the patient's arrival at the SRC ED

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

Uses

- Assists with determination of appropriate treatment
- Provides documentation of care
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- Physician's Office/Clinic/Urgent Care Records
- SRC Log
- ED Records
- Progress Notes

1st FIELD ECG DATE

Definition

Date of the first ECG performed prior to the patient's arrival at the SRC ED

Field Values

- Collected as MMDDYYYY
- ND: Not Documented

Additional Information

- Enter the date of the very first ECG, regardless of impression

Uses

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- Provides documentation of care
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- Physician's Office/Clinic/Urgent Care Records
- SRC Log
- ECG Tracing
- ED Records
- Progress Notes

1st FIELD ECG TIME

Definition

Time of day of the first ECG performed prior to the patient's arrival at the SRC ED

Field Values

- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Additional Information

- Enter the time of the very first ECG, regardless of impression

Uses

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- Provides documentation of care
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- Physician's Office/Clinic/Urgent Care Records
- SRC Log
- ECG Tracing
- ED Records
- Progress Notes

1st FIELD ECG PERFORMED BY

Definition

Checkbox indicating who performed the first ECG prior to the patient's arrival at the SRC ED

Field Values

- **EMS:** EMS Personnel
- **Clinic:** Physician's office, clinic, urgent care, other facility where medical care provided, etc.
- **ND:** Not Documented

Additional Information

- Enter the information from the very first ECG, regardless of impression

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- Physician's Office/Clinic/Urgent Care Records
- ED Records
- Progress Notes

FIELD SOFTWARE IDENTIFIED STEMI?

Definition

Checkbox indicating whether STEMI was identified by EMS field software

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

Additional Information

- Indicate yes only if the software interpretation is ***MEETS ST ELEVATION MI CRITERIA*** (Physio Control) or ***ST Elevation Acute MI*** (Zoll) or other manufacturer equivalent

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- ECG Tracing
- ED Records

1st FIELD STEMI ECG DATE

Definition

Date of the first ECG performed prior to the patient's arrival at the SRC ED that was interpreted as STEMI

Field Values

- Collected as MMDDYYYY
- ND: Not Documented

Uses

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- Provides documentation of care
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- Physician's Office/Clinic/Urgent Care Records
- SRC Log
- ECG Tracing
- ED Records
- Progress Notes

1st FIELD STEMI ECG TIME

Definition

Time of day of the first ECG performed prior to the patient's arrival at the SRC ED that was interpreted as STEMI, if applicable

Field Values

- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Uses

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- Provides documentation of care
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- Physician's Office/Clinic/Urgent Care Records
- SRC Log
- ECG Tracing
- ED Records
- Progress Notes

WAS THE FIELD ECG RECEIVED PRIOR TO PATIENT ARRIVAL?

Definition

Checkbox indicating whether a transmitted copy of the pre-SRC ECG was received by the SRC ED prior to the patient's arrival

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ECG Receiving Equipment (Cloud/Xchanger/Email/Fax)
- SRC Log
- ED Records

FIELD ECG RECEIVED DATE

Definition

Date the field ECG was received by your facility's ECG receiving equipment

Field Values

- Collected as MMDDYYYY
- ND: Not Documented

Additional Information

- ECG receiving equipment includes the Cloud, Xchanger, email (gmail, etc.), or fax

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ECG Receiving Equipment (Cloud/Xchanger/Email/Fax)
- SRC Log
- ED Records

FIELD ECG RECEIVED TIME

Definition

Time of day the field ECG was received by your facility's ECG receiving equipment

Field Values

- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Additional Information

- ECG receiving equipment includes the Cloud, Xchanger, email (gmail, etc.), or fax

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ECG Receiving Equipment (Cloud/Xchanger/Email/Fax)
- SRC Log
- ED Records

SRC ED ARRIVAL DATE

Definition

Date the patient arrived at the SRC ED

Field Values

- Collected as MMDDYYYY

Additional Information

- If the patient bypassed the ED and was transported directly to the cath lab, enter the cath lab door date

Uses

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- SRC Log
- ED Records
- EMS Report Form
- Other Hospital Records

SRC ED ARRIVAL TIME

Definition

Time of day the patient arrived at the SRC ED

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- If the patient bypassed the ED and was transported directly to the cath lab, enter the cath lab door time

Uses

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- SRC Log
- ED Records
- EMS Report Form
- Other Hospital Records

ED ECG PERFORMED?

Definition

Checkbox indicating whether an ECG was performed in the SRC ED

Field Values

- **Y:** Yes
- **N:** No

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ECG Tracing
- ED Records
- Other Hospital Records

INITIAL SRC ED ECG DATE

Definition

Date the initial ECG was performed at the SRC ED

Field Values

- Collected as MMDDYYYY
- ND: Not Documented

Additional Information

- Enter the date of the very first ECG performed, regardless of impression

Uses

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ECG Tracing
- ED Records
- Progress Notes
- Other Hospital Records

INITIAL SRC ED ECG TIME

Definition

Time of day the initial ECG was performed at the SRC ED

Field Values

- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Additional Information

- Enter the time from the very first ECG, regardless of impression

Uses

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ECG Tracing
- ED Records
- Progress Notes
- Other Hospital Records

STEMI IDENT. ON INITIAL SRC ED ECG?

Definition

Checkbox indicating whether the **initial** ECG performed at the SRC ED had a physician interpretation of STEMI

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

Uses

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ECG Tracing
- ED Records
- Progress Notes
- Other Hospital Records

STEMI IDENT. ON SUBSEQUENT SRC ED ECG?

Definition

Checkbox indicating whether a subsequent ECG performed at the SRC ED had a physician interpretation of STEMI

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

Additional Information

- Only enter when the initial SRC ED ECG is negative for STEMI and there is a repeat ECG positive for STEMI

Uses

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ECG Tracing
- ED Records
- Progress Notes
- Other Hospital Records

SUBSEQUENT SRC ED STEMI ECG DATE

Definition

Date that a subsequent ECG performed at the SRC ED had a physician interpretation of STEMI

Field Values

- Collected as MMDDYYYY
- ND: Not Documented

Additional Information

- Only enter the date of the subsequent SRC ED ECG when the initial SRC ED ECG is negative for STEMI and there is a repeat ECG positive for STEMI

Uses

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ECG Tracing
- ED Records
- Progress Notes
- Other Hospital Records

SUBSEQUENT SRC ED STEMI ECG TIME

Definition

Time of day that a subsequent ECG performed at the SRC ED had a physician interpretation of STEMI

Field Values

- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Additional Information

- Only enter the time of the subsequent SRC ED ECG when the initial SRC ED ECG is negative for STEMI and there is a repeat ECG positive for STEMI

Uses

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ECG Tracing
- ED Records
- Progress Notes
- Other Hospital Records

SRC ED SBP

Definition

Patient's initial ED systolic blood pressure

Field values

- Up to three-digit numeric field

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- Progress Notes
- Other Hospital Records

SRC ED HR

Definition

Patient's initial ED heart rate

Field values

- Up to three-digit numeric field

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- Progress Notes
- Other Hospital Records

ELEVATED TROPONIN?

Definition

Was the troponin elevated above lab threshold within the first 24 hours from SRC ED arrival?

Field values

- **Y:** Yes
- **N:** No

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Lab Records
- Progress Notes
- Other Hospital Records
- ED Records

PEAK TROPONIN VALUE

Definition

The highest troponin value recorded within the first 24 hours from SRC ED arrival

Field Values

- Up to three-digit numeric value

Additional Information

- Include decimals when indicated

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Lab Records
- Progress Notes
- Other Hospital Records
- ED Records

FIBRINOLYTIC INFUSION?

Definition

Checkbox indicating whether the patient received a fibrinolytic infusion at the SRF or SRC ED as an urgent treatment for a STEMI

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

Additional Information:

- Do not include the fibrinolytics used during percutaneous intervention

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Medication Records
- ED Records
- Progress Notes
- Other Hospital Records

FIBRINOLYTIC INFUSION DATE

Definition

Date patient received a fibrinolytic infusion at the SRF or SRC ED, if applicable

Field Values

- Collected as MMDDYYYY
- ND: Not Documented

Uses

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Medication Records
- ED Records
- Progress Notes
- Other Hospital Records

FIBRINOLYTIC INFUSION TIME

Definition

Time of day the patient received a fibrinolytic infusion at the SRF or SRC ED, if applicable

Field Values

- Collected as HHMM
- Use 24-hr clock
- ND: Not Documented

Additional Information

- Enter the time the infusion began

Uses

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Medication Records
- ED Records
- Progress Notes
- Other Hospital Records

CATH LAB (CL) ACTIVATED?

Definition

Checkbox indicating whether the cath lab team was activated from the field or SRC ED

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

Uses

- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Cath Lab pager
- ED Records
- SRC Log
- Progress Notes
- Other Hospital Records

REASON CL NOT ACTIVATED

Definition

Checkbox indicating the primary reason why the cath lab team was not activated from the field or SRC ED

Field Values

- **Poor Quality:** Poor quality Pre-SRC ECG
- **Non-ischemic:** Non-ischemic cause of ST-elevation
- **Dysrhythmia:** Dysrhythmia
- **Early Repol:** Early Repolarization
- **MD:** Physician Judgment
- **Vasospasm:** Vasospasm
- **DNR:** DNR
- **Refused:** Patient refused
- **Expired:** Patient expired
- **Other:** Other
- **ND:** Not Documented

Additional Information

- Non-ischemic cause of ST-elevation includes but is not limited to: Pericarditis/myocarditis, Brugada syndrome, Takotsubo syndrome, hyperkalemia, bundle branch blocks, paced rhythm, left ventricular aneurysm
- Dysrhythmia includes any atrial or ventricular dysrhythmia: atrial tachycardias, atrial fibrillation, atrial flutter, junctional tachycardias, ventricular tachycardias
- If “Other” is marked, must document reason in “Comment to Other” field

Uses

- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- SRC Log
- Progress Notes
- Other Hospital Records

COMMENT TO OTHER

Definition

Field provided to specify why “Other” was selected as the primary reason why the cath lab was not activated

Field Values

- Free-text

Additional Information

- Do not enter information into this field unless Reason CL Not Activated was “Other”

Uses

- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- Progress Notes
- Other Hospital Records

DIAGNOSIS AT DISCHARGE

Definition

Checkbox indicating whether any of the below diagnoses were included in the list of final diagnoses for the patient

Field Values

- **STEMI:** STEMI
- **NSTEMI:** NSTEMI
- **Neither:** Neither

Additional Information

- Patients with a final diagnosis of STEMI would have any of the following ICD-10 codes (and their sub lists, if applicable):
  - I21.0
  - I21.1
  - I21.2
  - I21.3
  - I22.0
  - I22.1
  - I22.8
  - I22.9
- Patients with a final diagnosis of NSTEMI would have any of the following ICD-10 codes (and their sub lists, if applicable):
  - I21.4
  - I22.2

Uses

- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- SRC Log
- Progress Notes
- Other Hospital Records

CATH LAB (CL)

PT LOCATION WHEN CL ACTIVATED

Definition

Patient's location when the cath lab team was activated

Field Values

- **Pre-SRC:** Pre-SRC
- **SRC:** SRC ED
- **ND:** Not Documented

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- SRC Log
- Cath Lab Report
- EMS Report Form

CL ACTIVATION DATE

Definition

Date the cath lab team was activated

Field Values

- Collected as MMDDYYYY
- ND: Not Documented

Uses

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Cath Lab Pager
- SRC Log
- ED Records
- Cath Lab Report
- Other Hospital Records

CL ACTIVATION TIME

Definition

Time of day the cath lab team was activated

Field Values

- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Uses

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Cath Lab Pager
- SRC Log
- ED Records
- Cath Lab Report
- Other Hospital Reports

DID THE PATIENT GO TO THE CATH LAB?

Definition

Checkbox indicating whether the patient went to the cath lab

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

Uses

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- SRC Log
- ED Records
- Cath Lab Report
- Other Hospital Reports

REASON PT DID NOT GO TO CL

Definition

Checkbox indicating the primary reason why the patient was not transported to the cath lab directly from the field or ED

Field Values

- **Poor quality:** Poor quality Pre-SRC ECG
- **Non-ischemic:** Non-ischemic cause of ST-elevation
- **Dysrhythmia:** Dysrhythmia
- **Early Repol:** Early Repolarization
- **Age:** Age
- **Allergy:** Allergy to contrast
- **CL Not Avail:** Cath lab not available
- **DNR:** DNR
- **Co-morbid:** Co-morbidities
- **Multi-vessel:** Known multi-vessel disease
- **CABG:** CABG (candidate or recent surgery)
- **Vasospasm:** Vasospasm
- **Refused:** Patient refused
- **Expired:** Patient expired
- **Other:** Other
- **ND:** Not documented

Additional Information

- Non-ischemic cause of ST-elevation includes but is not limited to: Pericarditis/myocarditis, Brugada syndrome, Takotsubo syndrome, hyperkalemia, bundle branch blocks, paced rhythm, left ventricular aneurysm
- Dysrhythmia includes any atrial or ventricular dysrhythmia: atrial tachycardias, atrial fibrillation, atrial flutter, junctional tachycardias, ventricular tachycardias

Uses

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Cath Lab Report
- Progress Notes
- ED Records

COMMENT TO OTHER

Definition

Field provided to specify why “Other” was selected as the primary reason why patient did not go to cath lab

Field Values

- Free- text

Additional Information

- Do not enter information into this field unless Reason Pt Did Not Go to CL was “Other”

Uses

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Cath Lab Report
- Progress Notes
- ED Records

LOCATION OF PATIENT WHEN ROUTED TO CATH LAB

Definition

Patient's location when directed to the cath lab

Field Values

- **E:** ED
- **F:** Field
- **I:** Inpatient

Additional Information

- Enter "ED" if the patient was transported to the cath lab from the ED
- Enter "Field" if the patient was transported directly to the cath lab by EMS and did not stop in the ED
- Enter "Inpatient" if the patient was transported to the cath lab from an inpatient bed within 24 hours of admission

Uses

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- SRC Log
- ED Records
- Cath Lab Report
- Other Hospital Reports

CL ARRIVAL DATE

Definition

Date patient arrived in the cath lab

Field Values

- Collected as MMDDYYYY
- ND: Not Documented

Uses

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Cath Lab Report

CL ARRIVAL TIME

Definition

Time of day patient arrived in the cath lab

Field Values

- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Uses

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Cath Lab Report

CATH STATUS

Definition

Checkbox indicating the urgency of the primary diagnostic catheterization

Field Values

- **U:** Urgent
- **E:** Emergent
- **S:** Salvage

Additional Information

- Urgent: inpatient procedure prior to discharge, includes non-salvage catheterization following ROSC
- Emergent: there is a concern for ongoing STEMI
- Salvage: last resort to save the patient's life, defined by the presence of at least **one** of the following:
    - The patient is in cardiogenic shock at the start of the procedure **OR**
    - The patient has received chest compressions within ten minutes of the start of the procedure **OR**
    - The patient was on unanticipated extracorporeal support

Uses

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Cath Lab Report
- Progress Notes

ARTERIAL ACCESS SITE

Definition

Checkbox indicating the location(s) used to gain vascular access for catheterization

Field Values

- **F:** Femoral only
- **B:** Brachial only
- **R:** Radial only
- **FB:** Femoral then Brachial
- **FR:** Femoral then Radial
- **BR:** Brachial then Femoral
- **RF:** Radial then Femoral
- **RB:** Radial then Brachial
- **ND:** Not Documented

Additional Information

- If access was not obtained, document sites attempted

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Cath Lab Report

PCI PERFORMED?

