WISCONSIN DEPARTMENT of HEALTH SERVICES

Division of Public Health

2025 Wisconsin State Trauma Registry Data Dictionary

Applicable: January 1, 2025

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

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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 a registrar has questions that cannot be answered in this data dictionary or other resources cited within, please contact dhstrauma@dhs.wisconsin.gov.

This is the 2025 edition of the dictionary and incorporates changes in requirements from the National Trauma Data Bank (NTDB); the WTCS; and any changes in data entry resulting from updates by the state trauma registry vendor.

The Department of Health Services (DHS) receives authority 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 from DHS 118.09. 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 the WTCS 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 DHS, 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

2025 Inclusion Criteria

Applicable to patients admitted: January 1, 2025, to December 31,2025

A trauma patient is defined as a patient sustaining a traumatic injury within 14 days of initial hospital encounter and meeting the following criteria below. 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:

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 regions)
- T79.A1-T79.A9 with 7th character modified of A ONLY (Traumatic Compartment Syndrome – initial encounter)

AND

Excluding the following isolated injuries

- S00 (Superficial injuries of the head)
- S10 (Superficial injuries of the neck)
- S20 (Superficial injuries of the thorax)
- S30 (Superficial injuries of the abdomen, pelvis, lower back, and external genitals)
- S40 (Superficial injuries of shoulder and upper arm)
- S50 (Superficial injuries of elbow and forearm)
- S60 (Superficial injuries of wrist, hand, and fingers)
- S70 (Superficial injuries of hip and thigh)
- S80 (Superficial injuries of knee and lower leg)
- S90 (Superficial injuries of ankle, foot, and toes)

Late effect codes, which are represented using the same range of injury diagnosis codes but with the 7th digit modifier code of D through S, are also excluded.

AND

Must include **one** of the following in addition to the first two criteria.

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 (e.g., 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

Note: Acute care hospital is defined as a hospital that provides inpatient medical care and other related services for surgery, acute medical conditions, or injuries (usually for a short-term illness or condition). Standalone EDs are included. "CMS Data Navigator Glossary of Terms" https://www.cms.gov/Research-Statistics-Data-and-Sytems/Research/ResearchGenInfo/Downloads/DataNav_Glossary_Alpha.pdf (accessed January 15, 2019).

OR

Patients transferred/discharged to hospice (e.g., hospice facility, hospice unit, home hospice)

OR

There was a leveled trauma team activation.

EXCLUDE:
In-house traumatic injuries sustained after initial ED/hospital arrival and before hospital discharge at the index hospital (the hospital reporting data), and all data associated with that injury event.

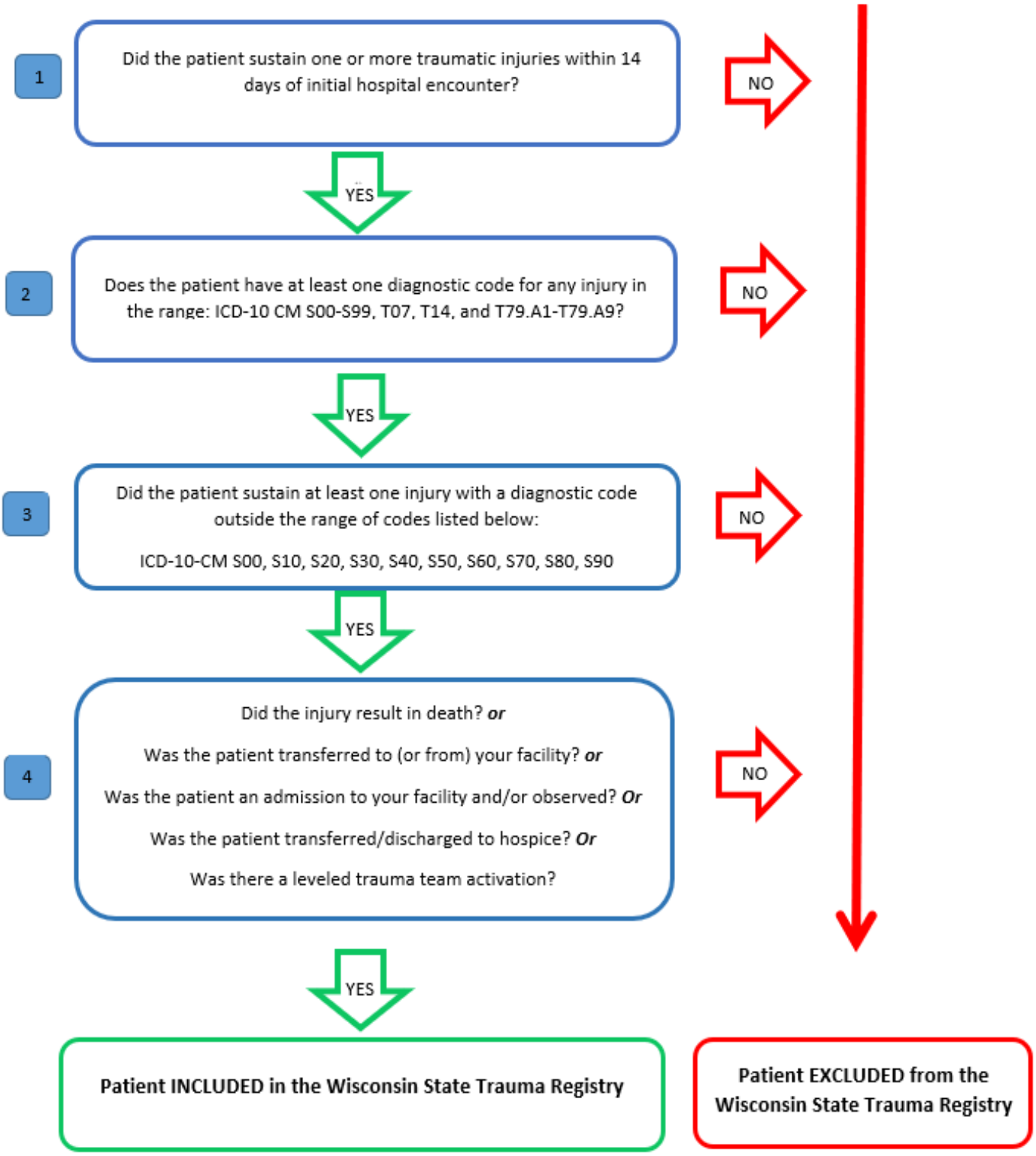
Facilities may also determine to include patients in their registry that meet their facility inclusion criteria. Examples of acceptable additional criteria include:

- 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.

**Below are further explanations of the ICD-10 Categories that patients must sustain to meet inclusion criteria

S00-S09	Injuries to the head
S10-S19	Injuries to the neck
S20-S29	Injuries to the thorax
S30-S39	Injuries to the abdomen, lower back, lumbar spine, pelvis, and external genitals
S40-S49	Injuries to the shoulder and upper arm
S50-S59	Injuries to the elbow and forearm
S60-S69	Injuries to the wrist, hand, and fingers
S70-S79	Injuries to the hip and thigh
S80-S89	Injuries to the knee and lower leg
S90-S99	Injuries to the ankle and foot
T07	Unspecified multiple injuries
T14	Injury of unspecified body region
T79.A1-TR9.A9	Traumatic compartment syndrome

2025 Inclusion Criteria Flowchart



Example Inclusion Scenarios

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

- 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).

- 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.

- 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.

- 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.

Null Values

These values are to be used as the null values:

- Not Applicable (NA): Applies when the information requested was not applicable at the time of the patient care event. For example, the common null value "NA" is reported in the data element *Other Transport Mode* if a patient had a single mode of transport.
- Not Known/Not Recorded (NK/NR), Not Documented, Unknown are interchangeable: Applies when the information is unknown (to the patient, family, health care provider) or not recorded at the time of the patient care event. For example, the common value "NK/NR" is reported in the data element *Injury Incident Date* if it was documented as "Unknown" in the patient medical record. Another example, the common null value "NK/NR" is reported when documentation was expected, but none was provided, i.e. *Initial ED/Hospital Temperature* was not documented in the patient medical record.

