TRAUMA CENTER DATA DICTIONARY

Los Angeles County
Emergency Medical Services Agency

Incorporating:
National Trauma Data Standards (NTDS®) 2021 Admissions
Trauma Quality Improvement Program (TQIP®)
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COMMON NULL VALUES

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

Field Values
- F6: Not Documented
- F7: Not Applicable

Additional Information
- For any collection of data to be of value and reliably represent 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-transports to the hospital.
NATIONAL TRAUMA DATABASE STANDARD (NTDS®) & TRAUMA QUALITY IMPROVEMENT PROGRAM (TQIP®)

Definition
National databases that LA County trauma centers contribute data to.

Field Values
- NTDS® values are mapped from the applicable LA County values
- TQIP® fields are identified by field titles in bold blue ink

Additional Information
- Additional fields specific to LA County, but not in NTDS® or TQIP®, are collected for system monitoring and evaluation.
FUNCTION AND HOT KEYS

Definition

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

Field Values

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<tr>
<td>F3</td>
<td>^E</td>
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<tr>
<td>^PgDn</td>
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(^ Control Key)
SCROLLING WINDOWS COMMANDS

Definition
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<td>^I</td>
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<td>^D</td>
</tr>
<tr>
<td>^C</td>
</tr>
<tr>
<td>ALT+F9</td>
</tr>
<tr>
<td>ALT+R</td>
</tr>
<tr>
<td>^F</td>
</tr>
<tr>
<td>^B</td>
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SYSTEM-WIDE

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<th>Selects object.</th>
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<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>
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</table>

(^ Control Key)
GENERAL INFORMATION
DHS PATIENT?

**Definition**
Indicates whether the patient meets TEMIS database inclusion criteria (LA Trauma Database Inclusion Criteria).

**Field Values**
- **Y**: Yes
- **N**: No

**Additional Information**
- “Yes” indicates that patient meets LA Trauma Database Inclusion Criteria.
- “No” indicates that patient does not meet LA Trauma Database Inclusion Criteria, and will not be included in the LA County Trauma Database.
- Patient’s with ONLY ICD-10-CM or ICD-10-CA codes “NFS”, or unspecified codes resulting in an AIS severity score of 9, and therefore no ISS, should be identified as DHS=No patients.
- DHS=Yes patients based upon inclusion criteria of Hospital Admission (AD), MUST be evaluated by the Trauma Service in the ED, and/or transferred and admitted to the Trauma Service for care of an injury.
- Null Values are not accepted for this data field.

**Uses**
- Determines which patients should be submitted to the LA County Trauma Database.

**Other Associated Elements**
- LA TRAUMA DATABASE INCLUSION CRITERIA
# TRAUMA CENTER CODE

## Definition
Three-letter code for the trauma center submitting data.

## Field Values

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<tr>
<td>CAL</td>
<td>Dignity Health – California Hospital Medical Center</td>
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<td>PVC</td>
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<td>UCL</td>
<td>Ronald Reagan UCLA Medical Center</td>
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<td>USC</td>
<td>LAC+USC Medical Center</td>
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</table>

## Additional Information
- Auto-populated as a read-only field – no user action necessary.

## Uses
- Identifies the treating facility.
- System evaluation and monitoring.
LAST NAME

Definition
Patient’s last name.

Field Values
- Free text

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

Uses
- Patient identifier.
- Link between other databases.

Data Source Hierarchy
- Facesheet
- ED Nurses Notes
- Triage Form/Trauma Flow Sheet
- EMS Record
- Billing Sheet/Medical Records Coding Summary Sheet
- ED Admission Form

Other Associated Elements
- FIRST NAME
- MIDDLE INITIAL
FIRST NAME

Definition
Patient’s first name.

Field Values
- Free text

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

Uses
- Patient identifier.
- Link between other databases.

Data Source Hierarchy
- Facesheet
- ED Nurses Notes
- Triage Form/Trauma Flow Sheet
- EMS Record
- Billing Sheet/Medical Records Coding Summary Sheet
- ED Admission Form

Other Associated Elements
- MIDDLE INITIAL
- LAST NAME
MIDDLE INITIAL

Definition
Patient’s middle initial.

Field Values
- Free text

Uses
- Patient identifier.
- Link between other databases.

Data Source Hierarchy
- Facesheet
- ED Nurses Notes
- Triage Form/Trauma Flow Sheet
- EMS Record
- Billing Sheet/Medical Records Coding Summary Sheet
- ED Admission Form

Other Associated Elements
- FIRST NAME
- LAST NAME
ARRIVAL DATE

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

Field Values
- Collected as MMDDYYYY

Additional Information
- If the patient was brought to the ED, enter the date patient arrived in the ED.
- If patient was directly admitted to the hospital, enter date patient was admitted to the hospital.
- Null Values are not accepted for this data field.
- Field value cannot be left blank.

Uses
- Establishes care intervals and incident timelines.
- Used to calculate Total Length of Hospital Stay (elapsed time from ED/Hospital Arrival to ED/Hospital Discharge).

Data Source Hierarchy
- ED Record
- EMS Record
- Billing Sheet/Medical Records Coding Summary Sheet
- Other Hospital Records
- Hospital Discharge Summary

Other Associated Elements
- ARRIVAL TIME
- DISPATCH DATE/TIME
- TRANSPORT ARRIVAL DATE
- TRANSPORT ARRIVAL TIME
- TRANSPORT LEFT DATE
- TRANSPORT LEFT TIME
ARRIVAL TIME

Definition
The time of the day the patient arrived to the ED/hospital.

Field Values
- Collected as HHMM
- Use 24-hour clock

Additional Information
- 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.

Uses
- Establishes care intervals and incident timelines.
- Used to calculate Total Length of Hospital Stay.

Data Source Hierarchy
- ED Records
- EMS Record

Other Associated Elements
- ARRIVAL DATE
- DISPATCH DATE
- DISPATCH TIME
- 1st ON SCENE
- TRANSPORT ARRIVAL DATE
- TRANSPORT ARRIVAL TIME
- TRANSPORT LEFT DATE
- TRANSPORT LEFT TIME
HOME ADDRESS

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

Field Values
- Free text

Additional Information
- If the only address provided is a P.O. Box, enter in place of the patient’s home address.

Uses
- Epidemiological statistics.
- Patient identifier.

Data Source Hierarchy
- Facesheet
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet
- EMS Record

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

Definition
The street name and type of the patient’s primary residence.

Field Values
- Free text

Uses
- Epidemiological statistics.
- Patient identifier.

Data Source Hierarchy
- Facesheet
- ED records
- Billing Sheet/Medical Records Coding Summary Sheet
- EMS Record

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

Definition
The apartment number of the patient’s primary residence.

Field Values
- Free text

Uses
- Allows data to be sorted based upon the geographic location of the patient’s home.
- Patient identifier.

Data Source Hierarchy
- Facesheet
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet
- EMS Record

Other Associated Elements
- HOME ADDRESS
- HOME STREET/TYPE
- HOME ZIP CODE
- ALTERNATE HOME RESIDENCE
- HOME CITY
- HOME COUNTY
- HOME STATE
- HOME COUNTRY
HOME ZIP CODE

Definition
The zip code of the patient’s primary residence.

Field Values
- Five-digit numeric value

Additional Information
- Data entry of a valid home zip code will auto-populate home city, home county, home state, and home country.
- Enter the null value of “Not Documented” if patient possess an address that cannot be found on any document.
- Enter the null value of “Not Applicable” for patients that do not have a home.
- Zip code entered as “Not Applicable” will auto-populate all subsequent 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.

Uses
- Used to calculate Federal Information Processing Standard (FIPS) code.
- Epidemiological statistics.

Data Source Hierarchy
- Facesheet
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet
- EMS Record

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

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

Field Values

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<tr>
<td>M</td>
<td>Migrant Worker</td>
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<tr>
<td>F</td>
<td>Foreign Visitor</td>
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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 the US without permission.
- Migrant Worker is defined as a person who temporarily leaves his/her principal place of residence within a country 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.

Uses
- Epidemiological statistics.

Data Source Hierarchy
- Facesheet
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet
- History and Physical
- EMS Record

Other Associated Elements
- HOME ADDRESS
- HOME STREET/TYPE
- HOME APT #
- HOME ZIP CODE
- HOME CITY
- HOME COUNTY
- HOME STATE
- HOME COUNTRY
**HOME CITY**

**Definition**
The city of the patient's primary residence.

**Field Values**

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</table>

| LM | La Mirada |
| LN | Lawndale |
| LO | Lomita |
| LP | La Puente |
| LQ | LAX |
| LR | La Crescenta |
| LS | Los Nietos |
| LT | Lancaster |
| LU | Lake Hughes |
| LV | La Verne |
| LW | Lake View Terrace |
| LX | Lennox |
| LY | Lynwood |
| MA | Malibu |
| MB | Manhattan Beach |
| MC | Malibu Beach |
| MD | Marina Del Rey |
| ME | Monteleone |
| MG | Montecito Heights |
| MH | Mission Hills |
| MI | Mint Canyon |
| ML | Malibu Lake |
| MM | Miracle Mile |
| MN | Montrose |
| MO | Montebello |
| MP | Monterey Park |
| MR | Mar Vista |
| MS | Mount Wilson |
| MT | Montclair |
| MU | Mount Olympus |
| MV | Monrovia |
| MW | Maywood |
| MY | Metler Valley |
| NA | Naples |
| NE | Newhall |
| NH | North Hollywood |
| NN | Neenach |
| NO | Norwalk |
| NR | Northridge |
| NT | North Hills |
| OP | Ocean Park |
| OT | Other |
| PA | Pasadena |
| PB | Pearblossom |
| PC | Pacoima |
| PD | Palmdale |
| PE | Pacific Palisades |
| PH | Pacific Highlands |
| PI | Phillips Ranch |
| PL | Playa Vista |
| PM | Paramount |
| PN | Panorama City |
| PO | Pomona |
### 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 subsequent 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.
- Data element cannot be left blank.

### Uses
- Used to calculate FIPS code.
- Epidemiological statistics.

### Data Source Hierarchy
- Facesheet
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet
- EMS Record

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

---

**Table: Home City Zip Code Cross Reference**

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<th>PP</th>
<th>Palos Verdes Peninsula</th>
<th>SK</th>
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<td>TT</td>
<td>Toluca Terrace</td>
<td>WV</td>
<td>Westlake Village</td>
</tr>
<tr>
<td>SJ</td>
<td>Silver Lake</td>
<td>UC</td>
<td>Universal City</td>
<td>WW</td>
<td>Westwood</td>
</tr>
</tbody>
</table>
HOME COUNTY

Definition
The county of the patient’s primary residence.

Field Values
- **Los Angeles**: Los Angeles
- **Orange**: Orange
- **Riverside**: Riverside
- **San Bernardino**: San Bernardino
- **San Diego**: San Diego
- **Ventura**: Ventura
- **Other**: Other

Additional Information
- Data entry of a valid home zip code will auto-populate the home county.
- Only complete when home zip code is "Not Documented" or "Not Known".
- Zip code entered as “Not Applicable” will auto-populate all subsequent address related fields with “Not Applicable”.
- Data element cannot be left blank.

Uses
- Epidemiological statistics.

Data Source Hierarchy
- Facesheet
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet
- EMS Record

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

Additional Information
- Data entry of a valid home zip code will auto-populate the home state.
- Only complete when home zip code is "Not Documented" or "Not Known".
- Zip code entered as “Not Applicable” will auto-populate all subsequent address related fields with “Not Applicable”.
- Data element cannot be left blank.

Uses
- Epidemiological statistics.

Data Source Hierarchy
- Facesheet
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet

Other Associated Elements
- HOME ADDRESS
- HOME STREET
- HOME APT #
- HOME ZIP CODE
- HOME CITY
- HOME COUNTY
- HOME COUNTRY
**HOME COUNTRY**

**Definition**

The country of the patient’s primary residence.

**Field Values**

<table>
<thead>
<tr>
<th>Code</th>
<th>Country</th>
<th>code</th>
<th>Country</th>
<th>Code</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFG</td>
<td>Afghanistan</td>
<td>EQU</td>
<td>Equatorial Guinea</td>
<td>MAS</td>
<td>Mauritius</td>
</tr>
<tr>
<td>ALB</td>
<td>Albania</td>
<td>ETH</td>
<td>Ethiopia</td>
<td>MAT</td>
<td>Malta</td>
</tr>
<tr>
<td>ALG</td>
<td>Algeria</td>
<td>FIJ</td>
<td>Fiji</td>
<td>MAU</td>
<td>Mauritania</td>
</tr>
<tr>
<td>ANG</td>
<td>Angola</td>
<td>FIN</td>
<td>Finland</td>
<td>MAV</td>
<td>Maldives</td>
</tr>
<tr>
<td>ANT</td>
<td>Antigua and Barbuda</td>
<td>FRA</td>
<td>France</td>
<td>MAY</td>
<td>Malaysia</td>
</tr>
<tr>
<td>ARG</td>
<td>Argentina</td>
<td>FRE</td>
<td>French Polynesia</td>
<td>MEX</td>
<td>Mexico</td>
</tr>
<tr>
<td>ARM</td>
<td>Armenia</td>
<td>GAB</td>
<td>Gabon</td>
<td>MON</td>
<td>Mongolia</td>
</tr>
<tr>
<td>AUS</td>
<td>Australia</td>
<td>GEM</td>
<td>German</td>
<td>MOZ</td>
<td>Mozambique</td>
</tr>
<tr>
<td>AUT</td>
<td>Austria</td>
<td>GHA</td>
<td>Ghana</td>
<td>MYA</td>
<td>Burma</td>
</tr>
<tr>
<td>BAH</td>
<td>Bahamas</td>
<td>GMI</td>
<td>Germany</td>
<td>NAM</td>
<td>Namibia</td>
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<tr>
<td>BAN</td>
<td>Bangladesh</td>
<td>GUA</td>
<td>Grenada</td>
<td>NEH</td>
<td>Netherlands Antilles</td>
</tr>
<tr>
<td>BAR</td>
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<td>Guinea</td>
<td>NEZ</td>
<td>New Caledonia</td>
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<td>GUT</td>
<td>Guinea-Bissau</td>
<td>NEW</td>
<td>New Zealand</td>
</tr>
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<td>BEN</td>
<td>Belize</td>
<td>GUY</td>
<td>Guyana</td>
<td>NIC</td>
<td>Nicaragua</td>
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<td>Bhutan</td>
<td>HAI</td>
<td>Haiti</td>
<td>NIE</td>
<td>Nigeria</td>
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<td>Bolivia</td>
<td>HON</td>
<td>Honduras</td>
<td>NIG</td>
<td>Niger</td>
</tr>
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<td>Botswana</td>
<td>HOK</td>
<td>Hong Kong</td>
<td>NOR</td>
<td>Norway</td>
</tr>
<tr>
<td>BRA</td>
<td>Brazil</td>
<td>HUN</td>
<td>Hungary</td>
<td>OMA</td>
<td>Oman</td>
</tr>
<tr>
<td>BRU</td>
<td>Brunei</td>
<td>ICE</td>
<td>Iceland</td>
<td>PAC</td>
<td>Pacific Islands</td>
</tr>
<tr>
<td>BUL</td>
<td>Bulgaria</td>
<td>IND</td>
<td>India</td>
<td>PAK</td>
<td>Pakistan</td>
</tr>
<tr>
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<td>Burkina Faso</td>
<td>INO</td>
<td>Indonesia</td>
<td>PAN</td>
<td>Panama</td>
</tr>
<tr>
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<td>Burundi</td>
<td>IRA</td>
<td>Iran</td>
<td>PAP</td>
<td>Papua New Guinea</td>
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<td>Cambodia</td>
<td>IRQ</td>
<td>Iraq</td>
<td>PAR</td>
<td>Paraguay</td>
</tr>
<tr>
<td>CAE</td>
<td>Cameroon</td>
<td>IRE</td>
<td>Ireland</td>
<td>PER</td>
<td>Peru</td>
</tr>
<tr>
<td>CAN</td>
<td>Canada</td>
<td>ISR</td>
<td>Israel</td>
<td>PHI</td>
<td>Philippines</td>
</tr>
<tr>
<td>CAP</td>
<td>Cape Verde</td>
<td>ITA</td>
<td>Italy</td>
<td>POL</td>
<td>Poland</td>
</tr>
<tr>
<td>CEN</td>
<td>Central African Republic</td>
<td>JAM</td>
<td>Jamaica</td>
<td>POR</td>
<td>Portugal</td>
</tr>
<tr>
<td>CHA</td>
<td>Chad</td>
<td>JAP</td>
<td>Japan</td>
<td>PUE</td>
<td>Puerto Rico</td>
</tr>
<tr>
<td>CHI</td>
<td>Chile</td>
<td>JOR</td>
<td>Jordan</td>
<td>QAT</td>
<td>Qatar</td>
</tr>
<tr>
<td>CHN</td>
<td>China</td>
<td>KEN</td>
<td>Kenya</td>
<td>REU</td>
<td>Reunion</td>
</tr>
<tr>
<td>COL</td>
<td>Columbia</td>
<td>KOE</td>
<td>South Korea</td>
<td>ROM</td>
<td>Romania</td>
</tr>
<tr>
<td>COM</td>
<td>Comoros</td>
<td>KOR</td>
<td>North Korea</td>
<td>RUS</td>
<td>Russia</td>
</tr>
<tr>
<td>CON</td>
<td>Congo</td>
<td>KUW</td>
<td>Kuwait</td>
<td>RWA</td>
<td>Rwanda</td>
</tr>
<tr>
<td>COS</td>
<td>Costa Rica</td>
<td>LAO</td>
<td>Laos</td>
<td>SAI</td>
<td>Saint Lucia</td>
</tr>
<tr>
<td>COT</td>
<td>Cote d'Ivoire</td>
<td>LEB</td>
<td>Lebanon</td>
<td>SAO</td>
<td>Sao Tome and Principe</td>
</tr>
<tr>
<td>CUB</td>
<td>Cuba</td>
<td>LES</td>
<td>Lesotho</td>
<td>SAU</td>
<td>Saudi Arabia</td>
</tr>
<tr>
<td>CYP</td>
<td>Cyprus</td>
<td>LBR</td>
<td>Liberia</td>
<td>SEN</td>
<td>Senegal</td>
</tr>
<tr>
<td>CZE</td>
<td>Czechoslovakia</td>
<td>LBY</td>
<td>Libya</td>
<td>SEY</td>
<td>Seychelles</td>
</tr>
<tr>
<td>DEN</td>
<td>Denmark</td>
<td>LUX</td>
<td>Luxembourg</td>
<td>SIE</td>
<td>Sierra Leone</td>
</tr>
<tr>
<td>DJI</td>
<td>Djibouti</td>
<td>LVA</td>
<td>Latvia</td>
<td>SIN</td>
<td>Singapore</td>
</tr>
<tr>
<td>DOM</td>
<td>Dominica</td>
<td>MAC</td>
<td>Macao</td>
<td>SOL</td>
<td>Solomon Islands</td>
</tr>
<tr>
<td>DOH</td>
<td>Dominica Republic</td>
<td>MAD</td>
<td>Madagascar</td>
<td>SOM</td>
<td>Somalia</td>
</tr>
<tr>
<td>ECU</td>
<td>Ecuador</td>
<td>MAI</td>
<td>Mali</td>
<td>SOU</td>
<td>South Africa</td>
</tr>
<tr>
<td>EGY</td>
<td>Egypt</td>
<td>MAL</td>
<td>Malawi</td>
<td>SPA</td>
<td>Spain</td>
</tr>
<tr>
<td>ELS</td>
<td>El Salvador</td>
<td>MAR</td>
<td>Martinique</td>
<td>SRI</td>
<td>Sri Lanka</td>
</tr>
<tr>
<td>STK</td>
<td>St. Kitts-Nevis</td>
<td>TON</td>
<td>Tonga</td>
<td>STV</td>
<td>St. Vincent &amp; The Grenadines</td>
</tr>
<tr>
<td>SUD</td>
<td>Sudan</td>
<td>TUN</td>
<td>Tunisia</td>
<td>VEN</td>
<td>Venezuela</td>
</tr>
</tbody>
</table>
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".
- If patient's home country is not US, then the null value “Not Applicable” is reported to NTDS® for: patient's home state, patient's home county, and patient's home city.
- Zip code entered as “Not Applicable” will auto-populate all subsequent address related fields with “Not Applicable”.
- Data element cannot be left blank.

Uses

- Epidemiological statistics.

Data Source Hierarchy

- Facesheet
- Billing Sheet/Medical Records Coding Summary Sheet

Other Associated Elements

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

Definition
Patient’s gender.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>M  Male</td>
<td>1</td>
</tr>
<tr>
<td>F  Female</td>
<td>2</td>
</tr>
<tr>
<td>N  Nonbinary</td>
<td>3</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 is a gender option within the State of California for individuals whose gender identity isn’t exclusively male or female.
- Field value cannot be a null value.
- Field value cannot be left blank.

Uses
- Epidemiological statistics.

Data Source Hierarchy
- Facesheet
- ED Records
- History and Physical
- EMS Record
DATE OF BIRTH (DOB)

Definition
Patient’s date of birth.

Field Values
- Collected as MMDDYYYY

Additional Information
- If "Not Documented", or "Not Known" complete variables: age and age units.

Uses
- Epidemiological statistics.

Data Source Hierarchy
- Facesheet
- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet
- EMS Record

Other Associated Elements
- AGE
- AGE UNITS
- PEDIATRIC/ADULT
AGE

Definition
Numeric value for the age (actual or best approximation) of the patient at the time of injury when the date of birth is unavailable.

Field Values
- Positive numeric value

Additional Information
- If date of birth is entered, the age and age units will be auto-populated.
- Entry required only when the date of birth is less than 24 hours, "Not Documented", or "Not Known".
- If approximation of the patient’s age is utilized, must also complete age unit field.

Uses
- Epidemiological statistics.

Data Source Hierarchy
- Facesheet
- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet
- EMS Record

Other Associated Elements
- DATE OF BIRTH
- AGE UNIT
AGE UNIT

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 Years</td>
<td>4 Years</td>
</tr>
<tr>
<td>M Months</td>
<td>3 Months</td>
</tr>
<tr>
<td>W Weeks</td>
<td>6 Weeks</td>
</tr>
<tr>
<td>D Days</td>
<td>2 Days</td>
</tr>
<tr>
<td>H Hours</td>
<td>1 Hours</td>
</tr>
<tr>
<td>(Not Applicable in LA County)</td>
<td>5 Minutes</td>
</tr>
<tr>
<td>YE Years Estimated</td>
<td>4 Years</td>
</tr>
<tr>
<td>ME Months Estimated</td>
<td>3 Months</td>
</tr>
<tr>
<td>WE Weeks Estimated</td>
<td>6 Weeks</td>
</tr>
<tr>
<td>DE Days Estimated</td>
<td>2 Days</td>
</tr>
<tr>
<td>HE Hours Estimated</td>
<td>1 Hours</td>
</tr>
</tbody>
</table>

Additional Information
• If date of birth is entered, the age and age unit will be auto-populated.
• Entry required only when the date of birth is less than 24 hours, "Not Documented", or "Not Known".
• If date of birth is unknown, use estimated field values.
• If unit of measurement used to document the best approximation of the patient’s age is 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 whose age is reported in weeks instead of months, use “W”.
• For patients 1 to 29 days old, use “D”.
• For patients up to 23 hours old, use “H”.

Uses
• Epidemiological statistics.

Data Source Hierarchy
• ED Nurses Notes
• EMS Record
• Triage Form/Trauma Flow Sheet
• Billing Sheet/Medical Records Coding Summary Sheet
• ED Admission Form

Other Associated Elements
• DATE OF BIRTH
• AGE
PEDIATRIC/ADULT

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

Field Values
- A: Adult
- P: Pediatric

Additional Information
- Normally calculated from date of birth and auto-populated.

Uses
- Epidemiological statistics.

Data Source Hierarchy
- ED Nurses Notes
- EMS Record
- Triage Form/Trauma Flow Sheet
- Billing Sheet/Medical Records Coding Summary Sheet
- ED Admission Form

Other Associated Elements
- DATE OF BIRTH
- AGE
- AGE UNIT
RACE/ETHNICITY

**Definition**

Patient’s race/ethnicity.

**Field Values**

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
<th>Race</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
<td>Asian</td>
<td>Not Hispanic or Latino</td>
</tr>
<tr>
<td>B</td>
<td></td>
<td>Black/African American</td>
<td>Not Hispanic or Latino</td>
</tr>
<tr>
<td>H</td>
<td></td>
<td>Hispanic/Latino</td>
<td>Hispanic or Latino</td>
</tr>
<tr>
<td>N</td>
<td></td>
<td>Native American/Alaska Native</td>
<td>Not Hispanic or Latino</td>
</tr>
<tr>
<td>P</td>
<td></td>
<td>Pacific Islander/Hawaiian</td>
<td>Not Hispanic or Latino</td>
</tr>
<tr>
<td>U</td>
<td></td>
<td>Unknown</td>
<td>Not Hispanic or Latino</td>
</tr>
<tr>
<td>W</td>
<td></td>
<td>White</td>
<td>Not Hispanic or Latino</td>
</tr>
<tr>
<td>O</td>
<td></td>
<td>Other Race</td>
<td>Not Hispanic or Latino</td>
</tr>
</tbody>
</table>

**Additional Information**

- Patient race/ethnicity should be based upon self-report or identified by a family member.
- Asian/Non-Pacific Islander is defined as a person with origins in the Far East, southeast Asia, or the Indian subcontinent, e.g. Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- Black/African American is defined as a person with origins in any of the Black racial groups of Africa (includes Haitians).
- Hispanic/Latino is defined as a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- Native American/Alaska Native is defined as a person with origins in North, Central, and South America and maintains tribal affiliation or community attachment.
- Pacific Islander/Native Hawaiian is defined as a person with origins in Hawaii, Guam, Samoa, or other Pacific Islands.
- White is defined as a person with origins in Europe, the Middle East, or North Africa.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

**Uses**

- Epidemiological statistics.

**Data Source Hierarchy**

- Facesheet
- ED Records
- History and Physical
ENTRY MODE

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

Field Values

<table>
<thead>
<tr>
<th>Entry Mode</th>
<th>Transport Mode</th>
<th>Interfacility Transfer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EMS:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMS/Ground</td>
<td>1 Ground</td>
<td>2 No</td>
</tr>
<tr>
<td>EMS/Air</td>
<td>2 Helicopter</td>
<td>2 No</td>
</tr>
<tr>
<td><strong>NON-EMS:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vehicle/Walk-in</td>
<td>4 Vehicle/Walk-in</td>
<td>2 No</td>
</tr>
<tr>
<td>Police</td>
<td>5 Police</td>
<td>2 No</td>
</tr>
<tr>
<td>Other</td>
<td>6 Other</td>
<td>2 No</td>
</tr>
<tr>
<td><strong>TRANSFERRED:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9-1-1 Re-Triage/Ground</td>
<td>1 Ground</td>
<td>1 Yes</td>
</tr>
<tr>
<td>9-1-1 Re-Triage/Air</td>
<td>2 Helicopter</td>
<td>1 Yes</td>
</tr>
<tr>
<td>ED to ED/Ground</td>
<td>1 Ground</td>
<td>1 Yes</td>
</tr>
<tr>
<td>ED to ED/Air</td>
<td>2 Helicopter</td>
<td>1 Yes</td>
</tr>
<tr>
<td>Direct Admit/Ground</td>
<td>1 Ground</td>
<td>1 Yes</td>
</tr>
<tr>
<td>Direct Admit/Air</td>
<td>2 Helicopter</td>
<td>1 Yes</td>
</tr>
<tr>
<td>(Not applicable in LA County)</td>
<td>3 Fixed Wing</td>
<td>1 Yes</td>
</tr>
</tbody>
</table>

Additional Information
- If entry mode is “Non-EMS”, “Vehicle”, “Police”, or “Other”, the EMS data fields will be auto-populated with “Not Applicable”, e.g. Dispatch Information, Provider, Field Vital Signs, etc.
- “9-1-1 Re-Triage” is indicated when the 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).
- “ED to ED” is indicated when the 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).
- “Direct Admit” is indicated when the 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”.

Uses
- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

Data Source Hierarchy
- EMS Record
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet

Other Associated Elements
- TRANSFERRED FROM
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. ARRIVAL DATE
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. ARRIVAL TIME
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. EXIT DATE
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. EXIT TIME
EMS RECORD AVAILABLE?

Definition
Indicates whether a copy of the EMS record is available for abstraction.

Field Values
- **Y**: Yes
- **N**: No

Additional Information
- The EMS Record is an essential link between the EMS, Base, and Trauma databases – **every effort should be made to obtain the EMS Record**.
- If entry mode is EMS, entering “No” will auto-populate the following EMS fields with “Not Documented”:
  - PROVIDER
  - RA/SQ
  - DISPATCH DATE
  - DISPATCH TIME
  - 1st ON SCENE
  - TRANSPORT ARRIVAL DATE
  - TRANSPORT ARRIVAL TIME
  - TRANSPORT LEFT SCENE DATE
  - TRANSPORT LEFT SCENE TIME
  - 1st FIELD GCS
  - FIELD INTUBATION?
  - PREHOSPITAL TOURNIQUET
  - 1st FIELD VS

Uses
- System evaluation and monitoring

Data Source Hierarchy
- EMS Record

Other Associated Elements
- ENTRY MODE
TRANSFERRED FROM

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

Field Values

<table>
<thead>
<tr>
<th>LOS ANGELES COUNTY 9-1-1 RECEIVING</th>
<th>KFW</th>
<th>Kaiser Foundation Hospital – West Los Angeles</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACH Alhambra Hospital Medical Center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AHM Catalina Island Medical Center</td>
<td>LBM</td>
<td>MemorialCare Long Beach Medical Center</td>
</tr>
<tr>
<td>AMH Methodist Hospital of Southern California</td>
<td>LCH</td>
<td>Palmdale Regional Medical Center</td>
</tr>
<tr>
<td>AVH Antelope Valley Hospital</td>
<td>LCM</td>
<td>Providence Little Co. of Mary M.C. - Torrance</td>
</tr>
<tr>
<td>BEV Beverly Hospital</td>
<td>MCP</td>
<td>Mission Community Hospital</td>
</tr>
<tr>
<td>BMC Southern California Hospital</td>
<td>MHG</td>
<td>Memorial Hospital of Gardena</td>
</tr>
<tr>
<td>CAL Dignity Health - California Hospital Medical Center</td>
<td>MID</td>
<td>Olympia Medical Center</td>
</tr>
<tr>
<td>CHH Children’s Hospital Los Angeles</td>
<td>MLK</td>
<td>Martin Luther King Jr. Community Hospital</td>
</tr>
<tr>
<td>CHP Community Hospital of Huntington Park</td>
<td>MPH</td>
<td>Monterey Park Hospital</td>
</tr>
<tr>
<td>CNT Centinela Hospital Medical Center</td>
<td>NOR</td>
<td>LA Community Hospital at Norwalk</td>
</tr>
<tr>
<td>CPM Coast Plaza Hospital</td>
<td>NRH</td>
<td>Dignity Health - Northridge Hospital Medical Center</td>
</tr>
<tr>
<td>CSM Cedars-Sinai Medical Center</td>
<td>OVM</td>
<td>LAC Olive View-UCLA Medical Center</td>
</tr>
<tr>
<td>DCH PIH Health Hospital - Downey</td>
<td>PAC</td>
<td>Pacifica Hospital of the Valley</td>
</tr>
<tr>
<td>DFM Cedars-Sinai Marina Del Rey Hospital</td>
<td>PIH</td>
<td>PIH Health Hospital - Whittier</td>
</tr>
<tr>
<td>DHL Lakewood Regional Medical Center</td>
<td>PVC</td>
<td>Pomona Valley Hospital Medical Center</td>
</tr>
<tr>
<td>ELA East Los Angeles Doctors Hospital</td>
<td>QOA</td>
<td>Hollywood Presbyterian Medical Center</td>
</tr>
<tr>
<td>ENH Encino Hospital Medical Center</td>
<td>QVH</td>
<td>Emanate Health Queen of the Valley Hospital</td>
</tr>
<tr>
<td>FPH Emanate Health Foothill Presbyterian Hospital</td>
<td>SDC</td>
<td>San Dimas Community Hospital</td>
</tr>
<tr>
<td>GAR Garfield Medical Center</td>
<td>SDC</td>
<td>San Dimas Community Hospital</td>
</tr>
<tr>
<td>GEM Greater El Monte Community Hospital</td>
<td>SFM</td>
<td>St. Francis Medical Center</td>
</tr>
<tr>
<td>GMH Dignity Health - Glendale Memorial Hospital and Health Center</td>
<td>SGC</td>
<td>San Gabriel Valley Medical Center</td>
</tr>
<tr>
<td>GSH Good Samaritan Hospital</td>
<td>SJH</td>
<td>Providence Saint John’s Health Center</td>
</tr>
<tr>
<td>GWT Adventist Health - Glendale</td>
<td>SJS</td>
<td>Providence Saint Joseph Medical Center</td>
</tr>
<tr>
<td>HCH Providence Holy Cross Medical Center</td>
<td>SMH</td>
<td>Santa Monica-UCLA Medical Center</td>
</tr>
<tr>
<td>HGH LAC Harbor-UCLA Medical Center</td>
<td>SMM</td>
<td>Dignity Health - St. Mary Medical Center</td>
</tr>
<tr>
<td>HMH Huntington Hospital</td>
<td>SOC</td>
<td>Sherman Oaks Hospital</td>
</tr>
<tr>
<td>HMN Henry Mayo Newhall Hospital</td>
<td>SPP</td>
<td>Providence Little Co. of Mary M.C. - San Pedro</td>
</tr>
<tr>
<td>HWH West Hills Hospital &amp; Medical Center</td>
<td>TOR</td>
<td>Torrance Memorial Medical Center</td>
</tr>
<tr>
<td>ICH Emanate Health Inter-Community Hospital</td>
<td>TRM</td>
<td>Providence Cedars-Sinai Tarzana Medical Center</td>
</tr>
<tr>
<td>KFA Kaiser Foundation Hospital – Baldwin Park</td>
<td>UCL</td>
<td>Ronald Reagan UCLA Medical Center</td>
</tr>
<tr>
<td>KFB Kaiser Foundation Hospital – Downey</td>
<td>USC</td>
<td>LAC+USC Medical Center</td>
</tr>
<tr>
<td>KFH Kaiser Foundation Hospital – South Bay</td>
<td>VHH</td>
<td>USC Verdugo Hills Hospital</td>
</tr>
<tr>
<td>KFL Kaiser Foundation Hospital – Sunset (Los Angeles)</td>
<td>VPH</td>
<td>Valley Presbyterian Hospital</td>
</tr>
<tr>
<td>KFO Kaiser Foundation Hospital – Woodland Hills</td>
<td>WHH</td>
<td>Whittier Hospital Medical Center</td>
</tr>
<tr>
<td>KFP Kaiser Foundation Hospital – Panorama City</td>
<td>WMH</td>
<td>Adventist Health - White Memorial</td>
</tr>
</tbody>
</table>
### ORANGE COUNTY 9-1-1 RECEIVING

<table>
<thead>
<tr>
<th>Code</th>
<th>Hospital Name and Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANH</td>
<td>Anaheim Regional Medical Center</td>
</tr>
<tr>
<td>CHO</td>
<td>Children’s Hospital of Orange County</td>
</tr>
<tr>
<td>FHP</td>
<td>Fountain Valley Regional Hospital and Medical Center</td>
</tr>
<tr>
<td>KHA</td>
<td>Kaiser Foundation Hospital – Anaheim</td>
</tr>
<tr>
<td>KFI</td>
<td>Kaiser Foundation Hospital – Irvine</td>
</tr>
<tr>
<td>LAG</td>
<td>Los Alamitos Medical Center</td>
</tr>
<tr>
<td>LPI</td>
<td>La Palma Intercommunity Hospital</td>
</tr>
<tr>
<td>PLH</td>
<td>Placentia Linda Hospital</td>
</tr>
<tr>
<td>SJD</td>
<td>St. Jude Medical Center</td>
</tr>
<tr>
<td>UCI</td>
<td>UCI Medical Center</td>
</tr>
<tr>
<td>WMC</td>
<td>Western Medical Center Santa Ana</td>
</tr>
</tbody>
</table>

### SAN BERNARDINO COUNTY 9-1-1 RECEIVING

<table>
<thead>
<tr>
<th>Code</th>
<th>Hospital Name and Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARM</td>
<td>Arrowhead Regional Medical Center</td>
</tr>
<tr>
<td>CHI</td>
<td>Chino Valley Medical Center</td>
</tr>
<tr>
<td>DHM</td>
<td>Montclair Hospital Medical Center</td>
</tr>
<tr>
<td>KFF</td>
<td>Kaiser Foundation Hospital - Fontana</td>
</tr>
<tr>
<td>KFN</td>
<td>Kaiser Foundation Hospital - Ontario</td>
</tr>
<tr>
<td>LLU</td>
<td>Loma Linda University Medical Center</td>
</tr>
<tr>
<td>SAC</td>
<td>San Antonio Community Hospital</td>
</tr>
</tbody>
</table>

### OTHER COUNTY 9-1-1 RECEIVING

<table>
<thead>
<tr>
<th>Code</th>
<th>Hospital Name and Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>LRR</td>
<td>Los Robles Hospital &amp; Medical Center (Ventura)</td>
</tr>
<tr>
<td>SIM</td>
<td>Adventist Health - Simi Valley Hospital (Ventura)</td>
</tr>
<tr>
<td>SJO</td>
<td>St. John Regional Medical Center (Ventura)</td>
</tr>
<tr>
<td>RCC</td>
<td>Ridgecrest Regional Hospital (Kern)</td>
</tr>
</tbody>
</table>

### NON-BASIC HOSPITALS

<table>
<thead>
<tr>
<th>Code</th>
<th>Hospital Name and Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>LBV</td>
<td>Long Beach VA</td>
</tr>
<tr>
<td>WVA</td>
<td>Wadsworth VA Medical Center</td>
</tr>
</tbody>
</table>

### Additional Information
- Excludes non-EMS transports and patients transferred from a private doctor’s office or stand-alone ambulatory surgery center.