Definition

Checkbox indicating whether a Percutaneous Coronary Intervention (PCI), or placement of device for the purpose of mechanical coronary revascularization, was performed

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Cath Lab Report

REASON PCI NOT PERFORMED

Definition

Checkbox indicating the primary reason why PCI was not performed

Field Values

- **CABG/IABP:** Candidate for CABG/IABP
- **No Access:** Unable to Gain Vascular Access
- **Lesion Unable:** Unable to Cross Lesion
- **Multi-vessel:** Multi-Vessel Disease
- **No Lesions:** No Lesions Found/Normal Coronaries
- **Expired:** Patient Expired in Cath Lab
- **Takotsubo:** Takotsubo Syndrome
- **Spasm:** Vessel Spasm
- **Other:** Other (reason in comment section)
- **ND:** Not Documented

Additional Information

- If “Other” is marked, must document reason in “Comment to Other” field

Uses

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Cath Lab Report

COMMENT TO OTHER

Definition

Field provided to specify why “Other” was selected as the primary reason why PCI was not performed

Field Values

- Free- text

Additional Information

- Do not enter information into this field unless Reason PCI Not Performed was “Other”

Uses

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Cath Lab Report

PCI DATE

Definition

Date PCI was performed

Field Values

- Collected as MMDDYYYY
- ND: Not Documented

Additional Information

- Use the date that the first device (excluding guidewire) intervened at the culprit lesion during the first PCI only

Uses

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Cath Lab Report

PCI TIME

Definition

Time of day PCI was performed

Field Values

- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Additional Information

- Use the time that the first device (excluding guidewire) intervened at the culprit lesion during the first PCI only
-

Uses

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Cath Lab Report

NON-SYSTEM DELAYS TO PCI?

Definition

Checkbox indicating whether there were patient-related delays to performing PCI

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

Uses

- Establishes care intervals and incident timelines
- Provides documentation of care
- System evaluation and monitoring

Data Source Hierarchy

- Cath Lab Report

DELAYS TO PCI

Definition

Checkbox indicating patient-related delays to performing PCI

Field Values

- **CA:** Cardiac Arrest
- **Intubation:** Intubation Required
- **Access:** Difficulty Obtaining Vascular Access
- **Lesion:** Difficulty Crossing Lesion
- **Consent:** Consent Delay
- **Other:** Other
- **ND:** Not Documented

Additional Information

- If “Other” is marked, must document reason in “Comment to Other” field

Uses

- Establishes care intervals and incident timelines
- Provides documentation of care
- System evaluation and monitoring

Data Source Hierarchy

- Cath Lab Report

COMMENT TO OTHER

Definition

Field provided to specify why “Other” was selected as the reason why there were patient-related delays to performing PCI

Field Values

- Free-text

Additional Information

- Do not enter information into this field unless Delays to PCI was “Other”

Uses

- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Cath Lab Report

CULPRIT LESION?

Definition

Checkbox indicating whether the primary lesion responsible for the acute coronary event was located

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Additional Information

- The primary lesion responsible for the acute coronary event as documented by the interventionalist
- If more than one lesion is stented, the lesion in the segment supplying blood to the largest area of myocardium should be considered the culprit lesion

Data Source Hierarchy

- Cath Lab Report
- Progress Notes
- Other Hospital Records

CULPRIT LESION LOCATION

Definition

Checkbox indicating the segment where the primary lesion responsible for the acute coronary event was located

Field Values

Culprit Lesion Segment Location			
pRCA	Proximal right coronary artery conduit	mCIRC	Mid - circumflex artery segment
mRCA	Mid - right coronary artery conduit	dCIRC	Distal circumflex artery
dRCA	Distal right coronary artery conduit	1st OM	First obtuse marginal branch
rPDA	Right posterior descending artery	Lat 1st OM	Lateral first obtuse marginal branch
rPAV	Right posterior atrioventricular	2nd OM	Second obtuse marginal branch
1st RPL	First right posterolateral	Lat 2nd OM	Lateral second obtuse marginal branch
2nd RPL	Second right posterolateral	3rd OM	Third obtuse marginal branch
3rd RPL	Third right posterolateral	Lat 3rd OM	Lateral third obtuse marginal branch
pDSP	Posterior descending septal perforators	CIRC AV	Circumflex artery AV groove continuation
aMarg	Acute marginal(s)	1st LPL	First left posterolateral branch
LM	Left main coronary artery	2nd LPL	Second left posterolateral branch
pLAD	Proximal LAD artery	3rd LPL	Third left posterolateral branch
mLAD	Mid - LAD artery	LPDA	Left posterolateral descending artery
dLAD	Distal LAD artery	Ramus	Ramus intermedius
1st Diag	First diagonal branch	Lat Ramus	Lateral ramus intermedius
Lat 1st Diag	Lateral first diagonal branch	3rd Diag	Third diagonal branch
2nd Diag	Second diagonal branch	Lat 3rd Diag	Lateral third diagonal branch
Lat 2nd Diag	Lateral second diagonal branch	ND	Not Documented
LAD SP	LAD septal perforators	OTH	Other
pCIRC	Proximal circumflex artery		

Additional Information

- If more than one lesion is stented, the lesion in the segment supplying blood to the largest area of myocardium should be considered the culprit lesion

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Cath Lab Report
- Progress Notes
- Other Hospital Records

PT INCURRED INTRA- OR POST-PROCEDURAL STROKE?

Definition

Checkbox indicating whether the patient experienced stroke signs or symptoms during or immediately following the PCI procedure that did not resolve within 24 hours

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

Additional Information

- Check “Yes” if symptoms started during the PCI procedure and did not resolve within 24 hours after the procedure

Uses

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Cath Lab Report
- Progress Notes
- Billing Sheet/ Medical Records Coding Summary Sheet

PT REQUIRED INTRA- OR POST-PROCEDURE TRANSFUSION?

Definition

Checkbox indicating whether the patient experienced a vascular complication requiring transfusion

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

Uses

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Cath Lab Report
- Progress Notes
- Billing Sheet/ Medical Records Coding Summary Sheet

CABG PERFORMED?

Definition

Checkbox indicating whether the patient had Coronary Artery Bypass Grafting (CABG) performed during the same hospitalization

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Operative Report
- Cath Lab Report
- Progress Notes
- Other Hospital Records

CABG STATUS

Definition

Checkbox indicating the urgency of the CABG

Field Values

- **U:** Urgent
- **E:** Emergent
- **S:** Salvage
- **EL:** Elective

Additional Information

- Urgent: procedure required during same hospitalization in order to minimize deterioration
- Emergent: patient has ischemic or mechanical dysfunction that is not responsive to any form of therapy except surgery
- Salvage: last resort to save the patient's life, defined by the presence of CPR en route to the operating room, or prior to induction of anesthesia
- Elective: patient's cardiac function has been stable prior to the operation, procedure can be deferred without risk of compromising cardiac outcome

Uses

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Operative Report
- Progress Notes

CABG DATE

Definition

Date the CABG was performed

Field Values

- Collected as MMDDYYYY
- ND: Not Documented

Uses

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Operative Report
- Cath Lab Report
- Progress Notes
- Other Hospital Records

CABG TIME

Definition

Time of day the CABG was performed

Field Values

- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Uses

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Operative Report
- Cath Lab Report
- Progress Notes
- Other Hospital Records

ROSC

ROSC?

Definition

Checkbox indicating whether Return of Spontaneous Circulation (ROSC) occurred, which is defined as restoration of a spontaneous perfusing rhythm. Signs of ROSC include: palpable pulse, breathing (more than an occasional gasp), coughing, movement, a measureable blood pressure, and/or a normal to high capnography reading

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

Additional Info

- Indicate yes if the patient had ROSC at any time during resuscitation, even if transient

Uses

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- ED Records
- Progress Notes

SUSTAINED ROSC?

Definition

Checkbox indicating whether sustained ROSC occurred, which is defined as persistent signs of circulation, with no chest compressions required, for at least twenty (20) consecutive minutes

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

Uses

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- ED Records
- Progress Notes

INIT. CARDIAC ARREST DATE

Definition

Date of the initial cardiac arrest

Field Values

- Collected as MMDDYYYY
- ND: Not Documented

Uses

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

INIT. CARDIAC ARREST TIME

Definition

Time of day of the initial cardiac arrest

Field Values

- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Additional Information

- If the cardiac arrest time is estimated, mark the “Est.” checkbox

Uses

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

INIT. CARDIAC ARREST LOCATION

Definition

Checkbox indicating where the patient was when the initial cardiac arrest occurred

Field Values

- **Home:** Home/Residence
- **SNF:** Nursing Home/Assisted Living
- **Public:** Public Building/Areas
- **Clinic:** Physician Office/Clinic/Urgent Care
- **Industrial:** Industrial Site
- **ED**
- **CL:** Cath Lab
- **Other:** Other
- **ND:** Not Documented

Uses

- Provides documentation of assessment
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

INIT. CARDIAC ARREST WITNESSED?

Definition

Checkbox indicating whether the initial cardiac arrest was witnessed

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

Uses

- Provides documentation of assessment
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

INIT. CARDIAC ARREST WITNESSED BY

Definition

Checkbox indicating who observed the initial cardiac arrest

Field Values

- **C:** Citizen
- **E:** EMS
- **H:** Healthcare Professional
- **ND:** Not Documented

Additional Information

- “Healthcare professionals” are defined as medically trained, **on-duty** individuals at a healthcare facility (clinic, doctor’s office, ED, etc.)
- “Citizens” are defined as good samaritans, such as off-duty healthcare professionals, law enforcement officers, and bystanders

Uses

- Provides documentation of assessment
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

INIT. CARDIAC ARREST RHYTHM

Definition

Checkbox indicating the initial cardiac rhythm observed during the initial cardiac arrest

Field Values

- **AA:** AED-Analyzed Only
- **AD:** AED-Defibrillated
- **AG:** Agonal
- **ASY:** Asystole
- **IV:** Idioventricular
- **PEA:** Pulseless Electrical Activity
- **VT:** Pulseless Ventricular Tachycardia
- **VF:** Ventricular Fibrillation
- **ND:** Not Documented

Uses

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

INIT. CARDIAC ARREST CPR INIT. BY

Definition

Checkbox indicating who initiated CPR during the initial cardiac arrest

Field Values

- **C:** Citizen
- **E:** EMS
- **H:** Healthcare Professional
- **ND:** Not Documented

Additional Information

- “Healthcare professionals” are defined as medically trained, **on-duty** individuals at a healthcare facility (clinic, doctor’s office, etc.)
- “Citizens” are defined as good samaritans, such as off-duty healthcare professionals, law enforcement officers, and bystanders

Uses

- Provides documentation of care
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

FIELD DEFIB?

Definition

Checkbox indicating whether defibrillation occurred in the field

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

Uses

- Provides documentation of care
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

FIELD DEFIB BY

Definition

Checkbox indicating who defibrillated the patient in the field

Field Values

- **AC:** AED Citizen
- **AE:** AED EMS
- **ED:** EMS Defibrillation
- **HP:** Healthcare Professional
- **ND:** Not Documented

Additional Information

- “Healthcare professionals” are defined as medically trained, **on-duty** individuals at a healthcare facility (clinic, doctor’s office, etc.)
- “Citizens” are defined as good samaritans, such as off-duty healthcare professionals, law enforcement officers, and bystanders

Uses

- Provides documentation of care
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

INIT. ROSC DATE

Definition

Date initial ROSC occurred

Field Values

- Collected as MMDDYYYY
- ND: Not Documented

Uses

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

INIT. ROSC TIME

Definition

Time of day initial ROSC occurred

Field Values

- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Uses

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

INIT. ROSC LOCATION

Definition

Checkbox indicating where the patient was when initial ROSC occurred

Field Values

- **F:** Field
- **SRF:** SRF ED
- **SRC:** SRC ED
- **ND:** Not Documented

Uses

- Establishes care intervals and incident timelines
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

1ST CARDIAC RHYTHM UPON ROSC

Definition

First documented cardiac rhythm observed upon ROSC

Field Values

- **AFI:** Atrial Fibrillation
- **AFL:** Atrial Flutter
- **AVR:** Accelerated Ventricular
- **1HB:** 1st Degree Heart Block
- **2HB:** 2nd Degree Heart Block
- **3HB:** 3rd Degree Heart Block
- **JR:** Junctional Rhythm
- **PM:** Pacemaker
- **PST:** Paroxysmal Supraventricular Tachycardia
- **SB:** Sinus Bradycardia
- **SR:** Sinus Rhythm
- **ST:** Sinus Tachycardia
- **SVT:** Supraventricular Tachycardia
- **VT:** Ventricular Tachycardia
- **OT:** Other
- **ND:** Not Documented

Uses

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

1st HEART RATE UPON ROSC

Definition

First documented heart rate upon ROSC

Field Values

- Up to three-digit numeric value
- ND: Not Documented

Uses

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

1st SYSTOLIC BLOOD PRESSURE UPON ROSC

Definition

First documented systolic blood pressure recorded upon ROSC

Field Values

- Up to three-digit numeric value
- ND: Not Documented

Uses

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

1ST TEMPERATURE UPON ROSC

Definition

First documented core temperature recorded upon ROSC

Field Values

- Up to three-digit numeric value
- ND: Not Documented

Additional Information

- Core temperature is measured via bladder, esophageal, or rectal methods
- Document to the 10th of a degree (e.g. 37.0ºC)

Uses

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

1st END TIDAL CO_2 UPON ROSC

Definition

1st end tidal CO_2 recorded immediately following ROSC

Field Values

- Up to two-digit numeric value
- ND: Not Documented

Uses

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

1st pH VALUE UPON ROSC

Definition

1st pH value resulted within two hours of ROSC

Field Values

- Up to three-digit numeric value
- ND: Not Documented

Additional Information

- Document to the 100th of a degree (e.g. 7.00)

Uses

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Lab Records
- ED Records
- Progress Notes
- Other Hospital Records

1st LACTATE VALUE UPON ROSC

Definition

1st lactate value resulted within two hours of ROSC

Field Values

- Up to three-digit numeric value
- ND: Not Documented

Additional Information

- Document to the 10th of a degree (e.g. 10.0)

Uses

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Lab Records
- ED Records
- Progress Notes
- Other Hospital Records

TOTAL GLASGOW COMA SCALE (GCS) UPON ROSC

Definition

Checkbox indicating the first documented GCS upon ROSC

Field Values

- **3**
- **4**
- **5**
- **6**
- **7**
- **8**
- **9**
- **10**
- **11**
- **12**
- **13**
- **14**
- **15**
- **ND:** Not Documented

Uses

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

VASOPRESSORS IVP?

Definition

Checkbox indicating whether the patient received epinephrine or vasopressin via intravenous (IV) push during cardiac arrest

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- ED Records
- Medication Records
- Progress Notes
- Other Hospital Records

VASOPRESSORS VIA CONT. INF.?