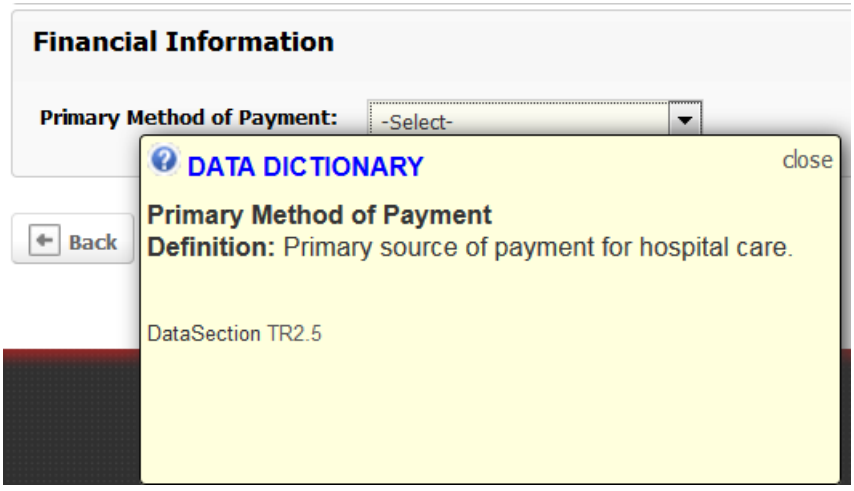
The data elements listed within this document are available for either direct user entry, or auto- population based on the information collected. Any element not listed in this document is either not currently required by the State of Wisconsin or does not allow for direct entry within the ImageTrend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

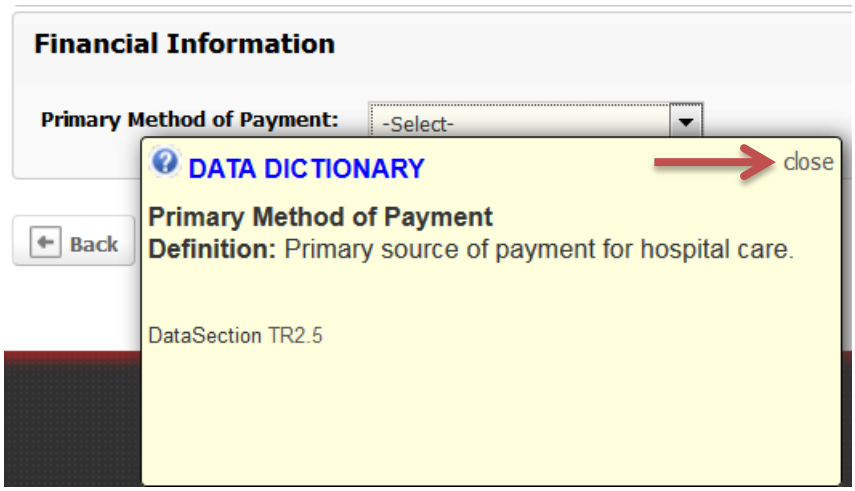
Dictionary Element Legend

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

- Enter the data entry form and locate your desired data element
- Select the title of the data element



- To return to the data entry form, select "close" in the definition window.



This data dictionary contains required fields for 2025 diagnoses. The data items on the following pages are listed by category. Each data item description contains:

Will appear if the element is required by the State of Wisconsin

Will appear if the element is required by the NTDB

Will appear if the element is required for upload by 3rd parties

Will appear if the element is optional for all incidents

ImageTrend Tab Location, Element Number, Element Title

Description

The general meaning of the data element.

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

Instructions for reporting the data element.

Data Source Hierarchy Guide

Sources where information can be obtained in the medical record.

Associated Edit Checks (NTDB)

If the element is NTDB required, the associated validation 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

Definition

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

Element Values

Relevant value for data element

Additional Information

- Can be stored as a 5- or 9-digit code (XXXXX-XXXX) for US 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*.
- 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)

Rule ID	Level	Message
0001	1	Invalid value
0002	2	Field cannot be blank
0040	1	Single Entry Max exceeded

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 (e.g., 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)

Rule ID	Level	Message
0101	1	Invalid value
0102	2	Element cannot be blank
0104	2	Element cannot be "Not Applicable"
0105	2	Element cannot be "Not Known/Not Recorded" when *Patient's Home ZIP/Postal Code* is any response other than "Not Applicable" or "Not Known/Not Recorded"
0140	1	Single Entry Max exceeded

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 *Patient's Home 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)

Rule ID	Level	Message
0201	1	Invalid value
0202	2	Element cannot be blank
0204	2	Element cannot be "Not Applicable" (Non-US hospitals only)
0205	2	Element cannot be "Not Known/Not Recorded" when *Patient's Home Zip/Postal Code* is reported
0240	1	Single Entry Max exceeded

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 reported 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)

Rule ID	Level	Message
0301	1	Invalid value
0302	2	Element cannot be blank
0304	2	Element cannot be "Not Applicable" (Non-US hospitals only)
0305	2	Element must be "Not Applicable" when *Patient's Home Zip/Postal Code* is reported
0340	1	Single Entry Max exceeded

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)

Rule ID	Level	Message
0401	1	Invalid value
0402	2	Element cannot be blank
0404	2	Element cannot be "Not Applicable" (Non-US hospitals only)
0405	2	Element must be "Not Applicable" when *Patient's Home Zip/Postal Code* is reported
0440	1	Single Entry Max exceeded

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
4. Not Applicable
5. Not Known/Not Recorded

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 his/her 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)

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

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)

Rule ID	Level	Message
0601	1	Invalid value
0602	2	Date out of range
0603	2	Element cannot be blank
0612	2	Date of Birth + 120 years must be less than *Injury Incident Date*
0613	2	Element cannot be "Not Applicable"
0650	1	Date cannot be later than upload date
0640	1	Single Entry Max exceeded

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)

Rule ID	Level	Message
0701	1	Age is outside the valid range of 0-120
0703	2	Element cannot be blank
0705	3	Age is greater than expected for the *Age Units* specified. Age must not exceed 60 minutes, 24 hours, 30 days, 24 months, or 120 years. Please verify this is correct.
0708	2	Element must be "Not Known/Not Recorded" when *Age Units* is "Not Known/Not Recorded"
0709	2	Element must be and can only be "Not Applicable" if *Date of Birth* is reported unless *Date of Birth* is same as *ED/Hospital Arrival Date*
0740	1	Single Entry Max exceeded

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
7. Not Applicable
8. Not Known/Not Recorded

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)

Rule ID	Level	Message
0801	1	Value is not a valid menu option
0803	2	Element cannot be blank
0806	2	Element must be "Not Known/Not Recorded" when *Age* is "Not Known/Not Recorded"
0810	2	Element must be and can only be "Not Applicable" if *Age* is "Not Applicable"
0840	1	Single Entry Max exceeded

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 and Physical

Associated Edit Checks (NTDB)

Rule ID	Level	Message
0901	1	Value is not a valid menu option
0902	2	Element cannot be blank
0903	2	Element cannot be "Not Applicable" (excluding Canadian hospitals)
0905	2	Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other value
0950	1	Multiple Entry Max exceeded

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 and Physical
6. EMS Run Report

Associated Edit Checks (NTDB)

Rule ID	Level	Message
1001	1	Value is not a valid menu option
1002	2	Element cannot be blank
1003	2	Element cannot be "Not Applicable" (excluding Canadian hospitals)
1040	1	Single Entry Max exceeded

Demographics TR1.56 – Sex Assigned at Birth

Description

The patient's sex assigned at birth.

Element Values

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

Additional Information

Also referred to as birth sex, natal sex, biological sex.

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

Associated Edit Checks (NTDB)

Rule ID	Level	Message
1101	1	Value is not a valid menu option
1102	2	Element cannot be blank
1103	2	Element cannot be "Not Applicable"
1140	1	Single Entry Max exceeded

Demographics TR1.51 – Gender

Description

The patient's gender identity.

Element Values

1. Man
2. Woman
3. Non-binary, genderqueer, gender nonconforming
4. Non-disclosed

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

Associated Edit Checks (NTDB)

Rule ID	Level	Message
1111	1	Value is not a valid menu option
1112	2	Element cannot be blank
1113	2	Element cannot be "Not Applicable"
11140	1	Single Entry Max exceeded

Demographics TR1.55 – Gender-Affirming Hormone Therapy

Description

Is the patient currently (i.e., within the past 30 days) taking hormone therapy?

EXCLUDE:
Patients who undergo hormone therapy for other medical reasons.

Element Values

1. Yes
2. No
3. Non-disclosed

Additional Information

- Gender-affirming hormone therapy includes but is not limited to estrogen, antiandrogens, and testosterone.
- If unclear if medication was for gender-affirming hormone therapy, then consult TMD or relevant physician/physician extender.

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

Associated Edit Checks (NTDB)

Rule ID	Level	Message
1301	1	Value is not a valid menu option
1302	2	Element cannot be blank
1303	2	Element cannot be "Not Applicable"
1340	1	Single Entry Max exceeded

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 (e.g., 911 call times) must not be reported.

Data Source Hierarchy Guide

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

Associated Edit Checks (NTDB)

Rule ID	Level	Message
1201	1	Date is not valid
1202	2	Date out of range
1203	2	Element cannot be blank
1204	2	*Injury Incident Date* is earlier than *Date of Birth*
1211	2	Element cannot be "Not Applicable"
1212	3	*Incident Injury Date* is greater than 14 days earlier than the *ED/Hospital Arrival Date*
1213	1	Date cannot be later than upload date
1240	1	Single Entry Max exceeded

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 (e.g., 911 call times) must not be reported.