### Uses
- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

### Data Source Hierarchy
- ED Records
- EMS Record
- Billing Sheet/Medical Records Coding Summary Sheet

### Other Associated Elements
- ENTRY MODE
9-1-1 RE-TRIAGE TRANSFERRING HOSP. 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
- Collected as MMDDYYYY

Uses
- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment and transport.
- System evaluation and monitoring.

Data Source Hierarchy
- ED Records
- EMS Record
- Billing Sheet/Medical Records Coding Summary Sheet

Other Associated Elements
- ENTRY MODE
- TRANSFERRED FROM
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. ARRIVAL TIME
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. EXIT DATE
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. EXIT TIME
9-1-1 RE-TRIAGE TRANSFERRING HOSP. ARRIVAL TIME

**Definition**
For 9-1-1 Re-triage, enter the time of day the patient arrived at the facility they are being transferred from.

**Collection Criterion**
ONLY COLLECT ON 9-1-1 RE-TRIAGE PATIENTS.

**Field Values**
- Collected as HHMM
- Use 24-hour clock

**Uses**
- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment and transport.
- System evaluation and monitoring.

**Data Source Hierarchy**
- ED Records
- EMS Record
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**
- ENTRY MODE
- TRANSFERRED FROM
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. ARRIVAL DATE
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. EXIT DATE
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. EXIT TIME
9-1-1 RE-TRIAGE TRANSFERRING HOSP. 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
- Collected as MMDDYYYY

Uses
- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment and transport.
- System evaluation and monitoring.

Data Source Hierarchy
- ED Records
- EMS Record
- Billing Sheet/Medical Records Coding Summary Sheet

Other Associated Elements
- ENTRY MODE
- TRANSFERRED FROM
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. ARRIVAL DATE
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. ARRIVAL TIME
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. EXIT TIME
**9-1-1 RE-TRIAGE TRANSFERRING HOSP. EXIT TIME**

**Definition**
For 9-1-1 Re-triage, enter the time of day the patient exited the facility they are being transferred from.

**Collection Criterion**
ONLY COLLECT ON 9-1-1 RE-TRIAGE PATIENTS.

**Field Values**
- Collected as HHMM
- Use 24-hour clock

**Uses**
- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment and transport.
- System evaluation and monitoring.

**Data Source Hierarchy**
- ED Records
- EMS Record
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**
- ENTRY MODE
- TRANSFERRED FROM
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. ARRIVAL DATE
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. ARRIVAL TIME
- 9-1-1 RE-TRIAGE TRANSFERRING HOSP. EXIT DATE
SEQUENCE #

Definition
Unique, alphanumeric EMS Record number found pre-printed at the top right corner of EMS Record hard copies or electronically assigned to electronic patient care records (ePCRs) by the EMS provider’s electronic capture device.

Field Values
- For EMS patients: consists of two letters and six digits on pre-printed EMS Records; or two-letters, ten digits if an approved ePCR provider.
- For non-EMS patients: consists of the 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.

Additional Information
- **REQUIRED** field for all patients.
- Sequence #s on EMS Report Form hard copies follow “Mod-9” formula: 2 letters and 6 numbers that when added together are divisible by 9.
- ePCR sequence #s utilizes the EMS provider’s two-letter code, the last 2-digits of the incident year, and an additional 8-digits.
- Non-EMS patients sequence #s (e.g. 20USC001) should only be utilized when ‘Entry Mode’ is not equal to “EMS” (ground or air).
- DHS=No patients without an existing EMS or Non-EMS # utilize: last two digits of the current year, followed by the two-letter Trauma Log Code “TL”, plus the sequential DHS=No patient number, e.g. 18TL001.
- Sequence #s are the 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.
- Dummy #s will not be issued for DHS=No patients.
- 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 #.
- None of the sequence # formats should contain spaces.
- Null Values are not accepted for this data field.

Uses
- Unique patient identifier.
- Essential link between other EMS databases.

Data Source Hierarchy
- EMS Record
- Base Hospital Form
- Audio Records
- Fire Station Logs
- EMS Agency

Other Associated Elements
- MEDICAL RECORD #
- OTHER #
**MEDICAL RECORD (MR) #**

**Definition**
Medical record number assigned to the patient by the treating facility.

**Field Values**
- Free text

**Uses**
- Patient identifier.
- Link between the other EMS Agency databases.

**Data Source Hierarchy**
- Facesheet
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet
OTHER #

Definition
Other number assigned to the patient by the treating facility.

Field Values
- Free text

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

Uses
- Patient identifier.

Data Source Hierarchy
- Facesheet
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet
PREHOSPITAL
INJURY DATE

Definition
The date the injury occurred.

Field Values
- Collected as MMDDYYYY

Additional Information
- 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.

Uses
- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment and transport.

Data Source Hierarchy
- EMS Record
- Base Hospital Form
- Audio Records
- ED Records
- History and Physical

Other Associated Elements
- INJURY TIME
INJURY TIME

Definition
The time of day the injury occurred.

Field Values
- Collected as HHMM
- Use 24-hour clock

Additional Information
- 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.

Uses
- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment and transport.

Data Source Hierarchy
- EMS Record
- Base Hospital Form
- Audio Records
- ED Records
- History and Physical

Other Associated Elements
- INJURY DATE
# PROVIDER

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

## Field Values

### PUBLIC PROVIDERS

<table>
<thead>
<tr>
<th>Code</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>AF</td>
<td>Arcadia Fire</td>
</tr>
<tr>
<td>AH</td>
<td>Alhambra Fire</td>
</tr>
<tr>
<td>AV</td>
<td>Avalon Fire</td>
</tr>
<tr>
<td>BA</td>
<td>Burbank Airport Fire</td>
</tr>
<tr>
<td>BF</td>
<td>Burbank Fire</td>
</tr>
<tr>
<td>BH</td>
<td>Beverly Hills Fire</td>
</tr>
<tr>
<td>CB</td>
<td>LA County Beaches</td>
</tr>
<tr>
<td>CC</td>
<td>Culver City Fire</td>
</tr>
<tr>
<td>CF</td>
<td>LA County Fire</td>
</tr>
<tr>
<td>CG</td>
<td>US Coast Guard</td>
</tr>
<tr>
<td>CI</td>
<td>LA City Fire</td>
</tr>
<tr>
<td>CM</td>
<td>Compton Fire</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>CS</td>
<td>LA County Sheriff</td>
</tr>
<tr>
<td>DF</td>
<td>Downey Fire</td>
</tr>
<tr>
<td>ES</td>
<td>El Segundo Fire</td>
</tr>
<tr>
<td>FS</td>
<td>U.S. Forest Service</td>
</tr>
<tr>
<td>GL</td>
<td>Glendale Fire</td>
</tr>
<tr>
<td>LH</td>
<td>Long Beach Fire</td>
</tr>
<tr>
<td>LV</td>
<td>La Habra Heights Fire</td>
</tr>
<tr>
<td>MB</td>
<td>Manhattan Beach Fire</td>
</tr>
<tr>
<td>MF</td>
<td>Monrovia Fire</td>
</tr>
<tr>
<td>MO</td>
<td>Montebello Fire</td>
</tr>
<tr>
<td>MP</td>
<td>Monterey Park Fire</td>
</tr>
</tbody>
</table>

### PRIVATE PROVIDERS

<table>
<thead>
<tr>
<th>Code</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>American Professional Ambulance</td>
</tr>
<tr>
<td>AB</td>
<td>AmbuLife Ambulance</td>
</tr>
<tr>
<td>AN</td>
<td>Antelope Ambulance</td>
</tr>
<tr>
<td>AR</td>
<td>American Medical Response Ambulance</td>
</tr>
<tr>
<td>AT</td>
<td>All Town Ambulance</td>
</tr>
<tr>
<td>AU</td>
<td>AmbuServe/Shoreline Ambulance</td>
</tr>
<tr>
<td>AW</td>
<td>AMWest Ambulance</td>
</tr>
<tr>
<td>AZ</td>
<td>Ambulnz Health, Inc.</td>
</tr>
<tr>
<td>CA</td>
<td>CARE Ambulance</td>
</tr>
<tr>
<td>CO</td>
<td>College Costal Care, LLC</td>
</tr>
<tr>
<td>CL</td>
<td>CAL-MED Ambulance</td>
</tr>
<tr>
<td>EA</td>
<td>Emergency Ambulance</td>
</tr>
<tr>
<td>EX</td>
<td>Explorer 1 Ambulance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>FC</td>
<td>First Care Ambulance</td>
</tr>
<tr>
<td>FM</td>
<td>Firstmed Ambulance</td>
</tr>
<tr>
<td>GG</td>
<td>Go Green Ambulance</td>
</tr>
<tr>
<td>GU</td>
<td>Guardian Ambulance</td>
</tr>
<tr>
<td>JA</td>
<td>Journey Ambulance</td>
</tr>
<tr>
<td>LE</td>
<td>LifeLine Ambulance</td>
</tr>
<tr>
<td>LT</td>
<td>Liberty Ambulance</td>
</tr>
<tr>
<td>LY</td>
<td>Lynch EMS Ambulance</td>
</tr>
<tr>
<td>MI</td>
<td>MedResponse</td>
</tr>
<tr>
<td>MR</td>
<td>MedReach Ambulance</td>
</tr>
<tr>
<td>MT</td>
<td>MedCoast Ambulance</td>
</tr>
<tr>
<td>MY</td>
<td>Mercy Air</td>
</tr>
<tr>
<td>PE</td>
<td>Premier Medical Transport</td>
</tr>
</tbody>
</table>

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

### Uses
- System evaluation and monitoring.

### Data Source Hierarchy
- EMS Record
- Base Hospital Form
- Audio Records
- ED Records

### Other Associated Elements
- RA/SQ
RA/SQ #

Definition
The alphanumeric apparatus code of the paramedic unit primarily responsible for the patient’s prehospital care.

Field Values
- Free text

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

Uses
- System evaluation and monitoring.

Data Source Hierarchy
- EMS Record
- Base Hospital Form
- Audio records
- ED Records

Other Associated Elements
- PROVIDER
DISPATCH DATE

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

Field Values
- Collected as MMDDYYYY

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

Uses
- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

Data Source Hierarchy
- EMS Record
- Base Hospital Form
- Audio records
- ED Records

Other Associated Elements
- DISPATCH TIME
- 1st ON SCENE
- TRANSPORT UNIT ARRIVAL DATE
- TRANSPORT UNIT ARRIVAL TIME
- TRANSPORT UNIT LEFT DATE
- TRANSPORT UNIT LEFT TIME
DISPATCH TIME

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

Field Values
- Collected as HHMM
- Use 24-hour clock

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

Uses
- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

Data Source Hierarchy
- EMS Record

Other Associated Elements
- DISPATCH DATE
- 1st ON SCENE
- TRANSPORT UNIT ARRIVAL DATE
- TRANSPORT UNIT ARRIVAL TIME
- TRANSPORT UNIT LEFT DATE
- TRANSPORT UNIT LEFT TIME
1st ON SCENE

Definition
The time of day of arrival of the first EMS unit (ALS or BLS) arrived on scene.

Field Values
- Collected as HHMM
- Use 24-hour clock

Additional Information
- Indicates time prehospital EMS care began.
- The null value of “Not Applicable” is auto-populated for non-EMS patients.

Uses
- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

Data Source Hierarchy
- EMS Record

Other Associated Elements
- DISPATCH DATE
- DISPATCH TIME
- TRANSPORT UNIT ARRIVAL DATE
- TRANSPORT UNIT ARRIVAL TIME
- TRANSPORT UNIT LEFT DATE
- TRANSPORT UNIT LEFT TIME
TRANSPORT UNIT ARRIVAL DATE

Definition
The date the unit *transporting the patient to your hospital* arrived on scene.

Field Values
- Collected as MMDDYYYY

Additional Information
- Auto-populated based upon the dispatch date. For midnight cross-over, user needs to manually change the date.

Uses
- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

Data Source Hierarchy
- EMS Record

Other Associated Elements
- DISPATCH DATE
- DISPATCH TIME
- 1st ON SCENE
- TRANSPORT UNIT ARRIVAL TIME
- TRANSPORT UNIT LEFT DATE
- TRANSPORT UNIT LEFT TIME
TRANSPORT UNIT ARRIVAL TIME

Definition
The time of day the unit *transporting the patient to your hospital* arrived on the scene.

Field Values
- Collected as HHMM
- Use 24-hour clock

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

Uses
- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

Data Source Hierarchy
- EMS Record

Other Associated Elements
- DISPATCH DATE
- DISPATCH TIME
- 1st ON SCENE
- TRANSPORT UNIT ARRIVAL DATE
- TRANSPORT UNIT LEFT DATE
- TRANSPORT UNIT LEFT TIME
TRANSPORT UNIT LEFT DATE

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

Field Values
- Collected as MMDDYYYY

Additional Information
- Auto-populated based upon the dispatch date. For midnight cross-over, user needs to manually change the date.
- The null value of “Not Applicable” is auto-populated for non-EMS patients.
- Field value cannot be left blank.

Uses
- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

Data Source Hierarchy
- EMS Record

Other Associated Elements
- DISPATCH DATE
- DISPATCH TIME
- 1st ON SCENE
- TRANSPORT UNIT ARRIVAL DATE
- TRANSPORT UNIT ARRIVAL TIME
- TRANSPORT UNIT LEFT TIME
TRANSPORT UNIT LEFT TIME

Definition
The time of day the unit *transporting the patient to your hospital* left the scene.

Field Values
- Collected as HHMM
- Use 24-hour clock

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

Uses
- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

Data Source Hierarchy
- EMS Record

Other Associated Elements
- DISPATCH DATE
- DISPATCH TIME
- 1st ON SCENE
- TRANSPORT UNIT ARRIVAL DATE
- TRANSPORT UNIT ARRIVAL TIME
- TRANSPORT UNIT LEFT DATE
BLUNT/PENETRATING/Critical BURN

**Definition**
Indicates the **type** of the injury sustained by the patient:
- **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 2\textsuperscript{nd} (partial thickness) and 3\textsuperscript{rd} (full thickness) degree burns involving equal to or greater than 20\% Total Body Surface Area (TBSA).
  - Patients ≤ 14 years of age with 2\textsuperscript{nd} (partial thickness) and 3\textsuperscript{rd} (full thickness) degree burns involving equal to or greater than 10\% TBSA.

**Field Values**
- **B**: Blunt
- **P**: Penetrating
- **U**: Critical Burn

**Additional Information**
- Injury Type, blunt, penetrating, and critical burn, is primarily utilized to identify a specific patient population. For this reason, only one Injury Type can be entered.
- 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 medic’s 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.

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

**Data Source Hierarchy**
- EMS Record
- Base Hospital Form
- Audio Records
- ED Records

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

Definition
The 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/Contusion</td>
<td>PL Minor Laceration</td>
<td>NA No Apparent Injury</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 Blunt Head with GCS ≤14</td>
<td>90 SBP &lt;90, 70 SBP &lt;1yr</td>
<td>RR Respiratory Rate &lt;10/&gt;29, &lt;20 if &lt;1y</td>
</tr>
<tr>
<td>BF Face/Mouth</td>
<td>PF Facial/Mouth</td>
<td>SX Suspected Pelvic Fracture</td>
</tr>
<tr>
<td>BN Neck</td>
<td>PN Neck</td>
<td>SC Spinal Cord Injury</td>
</tr>
<tr>
<td>BB Back</td>
<td>PB Back</td>
<td></td>
</tr>
<tr>
<td>BC Chest</td>
<td>PC Chest</td>
<td></td>
</tr>
<tr>
<td>FC Flail Chest</td>
<td>UC Uncontrolled Bleeding</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>

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), 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.
- 14, 90, RR should not be used instead of/or in addition to PT and BT.
- Field value cannot be left blank.
- Refer to Appendix 3: Glossary of Terms – Injury Description (Prehospital) for additional details.

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

Data Source Hierarchy
- EMS Record
- Base Hospital Form
- Audio Records
- ED Records

Other Associated Elements
- MECHANISM OF INJURY
- BLUNT/PENETRATING/Critical BURN
- PROTECTIVE DEVICES
MECHANISM OF INJURY

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

Field Values

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

Additional Information
- If the patient has more than one 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 Guidelines 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.
- Utilize the field value of Other (OT) for patients who are reported to have “fallen out of a moving vehicle”.
- Field value cannot be left blank.
- Refer to Appendix 3: Glossary of Terms – Mechanism of Injury (Prehospital) for additional details.

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

Data Source Hierarchy
- EMS Record
- Base Hospital Form
- Audio Records
- ED Records

Other Associated Elements
- INJURY DESCRIPTION
- BLUNT/PENETRATING/CRITICAL BURN
- PROTECTIVE DEVICES
PROTECTIVE DEVICES

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

Airbags

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

Child Restraints

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

Additional Information

- A value of “None” **MUST** be entered if no protective devices are in use at the time of injury.
- If a child restraint is present, a value for “Child Restraints” must be entered.
- Enter an “Airbags” value for all enclosed vehicle crashes.
- Enter the null value of “Not Documented” if no airbag use is documented under protective devices.
- Presence or use of protective devices may be reported or observed.
- Wheelchairs, walkers, etc. are medical devices and are not considered protective devices.
- Indicate all that apply.
- Field value cannot be left blank.

Uses

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

Data Source Hierarchy

- EMS Record
- Base Hospital Form
- Audio Records
- ED Record

Other Associated Elements

- INJURY DESCRIPTION
- MECHANISM OF INJURY
- BLUNT/PENETRATING/CRITICAL BURN
1st FIELD VS: SBP (Systolic Blood Pressure)

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
- Up to three-digit positive numeric value

Additional Information
- Enter the null value of “Not Documented” for references to capillary refill, or if the medics are unable to obtain a blood pressure in the field.
- 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 of “Not Applicable” is auto-populated for non-EMS patients.
- Field value cannot be left blank.

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

Data Source Hierarchy
- EMS Record

Other Associated Elements
- 1st Field VS: DBP (Diastolic Blood Pressure)
- 1st Field VS: HR (Heart Rate)
- 1st Field VS: RR (Respiratory Rate)
- 1st Field VS: O₂ SAT
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL GCS
1st FIELD VS: DBP (Diastolic Blood Pressure)

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

Field Values
- Up to three-digit positive numeric value

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

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

Data Source Hierarchy
- EMS Record

Other Associated Elements
- 1st Field VS: SBP (Systolic Blood Pressure)
- 1st Field VS: HR (Heart Rate)
- 1st Field VS: RR (Respiratory Rate)
- 1st Field VS: O₂ SAT
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL GCS
1st FIELD VS: HR (Heart Rate)

Definition
First recorded pulse (Heart Rate) measured at the scene of injury expressed as a number per minute.

Field Values
- Up to three-digit positive numeric 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.
- The null value of “Not Applicable” is auto-populated for non-EMS patients.
- Field value cannot be left blank.

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

Data Source Hierarchy
- EMS Record

Other Associated Elements
- 1st Field VS: SBP (Systolic Blood Pressure)
- 1st Field VS: DBP (Diastolic Blood Pressure)
- 1st Field VS: RR (Respiratory Rate)
- 1st Field VS: O₂ SAT
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL GCS
**1st FIELD VS: RR (Respiratory Rate)**

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

**Field Values**
- Up to three-digit positive numeric value

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

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

**Data Source Hierarchy**
- EMS Record

**Other Associated Elements**
- 1st Field VS: SBP (Systolic Blood Pressure)
- 1st Field VS: DBP (Diastolic Blood Pressure)
- 1st Field VS: HR (Heart Rate)
- 1st Field VS: O₂ SAT
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL GCS
1st FIELD VS: O₂ SAT

**Definition**
First recorded oxygen saturation (O₂ Sat) measured at the scene of injury.

**Field Values**
- Up to three-digit percentage from 0 to 100

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

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

**Data Source Hierarchy**
- EMS Record

**Other Associated Elements**
- 1st Field VS: SBP (Systolic Blood Pressure)
- 1st Field VS: DBP (Diastolic Blood Pressure)
- 1st Field VS: HR (Heart Rate)
- 1st Field VS: RR (Respiratory Rate)
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL GCS
1st FIELD GCS: EYE

Definition
The Glasgow Coma Scale (GCS) numerical value that corresponds to the patient’s initial eye opening response to stimuli.

Field Values

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

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

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

Data Source Hierarchy
- EMS Record

Other Associated Elements
- 1st Field VS: SBP (Systolic Blood Pressure)
- 1st Field VS: DBP (Diastolic Blood Pressure)
- 1st Field VS: HR (Heart Rate)
- 1st Field VS: RR (Respiratory Rate)
- 1st Field VS: O\textsubscript{2} SAT
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL GCS
1st FIELD GCS: VERBAL

Definition
The Glasgow Coma Scale (GCS) numerical value that corresponds to the patient’s initial verbal response to stimuli.

Field Values

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

<table>
<thead>
<tr>
<th>INFANT AND TODDLER</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Smiles and tracks objects, speech appropriate for age</td>
</tr>
<tr>
<td>4</td>
<td>Cries but consolable, or confused</td>
</tr>
<tr>
<td>3</td>
<td>Inconsistently consolable, or random words</td>
</tr>
<tr>
<td>2</td>
<td>Moaning, incoherent sounds only</td>
</tr>
<tr>
<td>1</td>
<td>No verbal response</td>
</tr>
</tbody>
</table>

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

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

Data Source Hierarchy
- EMS Record

Other Associated Elements
- 1st Field VS: SBP (Systolic Blood Pressure)
- 1st Field VS: DBP (Diastolic Blood Pressure)
- 1st Field VS: HR (Heart Rate)
- 1st Field VS: RR (Respiratory Rate)
- 1st Field VS: O₂ SAT
- 1st Field GCS: EYE
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL GCS
**1st FIELD GCS: MOTOR**

**Definition**
The Glasgow Coma Scale (GCS) numerical value that corresponds to the patient’s initial motor response to stimuli.

**Field Values**

<table>
<thead>
<tr>
<th>Field Values</th>
<th>LA COUNTY</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>

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

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

**Data Source Hierarchy**
- EMS Record

**Other Associated Elements**
- 1st Field VS: SBP (Systolic Blood Pressure)
- 1st Field VS: DBP (Diastolic Blood Pressure)
- 1st Field VS: HR (Heart Rate)
- 1st Field VS: RR (Respiratory Rate)
- 1st Field VS: O₂ SAT
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: TOTAL GCS
1st FIELD GCS: TOTAL GCS

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

Field Values
• One- or two-digit numeric value between 3 and 15

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

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

Data Source Hierarchy
• EMS Record

Other Associated Elements
• 1st Field VS: SBP (Systolic Blood Pressure)
• 1st Field VS: DBP (Diastolic Blood Pressure)
• 1st Field VS: HR (Heart Rate)
• 1st Field VS: RR (Respiratory Rate)
• 1st Field VS: O₂ SAT
• 1st Field GCS: EYE
• 1st Field GCS: VERBAL
• 1st Field GCS: MOTOR
PREHOSPITAL TOURNIQUET?

**Definition**
Checkbox indicating whether the patient had a tourniquet placed in the prehospital setting by EMS personnel.

**Field Values**
- **Y**: Yes
- **N**: No

**Additional Information**
- Non-commercial tourniquets (e.g. belts, etc.) not applied by EMS personnel should NOT be included.
- A prehospital tourniquet is not applied to most patients; therefore, this field will auto-populate with a value of ‘No’. If a prehospital tourniquet is applied, user should change the value from “No” to “Yes”.
- Tourniquets applied to patients to control non-traumatic bleeding, e.g. to control bleeding from a fistula, are **not** considered trauma patients and are only required to be transported to a trauma center per Reference No. 506 due to the likely need for immediate surgical intervention. These patients should not be included in the LA County Trauma Database.

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

**Data Source Hierarchy**
- EMS Record
- Base Hospital Form
- Audio Records
- ED Records
FIELD INTUBATION?

Definition
Indicates whether the patient was intubated in the prehospital setting.

Field Values
- Y: Yes
- N: No

Additional Information
- Includes endotracheal tube or King LTS-D placement.
- Field intubation does not occur in most patients; therefore, this field will auto-populate with a value of “No”. If the patient is intubated in the field, the user should change the value from “No” to “Yes”.

Uses
- Provides documentation of assessment and care.
- System evaluation and monitoring.

Data Source Hierarchy
- EMS Record
- Base Hospital Form
- Audio Records
- ED Medical Records
PREHOSPITAL CARDIAC ARREST?

Definition
 Indicates whether 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>Yes</td>
</tr>
<tr>
<td>N</td>
<td>No</td>
</tr>
</tbody>
</table>

Additional Information

- A patient who experienced a sudden cessation of cardiac activity, was unresponsive with no normal breathing and no signs of circulation.
- The event must have occurred outside of the hospital, prior to arrival 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.
- Prehospital cardiac arrest does not occur in most patients; therefore, this field will auto-populate with a value of ‘No’. If the patient experienced cardiac arrest in the field, user should change value from “No” to “Yes”.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.
- The following edit check has been applied to 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.

Uses

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

Data Source Hierarchy

- EMS Record
- Base Hospital Form
- Audio Records
- ED Records
- History & Physical
- Transfer Records
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 or ICD-10 CA code value for injury event

Additional Information
- The primary external cause of injury code should describe the main reason a patient is admitted to the hospital.
- ICD-10-CM or ICD-10-CA codes are accepted for this data element. Activity codes are not reported under the NTDS and should not be reported for this data element.
- If two or more events cause separate injuries, an external cause code should be reported for each cause according to the following hierarchy:
  ✓ 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 events.
  ✓ External cause codes for transport accidents take priority over all other external cause codes, except cataclysmic events, child and adult abuse, and terrorism events.
- Field value cannot be “Not Applicable”.
- Field value cannot be “Not Documented”.
- Field value cannot be left blank.

Uses
- System evaluation and monitoring.
- NTDS® uses the external cause to determine the trauma type (Blunt, Penetrating, Burn) and intentionality.

Data Source Hierarchy
- EMS Record
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet

Other Associated Elements
- ADDITIONAL CAUSE CODE
- PLACE OF OCCURRENCE CODE
ADDITIONAL 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 or ICD-10-CA code value for injury event up to six characters

Additional Information
- Only ICD-10-CM or ICD-10-CA codes will be accepted for ICD-10 Additional External Cause Code.
- Enter the null value “Not Applicable” if no additional external cause codes are used.
- If two or more events cause separate injuries, an external cause code should be reported for each cause according to the following hierarchy:
  - 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.

Uses
- System evaluation and monitoring.
- NTDS® uses the external cause to determine the trauma type (Blunt, Penetrating, Burn) and intentionality.

Data Source Hierarchy
- EMS Record
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet

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

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 or ICD-10-CA code value for injury event

Additional Information
- Only ICD-10-CM or ICD-10-CA codes are accepted for ICD-10 Place of Occurrence External Cause Code.
- Field value cannot be left blank.

Uses
- System evaluation and monitoring.

Data Source Hierarchy
- EMS Record
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet

Other Associated Elements
- EXTERNAL CAUSE CODE
- ADDITIONAL CAUSE CODE
INJURY LOCATION ZIP CODE

Definition
The zip code of the incident location.

Field Values
- Five-digit numeric value

Additional Information
- 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.

Uses
- Incident tracking.
- Epidemiological statistics.
- System evaluation and monitoring.

Data Source Hierarchy
- EMS Record
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet

Other Associated Elements
- INJURY LOCATION CITY
- INJURY LOCATION COUNTY
- INJURY LOCATION STATE
### INJURY LOCATION CITY

**Definition**
The city where the injury occurred.

**Field Values**

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>Field Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>Arleta</td>
</tr>
<tr>
<td>AC</td>
<td>Acton</td>
</tr>
<tr>
<td>AD</td>
<td>Altadena</td>
</tr>
<tr>
<td>AE</td>
<td>Arlington Heights</td>
</tr>
<tr>
<td>AG</td>
<td>Agua Dulce</td>
</tr>
<tr>
<td>AH</td>
<td>Agoura Hills</td>
</tr>
<tr>
<td>AL</td>
<td>Alhambra</td>
</tr>
<tr>
<td>AN</td>
<td>Athens</td>
</tr>
<tr>
<td>AO</td>
<td>Avocado Heights</td>
</tr>
<tr>
<td>AR</td>
<td>Arcadia</td>
</tr>
<tr>
<td>AT</td>
<td>Artesia</td>
</tr>
<tr>
<td>AV</td>
<td>Avalon</td>
</tr>
<tr>
<td>AW</td>
<td>Atwater Village</td>
</tr>
<tr>
<td>AZ</td>
<td>Azusa</td>
</tr>
<tr>
<td>BA</td>
<td>Bel Air Estates</td>
</tr>
<tr>
<td>BC</td>
<td>Bell Canyon</td>
</tr>
<tr>
<td>BE</td>
<td>Bellflower</td>
</tr>
<tr>
<td>BG</td>
<td>Bell Gardens</td>
</tr>
<tr>
<td>BH</td>
<td>Beverly Hills</td>
</tr>
<tr>
<td>BK</td>
<td>Bixby Knolls</td>
</tr>
<tr>
<td>BL</td>
<td>Bell</td>
</tr>
<tr>
<td>BN</td>
<td>Baldwin Hills</td>
</tr>
<tr>
<td>BO</td>
<td>Bouquet Canyon</td>
</tr>
<tr>
<td>BP</td>
<td>Baldwin Park</td>
</tr>
<tr>
<td>BR</td>
<td>Bradbury</td>
</tr>
<tr>
<td>BS</td>
<td>Belmont Shore</td>
</tr>
<tr>
<td>BT</td>
<td>Bassett</td>
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<tr>
<td>BU</td>
<td>Burbank</td>
</tr>
<tr>
<td>BV</td>
<td>Beverly Glen</td>
</tr>
<tr>
<td>BW</td>
<td>Brentwood</td>
</tr>
<tr>
<td>BX</td>
<td>Box Canyon</td>
</tr>
<tr>
<td>BY</td>
<td>Boyle Heights</td>
</tr>
<tr>
<td>BZ</td>
<td>Byzantine-Latino Quarter</td>
</tr>
<tr>
<td>CA</td>
<td>Carson</td>
</tr>
<tr>
<td>CB</td>
<td>Calabasas</td>
</tr>
<tr>
<td>CC</td>
<td>Culver City</td>
</tr>
<tr>
<td>CE</td>
<td>Cerritos</td>
</tr>
<tr>
<td>CH</td>
<td>Chatsworth</td>
</tr>
<tr>
<td>CI</td>
<td>Chinatown</td>
</tr>
<tr>
<td>CK</td>
<td>Charter Oak</td>
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<tr>
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<td>Claremont</td>
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<tr>
<td>CM</td>
<td>Compton</td>
</tr>
<tr>
<td>CN</td>
<td>Canyon Country</td>
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<tr>
<td>CO</td>
<td>Commerce</td>
</tr>
<tr>
<td>CP</td>
<td>Canoga Park</td>
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<tr>
<td>CR</td>
<td>Crenshaw</td>
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<tr>
<td>CS</td>
<td>Castaic</td>
</tr>
<tr>
<td>CT</td>
<td>Century City</td>
</tr>
<tr>
<td>CU</td>
<td>Cudahy</td>
</tr>
<tr>
<td>CV</td>
<td>Covina</td>
</tr>
<tr>
<td>CY</td>
<td>Cypress Park</td>
</tr>
<tr>
<td>DB</td>
<td>Diamond Bar</td>
</tr>
<tr>
<td>DO</td>
<td>Downey</td>
</tr>
</tbody>
</table>

**Notes:**

- LA COUNTY: The city where the injury occurred.
- Field Values: Specific locations within LA COUNTY.

**Example Values:**

- LA COUNTY: Arleta
- Field Values: Del Sur, Encino, La Puente

**Sample Data:**

- **Definition:** The city where the injury occurred.
- **Field Values:**
  - LA COUNTY: Arleta
  - Field Values: Del Sur, Encino, La Puente
Additional Information
- Data entry of a valid injury location zip code will auto-populate the injury location city.
- If a valid zip code is not entered, select the city from picklist, or enter a non-picklist city directly.
- Only complete when injury location zip code is "Not Documented" or "Not Known".
- Field value cannot be left blank.

Uses
- Incident tracking.
- Epidemiological statistics.
- System evaluation and monitoring.

Data Source Hierarchy
- EMS Record
- ED Records

Other Associated Elements
- INJURY LOCATION ZIP CODE
- INJURY LOCATION COUNTY
- INJURY LOCATION STATE
INJURY LOCATION COUNTY

Definition
The county where the injury occurred.

Field Values
- Kern: Kern
- Los Angeles: Los Angeles
- Orange: Orange
- Riverside: Riverside
- San Bernardino: San Bernardino
- San Diego: San Diego
- Ventura: Ventura
- Other: Other

Additional Information
- Data entry of a valid injury location zip code will auto-populate injury location county.
- If a valid zip code is not entered, select the county from picklist, or enter a non-picklist county directly.
- Only complete when injury location zip code is "Not Documented" or "Not Known".
- Field value cannot be left blank.

Uses
- Incident tracking.
- Epidemiological statistics.
- System evaluation and monitoring.

