Wisconsin State Trauma Registry
Data Dictionary
Version 2020.0
Release Date: 12/31/2019
Applicable to admissions starting
January 1, 2020

Contact DHSTrauma@dhs.wisconsin.gov with questions and feedback regarding this document.

P-01117 (5/2020)
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About this Data Dictionary

The primary purpose of this Data Dictionary is to assist Wisconsin trauma registrars in reporting trauma cases to the Wisconsin Trauma Care System (WTCS). If questions arise and are unable to be answered from the materials provided in this data dictionary or other resources cited within, please contact dhstrauma@dhs.wisconsin.gov.

This is the 2018 edition of the dictionary and incorporates changes in requirements from the National Trauma Data Bank (NTDB); the Wisconsin Trauma Care System; and any changes in data entry resulting from updates by the state trauma registry vendor.

DHS 118.09 provides the authority for the Department of Health Services to collect and analyze trauma system data to evaluate the delivery of adult and pediatric trauma care, develop injury prevention strategies for all ages, and provide resources for research and education. DHS 118.09(3) directs all hospitals, ambulance service providers and first responder services to submit data to the department on a quarterly basis determined by the department.

The purpose of Wisconsin's Trauma Care System is to reduce death and disability resulting from traumatic injury. The data in the trauma registry is used for performance improvement activities at the state, regional and local level.

This document is created, updated, and maintained by the Department of Health Services, Division of Public Health, Office of Health Informatics. Updated versions of this document may be released throughout a calendar year; however the inclusion criteria and required data elements will only be updated on an annual basis and will not change throughout the year.
Wisconsin State Trauma Registry

Inclusion Criteria

Applicable to patients admitted: January 1, 2020 to December 31, 2020

If the patient was injured within the past 14 days of their hospital encounter and was admitted, transferred, had a leveled trauma team activation, or died from their injuries, and had a qualifying injury excluding superficial wounds, they are included in the Wisconsin Trauma Registry.

A trauma patient is defined as a patient sustaining a traumatic injury within 14 days of initial hospital encounter and meeting the following criteria. Level I, II, III, & IV trauma centers will submit data from their trauma registries for all patients meeting these criteria.

Glossary to Flow Chart:

1. The patient must have sustained 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)
   - T20-T28 with 7th character modifier of A ONLY (Burns by specific body parts – initial encounter)
   - T30-T32 (Burn by TBSA percentages)

   AND

2. Excluding the following isolated injuries

   - 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.

**AND**

Must include one of the following in addition to steps 2 and 3

• **Hospital admission for the traumatic injury as defined by your facility specific trauma registry inclusion criteria**
  - *NOTE* patients transferred into your facility and/or admitted to rule out traumatic injury are not required if it is determined the patient had a non-traumatic diagnosis. However, if rule 1 applies, the patient is still included in the system.
  - **EXAMPLE:** A patient is admitted due to suspicion of a possible head injury from a traumatic encounter. However, after further evaluation it is determined this patient experienced a CVA. If Rules 1, 2, and 3 do not apply to this patient, their inclusion is not required.

**OR**

• **Death resulting from the traumatic injury, independent of hospital admission or transfer status**

**OR**

• **Patient transfer via EMS transport from one hospital to another**
  - Including air ambulance

**OR**

• **There was a leveled trauma team activation**

Facilities may also determine to include patients in their registry that meet their facility inclusion criteria. Examples of acceptable additional criteria include:

1. Trauma team activation where the patient is found to have no qualifying injuries and is discharged home from the emergency department.
2. Suicide attempts with superficial self-inflicted cuts
3. Hangings
4. Patients who are transferred from another facility for trauma care, via private vehicle, walk-ins or police transported patients.
1. Did the patient sustain one or more traumatic injuries within 14 days of initial hospital encounter?


3. Did the patient sustain at least one injury with a diagnostic code outside the range of codes listed below: ICD-10-CM S00, S10, S20, S30, S40, S50, S60, S70, S80, S90

4. Did the injury result in death?
   OR
   Was the patient transferred to (or from) your facility via EMS?
   OR
   Was the patient considered an admission to your facility?
   OR
   Was there a leveled trauma team activation?

   YES

Patient INCLUDED in the Wisconsin State Trauma Registry

Patient EXCLUDED from the Wisconsin State Trauma Registry
Example Inclusion Scenarios

1. A 31 year old female arrives to your emergency department via their friend's private vehicle. The patient states she fell down an unknown amount of stairs, landing on her arm. Her arm has an obvious proximal deformity. The trauma team is not activated. Radiology shows fractures to the left clavicle and humerus. Your facility does not have orthopedic services available today, so you advise the patient she will need to be transferred to another local facility where the appropriate interventions can be performed. A cast and sling are placed to protect the injured area. The receiving facility eventually agrees to accept this patient and after a 2 hour length of stay, the patient's friend picks them up and drives them to the receiving acute care center.

This patient does not meet inclusion criteria. Despite having a qualifying traumatic injury, none of the additional qualifiers are met. There is no trauma team activation, the patient did not die as a result of the traumatic injury, the patient was not admitted based on the hospital registry inclusion criteria, and the patient is transferred via private vehicle.

2. Your emergency department receives a radio report from local EMS stating they are bringing a 28 year old male with a stab wound to the upper left abdominal quadrant. A chest seal has been placed and needle chest decompression was performed with air return. Your facility's highest trauma team activation is called 10 minutes prior to patient arrival. The patient arrives with a SBP of 80 and is tachycardic at 150bpm. The patient is diagnosed with a grade 4 spleen laceration and a pneumothorax. After 1 hour in the ER, the patient is taken to the operating room and eventually is admitted to the ICU. Total facility length of stay is 4 days.

This patient does meet inclusion criteria. The patient has qualifying traumatic injuries and has two additional criteria met (trauma team activation and admission meeting hospital registry inclusion for the care of his traumatic injuries).

3. A 30 year old male pedestrian was struck when crossing the street by a sedan travelling approximately 10 miles per hour. The patient was not thrown and did not lose consciousness, but presented to local EMS with shortness of breath and tenderness in his pelvic region. The radio report from the transporting unit meets your facility's criteria to page a level 2 trauma team, your hospital's lower level activation. Patient arrives to your ER and assessment reveals minor road rash to his anterior pelvic region and bilateral bruising to the thighs. Radiology reveals no additional injury. The patient's final diagnosis is minor abrasions to the anterior hips and bilateral contusions to his thighs. After nearly 3.5 hours in the ER, the patient is discharged home without services.

This patient does not meet inclusion criteria. Despite having a level two activation, the patient's wounds are superficial and do not fall within the included code range.
4. A 13 year old male patient is brought to the ER by his coach after the patient fell face first into the boards during a hockey practice. The patient's parents couldn't be reached, and the coach didn't find it necessary to call EMS. The patient does not remember the accident, but is complaining of neck pain, a broken tooth, and a headache. The coach isn't clear whether the patient was unconscious after the fall, but he does state the patient didn't move for “a few seconds” after hitting the boards. A level two trauma team activation is called as a precaution and all team members respond within their required timelines. Consultation with the receiving pediatric center recommends transport to their facility by EMS for further evaluation. To prevent a delay in transfer, The MD at your facility elects not to perform radiological studies. After a 64 minute stay in your ER, the patient is transferred to the receiving pediatric trauma center by ground ambulance. Your facility's diagnosis is a broken tooth, strained neck ligaments, and a concussion with a loss of consciousness less than one minute.

This patient does meet inclusion criteria. The patient has a qualifying injury and has two additional criteria with trauma team activation and transfer to another acute care center via ground ambulance.

5. A 94 year old female presents via private vehicle with a persisting headache and bruising throughout her extremities. She is brought into your ER through triage. The patient states she hasn’t had a recent injury, is not on blood thinners, and just feels “tired.” There is no trauma team activation. The patient's son, who drove her to your facility, states the patient has been having issues with her gait and strength. He states that he believes the patient’s metoprolol is causing her to become unsteady after standing. Initial exam shows bruising at multiple stages of healing throughout her extremities. There are some small lacerations on her palm, just next to her thumbs that appear to be almost completely healed. Upon further interview, the patient states she has been falling more frequently, and her last fall was three weeks ago. She describes the fall as a “slip, where I just went to my hands and knees.” The patient’s son was able to help her back up, and place cold packs on the patient’s hands for treatment. This is her first hospital encounter to treat these injuries. The remainder of the workup is unremarkable for any injury or illness. The patient receives a medication review and is referred to a physical therapy program. The son is also advised on how to prevent falls in the patient's home. The patient is discharged home from the ER.

This patient does not meet criteria. While the lacerations on her hand may constitute a qualifying injury, the injuries were sustained over 14 days prior to this hospital encounter. In addition, there was no activation, transfer via EMS, death, or admission to the hospital.
Common Null Values

These values are to be used as the null Values:

1. Not Applicable applies if, at the time of the patient care documentation, the information requested was “Not Applicable” to the patient. For example, variables documenting EMS care would be “Not Applicable” if a patient self-transported to the hospital.

2. Not Known/Not Documented/Not Recorded/Unknown are interchangeable: This null value applies if, at the time of patient care documentation, information was “not known” to the patient, family, healthcare provider or no value for the element was recorded for the patient. This null value should be used in situations when the documentation was incomplete or missing.

The fields that all hospitals participating in the Wisconsin Trauma System must complete are listed as Wisconsin Core fields. Fields above and beyond “Core” fields are optional and may be collected at the discretion of the individual facilities.

The data elements listed within this document are available for either direct user entry, or auto-population based on the information collected. Any element not listed in this document is either not currently required by the State of Wisconsin, or does not allow for direct entry within the ImageTrend system.

Certain alpha-numeric data fields have null values available for use. These fields are indicated with a symbol “∅”. Selecting this symbol will allow the user to select a null value of Not Known/Not Recorded.
Definitions in the Data Entry Form

All definitions contained in this data dictionary are available on all data entry forms within the Wisconsin Trauma Registry. If a data element does not have a definition, please notify dhstrauma@dhs.wisconsin.gov. To view an element’s definition within the data entry form, perform the following. The below example locates the element definition for TR2.5, Primary Method of Payment:

1. Enter the data entry form and locate your desired data element
2. Select the title of the data element
3. To return to the data entry form, select “close” in the definition window
Dictionary Element Legend

This data dictionary contains required fields for 2020 diagnoses. The data items on the following pages are listed by category. Each data item description contains:

<table>
<thead>
<tr>
<th>Current Dictionary Version #</th>
<th>Data Dictionary Section and Element #</th>
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</thead>
<tbody>
<tr>
<td><strong>STATE</strong></td>
<td>Will appear if the element is required by the State of Wisconsin</td>
</tr>
<tr>
<td><strong>NTDB</strong></td>
<td>Will appear if the element is required by the NTDB</td>
</tr>
<tr>
<td><strong>3RD PARTY</strong></td>
<td>Will appear if the element is required for upload by 3rd parties</td>
</tr>
</tbody>
</table>

**ImageTrend Tab Location; Element Number; Element Title**

**Definition**
The definition of the data element, as shown on the data entry form within the ImageTrend registry

**Element Values**
Lists all available values for data element entry. The order in which these fields appear do not necessarily correspond with data import mappings.

**Additional Information**
Any additional information about the data element

**Data Source Hierarchy Guide**
Lists the appropriate sources for this information

**Associated Edit Checks (NTDB)**
If the element is NTDB required, the associated validity rules will be displayed here.
SECTION A:

National Trauma Data Bank (NTDB) Elements
Demographics TR1.20 – Patient ZIP

Definition

The Patient’s Home Zip/Postal Code of primary residence.

Element Values

Relevant value for data element

Additional Information

- Can be stored as a 5 or 9 digit code (XXXXX-XXXX) for US and Canada, or can be stored in the postal code format of the applicable country.
- May require adherence to HIPAA regulations
- If ZIP/Postal Code is “Not Applicable”, complete variable: Alternate home residence.
- If ZIP/Postal Code is “Not Known/Not Recorded”, complete variables Patient’s Home Country, Patient’s Home State (US only), Patient’s Home County (US only) and Patient’s Home City (US only)
- If ZIP/Postal code is known, must also complete Patient’s Home Country
- Not Known is indicated by typing “99999”

Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form

Associated Edit Checks (NTDB)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
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<td>0002</td>
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<td>Element cannot be blank</td>
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<tr>
<td>0040</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
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</table>
Demographics TR1.19 - Patient’s Home Country

**Definition**
The country where the patient resides

**Element Values**
Relevant value for data element (two digit alpha country code)

**Additional Information**
- Selections are made from a dropdown menu
- Values are country names (e.g., United States)
- If a patient's home country is not United States, then the null value “Not Applicable” is used for: Patient’s home state, patient’s home county, and patient’s home city.

**Data Source Hierarchy Guide**
1. Face Sheet
2. Billing Sheet
3. Admission Form
4. Triage/Trauma Flow Sheet
5. EMS Run Report

**Associated Edit Checks (NTDB)**

<table>
<thead>
<tr>
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<td>Element cannot be Not Applicable</td>
</tr>
<tr>
<td>0105</td>
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<td>Element cannot be Not Known/Not recorded when Home Zip/Postal Code is not: (1) blank, (2) Not Applicable, or (3) Not Known/Not Recorded</td>
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<tr>
<td>0140</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Demographics TR1.23 - Patient's Home State

Definition
The State (territory, province, or District of Columbia) where the patient resides.

Element Values
Relevant value for data element (two digit numeric FIPS code)

Additional Information
- Only completed when ZIP/Postal Code is “Not Known/Not Recorded” and country is US.
- Used to calculate FIPS code.
- Element will default to Wisconsin when ZIP is 99999

Data Source Hierarchy Guide
1. Face Sheet
2. Billing Sheet
3. Admission Form

Associated Edit Checks (NTDB)

<table>
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<tr>
<td>0240</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Demographics TR1.22 - Patient’s Home County

**Definition**
The patient’s county (or parish) of residence

**Element Values**
Relevant value for data element (three digit numeric FIPS code)

**Additional Information**
- Only completed when ZIP/Postal code is “Not Known/Not Recorded” and country is US.
- Used to calculate FIPS code.
- When ZIP is 99999, element will populate as “Not Known”.

**Data Source Hierarchy Guide**
1. Face Sheet
2. Billing Sheet
3. Admission Form

**Associated Edit Checks (NTDB)**

<table>
<thead>
<tr>
<th>Rule ID</th>
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</tr>
<tr>
<td>0340</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Demographics TR1.21 - Patient’s Home City

**Definition**
The patient's city (or township, or village) of residence.

**Element Values**
Relevant value for data element (five-digit numeric FIPS code)

**Additional Information**
- Only completed when ZIP code is “Not Recorded/Not Known.”
- Used to calculate FIPS code.
- When ZIP is 99999, element will populate as “Not Known”

**Data Source Hierarchy Guide**
1. ED Admission Form
2. Billing Sheet /Medical Records Coding Summary Sheet
3. EMS Run Sheet
4. Triage Form/ Trauma Flow Sheet
5. ED Nurse’s Notes

**Associated Edit Checks (NTDB)**

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>0401</td>
<td>1</td>
<td>Invalid Value</td>
</tr>
<tr>
<td>0402</td>
<td>2</td>
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</tr>
<tr>
<td>0440</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Demographics TR1.13 - Alternate Residence

Definition

Documentation of the type of patient without a Home ZIP/Postal code.

Element Values

1. Homeless
2. Undocumented Citizen
3. Migrant Worker

Additional Information

- Only completed when ZIP/Postal code is “Not Applicable”
- Homeless is defined as a person who lacks housing. The definition also includes a person living in transitional housing or a supervised public or private facility providing temporary living quarters.
- Undocumented citizen is defined as a national of another country who has entered or stayed in another country without permission.
- Migrant worker is defined as a person who temporarily leaves his/her principal place of residence within a country in order to accept seasonal employment in the same or different country.
- The null value “Not Applicable” is reported if Patient’s Home ZIP/Postal Code is documented.
- Report all that apply

Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form

Associated Edit Checks (NTDB)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
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</thead>
<tbody>
<tr>
<td>0501</td>
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<td>Value is not a valid menu option</td>
</tr>
<tr>
<td>0502</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
</tbody>
</table>
0503  2  Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other valid value
0540  1  Multiple Entry Max exceeded

Demographics TR1.7 - Date of Birth

Definition
The patient's date of birth

Element Values
Relevant value for data element

Additional Information
- Collected as MM-DD-YYYY
- If date of birth is Unknown, leave blank and complete variables Age and Age Units
- If date of Birth equals ED/Hospital Arrival Date, then the Age and Age Units variables must be completed.

Data Source Hierarchy Guide
1. Face Sheet
2. Billing Sheet
3. Admission Form
4. Triage/Trauma Flow Sheet
5. EMS Run Report
6. Case Management/Social service notes

Associated Edit Checks (NTDB)

<table>
<thead>
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<td>2</td>
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</tr>
<tr>
<td>0609</td>
<td>2</td>
<td>Date of Birth is later than Injury Date</td>
</tr>
</tbody>
</table>
0610  2  Date of Birth is later than ED Discharge Date
0611  2  Date of Birth is later than Hospital Discharge Date
0612  2  Date of Birth + 120 years must be less than Injury Date
0613  2  Element cannot be Not Applicable
0640  1  Single Entry Max exceeded

Demographics TR1.12 – Patient Age

Definition
The Patient’s age at the time of Injury (best approximation)

Element Values
Relevant value for data element

Additional Information
- Auto-calculated unless date of birth is unknown or is the same as date of ED Arrival.
- If date of birth is “not known/not recorded” complete variables Age and Age Units
- If date of birth equals ED/Hospital Arrival Date, then the age and Age Units variables must be completed.
- Must also complete variable: Age Units.
- If not known, leave blank.

Data Source Hierarchy Guide
1.  Face Sheet
2.  Billing Sheet
3.  Admission Form
4.  Triage/Trauma Flow Sheet
5.  EMS Run Report

Associated Edit Checks (NTDB)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
</table>
Age is outside the valid range of 0 – 120

Element cannot be blank

Age is greater than expected for the Age Units specified. Age should not exceed 60 minutes, 24 hours, 30 days, 24 months, or 120 years. Please verify this is correct.

Element must be Not Known/Not Recorded when Age Units is Not Known/Not Recorded

Single Entry Max exceeded
2. Billing Sheet
3. Admission Form
4. Triage/Trauma Flow Sheet
5. EMS Run Report

Associated Edit Checks (NTDB)

<table>
<thead>
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</tr>
<tr>
<td>0803</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>0806</td>
<td>2</td>
<td>Element must be Not Known/Not Recorded when Age is Not Known/Not Recorded</td>
</tr>
<tr>
<td>0840</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>

Demographics TR1.16 - Race

Definition
The patient's race

Element Values

1. Asian
2. Native Hawaiian or Other Pacific Islander
3. Other Race
4. American Indian
5. Black or African American
6. White
7. Not Known/Not Recorded

Additional Information

- Patient race should be based on self-report or identified by a family member
- Based on the 2010 US Census Bureau.
- Select all that apply.
- Hispanic is not a race. If the Race is not documented or unknown, you should report “Not Known/Not Recorded”

Data Source Hierarchy Guide

1. Face Sheet
Demographics TR1.17 - Ethnicity

**Definition**

The patient's ethnicity

**Element Values**

1. Hispanic or Latino
2. Not Hispanic or Latino
3. Not Known/Not Recorded

**Additional Information**

- Patient ethnicity should be based upon self-report of identified by a family member.
- The maximum number of ethnicities that may be reported for an individual patient is 1.
- Based on the 2010 US Census Bureau
Demographics TR1.15 - Sex

Definition

The patient’s sex

Element Values

1. Male
2. Female
3. Not Known/Not Recorded

Additional Information

- Patients who have undergone a surgical and/or hormonal sex reassignment should be coded using the current assignment
- This field cannot be not applicable

Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form
4. Triage/Trauma Flow Sheet
5. History & Physical
6. EMS Run Report

Associated Edit Checks (NTDB)

<table>
<thead>
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<td>1102</td>
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<tr>
<td>1103</td>
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<td>Element cannot be Not Applicable</td>
</tr>
<tr>
<td>1140</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>

NTDS INJURY INFORMATION
### Demographics TR5.1 – Incident Injury Date

**Definition**
The date the injury occurred

**Element Values**
Relevant value for data element

**Additional Information**
- Collected as MM-DD-YYYY
- Direct entry allows for use of the calendar function, typing MM/DD/YYYY, or MMDDYY.
- Estimates of date of injury should be based on report by patient, witness, family or healthcare provider. Other Proxy measures (e.g., 911 call times) should not be used.
- If not known, leave blank.

**Data Source Hierarchy Guide**
1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. History & Physical
4. Face Sheet

Associated Edit Checks (NTDB)

<table>
<thead>
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<tbody>
<tr>
<td>1201</td>
<td>1</td>
<td>Date is not valid</td>
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<tr>
<td>1202</td>
<td>1</td>
<td>Date out of range</td>
</tr>
<tr>
<td>1203</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>1204</td>
<td>2</td>
<td>Injury Incident Date is earlier than Date of Birth</td>
</tr>
<tr>
<td>1205</td>
<td>3</td>
<td>Injury Incident Date is later than EMS Dispatch Date</td>
</tr>
<tr>
<td>1206</td>
<td>3</td>
<td>Injury Incident Date is later than EMS Unit Arrival on Scene Date</td>
</tr>
<tr>
<td>1207</td>
<td>3</td>
<td>Injury Incident Date is later than EMS Unit Scene Departure Date</td>
</tr>
<tr>
<td>1208</td>
<td>3</td>
<td>Injury Incident Date is later than ED/Hospital Arrival Date</td>
</tr>
<tr>
<td>1209</td>
<td>3</td>
<td>Injury Incident Date is later than ED Discharge Date</td>
</tr>
<tr>
<td>1210</td>
<td>2</td>
<td>Injury Incident Date is later than Hospital Discharge Date</td>
</tr>
<tr>
<td>1211</td>
<td>2</td>
<td>Element cannot be Not Applicable</td>
</tr>
<tr>
<td>1212</td>
<td>3</td>
<td>Incident Injury Date is greater than 14 days earlier than the ED/Hospital Arrival Date</td>
</tr>
<tr>
<td>1240</td>
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<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>

WI Trauma Registry Data Dictionary v6.0

Demographics TR5.18 – Incident Injury Time

Definition

The time the injury occurred

Element Values

Relevant value for data element

Additional Information

- Collected as HH:MM Military time.
- Estimates of time of injury should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g., 911 call times) should not be used.
- If not known, leave blank.