Definition

Checkbox indicating whether vasopressors via continuous intravenous infusion were initiated post-ROSC in the ED or cath lab

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

Additional Information

- Vasopressors include Dopamine, Epinephrine, Norepinephrine (Levophed), Phenylephrine, and Vasopressin

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- ED Records
- Medication Records
- Progress Notes
- Other Hospital Records

TOTAL GCS AT DISCHARGE

Definition

Checkbox indicating the patient's GCS at time of discharge from the acute care unit at your facility

Field Values

- **3**
- **4**
- **5**
- **6**
- **7**
- **8**
- **9**
- **10**
- **11**
- **12**
- **13**
- **14**
- **15**
- **ND:** Not Documented

Additional Information

- If the patient expired, GCS is "3"

Uses

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- Hospital Discharge Summary
- Progress Notes
- Billing Sheet / Medical Records Coding Summary Sheet

CPC SCALE AT DISCHARGE

Definition

Checkbox indicating the patient's Cerebral Performance Categories (CPC) scale upon discharge from the acute care unit at your facility

Field Values

Cerebral Performance Categories Scale	
1	Good cerebral performance – conscious, alert, able to work, might have mild neurologic or psychologic deficit.
2	Moderate cerebral disability – conscious, sufficient cerebral function for independent activities of daily life. Able to work in sheltered environment.
3	Severe cerebral disability – conscious, dependent on others for daily support because of impaired brain function. Range from ambulatory state to severe dementia or paralysis.
4	Coma or vegetative state – any degree of coma without the presence of all brain death criteria. Unawareness, even if appears awake (vegetative state) without interaction with environment; may have spontaneous eye opening and sleep/awake cycles. Cerebral unresponsiveness.
5	Brain death: apnea, areflexia, EEG silence, etc.
ND	Not Documented

Additional Information

- If the patient expired, CPC is "5"
- The CPC Scale at discharge may be performed by a physician, trained RN, or occupational therapist
- SRC Clinical Director/RN data extractor may calculate only if not performed by above

Uses

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- Hospital Discharge Summary
- Progress Notes
- Billing Sheet / Medical Records Coding Summary Sheet

CHANGE IN BASELINE FUNCTIONAL STATUS?

Definition

Checkbox indicating whether a CPC scale= 3 or 4 at discharge is a change in the patient's baseline functional status

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

Uses

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- Hospital Discharge Summary
- Progress Notes
- Billing Sheet / Medical Records Coding Summary Sheet

TARGETEDTEMPERATURE MANAGEMENT (TTM) INFO

TTM INITIATED?

Definition

Checkbox indicating whether TTM measures were initiated to actively cool and/or maintain the patient at a temperature of 32-36 degrees Celsius

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- Progress Notes
- Other Hospital Records

CONTRAINDICATIONS TO TTM? (LIST ALL THAT APPLY)

Definition

Checkbox indicating why TTM measures were not initiated

Field Values

- **17:** Age < 18yrs
- **BL:** Active Bleeding
- **AR:** Awake/Responsive to verbal commands
- **CO:** Pre-existing coma
- **30:** Core temperature < 30 degrees Celsius
- **DN:** DNR
- **TI:** End stage terminal illness
- **EX:** Patient expired
- **HT:** Major head trauma
- **PH:** Persistent hypotension
- **PG:** Pregnancy
- **SS:** Septic Shock
- **UA:** Uncontrolled/recurrent ventricular dysrhythmia
- **NO:** None listed

Additional Information

- Enter multiple selections, if applicable, by pressing down and holding the “Control/Ctrl” key while making your selections
- Pre-existing coma refers to being in a comatose state prior to cardiac arrest due to a pre-existing condition, neurologic dysfunction, or severe dementia
- Persistent hypotension refers to patients who continue to be hypotensive despite interventions, including IV fluids, vasopressors, or an intra-aortic balloon pump
- Uncontrolled/recurrent ventricular dysrhythmia refers to recurrent ventricular fibrillation or ventricular tachycardia

Uses

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- Progress Notes
- Other Hospital Records

TTM INITIATED DATE

Definition

Date TTM measures were initiated

Field Values

- Collected as MMDDYYYY
- ND: Not Documented

Uses

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- Progress Notes
- Other Hospital Records
- EMS Report Form
- Base Hospital Form

TTM INITIATED TIME

Definition

Time of day TTM measures were initiated

Field Values

- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Uses

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- Progress Notes
- Other Hospital Records
- EMS Report Form
- Base Hospital Form

TTM INITIATED LOCATION

Definition

Checkbox indicating where the patient was when TTM measures were initiated

Field Values

- **P:** Pre-SRC
- **S:** SRC ED
- **C:** Cath Lab
- **I:** ICU
- **ND:** Not Documented

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- Progress Notes
- Other Hospital Records
- EMS Report Form
- Base Hospital Form

TTM MODALITY USED

Definition

Checkbox indicating type(s) of TTM measures initiated

Field Values

- **IP:** Ice Packs
- **ED:** External Cooling Device
- **CI:** Cold IV fluids
- **CD:** Central Vascular Cooling Device
- **OT:** Other
- **ND:** Not Documented

Additional Information

- Enter multiple selections, if applicable, by pressing down and holding the “Control/Ctrl” key while making your selections

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- Progress Notes
- Other Hospital Records
- EMS Report Form
- Base Hospital Form

TARGET TEMPERATURE

Definition

Checkbox indicating the desired body temperature to be achieved by TTM measures, as ordered by the physician or per protocol

Field Values

- **32:** 32 degrees Celsius
- **33:** 33 degrees Celsius
- **34:** 34 degrees Celsius
- **35:** 35 degrees Celsius
- **36:** 36 degrees Celsius
- **SR:** Specified range *(enter range in Target Temperature Range)*
- **ND:** Not Documented

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- Progress Notes
- Other Hospital Records

TARGET TEMPERATURE RANGE

Definition

Field provided to indicate the range of desired body temperature to be achieved by TTM measures, if applicable

Field Values

- Free-text field

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- Progress Notes
- Other Hospital Records

TARGET TEMPERATURE REACHED?

Definition

Checkbox indicating whether the desired body temperature was achieved by TTM measures

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- Progress Notes
- Other Hospital Records

TARGET TEMPERATURE REACHED DATE

Definition

Date that desired body temperature was achieved by TTM measures

Field Values

- Collected as MMDDYYYY
- ND: Not Documented

Uses

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- Progress Notes
- Other Hospital Records

TARGET TEMPERATURE REACHED TIME

Definition

Time of day that desired body temperature was achieved by TTM measures

Field Values

- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Uses

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- Progress Notes
- Other Hospital Records

RE-WARMING INITIATED?

Definition

Checkbox indicating whether re-warming measures were initiated

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Progress Notes
- Other Hospital Records
- ED Records

RE-WARMING INIT DATE

Definition

Date that re-warming measures were initiated

Field Values

- Collected as MMDDYYYY
- ND: Not Documented

Uses

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Progress Notes
- Other Hospital Records
- ED Records

RE-WARMING INIT TIME

Definition

Time of day that re-warming measures were initiated

Field Values

- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Uses

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Progress Notes
- Other Hospital Records
- ED Records

PATIENT DIED DURING RE-WARMING?

Definition

Checkbox indicating whether the patient died during the re-warming process

Field Values

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Progress Notes
- Other Hospital Records
- ED Records

RE-WARMING ENDED DATE

Definition

Date that re-warming measures were terminated

Field Values

- Collected as MMDDYYYY
- ND: Not Documented

Uses

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Progress Notes
- Other Hospital Records
- ED Records

RE-WARMING ENDED TIME

Definition

Time of day that re-warming measures were terminated, if applicable

Field Values

- Collected as HHMM
- Use 24-hour clock
- ND: Not Documented

Uses

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Progress Notes
- Other Hospital Records
- ED Records

ADVERSE EVENTS DURING TTM

Definition

Checkbox indicating whether any of the listed adverse events occurred during TTM – enter all that apply

Field Values

- **DY:** VF/VT
- **CG:** Coagulopathy/bleeding
- **DV:** Deep vein thrombosis
- **NO:** None of the above specified adverse events

Additional Information

- Enter multiple selections, if applicable, by pressing down and holding the “Control/Ctrl” key while making your selections
- Select ‘NO’ if there is no documentation of the adverse events listed

Uses

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Progress Notes
- Other Hospital Records
- ED Records

STROKE CENTER DATA DICTIONARY

Los Angeles County

Emergency Medical Services Agency

TABLE OF CONTENTS

INCLUSION CRITERIA

Definition

Checkboxes indicating which of the LA EMS Stroke Database criteria was met by patients that arrive via ambulance

Field Values

- Met Prehospital Care Policy Ref. No 1251, Stroke Acute Neurological Deficits
- Final hospital (if admitted) or ED (if not admitted) diagnosis is ischemic stroke, transient ischemic attack, intracerebral hemorrhage, intraventricular hemorrhage, or subarachnoid hemorrhage
- Transported to an Approved Stroke Center (ASC) as a specialty care center

Additional Information

- Criteria do not apply to walk-in patients
- At least one criteria needs to be checked in order to begin data entry
- Check all criteria that apply

Uses

- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- ASC Log
- ED Records
- Other Hospital Records

911 PREHOSPITAL DATA

SEQUENCE NUMBER

Definition

Unique, alphanumeric EMS record number provided by the EMS provider. Found pre-printed at the top right corner of EMS report form hard copies, or electronically assigned to ePCRs from approved providers.

Additional Information

- Data entry cannot begin without this number
- Consists of two letters and six digits on pre-printed EMS Report Forms; or two letters, ten digits if obtained from an approved ePCR provider
- If sequence number is missing or incorrectly documented, every effort must be taken to obtain it – by reviewing the patient's medical record, or by contacting either the Prehospital Care Coordinator of the applicable base hospital or the EMS provider that transported the patient

Uses

- Unique patient identifier

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- Base Hospital Log
- Fire Station logs

PROVIDER

Definition

Two-letter code for the EMS provider primarily responsible for the patient's prehospital care

Field Values

AF	Arcadia Fire
AH	Alhambra Fire
AV	Avalon Fire
BF	Burbank Fire
BH	Beverly Hills Fire
CC	Culver City Fire
CF	LA County Fire
CG	US Coast Guard
CI	LA City Fire
CM	Compton Fire
CS	LA County Sheriff
DF	Downey Fire
ES	El Segundo Fire
FS	U.S. Forest Service
GL	Glendale Fire
HB	Hermosa Beach Fire
LB	Long Beach Fire
LH	La Habra Heights Fire
LV	La Verne Fire
MB	Manhattan Beach Fire
MF	Monrovia Fire
MO	Montebello Fire
MP	Monterey Park Fire
OT	Other Provider
PF	Pasadena Fire
RB	Redondo Beach Fire
SA	San Marino Fire
SG	San Gabriel Fire
SI	Sierra Madre Fire
SM	Santa Monica Fire
SP	South Pasadena Fire
SS	Santa Fe Springs Fire
TF	Torrance Fire
VE	Ventura County Fire
UN	Unknown
WC	West Covina Fire
VF	Vernon Fire

Uses

- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form

ALS UNIT

Definition

Numeric unit number of the Advanced Life Support (ALS) provider that transported the patient

Field Values

- Up to three-digit numeric field

Additional Information

- This is a free-text field

Uses

- System evaluation and monitoring

Data Hierarchy

- EMS Report Form
- Base Hospital Form
- Base Hospital Log
- ED Records

PATIENT'S INITIAL COMPLAINT CODE

Definition

Two-letter code(s) representing the patient's most significant medical or trauma complaints

Field Values

MEDICAL CODES

AD	Agitated Delirium
AP	Abd/Pelvic Pain
AR	Allergic Reaction
AL	Altered LOC
AE	Apneic Episode
TE	Apparent Life Threatening Event (ALTE)
EH	Behavioral
OS	Bleeding Other Site (NOT associated with trauma, e.g., dialysis shunt)
CA	Cardiac Arrest (NOT associated with trauma)
CP	Chest Pain (NOT associated with trauma)
CH	Choking/Airway Obstruction
CC	Cough/Congestion
DC	Device Complaint (associated with an existing medical device – e.g., G-Tube, AICD, ventilator, etc.)
DI	Dizzy
DO	DOA (Dead On Arrival)
DY	Dysrhythmia
FE	Fever
FB	Foreign Body (anywhere in body)
GI	Gastrointestinal Bleeding
HP	Head Pain (NOT associated with trauma)
HY	Hypoglycemia
IM	Inpatient Medical Interfacility Transfer (IFT) of an admitted, ill (NOT injured) patient, from one facility to another facility
LA	Labor (>20 weeks pregnant with signs or symptoms of labor)
LN	Local Neuro Signs (weakness, numbness, paralysis – including slurred speech, facial droop, aphasia)
NV	Nausea/Vomiting
ND	Near-Drowning/Drowning (submersion causing water inhalation, unconsciousness, or death)
NB	Neck/Back Pain (NOT associated with trauma)
NW	Newborn (infant delivered outside of the hospital setting)
NC	No Medical Complaint
NO	Nosebleed
OB	Obstetrics (any complaints which may be related to a known pregnancy)
OP	Other Pain (pain at a site not listed, NOT associated with trauma – e.g., toothache, ear pain, etc.)
OD	Overdose (dose greater than recommended or generally given)
PO	Poisoning (ingestion of, or contact with, a toxic substance)
PS	Palpitations

RA Respiratory Arrest (cessation of breathing NOT associated with trauma)
SE Seizure (NOT associated with trauma)
SB Shortness Of Breath
SY Syncope
VA Vaginal Bleeding
WE Weakness
OT Other (signs or symptoms not listed above, NOT associated with trauma)

TRAUMA CODES
NA No Apparent Injury (no complaint or injury following a traumatic event)
BA Blunt Abdomen
BB Blunt Back
BC Blunt Chest
BE Blunt Extremities
BF Blunt Face/Mouth (from/including the eyebrows, down to/including the angle of the jaw and the ears)
BGBK Blunt Genitals/Buttocks
BH Blunt Head (from above the eyebrows to behind the ears; and facial injuries when brain injury is suspected)
BL Blunt Minor Lacerations (superficial abrasions/contusions to skin or subcutaneous tissue)
BN Blunt Neck (between the angle of the jaw and clavicles, including suspected cervical spine injuries)

Additional Information
- Enter up to three complaints
- If the patient has multiple complaints, enter in order of significance

Uses
- System evaluation and monitoring
- Epidemiological statistics

Data Source Hierarchy
- EMS Report Form
- ASC Log
- Base Hospital Form
- Base Hospital Log

LAST KNOWN WELL DATE

Definition

Date when the patient was last known to be well, symptom-free, or at baseline or usual state of health, per EMS provider documentation

Field Values

- Collected as MMDDYYYY
- NA: Not Applicable (last well date not known)
- ND: Not Documented (last well date not documented by EMS)

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- ASC Log
- EMS Report Form
- Base Hospital Form

LAST KNOWN WELL TIME

Definition

Time of day when the patient was last known to be well, symptom-free, or at baseline or usual state of health per EMS provider documentation

Field Values

- Collected as HHMM
- Use 24-hour clock
- NA: Not Applicable (last well date not known)
- ND: Not Documented (last well date not documented by EMS)

Additional Information

- Estimates to within nearest 15 minutes are acceptable

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- ASC Log
- EMS Report Form
- Base Hospital Form

911 ARRIVAL AT PATIENT DATE

Definition

Date 9-1-1 EMS personnel arrived at the patient

Field Values

- Collected as MMDDYYYY
- ND: Not Documented

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- EMS Report Form

911 ARRIVAL AT PATIENT TIME

Definition

Time 9-1-1 EMS personnel arrived at the patient

Field Values

- Collected as MMDDYYYY
- ND: Not Documented

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- EMS Report Form

BLOOD GLUCOSE

Definition

Initial numeric value of the patient's blood glucose measurement obtained by EMS personnel

Field Values

- Up to three-digit numeric value
- LO: Alpha reading indicating blood sugar level is lower than manufacturer's numeric low value threshold
- HI: Alpha reading indicating a blood sugar level is higher than manufacturer's numeric high value threshold
- ND: Not Documented

Additional Information

- Measured in milligrams per deciliter (mg/dl)

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- ED Records
- Other Hospital Records

mLAPSS Used?

