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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 2023 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 Preparedness and Emergency Health Care. 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.
Introduction:
Wisconsin Trauma Reporting Requirements
Wisconsin State Trauma Registry Inclusion Criteria

Applicable to patients admitted: January 1, 2023 to December 31, 2023

If the patient was injured within the past 14 days of their hospital encounter and was admitted or directly 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, and IV trauma centers will submit data from their trauma registries for all patients meeting these criteria.

**Glossary for 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)
     - T79.A1-T79.A9 with 7th character modifier of A ONLY (Traumatic Compartment Syndrome—initial encounter)

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

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

- Hospital admission and/or observed, including directly admitted to your hospital (exclude patients with isolated injuries admitted for elective and/or planned surgical intervention)
  
  Note: Now includes patients evaluated in the ED after a traumatic event where an included injury is treated in ED, but patient is admitted for work up of a medical condition (for example, syncope or seizure).

OR

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

OR

- Patient transfer from one acute care hospital to another acute care hospital
  
  Acute care hospital is defined as a hospital that provides inpatient medical care and other related services for surgery, acute medical conditions, or injuries. Standalone EDs are included.

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:

- Trauma team activation where the patient is found to have no qualifying injuries and is discharged home from the emergency department.
- Drownings.
- Hangings, strangulations, or asphyxiation.
- Isolated burn injuries.
2023 Inclusion Criteria Flowchart

1. Did the patient sustain one or more traumatic injuries within 14 days of initial hospital encounter?
2. Does the patient have at least one diagnostic code for any injury in the range: ICD-10 CM S00-S99, T07, T14, and T79.A1-T79.A9?
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? or
   Was the patient an admission to your facility and/or observed? or
   Was there a leveled trauma team activation?

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 number 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 two-hour length of stay, the patient's friend picks them up and drives them to the receiving acute care center.

This patient does meet inclusion criteria. The patient has a qualifying traumatic injury and was transferred from one acute care hospital to another acute care hospital.

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 one 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 four 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 two 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 from one acute care hospital to another, death, or admission to the hospital.
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, health care 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 dhstruma@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
This data dictionary contains required fields for 2018 diagnoses. The data items on the following pages are listed by category. Each data item description contains:

**Current Dictionary Version #**

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<th>NTDB</th>
<th>3rd Party</th>
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<td>Will appear if the element is required by the NTDB</td>
<td>Will appear if the element is required for upload by 3&lt;sup&gt;rd&lt;/sup&gt; parties</td>
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</tbody>
</table>

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

**Description**

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
NTDS DEMOGRAPHIC INFORMATION
Demographics TR1.20 – Patient’s Home ZIP/Postal Code

**Description**

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, or can be stored in the postal code format of the applicable country.
- May require adherence to HIPAA regulations.
- If Patient’s Home ZIP/Postal Code is “Not Applicable,” report data element Alternate home residence.
- If Patient’s Home ZIP/Postal Code is “Not Known/Not Recorded,” report: Patient’s Home Country, Patient’s Home State (US only), Patient’s Home County (US only) and Patient’s Home City (US only).
- If Patient’s Home ZIP/Postal Code is reported, must also report 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)**

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


Demographics TR1.19 - Patient’s Home Country

Description

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 two-character FIPS codes representing the country (for example, US).
- If Patient’s Home Country is not US, then the null value “Not Applicable” is reported 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

Associated Edit Checks (NTDB)

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<td>Element cannot be &quot;Not Applicable&quot;</td>
</tr>
<tr>
<td>0105</td>
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<td>Element cannot be “Not Known/Not Recorded’ when Patient’s Home ZIP/Postal Code is any response other than &quot;Not Applicable or Not Known/Not Recorded”</td>
</tr>
<tr>
<td>0140</td>
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<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Demographics TR1.23 - Patient’s Home State

**Description**

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 reported 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.
- The null value “Not Applicable” is reported if Patient’s Home ZIP/Postal code is reported.
- The null value “Not Applicable” is reported for non-US hospitals.

**Data Source Hierarchy Guide**

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

**Associated Edit Checks (NTDB)**

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<td>Single Entry Max exceeded</td>
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**Demographics TR1.22 - Patient’s Home County**

**Description**

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 Patient’s Home ZIP/Postal code is “Not Known/Not Recorded,” and the country is the US.
- Used to calculate the FIPS code.
- The null value “Not Applicable” is reported if Patient’s Home ZIP/Postal Code is reported.
- The null value “Not Applicable” is reported for non-US hospitals.
- 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)**

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<tr>
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<td>Element cannot be blank</td>
</tr>
<tr>
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<td>Element must be “Not Applicable” (Non-US hospitals only)</td>
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<td>0340</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Demographics TR1.21 - Patient’s Home City

Description

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 reported when Patient’s Home Zip/Postal Code is “Not Known/Not Recorded,” and country is the US.
- Used to calculate the FIPS code.
- The null value “Not Applicable” is reported if Patient’s Home ZIP/Postal Code is reported.
- The null value “Not Applicable” is reported for non-US hospitals.
- When ZIP is 99999, element will populate as “Not Known.”

Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet /Medical Records Coding Summary Sheet
3. Admission Form

Associated Edit Checks (NTDB)

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<tr>
<td>0440</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Demographics TR1.13 – Alternate Home Residence

Description
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 reported when Patient’s Home ZIP/Postal Code is “Not Applicable.”
- Report all that apply.
- Homeless is defined as a person who lacks housing and 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 their principal place of residence within a country 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 reported.

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>
</tr>
</thead>
<tbody>
<tr>
<td>0501</td>
<td>1</td>
<td>Value is not a valid menu option</td>
</tr>
<tr>
<td>0502</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>0503</td>
<td>2</td>
<td>Element cannot be &quot;Not Applicable&quot; or &quot;Not Known/Not Recorded&quot; along with any other value</td>
</tr>
<tr>
<td>0540</td>
<td>1</td>
<td>Multiple Entry Max exceeded</td>
</tr>
</tbody>
</table>
Demographics TR1.7 - Date of Birth

**Description**

The patient's date of birth.

**Element Values**

Relevant value for data element

**Additional Information**

- Reported as MM/DD/YYYY.
- If Date of Birth is “Not Known/Not Recorded,” report Age and Age Units.
- If Date of Birth is the same as the Injury Incident Date, then the Age and Age Units data elements must be reported.

**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>
<tbody>
<tr>
<td>0601</td>
<td>1</td>
<td>Invalid Value</td>
</tr>
<tr>
<td>0602</td>
<td>1</td>
<td>Date out of range</td>
</tr>
<tr>
<td>0603</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>0612</td>
<td>2</td>
<td>Date of Birth + 120 years must be less than Injury Incident Date</td>
</tr>
<tr>
<td>0613</td>
<td>2</td>
<td>Element cannot be &quot;Not Applicable&quot;</td>
</tr>
<tr>
<td>0640</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Demographics TR1.12 – Age

Description

The patient’s age at the time of Injury (best approximation).

Element Values

Relevant value for data element

Additional Information

- Must also report Age Units.
- Auto calculated unless date of birth is unknown or is the same as date of ED Arrival.
- Report Age and Age Units if Date of Birth is reported as “Not Known/Not Recorded.”
- Report Age and Age Units if Date of Birth is reported as the same as ED/Hospital Arrival Date.
- The null value “Not Applicable” is reported if Date of Birth is reported.

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>
<tbody>
<tr>
<td>0701</td>
<td>1</td>
<td>Age is outside the valid range of 0 – 120</td>
</tr>
<tr>
<td>0703</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>0705</td>
<td>3</td>
<td>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.</td>
</tr>
<tr>
<td>0708</td>
<td>2</td>
<td>Element must be &quot;Not Known/Not Recorded&quot; when Age Units is &quot;Not Known/Not Recorded&quot;</td>
</tr>
<tr>
<td>0709</td>
<td>2</td>
<td>Element must be and can only be &quot;Not Applicable&quot; if Date of Birth is reported unless Date of Birth is same as ED/Hospital Arrival Date</td>
</tr>
<tr>
<td>0740</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Demographics TR1.14 – Age Units

Description

The units used to report the patient’s age.

Element Values

1. Hours
2. Days
3. Months
4. Years
5. Minutes
6. Weeks

Additional Information

- Must also report Age.
- Age Units is either auto-populated using the date of birth and the incident injury date or is manually entered when either the Date of Birth is unknown, or the patient arrives on the first day of life.
- Report Age Units and Age if Date of Birth is “Not Known/Not Recorded.”
- Report Age Unit and Age if Date of Birth is the same as the ED/Hospital Arrival Date.
- The null value “Not Applicable” is reported if Date of Birth is reported.

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>
<tbody>
<tr>
<td>0801</td>
<td>1</td>
<td>Value is not a valid menu option</td>
</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>0810</td>
<td>2</td>
<td>Element must be and can only be “Not Applicable” if Age is “Not Applicable”</td>
</tr>
<tr>
<td>0840</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Demographics TR1.16 - Race

Description

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

- Report all that apply.
- Patient race should be based upon self-report or identified by a family member.
- Based on the 2010 US Census Bureau.

Data Source Hierarchy Guide

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

Associated Edit Checks (NTDB)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>0901</td>
<td>1</td>
<td>Value is not a valid menu option</td>
</tr>
<tr>
<td>0902</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>0903</td>
<td>2</td>
<td>Element cannot be “Not Applicable” (excluding Canadian hospitals)</td>
</tr>
<tr>
<td>0905</td>
<td>2</td>
<td>Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other value</td>
</tr>
<tr>
<td>0950</td>
<td>1</td>
<td>Multiple Entry Max exceeded</td>
</tr>
</tbody>
</table>
Demographics TR1.17 - Ethnicity

**Description**

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.

**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>
<tr>
<th>Rule ID</th>
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<th>Message</th>
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<tr>
<td>1001</td>
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<td>Value is not a valid menu option</td>
</tr>
<tr>
<td>1002</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>1003</td>
<td>2</td>
<td>Element cannot be “Not Applicable” (excluding Canadian hospitals)</td>
</tr>
<tr>
<td>1040</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
## Demographics TR1.15 – Sex

### Description

The patient’s sex.

### Element Values

1. Male
2. Female
3. Non-binary

### Additional Information

Patients who have undergone a surgical and/or hormonal sex reassignment should be coded using the current assignment.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDB)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>1101</td>
<td>1</td>
<td>Value is not a valid menu option</td>
</tr>
<tr>
<td>1102</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>1103</td>
<td>2</td>
<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
Injury TR5.1 – Injury Incident Date

Description

The date the injury occurred.

Element Values

Relevant value for data element

Additional Information

- Reported as MM/DD/YYYY.
- Direct entry allows for use of the calendar function, typing MM/DD/YYYY, or MMDDYYYY.
- Estimated injury date must be based on patient, witness, family, or health care provider report. Other proxy measures (for example, 911 call times) must not be reported.

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>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>1201</td>
<td>1</td>
<td>Date is not valid</td>
</tr>
<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>1211</td>
<td>2</td>
<td>Element cannot be &quot;Not Applicable&quot;</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>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Injury TR5.18 – Injury Incident Time

Description

The time the injury occurred.

Element Values

Relevant value for data element

Additional Information

- Reported as HH:MM Military time.
- Estimated injury time must be based on patient, witness, family, or health care provider report. Other proxy measures (for example, 911 call times) must not be reported.

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>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>1301</td>
<td>1</td>
<td>Time is not valid</td>
</tr>
<tr>
<td>1302</td>
<td>1</td>
<td>Time out of range</td>
</tr>
<tr>
<td>1303</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<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>
Injury TR2.10 – Work Related

Description

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, Patient's Occupational Industry and Patient's Occupation must be reported.
- 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>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>1401</td>
<td>1</td>
<td>Value is not a valid menu option</td>
</tr>
<tr>
<td>1402</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>1407</td>
<td>2</td>
<td>Element cannot be “Not Applicable”</td>
</tr>
<tr>
<td>1440</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Injury TR2.6 – Patient's Occupational Industry

**Description**

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

**Element Values**

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

**Additional Information**

- If work-related, Patient's Occupation must be reported.
- The null value "Not Applicable" is reported if Work-Related is Element Value “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>
</tr>
</thead>
<tbody>
<tr>
<td>1501</td>
<td>1</td>
<td>Value is not a valid menu option</td>
</tr>
<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>&quot;Not Applicable&quot; 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 Descriptions:

**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 are 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 (for example, 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 (for example, 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.
### Injury TR2.11 – Patient’s Occupation

#### Description

The occupation of the patient.

#### Element Values

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

#### Additional Information

- Only reported if injury is work-related.
- If work-related, Patient’s Occupational Industry must also be reported.
- The null value “Not Applicable” is reported if Work-Related is Element Value “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>
</tr>
</thead>
<tbody>
<tr>
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<td>Value is not a valid menu option</td>
</tr>
<tr>
<td>1604</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>1605</td>
<td>2</td>
<td>If Work-Related is “1. Yes,” Patient’s Occupation cannot be “Not Applicable”</td>
</tr>
<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

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>External Cause code used to describe the mechanism (or external factor) that caused the injury event.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Element Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relevant ICD-10-CM or ICD-10 CA code value for injury event</td>
</tr>
</tbody>
</table>

**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 or ICD-10 CA codes are accepted for ICD-10 Additional External Cause Code.
- Activity codes are not reported under the NTDS.
- 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 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)**

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>8901</td>
<td>1</td>
<td>E-Code is not a valid ICD-10-CM code (ICD-10 CM only)</td>
</tr>
<tr>
<td>8902</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>8904</td>
<td>2</td>
<td>Must 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 must not be Y93.X/Y93.XX (where X is A-Z or 0-9) (ICD-10 CM only)</td>
</tr>
<tr>
<td>8906</td>
<td>1</td>
<td>E-Code is not a valid ICD-10-CA code (ICD-10 CA only)</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>
<tr>
<td>9101</td>
<td>1</td>
<td>E-code is not a valid ICD-10-CM code (ICD-10 only)</td>
</tr>
<tr>
<td>9102</td>
<td>3</td>
<td>Additional External Cause Code ICD-10 must not be equal to Primary External</td>
</tr>
<tr>
<td>9103</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>9104</td>
<td>1</td>
<td>E-code is not a valid ICD-10-CA code (ICD-10 CA only)</td>
</tr>
<tr>
<td>9105</td>
<td>2</td>
<td>ICD-10-CM T74 and T76 codes cannot be submitted as Additional External Cause Codes</td>
</tr>
<tr>
<td>9106</td>
<td>2</td>
<td>Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any value</td>
</tr>
<tr>
<td>9140</td>
<td>1</td>
<td>Multiple Entry Max exceeded</td>
</tr>
</tbody>
</table>
### Injury TR200.5 – ICD-10 Place of Occurrence External Cause Code

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place of occurrence external cause code used to describe the place/site/location of the injury event (Y92.X).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Element Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relevant ICD-10-CM or ICD-10 CA codes value for injury event</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only ICD-10-CM or ICD-10 CA codes are accepted.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data Source Hierarchy Guide</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. EMS Run Report</td>
</tr>
<tr>
<td>2. Triage/Trauma Flow Sheet</td>
</tr>
<tr>
<td>3. Nursing Notes/Flow Sheet</td>
</tr>
<tr>
<td>4. History &amp; Physical</td>
</tr>
<tr>
<td>5. Progress Notes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Associated Edit Checks (NTDB)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rule ID</td>
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<tr>
<td>--------</td>
</tr>
<tr>
<td>9001</td>
</tr>
<tr>
<td>9002</td>
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<td>9003</td>
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<td>9004</td>
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<tr>
<td>9005</td>
</tr>
<tr>
<td>9006</td>
</tr>
<tr>
<td>9040</td>
</tr>
</tbody>
</table>
Injury TR5.6 – Incident Location ZIP/Postal Code

Description
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) for US and Canada or can be stored in the postal code format of the applicable country.
- If Incident Location ZIP/Postal Code is reported, report Incident Country.
- If “Not Known/Not Recorded,” report Incident Country, Incident State (US Only), Incident County (US Only) and Incident City (US Only).
- May require adherence to HIPAA regulations.
- 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>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>1</td>
<td>Invalid value</td>
</tr>
<tr>
<td>2002</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>2006</td>
<td>2</td>
<td>Element cannot be &quot;Not Applicable&quot;</td>
</tr>
<tr>
<td>2040</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Injury TR5.11 – Incident Country

Description
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
- Values are two-character FIPS codes representing the country (for example, US).
- If Incident Country is not US, then the null value "Not Applicable" is reported for Incident State, Incident County, and Incident City.

