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LOS ANGELES COUNTY TRAUMA DATABASE PATIENT INCLUSION

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT C

PATIENT INCLUSION IN THE TRAUMA DATA SYSTEM

EXCLUSIONS:
Patients with the following injuries are to be EXCLUDED from the registry, unless an additional injury that meets criteria/guidelines exists:
GROUND LEVEL FALLS:
resulting in isolated closed hip fractures in patients > 50 years of age; or fractures of or distal to the knee or elbow in patients of any age
OR
drownings; hangings; poisonings; late effect of injuries; foreign bodies; superficial injuries ($00, $10, $20, $30, $40, $50, $60, $70, $80, & $90); insect bites; and isolated injuries to fingers and/or toes.

INCLUSIONS:
Does the patient have at least one ICD-10 injury diagnostic code within the range of S00 - S99 & T79.A1 - T79.A9?

HOSPITAL ADMISSION?
Was the patient admitted for care of an injury after ED evaluation by Trauma services?
OR
Was the patient transferred and admitted to the Trauma Services for care of an injury?

DEATH?
Did the patient die of an injury-related problem?

DID THE PATIENT ARRIVE VIA EMS?

PREHOSPITAL DECISION?
Did the patient meet Trauma Triage Criteria, Guidelines, or Special Considerations per Reference 506?

Patient DOES NOT meet inclusion criteria

TRAUMA CRITERIA?
Did the NON-EMS patient meet Trauma Triage Physiological &/or Anatomical Criteria per Reference 506.1?
(Mechanism of Injury Criteria, Guidelines, and Special Considerations are NOT applicable for non-EMS patients)

Patient MEETS inclusion criteria

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.

July 1, 2018 (Implemented)
Valid until amended by the EMS Agency
(Replaces Exhibit C dated January 1, 2018)
2019 NATIONAL TRAUMA DATA STANDARD INCLUSION CRITERIA

National Trauma Data Standard Inclusion Criteria

Did the patient sustain one or more traumatic injuries?

Yes

Is the diagnostic code for any injury included in the following range;

No

Yes

Did the patient sustain at least one injury with a diagnostic code outside the range of codes listed below?
S00, S10, S20, S30, S40, S50, S60, S70, S80, S90

No

Yes

Did injury result in death?

OR

Was the patient transferred to (or from) your hospital via another hospital using EMS or air ambulance?

OR

Was the patient considered an admission based on your trauma registry inclusion criteria?

No

For ALL three

Patient INCLUDED in the National Trauma Data Standard

Patient NOT INCLUDED in the National Trauma Data Standard
Reference No. 506 TRAUMA TRIAGE

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: TRAUMA TRIAGE

PURPOSE: To establish criteria and standards which ensure that patients requiring the care of a trauma center are appropriately triaged and transported.

AUTHORITY: California Code of Regulations, Title 13, Section 1105(c) California Code of Regulations, Title 22, Section 100236 et seq; Health and Safety Code, Div. 2.5, Section 1797 et seq., and 1317.

PRINCIPLES:

1. Trauma patients should be secured and transported from the scene as quickly as possible, consistent with optimal trauma care.

2. Paramedics shall make base hospital contact and/or notification to the receiving trauma center on all injured patients who meet trauma triage criteria and/or guidelines, or if in the paramedic’s judgment it is in the patient’s best interest to be transported to a trauma center. Contact shall be accomplished in such a way as not to delay transport.

3. Do not delay transport of hypotensive patients with penetrating torso trauma in order to apply spinal motion restriction.

4. EMT personnel may immediately transport hypotensive patients with life-threatening, penetrating injuries to the torso to the closest trauma center, not the Most Accessible Receiving (MAR), when the transport time is less than the estimated time of paramedic arrival. The transporting unit should make every effort to contact the receiving trauma center.

5. When pediatric and adult trauma patients are transported together in one aircraft, the receiving trauma center shall be both a trauma center and a pediatric trauma center.

POLICY:

1. Trauma Criteria – Requires immediate transportation to a designated trauma center

   Patients who fall into one or more of the following categories are to be transported directly to the designated trauma center, if transport time does not exceed 30 minutes.

   A. Systolic blood pressure less than 90 mmHg, or less than 70 mmHg in infants age less than one year

   B. Respiratory rate greater than 29 breaths/minute (sustained), less than 10 breaths/minute, less than 20 breaths/minute in infants age less than one year, or requiring ventilatory support
SUBJECT: TRAUMA TRIAGE

C. Cardiopulmonary arrest with penetrating torso trauma unless based upon the paramedic's thorough assessment is found apneic, pulseless, asystolic, and without pupillary reflexes upon arrival of EMS personnel at the scene.

D. All penetrating injuries to head, neck, torso, and extremities proximal to the elbow or knee.

E. Blunt head injury associated with a suspected skull fracture, altered level of consciousness (Glasgow Coma Score less than or equal to 14), seizures, unequal pupils, or focal neurological deficit.

F. Injury to the spinal column associated with acute sensory or motor deficit.

G. Blunt injury to chest with unstable chest wall (flail chest).

H. Diffuse abdominal tenderness.

I. Suspected pelvic fracture (excluding isolated hip fracture from a ground level fall).

J. Extremity injuries with:
   1. Neurological / vascular compromise and/or crushed, degloved, or mangled extremity.
   2. Amputation proximal to the wrist or ankle.
   3. Fractures of two or more proximal (humerus/femur) long-bones.

K. Falls:
   1. Adult patients from heights greater than 15 foot.
   2. Pediatric patients from heights greater than 10 feet, or greater than 3 times the height of the child.

L. Passenger space intrusion of greater than 12 inches into an occupied passenger space.

M. Ejected from vehicles (partial or complete).

N. Auto versus pedestrian/bicyclist/motorcyclist thrown, run over, or with significant (greater than 20 mph) impact.

O. Unenclosed transport crash with significant (greater than 20 mph) impact.

P. Major / Critical Burn (if a recognized Burn Center, e.g., LAC+USC Medical Center, Torrance Memorial Medical Center, West Hills Hospital, is more accessible than the Trauma Center, patient should be transported to the recognized Burn Center):
   1. Patients equal to or greater than 15 years of age with 2nd (partial thickness) and 3rd (full thickness) degree burns involving equal to or greater than 20% Total Body Surface Area (TBSA).
   2. Patients less than or equal to 14 years of age with 2nd (partial thickness) and 3rd (full thickness) degree burns involving equal to or greater than 10% TBSA.
II. Trauma Guidelines – Mechanism of injury and patient history are the most effective methods of selecting critically injured patients before unstable vital signs develop. Paramedics and base hospital personnel should consider mechanism of injury and patient history when determining patient destination. At the discretion of the base hospital or approved SFTP provider agency, transportation to a trauma center is advisable for:

A. Passenger space intrusion of greater than 18 inches into any unoccupied passenger space

B. Automobile versus pedestrian/bicyclist/motorcyclist (impact equal to or less than 20 mph)

C. Injured victims of vehicular crashes in which a fatality occurred in the same vehicle

D. Patients requiring extrication

E. Vehicle telemetry data consistent with high risk of injury

F. Injured patients (excluding isolated minor extremity injuries):
   1. on anticoagulation therapy other than aspirin-only
   2. with bleeding disorders

III. Special Considerations – Consider transporting injured patients with the following to a trauma center:

A. Patients in blunt traumatic full arrest who, based on a paramedic’s thorough patient assessment believes transport is indicated

B. Adults age greater than 55 years

C. Systolic blood pressure less than 110 mmHg may represent shock after age 65 years

D. Pregnancy greater than 20 weeks gestation

E. Prehospital judgment

IV. Extremis Patients - Requires immediate transportation to the MAR:

A. Patients with an obstructed airway or those with concern for imminent airway obstruction due to inhalation injury

B. Patients, as determined by the base hospital personnel, whose lives would be jeopardized by transportation to any destination but the MAR

V. When, for whatever reason, base hospital contact cannot be made, the destination decision for injured patients will be made by paramedics using the principles set forth above.
VI. 9-1-1 Trauma Re-Triage – This section applies to injured patients in emergency departments of non-trauma centers whose injuries were initially estimated by EMS to be less serious (under triaged) or patients who self-transported (walk-in) to a non-trauma center, and subsequently assessed by the non-trauma center physician to require immediate trauma center care. The referring facility shall utilize the procedure outlined below to expedite transfer arrangements and rapid transport to the trauma center. This process should be reserved for patients with life-threatening traumatic injuries requiring emergent surgical intervention.

A. Determine if the injured patient meets any of the following 9-1-1 Trauma Re-Triage criteria:
   1. Persistent signs of poor perfusion
   2. Need for immediate blood replacement therapy
   3. Intubation required
   4. Glasgow Coma Score less than 9
   5. Glasgow Coma Score deteriorating by 2 or more points during observation
   6. Penetrating injuries to head, neck and torso
   7. Extremity injury with neurovascular compromise or loss of pulses
   8. Patients, who in the judgement of the evaluating emergency physician, have high likelihood of requiring emergent life- or limb-saving intervention within two (2) hours.

B. Contact the designated receiving trauma center or pediatric trauma center if the patient is less than or equal to 14 years of age and transport does not exceed 30 min. Do not delay transfer by initiating any diagnostic procedures that do not have direct impact on immediate resuscitative measures.

C. Contact 9-1-1 for transportation. The paramedic scope of practice (Ref. No. 803) does not include paralyzing agents and blood products.

D. Prepare patient and available medical records for immediate transport. Do not delay transport for medical records which could be sent at a later time.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 501, Hospital Directory
Ref. No. 502, Patient Destination
Ref. No. 503, Guidelines for Hospitals Requesting Diversion of ALS Units
Ref. No. 504, Trauma Patient Destination
Ref. No. 510, Pediatric Patient Destination
Ref. No. 803, Paramedic Scope of Practice
Ref. No. 814, Determination/Pronouncement of Death in the Field
Reference No. 506.1 TRAUMA TRIAGE DECISION SCHEME

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

REFERENCE No. 506.1 Trauma Triage Decision Scheme

Physiological Assessment

1. Systolic blood pressure (SBP): < 90 mmHg, or
   - < 70 mm Hg in infant < 1 yr
   - Respiratory rate: > 29 breaths/minute (sustained),
   - < 10 breaths/minute,
   - < 20 breaths/minute in infant < 1 yr, or requiring ventilatory support
   - Cardiopulmonary arrest with penetrating torso trauma

   NO

   Anatomical injury Assessment

   ALL penetrating injuries to head, neck, torso, and extremities above the elbow or knee
   Blunt head injury associated with:
   - Suspected skull fracture, GCS ≤ 14, seizures, unequal pupils, or focal neurological deficit
   - Spinal injury associated with acute sensory or motor deficit
   - Blunt chest injury with unstable chest wall (flail chest)
   - Diffuse abdominal tenderness
   - Suspected pelvic fracture (excluding isolated hip fracture from a ground level fall)
   - Extremity injuries with: neurological/vascular compromise and/or crushed, degloved or mangled; amputation proximal to the wrist or ankle; or fractures of ≥ 2 proximal (humerus/femur) long bones
   - Major/Critical Burns: ≥ 15 years with 2nd or 3rd degree burns ≥ 20% TBSA

   YES

   Mechanism of Injury Assessment

2. Falls: Adult Patients > 15 feet
   Pediatric Patients > 10 feet, or > 3 times the height of the child
   Passenger Space Intrusion: > 12 inches into an occupied passenger space
   Ejected from vehicle (partial or complete)
   Auto versus pedestrian/bicyclist/motorcyclist thrown, run over, or impact > 20 mph
   Unenclosed transport crash with significant impact (> 20 mph)

   YES

   Trauma Guidelines Assessment

3. Passenger Space Intrusion > 18 inches into an unoccupied passenger space
   Injured victims of vehicle crashes with a fatality in the same vehicle
   Patients requiring extrication
   Vehicle telemetry data consistent with high risk of injury
   Injured patients (excluding isolated minor extremity injuries):
   - on anticoagulation therapy other than aspirin-only; or
   - with bleeding disorders

   NO

   SPECIAL CONSIDERATIONS Assessment

4. Blunt traumatic full arrest
   Adults age > 55 years
   SBP < 110 mmHg may represent shock after age 65 years
   Pregnancy > 20 weeks
   Prehospital judgment

   YES

   If in doubt, transport to the Trauma Center

Immediate transport to designated Trauma Center

In consult with Trauma Center/ Base Hospital, transport to designated Trauma Center is advisable

Consider transport to designated Trauma Center

Page 1 of 1

EFFECTIVE: 05-01-12
REVISED: 07-01-18
SUPERSEDES: 02-06-17
## Trauma Patient Summary Form (TPS) - Page 1

<table>
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### General Info

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### Special Considerations

- Blunt Trauma Arrest
- Intraoperative Preg. >20wks
- Age >35
- Age >65 with SBP <110
- Prehospital Judgment

1. Antibiotic Administration (Any Open Fracture): Date: / / Time: 
2. IV Fluids in ED: mls
3. ARRIVED WITH SIGNS OF LIFE?: Y N
4. DEATH IN ED: DOA (minimal/no resuscitations) / 15min resuscitation / Other death in ED
5. NEXT PHASE AFTER ED: 0-24hr / OR / ICU / Ward / Tele/Step / Pediatric Ward / Pediatric ICU / Interventional Radiology / Special Procedures / Posthospital
## TRAUMA PATIENT SUMMARY FORM (TPS) - Page 2

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### CT/ANGIO/MRI

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### DRUGS OF ABUSE:
- Amphetamine
- Barbiturates
- Cannabinoids
- Cocaine
- Opiates
- PCP
- Other: __________

### MTP ACTIVATED?
- ☐ Y ☐ N

### TQIP Blood Inclusion?
- ☐ Y ☐ N

### Lowest Systolic B/P:
- Use Syst of arterial IP PRBC given with 104 hrs.

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### ENTER ALL THAT APPLY DURING HOSPITAL STAY

#### PHASE DATE START AT END @

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<td>ETT 08H17EZ</td>
<td>ETT 08H17EZ</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRIC 0B110F4 (Cric)</td>
<td>CRIC 0B110F4 (Cric)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHEST TUBE 0W8903Z</td>
<td>CHEST TUBE 0W8903Z</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IVC FILTER 06H03DZ</td>
<td>IVC FILTER 06H03DZ</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TRACH 0B110F4 (Opn)</td>
<td>TRACH 0B110F4 (Opn)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DPA 0W536X</td>
<td>DPA 0W536X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CENTRAL LINE 06H33OZ (Upper)</td>
<td>CENTRAL LINE 06H33OZ (Upper)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VENTILATOR</td>
<td>VENTILATOR</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### TOTAL VENTILATOR DAYS (All Episodes):

#### PHASE DATE CUT TIME END TIME PROCEDURES

<table>
<thead>
<tr>
<th>PROCEDURES</th>
<th>ICD-10 CODE</th>
<th>SURG TYPE</th>
<th>MD CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 1st Angiograph</td>
<td>☐ 1st Angiography Date</td>
<td>☐/☐</td>
<td>☐ 1st Angiography Time: __________</td>
</tr>
<tr>
<td>1st Angiograph</td>
<td>☐ Hemorrhage Control Date</td>
<td>☐/☐</td>
<td>☐ Hemorrhage Control Time: __________</td>
</tr>
<tr>
<td>Hemorrhage Control Type:</td>
<td>☐ Hemorrhage Control Date</td>
<td>☐/☐</td>
<td>☐ Hemorrhage Control Time: __________</td>
</tr>
<tr>
<td>PHASE AFTER OR:</td>
<td>☐ 1st VISIT</td>
<td>☐ 2nd VISIT</td>
<td>☐ 3rd VISIT</td>
</tr>
<tr>
<td>NAME</td>
<td>ARRIVAL DATE</td>
<td>ICU</td>
<td>SE#</td>
</tr>
<tr>
<td>------</td>
<td>--------------</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ICU ARRIVAL DATE / ICU EXIT DATE / CONSULT DATE / CONSULT SERVICE / MD CODE

TQIP TBI Inclusion? □ Y □ N
Initial Pupillary Response: □ Both □ One □ Neither

Highest GCS Total: [Enter Value]
Highest GCS Motor: [Enter Value]
Qualifier of Highest GCS:
Midline Shift? □ Y □ N □ Not imaged
Cerebral Monitor Type:
Date: / / Time: :

TQIP VTE Prophylaxis Inclusion? □ Y □ N
VTE Prophylaxis Date:

Withdrawal of Life Support Treatment? □ Y □ N

HOSPITAL DISPOSITION ORDER DATE: / / HOSPITAL DISPOSITION ORDER TIME: :

TRANSFERRED / DISCHARGED TO: □ Acute Care □ AMA/Blinded/LWBS □ Burn Center □ Home or Home Health □ Home vio □ Hospice □ Jail □ Morgue □ Rehab □ SNF □ Sub Acute □ Trauma Center □ LTHC □ Psych □ Other

FACILITY:

TRANSFER RATIONALE: □ Health Plan □ Financial
□ Specialized/Higher Level of Care □ Rehabilitation
□ Extracted Care □ In Custody □ Other

DISCHARGE CAPACITY: □ Pre-Injury Capacity (Discharged from ED with minimum or no injuries) □ Temporary Handicap (Admit for injuries)
□ Permanent Handicap □ 1 year 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

POST-HOSPITAL

DISCHARGE DIAGNOSES ICD-10 AIS DISCHARGE DIAGNOSES ICD-10 AIS

□ Anticoagulant Therapy □ ADD/ADHD □ Bleeding Disorder □ CVA/Neuro Deficit □ Chemotherapy (currently receiving) □ COPD
□ Cirrhosis □ Congenital Anomalies □ CHF □ Current Smoker □ Dementia □ Diabetes □ Dialysis (needs/on)
□ Disseminated Cancer □ Drug Substance Abuse/Dependence □ Functionally dependent Health Status □ HTN (requiring meds)
□ Mental/Personality Disorder □ MI (w/in 6mons) □ Peripheral Arterial Disease (PAD) □ Prematurity □ Seizure Disorder
□ Steroid Use

NTDS HOSPITAL COMPLICATIONS: □ Acute Kidney Injury (w/dialysis) □ ARDS □ Alcohol Withdrawal □ Cardiac Arrest w/CPR
□ Central Line-Associated Blood Infection (CLABSI) □ CVAC □ Decubitus (Pressure) Ulcer □ DVT
□ Extremity Compartment Syndrome □ MI □ Osteomyelitis □ Pneumonia Ventilator Associated (VAP) □ PE □ Sepsis
□ Surgical Site Infection: □ Superficial (Incisional) □ Deep □ Organ/Space □ Unplanned Intubation □ Unplanned Readmit
□ Unplanned Return to the ICU □ Unplanned Return to the OR □ UGI/EntericAssociated (CAUTI)

FINANCIALS

Private: □ HMO □ Medi-Cal HMO □ Auto Insurance □ Worker’s Comp □ Medicare Part A & B
□ Medi-Cal □ County Indigent □ Custody Funds □ Military Insurance
□ Organ Donor Subsidy □ VOC (Victims of Crime) □ Other Private □ Other Government □ Charitable
□ Other: □ Other

Medicaid: □ Medi-Cal pending □ Prepay
□ Other: □ Other

Self: □ Cash □ Charity
□ Other: □ Other

Not billed: □ Charitable

TOTAL CHARGES: $
SEQUENCE NUMBER ALGORITHM

TRAVMA CENTER
MODE OF ENTRY

EMS (ALS or BLS)

Non-EMS

TRANSFER

Out-of-County
(EMS/Transfer)

Utilize “Walk-in” Sequence Number (18ABC000)

MODE OF ENTRY AT TRANSFERRING (Sending) FACILITY

Request “Out-of-County” Sequence Number (X000000)

EMS (ALS or BLS)

Non-EMS

Utilize “Walk-in” Sequence Number (18ABC000)

EXPECTATION:
Utilize Original 9-1-1 Seq. #

ACCEPTABLE:
Utilize Transfer/Transport Unit Seq. #

LAST RESORT:
Request “Dummy” Seq. # (XX000000)

*ALL resources must be exhausted prior to requesting a dummy sequence number, including, but not limited to, contacting the applicable:
- Prehospital care office
- EMS Provider
- Transferring Facility
- Transporting Unit

If more than one sequence number exists, utilize the first sequence number unless Base Contact was made with an alternate number.
# Transportation Mechanisms of Injuries Quick Reference Guide

<table>
<thead>
<tr>
<th>If patient is:</th>
<th>AND:</th>
<th>Then applicable MOI choices are:</th>
</tr>
</thead>
<tbody>
<tr>
<td>STRUCK BY a moving transport, and NOT in an enclosed vehicle</td>
<td>Force is greater than 20mph, OR Patient is thrown, or run over by motorized transport</td>
<td>RT <em>(and MM if applicable)</em></td>
</tr>
<tr>
<td></td>
<td>Force is less than 20mph</td>
<td>PB, SP, CR*, FA*, OT <em>(and MM if applicable)</em></td>
</tr>
<tr>
<td>OPERATING any transport</td>
<td>Transport is unenclosed, and force is GREATER than 20mph</td>
<td>20 <em>(and MM if applicable)</em></td>
</tr>
<tr>
<td></td>
<td>Transport is unenclosed, and force is LESS than 20mph</td>
<td>SP, MM, CR*, FA*, OT</td>
</tr>
<tr>
<td></td>
<td>Transport is enclosed, regardless of speed</td>
<td>EV, EJ, EX, SP, OT</td>
</tr>
</tbody>
</table>

(*) - Rarely applicable in transport accidents.

Transport accident involves a device/vehicle designed and used primarily for conveying persons or goods from one place to another.

<table>
<thead>
<tr>
<th>MOTORIZED transports include, but are not limited to:</th>
<th>UNENCLOSED transports include, but are not limited to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Cars/Trucks</td>
<td>- Bicycles</td>
</tr>
<tr>
<td>- Vans</td>
<td>- Roller skates/blades</td>
</tr>
<tr>
<td>- Buses</td>
<td>- Skateboards</td>
</tr>
<tr>
<td>- Planes</td>
<td>- Non-motorized scooters</td>
</tr>
<tr>
<td>- Trains</td>
<td>- Non-motorized wheelchairs</td>
</tr>
<tr>
<td>- Motorcycles</td>
<td>- Horses</td>
</tr>
<tr>
<td>- Motorized bicycles (mopeds)</td>
<td>- Watercraft</td>
</tr>
<tr>
<td>- Motorized scooters</td>
<td>- ATVs</td>
</tr>
<tr>
<td>- Golf carts</td>
<td>-</td>
</tr>
</tbody>
</table>
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
- 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 (ND): This null value code applies if hospital documentation of 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 the information was “Not Documented”.
- Not Applicable (NA): 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-transported to the hospital.
FUNCTION AND HOT KEYS

**Definition**
These function and hot keys can be utilized at your discretion.

### Field Values

<table>
<thead>
<tr>
<th>FUNCTION KEYS</th>
<th>HOT KEYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>F2</td>
<td>^C</td>
</tr>
<tr>
<td>F3</td>
<td>^E</td>
</tr>
<tr>
<td>F4</td>
<td>^I</td>
</tr>
<tr>
<td>F6</td>
<td>^K</td>
</tr>
<tr>
<td>F7</td>
<td>^L</td>
</tr>
<tr>
<td>F8</td>
<td>^M</td>
</tr>
<tr>
<td>^F8</td>
<td>^N</td>
</tr>
<tr>
<td>F9</td>
<td>^O</td>
</tr>
<tr>
<td>F10</td>
<td>^P</td>
</tr>
<tr>
<td>F11</td>
<td>^S</td>
</tr>
<tr>
<td>F11</td>
<td>^T</td>
</tr>
<tr>
<td>Shift + F11</td>
<td>^U</td>
</tr>
<tr>
<td>F12</td>
<td>^V</td>
</tr>
<tr>
<td>^PgUp</td>
<td>^X</td>
</tr>
<tr>
<td>^PgDn</td>
<td>ALT + Q</td>
</tr>
</tbody>
</table>

- Enter the current date or time.
- Enter last entered date or time.
- Restore default value in selected field.
- Not Documented.
- Not Applicable.
- Calculate selected calculable field.
- Calculate all calculable fields in the window.
- Clear selected field.
- Set the current pathway and page to the user's defaults.
- Move to the next field group defined on the current window/page.
- Place non-leaf picklist item in selected field.
- Move to the previous field group defined on the current window/page.
- Return to parent.
- Go to previous page in pathway or in multiple-paged window.
- Go to next page in pathway or in multiple-paged window.

^ Control Key
SCROLLING WINDOWS COMMANDS

Definition
These commands can be utilized at your discretion.

Field Values

<table>
<thead>
<tr>
<th>COMMANDS FOR SCROLLING WINDOWS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PGUP</td>
<td>Move up a window full of items at a time in scrolling window and picklists.</td>
</tr>
<tr>
<td>PGDN</td>
<td>Move down a window full of items at a time in scrolling window and picklists.</td>
</tr>
<tr>
<td>^UP ARROW</td>
<td>Move out of scrolling window to previous item.</td>
</tr>
<tr>
<td>^DOWN ARROW</td>
<td>Move out of scrolling window to next item.</td>
</tr>
<tr>
<td>^A</td>
<td>Add new row to scrolling window.</td>
</tr>
<tr>
<td>^I</td>
<td>Insert new row above current row in scrolling window.</td>
</tr>
<tr>
<td>^D</td>
<td>Delete selected row in scrolling window.</td>
</tr>
<tr>
<td>^C</td>
<td>Copy selected row in scrolling window to the end of the scrolling window.</td>
</tr>
<tr>
<td>ALT+F9</td>
<td>Copy selected field value in scrolling window to the same field in successive rows having no values.</td>
</tr>
<tr>
<td>ALT+R</td>
<td>Resize scrolling windows and graphic boxes with arrows. (Valid only in Reconfiguration.)</td>
</tr>
<tr>
<td>^F</td>
<td>Go to first row in scrolling window.</td>
</tr>
<tr>
<td>^B</td>
<td>Go to last row in scrolling window.</td>
</tr>
</tbody>
</table>

SYSTEM-WIDE

<table>
<thead>
<tr>
<th>Single Click</th>
<th>Selects object.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Double Click</td>
<td>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.</td>
</tr>
<tr>
<td>Right Click</td>
<td>On an entry field, brings up associated picklist. On a picklist item, selects highlighted item or opens attached subpicklist.</td>
</tr>
<tr>
<td>ESC</td>
<td>Close open picklist, dialog window, or menu.</td>
</tr>
</tbody>
</table>

(^ Control Key)
GENERAL INFORMATION
DHS PATIENT?

Definition
Indicates whether or not the patient meets TEMIS database inclusion criteria (Exhibit C).

Field Values
- Y (Yes)
- N (No)

Additional Information
- “Yes” indicates that patient meets Exhibit C inclusion criteria.
- “No” indicates that patient does not meet Exhibit C inclusion criteria.
- DHS PATIENT? doesn’t appear as a field value on the Trauma Patient Summary form.
- Null Values are not accepted for this data field.

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 NTDS.

Other Associated Elements
- TPS RATIONALE

Data Format: [character, 1] single entry
Min Value: N/A  Max Value: N/A
Picklist: Yes, non-modifiable
Accepts Null Value: No
TRAUMA CENTER CODE

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.
- TRAUMA CENTER CODE does not appear as a field value on the Trauma Patient Summary form.

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

Definition
Patient’s last name.

Field Values
- Relevant value for data element

Additional Information
- Null Values are not accepted for this data field.

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: No
FIRST NAME

Definition
Patient’s first name.

Field Values
- Relevant value for data element

Additional Information
- Null Values are not accepted for this data field.

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: No
MIDDLE INITIAL

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
Min Value: N/A
Max Value: N/A
Accepts Null Value: Yes
ARRIVAL DATE

Definition
The date the patient arrived in the Emergency Department (ED) or was admitted to the hospital.

Field Values
- Relevant value for data element

Additional Information
- Collected as MM-DD-YYYY.
- 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.
- Null Values are not accepted for this data field.
- Field value cannot be left blank.

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
Min Value: current date minus 7 years
Max Value: current date
Picklist: No
Accepts Null Value: No
ARRIVAL TIME

Definition
The time the patient arrived to the ED / Hospital.

Field Values
- Relevant value for data element

Additional Information
- Collected as HHMM (military time).
- If the patient was brought to the ED, enter time patient arrived in the ED.
- If patient was directly admitted to the hospital, enter time patient was admitted to the hospital.
- Data entry of this field will auto-populate ED ARRIVAL TIME regardless of ENTRY MODE (ED ARRIVAL TIME will be auto-populated even if the patient is a Direct Admit).
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

Data Source Hierarchy
1. ED Records
2. EMS Report Form

Uses
- Allows data to be sorted based upon total length of hospital stay.
- Used to calculate Total EMS Time and 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
Min Value: 0000  Max Value: 2359
Picklist: No  Accepts Null Value: Yes
HOME ADDRESS

Definition
The house or building number of the patient’s primary residence.

Field Values

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
- HOME STREET
- HOME STREET TYPE
- HOME APT #
- HOME ZIP CODE
- ALTERNATE HOME RESIDENCE
- HOME CITY
- HOME COUNTY
- HOME STATE
- HOME COUNTRY

Data Format: [character, 6] single entry
Min Value: N/A
Max Value: N/A
Picklist: No
Accepts Null Value: Yes
HOME STREET

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
- HOME ADDRESS
- HOME STREET
- HOME APT #
- HOME ZIP CODE
- ALTERNATE HOME RESIDENCE
- HOME CITY
- HOME COUNTY
- HOME STATE
- HOME COUNTRY

Data Format: [character, 40] single entry
Picklist: No
Min Value: N/A
Max Value: N/A
Accepts Null Value: Yes
HOME STREET TYPE

**Definition**
The two-letter code for the street type of the patient’s primary residence.

**Field Values**

<table>
<thead>
<tr>
<th>AL</th>
<th>AVENUE</th>
<th>BL</th>
<th>CO</th>
<th>CL</th>
<th>CK</th>
<th>CR</th>
<th>CS</th>
<th>DR</th>
<th>EX</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALLEY</td>
<td>AVENUE</td>
<td>BOULEVARD</td>
<td>CALLE</td>
<td>CIRCLE</td>
<td>CREEK</td>
<td>CRESCENT</td>
<td>CROSSING</td>
<td>DRIVE</td>
<td>EXPRESSWAY</td>
</tr>
<tr>
<td>FY</td>
<td>GD</td>
<td>GN</td>
<td>GR</td>
<td>LP</td>
<td>PK</td>
<td>PY</td>
<td>PS</td>
<td>PL</td>
<td>PZ</td>
</tr>
<tr>
<td>FREEWAY</td>
<td>GARDEN</td>
<td>GLEN</td>
<td>GROVE</td>
<td>LOOP</td>
<td>PARK</td>
<td>PARKWAY</td>
<td>PASEO</td>
<td>PLACE</td>
<td>PLAZA</td>
</tr>
<tr>
<td>PT</td>
<td>RD</td>
<td>RT</td>
<td>SQ</td>
<td>TL</td>
<td>VS</td>
<td>WK</td>
<td>WY</td>
<td>OT</td>
<td>N/A</td>
</tr>
<tr>
<td>POINT</td>
<td>ROAD</td>
<td>ROUTE</td>
<td>SQUARE</td>
<td>TRAIL</td>
<td>VISTA</td>
<td>WALK</td>
<td>WAY</td>
<td>OTHER NOT LISTED</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**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**
- HOME ADDRESS
- HOME STREET
- HOME APT #
- HOME ZIP CODE
- ALTERNATE HOME RESIDENCE
- HOME CITY
- HOME COUNTY
- HOME STATE
- HOME COUNTRY

**Data Format:** [character, 2] single entry
**Min Value:** N/A  **Max Value:** N/A  **Picklist:** Yes, non-modifiable  **Accepts Null Value:** Yes
HOME APT #

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
- HOME ADDRESS
- HOME STREET
- HOME STREET TYPE
- HOME ZIP CODE
- ALTERNATE HOME RESIDENCE
- HOME CITY
- HOME COUNTY
- HOME STATE
- HOME COUNTRY

Data Format: [character, 6] single entry
Min Value: N/A Max Value: N/A Picklist: No Accepts Null Value: Yes
HOME ZIP CODE

Definition
The ZIP code of the patient's primary residence.

Field Values
- Relevant value for data element

Additional Information
- Use 5-digit code (XXXXX).
- Data entry of a valid HOME ZIP CODE will auto-populate HOME CITY, HOME COUNTY, HOME STATE, and HOME COUNTRY.
- 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 auto-populate all address related fields with "Not Applicable".
- If the only address provided is a P.O. Box, utilize the ZIP CODE for the P.O. Box.
- Data element cannot be left blank.

Data Source Hierarchy
1. Facesheet
2. Billing Sheet / Medical Records Coding Summary Sheet
3. EMS Report Form

Uses
- Used to calculate FIPS code.
- Allows data to be sorted based upon the geographic location of the patient's home.

Other Associated Elements
- HOME ADDRESS
- HOME STREET
- HOME STREET TYPE
- HOME APT #
- ALTERNATE HOME RESIDENCE
- HOME CITY
- HOME COUNTY
- HOME STATE
- 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

NTDS D_06

Definition
Documentation of the type of patient when the home zip code is “Not Applicable”.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>Homeless</td>
</tr>
<tr>
<td>U</td>
<td>Undocumented Citizen</td>
</tr>
<tr>
<td>M</td>
<td>Migrant Worker</td>
</tr>
<tr>
<td>F</td>
<td>Foreign Visitor</td>
</tr>
</tbody>
</table>

Additional Information
- Only complete 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 a national of another country who is visiting in Los Angeles County.
- Data element cannot be left blank.

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
- HOME ADDRESS
- HOME STREET
- HOME STREET TYPE
- HOME APT #
- HOME ZIP CODE
- HOME CITY
- HOME COUNTY
- HOME STATE
- HOME COUNTRY

Data Format: [character, 1] single entry
Picklist: Yes, non-modifiable
Min Value: N/A  Max Value: N/A  Accepts Null Value: Yes
HOME CITY

Definition
The city of the patient’s primary residence.

Field Values
- Relevant value for data element

Additional Information
- Data entry of a valid HOME ZIP CODE will auto-populate the HOME CITY.
- Only complete when ZIP CODE is "Not Documented" or "Not Known".
- ZIP CODE entered as "Not Applicable" will auto-populate all address related fields with "Not Applicable".
- 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. The EMS Agency and Lancet will work towards a resolution of the issue with the specific Zip Codes identified.
- Data element cannot be left blank.

Data Source Hierarchy
1. Facesheet
2. Billing Sheet / Medical Records Coding Summary Sheet
3. EMS Report Form

Uses
- Used to calculate FIPS code.
- Allows data to be sorted based upon the geographic location of the patient’s home.

Other Associated Elements
- HOME ADDRESS
- HOME STREET
- HOME STREET TYPE
- HOME APT #
- HOME ZIP CODE
- ALTERNATE HOME RESIDENCE
- HOME COUNTY
- HOME STATE
- HOME COUNTRY

Data Format: [character, 15] single entry
Min Value: N/A
Max Value: N/A
Picklist: Yes, non-modifiable
Accepts Null Value: Yes
HOME COUNTY

Definition
The county of the patient’s primary residence.

Field Values
- Los Angeles
- Orange
- Riverside
- San Bernardino
- San Diego
- Ventura

Additional Information
- Data entry of a valid HOME ZIP CODE will auto-populate the HOME COUNTY.
- Only complete when ZIP CODE is "Not Documented" or "Not Known".
- ZIP CODE entered as "Not Applicable" will auto-populate all address related fields with "Not Applicable".
- Data element cannot be left blank.

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
- HOME ADDRESS
- HOME STREET
- HOME STREET TYPE
- HOME APT #
- HOME ZIP CODE
- ALTERNATE HOME RESIDENCE
- HOME CITY
- HOME STATE
- HOME COUNTRY

Data Format: [character, 15] single entry
Picklist: Yes, modifiable
Min Value: N/A
Max Value: N/A
Accepts Null Value: Yes
HOME STATE  

**Definition**
The two-letter code for the state (territory, province, or District of Columbia) of the patient’s primary residence.

**Field Values**

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

**Additional Information**
- Data entry of a valid HOME ZIP CODE will auto-populate the HOME STATE.
- Only complete when ZIP CODE is "Not Documented" or "Not Known".
- ZIP CODE entered as “Not Applicable” will auto-populate all address related fields with “Not Applicable”.
- Data element cannot be left blank.

**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**
- HOME ADDRESS
- HOME STREET
- HOME STREET TYPE
- HOME APT #
- HOME ZIP CODE
- HOME CITY
- HOME COUNTY
- HOME COUNTRY

**Data Format:** [character, 2] single entry  
**Picklist:** Yes, non-modifiable  
**Min Value:** N/A  
**Max Value:** N/A  
**Accepts Null Value:** Yes
HOME COUNTRY

**Definition**
The country of the patient’s primary residence.

**Field Values**
- Auto-populated with USA – use picklist if needed for other countries

**Additional Information**
- Data entry of a valid HOME ZIP CODE will auto-populate the HOME COUNTRY.
- Only complete when ZIP CODE is "Not Documented" or "Not Known".
- ZIP CODE entered as “Not Applicable” will auto-populate all address related fields with “Not Applicable”.
- Data element cannot be left blank.

**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**
- HOME ADDRESS
- HOME STREET
- HOME STREET TYPE
- HOME APT #
- HOME ZIP CODE
- ALTERNATE HOME RESIDENCE
- HOME CITY
- HOME COUNTY
- HOME STATE

**Data Format:** [character, 15] single entry
**Picklist:** Yes, non-modifiable
**Min Value:** N/A
**Max Value:** N/A
**Accepts Null Value:** Yes
SEX

Definition
Patient’s gender.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>Male</td>
</tr>
<tr>
<td>F</td>
<td>Female</td>
</tr>
<tr>
<td>N</td>
<td>Nonbinary</td>
</tr>
<tr>
<td>U</td>
<td>Unknown</td>
</tr>
<tr>
<td></td>
<td>&quot;Not Documented&quot;</td>
</tr>
</tbody>
</table>

Additional Information
- Patients who are undergoing, or have undergone, a hormonal and/or surgical sex reassignment should be coded using their stated preference.
- Nonbinary refers to patients whose gender identity isn’t exclusively male or female.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

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
Min Value: N/A
Max Value: N/A
Picklist: Yes, non-modifiable
Accepts Null Value: Yes
DATE OF BIRTH (DOB)  NTDS D_07

Definition
Patient’s date of birth.

Field Values
- Relevant value for data element

Additional Information
- Collected as MM-DD-YYYY.
- If the patient is less than 24 hours old, complete variables: AGE and AGE UNITS.
- If "Not Documented", 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’s age in days, months, or years.