Definition

Checkbox indicating whether EMS providers used the Modified Los Angeles Prehospital Stroke Screen (mLAPSS) to assess the patient

Field Values

- Yes
- No
- ND: Not Documented

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- ASC Log
- ED Records
- Other Hospital Records

mLAPSS MET

Definition

Checkbox indicating whether or not patient met all Modified Los Angeles Prehospital Stroke Screen (mLAPSS) criteria

Field Values

- Yes: Yes, patient met all mLAPSS criteria
- No: No, patient did not meet all mLAPSS criteria
- Not Applicable: Patient did not have a mLAPSS performed
- Not Documented: Patient had a mLAPSS performed but the results are not documented

Additional Information

- mLAPSS criteria include:
  - Symptom duration of less than 2 hours
  - No history of seizures or epilepsy
  - Age ≥ 40
  - At baseline, patient is not wheel-chair bound or bedridden
  - Blood glucose value between 60 and 400mg/dL
  - Obvious asymmetry or unilateral weakness is observed in one or more of the following:
    - Facial Smile/Grimace
    - Grip
    - Arm Strength
- Blood glucose value must be documented in order to determine whether all criteria are met

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- ASC Log

PREHOSPITAL RESEARCH STUDY ENROLLMENT?

Definition

Checkbox indicating whether the patient was enrolled in a prehospital research study

Field Values

- Yes
- No
- ND: Not documented

Uses

- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- Base Hospital Log
- ASC Log

ED NOTIFIED?

Definition

Checkbox indicating whether the receiving hospital was notified prior to the arrival of the suspected stroke patient

Field Values

- Yes
- No
- ND: Not documented

Uses

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ASC Log
- ED Records
- EMS Report Form
- Base Hospital Form
- Base Hospital Log

BYPASSED/MAR?

Definition

Indicates which Most Accessible Receiving hospital (MAR) was bypassed in order to transport the patient to an Approved Stroke Center (ASC), if applicable

Field Values

- *LOS ANGELES COUNTY 9-1-1 RECEIVING HOSPITALS*

ALPHA CODE	NUMERIC CODE	HOSPITAL NAME
ACH	132	Alhambra Hospital Med Center
AHM	120	Catalina Island Medical Center
AMH	450	Methodist Hospital of Southern California
AVH	118	Antelope Valley Hospital
BEL	127	Bellflower Medical Center
BEV	135	Beverly Hospital
BMC	172	Southern California Hospital at Culver City
CAL	133	California Hospital Medical Center
CHH	145	Children's Hospital Los Angeles
CNT	141	Centinela Hospital Medical Center
CPM	150	Coast Plaza Doctors Hospital
CSM	139	Cedars-Sinai Medical Center
DCH	155	PIH Health Hospital – Downey
DFM	457	Marina Del Rey Hospital
DHL	412	Lakewood Regional Medical Center
ELA	157	East Los Angeles Doctors Hospital
ENH	191	Encino Hospital Medical Center
FPH	160	Foothill Presbyterian Hospital
GAR	216	Garfield Medical Center
GEM	168	Greater El Monte Community Hospital
GMH	514	Glendale Memorial Hospital & Health Center
GSH	220	Good Samaritan Hospital
GWT	210	Glendale Adventist Medical Center
HCH	305	Providence Holy Cross Medical Center
HEV	310	East Valley Hospital Medical Center
HGH	248	LAC Harbor-UCLA Medical Center
HMH	324	Huntington Memorial Hospital
HMN	270	Henry Mayo Newhall Memorial Hospital
HWH	913	West Hills Hospital and Medical Center
ICH	330	Citrus Valley Medical Center – Intercommunity Campus
KFA	311	Kaiser Baldwin Park Medical Center
KFB	340	Kaiser Downey Medical Center
KFH	400	Kaiser South Bay Medical Center
KFL	343	Kaiser Los Angeles Medical Center
KFO	370	Kaiser Woodland Hills Medical Center

KFP	381	Kaiser Panorama City Medical Center
KFW	362	Kaiser West Los Angeles Medical Center
LBC	445	Community Hospital of Long Beach
LBM	533	Long Beach Memorial Medical Center
LCH	418	Palmdale Regional Medical Center
LCM	440	Providence Little Company of Mary – Torrance
MHG	495	Memorial Hospital of Gardena
MID	537	Olympia Medical Center
MCP	540	Mission Community Hospital
MPH	552	Monterey Park Hospital
NOR	452	Norwalk Community Hospital
NRH	571	Northridge Hospital Medical Center
OTH	998	Other Hospital Not on List
OVM	575	LAC Olive View-UCLA Medical Center
PAC	761	Pacifica Hospital of the Valley
PIH	466	PIH Health Hospital – Whittier
PLB	580	College Medical Center
PVC	464	Pomona Valley Hospital Medical Center
QOA	286	Hollywood Presbyterian Medical Center
QVH	468	Citrus Valley Medical Center – Queen of the Valley
SAC	489	San Antonio Community Hospital
SDC	485	San Dimas Community Hospital
SFM	667	Saint Francis Medical Center
SGC	487	San Gabriel Valley Medical Center
SJH	680	Saint John's Health Center
SJS	685	Providence Saint Joseph Medical Center
SMH	742	Santa Monica-UCLA Medical Center
SMM	134	Saint Mary Medical Center
SOC	780	Sherman Oaks Hospital
SPP	726	Providence Little Company of Mary – San Pedro
TOR	805	Torrance Memorial Medical Center
TRI	820	Tri-City Regional Medical Center
TRM	799	Providence Tarzana Medical Center
UCL	818	Ronald Reagan UCLA Medical Center
USC	438	LAC+USC Medical Center
VHH	875	USC Verdugo Hills Hospital
VPH	856	Valley Presbyterian Hospital
WHH	507	Whittier Hospital Medical Center
WMH	970	White Memorial Med Center

- *ORANGE COUNTY 9-1-1 RECEIVING HOSPITALS*

ALPHA CODE	**NUMERIC CODE**	**HOSPITAL NAME**
ANH		Anaheim Memorial Hospital
LPI	420	La Palma Intercommunity Hospital

FHP		Fountain Valley Regional Hospital and Medical Center
PLH		Placentia Linda Hospital
KHA		Kaiser Permanente Orange County Anaheim Medical Center
SJD	474	Saint Jude Medical Center
UCI	500	UC Irvine Medical Center
LAG	422	Los Alamitos Medical Center
LPI	420	La Palma Intercommunity Hospital
MCP	540	Mission Community Hospital
PLH		Placentia Linda Hospital
SJD	474	Saint Jude Medical Center
UCI	500	UC Irvine Medical Center

- *SAN BERNADINO COUNTY 9-1-1 RECEIVING HOSPITALS*

ALPHA CODE	**NUMERIC CODE**	**HOSPITAL NAME**
CHI	124	Chino Valley Medical Center
DHM	504	Montclair Hospital Medical Center

- *VENTURA COUNTY 9-1-1 RECEIVING HOSPITALS*

ALPHA CODE	**NUMERIC CODE**	**HOSPITAL NAME**
LRR	424	Los Robles Hospital and Medical Center
SJO	472	Saint John's Regional Medical Center

- NA: Not applicable, the MAR was also the ASC
- ND: Not documented

Uses

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form

HOSPITAL-BASED DATA

DATE OF BIRTH

Definition

The patient's date of birth

Field Values

- Collected as MMDDYYYY
- ND: Not documented

Uses

- Used to calculate patient age in years
- Assists with patient identification
- System evaluation and monitoring

Data Source Hierarchy

- Facesheet
- ED Records
- Billing Sheet / Medical Records Coding Summary Sheet
- EMS Report Form

PATIENT AGE

Definition

Numeric value for the patient's age in years (actual or best approximation)

Field Values

- Up to three-digit numeric value
- ND**:** Not documented

Uses

- Allows for data sorting and tracking by age
- Assists with patient identification
- Epidemiological statistics

Data Source Hierarchy

- ASC Log
- Facesheet
- ED Records
- EMS Report Form
- Base Hospital Form
- Base Hospital Log
- History and Physical
- Billing Sheet / Medical Records Coding Summary Sheet

GENDER

Definition

Checkbox indicating the patient's gender

Field Values

- Female
- Male
- Other

Additional Information

- Patients who are undergoing or have undergone a hormonal and/or surgical sex reassignment should be coded using their stated preference
- Patients unable to state their preference should be coded according to medical observation/judgment

Uses

- Assists with patient identification
- Epidemiological statistics
- System evaluation and monitoring

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form
- ED Records
- ASC Log
- Base Hospital Log
- Facesheet
- History and Physical
- Billing Sheet / Medical Records Coding Summary Sheet

RACE

Definition

The patient's race and/or ethnicity

Field Values

- Asian/Non Pacific Islander : includes those from the Far East, southeast Asia, or the Indian subcontinent, including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Philippines, Hmong, Thailand, and Vietnam
- Black: Includes African-American and Haitian
- Native American: A person having origins in any of the original peoples of North and South American (including Central America) and who maintains tribal affiliation or community attachment (e.g., any recognized tribal entity in North and South America [including Central America], Native American).
- Native Hawaiian: Includes persons having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
- White: implies White or origins in Europe, Middle East or North Africa (e.g., Caucasian, Iranian, White)
- Other
- Unable to determine

Additional Information

- Patient race/ethnicity should be coded as stated by patient or family member

Uses

- Epidemiological statistics
- System evaluation and monitoring

Data Source Hierarchy

- Facesheet
- ED Records
- History and Physical
- Billing Sheet / Medical Records Coding Summary Sheet

HISPANIC?

Definition

Checkbox indicating whether or not the patient is of Hispanic or Latino ethnicity

Field Values

- Yes
- No
- UTD: Unable to determine

Additional Information

- Patient race/ethnicity should be coded as stated by patient or family member

Uses

- Epidemiological statistics
- System evaluation and monitoring

Data Source Hierarchy

- Facesheet
- ED Records
- History and Physical
- Billing Sheet / Medical Records Coding Summary Sheet

TRANSFERRED FROM

Definition

Acute care facility from which patient was transferred, if applicable

Field Values

- *LOS ANGELES COUNTY 9-1-1 RECEIVING HOSPITALS*

Alpha Code	***Numeric Code***	***Hospital Name***
ACH	132	Alhambra Hospital Med Center
AHM	120	Catalina Island Medical Center
AMH	450	Methodist Hospital of Southern California
AVH	118	Antelope Valley Hospital
BEL	127	Bellflower Medical Center
BEV	135	Beverly Hospital
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ELA	157	East Los Angeles Doctors Hospital
ENH	191	Encino Hospital Medical Center
FPH	160	Foothill Presbyterian Hospital
GAR	216	Garfield Medical Center
GEM	168	Greater El Monte Community Hospital
GMH	514	Glendale Memorial Hospital & Health Center
GSH	220	Good Samaritan Hospital
GWT	210	Glendale Adventist Medical Center
HCH	305	Providence Holy Cross Medical Center
HEV	310	East Valley Hospital Medical Center
HGH	248	LAC Harbor-UCLA Medical Center
HMH	324	Huntington Memorial Hospital
HMN	270	Henry Mayo Newhall Memorial Hospital
HWH	913	West Hills Hospital and Medical Center
ICH	330	Citrus Valley Medical Center – Intercommunity Campus
KFA	311	Kaiser Baldwin Park Medical Center
KFB	340	Kaiser Downey Medical Center
KFH	400	Kaiser South Bay Medical Center
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MPH	552	Monterey Park Hospital
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PIH	466	PIH Health Hospital – Whittier
PLB	580	College Medical Center
PVC	464	Pomona Valley Hospital Medical Center
QOA	286	Hollywood Presbyterian Medical Center
QVH	468	Citrus Valley Medical Center – Queen of the Valley
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SDC	485	San Dimas Community Hospital
SFM	667	Saint Francis Medical Center
SGC	487	San Gabriel Valley Medical Center
SJH	680	Saint John's Health Center
SJS	685	Providence Saint Joseph Medical Center
SMH	742	Santa Monica-UCLA Medical Center
SMM	134	Saint Mary Medical Center
SOC	780	Sherman Oaks Hospital
SPP	726	Providence Little Company of Mary – San Pedro
TOR	805	Torrance Memorial Medical Center
TRI	820	Tri-City Regional Medical Center
TRM	799	Providence Tarzana Medical Center
UCL	818	Ronald Reagan UCLA Medical Center
USC	438	LAC+USC Medical Center
VHH	875	USC Verdugo Hills Hospital
VPH	856	Valley Presbyterian Hospital
WHH	507	Whittier Hospital Medical Center
WMH	970	White Memorial Med Center

- *ORANGE COUNTY 9-1-1 RECEIVING HOSPITALS*

Alpha Code	***Numeric Code***	***Hospital Name***
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KHA		Kaiser Permanente Orange County Anaheim Medical Center
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UCI	500	UC Irvine Medical Center
LAG	422	Los Alamitos Medical Center
LPI	420	La Palma Intercommunity Hospital
MCP	540	Mission Community Hospital
PLH		Placentia Linda Hospital
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Alpha Code	***Numeric Code***	***Hospital Name***
CHI	124	Chino Valley Medical Center
DHM	504	Montclair Hospital Medical Center

- *VENTURA COUNTY 9-1-1 RECEIVING HOSPITALS*

Alpha Code	***Numeric Code***	***Hospital Name***
LRR	424	Los Robles Hospital and Medical Center
SJO	472	Saint John's Regional Medical Center

- NA: Not applicable (patient did not arrive via transfer)
- ND: Not documented (documentation of original facility cannot be found for transferred patient)

Uses

- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ASC Log
- Facesheet
- ED Records
- History and Physical
- Billing Sheet / Medical Records Coding Summary Sheet

ARRIVAL TO HOSPITAL DATE

Definition

The date the patient arrived at your facility

Field Values

- Collected as MMDDYYYY
- NA: Not applicable
- ND: Not documented

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- ASC Log
- Facesheet
- ED Records
- History and Physical

ARRIVAL AT HOSPITAL TIME

Definition

The time of day that the patient arrived at your facility

Field Values

- Collected as HHMM
- Use 24-hour clock

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- ASC Log
- Facesheet
- ED Records
- History and Physical

FINAL LAST KNOWN WELL DATE

Definition

Date when the patient was last known to be well, symptom-free, or at baseline or usual state of health, per hospital documentation

Field Values

- Collected as MMDDYYYY
- ND: Not documented

Uses

- Assists with determination of appropriate treatment
- Establishes care intervals and incident timelines
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- History and Physical
- Other hospital records

FINAL LAST KNOWN WELL TIME

Definition

Time when the patient was last known to be well, symptom-free, or at baseline or usual state of health, per hospital documentation

Field Values

- Collected as HHMM
- Use 24-hour clock

Additional Information

- Estimates to within nearest 15 minutes are acceptable

Uses

- Establishes care intervals and incident timelines
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- History and Physical
- Other hospital records

PRIOR AMBULATORY STATUS

Definition

Indicates patient's ambulatory status prior to current event

Field Values

- With assistance from another person (with or without device)
- Without assistance from another person (with or without device)
- Unable
- Not Documented

Uses

- Establishes patient's baseline ambulatory status
- Assists with determining the severity of the event and the patient's response to treatment

Data Source Hierarchy

- ED Records
- History and Physical
- Other hospital records

INIT NIH STROKE SCALE PERFORMED

Definition

Indicates whether the National Institutes of Health (NIH) Stroke Scale was performed on the patient at your facility

Field Values

- Yes
- No
- ND: Not Documented

Additional Information

- Only respond Yes if the complete NIH Stroke Scale was performed within 48 hours of presentation
- If another stroke scale was performed instead, including the Modified NIH Stroke Scale, answer No

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ED records
- History and Physical
- Other hospital records

NIH STROKE SCALE

Definition

The numerical value of the NIH Stroke Scale

Field Values

- Numeric value
- ND: Not documented
- NA: Not applicable (NIH Stroke Scale not performed)

Uses

- Provides documentation of assessment/care
- Assists with determination of severity of event

Data Source Hierarchy

- ED records
- History and Physical
- Other hospital records

BRAIN IMAGING DATE

Definition

Date of the initial non-contrast CT/MRI of the head performed at your facility from the DICOM header information. This is the date printed on the hard copy of the film, or available when reviewing the image digitally.