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>
</tr>
</thead>
<tbody>
<tr>
<td>2101</td>
<td>1</td>
<td>Invalid value</td>
</tr>
<tr>
<td>2102</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>2104</td>
<td>2</td>
<td>Element cannot be &quot;Not Applicable&quot;</td>
</tr>
<tr>
<td>2105</td>
<td>2</td>
<td>Element cannot be “Not Known/Not Recorded” when Incident Location ZIP/Postal code is any response other than not “Not Known/Not Recorded”</td>
</tr>
<tr>
<td>2140</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Injury TR5.7 – Incident State

**Description**

The state, territory, or province where the patient 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 reported when Incident Location ZIP/Postal code is “Not Known/Not Recorded,” and the country is the US.
- The null value “Not Applicable” is reported if Incident Location ZIP/Postal Code is reported.
- The null value “Not Applicable” is reported if Incident Country is not the US.
- Used to calculate the FIPS code.
- Element will default to Wisconsin when ZIP is 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>
</tr>
</thead>
<tbody>
<tr>
<td>2201</td>
<td>1</td>
<td>Invalid value</td>
</tr>
<tr>
<td>2203</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>2204</td>
<td>2</td>
<td>Element must be “Not Applicable” (Non-US hospitals)</td>
</tr>
<tr>
<td>2205</td>
<td>2</td>
<td>Element must be “Not Applicable” when Incident Location ZIP/Postal Code is reported</td>
</tr>
<tr>
<td>2240</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
**Injury TR5.9 – Incident County**

**Description**

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 reported when Incident Location ZIP/Postal Code is “Not recorded/Not Known” and country is the US.
- The null value “Not Applicable” is reported if incident Location ZIP/Postal Code is reported.
- The null value “Not Applicable” is reported if Incident Country is not the US.
- Used to calculate FIPS code.

**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>
</tr>
</thead>
<tbody>
<tr>
<td>2301</td>
<td>1</td>
<td>Invalid value (US only)</td>
</tr>
<tr>
<td>2303</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>2304</td>
<td>2</td>
<td>Element must be “Not Applicable” (Non-US hospitals)</td>
</tr>
<tr>
<td>2305</td>
<td>2</td>
<td>Element must be “Not Applicable” when Incident Location ZIP/Postal code is reported</td>
</tr>
<tr>
<td>2340</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Injury TR5.10 – Incident City

Description
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 reported when Incident Location ZIP/Postal code is “Not Known/Not Recorded,” and country is the US.
- If incident location resides outside of formal city boundaries, report nearest city/town.
- The null value “Not Applicable” is reported if Incident Location ZIP/Postal Code is reported.
- The null value “Not Applicable” is reported if Incident Country is not the US.
- Used to calculate the FIPS code.
- 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)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>2401</td>
<td>1</td>
<td>Invalid value</td>
</tr>
<tr>
<td>2403</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>2404</td>
<td>2</td>
<td>Element must be “Not Applicable” (Non-US hospitals)</td>
</tr>
<tr>
<td>2405</td>
<td>2</td>
<td>Element must be “Not Applicable” when Incident Location ZIP/Postal code is reported</td>
</tr>
<tr>
<td>2440</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Injury Protective Devices, Airbag Deployment, Child Specific Restraint

### Description

Protective devices (Safety Equipment): in use or worn by the patient at the time of the injury.
Airbag deployment: indication of airbag deployment during a motor vehicle crash.
Child specific restraints: devices used by patient at the time of injury.

### Element Values & Data Element

#### TR 29.24: Protective Devices

1. None
2. Three Point Restraint
3. Lap Belt
4. Personal Flotation Device
5. Protective Non-Clothing Gear (for example, 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

- Report 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.
• If Element Value “7. Child Care Restraint” is reported, report Child Specific Restraint.
• If Element Value “9. Airbag Present” is reported, report Airbag Deployment.
• Lap belt should be reported to include those patients that are restrained but not further specified.
• If the documentation indicates “3-point restraint,” report Element Value 3. Lap Belt and 11. Shoulder Belt.
• If documented that a “Child Restraint (booster seat or childcare seat)” was used or worn, but not properly fastened, either on the child or in the car, report Field Value “1. None.”
• 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).
• Report Element Value “1. Airbag Deployed Front” for patients with documented airbag deployment but are not further specified.
• Report the null value “Not Applicable” if Element Value “9. Airbag Present” is NOT reported for Protective Devices.
• 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.

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>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>2501</td>
<td>1</td>
<td>Value is not a valid menu option</td>
</tr>
<tr>
<td>2502</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>2507</td>
<td>2</td>
<td>Element cannot be “Not Applicable”</td>
</tr>
<tr>
<td>2508</td>
<td>2</td>
<td>Element cannot be “Not Known/Not Recorded” or ”1. None” along with element values 2, 3, 4, 5, 6, 7, 8, 9, 10 and/or 11.</td>
</tr>
<tr>
<td>2550</td>
<td>1</td>
<td>Multiple Entry Max exceeded</td>
</tr>
<tr>
<td>2601</td>
<td>1</td>
<td>Value is not a valid menu option</td>
</tr>
<tr>
<td>2603</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>2604</td>
<td>2</td>
<td>Element cannot be “Not Applicable” when Protective Devices is 7: Child Restraint</td>
</tr>
<tr>
<td>2640</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
<tr>
<td>2701</td>
<td>1</td>
<td>Value is not a valid menu option</td>
</tr>
<tr>
<td>2703</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>2704</td>
<td>2</td>
<td>Element cannot be “Not Applicable” when Protective Devices is 9: Airbag Present</td>
</tr>
<tr>
<td>2705</td>
<td>2</td>
<td>Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with</td>
</tr>
</tbody>
</table>
any other value

Multiple Entry Max exceeded
NTDS PRE-HOSPITAL INFORMATION
## Pre-Hospital TR8.10 – Transport Mode

### Description

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>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
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<tbody>
<tr>
<td>3401</td>
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<td>3402</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>3404</td>
<td>2</td>
<td>Element cannot be &quot;Not Applicable&quot;</td>
</tr>
<tr>
<td>3440</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Pre-Hospital TR8.11 – Other Transport Mode

Description

All other modes of transport used during patient care event (prior to arrival at your hospital), except the mode 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

Additional Information

- Report all that apply (maximum of 5).
- The null value “Not Applicable” is reported to indicate that a patient had a single mode of transport.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks (NTDB)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
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</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>3502</td>
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<td>Element cannot be blank</td>
</tr>
<tr>
<td>3503</td>
<td>2</td>
<td>Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other value</td>
</tr>
<tr>
<td>3550</td>
<td>1</td>
<td>Multiple Entry Max exceeded</td>
</tr>
</tbody>
</table>
Pre-Hospital TR7.7 – EMS Patient Care Report Universally Unique Identifier (UUID)

Description

The universally unique identifier (UUID) of the patient care report (PCR) of each emergency service (EMS) unit treating the patient from the time of injury to arrival at your ED/hospital.

Element Values

- Relevant value for data element.
- Must be represented in canonical form, matching the following regular expression.
  \[a-fA-F0-9\] \{8\}-\[a-fA-F0-9\] \{4\}-\[1-5\] \[a-fA-aF0-9\] \{3\}-\[89abAB\] \[a-fA-F0-9\] \{3\}-\[a-fA-F0-9\] \{12\}

Additional Information

- Report all that apply (maximum 20).
- A sample UUID is: e48cd734-01cc-4da4-ae6a-915b0b1290f6.
- Automated abstraction technology provided by registry product providers/vendors must be used for this data element. In the absence of automated technology, report the null value "Not Known/Not Recorded."
- Consistent with NEMSIS v3.5.0.
- The null value "Not Known/Not Recorded" must be reported if the UUID is not documented on the EMS Run Report. The UUID will not be documented on EMS Run Reports in NEMSIS versions lower than 3.5.0. In collaboration with NEMSIS, the ACS will communicate when NEMSIS 3.5.0 is widely implemented.
- The null value "Not Applicable" must be reported if the patient was never transported via EMS prior to arrival at your hospital.
- Assigned by any applicable transporting EMS agency in accordance with the IETF RFC 4122 standard.

Data Source Hierarchy Guide

EMS Run Report

Associated Edit Checks (NTDB)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>99000</td>
<td>1</td>
<td>Invalid value</td>
</tr>
<tr>
<td>99001</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>99002</td>
<td>2</td>
<td>Element cannot be &quot;Not Known/Not Recorded&quot; along with any other value</td>
</tr>
<tr>
<td>9940</td>
<td>1</td>
<td>Multiple Entry Max exceeded</td>
</tr>
</tbody>
</table>
Pre-Hospital TR25.54 – Inter-Facility Transfer

Description

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

Element Values

1. Yes
2. No

Additional Information

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

Data Source Hierarchy Guide

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

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>4401</td>
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</tr>
<tr>
<td>4402</td>
<td>1</td>
<td>Value is not a valid menu option</td>
</tr>
<tr>
<td>4405</td>
<td>2</td>
<td>Element cannot be “Not Applicable”</td>
</tr>
<tr>
<td>4440</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Pre-Hospital TR46.11 – Pre-Hospital Cardiac Arrest

Description
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 of the index hospital.
- Pre-hospital cardiac arrest could occur at a transferring institution.
- 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)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
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<td>9701</td>
<td>1</td>
<td>Value is not a valid menu option</td>
</tr>
<tr>
<td>9702</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>9703</td>
<td>2</td>
<td>Element cannot be “Not Applicable”</td>
</tr>
<tr>
<td>9740</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
NTDS Emergency Department Information
ED/TTA TR17.21.1 – Highest Activation

**Description**

Patient received the highest level of trauma activation at your hospital.

**INCLUDE:**
- Patients who receive the highest level of trauma activation initiated by emergency medical services (EMS) or by emergency department (ED) personnel at your hospital.
- Patients who received the highest level of trauma activation initiated by EMS or by ED personnel at your hospital and were downgraded after arrival to your center.
- Patients who received a lower level of trauma activation initiated by EMS or ED personnel at your hospital and were upgraded to the highest level of trauma activation.

**EXCLUDE:**
- Patients who received the highest level of trauma activation after ED discharge.

**Element Values**

1. Yes
2. No

**Additional Information**

- Highest level of activation is defined by your hospital's criteria.

**Data Source Hierarchy Guide**

1. Triage/Trauma Flow Sheet
2. ED Record
3. History & Physical
4. Physician Notes/Flow Sheet
5. Discharge Summary

**Associated Edit Checks (NTDB)**

<table>
<thead>
<tr>
<th>Rule ID</th>
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<th>Message</th>
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</tr>
<tr>
<td>14202</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>14240</td>
<td>1</td>
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</tbody>
</table>
### ED/TTA TR17.15.1–Trauma Surgeon Arrival Date

**Description**

The date the first trauma surgeon arrived at the patient's bedside.

**Element Values**

Relevant value for data element

**Additional Information**

- Reported as MM/DD/YYYY.
- Limited reporting to the 24 hours after ED/hospital arrival.
- The trauma surgeon leads the trauma team and is responsible for the overall care of trauma patient, including coordinating care with other specialties and maintaining continuity of care.
- The null value “Not Applicable” is reported for those patients who were not evaluated by a trauma surgeon within 24 hours of ED/Hospital arrival.
- The null value “Not Applicable” is reported if Element Value “2. No” is reported for Highest Activation.

**Data Source Hierarchy Guide**

1. Triage/Trauma Flow Sheet
2. History & Physical
3. Physician Notes/Flow Sheet
4. Nursing Notes/Flow Sheet

**Associated Edit Checks (NTDB)**

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ED/TTA TR17.15.2 – Trauma Surgeon Arrival Time

**Description**

The time the first trauma surgeon arrived at the patient's bedside.

**Element Values**

Relevant value for data element

**Additional Information**

- Reported as HH:MM Military time.
- Limited reporting to the 24 hours after emergency department/hospital arrival.
- The trauma surgeon leads the trauma team and is responsible for the overall care of trauma patient, including coordinating care with other specialties and maintaining continuity of care.
- The null value "not applicable" is reported for those patients who were not evaluated by a trauma surgeon within 24 hours of ED/Hospital arrival.
- The null value "not applicable" is reported if the data element Highest Activation is reported as 2. No.

**Data Source Hierarchy Guide**

1. Triage/Trauma Flow Sheet
2. History & Physical
3. Physician Notes
4. Nursing Notes

**Associated Edit Checks (NTDB)**

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ED/TTA TR18.55 – ED/Hospital Arrival Date

Description
The date the patient arrived at the ED/Hospital.

Element Values
Relevant value for data element

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

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>ED/Hospital Arrival Date occurs more than 14 days after Injury Incident Date</td>
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</table>
**ED/TTA TR18.56 – ED/Hospital Arrival Time**

**Description**

The time the patient arrived at the ED/Hospital.

**Element Values**

Relevant value for data element

**Additional Information**

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

**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

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

Element Values
Relevant value for data element

Additional Information
- Please note the 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 received 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. Nursing Notes/Flow Sheet
3. Physician Notes
4. History and Physical

Associated Edit Checks (NTDB)

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Initial Assessment TR18.2 – Initial ED/Hospital Pulse Rate

**Description**

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

**Element Values**

Relevant value for data element

**Additional Information**

- Please note the 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 received 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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</table>
Initial Assessment TR18.30 – Initial ED/Hospital Temperature

Description

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

Element Values

Relevant value for data element

Units: Route: TR18.147

1. C (Celsius) – TR18.30
2. F (Fahrenheit) – TR18.30.1

1. Oral
2. Tympanic
3. Rectal
4. Axillary
5. Temporal
6. Other
7. Not Known/Not Recorded

Additional Information

• Please note the 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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<td>The value is below 20.0</td>
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<tr>
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<td>Single Entry Max exceeded</td>
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</table>
**Initial Assessment TR18.7 - Initial ED/Hospital Respiratory Rate**

**Description**

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

**Element Values**

Relevant value for data element

**Additional Information**

- If reported, report Initial ED/Hospital Respiratory Assistance.
- Please note the 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)**

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</tr>
<tr>
<td>5040</td>
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<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Determination of respiratory assistance associated with the Initial ED/Hospital Respiratory Rate within 30 minutes of ED/hospital arrival.