Other Associated Elements
- AGE
- AGE UNITS

Data Format:  [date] single entry
Min Value:  Date minus 125yrs  Max Value:  Current date
Picklist:  No
Accepts Null Value:  Yes
AGE  
NTDS D_08

**Definition**
The best approximation of the patient's age at the time of injury when the date of birth is unavailable.

**Field Values**
- Relevant value for data element

**Additional Information**
- If DATE OF BIRTH is entered, the AGE and AGE UNITS will be auto-populated.
- 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

Definition
The unit of measurement used to document the best approximation of the patient’s age at the time of injury when the date of birth is unavailable.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Years</td>
</tr>
<tr>
<td>M</td>
<td>Months</td>
</tr>
<tr>
<td>D</td>
<td>Days</td>
</tr>
<tr>
<td>H</td>
<td>Hours</td>
</tr>
<tr>
<td>(Not Applicable in LA County)</td>
<td>5</td>
</tr>
<tr>
<td>(Not Applicable in LA County)</td>
<td>6</td>
</tr>
<tr>
<td>YE</td>
<td>Years Estimated</td>
</tr>
<tr>
<td>ME</td>
<td>Months Estimated</td>
</tr>
<tr>
<td>DE</td>
<td>Days Estimated</td>
</tr>
<tr>
<td>HE</td>
<td>Hours Estimated</td>
</tr>
</tbody>
</table>

Additional Information
- If DATE OF BIRTH is entered, the AGE and AGE UNITS will be auto-populated.
- 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  
Min Value: N/A  
Max Value: N/A  
Picklist: Yes, non-modifiable  
Accepts Null Value: Yes
**PEDIATRIC / ADULT**

**Definition**
Patient’s status, adult versus pediatric, at the time of injury.

**Field Values**
- A (Adult)
- P (Pediatric)
- U (Unknown)

**Additional Information**
- Normally calculated from DATE OF BIRTH and auto-populated.
- PEDIATRIC / ADULT does not appear as a field value on the Trauma Patient Summary form.

**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
- AGE UNITS

**Data Format:** [character, 1] single entry
**Min Value:** N/A **Max Value:** N/A **Picklist:** Yes, non-modifiable **Accepts Null Value:** Yes
RACE / ETHNICITY

NTDS D_10/D_11

Definition
Patient’s race/ethnicity.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>Race/Ethnicity</th>
<th>NTDS Race (D_10)</th>
<th>NTDS Ethnicity (D_11)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A  Asian</td>
<td>1 Asian</td>
<td>2 Not Hispanic or Latino</td>
<td></td>
</tr>
<tr>
<td>B  Black</td>
<td>5 Black/African American</td>
<td>2 Not Hispanic or Latino</td>
<td></td>
</tr>
<tr>
<td>F  Filipino</td>
<td>2 Hawaiian/Pacific Islander</td>
<td>2 Not Hispanic or Latino</td>
<td></td>
</tr>
<tr>
<td>H  Hispanic/Latino</td>
<td>6 White</td>
<td>1 Hispanic or Latino</td>
<td></td>
</tr>
<tr>
<td>N  Native American</td>
<td>4 American Indian</td>
<td>2 Not Hispanic or Latino</td>
<td></td>
</tr>
<tr>
<td>P  Pacific Islander/Hawaiian</td>
<td>2 Hawaiian/Pacific Islander</td>
<td>2 Not Hispanic or Latino</td>
<td></td>
</tr>
<tr>
<td>U  Unknown</td>
<td>3 Other Race</td>
<td>2 Not Hispanic or Latino</td>
<td></td>
</tr>
<tr>
<td>W  White</td>
<td>6 White</td>
<td>2 Not Hispanic or Latino</td>
<td></td>
</tr>
<tr>
<td>O  Other</td>
<td>3 Other Race</td>
<td>2 Not Hispanic or Latino</td>
<td></td>
</tr>
</tbody>
</table>

Additional Information
- Patient race/ethnicity should be based upon self-report or identified by a family member.
- Based upon the 2010 US Census Bureau.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

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
Min Value: N/A
Max Value: N/A
Picklist: Yes, non-modifiable
Accepts Null Value: Yes
**ENTRY MODE**

**NTDS P_07/P_20**

**Definition**
Mode of transport of the patient to the treating facility.

**Field Values**

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Entry Mode</strong></td>
<td><strong>Transport Mode (P_07)</strong></td>
</tr>
<tr>
<td>EMS: Ground</td>
<td>1 Ground</td>
</tr>
<tr>
<td>EMS: Air</td>
<td>2 Helicopter</td>
</tr>
<tr>
<td>NON-EMS: Vehicle/Walk-in</td>
<td>4 Vehicle/Walk-in</td>
</tr>
<tr>
<td>NON-EMS: Police</td>
<td>5 Police</td>
</tr>
<tr>
<td>NON-EMS: Other</td>
<td>6 Other</td>
</tr>
<tr>
<td>TRANSFERRED: 9-1-1 Re-Triage / Ground</td>
<td>1 Ground</td>
</tr>
<tr>
<td>TRANSFERRED: 9-1-1 Re-Triage / Air</td>
<td>2 Helicopter</td>
</tr>
<tr>
<td>TRANSFERRED: ED to ED / Ground</td>
<td>1 Ground</td>
</tr>
<tr>
<td>TRANSFERRED: ED to ED / Air</td>
<td>2 Helicopter</td>
</tr>
<tr>
<td>TRANSFERRED: Direct Admit / Ground</td>
<td>1 Ground</td>
</tr>
<tr>
<td>TRANSFERRED: Direct Admit / Air</td>
<td>2 Helicopter</td>
</tr>
<tr>
<td>(Not an option in LA County)</td>
<td>3 Fixed Wing</td>
</tr>
</tbody>
</table>

**Additional Information**
- If ENTRY MODE is Non-EMS: EMS data fields will auto-populate with “Not Applicable”, e.g. PROVIDER, RA/SQUAD, INJURY DESCRIPTION, MECHANISM OF INJURY, etc.
- “TRANSFERRED: 9-1-1 Re-Triage” is indicated when patient is transferred from the ED of an acute care facility emergently via 9-1-1 to the ED at your facility (Use Default Pathway for data entry).
- “TRANSFERRED: ED to ED” is indicated when patient is both transferred from the ED of 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 to your facility as an inpatient. Excludes patients transferred from a private doctor’s office, stand-alone ambulatory surgery center, or delivered to your hospital by a non-EMS transport (Use Direct Admit Pathway for data entry).
- Use of the Direct Admit Pathway will auto-populate ED specific data fields with “Not Applicable”.
- Field value cannot be “Not Applicable”.

**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
- 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
EMS FORM AVAILABLE?

Definition
Indicates whether or not a copy of the EMS Report Form is available for abstraction.

Field Values
- Y (Yes)
- N (No)

Additional Information
- The EMS Form is an essential link between the EMS, Base and Trauma databases – **every effort should be made to obtain the EMS Report Form.**
- If ENTRY MODE is EMS, entering “No” for EMS FORM AVAILABLE? will auto-populate the following EMS Provider fields with “*Not Documented*”:
  - PROVIDER
  - RA/SQUAD
  - TR DISP DATE
  - TR DISP TIME
  - 1st ON SCENE
  - TR ARRIVED
  - TR UNIT LEFT
  - 1st FIELD GCS Fields
  - FIELD INTUBATION?
  - 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
- ENTRY MODE

Data Format: [character, 1] single entry
Min Value: N/A
Max Value: N/A

Picklist: Yes, non-modifiable
Accepts Null Value: Yes
TRANSFERRED FROM (TF)

Definition
EMS Agency’s three-letter code for the hospital from which the patient was transferred to your facility, if applicable.

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 type of transfer.

Other Associated Elements
- ENTRY MODE
- TRANSFERRED FROM (TF): Arrival Date
- TRANSFERRED FROM (TF): Arrival Time
- TRANSFERRED FROM (TF): Exit Date
- TRANSFERRED FROM (TF): Exit Time

Data Format: [character, 3] single entry
Min Value: N/A    Max Value: N/A
Picklist: Yes, non-modifiable
Accepts Null Value: Yes
TRANSFERRED FROM (TF): Arrival Date

Definition
For 9-1-1 Re-triage, enter the date 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 MM-DD-YYYY.
- 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 type of transfer.

Other Associated Elements
- ENTRY MODE
- TRANSFERRED FROM (TF)
- TRANSFERRED FROM (TF): Arrival Time
- TRANSFERRED FROM (TF): Exit Date
- TRANSFERRED FROM (TF): Exit Time

Data Format: [date] single entry
Min Value: current date minus 7 years  Max Value: current date  Picklist: No  Accepts Null Value: Yes
TRANSFERRED FROM (TF): Arrival Time

Definition
For 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 type of transfer.

Other Associated Elements
- ENTRY MODE
- TRANSFERRED FROM (TF)
- TRANSFERRED FROM (TF): Arrival Date
- TRANSFERRED FROM (TF): Exit Date
- TRANSFERRED FROM (TF): Exit Time

Data Format: [time] single entry
Min Value: 0000  Max Value: 2359
Picklist: No  Accepts Null Value: Yes
TRANSFERRED FROM (TF): Exit Date

Definition
For 9-1-1 Re-triage, enter the date 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 MM-DD-YYYY.
- 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 type of transfer.

Other Associated Elements
- ENTRY MODE
- TRANSFERRED FROM (TF)
- TRANSFERRED FROM (TF): Arrival Date
- TRANSFERRED FROM (TF): Arrival Time
- TRANSFERRED FROM (TF): Exit Time

Data Format: [date] single entry
Min Value: current date minus 7 years Max Value: current date
Picklist: No Accepts Null Value: Yes
TRANSFERRED FROM (TF): Exit Time

Definition
For 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
4. ED Records
5. EMS Report Form
6. Billing Sheet / Medical Records Coding Summary Sheet

Uses
• Allows data to be sorted based upon type of transfer.

Other Associated Elements
• ENTRY MODE
• TRANSFERRED FROM (TF)
• TRANSFERRED FROM (TF): Arrival Date
• TRANSFERRED FROM (TF): Arrival Time
• TRANSFERRED FROM (TF): Exit Date

Data Format: [time] single entry
Min Value: 0000                      Max Value: 2359
Picklist: No                        Accepts Null Value: Yes
SEQUENCE #

Definition
Sequence Number (EMS record number) assigned to the patient, which is pre-printed on the EMS Report form.

Field Values
- Relevant value for data element

Additional Information
- EMS-generated SEQUENCE #s follow “Mod-9” formula: 2 letters, 6 numbers.
- Electronic Patient Care Record (ePCR) SEQUENCE #s utilize: EMS Provider’s two-letter code, 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 # 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. 18USC001.
- DHS = No patients without an existing SEQUENCE # 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. 18TL001.
- 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 #, 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 #.
- Null Values are not accepted for this data field.

Data Source Hierarchy
1. EMS Report Form
2. Base Hospital form, tapes, or electronic records

Uses
- Patient identifier.
- Essential link between the EMS, Base and Trauma databases.

Other Associated Elements
- MR #
- OTHER #

Data Format: [character, 12] single entry
Picklist: No
Min Value: N/A
Max Value: N/A
Accepts Null Value: No
MEDICAL RECORD (MR) #

Definition
Medical (or financial) record number assigned to the patient 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
Min Value: N/A Max Value: N/A Picklist: No Accepts Null Value: Yes
OTHER #

Definition
Other number assigned to the patient 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
PREHOSPITAL
INJURY DATE  

**Definition**
The date the injury occurred.

**Field Values**
- Relevant value for data element

**Additional Information**
- Collected as MM-DD-YYYY.
- Estimates of INJURY DATE 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.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

**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.

**Other Associated Elements**
- INJURY TIME

**Data Format:** [date] single entry
**Min Value:** current date minus 7 years  
**Max Value:** current date  
**Picklist:** No  
**Accepts Null Value:** Yes
INJURY TIME

Definition
The time the injury occurred.

Field Values
• Relevant value for data element

Additional Information
• Collected as HHMM (military time).
• Estimates of INJURY TIME 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.
• Field value cannot be “Not Applicable”.
• Field value cannot be left blank.

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.

Other Associated Elements
• INJURY DATE

Data Format: [time] single entry
Picklist: No
Min Value: 0000 Max Value: 2359 Accepts Null Value: Yes
PROVIDER

Definition
The two-letter code for the EMS provider primarily responsible for the patient’s prehospital care.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>PUBLIC PROVIDERS</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>AF</td>
<td>Arcadia Fire</td>
<td>DF</td>
<td>Downey Fire</td>
<td>RB</td>
</tr>
<tr>
<td>AH</td>
<td>Alhambra Fire</td>
<td>ES</td>
<td>El Segundo Fire</td>
<td>SA</td>
</tr>
<tr>
<td>AV</td>
<td>Avalon Fire</td>
<td>FS</td>
<td>U.S. Forest Service</td>
<td>SG</td>
</tr>
<tr>
<td>BA</td>
<td>Burbank Airport Fire</td>
<td>GL</td>
<td>Glendale Fire</td>
<td>SI</td>
</tr>
<tr>
<td>BF</td>
<td>Burbank Fire</td>
<td>LB</td>
<td>Long Beach Fire</td>
<td>SM</td>
</tr>
<tr>
<td>BH</td>
<td>Beverly Hills Fire</td>
<td>LH</td>
<td>La Habra Heights Fire</td>
<td>SP</td>
</tr>
<tr>
<td>CB</td>
<td>LA County Beaches</td>
<td>LV</td>
<td>La Verne Fire</td>
<td>SS</td>
</tr>
<tr>
<td>CC</td>
<td>Culver City Fire</td>
<td>MB</td>
<td>Manhattan Beach Fire</td>
<td>TF</td>
</tr>
<tr>
<td>CF</td>
<td>LA County Fire</td>
<td>MF</td>
<td>Monrovia Fire</td>
<td>UF</td>
</tr>
<tr>
<td>CG</td>
<td>US Coast Guard</td>
<td>MO</td>
<td>Montebello Fire</td>
<td>VE</td>
</tr>
<tr>
<td>CI</td>
<td>LA City Fire</td>
<td>MP</td>
<td>Monterey Park Fire</td>
<td>VF</td>
</tr>
<tr>
<td>CM</td>
<td>Compton Fire</td>
<td>OT</td>
<td>Other Provider</td>
<td>WC</td>
</tr>
<tr>
<td>CS</td>
<td>LA County Sheriff</td>
<td>PF</td>
<td>Pasadena Fire</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PRIVATE PROVIDERS</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>American Professional</td>
<td>FM</td>
<td>Firstmed Ambulance</td>
</tr>
<tr>
<td>AB</td>
<td>AmbuLife Ambulance</td>
<td>GU</td>
<td>Guardian Ambulance</td>
</tr>
<tr>
<td>AN</td>
<td>Antelope Ambulance</td>
<td>LE</td>
<td>Lifeline Ambulance</td>
</tr>
<tr>
<td>AR</td>
<td>American Medical Response</td>
<td>LT</td>
<td>Liberty Ambulance</td>
</tr>
<tr>
<td>AT</td>
<td>All Town Ambulance</td>
<td>LY</td>
<td>Lynch EMS Ambulance</td>
</tr>
<tr>
<td>AU</td>
<td>AmbuServe/Shoreline Ambu.</td>
<td>MA</td>
<td>Mauran Ambulance</td>
</tr>
<tr>
<td>AW</td>
<td>AMWest Ambulance</td>
<td>MI</td>
<td>MedResponse</td>
</tr>
<tr>
<td>AZ</td>
<td>Ambulnz Health, Inc.</td>
<td>MR</td>
<td>MedReach Ambulance</td>
</tr>
<tr>
<td>CA</td>
<td>CARE Ambulance</td>
<td>MT</td>
<td>MedCoast Ambulance</td>
</tr>
<tr>
<td>CL</td>
<td>CAL-MED Ambulance</td>
<td>MY</td>
<td>Mercy Air</td>
</tr>
<tr>
<td>EA</td>
<td>Emergency Ambulance</td>
<td>PE</td>
<td>Premier Medical Transport</td>
</tr>
<tr>
<td>EX</td>
<td>Explorer 1 Ambulance</td>
<td>PN</td>
<td>PRN Ambulance</td>
</tr>
<tr>
<td>FC</td>
<td>First Rescue Ambulance</td>
<td>RE</td>
<td>REACH Air Medical Service</td>
</tr>
</tbody>
</table>

Additional Information
- Non-picklist – manually enter information exactly as it appears on the EMS Report Form.
- The null value “Not Applicable” is auto-populated for non-EMS patients.

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
Min Value: N/A Max Value: N/A Picklist: Yes, non-modifiable
Accepts Null Value: Yes
RA / SQUAD

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-picklist – manually enter information exactly as it appears on the EMS Report Form.
- The null value “Not Applicable” is auto-populated for non-EMS patients.

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**

**NTDS P_01**

**Definition**
The date the unit *transporting the patient to your hospital* was notified by dispatch.

**Field Values**
- Relevant value for data element

**Additional Information**
- Collected as MM-DD-YYYY.
- The null value “Not Applicable” is auto-populated for non-EMS patients.
- Field value cannot be left blank.

**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 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:** current date minus 7 years  
**Max Value:** current date  
**Accepts Null Value:** Yes
DISPATCH TIME

Definition
The time the unit transporting the patient to your hospital was notified by dispatch.

Field Values
- Relevant value for data element

Additional Information
- Collected as HHMM (military time).
- The null value “Not Applicable” is auto-populated for non-EMS patients.
- Field value cannot be left blank.

Data Source Hierarchy
1. EMS Report Form

Uses
- Allows data to be sorted based upon EMS Provider time intervals.
- Used in calculating EMS times.

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
Min Value: 0000 Max Value: 2359 Picklist: No Accepts Null Value: Yes
1st ON SCENE

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.
- The null value “Not Applicable” is auto-populated for non-EMS patients.

Data Source Hierarchy
1. EMS Report Form

Uses
- Allows data to be sorted based upon EMS Provider time intervals.
- Used in calculating total EMS scene time.

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
Min Value: 0000                      Max Value: 2359                      Picklist: No
Accepts Null Value: Yes
TRANSPORT UNIT ARRIVAL DATE

NTDS 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
- Collected as MM-DD-YYYY.
- Auto-calculated based on dispatch information – does not appear as a field on the TPS form or in the data entry program.

Data Source Hierarchy
1. EMS Report Form

Uses
- Allows data to be sorted based upon EMS Provider 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
Min Value: current date minus 7 years        Max Value: current date        Picklist: No
Accepts Null Value: Yes
TRANSPORT UNIT ARRIVAL TIME

NTDS 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).
- The null value “Not Applicable” is auto-populated for non-EMS patients.
- Field value cannot be left blank.

Data Source Hierarchy
1. EMS Report Form

Uses
- Allows data to be sorted based upon EMS Provider 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
Min Value: 0000  Max Value: 2359  Picklist: No  Accepts Null Value: Yes
TRANSPORT UNIT LEFT DATE
NTDS_05

Definition
The date the unit transporting the patient to your hospital left the scene.

Field Values
- Relevant value for data element

Additional Information
- Collected as MM-DD-YYYY.
- Auto-calculated based on Dispatch information – does not appear as a field on the TPS form or in the data entry program.

Data Source Hierarchy
1. EMS Report Form

Uses
- Allows data to be sorted based upon EMS Provider 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
Min Value: current date minus 7 years Max Value: current date Picklist: No
Accepts Null Value: Yes
TRANSPORT UNIT LEFT TIME

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).
- The null value “Not Applicable” is auto-populated for non-EMS patients.
- Field value cannot be left blank.

Data Source Hierarchy
1. EMS Report Form

Uses
- Allows data to be sorted based upon EMS Provider 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
Min Value: 0000  Max Value: 2359
Picklist: No  Accepts Null Value: Yes
INJURY DESCRIPTION

Definition
The LA County two-letter complaint code(s) describing the patient’s injury.

Field Values

<table>
<thead>
<tr>
<th>BLUNT:</th>
<th>PENETRATING:</th>
<th>OTHER:</th>
</tr>
</thead>
<tbody>
<tr>
<td>BL Minor Laceration</td>
<td>PL Minor Laceration</td>
<td>NA No Apparent Injury</td>
</tr>
<tr>
<td>Minor Contusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BT Trauma Arrest</td>
<td>PT Trauma Arrest</td>
<td>CB Critical Burn</td>
</tr>
<tr>
<td>BH Head</td>
<td>PH Head</td>
<td>BU Burns / Electric Shock</td>
</tr>
<tr>
<td>14 BH with GCS ≤14</td>
<td></td>
<td>90 SBP &lt;90, 70 SBP &lt;1yr</td>
</tr>
<tr>
<td>BF Facial/Mouth</td>
<td>PF Facial/Mouth</td>
<td>RR Respiratory Rate &lt;10/&gt;29, &lt;20 if &lt;1y</td>
</tr>
<tr>
<td>BN Neck</td>
<td>PN Neck</td>
<td></td>
</tr>
<tr>
<td>BB Back</td>
<td>PB Back</td>
<td>SX Suspected Pelvic Fracture</td>
</tr>
<tr>
<td>BC Chest</td>
<td>PC Chest</td>
<td>SC Spinal Cord Injury</td>
</tr>
<tr>
<td>FC Flail Chest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BP Tension Pneumothorax</td>
<td>PP Tension Pneumothorax</td>
<td></td>
</tr>
<tr>
<td>BA Abdomen</td>
<td>PA Abdomen</td>
<td></td>
</tr>
<tr>
<td>BD Diffuse Tenderness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BG Genitals</td>
<td>PG Genitals</td>
<td></td>
</tr>
<tr>
<td>BK Buttocks</td>
<td>PK Buttocks</td>
<td>IT Inpatient Trauma (Direct Admit)</td>
</tr>
<tr>
<td>BE Extremity</td>
<td>PE Extremity ↓ elbow/knee</td>
<td></td>
</tr>
<tr>
<td>BR Fracture ≥ 2 long bone</td>
<td>PX Extremity ↑ elbow/knee</td>
<td></td>
</tr>
<tr>
<td>BI Amputation ↑ wrist/ankle</td>
<td>PI Amputation ↑ wrist/ankle</td>
<td></td>
</tr>
<tr>
<td>BV Neuro/Vascular/Mangled</td>
<td>PV Neuro/Vascular/Mangled</td>
<td></td>
</tr>
</tbody>
</table>

Transfer Inpatient:

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.
- The null value “Not Applicable” is auto-populated for non-EMS patients.
- Field value cannot be left blank.
- Refer to Appendix 2: Glossary of Terms – Injury Description (Prehospital) for additional details.

Data Source Hierarchy
1. EMS Report Form (preferred)
2. ED Records

Uses
- Allows data to be sorted based upon the injury description.

Other Associated Elements
- MECHANISM OF INJURY
- PROTECTIVE DEVICES

Data Format: [character, 2] multiple entries
Min Value: N/A
Max Value: N/A
Picklist: Yes, non-modifiable
Accepts Null Value: Yes
MECHANISM OF INJURY

Definition
The LA County two-letter code(s) describing the patient’s mechanism of injury.

Field Values

<table>
<thead>
<tr>
<th>Field Values</th>
<th>LA COUNTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>EV Enclosed Vehicle</td>
<td>AN Animal Bite</td>
</tr>
<tr>
<td>EJ Ejected</td>
<td>CR Crush</td>
</tr>
<tr>
<td>EX Extricated</td>
<td>TD Telemetry Data</td>
</tr>
<tr>
<td>PS Passenger Space Intrusion (PSI) - Unspecified</td>
<td>FA Fall</td>
</tr>
<tr>
<td>12 PSI &gt; 12 Inches – Occupied Passenger Space</td>
<td>15 Fall &gt;15Ft. Adult / &gt;10Ft. Child</td>
</tr>
<tr>
<td>18 PSI &gt;18 Inches - Unoccupied Passenger Space</td>
<td>SC Special Considerations</td>
</tr>
<tr>
<td>SF Survived Fatal Accident</td>
<td>SA Self-Inflicted Accidental</td>
</tr>
<tr>
<td>20 Unenclosed Vehicle &gt;20 MPH</td>
<td>SI Self-Inflicted Intentional</td>
</tr>
<tr>
<td>RT Ped/Bike Thrown / Runover &gt;20 MPH</td>
<td>ES Electrical Shock</td>
</tr>
<tr>
<td>PB Ped/Bike ≤20 MPH</td>
<td>TB Thermal Burn</td>
</tr>
<tr>
<td>MM Motorcycle / Moped</td>
<td>HE Hazmat Exposure</td>
</tr>
<tr>
<td>SP Sports / Recreation</td>
<td>WR Work Related</td>
</tr>
<tr>
<td>AS Assault</td>
<td>UN Unknown</td>
</tr>
<tr>
<td>ST Stabbing</td>
<td>OT Other</td>
</tr>
<tr>
<td>GS GSW</td>
<td></td>
</tr>
</tbody>
</table>

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).
- For PSI to meet Trauma Criteria and/or Guideline per Reference No. 506, the intrusion must be specified as greater than 12 inches into an occupied passenger space, or greater than 18 inches into an unoccupied passenger space.
- 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.
- The null value “Not Applicable” is auto-populated for non-EMS patients.
- Field value cannot be left blank.
- Refer to Appendix 2: Glossary of Terms – Mechanism of Injury (Prehospital) for additional details.

Data Source Hierarchy
1. EMS Report Form (preferred)
2. ED Records

Uses
- Allows data to be sorted based upon the mechanism of injury.

Other Associated Elements
- INJURY DESCRIPTION
- BLUNT vs PENETRATING
- PROTECTIVE DEVICES

Data Format: [character, 2] multiple entries
Min Value: N/A Max Value: N/A Picklist: Yes, non-modifiable
Accepts Null Value: Yes
BLUNT / PENETRATING / BURN

Definition
Indicates the type of the injury:
- BLUNT in which the tissues are injured by forces like compression (crushing), shearing (tearing), acceleration, and deceleration;
- PENETRATING in which tissues are penetrated by single or multiple objects; or
- CRITICAL BURN as defined as follows:
  - Patients 15 years of age or older with 2nd (partial thickness) and 3rd (full thickness) degree burns involving equal to or greater than 20% Total Body Surface Area (TBSA)
  - Patients ≤ 14 years of age with 2nd (partial thickness) and 3rd (full thickness) degree burns involving equal to or greater than 10% TBSA

Field Values
- Blunt
- Penetrating
- Burn

Additional Information
- The type of injury, BLUNT vs PENETRATING, should reflect the injury force, Blunt (MVA, Fall, & Auto vs Ped) versus Penetrating (GSW or ST).
- Critical Burn classification, degree and TBSA, should be based upon the physicians assessment.
- If the patient has more than one type of injury, use the type of injury for the most significant injury, the injury most likely to cause prolonged disability or death.
- Blunt force injuries can result in penetration of tissues, but the injury type is still BLUNT, e.g. shrapnel from a bomb blast.

Data Source Hierarchy
1. EMS Report Form (preferred)
2. ED Records

Uses
- Allows data to be sorted based upon the type of injury.

Other Associated Elements
- INJURY DESCRIPTION
- MECHANISM OF INJURY
- PROTECTIVE DEVICES

Data Format: [character, 1] single entry
Picklist: Yes, non-modifiable
Min Value: N/A
Max Value: N/A
Accepts Null Value: Yes
PROTECTIVE DEVICES  
NTDS I_14/I_15/I_16

Definition
Protective devices (safety equipment) in use or worn by the patient at the time of the injury.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>Protective Devices</th>
<th>NTDS</th>
<th>Child Specific Restraint (I_15)</th>
<th>Airbag Deployment (I_16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>None</td>
<td>1</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td>HE</td>
<td>Helmet</td>
<td>7</td>
<td>Helmet</td>
<td>N/A</td>
</tr>
<tr>
<td>PC</td>
<td>Protective Clothing</td>
<td>9</td>
<td>Clothing</td>
<td>N/A</td>
</tr>
<tr>
<td>PG</td>
<td>Protective Gear (non-clothing)</td>
<td>4</td>
<td>Non-Clothing Gear</td>
<td>N/A</td>
</tr>
<tr>
<td>EP</td>
<td>Eye Protection</td>
<td>5</td>
<td>Eye protection</td>
<td>N/A</td>
</tr>
<tr>
<td>PF</td>
<td>Personal Flotation</td>
<td>3</td>
<td>Personal Flotation</td>
<td>N/A</td>
</tr>
<tr>
<td>SB</td>
<td>SB Seatbelt - Shoulder Belt</td>
<td>10</td>
<td>Shoulder Belt</td>
<td>N/A</td>
</tr>
<tr>
<td>LB</td>
<td>LB Seatbelt - Lap Belt</td>
<td>2</td>
<td>Lap Belt</td>
<td>N/A</td>
</tr>
<tr>
<td>OT</td>
<td>OT Other</td>
<td>11</td>
<td>Other</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Airbags

| AN        | Airbag Not Deployed | 8 | Airbag Present                 | 1 | Airbag Not Deployed |
| AF        | Airbag Deployed - Front | 8 | Airbag Present                 | 2 | Airbag Deployed Front |
| AS        | Airbag Deployed - Side | 8 | Airbag Present                 | 3 | Airbag Deployed Side |
| AO        | Airbag Deployed - Other | 8 | Airbag Present                 | 4 | Airbag Deployed Other |

Child Restraints

| IC        | Infant Car Seat (up to 1yr/20lbs) | 6 | Child Restraint                | 2 | Infant Car Seat |
| CC        | Child Car Seat (>1yr/20-40lbs)    | 6 | Child Restraint                | 1 | Child Car seat |
| CB        | Child Booster (>40lbs/<4'9")      | 6 | Child Restraint                | 3 | Child Booster Seat |

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”.
- The null value “Not Applicable” is used if no “Airbag” is reported under Protective Devices.
- Presence or use of protective devices may be reported or observed.
- Indicate all that apply.
- Field value cannot be left blank.

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
- INJURY DESCRIPTION
- MECHANISM OF INJURY
- BLUNT vs PENETRATING

Data Format: [character, 2] multiple entries  
Picklist: Yes, non-modifiable  
Min Value: N/A  
Max Value: N/A  
Accepts Null Value: No
1st FIELD VS: BP (Systolic)

Definition
First recorded systolic blood pressure (*without the assistance of CPR or any type of mechanical chest compressions*) measured at the scene of injury.

Field Values
- Relevant value for data element

Additional Information
- Utilize "Not Documented" for references to capillary refill, or if reported to be "unable to obtain".
- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- The null value “Not Applicable” is auto-populated for non-EMS patients.
- Field value cannot be left blank.

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 (Diastolic)
- 1st Field VS: HR
- 1st Field VS: RR
- 1st Field VS: O₂ SAT %
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL

Data Format: [number, 3] single entry
Min Value: 0  Max Value: 300  Picklist: No  Accepts Null Value: Yes
1st FIELD VS: BP (Diastolic)

Definition
First recorded diastolic blood pressure measured at the scene of injury.

Field Values
- Relevant value for data element

Additional Information
- The null value “Not Documented” is used if the diastolic pressure is not measured (i.e., only palpated SYSTOLIC pressure measured).
- The null value “Not Applicable” is auto-populated for non-EMS patients.

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: O2 SAT %
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL

Data Format: [number, 3] single entry  
Picklist: No  
Min Value: 0  Max Value: 300  Accepts Null Value: Yes
DEFINITION
First recorded pulse (Heart 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

ADDITIONAL INFORMATION
• Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
• The null value “Not Applicable” is auto-populated for non-EMS patients.
• Field value cannot be left blank.

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: VERBAL
• 1st Field GCS: MOTOR
• 1st Field GCS: TOTAL

DATA FORMAT: [number, 3] single entry
Min Value: 0 Max Value: 300 Picklist: No Accepts Null Value: Yes
1st FIELD VS: RR

Definition
First recorded respiratory rate measured at the scene of injury, expressed as a number per minute.

Field Values
• Relevant value for data element

Additional Information
• The null value “Not Applicable” is auto-populated for non-EMS patients.
• Field value cannot be left blank.

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: HR
• 1st Field VS: O2 SAT %
• 1st Field GCS: EYE
• 1st Field GCS: VERBAL
• 1st Field GCS: MOTOR
• 1st Field GCS: TOTAL

Data Format: [number, 3] single entry
Min Value: 0 Max Value: 100 Picklist: No Accepts Null Value: Yes
\textbf{1st FIELD VS: O}_2\text{ SAT}

\textbf{Definition}  
First recorded oxygen saturation measured at the scene of injury, expressed as a percentage.

\textbf{Field Values}  
- Relevant value for data element

\textbf{Additional Information}  
- Value should be based upon assessment before the administration of oxygen.
- The null value \textit{“Not Applicable”} is auto-populated for non-EMS patients.
- Field value cannot be left blank.

\textbf{Data Source Hierarchy}  
1. EMS Report Form

\textbf{Uses}  
- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.

\textbf{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: VERBAL
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL

\textbf{Data Format:} [number, 3] single entry  
\textbf{Min Value:} 0 \hspace{1cm} \textbf{Max Value:} 100 \hspace{1cm} \textbf{Picklist:} No  
\textbf{Accepts Null Value:} Yes
**1st FIELD GCS: EYE**

**Definition**
First recorded Glasgow Coma (GCS) Eye Score measured at the scene of injury.

**Field Values**

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Opens eyes spontaneously</td>
<td>Opens eyes spontaneously</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Opens eyes in response to verbal stimulation</td>
<td>Opens eyes in response to verbal stimulation</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Opens eyes in response to painful stimulation</td>
<td>Opens eyes in response to painful stimulation</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>No eye opening</td>
<td>No eye movement when assessed</td>
</tr>
</tbody>
</table>

**Additional Information**
- The null value “Not Applicable” is auto-populated for non-EMS patients.
- Field value cannot be left blank.

**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: O₂ 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

Definition
First recorded GCS Verbal Score measured at the scene of injury.

Field Values

<table>
<thead>
<tr>
<th>Field Values</th>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADULT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Oriented X 3</td>
<td>5 Oriented</td>
</tr>
<tr>
<td>4</td>
<td>Confused</td>
<td>4 Confused</td>
</tr>
<tr>
<td>3</td>
<td>Inappropriate words</td>
<td>3 Inappropriate words</td>
</tr>
<tr>
<td>2</td>
<td>Incomprehensible sounds</td>
<td>2 Incomprehensible sounds</td>
</tr>
<tr>
<td>1</td>
<td>No verbal response</td>
<td>1 No verbal response</td>
</tr>
<tr>
<td>INFANT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Smiling or cooing appropriately</td>
<td>5 Smiles, oriented to sounds, follows objects, interacts</td>
</tr>
<tr>
<td>4</td>
<td>Crying but consolable</td>
<td>4 Cries but is consolable, inappropriate interactions</td>
</tr>
<tr>
<td>3</td>
<td>Crying or screaming is persistent and inappropriate for the incident</td>
<td>3 Inconsistently consolable, moaning</td>
</tr>
<tr>
<td>2</td>
<td>Grunts, agitated, or restless</td>
<td>2 Inconsolable, agitated</td>
</tr>
<tr>
<td>1</td>
<td>No verbal response</td>
<td>1 No vocal response</td>
</tr>
</tbody>
</table>

Additional Information
- If the patient is intubated then the GCS Verbal score is equal to 1.
- The null value “Not Applicable” is auto-populated for non-EMS patients.
- Field value cannot be left blank.

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: O₂ SAT %
- 1st Field GCS: EYE
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL

Data Format: [number, 1] single entry
Min Value: 1
Max Value: 5
Picklist: Yes, non-modifiable
Accepts Null Value: Yes
1st FIELD GCS: MOTOR

Definition
First recorded GCS Motor Score measured at the scene of injury.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Additional Information
- The null value “Not Applicable” is auto-populated for non-EMS patients.
- Field value cannot be left blank.

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: O2 SAT %
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: TOTAL

Data Format: [number] single entry
Min Value: 1
Max Value: 6
Picklist: Yes, non-modifiable
Accepts Null Value: Yes
1st FIELD GCS: TOTAL

Definition
First recorded GCS 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 1st FIELD GCS: TOTAL.
- Value may be hand-entered if GCS component fields are not documented, but a GCS total is recorded.
- 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.
- The null value “Not Applicable” is auto-populated for non-EMS patients.
- Field value cannot be left blank.

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: HR
- 1st Field VS: RR
- 1st Field VS: O₂ 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
FIELD INTUBATION?

Definition
Indicates whether or not the patient was intubated in the prehospital setting.

Field Values
• Y (Yes)
• N (No)

Additional Information
• Intubation includes alternate airway devices including Supraglottic Airway Devices, e.g. King Airway, Laryngeal Mask Airway (LMA), and Esophageal Tracheal Airway, e.g. Combitube.

Data Source Hierarchy
1. EMS Report Form
2. ED Medical Records

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: O₂ 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?

Definition
Indicates whether or not the patient experienced cardiac arrest prior to ED / Hospital arrival.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>1 Yes</td>
</tr>
<tr>
<td>N</td>
<td>2 No</td>
</tr>
</tbody>
</table>

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.
- Since PREHOSPITAL CARDIA ARREST does not occur in the majority of patients, this field will auto-populate with a value of ‘No’. In those cases where the patient did experience a cardiac arrest prior to ED / Hospital arrival, the ‘No’ value will need to be changed.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.
- The following edit check has been applied to the Trauma One®:
  ✓ PREHOSPITAL CARDIAC ARREST entered as “Yes”, but Prehospital Vital Signs other than BP-Systolic 0, HR 0, and RR 0 have been entered.

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
Min Value: N/A
Max Value: N/A
Picklist: Yes, non-modifiable
Accepts Null Value: Yes
PRIMARY EXTERNAL CAUSE CODE

Definition
External cause 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
- The primary external causes of injury code should describe the main reason a patient is admitted to the hospital.
- External cause codes are used to auto-generate two calculated fields: Trauma Type (Blunt, Penetrating, Burn) and Intentionality (based upon CDC matrix) in the National Trauma Data Bank (NTDB®).
- Activity codes should not be reported in this field.
- Field value cannot be “Not Applicable”.
- Field value cannot be “Not Documented”.
- Field value cannot be left blank.

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.
- EXTERNAL CAUSE CODES are used to auto-generated two calculated fields: Trauma Type (Blunt vs Penetrating) and Intentionality.

Other Associated Elements
- ADDITIONAL EXTERNAL CAUSE CODE
- LOCATION E-CODE

Data Format: [character, 6] single entry
Picklist: Yes, non-modifiable
Min Value: N/A
Max Value: N/A
Accepts Null Value: No
ADDITIONAL EXTERNAL CAUSE CODE

Definition
Additional External Cause Code used in conjunction with the Primary External Cause Code if multiple external cause codes are required to describe the event.

Field Values
- Relevant ICD-10-CM code value for injury event

Additional Information
- The null value "Not Applicable" is used if no additional external cause codes are used.
- Multiple Cause Coding Hierarchy: If two or more events cause separate injuries, an external cause code should be assigned for each cause. The first-listed external cause code will be selected in the following order:
  - External cause codes for child and adult abuse take priority over all other external cause codes.
  - External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse.
  - External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse, and terrorism.
  - External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, and child and adult abuse, and terrorism.
  - The first listed external cause code should correspond to the cause of the most serious diagnosis due to an assault, accident or self-harm, following the order of hierarchy listed above.
- Field value cannot be "Not Applicable".
- Field value cannot be left blank.

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.
- EXTERNAL CAUSE CODES are used to auto-generated two calculated fields: Trauma Type (Blunt vs Penetrating) and Intentionality.