Field Values

- Collected as MMDDYYYY
- NA: Not applicable
- ND: Not documented

Additional Information

- Record only CT/MRI date if the first study was performed at your hospital. If the CT/MRI was performed at a non ASC, document date as NA
- Use the date indicated on the radiology report only if it clearly indicates the date of study initiation or completion (date of initiation preferred) and NOT date of scheduling, dictation or reporting.
- For CT studies, use the date-time stamp on the non-contrast CT, not CT-angiography or CT-perfusion studies, if they were done.

Uses

- Provides documentation of assessment/care
- Establishes care intervals and incident timelines
- System evaluation and monitoring

Data Source Hierarchy

- Radiology report
- ED records
- History and Physical
- Other hospital records

BRAIN IMAGING TIME

Definition

Time of day of the initial non-contrast CT/MRI of the head performed at your facility from the DICOM header information. This is the time printed on the hard copy of the film, or available when reviewing the image digitally.

Field Values

- Collected as HHMM
- Use 24-hour clock
- NA: Not applicable
- ND: Not documented

Additional Information

- Record only CT/MRI time if the first study was performed at your hospital. If the CT/MRI was performed at a non ASC, document time as NA
- Use the time indicated on the radiology report only if it clearly indicates the time of study initiation or completion (time of initiation preferred) and NOT time of scheduling, dictation or reporting.
- For CT studies, use the date-time stamp on the non-contrast CT, not CT-angiography or CT-perfusion studies, if they were done.

Uses

- Provides documentation of assessment/care
- Establishes care intervals and incident timelines
- System evaluation and monitoring

Data Source Hierarchy

- ED records
- History and Physical
- Other hospital records

ED DISPOSITION

Definition

Patient's next phase of care after the Emergency Department (ED)

Field Values

- OR: Patient went to the OR from the ED
- ICU: Patient was admitted to the ICU from the ED
- Stepdown/Tele: Patient was admitted to Stepdown/Tele Unit from the ED
- Ward: Patient was admitted to a Ward from the ED
- <24 Obs: Patient was admitted to <24 Obs. Unit from the ED
- Neuro IR Rad: Patient went to Neuro IR Radiology from the ED
- Post Hosp: Patient was discharged from the ED or died in the ED

Additional Information

- If Post Hosp is checked, Hosp. Disposition field is required

Uses

- Provides documentation of care
- System evaluation and monitoring

Data Source Hierarchy

- ED records
- Billing sheet / Medical records coding summary sheet
- Other hospital records
- Hospital discharge summary

THROMBOLYTIC THERAPY?

Definition

Indicates whether thrombolytic therapy was initiated at your facility

Field Values

- Yes
- No

Additional Information

- If thrombolytic therapy was initiated at another facility, document No

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- ED records
- Other hospital records

IF THROMB. THERAPY YES, DATE

Definition

Date that the patient received thrombolytic therapy at your facility, if applicable

Field Values

- Collected as MMDDYYYY
- NA: Not applicable
- ND: Not documented

Uses

- Establishes care intervals and incident timelines
- System evaluation and monitoring

Data Source Hierarchy

- ED records
- Other hospital records

IF THROMB. THERAPY YES, TIME

Definition

Time of day that the patient received thrombolytic therapy at your facility, if applicable

Field Values

- Collected as HHMM
- Use 24-hour clock
- NA: Not applicable
- ND: Not documented

Uses

- Establishes care intervals and incident timelines
- System evaluation and monitoring

Data Source Hierarchy

- ED records
- Other hospital records

COMPLICATIONS OF THROMBOLYTIC THERAPY?

Definition

Indicates whether the patient experienced any complications related to thrombolytic therapy

Field Values

- Yes
- No
- NA: Not applicable, the patient did not receive thrombolytic therapy
- ND: Not documented

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Other hospital records

COMPLICATIONS

Definition

Indicates serious complications that occurred that were unexpected or out of proportion to the patient's expected course, and that were documented as complications of thrombolytic therapy, if applicable (e.g., rapid development of malignant edema, angioedema, or recurrent stroke)

Field Values

- ICH: Intracranial hemorrhage <36 hours from initiation of therapy – a CT within 36 hours shows intracranial hemorrhage AND physician's notes indicate clinical deterioration due to hemorrhage
- HEM: Systemic hemorrhage <36 hours from initiation of therapy – bleeding within 36 hours of therapy and > 3 transfused units of blood within 7 days, or before discharge (whichever is earlier) AND physician note attributing bleeding problem as reason for transfusion
- ADI: Additional interventions required – serious complications that require additional medical interventions
- PLS: Prolonged length of stay – serious complications that require prolonged length of stay
- WSE: Worsening stroke symptoms
- NON: No serious complications
- OTH: Other
- N/A: Patient did not receive thrombolytic therapy

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Other hospital records

CONTRAINDICATIONS/WARNINGS/DELAYS

Definition

Reasons or risk factors associated with delay or withholding of thrombolytic therapy, if applicable - use the Ctrl key to select all that apply.

Field Values

AB	Active internal bleeding <22 days prior to event
AGE	Advanced age
AN	Brain aneurysm
BLD	Platelets <100,000, PTT >40 sec. after heparin use, PT >15, INR >1.7, or known bleeding tendencies
BP	SBP > 185 or DBP > 110mmHG despite treatment
BS	Glucose <50 or >400 mg/dl
BT	History of brain tumor
CT	CT findings of ICH, SAH, or major infarct signs
DR	Diabetic hemorrhagic retinopathy
DX	Delay in stroke diagnosis
HD	Hemostatic defects
HTH	Left heart thrombus
HX	Prior stroke and diabetes
IH	History of intracranial hemorrhage
IMP	Rapid improvement
IRB	Increased risk of bleeding
IV	No IV access
MCA	CT findings of >1/3 Middle Cerebral Artery (MCA) Infarction
MOR	Life expectancy <1 year, severe co-morbid illness, or Comfort Measures Only (CMO) on admission
NA	Not applicable
NIH25	NIHSS >25
OAV	Occluded AV cannula
OR	Recent intracranial or spinal surgery, head trauma, or stroke (<3 mo.)
OTH	Other
PCAR	Acute pericarditis
PRG	Pregnancy
PTA	Delay in patient arrival
REF	Patient/family refused
SAH	Suspicion of subarachnoid hemorrhage
SE	Seizure at onset
SMD	Stroke severity too mild
SSV	Stroke severity too severe (e.g. NIHSS >22)
STB	Septic thrombophlebitis
tPA	IV or IA tPA given at outside hospital
TR	Recent surgery/trauma (<15 days)
UTD	Care team unable to determine eligibility
VA	History of vascular malformation
WAR	Currently taking oral anticoagulants (e.g., Warfarin)

Uses

- Provides documentation of assessment and/or care

- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ED records
- History and Physical
- Other hospital records

IA CATHETER?

Definition

Indicates whether IA catheter-based reperfusion was initiated at your facility

Field Values

- Yes
- No
- NA: Not applicable
- ND: Not documented

Additional Information

- IA catheter-based reperfusion therapy includes all uses of IA thrombolytic therapy, Including mechanical devices such as “clot retrieval devices”

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- OR records
- Billing sheet / Medical records coding summary sheet
- Progress notes
- Other hospital records

IA CATHETER, IF YES

Definition

Indicates the type of IA catheter-based reperfusion treatment that was used

Field Values

- IA Thrombolysis
- Endovascular retrieval device
- Endovascular aspiration device
- Angioplasty and/or stenting
- Other
- ND: Not documented

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Radiology records
- OR records
- Billing sheet / Medical records coding summary sheet
- Progress notes
- Other hospital records

IA CATHETER TYPE, IF OTHER

Definition

Field provided to specify type of IA catheter-based reperfusion therapy not identified in the “If Yes” picklist

Field Values

- Free text comment field

Additional Information

Required field if “Other” is chosen as in the “If Yes” field

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- OR records
- Billing sheet / Medical records coding summary sheet
- Progress notes
- Other hospital records

GROIN PUNCTURE DATE

Definition

Date groin puncture was performed

Field Values

- Collected as MMDDYYYY
- NA: Not applicable
- ND: Not documented

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- OR records
- Billing sheet / Medical records coding summary sheet
- Progress notes
- Other hospital records

GROIN PUNCTURE TIME

Definition

Time of day groin puncture was performed

Field Values

- Collected as HHMM
- Use 24-hour clock
- NA: Not applicable
- ND: Not documented

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- OR records
- Billing sheet / Medical records coding summary sheet
- Progress notes
- Other hospital records

MICROCATHETER ON CLOT DATE

Definition

Date the microcatheter was placed on the clot

Field Values

- Collected as MMDDYYYY
- NA: Not applicable
- ND: Not documented

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- OR records
- Billing sheet / Medical records coding summary sheet
- Progress notes
- Other hospital records

MICROCATHETER ON CLOT TIME

Definition

Time of day the microcatheter was placed on the clot

Field Values

- Collected as HHMM
- Use 24-hour clock
- NA: Not applicable
- ND: Not documented

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- OR records
- Billing sheet / Medical records coding summary sheet
- Progress notes
- Other hospital records

HOSP. DISCHARGE DATE

Definition

Date the patient was discharged from the acute care unit at your facility

Field Values

- Collected as MMDDYYYY

Additional Information

- Applicable when the patient:
  - Expires
  - Is discharged home
  - Leaves against medical advice (AMA)
  - Leaves without being seen or elopes (LWBS)
  - Is transferred to a rehabilitation, skilled nursing, or hospice unit at your facility
  - Is transferred to an acute inpatient unit at another facility

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Hospital discharge summary
- Progress notes
- Billing sheet / Medical records coding summary sheet

HOSP. DISPOSITION

Definition

Destination upon discharge from the acute care unit at your facility

Field Values

- Previous place of residence
- Other Approved Stroke Center (ASC)
- Other non-ASC facility
- SNF: Skilled nursing facility
- Rehab center
- Hospice
- AMA/Eloped/LWBS
- Morgue/Mortuary
- ND: Not documented

Uses

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring
- Epidemiological statistics

Data Source Hierarchy

- Hospital discharge summary
- Progress notes
- Billing sheet / Medical records coding summary sheet

RATIONALE FOR DISPOSITION

Definition

The primary reason for hospital disposition

Field Values

- Financial health plan
- Higher level or specialized care
- Rehab
- Extended care
- Discharged
- Expired
- Other
- ND: Not documented

Uses

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- Hospital discharge summary
- Progress notes
- Billing sheet / Medical records coding summary sheet

TRANSFERRED TO

Definition

Code indicating to which acute care facility the patient was transferred, if applicable

Field Values

- *LOS ANGELES COUNTY 9-1-1 RECEIVING HOSPITALS*

Alpha Code	***Numeric Code***	***Hospital Name***
ACH	132	Alhambra Hospital Med Center
AHM	120	Catalina Island Medical Center
AMH	450	Methodist Hospital of Southern California
AVH	118	Antelope Valley Hospital
BEL	127	Bellflower Medical Center
BEV	135	Beverly Hospital
BMC	172	Southern California Hospital at Culver City
CAL	133	California Hospital Medical Center
CHH	145	Children's Hospital Los Angeles
CNT	141	Centinela Hospital Medical Center
CPM	150	Coast Plaza Doctors Hospital
CSM	139	Cedars-Sinai Medical Center
DCH	155	PIH Health Hospital – Downey
DFM	457	Marina Del Rey Hospital
DHL	412	Lakewood Regional Medical Center
ELA	157	East Los Angeles Doctors Hospital
ENH	191	Encino Hospital Medical Center
FPH	160	Foothill Presbyterian Hospital
GAR	216	Garfield Medical Center
GEM	168	Greater El Monte Community Hospital
GMH	514	Glendale Memorial Hospital & Health Center
GSH	220	Good Samaritan Hospital
GWT	210	Glendale Adventist Medical Center
HCH	305	Providence Holy Cross Medical Center
HEV	310	East Valley Hospital Medical Center
HGH	248	LAC Harbor-UCLA Medical Center
HMH	324	Huntington Memorial Hospital
HMN	270	Henry Mayo Newhall Memorial Hospital
HWH	913	West Hills Hospital and Medical Center
ICH	330	Citrus Valley Medical Center – Intercommunity Campus
KFA	311	Kaiser Baldwin Park Medical Center
KFB	340	Kaiser Downey Medical Center
KFH	400	Kaiser South Bay Medical Center
KFL	343	Kaiser Los Angeles Medical Center
KFO	370	Kaiser Woodland Hills Medical Center
KFP	381	Kaiser Panorama City Medical Center

KFW	362	Kaiser West Los Angeles Medical Center
LBC	445	Community Hospital of Long Beach
LBM	533	Long Beach Memorial Medical Center
LCH	418	Palmdale Regional Medical Center
LCM	440	Providence Little Company of Mary – Torrance
MHG	495	Memorial Hospital of Gardena
MID	537	Olympia Medical Center
MCP	540	Mission Community Hospital
MPH	552	Monterey Park Hospital
NOR	452	Norwalk Community Hospital
NRH	571	Northridge Hospital Medical Center
OTH	998	Other Hospital Not on List
OVM	575	LAC Olive View-UCLA Medical Center
PAC	761	Pacifica Hospital of the Valley
PIH	466	PIH Health Hospital – Whittier
PLB	580	College Medical Center
PVC	464	Pomona Valley Hospital Medical Center
QOA	286	Hollywood Presbyterian Medical Center
QVH	468	Citrus Valley Medical Center – Queen of the Valley
SAC	489	San Antonio Community Hospital
SDC	485	San Dimas Community Hospital
SFM	667	Saint Francis Medical Center
SGC	487	San Gabriel Valley Medical Center
SJH	680	Saint John's Health Center
SJS	685	Providence Saint Joseph Medical Center
SMH	742	Santa Monica-UCLA Medical Center
SMM	134	Saint Mary Medical Center
SOC	780	Sherman Oaks Hospital
SPP	726	Providence Little Company of Mary – San Pedro
TOR	805	Torrance Memorial Medical Center
TRI	820	Tri-City Regional Medical Center
TRM	799	Providence Tarzana Medical Center
UCL	818	Ronald Reagan UCLA Medical Center
USC	438	LAC+USC Medical Center
VHH	875	USC Verdugo Hills Hospital
VPH	856	Valley Presbyterian Hospital
WHH	507	Whittier Hospital Medical Center
WMH	970	White Memorial Med Center

- *ORANGE COUNTY 9-1-1 RECEIVING HOSPITALS*

Alpha Code	**Numeric Code**	**Hospital Name**
ANH		Anaheim Memorial Hospital
LPI	420	La Palma Intercommunity Hospital

FHP		Fountain Valley Regional Hospital and Medical Center
PLH		Placentia Linda Hospital
KHA		Kaiser Permanente Orange County Anaheim Medical Center
SJD	474	Saint Jude Medical Center
UCI	500	UC Irvine Medical Center
LAG	422	Los Alamitos Medical Center
LPI	420	La Palma Intercommunity Hospital
MCP	540	Mission Community Hospital
PLH		Placentia Linda Hospital
SJD	474	Saint Jude Medical Center
UCI	500	UC Irvine Medical Center

- *SAN BERNADINO COUNTY 9-1-1 RECEIVING HOSPITALS*

Alpha Code	**Numeric Code**	**Hospital Name**
CHI	124	Chino Valley Medical Center
DHM	504	Montclair Hospital Medical Center

- *VENTURA COUNTY 9-1-1 RECEIVING HOSPITALS*

Alpha Code	**Numeric Code**	**Hospital Name**
LRR	424	Los Robles Hospital and Medical Center
SJO	472	Saint John's Regional Medical Center

- NA: Not applicable (patient did not arrive via transfer)
- ND: Not documented (documentation of original facility cannot be found for transferred patient)

Uses

- Assists with determination of appropriate treatment
- System evaluation and monitoring

Data Source Hierarchy

- ASC Log
- Facesheet
- ED Records
- History and Physical
- Billing Sheet / Medical Records Coding Summary Sheet

MODIFIED RANKIN PERFORMED AT DISCHARGE?