Data Source Hierarchy
- ED Records

Other Associated Elements
- INJURY LOCATION ZIP CODE
- INJURY LOCATION CITY
- INJURY LOCATION STATE
INJURY LOCATION STATE

Definition
The two-letter code for the state (territory, province, or District of Columbia) where the injury occurred.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>AK</td>
</tr>
<tr>
<td>AL</td>
</tr>
<tr>
<td>AR</td>
</tr>
<tr>
<td>AS</td>
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<td>AZ</td>
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<tr>
<td>WI</td>
</tr>
<tr>
<td>WV</td>
</tr>
<tr>
<td>WY</td>
</tr>
<tr>
<td>OT</td>
</tr>
</tbody>
</table>

Additional Information
- Data entry of a valid injury location zip code will auto-populate the injury location state.
- Only complete when injury location zip code is "Not Documented" or "Not Known".
- Field value cannot be left blank.

Uses
- Incident tracking.
- Epidemiological statistics.
- System evaluation and monitoring.

Data Source Hierarchy
- ED Records

Other Associated Elements
- INJURY LOCATION ZIP CODE
- INJURY LOCATION CITY
- INJURY LOCATION COUNTY
WORK RELATED?

**Definition**
Indicates whether 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</td>
<td>1</td>
</tr>
<tr>
<td>N</td>
<td>2</td>
</tr>
</tbody>
</table>

**Additional Information**
- If “Yes”, must complete “Occupation” and “Industry”.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

**Uses**
- Incident tracking.
- Epidemiological statistics.

**Data Source Hierarchy**
- ED Records
- EMS Record

**Other Associated Elements**
- INDUSTRY
- OCCUPATION
OCCUPATION

Definition
The occupation of the patient, if applicable.

Field Values

<table>
<thead>
<tr>
<th>Field</th>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARCH/ENG</td>
<td>Architecture &amp; Engineering</td>
<td>2 Architecture &amp; Engineering</td>
</tr>
<tr>
<td>ARTS</td>
<td>Arts, Design, Entertainment, Sports, &amp; Media</td>
<td>16 Arts, Design, Entertainment, Sports, &amp; Media</td>
</tr>
<tr>
<td>BUILD/MAINT</td>
<td>Building &amp; Grounds Cleaning &amp; Maintenance</td>
<td>7 Building &amp; Grounds Maintenance</td>
</tr>
<tr>
<td>COMM/SOC</td>
<td>Community &amp; Social Services</td>
<td>3 Community &amp; Social Services</td>
</tr>
<tr>
<td>COMP/MATH</td>
<td>Computer &amp; Mathematical</td>
<td>13 Computer &amp; Mathematical</td>
</tr>
<tr>
<td>CONSTRUCTION</td>
<td>Construction &amp; Extraction</td>
<td>21 Construction &amp; Extraction</td>
</tr>
<tr>
<td>ED/TRAINING</td>
<td>Education, Training, &amp; Library</td>
<td>4 Education, Training, &amp; Library</td>
</tr>
<tr>
<td>FARMING</td>
<td>Farming, Fishing, &amp; Forestry</td>
<td>9 Farming, Fishing, &amp; Forestry</td>
</tr>
<tr>
<td>FOOD</td>
<td>Food Preparation &amp; Serving</td>
<td>18 Food Preparation &amp; Serving</td>
</tr>
<tr>
<td>HEALTH PRACT</td>
<td>Healthcare Practitioners</td>
<td>5 Healthcare Practitioners</td>
</tr>
<tr>
<td>HEALTH SUPPORT</td>
<td>Healthcare Support</td>
<td>17 Healthcare Support</td>
</tr>
<tr>
<td>INST/MAINT</td>
<td>Installation, Maintenance, &amp; Repair</td>
<td>10 Installation, Maintenance, &amp; Repair</td>
</tr>
<tr>
<td>LEGAL</td>
<td>Legal</td>
<td>15 Legal</td>
</tr>
<tr>
<td>MANAGEMENT</td>
<td>Management</td>
<td>12 Management</td>
</tr>
<tr>
<td>MILITARY</td>
<td>Military Specific</td>
<td>23 Military Specific</td>
</tr>
<tr>
<td>OFFICE</td>
<td>Office &amp; Administrative Support</td>
<td>20 Office &amp; Administrative Support</td>
</tr>
<tr>
<td>PERSONAL</td>
<td>Personal Care &amp; Service</td>
<td>19 Personal Care &amp; Service</td>
</tr>
<tr>
<td>PRODUCTION</td>
<td>Production</td>
<td>22 Production</td>
</tr>
<tr>
<td>PROTECTIVE</td>
<td>Protective Service</td>
<td>6 Protective Service</td>
</tr>
<tr>
<td>SALES</td>
<td>Sales &amp; Related</td>
<td>8 Sales &amp; Related</td>
</tr>
<tr>
<td>SCIENCE</td>
<td>Life, Physical, &amp; Social Science</td>
<td>14 Life, Physical, &amp; Social Science</td>
</tr>
<tr>
<td>TRANSPORTATION</td>
<td>Transportation &amp; Material Moving</td>
<td>11 Transportation &amp; Material Moving</td>
</tr>
</tbody>
</table>

Additional Information
- Only complete if injury is work related – must also complete “Industry”.
- Field value cannot be left blank.

Uses
- Incident tracking.
- Epidemiological statistics.

Data Source Hierarchy
- Facesheet
- History & Physical
- ED Records

Other Associated Elements
- WORK RELATED?
- INDUSTRY
**INDUSTRY**

**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</td>
<td>Agricultural, Forestry, Fishing</td>
</tr>
<tr>
<td>CONSTRUCTION</td>
<td>Construction</td>
</tr>
<tr>
<td>ED/HEALTH</td>
<td>Education and Health Services</td>
</tr>
<tr>
<td>INFORMATION</td>
<td>Information Services</td>
</tr>
<tr>
<td>FIN/INS/REAL</td>
<td>Finance, Insurance, and Real Estate</td>
</tr>
<tr>
<td>GOVERNMENT</td>
<td>Government</td>
</tr>
<tr>
<td>LEISURE</td>
<td>Leisure and Hospitality</td>
</tr>
<tr>
<td>MANUFACTURING</td>
<td>Manufacturing</td>
</tr>
<tr>
<td>NATURAL</td>
<td>Natural Resources and Mining</td>
</tr>
<tr>
<td>PROFESSIONAL</td>
<td>Professional and Business Services</td>
</tr>
<tr>
<td>RETAIL</td>
<td>Retail Trade</td>
</tr>
<tr>
<td>TRANS/UTIL</td>
<td>Transport and Public Utilities</td>
</tr>
<tr>
<td>WHOLESAL E</td>
<td>Wholesale Trade</td>
</tr>
<tr>
<td>OTHER</td>
<td>Other Services</td>
</tr>
</tbody>
</table>

**Additional Information**
- Only complete if injury is work related – must also complete “Occupation”.
- Field value cannot be left blank.

**Uses**
- Incident tracking.
- Epidemiological statistics.

**Data Source Hierarchy**
- Facesheet
- History & Physical
- ED Records

**Other Associated Elements**
- WORK RELATED?
- OCCUPATION
EMERGENCY DEPARTMENT (ED)/HOSPITAL
ED NOTIFIED?

Definition
Indicates whether 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 patients.
- Enter the value of “No” for walk-ins.
- Enter the null value of “Not Applicable” for Direct Admits.

Uses
- System evaluation and monitoring.

Data Source Hierarchy
- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet
- EMS Record

Other Associated Elements
- ACTIVATION?
- ACTIVATION TIME
- ACTIVATION LEVEL
- MD SERVICE
- MD CODE
- STAT?
- REQ TIME
- ARR TIME
MET CRITERIA?

Definition
Indicates whether the patient met trauma criteria per LA County Reference No. 506.

Field Values
- **Y**: Yes
- **N**: No

Additional Information
- Do not include patients that meet trauma guidelines/special considerations.

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

Data Source Hierarchy
- EMS Record
- ED Records
- Base Hospital Form
- Audio records

Other Associated Elements
- GUIDELINES/SPECIAL CONSIDERATION MET
- LA TRAUMA DATABASE INCLUSION CRITERIA
Definition
Trauma Criteria/Guidelines/Special Considerations met, per LA County Reference No. 506.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY (ALL Patients)</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<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 Pediatric 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/&gt;29, &lt;20 if &lt;1yr.</td>
</tr>
<tr>
<td>CB</td>
<td>Critical Burn (CB or CB w/ 70, 90, RR, AN, 55, BP, IU &amp; PJ) Critical Burn (CB w/ any other code, excluding: 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, unspecified</td>
</tr>
<tr>
<td>12</td>
<td>Passenger Space Intrusion of &gt;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>TQ</td>
<td>Tourniquet (Commercial) applied</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>

Guidelines

| 18                       | Passenger Space Intrusion of >18 inches into an unoccupied passenger space |
| AN                       | Anticoagulant Medication (other than aspirin only) or with Bleeding Disorder |
| EX                       | Extrication Required |
| PB                       | Pedestrians/Bicyclists Impact ≤ 20 mph |
| SF                       | Survivor of Fatal Crash (same vehicle), with Complaint of Injury |
| TD                       | Telemetry Data |

Special Considerations

| BT                       | Blunt Trauma Full Arrest |
| 55                       | Age greater than 55 years |
| BP                       | Systolic B/P less than 110mmHg for patient greater than 65 years of age |
| IU                       | Pregnancy greater than 20 weeks |
| PJ                       | Prehospital judgment that transport to Trauma Center is in the patient’s best interest |
Additional Information

- If the patient did not meet trauma criteria, 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 and are NOT to be utilized by the trauma center as the rationale for trauma registry inclusion.
- For PSI to meet Trauma Criteria and/or Guidelines per Reference No. 506, the intrusion must be specified as greater than 12 inches (Criteria 12) 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.

Uses

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

Data Source Hierarchy

- EMS Record
- ED Records
- Base Hospital Form
- Audio Records

Other Associated Elements

- MET CRITERIA?
- LA TRAUMA DATABASE INCLUSION CRITERIA
ED/HOSPITAL ARRIVAL DATE

Definition
The date of day the patient arrived to the ED/hospital.

Field Values
- Collected as MMDDYYYY

Additional Information
- Used to calculate Total Length of Hospital Stay.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

Uses
- Establishes care intervals and incident timelines.

Data Source Hierarchy
- ED Records
- EMS Record

Other Associated Elements
- ARRIVAL DATE
- DISPATCH DATE
- DISPATCH TIME
- 1st ON SCENE
- TRANSPORT ARRIVAL DATE
- TRANSPORT ARRIVAL TIME
- TRANSPORT LEFT DATE
- TRANSPORT LEFT TIME
- ED/HOSPITAL ARRIVAL TIME
ED/HOSPITAL ARRIVAL TIME

Definition
The time of day the patient arrived to the ED/hospital.

Field Values
- Collected as HHMM
- Use 24-hour clock

Additional Information
- Used to calculate 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.

Uses
- Establishes care intervals and incident timelines.

Data Source Hierarchy
- ED Records
- EMS Record

Other Associated Elements
- ARRIVAL DATE
- DISPATCH DATE
- DISPATCH TIME
- 1st ON SCENE
- TRANSPORT ARRIVAL DATE
- TRANSPORT ARRIVAL TIME
- TRANSPORT LEFT DATE
- TRANSPORT LEFT TIME
- ED/HOSPITAL ARRIVAL DATE
TRAUMA TEAM ACTIVATION?

Definition
Indicates whether 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.

Uses
- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

Data Source Hierarchy
- ED Records
- Physician’s Progress Notes

Other Associated Elements
- LA TRAUMA DATABASE INCLUSION CRITERIA
- ACTIVATION TIME
- ACTIVATION LEVEL
ACTIVATION DATE

Definition
The date the treating facility’s trauma team was activated, if applicable.

Field Values
- Collected as MMDDYYYY

Uses
- Establishes care intervals and incident timelines.

Data Source Hierarchy
- ED Records
- Physician’s Progress Notes

Other Associated Elements
- LA TRAUMA DATABASE INCLUSION CRITERIA
- ACTIVATION?
- ACTIVATION LEVEL
- ACTIVATION TIME
ACTIVATION TIME

Definition
The time of day the treating facility’s trauma team was activated, if applicable.

Field Values
- Collected as HHMM
- Use 24-hour clock

Uses
- Establishes care intervals and incident timelines.

Data Source Hierarchy
- ED Records
- Physician’s Progress Notes

Other Associated Elements
- LA TRAUMA DATABASE INCLUSION CRITERIA
- ACTIVATION?
- ACTIVATION LEVEL
- ACTIVATION DATE
ACTIVATION LEVEL

Definition
The level of the trauma team’s activation, if applicable.

Field Values
- Customized list

Additional Information
- Enter activation level code directly, or create facility-specific picklist.
- If the Trauma Centers’ highest level of activation on file with the EMS Agency is indicated, it will be mapped to NTDB’s Highest Level of Activation. To ensure continued accuracy, the EMS Agency must be notified if changes are made to the customized list.
- Requests for Trauma Consults are NOT considered Activations.

Uses
- Establishes care intervals and incident timelines.

Data Source Hierarchy
- ED Records
- Physician’s Progress Notes

Other Associated Elements
- LA TRAUMA DATABASE INCLUSION CRITERIA
- ACTIVATION?
- ACTIVATION DATE
- ACTIVATION TIME
ED DISPOSITION ORDER DATE

Definition
The date the order was written for the patient to be dispositioned from the ED.

Field Values
- Collected as MMDDYYYY

Additional Information
- Enter the null value of “Not Applicable” if the patient is directly admitted to the hospital.
- Field value cannot be left blank.

Uses
- Establishes care intervals and incident timelines.

Data Source Hierarchy
- Physician’s Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet
- Hospital Discharge Summary

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

**Definition**
The time of day the order was written for the patient to be dispositioned from the ED.

**Field Values**
- Collected as HHMM
- Use 24-hour clock

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

**Uses**
- Establishes care intervals and incident timelines.

**Data Source Hierarchy**
- ED Records
- Hospital Record

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

Definition
The date the patient left the ED.

Field Values
- Collected as MMDDYYYY

Additional Information
- Enter the null value of “Not Applicable” if the patient is directly admitted to the hospital.
- Field value cannot be left blank.

Uses
- Establishes care intervals and incident timelines.

Data Source Hierarchy
- Physician’s Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet
- Hospital Discharge Summary

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

Definition
The time of day the patient left the ED.

Field Values
- Collected as HHMM
- Use 24-hour clock

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

Uses
- Establishes care intervals and incident timelines.

Data Source Hierarchy
- ED Records
- Hospital Record

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

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

Field Values
- Up to three-digit positive numeric value

Additional Information
- May be self-reported or provided by family.
- Enter a value “Not Documented” if the patient’s height was not provided within 24 hours of ED/hospital arrival.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

Data Source Hierarchy
- ED Nurses Notes
- Triage Form/Trauma Flow Sheet
- Billing Sheet/Medical Records Coding Summary Sheet
- ED Admission Form

Other Associated Elements
- HEIGHT UNITS
HEIGHT UNITS

Definition
Unit of measurement used to report the patient’s height, or the best approximation, within 24 hours of ED/hospital arrival.

Field Values
- I: Inches
- C: Centimeters

Additional Information
- May be self-reported or provided by family.
- Enter a value “Not Documented” if the patient’s height was not provided within 24 hours of ED/hospital arrival.

Data Source Hierarchy
- ED Nurses Notes
- Triage Form/Trauma Flow Sheet
- Billing Sheet/Medical Records Coding Summary Sheet
- ED Admission Form

Other Associated Elements
- HEIGHT
WEIGHT

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

Field Values
- Up to three-digit positive numeric value

Additional Information
- May be self-reported or provided by family.
- Enter a value “Not Documented” if the patient’s weight was not provided within 24 hours of ED/hospital arrival.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

Data Source Hierarchy
- ED Nurses Notes
- Triage Form/Trauma Flow Sheet
- Billing Sheet/Medical Records Coding Summary Sheet
- ED Admission Form

Other Associated Elements
- WEIGHT UNITS
WEIGHT UNITS

Definition
Unit of measurement used to report the patient’s weight, or the best approximation, within 24 hours of ED/Hospital arrival.

Field Values
- L: Pounds
- K: Kilograms

Additional Information
- May be self-reported or provided by family.
- Enter a value “Not Documented” if the patient’s weight was not provided within 24 hours of ED/hospital arrival.

Data Source Hierarchy
- ED Nurses Notes
- Triage Form/Trauma Flow Sheet
- Billing Sheet/Medical Records Coding Summary Sheet
- ED Admission Form

Other Associated Elements
- WEIGHT
1st ED/HOSPITAL VS: DATE

Definition
Date of the first recorded vital signs within 30 minutes of ED/hospital arrival.

Field Values
- Collected as MMDDYYYY

Additional Information
- 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.
- Enter the null value of "Not Documented" if the first recorded vital signs time is not within 30 minutes of ED/hospital arrival.

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

Data Source Hierarchy
- ED Records
- Physician’s Progress Notes

Other Associated Elements
- 1ST ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O₂ SAT
- 1st ED/HOSPITAL VS: ON O₂?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS – TOTAL
- 1st ED/HOSPITAL VS: GCS MODIFIERS
1st ED/HOSPITAL VS: TIME

Definition
Time of day of the first recorded vital signs within 30 minutes of ED/hospital arrival.

Field Values
- Collected as HHMM
- Use 24-hour clock

Additional Information
- 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.
- Enter the null value of “Not Documented” if the first recorded vital signs time is not within 30 minutes of ED/hospital arrival.

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

Data Source Hierarchy
- ED Records
- Physician’s Progress Notes

Other Associated Elements
- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O₂ SAT
- 1st ED/HOSPITAL VS: ON O₂?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS – TOTAL
- 1st ED/HOSPITAL VS: GCS MODIFIERS
**1st ED/HOSPITAL VS: BP – SYSTOLIC (SBP)**

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

**Field Values**
- Up to three-digit positive numeric 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.
- Enter the null value of "Not Documented" if the first recorded systolic blood pressure is not within 30 minutes of ED/hospital arrival.
- Field value cannot be "Not Applicable".
- Field value cannot be left blank.

**Uses**
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Used to calculate Revised Trauma Score - ED (adult & pediatric).

**Data Source Hierarchy**
- ED Records
- Physician’s Progress Notes

**Other Associated Elements**
- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O₂ SAT
- 1st ED/HOSPITAL VS: ON O₂?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS – TOTAL
- 1st ED/HOSPITAL VS: GCS MODIFIERS
Definition
Numeric value of the first recorded diastolic blood pressure (DBP) within 30 minutes of ED/hospital arrival.

Field Values
- Up to three-digit positive numeric value

Additional Information
- The null value "Not Documented" is used if the diastolic pressure is not measured (i.e., only palpated SYSTOLIC pressure measured or if the first recorded diastolic blood pressure is not within 30 minutes of ED/hospital arrival.

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

Data Source Hierarchy
- ED Records
- Physician’s Progress Notes

Other Associated Elements
- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O₂ SAT
- 1st ED/HOSPITAL VS: ON O₂?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS – TOTAL
- 1st ED/HOSPITAL VS: GCS MODIFIERS
1\textsuperscript{st} ED/HOSPITAL VS: HEART RATE (HR)

Definition
Numeric value of the first recorded pulse (Heart Rate \(HR\)) \((\text{palpated or auscultated ONLY – no monitor readings})\) within 30 minutes of ED/Hospital arrival.

Field Values
- Up to three-digit positive numeric value

Additional Information
- First recorded HR should be palpated or auscultated \textbf{ONLY}, no monitor readings.
- Measured in beats palpated per minute.
- 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.
- Enter the null value of “\textit{Not Documented}” if the first recorded heart rate is not within 30 minutes of ED/hospital arrival.
- Field value cannot be “\textit{Not Applicable}”.
- Field value cannot be left blank.

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

Data Source Hierarchy
- ED Records
- Physician’s Progress Notes

Other Associated Elements
- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O\textsubscript{2} SAT
- 1st ED/HOSPITAL VS: ON O\textsubscript{2}?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS – TOTAL
- 1st ED/HOSPITAL VS: GCS MODIFIERS
**1st ED/HOSPITAL VS: RESPIRATORY RATE (RR)**

**Definition**
Numeric value of the first recorded respiratory rate (RR) within 30 minutes of ED/hospital arrival.

**Field Values**
- Up to three-digit positive numeric value

**Additional Information**
- Enter actual rate only — indicate whether respirations were assisted in the next field: “ASST?”
- Enter the null value of “Not Documented” if the first recorded respiratory rate is not within 30 minutes of ED/hospital arrival.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

**Uses**
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Used to calculate Revised Trauma Score - ED (adult & pediatric).

**Data Source Hierarchy**
- ED Records
- Physician's Progress Notes

**Other Associated Elements**
- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O₂ SAT
- 1st ED/HOSPITAL VS: ON O₂?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS – TOTAL
- 1st ED/HOSPITAL VS: GCS MODIFIERS
1st ED/HOSPITAL VS: RESPIRATORY RATE (RR) ASSISTED?

Definition
Indicates whether there was respiratory assistance associated with the initial respiratory rate within 30 minutes of ED/hospital 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 (e.g. BMV, ventilator, etc.).
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

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

Data Source Hierarchy
- ED Records
- Physician’s Progress Notes

Other Associated Elements
- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: O₂ SAT
- 1st ED/HOSPITAL VS: ON O₂?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS – TOTAL
- 1st ED/HOSPITAL VS: GCS MODIFIERS
1st ED/HOSPITAL VS: O₂ SAT

Definition
Numeric value of the first recorded oxygen saturation (O₂ sat) within 30 minutes of ED/hospital arrival.

Field Values
- Up to three-digit percentage from 0 to 100

Additional Information
- Enter the null value of “Not Documented” if the first recorded oxygen saturation is not within 30 minutes of ED/hospital arrival.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

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

Data Source Hierarchy
- ED Records
- Physician’s Progress Notes

Other Associated Elements
- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: ON O₂?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS – TOTAL
- 1st ED/HOSPITAL VS: GCS MODIFIERS
**1st ED/HOSPITAL VS: ON O₂?**

**Definition**
Indicates whether supplemental oxygen was in use during the initial assessment of the O₂ saturation within 30 minutes of ED/hospital 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>
<tr>
<td>U</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

**Additional Information**
- Only complete if a numeric value is reported for 1st ED/hospital VS: O₂ saturation, otherwise enter the null value of “Not Applicable”.
- Field value cannot be left blank.

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

**Data Source Hierarchy**
- ED Records
- Physician’s Progress Notes

**Other Associated Elements**
- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O₂ SAT
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS – TOTAL
- 1st ED/HOSPITAL VS: GCS MODIFIERS
**1st ED/HOSPITAL VS: TEMPERATURE (TEMP)**

**Definition**
Numeric value of the first recorded temperature within 30 minutes of ED/hospital arrival.

**Field Values**
- Up to three-digit positive numeric value

**Additional Information**
- Document to the 10th of a degree (e.g. 37.2°C)
- Enter the null value of “Not Documented” if the first recorded temperature is not within 30 minutes of ED/hospital arrival.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

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

**Data Source Hierarchy**
- ED Records
- Physician’s Progress Notes

**Other Associated Elements**
- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O2 SAT
- 1st ED/HOSPITAL VS: ON O2?
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS – TOTAL
- 1st ED/HOSPITAL VS: GCS MODIFIERS
**1st ED/HOSPITAL VS: TEMP UNITS**

**Definition**
Unit of measurement for first recorded temperature within 30 minutes of ED/hospital arrival.

**Field Values**
- C: Celsius
- F: Fahrenheit

**Additional Information**
- Only complete if a numeric value is reported for 1st ED/hospital vital signs temperature, otherwise enter the null value of “Not Applicable”.

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

**Data Source Hierarchy**
- ED Records
- Physician’s Progress Notes

**Other Associated Elements**
- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O₂ SAT
- 1st ED/HOSPITAL VS: ON O₂?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS – TOTAL
- 1st ED/HOSPITAL VS: GCS MODIFIERS
1st ED/HOSPITAL VS: TEMP TIME

Definition
Time of the first recorded temperature within 30 minutes of ED/hospital arrival.

Field Values
- Collected as HHMM
- Use 24-hour clock

Additional Information
- If the first recorded temperature time in the ED/hospital is not within 30 minutes of arrival, enter the null value of “Not Documented”.

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

Data Source Hierarchy
- ED Records
- Physician’s Progress Notes

Other Associated Elements
- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O₂ SAT
- 1st ED/HOSPITAL VS: ON O₂?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS – TOTAL
- 1st ED/HOSPITAL VS: GCS MODIFIERS
**Definition**
The Glasgow Coma Scale (GCS) numerical value that corresponds to the patient’s initial eye opening response to stimuli, recorded within 30 minutes of ED/hospital arrival.

**Field Values**

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

**Additional Information**
- Enter the null value of "Not Documented" if the first recorded GCS eye score is not within 30 minutes of ED/hospital arrival.
- Field value cannot be "Not Applicable".
- Field value cannot be left blank.

**Uses**
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Used to calculate Total GCS.

**Data Source Hierarchy**
- ED Records
- Physician’s Progress Notes

**Other Associated Elements**
- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O₂ SAT
- 1st ED/HOSPITAL VS: ON O₂?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS – TOTAL
- 1st ED/HOSPITAL VS: GCS MODIFIERS
1st ED/HOSPITAL VS: GCS – VERBAL

**Definition**

The Glasgow Coma Scale (GCS) numerical value that corresponds to the patient’s initial verbal response to stimuli, recorded within 30 minutes of ED/hospital arrival.

**Field Values**

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ADULT</strong></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Oriented X 3</td>
</tr>
<tr>
<td>4</td>
<td>Confused</td>
</tr>
<tr>
<td>3</td>
<td>Inappropriate words</td>
</tr>
<tr>
<td>2</td>
<td>Incomprehensible sounds</td>
</tr>
<tr>
<td>1</td>
<td>No verbal response</td>
</tr>
<tr>
<td><strong>INFANT</strong></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Smiles and tracks objects, speech appropriate for age</td>
</tr>
<tr>
<td>4</td>
<td>Cries but consolable, or confused</td>
</tr>
<tr>
<td>3</td>
<td>Inconsistently consolable, or random words</td>
</tr>
<tr>
<td>2</td>
<td>Moaning, incoherent sounds only</td>
</tr>
<tr>
<td>1</td>
<td>No verbal response</td>
</tr>
</tbody>
</table>

**Additional Information**

- If the patient is intubated, then the GCS Verbal score is equal to 1.
- Enter the null value of “Not Documented” if the first recorded GCS verbal score is not within 30 minutes of ED/hospital arrival.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

**Uses**

- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Used to calculate Total GCS.

**Data Source Hierarchy**

- ED Records
- Physician’s Progress Notes

**Other Associated Elements**

- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O₂ SAT
- 1st ED/HOSPITAL VS: ON O₂?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS
• 1st ED/HOSPITAL VS: TEMP TIME
• 1st ED/HOSPITAL VS: GCS – EYE
• 1st ED/HOSPITAL VS: GCS – MOTOR
• 1st ED/HOSPITAL VS: GCS – TOTAL
• 1st ED/HOSPITAL VS: GCS MODIFIERS
Definition
The Glasgow Coma Scale (GCS) numerical value that corresponds to the patient’s initial motor response to stimuli, recorded within 30 minutes of ED/hospital arrival.

Field Values

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

Additional Information
- Enter the null value of “Not Documented” if the first recorded GCS motor score is not within 30 minutes of ED/hospital arrival.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

Uses
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Used to calculate Total GCS.

Data Source Hierarchy
- ED Records
- Physician’s Progress Notes

Other Associated Elements
- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O₂ SAT
- 1st ED/HOSPITAL VS: ON O₂?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – TOTAL
- 1st ED/HOSPITAL VS: GCS MODIFIERS
1st ED/HOSPITAL VS: GCS – TOTAL

Definition
Sum of the initial three numerical values for each element of the Glasgow Coma Scale, recorded within 30 minutes of ED/hospital arrival.

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

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, 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.

Uses
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Used to calculate Revised Trauma Score - EMS (adult & pediatric).

Data Source Hierarchy
- ED Records
- Physician’s Progress Notes

Other Associated Elements
- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O2 SAT
- 1st ED/HOSPITAL VS: ON O2?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS MODIFIERS
1st ED/HOSPITAL VS: GCS MODIFIERS

Definition
Indicates the presence of factors that could potentially affect the first GCS assessment within 30 minutes of ED/hospital 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>Not Applicable</td>
<td>Valid GCS: Patient was not sedated, not intubated, and did not have obstruction to the eye</td>
</tr>
</tbody>
</table>

Chemically Sedated or Paralyzed
Obstruction to the Patient’s Eye
Intubated

Additional Information
- Refers to 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.).
- Intubation includes alternate airway devices (e.g. LMA, etc.).
- Enter the null value of “Not Applicable” if the patient was not chemically sedated, intubated, and did not have eye obstruction.
- Field value cannot be left blank.

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

Data Source Hierarchy
- ED Records
- Physician’s Progress Notes

Other Associated Elements
- 1st ED/HOSPITAL VS: DATE
- 1st ED/HOSPITAL VS: TIME
- 1st ED/HOSPITAL VS: SBP
- 1st ED/HOSPITAL VS: DBP
- 1st ED/HOSPITAL VS: HR
- 1st ED/HOSPITAL VS: RR
- 1st ED/HOSPITAL VS: RR ASST?
- 1st ED/HOSPITAL VS: O₂ SAT
- 1st ED/HOSPITAL VS: ON O₂?
- 1st ED/HOSPITAL VS: TEMP
- 1st ED/HOSPITAL VS: TEMP UNITS
- 1st ED/HOSPITAL VS: TEMP TIME
- 1st ED/HOSPITAL VS: GCS – EYE
- 1st ED/HOSPITAL VS: GCS – VERBAL
- 1st ED/HOSPITAL VS: GCS – MOTOR
- 1st ED/HOSPITAL VS: GCS – TOTAL
LA TRAUMA DATABASE INCLUSION CRITERIA RATIONALE

Definition
Indicates the primary rationale for inclusion of the patient in the TEMIS database.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>PH</td>
</tr>
<tr>
<td>CG</td>
</tr>
<tr>
<td>AD</td>
</tr>
<tr>
<td>DI</td>
</tr>
<tr>
<td>TS</td>
</tr>
<tr>
<td>NO</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, and are NOT to be utilized by the trauma center as the rationale for LA Trauma Database inclusion for non-EMS patients.
- AD is only utilized for patients that do not meet the PH or CG rules and are admitted for care of an injury after ED evaluation by the Trauma Service.
- Inclusion criteria rationale of AD, MUST involve the evaluation of the Trauma Service in the ED.
- Inclusion criteria rationale of TS, MUST be admitted to the Trauma Service for care of an injury.
- 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 and/or Anatomical Criteria MUST exist (14, 70, 90, CB, 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.

Uses
- System evaluation and monitoring.

Data Source Hierarchy
- ED Records
- EMS Record
- Billing Sheet/Medical Records Coding Summary Sheet

Other Associated Elements
- DHS PATIENT?
- MET CRITERIA?
- CRITERIA MET
- GUIDELINES/SPECIAL CONSIDERATION MET
ADMITTING PHYSICIAN

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

Field Values
- Free text

Additional Information
- Can either enter the physician’s name or code at discretion of each facility.

Uses
- System evaluation and monitoring.

Data Source Hierarchy
- ED Admission Form
- Billing Sheet/Medical Records Coding Summary Sheet
- ED Records

Other Associated Elements
- ADMITTING SERVICE
ADMITTING SERVICE

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

Field Values

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>LA COUNTY</td>
<td></td>
</tr>
<tr>
<td>ANE</td>
<td>ANESTHESIOLOGY</td>
</tr>
<tr>
<td>BUR</td>
<td>BURN SPECIALIST</td>
</tr>
<tr>
<td>CAR</td>
<td>CARDIOLOGY</td>
</tr>
<tr>
<td>CTS</td>
<td>CARDIOTHORACIC SURGERY</td>
</tr>
<tr>
<td>CCI</td>
<td>CRITICAL CARE INTENSIVIST</td>
</tr>
<tr>
<td>DEN</td>
<td>DENTAL</td>
</tr>
<tr>
<td>DER</td>
<td>DERMATOLOGY</td>
</tr>
<tr>
<td>END</td>
<td>ENDOCRINOLOGY</td>
</tr>
<tr>
<td>FNM</td>
<td>FAMILY MEDICINE</td>
</tr>
<tr>
<td>GAS</td>
<td>GASTROENTEROLOGY</td>
</tr>
<tr>
<td>GES</td>
<td>GENERAL SURGERY</td>
</tr>
<tr>
<td>GER</td>
<td>GERIATRICS</td>
</tr>
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Uses
- System evaluation and monitoring.

Data Source Hierarchy
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet

Other Associated Elements
- ADMITTING PHYSICIAN
TRAUMA TEAM SERVICE

Definition
Services activated to evaluate the patient upon arrival to the ED, if applicable.

Field Values

<table>
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<tr>
<th>LA COUNTY</th>
<th>LA COUNTY</th>
<th>LA COUNTY</th>
</tr>
</thead>
<tbody>
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<td>CRITICAL CARE INTENSIVIST</td>
<td>OBS</td>
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<td>ED PHYSICIAN/ATTENDING</td>
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</tr>
<tr>
<td>INT</td>
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<td>PNS</td>
</tr>
</tbody>
</table>

Additional Information
- Trauma Team composition will vary by facility.
- Services requested that do NOT physically evaluate the patient while in the ED should be listed in the ICU/Acute Care section.

Uses
- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

Data Source Hierarchy
- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet

Other Associated Elements
- PHYSICIAN CODE (Trauma Team)
- REQUEST DATE (Trauma Team)
- REQUEST TIME (Trauma Team)
- STAT? (Trauma Team)
- ARRIVAL DATE (Trauma Team)
- ARRIVAL TIME (Trauma Team)
PHYSICIAN CODE *(Trauma Team)*

**Definition**
Name or code of trauma team (TT) physician activated to evaluate the patient upon arrival to the ED, if applicable.

**Field Values**
- Free text

**Additional Information**
- Enter physician name or code directly, or create facility-specific picklist.
- Services requested that do NOT physically evaluate the patient while in the ED should be listed in the ICU/Acute Care section.

**Uses**
- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

**Data Source Hierarchy**
- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**
- TRAUMA TEAM SERVICE
- REQUEST DATE *(Trauma Team)*
- REQUEST TIME *(Trauma Team)*
- STAT? *(Trauma Team)*
- ARRIVAL DATE *(Trauma Team)*
- ARRIVAL TIME *(Trauma Team)*
REQUEST DATE *(Trauma Team)*

**Definition**
Date that trauma team physician was activated to evaluate the patient upon arrival to the ED, if applicable.

**Field Values**
- Collected as MMDDYYYY

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

**Uses**
- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

**Data Source Hierarchy**
- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**
- TRAUMA TEAM SERVICE
- PHYSICIAN SERVICE *(Trauma Team)*
- REQUEST TIME *(Trauma Team)*
- STAT? *(Trauma Team)*
- ARRIVAL DATE *(Trauma Team)*
- ARRIVAL TIME *(Trauma Team)*
REQUEST TIME (Trauma Team)

Definition
Time of day that trauma team physician was activated to evaluate the patient upon arrival to the ED, if applicable.

Field Values
- Collected as HHMM
- Use 24-hour clock

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

Uses
- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

Data Source Hierarchy
- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet

Other Associated Elements
- TRAUMA TEAM SERVICE
- PHYSICIAN SERVICE (Trauma Team)
- REQUEST DATE (Trauma Team)
- STAT? (Trauma Team)
- ARRIVAL DATE (Trauma Team)
- ARRIVAL TIME (Trauma Team)
STAT? *(Trauma Team)*

**Definition**
Indicates whether the trauma team physician was requested to respond immediately (responding without delay when notified) to evaluate the injured patient upon arrival to the ED.