**Element Values**

- Unassisted Respiratory Rate
- Assisted Respiratory Rate
- Not Applicable
- Not Known/Not Recorded

**Additional Information**

- Only reported if Initial ED/Hospital Respiratory Rate is reported.
- Respiratory Assistance is defined as mechanical and/or external support of respiration.
- The null value "Not Applicable" is reported if Initial ED/Hospital Respiratory rate is "Not Known/Not Recorded."
- Please note the 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
3. Respiratory Therapy Notes/Flow Sheet

**Associated Edit Checks (NTDB)**

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<td>5140</td>
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</tbody>
</table>
Initial Assessment TR18.31– Initial ED/Hospital Oxygen Saturation

Description

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

Element Values

Relevant value for data element

Additional Information

- If reported, report Initial ED/Hospital Supplemental Oxygen.
- Please note the 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)

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<td>5240</td>
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</table>
Initial Assessment TR18.109 – Initial ED/Hospital Supplemental Oxygen

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

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

Associated Edit Checks (NTDB)

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<td>Element must be &quot;Not Applicable&quot; when Initial ED/Hospital Oxygen Saturation is &quot;Not Known/Not Recorded&quot;</td>
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<tr>
<td>5340</td>
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</table>
Initial Assessment TR18.14 – Initial ED/Hospital GCS - Eyes

Description

First recorded Glasgow Coma Scale (GCS) Eyes in the ED/hospital within 30 minutes 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 documented, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS, the appropriate numeric score may be reported. (For example, the chart indicates “patient’s pupils are PERRL,” a GCS Eyes of 4 may be reported, IF there is no other contradicting documentation).

• The null value “Not Known/Not Recorded” is reported if Initial ED/Hospital GCS-40 Eyes is documented.

• The null value “Not Known/Not Recorded” is reported if the patient’s Initial ED/Hospital GCS – Eyes was not measured within 30 minutes of ED/hospital arrival.

• Please note the 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
3. Physician Notes/Flow Sheet

Associated Edit Checks (NTDB)

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<tr>
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</table>
## Initial Assessment TR18.15.2 & TR18.15.0 – Initial ED/Hospital GCS - Verbal

### Description

First recorded Glasgow Coma Scale (GCS) Verbal in the ED/hospital within 30 minutes 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 is equal to 1.
- If a patient does not have a numeric GCS recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS, the appropriate numeric score may be reported. (For example, the chart indicates: "patient is oriented to person place and time," a GCS Verbal of 5 may be reported, IF there is no other contradicting documentation).
- The null value “Not Known/Not Recorded” is reported if the patient’s Initial ED/Hospital GCS-40 Verbal is reported.
- The null value “Not Known/Not Recorded” is reported if the patient’s Initial ED/Hospital GCS – Verbal was not measured within 30 minutes of ED/hospital arrival.
- Please note that first recorded hospital vitals do not need to be from the same assessment.
- 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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<tr>
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</tbody>
</table>
## Initial Assessment TR18.16.2 & TR18.16.0 - Initial ED/Hospital GCS - Motor

### Description

First recorded Glasgow Coma Scale (GCS) Motor in the ED/hospital within 30 minutes 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 recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS, the appropriate numeric score may be reported. (For example, 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 Known/Not Recorded” is reported if Initial ED/Hospital GCS-40 Motor is reported.
- The null value "Not Known/Not Recorded" is reported if the patient’s Initial ED/Hospital GCS – Motor was not measured within 30 minutes of ED/hospital arrival.
- Please note that the first recorded/hospital vitals do not need to be from the same assessment.
- 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
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</table>
**Initial Assessment TR18.22– Initial ED/Hospital GCS - Total**

**Description**
First recorded Glasgow Coma Scale (GCS) Total Score within 30 minutes of ED/hospital arrival.

**Element Values**
Relevant value for data element

**Additional Information**
- If a patient does not have a numeric GCS score recorded, but there is documentation related to their level of consciousness such as "AAOx3," "awake alert and oriented," or "patient with normal mental status," report this as GCS score of 15 IF there is no other contradicting documentation.
- 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 Initial ED/Hospital GCS – Eyes, Initial ED/Hospital GCS – Motor, Initial ED/Hospital GCS – Verbal was not measured within 30 minutes of ED/Hospital arrival.
- Please note that the 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
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>
<td>3</td>
<td>Initial ED/Hospital GCS - Total does not equal the sum of Initial ED/Hospital GCS - Eyes, Initial ED/Hospital GCS - Verbal, and Initial ED/Hospital GCS – Motor, unless any of these values are &quot;Not Known/Not Recorded&quot;</td>
</tr>
<tr>
<td>5705</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>5706</td>
<td>2</td>
<td>Element cannot be “Not Applicable”</td>
</tr>
<tr>
<td>5707</td>
<td>2</td>
<td>Element must be “Not Known/Not Recorded” when Initial ED/Hospital GCS-40 Eyes, Initial ED/Hospital GCS-40 Verbal, or Initial ED/Hospital GCS-40 Motor are reported.</td>
</tr>
<tr>
<td>5740</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
<tr>
<td>Description</td>
<td>Documentation of factors potentially affecting the first assessment of GCS within 30 minutes of ED/hospital arrival.</td>
<td></td>
</tr>
<tr>
<td>-------------</td>
<td>----------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
</tbody>
</table>
| **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** | - Report all that apply.  
- 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 (such as, ETOH, prescriptions, etc.).  
- Element Value “1. Patient Chemically Sedated or Paralyzed” is reported if an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible.  
- Neuromuscular blockade is typically induced following the administration of an 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.  
- 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 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>
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<td>5803</td>
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<td>Element cannot be “Not Applicable”</td>
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<tr>
<td>5804</td>
<td>2</td>
<td>Element must be “Not Known/Not Recorded” when Initial ED/Hospital GCS-40 Eyes, Initial ED/Hospital GCS-40 Verbal, or Initial ED/Hospital GCS-40 Motor are reported.</td>
</tr>
<tr>
<td>5805</td>
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<td>Element cannot be “Not Known/Not Recorded” along with any other value</td>
</tr>
<tr>
<td>5850</td>
<td>1</td>
<td>Multiple Entry Max exceeded</td>
</tr>
</tbody>
</table>
Initial Assessment TR18.40.2 – Initial ED/Hospital GCS-40 Eyes

Description
First recorded Glasgow Coma Scale 40 (GCS-40) Eyes within 30 minutes 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, the appropriate numeric score may be reported. (For example, the chart indicates: “patient’s eyes open spontaneously,” an GCS-40 Eyes of 4 may be recorded, IF there is no other contradicting documentation).
- Report Element Value “5. Not Testable” if unable to assess (for example, swelling to the eye(s)).
- The null value “Not Known/Not Recorded” is reported if the patient’s Initial ED/Hospital GCS-40 Eyes 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 – Eyes is reported.

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes/Flow Sheet
<table>
<thead>
<tr>
<th>Rule ID</th>
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<td>15301</td>
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<td>15304</td>
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<td>Element cannot be &quot;Not Applicable&quot;</td>
</tr>
<tr>
<td>15005</td>
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<td>Element must be “Not Known/Not Recorded” when Initial ED/Hospital GCS – Eyes is reported</td>
</tr>
<tr>
<td>15340</td>
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<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
### Initial Assessment TR18.41.2 – Initial ED/Hospital GCS-40 Verbal

#### Description
First recorded Glasgow Coma Scale 40 (GCS-40) Verbal within 30 minutes 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 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. (For example, 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 Element Value “6. Not Testable” if unable to assess (for example, patient is intubated).
- The null value “Not Known/Not Recorded” if Initial ED/Hospital GCS – Verbal is reported.
- The null value “Not Known/Not Recorded” if the patient's Initial ED/Hospital GCS-40 Verbal 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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<thead>
<tr>
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<td>Element cannot be “Not Applicable”</td>
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<td>15405</td>
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<td>Element must be “Not Known/Not Recorded” when Initial ED/Hospital GCS – Verbal is reported</td>
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<tr>
<td>15440</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Initial Assessment TR18.42.2 – Initial ED/Hospital GCS-40 Motor

Description
First recorded Glasgow Coma Scale 40 (GCS-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 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. (For example, the chart indicates: "patient opened mouth and stuck out tongue when asked" a GCS-40 Motor of 6 may be reported, IF there is no other contradicting documentation).
• Report Field Value “7. Not Testable” if unable to assess (for example, neuromuscular blockade).
• The null value “Not Known/Not Recorded” is reported if Initial ED/Hospital GCS - Motor is reported.
• 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.

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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<td>15503</td>
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<td>Element cannot be blank</td>
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<tr>
<td>15504</td>
<td>2</td>
<td>Element cannot be “Not Applicable”</td>
</tr>
<tr>
<td>15505</td>
<td>2</td>
<td>Element must be “Not Known/Not Recorded” when Initial ED/Hospital GCS – Motor is reported</td>
</tr>
<tr>
<td>15506</td>
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<td>If patient age is less than 5, Element Value 6 is not a valid menu option</td>
</tr>
<tr>
<td>15540</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Initial Assessment TR1.6.1 & TR1.6 – Initial ED/Hospital Height

**Description**

First recorded height after 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.
- Report the null value “Not Known/Not Recorded” if the patient’s Initial ED/Hospital Height was not recorded prior to discharge.
- Please note the 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
3. Pharmacy Record

**Associated Edit Checks (NTDB)**

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
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<tr>
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<td>3</td>
<td>The value is above 215</td>
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<td>Element cannot be “Not Applicable”</td>
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<tr>
<td>8505</td>
<td>2</td>
<td>The value submitted falls outside the valid range of 30-275</td>
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<tr>
<td>8506</td>
<td>3</td>
<td>The value is below 50</td>
</tr>
<tr>
<td>8540</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Initial Assessment TR1.6.5 – Initial ED/Hospital Weight

**Description**

First recorded weight within 24 hours 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.
- Report the value “Not Known/Not Recorded” if the patient’s Initial ED/Hospital Weight was not measured within 24 hours of ED/hospital arrival.
- Please note the 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
3. Pharmacy Record

**Associated Edit Checks (NTDB)**

<table>
<thead>
<tr>
<th>Rule ID</th>
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<td>Element cannot be “Not Applicable”</td>
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<td>8505</td>
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<td>The value submitted falls outside the valid range 1-650</td>
</tr>
<tr>
<td>8606</td>
<td>3</td>
<td>The value is below 3</td>
</tr>
<tr>
<td>8640</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Initial Assessment TR18.91–Drug Screen

Description

First recorded positive drug screen results within 24 hours after first hospital encounter.

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 (Opioid)  
9. OXY (Oxycodone)  
10. PCP (Phencyclidine)  
11. TCA (Tricyclic Antidepressant)  
12. THC (Cannabinoid)  
13. Other  
14. None  
15. Not Tested

Additional Information

• Report all that apply.
• Record positive drug screen results within 24 hours after the patient’s first hospital encounter, at either your facility or the transferring facility.
• Report Element Value “14. None” 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 picklist.

Data Source Hierarchy Guide

1. Lab Results  
2. Transferring Facility Records

Associated Edit Checks (NTDB)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
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<td>6012</td>
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<td>Element cannot be blank</td>
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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,” “14. None” or “15. Not tested” along with element values 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and/or 13</td>
</tr>
<tr>
<td>6050</td>
<td>1</td>
<td>Multiple Entry Max exceeded</td>
</tr>
</tbody>
</table>
Initial Assessment TR18.46–Alcohol Screen

**Description**
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)**

<table>
<thead>
<tr>
<th>Rule ID</th>
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<td>5912</td>
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<td>Element cannot be blank</td>
</tr>
<tr>
<td>5913</td>
<td>2</td>
<td>Element cannot be &quot;Not Applicable&quot;</td>
</tr>
<tr>
<td>5940</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Initial Assessment TR18.103 – Alcohol Screen Results

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

Element Values
Relevant value for data element

Additional Information
- Report 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.
- Report the null value “Not Applicable” for those patients who were not tested.

Data Source Hierarchy Guide
1. Lab Results
2. Transferring Facility Records

Associated Edit Checks (NTDB)

<table>
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<td>5932</td>
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<td>Element cannot be blank</td>
</tr>
<tr>
<td>5933</td>
<td>2</td>
<td>Element must and can only be “Not Applicable” when Alcohol Screen is Element Value “2. No”</td>
</tr>
<tr>
<td>5934</td>
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<td>Single Entry Max exceeded</td>
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<tr>
<td>5935</td>
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<td>The value submitted falls outside the value range of 0.0-1.5</td>
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<tr>
<td>5936</td>
<td>3</td>
<td>The value is above 0.4</td>
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</tbody>
</table>
ED/TTA TR17.27 – ED Discharge Disposition

Description

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

- If multiple orders were written, report the final disposition order.
- The null value "Not Applicable" is reported if the patient was directly admitted to the hospital.
- If ED Discharge Disposition is 4, 5, 6, 9, 10, 11, then Hospital Discharge Date, Hospital Discharge Time, and Hospital Discharge Disposition must be “Not Applicable.”

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>6140</td>
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<td>Single Entry Max exceeded</td>
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</tbody>
</table>
ED/TTA TR17.41 – ED Discharge Date

Description

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

Element Values

Relevant value for data element

Additional Information

- Reported as MM/DD/YYYY.
- The null value "Not Applicable" is reported if the patient was directly admitted to the hospital.
- If ED Discharge Disposition is Element Value "5. Deceased/Expired," then ED Discharge Date is the date of death as indicated on the patient’s death certificate.

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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<tr>
<td>6302</td>
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<td>Date out of range</td>
</tr>
<tr>
<td>6303</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>6307</td>
<td>2</td>
<td>ED Discharge Date is earlier than ED/Hospital Arrival Date</td>
</tr>
<tr>
<td>6310</td>
<td>3</td>
<td>ED Discharge Date occurs more than 365 days after ED/Hospital Arrival Date</td>
</tr>
<tr>
<td>6311</td>
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<td>Element must be and can only be “Not Applicable” when ED Discharge Disposition is “Not Applicable”</td>
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<td>6312</td>
<td>3</td>
<td>ED Discharge Date is earlier than Injury Incident Date</td>
</tr>
<tr>
<td>6313</td>
<td>2</td>
<td>If Hospital Discharge Disposition is “Not Applicable” then ED Discharged Date cannot be earlier than Hospital Procedure Start Date</td>
</tr>
<tr>
<td>6314</td>
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<td>Hospital Discharge Disposition is &quot;Not Applicable,&quot; and ED Discharge Date cannot be earlier than Cerebral Monitor Date</td>
</tr>
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<td>6315</td>
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<td>If Hospital Discharge Disposition is &quot;Not Applicable&quot; and ED Discharge Date cannot</td>
</tr>
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<td>Code</td>
<td>Count</td>
<td>Description</td>
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</tr>
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<td>6316</td>
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<td>If Hospital Discharge Disposition is “Not Applicable” and ED Discharge Date cannot be earlier than Venous Thromboembolism Prophylaxis Date</td>
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<td>If Hospital Discharge Disposition is “Not Applicable” and ED Discharge Date cannot be earlier than Angiography Date</td>
</tr>
<tr>
<td>6318</td>
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<td>If Hospital Discharge Disposition is “Not Applicable” and ED Discharge Date cannot be earlier than Surgery for Hemorrhage Control Date</td>
</tr>
<tr>
<td>6319</td>
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<td>If Hospital Discharge Disposition is “Not Applicable” and ED Discharge Date cannot be earlier than Withdrawal of Life Supporting Treatment Date</td>
</tr>
<tr>
<td>6340</td>
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</table>
ED/TTA TR17.42 – ED Discharge Time

Description

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

Element Values

Relevant value for data element

Additional Information

- Reported as HH:MM military time.
- The null value "Not Applicable" is reported if the patient is directly admitted to the hospital.
- If ED Discharge Disposition is Element Value "5. Deceased/Expired," then ED Discharge Time is the time of death as indicated on the patient’s death certificate.
- 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>-----</td>
<td>-------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
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<td>If Hospital Discharge Disposition is “Not Applicable” then ED Discharge Time cannot be earlier than Hospital Procedure Time</td>
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<td>If Hospital Discharge Disposition is “Not Applicable” then ED Discharge Time cannot be earlier than Cerebral Monitor Time</td>
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<td>If Hospital Discharge Disposition is “Not Applicable” then ED Discharge Time cannot be earlier than Venous Thromboembolism Prophylaxis Time</td>
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<td>If Hospital Discharge Disposition is “Not Applicable” then ED Discharge Time cannot be earlier than Surgery for Hemorrhage Control Time</td>
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</table>
ED/TTA TR18.205–Primary Trauma Service Type

**Description**

The primary service type responsible for the care of this patient.