Definition

Indicates whether the Modified Rankin Scale was performed on the patient at discharge

Field Values

- Yes
- No
- ND: Not Documented

Uses

- Provides documentation of assessment and/or care
- Assists with determination of outcome
- System evaluation and monitoring

Data Source Hierarchy

- Hospital discharge summary
- Progress notes
- Billing sheet / Medical records coding summary sheet
- Other hospital records

MODIFIED RANKIN SCALE

Definition

The numerical value of the Modified Rankin Scale

Field Values

- Numeric value
- ND: Not documented
- NA: Not applicable (Modified Rankin Scale not performed)

Additional Information

- 0: No disability
- 1: No significant disability despite symptoms, able to carry out all usual duties and activities
- 2: Slight disability, unable to carry out all routine activities, but able to look after own affairs without assistance
- 3: Moderate Disability, requiring some help, but able to walk without assistance from a person
- 4: Moderate-Severe disability, unable to walk without assistance, OR, unable to attend to own bodily needs without assistance from a person
- 5: Severe disability, bedridden, incontinent, and requiring constant nursing care
- 6: Dead

Uses

- Provides documentation of assessment and/or care
- Assists with determination of outcome
- System evaluation and monitoring

Data Source Hierarchy

- Hospital discharge summary
- Progress notes
- Billing sheet / Medical records coding summary sheet
- Other hospital records

STROKE RELATED ICD10 CODE

Definition

Indicates the patient's clinical hospital diagnosis or diagnoses related to stroke, if applicable

Field Values

I67.89	Acute, but ill-defined, cerebrovascular disease
I65.1	Basilar artery syndrome
G45.1	Carotid artery syndrome (hemispheric)
I63.50	Cerebral artery occlusion not otherwise specified with infarction
I66.9	Cerebral artery occlusion not otherwise specified without infarction
I63.40	Cerebral embolism with infarction
I66.9	Cerebral embolism without infarction
I63.9	Cerebral infarction, unspecified
I63.139	Cerebral infarction due to embolism of unspecified carotid artery
I63.119	Cerebral Infarction due to embolism of unspecified vertebral artery
I63.019	Cerebral Infarction due to thrombosis of unspecified vertebral artery
I63.231	Cerebral infarction due to unspecified occlusion or stenosis of right carotid arteries
I63.232	Cerebral infarction due to unspecified occlusion or stenosis of left carotid arteries
I63.239	Cerebral Infarction due to unspecified occlusion or stenosis of unspecified carotid arteries
I66.09	Cerebral thrombosis without infarction
O22.51	Cerebral venous thrombosis in pregnancy, first trimester
O22.52	Cerebral venous thrombosis in pregnancy, second trimester
O22.53	Cerebral venous thrombosis in pregnancy, third trimester
O99.419	Cerebrovascular disorders occurring in pregnancy, childbirth, or the puerperium unspecified as to episode of care
O99.43	Cerebrovascular disorders with delivery with postpartum complication
O99.411	Disease of the circulatory system complicating pregnancy, first trimester
O99.412	Disease of the circulatory system complicating pregnancy, second trimester
O99.413	Disease of the circulatory system complicating pregnancy, third trimester
O99.42	Diseases of the circulatory system complicating childbirth
I61.9	Intracerebral hemorrhage
I97.811	Intraoperative cerebrovascular infarction during other surgery
I61.1	Non-traumatic intracerebral hemorrhage
I61.5	Non-traumatic intracerebral hemorrhage, intraventricular
I63.20	Occluded artery not otherwise specified with infarct
I65.9	Occluded artery not otherwise specified without infarct
I63.22	Occluded basilar artery with infarct
I65.29	Occluded basilar artery without infarct
I63.139	Occluded carotid artery with infarct
I63.59	Occluded multiple and bilateral arteries with infarct
I65.8	Occluded multiple and bilateral arteries without infarct
I65.1	Occluded precerebral artery
I63.59	Occluded specified artery with infarct

I65.8	Occluded specified artery without infarct
I63.219	Occluded vertebral artery with infarct
I63.211	Occluded vertebral artery without infarct
I66.19	Occlusion and stenosis of unspecified anterior cerebral artery
I66.09	Occlusion and stenosis of unspecified middle cerebral artery
I66.29	Occlusion and stenosis of unspecified posterior cerebral artery
I67.848	Other cerebral vasospasm and vasoconstriction
O22.50	Other phlebitis and thrombosis complicating pregnancy and the puerperium unspecified as to episode of care
O87.3	Other phlebitis and thrombosis with delivery with postpartum complication
O87.3	Other postpartum phlebitis and thrombosis
G45.8	Other transient cerebral ischemic attacks and related syndromes
O99.43	Postpartum cerebrovascular disorders
I97.821	Postprocedural cerebrovascular infarction during other surgery
I60.9	Subarachnoid hemorrhage
G45.8	Subclavian steal syndrome
I63.8	Superior cerebellar artery syndrome
I63.30	Thrombosis with cerebral infarction
G45.1	Transient cerebral ischemia not elsewhere classified
G45.9	Transient cerebral ischemia not otherwise specified
G45.9	Transient cerebral ischemic attack, unspecified
I62.9	Unspecified intracranial hemorrhage
O22.91	Venous thrombosis in pregnancy, first trimester
O22.92	Venous thrombosis in pregnancy, second trimester
O22.93	Venous thrombosis in pregnancy, third trimester
I63.219	Vertebral infarction due to unspecified occlusion or stenosis of unspecified vertebral arteries
I65.09	Vertebral artery syndrome
G45.0	Vertebrobasilar artery syndrome

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- Hospital discharge summary
- Progress notes
- Other hospital records

FINAL CLINICAL DIAGNOSIS

Definition

Indicates the condition thought to be chiefly responsible for the event

Field Values

- Ischemic Stroke
- Transient ischemic attack
- Subarachnoid hemorrhage
- Intracerebral hemorrhage
- Stroke, not otherwise specified
- No stroke-related diagnosis

Additional Information

- Select most significant option based on the clinical information found in the medical record

Uses

- Assists with determination of appropriate treatment
- Provides documentation of assessment and/or care
- System evaluation and monitoring

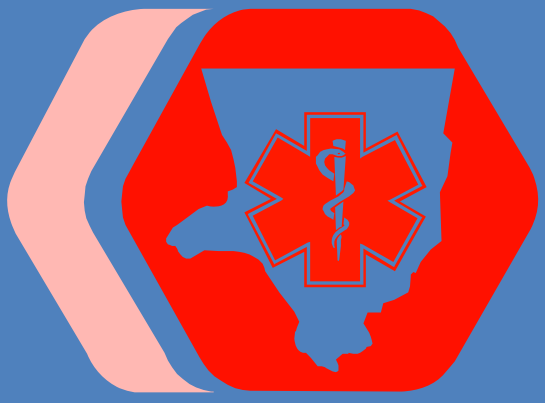
Data Source Hierarchy

- Hospital discharge summary
- Progress notes

9-1-1 RECEIVING HOSPITAL DATA DICTIONARY

Los Angeles County

Emergency Medical Services Agency



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KEYSTROKE SHORTCUTS

Data Entry

Ctrl + F2	Enter the current date or time
Ctrl + F3	Enter the last entered date or time
Ctrl + F6	Flag the selected field as Not Documented
Ctrl + F7	Flag the selected field as Not Applicable
Ctrl + F12	Clear current field
Ctrl + ←	Go to previous page in pathway
Ctrl + →	Go to next page in pathway
Ctrl + L	Display text for current field value if picklisted
Ctrl + M	Open Memo or Annotation on current field
Ctrl + Q	Open picklist for current field

Data Entry – Scrolling Window

Alt + N	Add new row to scrolling window
Alt + I	Insert new row above current row in scrolling window
Alt + L	Delete selected row in scrolling window
Alt + R	Copy selected row in scrolling window to the end of scrolling window
Alt + Y	Copy previous row in scrolling window to the selected row in scrolling window
Alt + ↑	To exit from the current R/G to previous control
Alt + ↓	To exit from the current R/G to next control

Populations

Ctrl + F8	Place non-leaf picklist item in selected field
PICKLISTS	
←	Go back to a previous list
Enter	Select the current item and close the picklist
Spacebar	Select/unselect the current item

Miscellaneous

Ctrl + E	Open shortcut key window

MEDICAL RECORD NUMBER

Definition

The patient's medical (or financial) record number as assigned by the treating facility

Field Values

- Up to fifteen-character, free-text field

Uses

- Patient identifier

Data Source Hierarchy

- Facesheet
- ED Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Log

SEQUENCE NUMBER

Definition

Unique, alphanumeric EMS record number provided by the 9-1-1 provider, and found pre-printed at the top right corner of EMS report form hard copies. Electronically assigned to electronic patient care records (ePCR) from approved providers

Additional Information

- Valid sequence number is required to proceed with data entry
- Consists of two letters and six digits on pre-printed EMS Report Forms; or two letters, ten digits if obtained from an approved ePCR provider
- If sequence number is missing or incorrectly documented, every effort must be taken to obtain it – by reviewing the patient's medical record, or by contacting either the Prehospital Care Coordinator of the applicable base hospital or the EMS provider that transported the patient

Uses

- Unique patient identifier
- Medical record linking

Data Source Hierarchy

- EMS Report Form
- Hospital Log
- Fire Station logs

ARRIVAL AT HOSPITAL DATE

Definition

The date the patient arrived at your facility

Field Values

- Collected as MMDDYYYY

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- Facesheet
- ED Records
- History and Physical

ARRIVAL AT HOSPITAL TIME

Definition

The time of day that the patient arrived at your facility

Field Values

- Collected as HHMM
- Use 24-hour clock

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- Facesheet
- ED Records
- History and Physical

LAST NAME

Definition

The patient's last name

Field Values

- Free-text field

Uses

- Patient identifier

Data Source Hierarchy

- Facesheet
- ED Records
- EMS Report Form
- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Log

FIRST NAME

Definition

The patient's first name

Field Values

- Free-text field

Uses

- Patient identifier

Data Source Hierarchy

- Facesheet
- ED Records
- EMS Report Form
- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Log

DOB

Definition

The date of birth of the patient

Field Values

- Collected as MMDDYYYY

Uses

- Allows for data sorting and tracking by age
- Assists with patient identification
- Epidemiological statistics

Data Source Hierarchy

- Facesheet
- ED Records
- EMS Report Form
- Base Hospital Form
- History and Physical
- Billing Sheet / Medical Records Coding Summary Sheet

AGE

Definition

Numeric value for the patient's age (actual or best approximation)

Field Values

- Up to three-digit numeric value

Additional Information

- Field autofills if valid date of birth is entered

Uses

- Allows for data sorting and tracking by age
- Assists with patient identification
- Epidemiological statistics

Data Source Hierarchy

- Facesheet
- ED Records
- EMS Report Form
- Base Hospital Form
- History and Physical
- Billing Sheet / Medical Records Coding Summary Sheet

AGE UNITS

Definition

One-letter code indicating the units of measurement used to report the patient's age

Field Values

- **Y**: Years – used for patients 2 years old or older
- **M**: Months – used for patients 1 month to 23 months old
- **D**: Days – used for patients 1 to 29 days old
- **H**: Hours – used for patients who are newborn and up to 23 hours old

Additional Information

- Field autofills if valid date of birth is entered

Uses

- Allows for data sorting and tracking by age
- Assists with patient identification
- Epidemiological statistics

Data Source Hierarchy

- Facesheet
- ED Records
- EMS Report Form
- Base Hospital Form
- History and Physical
- Billing Sheet / Medical Records Coding Summary Sheet

SEX

Definition

One-letter code indication the patient's gender

Field Values

- F: Female
- M: Male
- U: Unknown

Additional Information

- Patients who are undergoing or have undergone a hormonal and/or surgical sex reassignment should be coded using their stated preference
- Patients unable to state their preference should be coded according to medical observation/judgment

Uses

- Assists with patient identification
- Epidemiological statistics
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- EMS Report Form
- Facesheet
- History and Physical
- Billing Sheet / Medical Records Coding Summary Sheet

PROVIDER

Definition

Two-letter code for the EMS provider primarily responsible for the patient's prehospital care

Field Values

PUBLIC PROVIDERS

AF	Arcadia Fire
AH	Alhambra Fire
AV	Avalon Fire
BF	Burbank Fire
BH	Beverly Hills Fire
CB	LA County Beaches
CC	Culver City Fire
CF	LA County Fire
CG	US Coast Guard
CI	LA City Fire
CM	Compton Fire
CS	LA County Sheriff
DF	Downey Fire
ES	El Segundo Fire
FS	U.S. Forest Service
GL	Glendale Fire
HB	Hermosa Beach Fire
LB	Long Beach Fire
LH	La Habra Heights Fire
LV	La Verne Fire
MB	Manhattan Beach Fire
MF	Monrovia Fire
MO	Montebello Fire
MP	Monterey Park Fire
ND	Not Documented
OT	Other Provider
PF	Pasadena Fire
RB	Redondo Beach Fire
SA	San Marino Fire
SG	San Gabriel Fire
SI	Sierra Madre Fire
SM	Santa Monica Fire
SP	South Pasadena Fire
SS	Santa Fe Springs Fire
TF	Torrance Fire
VE	Ventura County Fire
WC	West Covina Fire
VF	Vernon Fire

PRIVATE PROVIDERS

AC	Americare Ambulance Service
AE	Aegis Ambulance Service
AN	Antelope Ambulance Service
AR	American Medical Response
AU	AmbuServe Ambulance
BO	Bowers Companies, Inc.
CA	CARE Ambulance

EX	Explorer 1 Ambulance & Med Srvcs
GC	Gentle Care Transport
GU	Guardian Ambulance Service
IA	Impulse Ambulance
LT	Liberty Ambulance
MI	MedResponse, Inc.
MY	Mercy Air
MR	MedReach Ambulance
PM	PRN Ambulance, Inc.
PT	Priority One
RE	REACH Air Medical Service
RR	Rescue Services International
SC	Schaefer Ambulance
SY	Symons Ambulance
WE	Westcoast Ambulance
WM	West Med/McCormick Ambulance Service

Uses

- System evaluation and monitoring
- Medical record linking

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form

UNIT #

Definition

Numeric unit number of the Advanced Life Support (ALS) or Basic Life Support (BLS) provider that transported the patient

Field Values

- Up to six-character, free-text field

Uses

- System evaluation and monitoring
- Medical record linking

Data Hierarchy

- EMS Report Form
- Base Hospital Form

BASE HOSPITAL

Definition

Three-letter code for the paramedic base hospital from which the patient was directed to your facility, if applicable

Field Values

Alpha Code	*Numeric Code*	*Hospital Name*
AMH	450	Methodist Hospital of Southern California
AVH	118	Antelope Valley Hospital
CAL	133	California Hospital Medical Center
CSM	139	Cedars-Sinai Medical Center
GWT	210	Glendale Adventist Medical Center
HCH	305	Providence Holy Cross Medical Center
HGH	248	LAC Harbor-UCLA Medical Center
HMH	324	Huntington Hospital
HMN	270	Henry Mayo Newhall Memorial Hospital
LBM	533	Long Beach Memorial Medical Center
LCM	440	Providence Little Company of Mary Hospital – Torrance
MAC		Medical Alert Center
NRH	571	Northridge Hospital Medical Center
PIH	466	PIH Health Hospital – Whittier
PVC	464	Pomona Valley Hospital Medical Center
QVH	468	Citrus Valley Medical Center – Queen of the Valley
SFM	667	St. Francis Medical Center
SJS	685	Providence Saint Joseph Medical Center
SMM	134	St. Mary Medical Center
TOR	805	Torrance Memorial Medical Center
UCL	818	Ronald Reagan UCLA Medical Center
USC	438	LAC+USC Medical Center
OTH	998	Other Hospital Not on List
CNA		Contact Not Attempted (no base contacted by the provider)
PRO		Protocol (SFTP providers only)