**Field Values**
- **Y**: Yes
- **N**: No

**Uses**
- Assists with determination of appropriate treatment.
- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

**Data Source Hierarchy**
- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**
- TRAUMA TEAM SERVICE
- PHYSICIAN CODE *(Trauma Team)*
- REQUEST DATE *(Trauma Team)*
- REQUEST TIME *(Trauma Team)*
- ARRIVAL DATE *(Trauma Team)*
- ARRIVAL TIME *(Trauma Team)*
ARRIVAL DATE (Trauma Team)

Definition
Date 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
- Collected as MMDDYYYY

Additional Information
- Trauma Team member equal to “TRS” will be mapped to NTDS’s “Trauma Surgeon Arrival Date”.
- 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.

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

Data Source Hierarchy
- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet

Other Associated Elements
- TRAUMA TEAM SERVICE
- PHYSICIAN CODE (Trauma Team)
- REQUEST DATE (Trauma Team)
- REQUEST TIME (Trauma Team)
- STAT? (Trauma Team)
- ARRIVAL TIME (Trauma Team)
ARRIVAL TIME (*Trauma Team*)

**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**
- Collected as HHMM
- Use 24-hour clock

**Additional Information**
- Trauma Team member equal to “TRS” will be mapped to NTDS’s “Trauma Surgeon Arrival 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.

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

**Data Source Hierarchy**
- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**
- TRAUMA TEAM SERVICE
- PHYSICIAN CODE (*Trauma Team*)
- REQUEST DATE (*Trauma Team*)
- REQUEST TIME (*Trauma Team*)
- STAT? (*Trauma Team*)
- ARRIVAL DATE (*Trauma Team*)
CONSULTATION SERVICE

Definition

Services consulted to evaluate the patient during the ED phase of care, if applicable.

Field Values

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<tr>
<th>Field Values</th>
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Additional Information

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

Uses

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

Data Source Hierarchy

- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet

Other Associated Elements

- PHYSICIAN CODE (ED Consult)
- REQUEST TIME (ED Consult)
- STAT? (ED Consult)
- ARRIVAL TIME (ED Consult)
PHYSICIAN CODE *(ED Consult)*

**Definition**
Name or code of physician consulted to evaluate the patient during the ED phase of care, if applicable.

**Field Values**
- Free text

**Additional Information**
- Enter physician name or code directly, or create facility-specific picklist.
- Services requested that do NOT physically evaluate the patient while in the ED should be listed in the *ICU/Acute Care* section.

**Uses**
- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

**Data Source Hierarchy**
- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**
- CONSULTATION SERVICES
- REQUEST DATE *(ED Consult)*
- REQUEST TIME *(ED Consult)*
- STAT? *(ED Consult)*
- ARRIVAL DATE *(ED Consult)*
- ARRIVAL TIME *(ED Consult)*
REQUEST DATE *(ED Consult)*

**Definition**
Date that the consult services was requested to evaluate the patient in the ED phase of care, if applicable.

**Field Values**
- Collected as MMDDYYYY

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

**Uses**
- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

**Data Source Hierarchy**
- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**
- CONSULTATION SERVICES
- PHYSICIAN CODE *(ED Consult)*
- REQUEST TIME *(ED Consult)*
- STAT? *(ED Consult)*
- ARRIVAL DATE *(ED Consult)*
- ARRIVAL TIME *(ED Consult)*
REQUEST TIME (*ED Consult*)

**Definition**
Time of day that the consult services was requested to evaluate the patient in the ED phase of care, if applicable.

**Field Values**
- Collected as HHMM
- Use 24-hour clock

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

**Uses**
- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

**Data Source Hierarchy**
- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**
- CONSULTATION SERVICES
- PHYSICIAN CODE (*ED Consult*)
- REQUEST DATE (*ED Consult*)
- STAT? (*ED Consult*)
- ARRIVAL DATE (*ED Consult*)
- ARRIVAL TIME (*ED Consult*)
STAT? (ED Consult)

Definition
Indicates whether the consulting service physician was requested to respond immediately (responding without delay when notified) to evaluate the patient in the ED phase of care, if applicable.

Field Values
- **Y**: Yes
- **N**: No

Uses
- Assists with determination of appropriate treatment.
- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

Data Source Hierarchy
- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet

Other Associated Elements
- CONSULTATION SERVICES
- PHYSICIAN CODE (ED Consult)
- REQUEST DATE (ED Consult)
- REQUEST TIME (ED Consult)
- ARRIVAL DATE (ED Consult)
- ARRIVAL TIME (ED Consult)
ARRIVAL DATE (ED Consult)

Definition
Date that the consulting services arrived at the bedside to evaluate the injured patient in the ED phase of care, if applicable.

Field Values
- Collected as MMDDYYYY

Additional Information
- 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.

Uses
- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

Data Source Hierarchy
- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet

Other Associated Elements
- CONSULTATION SERVICES
- PHYSICIAN CODE ED (Consult)
- REQUEST TIME (ED Consult)
- STAT? (ED Consult)
- ARRIVAL TIME (ED Consult)
ARRIVAL TIME (ED Consult)

Definition
Time of day that the consulting services arrived at the bedside to evaluate the injured patient in the ED phase of care, if applicable.

Field Values
- Collected as HHMM
- Use 24-hour clock

Additional Information
- 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.

Uses
- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

Data Source Hierarchy
- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet

Other Associated Elements
- CONSULTATION SERVICES
- PHYSICIAN CODE ED (Consult)
- REQUEST TIME (ED Consult)
- STAT? (ED Consult)
- ARRIVAL DATE (ED Consult)
1ST ANTIBIOTIC ADMINISTRATION DATE

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

Collection Criterion
- COLLECT ON ALL TRAUMA PATIENTS THAT MEET THE LA TRAUMA DATABASE INCLUSION CRITERIA WITH ANY OPEN FRACTURE.

Field Values
- Collected as MMDDYYYY

Additional Information
- Open fractures as defined by the codes listed in Association for the Advancement of Automotive Medicine Abbreviated Injury Scale (AIS) Coding Rules and Guidelines.
- Enter the null value of “Not Applicable” for patients that do not meet the collection criteria.

Uses
- Used in calculating time interval of time of arrival to antibiotic administration.
- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

Data Source Hierarchy
- ED Records

Other Associated Elements
- 1ST ANTIBIOTIC ADMINISTRATION TIME
- ARRIVAL DATE
- ARRIVAL TIME
1ST ANTIBIOTIC ADMINISTRATION TIME

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

Collection Criterion
• COLLECT ON ALL TRAUMA PATIENTS THAT MEET THE LA TRAUMA DATABASE INCLUSION CRITERIA WITH ANY OPEN FRACTURE.

Field Values
• Collected as HHMM
• Use 24-hour clock

Additional Information
• Open fractures as defined by the codes listed in Association for the Advancement of Automotive Medicine Abbreviated Injury Scale (AIS) Coding Rules and Guidelines.
• The null value of “Not Applicable” is used for patients that do not meet the collection criteria.

Uses
• Used in calculating time interval of time of arrival to antibiotic administration.
• Establishes care intervals and incident timelines.
• System evaluation and monitoring.

Data Source Hierarchy
• ED Records

Other Associated Elements
• 1ST ANTIBIOTIC ADMINISTRATION DATE
• ARRIVAL DATE
• ARRIVAL TIME
IV FLUIDS IN ED

Definition
Total amount of all crystalloids and colloids, excluding blood products, received by the patient in the ED.

Field Values
- Up to five-digit positive numeric value.

Additional Information
- Collected as milliliters – not liters or units.
- Enter the null value of "Not Documented" if IV fluids are documented, but the specific amount is not recorded.

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

Data Source Hierarchy
- ED Records
**SIGN OF LIFE ON ARRIVAL?**

**Definition**
Indicates whether the patient arrived in the ED/Hospital with signs of life.

**Field Values**
- Y: Yes
- N: No

**Additional Information**
- A patient with no signs of life is defined as having none of the following:
  - Organized ECG activity
  - Pupillary responses
  - Spontaneous respiratory effort
  - Unassisted blood pressure
- 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 “No”, 1st ED VS SBP, HR, and RR must be 0.

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

**Data Source Hierarchy**
- ED Records

**Other Associated Elements**
- DEATH IN ED
- NEXT PHASE AFTER ED
- ED EXIT ED DATE
- ED EXIT TIME
- TRANSFERRED/DISCHARGED TO
- PHASE PRIOR TO DISCHARGE
DEATH IN ED

Definition
Provides details on patients who are declared Dead on Arrival (DOA) or who died in the ED.

Field Values

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
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<td>Death declared on arrival no resuscitative efforts initiated in the ED.</td>
</tr>
<tr>
<td>F</td>
<td>Failed Resuscitation</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>
<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.
- Enter the null value of “Not Applicable” if the patient did not die in the ED

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

Data Source Hierarchy
- ED Records

Other Associated Elements
- SIGNS OF LIFE ON ARRIVAL?
- NEXT PHASE AFTER ED
- ED EXIT DATE
- ED EXIT TIME
- TRANSFERRED/DISCHARGED TO
- PHASE PRIOR TO DISCHARGE
NEXT PHASE AFTER ED

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>Next Phase After ED</td>
<td>ED Discharge Disposition</td>
</tr>
<tr>
<td>23HR OBS</td>
<td>&lt; 24 hour Observation</td>
</tr>
<tr>
<td>ICU</td>
<td>Intensive/Critical Care Unit</td>
</tr>
<tr>
<td>INT RAD</td>
<td>Interventional Radiology</td>
</tr>
<tr>
<td>OR</td>
<td>Operating Room</td>
</tr>
<tr>
<td>PICU</td>
<td>Pediatric ICU</td>
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<td>PEDSWARD</td>
<td>Pediatric Ward</td>
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<tr>
<td>SPECIAL</td>
<td>Special Procedures</td>
</tr>
<tr>
<td>STEPDOWN</td>
<td>Stepdown or Telemetry Unit</td>
</tr>
<tr>
<td>WARD</td>
<td>Ward/Floor</td>
</tr>
<tr>
<td>POSTHOSP</td>
<td>Posthospital - (Use LA County “Transfered/Discharged To:”)</td>
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<table>
<thead>
<tr>
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</tbody>
</table>

Additional Information

- Next phase begins when patient is no longer being cared for by the ED or ED personnel, except for Interventional Radiology and/or Special procedures.
- All patients admitted to observation status, regardless of their actual physical location – use 23hr OBS as the next phase after ED.
- ICU Admission is based upon the level of care the patient requires, and not the location of the patient within the hospital. If the patient is admitted to the ICU for a monitored bed only, the patient’s next phase after ED should be documented as Stepdown NOT ICU.

Uses

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

Data Source Hierarchy

- ED Records

Other Associated Elements

- ED EXIT DATE
- ED EXIT TIME
- DEATH IN ED
- TRANSFERRED/DISCHARGED TO
RADIOLOGY/LABORATORY
RADIOLOGY: Body Part/ICD-10

Definition
Body region and ICD-10 code of the radiological studies performed that were essential to the diagnosis of the 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>
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<tr>
<td>Head / Skull</td>
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<td>BW28ZZZ</td>
<td>BW281ZZZ</td>
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<td>BP06ZZZ</td>
<td>BP2EZZZ</td>
<td>BP2E1ZZZ</td>
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<td>B0201ZZZ</td>
<td>B0201ZZZ</td>
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<td>BP2NZZZ</td>
<td>BP2N1ZZZ</td>
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<tr>
<td>Orbits</td>
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<td>BN23ZZZ</td>
<td>BN231ZZZ</td>
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<td>BP2L1ZZZ</td>
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<td>BP2J1ZZZ</td>
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<td>BP2GZZZ</td>
<td>BP2G1ZZZ</td>
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<tr>
<td>NECK / SPINE</td>
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<td>Neck</td>
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<td>BW2F1ZZZ</td>
<td>BW2F1ZZZ</td>
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<td>BP2F1ZZZ</td>
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<td>Thoracic spine</td>
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<td>BP2MZZZ</td>
<td>BP2M1ZZZ</td>
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<td>CHEST / ABDOMEN</td>
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<td>BW241ZZZ</td>
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<td>Chest &amp; Abdomen</td>
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<td>BW241ZZZ</td>
<td>BW241ZZZ</td>
<td>Left clavicle</td>
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<td>BP251ZZZ</td>
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<td>Left Ribs</td>
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<td>Heart / Lung</td>
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<td>Right ankle</td>
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<td>Abdomen / Pelvis</td>
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<td>Kidneys (KUB)</td>
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<td>BT231ZZZ</td>
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<td>Right tibia/fibula</td>
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<td>Left Kidney</td>
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<td>BT221ZZZ</td>
<td>Right hip</td>
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<td>Right scapula</td>
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<td>Left hip</td>
<td>BW01ZZZ</td>
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</tbody>
</table>

Additional Information
- Head CT results are NOT considered abnormal if a facial fracture is 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”.
- A larger version of the above table can be found in Appendix 2.

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

Data Source Hierarchy
- Radiology Records
- ED Records

Other Associated Elements
- ED Records
- Other Information
- ICD-10

Section RL – Radiology/Laboratory
- RADIOLOGY: Date
- RADIOLOGY: Time
- RADIOLOGY: Result
- RADIOLOGY: Description
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 Values</th>
<th>LA COUNTY</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>Other</td>
<td>Other Study</td>
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</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 either procedure 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 if they identify missed injuries.
- 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.

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

Data Source Hierarchy
- Radiology Records
- ED Records

Other Associated Elements
- RADIOLOGY: Body Part/ICD-10
- RADIOLOGY: Date
- RADIOLOGY: Time
- RADIOLOGY: Result
- RADIOLOGY: Description
RADIOLOGY: Date

Definition
Date radiological studies were performed, if applicable.

Field Values
- Collected as MMDDYYYY

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

Data Source Hierarchy
- Radiology Records
- ED Records

Other Associated Elements
- RADIOLOGY: Body Part/ICD-10
- RADIOLOGY: Study
- RADIOLOGY: Time
- RADIOLOGY: Result
- RADIOLOGY: Description
RADIOLOGY: Time

Definition
Time of day that radiological studies were performed, if applicable.

Field Values
- Collected as HHMM
- Use 24-hour clock

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

Data Source Hierarchy
- Radiology Records
- ED Records

Other Associated Elements
- RADIOLOGY: Body Part/ICD-10
- RADIOLOGY: Study
- RADIOLOGY: Date
- RADIOLOGY: Result
- RADIOLOGY: Description
RADIOLOGY: Result

Definition
Results of radiological studies, if applicable.

Field Values
- N: Normal
- A: Abnormal

Additional Information
- Abnormal results are radiological findings due to the traumatic event. For example, a cervical spine x-ray with degenerative findings, is an abnormality; however, it is not a result of trauma. Therefore, the cervical spine x-ray would be considered normal.
- Head CT results are NOT considered abnormal if a facial fracture is the only abnormality identified.
- (Radiology) results are ONLY considered abnormal if the abnormality identified corresponds to the ordered body region being imaged, e.g. C-spine should not be identified as abnormal due to rib fractures previously identified on the CXR.
- “Possible”, “Probable”, “Questionable”, etc. radiology findings not substantiated by the discharge diagnosis should not be recorded as abnormal.

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

Data Source Hierarchy
- Radiology Records
- ED Records

Other Associated Elements
- RADIOLOGY: Body Part/ICD-10
- RADIOLOGY: Study
- RADIOLOGY: Date
- RADIOLOGY: Time
- RADIOLOGY: Description
RADIOLOGY: Description

**Definition**
Comments or additional information pertaining to radiology testing performed.

**Field Values**
- Free text

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

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

**Data Source Hierarchy**
- Radiology Records
- ED Records

**Other Associated Elements**
- RADIOLOGY: Body Part/ICD-10
- RADIOLOGY: Study
- RADIOLOGY: Date
- RADIOLOGY: Time
- RADIOLOGY: Result
SOLID ORGAN INJURY?

Definition
Indicates whether a solid organ injury exists.

Field Values
- **Y**: Yes
- **N**: No

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

Data Source Hierarchy
- Radiology Records
- ED Records

Other Associated Elements
- **RADIOLOGY**: Body Part/ICD-10
- **RADIOLOGY**: Study
- **RADIOLOGY**: Date
- **RADIOLOGY**: Time
- **RADIOLOGY**: Result
- **RADIOLOGY**: Description
- **ORGANS INJURED**
- **ORGAN GRADE – Liver**
- **ORGAN GRADE – Spleen**
- **ORGAN GRADE – Kidney**
ORGANS INJURED

Definition
Indicates which solid organ(s) were injured.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
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</thead>
<tbody>
<tr>
<td>LIVER</td>
<td>Liver</td>
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<td>Spleen</td>
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<tr>
<td>R KIDNEY</td>
<td>Right kidney</td>
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<tr>
<td>L KIDNEY</td>
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Uses
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

Data Source Hierarchy
- Radiology Records
- ED Records

Other Associated Elements
- RADIOLOGY: Body Part/ICD-10
- RADIOLOGY: Study
- RADIOLOGY: Date
- RADIOLOGY: Time
- RADIOLOGY: Result
- RADIOLOGY: Description
- SOLID ORGAN INJURY?
- ORGAN GRADE – Liver
- ORGAN GRADE – Spleen
- ORGAN GRADE – Kidney
ORGAN GRADE – Liver

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

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
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<tbody>
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<td><strong>Grade VI</strong></td>
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Uses
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

Data Source Hierarchy
- Radiology Records
- ED Records

Other Associated Elements
- RADIOLOGY: Body Part/ICD-10
- RADIOLOGY: Study
- RADIOLOGY: Date
- RADIOLOGY: Time
- RADIOLOGY: Result
- RADIOLOGY: Description
- SOLID ORGAN INJURY?
- ORGANS INJURED
- ORGAN GRADE – Spleen
- ORGAN GRADE – Kidney
### ORGAN GRADE – Spleen

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

#### Field Values

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<tbody>
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<td><strong>Grade V</strong></td>
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</table>

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

**Data Source Hierarchy**
- Radiology Records
- ED Records

**Other Associated Elements**
- RADIOLoGY: Body Part/ICD-10
- RADIOLoGY: Study
- RADIOLoGY: Date
- RADIOLoGY: Time
- RADIOLoGY: Result
- RADIOLoGY: Description
- SOLID ORGAN INJURY?
- ORGANS INJURED
- ORGAN GRADE – Liver
- ORGAN GRADE – Kidney
ORGAN GRADE – Kidney

Definition
Results of solid organ grading of one or both kidney(s), if applicable.

Field Values

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

Additional Information
- If both kidneys are injured, enter grading for both.

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

Data Source Hierarchy
- Radiology Records
- ED Records

Other Associated Elements
- RADILOGY: Body Part/ICD-10
- RADILOGY: Study
- RADILOGY: Date
- RADILOGY: Time
- RADILOGY: Result
- RADILOGY: Description
- SOLID ORGAN INJURY?
- ORGANS INJURED
- ORGAN GRADE – Liver
- ORGAN GRADE – Spleen
Definition
Date laboratory testing was performed, if applicable.

Field Values
- Collected as MMDDYYYY

Additional Information
- Scrolling window fields: enter date, time, group/panel, description and results for each test as applicable.

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

Data Source Hierarchy
- Lab Results
- ED Records

Other Associated Elements
- LABORATORY: Time
- LABORATORY: Group/Panel
- LABORATORY: Result
- LABORATORY: Description
LABORATORY: Time

Definition
Time of day laboratory testing was performed, if applicable.

Field Values
- Collected as HHMM
- Use 24-hour clock

Additional Information
- Scrolling window fields: enter time, group/panel, description, and results for each test as applicable.

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

Data Source Hierarchy
- Lab Results
- ED Records

Other Associated Elements
- LABORATORY: Date
- LABORATORY: Group/Panel
- LABORATORY: Result
- LABORATORY: Description
LABORATORY: Group/Panel

Definition
Type of laboratory testing performed, if applicable.

Field Values
- 24 Hour Urinalysis
- Blood Bank – Type & Cross
- Blood Bank – Type & Hold
- Blood Gas
- Cardiac Enzyme Fractions
- Cerebrospinal Fluid
- Chemistry
- Coagulation Studies
- Cultures
- Electrolytes
- Hemoglobin
- 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.

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

Data Source Hierarchy
- Lab Results
- ED Records

Other Associated Elements
- LABORATORY: Date
- LABORATORY: Time
- LABORATORY: Result
- LABORATORY: Description
LABORATORY: Result

Definition
Results of laboratory testing performed, if applicable.

Field Values
- N: Normal
- A: Abnormal

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.

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

Data Source Hierarchy
- Lab Results
- ED Records

Other Associated Elements
- LABORATORY: Date
- LABORATORY: Time
- LABORATORY: Group/Panel
- LABORATORY: Description
LABORATORY: Description

Definition
Comments or additional information pertaining to laboratory testing performed.

Field Values
- Free text

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

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

Data Source Hierarchy
- Lab Results
- ED Records

Other Associated Elements
- LABORATORY: Date
- LABORATORY: Time
- LABORATORY: Group/Panel
- LABORATORY: Results
ETOH/TOXICOLOGY: Date

Definition
Date ETOH/Toxicology testing occurred, if applicable.

Field Values
- Collected as MMDDYYYY

Additional Information
- Scrolling window fields: enter time, specimen source, substance, results, and comments for each test as applicable.
- Must be within 24 hours of ED/hospital arrival.
- Enter the null value of “Not Applicable” if ETOH/Toxicology testing was not done.

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

Data Source Hierarchy
- Lab Results
- ED Records

Other Associated Elements
- ETOH/TOXICOLOGY: Time
- ETOH/TOXICOLOGY: Substance
- ETOH/TOXICOLOGY: Source
- ETOH/TOXICOLOGY: Result
- ETOH VALUE
- ETOH UNITS
ETOH/TOXICOLOGY: Time

Definition
Time of day ETOH/Toxicology testing occurred, if applicable.

Field Values
- Collected as HHMM
- Use 24-hour clock

Additional Information
- Scrolling window fields: enter time, specimen source, substance, results, and comments for each test as applicable. Must be within 24 hours of ED/hospital arrival.
- Must be within 24 hours of ED/Hospital arrival.
- Enter the null value of “Not Applicable” if ETOH/Toxicology testing was not done.

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

Data Source Hierarchy
- Lab Results
- ED Records

Other Associated Elements
- ETOH/TOXICOLOGY: Date
- ETOH/TOXICOLOGY: Substance
- ETOH/TOXICOLOGY: Source
- ETOH/TOXICOLOGY: Result
- ETOH VALUE
- ETOH UNITS
ETOH/TOXICOLOGY: Substance

Definition
Type of toxicology screening that 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</td>
</tr>
<tr>
<td>Toxicology Screen</td>
<td>Drug Screen</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) Ecstasy</td>
<td>6 Ecstasy (MDMA)</td>
</tr>
<tr>
<td>Methadone</td>
<td>7 Methadone (MTD)</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>5 Methamphetamine (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 PERFORMED**, 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 PERFORMED** 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 instead of the picklist value of “Toxicology Screen”.
- Must be within 24 hours of ED/hospital arrival.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

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

Data Source Hierarchy
- Lab Results
- ED Records

Other Associated Elements
- ETOH/TOXICOLOGY: Date
- ETOH/TOXICOLOGY: Time
- ETOH/TOXICOLOGY: Source
- ETOH/TOXICOLOGY: Result
- ETOH VALUE
- ETOH UNITS
ETOH/TOXICOLOGY: Source

Definition
Specimen type used for ETOH/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.
- Must be within 24 hours of ED/hospital arrival.
- Enter the null value of “Not Applicable” if ETOH/Toxicology testing was not done.

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

Data Source Hierarchy
- Lab Results
- ED Records

Other Associated Elements
- ETOH/TOXICOLOGY: Date
- ETOH/TOXICOLOGY: Time
- ETOH/TOXICOLOGY: Substance
- ETOH/TOXICOLOGY: Result
- ETOH VALUE
- ETOH UNITS
ETOH/TOXICOLOGY: Result

Definition
Results of ETOH/toxicology testing, if applicable.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>ETOH/Toxicology</th>
<th>NTDS</th>
<th>Drug Screen</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOUND (Positive)</td>
<td>1 YES 1-13</td>
<td>ENTER IDENTIFIED TOXIN(S)</td>
<td></td>
</tr>
<tr>
<td>NOT FOUND (Negative/None)</td>
<td>1 YES 14</td>
<td>NONE</td>
<td></td>
</tr>
<tr>
<td>NOT TESTED</td>
<td>2 NO 15</td>
<td>NOT TESTED</td>
<td></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 PERFORMED**, 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 instead of the picklist value of "Toxicology Screen".
- If an ETOH Screen (Blood Alcohol Concentration [BAC]) was performed, a numeric value **MUST** be entered in the ETOH "Value" field.
- If ETOH Screen BAC results are NOT FOUND (Negative/None), a numeric value of "0" **MUST** be entered for the ETOH "Value" field.
- "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 control.
- Must be within 24 hour of ED/hospital arrival.
- Field value cannot be "Not Applicable".
- Field value cannot be left blank.

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

Data Source Hierarchy
- Lab Results
- ED Records

Other Associated Elements
- ETOH/TOXICOLOGY: Date
- ETOH/TOXICOLOGY: Time
- ETOH/TOXICOLOGY: Substance
- ETOH/TOXICOLOGY: Source
- ETOH VALUE
- ETOH UNITS
ETOH VALUE

Definition
Numeric value for blood alcohol concentration (BAC) results, if applicable.

Field Values
- Up to three-digit positive numeric value

Additional Information
- If an ETOH Screen (Blood Alcohol Concentration [BAC]) was performed, a numeric value received from your lab MUST be entered.
- If ETOH Screen BAC results are NOT FOUND (Negative/None), a numeric value of “0” MUST be entered.
- Must be within 24 hours of ED/hospital arrival.
- Enter the null value of “Not Applicable” for patients that were not tested for ETOH.
- Field value cannot be left blank.

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

Data Source Hierarchy
- Lab Results
- ED Records

Other Associated Elements
- ETOH/TOXICOLOGY: Date
- ETOH/TOXICOLOGY: Time
- ETOH/TOXICOLOGY: Substance
- ETOH/TOXICOLOGY: Source
- ETOH/TOXICOLOGY: Result
- ETOH UNITS
ETOH UNITS

Definition
Units used by your facility’s laboratory for reporting blood alcohol concentration (BAC), if applicable.

Field Values
- g/dl (grams/deciliter)
- mg/dl (milligrams/deciliter)

Additional Information
- If an ETOH Screen BAC was completed, and a numeric value was entered for the ETOH Value, even a numeric value of “0”, enter the ETOH units used by your facility’s laboratory for reporting BAC.
- BAC values entered as mg/dl (whole numbers) will be converted to g/dl (decimal numbers) prior to data submission to NTDS®/TQIP®.
- Enter the null value of “Not Applicable” for patients that were not tested for ETOH.

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

Data Source Hierarchy
- Lab Results
- ED Records

Other Associated Elements
- ETOH/TOXICOLOGY: Date
- ETOH/TOXICOLOGY: Time
- ETOH/TOXICOLOGY: Substance
- ETOH/TOXICOLOGY: Source
- ETOH/TOXICOLOGY: Result
- ETOH VALUE
MASSIVE TRANSFUSION PROTOCOL (MTP) ACTIVATED?

**Definition**
Indicates whether the Massive Transfusion Protocol (MTP) was activated within the **first four hours** of ED/hospital arrival.

**Field Values**
- **Y**: Yes
- **N**: No

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

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

**Data Source Hierarchy**
- Trauma Flow Sheet
- ED Records
- Blood Bank Records
- Transfusion Records

**Other Associated Elements**
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS
TQIP® BLOOD INCLUSION?

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

Field Values
- **Y**: Yes
- **N**: No

Additional Information
- Utilize the Blood Info button to access all information regarding blood collection.
- Enter a value of “No” if the patient did not receive blood.

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

Data Source Hierarchy
- Trauma Flow Sheet
- ED Records
- Physician’s Progress Notes
- Operative Report
- Other Hospital Records

Other Associated Elements
- MTP ACTIVATED?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS
LOWEST SYSTOLIC BLOOD PRESSURE (SBP)

Definition
Numeric value of the patient’s lowest systolic blood pressure (SBP) **WITHIN THE FIRST HOUR** of ED/hospital arrival.

Collection Criterion
**COLLECT ON ALL PATIENTS WITH TRANSFUDED PACKED RED BLOOD CELLS OR WHOLE BLOOD WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL.**

Field Values
- Up to three-digit positive numeric value

Additional Information
- Utilize the **Blood Info** button to access all information regarding blood collection.
- Enter the null value of “Not Applicable” if the patient did not meet the collection criteria.

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

Data Source Hierarchy
- Trauma Flow Sheet
- ED Records
- Physician’s Progress Notes
- Operative Report
- Other Hospital Records

Other Associated Elements
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS
WHOLE BLOOD (4 HOURS)

Definition
Total volume of whole blood received by the patient during the first 4 hours of care.

COLLECTION CRITERION
COLLECT ON ALL PATIENTS

Field Values
- Up to five-digit positive numeric value

Additional Information
- Collected in ccs.
- 1 unit of whole blood is equivalent to 500 ccs if the actual volume of the unit is not documented.
- If whole blood was not given in the first 4 hours, then enter the volume as zero.
- Volume should never be “Not Applicable”.

Uses
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

Data Source Hierarchy
- ED Records
- Blood Bank Records
- Transfusion Record
- Other Hospital Records

Other Associated Elements
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- PRBC (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS
PACKED CELLS (PRBC) (4 HOURS)

**Definition**
Total volume of packed red blood cells (PRBCs) received by the patient during the **first four hours** of care.

**COLLECTION CRITERION**
COLLECT ON ALL PATIENTS

**Field Values**
- Up to five-digit positive numeric value

**Additional Information**
- Collected in ccs.
- **1 unit of PRBCs** is equivalent to **350 ccs** if the actual volume of the unit is not documented.
- If no PRBCs were given in the first 4 hours, then enter the volume as zero.
- Volume should never be “Not Applicable”.

**Uses**
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

**Data Source Hierarchy**
- ED Records
- Blood Bank Records
- Transfusion Records

**Other Associated Elements**
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS
PLASMA (FFP) *(4 HOURS)*

**Definition**
Total volume of fresh frozen plasma (FFP) received by the patient during the **first four hours** of care.

**COLLECTION CRITERION**
**COLLECT ON ALL PATIENTS**

**Field Values**
- Up to five-digit positive numeric value

**Additional Information**
- Collected in ccs.
- **1 unit of plasma** is equivalent to **225 ccs** if the actual volume of the unit is not documented.
- If no plasma was given in the first 4 hours, then enter the volume as zero.
- Volume should never be **“Not Applicable”**.

**Uses**
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

**Data Source Hierarchy**
- ED Records
- Blood Bank Records
- Transfusion Records
- Other Hospital Records

**Other Associated Elements**
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD *(4 HOURS)*
- PRBC *(4 HOURS)*
- PLATELETS *(4 HOURS)*
- CRYOPRECIPITATE *(4 HOURS)*
- WHOLE BLOOD *(24 HOURS)*
- PRBC *(24 HOURS)*
- FFP *(24 HOURS)*
- PLATELETS *(24 HOURS)*
- CRYOPRECIPITATE *(24 HOURS)*
- WHOLE BLOOD *(TOTAL)*
- PRBC *(TOTAL)*
- FFP *(TOTAL)*
- PLATELETS *(TOTAL)*
- CRYOPRECIPITATE *(TOTAL)*
- TOTAL BLOOD PRODUCTS
PLATELETS (4 HOURS)

Definition
Total volume of platelets received by the patient during the first four hours of care.

COLLECTION CRITERION
COLLECT ON ALL PATIENTS

Field Values
- Up to five-digit positive numeric value

Additional Information
- Collected in ccs.
- 1 unit of Platelets is equivalent to 225 ccs if the actual volume of the unit is not documented.
- For facilities utilizing platelet Jumbo Packs, the facility specific unit value equivalent (how many units is a Jumbo Pack equivalent to) must be determine for the data entry of all platelet related data fields, 4 Hours, 24 Hours, and Total.
- If no platelets were given in the first 4 hours, then enter the volume as zero.
- Volume should never be “Not Applicable”.

Uses
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

Data Source Hierarchy
- ED Records
- Blood Bank Records
- Transfusion Records
- Other Hospital Records

Other Associated Elements
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- FFP (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS
CRYOPRECIPITATE (4 HOURS)

Definition
Total volume of cryoprecipitate received by the patient during the first four hours of care.

COLLECTION CRITERION
COLLECT ON ALL PATIENTS

Field Values
- Up to five-digit positive numeric value

Additional Information
- Collected in ccs.
- 1 pack of Cryoprecipitate is equivalent to 100 ccs if the actual volume of the pack is not documented.
- If no cryoprecipitate was given in the first 4 hours, then enter the volume as zero.
- Volume should never be “Not Applicable”.

Uses
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

Data Source Hierarchy
- ED Records
- Blood Bank Records
- Transfusion Records
- Other Hospital Records

Other Associated Elements
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS
WHOLE BLOOD (24 HOURS)

Definition
Total volume of whole blood received by the patient during the first 24 hours of care.

Field Values
- Up to five-digit positive numeric value

Additional Information
- Collected in ccs.
- 1 unit of Whole Blood is equivalent to 500 ccs if the actual volume of the unit is not documented.
- If no whole blood given in the first 24 hours, then enter the volume as zero.
- Volume should never be “Not Applicable”.

Uses
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

Data Source Hierarchy
- ED Records
- Blood Bank Records
- Transfusion Records
- Other Hospital Records

Other Associated Elements
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS
PACKED CELLS (PRBC) (24 HOURS)

Definition
Total volume of PRBCs received by the patient during the first 24 hours of care.

Field Values
- Up to five-digit positive numeric value

Additional Information
- Collected in ccs.
- 1 unit of PRBCs is equivalent to 350 ccs if the actual volume of the unit is not documented.
- If no packed red blood cells were given in the first 24 hours, then enter the volume as zero.
- Volume should never be “Not Applicable”.

Uses
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

Data Source Hierarchy
- ED Records
- Blood Bank Records
- Transfusion Records
- Other Hospital Records

Other Associated Elements
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS
PLASMA (FFP) (24 HOURS)

Definition
Total volume FFP received by the patient during the first 24 hours of care.

Field Values
- Up to five-digit positive numeric value

Additional Information
- Collected in ccs.
- 1 unit of plasma is equivalent to 225 ccs if the actual volume of the unit is not documented.
- If no plasma was given in the first 24 hours, then enter the volume as zero.
- Volume should never be “Not Applicable”.

Uses
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

Data Source Hierarchy
- ED Records
- Blood Bank Records
- Transfusion Records
- Other Hospital Records

Other Associated Elements
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS
PLATELETS (24 HOURS)

Definition
Total volume of platelets received by the patient during the first 24 hours of care.

Field Values
- Up to five-digit positive numeric value

Additional Information
- Collected in ccs.
- 1 unit of Platelets is equivalent to 225 ccs if the actual volume of the unit is not documented.
- For facilities utilizing platelet Jumbo Packs, the facility specific unit value equivalent (how many units is a Jumbo Pack equivalent to) must be determined for the data entry of all platelet related data fields, 4 Hours, 24 Hours, and Total.
- If no platelets were given in the first 24 hours, then enter the volume as zero.
- Volume should never be “Not Applicable”.

Uses
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

Data Source Hierarchy
- ED Records
- Blood Bank Records
- Transfusion Records
- Other Hospital Records

Other Associated Elements
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS
CRYOPRECIPITATE (24 HOURS)

Definition
Total volume of cryoprecipitate received by the patient during the first 24 hours of care.