**Element Values**

1. Adult
2. Pediatric

**Additional Information**

- The primary service type responsible for trauma elevation and care of the patient.
- This element will be used to determine which eligible Trauma Quality Program report [adult or pediatric] the patient will appear; report age criteria will still apply.
- Adult trauma centers that do not have a separate pediatric service must report Element Value “1. Adult.”
- Pediatric trauma centers that do not have a separate adult service must report Element Value “2. Pediatric.”

**Data Source Hierarchy Guide**

5. Triage/Trauma Flow Sheet
6. History & Physical
7. Discharge Summary

**Associated Edit Checks (NTDB)**

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</table>
NTDS PROCEDURE INFORMATION
Procedures TR200.2 – ICD-10 Hospital Procedures

Description
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 PCS or ICD-10 CA procedure codes
- The maximum number of procedures that may be reported for a patient is 200

Additional Information
- Only report procedures performed at your institution.
- Report all procedures performed in the operating room.
- Report 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, report only the first event. If there is no asterisk, report each event even if there is more than one.
- Note that the hospital may report additional procedures.
- Validity is activated when Procedure Performed (TR22.30) is “Yes.”
- Report the null value “Not Applicable” if the patient did not have procedures.

Diagnostic and Therapeutic Imaging
- Computerized tomographic Head*
- Computerized tomographic Chest*
- Computerized tomographic Abdomen*
- Computerized tomographic Pelvis*
- Computerized tomographic C-Spine*
- Computerized tomographic T-Spine*
- Computerized tomographic L-Spine*
- Doppler ultrasound of extremities *
- Diagnostic ultrasound (includes FAST) *
- Angiography
- IVC filter
- REBOA
- Diagnostic imaging interventions on the total body
- Plain radiography of whole body
- Plain radiography of whole skeleton
- Plain radiography of infant whole body

Musculoskeletal
- Soft tissue/bony debridement*
- Closed reduction of fractures
- Skeletal and halo traction
- Fasciotomy

Transfusion
- Transfusion of red cells* (only report first 24 hours after hospital arrival)
- Transfusion of platelets* (only report first 24 hours after hospital arrival)
- Transfusion of plasma* (only report first 24 hours after hospital arrival)
**Cardiovascular**
Open cardiac massage  
CPR

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

**Genitourinary**
Ureteric catheterization (such as, Ureteric stent)  
Suprapubic cystostomy

**Respiratory**
Insertion of endotracheal tube (exclude intubations performed in the OR)  
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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</table>
Procedures TR200.8 – Hospital Procedure Start Date

Description

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

Element Values

Relevant value for the data element

Additional Information

- Reported 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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</tbody>
</table>
Procedures TR200.9 – Hospital Procedure Start Time

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

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

**Additional Information**
- Reported 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 Record
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>Element must be “Not Known/Not Recorded when Hospital Procedure Start Date is “Not Known/Not Recorded”</td>
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<tr>
<td>6750</td>
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<td>Multiple Entry Max exceeded</td>
</tr>
</tbody>
</table>
NTDS PRE-EXISTING CONDITIONS
Description

The patient had a written request to limit life-sustaining treatment that restricted the scope of care for the patient during this patient care event.

Element Values

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

Additional Information

- The written request was signed/dated by the patient and/or the patient’s designee prior to arrival at your center.
- Life-sustaining treatments include but are not limited to intubation, ventilator support, CPR, transfusion of blood products, dialysis or other forms of renal support, institution of medications to support blood pressure or cardiac function, or a specific surgical, interventional or radiological procedure (for example, decompressive craniectomy, operation for hemorrhage control, angiography).
- Report Element Value “2. No” for patients with Advance Directives that did not limit life-sustaining treatments during this patient care event.
- 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 Notes/Flow Sheet
3. Progress Notes
4. Case Management/Social Services Notes
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks (NTDB)

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<tr>
<td>16040</td>
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</table>
Pre-Existing Conditions – Alcohol Use Disorder

Description

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
4. Not Applicable

Additional Information

- Present prior to injury.
- Only report on patients ≥ 15 years-of-age.
- The null value “Not Applicable” must be reported for patients < 15 years-of-age.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available for patients ≥ 15 years-of-age.
- Consistent with American Psychiatric Association (APA) DSM 5, 2013.

Data Source Hierarchy Guide

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

Associated Edit Checks (NTDB)

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<tr>
<td>16140</td>
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</table>
Pre-Existing Conditions – Anticoagulant Therapy

**Description**

Documentation in the medical record of the administration of medication (anticoagulants, antiplatelet agents, thrombin inhibitors, thrombolytic agents) that interferes with blood clotting. EXCLUDE patients whose only anticoagulant therapy is chronic aspirin.

<table>
<thead>
<tr>
<th>ANTICOAGULANTS</th>
<th>ANTIPLATELET AGENTS</th>
<th>THROMBIN INHIBITORS</th>
<th>THROMBOLYTIC AGENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fondaparinux</td>
<td>Tirofiban</td>
<td>Bevalirudin</td>
<td>Alteplase</td>
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<td>Warfarin</td>
<td>Dipyridamole</td>
<td>Argatroban</td>
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<td>Anagrelide</td>
<td>Lepirudin, Hirudin</td>
<td>Tenacteplase</td>
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<td>Eptifibatide</td>
<td>Drotrecogin alpha</td>
<td>Kabikinase</td>
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<td>Pentasaccaride</td>
<td>Clopidogrel</td>
<td>Dabigatran</td>
<td>tPA</td>
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<td>Cilostazol</td>
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<tr>
<td>Heparin</td>
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</table>

**Element Values**

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

**Additional Information**

- Present prior to injury.
- Anticoagulant must be part of the patient’s active medication.
- 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 Notes/Flow Sheet
3. Progress Notes
4. Case Management/Social Services Notes
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks (NTDB)

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</table>
**Pre-Existing Conditions – Attention deficit disorder/Attention deficit hyperactivity disorder (ADD/ADHD)**

**Description**
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 injury.
- 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 Notes/Flow Sheet
3. Progress Notes
4. Case Management/Social Services Notes
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

**Associated Edit Checks (NTDB)**

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</table>
Pre-Existing Conditions – Bipolar I/II Disorder

**Description**

A bipolar I/II disorder diagnosis documented in the medical record.

**Element Values**

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

**Additional Information**

- Present prior to injury.
- Only report on patients ≥ 15 years-of-age.
- The null value “Not Applicable” must be reported for patients < 15 years-of-age.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available for patients ≥ 15 years-of-age.

**Data Source Hierarchy Guide**

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

**Associated Edit Checks (NTDB)**

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<tr>
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<td>Single Entry Max exceeded</td>
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</tbody>
</table>
Pre-Existing Conditions - Bleeding Disorder

**Description**
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 (for example, Hemophilia, von Willenbrand Disease, Factor V Leiden).
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.
- Consistent with American Society of Hematology, 2015.

**Data Source Hierarchy Guide**

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

**Associated Edit Checks (NTDB)**

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</table>
Pre-Existing Conditions – Cerebral Vascular Accident (CVA)

**Description**

A history prior to injury of a cerebrovascular accident (embolic, thrombotic, or hemorrhagic) with persistent residual motor sensory or cognitive dysfunction (for example, 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 Notes/Flow Sheet
3. Progress Notes
4. Case Management/Social Services Notes
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

**Associated Edit Checks (NTDB)**

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<td>Single Entry Max exceeded</td>
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</tbody>
</table>
Pre-Existing Conditions – Chronic Obstructive Pulmonary Disease (COPD)

**Description**

Chronic obstructive pulmonary disease (COPD) is a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible. The more familiar terms "chronic bronchitis" and "emphysema" are no longer used but are now included within the COPD diagnosis.

EXCLUDE:
- Patients whose only pulmonary disease is asthma
- Patients with diffuse interstitial fibrosis or sarcoidosis

**Element Values**

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

**Additional Information**

- Present prior to injury.
- A diagnosis of COPD must be documented in the patient’s medical record.
- Only report on patients ≥ 15 years-of-age.
- The null value “Not Applicable” must be reported for patients < 15 years-of-age.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available for patients ≥ 15 years-of-age.
- Consistent with World Health Organization (WHO), 2019.

**Data Source Hierarchy Guide**

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Pre-Existing Conditions – Chronic Renal Failure

Description

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.

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Pre-Existing Conditions – Cirrhosis

**Description**

Cirrhosis is the replacement of normal liver tissue with non-living scar tissue related to other liver diseases. Must have 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.
- A diagnosis of cirrhosis, or documentation of cirrhosis by diagnostic imaging studies or a laparotomy/laparoscopy, must be in the patient’s medical record.
- Documentation in the medical record may include CHILD or MELD scores that support evidence of cirrhosis.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

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Pre-Existing Conditions – Congenital Anomalies

**Description**

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

**Element Values**

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**Additional Information**

- Present prior to injury.
- A diagnosis of congenital anomaly must be documented in the patient’s medical record.
- Only report on patients < 15 years-of-age.
- The null value “Not Applicable” must be reported for patients ≥ 15 years-of-age.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available for patients < 15 years-of-age.

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Pre-Existing Conditions – Congestive Heart Failure (CHF)

Description

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.

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Pre-Existing Conditions – Current Smoker

Description
A patient who reports smoking cigarettes every day or some days within the last 12 months. EXCLUDE:
  • Patients who smoke cigars or pipes or smokeless tobacco (chewing tobacco or snuff).

Element Values

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

Additional Information

  • Present prior to injury.
  • The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

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Pre-Existing Conditions – Currently Receiving Chemotherapy for Cancer

Description

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.

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Pre-Existing Conditions – Dementia

Description

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

Element Values

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

Additional Information

- Present prior to injury.
- A diagnosis of dementia including Alzheimer’s, Lewy Body Dementia, frontotemporal dementia (Pick’s Disease) and vascular dementia 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.
- Consistent with the National Institute on Aging December 2017.

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### Pre-Existing Conditions – Diabetes Mellitus

**Description**
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.
- Report Element Value “1. Yes” for patients who were non-compliant with their prescribed exogenous parenteral insulin or oral hypoglycemic agent.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

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Pre-Existing Conditions – Disseminated Cancer

**Description**
Cancer that has spread to one or more sites in addition to the primary site AND in 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.
- Another term describing disseminated cancer is "metastatic cancer."
- 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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Pre-Existing Conditions – Functionally Dependent Health Status

Description

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, were 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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Pre-Existing Conditions – Hypertension

Description

History of persistent elevated blood pressure requiring antihypertensive medication.

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.
- Report Element Value “1. Yes” for patients who were non-compliant with their prescribed antihypertensive medication.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

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Pre-Existing Conditions – Major Depressive Disorder

Description
A major depressive disorder diagnosis documented in the medical record.

Element Values

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

Additional Information

• Present prior to injury.
• Only report on patients ≥ 15 years-of-age.
• The null value "Not Applicable" must be reported for patients <15 years-of-age.
• The null value “Not Known/Not Recorded” is only reported if no past medical history is available for patients ≥ 15 years-of-age.

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</table>
Pre-Existing Conditions – Myocardial Infarction (MI)

**Description**

History of a myocardial infarction (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 myocardial infarction 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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Pre-Existing Conditions – Other Mental/Personality Disorders

Description

A diagnosis of any of the following documented in the medical record:

- Antisocial personality disorder
- Avoidant personality disorder
- Borderline personality disorder
- Dependent personality disorder
- Generalized anxiety disorder
- Histrionic personality disorder
- Narcissistic personality disorder
- Obsessive-compulsive disorder
- Obsessive-compulsive personality disorder
- Panic disorder
- Paranoid personality disorder
- Schizotypal personality disorder

Element Values

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

Additional Information

- Present prior to injury.
- Only report on patients ≥ 15 years-of-age.
- The null value “Not Applicable” must be reported for patients < 15 years-of-age.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available for patients ≥ 15 years-of-age.

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Pre-Existing Conditions – Peripheral Arterial Disease (PAD)

Description

The narrowing or blockage of the vessels that carry blood from the heart to the legs. It is primarily caused by the buildup of fatty plaque in the arteries, which is called atherosclerosis. Peripheral Arterial Disease (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
4. Not Applicable

Additional Information

- Present prior to injury.
- A diagnosis of Peripheral Arterial Disease must be documented in the patient’s medical record.
- Only report on patients ≥ 15 years-of-age.
- The null value “Not Applicable” must be reported for patients < 15 years-of-age.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available for patients ≥ 15 years-of-age.
- Consistent with Centers for Disease Control, 2014 Fact Sheet.

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</table>
Pre-Existing Conditions – Post-Traumatic Stress Disorder

**Description**

A post-traumatic stress disorder diagnosis documented in the medical record.

**Element Values**

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

**Additional Information**

- Present prior to injury.
- Only report on patients ≥ 15 years-of-age.
- The null value “Not Applicable” must be reported for patients < 15 years-of-age.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available or patients ≥ 15 years-of-age.

**Data Source Hierarchy Guide**

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

**Associated Edit Checks (NTDB)**

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Pre-Existing Conditions – Pregnancy

**Description**

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**

1. History & Physical
2. Physician Notes/Flow Sheet
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</table>
Pre-Existing Conditions – Prematurity

Description

Babies born before 37 weeks of pregnancy are completed.

Element Values

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

Additional Information

- Present prior to injury.
- Only report on patients < 15 years-of-age.
- 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 Applicable" must be reported for patients ≥ 15 years-of-age.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available for patients < 15 years-of-age.

Data Source Hierarchy Guide

1. History & Physical
2. Physician Notes/Flow Sheet
3. Progress Notes
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Pre-Existing Conditions – Schizoaffective Disorder

Description
A schizoaffective disorder diagnosis documented in the medical record

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

Additional Information
- Present prior to injury.
- Only report on patients ≥ 15 years-of-age.
- The null value "Not Applicable" must be reported for patients < 15 years-of-age
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥ 15 years-of-age.