Data Source Hierarchy Guide
1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. History & Physical
4. Face Sheet

Associated Edit Checks (NTDB)

<table>
<thead>
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<th>Level</th>
<th>Message</th>
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</thead>
<tbody>
<tr>
<td>1301</td>
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<td>Time is not valid</td>
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<td>Element cannot be blank</td>
</tr>
<tr>
<td>1304</td>
<td>3</td>
<td>Injury Incident Time is later than EMS Dispatch Time</td>
</tr>
<tr>
<td>1305</td>
<td>3</td>
<td>Injury Incident Time is later than EMS Unit Arrival on Scene Time</td>
</tr>
<tr>
<td>1306</td>
<td>3</td>
<td>Injury Incident Time is later than EMS Unit Scene Departure Time</td>
</tr>
<tr>
<td>1307</td>
<td>3</td>
<td>Injury Incident Time is later than ED/Hospital Arrival Time</td>
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<tr>
<td>1308</td>
<td>3</td>
<td>Injury Incident Time is later than ED Discharge Time</td>
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<tr>
<td>1309</td>
<td>2</td>
<td>Injury Incident Time is later than Hospital Discharge Time</td>
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<tr>
<td>1310</td>
<td>2</td>
<td>Element cannot be Not Applicable</td>
</tr>
<tr>
<td>1340</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>

WI Trauma Registry Data Dictionary v6.0

Injury TR2.10 – Work Related

Definition
Indication of whether the injury occurred during paid employment

Element Values
1. Yes
2. No
3. Not Known/Not Recorded

Additional Information
- If work related, two additional data fields must be completed: Patient's Occupational Industry and Patient's Occupation.
- Selecting “Yes” will show Occupational Industry (TR2.6) and Occupation (TR2.11)
Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. History & Physical
4. Face Sheet
5. Billing Sheet

Associated Edit Checks (NTDB)

<table>
<thead>
<tr>
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<td>Element cannot be blank</td>
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<tr>
<td>1407</td>
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<td>Element cannot be Not Applicable</td>
</tr>
<tr>
<td>1440</td>
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<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>

Injury TR2.6 – Occupational Industry

Definition

The occupational industry associated with the patient's work environment.

Element Values

1. Finance, Insurance, and Real Estate
2. Manufacturing
3. Retail Trade
4. Transportation and Public Utilities
5. Agriculture, Forestry, Fishing
6. Professional and Business Services
7. Education and Health Services
8. Construction
9. Government
10. Natural Resources and Mining
11. Information Services
12. Wholesale Trade
13. Leisure and Hospitality
14. Other Services
15. Not Applicable
16. Not Known/Not Recorded
**Additional Information**

- If Work related, also complete Patient’s Occupation
- Based upon US Bureau of Labor Statistics Industry Classification
- Element will default to Not Applicable if Work Related is “2. No”

**Data Source Hierarchy Guide**

1. Billing Sheet
2. Face Sheet
3. Case Management/Social Services Notes
4. EMS Run Report
5. Nursing Notes/Flow Sheet

**Associated Edit Checks (NTDB)**

<table>
<thead>
<tr>
<th>Rule ID</th>
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<tr>
<td>1504</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>1505</td>
<td>2</td>
<td>If Work-Related is “1. Yes”, Patient's Occupational Industry cannot be “Not Applicable”</td>
</tr>
<tr>
<td>1506</td>
<td>2</td>
<td>“Not Applicable” must be reported if Work-Related is “2. No”</td>
</tr>
<tr>
<td>1540</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>

**PATIENT’S OCCUPATIONAL INDUSTRY**: The occupational history associated with the patient’s work environment.

*Field Value Definitions:*

**Finance and Insurance** - The Finance and Insurance sector comprises establishments primarily engaged in financial transactions (transactions involving the creation, liquidation, or change in ownership of financial assets) and/or in facilitating financial transactions. Three principal types of activities are identified:
1. Raising funds by taking deposits and/or issuing securities and, in the process, incurring liabilities.
2. Pooling of risk by underwriting insurance and annuities.
3. Providing specialized services facilitating or supporting financial intermediation, insurance, and employee benefit programs.

**Manufacturing** - The Manufacturing sector comprises establishments engaged in the mechanical, physical, or chemical transformation of materials, substances, or components into new products. Establishments in the Manufacturing sector are often described as plants, factories, or mills and characteristically use power-driven machines and materials-handling equipment. However, establishments that make new products by hand, such as bakeries, candy stores, and custom tailors, may also be included in this sector.
Retail Trade - The Retail Trade sector comprises establishments engaged in retailing merchandise, generally without transformation, and rendering services incidental to the sale of merchandise. The retailing process is the final step in the distribution of merchandise; retailers are, therefore, organized to sell merchandise in small quantities to the general public. This sector comprises two main types of retailers:
1. Store retailers operate fixed point-of-sale locations, located and designed to attract a high volume of walk-in customers.
2. Non-store retailers, like store retailers, are organized to serve the general public, but their retailing methods differ.

Transportation and Public Utilities - The Transportation and Warehousing sector includes industries providing transportation of passengers and cargo, warehousing and storage for goods, scenic and sightseeing transportation, and support activities related to modes of transportation. The Utilities sector comprises establishments engaged in the provision of the following utility services: electric power, natural gas, steam supply, water supply, and sewage removal.

Agriculture, Forestry, Fishing - The Agriculture, Forestry, Fishing and Hunting sector comprises establishments primarily engaged in growing crops, raising animals, harvesting timber, and harvesting fish and other animals from a farm, ranch, or their natural habitats. The establishments in this sector are often described as farms, ranches, dairies, greenhouses, nurseries, orchards, or hatcheries.

Professional and Business Services - The Professional, Scientific, and Technical Services sector comprises establishments that specialize in performing professional, scientific, and technical activities for others. These activities require a high degree of expertise and training. The establishments in this sector specialize according to expertise and provide these services to clients in a variety of industries and, in some cases, to households. Activities performed include: legal advice and representation; accounting, bookkeeping, and payroll services; architectural, engineering, and specialized design services; computer services; consulting services; research services; advertising services; photographic services; translation and interpretation services; veterinary services; and other professional, scientific, and technical services.

Education and Health Services - The Educational Services sector comprises establishments that provide instruction and training in a wide variety of subjects. This instruction and training is provided by specialized establishments, such as schools, colleges, universities, and training centers. These establishments may be privately owned and operated for profit or not for profit, or they may be publicly owned and operated. They may also offer food and/or accommodation services to their students. The Health Care and Social Assistance sector comprises establishments providing health care and social assistance for individuals. The sector includes both health care and social assistance because it is sometimes difficult to distinguish between the boundaries of these two activities.

Construction - The construction sector comprises establishments primarily engaged in the construction of buildings or engineering projects (e.g., highways and utility systems). Establishments primarily engaged in the preparation of sites for new construction and establishments primarily engaged in subdividing land for sale as building sites also are included in this sector. Construction work done may include new work, additions, alterations, or maintenance and repairs.

Government – Civil service employees, often called civil servants or public employees, work in a variety of fields such as teaching, sanitation, health care, management, and administration for the
federal, state, or local government. Legislatures establish basic prerequisites for employment such as compliance with minimal age and educational requirements and residency laws.

**Natural Resources and Mining** - The Mining sector comprises establishments that extract naturally occurring mineral solids, such as coal and ores; liquid minerals, such as crude petroleum; and gases, such as natural gas. The term mining is used in the broad sense to include quarrying, well operations, beneficiating (e.g., crushing, screening, washing, and flotation), and other preparation customarily performed at the mine site, or as a part of mining activity.

**Information Services** - The Information sector comprises establishments engaged in the following processes:

(a) producing and distributing information and cultural products,
(b) providing the means to transmit or distribute these products as well as data or communications,
(c) processing data.

**Wholesale Trade** - The Wholesale Trade sector comprises establishments engaged in wholesaling merchandise, generally without transformation, and rendering services incidental to the sale of merchandise. The merchandise described in this sector includes the outputs of agriculture, mining, manufacturing, and certain information industries, such as publishing.

**Leisure and Hospitality** - The Arts, Entertainment, and Recreation sector includes a wide range of establishments that operate facilities or provide services to meet varied cultural, entertainment, and recreational interests of their patrons. This sector comprises (1) establishments that are involved in producing, promoting, or participating in live performances, events, or exhibits intended for public viewing; (2) establishments that preserve and exhibit objects and sites of historical, cultural, or educational interest; and (3) establishments that operate facilities or provide services that enable patrons to participate in recreational activities or pursue amusement, hobby, and leisure-time interests. The Accommodation and Food Services sector comprises establishments providing customers with lodging and/or preparing meals, snacks, and beverages for immediate consumption. The sector includes both accommodation and food services establishments because the two activities are often combined at the same establishment.

**Other Services** - The Other Services sector comprises establishments engaged in providing services not specifically provided for elsewhere in the classification system. Establishments in this sector are primarily engaged in activities, such as equipment and machinery repairing, promoting or administering religious activities, grant-making, advocacy, and providing dry-cleaning and laundry services, personal care services, death care services, pet care services, photofinishing services, temporary parking services, and dating services.
<table>
<thead>
<tr>
<th>Element Values</th>
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<tbody>
<tr>
<td>1. Business and Financial Operations Occupations</td>
</tr>
<tr>
<td>2. Architecture and Engineering Occupations</td>
</tr>
<tr>
<td>3. Community and Social Services Occupations</td>
</tr>
<tr>
<td>4. Education, Training and Library Occupations</td>
</tr>
<tr>
<td>12. Management Occupations</td>
</tr>
<tr>
<td>13. Computer and Mathematical Occupations</td>
</tr>
<tr>
<td>14. Life, Physical and social science occupations</td>
</tr>
<tr>
<td>15. Legal Occupations</td>
</tr>
<tr>
<td>16. Arts, Design, Entertainment, Sports and Media</td>
</tr>
<tr>
<td>17. Healthcare support Occupations</td>
</tr>
</tbody>
</table>
5. Healthcare Practitioners and Technical Occupations
6. Protective Service Occupations
7. Building and Grounds Cleaning and Maintenance
8. Sales and Related Occupations
9. Farming, fishing and forestry occupations
10. Installation, maintenance and repair occupations.
11. Transportation and Material moving occupations
18. Food Preparation and Serving Related Occupations
19. Personal Care And Service Occupations
20. Office and Administrative Support Occupations
21. Construction and Extraction Occupations
22. Production Occupations
23. Military Specific Occupations
24. Not Applicable
25. Not Known/Not Recorded

Additional Information

- Only Completed if injury is work-related
- If work related, also complete Patient’s Occupational Industry
- Based on 1999 US Bureau of Labor Statistics Standard Occupational Classification
- Element will default to Not Applicable if Work Related is “2. No”

Data Source Hierarchy Guide

1. Billing Sheet
2. Face Sheet
3. Case Management/Social Services Notes
4. EMS Run Report
5. Nursing Notes/Flow Sheet

Associated Edit Checks (NTDB)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
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</thead>
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<td>Value is not a valid menu option</td>
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<td>Element cannot be blank</td>
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<tr>
<td>1605</td>
<td>2</td>
<td>If Work-Related is “1. Yes”, Patient’s Occupation cannot be “Not Applicable”</td>
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<tr>
<td>1606</td>
<td>2</td>
<td>“Not Applicable” must be reported if “Work-Related is “2. No”</td>
</tr>
<tr>
<td>1640</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
### Injury TR200.3 – ICD-10 Primary External Cause Code; Additional External Cause Code

#### Definition

External Cause code used to describe the mechanism (or external factor) that caused the injury event

#### Element Values

Relevant ICD-10-CM code value for injury event
**Additional Information**

- The primary external cause code should describe the main reason a patient is admitted to the hospital.
- External cause codes are used to auto-generate two calculated fields: Trauma Type (Blunt, Penetrating, Burn) and intentionality (Based upon CDC Matrix)
- ICD-10-CM codes will be accepted for this data element. Activity codes are not collected under the NTDS and should not be reported in this field.
- ImageTrend does not have separate elements for Primary and Secondary External cause codes. Both primary and secondary codes should be entered into this field.
- Multiple Cause Coding Hierarchy: If two or more events cause separate injuries, an external cause code should be assigned for each cause. The first-listed external cause code will be selected in the following order:
  - External cause codes for child and adult abuse take priority over all other external cause codes.
  - External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse.
  - External cause codes for cataclysmic events take priority over all other external cause codes except cataclysmic events, and 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.

**Data Source Hierarchy Guide**

1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. Nursing Notes/Flow Sheet
4. History & Physical
5. Progress Notes

**Associated Edit Checks (NTDB)**

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<td>Element cannot be blank</td>
</tr>
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<td>Should not be Y92.X/Y92.XX/Y92.XXX (where X is A-Z or 0-9) (ICD-10 CM only)</td>
</tr>
<tr>
<td>8905</td>
<td>3</td>
<td>ICD-10 External Cause Code should not be Y93.X/Y93.XX (where X is A-Z or 0-9) (ICD-10 CM only)</td>
</tr>
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<td>8906</td>
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<td>E-Code is not a valid ICD-10-CA code (ICD-10 CA only)</td>
</tr>
<tr>
<td>Code</td>
<td>Value</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>8907</td>
<td>2</td>
<td>Element cannot be Not Applicable</td>
</tr>
<tr>
<td>8940</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>

### Injury TR200.5 – ICD-10 Place of Occurrence External Cause Code

**Definition**

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

**Element Values**
Relevant ICD-10-CM code value for injury event

Additional Information

- Only ICD-10-CM codes will be accepted for ICD-10 Place of Occurrence External Cause Code

Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. Nursing Notes/Flow Sheet
4. History & Physical
5. Progress Notes

Associated Edit Checks (NTDB)

<table>
<thead>
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<th>Message</th>
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<tr>
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<td>Invalid value (ICD-10 CM only)</td>
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<tr>
<td>9002</td>
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</tr>
<tr>
<td>9003</td>
<td>3</td>
<td>Place of Injury code should be Y92.X/Y92.XX/Y92.XXX (where X is (A-Z [Excluding I,O] or 0-9) (ICD-10 CM only)</td>
</tr>
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<td>9004</td>
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<td>Invalid value (ICD-10 CA only)</td>
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<tr>
<td>9005</td>
<td>3</td>
<td>Place of Injury code should be U98X (where X is 0-9) (ICD-10 CA only)</td>
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<tr>
<td>9006</td>
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<td>Element cannot be Not Applicable</td>
</tr>
<tr>
<td>9040</td>
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</tr>
</tbody>
</table>

Injury TR5.6 – Incident Location ZIP/Postal Code

Definition

The ZIP/Postal code of the incident location

Element Values
Relevant value for data element

**Additional Information**

- Can be stored as a 5 of 9 Digit code (XXXXX-XXXX)
- If “Not Applicable” or “Not Recorded/Not Known,” complete variables: Incident State (US Only), Incident County (US only), Incident City (US only) and Incident Country.
- May require adherence to HIPAA regulations.
- If ZIP/Postal code is known, then must complete incident Country.
- Not Known is indicated by typing “99999”

**Data Source Hierarchy Guide**

1. EMS Run Report
2. Triage/Trauma Flow Sheet

**Associated Edit Checks (NTDB)**

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
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</thead>
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<td>2002</td>
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<td>2006</td>
<td>2</td>
<td>Element cannot be Not Applicable</td>
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<tr>
<td>2040</td>
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<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>

**Injury TR5.11 – Incident Country**

**Definition**

The country where the patient was found or to which the unit responded (or best approximation)
### Element Values

Relevant value for data element (two digit alpha country code)

### Additional Information

- Only completed when incident location ZIP code is “Not Applicable” or “Not Recorded/Not Known”
- Values are two character fields representing a country (e.g., US)

### Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet

### Associated Edit Checks (NTDB)

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<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
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<tr>
<td>2104</td>
<td>2</td>
<td>Element cannot be Not Applicable</td>
</tr>
<tr>
<td>2105</td>
<td>2</td>
<td>Field cannot be “Not Known/Not Recorded” when Incident Location ZIP/Postal code is not “Not Known/Not Recorded”</td>
</tr>
<tr>
<td>2140</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>

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*WI Trauma Registry Data Dictionary v6.0*
The state, territory, or province where the patient’s injury occurred was found or to which the unit responded (or best approximation).

**Element Values**

Relevant value for data element (two digit numeric FIPS code)

**Additional Information**

- Only completed when Incident Location ZIP code is “Not Applicable” or “Not Recorded/Not Known” and country is US
- Used to calculate FIPS code
- Element will default to Wisconsin when ZIP is 99999

**Data Source Hierarchy Guide**

1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. ED Nurses’ Notes

**Associated Edit Checks (NTDB)**

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<td>2240</td>
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<td>Single Entry Max exceeded</td>
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</tbody>
</table>
### Definition
The county or parish where the patient was found or to which the unit responded (or best approximation)

### Element Values
Relevant value for data element (three digit FIPS code)

### Additional Information
- Only completed when incident location zip is “Not Applicable” or “Not recorded/Not Known”
- Used to calculate FIPS code.
- The null value “Not Applicable” is used if incident Location ZIP/Postal Code is reported.

### Data Source Hierarchy Guide
1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. ED Nurses’ Notes

### Associated Edit Checks (NTDB)

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<thead>
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<tr>
<td>2303</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>2340</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
### Injury TR5.10 – Incident City

**Definition**
The city or township where the patient was found or to which the unit responded

**Element Values**
Relevant value for data element (five digit numeric FIPS code)

**Additional Information**
- Only completed when Incident Location ZIP/Postal code is “Not Applicable” or “Not Known/Not Recorded/Unknown” and country is US
- Used to calculate FIPS code
- If incident location resides outside of formal city boundaries, report nearest city/town.
- The null value “Not Applicable” is used if Incident Location ZIP/Postal Code is reported.
- If Incident Country is not US, report the null value “Not Applicable”
- When ZIP is “99999”, element will populate as “Not Known”

**Data Source Hierarchy Guide**
1. EMS Run Report
2. Triage/Trauma Flow Sheet

**Associated Edit Checks (NTDB)**

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<thead>
<tr>
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</tr>
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</table>

**BACK TO TABLE OF CONTENTS**
Injury – Protective Devices, Airbag Deployment, Child Specific Restraint

**Definition**

Protective devices (Safety Equipment) in use or worn by the patient at the time of the injury.

**Element Values & Data Elements**

**TR 29.24: Protective Devices**

1. None
2. Three Point Restraint
3. Lap Belt
4. Personal Flotation Device
5. Protective Non-Clothing Gear (e.g., shin guard)
6. Eye Protection,
7. Child Care Restraint (booster seat or child car seat)
8. Helmet
9. Airbag Present
10. Protective Clothing
11. Shoulder Belt
12. Other
13. Not Known/Not Recorded

**TR 29.32: Airbag Deployment**

1. Airbag Deployed Front
2. Airbag Deployed Other
3. Airbag Deployed Side
4. Airbag Not Deployed
5. Not Applicable
6. Not Known/Not Recorded

**TR 29.31: Child Specific Restraint**
1. Child Booster Seat
2. Child Car Seat
3. Infant Car Seat
4. Not Known/Not Recorded

**Additional Information**

- Check all that apply.
- Hold the control key to select multiple items within the software.
- Evidence of the use of safety equipment may be reported or observed.
- Lap belt should be used to include those patients that are restrained but not further specified.
- Airbag deployed front should be used for patients with documented airbag deployments, but are not further specified.
- Selecting Airbag Present will display Airbag Deployment (TR29.32).
- Selecting Child Restraint (booster seat or child car seat) will display Child Specific Restraint (TR29.31).
- When Three Point Restraint is selected, Lap Belt and Shoulder Belt will auto-select.
- If documented that a “Child Restraint (booster seat or child care seat)” was used or worn, but not properly fastened, either on the child or in the car, report Field Value “1. None.”

**Data Source Hierarchy Guide**

1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. Nursing Notes/Flow Sheet
4. History & Physical

**Associated Edit Checks (NTDB)**

<table>
<thead>
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<th>Message</th>
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<td>Element cannot be blank</td>
</tr>
<tr>
<td>2507</td>
<td>2</td>
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</tr>
<tr>
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<td>Element cannot be “Not Known/Not Recorded” along with any other valid value</td>
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<td>Multiple Entry Max exceeded</td>
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<tr>
<td>Pre-Hospital TR9.1 – EMS Dispatched Date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>Definition</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NTDS PRE-HOSPITAL INFORMATION**

**Back to Table of Contents**
The date the unit transporting to your hospital was notified by dispatch.

**Element Values**

Relevant value for the data element

**Additional Information**

- Collected as MM-DD-YYYY.
- For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility was notified by dispatch or assigned to this transport.
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene was dispatched.
- Leave blank for patients not transported by EMS

**Data Source Hierarchy Guide**

1. EMS Run Report

**Associated Edit Checks (NTDB)**

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<thead>
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<th>Message</th>
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<td>Date out of range</td>
</tr>
<tr>
<td>2803</td>
<td>3</td>
<td>EMS Dispatch Date is earlier than Date of Birth</td>
</tr>
<tr>
<td>2804</td>
<td>3</td>
<td>EMS Dispatch Date is later than EMS Unit Arrival on Scene Date</td>
</tr>
<tr>
<td>2805</td>
<td>3</td>
<td>EMS Dispatch Date is later than EMS Unit Scene Departure Date</td>
</tr>
<tr>
<td>2806</td>
<td>3</td>
<td>EMS Dispatch Date is later than ED/Hospital Arrival Date</td>
</tr>
<tr>
<td>2807</td>
<td>3</td>
<td>EMS Dispatch Date is later than ED Discharge Date</td>
</tr>
<tr>
<td>2808</td>
<td>3</td>
<td>EMS Dispatch Date is later than Hospital Discharge Date</td>
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<tr>
<td>2809</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>2840</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
**Definition**

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

**Element Values**

Relevant value for the data element

**Additional Information**

- Collected as HH:MM
- For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility was notified by dispatch or assigned to this transport.
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene was dispatched.
- Leave blank for patients not transported by EMS

**Data Source Hierarchy Guide**

1. EMS Run Report

**Associated Edit Checks (NTDB)**

<table>
<thead>
<tr>
<th>Rule ID</th>
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<td>2903</td>
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<td>EMS Dispatch Time is later than EMS Unit Arrivial on Scene Time</td>
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<tr>
<td>2904</td>
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<td>EMS Dispatch Time is later than EMS Unit Scene Departure Time</td>
</tr>
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<td>2905</td>
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<td>EMS Dispatch Time is later than ED/Hospital Arrival Time</td>
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<tr>
<td>2907</td>
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<td>EMS Dispatch Time is later than Hospital Discharge Time</td>
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<td>2908</td>
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</tr>
<tr>
<td>2940</td>
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<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Pre-Hospital TR9.1 – EMS Unit Arrived on Scene Date

**Definition**

The date the unit transporting to your hospital arrived on the scene/transferring facility.