Other Associated Elements
- PRIMARY EXTERNAL CAUSE CODE
- PLACE OF OCCURRENCE EXTERNAL CAUSE CODE

Data Format: [character, 6] single entry
Min Value: N/A  Max Value: N/A  Picklist: Yes, non-modifiable  Accepts Null Value: Yes
PLACE OF OCCURRENCE EXTERNAL CAUSE CODE

NTDS I_07

Definition
Place of occurrence external cause code used to describe the place/site/location of the injury event (Y92.x).

Field Values
- Relevant ICD-10-CM code value for injury event

Additional Information
- Multiple Cause Coding Hierarchy: If two or more events cause separate injuries, an external cause code should be assigned for each cause. The first-listed external cause code will be selected in the following order:
  - External cause codes for child and adult abuse take priority over all other external cause codes.
  - External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse.
  - External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse, and terrorism.
  - External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, and child and adult abuse, and terrorism.
  - The first listed external cause code should correspond to the cause of the most serious diagnosis due to an assault, accident or self-harm, following the order of hierarchy listed above.
- Field value cannot be left blank.

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 EXTERNAL CAUSE CODE
- ADDITIONAL EXTERNAL CAUSE CODE

Data Format: [character, 1] single entry
Min Value: 0
Max Value: 9
Picklist: Yes, non-modifiable
Accepts Null Value: Yes

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INJURY LOCATION ZIP CODE

Definition
The ZIP code of the incident location.

Field Values
- Relevant value for data element

Additional Information
- Use 5 digit code (XXXXX).
- Data entry of a valid INJURY LOCATION ZIP CODE will auto-populate the INJURY LOCATION
  CITY, INJURY LOCATION COUNTY, and INJURY LOCATION STATE.
- If "Not Documented", or "Not Known", must complete variables of INJURY LOCATION CITY,
  INJURY LOCATION COUNTY, and INJURY LOCATION STATE.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

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 LOCATION CITY
- INJURY LOCATION COUNTY
- INJURY LOCATION STATE

Data Format: [number, 5] single entry
Min Value: 90001 (CA)  Max Value: 96162 (CA)
Picklist: No  Accepts Null Value: Yes
INJURY LOCATION CITY

Definition
The city 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
- Data entry of a valid INJURY LOCATION ZIP CODE will auto-populate the INJURY LOCATION CITY.
- Select city from picklist, or enter Non-picklist city directly.
- Only completed when INJURY LOCATION ZIP CODE is "Not Documented" or "Not Known".
- Field value cannot be left blank.

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 LOCATION ZIP CODE
- INJURY LOCATION COUNTY
- INJURY LOCATION STATE

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

NTDS I_12

Definition
The county where the injury occurred.

Field Values
- Los Angeles
- Orange
- Riverside
- San Bernardino
- San Diego
- Ventura

Additional Information
- Data entry of a valid INJURY LOCATION ZIP CODE will auto-populate INJURY LOCATION COUNTY.
- Select county from picklist, or enter Non-picklist county directly.
- Only completed when INJURY LOCATION ZIP CODE is "Not Documented" or "Not Known".
- Field value cannot be left blank.

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 LOCATION ZIP CODE
- INJURY LOCATION CITY
- INJURY LOCATION STATE

Data Format: [character, 30] single entry
Min Value: N/A       Max Value: N/A
Picklist: Yes, non-modifiable
Accepts Null Value: Yes
INJURY LOCATION STATE

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
- Data entry of a valid INJURY LOCATION ZIP CODE will auto-populate the INJURY LOCATION STATE.
- Only completed when INJURY LOCATION ZIP CODE is "Not Documented" or "Not Known".
- The null value “Not Applicable” is auto-populated if INJURY LOCATION ZIP CODE is entered.
- Field value cannot be left blank.

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 LOCATION ZIP CODE
- INJURY LOCATION CITY
- INJURY LOCATION COUNTY

Data Format: [character, 2] single entry
Picklist: Yes, non-modifiable
Min Value: N/A
Max Value: N/A
Accepts Null Value: Yes
WORK RELATED?

Definition
Indicates whether or not the patient’s injury occurred during paid employment.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y Yes</td>
<td>1 Yes</td>
</tr>
<tr>
<td>N No</td>
<td>2 No</td>
</tr>
</tbody>
</table>

Additional Information
- If WORK RELATED, must be completed: OCCUPATION and INDUSTRY.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

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

**Definition**
The occupation of the patient, if applicable.

**Field Values**

<table>
<thead>
<tr>
<th>OCBO</th>
<th>Description</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARCH/ENG</td>
<td>Architecture &amp; Engineering</td>
<td>Architecture &amp; Engineering</td>
</tr>
<tr>
<td>ARTS</td>
<td>Arts, Design, Entertainment, Sports, &amp; Media</td>
<td>Arts, Design, Entertainment, Sports, &amp; Media</td>
</tr>
<tr>
<td>BUILD/MAINT</td>
<td>Building &amp; Grounds Maintenance</td>
<td>Building &amp; Grounds Maintenance</td>
</tr>
<tr>
<td>COMM/SOC</td>
<td>Community &amp; Social Services</td>
<td>Community &amp; Social Services</td>
</tr>
<tr>
<td>COMP/MATH</td>
<td>Computer &amp; Mathematical</td>
<td>Computer &amp; Mathematical</td>
</tr>
<tr>
<td>CONSTRUCTION</td>
<td>Construction &amp; Extraction</td>
<td>Construction &amp; Extraction</td>
</tr>
<tr>
<td>ED/TRAINING</td>
<td>Education, Training, &amp; Library</td>
<td>Education, Training, &amp; Library</td>
</tr>
<tr>
<td>FARMING</td>
<td>Farming, Fishing, &amp; Forestry</td>
<td>Farming, Fishing, &amp; Forestry</td>
</tr>
<tr>
<td>FOOD</td>
<td>Food Preparation &amp; Serving</td>
<td>Food Preparation &amp; Serving</td>
</tr>
<tr>
<td>HEALTH PRACT</td>
<td>Healthcare Practitioners</td>
<td>Healthcare Practitioners</td>
</tr>
<tr>
<td>HEALTH SUPPORT</td>
<td>Healthcare Support</td>
<td>Healthcare Support</td>
</tr>
<tr>
<td>INST/MAINT</td>
<td>Installation, Maintenance, &amp; Repair</td>
<td>Installation, Maintenance, &amp; Repair</td>
</tr>
<tr>
<td>LEGAL</td>
<td>Legal</td>
<td>Legal</td>
</tr>
<tr>
<td>MANAGEMENT</td>
<td>Management</td>
<td>Management</td>
</tr>
<tr>
<td>MILITARY</td>
<td>Military Specific</td>
<td>Military Specific</td>
</tr>
<tr>
<td>OFFICE</td>
<td>Office &amp; Administrative Support</td>
<td>Office &amp; Administrative Support</td>
</tr>
<tr>
<td>PERSONAL</td>
<td>Personal Care &amp; Service</td>
<td>Personal Care &amp; Service</td>
</tr>
<tr>
<td>PRODUCTION</td>
<td>Production</td>
<td>Production</td>
</tr>
<tr>
<td>PROTECTIVE</td>
<td>Protective Service</td>
<td>Protective Service</td>
</tr>
<tr>
<td>SALES</td>
<td>Sales &amp; Related</td>
<td>Sales &amp; Related</td>
</tr>
<tr>
<td>SCIENCE</td>
<td>Life, Physical, &amp; Social Science</td>
<td>Life, Physical, &amp; Social Science</td>
</tr>
<tr>
<td>TRANSPORTATION</td>
<td>Transportation &amp; Material Moving</td>
<td>Transportation &amp; Material Moving</td>
</tr>
</tbody>
</table>

**Additional Information**
- Only completed if injury is WORK RELATED – must also complete INDUSTRY.
- Field value cannot be left blank.

**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

NTDS I_04

Definition
The occupational industry associated with the patient’s work environment, if applicable.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGRICULTURAL, Forestry, Fishing</td>
<td>Agricultural, Forestry, Fishing</td>
</tr>
<tr>
<td>Construction</td>
<td>Construction</td>
</tr>
<tr>
<td>Education and Health Services</td>
<td>Education and Health Services</td>
</tr>
<tr>
<td>Information Services</td>
<td>Information Services</td>
</tr>
<tr>
<td>Finance, Insurance, and Real Estate</td>
<td>Finance, Insurance, and Real Estate</td>
</tr>
<tr>
<td>Government</td>
<td>Government</td>
</tr>
<tr>
<td>Leisure and Hospitality</td>
<td>Leisure and Hospitality</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>Manufacturing</td>
</tr>
<tr>
<td>Natural Resources and Mining</td>
<td>Natural Resources and Mining</td>
</tr>
<tr>
<td>Professional and Business Services</td>
<td>Professional and Business Services</td>
</tr>
<tr>
<td>Retail Trade</td>
<td>Retail Trade</td>
</tr>
<tr>
<td>Transport and Public Utilities</td>
<td>Transport and Public Utilities</td>
</tr>
<tr>
<td>Wholesale Trade</td>
<td>Wholesale Trade</td>
</tr>
<tr>
<td>Other Services</td>
<td>Other Services</td>
</tr>
</tbody>
</table>

Additional Information
- Only completed if injury is WORK RELATED – must also complete OCCUPATION.
- Field value cannot be left blank.

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?

Definition
Indicates whether or not the Emergency Department (ED) received notification prior to the patient’s arrival.

Field Values
- Y (Yes)
- N (No)

Additional Information
- Indicate “Yes” or “No” for all patient, including walk-ins, with the exception of Direct Admits, which should be entered as “NA”.

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.
- Used in system evaluation of State Core Measures.

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?

Definition
Indicates whether or not the patient met TRAUMA CRITERIA per LA County Reference No. 506.

Field Values
- Y (Yes)
- N (No)
- U (Unknown)

Additional Information
- Do not include patients that meet TRAUMA GUIDELINES / SPECIAL CONSIDERATION.

Data Source Hierarchy
1. EMS Report Form
2. ED Records
3. Base hospital records

Uses
- Used in quality management for the evaluation of care.

Other Associated Elements
- CRITERIA MET
- GUIDELINES / SPECIAL CONSIDERATION MET
- TPS RATIONALE

Data Format: [character, 1] single entry
Min Value: N/A  Max Value: N/A  Picklist: Yes, non-modifiable
Accepts Null Value: Yes
### Definition

Trauma Criteria/Guidelines/Special Considerations met, per LA County Reference No. 506.

### Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria</td>
<td>Physiologic &amp; Anatomic (P_21) / Mechanism of Injury (P_22)</td>
</tr>
<tr>
<td>14</td>
<td>Blunt Head with GCS ≤14</td>
</tr>
<tr>
<td>15</td>
<td>Adult fall from heights &gt;15 feet, or Peds from heights &gt;10 feet, or &gt;3 times child's height</td>
</tr>
<tr>
<td>20</td>
<td>Unenclosed vehicle crash impact &gt;20 mph</td>
</tr>
<tr>
<td>70</td>
<td>Blood Pressure &lt;70mmHg Systolic Infant</td>
</tr>
<tr>
<td>90</td>
<td>Blood Pressure &lt;90mmHg Systolic Adult</td>
</tr>
<tr>
<td>RR</td>
<td>Respiratory Rate &lt;10/&lt;29, &lt;20 if &lt;1yr.</td>
</tr>
<tr>
<td>CB</td>
<td>Critical Burn (CB w/ 70, 90, RR, AN, 55, BP, IU &amp; PJ)</td>
</tr>
<tr>
<td>FC</td>
<td>Flail Chest</td>
</tr>
<tr>
<td>SX</td>
<td>Suspected Pelvic Fracture</td>
</tr>
<tr>
<td>SC</td>
<td>Spinal Cord Injury with Sensory Deficit</td>
</tr>
<tr>
<td>EJ</td>
<td>Ejected</td>
</tr>
<tr>
<td>PS</td>
<td>Passenger Space Intrusion of 12 inches into an occupied passenger space</td>
</tr>
<tr>
<td>RT</td>
<td>Ped/Bicyclist Run over / Thrown / Impact &gt;20 mph</td>
</tr>
<tr>
<td>BD</td>
<td>Blunt Abdomen with Diffuse Abd Tenderness</td>
</tr>
<tr>
<td>BI</td>
<td>Blunt Amputation above the Wrist or Ankle</td>
</tr>
<tr>
<td>BR</td>
<td>Blunt Fractures of Two or More Long Bones</td>
</tr>
<tr>
<td>BV</td>
<td>Blunt Extremity with Neuro / Vascular / Mangled</td>
</tr>
<tr>
<td>PA</td>
<td>Penetrating Abdomen</td>
</tr>
<tr>
<td>PC</td>
<td>Penetrating Chest</td>
</tr>
<tr>
<td>PF</td>
<td>Penetrating Face/Mouth</td>
</tr>
<tr>
<td>PG</td>
<td>Penetrating Genitals</td>
</tr>
<tr>
<td>PH</td>
<td>Penetrating Head</td>
</tr>
<tr>
<td>PI</td>
<td>Penetrating Amputation above the Wrist or Ankle</td>
</tr>
<tr>
<td>PK</td>
<td>Penetrating Buttocks</td>
</tr>
<tr>
<td>PN</td>
<td>Penetrating Neck</td>
</tr>
<tr>
<td>PT</td>
<td>Penetrating Full Arrest</td>
</tr>
<tr>
<td>PV</td>
<td>Penetrating Extremity with Neuro / Vascular / Mangled</td>
</tr>
<tr>
<td>PX</td>
<td>Penetrating Extremity above the Elbow or Knee</td>
</tr>
<tr>
<td>PY</td>
<td>Penetrating Back</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Guidelines</th>
<th>Mechanism of Injury (P_19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>Passenger Space Intrusion of 18 inches into an unoccupied passenger space</td>
</tr>
<tr>
<td>AN</td>
<td>Anticoagulant Medication (other than aspirin only) or with Bleeding Disorder</td>
</tr>
<tr>
<td>EX</td>
<td>Extrication Required</td>
</tr>
<tr>
<td>PB</td>
<td>Pedestrians/Bicyclists Impact ≤ 20 mph</td>
</tr>
<tr>
<td>SF</td>
<td>Survivor of Fatal Crash (same vehicle), with Complaint of Injury</td>
</tr>
<tr>
<td>TD</td>
<td>Telemetry Data</td>
</tr>
</tbody>
</table>
Special Considerations

<table>
<thead>
<tr>
<th></th>
<th>Mechanism of Injury (P_22)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BT</td>
<td>Blunt Trauma Full Arrest</td>
</tr>
<tr>
<td>55</td>
<td>Age greater than 55 years</td>
</tr>
<tr>
<td>BP</td>
<td>Systolic B/P less than 110mmHg for patient greater than 65 years of age</td>
</tr>
<tr>
<td>IU</td>
<td>Pregnancy greater than 20 weeks</td>
</tr>
<tr>
<td>PJ</td>
<td>Prehospital judgment that transport to Trauma Center is in the patient’s best interest</td>
</tr>
</tbody>
</table>

Additional Information

- If CRITERIA MET field value is “No”, values from the “Criteria” sub-picklist may NOT be selected.
- GUIDELINES & SPECIAL CONSIDERATIONS are Prehospital tools utilized to determine if the patient warrants transportation to a trauma center.
- GUIDELINES & SPECIAL CONSIDERATIONS are NOT to be utilized by the trauma center as the rationale for trauma registry inclusion (TPS Rationale).
- For PSI to meet Trauma Criteria and/or Guidelines per Reference No. 506, the intrusion must be specified as greater than 12 inches (Criteria PS) into an occupied passenger space or greater than 18 inches (Guideline 18) into an unoccupied passenger space.
- Refer to Appendix 2: Glossary of Terms – Criteria / Guidelines / Special Considerations (ED) for additional details.
- The following edit checks have been applied to Trauma One®:
  - Mechanism of Injury Criteria (15, 20, EJ, PS, & RT), Guidelines (18, AN, EX, PB, SF, & TD), & Special Considerations (55, BP, IU, & PJ) cannot be selected for non-EMS patients.
  - Special Considerations (BT, 55, BP, IU, & PJ) cannot be selected if a criteria/guideline exists.

Data Source Hierarchy

1. EMS Report Form
2. Base Hospital Records
3. ED Records

Uses

- Used in quality management for the evaluation of care.

Other Associated Elements

- MET CRITERIA?
- TPS RATIONALE

Data Format: [character, 2] multiple entries

Picklist: Yes, non-modifiable

Min Value: N/A
Max Value: N/A
Accepts Null Value: Yes
ED ARRIVAL TIME

NTDS ED_02

Definition
The time the patient arrived to the ED / Hospital.

Field Values
- Relevant value for data element

Additional Information
- Collected as HHMM (military time).
- Used to calculate Total EMS Time and Total Length of Hospital Stay.
- This field auto-populates from the data entered for ARRIVAL TIME from the GENERAL INFORMATION section.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

Data Source Hierarchy
1. ED Records
2. EMS Report Form

Uses
- Allows data to be sorted based upon arrival date / time.
- 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
Min Value: 0000 Max Value: 2359 Picklist: No Accepts Null Value: Yes
TRAUMA TEAM ACTIVATION?

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.
- 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)

Definition
The time the treating facility’s Trauma Team was activated, if applicable.

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
Min Value: 0000          Max Value: 2359          Picklist: No
Accepts Null Value: Yes
LEVEL (OF ACTIVATION)

Definition
The level of the Trauma Team’s activation, if applicable.

Field Values
- Customized list

Additional Information
- Enter LEVEL (OF ACTIVATION) or code directly, or create facility-specific picklist.
- Requests for Trauma Consults are NOT considered Activations.

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
ED DISPOSITION ORDER DATE

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.
- The null value “Not Applicable” is used if the patient is directly admitted to the hospital.
- Field value cannot be left blank.

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.
- Used to calculate Total ED Time.

Other Associated Elements
- ED DISPOSITION ORDER TIME
- ED EXIT DATE
- ED EXIT TIME
- NEXT PHASE AFTER ED

Data Format: [date] single entry
Min Value: current date minus 7 years  Max Value: current date
Picklist: No  Accepts Null Value: Yes
ED DISPOSITION ORDER TIME

**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).
- The null value “Not Applicable” is used if the patient is directly admitted to the hospital.
- Field value cannot be left blank.

**Data Source Hierarchy**
1. ED Records
2. Hospital Record

**Uses**
- Allows data to be sorted based upon ED length of stay.
- Used to calculate Total ED Time.

**Other Associated Elements**
- ED DISPOSITION ORDER DATE
- ED EXIT DATE
- ED EXIT TIME
- NEXT PHASE AFTER ED

**Data Format:** [time] single entry
- **Min Value:** 0000
- **Max Value:** 2359
- **Picklist:** No
- **Accepts Null Value:** Yes
ED EXIT DATE

Definition
The date the patient left the ED.

Field Values
• Relevant value for data element

Additional Information
• Collected as MM-DD-YYYY.
• The null value “Not Applicable” is used if the patient is directly admitted to the hospital.
• Field value cannot be left blank.

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.
• Used to calculate Total ED Time.

Other Associated Elements
• ED DISPOSITION ORDER DATE
• ED DISPOSITION ORDER TIME
• ED EXIT TIME
• NEXT PHASE AFTER ED

Data Format: [date] single entry
Min Value: current date minus 7 years  Max Value: current date  Picklist: No  Accepts Null Value: Yes
ED EXIT TIME

**Definition**
The time the patient left the ED.

**Field Values**
- Relevant value for data element

**Additional Information**
- Collected as HHMM (military time).
- The null value “Not Applicable” is used if the patient is directly admitted to the hospital.
- Field value cannot be left blank.

**Data Source Hierarchy**
1. ED Records
2. Hospital Record

**Uses**
- Allows data to be sorted based upon ED length of stay.
- Used to calculate Total ED Time.

**Other Associated Elements**
- ED DISPOSITION ORDER DATE
- ED DISPOSITION ORDER TIME
- ED EXIT DATE
- NEXT PHASE AFTER ED

**Data Format:** [time] single entry
**Picklist:** No
**Min Value:** 0000  
**Max Value:** 2359  
**Accepts Null Value:** Yes
HEIGHT

NTDS_18

Definition
Patient’s height, or the best approximation, within 24 hours of ED / Hospital arrival.

Field Values
- Relevant value for data element

Additional Information
- May be self-reported or provided by family.
- The null value “Not Known/Not Recorded” is reported if the patient’s Height was not measured within 24 hours of ED / Hospital arrival.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

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
- INCHES vs CENTIMETERS (Height Units)

Data Format: [character, 3] single entry
Min Value: N/A Max Value: 244 Picklist: No Accepts Null Value: No
INCHES vs CENTIMETERS (*Height Units*)

**Definition**
Unit of measurement used to report the patient’s height, or the best approximation, upon ED / Hospital arrival.

**Field Values**
- I (Inches)
- C (Centimeters)

**Additional Information**
- May be self-reported or provided by family.

**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**
- HEIGHT

**Data Format:** [character, 3] single entry
**Picklist:** No
**Min Value:** N/A  **Max Value:** 244  **Accepts Null Value:** No
WEIGHT

NTDS_19

Definition
Patient’s weight, or the best approximation, within 24 hours of ED / Hospital arrival.

Field Values
• Relevant value for data element

Additional Information
• May be self-reported or provided by family.
• The null value “Not Known/Not Recorded” is reported if the patient’s Weight was not measured within 24 hours of ED / Hospital arrival.
• Field value cannot be “Not Applicable”.
• Field value cannot be left blank.

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
• POUNDS vs KILOGRAMS (Weight Units)

Data Format: [character, 3] single entry
Picklist: No
Min Value: N/A Max Value: 907 Accepts Null Value: No
POUNDS vs KILOGRAMS *(Weight Units)*

**Definition**
Unit of measurement used to report the patient’s weight, or the best approximation, upon ED / Hospital arrival.

**Field Values**
- L (Pounds)
- K (Kilograms)

**Additional Information**
- May be self-reported or provided by family.

**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**
- WEIGHT

**Data Format:** [character, 3] single entry
**Min Value:** N/A
**Max Value:** 907
**Picklist:** No
**Accepts Null Value:** No
1st ED VS: TIME

Definition
Time of the first recorded vital signs in the ED / Hospital within 30 minutes of arrival.

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: BP – SYSTOLIC
• 1st ED VS: BP – DIASTOLIC
• 1st ED VS: HR
• 1st ED VS: RR / ASST?
• 1st ED VS: O₂ SAT / ON O₂?
• 1st ED VS: TEMP / UNITS / TIME
• 1st ED VS: GCS – EYE
• 1st ED VS: GCS – VERBAL
• 1st ED VS: GCS – MOTOR
• 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [time] single entry
Min Value: 0000 Max Value: 2359 Picklist: No Accepts Null Value: Yes
1st ED VS: BP – SYSTOLIC

Definition
Numeric value of the first recorded systolic blood pressure (without the assistance of CPR or any type of mechanical chest compressions) in the ED / Hospital within 30 minutes of arrival.

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

Additional Information
- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

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 - ED (adult & pediatric).

Other Associated Elements
- 1st ED VS: BP – TIME
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: O₂ SAT / ON O₂?
- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [character, 3] single entry
Min Value: 0 Max Value: 300 Picklist: No
Accepts Null Value: Yes
1st ED VS: BP – DIASTOLIC

Definition
Numeric value of the first recorded diastolic blood pressure in the ED / Hospital within 30 minutes of arrival.

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

Additional Information
- The null value “Not Documented” is used if the diastolic pressure is 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: BP – TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: O₂ SAT / ON O₂?
- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [character, 3] single entry
Min Value: 0 Max Value: 300 Picklist: No
Accepts Null Value: Yes
**1st ED VS: HR**

**Definition**
First recorded pulse (Heart Rate) (*palpated or auscultated ONLY – no monitor readings*) in the ED / Hospital within 30 minutes of arrival, expressed as a number per minute.

**Field Values**
- Relevant value for data element

**Additional Information**
- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- Field value cannot be "Not Applicable".
- Field value cannot be left blank.

**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: BP – TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: RR / ASST?
- 1st ED VS: O₂ SAT / ON O₂?
- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – MOTOR
- 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

Definition
First recorded respiratory rate in the ED / Hospital within 30 minutes of arrival, expressed as a number per minute.

Field Values
- Relevant value for data element

Additional Information
- Enter actual rate only – indicate whether or not respirations were assisted in the next field: “ASST?”
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

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 - ED (adult & pediatric).

Other Associated Elements
- 1st ED VS: BP – TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: ASST?
- 1st ED VS: O₂ SAT / ON O₂?
- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [character, 3] single entry
Min Value: 0 Max Value: 100
Picklist: No Accepts Null Value: Yes
1st ED VS: ASSISTED? (Resp)

**Definition**
Indicates whether or not there was respiratory assistance associated with the initial ED / Hospital respiratory rate within 30 minutes of arrival.

**Field Values**

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Yes</td>
</tr>
<tr>
<td>N</td>
<td>No</td>
</tr>
</tbody>
</table>

**Additional Information**
- Respiratory Assistance is defined as mechanical and/or external support of respiration.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

**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: BP – TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR
- 1st ED VS: O2 SAT / ON O2?
- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – MOTOR
- 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
1<sup>st</sup> ED VS: O₂ SAT

**Definition**
First recorded oxygen saturation in the ED / Hospital within 30 minutes of arrival, expressed as a percentage.

**Field Values**
- Relevant value for data element

**Additional Information**
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

**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: BP – TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: ON O₂?
- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – MOTOR
- 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 O₂? \((O₂ Sat)\)

**Definition**
Indicates whether or not supplemental oxygen was in use during assessment of initial ED / Hospital oxygen saturation level within 30 minutes of arrival.

**Field Values**

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Yes 2</td>
</tr>
<tr>
<td>N</td>
<td>No 1</td>
</tr>
<tr>
<td>U</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

**Additional Information**
- Only complete if a value is reported for 1st ED VS: \(O₂ \text{ SAT}\), otherwise value is "Not Applicable".
- Field value cannot be left blank.

**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: BP – TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: \(O₂ \text{ SAT}\)
- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – MOTOR
- 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**

**Definition**
First recorded temperature in the ED / Hospital within 30 minutes of arrival.

**Field Values**
- Relevant value for data element

**Additional Information**
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

**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: BP – TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: O₂ SAT / ON O₂?
- 1st ED VS: UNITS / TIME
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – TOTAL / QUALIFIERS

**Data Format:** [character, 5] single entry
**Picklist:** No
**Min Value:** 25  **Max Value:** 110  **Accepts Null Value:** Yes
FAHRENHEIT vs CELSIUS (1st Temp Units)

Definition
Unit of measurement for first recorded temperature in the ED / Hospital within 30 minutes of arrival.

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: BP – TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: O₂ SAT / ON O₂?
- 1st ED VS: TEMP / TIME
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [character, 1] single entry
Min Value: N/A  Max Value: N/A
Picklist: Yes, non-modifiable
Accepts Null Value: Yes
**TIME (1st Temp)**

**Definition**
Time of the first recorded temperature in the ED / Hospital within 30 minutes of arrival.

**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: BP – TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: O₂ SAT / ON O₂?
- 1st ED VS: TEMP / UNITS
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – TOTAL / QUALIFIERS

**Data Format:** [time] single entry

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Min Value</strong></td>
<td>0000</td>
<td></td>
</tr>
<tr>
<td><strong>Max Value</strong></td>
<td>2359</td>
<td></td>
</tr>
<tr>
<td><strong>Picklist</strong></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Accepts Null Value</strong></td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>
1st ED VS: GCS – EYE

Definition
First recorded GCS Eye Score in the ED / Hospital within 30 minutes of arrival.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 Opens eyes spontaneously</td>
<td>4 Opens eyes spontaneously</td>
</tr>
<tr>
<td>3 Opens eyes in response to verbal</td>
<td>3 Opens eyes in response to verbal</td>
</tr>
<tr>
<td>stimulation</td>
<td>stimulation</td>
</tr>
<tr>
<td>2 Opens eyes in response to painful</td>
<td>2 Opens eyes in response to painful</td>
</tr>
<tr>
<td>stimulation</td>
<td>stimulation</td>
</tr>
<tr>
<td>1 No eye opening</td>
<td>1 No eye movement when assessed</td>
</tr>
</tbody>
</table>

Additional Information
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

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: BP – TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: O₂ SAT / ON O₂?
- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [number, 1] single entry
Min Value: 1
Max Value: 4
Picklist: Yes, non-modifiable
Accepts Null Value: Yes
1st ED VS: GCS – VERBAL

Definition
First recorded GCS Verbal Score in the ED / Hospital within 30 minutes of arrival.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADULT</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>oriented x 3</td>
<td>oriented</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Confused</td>
<td>Confused</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Inappropriate words</td>
<td>Inappropriate words</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Incomprehensible sounds</td>
<td>Incomprehensible sounds</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>No verbal response</td>
<td>No verbal response</td>
</tr>
</tbody>
</table>

| INFANT    |      |
| 5         | 5    |
| Smiling or cooing appropriately | Smiles, oriented to sounds, follows objects, interacts |
| 4         | 4    |
| Crying but consolable | Cries but is consolable, inappropriate interactions |
| 3         | 3    |
| Crying or screaming is persistent and inappropriate for the incident | Inconsistently consolable, moaning |
| 2         | 2    |
| Grunts, agitated, or restless | Incomprehensible sounds |
| 1         | 1    |
| No verbal response | No vocal response |

Additional Information
- If the patient is intubated then the GCS Verbal score is equal to 1.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

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: BP – TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: O₂ SAT / ON O₂?
- 1st ED VS: TEMP / UNITS / TIME
- 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**

**Definition**
First recorded GCS Motor Score in the ED / Hospital within 30 minutes of arrival.

**Field Values**

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Obeys commands</td>
</tr>
<tr>
<td>5</td>
<td>Localizes pain</td>
</tr>
<tr>
<td>4</td>
<td>Withdraws from pain</td>
</tr>
<tr>
<td>3</td>
<td>Flexion (decorticate) to pain</td>
</tr>
<tr>
<td>2</td>
<td>Extension (decerebrate) to pain</td>
</tr>
<tr>
<td>1</td>
<td>No motor response</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NTDS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Obeys commands / Appropriate response to stimuli</td>
</tr>
<tr>
<td>5</td>
<td>Localizes pain</td>
</tr>
<tr>
<td>4</td>
<td>Withdraws from pain</td>
</tr>
<tr>
<td>3</td>
<td>Flexion (decorticate movement) to pain</td>
</tr>
<tr>
<td>2</td>
<td>Extension (decerebrate movement) to pain</td>
</tr>
<tr>
<td>1</td>
<td>No motor response</td>
</tr>
</tbody>
</table>

**Additional Information**
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

**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: BP – TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: O₂ SAT / ON O₂?
- 1st ED VS: TEMP / UNITS / TIME
- 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

Definition
First recorded GCS Total Score in the ED / Hospital within 30 minutes of arrival.

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.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

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: BP – TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: O₂ SAT / ON O₂?
- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – QUALIFIERS

Data Format: [number, 2] single entry
Min Value: 3
Max Value: 15
Picklist: No
Accepts Null Value: Yes
**1st ED VS: GCS (Qualifiers)**

**Definition**
Indicates the presence of factors potentially affecting the first assessment of GCS upon arrival in the ED / Hospital within 30 minutes of arrival.

**Field Values**

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>Sedated</td>
</tr>
<tr>
<td>E</td>
<td>Eye Obstruction</td>
</tr>
<tr>
<td>I</td>
<td>Intubated</td>
</tr>
<tr>
<td></td>
<td>Not Applicable</td>
</tr>
<tr>
<td>1</td>
<td>Chemically Sedated or Paralyzed</td>
</tr>
<tr>
<td>2</td>
<td>Obstruction to the Patient’s Eye</td>
</tr>
<tr>
<td>3</td>
<td>Intubated</td>
</tr>
<tr>
<td>4</td>
<td>Valid GCS: Patient was not sedated, not intubated, and did not have obstruction to the eye</td>
</tr>
</tbody>
</table>

**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”.
- Field value cannot be left blank.

**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: BP – TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: O₂ SAT / ON O₂?
- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – VERBAL
- 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
# TPS RATIONALE

**Definition**
Indicates the primary rationale for Trauma Patient Summary (TPS) completion and inclusion of the patient in the TEMIS database.

**Field Values**

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>LA COUNTY</td>
<td>Prehospital care personnel made destination decision to transport to a Trauma Center based on criteria, guidelines, or special considerations – must be documented on EMS report form.</td>
</tr>
<tr>
<td>PH</td>
<td>Non-EMS patient met Trauma Triage Physiological &amp; / or Anatomical criteria, per Reference No. 506.1, (excludes Trauma Triage Mechanism of Injuries, Guidelines &amp; Special Considerations).</td>
</tr>
<tr>
<td>CG</td>
<td>Admitted for care of an injury after ED evaluation by the Trauma Service.</td>
</tr>
<tr>
<td>AD</td>
<td>Died of an injury-related problem.</td>
</tr>
<tr>
<td>TS</td>
<td>Patient was transferred and admitted to the Trauma Service for care of an injury.</td>
</tr>
<tr>
<td>NO</td>
<td>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).</td>
</tr>
</tbody>
</table>

**Additional Information**
- Always use the rationale that occurs first in the patient’s course of treatment.
- MECHANISM OF INJURIES, GUIDELINES, & SPECIAL CONSIDERATIONS are Prehospital tools utilized to determine if the patient warrants transportation to a trauma center.
- MECHANISM OF INJURIES, GUIDELINES, & SPECIAL CONSIDERATIONS are NOT to be utilized by the trauma center as the rationale for trauma registry inclusion (TPS Rationale) for non-EMS patients.
- Null Values are not accepted for this data field.
- The following edit checks have been applied to Trauma One®:
  - PH - Mode of Entry MUST Be EMS.
  - CG - Physiological & / or Anatomical Criteria MUST exist (14, 70, 90, FC, BD, BI, BR, BV, PA, PC, PF, PG, PH, PI, PK, PN, PT, PV, PX, PY, RR, SC, & SX).
  - CG - EXCLUDES all Mechanism of Injury Criteria (15, 20, EJ, PS, & RT), Guidelines (18, AN, EX, PB, SF, & TD), & Special Considerations (55, BP, IU, & PJ).
  - AD - Mode of Entry cannot be EMS with an existing Criteria/Guideline.

**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
- MET CRITERIA?
- CRITERIA MET
- GUIDELINES / SPECIAL CONSIDERATION MET

**Data Format:** [character, 2] single entry  
**Picklist:** Yes, non-modifiable
**Min Value:** N/A  
**Max Value:** N/A  
**Accepts Null Value:** No
ADMITTING MD

Definition
The physician primarily responsible for admitting the patient to the hospital, if applicable.

Field Values
- Relevant value for data element

Additional Information
- Non-picklist – 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

Definition
The three-letter code for physician service primarily responsible for admitting the patient to the hospital, if applicable.

Field Values

<table>
<thead>
<tr>
<th>Service</th>
<th>Field Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>LA COUNTY</td>
<td>ANE ANESTHESIOLOGY, NEO NEONATOLOGY, PNS PEDIATRIC NEUROSURGEON</td>
</tr>
<tr>
<td>BUR</td>
<td>BURN SPECIALIST, NEP NEPHROLOGY, POS PEDIATRIC ORTHOPEDIC</td>
</tr>
<tr>
<td>CAR</td>
<td>CARDIOLOGY, NEU NEUROLOGY, POT PED. OTOLARYNGOLOGY</td>
</tr>
<tr>
<td>CTS</td>
<td>CARDIOTHORACIC SURGEON, NER NEURORADIOLOGY, PEP PEDIATRIC PATHOLOGY</td>
</tr>
<tr>
<td>CCI</td>
<td>CRITICAL CARE INTENSIVIST, NES NEUROSURGEON, PPY PEDIATRIC PSYCHIATRIST</td>
</tr>
<tr>
<td>DEN</td>
<td>DENTAL, OBS OBSTERICIS, PPS PED. PULM. SPECIALIST</td>
</tr>
<tr>
<td>DER</td>
<td>DERMATOLOGY, OPS OPTHAL. SURGEON, PER PEDIATRIC RADIOLOGY</td>
</tr>
<tr>
<td>EDP</td>
<td>ED PHYS/ATTENDING, ORS ORAL SURGEON, PES PEDIATRIC SURGEON</td>
</tr>
<tr>
<td>EDR</td>
<td>ED RESIDENT, ORT ORTHOPEDICS, PUR PEDIATRIC UROLOGY</td>
</tr>
<tr>
<td>END</td>
<td>ENDOCRINOLOGY, OML OTHER NOT LISTED, PED PEDIATRICS</td>
</tr>
<tr>
<td>FNM</td>
<td>FAMILY MEDICINE, OTO OTOLARYNGOLOGY, PHY PHYSIATRY</td>
</tr>
<tr>
<td>GAS</td>
<td>GASTROENTEROLOGY, PAL PALLIATIVE CARE, PLS PLASTIC SURGEON</td>
</tr>
<tr>
<td>GES</td>
<td>GENERAL SURGEON, PAT PATHOLOGY, POD PODIATRY</td>
</tr>
<tr>
<td>GER</td>
<td>GERIATRICS, PEA PEDIATRIC ALLERGY, PTN PRIMARY TRAUMA NURSE</td>
</tr>
<tr>
<td>GYN</td>
<td>GYNECOLOGY, PEC PEDIATRIC CARDIOLOGY, PSC PSYCHOLOGY</td>
</tr>
<tr>
<td>HAS</td>
<td>HAND SURGEON, PCA PEDIATRIC CHILD ADVOCACY, PSY PSYCHIATRY</td>
</tr>
<tr>
<td>HEM</td>
<td>HEMATOLOGY, PCS PED. CARDIOTHOR. SURGEON, PUL PULMONARY SPECIALIST</td>
</tr>
<tr>
<td>HMO</td>
<td>HMO CONSULTANT, PEN PEDIATRIC ENDOCRINOLOGY, RAD RADIOLOGY</td>
</tr>
<tr>
<td>HNS</td>
<td>HEAD &amp; NECK SURGEON, PEG PED. GASTROENTEROLOGY, RHE RHEUMATOLOGY</td>
</tr>
<tr>
<td>HBO</td>
<td>HYPERBARIC MEDICINE, PEH PEDIATRIC HEMATOLOGY, SPI SPINAL</td>
</tr>
<tr>
<td>INF</td>
<td>INFECTIOUS MEDICINE, PEI PEDIATRIC INTENSIVIST, THS THORACIC SURGEON</td>
</tr>
<tr>
<td>INR</td>
<td>INTERVENT. RADIOLOGY, PMS PAIN MANAGE SPECIALIST, TRR TRAUMA RESIDENT</td>
</tr>
<tr>
<td>INT</td>
<td>INTERNAL MEDICINE, PNP PEDIATRIC NEPHROLOGY, TRS TRAUMA SURG/ATTEND</td>
</tr>
<tr>
<td>MAS</td>
<td>MAXILLOFACIAL SURGEON, PNE PEDIATRIC NEUROLOGY, URO UROLOGY</td>
</tr>
<tr>
<td>NCC</td>
<td>NEURO CRITICAL CARE, PNR PEDIATRIC NEURORADIOLOGY, VAS VASCULAR SURGEON</td>
</tr>
</tbody>
</table>

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
Min Value: N/A, Max Value: N/A
Picklist: Yes, non-modifiable
Accepts Null Value: Yes
MD SERVICE

Definition
Services activated to evaluate the patient upon arrival, or services consulted during the ED phase of care, if applicable.