Data Source Hierarchy Guide
8. History & Physical
9. Physician Notes/Flow Sheet
10. Progress Notes
11. Case Management/Social Services Notes
12. Nursing Notes/Flow Sheet
13. Triage/Trauma Flow Sheet
14. Discharge Summary

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Pre-Existing Conditions – Schizophrenia

Description
A schizophrenia diagnosis documented in the medical record

Element Values

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

• Present prior to injury.  
• Only report on patients ≥ 15 years-of-age.  
• The null value "Not Applicable" must be reported for patients < 15 years-of-age  
• The null value “Not Known/Not Recorded” is only reported if no past medical history is available for patients ≥ 15 years-of-age.

Additional Information

15. History & Physical  
16. Physician Notes/Flow Sheet  
17. Progress Notes  
18. Case Management/Social Services Notes  
19. Nursing Notes/Flow Sheet  
20. Triage/Trauma Flow Sheet  
21. Discharge Summary

Data Source Hierarchy Guide

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</table>
Pre-Existing Conditions – Steroid Use

Description

Regular administration of oral or parenteral corticosteroid medications within 30 days prior to injury for a chronic medical condition.

EXCLUDE:

- Topical corticosteroids applied to the skin, and corticosteroids administered by inhalation or rectally.

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 Chronic Obstructive Pulmonary Disease (COPD), asthma, rheumatologic disease, rheumatoid arthritis, and inflammatory bowel disease.
- 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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Pre-Existing Conditions – Substance Use Disorder

**Description**
Descriptors documented in the patient’s medical record consistent with the diagnostic criteria of substance use disorders specifically cannabis, hallucinogens, inhalants, opioids, sedative/hypnotics, and stimulants (for example, 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**

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

**Additional Information**

- Present prior to injury.
- Only report on patients ≥ 15 years-of-age.
- The null value "Not Applicable" must be reported for patients < 15 years-of-age.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available for patients ≥ 15 years-of-age.
- Consistent with the American Psychiatric Association (APA) DSM 5, 2013.

**Data Source Hierarchy Guide**

1. History & Physical  
2. Physician Notes/Flow Sheets  
3. Progress Notes  
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5. Nursing Notes/Flow Sheet
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NTDS DIAGNOSIS INFORMATION
### Diagnosis TR200.1– ICD-10 Injury Diagnoses

**Description**

Diagnoses related to all identified injuries.

**Element Values**

- Injury diagnoses as defined by ICD-10-CM code range S00-S99, T07, T14, T79.A1-T79.A9 or compatible ICD-10-CA range code.
- 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 (for example, CVA, MI, Co-morbidities, etc.) may also be included in this element.
- Depending on your facility’s setup configuration, an AIS code may auto-associate.

**Data Source Hierarchy Guide**

1. Autopsy/Medical Examiner Report
2. Operative Reports
3. Radiology Reports
4. Physician Notes/Flow Sheets
5. Trauma Flow Sheet
6. History & Physical
7. Nursing Notes/Flow Sheet
8. Progress Notes
9. Discharge Summary

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**Description**

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**

None

**Data Source Hierarchy Guide**

1. AIS coding manual

**Associated Edit Checks (NTDB)**

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NTDS HOSPITAL EVENTS
Hospital Events TR23.1 – Acute Kidney Injury (AKI)

**Description**

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

**EXCLUDE:**

- Patients with renal failure that were requiring chronic renal replacement therapy such as periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration prior to injury.

**KDIGO Staging of AKI for Stage 3:**

- (Scr) 3 times baseline

  **OR:**

  - Increase in Scr to ≥ 4mg/dl (≥ 353.6µmol/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**

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of acute kidney injury (AKI) must be documented in the patient's medical record.
- If the patient or family refuses treatment (for example, dialysis,) the condition is still considered to be present if a combination of oliguria and creatinine are present.
- Consistent with the March 2012 Kidney Disease Improving Global Outcome (KDIGO) Guideline.
# Data Source Hierarchy Guide

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

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Hospital Events TR23.1 – Acute Respiratory Distress Syndrome (ARDS)

Description

- 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 of fluid overload. Need objective assessment (for example, echocardiography) to exclude hydrostatic edema if no risk factor present
- Oxygenation:
  - Mild 200 mm Hg < PaO2/FIO2 < 300 mm Hg With PEEP or CPAP ≥ 5 cm H2O
  - Moderate 100 mm Hg < PaO2/FIO2 < 200 mm Hg With PEEP >5 cm H2O
  - Severe PaO2/FIO2 < 100 mm Hg With PEEP or CPAP ≥5 cm H2O

Element Values

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

Additional Information

- Onset of symptoms began after arrival to your ED/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/Flow Sheet
3. Progress Notes
4. Case Management/Social Services Notes
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
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**Hospital Events TR23.1 – Alcohol Withdrawal Syndrome**

**Description**

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**

- Onset of symptoms began after arrival to your ED/hospital
- Documentation of alcohol withdrawal must be in the patient’s medical record.
- Consistent with the 2019 World Health Organization (WHO) definition of Alcohol Withdrawal Syndrome.

**Data Source Hierarchy Guide**

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

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Hospital Events TR23.1 – Cardiac Arrest with CPR

**Description**

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.

**INCLUDE:**

- Patients who, after arrival at your hospital, have had an episode of cardiac arrest evaluated by hospital personnel, and received compressions or defibrillation or cardioversion or cardiac pacing to restore circulation.

**EXCLUDE:**

- Patients whose ONLY episode of cardiac arrest with CPR was on arrival to your hospital

**Element Values**

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

**Additional Information**

- Onset of symptoms began after arrival to your ED/hospital
- Cardiac arrest must be documented in the patient’s medical record.

**Data Source Hierarchy Guide**

1. History and Physical  
2. Physician Notes/Flow Sheet  
3. Progress Notes  
4. Case Management/Social Services Notes  
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</table>
A urinary tract infection (UTI) where an indwelling urinary catheter was in place for >2 calendar days on the date of event, with day of device placement being Day 1,

AND

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

January 2019 CDC CAUTI Criterion SUTI1a:

Patient must meet 1, 2, and 3 below:

1. Patient has an indwelling urinary catheter in place for more than 2 consecutive days in an inpatient location on the date of event AND was either:
   - Present for any portion of the calendar day 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 (>38⁰C) Reminder: To use fever in a patient >65 years of age, the IUC needs to be in place for more than 2 consecutive days in an inpatient location on date of even and is either still in place OR removed the day before the DOE.
   - Suprapubic tenderness
   - Costovertebral angle pain or tenderness
   - Urinary urgency
   - Urinary frequency
   - Dysuria

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

January 2019 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 (>38.0⁰C)
   - hypothermia (<36.0⁰C)
   - apnea
   - bradycardia
• lethargy
• vomiting
• suprapubic tenderness

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

**Element Values**

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3. Not Known/Not Recorded

**Additional Information**

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of UTI must be documented in the patient’s medical record.
- Consistent with the January 2019 CDC defined CAUTI.

**Data Source Hierarchy Guide**

1. History and Physical
2. Physician Notes/Flow Sheet
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Hospital Events TR23.1 – Central Line-Associated Bloodstream Infection (CLABSI)

**Description**

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 (for example, 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 (such as, diphtheroids [Corynebacterium spp. not C. diphteriae], 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 (for example, 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 (such as, 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 (for example, 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.

Element Values

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

Additional Information

- Onset of symptoms began after arrival to your ED/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

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

Associated Edit Checks (NTDB)

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Hospital Events TR23.1 – Deep Surgical Site Infection

Description

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 (for example, 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 (for example, not Active Surveillance Culture/Testing (ASC/AST) or culture or non-culture based microbiologic testing method is not performed).

AND

Organism(s) identified from the deep soft tissues of the incision by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing (ASC/AST) or culture or non-culture based microbiologic testing method is not performed. A culture or non-culture based test from the deep soft tissues of the incision that has a negative finding does not meet this criterion).

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

** The term attending physician for the purposes of application of the NHSN SSI criteria may be interpreted to mean the surgeon(s), infectious disease, other physician on the case, emergency physician, or physician’s designee (nurse practitioner or physician’s assistant).

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 (for example, 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 (for example, 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

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<td>AMP</td>
<td>Limb amputation</td>
</tr>
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<td>APPY</td>
<td>Appendix surgery</td>
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<td>AVSD</td>
<td>Shunt for dialysis</td>
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<tr>
<td>BILI</td>
<td>Bile duct, liver, or pancreatic surgery</td>
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<td>CEA</td>
<td>Carcoid enterectomy</td>
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<td>CHOL</td>
<td>Gallbladder surgery</td>
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<td>Colon surgery</td>
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<td>Gastric surgery</td>
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<td>Heart transplant</td>
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<td>HYST</td>
<td>Abdominal hysterectomy</td>
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<td>CARD</td>
<td>Cardiac surgery</td>
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<tr>
<td>CBGB</td>
<td>Coronary artery bypass graft with both chest and donor site incisions</td>
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<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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<td>FUSN</td>
<td>Spinal fusion</td>
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<td>FX</td>
<td>Open reduction of fracture</td>
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<td>Herniorrhaphy</td>
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<td>PVBY</td>
<td>Peripheral vascular bypass surgery</td>
</tr>
<tr>
<td>VSHN</td>
<td>Ventricular shunt</td>
</tr>
</tbody>
</table>

**Element Values**

1. Yes 2. No

3. Not Known/Not Recorded

**Additional Information**

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of SSI must be documented in the patient’s medical record.
- Consistent with the January 2019 CDC defined SSI.

**Data Source Hierarchy Guide**

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

**Associated Edit Checks (NTDB)**

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Hospital Events TR23.1 – Deep Vein Thrombosis (DVT)

Description

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

Element Values

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

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of deep vein thrombosis (DVT) must be documented in the patient’s medical record, which may be confirmed by venogram, ultrasound, or CT.
- The patient must be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava.

Data Source Hierarchy Guide

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

Associated Edit Checks (NTDB)

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Hospital Events TR23.1 – Delirium

Description

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.

EXCLUDE:
- Patient's whose delirium is due to alcohol withdrawal.

Element Values

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

Additional Information

Onset of symptoms began after arrival to your ED/hospital

Data Source Hierarchy Guide

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

Associated Edit Checks (NTDB)

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</tbody>
</table>
Hospital Events TR23.1 – Myocardial Infarction (MI)

**Description**

An acute myocardial infarction (MI) 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**

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

**Additional Information**

Onset of symptoms began after arrival to your ED/hospital

**Data Source Hierarchy Guide**

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

**Associated Edit Checks (NTDB)**

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Hospital Events TR23.1 – Organ/Space Surgical Site Infection

Description

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 (for example, closed suction drainage system, open drain, T-tube drain, CT guided drainage).

b) Organisms are identified from 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 (for example, 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 evidence suggestive of infection.

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 day of the procedure

<table>
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<th>Operative Procedure</th>
<th>Code</th>
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<td>Abdominal aortic aneurysm repair</td>
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<td>Laminectomy</td>
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<td>AMP</td>
<td>Limb amputation</td>
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<td>Liver transplant</td>
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<td>APPY</td>
<td>Appendix surgery</td>
<td>NECK</td>
<td>Neck surgery</td>
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<tr>
<td>AVSD</td>
<td>Shunt for dialysis</td>
<td>NEPH</td>
<td>Kidney surgery</td>
</tr>
<tr>
<td>BILI</td>
<td>Bile duct, liver, or pancreatic surgery</td>
<td>OVRY</td>
<td>Ovarian surgery</td>
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<tr>
<td>CEA</td>
<td>Carotid endarterectomy</td>
<td>PRST</td>
<td>Prostate surgery</td>
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<td>CHOL</td>
<td>Gallbladder surgery</td>
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<td>Rectal surgery</td>
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<td>Colon surgery</td>
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<td>Small bowel surgery</td>
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<td>CSEC</td>
<td>Cesarean section</td>
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<td>Spleen surgery</td>
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<td>GAST</td>
<td>Gastric surgery</td>
<td>THOR</td>
<td>Thoracic surgery</td>
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<td>HTP</td>
<td>Heart transplant</td>
<td>THR</td>
<td>Thyroid and/or parathyroid surgery</td>
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<td>HYST</td>
<td>Abdominal hysterectomy</td>
<td>VHYS</td>
<td>Vaginal hysterectomy</td>
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### 30 DAY SURVEILLANCE

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<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>
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<td>Peripheral vascular bypass surgery</td>
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<td>VSHN</td>
<td>Ventricular shunt</td>
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### Table 3. Specific Sites of an Organ/Space SSI.

<table>
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<th>Code</th>
<th>SITE</th>
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<td>BONE</td>
<td>Osteomyelitis</td>
<td>MED</td>
<td>Mediastinitis</td>
</tr>
<tr>
<td>BRST</td>
<td>Breast abscess or mastitis</td>
<td>MEN</td>
<td>Meningitis or ventriculitis</td>
</tr>
<tr>
<td>CARD</td>
<td>Myocarditis or pericarditis</td>
<td>ORAL</td>
<td>Oral cavity infection (mouth, tongue, or gums)</td>
</tr>
<tr>
<td>DISC</td>
<td>Disc space infection</td>
<td>OREP</td>
<td>Deep pelvis tissue infection or other infection of the male or female reproductive tract</td>
</tr>
<tr>
<td>EAR</td>
<td>Ear, mastoid infection</td>
<td>PJI</td>
<td>Periprosthetic joint function</td>
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<tr>
<td>EMET</td>
<td>Endometritis</td>
<td>SA</td>
<td>Spinal abscess/infection</td>
</tr>
<tr>
<td>ENDO</td>
<td>Endocarditis</td>
<td>SINU</td>
<td>Sinusitis</td>
</tr>
<tr>
<td>GIT</td>
<td>Gastrointestinal (GI) tract infection</td>
<td>UR</td>
<td>Upper respiratory tract, pharyngitis, laryngitis, epiglottis</td>
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<tr>
<td>IAB</td>
<td>Intraabdominal infection, not specified elsewhere</td>
<td>USI</td>
<td>Urinary System infection</td>
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<tr>
<td>IC</td>
<td>Intracranial infection</td>
<td>VASC</td>
<td>Arterial or venous infection</td>
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<tr>
<td>JNT</td>
<td>Joint or bursa infection</td>
<td>VCUF</td>
<td>Vaginal cuff infection</td>
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<tr>
<td>LUNG</td>
<td>Other infection of the lower respiratory tract</td>
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**Element Values**

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

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of SSI must be documented in the patient’s medical record.
- Consistent with the CDC January 2019 defined SSI.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDB)

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Hospital Events TR23.1 – Osteomyelitis

Description

Osteomyelitis must meet at least one of the following criteria:

1. Patient has organism(s) identified from bone by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment, for example, 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, for example, not Active Surveillance Culture/Testing (ASC/AST) AND Imaging test evidence suggestive of infection (for example, x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation, specifically, physician documentation of antimicrobial treatment for osteomyelitis.

b. Imaging test evidence suggestive of infection (for example, x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation, specifically physician documentation of antimicrobial treatment for osteomyelitis.