**Element Values**

Relevant value for the data element

**Additional Information**

- Collected as MM-DD-YYYY.
- For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility arrived at the transferring facility (arrival is defined at date/time when the vehicle stopped moving)
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene arrived at the scene (arrival is defined at date/time when the vehicle stopped moving)
- Leave blank for patients not transported by EMS

**Data Source Hierarchy Guide**

1. EMS Run Report

**Associated Edit Checks (NTDB)**

<table>
<thead>
<tr>
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<td>3002</td>
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<td>3003</td>
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<td>EMS Unit Arrival on Scene Date is earlier than Date of Birth</td>
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<td>3004</td>
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<td>EMS Unit Arrival on Scene Date is earlier than EMS Dispatch Date</td>
</tr>
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<td>3005</td>
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<td>EMS Unit Arrival on Scene Date is later than EMS Unit Scene Departure Date</td>
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<tr>
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<td>EMS Unit Arrival on Scene Date is later than ED/Hospital Arrival Date</td>
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<td>3007</td>
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<td>EMS Unit Arrival on Scene Date is later than ED Discharge Date</td>
</tr>
<tr>
<td>3008</td>
<td>3</td>
<td>EMS Unit Arrival on Scene Date is later than Hospital Discharge Date</td>
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<tr>
<td>3009</td>
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<td>EMS Unit Arrival on Scene Date minus EMS Dispatch Date is greater than 7 days</td>
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<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Pre-Hospital TR9.2 – EMS Arrive Scene Time

**Definition**

The time the unit transporting to your hospital arrived on the scene/transferring facility.

**Element Values**

Relevant value for the data element

**Additional Information**

- Collected as HH:MM military time.
- Used to auto-generate two additional calculated fields: Total EMS Response Time (elapsed time from EMS dispatch to scene arrival) and Total EMS Scene Time (elapsed time from EMS scene arrival to scene departure).
- For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility arrived at the transferring facility (arrival is defined at date/time when the vehicle stopped moving).
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene arrived at the scene (arrival is defined at date/time when the vehicle stopped moving).
- Leave blank for patients not transported by EMS

**Data Source Hierarchy Guide**

1. EMS Run Report

**Associated Edit Checks (NTDB)**

<table>
<thead>
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<td>EMS Unit Arrival on Scene Time is later than EMS Unit Scene Departure Time</td>
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<td>3105</td>
<td>3</td>
<td>EMS Unit Arrival on Scene Time is later than ED/Hospital Arrival Time</td>
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<td>3106</td>
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<td>EMS Unit Arrival on Scene Time is later than ED Discharge Time</td>
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<td>3107</td>
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<td>EMS Unit Arrival on Scene Time is later than Hospital Discharge Time</td>
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<tr>
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<td>Single Entry Max exceeded</td>
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</tbody>
</table>

[BACK TO TABLE OF CONTENTS]
### Pre-Hospital TR9.3 – EMS Leave Scene Date

#### Definition

The date the unit transporting to your hospital left the scene/transferring facility.

#### Element Values

Relevant value for the data element

#### Additional Information

- Collected as MM-DD-YYYY
- Used to auto-generate two additional calculated fields: Total EMS Response Time (elapsed time from EMS dispatch to scene arrival) and Total EMS Scene Time (elapsed time from EMS scene arrival to scene departure).
- For inter-facility transfer patients, this is the date at which the unit transporting the patient to your facility from the transferring facility departed the transferring facility (arrival is defined at date/time when the vehicle stopped moving).
- For patients transported from the scene of injury to your hospital, this is the date at which the unit transporting the patient to your facility from the scene departed the scene (arrival is defined at date/time when the vehicle stopped moving).
- Leave blank for patients not transported by EMS

#### Data Source Hierarchy Guide

1. EMS Run Report

#### Associated Edit Checks (NTDB)

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<thead>
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<td>EMS Unit Scene Departure Date is earlier than EMS Dispatch Date</td>
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<td>EMS Unit Scene Departure Date is earlier than EMS Unit Arrival on Scene Date</td>
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<td>EMS Unit Scene Departure Date is later than ED/Hospital Arrival Date</td>
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<td>3</td>
<td>EMS Unit Scene Departure Date is later than ED Discharge Date</td>
</tr>
<tr>
<td>3208</td>
<td>3</td>
<td>EMS Unit Scene Departure Date is later than Hospital Discharge Date</td>
</tr>
<tr>
<td>3209</td>
<td>3</td>
<td>EMS Unit Scene Departure Date minus EMS Unit Arrival on Scene Date is greater than 7 days</td>
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</tr>
<tr>
<td>3240</td>
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<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>

BACK TO TABLE OF CONTENTS
Pre-Hospital TR9.3 – EMS Leave Scene Time

**Definition**

The time the unit transporting to your hospital left the scene/transferring facility.

**Element Values**

Relevant value for the data element

**Additional Information**

- Collected as HH:MM military time.
- Used to auto-generate two additional calculated fields: Total EMS Response Time (elapsed time from EMS dispatch to scene arrival) and Total EMS Scene Time (elapsed time from EMS scene arrival to scene departure).
- For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility departed the transferring facility (arrival is defined at date/time when the vehicle stopped moving).
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene departed the scene (arrival is defined at date/time when the vehicle stopped moving).
- Leave blank for patients not transported by EMS

**Data Source Hierarchy Guide**

1. EMS Run Report

**Associated Edit Checks (NTDB)**

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<td>EMS Unit Scene Departure Time is earlier than EMS Dispatch Time</td>
</tr>
<tr>
<td>3304</td>
<td>3</td>
<td>EMS Unit Scene Departure Time is earlier than EMS Unit Arrival on Scene Time</td>
</tr>
<tr>
<td>3305</td>
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<td>EMS Unit Scene Departure Time is later than ED/Hospital Arrival Time</td>
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</table>

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Pre-Hospital TR8.10 – Transport Mode

Definition

The mode of transport delivering the patient to your hospital

Element Values

1. Ground Ambulance
2. Helicopter Ambulance
3. Fixed-Wing ambulance
4. Private/Public vehicle/Walk-in
5. Police
6. Other
7. Not Known/Not Recorded

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks (NTDB)

<table>
<thead>
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<th>Rule ID</th>
<th>Level</th>
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</table>
Pre-Hospital TR18.67 – Initial Field Systolic Blood Pressure

Definition

First recorded systolic blood pressure measured at the scene of injury.

Element Values

Relevant value for the data element

Additional Information

- The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- The null value "Not Applicable" is reported for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- The null value “Not Known/Not Recorded” is reported if the patient's first recorded initial field systolic blood pressure was NOT measured at the scene of injury.
- If Not Known, select “Not Known/Not Recorded”.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

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<th>Level</th>
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Pre-Hospital TR18.69 – Initial Field Pulse Rate

Definition

First recorded pulse measured at the scene of injury (palpated or auscultated), expressed as a number per minute.

Element Values

Relevant value for the data element

Additional Information

- The null value ”Not Known/Not Recorded” is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- The null value “Not Applicable” is reported for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- The null value ”Not Known/Not Recorded” is reported if the patient’s first recorded initial field pulse rate was NOT measured at the scene of injury.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks (NTDB)

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<td>3740</td>
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<td>Single Entry Max exceeded</td>
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</table>
Pre-Hospital TR18.70 – Initial Field Respiratory Rate

Definition

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

Element Values

Relevant value for the data element

Additional Information

- Leave blank if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- The null value "Not Applicable" is reported for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded initial field pulse rate was NOT measured at the scene of injury.
- Completion of this field will show Pre-hospital Respiratory Assistance (TR18.80)

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks (NTDB)

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<td>3840</td>
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</table>
Pre-Hospital TR18.82 – Initial Field Oxygen Saturation

Definition

First recorded oxygen saturation measured at the scene of injury (expressed as a percentage).

Element Values

- Relevant value for the data element

Additional Information

- The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- Value should be based upon assessment before administration of supplemental oxygen.
- The null value “Not Applicable” is reported for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- The null value “Not Value/Not Recorded” is reported if the patient’s first recorded initial field oxygen saturation was NOT measured at the scene of injury.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks (NTDB)

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</table>
Pre-Hospital TR18.60 – Initial Field GCS - Eye

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

Element Values
1. No eye movement when assessed
2. Opens eyes in response to painful stimulation
3. Opens eyes in response to verbal stimulation
4. Opens eyes spontaneously
5. Not Known/Not Recorded

Additional Information
- The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation.
- The null value “Not Applicable” is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- The null value "Not Known/Not Recorded” is reported if the patient’s first recorded initial field GCS Eye was NOT measured at the scene of injury.
- The null value “Not Known/Not Recorded” is reported if Initial Field GCS 40 – Eye is reported.

Data Source Hierarchy Guide
1. EMS Run Report

Associated Edit Checks (NTDB)

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<td>4006</td>
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<td>Element must be “Not Applicable” when Initial Field GCS 40 – Eye is reported</td>
</tr>
</tbody>
</table>
Pre-Hospital TR18.61.2 & TR18.61.0 – Initial Field GCS - Verbal

Definition

First recorded Glasgow Coma Score (Verbal) measured at the scene of injury.

Element Values

**Pediatric (≤ 2 years):**

1. No vocal response
2. Inconsolable, agitated
3. Inconsistently consolable, moaning
4. Cries but is consolable, inappropriate interactions
5. Smiles, oriented to sounds, follows objects, interacts

**Adult**

1. No verbal response
2. Incomprehensible sounds
3. Inappropriate words
4. Confused
5. Oriented

Additional Information

- The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- If patient is intubated then the GCS Verbal score is equal to 1.
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation
- The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- The null value “Not Known/Not Recorded” is reported if the patient's first recorded initial field GCS Verbal was NOT measured at the scene of injury.
- The null value “Not Known/Not Recorded” is reported if Initial Field GCS 40 – Verbal is reported.
- Data elements automatically switched to Pediatrics for patients younger than 2 years

Data Source Hierarchy Guide
1. EMS Run Report

**Associated Edit Checks (NTDB)**

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</tbody>
</table>
Pre-Hospital TR18.62.2 & TR18.62.0 – Initial Field GCS - Motor

Definition

First recorded Glasgow Coma Score (Motor) measured at the scene of injury.

Element Values

**Pediatric (≤ 2 years):**

1. No motor response
2. Extension to pain
3. Flexion to pain
4. Withdrawal from pain
5. Localizing pain
6. Appropriate response to stimulation

**Adult**

1. No motor response
2. Extension to pain
3. Flexion to pain
4. Withdrawal from pain
5. Localizing pain
6. Obeys commands

Additional Information

- The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation.
- The null value “Not Applicable” is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded initial field GCS Motor was NOT measured at the scene of injury.
- The null value “Not Known/Not Recorded” is reported if Initial Field GCS 40 – Motor is reported.
- Data elements automatically switched to Pediatrics for patients younger than 2 years

Data Source Hierarchy Guide

1. EMS Run Report
**Associated Edit Checks (NTDB)**

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<thead>
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<td>Single Entry Max exceeded</td>
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</table>
Pre-Hospital TR18.65 – Initial Field GCS - Total

Definition

First recorded Glasgow Coma Score (Total) measured at the scene of injury.

Element Values

Relevant value for data element

Additional Information

- The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as "AAOx3," "awake alert and oriented," or "patient with normal mental status," interpret this as GCS of 15 IF there is no other contradicting documentation.
- Auto-calculated when GCS Eye, GCS Verbal, and GCS Motor are complete.
- The null value “Not Applicable” is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded initial field GCS Total was NOT measured at the scene of injury.
- The null value “Not Known/Not Recorded” is reported if Initial Field GCS 40 is reported.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks (NTDB)

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<tr>
<td>4303</td>
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<td>Initial Field GCS - Total does not equal the sum of Initial Field GCS - Eye, Initial Field GCS - Verbal, and Initial Field GCS – Motor, unless any of these values are &quot;Not Known/Not Recorded&quot;</td>
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<td>Element must be &quot;Not Known/Not Recorded&quot; when Initial Field GCS 40 – Eye, Initial Field GCS 40 – Verbal, and Initial Field GCS – Motor are reported</td>
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</table>
### Pre-Hospital TR18.65 – Initial Field GCS 40 - Eye

#### Definition

First recorded Glasgow Coma Score 40 (Eye) measured at the scene of injury.

#### Element Values

**Adults:**

1. None 3. To Sound
2. To Pressure 4. Spontaneous
0. Not Testable

**Pediatric < 5 Years:**

1. None 3. To Sound
2. To Pain 4. Spontaneous
0. Not Testable

#### Additional Information

- The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS 40 scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient's eyes open spontaneously," an Eye GCS 40 of 4 may be recorded, IF there is no other contradicting documentation.
- Report Field Value "0. Not Testable" if unable to assess (e.g. swelling to the eye(s)).
- The null value “Not Applicable” is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded initial field GCS 40 – Eye was NOT measured at the scene of injury.
- The null value “Not Known/Not Recorded” is reported if Initial Field GCS – Eye is reported.

#### Data Source Hierarchy Guide

1. EMS Run Report

### Associated Edit Checks (NTDB)
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<tr>
<td>15040</td>
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<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>

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Pre-Hospital TR18.65 – Initial Field GCS 40 - Verbal

Definition

First recorded Glasgow Coma Score 40 (Verbal) measured at the scene of injury.

Element Values

**Adults:**

1. None
2. Sounds
3. Words
4. Confused
5. Oriented
0. Not Testable

**Pediatric < 5 Years:**

1. None
2. Cries
3. Vocal Sounds
4. Words
5. Talks Normally
0. Not Testable

Additional Information

- The null value “Not Known/Not Recorded” is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- If a patient does not have a numeric GCS 40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS 40 scale, the appropriate numeric score may be listed. E.g. the chart indicates: “patient correctly gives name, place and date” a Verbal GCS 40 of 5 may be recorded, IF there is no other contradicting documentation.
- Report Field Value “0. Not Testable” if unable to assess (e.g. patient is intubated).
- The null value “Not Applicable” is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- The null value “Not Known/Not Recorded” is reported if the patient's first recorded initial field GCS 40 – Verbal was NOT measured at the scene of injury.
- The null value “Not Known/Not Recorded” is reported if Initial Field GCS – Verbal is reported.

Data Source Hierarchy Guide

1. EMS Run Report
## Associated Edit Checks (NTDB)

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</tbody>
</table>
Pre-Hospital TR18.65 – Initial Field GCS 40 - Motor

**Definition**

First recorded Glasgow Coma Score 40 (Motor) measured at the scene of injury.

**Element Values**

**Adults:**

1. None
2. Extension
3. Abnormal Flexion
4. Normal Flexion
5. Localizing
6. Obeys Commands
0. Not Testable

**Pediatric < 5 Years:**

1. None
2. Extension to Pain
3. Flexion to Pain
4. Localizes Pain
5. Obeys Commands
0. Not Testable

**Additional Information**

- The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- If a patient does not have a numeric GCS 40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS 40 scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient opened mouth and stuck out tongue when asked" a Motor GCS 40 of 6 may be recorded, IF there is no other contradicting documentation.
- Report Field Value "0. Not Testable" if unable to assess (e.g. neuromuscular blockade).
- The null value “Not Applicable” is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded initial field GCS 40 – motor was NOT measured at the scene of injury.
- The null value “Not Known/Not Recorded” is reported if Initial Field GCS – Motor is reported.

**Data Source Hierarchy Guide**

1. EMS Run Report

**Associated Edit Checks (NTDB)**

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<td>15240</td>
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<td>Single Entry Max exceeded</td>
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</tbody>
</table>
ED/TTA TR25.54 – Inter-Facility Transfer

**Definition**

Was the patient transferred to your facility from another acute care facility?

**Element Values**

1. Yes
2. No

**Additional Information**

- Must complete “Arrived From” (TR16.22) and “Mode of Arrival” (TR8.8) to populate this field.
- Patients transferred from a private doctor’s office, stand-alone ambulatory surgery center are not considered inter-facility transfers.
- Outlying facilities purporting to provide emergency care services or utilized to stabilize a patient are considered acute care facilities (Stand-Alone Emergency Rooms)

**Data Source Hierarchy Guide**

1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. History & Physical

**Associated Edit Checks (NTDB)**

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</table>
Pre-Hospital TR17.22 – Trauma Triage Criteria (Steps 1 and 2)

Definition

Physiologic and anatomic EMS trauma triage criteria for transport to a trauma center as defined by the Centers for Disease Control and Prevention and the American College of Surgeons - Committee on Trauma. This information must be found on the scene of injury EMS Run Report.

Element Values

1. Glasgow Coma Score <= 13
2. Systolic blood pressure < 90 mmHg
3. Respiratory rate < 10 or > 29 breaths per minute (< 20 in infants aged < 1 year) or need for ventilator support
4. All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
5. Chest wall instability or deformity (e.g., flail chest)
6. Two or more proximal long-bone fractures
7. Crushed, degloved, mangled, or pulseless extremity
8. Amputation proximal to wrist or ankle
9. Pelvic fracture
10. Open or depressed skull fracture
11. Paralysis
12. Not Applicable
13. Not Known/Not Recorded

Additional Information

- The null value "Not Applicable" should be used to indicate that the patient did not arrive by EMS.
- The null value "Not Applicable" should be used if EMS Run Report indicates patient did not meet any Trauma Triage Criteria.
- The null value "Not Known/Not Recorded" should be used if this information is not indicated, as an identical response choice, on the EMS Run Report or if the EMS Run Report is not available.
- Element values must be determined by the EMS provider and must not be assigned by the index hospital.
- Check all that apply.
- Consistent with NEMSIS v3.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks (NTDB)

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</table>
Pre-Hospital TR17.47 – Trauma Triage Criteria (Steps 3 and 4)

Definition

EMS trauma triage mechanism of injury criteria for transport to a trauma center as defined by the Centers for Disease Control and Prevention and the American College of Surgeons-Committee on Trauma. This information must be found on the scene of injury EMS Run Report.

Element Values

1. Fall adults: > 20 ft. (one story is equal to 10 ft.)
2. Fall children: > 10 ft. or 2-3 times the height of the child
3. Crash intrusion, including roof: > 12 in. occupant site; > 18 in. any site
4. Crash ejection (partial or complete) from automobile
5. Crash death in same passenger compartment
6. Crash vehicle telemetry data (AACN) consistent with high risk injury
7. Auto v. pedestrian/bicyclist thrown, run over, or >20 MPH impact
8. Motorcycle crash > 20 mph
9. For adults > 65; SBP < 110
10. Patients on anticoagulants and bleeding disorders
11. Pregnancy > 20 weeks
12. EMS provider judgment
13. Burns
14. Burns with Trauma

Additional Information

- The null value "Not Applicable" should be used to indicate that the patient did not arrive by EMS.
- The null value "Not Applicable" should be used if EMS Run Report indicates patient did not meet any Trauma Triage Criteria.
- The null value "Not Known/Not Recorded" should be used if this information is not indicated, as an identical response choice, on the EMS Run Report or if the EMS Run Report is not available.
- Element Values must be determined by the EMS provider and must not be assigned by the index hospital.
- Check all that apply.
- Consistent with NEMSIS v3.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks (NTDB)

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</table>
Pre-Hospital TR15.53 – Pre-Hospital Cardiac Arrest

Definition

Indication of whether patient experienced cardiac arrest prior to ED/Hospital Arrival.

Element Values

1. Yes
2. No
3. Not Known/Not Recorded

Additional Information

- A patient who experienced a sudden cessation of cardiac activity. The patient was unresponsive with no normal breathing and no signs of circulation.
- The event must have occurred outside the reporting hospital, prior to admission at the center in which the registry is maintained. Pre-Hospital cardiac arrest could occur at a transferring/referring facility.
- Any component of basic and/or advanced cardiac life support must have been initiated.

Data Source Hierarchy Guide

1. EMS Run Report
2. Nursing Notes/Flow Sheet
3. History & Physical
4. Transfer Notes

Associated Edit Checks (NTDB)

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NTDS Emergency Department Information
ED/TTA TR18.55 – ED/Hospital Arrival Date

Definition

The date the patient arrived to the ED/Hospital

Element Values

Relevant value for data element

Additional Information

- If the patient was brought to the ED, enter date patient arrived at ED. If patient was directly admitted to the hospital, enter date patient was admitted to the hospital.
- Collected as DD-MM-YYYY

Data Source Hierarchy Guide

1. Triage/Trauma Flow Sheet
2. ED Record
3. Face Sheet
4. Billing Sheet
5. Discharge Summary

Associated Edit Checks (NTDB)

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<td>4505</td>
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<td>Element cannot be Not Known/Not Recorded</td>
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<td>ED/Hospital Arrival Date is earlier than EMS Dispatch Date</td>
</tr>
<tr>
<td>4507</td>
<td>3</td>
<td>ED/Hospital Arrival Date is earlier than EMS Unit Arrival on Scene Date</td>
</tr>
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<td>4508</td>
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<td>ED/Hospital Arrival Date is earlier than EMS Unit Scene Departure Date</td>
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<td>ED/Hospital Arrival Date is later than ED Discharge Date</td>
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<td>ED/Hospital Arrival Date is earlier than Date of Birth</td>
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ED/TTA TR18.56 – ED/Hospital Arrival Time

Definition

The time the patient arrived to the ED/Hospital

Element Values

Relevant value for data element

Additional Information

- If the patient was brought to the ED, enter time patient arrived at ED. If patient was directly admitted to the hospital, enter time patient was admitted to the hospital.
- Collected as HH:MM military time.

Data Source Hierarchy Guide

1. Triage/Trauma Flow Sheet
2. ED Record
3. Face Sheet
4. Billing Sheet
5. Discharge Summary

Associated Edit Checks (NTDB)

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Initial Assessment TR18.11 – Initial ED/Hospital Systolic Blood Pressure

Definition

First recorded systolic blood pressure in the ED/hospital within 30 minutes or less of ED/hospital arrival.

Element Values

Relevant value for data element

Additional Information

- Please note that first recorded/hospital vitals do not need to be from the same assessment.
- 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.
- If Not Known select “Not Known/Not Recorded”.

Data Source Hierarchy Guide

1. Triage/Trauma Flow Sheet
2. ED Record
3. Face Sheet
4. Billing Sheet
5. Discharge Summary

Associated Edit Checks (NTDB)

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<td>The value is below 30</td>
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Initial Assessment TR18.2 - Initial ED/Hospital Pulse Rate

Definition

First recorded pulse in the ED/hospital (palpated or auscultated) within 30 minutes or less of ED/hospital arrival (expressed as a number per minute).

Element Values

Relevant value for data element

Additional Information

- Please note that first recorded/hospital vitals do not need to be from the same assessment.
- 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.
- If Not Known, select "Not Known/Not Recorded".

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet

Associated Edit Checks (NTDB)

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<tr>
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</table>
Initial Assessment– Initial ED/Hospital Temperature

Definition
First recorded temperature (in degrees Celsius [centigrade]) in the ED/hospital within 30 minutes or less of ED/hospital arrival.

Element Values
Relevant value for data element

Units:                      Route: TR18.147
1. C (Celsius) – TR18.30     1. Oral
2. F (Fahrenheit) – TR18.30.1 2. Tympanic
                           3. Rectal
                           4. Axillary
                           5. Temporal
                           6. Other
                           7. Not Known/Not Recorded

Additional Information
• Please note that first recorded/hospital vitals do not need to be from the same assessment.
• Entry in one unit will auto-populate the other.
• If temperature is not known, select “Not Known/Not Recorded”, and select “Not Known/Not Recorded” for Route.