Field Values

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Description</th>
<th>LA COUNTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANE</td>
<td>Anesthesiology</td>
<td>NEO Neonatology</td>
</tr>
<tr>
<td>BUR</td>
<td>Burn Specialist</td>
<td>NEP Nephrology</td>
</tr>
<tr>
<td>CAR</td>
<td>Cardiology</td>
<td>NEU Neurology</td>
</tr>
<tr>
<td>CTS</td>
<td>Cardi thoracic Surge</td>
<td>NER Neuroradiology</td>
</tr>
<tr>
<td>CCI</td>
<td>Critical Care Intensivist</td>
<td>NES Neurosurgeon</td>
</tr>
<tr>
<td>DEN</td>
<td>Dental</td>
<td>OBS Obstetrics</td>
</tr>
<tr>
<td>DER</td>
<td>Dermatology</td>
<td>OPS Ophthalm. Surgeon</td>
</tr>
<tr>
<td>EDP</td>
<td>ED Phys/Attending</td>
<td>ORS Oral Surgeon</td>
</tr>
<tr>
<td>EDR</td>
<td>ED Resident</td>
<td>ORT Orthopedics</td>
</tr>
<tr>
<td>END</td>
<td>Endocrinology</td>
<td>ONL Other Not Listed</td>
</tr>
<tr>
<td>FNM</td>
<td>Family Medicine</td>
<td>OTO Otolaryngology</td>
</tr>
<tr>
<td>GAS</td>
<td>Gastroenterology</td>
<td>PAL Palliative Care</td>
</tr>
<tr>
<td>GES</td>
<td>General Surgeon</td>
<td>PAT Pathology</td>
</tr>
<tr>
<td>GER</td>
<td>Geriatrics</td>
<td>PEA Pediatric Allergy</td>
</tr>
<tr>
<td>GYN</td>
<td>Gynecology</td>
<td>PEC Pediatric Cardiology</td>
</tr>
<tr>
<td>HAS</td>
<td>Hand Surgeon</td>
<td>PCA Pediatric Child Advocacy</td>
</tr>
<tr>
<td>HEM</td>
<td>Hematology</td>
<td>PCS Ped. Cardiothor. Surgeon</td>
</tr>
<tr>
<td>HMO</td>
<td>HMO Consultant</td>
<td>PEN Pediatric Endocrinology</td>
</tr>
<tr>
<td>HNS</td>
<td>Head &amp; Neck Surgeon</td>
<td>PEG Ped. Gastroenterology</td>
</tr>
<tr>
<td>HBO</td>
<td>Hyperbaric Medicine</td>
<td>PEH Pediatric Hematology</td>
</tr>
<tr>
<td>INF</td>
<td>Infectious Medicine</td>
<td>PEI Pediatric Intensivist</td>
</tr>
<tr>
<td>INR</td>
<td>Intervention. Radioiology</td>
<td>PMS Pain Manage Specialist</td>
</tr>
<tr>
<td>INT</td>
<td>Internal Medicine</td>
<td>PNP Pediatric Nephrology</td>
</tr>
<tr>
<td>MAS</td>
<td>Maxillofacial Surgeon</td>
<td>PNE Pediatric Neurology</td>
</tr>
<tr>
<td>NCC</td>
<td>Neuro Critical Care</td>
<td>PNR Pediatric Neuroradiology</td>
</tr>
</tbody>
</table>

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

Definition
Name or code of Trauma Team physician activated to evaluate the patient upon arrival, or services consulted during the ED phase of care.

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
Min Value: N/A  Max Value: N/A
Picklist: Yes, facility-modifiable
Accepts Null Value: Yes
REQUEST TIME (MD)

Definition
Time that Trauma Team physician was activated, or services consulted during the ED phase of care, for evaluation of the 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
Min Value: 0000 Max Value: 2359
Picklist: No
Accepts Null Value: Yes
STAT? (MD)

**Definition**
Indicates whether or not the Trauma Team physician, or services consulted during the ED phase of care, was/were 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)*

**Definition**
Time that Trauma Team physician, or services consulted during the ED phase of care, arrived at the bedside to evaluate the injured patient in the ED.

**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.
- Services requested that do NOT physically evaluate the patient while in the ED should be listed in the ICU/Acute Care section.

**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
1ST ANTIBIOTIC ADMIN. DATE

NTDS PM_37

Definition
Date of 1st antibiotic administration for patients that meet the collection criteria.

Collection Criterion
- COLLECT ON ALL PATIENTS WITH ANY OPEN FRACTURE.

Field Values
- Relevant value for data element

Additional Information
- Collected as MM-DD-YYYY.
- The null value “Not Applicable” is used for patients that do not meet the collection criteria.

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
Min Value: current date minus 7 years Max Value: current date Picklist: No Accepts Null Value: Yes
**1ST ANTIBIOTIC ADMIN. TIME**

**NTDS PM_38**

**Definition**
Time of 1st antibiotic administration for patients that meet the collection criteria.

**Collection Criterion**
- COLLECT ON ALL PATIENTS WITH ANY OPEN FRACTURE.

**Field Values**
- Relevant value for data element

**Additional Information**
- Collected as HHMM (military time).
- The null value “Not Applicable” is used for patients that do not meet the collection criteria.

**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
**Min Value:** 0000  **Max Value:** 2359  **Picklist:** No  **Accepts Null Value:** Yes
IV FLUIDS IN ED

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 the specific amount is not recorded, “Not Documented” is entered.

Data Source Hierarchy
1. ED Records

Uses
• Provides documentation of care.
• Used in quality management for the evaluation of care.
• Used in system research.

Data Format: [number, 5] single entry
Min Value: 0          Max Value: 99999
Picklist: No
Accepts Null Value: Yes
ARRIVED WITH SIGNS OF LIFE?

Definition
Indicates whether or not the patient arrived in the ED / Hospital with signs of life.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y  Yes</td>
<td>2 Arrived with signs of life</td>
</tr>
<tr>
<td>N  No</td>
<td>1 Arrived with NO signs of life</td>
</tr>
</tbody>
</table>

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.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.
- The following edit check has been applied to Trauma One®:
  - ARRIVED WITH SIGNS OF LIFE? entered as “Yes”, but 1st ED VS other than BP-Systolic 0, HR 0, and RR 0 have been entered.

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
- DEATH IN ED
- NEXT PHASE AFTER ED
- EXIT ED DATE/TIME
- TRANSFERRED / D/C'D TO
- PHASE PRIOR D/C

Data Format: [character, 1] single entry
Min Value: N/A
Max Value: N/A
Picklist: Yes, non-modifiable
Accepts Null Value: Yes
DEATH IN ED

Definition
Provides details on patients who are declared Dead on Arrival (DOA) or who are pronounced dead in the ED after failed resuscitative efforts.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>DOA</td>
</tr>
<tr>
<td></td>
<td>Death declared on arrival no resuscitative efforts initiated in the ED.</td>
</tr>
<tr>
<td>F</td>
<td>Failed Resuscitation</td>
</tr>
<tr>
<td></td>
<td>Death pronounced in the ED after failure to respond to resuscitative efforts within 15 minutes of ED arrival.</td>
</tr>
<tr>
<td>O</td>
<td>Died in ED</td>
</tr>
<tr>
<td></td>
<td>Death pronounced in the ED other than Failed Resuscitation.</td>
</tr>
</tbody>
</table>

Additional Information
- Although CPR is a resuscitative procedure, if that is the ONLY procedure performed while determining the patient’s DEATH IN ED status, the patient should be considered DOA.

Data Source Hierarchy
1. ED Records

Uses
- Allows data to be sorted based upon the type of ED death.
- Provides documentation of care.
- Used in quality management for the evaluation of care.
- Used in system research.

Other Associated Elements
- ARRIVED WITH SIGNS OF LIFE?
- NEXT PHASE AFTER ED
- EXIT ED DATE/TIME
- TRANSFERRED / D/C'D TO
- PHASE PRIOR D/C

Data Format: [character, 1] single entry
Min Value: N/A  Max Value: N/A  Picklist: Yes, non-modifiable  Accepts Null Value: Yes
Next Phase After ED

NTDS ED_23

**Definition**
Phase of care occurring directly after the ED phase (ED disposition).

**Field Values**

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Next Phase After ED</strong></td>
<td><strong>ED Discharge Disposition</strong></td>
</tr>
<tr>
<td>23HR OBS</td>
<td>2 Observation unit (provides &lt; 24 hour stays)</td>
</tr>
<tr>
<td>ICU</td>
<td>8 Intensive Care Unit (ICU)</td>
</tr>
<tr>
<td>INTERVENTIONAL RADIOLOGY (IR)</td>
<td>7 Operating Room</td>
</tr>
<tr>
<td>OR</td>
<td>7 Operating Room</td>
</tr>
<tr>
<td>PICU</td>
<td>8 Intensive Care Unit (ICU)</td>
</tr>
<tr>
<td>PEDSWARD</td>
<td>1 Floor bed (general admission, non-specialty bed)</td>
</tr>
<tr>
<td>SPECIAL PROCEDURES (anything other than IR)</td>
<td>8 Intensive Care Unit (ICU)</td>
</tr>
<tr>
<td>STEPDOWN</td>
<td>3 Telemetry/step-down unit (less acuity than ICU)</td>
</tr>
<tr>
<td>WARD</td>
<td>1 Floor bed (general admission, non-specialty bed)</td>
</tr>
</tbody>
</table>

**POSTHOSP** *(Use LA County "TRANSFERRED / D/C TO:"))*:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HOME W/O</td>
<td>9 Home without services</td>
</tr>
<tr>
<td>HOME WITH</td>
<td>4 Home with services</td>
</tr>
<tr>
<td>MORGUE</td>
<td>5 Deceased / expired</td>
</tr>
<tr>
<td>JAIL SCJ USC (Jail Ward at LAC+USC)</td>
<td>6 Other (jail, institutional care, mental health, etc )</td>
</tr>
<tr>
<td>AMA/ELOPED/LWBS</td>
<td>10 Left against medical advice</td>
</tr>
<tr>
<td>ACUTE CARE</td>
<td>11 Transferred to another hospital</td>
</tr>
<tr>
<td>BURN CENTER</td>
<td></td>
</tr>
<tr>
<td>TRAUMA CENTER</td>
<td></td>
</tr>
</tbody>
</table>

**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 / Study

Definition
Body region and radiological study performed during hospital stay that were essential to the diagnosis of patient’s specific injuries, if applicable.

Field Values

<table>
<thead>
<tr>
<th>BODY PART</th>
<th>X-Ray</th>
<th>CT</th>
<th>CT w/contrast</th>
<th>BODY PART</th>
<th>X-Ray</th>
<th>CT</th>
<th>CT w/contrast</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEAD</td>
<td></td>
<td></td>
<td></td>
<td>UPPER EXTREMITIES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head / Skull</td>
<td>BN00ZZZ</td>
<td>BW28ZZZ</td>
<td>BW281ZZ</td>
<td>Right Upper Extremity</td>
<td>BP0EZZZ</td>
<td>BP2EZZZ</td>
<td>BP2E1ZZ</td>
</tr>
<tr>
<td>Brain</td>
<td>B020ZZZ</td>
<td>B0201ZZ</td>
<td>Right hand</td>
<td>BP0NZZZ</td>
<td>BP2NZZZ</td>
<td>BP2N1ZZ</td>
<td></td>
</tr>
<tr>
<td>Orbits</td>
<td>BN03ZZZ</td>
<td>BN23ZZZ</td>
<td>BN231ZZ</td>
<td>Right wrist</td>
<td>BP0L0ZZZ</td>
<td>BP2LZZZ</td>
<td>BP2L1ZZ</td>
</tr>
<tr>
<td>Facial</td>
<td>BN05ZZZ</td>
<td>BN25ZZZ</td>
<td>BN251ZZ</td>
<td>Right forearm</td>
<td>BP0JZZZ</td>
<td>BP2JZZZ</td>
<td>BP2J1ZZ</td>
</tr>
<tr>
<td>Mandible</td>
<td>BN08ZZZ</td>
<td>BN26ZZZ</td>
<td>BN261ZZ</td>
<td>Right elbow</td>
<td>BP0GZZZ</td>
<td>BP2GZZZ</td>
<td>BP2G1ZZ</td>
</tr>
<tr>
<td>NECK / SPINE</td>
<td></td>
<td></td>
<td></td>
<td>Right humerus</td>
<td>BP0AZZZ</td>
<td>BP2AZZZ</td>
<td>BP2A1ZZ</td>
</tr>
<tr>
<td>Neck</td>
<td></td>
<td></td>
<td></td>
<td>Right clavicle</td>
<td>BP04ZZZ</td>
<td>BP24ZZZ</td>
<td>BP241ZZ</td>
</tr>
<tr>
<td>Cervical spine</td>
<td>BR00ZZZ</td>
<td>BR20ZZZ</td>
<td>BR201ZZ</td>
<td>Left Upper Extremity</td>
<td>BP0FZZZ</td>
<td>BP2FZZZ</td>
<td>BP2F1ZZ</td>
</tr>
<tr>
<td>Thoracic spine</td>
<td>BR07ZZZ</td>
<td>BR27ZZZ</td>
<td>BR271ZZ</td>
<td>Left hand</td>
<td>BP0PZZZ</td>
<td>BP2PZZZ</td>
<td>BP2P1ZZ</td>
</tr>
<tr>
<td>Lumbar spine</td>
<td>BR09ZZZ</td>
<td>BR29ZZZ</td>
<td>BR291ZZ</td>
<td>Left wrist</td>
<td>BP0MZZZ</td>
<td>BP2MZZZ</td>
<td>BP2M1ZZ</td>
</tr>
<tr>
<td>CHEST / ABDOMEN</td>
<td></td>
<td></td>
<td></td>
<td>Left forearm</td>
<td>BP0KZZZ</td>
<td>BP2KZZZ</td>
<td>BP2K1ZZ</td>
</tr>
<tr>
<td>Chest</td>
<td>BW03ZZZ</td>
<td>BW24ZZZ</td>
<td>BW241ZZ</td>
<td>Left elbow</td>
<td>BP0HZZZ</td>
<td>BP2HZZZ</td>
<td>BP2H1ZZ</td>
</tr>
<tr>
<td>Chest &amp; Abdomen</td>
<td>BW04ZZZ</td>
<td>BW24ZZZ</td>
<td>BW241ZZ</td>
<td>Left humerus</td>
<td>BP0BZZZ</td>
<td>BP2BZZZ</td>
<td>BP2B1ZZ</td>
</tr>
<tr>
<td>Chest, Abdomen, Pelvis</td>
<td>BW05ZZZ</td>
<td>BW24ZZZ</td>
<td>BW241ZZ</td>
<td>Left clavicle</td>
<td>BP0SZZZ</td>
<td>BP2SZZZ</td>
<td>BP2S1ZZ</td>
</tr>
<tr>
<td>Right Ribs</td>
<td>BP0XZZZ</td>
<td>BP2XZZZ</td>
<td>BP2X1ZZ</td>
<td>Left shoulder</td>
<td>BP09ZZZ</td>
<td>BP29ZZZ</td>
<td>BP291ZZ</td>
</tr>
<tr>
<td>LEFT RIBS</td>
<td></td>
<td></td>
<td></td>
<td>Right Lower Extremity</td>
<td>BW0CZZZ</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sternum</td>
<td>BR0HZZZ</td>
<td></td>
<td></td>
<td>Right Lower Extremity</td>
<td>BQ0DZZZ</td>
<td>BQ2DZZZ</td>
<td>BQ2D1ZZ</td>
</tr>
<tr>
<td>Heart / Lung</td>
<td>B226ZZZ</td>
<td>B2261ZZ</td>
<td>Right ankle</td>
<td>BQ0GZZZ</td>
<td>BQ2GZZZ</td>
<td>BQ2G1ZZ</td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td>BW20ZZZ</td>
<td>BW201ZZ</td>
<td>Right foot</td>
<td>BQ0LZZZ</td>
<td>BQ2LZZZ</td>
<td>BQ2L1ZZ</td>
<td></td>
</tr>
<tr>
<td>Abdomen / Pelvis</td>
<td>BW00ZZZ</td>
<td>BW21ZZZ</td>
<td>BW211ZZ</td>
<td>Right femur</td>
<td>BQ03ZZZ</td>
<td>BQ23ZZZ</td>
<td>BQ231ZZ</td>
</tr>
<tr>
<td>Kidneys (KUB)</td>
<td>BT03ZZZ</td>
<td>BT23ZZZ</td>
<td>BT231ZZ</td>
<td>Right knee</td>
<td>BQ07ZZZ</td>
<td>BQ27ZZZ</td>
<td>BQ271ZZ</td>
</tr>
<tr>
<td>Right Kidney</td>
<td>BT01ZZZ</td>
<td>BT21ZZZ</td>
<td>BT211ZZ</td>
<td>Right tibia/fibula</td>
<td>BQ08ZZZ</td>
<td>BQ28ZZZ</td>
<td>BQ281ZZ</td>
</tr>
<tr>
<td>Left Kidney</td>
<td>BT02ZZZ</td>
<td>BT22ZZZ</td>
<td>BT221ZZ</td>
<td>Right hip</td>
<td>BQ01ZZZ</td>
<td>BQ20ZZZ</td>
<td>BQ201ZZ</td>
</tr>
<tr>
<td>OTHER</td>
<td></td>
<td></td>
<td></td>
<td>Left Lower Extremity</td>
<td>BQ0FZZZ</td>
<td>BQ2FZZZ</td>
<td>BQ2F1ZZ</td>
</tr>
<tr>
<td>Right scapula</td>
<td>BP06ZZZ</td>
<td>BP26ZZZ</td>
<td>BP261ZZ</td>
<td>Left ankle</td>
<td>BQ04ZZZ</td>
<td>BQ24ZZZ</td>
<td>BQ241ZZ</td>
</tr>
<tr>
<td>Left scapula</td>
<td>BP07ZZZ</td>
<td>BP27ZZZ</td>
<td>BP271ZZ</td>
<td>Left foot</td>
<td>BQ03ZZZ</td>
<td>BQ23ZZZ</td>
<td>BQ231ZZ</td>
</tr>
<tr>
<td>Pelvis</td>
<td>BR0CZZZ</td>
<td>BW2GZZZ</td>
<td>BW2G1ZZ</td>
<td>Left knee</td>
<td>BQ08ZZZ</td>
<td>BQ28ZZZ</td>
<td>BQ281ZZ</td>
</tr>
<tr>
<td>Sacrum</td>
<td>BR0FZZZ</td>
<td>BR2FZZZ</td>
<td>BR2F1ZZ</td>
<td>Left tibia/fibula</td>
<td>BQ01ZZZ</td>
<td>BQ21ZZZ</td>
<td>BQ211ZZ</td>
</tr>
<tr>
<td>Skeletal Survey</td>
<td>BW0LZZZ</td>
<td></td>
<td></td>
<td>Left hip</td>
<td>BQ01ZZZ</td>
<td>BQ21ZZZ</td>
<td>BQ211ZZ</td>
</tr>
</tbody>
</table>

Additional Information
- Head CT results are NOT considered abnormal if facial fracture(s) is / are the only abnormality identified.
- The codes for CT’s with contrast are for Low Osmolar Contrast.
- For CTs using Other Contrast, replace the Approach Code of 1 (5th Digit) with Y.
- Code all CTs individually by “Body Part”.

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: Results

Data Format: [character, 22] multiple entries
Min Value: N/A Max Value: N/A Picklist: Yes, non-modifiable
Accepts Null Value: Yes
RADIOLOGY: Study

**Definition**
Type of radiological study performed during hospital stay that were **essential to the diagnosis** of patient’s specific injuries, if applicable.

**Field Values**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT SCAN</td>
<td>Computerized Tomography Scan</td>
</tr>
<tr>
<td>FAST</td>
<td>Focused Assessment Sonography for Trauma</td>
</tr>
<tr>
<td>MRI</td>
<td>Magnetic Resonance Imaging</td>
</tr>
<tr>
<td>PLAIN FILMS</td>
<td>Plain Films</td>
</tr>
<tr>
<td>RADIONUCLEOTIDE SCANS</td>
<td>Radionucleotide Scans</td>
</tr>
<tr>
<td>ULTRASOUND</td>
<td>Ultrasound</td>
</tr>
<tr>
<td>OT</td>
<td>Other Study</td>
</tr>
</tbody>
</table>

**Additional Information**
- CTs and MRIs are diagnostic radiology and may or may not include contrast.
- The ONLY difference between a **diagnostic** CT and MRI done with contrast versus “angiography” (CTA or MRA), is the timing of the contrast. To decrease variability and increase interrater reliability, **simply code as a CT or MRI**.
- Repeated diagnostic procedures (e.g., repeated CT scan) should not be recorded (record only the first procedure).
- Record subsequent radiology studies identifying missed injuries.
- All diagnostic imaging values entered are mapped to NTDS HP_01.
- Interventional Angiogram (Catheter Angiogram, Formal Angiogram) involves interventional radiology (IR). IR is considered an **invasive procedure**; therefore, **IR procedures should not be coded in the radiology section, they belong in the procedure section**. For IR a special 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, coiling, or other treatment 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: Results
- RADIOLOGY: Description

**Data Format:** [character, 25] multiple entries
**Picklist:** Yes, non-modifiable
**Min Value:** N/A
**Max Value:** N/A
**Accepts Null Value:** Yes
RADIOLOGY: Date

Definition
Date radiological studies were performed, if applicable.

Field Values
• Relevant value for data element

Additional Information
• Collected as MM-DD-YYYY.

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: Results
• RADIOLOGY: Description

Data Format: [date] single entry
Min Value: current date minus 7 years    Max Value: current date    Picklist: No    Accepts Null Value: Yes
RADIOLOGY: Time

Definition
Time radiological studies were performed, if applicable.

Field Values
• Relevant value for data element

Additional Information
• Collected as HHMM (military time).

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: Results
• RADIOLOGY: Description

Data Format: [time] multiple entries
Min Value: N/A        Max Value: 2359
Picklist: No
Accepts Null Value: Yes
RADIOLOGY: Results / Comments

Definition
Results of radiological studies, if applicable.

Field Values
- A Abnormal
- N Normal

Additional Information
- Abnormal results are radiological findings as a result of the traumatic event. For example a cervical spine x-ray with degenerative findings, is an abnormality; however, it is not as a result of trauma. Therefore cervical spine x-ray would be considered normal.
- Head CT results are NOT considered abnormal if facial fracture(s) is / are the only abnormality identified.
- “Possible”, “Probable”, “Questionable”, etc. radiology findings not substantiated by the discharge diagnosis should not be recorded as abnormal.

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
RADIOLOGY: Description

Definition
Comments or additional information pertaining to radiology testing performed.

Field Values
- Relevant value for data element

Additional Information
- OPTIONAL FIELD: This field may be used for free text comments at the discretion of each treating facility.

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
SOLID ORGAN INJURY?

Definition
Indicates whether or not a solid organ injury exists.

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
- ORGAN GRADING – LIVER
- ORGAN GRADING – SPLEEN
- ORGAN GRADING – RIGHT KIDNEY
- ORGAN GRADING – LEFT KIDNEY

Data Format: [character, 1] single entry
Picklist: Yes, non-modifiable
Min Value: N/A  Max Value: N/A
Accepts Null Value: Yes
ORGAN GRADING – LIVER

Definition
Results of solid organ grading of the liver, if applicable.

Field Values

<table>
<thead>
<tr>
<th>Grade</th>
<th>LA COUNTY (TRAUMA.ORG)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade I</td>
<td>Hematoma</td>
</tr>
<tr>
<td></td>
<td>Laceration</td>
</tr>
<tr>
<td>Grade II</td>
<td>Hematoma</td>
</tr>
<tr>
<td></td>
<td>Laceration</td>
</tr>
<tr>
<td>Grade III</td>
<td>Hematoma</td>
</tr>
<tr>
<td></td>
<td>Laceration</td>
</tr>
<tr>
<td>Grade IV</td>
<td>Laceration</td>
</tr>
<tr>
<td>Grade V</td>
<td>Laceration</td>
</tr>
<tr>
<td></td>
<td>Vascular</td>
</tr>
<tr>
<td>Grade VI</td>
<td>Vascular</td>
</tr>
</tbody>
</table>

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
- SOLID ORGAN INJURY?
- ORGAN GRADING – SPLEEN
- ORGAN GRADING – RIGHT KIDNEY
- ORGAN GRADING – LEFT KIDNEY

Data Format: [character, 1] multiple entries
Picklist: Yes, non-modifiable
Min Value: 1
Max Value: 6
Accepts Null Value: Yes
ORGAN GRADING – SPLEEN

Definition
Results of solid organ grading of the spleen, if applicable.

Field Values

<table>
<thead>
<tr>
<th>Grade I</th>
<th>Hematoma</th>
<th>Subcapsular, &lt;10% surface area</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Laceration</td>
<td>Capsular tear, &lt;1cm parenchymal depth</td>
</tr>
<tr>
<td>Grade II</td>
<td>Hematoma</td>
<td>Subcapsular, 10-50% surface area</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intraparenchymal, &lt;5cm diameter</td>
</tr>
<tr>
<td></td>
<td>Laceration</td>
<td>1-3cm parenchymal depth not involving a parenchymal vessel</td>
</tr>
<tr>
<td>Grade III</td>
<td>Hematoma</td>
<td>Subcapsular, &gt;50% surface area or expanding</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ruptured subcapsular or parenchymal hematoma</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intraparenchymal hematoma &gt;5cm</td>
</tr>
<tr>
<td></td>
<td>Laceration</td>
<td>&gt;3cm parenchymal depth or involving trabecular vessels</td>
</tr>
<tr>
<td>Grade IV</td>
<td>Laceration</td>
<td>Laceration of segmental or hilar vessels producing major devascularization (&gt;25% of spleen)</td>
</tr>
<tr>
<td>Grade V</td>
<td>Laceration</td>
<td>Completely shattered spleen</td>
</tr>
<tr>
<td></td>
<td>Vascular</td>
<td>Hilar vascular injury which devascularized the spleen</td>
</tr>
</tbody>
</table>

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
- SOLID ORGAN INJURY?
- ORGAN GRADING – LIVER
- ORGAN GRADING – RIGHT KIDNEY
- ORGAN GRADING – LEFT KIDNEY

Data Format: [character, 1] multiple entries
Picklist: Yes, non-modifiable
Min Value: 1
Max Value: 5
Accepts Null Value: Yes
ORGAN GRADING – RIGHT KIDNEY

Definition
Results of solid organ grading of the right kidney, if applicable.

Field Values

<table>
<thead>
<tr>
<th>Grade</th>
<th>LA COUNTY (TRAUMA.ORG)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade I</td>
<td>Contusion Microscopic or gross hematuria, urological studies normal</td>
</tr>
<tr>
<td></td>
<td>Hematoma Subcapsular, nonexpanding without parenchymal laceration</td>
</tr>
<tr>
<td>Grade II</td>
<td>Hematoma Nonexpanding perirenal hematoma confined to renal retroperitoneum</td>
</tr>
<tr>
<td></td>
<td>Laceration &lt;1cm parenchymal depth of renal cortex without urinary extravasation</td>
</tr>
<tr>
<td>Grade III</td>
<td>Laceration &gt;1cm depth of renal cortex, without collecting system rupture or urinary extravasation</td>
</tr>
<tr>
<td>Grade IV</td>
<td>Laceration Parenchymal laceration extending through the renal cortex, medulla and collecting system</td>
</tr>
<tr>
<td></td>
<td>Vascular Main renal artery or vein injury with contained hemorrhage</td>
</tr>
<tr>
<td>Grade V</td>
<td>Laceration Completely shattered kidney</td>
</tr>
<tr>
<td></td>
<td>Vascular Avulsion of renal hilum which devascularizes the kidney</td>
</tr>
</tbody>
</table>

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
- SOLID ORGAN INJURY?
- ORGAN GRADING – LIVER
- ORGAN GRADING – SPLEEN
- ORGAN GRADING – LEFT KIDNEY

Data Format: [character, 1] multiple entries
Picklist: Yes, non-modifiable
Min Value: 1
Max Value: 5
Accepts Null Value: Yes
ORGAN GRADING – LEFT KIDNEY

Definition
Results of solid organ grading of the left kidney, if applicable.

Field Values

<table>
<thead>
<tr>
<th>Grade</th>
<th>LA COUNTY (TRAUMA.ORG)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade I</td>
<td>Contusion</td>
</tr>
<tr>
<td></td>
<td>Hematoma</td>
</tr>
<tr>
<td>Grade II</td>
<td>Hematoma</td>
</tr>
<tr>
<td></td>
<td>Laceration</td>
</tr>
<tr>
<td>Grade III</td>
<td>Laceration</td>
</tr>
<tr>
<td>Grade IV</td>
<td>Laceration</td>
</tr>
<tr>
<td></td>
<td>Vascular</td>
</tr>
<tr>
<td>Grade V</td>
<td>Laceration</td>
</tr>
<tr>
<td></td>
<td>Vascular</td>
</tr>
</tbody>
</table>

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
- SOLID ORGAN INJURY?
- ORGAN GRADING – LIVER
- ORGAN GRADING – SPLEEN
- ORGAN GRADING – RIGHT KIDNEY

Data Format: [character, 1] multiple entries
Min Value: 1  Max Value: 5
Picklist: Yes, non-modifiable
Accepts Null Value: Yes
LABORATORY: Date

Definition
Date laboratory testing was performed, if applicable.

Field Values
- Relevant value for data element

Additional Information
- Collected as MM-DD-YYYY.
- Scrolling window fields: enter date, 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: Time
- LABORATORY: Results
- LABORATORY: Description (optional)

Data Format: [date] single entry
Min Value: current date minus 7 years  Max Value: current date  Picklist: No  Accepts Null Value: Yes
LABORATORY: Time

Definition
Time laboratory testing was performed, if applicable.

Field Values
• Relevant value for data element

Additional Information
• Collected as HHMM (military time).
• 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: Date
• LABORATORY: Results
• LABORATORY: Description (optional)

Data Format: [time] multiple entries
Min Value: 0000 Max Value: 2359 Picklist: No Accepts Null Value: Yes
LABORATORY: Group / Panel

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
- HEMAGLOBIN
- HEMATOCRIT
- PERITONEAL LAVAGE
- SEROLOGY STUDIES
- SPECIAL CHEMISTRY
- URINALYSIS

Additional Information
- Hemoglobin and/or 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: Date
- LABORATORY: Time
- LABORATORY: Result
- LABORATORY: Description (optional)

Data Format: [character, 5] multiple entries
Min Value: N/A
Max Value: N/A
Picklist: Yes, non-modifiable
Accepts Null Value: Yes
LABORATORY: Results

Definition
Indicate the results of laboratory testing performed, if applicable.

Field Values
- A Abnormal
- N Normal

Additional Information
- Hemoglobin (Hgb) and Hematocrit (Hct) should only be considered abnormal if results fall below the normal range.
- 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: Group/Panel
- LABORATORY: Date
- LABORATORY: Time
- 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 / Value

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: Group/Panel
- LABORATORY: Date
- LABORATORY: Time
- LABORATORY: Result

Data Format: [character, 50] multiple entries
Picklist: No
Min Value: N/A  Max Value: N/A
Accepts Null Value: Yes
ETOH / TOXICOLOGY: Date

Definition
Date specified toxicology testing occurred, if applicable.

Field Values
- Relevant value for data element

Additional Information
- Collected as MM-DD-YYYY.
- 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
- ETOH / TOXICOLOGY: Time
- ETOH / TOXICOLOGY: Substance (Screen)
- ETOH / TOXICOLOGY: Source
- ETOH / TOXICOLOGY: Results
- ETOH VALUE

Data Format: [date] single entry
Min Value: current date minus 7 years  Max Value: current date
Picklist: No  Accepts Null Value: Yes
ETOH / TOXICOLOGY: Time

Definition
Time specified toxicology testing occurred, if applicable.

Field Values
- Relevant value for data element

Additional Information
- Collected as HHMM (military time).
- 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
- ETOH / TOXICOLOGY: Date
- ETOH / TOXICOLOGY: Substance (Screen)
- ETOH / TOXICOLOGY: Source
- ETOH / TOXICOLOGY: Results
- ETOH VALUE

Data Format: [time] multiple entries
Min Value: 0000  Max Value: 2359  Picklist: No  Accepts Null Value: Yes
ETOH / TOXICOLOGY: Substance (Screen)

**Definition**
Indicate whether or not blood alcohol concentration (BAC) AND toxicology screening occurred within the first 24 hours of hospital arrival.

**Field Values**

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethanol (ETOH)</td>
<td>Alcohol Screen (ED_21)</td>
</tr>
<tr>
<td>Toxicology Screen</td>
<td>Drug Screen (ED_20)</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>1 Amphetamines (AMP)</td>
</tr>
<tr>
<td>Antidepressants (excluding Tricyclics)</td>
<td>13 Other</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>13 Other</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>3 Benzodiazepines (BZO)</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>2 Barbiturates (BAR)</td>
</tr>
<tr>
<td>Cannabinoids</td>
<td>12 Cannabinoids (THC)</td>
</tr>
<tr>
<td>Cocaine</td>
<td>4 Cocaine (COC)</td>
</tr>
<tr>
<td>MDMA (3,4-methylenedioxy-methamphetamine)</td>
<td>6 Ecstasy (MDMA)</td>
</tr>
<tr>
<td>Ecstasy (MDMA)</td>
<td>6 Ecstasy (MDMA)</td>
</tr>
<tr>
<td>Methadone</td>
<td>7 Methadone (MTD)</td>
</tr>
<tr>
<td>Methamphetamines</td>
<td>5 Methamphetamines (mAMP)</td>
</tr>
<tr>
<td>Narcotics / Opioids</td>
<td>8 Opioids (OPI)</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>9 Oxycodone (OXY)</td>
</tr>
<tr>
<td>PCP (Phencyclidine)</td>
<td>10 Phencyclidine (PCP)</td>
</tr>
<tr>
<td>Tricyclic Antidepressants</td>
<td>11 Tricyclic Antidepressants (TCA)</td>
</tr>
<tr>
<td>Other toxins</td>
<td>13 Other</td>
</tr>
</tbody>
</table>

**Additional Information**
- ETOH and Toxicology Screens are BOTH mandatory data fields for ALL patients.
- If an ETOH or Toxicology Screen(s) is (are) NOT completed, the results MUST be entered as NOT TESTED for the ETOH / TOXICOLOGY: Results.
- The choice of “Toxicology Screen” should only be utilized if the screen was NOT COMPLETED or was NEGATIVE for ALL toxins.
- If a toxin(s) is (are) identified, enter the toxin(s) from the picklist for the ETOH / TOXICOLOGY: Substance (Screen) instead of the picklist value of “Toxicology Screen”.
  - Field value cannot be “Not Applicable”.
  - Field value cannot be left blank.

**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**
- ETOH / TOXICOLOGY: Date
- ETOH / TOXICOLOGY: Time
- ETOH / TOXICOLOGY: Source
- ETOH / TOXICOLOGY: Results
- ETOH VALUE

**Data Format:** [character, 20] multiple entries

**Picklist:** Yes, non-modifiable

**Min Value:** N/A  
**Max Value:** N/A  
**Accepts Null Value:** Yes
ETOH / TOXICOLOGY: Source

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
- ETOH / TOXICOLOGY: Date
- ETOH / TOXICOLOGY: Time
- ETOH / TOXICOLOGY: Substance (Screen)
- ETOH / TOXICOLOGY: Results
- ETOH VALUE

Data Format: [character, 5] multiple entries
Picklist: Yes, non-modifiable
Min Value: N/A
Max Value: N/A
Accepts Null Value: Yes
ETOH / TOXICOLOGY: Results

Definition
Indicates whether or not specified toxicology testing occurred within 24 hours of hospital arrival, and if applicable, findings.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>ETOH/TOXICOLOGY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOUND (Positive)</td>
<td>1</td>
<td>YES</td>
</tr>
<tr>
<td>NOT FOUND (Negative/None)</td>
<td>1</td>
<td>YES</td>
</tr>
<tr>
<td>NOT TESTED</td>
<td>2</td>
<td>NO</td>
</tr>
</tbody>
</table>

Additional Information
- ETOH and Toxicology Screens are BOTH mandatory data fields for ALL patients.
- If an ETOH or Toxicology Screen(s) is (are) NOT completed, the results MUST be entered as NOT TESTED for the ETOH / TOXICOLOGY: Results.
- If a toxin(s) is (are) identified, enter the toxin(s) from the picklist for the ETOH / TOXICOLOGY: Substance (Screen) instead of the picklist value of “Toxicology Screen”.
- If an ETOH Screen (Blood Alcohol Concentration [BAC]) was completed, a numeric value MUST be entered for the ETOH VALUE.
- If ETOH Screen (Blood Alcohol Concentration [BAC]) results are NOT FOUND (Negative/None), a numeric value of “0” MUST be entered for the ETOH VALUE.
- “Not Found (Negative/None)” is used for patients whose only positive results are due to substances administered during the medical care provided e.g. morphine for pain.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

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
- ETOH / TOXICOLOGY: Date
- ETOH / TOXICOLOGY: Time
- ETOH / TOXICOLOGY: Substance (Screen)
- ETOH / TOXICOLOGY: Source
- ETOH VALUE

Data Format: [character, 10] multiple entries
Picklist: Yes, non-modifiable
Min Value: N/A
Max Value: N/A
Accepts Null Value: Yes
ETOH VALUE

**Definition**
Numeric value for blood alcohol concentration (BAC) completed within the first 24 hours of hospital arrival, if applicable.

**Field Values Field Values**
- Relevant value for data element

**Additional Information**
- If an ETOH Screen (Blood Alcohol Concentration [BAC]) was completed, a numeric value MUST be entered for the ETOH VALUE.
- If ETOH Screen (Blood Alcohol Concentration [BAC]) results are NOT FOUND (Negative/None), a numeric value of “0” MUST be entered for the ETOH VALUE.
- Enter the ETOH numeric value received from your lab.
- Field value “Not Applicable” can ONLY be used for patients that were NOT tested.
- Field value cannot be left blank.

**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**
- ETOH / TOXICOLOGY: Date
- ETOH / TOXICOLOGY: Time
- ETOH / TOXICOLOGY: Substance (Screen)
- ETOH / TOXICOLOGY: Source
- ETOH / TOXICOLOGY: Results

**Data Format:** [number, 12] multiple entries
**Min Value:** 0.00  **Max Value:** 99999999.999  **Picklist:** No  **Accepts Null Value:** Yes

Picklist: No  Accepts Null Value: Yes
DRUGS OF ABUSE

Definition
Indicates drugs known to be abused by the patient at time of injury (on TPS form only).