Field Values
- Up to five-digit positive numeric value

Additional Information
- Collected in ccs.
- 1 pack of Cryoprecipitate is equivalent to 100 ccs if the actual volume of the pack is not documented.
- If no cryoprecipitate was given in the first 24 hours, then enter the volume as zero.
- Volume should never be “Not Applicable”.

Uses
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

Data Source Hierarchy
- ED Records
- Blood Bank Records
- Transfusion Records
- Other Hospital Records

Other Associated Elements
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS
WHOLE BLOOD *(TOTAL)*

**Definition**
Total volume of whole blood received by the patient while hospitalized.

**Field Values**
- Up to five-digit positive numeric value

**Additional Information**
- Collected in ccs.
- 1 unit of Whole Blood is equivalent to 500 ccs if the actual volume of the unit is not documented.
- If no whole blood was given during the patient’s hospital stay, then enter the volume as zero.
- Volume should never be “Not Applicable”.

**Uses**
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

**Data Source Hierarchy**
- ED Records
- Blood Bank Records
- Transfusion Records
- Other Hospital Records

**Other Associated Elements**
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- PRBC (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS
PACKED CELLS (PRBC) *(TOTAL)*

**Definition**
Total volume of PRBCs received by the patient *while hospitalized*.

**Field Values**
- Up to five-digit positive numeric value

**Additional Information**
- Collected in ccs.
- *1 unit of PRBCs* is equivalent to **350 ccs** 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 enter the volume as zero.
- Volume should never be *“Not Applicable”*.

**Uses**
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

**Data Source Hierarchy**
- ED Records
- Blood Bank Records
- Transfusion Records
- Other Hospital Records

**Other Associated Elements**
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD *(4 HOURS)*
- PRBC *(4 HOURS)*
- FFP *(4 HOURS)*
- PLATELETS *(4 HOURS)*
- CRYOPRECIPITATE *(4 HOURS)*
- WHOLE BLOOD *(24 HOURS)*
- PRBC *(24 HOURS)*
- FFP *(24 HOURS)*
- PLATELETS *(24 HOURS)*
- CRYOPRECIPITATE *(24 HOURS)*
- WHOLE BLOOD *(TOTAL)*
- FFP *(TOTAL)*
- PLATELETS *(TOTAL)*
- CRYOPRECIPITATE *(TOTAL)*
- TOTAL BLOOD PRODUCTS
PLASMA (FFP) (*TOTAL*)

Definition
Total volume of FFP received by the patient while hospitalized.

Field Values
- Up to five-digit positive numeric value

Additional Information
- Collected in ccs.
- **1 unit of Plasma** is equivalent to **225 ccs** if the actual volume of the unit is not documented.
- If no plasma was given during the patient’s hospital stay, then enter the volume as zero.
- Volume should never be “Not Applicable”.

Uses
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

Data Source Hierarchy
- ED Records
- Blood Bank Records
- Transfusion Records
- Other Hospital Records

Other Associated Elements
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS
PLATELETS (TOTAL)

Definition
Total volume of platelets received by the patient while hospitalized.

Field Values
- Up to five-digit positive numeric value

Additional Information
- Collected in ccs.
- 1 unit of Platelets is equivalent to 225 ccs if the actual volume of the unit is not documented.
- For facilities utilizing platelet Jumbo Packs, the facility specific unit value equivalent (how many units is a Jumbo Pack equivalent to) must be determine for the data entry of all platelet related data fields, 4 Hours, 24 Hours, and Total.
- If no platelets were given during the patient’s hospital stay, then enter the volume as zero.
- Volume should never be “Not Applicable”.

Uses
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

Data Source Hierarchy
- ED Records
- Blood Bank Records
- Transfusion Records
- Other Hospital Records

Other Associated Elements
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- FFP (TOTAL)
- CRYOPRECIPITATE (TOTAL)
- TOTAL BLOOD PRODUCTS
CRYOPRECIPITATE (*TOTAL*)

**Definition**
Total volume of cryoprecipitate received by the patient while hospitalized.

**Field Values**
- Up to five-digit positive numeric value

**Additional Information**
- Collected in ccs.
- **1 pack of Cryoprecipitate** is equivalent to **100 ccs** if the actual volume of the pack is not documented.
- If no cryoprecipitate was given during the patient’s hospital stay, then enter the volume as zero.
- Volume should never be “Not Applicable”.

**Uses**
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Included in calculation of Total Blood Products.

**Data Source Hierarchy**
- ED Records
- Blood Bank Records
- Transfusion Records
- Other Hospital Records

**Other Associated Elements**
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD *(4 HOURS)*
- PRBC *(4 HOURS)*
- FFP *(4 HOURS)*
- PLATELETS *(4 HOURS)*
- CRYOPRECIPITATE *(4 HOURS)*
- WHOLE BLOOD *(24 HOURS)*
- PRBC *(24 HOURS)*
- FFP *(24 HOURS)*
- PLATELETS *(24 HOURS)*
- CRYOPRECIPITATE *(24 HOURS)*
- WHOLE BLOOD *(TOTAL)*
- PRBC *(TOTAL)*
- FFP *(TOTAL)*
- PLATELETS *(TOTAL)*
- TOTAL BLOOD PRODUCTS
TOTAL BLOOD PRODUCTS

Definition
Total volume of blood products, including whole blood, PRBCs, FFP, platelets, and cryoprecipitate given to the patient while hospitalized.

Field Values
- Up to five-digit positive numeric value

Additional Information
- Auto-calculated using sum of WHOLE BLOOD (TOTAL), PRBC (TOTAL), FFP (TOTAL), PLATELETS (TOTAL), and CRYOPRECIPITATE (TOTAL) values.

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

Data Source Hierarchy
- ED Records
- Blood Bank Records
- Transfusion Records
- Other Hospital Records

Other Associated Elements
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- LOWEST SBP
- WHOLE BLOOD (4 HOURS)
- PRBC (4 HOURS)
- FFP (4 HOURS)
- PLATELETS (4 HOURS)
- CRYOPRECIPITATE (4 HOURS)
- WHOLE BLOOD (24 HOURS)
- PRBC (24 HOURS)
- FFP (24 HOURS)
- PLATELETS (24 HOURS)
- CRYOPRECIPITATE (24 HOURS)
- WHOLE BLOOD (TOTAL)
- PRBC (TOTAL)
- FFP (TOTAL)
- PLATELETS (TOTAL)
- CRYOPRECIPITATE (TOTAL)
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, if applicable.

Field Values
- **23HR OBS**: <24 Hour Observation
- **ED**: Emergency Department
- **ICU**: Intensive/Critical Care Unit
- **INT RAD**: Interventional Radiology
- **OR**: Operating Room
- **PICU**: Pediatric ICU
- **PEDSWARD**: Pediatric Ward
- **READMIT**: Re-Admit
- **SPECIAL**: Special Procedures
- **STEPDOWN**: Stepdown or Telemetry Unit
- **WARD**: Ward/Floor

Additional Information
- 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.

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

Data Source Hierarchy
- OR Records
- ED Records
- Progress Notes
- Other Hospital Records

Other Associated Elements
- **START DATE**
- **START TIME**
- **END TIME**
- **PROCEDURES (ICD-10 Codes)**
- **SURGERY TYPE**
- **PHYSICIAN CODE**
- **TOTAL VENTILATOR DAYS**
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, if applicable.

Field Values
- Collected as MMDDYYYY

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

Data Source Hierarchy
- OR Records
- ED Records
- Progress Notes
- Other Hospital Records

Other Associated Elements
- PHASE BEGUN
- START TIME
- END TIME
- PROCEDURES (ICD-10 Codes)
- SURGERY TYPE
- PHYSICIAN CODE
- TOTAL VENTILATOR DAYS
START TIME

Definition
Time of day 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
- Collected as HHMM
- Use 24-hour clock

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

Data Source Hierarchy
- OR Records
- ED Records
- Progress Notes
- Other Hospital Records

Other Associated Elements
- PHASE BEGUN
- START DATE
- END TIME
- PROCEDURES (ICD-10 Codes)
- SURGERY TYPE
- PHYSICIAN CODE
- TOTAL VENTILATOR DAYS
END TIME

Definition
Time of day 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
- Collected as HHMM
- Use 24-hour clock

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

Data Source Hierarchy
- Operative Reports
- ED Records
- Billing Sheet/Medical Records Coding Summary Sheet
- Progress Notes
- Other Hospital Records

Other Associated Elements
- PHASE BEGUN
- START DATE
- START TIME
- PROCEDURES (ICD-10 Codes)
- SURGERY TYPE
- PHYSICIAN CODE
- TOTAL VENTILATOR DAYS
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, if applicable.

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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<tr>
<td>Central Line Approach:</td>
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<td>Inferior Vena Cava (IVC) Filters</td>
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<td>• Chest, Open</td>
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<td>(temporary or permanent) Approach:</td>
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<td>• Chest, Percutaneous</td>
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<td>• Open</td>
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<td>• Percutaneous Endoscopic</td>
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<td>approach used for placement.</td>
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<td>06H04DZ</td>
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<td>Interventional Angiogram (IA)</td>
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<td>depending on the site and the approach used.</td>
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<td>• Percutaneous Endoscopic</td>
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<td>Diagnostic Peritoneal Lavage (DPL)</td>
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<td>• Via Natural or Artificial Opening Endoscopic</td>
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<td>Ventilator:</td>
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</tbody>
</table>

Additional Information
- 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.

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

Data Source Hierarchy
- Operative Reports
- ED Records
- ICU Records
- Billing Sheet/Medical Records
- Other Hospital Records

Other Associated Elements
- PHASE BEGUN
- START DATE
• START TIME
• END TIME
• SURGERY TYPE
• PHYSICIAN CODE
• TOTAL VENTILATOR DAYS
SURGERY TYPE

Definition
Two-digit numerical code for the type of surgical procedure performed, 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

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

Data Source Hierarchy
- ED Records
- OR Reports
- Anesthesia Record
- Other Hospital Records

Other Associated Elements
- PHASE BEGUN
- START DATE
- START TIME
- END TIME
- PROCEDURES (ICD-10 Codes)
- PHYSICIAN CODE
- TOTAL VENTILATOR DAYS
PHYSICIAN CODE

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

Field Values
- Free text

Additional Information
- Non-picklist – free text physician name or code at discretion of each facility.

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

Data Source Hierarchy
- ED Records
- OR Records
- Anesthesia Record
- Other Hospital Records

Other Associated Elements
- PHASE BEGUN
- START DATE
- START TIME
- END TIME
- PROCEDURES (ICD-10 Codes)
- SURGERY TYPE
- TOTAL VENTILATOR DAYS
TOTAL VENTILATOR DAYS

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

Field Values
- Up to four-digit positive numeric value

Additional Information
- Recorded in full day increments with any partial day entered as one full day.
- Includes all invasive ventilator support days via endotracheal tube or tracheostomy tube.
- Excludes mechanical ventilation time associated with OR 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 a ventilator day.
- Enter the null value of “Not Applicable” if no ventilator episodes are recorded. Do not enter the numeric value of “0”.
- Non-invasive means of ventilatory support (CPAP or BIPAP) should not be considered in the calculation of ventilator days.

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

Data Source Hierarchy
- ED Records
- ICU Records
- Respiratory Therapy Records
- OR Records
- Anesthesia Record
- Progress Notes
- Other Hospital Records

Other Associated Elements
- PHASE BEGUN
- START DATE
- START TIME
- END TIME
- PROCEDURES (ICD-10 Codes)
- SURGERY TYPE
- PHYSICIAN CODE
1st ANGIOGRAPHY

Definition
First interventional angiogram performed for hemorrhage control within the first 24 hours of ED/hospital arrival, if applicable.

Collection Criterion
COLLECT ON ALL PATIENTS WITH TRANSFUSED WHOLE BLOOD OR PRBCs WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL.

Field Values

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

Additional Information
- Enter the null value of “Not Applicable” for patients that do not meet the collection criteria and for those who did not undergo an angiography.
- Excludes CTA.
- Only applies to angiograms performed in the IR suite.
- 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.

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

Data Source Hierarchy
- Radiology Report
- Operative Report
- Progress Notes
- Other Hospital Records

Other Associated Elements
- 1st ANGIOGRAPHY DATE
- 1st ANGIOGRAPHY TIME
- EMBOLIZATION SITES
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- WHOLE BLOOD (4 HOURS)
- PACKED CELLS (4 HOURS)
1st ANGIOGRAPHY DATE

Definition
Date the first interventional angiogram was performed for hemorrhage control within the first 24 hours of ED/hospital arrival, if applicable.

Collection Criterion
COLLECT ON ALL PATIENTS WITH TRANSFUSED WHOLE BLOOD OR PRBCs WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL.

Field Values
- Collected as MMDDYYYY

Additional Information
- Only applies to angiograms performed in the IR suite.
- Enter the null value of “Not Applicable” for patients that do not meet the collection criteria and for those who did not undergo an angiography.

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

Data Source Hierarchy
- Radiology Report
- Operative Report
- Progress Notes
- Other Hospital Records

Other Associated Elements
- 1st ANGIOGRAPHY
- 1st ANGIOGRAPHY TIME
- EMBOLIZATION SITES
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- WHOLE BLOOD (4 HOURS)
- PACKED CELLS (4 HOURS)
1st ANGIOGRAPHY TIME

Definition
Time of day the first interventional angiogram was performed for hemorrhage control within the first 24 hours of ED/hospital arrival, if applicable.

Collection Criterion
COLLECT ON ALL PATIENTS WITH TRANSFUSED WHOLE BLOOD OR PRBCs WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL.

Field Values
- Collected as HHMM
- Use 24-hour clock

Additional Information
- Only applies to angiograms performed in the IR suite.
- Enter the null value of “Not Applicable” for patients that do not meet the collection criteria and for those who did not undergo an angiography.

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

Data Source Hierarchy
- Radiology Report
- Operative Report
- Progress Notes
- Other Hospital Records

Other Associated Elements
- 1st ANGIOGRAPHY
- 1st ANGIOGRAPHY DATE
- EMBOLIZATION SITES
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- WHOLE BLOOD (4 HOURS)
- PACKED CELLS (4 HOURS)
EMBOLIZATION SITES

Definition
Organ/site of embolization for hemorrhage control, if applicable.

Collection Criterion
COLLECT ON ALL PATIENTS WITH TRANSFUSED WHOLE BLOOD OR PRBCs 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>Other</td>
<td>8 Other</td>
</tr>
</tbody>
</table>

Additional Information
- Limit collection of angiography data to the first 24 hours following ED/hospital arrival.
- Only applies to angiograms performed in the IR suite.
- The null value of “Not Applicable” is used for patients that do not meet the collection criteria, for those patients who underwent an angiography but without embolization, and for those who did not undergo an angiography.
- Select all applicable sites.

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

Data Source Hierarchy
- Radiology Report
- Operative Report
- Progress Notes
- Other Hospital Records

Other Associated Elements
- 1st ANGIOGRAPHY
- 1st ANGIOGRAPHY DATE
- 1st ANGIOGRAPHY TIME
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- WHOLE BLOOD (4 HOURS)
- PACKED CELLS (4 HOURS)
HEMORRHAGE CONTROL TYPE

Definition
First type of surgery performed for hemorrhage control within the first 24 hours of ED/hospital arrival, if applicable.

Collection Criterion
COLLECT ON ALL PATIENTS WITH TRANSFUSED WHOLE BLOOD OR PRBCs 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 / traumatic amputation</td>
<td>7 Mangled extremity / traumatic amputation</td>
</tr>
<tr>
<td>Other skin</td>
<td>8 Other skin / soft tissue</td>
</tr>
<tr>
<td>Pelvic Packing</td>
<td>9 Extraperitoneal Pelvic Packing</td>
</tr>
</tbody>
</table>

Additional Information
- REBOA is a minimally invasive procedure to temporarily occlude large vessels (aorta) in support of hemorrhage control. REBOA helps maintain blood flow to critical organs until the hemorrhage control can be definitively controlled via surgery. Therefore, it is not considered a first type of surgery for hemorrhage control.
- If unclear if surgery performed was for hemorrhage control, consult with the Trauma Medical Director or relevant surgeon.
- Enter the null value of “Not Applicable” for patients that do not meet the collection criteria.
- Select all that apply.

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

Data Source Hierarchy
- Operative Report
- Progress Notes

Other Associated Elements
- HEMORRHAGE CONTROL DATE
- HEMORRHAGE CONTROL TIME
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- WHOLE BLOOD (4 HOURS)
- PACKED CELLS (4 HOURS)
HEMORRHAGE CONTROL DATE

Definition
Date the first surgery was performed for hemorrhage control within the first 24 hours of ED/hospital arrival, if applicable.

Collection Criterion
COLLECT ON ALL PATIENTS WITH TRANSFUSED WHOLE BLOOD OR PRBCs WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL.

Field Values
- Collected as MMDDYYYY

Additional Information
- Refers to the date the incision was made (or the procedure started) for hemorrhage control.
- Enter the null value of “Not Applicable” for patients that do not meet the collection criteria and for those who did not undergo hemorrhage control surgery.

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

Data Source Hierarchy
- Operative Report
- Progress Notes

Other Associated Elements
- HEMORRHAGE CONTROL TYPE
- HEMORRHAGE CONTROL TIME
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- WHOLE BLOOD (4 HOURS)
- PACKED CELLS (4 HOURS)
HEMORRHAGE CONTROL TIME

Definition
Time of day the first surgery was performed for hemorrhage control within the first 24 hours of ED/hospital arrival, if applicable.

Collection Criterion
COLLECT ON ALL PATIENTS WITH TRANSFUSED WHOLE BLOOD OR PRBCs WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL.

Field Values
- Collected as HHMM
- Use 24-hour clock

Additional Information
- Refers to the time of day the incision was made (or the procedure started) for hemorrhage control.
- The null value of “Not Applicable” is used for patients that do not meet the collection criteria and for those who did not undergo hemorrhage control surgery.

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

Data Source Hierarchy
- Operative Report
- Progress Notes

Other Associated Elements
- HEMORRHAGE CONTROL TYPE
- HEMORRHAGE CONTROL DATE
- MTP ACTIVATED?
- TQIP® BLOOD INCLUSION?
- WHOLE BLOOD (4 HOURS)
- PACKED CELLS (4 HOURS)
NEXT PHASE AFTER OR

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

Field Values
- **23HR OBS**: <24 Hour Observation
- **ED**: Emergency Department
- **ICU**: Intensive/Critical Care Unit
- **INT RAD**: Interventional Radiology
- **OR**: Operating Room
- **PICU**: Pediatric ICU
- **PEDSWARD**: Pediatric Ward
- **POSTHOSP**: Posthospital
- **READMIT**: Re-Admit
- **SPECIAL**: Special Procedures
- **STEPDOWN**: Stepdown or Telemetry Unit
- **WARD**: Ward/Floor

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

Data Source Hierarchy
- Operative Report
- ICU records
- Progress Notes

Other Associated Elements
- **DISCHARGE DATE**
- **DISCHARGE TIME**
INTENSIVE CARE UNIT (ICU)/ACUTE CARE
ICU ARRIVAL DATE

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

Field Values
- Collected as MMDDYYYY

Additional Information
- ICU arrival date is the actual date the patient physically arrives in the ICU, regardless of when the order to admit to the ICU is written.
- ICU admission is based upon the level of care the patient requires, and not the location of the patient within the hospital. If the patient is admitted to the ICU for a monitored bed only, the patient’s NEXT PHASE AFTER ED should be documented as Stepdown NOT ICU.
- Enter the null value of “Not Applicable” if the patient was not admitted to the ICU.

Uses
- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Used to calculate ICU Length of Stay (LOS).

Data Source Hierarchy
- ICU Records
- ED Records
- Progress Notes

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

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

Field Values
- Collected as MMDDYYYY

Additional Information
- ICU exit date should be based on when the order for transfer out or discharge from the ICU is written, and ICU resources are no longer being utilized for the care of the patient.

Uses
- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
- Used to calculate ICU Length of Stay (LOS).

Data Source Hierarchy
- ICU Records
- Progress Notes

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

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

Field Values
- Up to four-digit positive numeric value

Additional Information
- ICU LOS should be based on the actual time the patient is physically in the ICU and ICU resources are being utilized for the care of the patient.
- 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.

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

Data Source Hierarchy
- ICU Records
- Progress Notes

Other Associated Elements
- ICU ARRIVAL DATE
- ICU EXIT DATE
CONSULTATION DATE

Definition
Date during the patient’s hospital stay when physician consultation occurred, if applicable.

Field Values
- Collected as MMDDYYYY

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

Data Source Hierarchy
- Progress Notes
- Consultation Notes

Other Associated Elements
- CONSULTATION SERVICE
- CONSULTATION PHYSICIAN
CONSULTATION SERVICE

Definition
Service/specialty of the physician consulted during the patient’s hospital stay, if applicable.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>Field Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANE ANESTHESIOLOGY</td>
<td>NCC NEURO CRITICAL CARE</td>
</tr>
<tr>
<td>BUR BURN SPECIALIST</td>
<td>NEO NEONATOLOGY</td>
</tr>
<tr>
<td>CAR CARDIOLOGY</td>
<td>NEP NEPHROLOGY</td>
</tr>
<tr>
<td>CTS CARDCIODTHORACIC SURGERY</td>
<td>NEU NEUROLOGY</td>
</tr>
<tr>
<td>CCI CRITICAL CARE INTENSIVIST</td>
<td>NES NEUROSURGERY</td>
</tr>
<tr>
<td>DEN DENTAL</td>
<td>OBS OBSTERICS</td>
</tr>
<tr>
<td>DER DERMATOLOGY</td>
<td>OPS OPHTALMOLOGIC SURGERY</td>
</tr>
<tr>
<td>END ENDOCRINOLOGY</td>
<td>ORS ORAL SURGERY</td>
</tr>
<tr>
<td>FNM FAMILY MEDICINE</td>
<td>ORT ORTHOPEDIC SURGERY</td>
</tr>
<tr>
<td>GAS GASTROENTEROLOGY</td>
<td>ONL OTHER NOT LISTED</td>
</tr>
<tr>
<td>GES GENERAL SURGERY</td>
<td>OTO OTOLARNGYOLOGY</td>
</tr>
<tr>
<td>GER GERIATRICS</td>
<td>PAL PALLIATIVE CARE</td>
</tr>
<tr>
<td>GYN GYNECOLOGY</td>
<td>PEA PEDIATRIC ALLERGY</td>
</tr>
<tr>
<td>HEM HEMATOLOGY</td>
<td>PCS PEDIATRIC CARDIOTHORACIC SURGER</td>
</tr>
<tr>
<td>HNS HEAD &amp; NECK SURGERY</td>
<td>PEN PEDIATRIC ENDOCRINOLOGY</td>
</tr>
<tr>
<td>HBO HYPERBARIC MEDICINE</td>
<td>PEG PEDIATRIC GASTROENTEROLOGY</td>
</tr>
<tr>
<td>INF INFECTIOUS MEDICINE</td>
<td>PEH PEDIATRIC HEMATOLOGY</td>
</tr>
<tr>
<td>INN INTERVENTONAL NEUROLOGY</td>
<td>PEI PEDIATRIC INTENSIVIST</td>
</tr>
<tr>
<td>INR INTERVENTONAL RADIOLOGY</td>
<td>PMS PAIN MANAGEMENT SPECIALIST</td>
</tr>
<tr>
<td>INT INTERNAL MEDICINE</td>
<td>PNP PEDIATRIC NEPHROLOGY</td>
</tr>
<tr>
<td>MAS MAXILLOFACIAL SURGERY</td>
<td>PNE PEDIATRIC NEUROLOGY</td>
</tr>
</tbody>
</table>

Uses
- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

Data Source Hierarchy
- Progress Notes
- Consultation Notes

Other Associated Elements
- CONSULTATION DATE
- CONSULTATION PHYSICIAN
CONSULTATION PHYSICIAN

Definition
Name or code of physician consulted during the patient’s hospital stay, if applicable.

Field Values
- Free text

Additional Information
- Enter physician name or code directly, or create facility-specific picklist.

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

Data Source Hierarchy
- Progress Notes
- Consultation Notes

Other Associated Elements
- CONSULTATION DATE
- CONSULTATION SERVICE
**TQIP® TBI INCLUSION?**

**Definition**
Indicates whether 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**
- Y: Yes
- N: No

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

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

**Data Source Hierarchy**
- Radiology Report
- Operative Report
- Procedure Notes
- Neurosurgical Notes
- ICU Records
- Progress Notes
- Anesthesia Records
- Hospital Discharge Summary

**Other Associated Elements**
- INITIAL PUPILLARY RESPONSE
- HIGHEST GCS TOTAL
- HIGHEST GCS MOTOR
- QUALIFIER FOR HIGHEST GCS
- MIDLINE SHIFT?
- CEREBRAL MONITOR TYPE
- CEREBRAL MONITOR DATE
- CEREBRAL MONITOR TIME
INITIAL PUPILLARY RESPONSE

Definition
Initial physiological pupil response within 30 minutes 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>BOTH</td>
<td>Both Reactive</td>
</tr>
<tr>
<td>ONE</td>
<td>One Reactive</td>
</tr>
<tr>
<td>NEITHER</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.
- Enter the null value of “Not Known/Not Recorded” 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.
- Enter the null value of “Not Applicable” for patients that do not meet the collection criteria.
- Field cannot be left blank.

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

Data Source Hierarchy
- ED Records
- Physician’s Progress Notes

Other Associated Elements
- TQIP® TBI INCLUSION?
- HIGHEST GCS TOTAL
- HIGHEST GCS MOTOR
- QUALIFIER FOR HIGHEST GCS
- MIDLINE SHIFT?
- CEREBRAL MONITOR TYPE
- CEREBRAL MONITOR DATE
- CEREBRAL MONITOR TIME
HIGHEST GCS TOTAL

Definition
Highest GCS total on the first 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
- One- or two-digit numeric value between 3 and 15

Additional Information
- Requires review of all data sources to obtain the highest GCS total. In many cases, the highest GCS may occur after the ED phase of care.
- 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 “A&Ox3,” “awake, alert, and oriented” interpret this as GCS of 15, if there is no other contradicting documentation.
- Enter the null value of “Not Applicable” for patients that do not meet the collection criteria or if the patient is discharged from your hospital prior to the next calendar day.
- Field cannot be left blank.

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

Data Source Hierarchy
- Neuro Assessment Flow Sheet
- Triage/Trauma/ICU Flow Sheet
- Nursing Notes/Flow Sheet
- Progress Notes

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

Definition
Highest GCS motor on the first 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>Obey 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>

Additional Information
- Requires review of all data sources to obtain the highest GCS motor. In many cases, the highest GCS motor may occur after the ED phase of care.
- Best obtained when sedatives or paralytics are withheld as part of sedation holiday.
- Enter the null value of “Not Applicable” for patients that do not meet the collection criteria or if the patient is discharged from your hospital prior to the next calendar day.
- Field cannot be left blank.

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

Data Source Hierarchy
- Neuro Assessment Flow Sheet
- Triage/Trauma/ICU Flow Sheet
- Nursing Notes/Flow Sheet
- Progress Notes

Other Associated Elements
- TQIP® TBI INCLUSION?
- INITIAL PUPILLARY RESPONSE
- HIGHEST GCS TOTAL
- QUALIFIER FOR HIGHEST GCS
- MIDLINE SHIFT?
- CEREBRAL MONITOR TYPE
- CEREBRAL MONITOR DATE
- CEREBRAL MONITOR TIME
QUALIFIER FOR HIGHEST GCS

Definition
Documentation of factors potentially affecting the highest GCS total on first 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 lacerations(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>2</td>
</tr>
<tr>
<td>S</td>
<td>1</td>
</tr>
<tr>
<td>T</td>
<td>3</td>
</tr>
<tr>
<td>TO</td>
<td>3</td>
</tr>
<tr>
<td>TS</td>
<td>3</td>
</tr>
<tr>
<td>TSO</td>
<td>3</td>
</tr>
<tr>
<td>SO</td>
<td>2</td>
</tr>
<tr>
<td>L</td>
<td>4</td>
</tr>
</tbody>
</table>

Additional Information
- Applies to 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, 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.
- Enter the null value of “Not Applicable” for patients that do not meet the collection criteria or if the patient is discharged from your hospital prior to the next calendar day.
- Field cannot be left blank.
Uses

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

Data Source Hierarchy

- ED Records
- Physician’s Progress Notes

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
# MIDLINE SHIFT?

## Definition
Indicates whether 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><strong>Y</strong> Yes</td>
<td>1 Yes</td>
</tr>
<tr>
<td><strong>N</strong> No</td>
<td>2 No</td>
</tr>
<tr>
<td><strong>O</strong> Not Imaged (e.g., CT Scan, MRI)</td>
<td>3 Not Imaged</td>
</tr>
</tbody>
</table>

## Additional Information
- If there is documentation of “massive” midline shift in lieu of >5mm shift measurement, enter field value “Yes”.
- Radiological and surgical documentation from transferring facilities should also be considered for this data field.
- Enter the null value “Not Known/Not Recorded” 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, enter the field value “Yes”, if there is no other contradicting documentation.
- If the patient was not imaged within 24 hours from the time of day of injury, enter the field value “Not Imaged (e.g., CT Scan, MRI)”.
- Enter the null value of “Not Applicable” is used for patients that do not meet the collection criteria.
- Field cannot be left blank.

## Uses
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.

## Data Source Hierarchy
- Radiology Report
- Operative Report
- Procedure Notes
- Neurosurgical Notes
- ICU Records
- Progress Notes
- Anesthesia Records
- Hospital Discharge Summary

## Other Associated Elements
- TQIP® TBI INCLUSION?
- INITIAL PUPILLARY RESPONSE
- HIGHEST GCS TOTAL
- HIGHEST GCS MOTOR
- QUALIFIER FOR HIGHEST GCS
- CEREBRAL MONITOR TYPE
- CEREBRAL MONITOR DATE
- CEREBRAL MONITOR TIME
CEREBRAL MONITOR TYPE

Definition
Indicate the type(s) of cerebral monitors that were placed, if applicable.

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>3  Intraparenchymal Oxygen Monitor (e.g. Licox)</td>
</tr>
<tr>
<td>Intraparenchymal Pressure Monitor (e.g. Camino bolt, subarachnoid bolt)</td>
<td>2  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>1  Intraventricular Drain/Catheter (e.g. Ventriculostomy, External Ventricular Drain)</td>
</tr>
<tr>
<td>Jugular Venous Bulb</td>
<td>4  Jugular Venous Bulb</td>
</tr>
<tr>
<td>None</td>
<td>5  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 "Not Applicable" for the Cerebral Monitor date and time.
• Enter the null value of “Not Applicable” for patients that do not meet the collection criteria.
• Field cannot be left blank.

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

Data Source Hierarchy
• Operative Report
• Procedure Notes
• Neurosurgical Notes
• ICU Records
• Progress Notes
• Anesthesia Records
• Hospital Discharge Summary

Other Associated Elements
• TQIP® TBI INCLUSION?
• INITIAL PUPILLARY RESPONSE
• HIGHEST GCS TOTAL
- HIGHEST GCS MOTOR
- QUALIFIER FOR HIGHEST GCS
- MIDLINE SHIFT?
- CEREBRAL MONITOR DATE
- CEREBRAL MONITOR TIME
CEREBRAL MONITOR DATE

Definition
Date that the first cerebral monitor was placed, if applicable.

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 lacerations(s), and scalp avulsion(s).

Field Values
• Collected as MMDDYYYY

Additional Information
• Enter the null value of “Not Applicable” for patients that do not meet the collection criteria.
• The field is auto-populated with the null value of “Not Applicable” if the cerebral monitor type is “none”.
• Field cannot be left blank.

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

Data Source Hierarchy
• Operative Report
• Procedure Notes
• Neurosurgical Notes
• ICU Records
• Progress Notes
• Anesthesia Records
• Hospital Discharge Summary

Other Associated Elements
• TQIP® TBI INCLUSION?
• INITIAL PUPILLARY RESPONSE
• HIGHEST GCS TOTAL
• HIGHEST GCS MOTOR
• QUALIFIER FOR HIGHEST GCS
• MIDLINE SHIFT?
• CEREBRAL MONITOR TYPE
• CEREBRAL MONITOR TIME
CEREBRAL MONITOR TIME

Definition
Time of day that the first cerebral monitor was placed, if applicable.

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 lacerations(s), and scalp avulsion(s).

Field Values
- Collected as HHMM
- Use 24-hour clock

Additional Information
- Enter the null value of “Not Applicable” for patients that do not meet the collection criteria.
- The field is auto-populated with the null value of “Not Applicable” if the cerebral monitor type is “none”.
- Field cannot be left blank.

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

Data Source Hierarchy
- Operative Report
- Procedure Notes
- Neurosurgical Notes
- ICU Records
- Progress Notes
- Anesthesia Records
- Hospital Discharge Summary

Other Associated Elements
- TQIP® TBI INCLUSION?
- INITIAL PUPILLARY RESPONSE
- HIGHEST GCS TOTAL
- HIGHEST GCS MOTOR
- QUALIFIER FOR HIGHEST GCS
- MIDLINE SHIFT?
- CEREBRAL MONITOR TYPE
- CEREBRAL MONITOR DATE
TQIP® VTE PROPHYLAXIS INCLUSION?

Definition
Indicates whether the patient received Venous Thromboembolism (VTE) prophylaxis at your facility.

Collection Criterion
COLLECT ON ALL PATIENTS

Field Values
- Y: Yes
- N: No

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

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

Data Source Hierarchy
- Progress Notes
- ICU records
- Hospital Discharge Summary

Other Associated Elements
- VTE PROPHYLAXIS TYPE
- VTE PROPHYLAXIS DATE
- VTE PROPHYLAXIS TIME
VTE PROPHYLAXIS TYPE

Definition
Type of VTE prophylaxis that was first administered to the patient at your facility, if applicable.

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>Oral 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
- If Aspirin is ordered for VTE prophylaxis utilize “other”.
- Null values are not accepted for this data field.
- Field value cannot be “Not Applicable”.
- Field value cannot be left blank.

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

Data Source Hierarchy
- Medication Summary
- Nursing Notes/Flow Sheet
- Pharmacy Record
- Progress Notes
- ICU records

Other Associated Elements
- TQIP® VTE PROPHYLAXIS INCLUSION?
- VTE PROPHYLAXIS DATE
- VTE PROPHYLAXIS TIME
VTE PROPHYLAXIS DATE

Definition
Date VTE prophylaxis was first administered to the patient at your facility, if applicable.

Collection Criterion
COLLECT ON ALL PATIENTS.

Field Values
- Collected as MMDDYYYY

Additional Information
- Enter the null value of “Not Applicable” if VTE Prophylaxis is equal to “none”.
- Field value cannot be left blank.

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

Data Source Hierarchy
- Medication Summary
- Nursing Notes/Flow Sheet
- Pharmacy Record
- Progress Notes
- ICU records

Other Associated Elements
- TQIP® VTE PROPHYLAXIS INCLUSION?
- VTE PROPHYLAXIS TYPE
- VTE PROPHYLAXIS TIME
VTE PROPHYLAXIS TIME

Definition
Time of day VTE prophylaxis was first administered to the patient at your facility, if applicable.

Collection Criterion
COLLECT ON ALL PATIENTS.

Field Values
- Collected as HHMM
- Use 24-hour clock

Additional Information
- Enter the null value of “Not Applicable” if VTE Prophylaxis Type is equal to “none”.
- Field value cannot be left blank.

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

Data Source Hierarchy
- Medication Summary
- Nursing Notes/Flow Sheet
- Pharmacy Record
- Progress Notes
- ICU records

Other Associated Elements
- TQIP® VTE PROPHYLAXIS INCLUSION?
- VTE PROPHYLAXIS TYPE
- VTE PROPHYLAXIS DATE
WITHDRAWAL OF LIFE SUPPORTING TREATMENT?