Data Source Hierarchy Guide

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

Associated Edit Checks (NTDB)

Rule ID	Level	Message
1301	1	Time is not valid
1302	1	Time out of range
1303	2	Element cannot be blank
1310	2	Element cannot be "Not Applicable"
1340	1	Single Entry Max exceeded

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.

Data Source Hierarchy Guide

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

Associated Edit Checks (NTDB)

Rule ID	Level	Message
1401	1	Value is not a valid menu option
1402	2	Element cannot be blank
1407	2	Element cannot be "Not Applicable"
1440	1	Single Entry Max exceeded

Injury TR2.6 – Patient's Occupational Industry

Description

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

Element Values

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

Additional Information

- If work-related, *Patient's Occupation* must be reported.
- The null value "Not Applicable" is reported if *Work-Related* is Element Value "2. No."
- Based upon US Bureau of Labor Statistics Industry Classification.

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)

Rule ID	Level	Message
1501	1	Value is not a valid menu option
1504	2	Element cannot be blank
1505	2	If *Work-Related* is "1. Yes," *Patient's Occupational Industry* cannot be "Not Applicable"
1506	2	"Not Applicable" must be reported if *Work-Related* is "2. No"
1540	1	Single Entry Max exceeded

PATIENT'S OCCUPATIONAL INDUSTRY:

The occupational industry 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 makes new products by hand, such as bakeries, candy stores, and custom tailors, may also be included in this sector.

Retail Trade -The Retail Trade sector comprises establishments engaged in retailing merchandise, generally without transformation, and rendering services incidental to the sale of merchandise. The retailing process is the final step in the distribution of merchandise; retailers are, therefore, organized to sell merchandise in small quantities to the general public.
This sector comprises two main types of retailers:
1. Store retailers operate fixed point-of-sale locations, located and designed to attract a high volume of walk-in customers.
2. Non-store retailers, like store retailers, are organized to serve the general public, but their retailing methods differ.

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

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

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

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

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

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

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

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

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

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

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

Other Services -The Other Services sector comprises establishments engaged in providing services not specifically provided for elsewhere in the classification system. Establishments in this sector are primarily engaged in activities, such as equipment and machinery repairing, promoting or administering religious activities, grant-making, advocacy, and providing dry-cleaning and laundry services, personal care services, death care services, pet care services, photofinishing services, temporary parking services, and dating services.

Injury TR2.11 – Patient's Occupation

Description

The occupation of the patient.

Element Values

1. Business and Financial Operations Occupations
2. Architecture and Engineering Occupations
3. Community and Social Services Occupations
4. Education, Training, and Library Occupations
5. Health Care Practitioners and Technical Occupations
6. Protective Service Occupations
7. Building and Grounds Cleaning and Maintenance
8. Sales and Related Occupations
9. Farming, Fishing and Forestry Occupations
10. Installation, Maintenance and Repair Occupations
11. Transportation and Material Moving Occupations
12. Management Occupations
13. Computer and Mathematical Occupations
14. Life, Physical, and Social Sciences Occupations
15. Legal Occupations
16. Arts, Design, Entertainment, Sports, and Media
17. Healthcare Support Occupations
18. Food Preparation and Serving Related
19. Personal Care and Service Occupations
20. Office and Administrative Support Occupations
21. Construction and Extraction Occupations
22. Production Occupations
23. Military Specific Occupations
24. Not Applicable
25. Not Known/Not Recorded

Additional Information

- Only 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."
- Based upon 1999 US Bureau of Labor Statistics Standard Occupational Classification (SOC).

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)

Rule ID	Level	Message
1601	1	Value is not a valid menu option
1604	2	Element cannot be blank
1605	2	If *Work-Related* is "1. Yes," *Patient's Occupation* cannot be "Not Applicable"
1606	2	"Not Applicable" must be reported if *Work-Related* is "2. No"
1640	1	Single Entry Max exceeded

Injury TR200.3 – ICD-10 Primary External Cause Code; Additional External Cause Code

Description

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

Element Values

Relevant ICD-10-CM or ICD-10 CA code value for injury event

Additional Information

- The primary external cause code must 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 must 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 and Physical
5. Progress Notes

Associated Edit Checks (NTDB)

Rule ID	Level	Message
8901	1	E-Code is not a valid ICD-10-CM code (ICD-10 CM only)
8902	2	Element cannot be blank
8904	2	Must not be Y92.X/Y92.XX/Y92.XXX (where X is A-Z or 0-9) (ICD- 10 CM only)

8905	3	ICD-10 External Cause Code must not be Y93.X/Y93.XX (where X is A-Z or 0-9) (ICD-10 CM only)
8906	1	E-Code is not a valid ICD-10-CA code (ICD-10 CA only)
8907	2	Element cannot be "Not Applicable"
8940	1	Single Entry Max exceeded
9101	1	E-code is not a valid ICD-10-CM code (ICD-10-CM only)
9102	3	Additional External Cause Code ICD-10 must not be equal to Primary External
9103	2	Element cannot be blank
9104	1	E-code is not a valid ICD-10-CA code (ICD-10 CA only)
9105	2	ICD-10-CM T74 and T76 codes cannot be submitted as Additional External Cause Codes
9106	2	Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any value
9140	1	Multiple Entry Max exceeded

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

Description

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

Element Values

Relevant ICD-10-CM or ICD-10 CA codes value for injury event

Additional Information

Only ICD-10-CM or ICD-10 CA codes are accepted.

Data Source Hierarchy Guide

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

Associated Edit Checks (NTDB)

Rule ID	Level	Message
9001	1	Invalid value (ICD-10 CM only)
9002	2	Element cannot be blank
9003	3	Place of Injury code must be Y92.X/Y92.XX/Y92.XXX (where X is A-Z [excluding I, O] or 0-9) (ICD-10 CM only)
9004	1	Invalid value (ICD-10 CA only)
9005	3	Place of Injury code should be U98X (where X is 0-9) (ICD-10 CA only)
9006	2	Element cannot be "Not Applicable"
9040	1	Single Entry Max exceeded

Injury TR5.6 – Incident Location Zip/Postal Code

Description

The ZIP/Postal code of the incident location.

Element Values

Relevant value for the 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.
- 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)

Rule ID	Level	Message
2001	1	Invalid value
2002	2	Element cannot be blank
2006	2	Element cannot be "Not Applicable"
2040	1	Single Entry Max exceeded

Injury TR5.11 – Incident Country

Description

The country where the incident occurred.

Element Values

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

Additional Information

- Values are two-character FIPS codes representing the country (e.g., 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)

Rule ID	Level	Message
2101	1	Invalid value
2102	2	Element cannot be blank
2104	2	Element cannot be "Not Applicable"
2015	2	Element cannot be "Not Known/Not Recorded" when *Incident Location ZIP/Postal Code* is any response other than not "Not Known/Not Recorded"
2140	1	Single Entry Max exceeded

Injury TR5.7 – Incident State

Description

The state, territory, or province where the incident occurred.

Element Values

Relevant value for the 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)

Rule ID	Level	Message
2201	1	Invalid value
2203	2	Element cannot be blank
2204	2	Element cannot be "Not Applicable" (Non-US hospitals)
2205	2	Element must be "Not Applicable" when *Incident Location ZIP/Postal Code* is reported
2240	1	Single Entry Max exceeded

Injury TR5.9 – Incident County

Description

The county or parish where the incident occurred.

Element Values

Relevant value for the data element (three-digit numeric FIPS code)

Additional Information

- Only reported when *Incident Location ZIP/Postal Code* is "Not Known/Not Recorded" 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)

Rule ID	Level	Message
2301	1	Invalid value (US only)
2303	2	Element cannot be blank
2304	2	Element cannot be "Not Applicable" (Non-US hospitals)
2305	2	Element must be "Not Applicable" when *Incident Location ZIP/Postal Code* is reported
2340	1	Single Entry Max exceeded

Injury TR5.10 – Incident City

Description

The city or township where the incident occurred.

Element Values

Relevant value for the 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)

Rule ID	Level	Message
2401	1	Invalid value
2403	2	Element cannot be blank
2404	2	Element cannot be "Not Applicable" (Non-US hospitals)
2405	2	Element must be "Not Applicable" when *Incident Location ZIP/Postal Code* is reported
2440	1	Single Entry Max exceeded

Injury Protective Devices, Airbag Deployment, Child Specific Restraint Description

Protective devices: 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: protective child restraint devices used by patient at the time of injury.