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amphetamine</td>
</tr>
<tr>
<td>Cocaine</td>
</tr>
<tr>
<td>Barbiturates</td>
</tr>
<tr>
<td>Opiates</td>
</tr>
<tr>
<td>Cannabinoids</td>
</tr>
<tr>
<td>PCP</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

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 only)
MTP ACTIVATED?

Definition
Indicates whether or not the Massive Transfusion Protocol (MTP) was activated during the care of the patient.

Field Values
- Y (Yes)
- N (No)

Additional Information
- Utilize the Blood Info button to access all information regarding blood collection.

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
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS (4 HOURS)
- PLASMA (FFP) (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- PACKED CELLS (24 HOURS)
- PLASMA (FFP) (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- PACKED CELLS (TOTAL {includes ED})
- PLASMA (FFP) (TOTAL {includes ED})
- PLATELETS (TOTAL {includes ED})
- CRYOPRECIPITATE (TOTAL {includes ED})
- TOTAL PRODUCTS (TOTAL {includes ED})
- MEASUREMENT
- CONVERSION

Data Format: {character, 1} single entry
Min Value: N/A Max Value: N/A Picklist: Yes, non-modifiable Accepts Null Value: Yes
TQIP BLOOD INCLUSION?

Definition
Indicates whether the patient received blood during the first four hours of ED / Hospital arrival.

Field Values
- Yes
- No

Additional Information
- Utilize the Blood Info button to access all information regarding blood collection.
- If no blood given, the TQIP 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?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS (4 HOURS)
- PLASMA (FFP) (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- PACKED CELLS (24 HOURS)
- PLASMA (FFP) (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- PACKED CELLS (TOTAL {includes ED})
- PLASMA (FFP) (TOTAL {includes ED})
- PLATELETS (TOTAL {includes ED})
- CRYOPRECIPITATE (TOTAL {includes ED})
- TOTAL PRODUCTS (TOTAL {includes ED})
- MEASUREMENT
- CONVERSION

Data Format: {character, 1} single entry
Min Value: N/A  Max Value: N/A  Picklist: Yes, non-modifiable
Accepts Null Value: Yes
LOWEST ED / HOSPITAL BP-SYSTOLIC

NTDS PM_25

Definition
Numeric value of the patient’s lowest 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

Additional Information
- Utilize the Blood Info button to access all information regarding blood collection.
- The null value “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?
- TQIP BLOOD INCLUSION?
- PACKED CELLS (4 HOURS)
- PLASMA (FFP) (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- PACKED CELLS (24 HOURS)
- PLASMA (FFP) (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- PACKED CELLS (TOTAL {includes ED})
- PLASMA (FFP) (TOTAL {includes ED})
- PLATELETS (TOTAL {includes ED})
- CRYOPRECIPITATE (TOTAL {includes ED})
- TOTAL PRODUCTS (TOTAL {includes ED})
- MEASUREMENT
- CONVERSION

Data Format: {character, 3} single entry
Picklist: No
Min Value: 0 Max Value: 300
Accepts Null Value: Yes
PACKED CELLS (4 HOURS)

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 in milliliters or units.
- If collected in milliliters, then the MEASUREMENT value is “mls”, and the conversion value is “Not Applicable”.
- If collected in units, then the MEASUREMENT value is “units”, and the conversion value is hospital specific unless the standard noted below is used.
- 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 4 hours, then the volume is zero.
- Packed red blood cells (4 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
- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PLASMA (FFP) (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- PACKED CELLS (24 HOURS)
- PLASMA (FFP) (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- PACKED CELLS (TOTAL {includes ED})
- PLASMA (FFP) (TOTAL {includes ED})
- PLATELETS (TOTAL {includes ED})
- CRYOPRECIPITATE (TOTAL {includes ED})
- TOTAL PRODUCTS (TOTAL {includes ED})
- MEASUREMENT
- CONVERSION

Data Format: [number, 5] single entry
Min Value: 0
Max Value: 99999
Picklist: No
Accepts Null Value: Yes
PLASMA (FFP) (4 HOURS)

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 in milliliters or units.
- If collected in milliliters, then the MEASUREMENT value is “mls”, and the conversion value is “Not Applicable”.
- If collected in units, then the MEASUREMENT value is “units”, and the conversion value is hospital specific unless the standard noted below is used.
- **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 4 hours, then the volume is zero.
- Plasma (4 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
- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- PACKED CELLS (24 HOURS)
- PLASMA (FFP) (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- PACKED CELLS (TOTAL {includes ED})
- PLASMA (FFP) (TOTAL {includes ED})
- PLATELETS (TOTAL {includes ED})
- CRYOPRECIPITATE (TOTAL {includes ED})
- TOTAL PRODUCTS (TOTAL {includes ED})
- MEASUREMENT
- CONVERSION

Data Format: [number, 5] single entry
Min Value: 0 Max Value: 99999
Picklist: No Accepts Null Value: Yes
PLATELETS (4 HOURS)

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 in milliliters or units.
- If collected in milliliters, then the MEASUREMENT value is “mls”, and the conversion value is “Not Applicable”.
- If collected in units, then the MEASUREMENT value is “units”, and the conversion value is hospital specific unless the standard noted below is used.
- Platelets 1 unit is equivalent to 225 mls if the actual volume of the unit is not documented.
- If no platelets were given in the first 4 hours, then the volume is zero.
- Platelets (4 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
- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS (4 HOURS)
- PLASMA (FFP) (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- PACKED CELLS (24 HOURS)
- PLASMA (FFP) (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- PACKED CELLS (TOTAL {includes ED})
- PLASMA (FFP) (TOTAL {includes ED})
- PLATELETS (TOTAL {includes ED})
- CRYOPRECIPITATE (TOTAL {includes ED})
- TOTAL PRODUCTS (TOTAL {includes ED})
- MEASUREMENT
- CONVERSION

Data Format: [number, 5] single entry
Picklist: No
Min Value: 0
Max Value: 99999
Accepts Null Value: Yes
**CRYOPRECIPITATE (4 HOURS)**

**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 in milliliters or units.
- If collected in milliliters, then the MEASUREMENT value is “mls”, and the conversion value is “Not Applicable”.
- If collected in units, then the MEASUREMENT value is “units”, and the conversion value is hospital specific unless the standard noted below is used.
- **Cryoprecipitate** pack is equivalent to **100mls** if the actual volume of the pack is not documented.
- If no cryoprecipitate was given in the first 4 hours, then the volume is zero.
- Cryoprecipitate (4 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**
- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS (4 HOURS)
- PLASMA (FFP) (4 HOURS)
- PLATELETS (4 HOURS)
- PACKED CELLS (24 HOURS)
- PLASMA (FFP) (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- PACKED CELLS (TOTAL {includes ED})
- PLASMA (FFP) (TOTAL {includes ED})
- PLATELETS (TOTAL {includes ED})
- CRYOPRECIPITATE (TOTAL {includes ED})
- TOTAL PRODUCTS (TOTAL {includes ED})
- MEASUREMENT
- CONVERSION

**Data Format:** [number, 5] single entry
**Picklist:** No
**Min Value:** 0
**Max Value:** 99999
**Accepts Null Value:** Yes
PACKED CELLS (24 HOURS)

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 in milliliters or units.
• If collected in milliliters, then the MEASUREMENT value is “mls”, and the conversion value is “Not Applicable”.
• If collected in units, then the MEASUREMENT value is “units”, and the conversion value is hospital specific unless the standard noted below is used.
• 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
• MTP ACTIVATED?
• TOIP BLOOD INCLUSION?
• LOWEST ED / HOSPITAL BP - SYSTOLIC
• PACKED CELLS (4 HOURS)
• PLASMA (FFP) (4 HOURS)
• PLATELETS (4 HOURS)
• CRYOPRECIPITATE (4 HOURS)
• PLASMA (FFP) (24 HOURS)
• PLATELETS (24 HOURS)
• CRYOPRECIPITATE (24 HOURS)
• PACKED CELLS (TOTAL {includes ED})
• PLASMA (FFP) (TOTAL {includes ED})
• PLATELETS (TOTAL {includes ED})
• CRYOPRECIPITATE (TOTAL {includes ED})
• TOTAL PRODUCTS (TOTAL {includes ED})
• MEASUREMENT
• CONVERSION

Data Format: [number, 5] single entry
Picklist: No
Min Value: 0
Max Value: 99999
Accepts Null Value: Yes
PLASMA (FFP) *(24 HOURS)*

**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 in milliliters or units.
- If collected in milliliters, then the MEASUREMENT value is “mls”, and the conversion value is “Not Applicable”.
- If collected in units, then the MEASUREMENT value is “units”, and the conversion value is hospital specific unless the standard noted below is used.
- 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**
- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS *(4 HOURS)*
- PLASMA (FFP) *(4 HOURS)*
- PLATELETS *(4 HOURS)*
- CRYOPRECIPITATE *(4 HOURS)*
- PACKED CELLS *(24 HOURS)*
- PLATELETS *(24 HOURS)*
- CRYOPRECIPITATE *(24 HOURS)*
- PACKED CELLS *(TOTAL {includes ED})*
- PLASMA (FFP) *(TOTAL {includes ED})*
- PLATELETS *(TOTAL {includes ED})*
- CRYOPRECIPITATE *(TOTAL {includes ED})*
- TOTAL PRODUCTS *(TOTAL {includes ED})*
- MEASUREMENT
- CONVERSION

**Data Format:** [number, 5] single entry
**Min Value:** 0  
**Max Value:** 99999  
**Picklist:** No  
**Accepts Null Value:** Yes
PLATELETS (24 HOURS)

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 in milliliters or units.
- If collected in milliliters, then the MEASUREMENT value is “mls”, and the conversion value is “Not Applicable”.
- If collected in units, then the MEASUREMENT value is “units”, and the conversion value is hospital specific unless the standard noted below is used.
- 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
- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS (4 HOURS)
- PLASMA (FFP) (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- PACKED CELLS (24 HOURS)
- PLASMA (FFP) (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- PACKED CELLS (TOTAL {includes ED})
- PLASMA (FFP) (TOTAL {includes ED})
- PLATELETS (TOTAL {includes ED})
- CRYOPRECIPITATE (TOTAL {includes ED})
- TOTAL PRODUCTS (TOTAL {includes ED})
- MEASUREMENT
- CONVERSION

Data Format: [number, 5] single entry
Min Value: 0                      Max Value: 99999
Picklist: No                      Accepts Null Value: Yes
CRYOPRECIPITATE (24 HOURS)

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 in milliliters or units.
- If collected in milliliters, then the MEASUREMENT value is “mls”, and the conversion value is “Not Applicable”.
- If collected in units, then the MEASUREMENT value is “units”, and the conversion value is hospital specific unless the standard noted below is used.
- 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
- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS (4 HOURS)
- PLASMA (FFP) (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- PACKED CELLS (24 HOURS)
- PLASMA (FFP) (24 HOURS)
- PLATELETS (24 HOURS)
- PACKED CELLS (TOTAL {includes ED})
- PLASMA (FFP) (TOTAL {includes ED})
- PLATELETS (TOTAL {includes ED})
- CRYOPRECIPITATE (TOTAL {includes ED})
- TOTAL PRODUCTS (TOTAL {includes ED})
- MEASUREMENT
- CONVERSION

Data Format: [number, 5] single entry
Min Value: 0
Max Value: 99999
Picklist: No
Accepts Null Value: Yes
PACKED CELLS (TOTAL {includes ED})

Definition
Total volume of packed cells received by the patient while hospitalized – including 24 hour total.

Field Values
- Relevant value for data element

Additional Information
- Collected in milliliters or units.
- If collected in milliliters, then the MEASUREMENT value is “mls”, and the conversion value is “Not Applicable”.
- If collected in units, then the MEASUREMENT value is “units”, and the conversion value is hospital specific unless the standard noted below is used.
- **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 (TOTAL {includes ED}) 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
- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS (4 HOURS)
- PLASMA (FFP) (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- PACKED CELLS (24 HOURS)
- PLASMA (FFP) (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- PLASMA (FFP) (TOTAL {includes ED})
- PLATELETS (TOTAL {includes ED})
- CRYOPRECIPITATE (TOTAL {includes ED})
- TOTAL PRODUCTS (TOTAL {includes ED})
- MEASUREMENT
- CONVERSION

Data Format: [number, 5] single entry
Min Value: 0 Max Value: 99999 Picklist: No
Accepts Null Value: Yes
PLASMA (FFP) \( (TOTAL \{\text{includes } ED\}) \)

**Definition**
Total volume of fresh frozen plasma received by the patient while hospitalized – including 24 hour total.

**Field Values**
- Relevant value for data element

**Additional Information**
- Collected in milliliters or units.
- If collected in milliliters, then the MEASUREMENT value is “mls”, and the conversion value is “Not Applicable”.
- If collected in units, then the MEASUREMENT value is “units”, and the conversion value is hospital specific unless the standard noted below is used.
- 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 \( (TOTAL \{\text{includes } ED\}) \) 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**
- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS (4 HOURS)
- PLASMA (FFP) (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- PACKED CELLS (24 HOURS)
- PLASMA (FFP) (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- PACKED CELLS \( (TOTAL \{\text{includes } ED\}) \)
- PLATELETS \( (TOTAL \{\text{includes } ED\}) \)
- CRYOPRECIPITATE \( (TOTAL \{\text{includes } ED\}) \)
- TOTAL PRODUCTS \( (TOTAL \{\text{includes } ED\}) \)
- MEASUREMENT
- CONVERSION

**Data Format:** [number, 5] single entry
**Min Value:** 0  **Max Value:** 99999  **Picklist:** No  **Accepts Null Value:** Yes
PLATELETS *(TOTAL {includes ED})*

**Definition**
Total volume of platelets received by the patient while hospitalized – including 24 hour total.

**Field Values**
- Relevant value for data element

**Additional Information**
- Collected in milliliters or units.
- If collected in milliliters, then the MEASUREMENT value is “mls”, and the conversion value is “Not Applicable”.
- If collected in units, then the MEASUREMENT value is “units”, and the conversion value is hospital specific unless the standard noted below is used.
- **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 *(TOTAL {includes ED})* 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**
- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS *(4 HOURS)*
- PLASMA (FFP) *(4 HOURS)*
- PLATELETS *(4 HOURS)*
- CRYOPRECIPITATE *(4 HOURS)*
- PACKED CELLS *(24 HOURS)*
- PLASMA (FFP) *(24 HOURS)*
- PLATELETS *(24 HOURS)*
- CRYOPRECIPITATE *(24 HOURS)*
- PACKED CELLS *(TOTAL {includes ED})*
- PLASMA (FFP) *(TOTAL {includes ED})*
- CRYOPRECIPITATE *(TOTAL {includes ED})*
- TOTAL PRODUCTS *(TOTAL {includes ED})*
- MEASUREMENT
- CONVERSION

**Data Format:** [number, 5] single entry
**Min Value:** 0
**Max Value:** 99999
**Picklist:** No
**Accepts Null Value:** Yes
CRYOPRECIPITATE (TOTAL {includes ED})

Definition
Total volume of cryoprecipitate received by the patient while hospitalized – including 24 hour total.

Field Values
- Relevant value for data element

Additional Information
- Collected in milliliters or units.
- If collected in milliliters, then the MEASUREMENT value is “mls”, and the conversion value is “Not Applicable”.
- If collected in units, then the MEASUREMENT value is “units”, and the conversion value is hospital specific unless the standard noted below is used.
- 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 (TOTAL {includes ED}) 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
- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS (4 HOURS)
- PLASMA (FFP) (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- PACKED CELLS (24 HOURS)
- PLASMA (FFP) (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- PACKED CELLS (TOTAL {includes ED})
- PLASMA (FFP) (TOTAL {includes ED})
- PLATELETS (TOTAL {includes ED})
- TOTAL PRODUCTS (TOTAL {includes ED})
- MEASUREMENT
- CONVERSION

Data Format: [number, 5] single entry
Min Value: 0 Max Value: 99999 Picklist: No
Accepts Null Value: Yes
MEASUREMENT

NTDS PM_14/PM_17/PM_20/PM_23

Definition
The unit of measurement used to document the patient’s specific blood components (PRBCs, Plasma, Platelets, and Cryoprecipitate) transfused while hospitalized.

Field Values
- mls
- unit

Additional Information
- The null value “Not Applicable” is used for patients that do not meet the collection criterion.
- The null value "Not Applicable" is used if no specific blood components were transfused.

Data Source Hierarchy
1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses
- Identifies patients that received blood.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements
- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS (4 HOURS)
- PLASMA (FFP) (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- PACKED CELLS (24 HOURS)
- PLASMA (FFP) (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- PACKED CELLS (TOTAL {includes ED})
- PLASMA (FFP) (TOTAL {includes ED})
- PLATELETS (TOTAL {includes ED})
- CRYOPRECIPITATE (TOTAL {includes ED})
- TOTAL PRODUCTS (TOTAL {includes ED})
- CONVERSION

Data Format: [number, 5] single entry
Picklist: No
Min Value: 0
Max Value: 99999
Accepts Null Value: Yes
CONVERSION

NTDS PM_15/PM_18/PM_21/PM_24

Definition
The quantity of milliliters constituting a “unit” for the specific blood components (PRBCs, Plasma, Platelets, and Cryoprecipitate) at your hospital.

Field Values
- Relevant value for data element

Additional Information
- The null value "Not Applicable" is used for patients that do not meet the collection criterion.
- The null value "Not Applicable" is used if no specific blood components were transfused.

Data Source Hierarchy
1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses
- Identifies patients that received blood.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements
- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS (4 HOURS)
- PLASMA (FFP) (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- PACKED CELLS (24 HOURS)
- PLASMA (FFP) (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- PACKED CELLS (TOTAL {includes ED})
- PLASMA (FFP) (TOTAL {includes ED})
- PLATELETS (TOTAL {includes ED})
- CRYOPRECIPITATE (TOTAL {includes ED})
- TOTAL PRODUCTS (TOTAL {includes ED})
- MEASUREMENT

Data Format: [number, 5] single entry
Min Value: 0
Max Value: 99999
Picklist: No
Accepts Null Value: Yes
TOTAL PRODUCTS

Definition
Total blood/products, packed cells, plasma, platelets, and cryoprecipitate given to the patient while hospitalized – including 24 hour total.

Field Values
- Relevant value for data element

Additional Information
- Auto-calculated using sum of PACKED CELLS (TOTAL {includes ED}), PLASMA (TOTAL {includes ED}), PLATELETS (TOTAL {includes ED}), and CRYOPRECIPITATE (TOTAL {includes ED}) values.
- TOTAL PRODUCTS does not appear as a field value on the Trauma Patient Summary form.

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
- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS (4 HOURS)
- PLASMA (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- PACKED CELLS (24 HOURS)
- PLASMA (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- PACKED CELLS (TOTAL {includes ED})
- PLASMA (TOTAL {includes ED})
- PLATELETS (TOTAL {includes ED})
- CRYOPRECIPITATE (TOTAL {includes ED})
- TOTAL PRODUCTS (TOTAL {includes ED})
- MEASUREMENT
- CONVERSION

Data Format: [number, 5] single entry
Picklist: No
Min Value: 0
Max Value: 99999
Accepts Null Value: Yes
PROCEDURES / OPERATIONS
PHASE BEGUN

Definition
Phase of care where operative or essential major and minor procedures conducted during hospital stay that were essential to the stabilization or treatment of the patient's specific injuries or complications 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, 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 DATE
- START / CUT TIME
- END TIME
- PROCEDURES (ICD-10 Codes)
- TOTAL VENTILATOR DAYS
- SURGERY TYPE
- MD CODE

Data Format: [character, 8] single entry
Min Value: N/A  Max Value: N/A
Picklist: Yes, non-modifiable  Accepts Null Value: Yes
START DATE

Definition
Date when operative or essential major and minor procedures conducted during hospital stay that were essential to the stabilization or treatment of the patient’s specific injuries or complications were begun.

Field Values
- Relevant value for data element

Additional Information
- Collected as MM-DD-YYYY.

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 / CUT TIME
- END TIME
- PROCEDURES (ICD-10 Codes)
- TOTAL VENTILATOR DAYS
- SURGERY TYPE
- MD CODE

Data Format: [date] single entry
Min Value: current date minus 7 years
Max Value: current date
Picklist: No
Accepts Null Value: Yes
START / CUT TIME

NTDS HP_03

Definition
Time when operative or essential major and minor procedures conducted during hospital stay that were essential to the stabilization or treatment of the patient’s specific injuries or complications were begun, if applicable.

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
- PROCEDURES (ICD-10 Codes)
- TOTAL VENTILATOR DAYS
- SURGERY TYPE
- MD CODE

Data Format: [time] single entry
Min Value: 0000  Max Value: 2359
Picklist: No  Accepts Null Value: Yes
END TIME

Definition
Time when operative or essential major and minor procedures conducted during hospital stay that were essential to the stabilization or treatment of the patient’s specific injuries or complications ended, if applicable.

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
- START DATE
- START / CUT TIME
- PROCEDURES (ICD-10 Codes)
- TOTAL VENTILATOR DAYS
- SURGERY TYPE
- MD CODE

Data Format: [time] single entry
Min Value: 0000  Max Value: 2359  Picklist: No  Accepts Null Value: Yes
PROCEDURES (ICD-10 Codes)

Definition
Operative or essential major and minor procedures conducted during hospital stay that were essential to the stabilization or treatment of the patient’s specific injuries or complications.

Field Values

<table>
<thead>
<tr>
<th>MANDATORY PROCEDURES</th>
<th>ICD-10 CODES</th>
<th>MANDATORY PROCEDURES</th>
<th>ICD-10 CODES</th>
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<tbody>
<tr>
<td>Central Line Approach:</td>
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<td>Inferior Vena Cava (IVC) Filters (temporary or permanent) Approach:</td>
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<td>• Chest, Open</td>
<td>0JH60XZ</td>
<td>• Open</td>
<td>06H00DZ</td>
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<td>• Chest, Percutaneous</td>
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<td>• Percutaneous</td>
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<td>• Percutaneous Endoscopically</td>
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<td>The ICD-10 Code for central lines varies depending on the site and the approach used.</td>
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<td>Chest Tube (left)</td>
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<td>Cricothyroidotomy Approach:</td>
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<td>Intracranial Pressure (ICP) Monitor:</td>
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<td>• Percutaneous</td>
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<td>• Percutaneous</td>
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<td>• Via Natural or Artificial Opening</td>
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<td>• Percutaneous Endoscopic</td>
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<td>Percutaneous Endoscopic Gastrostomy (PEG) Approach:</td>
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<td>• Percutaneous Endoscopically</td>
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<td>The ICD-10 Code for embolization varies depending on the site embolized and the approach used.</td>
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<td>Endotracheal (ETT) Intubation:</td>
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<td>Tracheostomy Approach:</td>
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<td>0BH18EZ</td>
<td>• Percutaneous</td>
<td>0B113F4</td>
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<tr>
<td>• Percutaneous Endoscopically</td>
<td>0B114F4</td>
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</tr>
</tbody>
</table>

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.
- Optional operative or essential major and minor procedures ICD-10-CM codes conducted during hospital stay include the following: Licox, Bronchoscopy, & PICC line.
- All Operative or essential major and minor procedures must be entered.
- All Operative or essential major and minor procedures values entered are mapped to NTDS HP_01.

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
- PHASE BEGUN
- START DATE
- START / CUT TIME
- END TIME
- TOTAL VENTILATOR DAYS
- SURGERY TYPE
- MD CODE

Data Format: [character, 6] multiple entries
Min Value: N/A  Max Value: N/A
Picklist: Yes, non-modifiable
Accepts Null Value: Yes
SURGERY TYPE

Definition
Two-digit numerical code for the type of surgical procedure performed in the operating room, if applicable.

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
- PHASE BEGUN
- START DATE
- START / CUT TIME
- END TIME
- PROCEDURES (ICD-10 Codes)
- TOTAL VENTILATOR DAYS
- 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

Definition
Name or code of the surgeon that performed the surgical procedure in the operating room, if applicable.

Field Values
• Relevant value for data element

Additional Information
• Non-picklist – 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
• PHASE BEGUN
• START DATE
• START / CUT TIME
• END TIME
• PROCEDURES (ICD-10 Codes)
• TOTAL VENTILATOR DAYS
• SURGERY TYPE

Data Format: [character, 15] multiple entries
Min Value: N/A  Max Value: N/A
Picklist: Yes, facility-modifiable  Accepts Null Value: Yes
TOTAL VENTILATOR DAYS

Definition
The total number of days the patient spent on a mechanical ventilator (include all episodes), if applicable.

Field Values
- Relevant value for data element

Additional Information
- Recorded in full day increments with any partial day entered as one full day.
- Includes all invasive ventilatory support days via endotracheal tube or tracheostomy tube.
- 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.
- 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
- PHASE BEGUN
- START DATE
- START / CUT TIME
- END TIME
- PROCEDURES (ICD-10 Codes)
- TOTAL VENTILATOR DAYS
- SURGERY TYPE
- MD CODE

Data Format: [number, 4] single entry
Min Value: 0
Max Value: 9999
Picklist: No
Accepts Null Value: Yes
1ST ANGIOGRAPHY

Definition
First 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

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angiogram Only</td>
<td>2</td>
</tr>
<tr>
<td>Angiogram with Embolization</td>
<td>3</td>
</tr>
<tr>
<td>Angiogram with Stenting</td>
<td>4</td>
</tr>
<tr>
<td>None</td>
<td>1</td>
</tr>
</tbody>
</table>

Additional Information
- Limit collection of angiography data to the first 24 hours following ED / Hospital arrival.
- The null value “Not Applicable” is used for patients that do not meet the collection criterion.
- Excludes CTA.
- Interventional Angiogram (Catheter Angiogram, Formal Angiogram) involves interventional radiology (IR). For IR a special 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, coiling, or other treatment if needed.

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
- 1ST ANGIOGRAPHY DATE
- 1ST ANGIOGRAPHY TIME
- EMBOLIZATION SITE
- MTP ACTIVATED?
- PACKED CELLS (4 HOURS)

Data Format: {character, 30} single entry
Picklist: Yes, non-modifiable
Min Value: N/A Max Value: N/A Accepts Null Value: Yes
**1ST ANGIOGRAPHY DATE**

**Definition**
Date the 1st 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.
- The null value “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**
- 1ST ANGIOGRAPHY
- 1ST ANGIOGRAPHY TIME
- EMBOLIZATION SITE
- MTP ACTIVATED?
- PACKED CELLS (4 HOURS)

**Data Format:** [date] single entry
**Min Value:** current date minus 7 years  **Max Value:** current date  **Picklist:** No  **Accepts Null Value:** Yes
**1ST ANGIOGRAPHY TIME**

**Definition**
Time the 1st 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 HHMM (military time).
- Limit collection of angiography data to the first 24 hours following ED / Hospital arrival.
- The null value “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**
- 1ST ANGIOGRAPHY
- 1ST ANGIOGRAPHY DATE
- EMBOLIZATION SITE
- MTP ACTIVATED?
- PACKED CELLS (4 HOURS)

**Data Format:** [time] single entry
**Picklist:** No
**Min Value:** 0000  **Max Value:** 2359  **Accepts Null Value:** Yes
EMBOLIZATION SITE

NTDS PM_27

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

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liver</td>
<td>1 Liver</td>
</tr>
<tr>
<td>Spleen</td>
<td>2 Spleen</td>
</tr>
<tr>
<td>Kidneys</td>
<td>3 Kidneys</td>
</tr>
<tr>
<td>Pelvic (iliac, gluteal, obturator)</td>
<td>4 Pelvic (iliac, gluteal, obturator)</td>
</tr>
<tr>
<td>Retroperitoneum (lumbar, sacral)</td>
<td>5 Retroperitoneum (lumbar, sacral)</td>
</tr>
<tr>
<td>Peripheral vascular (neck, extremities)</td>
<td>6 Peripheral vascular (neck, extremities)</td>
</tr>
<tr>
<td>Aortic (thoracic, abdominal)</td>
<td>7 Aortic (thoracic, abdominal)</td>
</tr>
<tr>
<td>Other</td>
<td>8 Other</td>
</tr>
</tbody>
</table>

Additional Information
- Limit collection of embolization site to the first 24 hours following ED / Hospital arrival.
- The null value “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
- 1ST ANGIOGRAPHY
- 1ST ANGIOGRAPHY DATE
- 1ST ANGIOGRAPHY TIME
- MTP ACTIVATED?
- PACKED CELLS (4 HOURS)

Data Format: {character, 30} single entry
Picklist: Yes, non-modifiable
Min Value: N/A
Max Value: N/A
Accepts Null Value: Yes
HEMORRHAGE CONTROL TYPE

NTDS PM_30

Definition
First 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

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>1 None</td>
</tr>
<tr>
<td>Laparotomy</td>
<td>2 Laparotomy</td>
</tr>
<tr>
<td>Thoracotomy</td>
<td>3 Thoracotomy</td>
</tr>
<tr>
<td>Sternotomy</td>
<td>4 Sternotomy</td>
</tr>
<tr>
<td>Extremity</td>
<td>5 Extremity</td>
</tr>
<tr>
<td>Neck</td>
<td>6 Neck</td>
</tr>
<tr>
<td>Mangled extremity / traumatic amputation</td>
<td>7 Mangled extremity / traumatic amputation</td>
</tr>
<tr>
<td>Other skin / soft tissue</td>
<td>8 Other skin / soft tissue</td>
</tr>
<tr>
<td>Extraperitoneal Pelvic Packing</td>
<td>9 Extraperitoneal Pelvic Packing</td>
</tr>
</tbody>
</table>

Additional Information
• If unclear if surgery was for hemorrhage control, consult with the Trauma Medical Director or relevant surgeon.
• The null value “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
• HEMORRHAGE CONTROL DATE
• HEMORRHAGE CONTROL TIME
• MTP ACTIVATED?
• PACKED CELLS (4 HOURS)

Data Format: {character, 30} single entry
Min Value: N/A Max Value: N/A Picklist: Yes, non-modifiable Accepts Null Value: Yes
HEMORRHAGE CONTROL DATE

NTDS PM_31

Definition
Date of first 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.
- The null value “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
- HEMORRHAGE CONTROL TYPE
- HEMORRHAGE CONTROL TIME
- MTP ACTIVATED?
- PACKED CELLS (4 HOURS)

Data Format: [date] single entry
Min Value: current date minus 7 years   Max Value: current date   Picklist: No   Accepts Null Value: Yes
HEMORRHAGE CONTROL TIME

NTDS PM_32

**Definition**
Time of first 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.
- The null value “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**
- HEMORRHAGE CONTROL TYPE
- HEMORRHAGE CONTROL DATE
- MTP ACTIVATED?
- PACKED CELLS (4 HOURS)

**Data Format:** [time] single entry
**Picklist:** No
**Min Value:** 0000  **Max Value:** 2359
**Accepts Null Value:** Yes
PHASE AFTER OR

Definition
Phase of care occurring directly following each OR phase, if applicable.

Field Values
- 23HR OBS <24 Hour Observation
- ICU Intensive/Critical Care Unit
- INTERVENTIONAL 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
- DISCHARGE DATE
- DISCHARGE TIME

Data Format: [character, 17] single entry
Min Value: N/A  Max Value: N/A
Picklist: Yes, non-modifiable
Accepts Null Value: Yes
ICU / ACUTE CARE
ICU ARRIVAL DATE

Definition
Date the patient was admitted to the Intensive Care Unit (ICU), if applicable.

Field Values
- Relevant value for data element

Additional Information
- Collected as MM-DD-YYYY.

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.
- Used to calculate ICU – LENGTH OF STAY (LOS)
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements
- ICU EXIT DATE
- ICU – LENGTH OF STAY (LOS)

Data Format: [date] single entry
Min Value: current date minus 7 years
Max Value: current date
Picklist: No
Accepts Null Value: Yes
ICU EXIT DATE

Definition
Date patient was discharged or transferred from ICU, if applicable.

Field Values
• Relevant value for data element

Additional Information
• Collected as MM-DD-YYYY.

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.
• Used to calculate ICU – LENGTH OF STAY (LOS)
• Provides documentation of care.
• Used in quality management for the evaluation of care.

Other Associated Elements
• ICU ARRIVAL DATE
• ICU – LENGTH OF STAY (LOS)

Data Format: [date] single entry
Min Value: current date minus 7 years Max Value: current date Picklist: No
Accepts Null Value: Yes
ICU – LENGTH OF STAY (LOS)

Definition
The total number of patient days in any ICU (including all episodes), if applicable.

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 auto-populates the total ICU LOS.
- ICU LENGTH OF STAY (LOS) does not appear as a field value on the Trauma Patient Summary form.

Data Source Hierarchy
1. ICU Records
2. ED Records
3. Progress Notes

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.

Other Associated Elements
- ICU ARRIVAL DATE
- ICU EXIT DATE

Data Format: [number, 4] auto-calculated
Min Value: 1 Max Value: 9999
Picklist: No Accepts Null Value: Yes
CONSULT DATE

Definition
Date during hospital stay when physician consultation occurred, if applicable.

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
Min Value: current date minus 7 years  Max Value: current date  Picklist: No  Accepts Null Value: Yes
CONSULT SERVICE

Definition
Service of physician consulted during hospital stay, if applicable.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANE ANESTHESIOLOGY</td>
</tr>
<tr>
<td>BUR BURN SPECIALIST</td>
</tr>
<tr>
<td>CAR CARDIOLOGY</td>
</tr>
<tr>
<td>CTS CARDIOTHORACIC SURGEON</td>
</tr>
<tr>
<td>CCI CRITICAL CARE INTENSIVIST</td>
</tr>
<tr>
<td>DEN DENTAL</td>
</tr>
<tr>
<td>DER DERMATOLOGY</td>
</tr>
<tr>
<td>EDP ED PHYS/ATTENDING</td>
</tr>
<tr>
<td>EDR ED RESIDENT</td>
</tr>
<tr>
<td>END ENDOCRINOLOGY</td>
</tr>
<tr>
<td>FNM FAMILY MEDICINE</td>
</tr>
<tr>
<td>GAS GASTROENTEROLOGY</td>
</tr>
<tr>
<td>GES GENERAL SURGEON</td>
</tr>
<tr>
<td>GER GERIATRICS</td>
</tr>
<tr>
<td>GYN GYNECOLOGY</td>
</tr>
<tr>
<td>HAS HAND SURGEON</td>
</tr>
<tr>
<td>HEM HEMATOLOGY</td>
</tr>
<tr>
<td>HMO HMO CONSULTANT</td>
</tr>
<tr>
<td>HNS HEAD &amp; NECK SURGEON</td>
</tr>
<tr>
<td>HBO HYPERBARIC MEDICINE</td>
</tr>
<tr>
<td>INF INFECTIOUS MEDICINE</td>
</tr>
<tr>
<td>INR INTERVENT. RADIOLOGY</td>
</tr>
<tr>
<td>INT INTERNAL MEDICINE</td>
</tr>
<tr>
<td>MAS MAXILLOFACIAL SURGEON</td>
</tr>
<tr>
<td>NCC NEURO CRITICAL CARE</td>
</tr>
</tbody>
</table>

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

Definition
Name or code of physician consulted during hospital stay, if applicable.

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
**TQIP TBI INCLUSION?**

**Definition**
Indicates whether or not the patient meets the Trauma Quality Improvement Program (TQIP®) Traumatic Brain Injury (TBI) inclusion criteria.

**Collection Criterion**
- **ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION,** excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s), and scalp avulsion(s).

**Field Values**
- Yes
- No

**Additional Information**
- The null value “Not Applicable” is used for patients that do not meet the collection criteria.

**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**
- INITIAL PUPILLARY RESPONSE
- HIGHEST GCS TOTAL
- HIGHEST GCS MOTOR
- QUALIFIER OF HIGHEST GCS
- MIDLINE SHIFT?
- CEREBRAL MONITOR TYPE
- CEREBRAL MONITOR DATE
- CEREBRAL MONITOR TIME

**Data Format:** [character, 1] single entry

**Min Value:** N/A  
**Max Value:** N/A  
**Picklist:** Yes, non-modifiable  
**Accepts Null Value:** Yes
INITIAL PUPILLARY RESPONSE

Definition
Initial physiological pupil response within 30 minutes or less of ED / Hospital arrival.

Collection Criterion
- ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s), and scalp avulsion(s).

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Both Reactive</td>
</tr>
<tr>
<td>1</td>
<td>One Reactive</td>
</tr>
<tr>
<td>0</td>
<td>Neither Reactive</td>
</tr>
</tbody>
</table>

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.
- One reactive should be reported for patients who have a prosthetic eye.
- 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.
- The null value “Not Applicable” is used for patients that do not meet the collection criteria.
- Field cannot be left blank.

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
- TQIP TBI INCLUSION?
- HIGHEST GCS TOTAL
- HIGHEST GCS MOTOR
- QUALIFIER OF HIGHEST GCS
- MIDLINE SHIFT?
- CEREBRAL MONITOR TYPE
- CEREBRAL MONITOR DATE
- CEREBRAL MONITOR TIME

Data Format: [character, 1] multiple entries
Picklist: Yes, non-modifiable
Min Value: 0
Max Value: 2
Accepts Null Value: Yes
**HIGHEST GCS TOTAL**

**Definition**
Highest GCS total on calendar day after ED / Hospital arrival.

**Collection Criterion**
- ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s), and scalp avulsion(s).

**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.
- The null value “Not Applicable” is used for patients that do not meet the collection criteria.
- Field cannot be left blank.

**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.

**Other Associated Elements**
- TQIP TBI INCLUSION?
- INITIAL PUPILLARY RESPONSE
- HIGHEST GCS MOTOR
- QUALIFIER OF HIGHEST GCS
- MIDLINE SHIFT?
- CEREBRAL MONITOR TYPE
- CEREBRAL MONITOR DATE
- CEREBRAL MONITOR TIME

**Data Format:** [number, 2] single entry

**Picklist:** No

**Min Value:** 3  
**Max Value:** 15  
**Accepts Null Value:** Yes
HIGHEST GCS MOTOR

Definition

Highest GCS motor on calendar day after ED / Hospital arrival.

Collection Criterion

- ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s), and scalp avulsion(s).

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
</tr>
<tr>
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<td>3</td>
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<tr>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

- Obeys commands
- Localizes pain
- Withdraws from pain
- Flexion (decorticate) to pain
- Extension (decerebrate) to pain
- No motor response

Additional Information

- Requires review of all data sources to obtain the highest GCS motor. In many cases, the highest GCS motor may occur after ED discharge.
- Best obtained when sedatives or paralytics are withheld as part of sedation holiday.
- The null value “Not Applicable” is used for patients that do not meet the collection criteria.
- Field cannot be left blank.

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.

Other Associated Elements

- TQIP TBI INCLUSION?
- INITIAL PUPILLARY RESPONSE
- HIGHEST GCS TOTAL
- QUALIFIER OF HIGHEST GCS
- MIDLINE SHIFT?
- CEREBRAL MONITOR TYPE
- CEREBRAL MONITOR DATE
- CEREBRAL MONITOR TIME

Data Format: [number, 1 single entry]

Min Value: 1  Max Value: 6 Picklist: Yes, non-modifiable

Accepts Null Value: Yes
QUALIFIER OF HIGHEST GCS

**NTDS PM_03**

**Definition**
Documentation of factors potentially affecting the highest GCS total on calendar day after ED / Hospital arrival.