Data Source Hierarchy Guide
1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
Associated Edit Checks (NTDB):

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Initial Assessment TR18.7 – Initial ED/Hospital Respiratory Rate

Definition

First recorded respiratory rate in the ED/hospital within 30 minutes or less of ED/hospital arrival (expressed as a number per minute).

Element Values

Relevant value for data element

Additional Information

- If available, complete additional field: "Resp. Assistance."
- Please note that first recorded/hospital vitals do not need to be from the same assessment.
- If Not Known, select "Not Known/Not Recorded" and select "Not Applicable" for “Resp. Assistance”.

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Respiratory Therapy Notes/Flow Sheet

Associated Edit Checks (NTDB)
Initial Assessment TR18.10 – Initial ED/Hospital Respiratory Assistance

**Definition**
Determination of respiratory assistance associated with the initial ED/hospital respiratory rate within 30 minutes or less of ED/hospital arrival.

**Element Values**
- Unassisted Respiratory Rate
- Assisted Respiratory Rate
- Not Applicable
- Not Known/Not Recorded

**Additional Information**
- Only completed if a value is provided for Initial ED/Hospital Respiratory Rate.
- Respiratory Assistance is defined as mechanical and/or external support of respiration.
- Please note that first recorded hospital vitals do not need to be from the same assessment.
- When "Initial ED/Hospital Respiratory Rate" is "Not Known/Not Recorded", select "Not Applicable"

**Data Source Hierarchy Guide**
1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet

---

5001 1 Invalid value
5002 2 Element cannot be blank
5005 2 The value submitted falls outside the valid range of 0-100
5006 2 Element cannot be Not Applicable
5007 3 The value is below 5
5008 3 The value is above 75
5040 1 Single Entry Max exceeded
3. Respiratory Therapy Notes/Flow Sheet

**Associated Edit Checks (NTDB)**

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</table>

**Initial Assessment TR18.31 – Initial ED/Hospital Oxygen Saturation**

**Definition**

First recorded oxygen saturation in ED/hospital within 30 minutes or less of ED/hospital arrival (expressed as a percentage).

**Element Values**

Relevant value for data element

**Additional Information**

- If available, complete additional field: Initial ED/Hospital Supplemental Oxygen.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.
- If Not Known, select “Not Known/Not Recorded”.

**Data Source Hierarchy Guide**

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Respiratory Therapy Notes/Flow Sheet

**Associated Edit Checks (NTDB):**
Initial Assessment TR18.109– Initial ED/Hospital Supplemental Oxygen

**Definition**

Determination of the presence of supplemental oxygen during assessment of initial ED/hospital oxygen saturation level within 30 minutes or less of ED/hospital arrival.

**Element Values**

- Yes
- No
- Not Applicable
- Not Known/Not Recorded

**Additional Information**

- Only completed if a value is provided for "Initial ED/Hospital Oxygen Saturation."
- The null value “Not Applicable” is reported if the Initial ED/Hospital Oxygen Saturation is “Not Known/Not Recorded”
- Please note that first recorded/hospital vitals do not need to be from the same assessment.
Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet

Associated Edit Checks (NTDB):

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Initial Assessment TR18.14– Initial ED/Hospital GCS - Eye

Definition
First recorded Glasgow Coma Score (Eye) in the ED/hospital within 30 minutes or less of ED/hospital arrival.

Element Values
1. No eye movement when assessed
2. Opens eyes in response to painful stimulation
3. Opens eyes in response to verbal stimulation
4. Opens eyes spontaneously
5. Not Known/Not Recorded

Additional Information
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation.
• Please note that first recorded/hospital vitals do not need to be from the same assessment.
• The null value “Not Known/Not Recorded” is reported if Initial ED/Hospital GCS 40 – Eye is documented.
• The null value "Not Known/Not Recorded" is reported if the patient's Initial ED/Hospital GCS – Eye was not measured within 30 minutes or less of ED/hospital arrival.

**Data Source Hierarchy Guide**

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes/Flow Sheet

**Associated Edit Checks (NTDB):**

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</table>

**WI Trauma Registry Data Dictionary v6.0**

**Initial Assessment TR18.16.0 & TR18.15.0– Initial ED/Hospital GCS - Verbal**

**Definition**

First recorded Glasgow Coma Score (Verbal) in the ED/hospital within 30 minutes or less of ED/hospital arrival.

**Element Values**
**Pediatric (≤ 2 years):**

1. No vocal response
2. Inconsolable, agitated
3. Inconsistently consolable, moaning
4. Cries but is consolable, inappropriate interactions
5. Smiles, oriented to sounds, follows objects, interacts

**Adult**

1. No verbal response
2. Incomprehensible sounds
3. Inappropriate words
4. Confused
5. Oriented

**Additional Information**

- If patient is intubated then the GCS Verbal score is equal to 1.
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.
- The null value “Not Known/Not Recorded” is reported if Initial ED/Hospital GCS 40 – Verbal is documented.
- The null value “Not Known/Not Recorded” is reported if the patient’s Initial ED/Hospital GCS – Verbal was not measured within 30 minutes or less of ED/hospital arrival.
- Elements automatically switch to Pediatrics for patients younger than 2 years

**Data Source Hierarchy Guide**

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes/Flow Sheet

**Associated Edit Checks (NTDB):**

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Initial Assessment TR18.16.2 & TR18.16.0 - Initial ED/Hospital GCS - Motor

**Definition**

First recorded Glasgow Coma Score (Motor) in the ED/hospital within 30 minutes or less of ED/hospital arrival.
Element Values

**Pediatric (≤ 2 years):**

1. No motor response
2. Extension to pain
3. Flexion to pain
4. Withdrawal from pain
5. Localizing pain
6. Appropriate response to stimulation

**Adult**

1. No motor response
2. Extension to pain
3. Flexion to pain
4. Withdrawal from pain
5. Localizing pain
6. Obeys commands

**Additional Information**

- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.
- The null value “Not Known/Not Recorded” is reported if Initial ED/Hospital GCS 40 – Motor is documented.
- The null value "Not Known/Not Recorded" is reported if the patient's Initial ED/Hospital GCS – Motor was not measured within 30 minutes or less of ED/hospital arrival.
- Elements automatically switch to Pediatrics for patients younger than 2 years

**Data Source Hierarchy Guide**

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes/Flow Sheet

**Associated Edit Checks (NTDB):**

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</table>
Initial Assessment TR18.22– Initial ED/Hospital GCS - Total

**Definition**

First recorded Glasgow Coma Score (Total) in the ED/hospital within 30 minutes or less of ED/hospital arrival.
**Element Values**

Relevant value for data element

**Additional Information**

- If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as "A&Ox4," "awake alert and oriented," or "patient with normal mental status," interpret this as GCS of 15 IF there is no other contradicting documentation.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.
- The null value “Not Known/Not Recorded” is reported if Initial ED/Hospital GCS 40 is documented.
- The null value “Not Known/Not Recorded” is reported if Initial ED/Hospital GCS – Eye, Initial ED/Hospital GCS – Motor, Initial ED/Hospital GCS – Verbal were not measured within 30 minutes or less of ED/Hospital arrival.

**Data Source Hierarchy Guide**

1.  Triage/Trauma/Hospital Flow Sheet
2.  Nurses Notes/Flow Sheet
3.  Physician Notes/Flow Sheet

**Associated Edit Checks (NTDB):**

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>5701</td>
<td>1</td>
<td>GCS Total is outside the valid range of 3 - 15</td>
</tr>
<tr>
<td>5703</td>
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<td>Initial ED/Hospital GCS - Total does not equal the sum of Initial ED/Hospital GCS - Eye, Initial ED/Hospital GCS - Verbal, and Initial ED/Hospital GCS – Motor, unless any of</td>
</tr>
<tr>
<td>5705</td>
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<td>Element cannot be blank</td>
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<tr>
<td>5706</td>
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<td>Element cannot be Not Applicable</td>
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<tr>
<td>5707</td>
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<td>Element must be “Not Known/Not Recorded” when Initial ED/Hospital GCS 40 – Eye, Initial ED/Hospital GCS 40 – Verbal, or Initial ED/Hospital GCS 40 – Motor are reported.</td>
</tr>
<tr>
<td>5740</td>
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<td>Single Entry Max exceeded</td>
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</table>

**WI Trauma Registry Data Dictionary v6.0**

**Initial Assessment TR18.21– Initial ED/Hospital GCS Assessment Qualifiers**

**Definition**

Documentation of factors potentially affecting the first assessment of GCS within 30 minutes or less of ED/hospital arrival.
**Element Values**

1. Patient Chemically Sedated or Paralyzed
2. Obstruction to the Patient’s Eye
3. Patient Intubated
4. Valid GCS: Patient was not sedated, not intubated, and did not have obstruction to the eye
5. Not Known/Not Recorded

**Additional Information**

- Identifies treatments given to the patient that may affect the first assessment of GCS. This field does not apply to self-medications the patient may administer (i.e., ETOH, prescriptions, etc.).
- 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 agent like succinylcholine, mivacurium, rocuronium, (cis)atracurium, vecuronium, or pancuronium. While these are the most common agents, please review what might be typically used in your center so it can be identified in the medical record.
- Each of these agents has a slightly different duration of action, so their effect on the GCS depends on when they were given. For example, succinylcholine’s effects last for only 5-10 minutes.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.
- Report all that apply.
- The null value “Not Known/Not Recorded” is reported if Initial ED/Hospital GCS 40 is reported.
- The null value “Not Known/Not Recorded” is reported if the Initial ED/Hospital GCS Assessment Qualifiers are not documented within 30 minutes or less of ED/Hospital arrival.

**Data Source Hierarchy Guide**

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes/Flow Sheet

**Associated Edit Checks (NTDB)**

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<thead>
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</table>
Pre-Hospital TR18.65 – Initial ED/Hospital GCS 40 - Eye

**Definition**
First recorded Glasgow Coma Score 40 (Eye) within 30 minutes or less of ED/hospital arrival.

**Element Values**

**Adults:**
1. None
2. To Pressure
3. To Sound
4. Spontaneous
5. Not Testable

**Pediatric < 5 Years:**
1. None
2. To Pain
3. To Sound
4. Spontaneous
5. Not Testable

**Additional Information**
- If a patient does not have a numeric GCS 40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS 40 scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient's eyes open spontaneously," an Eye GCS 40 of 4 may be recorded, if there is no other contradicting documentation.
- Report Field Value "5. Not Testable" if unable to assess (e.g. swelling to the eye(s)).
- The null value “Not Known/Not Recorded” is reported if the patient’s Initial ED/Hospital GCS 40 – Eye was not measured within 30 minutes or less of ED/hospital arrival.
- The null value “Not Known/Not Recorded” is reported if Initial ED/Hospital GCS – Eye is reported.

**Data Source Hierarchy Guide**
1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes/Flow Sheet

**Associated Edit Checks (NTDB)**

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</tr>
<tr>
<td>15040</td>
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<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Pre-Hospital TR18.65 – Initial ED/Hospital GCS 40 - Verbal

Definition

First recorded Glasgow Coma Score 40 (Verbal) within 30 minutes or less of ED/hospital arrival.

Element Values

**Adults:**

1. None
2. Sounds
3. Words
4. Confused
5. Oriented
6. Not Testable

**Pediatric < 5 Years:**

1. None
2. Cries
3. Vocal Sounds
4. Words
5. Talks normally
6. Not Testable

Additional Information

- If a patient does not have a numeric GCS 40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS 40 scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient correctly gives name, place and date" a Verbal GCS 40 of 5 may be recorded, IF there is no other contradicting documentation.
- Report Field Value “6. Not Testable” if unable to assess (e.g. patient is intubated).
- The null value “Not Known/Not Recorded” is reported if the patient’s Initial ED/Hospital GCS 40 – Verbal was not measured within 30 minutes or less of ED/hospital arrival.
- The null value “Not Known/Not Recorded” is reported if Initial ED/Hospital GCS – Verbal is reported.

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes/Flow Sheet

Associated Edit Checks (NTDB)
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</table>
Pre-Hospital TR18.65 – Initial ED/Hospital GCS 40 - Motor

Definition

First recorded Glasgow Coma Score 40 (Motor) within 30 minutes or less of ED/hospital arrival.

Element Values

**Adults:**
1. None
2. Extension
3. Abnormal Flexion
4. Normal Flexion
5. Localizing
6. Obeys Commands
7. Not Testable

**Pediatric < 5 Years:**
1. None
2. Extension to Pain
3. Flexion to Pain
4. Localizes Pain
5. Obeys Commands
6. Not Testable

Additional Information

- If a patient does not have a numeric GCS 40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS 40 scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient opened mouth and stuck out tongue when asked" a Motor GCS 40 of 6 may be recorded, IF there is no other contradicting documentation.
- Report Field Value “7. Not Testable” if unable to assess (e.g. neuromuscular blockade).
- The null value “Not Known/Not Recorded” is reported if the patient’s Initial ED/Hospital GCS 40 – Motor was not measured within 30 minutes or less of ED/hospital arrival.
- The null value “Not Known/Not Recorded” is reported if Initial ED/Hospital GCS – Motor is reported.

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes/Flow Sheet

Associated Edit Checks (NTDB)

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<thead>
<tr>
<th>Rule ID</th>
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<th>Message</th>
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</table>

15501 1 Value is not a valid menu option
15503 2 Element cannot be blank
15504 2 Element cannot be “Not Applicable”
15505 2 Element must be “Not Known/Not Recorded” when Initial ED/Hospital GCS – Motor is reported
15540 1 Single Entry Max exceeded
Initial Assessment TR1.6.1 & TR1.6 – Initial ED/Hospital Height

**Definition**

First recorded height within 24 hours or less of ED/hospital arrival

**Element Values**

- Relevant value for the data element for height
- Units:
  - Centimeters - TR1.6
  - Inches - TR1.6.1

**Additional Information**

- Can be recorded in centimeters or inches, and will be converted and reported in centimeters for NTDB submission.
- Entering a value into one unit will auto-populate the other.
- May be based on family or self-report.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.
- The null value “Not Known/Not Recorded” is reported if the patient’s Initial ED/Hospital Height was not measured within 24 hours or less of ED/hospital arrival.
- If Not Known/Not Recorded, leave blank.

**Data Source Hierarchy Guide**

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Pharmacy Record

**Associated Edit Checks (NTDB):**

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<tr>
<td>8505</td>
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<td>The value submitted falls outside the valid range of 30-275</td>
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<tr>
<td>8506</td>
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<td>The value is below 50</td>
</tr>
<tr>
<td>8540</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
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</tbody>
</table>
Initial Assessment TR1.6.5– Initial ED/Hospital Weight

Definition
First recorded weight within 24 hours or less of ED/hospital arrival

Element Values

- Relevant value for the data element for weight
- Units:
  - Kilograms
  - Pounds

Additional Information

- Can be recorded in kilograms or pounds, will be converted to kilograms for NTDB submission
- May be based on family or self-report.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.
- The null value “Not Known/Not Recorded” is reported if the patient’s Initial ED/Hospital Weight was not measured within 24 hours or less of ED/hospital arrival.
- If Not Known/Not Recorded, leave blank

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Pharmacy Record

Associated Edit Checks (NTDB):

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<th>Rule ID</th>
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<td>8603</td>
<td>3</td>
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<td>8604</td>
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<td>8606</td>
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<td>The value is below 3</td>
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<tr>
<td>8640</td>
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<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Initial Assessment TR18.91–Drug Screen

**Definition**

First recorded positive drug screen results within 24 hours after first hospital encounter (select all that apply).

**Element Values**

1. AMP (Amphetamine)  
2. BAR (Barbiturate)  
3. BZO (Benzodiazepines)  
4. COC (Cocaine)  
5. mAMP (Methamphetamine)  
6. MDMA (Ecstasy)  
7. MTD (Methadone)  
8. OPI (Opoid)  
9. OXY (Oxycodone)  
10. PCP (Phencyclidine)  
11. TCA (Tricyclic Antidepressant)  
12. THC (Cannabinoi)  
13. Other  
14. None  
15. Not Tested

**Additional Information**

- Record positive drug screen results within 24 hours after first hospital encounter, at either your facility or the transferring facility.
- "None" is reported for patients whose only positive results are due to drugs administered at any facility (or setting) treating this patient event, or for patients who were tested and had no positive results.
- If multiple drugs are detected, only report drugs that were NOT administered at any facility (or setting) treating this patient event.
- Selections are made in a pick-list.

**Data Source Hierarchy Guide**

1. Lab Results  
2. Transferring Facility Records

**Associated Edit Checks (NTDB):**

<table>
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<tr>
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<tr>
<td>6013</td>
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<td>Element cannot be Not Applicable</td>
</tr>
<tr>
<td>6014</td>
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<td>Element cannot be “Not Known/Not Recorded” along with any other valid value</td>
</tr>
<tr>
<td>6050</td>
<td>1</td>
<td>Multiple Entry Max exceeded</td>
</tr>
</tbody>
</table>
Initial Assessment TR18.46–Alcohol Screen

Definition

A blood alcohol concentration (BAC) test was performed on the patient within 24 hours after first hospital encounter.

Element Values

1. Yes
2. No

Additional Information

- Alcohol screen may be administered at any facility, unit, or setting treating this patient event.
- Selecting “Yes” will show TR18.103 Blood Alcohol Content.

Data Source Hierarchy Guide

1. Lab Results
2. Transferring Facility Records

Associated Edit Checks (NTDB):

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<tr>
<td>5940</td>
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<td>Single Entry Max exceeded</td>
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</table>
Initial Assessment TR18.103 – Alcohol Screen Results

Definition

First recorded blood alcohol concentration (BAC) results within 24 hours after first hospital encounter.

Element Values

Relevant value for data element

Additional Information

- Collect as X.XX grams per deciliter (g/dl)
- Record BAC results within 24 hours after first hospital encounter, at either your facility or the transferring facility.
- For those patients who were not tested, leave blank

Data Source Hierarchy Guide

1. Lab Results
2. Transferring Facility Records

Associated Edit Checks (NTDB):

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<tr>
<td>5936</td>
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<td>The value is above 0.4</td>
</tr>
</tbody>
</table>
ED/TTA TR17.27 – ED Discharge Disposition

**Definition**

The disposition unit the order was written for the patient to be discharged from the ED.

**Element Values**

1. Floor bed (general admission, non-specialty unit bed)
2. Observation Unit
3. Telemetry/step-down unit (less acuity than ICU)
4. Home with services
5. Deceased/Expired
6. Other (jail, institutional care, mental health, etc.)
7. Operating Room
8. Intensive Care Unit (ICU)
9. Home without services
10. Left against medical advice
11. Transferred to another hospital
12. Not Applicable

**Additional Information**

- The null value "Not Applicable" is used if the patient is directly admitted to the hospital.
- If ED Discharge Disposition is 4, 5, 6, 9, 10, 11, then Hospital Discharge Date, Time, and Disposition will lock and not be available for data entry.
- If multiple orders were written, report the final disposition order.

**Data Source Hierarchy Guide**

1. Physician Order
2. Discharge Summary
3. Nursing Notes/Flow Sheet
4. Case Management/Social Services Notes
5. ED Record
6. History & Physical

**Associated Edit Checks (NTDB)**

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<td>Element cannot be &quot;Not Applicable&quot; when Hospital Discharge Date is &quot;Not Applicable&quot;</td>
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6107 2 Element cannot be “Not Applicable” when Hospital Discharge Date is “Not Known/Not Recorded”

6108 2 Element cannot be “Not Applicable” when Hospital Discharge Disposition is “Not Applicable”

6109 2 Element cannot be “Not Applicable” when Hospital Discharge Disposition is “Not Known/Not Recorded”

6140 1 Single Entry Max exceeded

ED/TTA TR17.41 – ED Discharge Date

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

Element Values
Relevant value for data element

Additional Information
- Collected as YYYY-MM-DD.
- The null value "Not Applicable" is used if the patient is directly admitted to the hospital.
- If ED Discharge Disposition is 5 Deceased/Expired, then ED Discharge Date is the date of death as indicated on the patient’s death certificate.
- If ED Discharge Disposition is 10 Left Against Medical Advice, report the date the patient signed the AMA form. If a patient signature was not obtained on the AMA form, report the date it was noted in the medical record the patient indicated that they were going to leave AMA.
- If not known, leave blank

Data Source Hierarchy Guide
1. Physician Order
2. ED Record
3. Triage/Trauma/Hospital Flow Sheet
4. Nursing Notes/Flow Sheet
5. Discharge Summary
6. Billing Sheet
7. Progress Notes

Associated Edit Checks (NTDB)

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<td>Date out of range</td>
</tr>
<tr>
<td>6303</td>
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<td>Element cannot be blank</td>
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</tbody>
</table>
**ED Discharge Date** is earlier than EMS Dispatch Date

**ED Discharge Date** is earlier than EMS Unit Arrival on Scene Date

**ED Discharge Date** is earlier than EMS Unit Scene Departure Date

**ED Discharge Date** is earlier than ED/Hospital Arrival Date

**ED Discharge Date** is later than Hospital Discharge Date

**ED Discharge Date** is earlier than Date of Birth

**ED Discharge Date** minus ED/Hospital Arrival Date is greater than 365 days

Single Entry Max exceeded

**Definition**

The time the order was written for the patient to be discharged from the ED

**Element Values**

Relevant value for data element

**Additional Information**

- Collected as HH:MM military time.
- The null value "Not Applicable" is used if the patient is directly admitted to the hospital.
- If ED Discharge Disposition is 5 Deceased/Expired, then ED Discharge Time is the time of death as indicated on the patient’s death certificate.
- If ED Discharge Disposition is 10 Left Against Medical Advice, report the time the patient signed the AMA form. If a patient signature was not obtained on the AMA form, report the time it was noted in the medical record the patient indicated that they were going to leave AMA.
- If not known, leave blank

**Data Source Hierarchy Guide**

1. Physician Order
2. ED Record
3. Triage/Trauma/Hospital Flow Sheet
4. Nursing Notes/Flow Sheet
5. Discharge Summary
6. Billing Sheet
7. Progress Notes

**Associated Edit Checks (NTDB)**

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<th>Message</th>
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6402  1  Time out of range
6403  2  Element cannot be blank
6404  3  ED Discharge Time is earlier than EMS Dispatch Time
6405  3  ED Discharge Time is earlier than EMS Unit Arrival on Scene Time
6406  3  ED Discharge Time is earlier than EMS Unit Scene Departure Time
6407  2  ED Discharge Time is earlier than ED/Hospital Arrival Time
6408  2  ED Discharge Time is later than Hospital Discharge Time
6440  1  Single Entry Max exceeded

NTDS PROCEDURE INFORMATION
**Procedures TR200.2 – ICD-10 Hospital Procedures**

**Definition**
Operative and selected non-operative procedures conducted during hospital stay. Operative and selected non-operative procedures are those that were essential to the diagnosis, stabilization, or treatment of the patient’s specific injuries or complications. The list of procedures below should be used as a guide to non-operative procedures that should be provided to NTDB.