Element Values & Data Element

TR29.24: Protective Devices

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

TR29.32: 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

TR29.31: 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 (booster seat or child car seat)" 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 Element Value "1. None."
- *Airbag deployed front* should be used for patients with documented airbag deployments but are not further specified.
- 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.
- Marking this element *Three Point Restraint* will cause *Lap Belt* and *Shoulder Belt* to be auto selected.

Data Source Hierarchy Guide

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

Associated Edit Checks (NTDB)

Rule ID	Level	Message
2501	1	Value is not a valid menu option
2502	2	Element cannot be blank
2507	2	Element cannot be "Not Applicable"
2508	2	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.
2550	1	Multiple Entry Max exceeded
2601	1	Value is not a valid menu option
2603	2	Element cannot be blank
2604	2	Element cannot be "Not Applicable" when *Protective Devices* is 7: Child Restraint
2640	1	Single Entry Max exceeded
2701	1	Value is not a valid menu option
2703	2	Element cannot be blank
2704	2	Element cannot be "Not Applicable" when *Protective Devices* is 9: Airbag Present
2705	2	Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other value
2750	1	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

EMS Run Report

Associated Edit Checks (NTDB)

Rule ID	Level	Message
3401	1	Value is not a valid menu option
3402	2	Element cannot be blank
3404	2	Element cannot be "Not Applicable"
3440	1	Single Entry Max exceeded

Pre-Hospital TR8.11 – Other Transport Mode

Description

All other modes of transport used during the 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
7. Not Known/Not Recorded

Additional Information

- Report all that apply (maximum of 5).
- Report Element Value "6. Other" for unspecified modes of transport.
- The null value "Not Applicable" is reported to indicate that a patient had a single mode of transport.

Data Source Hierarchy Guide

EMS Run Report

Associated Edit Checks (NTDB)

Rule ID	Level	Message
3501	1	Value is not a valid menu option
3502	2	Element cannot be blank
3503	2	Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other value
3550	1	Multiple Entry Max exceeded

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)

Rule ID	Level	Message
90000	1	Invalid value
90001	2	Element cannot be blank
90002	2	Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other value
9940	1	Multiple Entry Max exceeded

Pre-Hospital TR25.54 – Inter-Facility Transfer

Description

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

INCLUDE:
Patients who require physical transfer from a free-standing emergency department (ED) to an affiliated trauma center.

EXCLUDE:
Patients transferred from a private doctor's office or stand-alone ambulatory surgery center.

Element Values

1. Yes
2. No

Additional Information

- Outlying facilities purporting to provide emergency care services or utilized to stabilize a patient are considered acute care facilities.
- Acute Care Hospital is defined as a hospital that provides inpatient medical care and other related services for surgery, acute medical conditions, or injuries (usually for a short-term illness or condition)."CMS Data Navigator Glossary of Terms" https://www.cms.gov/Research-Statistics-Data-and-systems/Research/ResearchGenInfo/Downloads/DataNav_Glossary_Alpha.pdf (accessed Jan 15, 2019).
- Must complete TR16.22 *Arrived From* and TR8.8 *Mode of Arrival* to populate this field.

Data Source Hierarchy Guide

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

Associated Edit Checks (NTDB)

Rule ID	Level	Message
4401	2	Element cannot be blank
4402	1	Value is not a valid menu option
4405	2	Element cannot be "Not Applicable"
4440	1	Single Entry Max exceeded

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 and Physical
4. Transfer Notes

Associated Edit Checks (NTDB)

Rule ID	Level	Message
9701	1	Value is not a valid menu option
9702	2	Element cannot be blank
9703	2	Element cannot be "Not Applicable"
9740	1	Single Entry Max exceeded

Pre-Hospital TR60.1 – Intubation Prior to Arrival

Description

The patient was intubated with a definitive airway due to this injury prior to arrival at your hospital.

INCLUDE:
Definitive airways placed below the vocal cords (e.g., endotracheal tube (ET), tracheostomy, cricothyroidotomy).

EXCLUDE:
Airways not placed below the vocal cords (e.g., combitube, KING, laryngeal mask airway (LMA), I-Gel).

Element Values

1. Yes
2. No
3. Not Applicable

Additional Information

- If Element Value "1. Yes" is reported, report *Intubation Location*.
- The null value "Not Applicable" is reported for patients who had an established airway prior to this injury event (e.g., Chronic Ventilator Dependence).

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)

Rule ID	Level	Message
2601	1	Value is not a valid menu option
2602	2	Element cannot be blank
2640	1	Single Entry Max exceeded

Pre-Hospital TR60.2 – Intubation Location

Description

The location the patient was intubated at prior to hospital arrival.

Element Values

1. Out of hospital intubation
2. Transferring facility
3. Not Applicable
4. Not Known/Not Recorded

Additional Information

- Only reported if *Intubation Prior to Arrival* is Element Value "1. Yes."
- The null value "Not Applicable" is reported if *Intubation Prior to Arrival* is reported as Element Value "2. No."
- The null value "Not Applicable" is reported if *Intubation Prior to Arrival* is reported as "Not Applicable."
- The null value "Not Known/Not Recorded" is reported if *Intubation Prior to Arrival* is reported as "Not Known/Not Recorded."
- Element Value "1. Out of hospital intubation" includes intubations performed in the field, during transport to the hospital, or during an inter-facility transport.
- If multiple intubations occurred, report the location of the first intubation.

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)

Rule ID	Level	Message
2701	1	Value is not a valid menu option
2702	2	Element cannot be blank
2703	2	Element must be and can only be "Not Applicable" when *Intubation Prior to Arrival* is "Not Applicable" or Element Value "2. No"
2704	2	Element must be "Not Known/Not Recorded" when *Intubation Prior to Arrival* is "Not Known/Not Recorded"
2740	1	Single Entry Max exceeded

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

The 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 and Physical
4. Physician Notes/Flow Sheet
5. Discharge Summary

Associated Edit Checks (NTDB)

Rule ID	Level	Message
14201	1	Value is not a valid menu option
14202	2	Element cannot be blank
14203	2	Element cannot be "Not Applicable"
14240	1	Single Entry Max exceeded

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

- Collected 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 and Physical
3. Physician Notes/Flow Sheet
4. Nursing Notes/Flow Sheet

Associated Edit Checks (NTDB)

Rule ID	Level	Message
14301	1	Date is not valid
14302	1	Date is out of range
14303	2	Element cannot be blank
14304	3	*Trauma Surgeon Arrival Date* is earlier than *Injury Incident Date*
14450	1	Date cannot be later than upload date
14340	1	Single Entry Max exceeded

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

- Collected as HH:MM Military time.
- 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 and Physical
3. Physician Notes
4. Nursing Notes

Associated Edit Checks (NTDB)

Rule ID	Level	Message
14401	1	Time is not valid
14402	1	Time is out of range
14403	2	Element cannot be blank
14404	3	*Trauma Surgeon Arrival Time* is earlier than *Injury Incident Time*
14440	1	Single Entry Max exceeded

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, report the date the 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)

Rule ID	Level	Message
4501	1	Date is not valid
4502	1	Date is out of range
4503	2	Element cannot be blank
4505	2	Element cannot be "Not Known/Not Recorded"
4511	3	*ED/Hospital Arrival Date* is earlier than *Date of Birth*
4513	3	*ED/Hospital Arrival Date* occurs more than 14 days after *Injury Incident Date*
4515	2	Element cannot be "Not Applicable"
4516	3	*ED/Hospital Arrival Date* is earlier than the *Injury Incident Date*
4550	1	Date cannot be later than upload date
4540	1	Single Entry Max exceeded

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 the patient arrived at the ED. If the patient was directly admitted to the hospital, report the time the 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)

Rule ID	Level	Message
4601	1	Time is not valid
4602	1	Time is out of range
4603	2	Element cannot be blank
4609	2	Element cannot be "Not Applicable"
4610	3	*ED/Hospital Arrival Time* is earlier than *Injury Incident Time*
4640	1	Single Entry Max exceeded

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 reported 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)

Rule ID	Level	Message
4701	1	Invalid Value
4702	2	Element cannot be blank
4704	3	The value is above 220
4705	2	Element cannot be "Not Applicable"
4706	2	The value submitted falls outside the valid range of 0 - 380
4707	3	The value is below 30
4740	1	Single Entry Max exceeded

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 reported 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)

Rule ID	Level	Message
4801	1	Invalid Value
4802	2	Element cannot be blank
4804	3	The value is above 220
4805	2	Element cannot be "Not Applicable"
4806	2	The value submitted falls outside the valid range of 0 – 300
4807	3	The value is below 30
4840	1	Single Entry Max exceeded

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:

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

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.