**Collection Criterion**
- **ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION**, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s), and scalp avulsion(s).

**Field Values**

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>Obstruction Eye 2</td>
</tr>
<tr>
<td>S</td>
<td>Sedated / Paralyzed 1</td>
</tr>
<tr>
<td>T</td>
<td>Intubated 3</td>
</tr>
<tr>
<td>TO</td>
<td>Intubated &amp; Obstruction 3</td>
</tr>
<tr>
<td>TS</td>
<td>Intubated &amp; Sedated / Paralyzed 3</td>
</tr>
<tr>
<td>TSO</td>
<td>Intubated, Sedated / Paralyzed, &amp; Obstruction 3</td>
</tr>
<tr>
<td>SO</td>
<td>Sedated / Paralyzed &amp; Obstruction 1</td>
</tr>
<tr>
<td>L</td>
<td>Valid GCS, Not sedated, intubated, or obstructed 4</td>
</tr>
</tbody>
</table>

**Additional Information**
- Identified medical treatments 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.
- The null value “Not Applicable” is used for patients that do not meet the collection criteria.
- Field cannot be left blank.

**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**
- TQIP TBI INCLUSION?
- INITIAL PUPILLARY RESPONSE
- HIGHEST GCS TOTAL
- HIGHEST GCS MOTOR
- MIDLINE SHIFT?
- CEREBRAL MONITOR TYPE
- CEREBRAL MONITOR DATE
- CEREBRAL MONITOR TIME

**Data Format:** [character] multiple entries
**Picklist:** Yes, non-modifiable
**Min Value:** N/A **Max Value:** N/A **Accepts Null Value:** Yes
MIDLINE SHIFT?

Definition
Indicates if a midline shift exists (>5mm shift past its center line) within 24 hours after time of injury.

Collection Criterion
- ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s), and scalp avulsion(s).

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Yes</td>
</tr>
<tr>
<td>N</td>
<td>No</td>
</tr>
<tr>
<td>O</td>
<td>Not Imaged</td>
</tr>
</tbody>
</table>

Additional Information
- If there is documentation of “massive” midline shift in lieu of >5mm shift measurement, submit field value 1. Yes.
- Radiological and surgical documentation from transferring facilities should be considered for this data field.
- The null value “Not Known/Not Recorded” is used if both the injury date and injury time are unknown.
- If the injury time is unknown, but there is supporting documentation that the injury occurred within 24-hours of any CT measuring a >5mm shift, report the field value “1. Yes” if there is no other contradicting documentation.
- If the patient was not imaged within 24 hours from the time of injury, report the field value “3. Not Imaged (e.g. CT Scan, MRI)”.
- The null value “Not Applicable” is used for patients that do not meet the collection criteria.
- Field cannot be left blank.

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
- TQIP TBI INCLUSION?
- INITIAL PUPILLARY RESPONSE
- HIGHEST GCS TOTAL
- HIGHEST GCS MOTOR
- QUALIFIER OF HIGHEST GCS
- CEREBRAL MONITOR TYPE
- CEREBRAL MONITOR DATE
- CEREBRAL MONITOR TIME

Data Format: [character, 1] single entry
Min Value: N/A
Max Value: N/A
Picklist: Yes, non-modifiable
Accepts Null Value: Yes
### CEREBRAL MONITOR TYPE

**Definition**

Indicate the type(s) of cerebral monitors that were placed.

**Collection Criterion**

- **ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION**, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s), and scalp avulsion(s).

**Field Values**

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intraparenchymal Oxygen Monitor (e.g. Licox)</td>
<td>Intraparenchymal Oxygen Monitor (e.g. Licox)</td>
</tr>
<tr>
<td>Intraparenchymal Pressure Monitor (e.g. Camino bolt, subarachnoid bolt)</td>
<td>Intraparenchymal Pressure Monitor (e.g. Camino bolt, subarachnoid bolt, Intraparenchymal catheter)</td>
</tr>
<tr>
<td>Intraventricular Drain/Catheter (e.g. Ventriculostomy, External Ventricular Drain)</td>
<td>Intraventricular Drain/Catheter (e.g. Ventriculostomy, External Ventricular Drain)</td>
</tr>
<tr>
<td>Jugular Venous Bulb</td>
<td>Jugular Venous Bulb</td>
</tr>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

**Additional Information**

- Refers to insertion of an ICP monitor (or other measures of cerebral perfusion) for the purposes of managing severe TBI.
- Cerebral monitor placed at a referring facility would be acceptable if such a monitor was used by receiving facility to monitor the patient.
- Selection of the field value of ‘none’ for the Cerebral Monitor Type, will result in the autofill of “NA” for the Date and Time.
- The null value “Not Applicable” is used for patients that do not meet the collection criteria.
- Field cannot be left blank.

**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**

- TQIP TBI INCLUSION?
- INITIAL PUPILLARY RESPONSE
- HIGHEST GCS TOTAL
- HIGHEST GCS MOTOR
- QUALIFIER OF HIGHEST GCS
- MIDLINE SHIFT?
- CEREBRAL MONITOR DATE
- CEREBRAL MONITOR TIME

**Data Format:** [character, 2] multiple entries

**Min Value:** N/A

**Max Value:** N/A

**Picklist:** Yes, non-modifiable

**Accepts Null Value:** Yes
**CEREBRAL MONITOR DATE**

**NTDS PM_08**

**Definition**
Date of first cerebral monitor placement.

**Collection Criterion**
- ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s), and scalp avulsion(s).

**Field Values**
- Relevant value for data element

**Additional Information**
- Collected as MM-DD-YYYY.
- The null value “Not Applicable” is used for patients that do not meet the collection criteria.
- The null value “Not Applicable” is also used if the CEREBRAL MONITOR TYPE is “none”.
- Field cannot be left blank.

**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**
- TQIP TBI INCLUSION?
- INITIAL PUPILLARY RESPONSE
- HIGHEST GCS TOTAL
- HIGHEST GCS MOTOR
- QUALIFIER OF HIGHEST GCS
- MIDLINE SHIFT?
- CEREBRAL MONITOR TYPE
- CEREBRAL MONITOR TIME

**Data Format:** [date] single entry
**Min Value:** current date minus 7 years  **Max Value:** current date  **Picklist:** No  **Accepts Null Value:** Yes
CEREBRAL MONITOR TIME

Definition
Time of first cerebral monitor placement.

Collection Criterion
- **ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION**, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s), and scalp avulsion(s).

Field Values
- Relevant value for data element

Additional Information
- Collected as HHMM (military time).
- The null value “Not Applicable” is used for patients that do not meet the collection criteria.
- The null value “Not Applicable” is also used if the CEREBRAL MONITOR TYPE is “none”.
- Field cannot be left blank.

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
- TQIP TBI INCLUSION?
- INITIAL PUPILLARY RESPONSE
- HIGHEST GCS TOTAL
- HIGHEST GCS MOTOR
- QUALIFIER OF HIGHEST GCS
- MIDLINE SHIFT?
- CEREBRAL MONITOR TYPE
- CEREBRAL MONITOR DATE

Data Format: [time] single entry
Min Value: 0000 Max Value: 2359
Picklist: No Accepts Null Value: Yes
TQIP VTE PROPHYLAXIS INCLUSION?

Definition
Indicates whether or not the patient received Venous Thromboembolism (VTE) prophylaxis at your facility.

Collection Criterion
- COLLECT ON ALL PATIENTS

Field Values
- Y (Yes)
- N (No)

Additional Information
- Collected as HHMM (military time).
- Field value cannot be “Not Applicable”.
- Field cannot be left blank.

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
Min Value: N/A Max Value: N/A Picklist: Yes, non-modifiable Accepts Null Value: Yes
VTE PROPHYLAXIS TYPE

NTDS PM_10

**Definition**
Type of VTE prophylaxis first administered to the patient at your facility.

**Collection Criterion**
- COLLECT ON ALL PATIENTS.

**Field Values**

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>5</td>
</tr>
<tr>
<td>LMWH (Dalteparin, Enoxaparin, etc.)</td>
<td>6</td>
</tr>
<tr>
<td>Direct Thrombin Inhibitor (Dabigatran, etc.)</td>
<td>7</td>
</tr>
<tr>
<td>Xa Inhibitor (Rivaroxaban, etc.)</td>
<td>8</td>
</tr>
<tr>
<td>Coumadin</td>
<td>10</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
</tr>
<tr>
<td>Unfractionated Heparin (UH) (Heparin Drip &amp;/or SQ Heparin)</td>
<td>11</td>
</tr>
</tbody>
</table>

**Additional Information**
- Does not accept null values.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

**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 INCLUSION?
- VTE PROPHYLAXIS DATE
- VTE PROPHYLAXIS TIME

**Data Format:** [number, 2] single entry

**Min Value:** 1  
**Max Value:** 10  
**Picklist:** Yes, non-modifiable

**Accepts Null Value:** No
VTE PROPHYLAXIS DATE

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.
• Field value cannot be left blank.

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 INCLUSION?
• VTE PROPHYLAXIS TYPE
• VTE PROPHYLAXIS TIME

Data Format: [date] single entry
Min Value: current date minus 7 years Max Value: current date
Picklist: No Accepts Null Value: Yes
VTE PROPHYLAXIS TIME

NTDS PM_12

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.
- Field value cannot be left blank.

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 INCLUSION?
- VTE PROPHYLAXIS TYPE
- VTE PROPHYLAXIS DATE

Data Format: [time] single entry
Min Value: 0000  Max Value: 2359
Picklist: No  Accepts Null Value: Yes
WITHDRAWAL OF LIFE SUPPORTING TREATMENT?

Definition
Indicates whether or not 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

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Yes 1</td>
</tr>
<tr>
<td>N</td>
<td>No   2</td>
</tr>
</tbody>
</table>

Additional Information
- DNR is not a requirement.
- WITHDRAWAL OF LIFE SUPPORTING TREATMENT 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.
- Field value cannot be left blank.

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 LIFE SUPPORTING TREATMENT DATE
- WITHDRAWAL OF LIFE SUPPORTING TREATMENT 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 LIFE SUPPORTING TREATMENT DATE

Definition
The date care was withdrawn, if applicable.

Field Values
- Relevant value for data element

Additional Information
- Collected as MM-DD-YYYY.
- Field value cannot be left blank.

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 LIFE SUPPORTING TREATMENT?
- WITHDRAWAL OF LIFE SUPPORTING TREATMENT TIME

Data Format: [date] single entry
Min Value: current date minus 7 years Max Value: current date
Picklist: No Accepts Null Value: Yes
WITHDRAWAL OF LIFE SUPPORTING TREATMENT TIME

**Definition**

The time care was withdrawn, if applicable.

**Field Values**

- Relevant value for data element

**Additional Information**

- Collected as HHMM (military time).
- Field value cannot be left blank.

**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 LIFE SUPPORTING TREATMENT?
- WITHDRAWAL OF LIFE SUPPORTING TREATMENT DATE

**Data Format:** [time] single entry

<table>
<thead>
<tr>
<th>Min Value:</th>
<th>Max Value:</th>
<th>Picklist:</th>
<th>Accepts Null Value:</th>
</tr>
</thead>
<tbody>
<tr>
<td>0000</td>
<td>2359</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
HOSPITAL DISPOSITION ORDER DATE

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 MM-DD-YYYY.
- 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 Hospital LOS.
- Allows data to be sorted based upon Hospital LOS.

Other Associated Elements
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PRIOR PHASE
- TRANSFERRED / DISCHARGED TO
- FACILITY
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- DISCHARGE CAPACITY

Data Format: [date] single entry
Picklist: No
Min Value: current date minus 7 years
Max Value: current date
Accepts Null Value: Yes
HOSPITAL DISPOSITION ORDER TIME

NTDS O_04

**Definition**

The *time the order was written* for the patient to be transferred or discharged from the hospital, or the time 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 Hospital LOS.
- Allows data to be sorted based Hospital LOS.

**Other Associated Elements**

- HOSPITAL DISPOSITION ORDER DATE
- DISCHARGE DATE
- DISCHARGE TIME
- PRIOR PHASE
- TRASFERRED / DISCHARGED TO
- FACILITY
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- DISCHARGE CAPACITY

**Data Format:** [time] single entry

**Picklist:** No

**Min Value:** 0000

**Max Value:** 2359

**Accepts Null Value:** Yes
DISCHARGE DATE

Definition
The date the patient was discharged or transferred from the hospital, or the date the patient died.

Field Values
- Relevant value for data element

Additional Information
- Collected as MM-DD-YYYY.
- 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 Hospital LOS.
- Allows data to be sorted based upon Hospital LOS.

Other Associated Elements
- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE TIME
- PRIOR PHASE
- TRANSFERRED / DISCHARGED TO
- FACILITY
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- DISCHARGE CAPACITY

Data Format: [date] single entry
Min Value: current date minus 7 years      Max Value: current date      Picklist: No
Accepts Null Value: Yes
DISCHARGE TIME

Definition
The time the patient was discharged or transferred from the hospital, or the time 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 Hospital LOS.
- Allows data to be sorted based upon Hospital LOS.

Other Associated Elements
- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- PRIOR PHASE
- TRANSFERRED / DISCHARGED TO
- FACILITY
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- DISCHARGE CAPACITY

Data Format: [time] single entry
Min Value: 0000
Max Value: 2359
Picklist: No
Accepts Null Value: Yes
PRIOR PHASE

Definition
Phase of care occurring directly prior to hospital discharge of the 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
- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- TRASFERRED / DISCHARGED TO
- FACILITY
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- DISCHARGE CAPACITY

Data Format: [character, 8] single entry
Picklist: No
Min Value: N/A
Max Value: N/A
Accepts Null Value: Yes
TRANSFERRED / DISCHARGED TO

NTDS O_05

Definition
The disposition of the patient when discharged from the hospital.

Field Values

<table>
<thead>
<tr>
<th>Field Values</th>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACUTE</td>
<td>Acute Care Facility</td>
<td>1 Transferred to another acute care hospital using EMS</td>
</tr>
<tr>
<td>AMA</td>
<td>AMA/Eloped/LWBS</td>
<td>4 Left against medical advice</td>
</tr>
<tr>
<td>BURN</td>
<td>Burn Center</td>
<td>1 Transferred to another acute care hospital using EMS</td>
</tr>
<tr>
<td>HOME WITH</td>
<td>Home W/Home Hlth Srvcs</td>
<td>3 Discharged home under care of Home Health Agency</td>
</tr>
<tr>
<td>HOME W/O</td>
<td>Home Without Services</td>
<td>6 Discharged home with no home services</td>
</tr>
<tr>
<td>HOSPICE</td>
<td>Hospice</td>
<td>8 Discharged to hospice care</td>
</tr>
<tr>
<td>JAIL</td>
<td>Jail</td>
<td>10 Discharged/Transferred to court/law enforcement</td>
</tr>
<tr>
<td>LTCH</td>
<td>Long Term Care Hospital</td>
<td>12 Discharged/Transferred to Long Term Care Hospital (LTCH)</td>
</tr>
<tr>
<td>MORGUE</td>
<td>Morgue</td>
<td>5 Deceased / Expired</td>
</tr>
<tr>
<td>PSYCH</td>
<td>Psychiatric Facility</td>
<td>13 Discharged/Transferred to a psych hospital/hospital psych unit</td>
</tr>
<tr>
<td>REHAB</td>
<td>Rehabilitation Center</td>
<td>11 Transferred to inpatient rehabilitation or designated unit</td>
</tr>
<tr>
<td>SCJ</td>
<td>Jail Ward at LAC+USC</td>
<td>10 Discharged/Transferred to court/law enforcement</td>
</tr>
<tr>
<td>SNF</td>
<td>Skilled Nursing Facility</td>
<td>7 Transferred to Skilled Nursing Facility</td>
</tr>
<tr>
<td>SUBACUTE</td>
<td>Subacute Care</td>
<td>2 Transferred to an Intermediate Care Facility</td>
</tr>
<tr>
<td>TRAUMA</td>
<td>Trauma Center</td>
<td>1 Transferred to another acute care hospital using EMS</td>
</tr>
<tr>
<td>OTHER</td>
<td>Other</td>
<td>14 Discharged/Transferred to another type of facility not defined</td>
</tr>
</tbody>
</table>

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.
- “Home” refers to the patient’s current place of residence, e.g., prison, Child Protective Services, etc.

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
- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PRIOR PHASE
- FACILITY
--transferred out via
- TRANSFER RATIONALE
- DISCHARGE CAPACITY

Data Format: [character, 9] single entry
Min Value: N/A                 Max Value: N/A                      Picklist: Yes, non-modifiable
Accepts Null Value: Yes
FACILITY

Definition
The three-letter code for the facility to which the patient was transferred, if applicable.

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
- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PRIOR PHASE
- TRANSFERRED / DISCHARGED TO
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- DISCHARGE CAPACITY

Data Format: [character, 3] single entry
Picklist: Yes, non-modifiable
Min Value: N/A                Max Value: N/A
Accepts Null Value: Yes
TRANSFERRED OUT VIA

Definition
Method used for transferring the patient, if applicable.

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
- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PRIOR PHASE
- TRANSFERRED / DISCHARGED TO
- FACILITY
- TRANSFER RATIONALE
- DISCHARGE CAPACITY

Data Format: [character, 3] single entry
Min Value: N/A          Max Value: N/A
Picklist: Yes, non-modifiable
Accepts Null Value: Yes
TRANSFER RATIONALE

Definition
The rationale for transfer of the patient, if applicable.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>CU</td>
</tr>
<tr>
<td>EX</td>
</tr>
<tr>
<td>FI</td>
</tr>
<tr>
<td>HP</td>
</tr>
<tr>
<td>OT</td>
</tr>
<tr>
<td>RH</td>
</tr>
<tr>
<td>SC</td>
</tr>
</tbody>
</table>

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
- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PRIOR PHASE
- TRANSFERRED / DISCHARGED TO
- FACILITY
- TRANSFERRED OUT VIA
- DISCHARGE CAPACITY

Data Format: [character, 2] single entry
Min Value: N/A Max Value: N/A Picklist: Yes, non-modifiable
Accepts Null Value: Yes
DISCHARGE CAPACITY

Definition
Patient’s gross functional capacity upon discharge from the hospital.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>PERMANENT HANDICAP</td>
</tr>
<tr>
<td>T</td>
<td>TEMPORARY HANDICAP</td>
</tr>
<tr>
<td>P</td>
<td>PRE-INJURY CAPACITY</td>
</tr>
</tbody>
</table>

Additional Information
- The null value of “Not Applicable” is used if the patient expired.
- A splenectomy is 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
- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PRIOR PHASE
- TRANSFERRED / DISCHARGED TO
- FACILITY
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE

Data Format: [character, 1] single entry
Min Value: N/A  Max Value: N/A  Accepts Null Value: Yes
PHYSICAL ABUSE REPORTED?  

Definition
Indicates whether or not a report of suspected physical abuse was made to law enforcement and/or protective services.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Yes</td>
</tr>
<tr>
<td>N</td>
<td>No</td>
</tr>
</tbody>
</table>

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 must be completed.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

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
Min Value: N/A  Max Value: N/A
Picklist: Yes, non-modifiable
Accepts Null Value: Yes
INVESTIGATION INITIATED?  

NTDS I_18

Definition
Indicates whether or not an investigation by law enforcement and/or protective services was initiated because of suspected physical abuse.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Yes 1 Yes</td>
</tr>
<tr>
<td>N</td>
<td>No 2 No</td>
</tr>
</tbody>
</table>

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 must be completed.
- If PHYSICAL ABUSE REPORTED? is “No”, then INVESTIGATION INITIATED will auto fill with “Not Applicable”.

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?

**Definition**
Indicates whether or not the patient was discharged to a caregiver different than the caregiver at admission due to suspected physical abuse.

**Field Values**

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y  Yes</td>
<td>1 Yes</td>
</tr>
<tr>
<td>N  No</td>
<td>2 No</td>
</tr>
</tbody>
</table>

**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 must be completed.
- If PHYSICAL ABUSE REPORTED? is “No”, then CAREGIVER CHANGE will auto fill with “Not Applicable”.
- All values of “Yes” are mapped to NTDS value of “Yes”. NTDB may choose to exclude any “Yes” values based upon the age of the patient.

**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
LIVED / DIED

Definition
Indicates whether or not the patient died of injuries during the 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
- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PRIOR PHASE
- TRANSFERRED / DISCHARGED TO
- FACILITY
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- AUTOPSY UPDATE?
- CORONER #
- ORGAN REFERRAL?
- ORGAN DONOR?
- ORGANS DONATED

Data Format: [character, 1] single entry
Picklist: Yes, non-modifiable
Min Value: N/A          Max Value: N/A          Accepts Null Value: Yes
AUTOPSY UPDATE?

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
- LIVED / DIED
- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PRIOR PHASE
- TRANSFERRED / DISCHARGED TO
- FACILITY
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- CORONER #
- ORGAN REFERRAL?
- ORGAN DONOR?
- ORGANS DONATED

Data Format: [character, 1] single entry
Picklist: Yes, non-modifiable
Min Value: N/A Max Value: N/A Accepts Null Value: Yes
CORONER #

**Definition**
Coroner’s ID number or code, if applicable.

**Field Values**
- Relevant value for data element

**Additional Information**
- Non-picklist – 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
- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PRIOR PHASE
- TRANSFERRED / DISCHARGED TO
- FACILITY
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- AUTOPSY UPDATE?
- ORGAN REFERRAL?
- ORGAN DONOR?
- ORGANS DONATED

**Data Format:** [character, 10] single entry
**Min Value:** N/A  **Max Value:** N/A  **Picklist:** No  **Accepts Null Value:** Yes
ORGAN REFERRAL?

Definition
Indicates whether or not the patient was referred for potential solid 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
- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PRIOR PHASE
- TRANSFERRED / DISCHARGED TO
- FACILITY
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- AUTOPSY UPDATE?
- CORONER #
- ORGAN DONOR?
- ORGANS DONATED

Data Format: [character, 1] single entry
Picklist: Yes, non-modifiable
Min Value: N/A
Max Value: N/A
Accepts Null Value: Yes
ORGAN DONOR?

ACS PRQ

Definition
Indicates whether or not the patient’s solid organs were donated.

Field Values (Organ Donor?)
- Y (Yes)
- N (No)

Additional Information
- Organ donation is in reference to solid organ donations only.
- Excludes non solid organ donations such as bone, bone marrow, eyes, skin, etc.

Data Source Hierarchy
1. Hospital Discharge Summary
2. Progress Notes

Uses
- Allows tracking of organ donation.

Other Associated Elements
- LIVED / DIED
- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PRIOR PHASE
- TRANSFERRED / DISCHARGED TO
- FACILITY
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- AUTOPSY UPDATE?
- CORONER #
- ORGAN REFERRAL?
- ORGANS DONATED

Data Format: [character, 1] single entry
Min Value: N/A
Max Value: N/A
Picklist: Yes, non-modifiable
Accepts Null Value: Yes
ORGANS DONATED

Definition
Indicates which specific solid organs were donated.

Field Values (Organs Donated)
- Heart
- Intestine
- Kidney (1)
- Kidneys (2)
- Liver
- Lung (1)
- Lungs (2)
- Pancreas

Additional Information
- Organ donation is in reference to solid organ donations only.
- Excludes non solid organ donations such as bone, bone marrow, eyes, skin, etc.

Data Source Hierarchy
1. Hospital Discharge Summary
2. Progress Notes

Uses
- Allows tracking of organ donation.

Other Associated Elements
- LIVED / DIED
- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PRIOR PHASE
- TRANSFERRED / DISCHARGED TO
- FACILITY
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- AUTOPSY UPDATE?
- CORONER #
- ORGAN REFERRAL?
- ORGAN DONOR?

Data Format: [character, 9] multiple entries
Picklist: Yes, non-modifiable
Min Value: N/A  Max Value: N/A  Accepts Null Value: Yes
DISCHARGE DIAGNOSES – ICD-10 CM CODES

NTDS DG_01

Definition
All identified discharge diagnoses related to the patient’s injury.

Field Values
- ICD-10-CM codes

Additional Information
- Injury diagnoses as defined by ICD-10 codes range S00-S99, T07, T14, T20-T28, 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 AIS and Injury Severity Score.
- Additional injuries identified at the transferring facilities should not be entered into the database of the sending facility. This allows for accurate reflection of the extent of the patient’s known injuries while being treated at the sending facility. If additional injuries are identified at the receiving facility they will be documented accordingly.
- Patients transferred from the Emergency Department are excluded from the TQIP® benchmark reports and thus this will have no effect on the sending facilities benchmarking.
- 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. ER, ICU, OR Records
3. Physician Notes / Nursing Notes
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
- DISCHARGE DIAGNOSES – ABBREVIATED INJURY SCALE
- NTDS CO-MORBID CONDITIONS
- NTDS HOSPITAL COMPLICATIONS

Data Format: [character, 6] multiple entries
Min Value: N/A
Max Value: N/A
Picklist: Yes, non-modifiable
Accepts Null Value: Yes
DISCHARGE DIAGNOSES – ABBREVIATED INJURY SCALE

Definition
The Abbreviated Injury Scale (AIS) is an anatomical-based coding system to classify and describe the severity of injuries. It represents the threat to life associated with the injury rather than the comprehensive assessment of the severity of the injury.

Field Values
- Relevant value for data element

Additional Information
- The scale describes three aspects of the injury, type, location, and severity using 7 numbers written as 12(34)(56).7

THE NUMBERS 12(34)(56).7 INDICATE THE FOLLOWING:

<table>
<thead>
<tr>
<th>1 – Body Region</th>
<th>EXAMPLE: 851814.3, FEMORAL SHAFT FRACTURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Head (Cranium &amp; Brain)</td>
<td></td>
</tr>
<tr>
<td>2. Face (including eyes &amp; ears)</td>
<td></td>
</tr>
<tr>
<td>3. Neck</td>
<td></td>
</tr>
<tr>
<td>4. Thorax</td>
<td></td>
</tr>
<tr>
<td>5. Abdomen</td>
<td></td>
</tr>
<tr>
<td>6. Spine</td>
<td></td>
</tr>
<tr>
<td>7. Upper Extremity</td>
<td></td>
</tr>
<tr>
<td>8. Lower Extremity</td>
<td></td>
</tr>
<tr>
<td>9. External &amp; Other</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2 – Type of Anatomic Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 = Type of Anatomic Structure: Skeletal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3,4 – Specific Anatomic Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 = Specific Anatomic Structure: Femur</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5,6 – Level of Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>14 = Level of Injury: Shaft</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>.7 – AIS: Severity Score (Ranging from 1 {least severe} to 6 {most severe})</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Minor</td>
</tr>
<tr>
<td>2. Moderate</td>
</tr>
<tr>
<td>3. Serious</td>
</tr>
<tr>
<td>4. Severe</td>
</tr>
<tr>
<td>5. Critical</td>
</tr>
<tr>
<td>6. Maximal (currently untreatable)</td>
</tr>
<tr>
<td>9. Unable to assign</td>
</tr>
</tbody>
</table>

- Used to calculate 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.
- Enter AIS: Severity Score of “9” if it is not possible to assign a severity to an injury.
- Field value cannot be “Not Applicable”.
- Field cannot be left blank.

Data Source Hierarchy
1. AIS Coding Manual (AIS 05, Update 08)
2. Hospital Discharge Summary
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 AIS codes.

Other Associated Elements
- DISCHARGE DIAGNOSES – ICD-10 CM CODES
- NTDS CO-MORBID CONDITIONS
- NTDS HOSPITAL COMPLICATIONS

Data Format: [character, 6] multiple entries
Min Value: N/A
Max Value: N/A
Accepts Null Value: Yes

Picklist: Yes, non-modifiable
CO-MORBID (PRE-EXISTING) CONDITIONS

Definition
Pre-existing co-morbid factors present before patient arrival at the ED / Hospital.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS (CC_XX)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Co-Morbid (Pre-existing) Conditions</td>
<td></td>
</tr>
<tr>
<td>Co-Morbid (Pre-existing) Conditions are Not Known</td>
<td></td>
</tr>
<tr>
<td>Alcoholism</td>
<td>02 Alcohol Use Disorder</td>
</tr>
<tr>
<td>Angina (Pectoris)</td>
<td>16 History of Angina within 30 days NTDS RETIRED IN 2017</td>
</tr>
<tr>
<td>Anticoagulant Therapy</td>
<td>04 Anticoagulant Therapy</td>
</tr>
<tr>
<td>Attention Deficit Disorder/Hyperactivity Disorder (ADD/ADHD)</td>
<td>05 Attention Deficit Disorder/Hyperactivity Disorder (ADD/ADHD)</td>
</tr>
<tr>
<td>Bleeding Disorder</td>
<td>06 Bleeding Disorder</td>
</tr>
<tr>
<td>Cerebral Vascular Accident (CVA) / Residual Neuro Deficit</td>
<td>07 Cerebral Vascular Accident (CVA)</td>
</tr>
<tr>
<td>Chemotherapy (currently receiving)</td>
<td>14 Currently receiving Chemotherapy for cancer</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>08 Chronic Obstructive Pulmonary Disease (COPD)</td>
</tr>
<tr>
<td>Cirrhosis</td>
<td>10 Cirrhosis</td>
</tr>
<tr>
<td>Congenital Anomalies</td>
<td>11 Congenital Anomalies</td>
</tr>
<tr>
<td>Congestive Heart Failure (CHF)</td>
<td>12 Congestive Heart Failure (CHF)</td>
</tr>
<tr>
<td>Current Smoker</td>
<td>13 Current Smoker</td>
</tr>
<tr>
<td>Dementia</td>
<td>15 Dementia</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>16 Diabetes Mellitus</td>
</tr>
<tr>
<td>Dialysis</td>
<td>09 Chronic Renal Failure</td>
</tr>
<tr>
<td>Disseminated Cancer</td>
<td>17 Disseminated Cancer</td>
</tr>
<tr>
<td>Drug (Substance) Abuse or Dependence</td>
<td>28 Drug Use Disorder NTDS RETIRED IN 2017</td>
</tr>
<tr>
<td>Functionally Dependent Health Status</td>
<td>18 Functionally Dependent Health Status</td>
</tr>
<tr>
<td>Hypertension</td>
<td>19 Hypertension</td>
</tr>
<tr>
<td>Mental/Personality Disorder</td>
<td>27 Major Psychiatric Illness NTDS RETIRED IN 2017</td>
</tr>
<tr>
<td>Myocardial Infarction</td>
<td>20 Mental/Personality Disorder</td>
</tr>
<tr>
<td>17 History of Myocardial Infarction NTDS RETIRED IN 2017</td>
<td>21 Myocardial Infarction (MI)</td>
</tr>
<tr>
<td>Peripheral Arterial Disease (PAD)</td>
<td>22 Peripheral Arterial Disease (PAD)</td>
</tr>
<tr>
<td>Prematurity</td>
<td>23 Prematurity</td>
</tr>
<tr>
<td>Seizure Disorder</td>
<td>N/A</td>
</tr>
<tr>
<td>Steroid Use</td>
<td>24 Steroid Use</td>
</tr>
<tr>
<td>Other:</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Additional Information
- Select the applicable field values from the Co-Morbid Conditions listed above for the patient.
- Select the field value “No Co-Morbid Conditions” if none of the co-morbid conditions listed above are present for the patient.
- Select the field value of “Co-Morbid Conditions are Not Known” if the Co-Morbid Conditions listed above are not known for the patient.
- Following data entry, select the “Confirm Co-Morbid Conditions” to populate the appropriate values of “Yes”, “No”, and “Not Known” for each of the Co-Morbid Conditions listed.
- Additional injuries identified at transferring facilities should not be entered into the database of the sending facility.
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
   • DISCHARGE DIAGNOSES – ICD-10 CM CODES
   • DISCHARGE DIAGNOSES - ABBREVIATED INJURY SCALE
   • NTDS HOSPITAL COMPLICATIONS

Data Format: [character, 22] multiple entries
Picklist: Yes, non-modifiable
Min Value: N/A
Max Value: N/A
Accepts Null Value: Yes
HOSPITAL (EVENTS) COMPLICATIONS

Definition
Any medical (events) complication that occurred during the patient’s stay at your hospital.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS (HE_XX)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Listed Hospital Complications Occurred</td>
<td>01 Acute Kidney Injury</td>
</tr>
<tr>
<td>Acute Kidney Injury (dialysis)</td>
<td>02 Acute Respiratory Distress Syndrome (ARDS)</td>
</tr>
<tr>
<td>Alcohol Withdrawal</td>
<td>13 Drug/Alcohol Withdrawal NTDS RETIRED IN 2017</td>
</tr>
<tr>
<td>Cardiac Arrest with CPR</td>
<td>03 Alcohol Withdrawal Syndrome</td>
</tr>
<tr>
<td>Central Line-Associated Bloodstream Infection (CLABSI)</td>
<td>04 Cardiac Arrest with CPR</td>
</tr>
<tr>
<td>Cerebral Vascular Accident (CVA) / Stroke</td>
<td>06 Central line-associated bloodstream infection (CLABSI)</td>
</tr>
<tr>
<td>Decubitus (Pressure) Ulcer</td>
<td>11 Stroke / CVA</td>
</tr>
<tr>
<td>Deep Vein Thrombosis (DVT) / Thrombophlebitis</td>
<td>14 Decubitus Ulcer NTDS RETIRED IN 2017</td>
</tr>
<tr>
<td>Extremity Compartment Syndrome</td>
<td>08 Deep Vein Thrombosis (DVT) /Thrombophlebitis</td>
</tr>
<tr>
<td>Myocardial Infarction</td>
<td>09 Extremity Compartment Syndrome</td>
</tr>
<tr>
<td>Osteomyelitis</td>
<td>10 Myocardial Infarction</td>
</tr>
<tr>
<td>Pneumonia Ventilator Associated (VAP)</td>
<td>11 Osteomyelitis</td>
</tr>
<tr>
<td>Pulmonary Embolism (PE)</td>
<td>21 Ventilator Associated Pneumonia</td>
</tr>
<tr>
<td>Sepsis and/or Severe Sepsis</td>
<td>12 Pulmonary Embolism</td>
</tr>
<tr>
<td>Surgical (Incisional) Site Infection (superficial)</td>
<td>24 Systemic Sepsis NTDS RETIRED IN 2011</td>
</tr>
<tr>
<td>Surgical Site Infection (deep)</td>
<td>15 Severe Sepsis</td>
</tr>
<tr>
<td>Surgical Site Infection (organ/space)</td>
<td>07 Deep Surgical Site Infection</td>
</tr>
<tr>
<td>Unplanned Intubation</td>
<td>11 Organ/space Surgical Site Infection</td>
</tr>
<tr>
<td>Unplanned Readmission</td>
<td>19 Unplanned Intubation</td>
</tr>
<tr>
<td>Unplanned Return to the ICU</td>
<td>N/A</td>
</tr>
<tr>
<td>Unplanned Return to the OR</td>
<td>18 Unplanned Admission to the ICU</td>
</tr>
<tr>
<td>Urinary Tract Infection Catheter Associated (CAUTI)</td>
<td>20 Unplanned Return to the OR</td>
</tr>
<tr>
<td>Other:</td>
<td>05 Catheter-associated Urinary Tract Infection</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>

Additional Information
- Select the applicable field values from the Hospital Complications listed above for the patient.
- Select the field value “No Listed Hospital Complications Occurred” if none of the hospital complications listed above are present for the patient.
- Following data entry, select the “Confirm Hospital Complications” to populate the appropriate values of “Yes” and “No” for each of the Hospital Complications listed.

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.

Other Associated Elements
- DISCHARGE DIAGNOSES – ICD-10 CM CODES
- DISCHARGE DIAGNOSES - ABBREVIATED INJURY SCALE
- NTDS CO-MORBID CONDITIONS

Data Format: [character, 22] multiple entries
Picklist: Yes, non-modifiable
Min Value: N/A
Max Value: N/A
Accepts Null Value: Yes
UNPLANNED READMISSION
READMIT DATE

Definition
The date the patient returned to the hospital for an unplanned readmission to an inpatient bed following discharge, elopement, AMA, etc., from a previous inpatient status related to the same event and within 30 days. ED visits are NOT considered inpatient status.

Collection Criterion
- ONLY COLLECT READMISSION INFORMATION ON PATIENTS WHO HAVE AN UNPLANNED RETURN WITHIN 30 DAYS OF ED/HOSPITAL DISCHARGE.

Field Values
- Relevant value for data element

Additional Information
- Readmission is based on the same event and must be a “DHS=Yes” patient.
- If the patient is admitted to an inpatient bed from the ED, enter the date the patient returned to the ED. If patient was directly admitted to the hospital, enter the date the patient was re-admitted to the hospital.
- Only applicable if patient returns within 30 days of ED/Hospital Discharge.
- Collected as MM-DD-YYYY.
- The following edit check has been applied to the Trauma One®:
  ✔ Readmission date must occur within 30 days of ED/Hospital Discharge.

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 TIME
- READMIT COMMENTS
- READMIT COMPLICATIONS
- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRANSFERRED / DISCHARGED TO
- READMIT RATIONALE
- READMIT FACILITY
- READMIT DISCHARGE CAPACITY

Data Format: [date] single entry
Min Value: current date minus 7 years  Max Value: current date  Picklist: No
Accepts Null Value: Yes
READMIT TIME

Definition
The time the patient was readmitted to the hospital for an unplanned readmission to an inpatient bed following discharge, elopement, AMA, etc., from a previous inpatient status. ED visits are NOT considered inpatient status.

Collection Criterion
- ONLY COLLECT READMISSION INFORMATION ON PATIENTS WHO HAVE AN UNPLANNED RETURN WITHIN 30 DAYS OF ED/HOSPITAL DISCHARGE.

Field Values
- Relevant value for data element

Additional Information
- Readmission is based on the same injury and must be a “DHS=Yes” patient.
- If the patient is admitted to an inpatient bed from the ED, enter the date the patient returned to the ED. If patient was directly admitted to the hospital, enter the date the patient was re-admitted to the hospital.
- Only applicable if patient returns within 30 days of ED/Hospital Discharge.

Data Source Hierarchy
1. Hospital Discharge Summary
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
- READMIT COMMENTS
- READMIT COMPLICATIONS
- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRANSFERRED / DISCHARGED TO
- READMIT RATIONALE
- READMIT FACILITY
- READMIT DISCHARGE CAPACITY

Data Format: [time] single entry
Picklist: No
Min Value: 0000
Max Value: 2359
Accepts Null Value: Yes
READMIT COMMENTS

Definition
Comments related to the unplanned readmission of the patient.

Collection Criterion
- ONLY COLLECT READMISSION INFORMATION ON PATIENTS WHO HAVE AN UNPLANNED RETURN WITHIN 30 DAYS OF ED/HOSPITAL DISCHARGE.

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
- Allows information to be collected on patient’s that are readmitted.