Definition
Indicates whether care was withdrawn based on a decision to either remove or withhold further life sustaining intervention.

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
- DNR is not a requirement and is not the same as withdrawal of care.
- 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.
- This decision 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).
- Field value cannot be left blank.

Uses
- System evaluation and monitoring.
- Provides documentation of care.

Data Source Hierarchy
- Progress Notes
- ICU Records
- Withdrawal of Care Order
- Hospital Discharge Summary

Other Associated Elements
- WITHDRAWAL OF LIFE SUPPORTING TREATMENT DATE
- WITHDRAWAL OF LIFE SUPPORTING TREATMENT TIME
WITHDRAWAL OF LIFE SUPPORTING TREATMENT DATE

Definition
The date care was withdrawn, if applicable.

Field Values
- Collected as MMDDYYYY

Additional Information
- Enter the null value of “Not Applicable” if care was not withdrawn.
- Field value cannot be left blank.

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

Data Source Hierarchy
- Progress Notes
- ICU Records
- Withdrawal of Care Order
- Hospital Discharge Summary

Other Associated Elements
- WITHDRAWAL OF LIFE SUPPORTING TREATMENT?
- WITHDRAWAL OF LIFE SUPPORTING TREATMENT TIME
WITHDRAWAL OF LIFE SUPPORTING TREATMENT TIME

Definition
The time of day care was withdrawn, if applicable.

Field Values
- Collected as HHMM
- Use 24-hour clock

Additional Information
- Enter the null value of “Not Applicable” if care was not withdrawn.
- Field value cannot be left blank.

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

Data Source Hierarchy
- Progress Notes
- ICU records
- Withdrawal of Care Order
- Hospital Discharge Summary

Other Associated Elements
- WITHDRAWAL OF LIFE SUPPORTING TREATMENT?
- WITHDRAWAL OF LIFE SUPPORTING TREATMENT DATE
POSTHOSPITAL
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
- Collected as MMDDYYYY

Additional Information
- Utilize the time of day the patient was pronounced brain dead in situations when care is assumed by an organ procurement agency.

Uses
- Establishes care intervals and incident times.
- Used to calculate Hospital LOS.
- System evaluation and monitoring.

Data Source Hierarchy
- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

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

**Definition**

The time of day the order was written for the patient to be transferred or discharged from the hospital, or the time of day the patient died.

**Field Values**

- Collected as HHMM
- Use 24-hour clock

**Additional Information**

- Utilize The time of day the patient was pronounced brain dead in situations when care is assumed by an organ procurement agency.

**Uses**

- Establishes care intervals and incident times.
- Used to calculate Hospital LOS.
- System evaluation and monitoring.

**Data Source Hierarchy**

- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

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

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

Field Values
- Collected as MMDDYYYY

Additional Information
- Utilize The time of day the patient was pronounced brain dead in situations when care is assumed by an organ procurement agency.

Uses
- Establishes care intervals and incident times.
- Used to calculate Hospital LOS.
- System evaluation and monitoring.

Data Source Hierarchy
- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

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

Definition
The time of day the patient was discharged or transferred from the hospital, or the time of day the patient died.

Field Values
- Collected as HHMM
- Use 24-hour clock

Additional Information
- Utilize the time of day the patient was pronounced brain dead in situations when care is assumed by an organ procurement agency.

Uses
- Establishes care intervals and incident times.
- Used to calculate Hospital LOS.
- System evaluation and monitoring.

Data Source Hierarchy
- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

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

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
- **INT RAD**: Interventional Radiology
- **OR**: Operating Room
- **PICU**: Pediatric ICU
- **PEDSWARD**: Pediatric Ward
- **READMIT**: Re-Admit
- **SPECIAL**: Special Procedures
- **STEPDOWN**: Stepdown or Telemetry Unit
- **WARD**: Ward/Floor

Additional Information
- For patients with phase of care prior to discharge equal to 23HR OBS, if the patient’s LOS does not exceed the 23 hours, the phase prior to discharge remains 23HR OBS.
- For patients with phase of care prior to discharge equal to 23HR OBS, if the patient’s LOS exceeds the 23 hours, use the actual unit the patient was discharged from.

Uses
- Establishes care intervals and incident times.
- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

Data Source Hierarchy
- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

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

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

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACUTE</td>
<td>Acute Care Facility</td>
</tr>
<tr>
<td>AMA</td>
<td>AMA/Eloped/LWBS</td>
</tr>
<tr>
<td>BURN</td>
<td>Burn Center</td>
</tr>
<tr>
<td>CLF</td>
<td>Congregate Living Facility</td>
</tr>
<tr>
<td>HOME WITH</td>
<td>Home W/Home Health Services</td>
</tr>
<tr>
<td>HOME W/O</td>
<td>Home Without Services</td>
</tr>
<tr>
<td>HOSPICE</td>
<td>Hospice</td>
</tr>
<tr>
<td>JAIL</td>
<td>Jail</td>
</tr>
<tr>
<td>LTCH</td>
<td>Long Term Care Hospital</td>
</tr>
<tr>
<td>MORGUE</td>
<td>Morgue</td>
</tr>
<tr>
<td>PSYCH</td>
<td>Psychiatric Hospital or Department of Hospital</td>
</tr>
<tr>
<td>RCF</td>
<td>Recuperative Care Facility</td>
</tr>
<tr>
<td>REHAB</td>
<td>Rehabilitation Center</td>
</tr>
<tr>
<td>SCJ</td>
<td>Jail Ward at LAC+USC</td>
</tr>
<tr>
<td>SNF</td>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>SUBACUTE</td>
<td>Subacute Care</td>
</tr>
<tr>
<td>TRAUMA</td>
<td>Trauma Center</td>
</tr>
<tr>
<td>OTHER</td>
<td>Other</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) focus on patients who, on average, stay more than 25 days, and no longer need the level of services that an acute care hospital provides.
- A 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.
- Patients discharged to Hospice care are considered a death by TQIP® for purposes of risk-adjusted benchmark reporting.

Uses
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.
Data Source Hierarchy

- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

Other Associated Elements

- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PHASE PRIOR TO DISCHARGE
- FACILITY NAME
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- DISCHARGE CAPACITY
### FACILITY NAME

**Definition**

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

#### Field Values

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Definition</th>
<th>Field Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOS ANGELES COUNTY 9-1-1 RECEIVING</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACH</td>
<td>Alhambra Hospital Medical Center</td>
<td>KFW</td>
</tr>
<tr>
<td>AHM</td>
<td>Catalina Island Medical Center</td>
<td>LBM</td>
</tr>
<tr>
<td>AMH</td>
<td>Methodist Hospital of Southern California</td>
<td>LCH</td>
</tr>
<tr>
<td>AVH</td>
<td>Antelope Valley Hospital</td>
<td>LCM</td>
</tr>
<tr>
<td>BEV</td>
<td>Beverly Hospital</td>
<td>MCP</td>
</tr>
<tr>
<td>BMC</td>
<td>Southern California Hospital at Culver City</td>
<td>MHG</td>
</tr>
<tr>
<td>CAL</td>
<td>Dignity Health - California Hospital Medical Center</td>
<td>MID</td>
</tr>
<tr>
<td>CHH</td>
<td>Children’s Hospital Los Angeles</td>
<td>MLK</td>
</tr>
<tr>
<td>CHP</td>
<td>Community Hospital of Huntington Park</td>
<td>MPH</td>
</tr>
<tr>
<td>CNT</td>
<td>Centinela Hospital Medical Center</td>
<td>NOR</td>
</tr>
<tr>
<td>CPM</td>
<td>Coast Plaza Hospital</td>
<td>NRH</td>
</tr>
<tr>
<td>CSM</td>
<td>Cedars-Sinai Medical Center</td>
<td>OVM</td>
</tr>
<tr>
<td>DCH</td>
<td>PIH Health Hospital - Downey</td>
<td>PAC</td>
</tr>
<tr>
<td>DFM</td>
<td>Cedars-Sinai Marina Del Rey Hospital</td>
<td>PIH</td>
</tr>
<tr>
<td>DHL</td>
<td>Lakewood Regional Medical Center</td>
<td>PLB</td>
</tr>
<tr>
<td>ELA</td>
<td>East Los Angeles Doctors Hospital</td>
<td>PVC</td>
</tr>
<tr>
<td>ENH</td>
<td>Encino Hospital Medical Center</td>
<td>QOA</td>
</tr>
<tr>
<td>FPH</td>
<td>Emanate Health Foothill Presbyterian Hospital</td>
<td>QVH</td>
</tr>
<tr>
<td>GAR</td>
<td>Garfield Medical Center</td>
<td>SDC</td>
</tr>
<tr>
<td>GEM</td>
<td>Greater El Monte Community Hospital</td>
<td>SFM</td>
</tr>
<tr>
<td>GMH</td>
<td>Dignity Health - Glendale Memorial Hospital and Health Center</td>
<td>SGC</td>
</tr>
<tr>
<td>GSH</td>
<td>Good Samaritan Hospital</td>
<td>SJH</td>
</tr>
<tr>
<td>GWT</td>
<td>Adventist Health - Glendale</td>
<td>SJS</td>
</tr>
<tr>
<td>HCH</td>
<td>Providence Holy Cross Medical Center</td>
<td>SMH</td>
</tr>
<tr>
<td>HGH</td>
<td>LAC Harbor-UCLA Medical Center</td>
<td>SMM</td>
</tr>
<tr>
<td>HMH</td>
<td>Huntington Hospital</td>
<td>SOC</td>
</tr>
<tr>
<td>HMN</td>
<td>Henry Mayo Newhall Hospital</td>
<td>SPP</td>
</tr>
<tr>
<td>HWH</td>
<td>West Hills Hospital &amp; Medical Center</td>
<td>TOR</td>
</tr>
<tr>
<td>ICH</td>
<td>Emanate Health Inter-Community Hospital</td>
<td>TRM</td>
</tr>
<tr>
<td>KFA</td>
<td>Kaiser Foundation Hospital – Baldwin Park</td>
<td>UCL</td>
</tr>
<tr>
<td>KFB</td>
<td>Kaiser Foundation Hospital – Downey</td>
<td>USC</td>
</tr>
<tr>
<td>KFH</td>
<td>Kaiser Foundation Hospital – South Bay</td>
<td>VHH</td>
</tr>
<tr>
<td>KFL</td>
<td>Kaiser Foundation Hospital – Sunset (Los Angeles)</td>
<td>VPH</td>
</tr>
<tr>
<td>KFO</td>
<td>Kaiser Foundation Hospital – Woodland Hills</td>
<td>WHH</td>
</tr>
<tr>
<td>KFP</td>
<td>Kaiser Foundation Hospital – Panorama City</td>
<td>WMH</td>
</tr>
<tr>
<td>ORANGE COUNTY 9-1-1 RECEIVING</td>
<td>SAN BERNARDINO COUNTY 9-1-1 RECEIVING</td>
<td>OTHER COUNTY 9-1-1 RECEIVING</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>ANH</td>
<td>Anaheim Regional Medical Center</td>
<td>LPI</td>
</tr>
<tr>
<td>CHO</td>
<td>Children’s Hospital of Orange County</td>
<td>PLH</td>
</tr>
<tr>
<td>FHP</td>
<td>Fountain Valley Regional Hospital and Medical Center</td>
<td>SJD</td>
</tr>
<tr>
<td>KHA</td>
<td>Kaiser Foundation Hospital – Anaheim</td>
<td>UCI</td>
</tr>
<tr>
<td>KFI</td>
<td>Kaiser Foundation Hospital – Irvine</td>
<td>WMC</td>
</tr>
<tr>
<td>LAG</td>
<td>Los Alamitos Medical Center</td>
<td></td>
</tr>
<tr>
<td>ARM</td>
<td>Arrowhead Regional Medical Center</td>
<td>KFN</td>
</tr>
<tr>
<td>CHI</td>
<td>Chino Valley Medical Center</td>
<td>LLU</td>
</tr>
<tr>
<td>DHM</td>
<td>Montclair Hospital Medical Center</td>
<td>SAC</td>
</tr>
<tr>
<td>KFF</td>
<td>Kaiser Foundation Hospital - Fontana</td>
<td></td>
</tr>
<tr>
<td>LRR</td>
<td>Los Robles Hospital &amp; Medical Center (Ventura)</td>
<td>SJO</td>
</tr>
<tr>
<td>SIM</td>
<td>Adventist Health - Simi Valley Hospital (Ventura)</td>
<td>RCC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REHABILITATION CENTERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMR</td>
</tr>
<tr>
<td>BMR</td>
</tr>
<tr>
<td>CCC</td>
</tr>
<tr>
<td>CHR</td>
</tr>
<tr>
<td>CNR</td>
</tr>
<tr>
<td>CRI</td>
</tr>
<tr>
<td>DFR</td>
</tr>
<tr>
<td>ENR</td>
</tr>
<tr>
<td>GMR</td>
</tr>
<tr>
<td>GRR</td>
</tr>
<tr>
<td>GSR</td>
</tr>
<tr>
<td>GWR</td>
</tr>
<tr>
<td>HCR</td>
</tr>
<tr>
<td>HMR</td>
</tr>
<tr>
<td>HNR</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BURN CENTERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>USB</td>
</tr>
<tr>
<td>HWB</td>
</tr>
</tbody>
</table>
DISASTER RECEIVING FACILITIES

<table>
<thead>
<tr>
<th>Code</th>
<th>Facility Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>BRH</td>
<td>Barlow Respiratory Hospital</td>
</tr>
<tr>
<td>COA</td>
<td>Silver Lake Medical Center</td>
</tr>
<tr>
<td>COH</td>
<td>City of Hope National Medical Center</td>
</tr>
<tr>
<td>LAC</td>
<td>Los Angeles Community Hospital – Olympic</td>
</tr>
<tr>
<td>HOL</td>
<td>Southern California Hospital at Hollywood</td>
</tr>
<tr>
<td>KMC</td>
<td>Kern Medical Center</td>
</tr>
<tr>
<td>NCH</td>
<td>USC Kenneth Norris Jr. Cancer Center</td>
</tr>
<tr>
<td>PAM</td>
<td>Pacific Alliance Medical Center</td>
</tr>
<tr>
<td>RLA</td>
<td>LAC-Rancho Los Amigos</td>
</tr>
<tr>
<td>TEM</td>
<td>Temple Community Hospital</td>
</tr>
</tbody>
</table>

SKILLED NURSING FACILITIES

<table>
<thead>
<tr>
<th>Code</th>
<th>Facility Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACS</td>
<td>Alhambra Healthcare</td>
</tr>
<tr>
<td>CAS</td>
<td>California Post-Acute</td>
</tr>
<tr>
<td>ENS</td>
<td>Encino Hospital Medical Center (SNF)</td>
</tr>
<tr>
<td>GHS</td>
<td>Granada Hills Convalescent Hospital</td>
</tr>
<tr>
<td>GMS</td>
<td>Glendale Memorial Hospital and Health Center</td>
</tr>
<tr>
<td>GSS</td>
<td>Good Samaritan Hospital (SNF)</td>
</tr>
<tr>
<td>GWS</td>
<td>Glendale Post-Acute</td>
</tr>
<tr>
<td>HCS</td>
<td>Holy Cross Medical Center (SNF)</td>
</tr>
<tr>
<td>HMS</td>
<td>Huntington Post-Acute</td>
</tr>
<tr>
<td>LBS</td>
<td>Long Beach Memorial Medical Center</td>
</tr>
<tr>
<td>LCS</td>
<td>Providence Little Company of Mary Transitional Care Center</td>
</tr>
<tr>
<td>LDS</td>
<td>Lanterman Development Center (SNF)</td>
</tr>
<tr>
<td>LES</td>
<td>Las Encinas Hospital</td>
</tr>
<tr>
<td>MHS</td>
<td>Skyline Healthcare Center</td>
</tr>
<tr>
<td>OTS</td>
<td>Other Skilled Nursing Facility</td>
</tr>
<tr>
<td>SFS</td>
<td>St. Francis Medical Center (SNF)</td>
</tr>
<tr>
<td>SGS</td>
<td>San Gabriel Convalescent Center</td>
</tr>
<tr>
<td>SHS</td>
<td>Santa Monica Health Care Center</td>
</tr>
</tbody>
</table>

Additional Information

- For patients transferred to non-acute care facilities (e.g., Rehab, SNF, Subacute) use “Other” if no three-letter code exists for the facility.

Uses

- Provides documentation of assessment and/or care.

Data Source Hierarchy

- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

Other Associated Elements

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

Definition
Method used for transferring the patient to another facility, if applicable.

Field Values
- G: Ground
- A: Air

Additional Information
- This field will automatically be filled with “Not Applicable” for patients Discharged To:
  - AMA/Eloped/LWBS (Left Without Being Seen)
  - Home w/Home Health Services
  - Home w/o Services
  - Morgue
  - Jail
  - USC Jail

Uses
- Provides documentation of assessment and/or care.

Data Source Hierarchy
- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

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

**Definition**

The rationale for transfer of the patient, if applicable.

<table>
<thead>
<tr>
<th>Field Values</th>
<th>LA COUNTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>CU In Custody</td>
<td>Patient discharged/transferred in custody of law enforcement</td>
</tr>
<tr>
<td>EX Extended Care</td>
<td>Patient discharged from acute care setting of hospital, but required subacute care in the setting of a long-term care hospital (LTCH), skilled nursing facility (SNF), convalescent home, board-and-care, etc.</td>
</tr>
<tr>
<td>FI Financial</td>
<td>Decision based on financial status (i.e., cash or self-pay, uninsured)</td>
</tr>
<tr>
<td>HO Hospice</td>
<td>Patient transferred to hospice</td>
</tr>
<tr>
<td>HP Health Plan</td>
<td>Health Plan decision</td>
</tr>
<tr>
<td>OT Other</td>
<td>Transfer rationale other than above (Includes Psych)</td>
</tr>
<tr>
<td>RH Rehab</td>
<td>Patient required rehabilitation</td>
</tr>
<tr>
<td>SH 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, and reimplantation (Excludes Psych)</td>
</tr>
</tbody>
</table>

**Additional Information**

- Enter the null value of “Not Applicable” if the patient was not transferred to another facility.

**Uses**

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

**Data Source Hierarchy**

- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**

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

- **H**: PERMANENT HANDICAP
  - Limitations from the injury expected to last more than one year
- **T**: TEMPORARY HANDICAP
  - Required ADMISSION to the hospital for injuries sustained
- **P**: PRE-INJURY CAPACITY
  - Discharged FROM THE ED with minimal or no injury

Additional Information
- The value of “P” for Pre-injury capacity should be utilized for all patients discharged home from the ED, eloped, or left AMA (Against Medical Advice).
- Enter the null value of “Not Applicable” if the patient expired.
- A splenectomy in NOT considered a permanent handicap.

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

Data Source Hierarchy
- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

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

**Definition**
Indicates whether the patient died of injuries during the hospital stay.

**Field Values**
- L: Lived
- D: Died

**Additional Information**
- Patients discharged to hospice care are considered a death by TQIP® for purposes of risk-adjusted benchmark reporting.

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

**Data Source Hierarchy**
- Hospital Records
- Hospital Discharge Summary
- Progress Notes

**Other Associated Elements**
- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PHASE PRIOR TO DISCHARGE
- TRANSFERRED/DISCHARGED TO
- FACILITY NAME
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- AUTOPSY UPDATE?
- CORONER #
**AUTOPSY UPDATE?**

**Definition**
Indicates whether 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.

**Uses**
- Assists with determination of appropriate treatment.
- Provides documentation of assessment and/or care.

**Data Source Hierarchy**
- Coroner’s Report

**Other Associated Elements**
- CORONER #
CORONER #

Definition
Coroner’s ID number or code, if applicable.

Field Values
- Free text

Additional Information
- Non-picklist – free text Coroner ID number or code at discretion of facility.

Uses
- Identifies the coroner case number

Data Source Hierarchy
- Coroner’s Report

Other Associated Elements
- AUTOPSY UPDATE?
ORGAN REFERRAL?

 Definition
 Indicates whether the patient was referred for potential solid organ donation.

 Field Values
 - Y: Yes
 - N: No

 Uses
 - Allows tracking of organ referrals.

 Data Source Hierarchy
 - Hospital Discharge Summary
 - Progress Notes

 Other Associated Elements
 - ORGAN DONOR?
 - ORGANS DONATED
ORGAN DONOR?

Definition
Indicates whether the patient’s solid organs were donated.

Field Values
- Y: Yes
- N: No

Additional Information
- Excludes non-solid organ donations such as bone, bone marrow, eyes, skin, etc.

Uses
- Allows tracking of organ donation.

Data Source Hierarchy
- Hospital Discharge Summary
- Progress Notes
- OR Records

Other Associated Elements
- ORGAN REFERRAL?
- ORGANS DONATED
ORGANS DONATED

Definition
Indicates which specific solid organs were donated.

Field Values
- Heart
- Intestine
- Kidney (1)
- Kidneys (2)
- Liver
- Lung (1)
- Lungs (2)
- Pancreas

Additional Information
- Excludes non-solid organ donations such as bone, bone marrow, eyes, skin, etc.

Uses
- Allows tracking of organ donation.

Data Source Hierarchy
- Hospital Discharge Summary
- Progress Notes
- OR Records

Other Associated Elements
- ORGAN REFERRAL?
- ORGAN DONOR?
DISCHARGE DIAGNOSES – ICD-10 CODES

Definition
All identified ICD-10 discharge diagnoses related to the patient’s injuries.

Field Values
- ICD-10 codes

Additional Information
- Injury diagnoses as defined by ICD-10-CM codes are in the range of S00-S99, T07, T14, T20-T28, ,T30-T32, and T79.A1-T79.A9, or compatible ICD-10-CA code range.
- ICD-10-CM codes are in the range of T20-T28 and T30-T32, or compatible ICD-10-CA code range, have been removed for NTDS’s inclusion criteria.
- ICD-10 codes should be listed starting with the most 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.
- Patients with ONLY ICD-10 NFS codes or unspecified codes, resulting in an AIS severity score of 9, and no ISS score, should be DHS=No patients.
- Enter the COVID-19 ICD-10 code if the patient arrives with a known positive test or a positive test is acquired while hospitalized.
- Additional injuries identified at the transferring facilities should not be entered into the database by 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 ED are excluded from the TQIP® benchmark reports and thus this will have no effect on the sending facility’s benchmarking reports.
- 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.

Uses
- Used to calculate Abbreviated Injury Scale (AIS) and Injury Severity Score (ISS).
- Provides documentation of assessment and/or care.
- System evaluation and monitoring.

Data Source Hierarchy
- Hospital Discharge Summary
- ER Records
- ICU Records
- OR Records
- Physician Notes
- Coroner’s Report

Other Associated Elements
- DISCHARGE DIAGNOSES – ABBREVIATED INJURY SCALE
- CO-MORBID CONDITIONS
- COMPLICATIONS
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
• Up to six-digit positive numeric value

Additional Information
• The scale describes three aspects of the injury, type, location, and severity using 7 numbers written as 123456.7

<table>
<thead>
<tr>
<th>THE NUMBERS 123456.7</th>
<th>EXAMPLE: 851814.3, FEMORAL SHAFT FRACTURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>INDICATE THE FOLLOWING:</td>
<td></td>
</tr>
<tr>
<td>1 – Body Region</td>
<td></td>
</tr>
<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>
<tr>
<td>8 = Body Region: Lower Extremity</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2 – Type of Anatomic Structure</th>
<th>5 = Type of Anatomic Structure: Skeletal</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3 &amp; 4 – Specific Anatomic Structure</th>
<th>18 = Specific Anatomic Structure: Femur</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>5 &amp; 6 – Level of Injury</th>
<th>14 = Level of Injury: Shaft</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>.7 – AIS: Severity Score</th>
<th>(Ranging from 1 {least severe} to 6 {most severe})</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Minor</td>
<td></td>
</tr>
<tr>
<td>2. Moderate</td>
<td></td>
</tr>
<tr>
<td>3. Serious</td>
<td></td>
</tr>
<tr>
<td>4. Severe</td>
<td></td>
</tr>
<tr>
<td>5. Critical</td>
<td></td>
</tr>
<tr>
<td>6. Maximal (currently untreatable)</td>
<td></td>
</tr>
<tr>
<td>9. Unable to assign</td>
<td></td>
</tr>
<tr>
<td>.3 = AIS: Severity Score</td>
<td>Serious</td>
</tr>
</tbody>
</table>

• 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.
• In Trauma One the AIS is displayed as AIS Severity (postdot), ISS Body Part, and then AIS 6-digit code (predot).
• Field value cannot be “Not Applicable”.
• Field cannot be left blank.

Uses
• Used to calculate Injury Severity Score.
• Assists with determination of appropriate treatment.
• System evaluation and monitoring.
Data Source Hierarchy
- AIS Coding Manual (AIS 15)
- Hospital Discharge Summary
- ER Records
- ICU Records
- OR Records
- Coroner’s Report

Other Associated Elements
- DISCHARGE DIAGNOSES – ICD-10 CODES
- CO-MORBID CONDITIONS
- COMPLICATIONS
CO-MORBID 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 NTDS Co-Morbidities</td>
<td></td>
</tr>
<tr>
<td>Co-Morbid <em>(Pre-existing)</em> Conditions are Not Known</td>
<td></td>
</tr>
<tr>
<td>Alcoholism</td>
<td>Alcohol Use Disorder</td>
</tr>
<tr>
<td>Angina (Pectoris)</td>
<td>Angina Pectoris</td>
</tr>
<tr>
<td>Anticoagulant Therapy</td>
<td>Anticoagulant Therapy</td>
</tr>
<tr>
<td>Attention Deficit Disorder/Hyperactivity Disorder (ADD/ADHD)</td>
<td>Attention Deficit Disorder/Hyperactivity Disorder (ADD/ADHD)</td>
</tr>
<tr>
<td>Bleeding Disorder</td>
<td>Bleeding Disorder</td>
</tr>
<tr>
<td>Cerebral Vascular Accident (CVA) / Residual Neuro Deficit</td>
<td>Cerebral Vascular Accident (CVA)</td>
</tr>
<tr>
<td>Chemotherapy (currently receiving)</td>
<td>Currently receiving Chemotherapy for cancer</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
</tr>
<tr>
<td>Cirrhosis</td>
<td>Cirrhosis</td>
</tr>
<tr>
<td>Congenital Anomalies</td>
<td>Congenital Anomalies</td>
</tr>
<tr>
<td>Congestive Heart Failure (CHF)</td>
<td>Congestive Heart Failure (CHF)</td>
</tr>
<tr>
<td>Current Smoker</td>
<td>Current Smoker</td>
</tr>
<tr>
<td>Dementia</td>
<td>Dementia</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>Diabetes Mellitus</td>
</tr>
<tr>
<td>Dialysis</td>
<td>Chronic Renal Failure</td>
</tr>
<tr>
<td>Disseminated Cancer</td>
<td>Disseminated Cancer</td>
</tr>
<tr>
<td>Drug (Substance) Abuse or Dependence</td>
<td>Substance Abuse Disorder</td>
</tr>
<tr>
<td>Functionally Dependent Health Status</td>
<td>Functionally Dependent Health Status</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Hypertension</td>
</tr>
<tr>
<td>Mental/Personality Disorder</td>
<td>Mental/Personality Disorder</td>
</tr>
<tr>
<td>Myocardial Infarction</td>
<td>Myocardial Infarction (MI)</td>
</tr>
<tr>
<td>Peripheral Arterial Disease (PAD)</td>
<td>Peripheral Arterial Disease (PAD)</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Pregnancy</td>
</tr>
<tr>
<td>Prematurity</td>
<td>Prematurity</td>
</tr>
<tr>
<td>Seizure Disorder</td>
<td></td>
</tr>
<tr>
<td>Steroid Use</td>
<td>Steroid Use</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

Additional Information
- Select the applicable field values from the Co-Morbid Conditions listed above for the patient.
- Enter the field value “No Co-Morbid Conditions” if none of the co-morbid conditions listed above are present for the patient.
- Enter 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”, for the co-morbid conditions selected, and “No” for those not selected., or “Not Known” for patients with unknown medical history.

**Uses**
- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

**Data Source Hierarchy**
- Progress/Consultation Notes
- Nursing Notes

**Other Associated Elements**
- DISCHARGE DIAGNOSES – ICD-10 CODES
- DISCHARGE DIAGNOSES - ABBREVIATED INJURY SCALE
- COMPLICATIONS
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</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Listed Hospital Complications Occurred</td>
<td></td>
</tr>
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</tr>
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</tr>
<tr>
<td>Alcohol Withdrawal</td>
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<td>Cardiac Arrest with CPR</td>
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<tr>
<td>Central Line-Associated Bloodstream Infection (CLABSI)</td>
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<td>Deep Vein Thrombosis (DVT) / Thrombophlebitis</td>
<td>Deep Vein Thrombosis (DVT)</td>
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<tr>
<td>Delirium</td>
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</tr>
<tr>
<td>Extremity Compartment Syndrome</td>
<td>Extremity Compartment Syndrome</td>
</tr>
<tr>
<td>Myocardial Infarction</td>
<td>Myocardial Infarction (MI)</td>
</tr>
<tr>
<td>Osteomyelitis</td>
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</tr>
<tr>
<td>Pneumonia Ventilator Associated (VAP)</td>
<td>Ventilator-Associated Pneumonia (VAP)</td>
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<tr>
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<td>Severe Sepsis</td>
</tr>
<tr>
<td>Surgical (Incisional) Site Infection (superficial)</td>
<td>Superficial Incisional Surgical Site Infection</td>
</tr>
<tr>
<td>Surgical Site Infection (deep)</td>
<td>Deep Surgical Site Infection</td>
</tr>
<tr>
<td>Surgical Site Infection (organ/space)</td>
<td>Organ/Space Surgical Site Infection</td>
</tr>
<tr>
<td>Unplanned Intubation</td>
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</tr>
<tr>
<td>Unplanned Readmission</td>
<td></td>
</tr>
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<td>Unplanned Return to the ICU</td>
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</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

Additional Information
- Select the applicable field values from the Hospital Complications listed above for the patient.
- Enter the field value “No Listed Hospital Complications Occurred” if none of the hospital complications listed above occurred during the patient’s hospital stay.
- Following data entry, select the “Confirm Hospital Complications” to populate the appropriate values of “Yes” and “No” for each of the Hospital Complications listed.

Uses
- Assists with determination of appropriate treatment.
- System evaluation and monitoring.
Data Source Hierarchy
- Progress/Consultation Notes
- Hospital Nursing Notes

Other Associated Elements
- DISCHARGE DIAGNOSES – ICD-10 CODES
- DISCHARGE DIAGNOSES - ABBREVIATED INJURY SCALE
- NTDS CO-MORBID CONDITIONS
UNPLANNED READMISSION
DATE OF READMISSION

Definition
The date the patient returned to an inpatient bed for an unplanned readmission within 30 days of discharge, elopement, AMA, etc., from a previous inpatient status related to the same event.

Field Values
- Collected as MMDDYYYY

Additional Information
- ED visits are NOT considered inpatient status.
- 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.
- The following edit check has been applied to Trauma One®:
  ✓ Readmission date must occur within 30 days of ED/Hospital Discharge.

Uses
- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

Data Source Hierarchy
- ED Record
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

Other Associated Elements
- TIME OF READMISSION
- READMISSION COMMENTS
- READMISSION COMPLICATIONS
- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRANSFERRED/DISCHARGED TO
- READMIT TRANSFER RATIONALE
- READmit TRANSFER TO
- READMIT DISCHARGE CAPACITY
TIME OF READMISSION

Definition
The time of day the patient was readmitted to an inpatient bed for an **unplanned readmission** within 30 days of discharge, elopement, AMA, etc., from a previous inpatient status related to the same event.

Field Values
- Collected as HHMM
- Use 24-hour clock

Additional Information
- ED visits are NOT considered inpatient status.
- Readmission is based on the same event and must be a “DHS=Yes” patient.

Uses
- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

Data Source Hierarchy
- ED Record
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

Other Associated Elements
- DATE OF READMISSION
- READMISSION COMMENTS
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- READMIT TRANSFER RATIONALE
- READMIT TRANSFER TO
- READMIT DISCHARGE CAPACITY
READMISSION COMMENT

Definition
Comment(s) related to the unplanned readmission of the patient.

Field Values
- Free text

Uses
- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

Data Source Hierarchy
- ED Records
- ICU Records
- Operative Reports
- Billing Sheet/Medical Records Coding Summary Sheet
- Hospital Discharge Summary

Other Associated Elements
- DATE OF READMISSION
- TIME OF READMISSION
- READMISSION COMPLICATIONS
- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRANSFERRED/DISCHARGED TO
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- READMIT DISCHARGE CAPACITY
READMISSION COMPLICATIONS

Definition
Any medical complication that occurred during the patient’s unplanned readmission.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>NTDS</th>
</tr>
</thead>
<tbody>
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</table>

Uses
- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

Data Source Hierarchy
- Progress/Consultation Notes
- Billing Sheet/Medical Records Coding Summary Sheet
- Hospital Discharge Summary

Other Associated Elements
- DATE OF READMISSION
- TIME OF READMISSION
- READMISSION COMMENTS
- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRANSFERRED/DISCHARGED TO
- READMIT TRANSFER RATIONALE
- READMIT TRANSFER TO
- READMIT DISCHARGE CAPACITY
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
- Collected as MMDDYYYY

Uses
- Establishes care intervals and incident timelines
- System evaluation and monitoring

Data Source Hierarchy
- ED Record
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

Other Associated Elements
- DATE OF READMISSION
- TIME OF READMISSION
- READMISSION COMMENTS
- READMISSION COMPLICATIONS
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRANSFERRED/DISCHARGED TO
- READMIT TRANSFER RATIONALE
- READMIT TRANSFER TO
- READMIT DISCHARGE CAPACITY
READMIT DISCHARGE TIME

Definition
The time of day the patient was discharged or transferred from the hospital following the unplanned readmission, or the date the patient died following readmission.

Field Values
- Collected as HHMM
- Use 24-hour clock

Additional Information
- Utilize The time of day the patient was pronounced brain dead in situations when care is assumed by an organ procurement agency.

Uses
- Establishes care intervals and incident timelines.
- System evaluation and monitoring.

Data Source Hierarchy
- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

Other Associated Elements
- DATE OF READMISSION
- TIME OF READMISSION
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- READMIT TRANSFER TO
- READMIT DISCHARGE CAPACITY
READMIT PRIOR PHASE

Definition
Phase of care prior to discharge of the patient following the unplanned readmission.