Additional Information

- Three-digit codes are used by LA City Fire Dept. only, and are provided only as a reference to the appropriate three-letter code

Uses

- System evaluation and monitoring
- Medical record linking

Data Source Hierarchy

- EMS Report Form
- Hospital Log

CHIEF COMPLAINT CODE

Definition

Two-letter code(s) representing the patient's most significant medical or trauma complaints

Field Values

Medical Codes

AD	Agitated Delirium
AP	Abd/Pelvic Pain
AR	Allergic Reaction
AL	Altered LOC
AE	Apneic Episode
TE	Apparent Life Threatening Event (ALTE)
EH	Behavioral
OS	Bleeding Other Site (NOT associated with trauma, e.g., dialysis shunt)
CA	Cardiac Arrest (NOT associated with trauma)
CP	Chest Pain (NOT associated with trauma)
CH	Choking/Airway Obstruction
CC	Cough/Congestion
DC	Device Complaint (associated with an existing medical device – e.g., G-Tube, AICD, ventilator, etc.)
DI	Dizzy
DO	DOA (Dead On Arrival)
DY	Dysrhythmia
FE	Fever
FB	Foreign Body (anywhere in body)
GI	Gastrointestinal Bleeding
HP	Head Pain (NOT associated with trauma)
HY	Hypoglycemia
IM	Inpatient Medical (interfacility transfer of an ill – NOT injured – patient
LA	Labor (>20 weeks pregnant with signs or symptoms of labor)
LN	Local Neuro Signs (weakness, numbness, paralysis – including slurred speech, facial droop, aphasia)
NV	Nausea/Vomiting
ND	Near-Drowning/Drowning (submersion causing water inhalation, unconsciousness, or death)
NB	Neck/Back Pain (NOT associated with trauma)
NW	Newborn (infant delivered outside of the hospital setting)
NC	No Medical Complaint
NO	Nosebleed
OB	Obstetrics (any complaints which may be related to a known pregnancy)
OP	Other Pain (NON-traumatic pain at a site not listed, e.g., toothache, ear pain, etc.)
OD	Overdose (dose greater than recommended or generally given)
PO	Poisoning (ingestion of, or contact with, a toxic substance)
PS	Palpitations
RA	Respiratory Arrest (cessation of breathing NOT associated with trauma)
SE	Seizure (NOT associated with trauma)
SB	Shortness of Breath
SY	Syncope
VA	Vaginal Bleeding
WE	Weakness
OT	Other (signs or symptoms not listed above, NOT associated with trauma)

Trauma Codes

NA	No Apparent Injury (no complaint or injury following a traumatic event)

BH/PH Blunt/Penetrating Head (from above the eyebrows to behind the ears; and facial injuries when brain injury is suspected)
BF/PF Blunt/Penetrating Face/Mouth (from/including the eyebrows, down to/including the angle of the jaw and the ears)
BN/PN Blunt/Penetrating Neck (between the angle of the jaw and clavicles, including suspected cervical spine injuries)
BB/PB Blunt/Penetrating Back
BC/PC Blunt/Penetrating Chest
BA/PA Blunt/Penetrating Abdomen
BG/PG Blunt/Penetrating Genitals
BK/PK Blunt/Penetrating Buttocks
BE/PE Blunt/Penetrating Extremities
BL/PL Blunt/Penetrating Minor Lacerations (superficial abrasions/contusions to skin)
BI/PI Amputation proximal to (above) the wrist or ankle due to blunt or penetrating force
BT/PT Traumatic Arrest: cessation of cardiac output and effective circulation due to blunt or penetrating force
BU Burns/Electrical Shock
90 Systolic blood pressure <90mmHg (<70 if <1yr old) in the presence of trauma
RR Respiratory rate <10 or >29bpm (<20 if <1yr old) in the presence of trauma
SF Suspected pelvic fracture, excluding isolated hip fractures from a ground level fall
SC Suspected spinal cord injury, or presence of weakness/paralysis/parasthesia following a traumatic event
IT Inpatient Trauma (interfacility transfer of an injured – NOT ill – patient)

Additional Information

- Enter up to three complaints

Uses

- System evaluation and monitoring
- Epidemiological statistics

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form

MECHANISM OF INJURY

Definition

Two-letter code(s) representing the manner in which the patient sustained injury, if applicable

Field Values

MECHANISM CODES			
SB	Seatbelt	ST	Stabbing
AB	Airbag	GS	GSW
HL	Helmet	MM	Motorcycle/Moped
CS	Child Car seat/Booster seat	SP	Sports/Recreation
EV	Enclosed Vehicle	SA	Self-Inflicted Accidental
EJ	Ejected	SI	Self-Inflicted Intentional
EX	Extricated	AC	Anticoagulants
PS	Passenger Space Intrusion	SC	Special Considerations
18	Passenger Space Intrusion >18in (unoccupied space)	TD	Telemetry Data
12	Passenger Space Intrusion >12in (occupied space)	HE	Hazmat Exposure
SF	Survived Fatal Accident	AN	Animal Bite
20	Unenclosed Vehicle >20mph	CR	Crush
RT	Ped/Bike Thrown/Runover >20mph	ES	Electrical Shock
PB	Ped/Bike <20mph	TB	Thermal Burn
FA	Fall	WR	Work Related
15	Fall >15ft Adult (>10ft Child)	UN	Unknown
AS	Assault	OT	Other

Additional Information

- Enter up to three mechanisms
- Enter Not Applicable if no injury complaint (medical complaint only)

Uses

- System evaluation and monitoring
- Epidemiological statistics

Data Source Hierarchy

- EMS Report Form
- Base Hospital Form

ED DISCHARGE DATE

Definition

The date the patient was discharged from the emergency department

Field Values

- Collected as MMDDYYYY

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- Facesheet
- ED Records
- History and Physical

ED DISCHARGE TIME

Definition

The time of day that the patient was discharged from the emergency department

Field Values

- Collected as HHMM
- Use 24-hour clock

Uses

- Establishes care intervals and incident timelines

Data Source Hierarchy

- ED Records
- History and Physical

ED DISPOSITION

Definition

Patient's next phase of care after the Emergency Department (ED)

Field Values

D Discharged: Patient went home/prior residence
R OR: Patient went to the OR from the ED
E ICU: Patient was admitted to the ICU from the ED
S Stepdown/Tele: Patient was admitted to Stepdown/Tele Unit from the ED
W Ward: Patient was admitted to a Ward from the ED
H <24 Obs: Patient was admitted to <24 Observation Unit from the ED
V IR Rad: Patient went to Interventional Radiology from the ED
E Expired: Patient died in the ED
B OB: Patient was admitted to Obstetrics
C Cath Lab: Patient went to the Cardiac Catheterization Lab from the ED
T Transfer: patient was transferred to another Acute Care Facility
O Other

Uses

- Provides documentation of care
- System evaluation and monitoring

Data Source Hierarchy

- ED records
- Billing sheet / Medical records coding summary sheet
- Hospital log
- Hospital discharge summary

TRANSFERRED TO

Definition

Code indicating to which acute care facility the patient was transferred, if applicable

Field Values

- *LOS ANGELES COUNTY 9-1-1 RECEIVING HOSPITALS*

Alpha Code	***Numeric Code***	***Hospital Name***
ACH	132	Alhambra Hospital Med Center
AHM	120	Catalina Island Medical Center
AMH	450	Methodist Hospital of Southern California
AVH	118	Antelope Valley Hospital
BEL	127	Bellflower Medical Center
BEV	135	Beverly Hospital
BMC	172	Southern California Hospital at Culver City
CAL	133	California Hospital Medical Center
CHH	145	Children's Hospital Los Angeles
CNT	141	Centinela Hospital Medical Center
CPM	150	Coast Plaza Doctors Hospital
CSM	139	Cedars-Sinai Medical Center
DCH	155	PIH Health Hospital – Downey
DFM	457	Marina Del Rey Hospital
DHL	412	Lakewood Regional Medical Center
ELA	157	East Los Angeles Doctors Hospital
ENH	191	Encino Hospital Medical Center
FPH	160	Foothill Presbyterian Hospital
GAR	216	Garfield Medical Center
GEM	168	Greater El Monte Community Hospital
GMH	514	Glendale Memorial Hospital & Health Center
GSH	220	Good Samaritan Hospital
GWT	210	Glendale Adventist Medical Center
HCH	305	Providence Holy Cross Medical Center
HEV	310	East Valley Hospital Medical Center
HGH	248	LAC Harbor-UCLA Medical Center
HMH	324	Huntington Memorial Hospital
HMN	270	Henry Mayo Newhall Memorial Hospital
HWH	913	West Hills Hospital and Medical Center
ICH	330	Citrus Valley Medical Center – Intercommunity Campus
KFA	311	Kaiser Baldwin Park Medical Center
KFB	340	Kaiser Downey Medical Center
KFH	400	Kaiser South Bay Medical Center
KFL	343	Kaiser Los Angeles Medical Center
KFO	370	Kaiser Woodland Hills Medical Center
KFP	381	Kaiser Panorama City Medical Center

KFW	362	Kaiser West Los Angeles Medical Center
LBC	445	Community Hospital of Long Beach
LBM	533	Long Beach Memorial Medical Center
LCH	418	Palmdale Regional Medical Center
LCM	440	Providence Little Company of Mary – Torrance
MHG	495	Memorial Hospital of Gardena
MID	537	Olympia Medical Center
MCP	540	Mission Community Hospital
MPH	552	Monterey Park Hospital
NOR	452	Norwalk Community Hospital
NRH	571	Northridge Hospital Medical Center
OTH	998	Other Hospital Not on List
OVM	575	LAC Olive View-UCLA Medical Center
PAC	761	Pacifica Hospital of the Valley
PIH	466	PIH Health Hospital – Whittier
PLB	580	College Medical Center
PVC	464	Pomona Valley Hospital Medical Center
QOA	286	Hollywood Presbyterian Medical Center
QVH	468	Citrus Valley Medical Center – Queen of the Valley
SAC	489	San Antonio Community Hospital
SDC	485	San Dimas Community Hospital
SFM	667	Saint Francis Medical Center
SGC	487	San Gabriel Valley Medical Center
SJH	680	Saint John's Health Center
SJS	685	Providence Saint Joseph Medical Center
SMH	742	Santa Monica-UCLA Medical Center
SMM	134	Saint Mary Medical Center
SOC	780	Sherman Oaks Hospital
SPP	726	Providence Little Company of Mary – San Pedro
TOR	805	Torrance Memorial Medical Center
TRI	820	Tri-City Regional Medical Center
TRM	799	Providence Tarzana Medical Center
UCL	818	Ronald Reagan UCLA Medical Center
USC	438	LAC+USC Medical Center
VHH	875	USC Verdugo Hills Hospital
VPH	856	Valley Presbyterian Hospital
WHH	507	Whittier Hospital Medical Center
WMH	970	White Memorial Med Center

- *ORANGE COUNTY 9-1-1 RECEIVING HOSPITALS*

Alpha Code	***Numeric Code***	***Hospital Name***
ANH		Anaheim Memorial Hospital
LPI	420	La Palma Intercommunity Hospital

FHP		Fountain Valley Regional Hospital and Medical Center
PLH		Placentia Linda Hospital
KHA		Kaiser Permanente Orange County Anaheim Medical Center
SJD	474	Saint Jude Medical Center
UCI	500	UC Irvine Medical Center
LAG	422	Los Alamitos Medical Center
LPI	420	La Palma Intercommunity Hospital
MCP	540	Mission Community Hospital
PLH		Placentia Linda Hospital
SJD	474	Saint Jude Medical Center
UCI	500	UC Irvine Medical Center

- *SAN BERNADINO COUNTY 9-1-1 RECEIVING HOSPITALS*

Alpha Code	***Numeric Code***	***Hospital Name***
CHI	124	Chino Valley Medical Center
DHM	504	Montclair Hospital Medical Center

- *VENTURA COUNTY 9-1-1 RECEIVING HOSPITALS*

Alpha Code	***Numeric Code***	***Hospital Name***
LRR	424	Los Robles Hospital and Medical Center
SJO	472	Saint John's Regional Medical Center

Additional Information

- Three-digit codes are used by LA City Fire Dept. only, and are provided only as a reference to the appropriate three-letter code

Uses

- Assists with determination of appropriate treatment
- System evaluation and monitoring
- Medical record linking

Data Source Hierarchy

- Hospital Log
- Facesheet
- ED Records
- History and Physical
- Billing Sheet / Medical Records Coding Summary Sheet

TRANSFER RATIONALE

Definition

The reason for the patient's transfer from the ED, if applicable

Field Values

Transfer Rationale

HP	Health Plan: Decision based on patients medical home/insurance
FI	Financial: Decision based on financial status (i.e., cash or self-pay, uninsured)
SC	Specialized/ Higher Level Care: Patient required acute specialized care or higher level of care not available at your facility (e.g., pediatrics, burns, complex pelvic fracture, reimplantation)
EX	Extended Care: Patient discharged from acute care setting of hospital, but required sub-acute care in the setting of a convalescent home, board-and-care, etc.
CU	In Custody: Patient discharged/transferred in custody of law enforcement
RH	Rehabilitation: Patient discharged from acute care setting of hospital, but required inpatient rehabilitation services
OT	Other: Transfer rationale other than above

Uses

- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- Hospital discharge summary
- Progress notes

ED DIAGNOSIS

Definition

ICD-10 diagnosis code indicating the ED physician's impression of the condition thought to be chiefly responsible for the event

Additional Information

- Enter all ED diagnoses

Uses

- Assists with determination of appropriate treatment
- Provides documentation of assessment and/or care
- System evaluation and monitoring

Data Source Hierarchy

- ED Records
- Progress notes
- Hospital discharge summary
- Other hospital records

DISCHARGE COMMENTS

Definition

Free-text field which can be used to document additional discharge information (optional)

LAC DHS Emergency Medical Services Agency (EMS)
Functional Requirements Matrix
Data Reporting Requirements

EXHIBIT G - Example

Trauma Center	Frequency	Percentage
EFG	10	20%
ABC	9	18%
CDE	8	16%
DEF	7	14%
BCD	6	12%
GHI	5	10%
FGH	4	8%
Total	49	100%

LAC DHS Emergency Medical Services Agency (EMS)
Functional Requirements Matrix
Data Reporting Requirements

EXHIBIT H - Example

Age in Years	Frequency	Percentage
0 to < 10	10	20%
10 to < 20	9	18%
20 to < 30	8	16%
30 to < 40	7	14%
40 to < 50	6	12%
50 to < 60	5	10%
60 to < 70	4	8%
70 to < 80	3	6%
80 to < 90	2	4%
90 to < 100	1	2%
Total	49	100%

LAC DHS Emergency Medical Services Agency (EMS)
Functional Requirements Matrix
Data Reporting Requirements

EXHIBIT I - Example

Descending

Trauma Center	Frequency	Percentage
EFG	10	20%
ABC	9	18%
CDE	8	16%
DEF	7	14%
BCD	6	12%
GHI	5	10%
FGH	4	8%
Total	49	100%

Ascending

Age in Years	Frequency	Percentage
0 to < 10	3	2%
10 to < 20	5	3%
20 to < 30	30	19%
30 to < 40	25	16%
40 to < 50	23	15%
50 to < 60	20	13%
60 to < 70	18	12%
70 to < 80	20	13%
80 to < 90	9	6%
90 to < 100	3	2%
Total	156	100%