Other Associated Elements
- READMIT DATE
- READMIT TIME
- READMIT COMPLICATIONS
- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRANSFERRED / DISCHARGED TO
- READMIT RATIONALE
- READMIT FACILITY
- READMIT DISCHARGE CAPACITY

Data Format: [character, 6] single entry
Min Value: N/A Max Value: Unlimited
Picklist: Yes, non-modifiable
Accepts Null Value: Yes
READMIT HOSPITAL (EVENTS) COMPLICATIONS

Definition
Any medical complication that occurred during the patient’s unplanned readmission.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS (HE_XX)</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Alcohol Withdraw</td>
<td>13 Drug/Alcohol Withdrawal NTDS RETIRED IN 2017</td>
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<td>Cerebral Vascular Accident (CVA) / Stroke</td>
<td>06 Central line-associated bloodstream infection (CLABSI)</td>
</tr>
<tr>
<td>Decubitus (Pressure) Ulcer</td>
<td>11 Decubitus Ulcer NTDS RETIRED IN 2017</td>
</tr>
<tr>
<td>Deep Vein Thrombosis (DVT) / Thrombophlebitis</td>
<td>14 Pressure Ulcer</td>
</tr>
<tr>
<td>Extremity Compartment Syndrome</td>
<td>08 Deep Vein Thrombosis (DVT )/Thrombophlebitis</td>
</tr>
<tr>
<td>Myocardial Infarction</td>
<td>09 Extremity Compartment Syndrome</td>
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<td>Sepsis and/or Severe Sepsis</td>
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<td>Surgical (Incisional) Site Infection (superficial)</td>
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</tr>
<tr>
<td>Surgical Site Infection (deep)</td>
<td>15 Severe Sepsis</td>
</tr>
<tr>
<td>Surgical Site Infection (organ/space)</td>
<td>23 Superficial Surgical Site Infection NTDS RETIRED IN 2017</td>
</tr>
<tr>
<td>Unplanned Intubation</td>
<td>17 Superficial Incisional Surgical Site Infection</td>
</tr>
<tr>
<td>Unplanned Readmission</td>
<td>19 Unplanned Intubation</td>
</tr>
<tr>
<td>Unplanned Return to the ICU</td>
<td>N/A Unplanned Readmission</td>
</tr>
<tr>
<td>Unplanned Return to the OR</td>
<td>18 Unplanned Admission to the ICU</td>
</tr>
<tr>
<td>Urinary Tract Infection Catheter Associated (CAUTI)</td>
<td>20 Unplanned Return to the OR</td>
</tr>
<tr>
<td></td>
<td>05 Catheter-associated Urinary Tract Infection</td>
</tr>
</tbody>
</table>

Data Source Hierarchy
1. Progress/Consultation Notes
2. Hospital Nursing Notes

Uses
- Allows information to be collected on patient’s that are readmitted.

Other Associated Elements
- READMIT DATE
- READMIT TIME
- READMIT COMMENTS
- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRANSFERRED / DISCHARGED TO
- READMIT RATIONALE
- READMIT FACILITY
- READMIT DISCHARGE CAPACITY

Data Format: [character, 22] multiple entries
Min Value: N/A
Max Value: N/A
Picklist: Yes, non-modifiable
Accepts Null Value: Yes
READMIT DISCHARGE DATE

Definition
The date the patient was discharged or transferred from the hospital following the unplanned readmission, or the date the patient died following readmission.

Field Values
- Relevant value for data element

Additional Information
- Collected as MM-DD-YYYY.

Data Source Hierarchy
1. Hospital Discharge Summary
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
- READMIT TIME
- READMIT COMMENTS
- READMIT COMPLICATIONS
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRANSFERRED / DISCHARGED TO
- READMIT RATIONALE
- READMIT FACILITY
- READMIT DISCHARGE CAPACITY

Data Format: [date] single entry
Min Value: current date minus 7 years  Max Value: current date  Picklist: No
Accepts Null Value: Yes
READMIT DISCHARGE TIME

Definition
The time the patient was discharged or transferred from the hospital following the unplanned readmission, or the date the patient died 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
- Allows information to be collected on patient’s that are readmitted.

Other Associated Elements
- READMIT DATE
- READMIT COMMENTS
- READMIT COMPLICATIONS
- READMIT DISCHARGE DATE
- READMIT PRIOR PHASE
- READMIT TRASFERRED / DISCHARGED TO
- READMIT RATIONALE
- READMIT FACILITY
- READMIT DISCHARGE CAPACITY

Data Format: [time] single entry
Picklist: No
Min Value: 0000
Max Value: 2359
Accepts Null Value: Yes
READMIT PRIOR PHASE

Definition
Phase of care prior to discharge of the patient following the unplanned 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 information to be collected on patient’s that are readmitted.

Other Associated Elements

Data Format:  \[\text{[character, 8]}\] single entry  \[\text{Picklist: No}\]
Min Value:  \[\text{N/A}\]  \[\text{Max Value: N/A}\]  \[\text{Accepts Null Value: Yes}\]
# READMIT TRANSFERRED / DISCHARGED TO

## Definition
The disposition of the patient following the unplanned readmission.

## Field Values

<table>
<thead>
<tr>
<th>Field</th>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACUTE Acute Care Facility</td>
<td>1</td>
<td>Transferred to another acute care hospital using EMS</td>
</tr>
<tr>
<td>AMA AMA/Eloped/LWBS</td>
<td>4</td>
<td>Left against medical advice</td>
</tr>
<tr>
<td>BURN Burn Center</td>
<td>1</td>
<td>Transferred to another acute care hospital using EMS</td>
</tr>
<tr>
<td>HOME WITH Home W/Home Hlth Srvcs</td>
<td>3</td>
<td>Discharged home under care of Home Health Agency</td>
</tr>
<tr>
<td>HOME W/O Home Without Services</td>
<td>6</td>
<td>Discharged home with no home services</td>
</tr>
<tr>
<td>HOSPICE Hospice</td>
<td>8</td>
<td>Discharged to hospice care</td>
</tr>
<tr>
<td>JAIL Jail</td>
<td>10</td>
<td>Discharged/Transferred to court/law enforcement</td>
</tr>
<tr>
<td>MORGUE Morgue</td>
<td>5</td>
<td>Deceased/Expired</td>
</tr>
<tr>
<td>REHAB Rehabilitation Center</td>
<td>11</td>
<td>Transferred to inpatient rehabilitation or designated unit</td>
</tr>
<tr>
<td>SCJ Jail Ward at LAC+USC</td>
<td>10</td>
<td>Discharged/Transferred to court/law enforcement</td>
</tr>
<tr>
<td>SNF Skilled Nursing Facility</td>
<td>7</td>
<td>Transferred to Skilled Nursing Facility</td>
</tr>
<tr>
<td>SUBACUTE Subacute Care</td>
<td>2</td>
<td>Transferred to an Intermediate Care Facility</td>
</tr>
<tr>
<td>TRAUMA Trauma Center</td>
<td>1</td>
<td>Transferred to another acute care hospital using EMS</td>
</tr>
<tr>
<td>LTCH Long Term Care Hospital</td>
<td>12</td>
<td>Discharged/Transferred to Long Term Care Hospital (LTCH)</td>
</tr>
<tr>
<td>PSYCH Psychiatric Facility</td>
<td>13</td>
<td>Discharged/Transferred to a psych hospital or a hospital psych unit</td>
</tr>
<tr>
<td>OTHER Other</td>
<td>14</td>
<td>Discharged/Transferred to another type of institution not defined</td>
</tr>
</tbody>
</table>

## 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
- Allows information to be collected on patient’s that are readmitted.

## Other Associated Elements
- READMIT DATE
- READMIT TIME
- READMIT COMMENTS
- READMIT COMPLICATIONS
- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT RATIONALE
- READMIT FACILITY
- READMIT DISCHARGE 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

Definition
The rationale for transfer following the unplanned readmission, if applicable.

Field Values

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CU</td>
<td>In Custody</td>
<td>Patient discharged/transferred in custody of law enforcement</td>
</tr>
<tr>
<td>EX</td>
<td>Extended Care</td>
<td>Patient discharged from acute care setting of hospital, but required sub-acute care in the setting of a convalescent home, board-and-care, etc.</td>
</tr>
<tr>
<td>FI</td>
<td>Financial</td>
<td>Decision based on financial status (i.e., cash or self-pay, uninsured)</td>
</tr>
<tr>
<td>HP</td>
<td>Health Plan</td>
<td>Health Plan decision</td>
</tr>
<tr>
<td>OT</td>
<td>Other</td>
<td>Transfer rationale other than above</td>
</tr>
<tr>
<td>RH</td>
<td>Rehab</td>
<td>Patient required rehabilitation</td>
</tr>
<tr>
<td>SC</td>
<td>Specialized/Higher Level Care</td>
<td>Patient required acute specialized care or higher level of care not available at the transferring facility, e.g., pediatrics, burns, complex pelvic fracture, reimplantation</td>
</tr>
</tbody>
</table>

Data Source Hierarchy
1. Hospital Discharge Summary
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
- READMIT TIME
- READMIT COMMENTS
- READMIT COMPLICATIONS
- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRANSFERRED / DISCHARGED TO
- READMIT FACILITY
- READMIT DISCHARGE CAPACITY

Data Format: [character, 2] single entry
Picklist: Yes, non-modifiable
Min Value: N/A
Max Value: N/A
Accepts Null Value: Yes
READMIT FACILITY

Definition
The three-letter code for the facility to which the patient was transferred following the unplanned readmission, if applicable.

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
- Allows information to be collected on patient’s that are readmitted.

Other Associated Elements
- READMIT DATE
- READMIT TIME
- READMIT COMMENTS
- READMIT COMPLICATIONS
- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRANSFERRED / DISCHARGED TO
- READMIT RATIONALE
- READMIT DISCHARGE CAPACITY

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

Definition
Patient’s gross functional capacity upon discharge following the unplanned readmission.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>H PERMANENT HANDICAP</td>
</tr>
<tr>
<td>T TEMPORARY HANDICAP</td>
</tr>
<tr>
<td>P PRE-INJURY CAPACITY</td>
</tr>
</tbody>
</table>

- Limitations from the injury expected to last more than one year
- Required ADMISSION to the hospital for injuries sustained
- Discharged FROM THE ED with minimal or no injury

Additional Information
- The null value of “Not Applicable” is used if the 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 information to be collected on patient’s that are readmitted.

Other Associated Elements
- READMIT DATE
- READMIT TIME
- READMIT COMMENTS
- READMIT COMPLICATIONS
- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRASFERRED / DISCHARGED TO
- READMIT RATIONALE
- READMIT FACILITY

Data Format: [character, 1] single entry
Min Value: N/A Max Value: N/A
Picklist: Yes, non-modifiable
Accepts Null Value: Yes
FINANCES
### FINANCES (Payor)

**Definition**
Indicate the primary source of payment for patient’s hospital care.

**Field Values**

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Private:</strong></td>
<td></td>
</tr>
<tr>
<td>HMO</td>
<td>4 Private/Commercial Insurance</td>
</tr>
<tr>
<td>Medi-Cal HMO</td>
<td>4 Private/Commercial Insurance</td>
</tr>
<tr>
<td>Auto Insurance</td>
<td>4 Private/Commercial Insurance</td>
</tr>
<tr>
<td>Worker’s Comp.</td>
<td>4 Private/Commercial Insurance</td>
</tr>
<tr>
<td>Organ Donor Subsidy</td>
<td>7 Other Government</td>
</tr>
<tr>
<td>Other Private</td>
<td>4 Private/Commercial Insurance</td>
</tr>
<tr>
<td><strong>Medicaid:</strong></td>
<td></td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>1 Medicaid</td>
</tr>
<tr>
<td>Medi-Cal pending</td>
<td>1 Medicaid</td>
</tr>
<tr>
<td>Medicare Part A &amp; B (including Medicare HMO)</td>
<td>6 Medicare</td>
</tr>
<tr>
<td>Medicare Part A only</td>
<td>6 Medicare</td>
</tr>
<tr>
<td>Medicare Part B only</td>
<td>6 Medicare</td>
</tr>
<tr>
<td><strong>Self:</strong></td>
<td></td>
</tr>
<tr>
<td>Cash</td>
<td>3 Self Pay</td>
</tr>
<tr>
<td>ATP w/liability</td>
<td>3 Self Pay</td>
</tr>
<tr>
<td>Pre-pay</td>
<td>3 Self Pay</td>
</tr>
<tr>
<td><strong>Not billed:</strong></td>
<td></td>
</tr>
<tr>
<td>Charity</td>
<td>2 Not Billed (for any reason)</td>
</tr>
<tr>
<td>ATP w/o liability</td>
<td>2 Not Billed (for any reason)</td>
</tr>
<tr>
<td><strong>Government:</strong></td>
<td></td>
</tr>
<tr>
<td>CCS (California Children’s Services)</td>
<td>7 Other Government</td>
</tr>
<tr>
<td>County Indigent</td>
<td>7 Other Government</td>
</tr>
<tr>
<td>Custody Funds</td>
<td>7 Other Government</td>
</tr>
<tr>
<td>Military insurance</td>
<td>7 Other Government</td>
</tr>
<tr>
<td>VOC (Victims of Crime)</td>
<td>7 Other Government</td>
</tr>
<tr>
<td>Other Government</td>
<td>7 Other Government</td>
</tr>
<tr>
<td>Other</td>
<td>10 Other</td>
</tr>
</tbody>
</table>

**Additional Information**
- Field value cannot be “Not Applicable”.

**Data Source Hierarchy**
1. Facesheet
2. Billing Sheet / Medical Records Coding Summary Sheet

**Uses**
- Allows data to be sorted based upon payor mix.

**Other Associated Elements**
- TOTAL CHARGES

**Data Format:** [character, 15] single entry

**Min Value:** N/A  
**Max Value:** N/A  
**Picklist:** Yes, non-modifiable  
**Accepts Null Value:** Yes
TOTAL CHARGES

Definition
Indicate the total of all charges for patient’s hospital care.

Field Values
- Relevant value for data element

Additional Information
- Field value cannot be “Not Applicable”.

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 (PAYOR)

Data Format: [number, 12] single entry  
Min Value: 0  
Max Value: 999999999.99  
Picklist: No  
Accepts Null Value: Yes
RECORD COMPLETE?

Definition
Indicate whether or not the patient’s record is complete.

Field Values
- Y (Yes)
- N (No)

Additional Information
- RECORD COMPLETE? does not appear as a field value on the Trauma Patient Summary form.
- Field value defaults to “No”.
- “No” indicates that the patient’s record is not complete.
- Upon completion of the record, the ‘No’ value needs to be changed to “Yes”.
- “Yes” indicates that the patient’s record is complete.
- Null Values are not accepted for this data field.
- Only records that indicate ‘yes’, RECORD COMPLETE, are exported to NTDB® and TQIP®.
- The following edit checks has been applied to the Trauma One®:
  - Record cannot be marked complete if DHS PATIENT?, SEQUENCE NUMBER, or TPS RATIONALE data fields are incomplete or invalid.

Data Source Hierarchy
1. All applicable patient care records

Uses
- Identifies if the record is complete for export to NTDB® and TQIP®.

Data Format: [character, 1] single entry
Picklist: Yes, non-modifiable
Min Value: N/A
Max Value: N/A
Accepts Null Value: No
APPENDIX 1: Reference Guides
### Reference Guide: ICD-10 PCS – Section 1 – Medical/Surgical (0)

<table>
<thead>
<tr>
<th><strong>GROUP 1:</strong></th>
<th><strong>0 MEDICAL / SURGICAL</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GROUP 2:</strong></td>
<td><strong>OB</strong></td>
</tr>
<tr>
<td><strong>GROUP 3:</strong></td>
<td><strong>B Imaging</strong></td>
</tr>
<tr>
<td></td>
<td><strong>C Nuclear Med</strong></td>
</tr>
<tr>
<td></td>
<td><strong>D Radiation Oncology</strong></td>
</tr>
<tr>
<td></td>
<td><strong>F Rehabilitation / Audiology</strong></td>
</tr>
<tr>
<td></td>
<td><strong>G Mental Health</strong></td>
</tr>
<tr>
<td></td>
<td><strong>H Sub Abuse</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Treatment</strong></td>
</tr>
</tbody>
</table>

### Appendix 1 – Reference Guides PAGE 258 OF 301

#### Reference No. 646

**SUBJECT:** TRAUMA CENTER DATA DICTIONARY

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## REFERENCE GUIDE: ICD-10 PCS – Section 1 – Imaging (B)

<table>
<thead>
<tr>
<th>SECTION 1: GROUP 2: OB</th>
<th>GROUP 3: IMAGING</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Medical/Surgical</td>
<td>B Radiology</td>
</tr>
<tr>
<td>1 OB</td>
<td>C Nuclear Med</td>
</tr>
<tr>
<td>2 Placement</td>
<td>D Radiation</td>
</tr>
<tr>
<td>3 Administration</td>
<td>E Oncology</td>
</tr>
<tr>
<td>4 Measurement</td>
<td>F Audiology</td>
</tr>
<tr>
<td>5 &amp; Monitoring</td>
<td>G Mental Health</td>
</tr>
<tr>
<td>6 &amp; Monitoring</td>
<td>H Sub Abuse</td>
</tr>
<tr>
<td>7 Other</td>
<td>I Female Reproductive</td>
</tr>
<tr>
<td>8 Other</td>
<td>J Male Reproductive</td>
</tr>
<tr>
<td>9 Chiropractic</td>
<td>K Allied Health</td>
</tr>
<tr>
<td></td>
<td>L Occupational Health</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BODY SYSTEM</th>
<th>TYPE</th>
<th>MEANINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Central Nervous System</td>
<td>0 Plain Radiology</td>
<td>TOO NUMEROUS TO LIST</td>
</tr>
<tr>
<td>1 Heart</td>
<td>1 Fluoroscopy</td>
<td></td>
</tr>
<tr>
<td>2 Lymphatic System</td>
<td>2 Computerized Tomography (CT) Scan</td>
<td></td>
</tr>
<tr>
<td>3 Lower Airways</td>
<td>3 Magnetic Resonance Imaging (MRI)</td>
<td></td>
</tr>
<tr>
<td>4 Upper Airways</td>
<td>4 Ultrasoundography</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>QUALIFIER</th>
<th>CONTRAST</th>
<th>MEANINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Unenhanced &amp; Enhanced Osmolar</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Laser</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Intravascular Osmolar</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Intravascular Coherence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Trans-esophageal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 None</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>QUALIFIER</th>
<th>CONTRAST</th>
<th>MEANINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 None</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

QUALIFIER values used in Section 1 – Imaging (B).
REFERENCE GUIDE: Abbreviated Injury Scale (AIS)

The Abbreviated Injury Scale (AIS) is an anatomical-based coding system to classify and describe the severity of injuries. It represents the threat to life associated with the injury rather than the comprehensive assessment of the severity of the injury.

Each injury description has been assigned a 6-digit unique numerical identifier to the left of the decimal (known as the pre-dot code). The single digit to the right of the decimal (known as the post-dot code) is the AIS severity code.

The scale describes three aspects of the injury: Type, Location, & Severity using 7 numbers written as 12(34)(56).7. The first digit of AIS identifies the Body Region; the second digit identifies the Type of Anatomical Structure; the third and fourth digits identify the Specific Anatomical Structure, or in the case of injuries to the external region, the Specific Nature of the Injury; and the fifth and sixth digits identify the Level of the Injury within a specific body region and anatomic structure. The seventh digit to the right of the decimal (post-dot code) is the AIS Severity Score.

<table>
<thead>
<tr>
<th>BODY REGION FIRST DIGIT</th>
<th>TYPE OF ANATOMICAL STRUCTURE SECOND DIGIT</th>
<th>SPECIFIC NATURE OF INJURY THIRD &amp; FOURTH DIGITS</th>
<th>LEVEL FIFTH &amp; SIXTH DIGITS</th>
<th>SEVERITY SCORE SEVENTH DIGIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Head</td>
<td>1 - Whole Area</td>
<td>Whole Area</td>
<td>Injuries are assigned consecutive two-digit numbers beginning with 02.</td>
<td>1 - Minor</td>
</tr>
<tr>
<td>2 - Face</td>
<td>2 - Vessels</td>
<td>02 - Skin – Abrasion</td>
<td>An injury Not Further Specified (NFS) is assigned 00.</td>
<td>2 - Moderate</td>
</tr>
<tr>
<td>3 - Neck</td>
<td>3 - Nerves</td>
<td>04 - Skin – Contusion</td>
<td>An injury NFS as to lesion or severity is assigned 99.</td>
<td>3 - Serious</td>
</tr>
<tr>
<td>4 - Thorax</td>
<td>4 - Organs</td>
<td>06 - Skin – Laceration</td>
<td></td>
<td>4 - Severe</td>
</tr>
<tr>
<td>5 - Abdomen</td>
<td>5 - Skeletal</td>
<td>08 - Skin – Avulsion</td>
<td></td>
<td>5 - Critical</td>
</tr>
<tr>
<td>6 - Spine</td>
<td>6 - Head</td>
<td>09 - Trauma</td>
<td></td>
<td>6 - Maximal</td>
</tr>
<tr>
<td>7 - Upper Extremity</td>
<td>7 - Joints</td>
<td>10 - Amputation</td>
<td></td>
<td>9 - Unknown</td>
</tr>
<tr>
<td>8 - Lower Extremity</td>
<td>Organ includes Muscles &amp; Ligaments.</td>
<td>Head</td>
<td>A Severity Score of 6 (Maximal) is considered untreatable and should only be used for injuries specifically assigned a severity level of 6, and not to be an arbitrary choice simply because the patient died.</td>
<td></td>
</tr>
<tr>
<td>9 - External</td>
<td></td>
<td>10 - Cervical</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>04 - Thoracic</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>06 - Lumbar</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>02 - Cervical</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>04 - Thoracic</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>06 - Lumbar</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>02 - Cervical</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>04 - Thoracic</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>06 - Lumbar</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>02 - Cervical</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>04 - Thoracic</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>06 - Lumbar</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Example: **851814.3** (Femoral Shaft Fracture).
- **8** = Body Region: **Lower Extremity**
- **5** = Type of Anatomic Structure: **Skeletal**
- **18** = Specific Anatomic Structure: **Femur**
- **14** = Level of Injury: **Shaft**
- **.3** = AIS: Severity Score: **Serious**

AIS is used to calculate the **Injury Severity Score (ISS)**.
REFERENCE GUIDE: Injury Severity Score (ISS)

The Injury Severity Score (ISS) is the sum of the squares of the highest AIS scores in the three most severely injured ISS Body Regions.

ISS Body Regions do NOT match the AIS Body Regions. There are 9 Body Regions in AIS, and only 6 Body Regions in ISS.

### COMPARISON OF ISS AND AIS BODY REGIONS

<table>
<thead>
<tr>
<th>ISS</th>
<th>AIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head / Neck</td>
<td>Head</td>
</tr>
<tr>
<td>Face</td>
<td>Neck</td>
</tr>
<tr>
<td>Chest</td>
<td>Face</td>
</tr>
<tr>
<td>Abdomen / Pelvis</td>
<td>Thorax</td>
</tr>
<tr>
<td>Head / Neck; or Abdomen / Pelvis</td>
<td>Abdomen</td>
</tr>
<tr>
<td>Extremities / Pelvic Girdle</td>
<td>Spine</td>
</tr>
<tr>
<td>External</td>
<td>Upper extremity</td>
</tr>
<tr>
<td>External</td>
<td>Lower extremity</td>
</tr>
<tr>
<td>External</td>
<td>External</td>
</tr>
</tbody>
</table>

ISS Scores range from 1 to 75.

Example:

<table>
<thead>
<tr>
<th>ISS Body Region</th>
<th>Injury</th>
<th>AIS Code</th>
<th>Highest Severity</th>
<th>AIS Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head/Neck</td>
<td>Cerebral contusion</td>
<td>140602.3</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Complete transection of internal carotid</td>
<td>320212.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Face</td>
<td>Ear laceration</td>
<td>210600.1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Chest</td>
<td>Rib fractures, ribs 3-4</td>
<td>450420.2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td>Retroperitoneal hematoma</td>
<td>543800.3</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Extremities</td>
<td>Femur fracture</td>
<td>851800.3</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>External</td>
<td>Overall abrasions</td>
<td>910200.1</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

**ISS = 34**
# REFERENCE GUIDE: ICD-10 Root Operations

<table>
<thead>
<tr>
<th>3</th>
<th>ROOT OPERATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TAKES OUT SOME OR ALL OF A BODY PART</strong></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Destruction</td>
</tr>
<tr>
<td>6</td>
<td>Detachment</td>
</tr>
<tr>
<td><strong>B</strong></td>
<td>Excision</td>
</tr>
<tr>
<td><strong>D</strong></td>
<td>Extraction</td>
</tr>
<tr>
<td><strong>T</strong></td>
<td>Resection</td>
</tr>
<tr>
<td><strong>TAKES OUT SOLIDS / FLUIDS / GASES</strong></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Drainage</td>
</tr>
<tr>
<td><strong>C</strong></td>
<td>Extirpation</td>
</tr>
<tr>
<td><strong>F</strong></td>
<td>Fragmentation</td>
</tr>
<tr>
<td><strong>INvolves cutting or Separation ONLY</strong></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Division</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td>Release</td>
</tr>
<tr>
<td><strong>PUTS IN / BACK OR MOVES A BODY PART</strong></td>
<td></td>
</tr>
<tr>
<td><strong>M</strong></td>
<td>Reattachment</td>
</tr>
</tbody>
</table>
| **S** | Reposition | Moving to its normal location or other suitable location all or a portion of a body part. The body part is moved to a new location from an abnormal location, or
from a normal location where it is not functioning correctly. The body part may or may not be cut out or off to be moved to the new location. **Examples:** Reposition of undescended testicle, fracture reduction

| X | Transfer | Moving, without taking out, all or a portion of a body part to another location to take over the function of all or a portion of a body part. The body part transferred remains connected to its vascular and nervous supply. **Examples:** Tendon transfer, pedicle flap transfer |
| Y | Transplantation | Putting in or on all or a portion of a living body part taken from another individual or animal to physically take the place and/or function of all or a portion of a similar body part. The native body part may or may not be taken out, and the transplanted body part may take over all or a portion of its function. **Examples:** Kidney and heart transplants |

### ALTERS THE DIAMETER / ROUTE (TUBULAR)

| 1 | Bypass | Altering the route of passage of the contents of a tubular body part. **Examples:** Coronary artery bypass, colostomy formation |
| 7 | Dilation | Expanding an orifice or the lumen of a tubular body part. Accomplished by stretching a tubular body part using intraluminal pressure or by cutting part of the orifice or wall of the tubular body part. **Examples:** Percutaneous transluminal angioplasty, pyloromyotomy |
| L | Occlusion | Completely closing an orifice or lumen (“ligation”) of a tubular body part. “Embolization” can be either occlusive or restrictive. **Examples:** Fallopian tube ligation, ligation of IVC |
| V | Restriction | Partially closing an orifice or the lumen (“clipping”) of a tubular body part. “Embolization” can be either occlusive or restrictive. **Examples:** Esophagogastric fundoplication, cervical cerclage |

### ALWAYS INVOLVES A DEVICE

| 2 | Change | Taking out of off a device from a body part and putting back an identical or similar device in or on the same body part without cutting or puncturing the skin or a mucous membrane. **Examples:** Urinary catheter change, gastrostomy tube change |
| H | Insertion | Putting in a nonbiological appliance that monitors, assists, performs, or prevents a physiological function but does not physically take the place of a body part. **Examples:** Insertion of radioactive implant, insertion of central venous catheter |
| P | Removal | Taking out or off a device from a body part. **Examples:** Drainage tube removal, cardiac pacemaker removal |
| R | Replacement | Putting in or on a biological or synthetic material that physically takes the place and/or function of all or a portion of a body part. The body part may have been taken out or replaced, or may be taken out, physically eradicated, or rendered nonfunctional during the REPLACEMENT procedure. A REMOVAL procedure is coded for taking out the device used in a previous replacement procedure. **Examples:** Total hip replacement, free skin graft |
| U | Supplement | Putting in or on biological or synthetic material that physically reinforces and/or augments the function of a portion of a body part. The body part may have been previously replaced, and the SUPPLEMENTATION procedure is performed to physically reinforce and/or augment the function of the replaced body part. **Examples:** Free nerve graft, mitral valve ring annuloplasty, |
| W | Revision | Correcting, to the extent possible, a portion of a malfunctioning device or the position of a displaced device. Revision can include correcting a malfunctioning or displaced device by taking out or putting in components of the device such as a screw or pin. **Examples:** Adjustment of position of pacemaker lead, recementing of hip prosthesis |
**INVOLVES EXAMINATION ONLY**

| J  | Inspection | Visually and/or manually exploring a body part. Visual exploration may be performed with or without optical instrumentation. Manual exploration may be performed directly or through intervening body layers. **Examples:** Diagnostic arthroscopy, exploratory laparotomy |
| K  | Map | Locating the route of passage of electrical impulses and/or location functional areas of a body part. Applicable only to cardiac conduction mechanism and the central nervous system. **Examples:** Cardiac mapping, cortical mapping |

**DEFINES OTHER REPAIRS**

| 3  | Control | Stopping or attempting to stop, post procedural bleeding. The site of the bleeding is coded as an anatomical region and not to a specific body site. **Examples:** Control of post-prostatectomy or post-tonsillectomy hemorrhage |
| Q  | Repair | Restoring, to the extent possible, a body part to its normal anatomic structure and function. Used only when the method to accomplish the repair is not one of the other root operations. **Examples:** Colostomy takedown, suture of laceration |

**DEFINES OTHER OBJECTIVES**

| 0  | Alteration | Modifying the natural anatomic structure of a body part without affecting the function of the body part. Purpose to improve appearance. **Examples:** Face lift, breast augmentation |
| 4  | Creation | Making a new genital structure that does not take over the function of a body part. Used only for sex change operations |
| G  | Fusion | Joining together portions of an articular body part, rendering the articular body part immobile. The body part is joined together by fixation device, bone graft, or other means. **Examples:** Spinal fusion, ankle arthrodesis |
### REFERENCE GUIDE: Mechanism of Injuries

<table>
<thead>
<tr>
<th>Incident Type</th>
<th>Code</th>
<th>Code Description (Initial Encounter)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACCIDENTAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall - struck object</td>
<td>W00.198A</td>
<td>Fall on same level with subsequent striking against other object</td>
</tr>
<tr>
<td>Fall - down stairs</td>
<td>W10.8XXA</td>
<td>Fall (on) (from) other stairs and steps</td>
</tr>
<tr>
<td>Fall - from bed</td>
<td>W06.XXXA</td>
<td>Fall from bed, initial encounter</td>
</tr>
<tr>
<td>Fall - from/off toilet</td>
<td>W18.12XA</td>
<td>Fall from or off toilet with subsequent striking against object</td>
</tr>
<tr>
<td>Fall - from cliff</td>
<td>W15.XXXA</td>
<td>Fall from cliff</td>
</tr>
<tr>
<td>Fall - from building</td>
<td>W13.8XXA</td>
<td>Fall from, out of or through building or structure</td>
</tr>
<tr>
<td>Fall - off chair</td>
<td>W07.XXXA</td>
<td>Fall from chair</td>
</tr>
<tr>
<td>Fall - off ladder</td>
<td>W11.XXXA</td>
<td>Fall on and from ladder</td>
</tr>
<tr>
<td>Fall - off roof</td>
<td>W13.2XXA</td>
<td>Fall from, out of or through roof</td>
</tr>
<tr>
<td>Fall - off sidewalk</td>
<td>W10.1XXA</td>
<td>Fall (on)(from) sidewalk curb</td>
</tr>
<tr>
<td>Fall - on ice/snow</td>
<td>W00.0XXA</td>
<td>Fall on same level due to ice and snow</td>
</tr>
<tr>
<td>Fall - onto glass</td>
<td>W01.110A</td>
<td>Fall on same level with subsequent striking against sharp glass</td>
</tr>
<tr>
<td>Fall - out of window</td>
<td>W13.4XXA</td>
<td>Fall from, out of or through window</td>
</tr>
<tr>
<td>Fall - same level</td>
<td>W01.0XXA</td>
<td>Fall on same level without subsequent striking against object</td>
</tr>
<tr>
<td>Fall – unspecified fall</td>
<td>W19.XXXA</td>
<td>Fall unspecified</td>
</tr>
<tr>
<td><strong>Motorcycle/Motor Vehicle Collision</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCC - driver vs car</td>
<td>V23.4XXA</td>
<td>Motorcycle driver injured in collision with car, pickup truck or van in traffic accident</td>
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<tr>
<td>MCC - passenger vs car</td>
<td>V23.5XXA</td>
<td>Motorcycle passenger injured in collision with car, pickup truck or van in traffic accident</td>
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<tr>
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<td>MVC - pedestrian vs car</td>
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<td>V03.12XA</td>
<td>Pedestrian on skateboard injured in collision with car, pickup truck or van in traffic accident</td>
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<td>V00.182A</td>
<td>Pedestrian on other rolling-type pedestrian conveyance colliding with stationary object</td>
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<tr>
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<td>05HQ33Z</td>
<td>Insertion of Infusion Device into L External Jugular, <strong>Percutaneous</strong></td>
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<td>R External Jugular</td>
<td>05HP33Z</td>
<td>Insertion of Infusion Device into R External Jugular, <strong>Percutaneous</strong></td>
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<tr>
<td>L Internal Jugular</td>
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<td>Insertion of Infusion Device into L Internal Jugular, <strong>Percutaneous</strong></td>
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<tr>
<td>R Internal Jugular</td>
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<td>Insertion of Infusion Device into R Internal Jugular, <strong>Percutaneous</strong></td>
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<tr>
<td>L Subclavian</td>
<td>05H633Z</td>
<td>Insertion of Infusion Device into L Subclavian, <strong>Percutaneous</strong></td>
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<tr>
<td>R Subclavian</td>
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<td>Insertion of Infusion Device into R Subclavian, <strong>Percutaneous</strong></td>
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<td>Insertion of Infusion Device into Lower, <strong>Percutaneous</strong></td>
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<td>L Femoral</td>
<td>06HN33Z</td>
<td>Insertion of Infusion Device into L Femoral, <strong>Percutaneous</strong></td>
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<tr>
<td>R Femoral</td>
<td>06HM33Z</td>
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<td>L Saphenous</td>
<td>06HQ33Z</td>
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<tr>
<td>R Saphenous</td>
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<tr>
<td>Chest Tube, R Chest</td>
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<tr>
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<td>Bypass Trachea with Tracheostomy Device, <strong>Open</strong></td>
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<td>0B113F4</td>
<td>Bypass Trachea with Tracheostomy Device, <strong>Percutaneous</strong>, <strong>Endoscopic</strong></td>
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<td>0B114F4</td>
<td>Bypass Trachea with Tracheostomy Device, <strong>Percutaneous</strong>, <strong>Endoscopic</strong></td>
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<tr>
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<td>0W9G3ZX</td>
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<tr>
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<tr>
<td>Endotracheal Intubation</td>
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<tr>
<td></td>
<td>0B113F4</td>
<td>Bypass trachea to cutaneous with Tracheostomy Device, <strong>Percutaneous</strong></td>
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<td></td>
<td>0B114F4</td>
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# REFERENCE GUIDE: Orthopedic Procedures

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<tr>
<td>Left Fibula Fracture</td>
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<tr>
<td>Left Radius Fracture</td>
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<td>Reposition Left Radius</td>
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<tr>
<td>Left Shoulder Dislocation</td>
<td>0RSKXZZ</td>
<td>Reposition Left Shoulder Joint</td>
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<tr>
<td>Left Tibia Fracture</td>
<td>0QSHXZZ</td>
<td>Reposition Left Tibia</td>
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<tr>
<td>Left Ulna Fracture</td>
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<tr>
<td>Right Ankle Dislocation</td>
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<td>Reposition Right Ankle Joint</td>
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<tr>
<td>Right Fibula Fracture</td>
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<td>Right Shoulder Dislocation</td>
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<td>Right Tibia Fracture</td>
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<td>Right Ulna Fracture</td>
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<td>Right Ulna</td>
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The codes for CTs with contrast are for Low Osmolar Contrast.

For CTs using Other Contrast, replace the Approach Code of 1 (the 5th Digit) with Y.
# REFERENCE GUIDE: Imaging Procedures

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APPENDIX 2: Glossary of Terms
CO-MORBID (PRE-EXISTING) CONDITIONS

Advanced Directive (limiting care) (NTDS CC_01): The patient had a Do-Not-Resuscitate (DNR) document or similar advance directive recorded prior to injury.

Alcoholism (Alcohol Use Disorder) (NTDS CC_02): Evidence of chronic use, such as withdrawal episodes. Exclude isolated elevated blood alcohol level in the absence of history of abuse. A diagnosis of Alcohol Use Disorder must be documented in the patient’s medical record.

Angina (Pectoris) (NTDS CC_03): (Consistent with the American Heart Association (AHA), May 2015. Always use the most recent definition provided by the AHA.) Chest pain or discomfort due to Coronary Heart Disease, present prior to injury. Usually causes uncomfortable pressure, fullness, squeezing or pain in the center of the chest. Patient may also feel the discomfort in the neck, jaw, shoulder, back or arm. Symptoms may be different in women than men. A diagnosis of Angina or Chest Pain must be documented in the patient’s medical record.

Anticoagulant Therapy (NTDS CC_04): Documentation in the medical record of the administration of medication (anticoagulants, antiplatelet agents, thrombin inhibitors, thrombolytic agents) that interferes with blood clotting, present prior to injury. Exclude patients who are on chronic Aspirin therapy. Some examples are:

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Attention Deficit Disorder / Hyperactivity Disorder (ADD/ADHD) (NTDS CC_05): History of a disorder involving inattention, hyperactivity, or impulsivity requiring medication for treatment. A diagnosis of ADD/ADHD must be documented in the patient’s medical record.

Bleeding Disorder (NTDS CC_06): (Consistent with the American Society of Hematology, 2015. Always use the most recent definition provided by the American Society of Hematology.) A group of conditions that result when the blood cannot clot properly, present prior to injury. A Bleeding Disorder diagnosis must be documented in the patient’s medical record (e.g. Hemophilia, von Willenbrand Disease, Factor V Leiden.)

Cerebral Vascular Accident (CVA) / Residual Neurological Deficit (NTDS CC_07): 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). A diagnosis of CVA must be documented in the patient’s medical record.
Chemotherapy (currently receiving for cancer) (NTDS CC_14): 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.

Chronic Obstructive Pulmonary Disease (COPD) (NTDS CC_08): Consistent with World Health Organization (WHO), 2015. Always use the most recent definition provided by the WHO.) Lung ailment that is characterized by a persistent blockage of airflow from the lungs, present prior to injury. It is not one single disease but an umbrella term used to describe chronic lung diseases that cause limitations in lung airflow. The more familiar terms "chronic bronchitis" and "emphysema" are no longer used, but are now included within the COPD diagnosis and result in any one or more of the following:
- Functional disability from COPD (e.g., dyspnea, inability to perform activities of daily living [ADLs]).
- Hospitalization in the past for treatment of COPD.
- Requires chronic bronchodilator therapy with oral or inhaled agents.
- A Forced Expiratory Volume in 1 second (FEV1) of < 75% or predicted on pulmonary function testing.