Field Values
- **23HR OBS**: <24 Hour Observation
- **ICU**: Intensive/Critical Care Unit
- **INT RAD**: Interventional Radiology
- **OR**: Operating Room
- **PICU**: Pediatric ICU
- **PEDSWARD**: Pediatric Ward
- **SPECIAL**: Special Procedures
- **STEPDOWN**: Stepdown or Telemetry Unit
- **WARD**: Ward/Floor

Uses
- Establishes care intervals and incident timelines.
- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

Data Source Hierarchy
- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

Other Associated Elements
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- **READMISSION COMPLICATIONS**
- **READMIT DISCHARGE DATE**
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- **READMIT TRANSFER RATIONALE**
- **READMIT TRANSFER TO**
- **READMIT DISCHARGE CAPACITY**
READMIT TRANSFERRED/DISCHARGED TO

Definition
The disposition of the patient following the unplanned readmission.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
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</tr>
</thead>
<tbody>
<tr>
<td>ACUTE Acute Care Facility</td>
<td>Discharged/Transferred to another acute care hospital for inpatient care</td>
</tr>
<tr>
<td>AMA AMA/Eloped/LWBS</td>
<td>Left against medical advice or discontinued care</td>
</tr>
<tr>
<td>BURN Burn Center</td>
<td>Discharged/Transferred to another acute care hospital for inpatient care</td>
</tr>
<tr>
<td>CLF Congregate Living Facility</td>
<td>Discharged/Transferred to another type of institution not defined elsewhere</td>
</tr>
<tr>
<td>HOME WITH Home W/Home Health Services</td>
<td>Discharged/Transferred to home under care of organized home health service</td>
</tr>
<tr>
<td>HOME W/O Home Without Services</td>
<td>Discharged home (routine discharge)</td>
</tr>
<tr>
<td>HOSPICE Hospice</td>
<td>Discharged/Transferred to hospice care</td>
</tr>
<tr>
<td>JAIL Jail</td>
<td>Discharged/Transferred to court/law enforcement</td>
</tr>
<tr>
<td>LTCH Long Term Care Hospital</td>
<td>Discharged/Transferred to Long Term Care Hospital (LTCH)</td>
</tr>
<tr>
<td>MORGUE Morgue</td>
<td>Deceased/Expired</td>
</tr>
<tr>
<td>PSYCH Psychiatric Hospital or Department of Hospital</td>
<td>Discharged/Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital</td>
</tr>
<tr>
<td>RCF Recuperative Care Facility</td>
<td>Discharged/Transferred to another type of institution not defined elsewhere</td>
</tr>
<tr>
<td>REHAB Rehabilitation Center</td>
<td>Discharged/Transferred to inpatient rehab or designated unit</td>
</tr>
<tr>
<td>SCJ Jail Ward at LAC+USC</td>
<td>Discharged/Transferred to court/law enforcement</td>
</tr>
<tr>
<td>SNF Skilled Nursing Facility</td>
<td>Transferred to Skilled Nursing Facility (SNF)</td>
</tr>
<tr>
<td>SUBACUTE Subacute Care</td>
<td>Transferred to an Intermediate Care Facility (ICF)</td>
</tr>
<tr>
<td>TRAUMA Trauma Center</td>
<td>Transferred to another acute care hospital for inpatient care</td>
</tr>
<tr>
<td>OTHER Other</td>
<td>Discharged/Transferred to another type of institution not defined elsewhere</td>
</tr>
</tbody>
</table>

Additional Information
- Enter “Morgue” for patients who are 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.
- A 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.

Uses
- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

Data Source Hierarchy
- ED Record
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet
Other Associated Elements

- DATE OF READMISSION
- TIME OF READMISSION
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READMIT TRANSFER RATIONALE

Definition
The rationale for transfer following the unplanned readmission, if applicable.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
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<tbody>
<tr>
<td><strong>CU</strong> In Custody</td>
</tr>
<tr>
<td>Patient discharged/transfered in custody of law enforcement</td>
</tr>
<tr>
<td><strong>EX</strong> Extended Care</td>
</tr>
<tr>
<td>Patient discharged from acute care setting of hospital, but required sub-acute care in the setting of a long-term care hospital (LTCH), skilled nursing facility (SNF), convalescent home, board-and-care, etc.</td>
</tr>
<tr>
<td><strong>FI</strong> Financial</td>
</tr>
<tr>
<td>Decision based on financial status (i.e., cash or self-pay, uninsured)</td>
</tr>
<tr>
<td><strong>HO</strong> Hospice</td>
</tr>
<tr>
<td>Patient transferred to hospice</td>
</tr>
<tr>
<td><strong>HP</strong> Health Plan</td>
</tr>
<tr>
<td>Health Plan decision</td>
</tr>
<tr>
<td><strong>OT</strong> Other</td>
</tr>
<tr>
<td>Transfer rationale other than above (Includes Psych)</td>
</tr>
<tr>
<td><strong>RH</strong> Rehabilitation</td>
</tr>
<tr>
<td>Patient required rehabilitation</td>
</tr>
<tr>
<td><strong>SH</strong> Specialized/Higher Level Care</td>
</tr>
<tr>
<td>Patient required acute specialized care or higher level of care not available at the transferring facility, e.g., pediatrics, burns, complex pelvic fracture, and reimplantation (Excludes Psych)</td>
</tr>
</tbody>
</table>

Uses
- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

Data Source Hierarchy
- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

Other Associated Elements
- DATE OF READMISSION
- TIME OF READMISSION
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- READMIT TRANSFER TO
- READMIT DISCHARGE CAPACITY
### LOS ANGELES COUNTY 9-1-1 RECEIVING

<table>
<thead>
<tr>
<th>Facility Code</th>
<th>Facility Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACH</td>
<td>Alhambra Hospital Medical Center</td>
</tr>
<tr>
<td>AHM</td>
<td>Catalina Island Medical Center</td>
</tr>
<tr>
<td>AMH</td>
<td>Methodist Hospital of Southern California</td>
</tr>
<tr>
<td>AVH</td>
<td>Antelope Valley Hospital</td>
</tr>
<tr>
<td>BEV</td>
<td>Beverly Hospital</td>
</tr>
<tr>
<td>BMC</td>
<td>Southern California Hospital at Culver City</td>
</tr>
<tr>
<td>CAL</td>
<td>Dignity Health - California Hospital Medical Center</td>
</tr>
<tr>
<td>CHH</td>
<td>Children’s Hospital Los Angeles</td>
</tr>
<tr>
<td>CHP</td>
<td>Community Hospital of Huntington Park</td>
</tr>
<tr>
<td>CNT</td>
<td>Centinela Hospital Medical Center</td>
</tr>
<tr>
<td>CPM</td>
<td>Coast Plaza Hospital</td>
</tr>
<tr>
<td>CSM</td>
<td>Cedars-Sinai Medical Center</td>
</tr>
<tr>
<td>DCH</td>
<td>PIH Health Hospital - Downey</td>
</tr>
<tr>
<td>DFM</td>
<td>Cedars-Sinai Marina Del Rey Hospital</td>
</tr>
<tr>
<td>DHL</td>
<td>Lakewood Regional Medical Center</td>
</tr>
<tr>
<td>ENH</td>
<td>Encino Hospital Medical Center</td>
</tr>
<tr>
<td>FPH</td>
<td>Emanate Health Foothill Presbyterian Hospital</td>
</tr>
<tr>
<td>GAR</td>
<td>Garfield Medical Center</td>
</tr>
<tr>
<td>GEM</td>
<td>Greater El Monte Community Hospital</td>
</tr>
<tr>
<td>GMH</td>
<td>Dignity Health - Glendale Memorial Hospital and Health Center</td>
</tr>
<tr>
<td>GSH</td>
<td>Good Samaritan Hospital</td>
</tr>
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<td>GWT</td>
<td>Adventist Health - Glendale</td>
</tr>
<tr>
<td>HCH</td>
<td>Providence Holy Cross Medical Center</td>
</tr>
<tr>
<td>HGH</td>
<td>LAC Harbor-UCLA Medical Center</td>
</tr>
<tr>
<td>HMH</td>
<td>Huntington Hospital</td>
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<tr>
<td>HN</td>
<td>Henry Mayo Newhall Hospital</td>
</tr>
<tr>
<td>HWH</td>
<td>West Hills Hospital &amp; Medical Center</td>
</tr>
<tr>
<td>ICH</td>
<td>Emanate Health Inter-Community Hospital</td>
</tr>
<tr>
<td>KFA</td>
<td>Kaiser Foundation Hospital – Baldwin Park</td>
</tr>
<tr>
<td>KFB</td>
<td>Kaiser Foundation Hospital – Downey</td>
</tr>
<tr>
<td>KFH</td>
<td>Kaiser Foundation Hospital – South Bay</td>
</tr>
<tr>
<td>KFL</td>
<td>Kaiser Foundation Hospital – Sunset (Los Angeles)</td>
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<td>KFO</td>
<td>Kaiser Foundation Hospital – Woodland Hills</td>
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<td>KFP</td>
<td>Kaiser Foundation Hospital – Panorama City</td>
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<tr>
<td>KFW</td>
<td>Kaiser Foundation Hospital – West Los Angeles</td>
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<tr>
<td>LBM</td>
<td>MemorialCare Long Beach Medical Center</td>
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<td>LCH</td>
<td>Palmdale Regional Medical Center</td>
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<tr>
<td>LCM</td>
<td>Providence Little Co. of Mary M.C. - Torrance</td>
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<tr>
<td>MCP</td>
<td>Mission Community Hospital</td>
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<td>MHG</td>
<td>Memorial Hospital of Gardena</td>
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<td>MLK</td>
<td>Martin Luther King Jr. Community Hospital</td>
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<td>Monterey Park Hospital</td>
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<tr>
<td>NOR</td>
<td>LA Community Hospital at Norwalk</td>
</tr>
<tr>
<td>NRH</td>
<td>Dignity Health - Northridge Hospital Medical Center</td>
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<tr>
<td>OVM</td>
<td>LAC Olive View-UCLA Medical Center</td>
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<tr>
<td>PAC</td>
<td>Pacifica Hospital of the Valley</td>
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<tr>
<td>PIH</td>
<td>PIH Health Hospital - Whittier</td>
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<tr>
<td>PLB</td>
<td>College Medical Center</td>
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<tr>
<td>PVC</td>
<td>Pomona Valley Hospital Medical Center</td>
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<td>QOA</td>
<td>Hollywood Presbyterian Medical Center</td>
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<td>Emanate Health Queen of the Valley</td>
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<tr>
<td>SDC</td>
<td>San Dimas Community Hospital</td>
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<td>St. Francis Medical Center</td>
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<td>SGC</td>
<td>San Gabriel Valley Medical Center</td>
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<td>SJH</td>
<td>Providence Saint John’s Health Center</td>
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<td>SJS</td>
<td>Providence Saint Joseph Medical Center</td>
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<td>SMH</td>
<td>Santa Monica-UCLA Medical Center</td>
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<td>Dignity Health - St. Mary Medical Center</td>
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<td>Sherman Oaks Hospital</td>
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<td>TOR</td>
<td>Torrance Memorial Medical Center</td>
</tr>
<tr>
<td>TRM</td>
<td>Providence Cedars-Sinai Tarzana Medical Center</td>
</tr>
<tr>
<td>UCL</td>
<td>Ronald Reagan UCLA Medical Center</td>
</tr>
<tr>
<td>USC</td>
<td>LAC+USC Medical Center</td>
</tr>
<tr>
<td>VHH</td>
<td>USC Verdugo Hills Hospital</td>
</tr>
<tr>
<td>VPH</td>
<td>Valley Presbyterian Hospital</td>
</tr>
<tr>
<td>WHH</td>
<td>Whittier Hospital Medical Center</td>
</tr>
<tr>
<td>WMH</td>
<td>Adventist Health - White Memorial</td>
</tr>
</tbody>
</table>
### ORANGE COUNTY 9-1-1 RECEIVING

<table>
<thead>
<tr>
<th>ANH</th>
<th>Anaheim Regional Medical Center</th>
<th>LPI</th>
<th>La Palma Intercommunity Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHO</td>
<td>Children’s Hospital of Orange County</td>
<td>PLH</td>
<td>Placentia Linda Hospital</td>
</tr>
<tr>
<td>FHP</td>
<td>Fountain Valley Regional Hospital and Medical Center</td>
<td>SJD</td>
<td>St. Jude Medical Center</td>
</tr>
<tr>
<td>KHA</td>
<td>Kaiser Foundation Hospital – Anaheim</td>
<td>UCI</td>
<td>UCI Medical Center</td>
</tr>
<tr>
<td>KFI</td>
<td>Kaiser Foundation Hospital – Irvine</td>
<td>WMC</td>
<td>Western Medical Center Santa Ana</td>
</tr>
<tr>
<td>LAG</td>
<td>Los Alamitos Medical Center</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### SAN BERNARDINO COUNTY 9-1-1 RECEIVING

<table>
<thead>
<tr>
<th>ARM</th>
<th>Arrowhead Regional Medical Center</th>
<th>KFN</th>
<th>Kaiser Foundation Hospital - Ontario</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHI</td>
<td>Chino Valley Medical Center</td>
<td>LLU</td>
<td>Loma Linda University Medical Center</td>
</tr>
<tr>
<td>DHM</td>
<td>Montclair Hospital Medical Center</td>
<td>SAC</td>
<td>San Antonio Community Hospital</td>
</tr>
<tr>
<td>KFF</td>
<td>Kaiser Foundation Hospital - Fontana</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### OTHER COUNTY 9-1-1 RECEIVING

<table>
<thead>
<tr>
<th>LRR</th>
<th>Los Robles Hospital &amp; Medical Center (Ventura)</th>
<th>SJO</th>
<th>St. John Regional Medical Center (Ventura)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIM</td>
<td>Adventist Health - Simi Valley Hospital (Ventura)</td>
<td>RCC</td>
<td>Ridgecrest Regional Hospital (Kern)</td>
</tr>
</tbody>
</table>

### NON-BASIC HOSPITALS

| LBV | Long Beach VA | WVA | Wadsworth VA Medical Center |

**Uses**
- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

**Data Source Hierarchy**
- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**
- DATE OF READMISSION
- TIME OF READMISSION
- READMISSION COMMENTS
- READMISSION COMPLICATIONS
- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRANSFERRED/DISCHARGED TO
- READMIT TRANSFER RATIONALE
- READMIT DISCHARGE CAPACITY
READMIT DISCHARGE CAPACITY

Definition
Patient’s gross functional capacity upon discharge following the unplanned readmission.

Field Values

<table>
<thead>
<tr>
<th>LA COUNTY</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>H PERMANENT HANDICAP</td>
<td>Limitations from the injury expected to last more than one year</td>
</tr>
<tr>
<td>T TEMPORARY HANDICAP</td>
<td>Required ADMISSION to the hospital for injuries sustained</td>
</tr>
<tr>
<td>P PRE-INJURY CAPACITY</td>
<td>Discharged FROM THE ED with minimal or no injury</td>
</tr>
</tbody>
</table>

Additional Information
- Enter the null value of “Not Applicable” if the patient expired.
- A splenectomy is NOT considered a permanent handicap.

Uses
- Assists with determination of appropriate treatment.
- System evaluation and monitoring.

Data Source Hierarchy
- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

Other Associated Elements
- DATE OF READMISSION
- TIME OF READMISSION
- READMISSION COMMENTS
- READMISSION COMPLICATIONS
- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRANSFERRED/DISCHARGED TO
- READMIT TRANSFER RATIONALE
- READMIT TRANSFER TO
FINANCIAL
**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/Commercial:</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 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 without Ability to Pay</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><strong>Other</strong></td>
<td>10 Other</td>
</tr>
</tbody>
</table>

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

**Uses**
- System evaluation and monitoring.

**Data Source Hierarchy**
- Facesheet
- Billing Sheet/Medical Records Coding Summary Sheet

**Other Associated Elements**
- TOTAL HOSPITAL CHARGES
TOTAL HOSPITAL CHARGES

Definition
The total amount of all charges for the patient’s hospital care.

Field Values
- Up to twelve-digit positive numeric value

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

Uses
- System evaluation and monitoring.

Data Source Hierarchy
- Billing Sheet/Medical Records Coding Summary Sheet

Other Associated Elements
- PAYOR
RECORD COMPLETE?

Definition
Indicates whether the patient’s record is complete.

Field Values
- Y: Yes
- N: No

Additional Information
- Field value defaults to “No”, upon completion of the record, user needs to change the ‘No’ value to “Yes”.
- Null Values are not accepted for this data field.
- Only records that indicate “yes”, 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 LA Trauma Database Inclusion Criteria data fields are incomplete.

Uses
- Identifies if the record is complete for export to NTDB® and TQIP®.
- System evaluation and monitoring.
APPENDIX 1: Reference Documents
Appendix 1 – Reference Documents
NATIONAL TRAUMA DATA STANDARD (NTDS®) PATIENT INCLUSION CRITERIA

DEFINITION: To ensure consistent data collection across States into the National Trauma Data Standard, a trauma patient is defined as a patient sustaining a traumatic injury within 14 days of initial hospital encounter and meeting the following criteria:

At least ONE of the following injury diagnostic codes defined as follows:

**International Classification of Diseases, Tenth Revision (ICD-10-CM):**
- S00-S99 with 7th character modifiers of A, B, or C ONLY. (Injuries to specific body parts–initial encounter)
- T07 (unspecified multiple injuries)
- T14 (injury of unspecified body region)

EXCLUDING the following isolated injuries:

**ICD-10-CM:**
- S00 (Superficial injuries of the head)
- S10 (Superficial injuries of the neck)
- S20 (Superficial injuries of the thorax)
- S30 (Superficial injuries of the abdomen, pelvis, lower back and external genitals)
- S40 (Superficial injuries of shoulder and upper arm)
- S50 (Superficial injuries of elbow and forearm)
- S60 (Superficial injuries of wrist, hand and fingers)
- S70 (Superficial injuries of hip and thigh)
- S80 (Superficial injuries of knee and lower leg)
- S90 (Superficial injuries of ankle, foot and toes)

Late effect codes, which are represented using the same range of injury diagnosis codes but with the 7th digit modifier code of D through S, are also excluded.


- Death resulting from the traumatic injury (independent of hospital admission or hospital transfer status);
  **OR**
- Patient transfer from one acute care hospital* to another acute care hospital;
  **OR**
- Patients directly admitted to your hospital (exclude patients with isolated injuries admitted for elective and/or planned surgical intervention);
  **OR**
- Patients who were an in-patient admission and/or observed

NTDS® INCLUSION CRITERIA ALGORITHM 2021

**STEP #1:**

- Did the patient sustain one or more traumatic injuries within 14 days of initial hospital encounter? **NO**
  - Patient NOT INCLUDED in the National Trauma Data Standard

- Is the diagnostic code for any injury included in the following ICD-10-CM range? $S00-S99, T07, T14, T79.A1—T79.A9$ **NO**
  - Patient NOT INCLUDED in the National Trauma Data Standard

- Did the patient sustain at least one injury with a diagnosis code outside the ranges of ICD-10-CM codes below? $S00, S10, S20, S30, S40, S50, S60, S70, S80, S90$ **NO**
  - Patient NOT INCLUDED in the National Trauma Data Standard

**CONTINUE TO STEP #2**

**STEP #2:**

- Did the patient’s injury result in death? **YES**
  - Patient INCLUDED in the National Trauma Data Standard

- Was the patient transferred from one acute care hospital to another acute care hospital? **NO**
  - Patient NOT INCLUDED in the National Trauma Data Standard

- Was the patient directly admitted to your hospital (exclude patients with isolated injuries admitted for elective and/or planned surgical intervention)? **YES**
  - Patient INCLUDED in the National Trauma Data Standard

- Was the patient an in-patient admission and/or observed? **NO**
  - Patient NOT INCLUDED in the National Trauma Data Standard
SEQUENCE NUMBER ALGORITHM

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 (and MM if applicable)</td>
</tr>
<tr>
<td></td>
<td>Force is less than 20mph</td>
<td>PB SP CR* FA* OT (and MM if applicable)</td>
</tr>
<tr>
<td>OPERATING any transport</td>
<td>Transport is unenclosed, and force is GREATER than 20mph</td>
<td>20 (and MM if applicable)</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.

### MOTORIZED transports include, but are not limited to:
- Cars/Trucks
- Vans
- Buses
- Planes
- Trains
- Motorcycles
- Motorized bicycles (mopeds)
- Motorized scooters
- Golf carts

### UNENCLOSED transports include, but are not limited to:
- Bicycles
- Roller skates/blades
- Skateboards
- Non-motorized scooters
- Non-motorized wheelchairs
- Horses
- Watercraft
- ATVs
APPENDIX 2: Reference Guides
### Appendix 2 – Reference Guides

#### ICD-10 PCS – SECTION 1 – MEDICAL/SURGICAL (0)

<table>
<thead>
<tr>
<th>Qualifier</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Allergic</td>
<td>Anaphylactic</td>
<td>Anaphylactic Reaction</td>
<td>Anaphylaxis</td>
<td>Anaphylactic Shock</td>
<td>Anaphylactic Reaction to Food</td>
<td>Anaphylactic Reaction to Medication</td>
<td>Anaphylactic Reaction to Venom</td>
</tr>
<tr>
<td>1</td>
<td>Syngeneic</td>
<td>Zoonotic</td>
<td>Other Animal</td>
<td>Rodent</td>
<td>Non-Human Primate</td>
<td>Other Animal</td>
<td>Rodent</td>
<td>Non-Human Primate</td>
</tr>
<tr>
<td>2</td>
<td>Zooplastic</td>
<td>Infectious</td>
<td>Bacterial</td>
<td>Viral</td>
<td>Parasitic</td>
<td>Bacterial</td>
<td>Viral</td>
<td>Parasitic</td>
</tr>
<tr>
<td>3</td>
<td>R</td>
<td>K</td>
<td>L</td>
<td>R</td>
<td>K</td>
<td>L</td>
<td>R</td>
<td>K</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Device:** drainage, radioactive, percutaneous, endoscopic, autologous, tissue, extraluminal, intraluminal, endobronchial, surgical, cutaneous, leukemic, bladderic, ileal, colonic, cutaneous, sphincteric, electrical, feeding, other, no device.

**Approach:** open, percutaneous, endoscopic, natural, artificial, opening, natural, artificial, opening, natural, artificial, percutaneous, endoscopic, external, approach values used in Section 1 – Medical/Surgical (0).

**Body Part:** too numerous to list, corresponding body parts and their anatominical subdivisions of the body part.

**Root Operation:** alteration, bypass, change, control, creation, destruction, dilation, division, drainage, excision, extrusion, fusion, insertion, inspection, map, occlusion, reattachment, removal, repair, replacement, revision, transplantation.

**Body System:** CNS, peripheral nerve, heart, upper aeries, lower aeries, lymphatic, ear/nose/sinus, respiratory, mouth/throat, GI, endocrine, skin/breast, SQ tissue, musculoskeletal, tendons, ligament, joint, bone, brain, nerve, cranial nerve, eye, ear, nose, sinus, mouth, teeth, skin, breast, muscle, bone, ligament, tendon, joint, spine, brain, other.

**Group 1:** medical/surgical.

**Group 2:** group 2.

**Group 3:** imaging, nuclear medicine, radiation, oncology, rehabilitation, audiology, mental health, abuse, treatment, anatomic gen, anatomic upper, anatomic lower.
<table>
<thead>
<tr>
<th>BODY SYSTEM</th>
<th>SECTION</th>
<th>MEANINGS</th>
<th>TYPE</th>
<th>CONTRAST</th>
<th>QUALIFIER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Nervous System</td>
<td>0</td>
<td>Plain Radiology, Fluoroscopy</td>
<td>3</td>
<td>High Osmolar</td>
<td>7</td>
</tr>
<tr>
<td>Upper Airways</td>
<td>3</td>
<td>CT (CT) Scan</td>
<td>5</td>
<td>Low Osmolar</td>
<td>6</td>
</tr>
<tr>
<td>Heart</td>
<td>2</td>
<td>Computed Tomography</td>
<td>1</td>
<td>Other Contrast</td>
<td>5</td>
</tr>
<tr>
<td>Lymphatic System</td>
<td>4</td>
<td>Magnetic Resonance Imaging (MRI)</td>
<td>4</td>
<td>None</td>
<td>5</td>
</tr>
<tr>
<td>Ear/ Nose/ Throat</td>
<td>9</td>
<td>Ultrasonography</td>
<td>4</td>
<td>None</td>
<td>5</td>
</tr>
<tr>
<td>Eye</td>
<td>5</td>
<td>Endovascular System</td>
<td>3</td>
<td>None</td>
<td>5</td>
</tr>
<tr>
<td>Gastrointestinal System</td>
<td>6</td>
<td>Endovascular System</td>
<td>3</td>
<td>None</td>
<td>5</td>
</tr>
<tr>
<td>Head/ Neck</td>
<td>16</td>
<td>Endovascular System</td>
<td>3</td>
<td>None</td>
<td>5</td>
</tr>
<tr>
<td>Spine</td>
<td>17</td>
<td>Endovascular System</td>
<td>3</td>
<td>None</td>
<td>5</td>
</tr>
<tr>
<td>Skin/ Breast/ SQ Tissue</td>
<td>25</td>
<td>Endovascular System</td>
<td>3</td>
<td>None</td>
<td>5</td>
</tr>
<tr>
<td>Connective Tissue</td>
<td>32</td>
<td>Endovascular System</td>
<td>3</td>
<td>None</td>
<td>5</td>
</tr>
<tr>
<td>Upper Extremity</td>
<td>64</td>
<td>Endovascular System</td>
<td>3</td>
<td>None</td>
<td>5</td>
</tr>
<tr>
<td>Lower Extremity</td>
<td>73</td>
<td>Endovascular System</td>
<td>3</td>
<td>None</td>
<td>5</td>
</tr>
<tr>
<td>Pelvis/ Lower Extremity</td>
<td>83</td>
<td>Endovascular System</td>
<td>3</td>
<td>None</td>
<td>5</td>
</tr>
<tr>
<td>Thorax</td>
<td>92</td>
<td>Endovascular System</td>
<td>3</td>
<td>None</td>
<td>5</td>
</tr>
<tr>
<td>Upper Quarter</td>
<td>101</td>
<td>Endovascular System</td>
<td>3</td>
<td>None</td>
<td>5</td>
</tr>
<tr>
<td>Lower Quarter</td>
<td>111</td>
<td>Endovascular System</td>
<td>3</td>
<td>None</td>
<td>5</td>
</tr>
<tr>
<td>Foot</td>
<td>121</td>
<td>Endovascular System</td>
<td>3</td>
<td>None</td>
<td>5</td>
</tr>
<tr>
<td>Anatomic Regions</td>
<td>131</td>
<td>Endovascular System</td>
<td>3</td>
<td>None</td>
<td>5</td>
</tr>
<tr>
<td>Obstetrics &amp; Gynecology</td>
<td>141</td>
<td>Endovascular System</td>
<td>3</td>
<td>None</td>
<td>5</td>
</tr>
</tbody>
</table>

**Qualifiers (Section 1 - Imaging (B))**
- 0: Unenhanced
- 1: Laser
- 2: Intraocular
- 3: Intraocular Optical Coherence
- 4: Trans-esophageal
- 5: None
- 6: Guidance

**Values used in Section 1 - Imaging (B)**
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 Anatomic 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</td>
<td>1 - Minor</td>
</tr>
<tr>
<td>2 - Face</td>
<td>2 - Vessels</td>
<td>02 - Skin – Abrasion</td>
<td>consecutive two-dig</td>
<td>2 - Moderate</td>
</tr>
<tr>
<td>3 - Neck</td>
<td>3 - Nerves</td>
<td>04 - Skin – Contusion</td>
<td>digit numbers beginning</td>
<td>3 - Serious</td>
</tr>
<tr>
<td>4 - Thorax</td>
<td>4 - Organs</td>
<td>06 - Skin – Laceration</td>
<td>with 02.</td>
<td>4 - Severe</td>
</tr>
<tr>
<td>5 - Abdomen</td>
<td>5 - Skeletal</td>
<td>08 - Skin – Avulsion</td>
<td>An injury Not</td>
<td>5 - Critical</td>
</tr>
<tr>
<td>6 - Spine</td>
<td>6 - Head</td>
<td>09 - Trauma</td>
<td>Further Specified</td>
<td>6 - Maximal</td>
</tr>
<tr>
<td>7 - Upper Extremity</td>
<td>7 - Joints</td>
<td>10 - Amputation</td>
<td>(NFS) is assigned</td>
<td>9 - Unknown</td>
</tr>
<tr>
<td>8 - Lower Extremity</td>
<td></td>
<td>20 - Burn</td>
<td>00.</td>
<td>A Severity Score of</td>
</tr>
<tr>
<td>9 - External</td>
<td></td>
<td>30 - Crush</td>
<td>An injury NFS as</td>
<td>6 (Maximal) is</td>
</tr>
<tr>
<td></td>
<td></td>
<td>40 - Degloving</td>
<td>to lesion or severity</td>
<td>considered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>50 - Injury NFS</td>
<td>is assigned</td>
<td>untreated and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>60 - Penetrating</td>
<td>99.</td>
<td>should only be used</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>for injuries</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>specifically assigned</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>a severity level of 6,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>and not to be an</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>arbitrary choice</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>simply because the patient</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>died.</td>
</tr>
<tr>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

Organs includes Muscles & Ligaments.

An injury NFS as to lesion or severity is assigned 99.

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).
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 Body Region</th>
<th>AIS Body Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Head / Neck</td>
<td>1 - Head</td>
</tr>
<tr>
<td>(Includes brain, skull, cervical spine and spinal cord.)</td>
<td>2 - Neck</td>
</tr>
<tr>
<td>2 - Face</td>
<td>3 - Face</td>
</tr>
<tr>
<td>(Includes mouth, ears, eyes, nose and facial bones.)</td>
<td></td>
</tr>
<tr>
<td>3 - Chest</td>
<td>4 - Thorax</td>
</tr>
<tr>
<td>(Includes all internal thoracic organs, diaphragm, rib cage, and thoracic spine and spinal cord.)</td>
<td></td>
</tr>
<tr>
<td>4 - Abdomen / Pelvis</td>
<td>5 - Abdomen</td>
</tr>
<tr>
<td>(Includes all internal abdominal organs, and lumbar spine, and spinal cord.)</td>
<td></td>
</tr>
<tr>
<td>5 - Extremities / Pelvic Girdle</td>
<td>6 - Spine</td>
</tr>
<tr>
<td>(Includes all sprains, fractures, dislocations and amputation - Except for those of the spine, skull and rib cage.)</td>
<td></td>
</tr>
<tr>
<td>6 - External</td>
<td>7 - Upper extremity</td>
</tr>
<tr>
<td>(Includes lacerations, contusions, abrasions, and burns - independent of body region.)</td>
<td>8 - Lower extremity</td>
</tr>
<tr>
<td>9 - External</td>
<td></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 Complete transection of internal carotid</td>
<td>140602.3 320212.4</td>
<td>4</td>
<td>16</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>

\[
\text{ISS} = 34
\]
### ICD-10 ROOT OPERATIONS

#### TAKES OUT SOME OR ALL OF A BODY PART

**3 ROOT OPERATION**  
(SECTION 1 - 0 Medical/Surgical)

<table>
<thead>
<tr>
<th>ROOT OPERATION</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>S</strong> Physical eradication of all or a portion of a body part by the direct use of energy, force, or a destructive agent (&quot;Coagulation, Ablation, Cryotherapy, Cauterization&quot;). None of the body part is physically taken out. <strong>Examples:</strong> Fulguration of rectal polyp, cautery of skin lesion</td>
<td></td>
</tr>
<tr>
<td><strong>6</strong> Cutting off all or part of the upper or lower extremities only. The body part value is the site of the detachment, with a qualifier to further specify the level where the extremity was detached. <strong>Examples:</strong> Below knee amputation, disarticulation of shoulder</td>
<td></td>
</tr>
<tr>
<td><strong>B</strong> Cutting out or off, without replacement, a portion of a body part (&quot;Harvesting&quot;). The qualifier &quot;diagnostic&quot; is used to identify procedures that are biopsies. <strong>Examples:</strong> Partial nephrectomy, liver biopsy</td>
<td></td>
</tr>
<tr>
<td><strong>D</strong> Pulling or stripping out or off all or a portion of a body part by the use of force. The qualifier &quot;diagnostic&quot; is used to identify extractions that are biopsies. <strong>Examples:</strong> Dilation and curettage, vein stripping, bone marrow extraction</td>
<td></td>
</tr>
<tr>
<td><strong>T</strong> Cutting out or off, without replacement, all of a body part, or any subdivision of a body part that has its own body part value in ICD-10PCS. <strong>Examples:</strong> Nephrectomy, Pneumonecctomy</td>
<td></td>
</tr>
</tbody>
</table>

#### TAKES OUT SOLIDS / FLUIDS / GASES

<table>
<thead>
<tr>
<th>ROOT OPERATION</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>9</strong> Drainage</td>
<td>Taking or letting out fluids and/or gases from a body part. The qualifier &quot;diagnostic&quot; is used to identify drainage procedures that are biopsies. <strong>Examples:</strong> Thoracentesis, phlebotomy</td>
</tr>
<tr>
<td><strong>C</strong> Extirpation</td>
<td>Taking or cutting out solid matter from a body part. The solid matter may be an abnormal byproduct of a biological function or a foreign body; it may be imbedded in a body part or in the lumen of a tubular body part. The solid matter may or may not have been previously broken into pieces. <strong>Examples:</strong> Thrombectomy, choledocholithotomy, endarterectomy, embolectomy</td>
</tr>
<tr>
<td><strong>F</strong> Fragmentation</td>
<td>Breaking solid matter in a body part into pieces. Physical force (e.g. manual, ultrasonic) applied directly or indirectly through intervening body parts are used to break the solid matter into pieces. The solid matter may be abnormal byproduct of a biological function or a foreign body. The pieces of solid matter are not taken out, but are assimilated or absorbed through normal biological functions. <strong>Examples:</strong> ESW lithotripsy, transurethral lithotripsy</td>
</tr>
<tr>
<td><strong>8</strong> Division</td>
<td>Cutting into a body part without draining fluids and/or gases from the body part in order to separate or transect a body part. <strong>Examples:</strong> Spinal cordotomy, osteotomy, episiotomy</td>
</tr>
<tr>
<td><strong>N</strong> Release</td>
<td>Freeing of a body part from an abnormal physical constraint by cutting or by use of force (&quot;Manipulation&quot;). Some of the restraining tissue may be taken out but none of the body part is taken out. <strong>Examples:</strong> Adhesiolysis, carpal tunnel release</td>
</tr>
<tr>
<td><strong>M</strong> Reposition</td>
<td>Putting back in or on all or a portion of a separated body part to its normal location of other suitable location. Vascular circulation and nervous pathways may or may not be reestablished. <strong>Examples:</strong> Reattachment of hand, reattachment of avulsed kidney</td>
</tr>
<tr>
<td><strong>S</strong> Reposition</td>
<td>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.</td>
</tr>
</tbody>
</table>
### Transfer

| X | 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 | 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)

<table>
<thead>
<tr>
<th>Y</th>
<th>Transplantation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>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. <strong>Examples:</strong> Percutaneous transluminal angioplasty, pyloromyotomy</td>
</tr>
<tr>
<td>7</td>
<td>Completely closing an orifice or lumen (&quot;ligation&quot;) of a tubular body part. &quot;Embolization&quot; can be either occlusive or restrictive. <strong>Examples:</strong> Fallopian tube ligation, ligation of IVC</td>
</tr>
<tr>
<td>L</td>
<td>Partially closing an orifice or the lumen (&quot;clipping&quot;) of a tubular body part. &quot;Embolization&quot; can be either occlusive or restrictive. <strong>Examples:</strong> Esophagogastric fundoplication, cervical cerclage</td>
</tr>
</tbody>
</table>

### ALWAYS INVOLVES A DEVICE

<table>
<thead>
<tr>
<th>2</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>Insertion</td>
</tr>
<tr>
<td>P</td>
<td>Removal</td>
</tr>
<tr>
<td>R</td>
<td>Replacement</td>
</tr>
<tr>
<td>U</td>
<td>Supplement</td>
</tr>
<tr>
<td>W</td>
<td>Revision</td>
</tr>
</tbody>
</table>

<p>| 2 | 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. <strong>Examples:</strong> Urinary catheter change, gastrostomy tube change |
| H | 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. <strong>Examples:</strong> Insertion of radioactive implant, insertion of central venous catheter |
| P | Taking out or off a device from a body part. <strong>Examples:</strong> Drainage tube removal, cardiac pacemaker removal |
| R | 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. <strong>Examples:</strong> Total hip replacement, free skin graft |
| U | 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 SUPPLEMENT procedure is performed to physically reinforce and/or augment the function of the replaced body part. <strong>Examples:</strong> Free nerve graft, mitral valve ring annuloplasty |
| W | 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. <strong>Examples:</strong> Adjustment of position of pacemaker lead, recementing of hip prosthesis |</p>
<table>
<thead>
<tr>
<th>Reference No. 646</th>
</tr>
</thead>
</table>