Data Source Hierarchy Guide

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

Associated Edit Checks (NTDB)

Rule ID	Level	Message
4901	1	Invalid Value
4902	2	Element cannot be blank
4903	3	The value is above 40.0
4904	2	Element cannot be "Not Applicable"
4905	2	The value submitted falls outside the valid range of 10.0 – 45.0
4906	3	The value is below 25.0
4940	1	Single Entry Max exceeded

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)

Rule ID	Level	Message
5001	1	Invalid Value
5002	2	Element cannot be blank
5005	2	The value submitted falls outside the valid range 0 – 100
5006	2	Element cannot be "Not Applicable"
5007	3	The value is below 5
5008	3	The value is above 75
5040	1	Single Entry Max exceeded

Initial Assessment TR18.10 – Initial ED/Hospital Respiratory Assistance

Description

Determination of respiratory assistance associated with the *Initial ED/Hospital Respiratory Rate* within 30 minutes of ED/hospital arrival.

Element Values

1. Unassisted Respiratory Rate
2. Assisted Respiratory Rate
3. Not Applicable
4. 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)

Rule ID	Level	Message
5101	1	Value is not a valid menu option
5102	2	Element cannot be blank
5103	2	Element must be "Not Applicable" when *Initial ED/Hospital Respiratory Rate* is "Not Known/Not Recorded"
5140	1	Single Entry Max exceeded

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)

Rule ID	Level	Message
5201	1	Invalid value
5202	2	Element cannot be blank
5205	2	Element cannot be "Not Applicable"
5206	2	The value submitted falls outside the valid range of 0 - 100
5207	3	The value is below 40
5240	1	Single Entry Max exceeded

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

1. Yes
2. No
3. Not Applicable
4. 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)

Rule ID	Level	Message
5301	1	Value is not a valid menu option
5303	2	Element cannot be blank
5304	2	Element cannot be "Not Applicable" when *Initial ED/Hospital Oxygen Saturation* is "Not Known/Not Recorded"
5340	1	Single Entry Max exceeded

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 (e.g., 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 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)

Rule ID	Level	Message
5401	1	Value is not a valid menu option
5403	2	Element cannot be blank
5404	2	Element cannot be "Not Applicable"
5405	2	Element must be "Not Known/Not Recorded" when *Initial ED/Hospital GCS – 40 Eyes* is reported
5440	1	Single Entry Max exceeded

Initial Assessment TR18.15.2 & TR18.15.0 – Initial ED/Hospital GCS - Verbal

Description

First recorded Glasgow Coma Scale (GCS) Verbal within 30 minutes of ED/hospital arrival.

Element Values

Adult TR18.15.2:

1. No verbal response
2. Incomprehensible sounds
3. Inappropriate words
4. Confused
5. Oriented
6. Not Known/Not Recorded

Pediatric (≤ 2 years) TR18.15.0:

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

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. (E.g., 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 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

Associated Edit Checks (NTDB)

Rule ID	Level	Message
5501	1	Value is not a valid menu option
5503	2	Element cannot be blank
5504	2	Element cannot be "Not Applicable"
5505	2	Element must be "Not Known/Not Recorded" when *Initial ED/Hospital GCS – 40 Verbal* is reported
5540	1	Single Entry Max exceeded

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

Description

First recorded Glasgow Coma Scale (GCS) Motor within 30 minutes of ED/hospital arrival.

Element Values

Adult TR18.16.2:

1. No motor response
2. Extension to pain
3. Flexion to pain
4. Withdrawal from pain
5. Localizing pain
6. Obeys commands
7. Not Applicable
8. Not Known/Not Recorded

Pediatric (≤ 2 years) TR18.16.0:

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

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. (E.g., the chart indicates: "patient withdraws from a painful stimulus," a GCS Motor 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

Associated Edit Checks (NTDB)

Rule ID	Level	Message
5601	1	Value is not a valid menu option
5603	2	Element cannot be blank
5604	2	Element cannot be "Not Applicable"
5605	2	Element must be "Not Known/Not Recorded" when *Initial ED/Hospital GCS – 40 Motor* is reported
5640	1	Single Entry Max exceeded

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* were 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)

Rule ID	Level	Message
5701	1	GCS Total is outside the valid range of 3 - 15
5703	3	*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 "Not Known/Not Recorded"
5705	2	Element cannot be blank
5706	2	Element cannot be "Not Applicable"
5707	2	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.
5740	1	Single Entry Max exceeded

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

Description

Documentation of factors potentially affecting the first assessment of GCS within 30 minutes of ED/hospital arrival.

Element Values

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

Additional Information

- Report all that apply.
- Identifies treatments given to the patient that may affect the first GCS assessment. 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 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. (e.g., 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)

Rule ID	Level	Message
5801	1	Value is not a valid menu option
5802	2	Element cannot be blank
5803	2	Element cannot be "Not Applicable"
5804	2	Element must be "Not Known/Not Recorded" when *Initial ED/Hospital GCS – 40 Eye, Initial ED/Hospital GCS – 40 verbal*, or *Initial ED/Hospital GCS – 40 Motor* are reported.
5805	2	Element cannot be "Not Known/Not Recorded" along with any other value
5806	2	The null value "Not Known/Not Recorded" is reported if the *Initial ED/Hospital GCS-Eyes, Initial ED/Hospital GCS-Verbal*, and *Initial ED/Hospital GCS-Motor* are reported as "Not Known/Not Recorded"
5850	1	Multiple Entry Max exceeded

Initial Assessment TR18.40.2 & TR18.40.0 – Initial ED/Hospital GCS – 40 Eyes

Description

First recorded Glasgow Coma Scale 40 (GCS-40) Eyes score in the ED/hospital within 30 minutes of ED/hospital arrival.

Element Values

Adults TR18.40.2:

1. None
2. To Pressure
3. To Sound
4. Spontaneous
5. Not Testable
6. Not Known/Not Recorded

Pediatric < 5 Years TR18.40.2:

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. (e.g., 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 (e.g., swelling to the eye(s)).
- The null value "Not Known/Not Recorded" is reported if *Initial ED/Hospital GCS – Eyes* is reported.
- 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.

Data Source Hierarchy Guide

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

Associated Edit Checks (NTDB)

Rule ID	Level	Message
15301	1	Value is not a valid menu option
15303	2	Element cannot be blank
15304	2	Element cannot be "Not Applicable"
15305	2	Element must be "Not Known/Not Recorded" when *Initial ED/Hospital GCS – Eyes* is reported
15340	1	Single Entry Max exceeded

Initial Assessment TR18.41.2 & TR18.41.0 – 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 TR18.41.2:

1. None
2. Sounds
3. Words
4. Confused
5. Oriented
6. Not Testable
7. Not Known/Not Recorded

Pediatric < 5 Years TR18.41.0:

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 reported. (e.g., the chart indicates: "patient correctly gives name, place and date" a Verbal GCS-40 of 5 may be reported, IF there is no other contradicting documentation).
- Report Element Value "5. Not Testable" if unable to assess (e.g., patient is intubated).
- The null value "Not Known/Not Recorded" is reported if *Initial ED/Hospital GCS – Verbal* is reported.
- The null value "Not Known/Not Recorded" is reported if the patient's *Initial ED/Hospital GCS-40 Verbal* was not measured within 30 minutes or less of ED/hospital arrival.

Data Source Hierarchy Guide

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

Associated Edit Checks (NTDB)

Rule ID	Level	Message
15401	1	Value is not a valid menu option
15403	2	Element cannot be blank
15404	2	Element cannot be "Not Applicable"
15405	2	Element must be "Not Known/Not Recorded" when *Initial ED/Hospital GCS – Verbal* is reported
15440	1	Single Entry Max exceeded

Initial Assessment TR18.42.2 & TR18.42.0 – 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 TR18.42.2:

1. None
2. Extension
3. Abnormal Flexion
4. Normal Flexion
5. Localizing
6. Obeys Commands
7. Not Testable
8. Not Known/Not Recorded

Pediatric < 5 Years TR18.42.0:

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, the appropriate numeric score may be listed. (e.g., 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 (e.g., 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)

Rule ID	Level	Message
15501	1	Value is not a valid menu option
15503	2	Element cannot be blank
15504	2	Element cannot be "Not Applicable"
15505	2	Element must be "Not Known/Not Recorded" when *Initial ED/Hospital GCS – Motor* is reported
15506	2	If patient age is less than 5, Element Value 6 is not a valid menu option
15540	1	Single Entry Max exceeded

Initial Assessment TR1.6.1 & TR1.6 – Initial ED/Hospital Height

Description

First recorded height after ED/hospital arrival.