* With no other recognized cause

Element Values

1. Yes
2. No

3. Not Known/Not Recorded

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of osteomyelitis must be documented in the patient’s medical record.
- Consistent with the January 2020 CDC definition of Bone and Joint infection

Data Source Hierarchy Guide

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

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Pressure Ulcer

Description

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

- Onset of symptoms began after arrival to your ED/hospital
- Pressure ulcer documentation must be in the patient’s medical record.
- Consistent with the NPUAP 2014.

Data Source Hierarchy Guide

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

Associated Edit Checks (NTDB)

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</table>
Hospital Events TR23.1 – Pulmonary Embolism (PE)

**Description**

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.

**EXCLUDE:**
- Subsegmental PEs.

**Element Values**

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

**Additional Information**

- Onset of symptoms began after arrival to your ED/hospital
- Consider the condition present if the patient has a VQ 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.

**Data Source Hierarchy Guide**

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

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</table>
Hospital Events TR23.1 – Severe Sepsis

Description

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

- Onset of symptoms began after arrival to your ED/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

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

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**Hospital Events TR23.1 – Stroke/CVA**

**Description**

A focal or global neurological deficit of rapid onset and NOT present on admission caused by a clot obstructing the flow of blood flow to the brain (ischemic stroke). Or by a blood vessel rupturing and preventing blood flow to the brain (hemorrhagic stroke). Or a transient ischemic attack which is temporary caused by a temporary clot. The patient must have at least one of the following symptoms:

- Change in level of consciousness
- Hemiplegia
- Hemiparesis
- Numbness or sensory loss affecting one side of the body
- Dysphasia or aphasia
- Hemianopia
- Amaurosis fugax

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, for example, 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**

- Onset of symptoms began after arrival to your ED/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 (for example, blunt cerebrovascular injury, dysrhythmia) may be present on admission.
1. History and Physical
2. Physician Notes/Flow Sheet
3. Progress Notes
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5. Nursing Notes/Flow Sheet
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7. Discharge Summary

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</table>
**Hospital Events TR23.1 –Superficial Incisional Surgical Site Infection**

**Description**

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 (for example, 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.

** The term attending physician for the purposes of application of the NHSN SSI criteria may be interpreted to mean the surgeon(s), infectious disease, other physician on the case, emergency physician, or physician's designee (nurse practitioner or physician's assistant).

**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 (for example, C-section incision or chest incision for CBGB)

2. Superficial Incisional Secondary (SIS) – a superficial incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (for example, donor site incision for CBGB)

**Element Values**

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

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of SSI must be documented in the patient’s medical record.
- Consistent with the January 2019 CDC defined SSI.

**Data Source Hierarchy Guide**

1. History and Physical
2. Physician Notes/Flow Sheet
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Hospital Events TR23.1 – Unplanned Admission to ICU

**Description**

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.

**INCLUDE:**
- Patients who required ICU care due to an event that occurred during surgery or in the PACU.

**EXCLUDE:**
- Patients with a planned post-operative ICU stay.

**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.

**Data Source Hierarchy Guide**

1. History and Physical
2. Physician Notes/Flow Sheets
3. Progress Notes
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Hospital Events TR23.1 – Unplanned Intubation

Description

Patient requires placement of an endotracheal tube and mechanical or assisted ventilation 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.
- For patients who were intubated in the field or emergency department, or those intubated for surgery, an unplanned intubation occurs if they require reintubation > 24 hours after they were extubated.

Data Source Hierarchy Guide

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Hospital Events TR23.1 – Unplanned Visit to the Operating Room

Description

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

EXCLUDE:

- Non-urgent tracheostomy and percutaneous endoscopic gastrostomy.
- Pre-planned, staged, and/or procedures for incidental findings.
- Operative management related to a procedure that was initially performed prior to arrival at your center.

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.

Data Source Hierarchy Guide

1. History and Physical
2. Physician Notes/Flow Sheet
3. Progress Notes
4. Case Management/Social Services Notes
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Hospital Events TR23.1 – Ventilator-Associated Pneumonia (VAP)

**Description**

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>
<thead>
<tr>
<th>IMAGING TEST EVIDENCE</th>
<th>SIGNS/SYMPOTMS</th>
<th>LABORATORY</th>
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</thead>
<tbody>
<tr>
<td>Two or more serial chest imaging test results with at least <strong>one</strong> of the following:</td>
<td>At least <strong>one</strong> of the following:</td>
<td>At least <strong>one</strong> of the following:</td>
</tr>
<tr>
<td>- New and persistent or progressive and persistent</td>
<td>- Fever (&gt;38°C or &gt;100.4°F)</td>
<td>- Organism identified from blood</td>
</tr>
<tr>
<td>- Infiltrate</td>
<td>- Leukopenia (&lt;4000 WBC/mm³) or leukocytosis (≥12,000 WBC/mm³)</td>
<td>- Organism identified from pleural fluid</td>
</tr>
<tr>
<td>- Consolidation</td>
<td>- For adults ≥70 years old, altered mental status with no other recognized cause</td>
<td>- Positive quantitative culture or corresponding semi-quantitative culture result from minimally-contaminated LRT specimen (specifically, BAL, protected specimen brushing or endotracheal aspirate)</td>
</tr>
<tr>
<td>- Cavitation</td>
<td>- ≥5% BAL-obtained cells contain intracellular bacteria on direct microscopic exam (for example: Gram's stain)</td>
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<tr>
<td>- Pneumatoceles, in infants ≤1-year-old</td>
<td>- New onset of purulent sputum or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</td>
<td>* <strong>Note:</strong> In patients <em>without</em> underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), <strong>one definitive</strong> chest imaging test result is acceptable.</td>
</tr>
<tr>
<td></td>
<td>- New onset or worsening cough, or dyspnea, or tachypnea</td>
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<td></td>
<td>- Rales or bronchial breath sounds</td>
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<td></td>
<td>- Worsening gas exchange (for example: O₂ desaturations [for example: PaO₂/FiO₂ &lt;240], increased oxygen requirements, or increased ventilator demand)</td>
<td>- Positive quantitative culture or corresponding semi-quantitative culture result of lung tissue</td>
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<td>- Histopathologic exam shows at least <strong>one</strong> of the following evidences of pneumonia:</td>
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<td>- Abscess formation or foci of consolidation with intense PMN accumulation in bronchioles and alveoli</td>
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<td>- Evidence of lung parenchyma invasion by fungal hyphae or pseudohyphae</td>
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### VAP Algorithm (PNV2 Viral, Legionella, and other Bacterial Pneumonias):

<table>
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<tr>
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<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 and persistent or progressive and persistent infiltrate</td>
<td>• Fever (&gt;38°C or &gt;100.4°F)</td>
<td>• Virus, <em>Bordetella, Legionella, Chlamydia</em> or <em>Mycoplasma</em> 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 (for example: not Active Surveillance Culture/Testing (ASC/AST)).</td>
</tr>
<tr>
<td>• Infiltrate</td>
<td>• Leukopenia (&lt;4000 WBC/mm³) or leukocytosis (≥12,000 WBC/mm³)</td>
<td>• Fourfold rise in paired sera (IgG) for pathogen (e.g., influenza viruses, <em>Chlamydia</em>).</td>
</tr>
<tr>
<td>• Consolidation</td>
<td>• For adults ≥70 years old, altered mental status with no other recognized cause</td>
<td>• Fourfold rise in <em>Legionella</em> pneumophila serogroup 1 antibody titer to ≥1:128 in paired acute and convalescent sera by indirect IFA.</td>
</tr>
<tr>
<td>• Cavitation</td>
<td>AND at least one of the following:</td>
<td>• Detection of <em>L. pneumophila</em> serogroup 1 antigens in urine by RIA or EIA.</td>
</tr>
<tr>
<td>• Pneumatoceles, in infants ≤1-year-old</td>
<td>• New onset of purulent sputum or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</td>
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**NOTE:** In patients without underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.
<table>
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<tr>
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<th>LABORATORY</th>
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<tbody>
<tr>
<td>Two or more serial chest imaging test results with at least one of the following:</td>
<td>Patient who is immunocompromised (see definition in footnote) has at least one of the following:</td>
<td>At least one of the following:</td>
</tr>
<tr>
<td>• New and persistent or progressive and persistent</td>
<td>• Fever (&gt;38°C or &gt;100.4°F)</td>
<td>• Identification of matching Candida spp. from blood and one of the following: sputum, endotracheal aspirate, BAL or protected specimen brushing.</td>
</tr>
<tr>
<td>• Infiltrate</td>
<td>• For adults ≥70 years old, altered mental status with no other recognized cause</td>
<td>• Evidence of fungi from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing) from one of the following:</td>
</tr>
</tbody>
</table>
| • Consolidation                                                                       | • New onset of purulent sputum or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements |   - Direct microscopic exam  
   - Positive culture of fungi  
   - Non-culture diagnostic laboratory test |
| • Cavitation                                                                          | • New onset or worsening cough, or dyspnea, or tachypnea                                        | OR                                                                                               |
| • Pneumatoceles, in infants ≤1-year-old                                               | • Rales or bronchial breath sounds                                                                | • Any of the following from:                                                                    |
| **NOTE:** In patients without underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable. | • Worsening gas exchange (for example: O2 desaturations [for example: PaO2/FiO2<240], increased oxygen requirements, or increased ventilator demand) | LABORATORY CRITERIA DEFINED UNDER PNU2                                                        |
### VAP Algorithm ALTERNATE CRITERIA (PNU1), for infant’s ≤ 1 year old:

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<tbody>
<tr>
<td>Two or more serial chest imaging test results with at least <strong>one</strong> of the following:</td>
<td>Worsening gas exchange (for example: 2 desaturations [for example pulse oximetry &lt;94%], increased oxygen requirements, or increased ventilator demand)</td>
</tr>
<tr>
<td>• New and persistent <em>or</em> progressive and persistent</td>
<td>And at least <strong>three</strong> of the following:</td>
</tr>
<tr>
<td>• Infiltrate</td>
<td>• Temperature instability</td>
</tr>
<tr>
<td>• Consolidation</td>
<td>• Leukopenia (≤4000 WBC/mm³) or leukocytosis (&gt;15,000 WBC/mm³) and left shift (&gt;10% band forms)</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>• Pneumatoceles, in infants ≤1-year-old</td>
<td>• Apnea, tachypnea, nasal flaring with retraction of chest wall or nasal flaring with grunting</td>
</tr>
</tbody>
</table>

**NOTE:** In patients **without** underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.

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

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<tr>
<td>Two or more serial chest imaging test results with at least <strong>one</strong> of the following:</td>
<td><strong>ALTERNATE CRITERIA</strong>, for child &gt;1 year old or ≤12 years old, at least <strong>three</strong> of the following:</td>
</tr>
<tr>
<td>• New and persistent <em>or</em> progressive and persistent</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>• Infiltrate</td>
<td>• Leukopenia (≤4000 WBC/mm³) or leukocytosis (≥15,000 WBC/mm³)</td>
</tr>
<tr>
<td>• Consolidation</td>
<td>• New onset of purulent sputum or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</td>
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<td>• Cavitation</td>
<td>• New onset or worsening cough, or dyspnea, apnea, or tachypnea</td>
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<tr>
<td>• Pneumatoceles, in infants ≤1-year-old</td>
<td>• Rales or bronchial breath sounds</td>
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</table>

**NOTE:** In patients **without** underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.
Element Values

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

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of pneumonia must be documented in the patient’s medical record.
- Consistent with the January 2019 CDC defined VAP.

Data Source Hierarchy Guide

1. History and Physical
2. Physician Notes/Flow Sheet
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<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Outcome TR26.9– Total ICU Length of Stay

Description

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 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.
- At no time should the ICU LOS exceed the hospital LOS.
- The null value “Not Known/Not Recorded” is reported if any dates are missing.
- If patient has multiple ICU episodes on the same calendar day, count as one calendar day.
- The null value “Not Applicable” is reported if the patient has no ICU days according to the above description.
- 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.
**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

**Description**

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.
- Reported 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.
- At no time should the Total Ventilator Days exceed the hospital LOS.
- The null value “Not Known/Not Recorded” is reported if any dates are missing.
- The null value “Not Applicable” is reported if the patient was not on the ventilator according to the above description.
- 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.
### Data Source Hierarchy Guide

1. Respiratory Therapy Notes/Flow Sheet
2. ICU Flow Sheet
3. Progress Notes

### 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 is greater than the difference between ED/Hospital Arrival Date and the latter of the known ED Discharge Date or 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

## Description

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

## Element Values

Relevant value for data element

## Additional Information

- Reported as MM/DD/YYYY
- The null value “Not Applicable” is used if ED Discharge Disposition is “4, 5, 6, 9, 10, or 11.”
- If Hospital Discharge Disposition is Element Value “5. Deceased/Expired,” then Hospital Discharge Date is the date of death as indicated on the patient’s death certificate.
- 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>7703</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>7707</td>
<td>2</td>
<td>Hospital Discharge Date cannot be earlier than ED/Hospital Arrival Date</td>
</tr>
<tr>
<td>7708</td>
<td>2</td>
<td>Hospital Discharge Date cannot be earlier than ED Discharge Date</td>
</tr>
<tr>
<td>7711</td>
<td>3</td>
<td>Hospital Discharge Date occurs more than 365 days after ED/Hospital Arrival Date</td>
</tr>
<tr>
<td>7713</td>
<td>2</td>
<td>Element must be and can only be “Not Applicable” when Hospital Discharge Disposition is “Not Applicable”</td>
</tr>
<tr>
<td>7714</td>
<td>3</td>
<td>Hospital Discharge Date is earlier than Injury Incident Date</td>
</tr>
<tr>
<td>7715</td>
<td>2</td>
<td>Hospital Discharge Date is earlier than Hospital Procedure Start Date</td>
</tr>
<tr>
<td>7716</td>
<td>2</td>
<td>Hospital Discharge Date is earlier than Cerebral Monitor Date</td>
</tr>
<tr>
<td>7717</td>
<td>2</td>
<td>Hospital Discharge Date is earlier than Venous Thromboembolism Prophylaxis Date</td>
</tr>
<tr>
<td>7718</td>
<td>2</td>
<td>Hospital Discharge Date is earlier than Angiography Date</td>
</tr>
<tr>
<td>7719</td>
<td>2</td>
<td>Hospital Discharge Date is earlier than Surgery for Hemorrhage Control Date</td>
</tr>
<tr>
<td>7720</td>
<td>2</td>
<td>Hospital Discharge Date is earlier than Withdrawal of Life Supporting Treatment Date</td>
</tr>
<tr>
<td>7721</td>
<td>3</td>
<td>Hospital Discharge Date is earlier than Antibiotic Therapy Date</td>
</tr>
<tr>
<td>7740</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Outcome TR25.94– Hospital Discharge Time

Description

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

Element Values

Relevant value for data element

Additional Information

- Reported as HH:MM Military time.
- The null value “Not Applicable” is reported if ED DischargeDisposition is “4, 5, 6, 9, 10, or 11.”
- If Hospital DischargeDisposition is Element Value “5. Deceased/Expired,” then Hospital Discharge Time is the time of death as indicated on the patient’s death certificate.
- 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>7801</td>
<td>1</td>
<td>Time is not valid</td>
</tr>
<tr>
<td>7802</td>
<td>1</td>
<td>Time out of range</td>
</tr>
<tr>
<td>7803</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>7807</td>
<td>2</td>
<td>Hospital Discharge Time cannot be earlier than ED/Hospital Arrival Time</td>
</tr>
<tr>
<td>7808</td>
<td>2</td>
<td>Hospital Discharge Time cannot be earlier than or equal to ED Discharge Time</td>
</tr>
<tr>
<td>7810</td>
<td>2</td>
<td>Element must be and can only be &quot;Not Applicable&quot; when Hospital Discharge Date is “Not Applicable”</td>
</tr>
<tr>
<td>7811</td>
<td>2</td>
<td>Element must be “Not Known/Not Recorded” when Hospital Discharge Date is “Not Known/Not Recorded”</td>
</tr>
<tr>
<td>7812</td>
<td>3</td>
<td>Hospital Discharge Time is earlier than the Injury Incident Time</td>
</tr>
<tr>
<td>7813</td>
<td>2</td>
<td>Hospital Discharge Time is earlier than the Hospital Procedure Start Time</td>
</tr>
<tr>
<td>7814</td>
<td>2</td>
<td>Hospital Discharge Time is earlier than the Cerebral Monitor Time</td>
</tr>
<tr>
<td>7815</td>
<td>2</td>
<td>Hospital Discharge Time is earlier than the Venous Thromboembolism Prophylaxis Time</td>
</tr>
<tr>
<td>7816</td>
<td>2</td>
<td>Hospital Discharge Time is earlier than the Angiography Time</td>
</tr>
<tr>
<td>7817</td>
<td>2</td>
<td>Hospital Discharge Time is earlier than the Surgery for Hemorrhage Control Time</td>
</tr>
<tr>
<td>7818</td>
<td>2</td>
<td>Hospital Discharge Time is earlier than the Withdrawal of Life Supporting Treatment Time</td>
</tr>
<tr>
<td>7819</td>
<td>3</td>
<td>Hospital Discharge Time is earlier than the Antibiotic Therapy Time</td>
</tr>
<tr>
<td>7840</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
**Outcome TR25.27– Hospital Discharge Disposition**

**Description**

The disposition of the patient when discharged from the hospital.