**Element Values**
- Major and minor procedure ICD-10-CM procedure codes.
- The maximum number of procedures that may be reported for a patient is 200.

**Additional Information**
- The null value "Not Applicable" is used if the patient did not have procedures.
- Include only procedures performed at your institution.
- Capture all procedures performed in the operating room.
- Capture all procedures in the ED, ICU, ward, or radiology department that were essential to the diagnosis, stabilization, or treatment of the patient’s specific injuries or their complications.
- Procedures with an asterisk have the potential to be performed multiple times during one episode of hospitalization. In this case, capture only the first event. If there is no asterisk, capture each event even if there is more than one.
- Note that the hospital may capture additional procedures.
- Validity is activated when Procedure Performed (TR22.30) is “Yes”

<table>
<thead>
<tr>
<th>Diagnostic and Therapeutic Imaging</th>
<th>Musculoskeletal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computerized tomographic Head*</td>
<td>Soft tissue/bony debridements*</td>
</tr>
<tr>
<td>Computerized tomographic Chest*</td>
<td>Closed reduction of fractures</td>
</tr>
<tr>
<td></td>
<td>Skeletal and halo traction</td>
</tr>
<tr>
<td></td>
<td>Fasciotomy</td>
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Computerized tomographic Abdomen*  
Computerized tomographic Pelvis*  
Computerized tomographic C-Spine*  
Computerized tomographic T-Spine*  
Computerized tomographic L-Spine*  
Diagnostic ultrasound (includes FAST)*  
Doppler ultrasound of extremities *  
Angiography  
Angioembolization  
REBOA  
IVC filter  

**Cardiovascular**  
Open cardiac massage  
CPR  

**CNS**  
Insertion of ICP monitor *  
Ventriculostomy*  
Cerebral oxygen monitoring *  

**Genitourinary**  
Ureteric catheterization (i.e. Ureteric stent)  
Suprapubic cystostomy  

**Transfusion**  
Transfusion of red cells* (only capture first 24 hours after hospital arrival)  
Transfusion of platelets* (only capture first 24 hours after hospital arrival)  
Transfusion of plasma* (only capture first 24 hours after hospital arrival)  

**Respiratory**  
Insertion of endotracheal tube*  
Continuous mechanical ventilation*  
Chest tube*  
Bronchoscopy*  
Tracheostomy  

**Gastrointestinal**  
Endoscopy (includes gastroscopy, sigmoidoscopy, colonoscopy)  
Gastrostomy/jejunostomy (percutaneous or endoscopic)  
Percutaneous (endoscopic) gastrojejunoscopy  

---

**Data Source Hierarchy Guide**

1. Operative Reports  
2. Procedure Notes  
3. Trauma Flow Sheet  
4. ED Record  
5. Nursing Notes / Flow Sheet  
6. Radiology Reports  
7. Discharge Summary  

**Associated Edit Checks (NTDB):**

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Procedures TR200.8 – Hospital Procedure Start Date

Definition

The date operative and selected non-operative procedures were performed.

Element Values

Relevant value for the data element

Additional Information

- Collected as MM/DD/YYYY
- Validity is activated when Procedure Performed (TR22.30) is “Yes”

Data Source Hierarchy Guide

1. Operative Reports
2. Procedure Notes
3. Trauma Flow Sheet
4. ED Record
5. Nursing Notes/Flow Sheet
6. Radiology Reports
7. Discharge Summary

Associated Edit Checks (NTDB):

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<td>Hospital Procedure Start Date is earlier than EMS Dispatch Date</td>
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### Procedures TR200.9 – Hospital Procedure Start Time

**Definition**
The time operative and selected non-operative procedures were performed.

**Element Values**
Relevant value for the data element

**Additional Information**
- Collected as HH:MM military time.
- Procedure start time is defined as the time the incision was made (or the procedure started).
- Validity is activated when Procedure Performed (TR22.30) is “Yes”

**Data Source Hierarchy Guide**

1. Operative Reports
2. Anesthesia Reports
3. Procedure Notes
4. Trauma Flow Sheet
5. ED Record
6. Nursing Notes/Flow Sheet
7. Radiology Reports
8. Discharge Summary

**Associated Edit Checks (NTDB):**

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<td>6704</td>
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<td>Hospital Procedure Start Time is earlier than EMS Unit Arrival on Scene Time</td>
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<td>Hospital Procedure Start Time is earlier than ED/Hospital Arrival Time</td>
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**NTDS PRE-EXISTING CONDITIONS**
Diagnosis TR21.21 – Advance Directive Limiting Care

**Definition**

The patient had a written request limiting life sustaining therapy, or similar advanced directive

**Element Values**

1. Yes
2. No
3. Not Known/Not Recorded

**Additional Information**

- Present prior to arrival at your center.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available

**Data Source Hierarchy Guide**

1. History & Physical
2. Physician’s Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

**Associated Edit Checks (NTDB)**

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</table>
### Diagnosis TR21.21 - Alcohol Use Disorder

**Definition**

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.

**Element Values**

1. Yes
2. No
3. Not Known/Not Recorded

**Additional Information**

- Present prior to injury.
- Consistent with American Psychiatric Association (APA) DSM 5, 2013.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

**Data Source Hierarchy Guide**

1. History & Physical
2. Physician’s Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

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### WI Trauma Registry Data Dictionary v6.0

#### Diagnosis TR21.21 - Anticoagulant Therapy

**Definition**

Documentation in the medical record of the administration of medication (anticoagulants, antiplatelet agents, thrombin inhibitors, thrombolytic agents) that interferes with blood clotting, present prior to injury. Exclude patients who are on chronic Aspirin therapy. Some examples are:

<table>
<thead>
<tr>
<th>ANTICOAGULANTS</th>
<th>ANTIPLATELET</th>
<th>THROMBIN</th>
<th>THROMBOLYTIC</th>
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<td>Tirofiban</td>
<td>Bevalirudin</td>
<td>Alteplase</td>
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<td>Dipyridamole</td>
<td>Argatroban</td>
<td>Reteplase</td>
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<td>Anagrelide</td>
<td>Lepirudin, Hirudin</td>
<td>Tenacteplase</td>
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<td>Lovenox</td>
<td>Eptifibatide</td>
<td>Drotrecogin alpha</td>
<td>kabikinase</td>
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<td>Apixaban</td>
<td>Prasugrel</td>
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</table>
Heparin
Ticagrelor

**Element Values**

1. Yes
2. No
3. Not Known/Not Recorded

**Additional Information**

- Present prior to injury.
- Excludes patients whose only anticoagulant therapy is chronic Aspirin.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available

**Data Source Hierarchy Guide**

1. History & Physical
2. Physician’s Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

**Associated Edit Checks (NTDB)**

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</table>
## Diagnosis TR21.21– Attention deficit disorder/Attention deficit hyperactivity disorder (ADD/ADHD)

### Definition
History of a disorder involving inattention, hyperactivity or impulsivity requiring medication for treatment.

### Element Values
1. Yes
2. No
3. Not Known/Not Recorded

### Additional Information
- Present prior to ED/Hospital arrival.
- A diagnosis of ADD/ADHD must be documented in the patient’s medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

### Data Source Hierarchy Guide
1. History & Physical
2. Physician’s Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks (NTDB)

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</tbody>
</table>

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WI Trauma Registry Data Dictionary v6.0

### Diagnosis TR21.21 - Bleeding Disorder

**Definition**

A group of conditions that result when the blood cannot clot properly.

**Element Values**

1. Yes
2. No
3. Not Known/Not Recorded

**Additional Information**

- 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)
- Consistent with American Society of Hematology, 2015.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available

**Data Source Hierarchy Guide**

1. History & Physical
2. Physician’s Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks (NTDB)

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</table>

WI Trauma Registry Data Dictionary v6.0

**Diagnosis TR21.21– Cerebral Vascular Accident (CVA)**

**Definition**

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).

**Element Values**

1. Yes
2. No
3. Not Known/Not Recorded

**Additional Information**

- Present prior to injury.
- A diagnosis of CVA must be documented in the patient’s medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available

**Data Source Hierarchy Guide**

1. History & Physical
2. Physician's Notes
3. Progress Notes
Diagnosis TR21.21– Chronic Obstructive Pulmonary Disease (COPD)

**Definition**

Lung ailment that is characterized by a persistent blockage of airflow from the lungs, present prior to injury. It is not one single disease but an umbrella term used to describe chronic lung diseases that cause limitations in lung airflow. The more familiar terms "chronic bronchitis" and "emphysema" are no longer used, but are now included within the COPD diagnosis and result in any one or more of the following:

- Functional disability from COPD (e.g., dyspnea, inability to perform activities of daily living [ADLs].)
- Hospitalization in the past for treatment of COPD.
- Requires chronic bronchodilator therapy with oral or inhaled agents.
- A Forced Expiratory Volume in 1 second (FEV1) of <75% of predicted on pulmonary function testing.

**Element Values**

1. Yes
2. No
3. Not Known/Not Recorded

**Additional Information**

- Present prior to injury.
- A diagnosis of COPD must be documented in the patient’s medical record.
• Do not include patients whose only pulmonary disease is acute asthma.
• Do not include patients with diffuse interstitial fibrosis or sarcoidosis.
• Consistent with World Health Organization (WHO), 2015.
• The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

### Data Source Hierarchy Guide

1. History & Physical
2. Physician’s Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

### Associated Edit Checks (NTDB)

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Diagnosis TR21.21 - Chronic Renal Failure

**Definition**
Chronic renal failure prior to injury that was requiring periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration.

**Element Values**
1. Yes
2. No
3. Not Known/Not Recorded

**Additional Information**
- Present prior to injury.
- A diagnosis of Chronic Renal Failure must be documented in the patient's medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available

**Data Source Hierarchy Guide**
1. History & Physical
2. Physician’s Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks (NTDB)

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WI Trauma Registry Data Dictionary v6.0

Diagnosis TR21.21– Cirrhosis

Definition

Documentation in the medical record of cirrhosis, which might also be referred to as end stage liver disease.

Element Values

1. Yes
2. No
3. Not Known/Not Recorded

Additional Information

- Present prior to injury.
- 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.
- A diagnosis of Cirrhosis, or documentation of Cirrhosis by diagnostic imaging studies or a laparotomy/laparoscopy, must be in the patient’s medical record.
• The null value “Not Known/Not Recorded” is only reported if no past medical history is available

**Data Source Hierarchy Guide**

1. History & Physical
2. Physician’s Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

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**Diagnosis TR21.21– Congenital Anomalies**

**Definition**

Documentation of a cardiac, pulmonary, body wall, CNS/spinal, GI, renal, orthopedic, or metabolic anomaly.

**Element Values**

1. Yes
2. No
3. Not Known/Not Recorded

**Additional Information**

• Present prior to injury.
• A diagnosis of Congenital Anomaly must be in the patient’s medical record.
• The null value “Not Known/Not Recorded” is only reported if no past medical history is available
**Data Source Hierarchy Guide**

1. History & Physical
2. Physician’s Notes
3. Progress Notes
4. Case Management/Social Services
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6. Triage/Trauma Flow Sheet
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**Diagnosis TR21.21- Congestive Heart Failure (CHF)**

**Definition**

The 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.

**Element Values**

1. Yes
2. No
3. Not Known/Not Recorded

**Additional Information**

- Present prior to injury.
- A diagnosis of CHF must be documented in the patient’s medical record.
- To be included, this condition must be noted in the medical record as CHF, congestive heart failure, or pulmonary edema with onset of increasing symptoms within 30 days prior to injury.
- Common manifestations are:
• Abnormal limitation in exercise tolerance due to dyspnea or fatigue
• Orthopnea (dyspnea or lying supine)
• Paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea)
• Increased jugular venous pressure
• Pulmonary rales on physical examination
• Cardiomegaly
• Pulmonary vascular engorgement

The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. History & Physical
2. Physician’s Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

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Diagnosis TR21.21 - Current Smoker

**Definition**
A patient who reports smoking cigarettes every day or some days within the last 12 months.

**Element Values**

1. Yes
2. No
3. Not Known/Not Recorded

**Additional Information**
- Present prior to injury.
- Exclude patients who report smoke cigars or pipes or smokeless tobacco (chewing tobacco or snuff).
The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. History & Physical
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7. Discharge Summary

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Diagnosis TR21.21– Currently Receiving Chemotherapy for Cancer

Definition

A patient who is currently receiving any chemotherapy treatment for cancer prior to injury.

Element Values

1. Yes
2. No
3. Not Known/Not Recorded

Additional Information

• Present prior to injury.
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.

The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

### Data Source Hierarchy Guide

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**Diagnosis TR21.21- Dementia**

**Definition**

Documentation in the patient’s medical record of dementia including senile or vascular dementia (e.g., Alzheimer’s).

**Element Values**

1. Yes
2. No
3. Not Known/Not Recorded
**Additional Information**

- Present prior to injury.
- A diagnosis of Dementia must be documented in the patient’s medical record number.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

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**Diagnosis TR21.21 – Diabetes Mellitus**

**Definition**

Diabetes mellitus that requires exogenous parenteral insulin or an oral hypoglycemic agent.

**Element Values**

1. Yes  
2. No  
3. Not Known/Not Recorded
Additional Information

- Present prior to injury.
- A diagnosis of Diabetes Mellitus must be documented in the patient's medical record number.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

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Diagnosis TR21.21– Disseminated Cancer

Definition

Patients who have cancer that has spread to one 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.

Element Values

1. Yes
2. No
3. Not Known/Not Recorded

Additional Information

- Present prior to injury.
- 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, bone).
- A diagnosis of Cancer that has spread to one or more sites must be documented in the patient's medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

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WI Trauma Registry Data Dictionary v6.0

Diagnosis TR21.21- Functionally Dependent Health Status

Definition

Pre-injury functional status may be represented by the ability of the patient to complete age appropriate activities of daily living (ADL).

Element Values
1. Yes
2. No
3. Not Known/Not Recorded

**Additional Information**

- Present prior to injury.
- Activities of Daily Living include: bathing, feeding, dressing, toileting, and walking.
- Include patients whom prior to injury, and as a result of cognitive or physical limitations relating to a pre-existing medical condition, was partially dependent or completely dependent upon equipment, devices or another person to complete some or all activities of daily living.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

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**Diagnosis TR21.21– Hypertension**

**Definition**

History of persistent elevated blood pressure requiring medical therapy.

**Element Values**
1. Yes
2. No
3. Not Known/Not Recorded

**Additional Information**

- Present prior to injury.
- A diagnosis of Hypertension must be documented in the patient’s medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

**Data Source Hierarchy Guide**

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WI Trauma Registry Data Dictionary v6.0
• Bipolar Disorder
• Major Depressive Disorder
• Social Anxiety Disorder
• Posttraumatic Stress Disorder
• Antisocial Personality Disorder

**Element Values**

1. Yes
2. No
3. Not Known/Not Recorded

**Additional Information**

- Present prior to injury.
- Consistent with American Psychiatric Association (APA) DSM 5, 2013.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

**Data Source Hierarchy Guide**

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History of a MI in the six months prior to injury.

**Element Values**

1. Yes
2. No
3. Not Known/Not Recorded

**Additional Information**

- Present prior to injury.
- A diagnosis of MI must be documented in the patient’s medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

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**Definition**

The narrowing or blockage of the vessels that carry blood from the heart to the legs, present prior to injury. It is primarily caused by the buildup of fatty plaque in the arteries, which is called atherosclerosis. PAD can occur in any blood vessel, but it is more common in the legs than the arms.

**Element Values**

1. Yes
2. No
3. Not Known/Not Recorded

**Additional Information**

- Present prior to injury.
- Consistent with Centers for Disease Control, 2014 Fact Sheet.
- A diagnosis of PAD must be documented in the patient’s medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

**Data Source Hierarchy Guide**

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Diagnosis TR21.21– Pregnancy

Definition
Pregnancy confirmed by lab, ultrasound, or other diagnostic tool OR diagnosis of pregnancy documented in the patient’s medical record.

Element Values
1. Yes
2. No
3. Not Known/Not Recorded

Additional Information
- Present prior to arrival at your center.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide
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Discharge Summary Associated Edit Checks (NTDB)

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Diagnosis TR21.21– Prematurity

**Definition**
Babies born before 37 weeks of pregnancy are completed.

**Element Values**

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<tr>
<td>3.</td>
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**Additional Information**

- Present prior to injury.
- A diagnosis of Prematurity, or delivery before 37 weeks of pregnancy are completed, must be documented in the patient’s medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

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**Diagnosis TR21.21- Steroid Use**

**Definition**

Patients that require the regular administration of oral or parenteral corticosteroid medications within 30 days prior to injury for a chronic medical condition.

**Element Values**

1. Yes
2. No
3. Not Known/Not Recorded

**Additional Information**

- Present prior to injury.
- Examples of oral or parenteral corticosteroid medications are: prednisone and dexamethasone.
- Examples of chronic medical conditions are: COPD, asthma, rheumatologic disease, rheumatoid arthritis, and inflammatory bowel disease.
- Exclude topical corticosteroids applied to the skin, and corticosteroids administered by inhalation or rectally.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

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### Diagnosis TR21.21- Substance Use Disorder

**Definition**

Descriptors documented in the patient’s medical record consistent with the diagnostic criteria of substance use disorders specifically cannabis, hallucinogens, inhalants, opioids, sedatives or 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

**Element Values**

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**Additional Information**

- Present prior to arrival at your center.
- Consistent with the American Psychiatric Association (APA) DSM 5, 2013. The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

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NTDS DIAGNOSIS INFORMATION
Diagnosis TR200.1– ICD-10 Injury Diagnoses

**Definition**
Diagnoses related to all identified injuries

**Element Values**
- Injury diagnoses as defined by ICD-10-CM code range S00-S99, T07, T14, T20-T28 and T30-32.
- The maximum number of diagnoses that may be reported for an individual patient is 50.

**Additional Information**
- ICD-10 codes pertaining to other medical conditions (e.g., CVA, MI, Co-morbidities, etc (may also be included in this field)
- Depending on your facility’s setup configuration, an AIS code may auto-associate.

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1. Autopsy/Medical Examiner Report
2. Operative Reports
3. Radiology Reports
4. Physician’s Notes
5. Trauma Flow Sheet
6. History & Physical
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WI Trauma Registry Data Dictionary v6.0


Definition

The Abbreviated Injury Scale (AIS) code(s) that reflect the patient's injuries.

Element Values

The code is the 8 digit AIS code

Additional Information

Data Source Hierarchy Guide

1. AIS coding manual

Associated Edit Checks (NTDB)

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Complications/PI TR23.1 – Acute Kidney Injury

**Definition**

Acute Kidney Injury, AKI (stage 3), is an abrupt decrease in kidney function.

**KDIGO (State 3) Table:**

(Scr) 3 times baseline

 OR;

 Increase in Scr to ≥ 4mg/dL (≥ 353.3µmol/L)

 OR;

 Initiation of renal replacement therapy OR, In patients < 18 years, decrease in eGFR to <35 ml/min per 1.73 m²

 OR;

 Urine output <0.3 ml/kg/h for > 24 hours

 OR;

 Anuria for ≥ 12 hrs.

**Element Values**

1. Yes

2. No

3. Not Known/Not Recorded

**Additional Information**

- Must have occurred during the patient’s initial stay at your hospital.
- A diagnosis of AKI must be documented in the patient's medical record.
- 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 are present.
- EXCLUDE patients with renal failure that were requiring chronic renal replacement therapy such as periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration prior to injury.
- Consistent with the March 2012 Kidney Disease Improving Global Outcome (KDIGO) Guideline.
**Data Source Hierarchy Guide**

1. History and Physical
2. Physician Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

**Associated Edit Checks (NTDB)**

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Complications/PI TR23.1 – Acute Respiratory Distress Syndrome (ARDS)

**Definition**

- **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 collapse, or nodules
- **Origin of edema:** Respiratory failure not fully explained by cardiac failure or fluid overload. Need objective assessment (e.g., echocardiography) to exclude hydrostatic edema if no risk factor present.
- **Oxygenation:**
  - Mild: $200 < \text{PaO}_2/\text{FiO}_2 < 300$ (at a minimum) With PEEP or CPAP $\geq 5$ cmH$_2$O
  - Moderate: $100 < \text{PaO}_2/\text{FiO}_2 < 200$ mm Hg With PEEP $> 5$ cm H$_2$O
  - Severe: $\text{PaO}_2/\text{FiO}_2 < 100$ mm Hg With PEEP or CPAP $> 5$ cm H$_2$O

**Element Values**

1. Yes
2. No
3. Not Known/Not Recorded

**Additional Information**

- Must have occurred during the patient’s initial stay at your hospital.
- A diagnosis of ARDS must be documented in the patient's medical record.
- Consistent with the 2012 New Berlin Definition

**Data Source Hierarchy Guide**

1. History and Physical
2. Physician Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

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Complications/PI TR23.1 – Alcohol Withdrawal Syndrome

**Definition**

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).

**Element Values**

1. Yes  
2. No  
3. Not Known/Not Recorded

**Additional Information**

- Must have occurred during the patient’s initial stay at your hospital.  
- A diagnosis of alcohol withdrawal must be documented in the patient’s medical record.  
- Consistent with the 2016 World Health Organization (WHO) definition of Alcohol Withdrawal Syndrome.

**Data Source Hierarchy Guide**

1. History and Physical  
2. Physician Notes  
3. Progress Notes  
4. Case Management/Social Services  
5. Nursing Notes/Flow Sheet  
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Complications/PI TR23.1 – Cardiac Arrest with CPR

**Definition**

Cardiac arrest is 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.

**Element Values**

1. Yes
2. No
3. Not Known/Not Recorded

**Additional Information**

- Must have occurred during the patient’s initial stay at your hospital.
- Cardiac Arrest must be documented in the patient’s medical record.
- EXCLUDE patients whose ONLY episode of cardiac arrest with CPR was on arrival to your hospital.
- 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.

**Data Source Hierarchy Guide**

1. History and Physical
2. Physician Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
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7. Discharge Summary

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</table>
A UTI where an indwelling urinary catheter was in place for >2 calendar days on the date of event, with day of device placement being Day 1,

AND

An indwelling urinary catheter was in place on the date of event or the day before. If an indwelling urinary catheter was in place for >2 calendar days and then removed, the date of event for the UTI must be the day of discontinuation or the next day for the UTI to be catheter-associated.