A diagnosis of COPD must be documented in the patient’s medical record. Do not include patients whose only pulmonary disease is acute asthma.

Cirrhosis (NTDS CC_10): 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.


Congestive Heart Failure (CHF) (NTDS CC_12): 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 (NTDS CC_13): A patient who reports smoking cigarettes every day or some days within the last 12 months. Exclude patients who smoke cigars or pipes or use smokeless tobacco (chewing tobacco or snuff).

Dementia (NTDS CC_15): 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). A diagnosis of Dementia must be documented in the patient’s medical record.

**Diabetes Mellitus (NTDS CC_16):** 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. A diagnosis of Diabetes Mellitus must be documented in the patient’s medical record.

**Dialysis (Chronic Renal Failure) (NTDS CC_09):** Renal failure prior to injury that was requiring periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration. A diagnosis of Chronic Renal Failure must be documented in the patient’s medical record.

**Disseminated Cancer (NTDS CC_17):** Patients who have cancer that:
- Has spread to one site or more sites in addition to the primary site
- 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 (Substance) Abuse or Dependence (NTDS CC_25):** (Consistent with American Psychiatric Association (APA) DSM 5, 2013. Always use the most recent definition provided by the APA.) Documentation of Substance Abuse Disorder documented in the patient medical record, present prior to injury. A diagnosis of Substance Abuse Disorder must be documented in the patient's medical record.

**Functionally Dependent Health Status (NTDS CC_18):** 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. The patient is considered to have a Functionally Dependent Health Status if prior to injury they were 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 (NTDS CC_19):** History of persistent elevated blood pressure requiring medical therapy, present prior to injury. A diagnosis of Hypertension must be documented in the patient's medical record.

**Mental / Personality Disorder (NTDS CC_20):** (Consistent with American Psychiatric Association (APA) DSM 5, 2013. Always use the most recent definition provided by the APA.) Documentation of the presence of pre-injury depressive disorder, bipolar disorder, schizophrenia, borderline or antisocial personality disorder, and/or adjustment disorder/post-traumatic stress disorder. A diagnosis of Mental/Personality Disorder must be documented in the patient's medical record.

**Myocardial Infarction (MI) (NTDS CC_21):** History of a MI in the six months prior to injury. A diagnosis of MI must be documented in the patient's medical record.
Peripheral Arterial Disease (PAD) (NTDS CC_22): *(Consistent with Centers for Disease Control, 2014 Fact Sheet. Always use the most recent definition provided by the CDC.)* The narrowing or blockage of the vessels that carry blood from the heart to the legs, present prior to injury. It is primarily caused by the buildup of fatty plaque in the arteries, which is called atherosclerosis. PAD can occur in any blood vessel, but it is more common in the legs than the arms. A diagnosis of PAD must be documented in the patient's medical record.

Prematurity (NTDS CC_23): 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, and must be documented in the patient’s medical record.

Seizure Disorder (history of): History of a seizure disorder prior to injury that required medication to control.

Steroid Use (NTDS CC_24): 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 (EVENTS) COMPLICATIONS

**Acute Kidney Injury (dialysis) (NTDS HE_01):** 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 (≥353.6µmol/l)
OR
- Patients <18 years with a decrease in eGFR to <35 ml/min per 1.73m²
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) (NTDS HE_02):**
- **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 hydrostatic edema if no risk factors present.
- **Oxygenation:**
  - **Mild** 200mmHg<PaO₂/FIO₂≤300mmHg **WITH** PEEP or CRAP≥5cm H₂O
  - **Moderate** 100mmHg<PaO₂/FIO₂≤200mmHg **WITH** PEEP>5cm H₂O
  - **Severe** PaO₂/FIO₂<100mmHg **WITH** PEEP or CRAP≥5cm H₂O

**Alcohol Withdrawal (Syndrome) (NTDS HE_03):** (Consistent with the 2016 World Health Organization (WHO) definition of Alcohol Withdrawal Syndrome. Always use the most recent definition provided by the WHO.) Characterized by tremor, sweating, anxiety, agitation, depression, nausea, and malaise. It occurs 6-48 hours after cessation of alcohol consumption, and when uncomplicated, abates after 2-5 days. It may be complicated by grand mal seizures and may progress to delirium (known as delirium tremens). Must have occurred during the patient's initial stay at your hospital, and documentation of alcohol withdrawal must be in the patient's medical record.

**Cardiac Arrest with CPR (NTDS HE_04):** 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.

**Central Line-Associated Bloodstream Infection (CLABSI)** (NTDS HE_06): 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. Such lines continue to be eligible for CLABSI once they are accessed until they are either discontinued or the day after patient discharge (as per the Transfer Rule.) Note that the "de-access" of a port does not result in the patient’s removal from CLABSI surveillance.

**Criterion 1:**
Patient has a recognized pathogen identified from one or more blood specimens by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).

**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
- hypotension

**AND**

Organism(s) identified from blood is 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 identified from two or more blood specimens drawn on separate occasions, by a culture diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). Criterion elements must occur within the Infection Window Period, the 7-day time period which includes the collection date of the positive blood, the 3 calendar days before and the 3 calendar days after.

**Criterion 3:**
Patient ≤ 1 year of age has at least one of the following signs or symptoms:
- fever (>38°C)
- hypothermia
- apnea
- bradycardia

**AND**

Organism(s) identified from blood is 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 identified from two or more blood specimens drawn on separate occasions, by a culture
diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). Criterion elements must occur within the Infection Window Period, the 7-day time period which includes the collection date of the positive blood, the 3 calendar days before and the 3 calendar days after.

**Cerebral Vascular Accident (CVA) / Stroke (NTDS HE_16):** 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 non-stroke 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, or 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.

**Decubitus (Pressure) Ulcer (NTDS HE_14):** (Consistent with the National Pressure Ulcer Advisory Panel (NPUAP) 2014. Always use the most recent definition provided by the NPUAP.) A localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated. Equivalent to NPUAP Stages II-IV, Unstageable/Unclassified, and Suspected Deep Tissue Injury. Documentation of Pressure Ulcer must be in the patient’s medical record, and must have occurred during the patient’s initial stay at your hospital.

**Deep Vein Thrombosis (DVT) / Thrombophlebitis (NTDS HE_08):** The formation, development, or existence of a blood clot or thrombus within the vascular system, which may be coupled with inflammation. A diagnosis of DVT must be documented in the patient’s medical record, which 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 (NTDS HE_09):** 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. A diagnosis of Extremity Compartment Syndrome must be documented in the patient's medical record.

**Myocardial Infarction (MI) (NTDS HE_10):** An acute myocardial infarction must be noted with documentation of any of the following:

Documentation of ECG changes indicative of acute MI (one or more of the following):

- ST elevation >1 mm in two or more contiguous leads
- New left bundle branch block
- New Q-wave in two or more contiguous leads

**OR**

New elevation in troponin greater than three times upper level of the reference range in the setting of suspected myocardial ischemia

**OR**

Physician diagnosis of myocardial infarction

Must have occurred during the patient’s initial stay at your hospital. A diagnosis of MI must be documented in the patient’s medical record.

**Osteomyelitis (NTDS HE_12):** Existence of at least one of the following criteria:

- Organisms identified from bone by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)).
- 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, pain or tenderness, heat, or drainage at suspected site of bone infection

  **AND** at least one of the following:

  - Organisms identified from blood by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)) in a patient with imaging test evidence suggestive of infection (e.g., x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for osteomyelitis).
  - Imaging test evidence suggestive of infection (e.g., x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for osteomyelitis)

**Pulmonary Embolism (PE) (NTDS HE_13):** 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 and/or a diagnosis of PE is documented in the patient’s medical record.

**Sepsis / Severe Sepsis (NTDS HE_15):** (Consistent with the American College of Chest Physicians and the Society of Critical Care Medicine October 2010. Always use the most recent definition provided by the American College of Chest Physicians and the Society of Critical Care Medicine.)
Severe sepsis: sepsis plus organ dysfunction, hypotension (low blood pressure), or hypoperfusion (insufficient blood flow) to 1 or more organs. Septic shock: sepsis with persisting arterial hypotension or hypoperfusion despite adequate fluid resuscitation. A diagnosis of Sepsis must be documented in the patient’s medical record, and must have occurred during the patient’s initial stay at your hospital.

**Surgical Site Infection (SSI) (superficial) (NTDS HE_17):** A diagnosis of SSI must be documented in the patient’s medical record, and meet the following criteria: Infection occurs within 30 days after any NHSN operative procedure (where day 1 = the procedure date)

**AND**
- involves only skin and subcutaneous tissue of the incision

**AND**
- patient has at least **one** of the following:
  - purulent drainage from the superficial incision.
  - organisms identified from an aseptically-obtained specimen from the superficial incision or subcutaneous tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)).
  - superficial incision that is deliberately opened by a surgeon, attending physician** or other designee and culture or non-culture based testing is not performed.

**AND**
- patient has at least **one** of the following signs or symptoms: pain or tenderness; localized swelling; erythema; or heat. A culture or non-culture based test that has a negative finding does not meet this criterion.
- diagnosis of a superficial incisional SSI by the surgeon or attending physician** or other designee.

**COMMENTS:** There are two specific types of superficial incisional SSIs:

1. **Superficial Incisional Primary (SIP) –** a superficial incisional SSI that is identified in the 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)

2. **Superficial Incisional Secondary (SIS) –** a superficial 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 incision for CBGB)

**Surgical Site Infection (deep) (NTDS HE_07):** (Consistent with the January 2016 CDC defined SSI. Always use the most recent definition provided by the CDC.) Must meet the following criteria:

Infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) according to list in Table 2

**AND**
- involves deep soft tissues of the incision (e.g., fascial and muscle layers)

**AND**
- patient has at least **one** of the following:
  - purulent drainage from the deep incision
  - a deep incision that spontaneously dehisces, or is deliberately opened or aspirated by a surgeon, attending physician** or other designee and organism is identified by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST) or culture or non-culture based microbiologic testing method is not performed

**AND**
- patient has at least **one** of the following signs or symptoms:
fever (>38°C); localized pain or tenderness
- a culture or non-culture based test that has a negative finding does not meet this criterion
- an abscess or other evidence of infection involving the deep incision that is detected on gross anatomical or histopathologic exam, or imaging test.

**COMMENTS:** There are two specific types of deep incisional SSIs:

1. **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)

2. **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 incision for CBGB)

**Table 2. Surveillance Period for Deep Incisional or Organ/Space SSI Following Selected NHSN Operative Procedure Categories. Day 1 = the date of the procedure.**

<table>
<thead>
<tr>
<th>Code</th>
<th>Operative Procedure</th>
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</tr>
</thead>
<tbody>
<tr>
<td>AAA</td>
<td>Abdominal aortic aneurysm repair</td>
<td>LAM</td>
<td>Laminectomy</td>
</tr>
<tr>
<td>AMP</td>
<td>Limb amputation</td>
<td>LTP</td>
<td>Liver transplant</td>
</tr>
<tr>
<td>APPY</td>
<td>Appendix surgery</td>
<td>NECK</td>
<td>Neck surgery</td>
</tr>
<tr>
<td>AVSD</td>
<td>Shunt for dialysis</td>
<td>NEPH</td>
<td>Kidney surgery</td>
</tr>
<tr>
<td>BILI</td>
<td>Bile duct, liver or pancreatic surgery</td>
<td>OVRY</td>
<td>Ovarian surgery</td>
</tr>
<tr>
<td>CEA</td>
<td>Carotid endarterectomy</td>
<td>PRST</td>
<td>Prostate surgery</td>
</tr>
<tr>
<td>CHOL</td>
<td>Gallbladder surgery</td>
<td>REC</td>
<td>Rectal surgery</td>
</tr>
<tr>
<td>COLO</td>
<td>Colon surgery</td>
<td>SB</td>
<td>Small bowel surgery</td>
</tr>
<tr>
<td>CSEC</td>
<td>Cesarean section</td>
<td>SPLE</td>
<td>Spleen surgery</td>
</tr>
<tr>
<td>GAST</td>
<td>Gastric surgery</td>
<td>THOR</td>
<td>Thoracic surgery</td>
</tr>
<tr>
<td>HTP</td>
<td>Heart transplant</td>
<td>THUR</td>
<td>Thyroid and/or parathyroid surgery</td>
</tr>
<tr>
<td>HYST</td>
<td>Abdominal hysterectomy</td>
<td>VHYS</td>
<td>Vaginal hysterectomy</td>
</tr>
<tr>
<td>KTP</td>
<td>Kidney transplant</td>
<td>XLAP</td>
<td>Exploratory Laparotomy</td>
</tr>
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**30-day Surveillance**

**90-day Surveillance**

A diagnosis of SSI must be documented in the patient’s medical record, and must have occurred during the patient’s initial stay at your hospital.

**Surgical Site Infection (organ/space) (NTDS HE_11):** (Consistent with the January 2016 CDC defined SSI. Always use the most recent definition provided by the CDC.) Must meet the following criteria:

Infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) according to the list in Table 2
infection involves any part of the body deeper than the fascial/muscle layers, that is opened or manipulated during the operative procedure

AND

patient has at least one of the following:

- purulent drainage from a drain that is placed into the organ/space (e.g., closed suction drainage system, open drain, T-tube drain, CT guided drainage)
- organisms are identified from an aseptically-obtained fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)).
- an abscess or other evidence of infection involving the organ/space that is detected on gross anatomical or histopathologic exam, or imaging test

AND

meets at least one criterion for a specific organ/space infection site listed in Table 3. These criteria are found in the Surveillance Definitions for Specific Types of Infections chapter.

Table 2. Surveillance Period for Deep Incisional or Organ/Space SSI Following Selected NHSN Operative Procedure Categories. Day 1 = the date of the procedure.

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<td>Heart transplant</td>
<td>VHY</td>
<td>Vaginal hysterectomy</td>
</tr>
<tr>
<td>HYST</td>
<td>Abdominal hysterectomy</td>
<td>XLA</td>
<td>Exploratory Laparotomy</td>
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</tbody>
</table>

Table 3. Specific Sites of an Organ/Space SSI.

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</tr>
</thead>
<tbody>
<tr>
<td>BONE</td>
<td>Osteomyelitis</td>
<td>LUNG</td>
<td>Other infections of the respiratory tract</td>
</tr>
<tr>
<td>BRST</td>
<td>Breast abscess mastitis</td>
<td>MED</td>
<td>Mediastinitis</td>
</tr>
</tbody>
</table>
A diagnosis of SSI must be documented in the patient’s medical record, and must have occurred during the patient’s initial stay at your hospital.

**Unplanned Intubation (NTDS HE_19):** 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 readmission to an inpatient bed following discharge, elopement, AMA, etc., from a previous inpatient status.

**Unplanned Return (admission) to the ICU (NTDS HE_18):** 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 (NTDS HE_20):** Unplanned return to the operating room after initial operation management for a similar or related previous procedure.

**Urinary Tract Infection Catheter-Associated (CAUTI) (NTDS HE_05):** 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 1:** 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) AND was either:
     - Present for any portion of the calendar day of the event, OR
     - Removed the day before the date of event
  2. Patient has at least one of the following signs or symptoms:
     - Fever (>38°C)
     - Suprapubic tenderness with no other recognized cause
     - Costovertebral angle pain or tenderness with no other recognized cause

---

### Glossary of Terms

<table>
<thead>
<tr>
<th>CARD</th>
<th>Myocarditis or pericarditis</th>
<th>MEN</th>
<th>Meningitis or ventriculitis</th>
</tr>
</thead>
<tbody>
<tr>
<td>DISC</td>
<td>Disc space</td>
<td>ORAL</td>
<td>Oral cavity (mouth, tongue, or gums)</td>
</tr>
<tr>
<td>EAR</td>
<td>Ear, mastoid</td>
<td>OREP</td>
<td>Other infections of the male or female reproductive tract</td>
</tr>
<tr>
<td>EMET</td>
<td>Endometritis</td>
<td>PJI</td>
<td>Periprosthetic Joint Infection</td>
</tr>
<tr>
<td>ENDO</td>
<td>Endocarditis</td>
<td>SA</td>
<td>Spinal abscess without meningitis</td>
</tr>
<tr>
<td>EYE</td>
<td>Eye, other than conjunctivitis</td>
<td>SINU</td>
<td>Sinusitis</td>
</tr>
<tr>
<td>GIT</td>
<td>GI tract</td>
<td>UR</td>
<td>Upper respiratory tract</td>
</tr>
<tr>
<td>HEP</td>
<td>Hepatitis</td>
<td>USI</td>
<td>Urinary System Infection</td>
</tr>
<tr>
<td>IAB</td>
<td>Intraabdominal, not specified</td>
<td>VASC</td>
<td>Arterial or venous infection</td>
</tr>
<tr>
<td>IC</td>
<td>Intracranial, brain abscess or dura</td>
<td>VCUF</td>
<td>Vaginal cuff</td>
</tr>
<tr>
<td>JNT</td>
<td>Joint or bursa</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 $\leq 1$ year of age
2. Patient has at least one of the following signs or symptoms:
   - fever ($>38.0^\circ C$)
   - hypothermia ($<36.0^\circ C$)
   - 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 $\geq 10^5$ CFU/ml.

**Pneumonia Ventilator-Associated (VAP) (NTDS HE_21):** 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):**

<table>
<thead>
<tr>
<th>Radiology</th>
<th>Signs/Symptoms</th>
<th>Laboratory</th>
</tr>
</thead>
</table>
| 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 | At least one of the following:  
  - Fever (>38°C or >100.4°F)  
  - Leukopenia (<4000 WBC/mm³) or leukocytosis (≥12,000 WBC/mm³)  
  - For adults ≥70 years old, altered mental status with no other recognized cause AND at least two of the following:  
    - 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, or tachypnea  
    - Rales or bronchial breath sounds  
    - Worsening gas exchange (e.g., PaO₂/FiO₂ ≤240), increased oxygen requirements, or increased ventilator demand | 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:  
    - Abscess formation or foci of consolidation with intense PMN accumulation in bronchioles and alveoli  
    - Evidence of lung parenchyma invasion by fungal hyphae or pseudohyphae |

**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.

---

**VAP ALGORITHM (PNU2 VIRAL, LEGIONELLA, AND OTHER BACTERIAL PNEUMONIAS):**

<table>
<thead>
<tr>
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</tr>
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</table>
| 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 | At least one of the following:  
  - Fever (>38°C or >100.4°F)  
  - Leukopenia (<4000 WBC/mm³) or leukocytosis (≥12,000 WBC/mm³)  
  - For adults ≥70 years old, altered mental status with no other recognized cause AND at least two of the following:  
    - 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, or tachypnea  
 | 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, Chlamydia, 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) |

**NOTE:** In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome,
<table>
<thead>
<tr>
<th>Radiology</th>
<th>Signs/Symptoms</th>
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</tr>
</thead>
</table>
| bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest radiograph is acceptable. | o Rales or bronchial breath sounds  
o Worsening gas exchange (e.g., $O_2$ desaturations (e.g., $PaO_2/FiO_2 \leq 240$), increased oxygen requirements, or increased ventilator demand) | • Fourfold rise in L. pneumophila serogroup 1 antibody titer to $\geq 1:128$ in paired acute and convalescent sera by indirect IFA  
• Detection of Legionella pneumophila serogroup 1 antigens in urine by RIA or EIA |

**VAP ALGORITHM (PNU3 IMMUNOCOMPROMISED PATIENTS):**

<table>
<thead>
<tr>
<th>Radiology</th>
<th>Signs/Symptoms</th>
<th>Laboratory</th>
</tr>
</thead>
</table>
| 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 | Patient who is immunocompromised has at least one of the following:  
- Fever ($>38^\circ$C or $>100.4^\circ$F)  
- For adults ≥70 years old, altered mental status with no other recognized cause  
- 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, or tachypnea  
- Rales or bronchial breath sounds  
- Worsening gas exchange (e.g., $O_2$ desaturations (e.g., $PaO_2/FiO_2 \leq 240$), increased oxygen requirements, or increased ventilator demand)  
- Hemoptysis  
- Pleuritic chest pain | At least one of the following:  
- Identification of matching Candida spp. From blood and sputum, endotracheal aspirate, BAL, or protected specimen brushing 11, 12, 13  
- Evidence of fungi from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing) from one of the following:  
  o Direct microscopic exam  
  o Positive culture of fungi  
  o Non-culture diagnostic laboratory test  
Any of the following:  
LABORATORY CRITERIA DEFINED UNDER PNU2 |

**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.

**VAP ALGORITHM ALTERNATE CRITERIA (PNU1), FOR INFANT’S ≤1 YEAR OLD:**

<table>
<thead>
<tr>
<th>Radiology</th>
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</tr>
</thead>
</table>
| 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 | 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/mm$^3$) or leukocytosis ($\geq 15,000$ WBC/mm$^3$) and left shift ($\geq 10\%$ band forms) |
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.

- 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:**

<table>
<thead>
<tr>
<th>Radiology</th>
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</tr>
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</table>
| 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  
| At least three of the following:  
  - Fever (>38.0°C or >100.4°F) or hypothermia (<36.0°C or <96.8°F)  
  - Leukopenia (<4000 WBC/mm³) or leukocytosis (≥15,000 WBC/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., O₂ desaturations [e.g., pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand |
### INJURY DESCRIPTIONS (Prehospital)

<table>
<thead>
<tr>
<th>INJURY DESCRIPTION</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>14</strong> GCS &lt;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.</td>
<td><strong>90</strong> SBP &lt;90 (&lt;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.</td>
</tr>
<tr>
<td><strong>BA</strong> Blunt Abdomen: Injury to any of the abdominal quadrants, flanks, or pelvis due to blunt force.</td>
<td><strong>BB</strong> Blunt Back: Injury to the area from the shoulders to the buttocks (but not including the buttocks) due to blunt force.</td>
</tr>
<tr>
<td><strong>BC</strong> Blunt Chest: 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.</td>
<td><strong>BD</strong> Blunt Diffuse Abdominal Tenderness: Blunt force injury to the abdomen resulting in tenderness in two or more quadrants.</td>
</tr>
<tr>
<td><strong>BE</strong> Blunt Extremities: Injury or pain to the shoulders, arms, hands, legs, or feet due to blunt force.</td>
<td><strong>BF</strong> Blunt Face/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.</td>
</tr>
<tr>
<td><strong>BG</strong> Blunt Genitals: Injury to the external reproductive structures due to blunt force.</td>
<td><strong>BH</strong> Blunt Head: 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.</td>
</tr>
<tr>
<td><strong>BI</strong> Blunt Amputation: Amputation proximal to (above) the wrist or ankle due to blunt force.</td>
<td><strong>BK</strong> Blunt ButtocKs: Injury to the buttocks due to blunt force.</td>
</tr>
<tr>
<td><strong>BL</strong> Blunt Minor Lacerations: Superficial or non-serious lacerations, abrasions, or contusions involving the skin or subcutaneous tissue, due to blunt force.</td>
<td><strong>BN</strong> Blunt Neck: Injury or pain to the area between the angle of the jaw and clavicles (including probable cervical spine injuries) due to blunt force.</td>
</tr>
<tr>
<td><strong>BP</strong> Blunt Tension Pneumothorax: Injury resulting in air entering the pleural space due to blunt force, creating pressure on chest organs.</td>
<td><strong>BR</strong> Blunt Fracture of 2 or more long bones: Blunt force injury resulting in apparent fracture of 2 or more proximal long bones (humerus, femur).</td>
</tr>
<tr>
<td><strong>BT</strong> Blunt Trauma Arrest: Cessation of cardiac output and effective circulation due to blunt force.</td>
<td><strong>BU</strong> Burns/Elec. Shock: Thermal or chemical burn, or electric shock.</td>
</tr>
<tr>
<td><strong>BV</strong> Blunt extremity injury with neurological and/or Vascular compromise, or one that is crushed, degloved, or mangled due to blunt force.</td>
<td><strong>CB</strong> Critical Burn: Patients ≥15 years w/ 2nd and 3rd degree burns involving ≥20% Total Body Surface Area (TBSA) or Patients ≤14 years of age with 2nd and 3rd degree burns involving ≥10% TBSA.</td>
</tr>
<tr>
<td>INJURY DESCRIPTION</td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
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</tr>
<tr>
<td>FC</td>
<td>Flail Chest: Blunt force injury to the chest wall resulting in an unstable chest wall, characterized by paradoxical chest wall movement with respirations.</td>
</tr>
<tr>
<td>IT</td>
<td>Inpatient Trauma: Interfacility transfer (IFT) of an admitted, injured patient from one facility to an inpatient bed at another facility, excluding ER to ER transfers.</td>
</tr>
<tr>
<td>NA</td>
<td>No Apparent Injury: No complaint, or signs or symptoms of injury following a traumatic event.</td>
</tr>
<tr>
<td>PA</td>
<td>Penetrating Abdomen: Injury to any of the abdominal quadrants, flanks, or pelvis due to penetrating force.</td>
</tr>
<tr>
<td>PB</td>
<td>Penetrating Back: Injury to the area from the shoulders to the buttocks (but not including the buttocks) due to penetrating force.</td>
</tr>
<tr>
<td>PC</td>
<td>Penetrating Chest: Injury to the anterior chest in the area between the clavicle and the xiphoid process, bordered on either side by the posterior axillary line, due to penetrating force.</td>
</tr>
<tr>
<td>PE</td>
<td>Penetrating Extremities: Injury or pain to the shoulders, arms, hands, legs, or feet due to penetrating force.</td>
</tr>
<tr>
<td>PF</td>
<td>Penetrating Face/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.</td>
</tr>
<tr>
<td>PG</td>
<td>Penetrating Genitals: Injury to the external reproductive structures due to penetrating force.</td>
</tr>
<tr>
<td>PH</td>
<td>Penetrating Head: 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.</td>
</tr>
<tr>
<td>PI</td>
<td>Penetrating Amputation: Amputation proximal to (above) the wrist or ankle due to penetrating force.</td>
</tr>
<tr>
<td>PK</td>
<td>Penetrating Buttocks: Injury to the buttocks due to penetrating force.</td>
</tr>
<tr>
<td>PL</td>
<td>Penetrating Minor Lacerations (Penetrating): Superficial or non-serious lacerations, abrasions, or contusions involving the skin or subcutaneous tissue, due to penetrating force.</td>
</tr>
<tr>
<td>PN</td>
<td>Penetrating Neck: Injury or pain to the area between the angle of the jaw and clavicles (including probable cervical spine injuries) due to penetrating force.</td>
</tr>
<tr>
<td>PP</td>
<td>Penetrating Tension Pneumothorax: Injury resulting in air entering the pleural space due to penetrating force, creating pressure on chest organs.</td>
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<tr>
<td>PT</td>
<td>Penetrating Trauma Arrest: Cessation of cardiac output and effective circulation due to penetrating force.</td>
</tr>
<tr>
<td>PV</td>
<td>Penetrating extremity injury with neurological and/or vascular compromise, or one that is crushed, degloved, or mangled due to penetrating force.</td>
</tr>
<tr>
<td>PX</td>
<td>Penetrating Extremity injury proximal to (above) the knee or elbow due to penetrating force.</td>
</tr>
<tr>
<td>RR</td>
<td>RR &lt;10/29 (&lt;20 if &lt;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.</td>
</tr>
<tr>
<td>SC</td>
<td>Spinal Cord Injury: Suspected spinal cord injury, or presence of weakness/paralysis/paresthesia following a traumatic event.</td>
</tr>
<tr>
<td>SX</td>
<td>Suspected Pelvic Fracture: Suspected pelvic fracture, excluding isolated hip fractures from a ground level fall.</td>
</tr>
</tbody>
</table>
### MECHANISM OF INJURY (Prehospital)

<table>
<thead>
<tr>
<th>Code</th>
<th>MECHANISM OF INJURY (MOI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Intrusion of &gt;12 inches into an occupied passenger space.</td>
</tr>
<tr>
<td>15</td>
<td>Fall &gt;15 ft. (&gt;10 ft. Peds): A vertical, uninterrupted fall of &gt;15 feet for an adult or &gt;10 feet or 3 times the height of the child for a pediatric patient. Excludes falling down stairs or rolling down a sloping cliff.</td>
</tr>
<tr>
<td>18</td>
<td>Intrusion of &gt;18 inches into an unoccupied passenger space.</td>
</tr>
<tr>
<td>20</td>
<td>An unenclosed transport crash (e.g., skateboard, bicycle, horse) with an estimated impact of &gt;20 mph, not involving a moving auto.</td>
</tr>
<tr>
<td>AN</td>
<td>Animal Bite: The teeth of a human, reptile, dog, cat, or other animal inflicted an injury.</td>
</tr>
<tr>
<td>AS</td>
<td>Assault: Patient was physically assaulted (kicked, punched, strangled, etc.) by means other than stabbing or shooting.</td>
</tr>
<tr>
<td>CR</td>
<td>Crush: Injury sustained as the result of external pressure being placed on body parts between two opposing forces.</td>
</tr>
<tr>
<td>EJ</td>
<td>Ejected: Patient was fully or partially thrown from a vehicle, including convertibles and trucks. Does NOT include motorcycles.</td>
</tr>
<tr>
<td>ES</td>
<td>Electrical Shock: Passage of an electrical current through the body due to contact with an electrical source.</td>
</tr>
<tr>
<td>EV</td>
<td>Enclosed Vehicle: Patient involved in collision while in an enclosed vehicle, such as an automobile, bus, or other enclosed motorized vehicle.</td>
</tr>
<tr>
<td>EX</td>
<td>Extrication: Use of a pneumatic tool was required to remove patient from the vehicle.</td>
</tr>
<tr>
<td>FA</td>
<td>Fall: Any injury resulting from a fall from any height.</td>
</tr>
<tr>
<td>GS</td>
<td>Gun Shot Wound (GSW): Injury was caused by discharge of a gun (accidental or intentional).</td>
</tr>
<tr>
<td>HE</td>
<td>Hazmat Exposure: An injury that occurs as a result of a hazmat exposure.</td>
</tr>
<tr>
<td>MM</td>
<td>Motorcycle/Moped: 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).</td>
</tr>
<tr>
<td>OT</td>
<td>Other: A cause of injury that does not fall into any of the existing categories.</td>
</tr>
<tr>
<td>PB</td>
<td>Pedestrian/Bicyclist/motorcyclist is struck by a motorized vehicle who is NOT thrown or run over, and impact is estimated to be ≤20 MPH.</td>
</tr>
<tr>
<td>PS</td>
<td>Passenger Space Intrusion: Unspecified.</td>
</tr>
<tr>
<td>RT</td>
<td>Moving auto vs. pedestrian/bicyclist/motorcyclist: Run over, Thrown, or estimated impact of &gt;20 MPH.</td>
</tr>
<tr>
<td>SA</td>
<td>Self-Inflicted, Accidental: The injury appears to have been accidentally caused by the patient.</td>
</tr>
<tr>
<td>SC</td>
<td>Special Considerations: Injured patient meets Special Considerations of age greater than 55 years, pregnancy &gt; 20 weeks, or age greater than 65 years with a systolic BP of less than 110mmHg.</td>
</tr>
<tr>
<td>SF</td>
<td>Survived Fatal crash: An injured patient that survived a collision in which a person in the same vehicle was fatally injured.</td>
</tr>
<tr>
<td>SI</td>
<td>Self-Inflicted, Intentional: The injury appears to have been intentionally caused by the patient.</td>
</tr>
<tr>
<td>SP</td>
<td>Sports/Recreation: Any injury that occurs during a sporting or recreational athletic activity.</td>
</tr>
<tr>
<td>ST</td>
<td>Stabbing: A sharp or piercing instrument (e.g. knife, broken glass, ice pick, etc.) was used to cause an injury which penetrated the skin.</td>
</tr>
<tr>
<td>TB</td>
<td>Thermal Burn: Burn caused by heat.</td>
</tr>
<tr>
<td>TD</td>
<td>Telemetry Data: Vehicle telemetry data that is consistent with high risk of serious injury.</td>
</tr>
<tr>
<td>UN</td>
<td>Unknown: The cause or mechanism of injury is unknown.</td>
</tr>
<tr>
<td>WR</td>
<td>Work-Related: Injury occurred while patient was working.</td>
</tr>
</tbody>
</table>
### LA COUNTY

#### Physiological & Anatomical Criteria

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Notes</th>
</tr>
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<tbody>
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<td>14</td>
<td>GCS &lt;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.</td>
<td></td>
</tr>
<tr>
<td>70</td>
<td>SBP &lt;70: Systolic blood pressure less than 70mmHg in a patient less than one year of age following a traumatic event.</td>
<td></td>
</tr>
<tr>
<td>90</td>
<td>SBP &lt;90: Systolic blood pressure less than 90mmHg in a patient greater than one year of age following a traumatic event.</td>
<td></td>
</tr>
<tr>
<td>BD</td>
<td>Blunt Diffuse Abdominal Tenderness: Blunt force injury to the abdomen resulting in tenderness in two or more quadrants.</td>
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<td></td>
</tr>
<tr>
<td>BR</td>
<td>Blunt Fracture of 2 or more long bones: Blunt force injury resulting in apparent fracture of 2 or more proximal long bones (humerus, femur).</td>
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<tr>
<td>BV</td>
<td>Blunt extremity injury with neurological and/or vascular compromise, or one that is crushed, degloved, or mangled due to blunt force.</td>
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<tr>
<td>CB</td>
<td>Critical Burn: Patients ≥15 years w/ 2nd and 3rd degree burns involving ≥20% Total Body Surface Area (TBSA) or Patients ≤14 years of age with 2nd and 3rd degree burns involving ≥10% TBSA.</td>
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<tr>
<td>FC</td>
<td>Flail Chest: Blunt force injury to the chest wall resulting in an unstable chest wall, characterized by paradoxical chest wall movement with respirations.</td>
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<tr>
<td>PA</td>
<td>Penetrating Abdomen: Injury to the abdomen, flanks, or pelvis due to penetrating force.</td>
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<tr>
<td>PC</td>
<td>Penetrating Chest: 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.</td>
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<tr>
<td>PF</td>
<td>Penetrating Face/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.</td>
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<tr>
<td>PG</td>
<td>Penetrating Genitals: Injury to the external reproductive structures due to penetrating force.</td>
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<tr>
<td>PH</td>
<td>Penetrating Head: 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.</td>
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<tr>
<td>PI</td>
<td>Penetrating Amputation: Amputation proximal to (above) the wrist or ankle due to penetrating force.</td>
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<tr>
<td>PK</td>
<td>Penetrating Buttocks: Injury to the buttocks due to penetrating force.</td>
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<tr>
<td>PN</td>
<td>Penetrating Neck: Injury or pain to the area between the angle of the jaw and clavicles (including probable cervical spine injuries) due to penetrating force.</td>
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<tr>
<td>PT</td>
<td>Penetrating Trauma Arrest: Cessation of cardiac output and effective circulation due to penetrating force.</td>
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<tr>
<td>PV</td>
<td>Penetrating extremity injury with neurological and/or vascular compromise, or one that is crushed, degloved, or mangled due to penetrating force.</td>
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<tr>
<td>PX</td>
<td>Penetrating Extremity injury proximal to (above) the knee or elbow due to penetrating force.</td>
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<tr>
<td>PY</td>
<td>Penetrating Back: Injury to the area from the shoulders to the buttocks (but not including the buttocks) due to penetrating force. WhY, because PB was already used.</td>
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<tr>
<td>RR</td>
<td>RR &lt;10/&gt;29 (&lt;20 if &lt;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.</td>
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<tr>
<td>SC</td>
<td>Spinal Cord Injury: Suspected spinal cord injury, or presence of weakness/paralysis/paresthesia following a traumatic event.</td>
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<tr>
<td>SX</td>
<td>Suspected Pelvic Fracture: Suspected pelvic fracture, excluding isolated hip fractures from a ground level fall.</td>
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<tr>
<td><strong>Mechanism of Injury Criteria</strong></td>
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<tr>
<td>15</td>
<td>Fall &gt;15 ft. (&gt;10 ft. Peds): A vertical, uninterrupted fall of &gt;15 feet for an adult or &gt;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.</td>
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<tr>
<td>20</td>
<td>An unenclosed transport crash (e.g., skateboard, bicycle, horse) with an estimated impact of &gt;20 mph, not involving a moving auto.</td>
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<td>EJ</td>
<td>EJicted: Patient was fully or partially thrown from a vehicle, including convertibles and trucks. Does NOT include motorcycles.</td>
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<td>PS</td>
<td>Passenger Space Intrusion of 12 inches into an occupied passenger space.</td>
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<td>RT</td>
<td>Moving auto vs. pedestrian/bicyclist/motorcyclist: Run over, Thrown, or estimated impact of &gt;20 MPH</td>
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<tr>
<td><strong>Guidelines</strong></td>
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<tr>
<td>18</td>
<td>Intrusion of &gt;18 inches into an unoccupied passenger space.</td>
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<tr>
<td>AN</td>
<td>Injured patient on ANticoagulant Medication (other than aspirin only) or with known bleeding disorder.</td>
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<tr>
<td>EX</td>
<td>EXtrication: Use of a pneumatic tool was required to remove patient from the vehicle.</td>
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<tr>
<td>PB</td>
<td>Pedestrian/Bicyclist/motorcyclist is struck by a motorized vehicle who is NOT thrown or run over, and impact is estimated to be ≤20 MPH.</td>
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<tr>
<td>SF</td>
<td>Survived Fatal crash: An injured patient that survived a collision in which a person in the same vehicle was fatally injured.</td>
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<tr>
<td>TD</td>
<td>Telemetry Data: Vehicle telemetry data that is consistent with high risk of serious injury.</td>
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<tr>
<td><strong>Special Considerations</strong></td>
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<tr>
<td>BT</td>
<td>Blunt Trauma Arrest: Cessation of cardiac output and effective circulation due to blunt force.</td>
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<tr>
<td>55</td>
<td>Injured patient that is greater than 55 years of age.</td>
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<tr>
<td>BP</td>
<td>Systolic Blood Pressure less than 110mmHg for patient greater than 65 years of age following a traumatic event.</td>
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<tr>
<td>IU</td>
<td>Injured patient with an IntraUterine pregnancy greater than 20 weeks.</td>
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<tr>
<td>PJ</td>
<td>Prehospital Judgment that transport to Trauma Center is in the patient’s best interest.</td>
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APPENDIX 3: Auto-calculated Variables
AUTO-CALCULATED VARIABLES

Injury Severity Score: 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): 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): 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 - ED (adult and pediatric): 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/Hospital Systolic Blood Pressure) + 0.2908 (Initial ED/Hospital Respiratory Rate)

Total Length of Hospital Stay: The total elapsed time the patient was in the hospital.

Calculation: Hospital Discharge Date/Time – ED/Hospital Arrival Date/Time

Trauma Injury Severity Score (TRISS)/ Probability of Survival (POS): The Trauma Injury Severity Score (TRISS) determines the Probability of Survival of a patient based upon the patient’s age, type of injury (blunt versus penetrating), the Injury Severity Score (ISS), and the Revised Trauma Score (RTS).