**Element Values**

1. Discharged/Transferred to a short-term general hospital for inpatient care
2. Discharged/Transferred to an Intermediate Care Facility (ICF)
3. Discharged/Transferred to home under care of organized home health service
4. Left against medical advice or discontinued care (AMA)
5. Deceased/Expired
6. Discharged to home or self-care (routine discharge)
7. Discharged/Transferred to Skilled Nursing Facility (SNF)
8. Discharged/Transferred to hospice care
9. Present on discharge
10. Discharged/Transferred to court/law enforcement
11. Discharged/Transferred to inpatient rehab or designated unit
12. Discharged/Transferred to Long Term Care Hospital (LTCH)
13. Discharged/Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
14. Discharged/Transferred to another type of institution not defined elsewhere
15. Not Known/Not Recorded

**Additional Information**

- If multiple orders were written, report the final disposition order.
- Element Values based upon UB-04 disposition coding.
- Element Value “6. Home” refers to the patient’s current place of residence (for example, Prison, Child protective services, etc.).
- Disposition to any other non-medical facility must be reported as Element Value “6. Discharged to home or self-care (routine discharge).”
- Discharged to any other medical facility must be reported as Element Value “14. Discharged/Transferred to another type of institution not defined elsewhere.”
- The null value “Not Applicable” is reported if ED Discharge Disposition is reported as Element Value 4, 5, 6, 9, 10, or 11.
- Hospital Discharge Dispositions which were retired greater than 2 years before the current NTDS versions 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.
- 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>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 must be and can only be &quot;Not Applicable&quot; when ED Discharge Disposition is 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;</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

Description

Primary source of payment for hospital care.

Element Values

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

Additional Information

- No Fault Automobile, Workers compensation, and Blue Cross/Blue Shield should be reported as Element 4 “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>
<td>2</td>
<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
WI DEMOGRAPHIC INFORMATION
### Demographics TR1.2– Medical Record #

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>The facility medical record number that represents the patient</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Element Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relevant value for data element</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>This number will not change for the person regardless of changes to the account number of facilities 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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data Source Hierarchy Guide</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.  Face Sheet</td>
</tr>
<tr>
<td>2.  Billing Sheet</td>
</tr>
<tr>
<td>3.  Discharge Summary</td>
</tr>
<tr>
<td>4.  Admission Form</td>
</tr>
</tbody>
</table>
# Demographics TR1.9 – Patient’s Last Name

## Description

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

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>The first name of the patient</td>
</tr>
</tbody>
</table>

| Relevant value for data element |

<table>
<thead>
<tr>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If Alias is used it will be documented in the alias sections, this field should be the patient’s actual legal name.</td>
</tr>
<tr>
<td>If the patient’s legal name is not known, leave blank.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data Source Hierarchy Guide</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Face Sheet</td>
</tr>
<tr>
<td>2. Billing Sheet</td>
</tr>
<tr>
<td>3. Admission Form</td>
</tr>
</tbody>
</table>
Demographics TR1.51 – Gender

**Description**

The patient’s gender identity

**Element Values**

1. Male-to-Female (MTF)/Transgender Female/Trans Woman
2. Male
3. Genderqueer, neither exclusively male nor female
4. Female-to-Male (FTM)/Transgender Male/Trans Man
5. Female
6. Did not disclose
7. Not known

**Additional Information**

Patient gender should be based upon self-report or identified by a family member.

**Data Source Hierarchy Guide**

1. Face Sheet
2. Billing Sheet
3. Admission Form
4. Triage/Trauma Flow sheet
5. EMS Run Report
6. History and Physical
### Demographics TR200.3.3 – Injury Type

**Description**
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
6. Not Applicable

**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_ca_use_matrix.ashx](https://www.facs.org/~/media/files/quality%20programs/trauma/icd10cm_nonpoisoning_ca_use_matrix.ashx)

**Data Source Hierarchy Guide**
- NTDB External Cause of Injury Matrix.
Pre-Hospital TR5.33 – Was the Patient Extricated?

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the patient extricated?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Element Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Yes</td>
</tr>
<tr>
<td>2. No</td>
</tr>
<tr>
<td>3. Not Known/Not Recorded</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Element Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relevant value for the data element</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Picked from a drop-down menu after selecting agency state.</td>
</tr>
<tr>
<td>• If agency cannot be found, select “Out of State Agency,” and inform trauma program by emailing <a href="mailto:DHSTrauma@dhs.wisconsin.gov">DHSTrauma@dhs.wisconsin.gov</a>.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data Source Hierarchy Guide</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. EMS Run Report</td>
</tr>
</tbody>
</table>
Pre-Hospital TR15.38 – EMS Run Sheet Present?

**Description**
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 7 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 TR9.1 – EMS Dispatch Date

Description

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

Element Values

Relevant value for the data element

Additional Information

- Reported 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)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>2801</td>
<td>1</td>
<td>Date is not valid</td>
</tr>
<tr>
<td>2802</td>
<td>1</td>
<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>
</tr>
<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>
The time the unit transporting to your hospital was notified by dispatch.

### Element Values

Relevant value for the data element

### Additional Information

- Reported as HH:MM military time.
- 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>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>2901</td>
<td>1</td>
<td>Time is not valid</td>
</tr>
<tr>
<td>2902</td>
<td>1</td>
<td>Time out of range</td>
</tr>
<tr>
<td>2903</td>
<td>3</td>
<td>EMS Dispatch Time is later than EMS Unit Arrival on Scene Time</td>
</tr>
<tr>
<td>2904</td>
<td>3</td>
<td>EMS Dispatch Time is later than EMS Unit Scene Departure Time</td>
</tr>
<tr>
<td>2905</td>
<td>3</td>
<td>EMS Dispatch Time is later than ED/Hospital Arrival Time</td>
</tr>
<tr>
<td>2906</td>
<td>3</td>
<td>EMS Dispatch Time is later than ED Discharge Time</td>
</tr>
<tr>
<td>2907</td>
<td>3</td>
<td>EMS Dispatch Time is later than Hospital Discharge Time</td>
</tr>
<tr>
<td>2908</td>
<td>2</td>
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</tr>
<tr>
<td>2940</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
The date the unit transporting to your hospital arrived on the scene/transferring facility.

**Element Values**

Relevant value for the data element

**Additional Information**

- Reported 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>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
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<tbody>
<tr>
<td>3001</td>
<td>1</td>
<td>Date is not valid</td>
</tr>
<tr>
<td>3002</td>
<td>1</td>
<td>Date out of range</td>
</tr>
<tr>
<td>3003</td>
<td>3</td>
<td>EMS Unit Arrival on Scene Date is earlier than Date of Birth</td>
</tr>
<tr>
<td>3004</td>
<td>3</td>
<td>EMS Unit Arrival on Scene Date is earlier than EMS Dispatch Date</td>
</tr>
<tr>
<td>3005</td>
<td>3</td>
<td>EMS Unit Arrival on Scene Date is later than EMS Unit Scene Departure Date</td>
</tr>
<tr>
<td>3006</td>
<td>3</td>
<td>EMS Unit Arrival on Scene Date is later than ED/Hospital Arrival Date</td>
</tr>
<tr>
<td>3007</td>
<td>3</td>
<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>
</tr>
<tr>
<td>3009</td>
<td>3</td>
<td>EMS Unit Arrival on Scene Date minus EMS Dispatch Date is greater than 7 days</td>
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<tr>
<td>3040</td>
<td>1</td>
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</tbody>
</table>
Pre-Hospital TR9.2.1 – EMS Arrive Scene Time

Description

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

Element Values

Relevant value for the data element

Additional Information

- Reported 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)

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<th>Message</th>
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<td>3102</td>
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<td>3103</td>
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<td>EMS Unit Arrival on Scene Time is earlier than EMS Dispatch Time</td>
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<tr>
<td>3104</td>
<td>3</td>
<td>EMS Unit Arrival on Scene Time is later than EMS Unit Scene Departure Time</td>
</tr>
<tr>
<td>3105</td>
<td>3</td>
<td>EMS Unit Arrival on Scene Time is later than ED/Hospital Arrival Time</td>
</tr>
<tr>
<td>3106</td>
<td>3</td>
<td>EMS Unit Arrival on Scene Time is later than ED Discharge Time</td>
</tr>
<tr>
<td>3107</td>
<td>3</td>
<td>EMS Unit Arrival on Scene Time is later than Hospital Discharge Time</td>
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<td>3108</td>
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</table>
Pre-Hospital TR9.3 – EMS Leave Scene Date

Description

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

Element Values

Relevant value for the data element

Additional Information

- Reported 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>
<tr>
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<th>Level</th>
<th>Message</th>
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<tr>
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<td>Date is not valid</td>
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<tr>
<td>3202</td>
<td>1</td>
<td>Date out of range</td>
</tr>
<tr>
<td>3203</td>
<td>3</td>
<td>EMS Unit Scene Departure Date is earlier than Date of Birth</td>
</tr>
<tr>
<td>3204</td>
<td>3</td>
<td>EMS Unit Scene Departure Date is earlier than EMS Dispatch Date</td>
</tr>
<tr>
<td>3205</td>
<td>3</td>
<td>EMS Unit Scene Departure Date is earlier than EMS Unit Arrival on Scene Date</td>
</tr>
<tr>
<td>3206</td>
<td>3</td>
<td>EMS Unit Scene Departure Date is later than ED/Hospital Arrival Date</td>
</tr>
<tr>
<td>3207</td>
<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>
</tr>
<tr>
<td>3210</td>
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</tr>
<tr>
<td>3240</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Pre-Hospital TR9.3.1 – EMS Leave Scene Time

Description

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

Element Values

Relevant value for the data element

Additional Information

- Reported 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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<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
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<td>3301</td>
<td>1</td>
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<td>3302</td>
<td>1</td>
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<td>3303</td>
<td>3</td>
<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>
<td>3</td>
<td>EMS Unit Scene Departure Time is later than ED/Hospital Arrival Time</td>
</tr>
<tr>
<td>3306</td>
<td>3</td>
<td>EMS Unit Scene Departure Time is later than the ED Discharge Time</td>
</tr>
<tr>
<td>3307</td>
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<td>EMS Unit Scene Departure Time is later than Hospital Discharge Time</td>
</tr>
<tr>
<td>3308</td>
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</tr>
<tr>
<td>3340</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Pre-Hospital TR18.67 – Initial Field Systolic Blood Pressure

Description

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

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
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<td>3601</td>
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<td>Invalid value</td>
</tr>
<tr>
<td>3602</td>
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</tr>
<tr>
<td>3603</td>
<td>3</td>
<td>The value is above 220</td>
</tr>
<tr>
<td>3606</td>
<td>2</td>
<td>The value submitted falls outside the valid range of 0-380</td>
</tr>
<tr>
<td>3607</td>
<td>3</td>
<td>The value is below 30</td>
</tr>
<tr>
<td>3640</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Pre-Hospital TR18.69 – Initial Field Pulse Rate

Description

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)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>3701</td>
<td>1</td>
<td>Invalid value</td>
</tr>
<tr>
<td>3702</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>3703</td>
<td>3</td>
<td>The value submitted is above 220</td>
</tr>
<tr>
<td>3706</td>
<td>2</td>
<td>The value submitted falls outside the valid range of 0-300</td>
</tr>
<tr>
<td>3707</td>
<td>3</td>
<td>The value submitted is below 30</td>
</tr>
<tr>
<td>3740</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Pre-Hospital TR18.70 – Initial Field Respiratory Rate

**Description**

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)**

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>3801</td>
<td>1</td>
<td>Invalid value or Respiratory Rate exceeds 120</td>
</tr>
<tr>
<td>3802</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>3806</td>
<td>2</td>
<td>The value submitted falls outside the valid range of 0-100</td>
</tr>
<tr>
<td>3807</td>
<td>3</td>
<td>The value is below 5</td>
</tr>
<tr>
<td>3808</td>
<td>3</td>
<td>The value is above 75</td>
</tr>
<tr>
<td>3840</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Pre-Hospital TR18.80 – Pre-Hospital Respiratory Assistance

Description

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
Pre-Hospital TR18.82 – Initial Field Oxygen Saturation

Description

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)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>3901</td>
<td>1</td>
<td>Invalid value</td>
</tr>
<tr>
<td>3902</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>3906</td>
<td>2</td>
<td>The value submitted falls outside the valid range of 0-100</td>
</tr>
<tr>
<td>3907</td>
<td>3</td>
<td>The value is below 40</td>
</tr>
<tr>
<td>3940</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
First recorded Glasgow Coma Scale (Eyes) 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 recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS, the appropriate numeric score may be listed. (For example, the chart indicates: "patient’s pupils are PERRL,” an Eye GCS of 4 may be reported, 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 Eyes was NOT measured at the scene of injury.
- The null value “Not Known/Not Recorded” is reported if Initial Field GCS-40 Eyes is reported.

**Data Source Hierarchy Guide**

1. EMS Run Report

**Associated Edit Checks (NTDB)**

<table>
<thead>
<tr>
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<th>Message</th>
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<td>Value is not a valid menu option</td>
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<tr>
<td>4003</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>4006</td>
<td>2</td>
<td>Element must be “Not Applicable” when Initial Field GCS-40 Eyes is reported</td>
</tr>
<tr>
<td>4040</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
First recorded Glasgow Coma Scale (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 recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS, the appropriate numeric score may be listed. (For example, the chart indicates: "patient is oriented to person place and time," a Verbal GCS of 5 may be reported, 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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<th>Message</th>
</tr>
</thead>
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<td>Element cannot be blank</td>
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<tr>
<td>4106</td>
<td>2</td>
<td>Element must be &quot;Not Applicable&quot; when Initial Field GCS-40 Verbal is reported</td>
</tr>
<tr>
<td>4140</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
### Description
First recorded Glasgow Coma Scale (Motor) measured at the scene of injury.