**January 2016 CDC CAUTI Criterion SUTI 1a:**

Patient must meet 1, 2, and 3 below:

1. Patient has an indwelling urinary catheter in place for the entire day on the date of event and such catheter had been in place for >2 calendar days, on that date (day of device placement = Day 1) AND was either:
   - Present for any portion of the calendar day on the date of event, OR
   - Removed the day before the event

2. Patient has at least one of the following signs or symptoms:
   - Fever (>38°C)
   - Suprapubic tenderness with no other recognized cause
   - Costovertebral angle pain or tenderness with no other recognized cause

3. Patient has a urine culture with no more than two species of organisms, at least one of which is a bacteria >10⁵ CFU/ml.

**January 2016 CDC CAUTI Criterion SUTI 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 with no other recognized cause
- bradycardia with no other recognized cause
- lethargy with no other recognized cause
- vomiting with no other recognized cause
- suprapubic tenderness with no other recognized cause

3. Patient has a urine culture with no more than two species of organisms, at least one of which is bacteria of ≥10^5 CFU/ml.

**Element Values**

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**Additional Information**

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of UTI must be documented in the patient's medical record.
- Consistent with the January 2016 CDC defined CAUTI.

**Data Source Hierarchy Guide**

1. History and Physical
2. Physician Notes
3. Progress Notes
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Complications/PI TR23.1 – Central Line-Associated Bloodstream Infection (CLABSI)

**Definition**

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

The line was also 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 date of event of the LCBI must be the day of discontinuation or the next day to be a CLABSI. If the patient is admitted or transferred into a facility with an implanted central line (port) in place, and that is the patient’s only central line, day of first access in an inpatient location 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.

**January 2016 CDC Criterion LCBI 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(s) identified in blood is not related to an infection at another site.

OR

**January 2016 CDC Criterion LCBI 2:**

Patient has at least one of the following signs or symptoms: fever (>38°C), chills, or 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 or nonculture based microbiologic testing method which is performed for purposes of clinical 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.

OR

January 2016 CDC Criterion LCBI 3:

Patient ≤ 1 year of age has at least one of the following signs or symptoms: fever (>38° C), hypothermia (<36° C), apnea, or bradycardia

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 or nonculture base microbiologic testing method which is performed for purposes of clinical 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:

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<td>2. No</td>
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<tr>
<td>3. Not Known/Not Recorded</td>
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</tbody>
</table>

**Additional Information**

- Must have occurred during the patient’s initial stay at your hospital.
- A diagnosis of CLABSI must be documented in the patient’s medical record.
• Consistent with the January 2016 CDC defined CLABSI.

### Data Source Hierarchy Guide

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2. Physician Notes
3. Progress Notes
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5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

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Complications/PI TR23.1 – Deep Surgical Site Infection

**Definition**

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:

a) purulent drainage from the deep incision.

b) 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. c. 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>30-day Surveillance</th>
<th>Code</th>
<th>Operative Procedure</th>
<th>Code</th>
<th>Operative Procedure</th>
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<tbody>
<tr>
<td>AAA</td>
<td>Abdominal aortic aneurysm repair</td>
<td>LAM</td>
<td>Laminectomy</td>
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</tr>
<tr>
<td>AMP</td>
<td>Limb amputation</td>
<td>LTP</td>
<td>Liver transplant</td>
<td></td>
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<tr>
<td>APPY</td>
<td>Appendix surgery</td>
<td>NECK</td>
<td>Neck surgery</td>
<td></td>
</tr>
<tr>
<td>AVSD</td>
<td>Shunt for dialysis</td>
<td>NEPH</td>
<td>Kidney surgery</td>
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<tr>
<td>BILI</td>
<td>Bile duct, liver or pancreatic surgery</td>
<td>OVRY</td>
<td>Ovarian surgery</td>
<td></td>
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<tr>
<td>CEA</td>
<td>Carotid endarterectomy</td>
<td>PRST</td>
<td>Prostate surgery</td>
<td></td>
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<tr>
<td>CHOL</td>
<td>Gallbladder surgery</td>
<td>REC</td>
<td>Rectal surgery</td>
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<td>COLO</td>
<td>Colon surgery</td>
<td>SB</td>
<td>Small bowel surgery</td>
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<td>CSEC</td>
<td>Cesarean section</td>
<td>SPLE</td>
<td>Spleen surgery</td>
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<td>THOR</td>
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<tr>
<td>HTP</td>
<td>Heart transplant</td>
<td>THUR</td>
<td>Thyroid and/or parathyroid surgery</td>
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<td>Abdominal hysterectomy</td>
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<tr>
<td>KTP</td>
<td>Kidney transplant</td>
<td>XLAP</td>
<td>Exploratory Laparotomy</td>
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<tr>
<td>CARD</td>
<td>Cardiac surgery</td>
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</tr>
<tr>
<td>CBGB</td>
<td>Coronary artery bypass graft with both chest and donor site incisions</td>
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</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>
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<tr>
<td>FUSN</td>
<td>Spinal fusion</td>
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<tr>
<td>FX</td>
<td>Open reduction of fracture</td>
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</tr>
<tr>
<td>KPRO</td>
<td>Knee prosthesis</td>
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<tr>
<td>PACE</td>
<td>Pacemaker surgery</td>
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<td>PVBY</td>
<td>Peripheral vascular bypass surgery</td>
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<tr>
<td>VSHN</td>
<td>Ventricular shunt</td>
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**Element Values**

1. Yes
2. No
3. Not Known/Not Recorded

**Additional Information**

- Must have occurred during the patient’s initial stay at your hospital.
- A diagnosis of SSI must be documented in the patient’s medical record.
- Consistent with the January 2016 CDC defined SSI.

**Data Source Hierarchy Guide**

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Complications/PI TR23.1 – Deep Vein Thrombosis (DVT)

**Definition**

The formation, development, or existence of a blood clot or thrombus within the vascular system, which may be coupled with inflammation.

**Element Values**

1. Yes
2. No
3. Not Known/Not Recorded

**Additional Information**

- Must have occurred during the patient’s initial stay at your hospital.
- The patient must be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava.
- A diagnosis of DVT must be documented in the patient’s medical record, which may be confirmed by venogram, ultrasound, or CT.

**Data Source Hierarchy Guide**

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3. Progress Notes
4. Case Management/Social Services
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**Complications/PI TR23.1 – Delirium**

**Definition**

Acute onset of behaviors 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.

**Element Values**

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<tr>
<td>3. Not Known/Not Recorded</td>
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</table>

**Additional Information**

- Must have occurred during the patient's initial stay at your hospital.
- EXCLUDE: Patients whose delirium is due to alcohol withdrawal.

**Data Source Hierarchy Guide**

1. History and Physical
2. Physician Notes
3. Progress Notes
   - Case Management/Social Services
4. Nursing Notes/Flow Sheet
   - Triage/Trauma Flow Sheet
   - Discharge Summary
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Complications/PI TR23.1 – Extremity Compartment Syndrome

**Definition**

A 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.

**Element Values**

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<tr>
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</table>

**Additional Information**

- Must have occurred during the patient's initial stay at your hospital.
- 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.

**Data Source Hierarchy Guide**

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</table>
Complications/PI TR23.1 – Myocardial Infarction (MI)

Definition
An acute myocardial infarction must be noted with documentation of ECG changes indicative of an 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 an acute myocardial infarction that occurred subsequent to arrival at your center

Element Values

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Additional Information
- Must have occurred during the patient’s initial stay at your hospital.

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1. History and Physical
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3. Progress Notes
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5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

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Complications/PI TR23.1 – Organ/Space Surgical Site Infection

Definition

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:

a) 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)

b) 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).

c) 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Operative Procedure</th>
<th>Code</th>
<th>Operative Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAA</td>
<td>Abdominal aortic aneurysm repair</td>
<td>IVM</td>
<td>Ileum resection</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>OVAR</td>
<td>Ovarian surgery</td>
</tr>
<tr>
<td>CEA</td>
<td>Carotid endarterectomy</td>
<td>PRST</td>
<td>Prostate surgery</td>
</tr>
<tr>
<td>CHOL</td>
<td>Gallbladder surgery</td>
<td>REC</td>
<td>Rectal surgery</td>
</tr>
<tr>
<td>COLO</td>
<td>Colon surgery</td>
<td>SB</td>
<td>Small bowel surgery</td>
</tr>
<tr>
<td>CSEC</td>
<td>Cesarean section</td>
<td>SPLE</td>
<td>Spleen surgery</td>
</tr>
<tr>
<td>GAST</td>
<td>Gastric surgery</td>
<td>THOR</td>
<td>Thoracic surgery</td>
</tr>
<tr>
<td>HTP</td>
<td>Heart transplant</td>
<td>THY</td>
<td>Thyroid and/or parathyroid surgery</td>
</tr>
<tr>
<td>HYST</td>
<td>Abdominal hysterectomy</td>
<td>VHY</td>
<td>Vaginal hysterectomy</td>
</tr>
<tr>
<td>KTP</td>
<td>Kidney transplant</td>
<td>XLP</td>
<td>Exploratory Laparotomy</td>
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<thead>
<tr>
<th>Code</th>
<th>Operative Procedure</th>
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<tbody>
<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>
</tr>
<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>Hemiorrhaphy</td>
</tr>
<tr>
<td>HPRO</td>
<td>Hip prosthesis</td>
</tr>
<tr>
<td>KPRO</td>
<td>Knee prosthesis</td>
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<tr>
<td>PACE</td>
<td>Pacemaker surgery</td>
</tr>
<tr>
<td>PVBY</td>
<td>Peripheral vascular bypass surgery</td>
</tr>
<tr>
<td>VSHN</td>
<td>Ventricular shunt</td>
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</table>

### Table 3. Specific Sites of an Organ/Space SSI.

<table>
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<tr>
<th>Code</th>
<th>Site</th>
<th>Code</th>
<th>Site</th>
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<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>
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</table>

**Element Values**

1. Yes
2. No
3. Not Known/Not Recorded
**Additional Information**

- Must have occurred during the patient’s initial stay at your hospital.
- A diagnosis of SSI must be documented in the patient’s medical record.
- Consistent with the January 2016 CDC defined SSI

**Data Source Hierarchy Guide**

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Complications/PI TR23.1 – Osteomyelitis

Definition

Osteomyelitis must meet at least one of the following criteria:

1. Patient has 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)).
2. Patient has evidence of osteomyelitis on gross anatomic or histopathologic exam.
3. Patient has at least two of the following localized signs or symptoms: fever (>38.0°C), swelling*, pain or tenderness*, heat*, or drainage*

AND at least one of the following:

a. 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).

b. 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).

* With no other recognized cause

Element Values

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</table>

Additional Information

- Must have occurred during the patient’s initial stay at your hospital.
- A diagnosis of osteomyelitis must be documented in the patient’s medical record.
- Consistent with the January 2016 CDC definition of Bone and Joint infection

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Complications/PI TR23.1 – Pulmonary Embolism (PE)

**Definition**
A 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.

**Element Values**
1. Yes
2. No
3. Not Known/Not Recorded

**Additional Information**
- Must have occurred during the patient’s initial stay at your hospital.
- 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 sub segmental PE’s.

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Complications/PI TR23.1 - Pressure Ulcer

Definition

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.

Element Values

1. Yes
2. No
3. Not Known/Not Recorded

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- Pressure Ulcer documentation must be in the patient's medical record.
- Consistent with the NPUAP 2014.

Data Source Hierarchy Guide

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Complications/PI TR23.1 – Severe Sepsis

**Definition**
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.

**Element Values**
1. Yes  
2. No  
3. Not Known/Not Recorded

**Additional Information**
- Must have occurred during the patient’s initial stay at your hospital.
- 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.

**Data Source Hierarchy Guide**
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Complications/PI TR23.1 – Stroke/CVA

Definition

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 on side of the body
- Dysphasia or aphasia
- Hemianopia
- Amaurosis fugax
- 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, angiography,) or lumbar puncture (CSF demonstrating intracranial hemorrhage that was not present on admission.)
**Element Values**

1. Yes
2. No
3. Not Known/Not Recorded

**Additional Information**

- Must have occurred during the patient’s initial stay at your hospital.
- A diagnosis of stroke/CVA must be documented in the patient’s medical record.
- 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.

**Data Source Hierarchy Guide**

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Complications/PI TR23.1 – Superficial Incisional Surgical Site Infection

Definition

Must 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:

a. purulent drainage from the superficial incision.

b. 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)).

c. 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.

d. 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., Csection 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)

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<tr>
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</tr>
</tbody>
</table>

**Additional Information**

- Must have occurred during the patient’s initial stay at your hospital.
- A diagnosis of SSI must be documented in the patient’s medical record.
- Consistent with the January 2016 CDC defined SSI.

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Complications/PI TR23.1 – Unplanned Admission to ICU

**Definition**

Patients admitted to the ICU after initial transfer to the floor, and/or patients with an unplanned return to the ICU after initial ICU discharge.

**Element Values**

1. Yes  
2. No  
3. Not Known/Not Recorded

**Additional Information**

- Must have occurred during the patient’s initial stay at your hospital.
- EXCLUDE: Patients in which ICU care was required for postoperative care of a planned surgical procedure.

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Complications/PI TR23.1 - Unplanned Intubation

Definition

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.

Element Values

1. Yes
2. No
3. Not Known/Not Recorded

Additional Information

- Must have occurred during the patient’s initial stay at your hospital.
- 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.

Data Source Hierarchy Guide

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Associated Edit Checks (NTDB)
Complications/PI TR23.1 – Unplanned Visit to the Operating Room

**Definition**

Patients with an unplanned operative procedure OR patients returned to the operating room after initial operation management of a related previous procedure.

**Element Values**

1. Yes
2. No
3. Not Known/Not Recorded

**Additional Information**

- Must have occurred during the patient’s initial stay at your hospital.
  - EXCLUDE: Pre-planned, staged and/or procedures for incidental findings.
  - EXCLUDE: Operative management related to a procedure that was initially performed prior to arrival at your center.

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BACK TO TABLE OF CONTENTS
Complications/PI TR23.1 - Ventilator-Associated Pneumonia (VAP)

Definition

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.

### VAP Algorithm (PNU2 Bacterial or Filamentous Fungal Pathogens):

<table>
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<th>IMAGING TEST EVIDENCE</th>
<th>SIGNS/SYMPOTMS</th>
<th>LABORATORY</th>
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<td>Two or more serial chest imaging test results with at least one of the following:</td>
<td>All 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>- Organism identified from blood</td>
</tr>
<tr>
<td>- Consolidation</td>
<td>- Leukopenia (≤4000 WBC/mm³) or leukocytosis (≥12,000 WBC/mm³)</td>
<td>- Organism identified from pleural fluid</td>
</tr>
<tr>
<td>- Cavitation</td>
<td>- For adults ≥70 years old, altered mental status with no other recognized cause</td>
<td>- Positive quantitative culture of intracellular bacteria on direct microscopic exam (e.g., Gram's stain)</td>
</tr>
<tr>
<td>- Pneumatoceles, in infants &lt;1 year old</td>
<td>AND at least two of the following:</td>
<td>- ≥25% BAL-obtained cells contain intracellular bacteria on direct microscopic examination (e.g., Gram's stain)</td>
</tr>
<tr>
<td>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 imaging test result is acceptable.</td>
<td>- New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</td>
<td>- Histopathologic exam shows at least one of the following evidences of pneumonia:</td>
</tr>
<tr>
<td></td>
<td>- New onset or worsening cough, or dyspnea, or tachypnea</td>
<td>- Abscess formation or foci of consolidation with intense PMN accumulation in bronchioles and alveoli</td>
</tr>
<tr>
<td></td>
<td>- Rales or bronchial breath sounds</td>
<td>- Evidence of lung parenchyma invasion by fungal hyphae or pseudohyphae</td>
</tr>
<tr>
<td></td>
<td>- Worsening gas exchange (e.g., O₂ desaturations (e.g., PaO₂/FiO₂&lt;240), increased oxygen requirements, or increased ventilator demand)</td>
<td></td>
</tr>
</tbody>
</table>
**VAP Algorithm (PNU2 Viral, Legionella, and other Bacterial Pneumonias):**

<table>
<thead>
<tr>
<th>IMAGING TEST EVIDENCE</th>
<th>SIGNS/SYMPTOMS</th>
<th>LABORATORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two or more serial chest imaging test results 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>• Virus, Bordetella, Legionella, Chlamydia or Mycoplasma identified from respiratory secretions or 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)).</td>
</tr>
<tr>
<td>• Consolidation</td>
<td>• Leukopenia (≤4000 WBC/mm³) or leukocytosis (≥12,000 WBC/mm³)</td>
<td>• Fourfold rise in paired sera (IgG) for pathogen (e.g., influenza viruses, Chlamydia)</td>
</tr>
<tr>
<td>• Cavitation</td>
<td>• For adults ≥70 years old, altered mental status with no other recognized cause</td>
<td>• Fourfold rise in Legionella pneumophila serogroup 1 antibody titer to ≤1.128 in paired acute and convalescent sera by indirect IFA.</td>
</tr>
<tr>
<td>• Pneumatoceles, in infants ≤1 year old</td>
<td>AND at least one of the following:</td>
<td>• Detection of L. pneumophila serogroup 1 antigens in urine by RIA or EIA</td>
</tr>
<tr>
<td>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 imaging test result is acceptable.</td>
<td>• New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</td>
<td></td>
</tr>
</tbody>
</table>
### VAP Algorithm (PNU3 Immunocompromised Patients):  

<table>
<thead>
<tr>
<th>IMAGING TEST/EVIDENCE</th>
<th>SIGNS/SYMPTOMS</th>
<th>LABORATORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two or more serial chest imaging test results with at least one of the following:</td>
<td>Patient who is immunocompromised has 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>- Identification of matching Candida spp. from blood and sputum; endotracheal aspirate, BAL or protected specimen brushing; 11, 12, 13</td>
</tr>
</tbody>
</table>
| - Consolidation | - For adults ≥70 years old, altered mental status with no other recognized cause | - 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 diagnosis laboratory test |
| - Cavitation | - New onset of purulent sputum, change in character of sputum, or increased respiratory secretions, or increased suctioning requirements | Any of the following from LABORATORY CRITERIA DEFINED UNDER PNU2 |
| - Pneumatoceles, in infants <1 year old | - New onset or worsening cough, or dyspnea, or tachypnea | - Worsening gas exchange (e.g., O2 desaturations [e.g., PaO2/FiO2 <240], increased oxygen requirements, or increased ventilator demand) |
| 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 imaging test result is acceptable. | - Railes or bronchial breath sounds | - Hemoptysis |
| | | - Pleuritic chest pain |
### VAP Algorithm ALTERNATE CRITERIA (PNU1), for infant's ≤1 year old:

<table>
<thead>
<tr>
<th>IMAGING TEST EVIDENCE</th>
<th>SIGNS/SYMPTOMS/LABORATORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two or more serial chest imaging test results with at least one of the following:</td>
<td>Worsening gas exchange (e.g., ( O_2 ) desaturation [e.g. pulse oximetry &lt;94%], increased oxygen requirements, or increased ventilator demand)</td>
</tr>
<tr>
<td>• New or progressive and persistent infiltrate</td>
<td>AND at least three of the following:</td>
</tr>
<tr>
<td>• Consolidation</td>
<td>• Temperature instability</td>
</tr>
<tr>
<td>• Cavitation</td>
<td>• Leukopenia (&lt;4000 WBC/mm(^3)) or leukocytosis (≥15,000 WBC/mm(^3)) and left shift (≥10% band forms)</td>
</tr>
<tr>
<td>Pneumatocele, 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>
</tr>
</tbody>
</table>

**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 imaging test result is acceptable.

### VAP Algorithm ALTERNATE CRITERIA (PNU1), for children >1 year old or ≤12 years old:

<table>
<thead>
<tr>
<th>IMAGING TEST EVIDENCE</th>
<th>SIGNS/SYMPTOMS/LABORATORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two or more serial chest imaging test results with at least one of the following:</td>
<td>At least three of the following:</td>
</tr>
<tr>
<td>• New or progressive and persistent infiltrate</td>
<td>• Fever (&gt;38.0°C or &gt;100.4°F) or hypothermia (&lt;36.0°C or &lt;96.8°F)</td>
</tr>
<tr>
<td>• Consolidation</td>
<td>• Leukopenia (&lt;4000 WBC/mm(^3)) or leukocytosis (≥15,000 WBC/mm(^3))</td>
</tr>
<tr>
<td>• Cavitation</td>
<td>• New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</td>
</tr>
<tr>
<td>Pneumatocele, in infants ≤1 year old</td>
<td>• New onset or worsening cough, or dyspnea, apnea, or tachypnea</td>
</tr>
</tbody>
</table>

**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 imaging test result is acceptable.

### Element Values

1. Yes
2. No
3. Not Known/Not Recorded

### Additional Information

- Must have occurred during the patient’s initial stay at your hospital.
- A diagnosis of pneumonia must be documented in the patient’s medical record.
- Consistent with the January 2016 CDC defined VAP.

### Data Source Hierarchy Guide

1. History and Physical
2. Physician Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

**Associated Edit Checks (NTDB)**

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>20501</td>
<td>1</td>
<td>Value is not a valid menu option</td>
</tr>
<tr>
<td>20503</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>20504</td>
<td>2</td>
<td>Element cannot be &quot;Not Applicable&quot;</td>
</tr>
<tr>
<td>20540</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
NTDS OUTCOME INFORMATION
Outcome TR26.9– Total ICU Length of Stay

**Definition**

The cumulative amount of time spent in the ICU. Each partial or full day should be measured as one calendar day.

**Element Values**

Relevant value for data element (auto-calculated by the registry software)

**Additional Information**

- Recorded in full day increments with any partial calendar day counted as a full calendar day.
- The calculation assumes that the date and time of starting and stopping an ICU episode are recorded in the patient’s chart.
- If any dates are missing then a LOS cannot be calculated.
- If patient has multiple ICU episodes on the same calendar day, count as one calendar day.
- At no time should the ICU LOS exceed the Hospital LOS.
- This field is auto-calculated, but can be manually edited.entered.
- This field will lock when the ED disposition is 4, 5, 6, 9, 10, or 11.