Element Values

Relevant value for data element

Units:

1. Centimeters - TR1.6
2. 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)

Rule ID	Level	Message
8501	1	Invalid value
8502	2	Element cannot be blank
8503	3	The value is above 215
8504	2	Element cannot be "Not Applicable"
8505	2	The value submitted falls outside the valid range of 30 – 275
8506	3	The value is below 50
8540	1	Single Entry Max exceeded

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 data element

Units:

1. Kilograms – TR1.6.5
2. Pounds – TR1.6.6

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)

Rule ID	Level	Message
8601	1	Invalid value
8602	2	Element cannot be blank
8603	3	The value is above 200
8604	2	Element cannot be "Not Applicable"
8605	2	The value submitted falls outside the valid range of 1 – 650
8606	3	The value is below 3
8640	1	Single Entry Max exceeded

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)

Rule ID	Level	Message
6011	1	Value is not a valid menu option
6012	2	Element cannot be blank
6013	2	Element cannot be "Not Applicable"
6014	2	Element must 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
6050	1	Multiple Entry Max exceeded

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
3. Not Known/Not Recorded

Additional Information

Alcohol screen may be administered at any facility, unit, or setting treating this patient event.

Data Source Hierarchy Guide

1. Lab Results
2. Transferring Facility Records

Associated Edit Checks (NTDB)

Rule ID	Level	Message
5911	1	Value is not a valid menu option
5912	2	Element cannot be blank
5913	2	Element cannot be "Not Applicable"
5940	1	Single Entry Max exceeded

Initial Assessment TR18.103 & TR18.103.2– 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

Units:
1. X.XX grams per deciliter (g/dl) – TR18.103
2. X.XX milligrams per deciliter (mg/dl) – TR18.103.2

Additional Information

- Entry in one unit will auto-populate the other.
- 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)

Rule ID	Level	Message
5931	1	Invalid value
5932	2	Element cannot be blank
5933	2	Element must and can only be "Not Applicable" when *Alcohol Screen* is Element Value "2. No"
5935	1	The value submitted falls outside the valid range of 0.0 – 1.5
5936	3	The value is above 0.4
5934	1	Single Entry Max exceeded

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 (Hybrid OR)
8. Intensive Care Unit (ICU)
9. Home without services
10. Left against medical advice
11. Transferred to another hospital
12. Interventional Radiology Suite
13. Hospice (e.g., hospice facility, hospice unit, home hospice)
14. Not Applicable

Additional Information

- If the patient was boarded in the ED, the disposition must be the location the patient was ordered to go when their ED workup was complete.
- 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, or 13 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 and Physical

Associated Edit Checks (NTDB)

Rule ID	Level	Message
6101	1	Value is not a valid menu option
6102	2	Element cannot be blank
6104	2	Element cannot be "Not Known/Not Recorded"
6141	2	Element cannot be 4,6,9, or 10 when *Inter-Facility Transfer* is "2. No"
6140	1	Single Entry Max exceeded

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)

Rule ID	Level	Message
6301	1	Date is not valid
6302	1	Date out of range
6303	2	Element cannot be blank
6307	2	*ED Discharge Date* is earlier than *ED/Hospital Arrival Date*
6310	3	*ED Discharge Date* occurs more than 365 days after *ED/Hospital Arrival Date*
6311	2	Element must be and can only be "Not Applicable" when *ED Discharge Disposition* is "Not Applicable"
6312	3	*ED Discharge Date* is earlier than *Injury Incident Date*
6313	2	If *Hospital Discharge Disposition* is "Not Applicable" and *ED Discharge Date* cannot be earlier than *Hospital Procedures Start Date*
6314	3	*Hospital Discharge Disposition* is "Not Applicable," and *ED Discharge Date* cannot be earlier than *Cerebral Monitor Date*
6315	2	If *Hospital Discharge Disposition* is "Not Applicable" and *ED Discharge Date* cannot be earlier than *Venous Thromboembolism Prophylaxis Date*
6316	2	If *Hospital Discharge Disposition* is "Not Applicable" and *ED Discharge Date* cannot be earlier than *Angiography Date*
6317	2	If *Hospital Discharge Disposition* is "Not Applicable" and *ED Discharge Date* cannot be earlier than *Surgery for Hemorrhage Control Date*
6318	2	If *Hospital Discharge Disposition* is "Not Applicable" and *ED Discharge Date* cannot be earlier than *Withdrawal of Life Supporting Treatment Date*

6319	2	If *Hospital Discharge Disposition* is "Not Applicable" and *ED Discharge Date* cannot be earlier than *Antibiotic Therapy Date*
6350	1	Date cannot be later than upload date
6340	1	Single Entry Max exceeded

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)

Rule ID	Level	Message
6401	1	Time is not valid
6402	1	Time out of range
6403	2	Element cannot be blank
6407	2	*ED Discharge Time* is earlier than *ED/Hospital Arrival Time*
6409	2	Element must and can only be "Not Applicable" when *ED Discharge Date* is "Not Applicable"
6410	3	Element must be "Not Known/Not Recorded" when *ED Discharge Date* is "Not Known/Not Recorded"
6411	3	*ED Discharge Time* is earlier than *Injury Incident Time*
6412	2	If *Hospital Discharge Disposition* is "Not Applicable" then *ED Discharge Time* cannot be earlier than *Hospital Procedure Time*
6413	3	If *Hospital Discharge Disposition* is "Not Applicable" then *ED Discharge Time* cannot be earlier than *Cerebral Monitor Time*
6414	2	If *Hospital Discharge Disposition* is "Not Applicable" then *ED Discharge Time* cannot be earlier than *Venous Thromboembolism Prophylaxis Time*
6415	2	If *Hospital Discharge Disposition* is "Not Applicable" then *ED Discharge Time* cannot be earlier than *Angiography Time*
6416	2	If *Hospital Discharge Disposition* is "Not Applicable" then *ED Discharge Time* cannot be earlier than *Surgery for Hemorrhage Control Time*

6417	2	If *Hospital Discharge Disposition* is "Not Applicable" then *ED Discharge Time* cannot be earlier than *Withdrawal of Life Supporting Treatment Time*
6418	2	If *Hospital Discharge Disposition* is "Not Applicable" then *ED Discharge Time* cannot be earlier than *Antibiotic Therapy Time*
6440	1	Single Entry Max exceeded

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
3. Not Known

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

1. Triage/Trauma Flow Sheet
2. History and Physical
3. Discharge Summary

Associated Edit Checks (NTDB)

Rule ID	Level	Message
22501	1	Value is not a valid menu option
22502	2	Element cannot be blank
22540	1	Single Entry Max exceeded

ED/TTA TR18.220– Primary Medical Event

Description

The patient experienced a documented primary medical event (e.g., seizure, cerebral vascular accident, myocardial infarction, arrythmia, syncope, stroke, hypoglycemia) that immediately preceded the traumatic injury.

Element Values

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

Additional Information

- Element Value "1. Yes" is reported if the patient experienced a medical event immediately preceding the trauma.
- The null value "Not Known/Not Recorded" is reported if it is unknown the primary medical event immediately preceded the traumatic injury.

Data Source Hierarchy Guide

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

Associated Edit Checks (NTDB)

Rule ID	Level	Message
2501	1	Value is not a valid menu option
2502	2	Element cannot be blank
2503	2	Element cannot be "Not Applicable"
2540	1	Single Entry Max exceeded

NTDS Procedures 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 TR22.30 *Procedure Performed* 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) *
Angioembolization
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

Cardiovascular
Open cardiac massage
CPR

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)

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

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

Respiratory
Insertion of endotracheal tube* (exclude intubations performed in the OR)
Continuous mechanical ventilation*

Chest tube
Bronchoscopy*
Tracheostomy

CNS
Insertion of ICP monitor *
Ventriculostomy
Cerebral oxygen monitoring *

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)

Rule ID	Level	Message
8801	1	Invalid value (ICD-10 PCS only)
8803	2	Element cannot be blank
8804	2	Element must not be "Not Applicable" or "Not Known/Not Recorded" along with any other value
8805	1	Invalid value (ICD-10 CA only)
8850	1	Multiple Max Entry exceeded

Procedures TR200.8– Hospital Procedures 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 TR22.30 *Procedure Performed* 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)

Rule ID	Level	Message
6601	1	Date is not valid
6602	1	Date out of range
6606	3	*Hospital Procedures Start Date* is earlier than *ED/Hospital Arrival Date*
6609	2	Element cannot be blank
6610	2	Element must be and can only be "Not Applicable" when *ICD-10 Hospital Procedures* is "Not Applicable"
6611	2	Element must be "Not Known/Not Recorded when *ICD-10 Hospital Procedures* is "Not Known/Not Recorded"
6660	1	Date cannot be later than upload date
6650	1	Multiple Entry Max exceeded

Procedures TR200.9 – Hospital Procedures Start Time

Description

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

Element Values

Relevant values 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 TR22.30 *Procedure Performed* 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)

Rule ID	Level	Message
6701	1	Time is not valid
6702	1	Time out of range
6706	3	*Hospital Procedures Start Time* is earlier than *ED/Hospital Arrival Time*
6708	2	Element cannot be blank
6709	2	Element must be and can only be "Not Applicable" when *Hospital Procedure Start Date* is "Not Applicable"
6710	2	Element must be "Not Known/Not Recorded" when *Hospital Procedure Start Date* is "Not Known/Not Recorded"
6750	1	Multiple Entry Max exceeded

NTDS Pre-Existing Conditions

Pre-Existing Conditions – Advance Directive Limiting Care

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 (e.g., 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 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)

Rule ID	Level	Message
16001	1	Value is not a valid menu option
16003	2	Element cannot be blank
16004	2	Element cannot be "Not Applicable"
16040	1	Single Entry Max exceeded

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.
- Based on the patient's age on the day of arrival at your hospital.
- 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 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)

Rule ID	Level	Message
16101	1	Value is not a valid menu option
16103	2	Element cannot be blank
16104	2	Element must be and can only be "Not Applicable" for patients < 15 years-of-age
16140	1	Single Entry Max exceeded

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.