LAC DHS Emergency Medical Services Agency (EMS)
Functional Requirements Matrix
Data Reporting Requirements

EXHIBIT J - Example

Injury Diagnosis ICD-9 Code report with Liver Injuries
This report also includes non-liver injuries

Injury Diagnosis	Frequency	Percentage
864.04	3	12%
864.00	2	8%
564.01	2	8%
801.10	1	4%
825.10	1	4%
864.03	1	4%
865.02	1	4%
852.14	1	4%
861.01	1	4%
823.10	1	4%
852.00	1	4%
823.20	1	4%
823.31	1	4%
853.11	1	4%
876.00	1	4%
853.10	1	4%
812.20	1	4%
895.10	1	4%
800.02	1	4%
800.01	1	4%
864.12	1	4%
Total	25	100%

Injury Diagnosis ICD-9 Code report with Liver Injuries constraint
The Constraint applied to the variable eliminates ICD-9 codes for non-liver injuries

Injury Diagnosis	Frequency	Percentage
Blank	14	61%
864.04	3	13%
864.00	2	9%
864.01	2	9%
864.03	1	4%
864.12	1	4%
Total	23	100%

LAC DHS Emergency Medical Services Agency (EMS)
Functional Requirements Matrix
Data Reporting Requirements

EXHIBIT K - Example

Injury Diagnosis ICD-9 Code without grouping picklist choices

Injury Diagnosis	Frequency	Percentage
865.02	3	6%
864.04	3	6%
823.31	3	6%
801.10	2	4%
867.10	2	4%
800.00	2	4%
851.10	2	4%
864.00	2	4%
845.01	2	4%
864.01	2	4%
Blank	2	4%
825.10	1	2%
864.03	1	2%
852.14	1	2%
861.01	1	2%
845.11	1	2%
851.00	1	2%
866.00	1	2%
868.11	1	2%
802.22	1	2%
920.00	1	2%
823.10	1	2%
852.00	1	2%
925.10	1	2%
854.11	1	2%
865.00	1	2%
823.20	1	2%
853.11	1	2%
876.00	1	2%
853.10	1	2%
802.34	1	2%
885.10	1	2%
860.00	1	2%
812.00	1	2%
895.10	1	2%
800.02	1	2%
800.01	1	2%
864.12	1	2%
Total	52	100%

Injury Diagnosis ICD-9 Code with grouping picklist choices

Injury Diagnosis		Frequency	Percentage
860 - 869	Internal Injury of Chest, Abdomen, and Pelvis	19	37%
800 - 804	Fracture of Skull	8	15%
850 - 854	Intracranial Injury, excluding those with skull franctures	8	15%
820 - 829	Fracture of Lower Limb	6	12%
840 - 848	Sprains and Strains of Joints and Adjacent Muscles	3	6%
Blank		2	4%
920 - 924	Contusion with Intact Skin Surface	1	2%
925 - 929	Crushing Injury	1	2%
870 - 879	Open Wound of Head, Neck, and Trunk	1	2%
880 - 887	Open Wound of Upper Limb	1	2%
810 - 819	Fracture of Upper Limb	1	2%
890 - 897	Open Wound of Lower Limb	1	2%
Total		52	100%

LAC DHS Emergency Medical Services Agency (EMS)
Functional Requirements Matrix
Data Reporting Requirements

EXHIBIT L - Example

Injury Diagnosis ICD-9 Code Showing a User specified Number of Hits

Injury Diagnosis	Frequency	Percentage
865.02	3	6%
864.04	3	6%
823.31	3	6%
801.10	2	4%
867.10	2	4%
800.00	2	4%
851.10	2	4%
864.00	2	4%
845.01	2	4%
864.01	2	4%
Blank	2	4%
Other	27	52%
Total	52	100%

This report shows that the user specified to display only those responses that garnered two or more hits.

LAC DHS Emergency Medical Services Agency (EMS)
Functional Requirements Matrix
Data Reporting Requirements

EXHIBIT M - Example

Injury Diagnosis ICD-9 Code Showing a User Specified Top Hits

Injury Diagnosis	Frequency	Percentage
865.02	3	6%
864.04	3	6%
Other	46	88%
Total	52	100%

This report shows that the user selected to display only the top 2 responses that garnered the most hits.

LAC DHS Emergency Medical Services Agency (EMS)
Functional Requirements Matrix
Data Reporting Requirements

EXHIBIT N - Example

Cross Tabulation showing cell percentage of grand total

Y axis: Dead or Alive
X axis: Sex
( ) : Percentage of Grand Total

Variable	Lived	Died	Total
Male	8 (44)	2 (11)	10
Female	5 (28)	3 (17)	8
Total	13	5	18

Cross Tabulation showing cell percentage of row and column totals

Y axis: Dead or Alive
X axis: Sex
{ } : Percentage of Row Total
[ ] : Percentage of Column Total

Variable	Lived	Died	Total
Male	8 {80} [62]	2 {20} [40]	10
Female	5 {63} [38]	3 {38} [60]	8
Total	13	5	18

Cross Tabulation showing cell percentage of grand total, cell percentage of row and column totals, and row and column percentages of grand total

Y axis: Dead or Alive
X axis: Sex
{ } : Percentage of Row Total
[ ] : Percentage of Column Total
( ) : Percentage of Grand Total

Variable	Lived	Died	Total
Male	8 {80} [62] (44)	2 {20} [40] (11)	10
Female	5 [63] (38) (28)	3 [38] (60) (17)	8
Total	13 (72)	5 (28)	18

LAC DHS Emergency Medical Services Agency (EMS)
Functional Requirements Matrix
Data Reporting Requirements

EXHIBIT O - Example

Multi-Variable Report Sorted by First Column (default setting)

Date	Seq #	Chief Complaint 1	Chief Complaint 2	Mechanism of Injury	Incident Zip
09/04/2011	AA123456	Blunt Head	Blunt Extremities	Other	91754
01/03/2013	AA123457	Head Injury	Blunt Extremities	Motorcycle/Moped	*ND
01/05/2013	AA123458	Blunt Head	Minor Lacerations	Fall	90706
01/09/2013	AA123459	Blunt Neck	Blunt Abdomen	Auto vs Pedestrian	90501
01/10/2013	AA123460	Penetrating Back	*BL	Stabbing	90706
01/13/2013	AA123461	Blunt Extremities	*BL	Auto vs Pedestrian	90706
02/24/2013	AA123462	Blunt Head	*NA	Fall	90012
04/15/2013	AA123463	Blunt Face/Mouth	Blunt Chest	Enclosed Vehicle	91354
01/01/2014	AA123464	Head Injury	*NA	Fall	*ND
01/01/2014	AA123465	Blunt Face/Mouth	Blunt Chest	Enclosed Vehicle	*ND
01/01/2014	AA123466	Blunt Head	*BL	Assault	90021
01/01/2014	AA123467	Blunt Head	*NA	Auto vs Pedestrian	90065
01/01/2014	AA123468	Penetrating Extremity	*BL	Other	90057
01/01/2014	AA123469	Penetrating Abdomen	Penetrating Extremity	GSW	90017

Multi-Variable Report Sorted by Chief Complaint 1, then Mechanism of Injury

Date	Seq #	Chief Complaint 1	Chief Complaint 2	Mechanism of Injury	Incident Zip
01/13/2013	AA123461	Blunt Extremities	*BL	Auto vs Pedestrian	90706
04/15/2013	AA123463	Blunt Face/Mouth	Blunt Chest	Enclosed Vehicle	91354
01/01/2014	AA123465	Blunt Face/Mouth	Blunt Chest	Enclosed Vehicle	*ND
01/01/2014	AA123466	Blunt Head	*BL	Assault	90021
01/01/2014	AA123467	Blunt Head	*NA	Auto vs Pedestrian	90065
01/05/2013	AA123458	Blunt Head	Minor Lacerations	Fall	90706
02/24/2013	AA123462	Blunt Head	*NA	Fall	90012
09/04/2011	AA123456	Blunt Head	Blunt Extremities	Other	91754
01/09/2013	AA123459	Blunt Neck	Blunt Abdomen	Auto vs Pedestrian	90501
01/01/2014	AA123464	Head Injury	*NA	Fall	*ND
01/03/2013	AA123457	Head Injury	Blunt Extremities	Motorcycle/Moped	*ND
01/01/2014	AA123469	Penetrating Abdomen	Penetrating Extremity	GSW	90017
01/10/2013	AA123460	Penetrating Back	*BL	Stabbing	90706
01/01/2014	AA123468	Penetrating Extremity	*BL	Other	90057

LAC DHS Emergency Medical Services Agency (EMS)
Functional Requirements Matrix
Data Reporting Requirements

EXHIBIT P - Example

Multi-Variable Report Showing Notes Attached to Specific Variables

Date	Seq #	Procedure Performed (ICD9 Code)	Procedure/OR Details -> Notes
09/04/2011	AA123456	79.66 DEBRIDEMENT OF OPEN FRACTURE OF TIBIA AND FIBULA	
01/03/2013	AA123457	79.16 CLOSED REDUCTION OF FRACTURE OF TIBIA AND FIBULA WITH INTERNAL FIXATION	Minimal bone loss
01/05/2013	AA123458	*NA	
01/09/2013	AA123459	76.76 OPEN REDUCTION OF MANDIBULAR FRACTURE	Major fractures. Grade 5.
01/10/2013	AA123460	93.54 APPLICATION OF SPLINT	Splint applied to right tibia.
01/13/2013	AA123461	93.57 APPLICATION OF OTHER WOUND DRESSING	
02/24/2013	AA123462	*BL	
04/15/2013	AA123463	86.59 CLOSURE OF SKIN AND SUBCUTANEOUS TISSUE OTHER SITES	
01/01/2014	AA123464	45.62 OTHER PARTIAL RESECTION OF SMALL INTESTINE	Wound infection severe. Requires antibiotics.
01/01/2014	AA123465	76.75 CLOSED REDUCTION OF MANDIBULAR FRACTURE	
01/01/2014	AA123466	99.01 EXCHANGE TRANSFUSION	ORDER PLACED ON 7/2/15 AT 06:09AM
01/01/2014	AA123467	*NA	
01/01/2014	AA123468	*NA	
01/01/2014	AA123469	96.04 INSERTION OF ENDOTRACHEAL TUBE	Removed from Ascending Colon

LAC DHS Emergency Medical Services Agency (EMS)
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EXHIBIT Q - Example

Multi-Variable Report Showing Linked Variables

(The correct unit must link to the correct time)

Unit 1	Arrival Time	Unit 2	Arrival Time	Unit 3	Arrival Time
E4	16:20:00	S141	16:20:00	RA4	16:20:00
E11	14:22:00	S141	14:22:00	RA5	14:22:00
E14	21:30:00	S141	21:31:00	RA4	21:31:00
E12	9:35:00	S141	9:37:00	*BL	*BL
E12	10:27:00	*BL	*BL	S141	10:27:00
E14	15:14:00	S142	15:14:00	RA4	15:14:00
E12	12:13:00	S142	12:13:00	RA7	12:13:00
E13	14:07:00	S142	14:08:00	*BL	*BL
E12	11:12:00	S142	11:12:00	*BL	*BL
E11	7:20:00	S142	7:20:00	5A4	7:20:00
E12	11:15:00	S143	11:15:00	RA5	11:15:00
E12	10:08:00	*BL	*BL	*BL	*BL
E12	17:23:00	S143	17:23:00	RA7	17:23:00
E12	9:24:00	S143	9:24:00	RA4	9:24:00
E13	13:29:00	S143	13:27:00	RA4	13:27:00
E13	16:23:00	S143	16:25:00	*BL	*BL
E13	15:45:00	S143	15:45:00	*BL	*BL
E14	10:40:00	S143	10:39:00	RA5	10:47:00
E12	14:17:00	S143	14:17:00	RA6	14:20:00
E13	10:15:00	S143	10:15:00	RA4	10:14:00

LAC DHS Emergency Medical Services Agency (EMS)
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EXHIBIT R - Example

Multi-Variable Report Showing Counts and Totals for Individual Responses

Insurance	Patient Last Name	Patient First Name	Total Charges
WELFARE	WALKER	JIMMY	123.00
Count of Insurance for Insurance WELFARE = 1			
Total of Total Charges for Insurance WELFARE = 123.00			
SELF PAY	BLY	NELLIE	56,789.00
SELF PAY	PARKER	DOROTHY	345,657.00
SELF PAY	SMITH	BARKLEY	3,232.00
Count of Insurance for Insurance SELFPAY = 3			
Total of Total Charges for Insurance SELFPAY = 405,678.00			
PRIVATE	SANGER	MARGARET	465,756.00
PRIVATE	LAGUARDIA	FIORELLO	56,789.00
PRIVATE	BUCHANAN	DAISY	455,436.00
Count of Insurance for Insurance PRIVATE = 3			
Total of Total Charges for Insurance PRIVATE = 977,981.00			
MEDICARE	LINDSAY	JOHN	48,986.00
Count of Insurance for Insurance MEDICARE = 1			
Total of Total Charges for Insurance MEDICARE = 48,986.00			
Total of Total Charges for ALL Insurance = 1,432,768.00			

LAC DHS Emergency Medical Services Agency (EMS)
Functional Requirements Matrix
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EXHIBIT S - Example

Quality Improvement Issue and Problem Report WITHOUT Summary

Issue/Problem Report	
A	Absence of EMS Report Form
B	Chest pain without 12-Lead ECG
C	GCS <8 and left ED without definitive airway
D	GSW to abdomen and managed nonoperatively
E	Abdominal Injury with late laparotomy
F	Epidural/Subdural Hematoma with late craniotomy
G	Late >8hrs. initial debridement of open tibial fracture
H	Ischemic Stroke without last known well date and time
I	Scene Time greater than 20 minutes on hypotensive patient

Seq #	A	B	C	D	E	F	G	H	I	Total
AA123456	-	x	-	-	-	-	-	-	-	1
AA123457	-	-	-	-	-	-	-	-	-	0
AA123458	-	-	-	-	-	-	-	-	x	1
AA123459	-	-	-	x	x	-	-	-	x	3
AA123460	-	-	-	-	-	-	-	-	-	0
AA123461	-	-	-	-	x	x	x	-	-	3
AA123464	-	-	-	-	-	-	-	x	-	1
AA123465	-	-	-	-	x	-	-	-	-	1
AA123466	x	-	-	-	-	-	-		-	1
AA123467	x	-	-	-	-	-	x	-	-	2
AA123468	x	-	-	-	x	-	-	-	-	2
AA123469	-	-	-	-	-	-	-	-	-	0

Quality Improvement Issue and Problem Report WITH Summary

Summary of Issue/Problem Report		Total	Percentage
A	Absence of EMS Report Form	3	19%
B	Chest pain without 12-Lead ECG	2	13%
C	GCS <8 and left ED without definitive airway	0	0%
D	GSW to abdomen and managed nonoperatively	1	6%
E	Abdominal Injury with late laparotomy	4	25%
F	Epidural/Subdural Hematoma with late craniotomy	1	6%
G	Late >8hrs. initial debridement of open tibial fracture	2	13%
H	Ischemic Stroke without last known well date and time	1	6%
I	Scene Time greater than 20 minutes on hypotensive patient	2	13%

LAC DHS Emergency Medical Services Agency (EMS)
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Data Reporting Requirements

EXHIBIT T - Example

Exception Report - showing missing variables

Patient Name	Missing Variable
Smith, John	Missing TIME OF ED ARRIVAL
	Missing ETOH LEVEL
	Missing EMS FORM
	Missing ED DIAGNOSIS
Contreras, Rosa	Missing TIME OF DISCHARGE
	Missing TRAUMA CRITERIA
	Missing TIME ADMITTED