<table>
<thead>
<tr>
<th>Example #</th>
<th>Start Date</th>
<th>Start Time</th>
<th>Stop Date</th>
<th>Stop Time</th>
<th>LOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>01/01/11</td>
<td>01:00</td>
<td>01/01/11</td>
<td>04:00</td>
<td>1 day (one calendar day)</td>
</tr>
<tr>
<td>B.</td>
<td>01/01/11</td>
<td>01:00</td>
<td>01/01/11</td>
<td>04:00</td>
<td>1 day (2 episodes within one calendar day)</td>
</tr>
<tr>
<td>C.</td>
<td>01/01/11</td>
<td>16:00</td>
<td>01/01/11</td>
<td>18:00</td>
<td>2 days (episodes on 2 separate calendar days)</td>
</tr>
<tr>
<td>D.</td>
<td>01/02/11</td>
<td>01:00</td>
<td>01/02/11</td>
<td>16:00</td>
<td>2 days (episodes on 2 separate calendar days)</td>
</tr>
<tr>
<td>E.</td>
<td>01/01/11</td>
<td>01:00</td>
<td>01/01/11</td>
<td>16:00</td>
<td>2 days (episodes on 2 separate calendar days)</td>
</tr>
<tr>
<td>F.</td>
<td>01/01/11</td>
<td>Unknown</td>
<td>01/01/11</td>
<td>16:00</td>
<td>2 days (patient was in ICU on 2 separate calendar days)</td>
</tr>
<tr>
<td>G.</td>
<td>01/02/11</td>
<td>Unknown</td>
<td>01/02/11</td>
<td>16:00</td>
<td>2 days (patient was in ICU on 2 separate calendar days)</td>
</tr>
<tr>
<td>H.</td>
<td>01/02/11</td>
<td>18:00</td>
<td>Unknown</td>
<td>16:00</td>
<td>2 days (patient was in ICU on 2 separate calendar days)</td>
</tr>
<tr>
<td>I.</td>
<td>01/01/11</td>
<td>Unknown</td>
<td>01/02/11</td>
<td>16:00</td>
<td>2 days (patient was in ICU on 2 separate calendar days)</td>
</tr>
</tbody>
</table>
Data Source Hierarchy Guide

1. ICU Flow Sheet
2. Nursing Notes/Flow Sheet

Associated Edit Checks (NTDB):

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>7501</td>
<td>1</td>
<td>Invalid value</td>
</tr>
<tr>
<td>7502</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>7503</td>
<td>2</td>
<td>Total ICU Length of Stay is greater than the difference between ED/Hospital Arrival Date and Hospital Discharge Date</td>
</tr>
<tr>
<td>7504</td>
<td>3</td>
<td>The value is above 60</td>
</tr>
<tr>
<td>7505</td>
<td>2</td>
<td>The value submitted falls outside the valid range of 1-575</td>
</tr>
<tr>
<td>7540</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
# Outcome TR26.58 – Total Ventilator Days

## Definition

The cumulative amount of time spent on the ventilator. Each partial or full day should be measured as one calendar day.

## Element Values

Relevant value for data element

## Additional Information

- Excludes mechanical ventilation time associated with OR procedures.
- Non-invasive means of ventilatory support (CPAP or BIPAP) should not be considered in the calculation of ventilator days.
- Recorded in full day increments with any partial calendar day counted as a full calendar day.
- The calculation assumes that the date and time of starting and stopping Ventilator episode are recorded in the patient’s chart.
- If any dates are missing then a Total Vent Days cannot be calculated.
- At no time should the Total Vent Days exceed the Hospital LOS.
- This field is auto-calculated with completion in the “Ventilator” tab of the registry, but can be manually edited/entered.
- This field will lock when the ED disposition is 4, 5, 6, 9, 10, or 11.
<table>
<thead>
<tr>
<th>Example #</th>
<th>Start Date</th>
<th>Start Time</th>
<th>Stop Date</th>
<th>Stop Time</th>
<th>LOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>01/01/11</td>
<td>01:00</td>
<td>01/01/11</td>
<td>04:00</td>
<td>1 day (one calendar day)</td>
</tr>
<tr>
<td>B.</td>
<td>01/01/11</td>
<td>01:00</td>
<td>01/01/11</td>
<td>04:00</td>
<td>1 day (2 episodes within one calendar day)</td>
</tr>
<tr>
<td>C.</td>
<td>01/01/11</td>
<td>01:00</td>
<td>01/01/11</td>
<td>18:00</td>
<td>2 days (episodes on 2 separate calendar days)</td>
</tr>
<tr>
<td>D.</td>
<td>01/02/11</td>
<td>01:00</td>
<td>01/02/11</td>
<td>18:00</td>
<td>2 days (episodes on 2 separate calendar days)</td>
</tr>
<tr>
<td>E.</td>
<td>01/01/11</td>
<td>09:00</td>
<td>01/02/11</td>
<td>21:00</td>
<td>2 days (episodes on 2 separate calendar days)</td>
</tr>
<tr>
<td>F.</td>
<td>01/01/11</td>
<td>Unknown</td>
<td>01/02/11</td>
<td>16:00</td>
<td>1 day</td>
</tr>
<tr>
<td>G.</td>
<td>01/01/11</td>
<td>Unknown</td>
<td>01/02/11</td>
<td>16:00</td>
<td>2 days (patient was on Vent on 2 separate calendar days)</td>
</tr>
<tr>
<td>H.</td>
<td>01/02/11</td>
<td>16:00</td>
<td>Unknown</td>
<td>Unknown</td>
<td>2 days (patient was on Vent on 2 separate calendar days)</td>
</tr>
<tr>
<td>I.</td>
<td>01/02/11</td>
<td>18:00</td>
<td>01/02/11</td>
<td>20:00</td>
<td>2 days (patient was in on Vent on 2 separate calendar days)</td>
</tr>
<tr>
<td>J.</td>
<td>01/01/11</td>
<td>Unknown</td>
<td>01/02/11</td>
<td>16:00</td>
<td>3 days (patient was on Vent on 3 separate calendar days)</td>
</tr>
</tbody>
</table>

**Associated Edit Checks (NTDB)**

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>7601</td>
<td>1</td>
<td>Invalid value</td>
</tr>
<tr>
<td>7602</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>7603</td>
<td>2</td>
<td>Total Ventilator Days should not be greater than the difference between ED/Hospital Arrival Date and Hospital Discharge Date</td>
</tr>
<tr>
<td>7604</td>
<td>3</td>
<td>The value is above 60</td>
</tr>
<tr>
<td>7605</td>
<td>2</td>
<td>The value submitted falls outside the valid range 1-575</td>
</tr>
<tr>
<td>7640</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Outcome TR25.93 – Hospital Discharge Date

Definition

The date the order was written for the patient to be discharged from the hospital

Element Values

Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY
- The null value “Not Applicable” is used if ED Discharge Disposition = 5 Deceased/Expired
- The null value “Not Applicable” is used if ED Discharge Disposition = 4, 6, 9, 10, or 11.
- If Hospital Discharge Disposition is Deceased/Expired, then the hospital discharge date is the date of death as indicated on the patient’s death certificate.
- If the patient is an organ donor, the date of death is the date that the patient was pronounced dead as indicated on the death certificate (NOT the date that the patient was taken to the OR)
- If Hospital Discharge Disposition is 4 Left Against Medical Advice or Discontinued Care, report the date the patient signed the AMA form. If a patient signature was not obtained on the AMA form, report the date it was noted in the medical record the patient indicated that they were going to leave AMA.
- This field will lock when the ED disposition is 4, 5, 6, 9, 10, or 11.

Data Source Hierarchy Guide

1. Physician Order
2. Discharge instructions
3. Nursing Notes/Flow Sheet
4. Case Management/Social Services Notes
5. Discharge Summary

Associated Edit Checks (NTDB):

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>7701</td>
<td>1</td>
<td>Date is not valid</td>
</tr>
<tr>
<td>7702</td>
<td>1</td>
<td>Date out of range</td>
</tr>
<tr>
<td>Code</td>
<td>Count</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>7703</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>7704</td>
<td>3</td>
<td>Hospital Discharge Date is earlier than EMS Dispatch Date</td>
</tr>
<tr>
<td>7705</td>
<td>3</td>
<td>Hospital Discharge Date is earlier than EMS Unit Arrival on Scene Date</td>
</tr>
<tr>
<td>7706</td>
<td>3</td>
<td>Hospital Discharge Date is earlier than EMS Unit Scene Departure Date</td>
</tr>
<tr>
<td>7707</td>
<td>2</td>
<td>Hospital Discharge Date is earlier than ED/Hospital Arrival Date</td>
</tr>
<tr>
<td>7708</td>
<td>2</td>
<td>Hospital Discharge Date is earlier than ED Discharge Date</td>
</tr>
<tr>
<td>7709</td>
<td>2</td>
<td>Hospital Discharge Date is earlier than Date of Birth</td>
</tr>
<tr>
<td>7710</td>
<td>3</td>
<td>Hospital Discharge Date minus Injury Incident Date is greater than 365 days, please verify this is correct</td>
</tr>
<tr>
<td>7711</td>
<td>3</td>
<td>Hospital Discharge Date minus ED/Hospital Arrival Date is greater than 365 days, please verify this is correct</td>
</tr>
<tr>
<td>7712</td>
<td>2</td>
<td>Element must be Not Applicable when ED Discharge Disposition = 4, 5, 6, 9, 10, or 11</td>
</tr>
<tr>
<td>7740</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Outcome TR25.94– Hospital Discharge Time

**Definition**
The time the order was written for the patient to be discharged from the hospital

**Element Values**
Relevant value for data element

**Additional Information**
- Collected as HH:MM Military time
- The null value “Not Applicable” is used if ED Discharge Disposition = 5 Deceased/Expired
- The null value “Not Applicable” is used if ED Discharge Disposition = 4, 6, 9, 10, or 11.
- If hospital discharge disposition is deceased/expired then hospital discharge time is the time of death as indicated on the patient's death certificate.
- If a patient is an organ donor, the time the patient was pronounced deceased is the time that is recorded in this field.
- If Hospital Discharge Discharge Disposition is 4 Left Against Medical Advice or Discontinued Care, report the date the patient signed the AMA form. If a patient signature was not obtained on the AMA form, report the date it was noted in the medical record the patient indicated that they were going to leave AMA.
- This field will lock when the ED disposition is 4, 5, 6, 9, 10, or 11.

**Data Source Hierarchy Guide**
1. Physician Order
2. Discharge instructions
3. Nursing Notes/Flow Sheet
4. Case Management/Social Services Notes
5. Discharge Summary

**Associated Edit Checks (NTDB):**

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7801</td>
<td>1</td>
<td>Time is not valid</td>
<td></td>
</tr>
<tr>
<td>7802</td>
<td>1</td>
<td>Time out of range</td>
<td></td>
</tr>
<tr>
<td>7803</td>
<td>2</td>
<td>Element cannot be blank</td>
<td></td>
</tr>
<tr>
<td>7804</td>
<td>3</td>
<td>Hospital Discharge Time is earlier than EMS Dispatch Time</td>
<td></td>
</tr>
<tr>
<td>7805</td>
<td>3</td>
<td>Hospital Discharge Time is earlier than EMS Unit Arrival on Scene Time</td>
<td></td>
</tr>
</tbody>
</table>
# Outcome TR26.07 - Hospital Discharge Disposition

**Definition**

The disposition of the patient when discharged from the hospital

## Element Values

|----------------|--------------------------------------------------------------------------------|-------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------------------------|-----------------------------|-------------------------------------------------|-----------------------------------------------|-----------------------------------------------|-----------------------------------------------|-----------------------------------------------|-----------------------------------------------|-----------------------------------------------|-----------------------------------------------|-----------------------------------------------|

### Additional Information

- Home refers to the patient’s current place of residence (immediately prior to injury) e.g. prison, child protective services etc.
- Element values based on UB-04 disposition coding
- Disposition to any other non-medical facility should be coded as discharged to home or self-care (routine discharge)
- The null value “Not Applicable” is used if ED Discharge Disposition = 5 Deceased/Expired
- The null value “Not Applicable” is used if ED Discharge Disposition = 4, 6, 9, 10, or 11.
• Disposition to any other medical facility should be coded as discharged to another type of inpatient facility not defined elsewhere
• This field will lock when the ED disposition is 4, 5, 6, 9, 10, or 11.
• Hospital Discharge Dispositions which were retired greater than 2 years before the current NTDS version are no longer listed under Element Values above, which is why there are numbering gaps. Refer to the NTDS Change Log for a full list of retired Hospital Discharge Dispositions.

If multiple orders were written, report the final disposition order.

Data Source Hierarchy Guide

1. Physician Order
2. Discharge instructions
3. Case Management/Social Services Notes
4. Nursing Notes/Flow Sheet
5. Discharge Summary

Associated Edit Checks (NTDB)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>7901</td>
<td>1</td>
<td>Value is not a valid menu option</td>
</tr>
<tr>
<td>7902</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>7907</td>
<td>2</td>
<td>Element cannot be &quot;Not Applicable&quot; if ED Discharge Disposition is not 4, 5, 6, 9, 10, or 11</td>
</tr>
<tr>
<td>7909</td>
<td>2</td>
<td>Element cannot be &quot;Not Known/Not Recorded&quot; when Hospital Arrival Date and Hospital</td>
</tr>
<tr>
<td>7940</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
NTDS FINANCIAL INFORMATION
# Outcome TR2.5 – Primary Method of Payment

## Definition

Primary source of payment for hospital care

### Element Values

1. Medicaid
2. Not Billed (for any reason)
3. Self-Pay
4. Private/Commercial Insurance
5. Medicare
6. Other Government
7. Other

### Additional Information

- No Fault Automobile, Workers compensation, and Blue Cross/Blue Shield should be captured as Private/Commercial Insurance.
- Primary methods of payments which were retired greater than 2 years before the current NTDS version are no longer listed under Element Values. Refer to the NTDS Change Log for a full list of retired Primary Methods of Payments.

### Data Source Hierarchy Guide

1. Billing Sheet
2. Admission Form
3. Face Sheet

### Associated Edit Checks (NTDB)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>8001</td>
<td>1</td>
<td>Value is not a valid menu option</td>
</tr>
<tr>
<td>8002</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>8003</td>
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<td>Element cannot be Not Applicable</td>
</tr>
<tr>
<td>8040</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
SECTION B:

Wisconsin Core Data Elements
### Demographics TR1.2 – Medical Record #

**Definition**

The facility medical record number that represents the patient

**Element Values**

Relevant value for data element

**Additional Information**

This number will not change for the person regardless of changes to the account number of facility trauma registry number. If the patient is identified as an existing patient late in their care use the final medical record number to complete this field rather than the initially assigned medical record that was used prior to discover of the existing MRN.

**Data Source Hierarchy Guide**

1. Face Sheet
2. Billing Sheet
3. Discharge Summary
4. Admission Form
### Demographics TR1.9 – Patient’s Last Name

**Definition**

The last name of the patient.

**Element Values**

Relevant value for data element

**Additional Information**

- If Alias is used it will be documented in the alias sections, this field should be the patient’s actual legal name
- If the patient’s legal name is not known, leave blank.

**Data Source Hierarchy Guide**

1. Face Sheet
2. Billing Sheet
3. Admission Form
### Demographics TR1.8 – Patient’s First Name

**Definition**
The first name of the patient.

**Element Values**
Relevant value for data element

**Additional Information**
- If Alias is used it will be documented in the alias sections, this field should be the patient’s actual legal name
- If the patient’s legal name is not known, leave blank.

**Data Source Hierarchy Guide**
1. Face Sheet
2. Billing Sheet
3. Admission Form
Injury 5.13 – Injury Type

Definition
This is the initial type of injury. The force that caused the most severe injury based on a matrix.

Element Values
1. Blunt
2. Burn
3. Penetrating
4. Other
5. Not Known/Not Recorded

Additional Information
- This field is often auto-populated based on the ICD 10 matrix, however it may need to be manually entered.
- ICD-10 Matrix: [https://www.facs.org/~/media/files/quality%20programs/trauma/icd10cm_nonpoisoning_cause_matrix.ashx](https://www.facs.org/~/media/files/quality%20programs/trauma/icd10cm_nonpoisoning_cause_matrix.ashx)

Data Source Hierarchy Guide
- NTDB External Cause of Injury Matrix.
## Pre-Hospital TR5.33 – Was patient extricated?

### Definition

Was the patient extricated?

### Element Values

1. Yes
2. No
3. Not Known/Not Recorded

### Additional Information

This can be from a MVC but can also refer to other times patient requires extrication.

### Data Source Hierarchy Guide

1. EMS Run Report
**Pre-Hospital TR7.3 – Scene/Transport Agency Name**

**Definition**

The Service name of the first ambulance/flight service attending to the patient at the scene, if applicable. This field applies only if patient arrived to your facility by EMS.

**Element Values**

Relevant value for the data element

**Additional Information**

- Picked from a drop-down menu after selecting agency state.
- If agency cannot be found, select “Out of State Agency” and inform trauma program by emailing [DHSTrauma@dhs.wisconsin.gov](mailto:DHSTrauma@dhs.wisconsin.gov)

**Data Source Hierarchy Guide**

1. EMS Run Report
Pre-Hospital TR15.38– EMS ePCR Available?

**Definition**

This field applies only if an ambulance/flight selection was made from previous “Mode” field. Select “Complete” if a full EMS report was available, through the Elite database, or the agency's electronic medical record system at the time of abstraction. Select “Missing” if no EMS report was available at the time of abstraction or if greater than 10 days have passed since the date of service and the ePCR is not available in Elite.

**Element Values**

1. Complete
2. Missing
3. Not applicable

**Data Source Hierarchy Guide**

1. EMS Run Report
Pre-Hospital TR18.80 – Pre-Hospital Respiratory Assistance

**Definition**

Was the patient being assisted with breathing during the time the vitals were taken with mechanical ventilation or bag mask ventilation?

**Element Values**

1. Unassisted Respiratory Rate
2. Assisted Respiratory Rate
3. Not Applicable
4. Not Known/Not Recorded

**Additional Information**

- Only completed if a value is provided for Pre-Hospital Respiratory Rate (TR18.70).
- Respiratory Assistance is defined as mechanical and/or external support of respiration.
- Please note that first recorded hospital vitals do not need to be from the same assessment.
- When “Pre-Hospital Respiratory Rate” is “Not Known/Not Recorded”, select “Not Applicable”

**Data Source Hierarchy Guide**

1. EMS Run Report
## Referring Facility TR33.64– Transfer In

### Definition
Was the facility transferred to your facility from another acute care facility?

### Element Values

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Yes</td>
</tr>
<tr>
<td>2.</td>
<td>No</td>
</tr>
</tbody>
</table>

### Additional Information

If "No" is selected then click “Add Referring Hospital Info” and submit the tab to continue data entry.

### Data Source Hierarchy Guide

1. EMS run sheet
2. Trauma/Triage/Hospital Flow Sheet
3. Referring facility paperwork
Referring Facility TR33.1 - Referring Facility

**Definition**

The name of the facility that cared for the patient immediately before the patient arrived at your facility

**Element Values**

1. Wisconsin Facilities with DHS identification Name
2. Other (used for out of state facilities)

**Additional Information**

If “other” is selected then must fill out additional field “if other”

**Data Source Hierarchy Guide**

1. EMS run sheet
2. Trauma/Triage/Hospital Flow Sheet
3. Referring facility paperwork
# Referring Facility TR33.1.1 - Other Facility

## Definition
Free text field to identify the name of the out-of-state facility that transferred the patient to your facility.

## Element Values
Free text description of the facility that transferred the patient to your facility.

## Additional Information
- Only used when the referring facility is not listed.
- Will show when Referring Hospital is set to Other.

## Data Source Hierarchy Guide
1. EMS run sheet
2. Trauma/Triage/Hospital Flow Sheet
<table>
<thead>
<tr>
<th><strong>Definition</strong></th>
<th>The date the patient arrived at the referring facility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Element Values</strong></td>
<td>Relevant data values in MM/DD/YYYY</td>
</tr>
<tr>
<td><strong>Additional Information</strong></td>
<td>If date of arrival is not documented, leave blank</td>
</tr>
</tbody>
</table>
| **Data Source Hierarchy Guide** | 1. Referring facility documentation  
2. Trauma/Transfer/Hospital Flow Sheet  
3. EMS Run Sheet |
# Referring Facility TR33.3 - Referring Facility Arrival Time

## Definition

The time the patient arrived at the referring facility

## Element Values

Time in 24 hour format HH:MM

## Additional Information

If time of arrival is not documented, leave blank

## Data Source Hierarchy Guide

1. Referring facility documentation
2. Trauma/Transfer/Hospital Flow Sheet
### Referring Facility TR33.30 - Referring Facility Discharge Date

**Definition**
The date the patient was discharged from the referring facility.

**Element Values**
Relevant data values in MM/DD/YYYY.

**Additional Information**
If date of discharge is not documented, leave blank.

**Data Source Hierarchy Guide**
1. Referring facility documentation
2. Trauma/Transfer/Hospital Flow Sheet
### Referring Facility TR33.31 - Referring Facility Discharge Time

#### Definition
The time the patient was discharged from the referring facility

#### Element Values
Time in 24 hour format HH:MM

#### Additional Information
If time of discharge is not documented, leave blank

#### Data Source Hierarchy Guide
1. Referring facility documentation
2. Trauma/Transfer/Hospital Flow Sheet
### ED/TTA TR17.65 - Facility Access

#### Definition
How did the patient come into your facility?

#### Element Values

1. Emergency Department
2. Direct Admit – not ED or Trauma Department
3. Trauma Department – Independent from ED
4. Not Applicable
5. Not Known/Not Recorded

#### Data Source Hierarchy Guide

1. Trauma/Triage/Hospital Flow Sheet
2. Nursing Notes
3. Access Center Record/Communication Center
4. EMS Run Sheet
## ED/TTA TR16.22 – Arrived From

### Definition
Location the patient arrived from

### Element Values
- Scene
- Referring Hospital
- Clinic/MD Office
- Jail
- Home
- Nursing Home
- Supervised Living
- Urgent Care
- Not Known/Not Recorded

### Additional Information
Patients injured at home should be coded as “Scene”

### Data Source Hierarchy Guide
1. Trauma/Triage/Hospital Flow Sheet
2. Nursing Notes
3. Access Center Record/Communication Center
4. EMS Run Sheet
**ED/TTA TR8.8 – Mode of Arrival**

**Definition**

The modality that brought the patient to your facility, if multiple modes indicate the last mode that brought the patient to your facility.

**Element Values**

- Ground Ambulance
- Helicopter Ambulance
- Fixed-wing Ambulance
- Private Vehicle/Walk-in
- Police
- Other
- Not Applicable
- Not Known/Not Recorded

**Additional Information**

The last mode that brought the patient to your facility

**Data Source Hierarchy Guide**

1. Trauma/Triage/Hospital Flow Sheet
2. Nursing Notes
3. EMS Run Sheet
## ED/TTA TR17.45 - Transfer Delay

**Definition**

Was there a delay in transferring this patient to another facility?

**Element Values**

1. Yes
2. No
3. Not Applicable
4. Not Known/Not Recorded

**Additional Information**

Marking this element as "Yes" will generate TR17.44, Reason for Transfer Delay

**Data Source Hierarchy Guide**

1. Trauma/Triage/Hospital Flow Sheet
2. Nursing Notes
3. Access Center Record/Communication Center
4. EMS Run Sheet
ED/TTA TR17.44 – Reason for Transfer Delay

**Definition**

The cause of the delay in patient transfer out of the ED.