ANTICOAGULANTS	ANTIPLATELET AGENTS	THROMBIN INHIBITORS	THROMBOLYTIC AGENTS
Fondaparinux	Tirofiban	Bevalirudin	Alteplase
Warfarin	Dipyridamole	Argatroban	Reteplase
Dalteparin	Anagrelide	Lepirudin, Hirudin	Tenacteplase
Lovenox	Eptifibatide	Drotrecogin alpha	Kabikinase
Pentasaccaride	Dipyridamole	Dabigatran	tPA
APC	Clopidogrel		
Ximelagatran	Cilostazol		
Pentoxifylline	Abciximab		
Rivaroxaban	Ticlopidine		
Apixaban	Prasugrel		
Heparin	Ticagrelor		

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 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)

Rule ID	Level	Message
16301	1	Value is not a valid menu option
16303	2	Element cannot be blank
16304	2	Element cannot be “Not Applicable”
16340	1	Single Entry Max exceeded

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 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)

Rule ID	Level	Message
16401	1	Value is not a valid menu option
16403	2	Element cannot be blank
16404	2	Element cannot be "Not Applicable"
16440	1	Single Entry Max exceeded

Pre-Existing Conditions – Autism Spectrum Disorder (ASD)

Description

A disorder involving problems with social communication and interaction, and restricted or repetitive behaviors or interests as well as different ways of learning, moving, or paying attention.

Element Values

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

Additional Information

- Present prior to injury.
- A diagnosis of ASD must be documented in the patient's medical record (e.g., autism, autism spectrum disorder, or Asperger's syndrome/disorder).
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. Physician Notes/Flow Sheet
2. History and Physical
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)

Rule ID	Level	Message
6201	1	Value is not a valid menu option
6202	2	Element cannot be blank
6203	2	Element cannot be "Not Applicable"
6240	1	Single Entry Max exceeded

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.
- Based on the patient's age on the day of arrival at your hospital.
- 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 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)

Rule ID	Level	Message
21901	1	Value is not a valid menu option
21902	2	Element cannot be blank
21903	2	Element must be and can only be "Not Applicable" for patients < 15 years-of-age
21940	1	Single Entry Max exceeded

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 (e.g., Hemophilia, von Willebrand 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 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)

Rule ID	Level	Message
16501	1	Value is not a valid menu option
16503	2	Element cannot be blank
16504	2	Element cannot be "Not Applicable"
16540	1	Single Entry Max exceeded

Pre-Existing Conditions – Bronchopulmonary Dysplasia/Chronic Lung Disease

Description

The disorders which constitute Chronic Lung Disease (CLD) generally have a slow tempo of progression over many months or even years. The most common causes of CLD in children are Cystic Fibrosis (CF), and other causes of bronchiectasis (such as immunodeficiency, and in the third world, post-infective bronchiectasis (e.g., measles), Bronchopulmonary Dysplasia (BPD), or lung disease of prematurity).

INCLUDE:
Patients with a diagnosis of Cystic Fibrosis with pulmonary involvement.

EXCLUDE:
Patients with a diagnosis of Cystic Fibrosis with no documentation of lung disease.

Element Values

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

Additional Information

- Present prior to injury.
- Based on the patient's age on the day of arrival at your hospital.
- 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.
- Examples of evidence of Cystic Fibrosis-associated pulmonary disease include, but are not limited to:
  - Use of Chest Physiotherapy (CPT) or other airway clearing techniques.
  - Vest therapy or intrapulmonary percussive ventilator.
  - Intravenous, inhaled, or oral antibiotics to treat chronic respiratory infections related to Cystic Fibrosis.
- Consistent with the ncbi.nlm.nih.gov.

Data Source Hierarchy Guide

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7. Discharge Summary

Associated Edit Checks (NTDB)

Rule ID	Level	Message
6301	1	Value is not a valid menu option
6302	2	Element cannot be blank
6330	2	Element cannot be “Not Applicable” for patients < 15 years-of-age
6340	1	Single Entry Max exceeded

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 (e.g., hemiplegia, hemiparesis, aphasia, sensory deficit, impaired memory).

Element Values

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

Additional Information

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

Data Source Hierarchy Guide

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

Associated Edit Checks (NTDB)

Rule ID	Level	Message
16601	1	Value is not a valid menu option
16603	2	Element cannot be blank
16604	2	Element cannot be "Not Applicable"
16640	1	Single Entry Max exceeded

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.
- Based on the patient's age on the day of arrival at your hospital.
- 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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Associated Edit Checks (NTDB)

Rule ID	Level	Message
16701	1	Value is not a valid menu option
16703	2	Element cannot be blank
16704	2	Element must be and can only be "Not Applicable" for patients < 15 years-of-age
16740	1	Single Entry Max exceeded

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.

Data Source Hierarchy Guide

1. History and Physical
2. Physician Notes/Flow Sheet
3. Progress Notes
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7. Discharge Summary

Associated Edit Checks (NTDB)

Rule ID	Level	Message
16801	1	Value is not a valid menu option
16803	2	Element cannot be blank
16804	2	Element cannot be "Not Applicable"
16840	1	Single Entry Max exceeded

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.

EXCLUDE:
Patients who no longer have cirrhosis due to a successful liver transplant.

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.

Data Source Hierarchy Guide

1. History and Physical
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Associated Edit Checks (NTDB)

Rule ID	Level	Message
16901	1	Value is not a valid menu option
16903	2	Element cannot be blank
16904	2	Element cannot be "Not Applicable"
16940	1	Single Entry Max exceeded

Pre-Existing Conditions – Congenital Anomalies

Description

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

Element Values

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

Additional Information

- Present prior to injury.
- A diagnosis of congenital anomaly must be documented in the patient's medical record.
- Based on the patient's age on the day of arrival at your hospital.
- 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

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Associated Edit Checks (NTDB)

Rule ID	Level	Message
17001	1	Value is not a valid menu option
17003	2	Element cannot be blank
17004	2	Element must be and can only be "Not Applicable" for patients ≥ 15 years-of-age
17040	1	Single Entry Max exceeded

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.

Data Source Hierarchy Guide

1. History and Physical
2. Physician Notes/Flow Sheet
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Associated Edit Checks (NTDB)

Rule ID	Level	Message
17101	1	Value is not a valid menu option
17103	2	Element cannot be blank
17104	2	Element cannot be "Not Applicable"
17140	1	Single Entry Max exceeded

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.

Data Source Hierarchy Guide

1. History and Physical
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Associated Edit Checks (NTDB)

Rule ID	Level	Message
17201	1	Value is not a valid menu option
17203	2	Element cannot be blank
17204	2	Element cannot be "Not Applicable"
17240	1	Single Entry Max exceeded

Pre-Existing Conditions – Current 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.

Data Source Hierarchy Guide

1. History and Physical
2. Physician Notes/Flow Sheet
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Associated Edit Checks (NTDB)

Rule ID	Level	Message
17301	1	Value is not a valid menu option
17303	2	Element cannot be blank
17304	2	Element cannot be "Not Applicable"
17340	1	Single Entry Max exceeded

Pre-Existing Conditions – Dementia

Description

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

Element Values

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

Additional Information

- Present prior to injury.
- A diagnosis of dementia including Alzheimer's, Lewy Body Dementia, frontotemporal dementia (Pick's Disease) or 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.

Data Source Hierarchy Guide

1. History and Physical
2. Physician Notes/Flow Sheet
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Associated Edit Checks (NTDB)

Rule ID	Level	Message
17401	1	Value is not a valid menu option
17403	2	Element cannot be blank
17404	2	Element cannot be "Not Applicable"
17440	1	Single Entry Max exceeded

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.
- 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.