## INVOLVES EXAMINATION ONLY

- **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

- **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

- **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

## 3 DEFINES OTHER OBJECTIVES

- **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

- **Creation**: Making a new genital structure that does not take over the function of a body part. Used only for sex change operations

- **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

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### 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><strong>Fall</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall - struck object</td>
<td>W01.198A</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>
</tr>
<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>
</tr>
<tr>
<td>MCC - driver solo collision</td>
<td>V28.4XXA</td>
<td>Motorcycle driver injured in non-collision transport accident in traffic accident</td>
</tr>
<tr>
<td>MVC - bike vs car</td>
<td>V13.4XXA</td>
<td>Pedal cycle driver injured in collision with car, pickup truck, or van in traffic accident</td>
</tr>
<tr>
<td>MVC - driver car vs car</td>
<td>V43.52XA</td>
<td>Car driver injured in collision with other type car in traffic accident</td>
</tr>
<tr>
<td>MVC - driver car vs object</td>
<td>V47.5XXA</td>
<td>Driver of car injured in collision with fixed or stationary object in traffic accident</td>
</tr>
<tr>
<td>MVC - driver truck vs car</td>
<td>V53.5XXA</td>
<td>Driver of pickup truck or van injured in collision with car, pickup truck or van in traffic accident</td>
</tr>
<tr>
<td>MVC - passenger car vs car</td>
<td>V43.62XA</td>
<td>Car passenger injured in collision with other type car in traffic accident</td>
</tr>
<tr>
<td>MVC - car vs scooter (non-motorized)</td>
<td>V98.8XXA</td>
<td>Other specified transport accidents</td>
</tr>
<tr>
<td>MVC - pedestrian vs car</td>
<td>V03.10XA</td>
<td>Pedestrian on foot injured in collision with car, pickup truck or van in traffic accident</td>
</tr>
<tr>
<td>MVA - skateboard vs car</td>
<td>V03.12XA</td>
<td>Pedestrian on skateboard injured in collision with care, pickup truck or van in traffic accident</td>
</tr>
</tbody>
</table>
### Incidents Types and Codes

<table>
<thead>
<tr>
<th>Incident Type</th>
<th>Code</th>
<th>Code Description (Initial Encounter)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Motorized Scooter (MS) (i.e. Birds, Limes, etc.)</strong></td>
<td>V00.182A</td>
<td>Pedestrian on other rolling-type pedestrian conveyance colliding with stationary object</td>
</tr>
<tr>
<td><strong>MS vs Stationary Object</strong></td>
<td>V00.181A</td>
<td>Fall from other rolling-type pedestrian conveyance</td>
</tr>
<tr>
<td><strong>Fall from MS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MS vs Motor Vehicle</strong></td>
<td>V03.19XA</td>
<td>Pedestrian with other conveyance injured in collision with car, pick-up truck, or van in traffic accident</td>
</tr>
<tr>
<td><strong>Pedestrian vs MS</strong></td>
<td>V00.09XA</td>
<td>Pedestrian on foot injured in collision with other pedestrian conveyance</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Shot - handgun</strong></td>
<td>W32.0XXA</td>
<td>Accidental handgun discharge</td>
</tr>
<tr>
<td><strong>Shot - other gun</strong></td>
<td>W34.00XA</td>
<td>Accidental discharge from unspecified firearms or gun</td>
</tr>
<tr>
<td><strong>INTENTIONAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Abuse, Physical - Adult</strong></td>
<td>T74.11XA</td>
<td>Adult physical abuse, confirmed</td>
</tr>
<tr>
<td><strong>Assault</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Assault - blunt object</strong></td>
<td>Y00.XXXA</td>
<td>Assault by blunt object</td>
</tr>
<tr>
<td><strong>Assault - fists</strong></td>
<td>Y04.0XXA</td>
<td>Assault by unarmed brawl or fight</td>
</tr>
<tr>
<td><strong>Assault - human bite</strong></td>
<td>Y04.1XXA</td>
<td>Assault by human bite</td>
</tr>
<tr>
<td><strong>Assault - pushed down stairs</strong></td>
<td>Y01.XXXA</td>
<td>Assault by pushing from high place</td>
</tr>
<tr>
<td><strong>Assault – struck by car</strong></td>
<td>Y03.0XXA</td>
<td>Assault by being hit or run over by motor vehicle</td>
</tr>
<tr>
<td><strong>Shot - BB gun</strong></td>
<td>X95.01XA</td>
<td>Assault by air gun discharge</td>
</tr>
<tr>
<td><strong>Shot - hand gun</strong></td>
<td>X93.XXXA</td>
<td>Assault by handgun discharge</td>
</tr>
<tr>
<td><strong>Shot - shot gun</strong></td>
<td>X94.0XXA</td>
<td>Assault by shotgun</td>
</tr>
<tr>
<td><strong>Shot - unspecified</strong></td>
<td>X95.9XXA</td>
<td>Assault by unspecified firearm discharge</td>
</tr>
<tr>
<td><strong>Stabbed - knife</strong></td>
<td>X99.1XXA</td>
<td>Assault by knife</td>
</tr>
<tr>
<td><strong>Stabbed - other sharp object</strong></td>
<td>X99.8XXA</td>
<td>Assault by other sharp object</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cut - self-inflicted</strong></td>
<td>X78.8XXA</td>
<td>Intentional self-harm by other sharp object</td>
</tr>
<tr>
<td><strong>Punched through glass</strong></td>
<td>W25.XXXA</td>
<td>Contact with sharp glass</td>
</tr>
<tr>
<td><strong>Shot - self-inflicted handgun</strong></td>
<td>X72.XXXA</td>
<td>Intentional self-harm by handgun discharge</td>
</tr>
<tr>
<td><strong>OTHER</strong></td>
<td></td>
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<td>Exposure to other specified factors</td>
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## ED PROCEDURES

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<td>Insertion of Infusion Device into L External Jugular, Percutaneous</td>
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<td>Chest Tube, R Chest</td>
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<td>Diagnostic Peritoneal Lavage (DPL)</td>
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<td>Occlusion of Thoracic Aorta with Intraluminal Device, Percutaneous</td>
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<td>Bypass trachea to cutaneous with Tracheostomy Device, Percutaneous, Endoscopic</td>
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## ORTHOPEDIC PROCEDURES

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<td>Division of Right Lower Leg Subcutaneous Tissue and Fascia, <strong>Open</strong></td>
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<td>Monitoring of Intracranial Pressure, <strong>Percutaneous</strong></td>
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<td>4A107BD</td>
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<td>Monitoring of Central Nervous Electrical Activity, Intraoperative, <strong>Percutaneous</strong></td>
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<td>Packing, Abdominal Wall</td>
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<td>Packing of Abdominal Wall using Packing Material</td>
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<td>Percutaneous Endoscopic Gastrostomy (PEG)</td>
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<td>Insertion of Feeding Device into Stomach, <strong>Percutaneous</strong></td>
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<td>Introduction of Regional Anesthetic into Peripheral Nerves and Plexi, <strong>Percutaneous</strong></td>
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# RadioLOGY Body Part / ICD-10 PCS CoDe

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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.
# IMAGING PROCEDURES

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APPENDIX 3: Glossary of Terms
CO-MORBID (PRE-EXISTING) CONDITIONS

Advanced Directive (limiting care): The patient had a Do-Not-Resuscitate (DNR) document or similar advance directive recorded prior to arrival at your center.

Alcohol Use Disorder (Alcoholism): Descriptors documented in the medical record consistent with the diagnostic criteria of alcohol use disorder OR a diagnosis of alcohol use disorder documented in the patient’s medical record, consistent with American Psychiatric Association (APA) DSM 5, 2013.

Angina (Pectoris): 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, consistent with American Heart Association (AHA), May 2015, must be documented in the patient’s medical record.

Anticoagulant Therapy: 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. Anticoagulant must be part of the patient’s active medication. Exclude patients who are on chronic Aspirin therapy. Some examples are:

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<th>ANTICOAGULANTS</th>
<th>ANTIPLATELET AGENTS</th>
<th>THROMBIN INHIBITORS</th>
<th>THROMBOLYTIC AGENTS</th>
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<td>Heparin</td>
<td>Ticagrelor</td>
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Attention Deficit Disorder/Hyperactivity Disorder (ADD/ADHD): 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: 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, Thrombocytopenia), consistent with American Society of Hematology, 2015. Sickle cell anemia is not a clotting disorder; therefore, it is not considered a bleeding disorder.

Cerebral Vascular Accident (CVA): 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): 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):** Chronic obstructive pulmonary disease (COPD) is a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible. The more familiar terms "chronic bronchitis" and "emphysema" are no longer used, but are now included within the COPD diagnosis. COPD must be documented in the patient’s medical record, consistent with World Health Organization (WHO), 2019. Do not include patients whose only pulmonary disease is acute asthma, and patients with diffuse interstitial fibrosis or sarcoidosis.

**Cirrhosis:** Documentation in the medical record of cirrhosis, which might also be referred to as end stage liver disease. If there is documentation of prior or present esophageal or gastric varices, portal hypertension, previous hepatic encephalopathy, or ascites with notation of liver disease, then cirrhosis should be considered present. Cirrhosis should also be considered present if documented by diagnostic imaging studies or a laparotomy/laparoscopy.

**Congenital Anomalies:** Documentation of a cardiac, pulmonary, body wall, CNS/spinal, gastrointestinal, renal, orthopedic, or metabolic congenital anomaly. A diagnosis of a Congenital Anomaly must be documented in the patient’s medical record.

**Congestive Heart Failure (CHF):** Inability of the heart to pump a sufficient quantity of blood to meet the metabolic needs of the body or can do so only at an increased ventricular filling pressure. To be included, this condition must be noted in the medical record as CHF, congestive heart failure, or pulmonary edema with onset or increasing symptoms within 30 days prior to injury. Common manifestations are:
- Abnormal limitation in exercise tolerance due to dyspnea or fatigue
- Orthopnea (dyspnea on lying supine)
- Paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea)
- Increased jugular venous pressure
- Pulmonary rales on physical examination
- Cardiomegaly
- Pulmonary vascular engorgement

**Current Smoker:** A patient who reports smoking cigarettes every day or some days within the last 12 months. Exclude patients who smoke cigars or pipes or use smokeless tobacco (E-cigarettes, vape pens, chewing tobacco or snuff).

**Dementia:** Brain diseases that cause a long term and often gradual decrease in the ability to think and remember such that a person's daily functioning is affected. Pay particular attention to senile or vascular dementia (e.g., Alzheimer’s). A diagnosis of Dementia must be documented in the patient’s medical record.

**Diabetes Mellitus:** Diabetes mellitus prior to injury that required exogenous parenteral insulin or an oral hypoglycemic agent. Do not include a patient if diabetes is controlled by diet alone. A diagnosis of Diabetes Mellitus must be documented in the patient’s medical record.

**Dialysis (Chronic Renal Failure):** 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:** Patients who have cancer that:
- Has spread to one site or more sites in addition to the primary site
AND

- In whom the presence of multiple metastases indicates the cancer is widespread, fulminant, or near terminal. Other terms describing disseminated cancer include “diffuse,” “widely metastatic,” “widespread,” or “carcinomatosis.” Common sites of metastases include major organs (e.g., brain, lung, liver, meninges, abdomen, peritoneum, pleura, or bone).

Drug (Substance) Use Disorder: Descriptors documented in the patient’s medical record consistent with the diagnostic criteria of substance use disorders specifically cannabis, hallucinogens, inhalants, opioids, sedative/hypnotics, and stimulants (e.g. patient has a history of drug use; patient has a history of opioid use) OR diagnosis of any of the following documented in the patient’s medical record:
  - Cannabis Use Disorder; Other Cannabis-Induced Disorder; Unspecified Cannabis-Related Disorder
  - Phencyclidine Use Disorder; Other Hallucinogen Use Disorder; Hallucinogen Persisting Perception Disorder; Other Phencyclidine-Induced Disorder; Other Hallucinogen-Induced Disorder; Unspecified Phencyclidine-Related Disorder; Unspecified Hallucinogen-Related Disorder
  - Inhalant Use Disorder; Other Inhalant-Induced Disorder; Unspecified Inhalant-Related Disorder
  - Opioid Use Disorder; Other Opioid-Induced Disorder; Unspecified Opioid-Related Disorder
  - Sedative, Hypnotic, or Anxiolytic Use Disorder; Other Sedative, Hypnotic, or Anxiolytic-Induced Disorder; Unspecified Sedative, Hypnotic, or Anxiolytic-Related Disorder
  - Stimulant Use Disorder; Other Stimulant-Induced Disorder; Unspecified Stimulant-Related Disorder

Functionally Dependent Health Status: Pre-injury functional status may be represented by the ability of the patient to complete activities of daily living (ADL) including: bathing, feeding, dressing, toileting, and walking. 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.

Hypertension: 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: History of a diagnosis and/or treatment for the following disorder(s) documented in the patient’s medical record: major depressive disorder, bipolar disorder, schizophrenia, antisocial personality disorder, post-traumatic stress disorder, and social anxiety disorder.

Myocardial Infarction (MI): 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): 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 is a type of PVD (Peripheral Vascular Disease) and can occur in any blood vessel, but it is more common in the legs than the arms. A diagnosis of PVD or PAD must be documented in the patient’s medical record, consistent with Centers for Disease Control, 2014 Fact Sheet.

Pregnancy: Pregnancy confirmed by lab, ultrasound, or other diagnostic tool OR diagnosis of pregnancy documented in the patient’s medical record.

Prematurity: Defined as documentation of premature birth, a history of bronchopulmonary dysplasia, or ventilator support for greater than 7 days after birth. Premature birth is defined as infants delivered...
before 37 weeks from the first day of the last menstrual period, 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:** 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):** 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).

A diagnosis of AKI must be documented in the patient's medical record, that is consistent with the March 2012 Kidney Disease Improving Global Outcome (KDIGO) Guideline.

**NOTE:** Even if the patient or family refuses treatment (e.g., dialysis) the condition is still considered to be present if a combination of oliguria and creatinine.

EXCLUDE patients with renal failure that were requiring chronic renal replacement therapy such as periodic peritoneal dialysis, hemodialysis, hemofiltration or hemodiafiltration prior to injury.

**Acute Respiratory Distress Syndrome (ARDS):**

- **Timing:** Within 1 week of known clinical insult or new or worsening respiratory symptoms.
- **Chest imaging:** Bilateral opacities – not fully explained by effusions, lobar/lung collagen, or nodules.
- **Origin of edema:** Respiratory failure not fully explained by cardiac failure or fluid overload. Need objective assessment (e.g., echocardiography) to exclude hybrostatic edema if no risk factors present.

**Oxygenation:**
- **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

A diagnosis of ARDS must be documented in the patient's medical record, that is consistent with the 2012 New Berlin Definition.

**Alcohol Withdrawal (Syndrome):** 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, that is consistent with the 2019 World Health Organization (WHO) definition of Alcohol Withdrawal Syndrome.
**Cardiac Arrest with CPR:** The sudden cessation of cardiac activity after hospital arrival. The patient becomes unresponsive with no normal breathing and no signs of circulation. If corrective measures are not taken rapidly, this condition progresses to sudden death.

INCLUDE patients who, after arrival at your hospital, 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 whose ONLY episode of cardiac arrest with CPR was in the prehospital setting prior to arrival to your hospital.

**Central Line-Associated Bloodstream Infection (CLABSI):** 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. A diagnosis of CLABSI must be documented in the patient's medical record, that is consistent with the January 2016 CDC defined CLABSI.

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:** 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:** 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, consistent with the NPUAP 2014, and must have occurred during the patient’s initial stay at your hospital.

**Deep Vein Thrombosis (DVT)/Thrombophlebitis:** The formation, development, or existence of a blood clot or thrombus within the vascular system, which may be coupled with inflammation. 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.

**Delirium:** Acute onset of behaviors occurring during the patient’s initial hospital stay at your hospital characterized by restlessness, illusions, and incoherence of thought and speech. Delirium can often be traced to one or more contributing factors, such as a severe or chronic medical illness, changes in your metabolic balance (such as low sodium), medication, infection, surgery, or alcohol or drug withdrawal.

**OR**
- Patient tests positive after using an objective screening tool like the Confusion Assessment Method (CAM) or the Intensive Care Delirium Screening Checklist (ICDSC).

**OR**
- A diagnosis of delirium documented in the patient’s medical record.

**EXCLUDE** patients whose delirium is due to alcohol withdrawal.

**Extremity Compartment Syndrome:** Condition not present at admission in which there is documentation of tense muscular compartments of an extremity through clinical assessment or direct measurement of intracompartmental pressure requiring fasciotomy. Compartment syndromes usually involve the leg but can also occur in the forearm, arm, thigh, and shoulder. Record as a complication if it is originally missed, leading to late recognition, a need for late intervention, and has threatened limb viability. A diagnosis of Extremity Compartment Syndrome must be documented in the patient’s medical record.

**Myocardial Infarction (MI):** An acute myocardial infarction must be noted with documentation of ECG changes indicative of acute MI **AND**
- New elevation in troponin greater than three times upper level of the reference range in the setting of suspected myocardial ischemia

**AND**
- Physician diagnosis of myocardial infarction that occurred subsequent to arrival at your facility.

**Osteomyelitis:** 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).
A diagnosis of osteomyelitis must be documented in the patient’s medical record, that is consistent with the January 2016 CDC definition of Bone and Joint Infection

**Pulmonary Embolism (PE):** Lodging of a blood clot in a pulmonary artery with subsequent obstruction of blood supply to the lung parenchyma. The blood clots usually originate from the deep leg veins or the pelvic venous system. Consider the condition present if the patient has a V-Q scan interpreted as high probability of pulmonary embolism or a positive pulmonary arteriogram or positive CT angiogram and/or a diagnosis of PE is documented in the patient’s medical record. Exclude subsegmental PEs.

**Sepsis/Severe Sepsis:** 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, consistent with the American College of Chest Physicians and the Society of Critical Care Medicine October 2010, and must have occurred during the patient’s initial stay at your hospital.

**Surgical Site Infection (SSI) (superficial):** A diagnosis of SSI must be documented in the patient’s medical record, consistent with the January 2019 CDC defined SSI, 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):** 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>SPL</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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<tr>
<th>Code</th>
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<tr>
<td>BRST</td>
<td>Breast surgery</td>
</tr>
<tr>
<td>CARD</td>
<td>Cardiac surgery</td>
</tr>
<tr>
<td>CBGB</td>
<td>Coronary artery bypass graft with both chest and donor site incisions</td>
</tr>
<tr>
<td>CBGC</td>
<td>Coronary artery bypass graft with chest incision only</td>
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<tr>
<td>CRAN</td>
<td>Craniotomy</td>
</tr>
<tr>
<td>FUSN</td>
<td>Spinal fusion</td>
</tr>
<tr>
<td>FX</td>
<td>Open reduction of fracture</td>
</tr>
<tr>
<td>HER</td>
<td>Herniorrhaphy</td>
</tr>
<tr>
<td>HPRO</td>
<td>Hip prosthesis</td>
</tr>
<tr>
<td>KPRO</td>
<td>Knee prosthesis</td>
</tr>
<tr>
<td>PACE</td>
<td>Pacemaker surgery</td>
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A diagnosis of SSI must be documented in the patient’s medical record, consistent with the January 2019 CSC defined SSI, and must have occurred during the patient’s initial stay at your hospital.

**Surgical Site Infection (organ/space):** 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

AND

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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<th>90-day Surveillance</th>
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<td>Hip prosthesis</td>
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<td>Knee prosthesis</td>
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Table 3. Specific Sites of an Organ/Space SSI.

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<th>Site</th>
</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>
<tr>
<td>CARD</td>
<td>Myocarditis or pericarditis</td>
<td>MEN</td>
<td>Meningitis or ventriculitis</td>
</tr>
<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>

A diagnosis of SSI must be documented in the patient’s medical record, consistent with the January 2019 CDC defined SSI, and must have occurred during the patient’s initial stay at your hospital.

**Unplanned Intubation**: Patient requires placement of an endotracheal tube and mechanical or assisted ventilation because of the onset of respiratory or cardiac failure manifested by severe respiratory distress, hypoxia, hypercarbia, or respiratory acidosis. In patients who were intubated in the field or Emergency Department, or those intubated for surgery, unplanned intubation occurs if they require reintubation > 24 hours after extubation.

**Unplanned Readmission**: Unplanned readmission to an inpatient bed following discharge, elopement, AMA, etc., from a previous inpatient status.

**Unplanned Return (admission) to the ICU**: Unplanned return to the intensive care unit after initial ICU discharge or admission to the ICU after initial transfer to the floor.

EXCLUDE patients in which the ICU care is required postoperatively for a planned surgical procedure.

**Unplanned Visit to the OR**: Unplanned operative procedure or patients returned to the operating room after initial operation management for a similar or related previous procedure.

EXCLUDE pre-planned, staged and/or procedures for incidental findings and operative management related to a procedure that was initially performed prior to arrival at your center.

**Urinary Tract Infection Catheter-Associated (CAUTI)**: A urinary tract infection (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 more than 2 consecutive days in an inpatient location and then removed, the date of event for the UTI must be the day of device discontinuation or the next day for the UTI to be catheter-associated. A diagnosis of UTI must be documented in the patient’s medical record that is consistent with the January 2019 CDC defined CAUTI.
Criterion 1:

- **Criterion 1:** Patient must meet 1, 2, and 3 below:
  1. Patient has an indwelling urinary catheter that had been in place for more than 2 consecutive days in an inpatient location on the date of event 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): Reminder: To use fever in a patient >65 years of age, the IUC needs to be in place for more than 2 consecutive days in an inpatient location on date of event and is either still in place OR was removed the day before the DOE
     - Suprapubic tenderness
     - Costovertebral angle pain or tenderness
     - Urinary urgency
     - Urinary frequency
     - Dysuria
  3. Patient has a urine culture with no more than two species of organisms identified, at least one of which is a bacterium >$10^5$ CFU/ml.

Criterion 2: Patient must meet 1, 2 and 3 below:

1. Patient is ≤1 year of age
2. Patient has at least one of the following signs or symptoms:
   - Fever (>38.0°C)
   - Hypothermia (<36.0°C)
   - Apnea
   - Bradycardia
   - Lethargy
   - Vomiting
   - Suprapubic tenderness
3. Patient has a urine culture with no more than two species of organisms, at least one of which is bacterium of ≥$10^5$ CFU/ml.

Consistent with the January 2019 CDC defined CAUTI.

**Pneumonia Ventilator-Associated (VAP):** 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>
<tbody>
<tr>
<td>Two or more serial chest radiographs with at least one of the following:</td>
<td>At least one of the following:</td>
<td>At least one of the following:</td>
</tr>
<tr>
<td>- New or progressive and persistent infiltrate</td>
<td>- Fever (&gt;38°C or &gt;100.4°F)</td>
<td>- Positive growth in blood culture not related to another source of infection</td>
</tr>
<tr>
<td>- Consolidation</td>
<td>- Leukopenia (&lt;4000 WBC/mm³) or leukocytosis (≥12,000 WBC/mm³)</td>
<td>- Positive growth in culture of pleural fluid</td>
</tr>
<tr>
<td>- Cavitation</td>
<td>- For adults ≥70 years old, altered mental status with no other recognized cause AND at least two of the following:</td>
<td>- Positive quantitative culture from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing)</td>
</tr>
<tr>
<td></td>
<td>- New onset of purulent sputum, or change in character of sputum, or</td>
<td>- ≥5% BAL-obtained cells contain intracellular bacteria on direct</td>
</tr>
</tbody>
</table>
- Pneumatoceles, in infants ≤1 year old

**NOTE:** In patients **without** underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest radiograph is acceptable.

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., $\text{PaO}_2/\text{FiO}_2 \leq 240$), increased oxygen requirements, or increased ventilator demand)

- 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

---

**VAP ALGORITHM (PNU2 VIRAL, LEGIONELLA, AND OTHER BACTERIAL PNEUMONIAS):**

<table>
<thead>
<tr>
<th>Radiology</th>
<th>Signs/Symptoms</th>
<th>Laboratory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two or more serial chest radiographs with at least one of the following:</td>
<td>At least one of the following:</td>
<td>At least one of the following:</td>
</tr>
<tr>
<td>- New or progressive and persistent infiltrate</td>
<td>- Fever (&gt;38°C or &gt;100.4°F)</td>
<td>- Positive culture of virus, Legionella or Chlamydia from respiratory secretions</td>
</tr>
<tr>
<td>- Consolidation</td>
<td>- Leukopenia (&lt;4000 WBC/mm$^3$) or leukocytosis ($\geq 12,000$ WBC/mm$^3$)</td>
<td>- Positive non culture diagnostic laboratory test of respiratory secretions or tissue for virus, Bordetella, Chlamydia, Mycoplasma, Legionella (e.g., EIA &lt; FAMA &lt; shell vial assay, PCR, micro-IF)</td>
</tr>
<tr>
<td>- Cavitation</td>
<td>- For adults ≥70 years old, altered mental status with no other recognized cause <strong>AND</strong> at least two of the following:</td>
<td>- Fourfold rise in pared sera (IgG) for pathogen (e.g., influenza viruses, Chlamydia)</td>
</tr>
<tr>
<td>- Pneumatoceles, in infants ≤1 year old</td>
<td>- New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</td>
<td>- Fourfold rise in L. pneumophila serogroup 1 antibody titer to ≥1:128 in pared acute and convalescent sera by indirect IFA</td>
</tr>
<tr>
<td><strong>NOTE:</strong> In patients <strong>without</strong> 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.</td>
<td>- New onset or worsening cough, or dyspnea, or tachypnea</td>
<td>- Detection of Legionella pneumophila serogroup 1 antigens in urine by RIA or EIA</td>
</tr>
</tbody>
</table>

---

**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°C or >100.4°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., O2 desaturations [e.g., PaO2/FiO2 ≤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  
- Evidence of fungi from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing) from one of the following:  
- Direct microscopic exam  
- Positive culture of fungi  
- Non-culture diagnostic laboratory test  |

**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>
<th>Signs/Symptoms</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  |
| Worsening gas exchange (e.g., O2 desaturation [e.g. pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand)  |

**AND at least three of the following:**

- Temperature instability  
- Leukopenia (<4000 WBC/mm³) or leukocytosis (≥15,000 WBC/mm³) and left shift (≥10% band forms)  
- New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements  
- Apnea, tachypnea, nasal flaring with retraction of chest wall, or nasal flaring with grunting  
- Wheezing, rales, or rhonchi  
- Cough  
- Bradycardia (<100 beats/min) or tachycardia (>170 beats/min)  |

### VAP ALGORITHM ALTERNATE CRITERIA (PNU1), FOR CHILDREN >1 YEAR OLD OR ≤12 YEARS OLD:

<table>
<thead>
<tr>
<th>Radiology</th>
<th>Signs/Symptoms/Laboratory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two or more serial chest radiographs with at least <strong>one</strong> of the following:</td>
<td></td>
</tr>
<tr>
<td>Worsening gas exchange (e.g., O2 desaturations [e.g. pulse oximetry &lt;94%], increased oxygen requirements, or increased ventilator demand)</td>
<td></td>
</tr>
</tbody>
</table>

**At least three of the following:**

- Temperature instability  
- Leukopenia (<4000 WBC/mm³) or leukocytosis (≥15,000 WBC/mm³) and left shift (≥10% band forms)  
- New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements  
- Apnea, tachypnea, nasal flaring with retraction of chest wall, or nasal flaring with grunting  
- Wheezing, rales, or rhonchi  
- Cough  
- Bradycardia (<100 beats/min) or tachycardia (>170 beats/min)  |
• New or progressive and persistent infiltrate
• Consolidation
• Cavitation
• Pneumatoceles, in infants ≤1 year old

NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest radiograph is acceptable

A diagnosis of pneumonia must be documented in the patient’s medical record that is consistent with the January 2019 CDC defined VAP.

• 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>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>GCS ≤14</td>
<td>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>
</tr>
<tr>
<td>SBP &lt;90 (&lt;70 if under 1y)</td>
<td>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>Blunt Abdomen:</td>
<td>Injury to any of the abdominal quadrants, flanks, or pelvis due to blunt force.</td>
</tr>
<tr>
<td>Blunt Back:</td>
<td>Injury to the area from the shoulders to the buttocks (but not including the buttocks) due to blunt force.</td>
</tr>
<tr>
<td>Blunt Chest:</td>
<td>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>
</tr>
<tr>
<td>Blunt Diffuse Abdominal Tenderness:</td>
<td>Blunt force injury to the abdomen resulting in tenderness in two or more quadrants.</td>
</tr>
<tr>
<td>Blunt Extremities:</td>
<td>Injury or pain to the shoulders, arms, hands, legs, or feet due to blunt force.</td>
</tr>
<tr>
<td>Blunt Face/mouth:</td>
<td>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>Blunt Genitals:</td>
<td>Injury to the external reproductive structures due to blunt force.</td>
</tr>
<tr>
<td>Blunt Head:</td>
<td>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>Blunt Amputation:</td>
<td>Amputation proximal to (above) the wrist or ankle due to blunt force.</td>
</tr>
<tr>
<td>Blunt Buttocks:</td>
<td>Injury to the buttocks due to blunt force.</td>
</tr>
<tr>
<td>Blunt Minor Lacerations:</td>
<td>Superficial or non-serious lacerations, abrasions, or contusions involving the skin or subcutaneous tissue, due to blunt force.</td>
</tr>
<tr>
<td>Blunt Neck:</td>
<td>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>Blunt Tension Pneumothorax:</td>
<td>Injury resulting in air entering the pleural space due to blunt force, creating pressure on chest organs.</td>
</tr>
<tr>
<td>Blunt Fracture of 2 or more long bones:</td>
<td>Blunt force injury resulting in apparent fracture of 2 or more proximal long bones (humerus, femur).</td>
</tr>
<tr>
<td>Blunt Trauma Arrest:</td>
<td>Cessation of cardiac output and effective circulation due to blunt force.</td>
</tr>
<tr>
<td>Burns/Elec. Shock:</td>
<td>Thermal or chemical burn, or electric shock.</td>
</tr>
<tr>
<td>Blunt extremity injury with neurological and/or vascular compromise, or one that is crushed, degloved, or mangled due to blunt force.</td>
<td></td>
</tr>
<tr>
<td>Critical Burn:</td>
<td>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>
<td></td>
</tr>
<tr>
<td><strong>FC</strong></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><strong>IT</strong></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><strong>NA</strong></td>
<td>No Apparent Injury: No complaint, or signs or symptoms of injury following a traumatic event.</td>
</tr>
<tr>
<td><strong>PA</strong></td>
<td>Penetrating Abdomen: Injury to any of the abdominal quadrants, flanks, or pelvis due to penetrating force.</td>
</tr>
<tr>
<td><strong>PB</strong></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><strong>PC</strong></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>
</tr>
<tr>
<td><strong>PE</strong></td>
<td>Penetrating Extremities: Injury or pain to the shoulders, arms, hands, legs, or feet due to penetrating force.</td>
</tr>
<tr>
<td><strong>PF</strong></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><strong>PG</strong></td>
<td>Penetrating Genitals: Injury to the external reproductive structures due to penetrating force.</td>
</tr>
<tr>
<td><strong>PH</strong></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><strong>PI</strong></td>
<td>Penetrating Amputation: Amputation proximal to (above) the wrist or ankle due to penetrating force.</td>
</tr>
<tr>
<td><strong>PK</strong></td>
<td>Penetrating Buttocks: Injury to the buttocks due to penetrating force.</td>
</tr>
<tr>
<td><strong>PL</strong></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><strong>PN</strong></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><strong>PP</strong></td>
<td>Penetrating Tension Pneumothorax: Injury resulting in air entering the pleural space due to penetrating force, creating pressure on chest organs.</td>
</tr>
<tr>
<td><strong>PT</strong></td>
<td>Penetrating Trauma Arrest: Cessation of cardiac output and effective circulation due to penetrating force.</td>
</tr>
<tr>
<td><strong>PV</strong></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><strong>PX</strong></td>
<td>Penetrating Extremity injury proximal to (above) the knee or elbow due to penetrating force.</td>
</tr>
<tr>
<td><strong>RR</strong></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>
</tr>
<tr>
<td><strong>SC</strong></td>
<td>Spinal Cord Injury: Suspected spinal cord injury, or presence of weakness/paralysis/paresthesia following a traumatic event.</td>
</tr>
<tr>
<td><strong>SX</strong></td>
<td>Suspected Pelvic Fracture: Suspected pelvic fracture, excluding isolated hip fractures from a ground level fall.</td>
</tr>
<tr>
<td><strong>UB</strong></td>
<td>Uncontrolled Bleeding: Extremity bleeding requiring use of a tourniquet or hemostatic dressing.</td>
</tr>
</tbody>
</table>
### MECHANISM OF INJURY (Prehospital)

<table>
<thead>
<tr>
<th>MECHANISM OF INJURY (MOI)</th>
<th>Description</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 day 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>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>TA</td>
<td>Taser: Injury due to the deployment of a conducted electrical weapon (CEW), e.g. Taser®.</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>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>GCS ≤14: Blunt force head injury associated with a G 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>
</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>
</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>
</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>
</tr>
<tr>
<td>BL</td>
<td>Blunt Amputation: Amputation proximal to (above) the wrist or ankle due to blunt force.</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>
</tr>
<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>
</tr>
<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>
</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>PA</td>
<td>Penetrating Abdomen: Injury to the abdomen, flanks, or pelvis 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 xyphoid process, bordered on either side by the posterior axillary line, 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>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>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>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>
</tr>
<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>
</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>
<tr>
<td>TQ</td>
<td>TourniQuet: Tourniquet (Commercial) was required to control extremity bleeding not controlled by direct pressure.</td>
</tr>
<tr>
<td>----</td>
<td>-------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td><strong>Mechanism of Injury Criteria</strong></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. This mechanism is a subcategory of “Fall.” This does not include falling down stairs or rolling down a sloping cliff.</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>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>12</td>
<td>Intrusion of &gt;12 inches into an occupied passenger space.</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></td>
<td><strong>Guidelines</strong></td>
</tr>
<tr>
<td>18</td>
<td>Intrusion of &gt;18 inches into an unoccupied passenger space.</td>
</tr>
<tr>
<td>AN</td>
<td>Injured patient on ANticoagulant Medication (other than aspirin only) or with known bleeding disorder.</td>
</tr>
<tr>
<td>EX</td>
<td>EXtraction: Use of a pneumatic tool was required to remove patient from the vehicle.</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>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>TD</td>
<td>Telemetry Data: Vehicle telemetry data that is consistent with high risk of serious injury.</td>
</tr>
<tr>
<td></td>
<td><strong>Special Considerations</strong></td>
</tr>
<tr>
<td>BT</td>
<td>Blunt Trauma Arrest: Cessation of cardiac output and effective circulation due to blunt force.</td>
</tr>
<tr>
<td>55</td>
<td>Injured patient that is greater than 55 years of age.</td>
</tr>
<tr>
<td>BP</td>
<td>Systolic Blood Pressure less than 110mmHg for patient greater than 65 years of age following a traumatic event.</td>
</tr>
<tr>
<td>IU</td>
<td>Injured patient with an IntraUterine 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>
APPENDIX 4: 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:* $RTS = 0.9368 \times (\text{Initial ED/Hospital GCS Total}) + 0.7326 \times (\text{Initial ED/Hospital Systolic Blood Pressure}) + 0.2908 \times (\text{Initial ED/Hospital Respiratory Rate})$

**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).

**Length of Stay (Days) in Readmission:** The total elapsed time the patient was in the hospital for readmission.

*Calculation:* Readmit Discharge Date/Time – Date/Time of Readmission