**Element Values**

1. Communication Issue
   
   a. Selecting this field value will show TR17.44.Communication with the following options:
      
      i. Miscommunication between sending and receiving facility
      ii. Nursing delay in calling for/arranging transportation
      iii. Nursing delay in contacting EMS
      iv. Physician response delay
      v. Not Known

2. Delay Issue
   
   a. Selecting this field value will show TR17.44.Delay with the following options:
      
      i. Delay in diagnosis
      ii. Delay in Emergency Department disposition decision
      iii. Delay in trauma team activation
      iv. Not Known

3. Delayed identification that the patient needed trauma center resources

4. EMS Issue
   
   a. Selecting this field value will show TR17.44.EMS with the following options:
      
      i. Air transport ETA greater than ground transport ETA
      ii. Air transport not available due to weather
      iii. Out of county
      iv. Shortage of available ground transportation
      v. Not Known

5. Error Issue
   
   a. Selecting this field value will show TR17.44.Error with the following options:
      
      i. Error in judgement
      ii. Error in technique
      iii. Error in treatment
      iv. Not Known
6. Family, Legal Guardian, or Patient Issue  
   a. Selecting this field value will show TR17.44.Patient with the following options:  
      i. Change in patient condition  
      ii. Child Protective Services (CPS)  
      iii. Family requested transfer  
      iv. Patient requested transfer  
      v. Not Known

7. Referring Facility Issue  
   a. Selecting this field value will show TR17.44.Referred with the following options:  
      i. Physician decision making  
      ii. Priority of transfer  
      iii. Radiology workup delay  
      iv. Surgeon availability  
      v. Not Known

8. Equipment issue  
   a. Selecting this field value will show TR17.44.Equipment with the following options:  
      i. Equipment broken  
      ii. Equipment missing/unavailable  
      iii. Not Known

9. High ED census at receiving hospital/busy
10. High ED census at transferring hospital/busy
11. In-house imaging delay
12. Late requesting transporting EMS unit
13. Low patient acuity
14. Other  
   a. Selecting this field will open a free-text field
15. Patient status change/complication
16. Referring hospital Issue – Radiology

17. Receiving Facility Issue  
   a. Selecting this field value will show TR17.44.Receiving with the following options:  
      i. Physician decision making  
      ii. Priority of transfer  
      iii. Radiology workup delay  
      iv. Surgeon availability  
      v. Not Known

18. Referring Physician Decision Making
19. Weather or Natural Factors Issue
   a. Selecting this field value will show TR17.44.Weather with the following options:
      i. Flooding
      ii. Rain
      iii. Snow
      iv. Tornado
      v. Not Known

20. Waiting for transporting EMS unit
21. Not Applicable
22. Not Known/Not Recorded

**Additional Information**

This element is required when TR17.45 is marked as “Yes”

**Data Source Hierarchy Guide**

1. Trauma/Triage/Hospital Flow Sheet
2. Nursing Notes
3. Access Center Record/Communication Center
4. EMS Run Sheet
ED/TTA TR17.21 - Trauma Team Activation Level

**Definition**
Was the facility-specific trauma activation/alert activated?

**Element Values**
- Level 1
- Level 2
- Level 3
- Not Activated
- Not Known/Not Recorded

**Additional Information**
- This should be the initial level/alert that was sent out. If the level was upgraded put the first activation that went out.
- If no activation/alert was sent out but trauma/surgeon saw the patient in the ED select “Level 3”
- If the patient was a direct admit, Select “Not Activated”
- Not applicable should not be used for this field.
- If your facility has only one level of activation, select Level 1.
- If your facility has two levels of activation, Level 1 is associated with the highest level.

**Data Source Hierarchy Guide**
1. Trauma/Triage/Hospital Flow Sheet
2. Nursing Notes
3. Physician Notes
ED/TTA TR17.78.3–Activation Level Upgrade/Downgrade

**Definition**

If the trauma team activation level was upgraded or downgraded, select the new activation level.

**Element Values**

- Level 1
- Level 2
- Level 3
- Not Activated
- Not Known/Not Recorded
- Not Applicable

**Additional Information**

- If the activation was cancelled, select “Not Activated”
- If your facility has only one level of activation, select Level 1.
- If your facility has two levels of activation, Level 1 is associated with the highest level.
- If the activation level was not updated, select “Not Applicable”.

**Data Source Hierarchy Guide**

1. Trauma/Triage/Hospital Flow Sheet
2. Nursing Notes
3. Physician Notes
### ED/TTA TR17.31 - Date Trauma Team Activated

**Definition**
The date the facility specific trauma alert/activation was paged out

**Element Values**
Relevant data values in MM/DD/YYYY

**Additional Information**
- Required if a leveled trauma activation is entered (Level 1, Level 2, Level 3)
- If the patient was not an activation/alert, leave blank

**Data Source Hierarchy Guide**
1. Trauma/Triage/Hospital Flow Sheet
ED/TTA TR17.34 – Time Trauma Team Activated

Definition

The time the facility specific trauma alert/activation was paged out

Element Values

Time in 24 hour format HH:MM

Additional Information

- Required if a leveled trauma activation is entered (Level 1, Level 2, Level 3)
- If the patient was not an activation/alert, leave blank

Data Source Hierarchy Guide

1. Trauma/Triage/Hospital Flow Sheet
ED/TTA TR18.99 - Admitting Service

**Definition**
The service the patient was admitted to at your facility

**Element Values**

<table>
<thead>
<tr>
<th>1. Anesthesia/CRNA</th>
<th>19. Not Known/Not Recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Burn</td>
<td>20. OB</td>
</tr>
<tr>
<td>5. Critical Care Medicine</td>
<td>23. OralMax</td>
</tr>
<tr>
<td>7. ENT</td>
<td>25. Other</td>
</tr>
<tr>
<td>11. Hospitalist</td>
<td>29. Pulmonary Medicine</td>
</tr>
<tr>
<td>12. Infection Control</td>
<td>30. Radiology</td>
</tr>
<tr>
<td>13. Internal Medicine</td>
<td>31. Respiratory Therapy</td>
</tr>
<tr>
<td>15. Neurology</td>
<td>33. Trauma</td>
</tr>
<tr>
<td>16. Neurosurgery</td>
<td>34. Trauma Nurse</td>
</tr>
<tr>
<td>17. Non-Surgical</td>
<td>35. Urology</td>
</tr>
<tr>
<td>18. Not Applicable</td>
<td>36. Vascular</td>
</tr>
</tbody>
</table>

**Additional Information**

- The admitting attending will determine what service the patient was admitted to
- If the patient was discharged from the ED, Select “Not Applicable”

**Data Source Hierarchy Guide**

1. Trauma/Triage/Hospital Flow Sheet
2. History & Physical
ED/TTA TR17.25 – ED Physical Discharge Date

Definition

The date the patient was physically discharged from the ED or transferred to inpatient unit/OR.

Element Values

Relevant value for data element

Additional Information

- Collected as YYYY-MM-DD.
- Used to auto-generate an additional calculated field: Length of Stay (elapsed time from ED admit to ED discharge).
- The null value "Not Applicable" is used if the patient is directly admitted to the hospital.

Data Source Hierarchy Guide

1. Physician Order
2. Triage/Trauma/Hospital Flow Sheet
3. Nursing Notes/Flow Sheet
4. Discharge Summary
5. Billing Sheet
6. Progress Notes
ED/TTA TR17.26 – ED Physical Discharge Time

Definition
The time the patient was physically discharged from the ED or transferred to inpatient unit/OR.

Element Values
Relevant value for data element

Additional Information
- Collected as HH:MM.
- Used to auto-generate an additional calculated field: Length of Stay: (elapsed time from ED admit to ED discharge).
- The null value "Not Applicable" is used if the patient is directly admitted to the hospital.

Data Source Hierarchy Guide
1. Physician Order
2. Triage/Trauma/Hospital Flow Sheet
3. Nursing Notes/Flow Sheet
4. Discharge Summary
5. Billing Sheet
6. Progress Notes
Procedures TR22.30 – Procedure Performed?

Definition

Indicate if the patient had a procedure performed upon them while in your facility

Element Values

- Yes
- No
- Not Known/Not Recorded

Additional Information

If the answer is “No”, leave ICD-10 Procedures, Date Performed, and Time blank.

Data Source Hierarchy Guide

1. Trauma/Triage/Hospital Flow Sheet


**Diagnosis – Injury Severity Score**

**Definition**

Injury Severity Score (ISS) that reflects the patient’s injuries

**Element Values**

Relevant value for the constellation of injuries

**Additional Information**

The Injury Severity Score (ISS) is an anatomical scoring system that provides an overall score for patients with multiple injuries. 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), External). Only the highest AIS score in each body region is used. The three most severely injured body regions have their score squared and added together to produce the ISS score.

The ISS score takes values from 0 to 75. If an injury is assigned an AIS of 6 (unsurvivable injury), the ISS score is automatically assigned to 75. The ISS score is virtually the only anatomical scoring system in use and correlates linearly with mortality, morbidity, hospital stay and other measures of severity.

This value is auto-populated by the ImageTrend system

⚠ Must complete ICD-10 Diagnosis and AIS code to populate
**Outcome TR25.34 – Hospital Physical Discharge Date**

**Definition**

The date the patient expired or was physically discharged from the hospital (separate from the order for discharge)

**Element Values**

Relevant value for data element

**Additional Information**

- Collected as YYYY-MM-DD.
- Used to auto-generate an additional calculated field: Hospital Length of Stay – Calendar Days: (elapsed time from hospital admit to hospital discharge).
- The null value "Not Applicable" is used if the patient is directly admitted to the hospital.
- This field will lock when the ED disposition is 4, 5, 6, 9, 10, or 11.

**Data Source Hierarchy Guide**

1. Physician Order
2. Triage/Trauma/Hospital Flow Sheet
3. Nursing Notes/Flow Sheet
4. Discharge Summary
5. Billing Sheet
6. Progress Notes
Outcome TR25.48 – Hospital Physical Discharge Time

**Definition**

The time the patient expired or was physically discharged from the hospital (separate from the order for discharge)

**Element Values**

Relevant value for data element

**Additional Information**

- Collected as HH:MM.
- Used to auto-generate an additional calculated field: Hospital Length of Stay – Calendar Days: (elapsed time from hospital admit to hospital discharge).
- The null value "Not Applicable" is used if the patient is directly admitted to the hospital.
- This field will lock when the ED disposition is 4, 5, 6, 9, 10, or 11.

**Data Source Hierarchy Guide**

1. Physician Order
2. Triage/Trauma/Hospital Flow Sheet
3. Nursing Notes/Flow Sheet
4. Discharge Summary
5. Billing Sheet
6. Progress Notes
## Diagnosis – ISS Region

### Definition

The Injury Severity Score (ISS) body region codes that reflect the patient’s injuries

<table>
<thead>
<tr>
<th>Element Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Head – TR21.2</td>
</tr>
<tr>
<td>2. Face – TR21.5</td>
</tr>
<tr>
<td>4. Abdomen – TR21.6</td>
</tr>
<tr>
<td>5. Extremity – TR21.4</td>
</tr>
</tbody>
</table>

### Additional Information

- Auto-populated by entering ICD 10 Diagnosis and AIS Code
- Head or Neck Injuries include injury to the brain or cervical spine, skull or cervical spine fractures.
- Facial injuries include those involving the mouth, ears, nose and facial bones.
- Chest injuries include all lesions to internal organs. Chest injuries also include those to the diaphragm, rib cage, and thoracic spine.
- Abdominal or pelvic contents injuries include all lesions to internal organs. Lumbar spine lesions are included in the abdominal or pelvic region.
- Injuries to the extremities or to the pelvic or shoulder girdle including sprains, fractures, dislocations, and amputations, except for the spinal column, skull and rib cage.
- External injuries include lacerations, contusions, abrasions, and burns, independent of their location on the body surface.

### Data Source Hierarchy Guide

1. Physician Order
2. Triage/Trauma/Hospital Flow Sheet
3. Nursing Notes/Flow Sheet
4. Discharge Summary
5. Billing Sheet
6. Progress Notes
SECTION C:

Report Writer Dataset Elements
The ImageTrend Report Writer utilizes two separate datasets, Transactional and Analytical. Elements can typically be found by using the ImageTrend Data Element Number (TR#.##). “N/A” indicates a field that is either unavailable in Report Writer or is currently under development for future use. The following tables identify the level of requirement (NTDB or WI CORE), the associated ImageTrend Data Element Number, the element title as displayed on the data entry form, the element as it appears within the Report Writer for transactional reports, and the element as it appears within the Report Writer for analytical reports respectively. These tables are ordered as the data items appear within this data dictionary.

### DEMOGRAPHICS

<table>
<thead>
<tr>
<th>Required</th>
<th>Data Element</th>
<th>Element Name</th>
<th>Transactional Report Name</th>
<th>Analytical Report Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>NTDB</td>
<td>TR1.20</td>
<td>ZIP</td>
<td>Patient Home Zip (TR1.20)</td>
<td>Patient Home Zip (TR1.20)</td>
</tr>
<tr>
<td>NTDB</td>
<td>TR1.19</td>
<td>Country</td>
<td>Patient Home Country (TR1.19)</td>
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<td>NTDB</td>
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</tr>
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<td>Age</td>
<td>Patient Age (TR1.12)</td>
<td>Patient Age (TR1.12)</td>
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<tr>
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| NTDB     | TR18.61.2/   | GCS Verbal                       | Prehospital GCS Verbal (TR18.61.2)           | **Adult:** Prehospital GCS Verbal (TR18.61.2)  
| NTDB     | TR18.61.0    |                                  |                                               | **Pediatric:** Prehospital GCS Verbal - Pediatric (TR18.61.0)  |
| NTDB     | TR18.62.2/   | GCS Motor                        | Prehospital GCS Motor (TR18.62.2)            | **Adult:** Prehospital GCS Motor (TR18.62.2)  
| NTDB     | TR18.62.0    |                                  |                                               | **Pediatric:** Prehospital GCS Motor – Pediatric (TR18.62.2) |
| NTDB     | TR18.65      | GCS Total                        | Prehospital GCS Calculated (TR18.65)         | Prehospital GCS Calculated (TR18.65)       |
| NTDB     | TR25.54      | Inter-Facility Transfer          | InterFacility Transfer (TR25.54)              | InterFacility Transfer (TR25.54)           |
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| NTDB     | TR18.7       | Respiratory Rate   | Initial Assessment Respiratory Rate (TR18.7)      | Initial Assessment Respiratory Rate (TR18.7)   |
| NTDB     | TR18.10      | Respiratory Assistance | Initial Assessment Respiratory Assistance (TR18.10) | Initial Assessment Respiratory Assistance (TR18.10) |
| NTDB     | TR18.31      | 02Sat              | Initial Assessment Pulse Oximetry (TR18.31)       | Initial Assessment Pulse Oximetry (TR18.31)    |
| NTDB     | TR18.109     | Supplemental 02    | Initial Assessment Supplemental Oxygen (TR18.109)  | Initial Assessment Supplemental Oxygen (TR18.109) |
| NTDB     | TR18.14      | GCS Eye            | Initial Assessment GCS Eye (TR18.14)              | Initial Assessment GCS Eye (TR18.14)           |
| NTDB     | TR18.16.0/18.15.0 | GCS Verbal     | Initial Assessment GCS Verbal (TR18.16.0)         | **Adult:** Initial Assessment GCS Verbal (TR18.16.0)  
**Pediatric:** Initial Assessment GCS Verbal - Pediatric (TR18.16.0) |
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|       |         |                | Centimeters: Patient Height In Inches (TR1.6.1)  |
| NTDB  | TR1.6.5 | Weight         | Kilograms: Patient Weight In Kilograms (TR6.5)  
Pounds: Patient Weight In Pounds (TR6.6) |
<p>| NTDB  | TR18.91 | Drug Screen    | Drug Screen (TR18.91) |
| NTDB  | TR18.46 | Alcohol Use Indicator | Alcohol Screen (TR18.46) |
| NTDB  | TR18.103 | Alcohol Screen Results | ED/Acute Care Blood Alcohol Description (TR18.103) |
| NTDB  | TR17.27 | Discharge Disposition | ED Discharge Disposition (TR17.27) |
| NTDB  | TR27.14 | Signs of Life  | Signs of Life (TR27.14) |
| NTDB  | TR17.41 | Discharge Order Date | ED Decision to Discharge/Transfer Date (TR17.41) |
| NTDB  | TR17.42 | Discharge Order Time | ED Decision to Discharge/Transfer Time (TR17.42) |
| CORE  | TR17.65 | Facility Access | Facility Access (TR17.65) |
| CORE  | TR16.22 | Arrived From   | Arrived From (TR16.22) |
| CORE  | TR17.21 | Trauma Team Activation | Trauma Team Activation Level (TR17.21) |
| CORE  | TR17.31 | Activation Date | Trauma Team Activated Date (TR17.31) |</p>
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<th>Transactional Report Name</th>
<th>Analytical Report Name</th>
</tr>
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<tbody>
<tr>
<td>NTDB</td>
<td>TR200.14.1</td>
<td>ICD10 AIS Codes</td>
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OUTCOME

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<th>Analytical Report Name</th>
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<tbody>
<tr>
<td>NTDB</td>
<td>TR26.9</td>
<td>Total ICU Days</td>
<td>Total ICU Length Of Stay - Days (TR26.9)</td>
<td>Total ICU Length Of Stay - Days (TR26.9)</td>
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<tr>
<td>NTDB</td>
<td>TR26.58</td>
<td>Total Ventilator Days</td>
<td>Total Ventilator Days (TR26.58)</td>
<td>Total Ventilator Days (TR26.58)</td>
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<tr>
<td>NTDB</td>
<td>TR25.93</td>
<td>Discharge Order Date</td>
<td>Hospital Discharge Orders Written Date (TR25.93)</td>
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<tr>
<td>NTDB</td>
<td>TR25.94</td>
<td>Discharge Order Time</td>
<td>Hospital Discharge Orders Written Time (TR25.94)</td>
<td>N/A</td>
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<td>NTDB</td>
<td>TR26.07</td>
<td>Discharge Disposition</td>
<td>Hospital Discharge Disposition (TR26.07)</td>
<td>Hospital Discharge Disposition (TR26.07)</td>
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<tr>
<td>CORE</td>
<td>TR25.44</td>
<td>Length of Stay</td>
<td>Hospital Length Of Stay - Calendar Days (Physical D/C) (TR25.44)</td>
<td>Hospital Length Of Stay (TR25.44)</td>
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<tr>
<td>CORE</td>
<td>TR25.34</td>
<td>Discharge Date</td>
<td>Hospital Discharge Date (TR25.34)</td>
<td>Hospital Discharge Date (TR25.34)</td>
</tr>
<tr>
<td>CORE</td>
<td>TR25.48</td>
<td>Discharge Time</td>
<td>Hospital Discharge Time (TR25.48)</td>
<td>Hospital Discharge Time (TR25.48)</td>
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<tr>
<td>CORE</td>
<td>TR25.92</td>
<td>Discharge Status</td>
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### FINANCIAL INFORMATION

<table>
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<tr>
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<tbody>
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<td>TR2.5</td>
<td>Primary Method of Payment</td>
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### HOSPITAL COMPLICATIONS

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<tr>
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<th>Analytical Report Name</th>
</tr>
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<tr>
<td>NTDB</td>
<td>TR23.1</td>
<td>Complications</td>
<td>Injury Complication Type (TR23.1)</td>
<td>Injury Complication Type (TR23.1)</td>
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</tbody>
</table>
In addition to the required elements above, the following options are commonly used within reports.

**OTHER COMMON ELEMENTS**

<table>
<thead>
<tr>
<th>Element Name</th>
<th>Transactional Report Name</th>
<th>Analytical Report Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Name</td>
<td>Facility Name</td>
<td>Facility Name</td>
</tr>
<tr>
<td>Region Name</td>
<td>Region Name</td>
<td>Region Name</td>
</tr>
<tr>
<td>Facility Trauma Level (I, II, III, IV)</td>
<td>Hospital Trauma Level</td>
<td>Hospital Trauma Level</td>
</tr>
<tr>
<td>ED Length of Stay (until phys. DC)</td>
<td>ED/Acute Care Length Of Stay Total Minutes (until Physical D/C) (TR17.99)</td>
<td>N/A</td>
</tr>
<tr>
<td>ED Length of Stay (until orders)</td>
<td>ED/Acute Care Length Of Stay Total Minutes (until Orders Written) (TR17.99.Written)</td>
<td></td>
</tr>
<tr>
<td>Incident Status</td>
<td>Incident Status</td>
<td>Incident Status</td>
</tr>
<tr>
<td>Incident Form Title</td>
<td>Incident Form Title</td>
<td>Incident Form Title</td>
</tr>
<tr>
<td>EMS Scene Time</td>
<td>EMS Scene Time in Minutes (TR9.8)</td>
<td>Pre-Hospital EMS Scene Arrival to EMS Scene</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Departure in Minutes</td>
</tr>
<tr>
<td>EMS Transport Time</td>
<td>EMS Transport Time (Minutes)</td>
<td>Pre-Hospital EMS Scene Departure to ED-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hospital Patient Arrival in Minutes</td>
</tr>
<tr>
<td>ICD-10 Diagnosis Code</td>
<td>ED-Hospital ICD-10 Diagnosis Category (TR200.1)</td>
<td>ED-Hospital ICD-10 Diagnosis Category (TR200.1)</td>
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<td>ICD-10 Injury Code</td>
<td>Incident ICD-10 Injury Category (TR200.3)</td>
<td>Incident ICD-10 Injury Category (TR200.3)</td>
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<td>ICD-10 Procedure Code</td>
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<td>ED-Hospital ICD-10 Procedure Category (TR200.2)</td>
</tr>
</tbody>
</table>
SECTION D:

Wisconsin NTDB Extension Import Mappings

If needed, contact the Trauma Registry Data Manager for a copy of the import schema.
### Demographics TR1.8 – Patient’s First Name

**Definition**
The first name of the patient.

**Schema Data Type**
String

**XSD Type**
- `xs:string`

### Demographics TR1.9 – Patient’s Last Name

**Definition**
The last name of the patient.

**Schema Data Type**
String

**XSD Type**
- `xs:string`

### Demographics TR1.10 – Patient’s Middle Initial

**Definition**
The patient's middle initial

**Schema Data Type**
String

**XSD Type**
- `xs:string`
### Demographics TR1.2 – Medical Record #

**Definition**
The facility medical record number that represents the patient

**Schema Data Type**
String

**XSD Type**
- `xs:string`

### ED/TTA TR17.21 – Trauma Team Activation Level

**Definition**
Was the facility-specific trauma activation/alert activated?

**Schema Data Type**
String

**XSD Type**
- `xs:string`

**Element Values**

<table>
<thead>
<tr>
<th>Activation Level</th>
<th>3rd party upload code</th>
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</thead>
<tbody>
<tr>
<td>Level 1</td>
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</tr>
<tr>
<td>Level 2</td>
<td>2</td>
</tr>
<tr>
<td>Level 3</td>
<td>3</td>
</tr>
<tr>
<td>Not Activated</td>
<td>0</td>
</tr>
<tr>
<td>Not Known/Not Recorded</td>
<td>-45</td>
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</table>