### Element Values

**Pediatric (≤ 2 years):**

<table>
<thead>
<tr>
<th>1. No motor response</th>
<th>4. Withdrawal from pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Extension to pain</td>
<td>5. Localizing pain</td>
</tr>
<tr>
<td>3. Flexion to pain</td>
<td>6. Appropriate response to stimulation</td>
</tr>
</tbody>
</table>

**Adult**

<table>
<thead>
<tr>
<th>1. No motor response</th>
<th>4. Withdrawal from pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Extension to pain</td>
<td>5. Localizing pain</td>
</tr>
<tr>
<td>3. Flexion to pain</td>
<td>6. Obeys commands</td>
</tr>
</tbody>
</table>

### 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 written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS, the appropriate numeric score may be listed. (For example, 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
<table>
<thead>
<tr>
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<th>Level</th>
<th>Message</th>
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</thead>
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<tr>
<td>4203</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>4206</td>
<td>2</td>
<td>Element must be “Not Applicable” when Initial Field GCS-40 Motor is reported</td>
</tr>
<tr>
<td>4240</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
First recorded Glasgow Coma Scale (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 Eyes, 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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<th>Message</th>
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</thead>
<tbody>
<tr>
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<td>1</td>
<td>GCS Total is outside the valid range of 3 - 15</td>
</tr>
<tr>
<td>4303</td>
<td>3</td>
<td>Initial Field GCS - Total does not equal the sum of Initial Field GCS - Eyes, Initial Field GCS - Verbal, and Initial Field GCS – Motor, unless any of these values are “Not Known/Not Recorded”</td>
</tr>
<tr>
<td>4304</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>4306</td>
<td>2</td>
<td>Element must be “Not Known/Not Recorded” when Initial Field GCS-40 Eyes, Initial Field GCS-40 Verbal, or Initial Field GCS-40 Motor are reported.</td>
</tr>
<tr>
<td>4340</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
## Pre-Hospital TR18.90.2 & TR18.90.0 – Initial Field GCS-40 Eyes

### Description
First recorded Glasgow Coma Scale 40 (Eyes) measured at the scene of injury.

### Element Values

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

**Pediatric < 5 Years:**
- 1. None
- 2. To Pain
- 3. To Sound
- 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 recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS-40, the appropriate numeric score may be listed. For example, the chart indicates: "patient's eyes open spontaneously," an Eyes GCS-40 of 4 may be recorded, IF there is no other contradicting documentation.
- Report Field Value "0. Not Testable" if unable to assess (for example 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 Eyes was NOT measured at the scene of injury.
- The null value “Not Known/Not Recorded” is reported if Initial Field GCS – Eyes is reported.

### Data Source Hierarchy Guide
1. EMS Run Report
<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>15001</td>
<td>1</td>
<td>Value is not a valid menu option</td>
</tr>
<tr>
<td>15003</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>15006</td>
<td>2</td>
<td>Element must be “Not Known/Not Recorded” when Initial Field GCS – Eyes is reported</td>
</tr>
<tr>
<td>15040</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
**Pre-Hospital TR18.91.2 & TR18.91.0 – Initial Field GCS-40 Verbal**

**Description**

First recorded Glasgow Coma Scale 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. For example, 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 (for example patient is intubated).
- The null value “Not Applicable” is used for patients who arrive by 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)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>15101</td>
<td>1</td>
<td>Value is not a valid menu option</td>
</tr>
<tr>
<td>15103</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>15106</td>
<td>2</td>
<td>Element must be “Not Known/Not Recorded” when Initial Field GCS – Verbal is reported</td>
</tr>
<tr>
<td>15140</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
First recorded Glasgow Coma Scale 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. For example, 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 (for example, 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)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>15201</td>
<td>1</td>
<td>Value is not a valid menu option</td>
</tr>
<tr>
<td>15203</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>15205</td>
<td>2</td>
<td>Element must be “Not Applicable” when Transport Mode is “4. Private/Public Vehicle/Walk in”</td>
</tr>
<tr>
<td>15240</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Pre-Hospital TR17.22 – Trauma Triage Criteria (Steps 1 and 2)

**Description**

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 (for example, 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)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>9501</td>
<td>1</td>
<td>Value is not a valid menu option</td>
</tr>
<tr>
<td>9502</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>9506</td>
<td>2</td>
<td>Element cannot be “Applicable” or “Not Known/Not Recorded” along with any other valid value</td>
</tr>
<tr>
<td>9550</td>
<td>1</td>
<td>Multiple Entry Max exceeded</td>
</tr>
</tbody>
</table>
### Pre-Hospital TR17.47 – Trauma Triage Criteria (Steps 3 and 4)

**Description**

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**

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

**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)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>9601</td>
<td>1</td>
<td>Value is not a valid menu option</td>
</tr>
<tr>
<td>9602</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>9607</td>
<td>2</td>
<td>Element cannot be “Not Applicable” or &quot;Not Known/Not Recorded&quot; along with any other valid value</td>
</tr>
<tr>
<td>9650</td>
<td>1</td>
<td>Multiple Entry Max exceeded</td>
</tr>
</tbody>
</table>
WI REFERRING FACILITY INFORMATION
Referring Facility TR33.64 – Transfer In

<table>
<thead>
<tr>
<th>Description</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the facility transferred to your facility from another acute care facility?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Element Values</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Yes</td>
<td></td>
</tr>
<tr>
<td>2. No</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>If &quot;No&quot; is selected, then click “Add Referring Hospital Info” and submit the tab to continue data entry.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data Source Hierarchy Guide</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. EMS run sheet</td>
<td></td>
</tr>
<tr>
<td>2. Trauma/Triage/Hospital Flow Sheet</td>
<td></td>
</tr>
<tr>
<td>3. Referring facility paperwork</td>
<td></td>
</tr>
</tbody>
</table>
### Referring Facility TR33.1 – Referring Hospital

**Description**

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
<table>
<thead>
<tr>
<th>Referring Facility TR33.1.1 – Other Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
</tr>
<tr>
<td>Free text field to identify the name of the out-of-state facility that transferred the patient to your facility.</td>
</tr>
<tr>
<td><strong>Element Values</strong></td>
</tr>
<tr>
<td>Free text description of the facility that transferred the patient to your facility</td>
</tr>
<tr>
<td><strong>Additional Information</strong></td>
</tr>
<tr>
<td>• Only used when the referring facility is not listed.</td>
</tr>
<tr>
<td>• Will show when Referring Hospital is set to Other.</td>
</tr>
<tr>
<td><strong>Data Source Hierarchy Guide</strong></td>
</tr>
<tr>
<td>1. EMS run sheet</td>
</tr>
<tr>
<td>2. Trauma/Triage/Hospital Flow Sheet</td>
</tr>
</tbody>
</table>
## Referring Facility TR33.1.2 – Other Facility Transferred From City

### Description
The city the patient was transferred from.

### Element Values
Free text description of the city 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
3. EMS run sheet
4. Trauma/Triage/Hospital Flow Sheet
## Referring Facility TR33.1.3 – Other Facility Transferred From State

### Description

The name of the state the patient was transferred from.

### Element Values

Relevant value for data element

### Additional Information

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

### Data Source Hierarchy Guide

5. EMS run sheet
6. Trauma/Triage/Hospital Flow Sheet
### Referring Facility TR33.1.4 – Other Facility Transferred from Country

**Description**
The name of the country the patient was transferred from.

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

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

**Data Source Hierarchy Guide**
- 7. EMS run sheet
- 8. Trauma/Triage/Hospital Flow Sheet
## Referring Facility TR 33.2 – Referring Facility Arrival Date

### Description

The date the patient arrived at the referring facility.

### Element Values

Relevant data values in MM/DD/YYYY

### Additional Information

If date of arrival is not documented, leave blank.

### 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

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>The time the patient arrived at the referring facility.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Element Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reported as HH: MM.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If time of arrival is not documented, leave blank.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data Source Hierarchy Guide</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Referring facility documentation</td>
</tr>
<tr>
<td>2. Trauma/Transfer/Hospital Flow Sheet</td>
</tr>
</tbody>
</table>
### Referring Facility TR33.30 – Discharge Date

<table>
<thead>
<tr>
<th><strong>Description</strong></th>
<th>The date the patient was discharged from 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 discharge is not documented, leave blank.</td>
</tr>
</tbody>
</table>
| **Data Source Hierarchy Guide** | 1. Referring facility documentation  
2. Trauma/Transfer/Hospital Flow Sheet |
### Referring Facility TR33.31 – Discharge Time

**Description**
The time the patient was discharged from the referring facility.

**Element Values**
Reported as 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

### Description

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

### Description
Location the patient arrived from.

### Element Values
1. Scene
2. Referring Hospital
3. Clinic/MD Office
4. Jail
5. Home
6. Nursing Home
7. Supervised Living
8. Urgent Care
9. 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**

**Description**
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**
1. Ground Ambulance
2. Helicopter Ambulance
3. Fixed-wing Ambulance
4. Private Vehicle/Walk-in
5. Police
6. Other
7. Not Applicable
8. 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**

**Description**
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
Description

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. Referring 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

**Description**

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

Description

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

Element Values

1. Level 1
2. Level 2
3. Level 3
4. Not Activated
5. Not Known/Not Recorded
6. 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

**Description**
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

**Description**

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

**Element Values**

Reported as 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

**Description**
The service the patient was admitted to at your facility.

**Element Values**

<table>
<thead>
<tr>
<th>Element Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Anesthesia/CRNA</td>
</tr>
<tr>
<td>2. Burn</td>
</tr>
<tr>
<td>3. Cardiology</td>
</tr>
<tr>
<td>4. Cardiovascular (CV) Surgery</td>
</tr>
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</tr>
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<td>6. Emergency Medicine</td>
</tr>
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<td>7. ENT</td>
</tr>
<tr>
<td>8. Gastrointestinal</td>
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<tr>
<td>9. General Surgery</td>
</tr>
<tr>
<td>10. Gynecology</td>
</tr>
<tr>
<td>11. Hospitalist</td>
</tr>
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<td>12. Infection Control</td>
</tr>
<tr>
<td>13. Internal Medicine</td>
</tr>
<tr>
<td>14. Nephrology</td>
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<td>15. Neurology</td>
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<td>16. Neurosurgery</td>
</tr>
<tr>
<td>17. Non-Surgical</td>
</tr>
<tr>
<td>18. Not Applicable</td>
</tr>
<tr>
<td>19. Not Known/Not Recorded</td>
</tr>
<tr>
<td>20. OB</td>
</tr>
<tr>
<td>21. Ophthalmology</td>
</tr>
<tr>
<td>22. Or Surg</td>
</tr>
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<td>23. OralMax</td>
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<td>32. Thoracic Surgery</td>
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<td>33. Trauma</td>
</tr>
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</tr>
<tr>
<td>35. Urology</td>
</tr>
<tr>
<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

### Description
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
- Reported as MM/DD/YYYY.
- 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
**Description**
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**
- Reported 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
WI PROCEDURE INFORMATION
### Procedures TR22.30 – Procedure Performed?

<table>
<thead>
<tr>
<th>Description</th>
<th>Element Values</th>
<th>Additional Information</th>
<th>Data Source Hierarchy Guide</th>
</tr>
</thead>
</table>
| Indicate if the patient had a procedure performed upon them while in your facility. | 1. Yes  
2. No  
3. Not Known/Not Recorded | If the answer is “No,” leave ICD-10 Procedures, Date Performed, and Time blank. | 1. Trauma/Triage/Hospital Flow Sheet |
**Diagnosis – Injury Severity Score**

**Description**

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 UUI code to populate**
WI OUTCOME INFORMATION
### Outcome TR25.34 – Hospital Physical Discharge Date

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

**Additional Information**
- Reported as MM/DD/YYYY.
- 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

**Description**
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**
- Reported as HH:MM military time.
- 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 – Injury Severity Score Region

### Description

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

### Element Values

1. Head – TR21.2
2. Face – TR21.5
4. Abdomen – TR21.6
5. Extremity – TR21.4

### 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
### Outcome TR25.92 Discharge Status

**Description**

Patient discharge status indicated discharged status from trauma care facility.

**Element Values**

1. Alive
2. Dead

**Additional Information**

Relevant value for data element

**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 Data 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

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<th>Analytical Report Name</th>
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### PRE-HOSPITAL

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**Celsius:** Temperature measured in degrees Celsius (°C).<br>**Fahrenheit:** Temperature measured in degrees Fahrenheit (°F).
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## PROCEDURES

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| CORE     | NA           | TRISS        | • TRISS Blunt  
• TRISS Penetrating | ED-Hospital Probability Of Survival TRISS - Calculated (TR21.9) |
| CORE     | 7. Head – TR21.2  
8. Face – TR21.5  
10. Abdomen – TR21.6  
11. Extremity – TR21.4  
12. External – TR21.7 | ISS Region | 1. AIS Head Calculated (TR21.2.1)  
2. AIS Face Calculated (TR21.5.1)  
3. AIS Chest Calculated (TR21.3.1)  
4. AIS Abdomen Calculated (TR21.6.1)  
5. AIS Extremity Calculated (TR21.4.1)  
6. AIS External Calculated (TR21.7.1) | 1. ED-Hospital AIS Head Region Score - Calculated (TR21.2.1)  
2. ED-Hospital AIS Face Region Score - Calculated (TR21.5.1)  
3. ED-Hospital AIS Chest Region Score - Calculated (TR21.3.1)  
4. ED-Hospital AIS Abdomen Region Score - Calculated (TR21.6.1)  
5. ED-Hospital AIS Extremities Region Score - Calculated (TR21.4.1)  
6. ED-Hospital AIS External Region Score - Calculated (TR21.7.1) |
## INJURY SEVERITY INFORMATION

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## HOSPITAL COMPLICATIONS

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### OTHER COMMON ELEMENTS

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SECTION D:
Wisconsin NTDB Extension Import Mapping

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

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

**Schema Data Type**
String

**XSD Type**
xs:string

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

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

**Schema Data Type**
String

**XSD Type**
xs:string

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

**Description**
The patient’s middle initial

**Schema Data Type**
String

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

**Description**
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

**Description**
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>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>1</td>
</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>
</tr>
</tbody>
</table>
### Demographics TR1.51 – Patient Gender Identity

**Description**
The gender identity of the patient.

**Schema Data Type**
String

**XSD Type**
xs:string

**Element Values**

<table>
<thead>
<tr>
<th>Activation Level</th>
<th>3&lt;sup&gt;rd&lt;/sup&gt; party upload code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>1</td>
</tr>
<tr>
<td>Female</td>
<td>2</td>
</tr>
<tr>
<td>Female-to-Male</td>
<td>3</td>
</tr>
<tr>
<td>Male-to-Female</td>
<td>4</td>
</tr>
<tr>
<td>Genderqueer</td>
<td>5</td>
</tr>
<tr>
<td>Did not disclose</td>
<td>7</td>
</tr>
</tbody>
</table>