Data Source Hierarchy Guide

1. History and Physical
2. Physician Notes/Flow Sheet
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Associated Edit Checks (NTDB)

Rule ID	Level	Message
17501	1	Value is not a valid menu option
17503	2	Element cannot be blank
17504	2	Element cannot be "Not Applicable"
17540	1	Single Entry Max exceeded

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.

Data Source Hierarchy Guide

1. History and Physical
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Associated Edit Checks (NTDB)

Rule ID	Level	Message
17601	1	Value is not a valid menu option
17603	2	Element cannot be blank
17604	2	Element cannot be "Not Applicable"
17640	1	Single Entry Max exceeded

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.

Data Source Hierarchy Guide

1. History and Physical
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Associated Edit Checks (NTDB)

Rule ID	Level	Message
17701	1	Value is not a valid menu option
17703	2	Element cannot be blank
17704	2	Element cannot be "Not Applicable"
17740	1	Single Entry Max exceeded

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.

Data Source Hierarchy Guide

1. History and Physical
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Associated Edit Checks (NTDB)

Rule ID	Level	Message
17801	1	Value is not a valid menu option
17803	2	Element cannot be blank
17804	2	Element cannot be "Not Applicable"
17840	1	Single Entry Max exceeded

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.
- Based on the patient's age on the day of arrival at your hospital.
- 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 and Physical
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Associated Edit Checks (NTDB)

Rule ID	Level	Message
22001	1	Value is not a valid menu option
22002	2	Element cannot be blank
22003	2	Element must be and can only be "Not Applicable" for patient's < 15 years-of-age
22040	1	Single Entry Max exceeded

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.

Data Source Hierarchy Guide

1. History and Physical
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Associated Edit Checks (NTDB)

Rule ID	Level	Message
18001	1	Value is not a valid menu option
18003	2	Element cannot be blank
18004	2	Element cannot be "Not Applicable"
18040	1	Single Entry Max exceeded

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.
- Based on the patient's age on the day of arrival at your hospital.
- 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 and Physical
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Associated Edit Checks (NTDB)

Rule ID	Level	Message
22101	1	Value is not a valid menu option
22102	2	Element cannot be blank
22103	2	Element must be and can only be "Not Applicable" for patients < 15 years-of-age
22140	1	Single Entry Max exceeded

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.
- Based on the patient's age on the day of arrival at your hospital.
- 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.

Data Source Hierarchy Guide

1. History and Physical
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Associated Edit Checks (NTDB)

Rule ID	Level	Message
18101	1	Value is not a valid menu option
18103	2	Element cannot be blank
18104	2	Element must be and can only be "Not Applicable" for patients < 15 years-of-age
18140	1	Single Entry Max exceeded

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.
- Based on the patient's age on the day of arrival at your hospital.
- 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 and Physical
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Associated Edit Checks (NTDB)

Rule ID	Level	Message
22201	1	Value is not a valid menu option
22202	2	Element cannot be blank
22203	2	Element must be and can only be "Not Applicable" for patients < 15 years-of-age
22240	1	Single Entry Max exceeded

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 and Physical
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Associated Edit Checks (NTDB)

Rule ID	Level	Message
21501	1	Value is not a valid menu option
21503	2	Element cannot be blank
21504	2	Element cannot be "Not Applicable"
21540	1	Single Entry Max exceeded

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.
- Based on the patient's age on the day of arrival at your hospital.
- 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

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Associated Edit Checks (NTDB)

Rule ID	Level	Message
18201	1	Value is not a valid menu option
18203	2	Element cannot be blank
18204	2	Element must be and can only be "Not Applicable" for patients > 15 years-of-age
18240	1	Single Entry Max exceeded

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.
- Based on the patient's age on the day of arrival at your hospital.
- 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

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Associated Edit Checks (NTDB)

Rule ID	Level	Message
22301	1	Value is not a valid menu option
22302	2	Element cannot be blank
22303	2	Element must be and can only be "Not Applicable" for patients < 15 years-of-age
22340	1	Single Entry Max exceeded

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

Additional Information

- Present prior to injury.
- Based on the patient's age on the day of arrival at your hospital.
- 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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Associated Edit Checks (NTDB)

Rule ID	Level	Message
22401	1	Value is not a valid menu option
22402	2	Element cannot be blank
22403	2	Element must be and can only be "Not Applicable" for patients < 15 years-of-age
22440	1	Single Entry Max exceeded

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 and Physical
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Associated Edit Checks (NTDB)

Rule ID	Level	Message
18301	1	Value is not a valid menu option
18303	2	Element cannot be blank
18304	2	Element cannot be "Not Applicable"
18340	1	Single Entry Max exceeded

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 (e.g., patient has a history of drug use; patient has a history of opioid use) or diagnosis of any of the following documented in the patient's medical record:

- Cannabis Use Disorder; Other Cannabis-Induced Disorder; Unspecified Cannabis-Related Disorder
- Phencyclidine Use Disorder; Other Hallucinogen Use Disorder; Hallucinogen Persisting Perception Disorder; Other Phencyclidine-Induced Disorder; Other Hallucinogen-Induced Disorder; Unspecified Phencyclidine-Related Disorder; Unspecified Hallucinogen-Related Disorder
- Inhalant Use Disorder; Other Inhalant-Induced Disorder; Unspecified Inhalant-Related Disorder
- Opioid Use Disorder; Other Opioid-Induced Disorder; Unspecified Opioid-Related Disorder
- Sedative, Hypnotic, or Anxiolytic Use Disorder; Other Sedative, Hypnotic, or Anxiolytic-Induced Disorder; Unspecified Sedative, Hypnotic, or Anxiolytic-Related Disorder
- Stimulant Use Disorder; Other Stimulant-Induced Disorder; Unspecified Stimulant-Related Disorder

Element Values

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

Additional Information

- Present prior to injury.
- Based on the patient's age on the day of arrival at your hospital.
- 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 and Physical
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Associated Edit Checks (NTDB)

Rule ID	Level	Message
18401	1	Value is not a valid menu option
18403	2	Element cannot be blank
18404	2	Element must be and can only be "Not Applicable" for patients < 15 years-of-age
18440	1	Single Entry Max exceeded

Pre-Existing Conditions – Ventilator Dependence

Description

Patients who are ventilator dependent with a tracheostomy prior to injury.

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.

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)

Rule ID	Level	Message
17901	1	Value is not a valid menu option
17902	2	Element cannot be blank
17903	2	Element cannot be "Not Applicable"
17904	2	If *Total Ventilator Days* is "Not Applicable," *Ventilator Dependence* must be Element Value "2. No"
17940	1	Single Entry Max exceeded

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.A.1-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 (e.g., 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 and Physical
7. Nursing Notes/Flow Sheet
8. Progress Notes
9. Discharge Summary

Associated Edit Checks (NTDB)

Rule ID	Level	Message
8701	1	Invalid value (ICD-10 CM only)
8702	2	Element cannot be blank
8703	2	At least one diagnosis must be provided and meet inclusion criteria. (ICD-10 CM only)
8705	1	Invalid value (ICD-10 CA only)
8706	2	At least one diagnosis must be provided and meet inclusion criteria (ICD-10 CA only)
8707	2	Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other value
8750	1	Multiple Entry Max exceeded

Injury Severity Information TR200.14.1 – AIS Code

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

AIS Coding Manual

Associated Edit Checks (NTDB)

Rule ID	Level	Message
21001	1	Invalid value
21004	2	AIS codes submitted are not valid AIS 2015 codes
21007	2	Element cannot be blank
21008	2	Element cannot be "Not Applicable"
21009	2	Element cannot be "Not Known/Not Recorded" along with any other value
21050	1	Multiple Entry Max exceeded

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 m^2

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 AKI Stage 3 began after arrival to your ED/hospital.
- A diagnosis of acute kidney injury (AKI) must be documented in the patient's medical record.
- 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

Associated Edit Checks (NTDB)

Rule ID	Level	Message
18501	1	Value is not a valid menu option
18503	2	Element cannot be blank
18504	2	Element cannot be “Not Applicable”
18540	1	Single Entry Max exceeded

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 (e.g., 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 H2Oc
  - 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
7. Discharge Summary

Associated Edit Checks (NTDB)

Rule ID	Level	Message
18601	1	Value is not a valid menu option
18603	2	Element cannot be blank
18604	2	Element cannot be "Not Applicable"
18640	1	Single Entry Max exceeded

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
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks (NTDB)

Rule ID	Level	Message
18701	1	Value is not a valid menu option
18703	2	Element cannot be blank
18704	2	Element cannot be "Not Applicable"
18740	1	Single Entry Max exceeded

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
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks (NTDB)

Rule ID	Level	Message
18801	1	Value is not a valid menu option
18803	2	Element cannot be blank
18804	2	Element cannot be "Not Applicable"
18840	1	Single Entry Max exceeded

Hospital Events TR23.1 – Catheter-Associated Urinary Tract Infection

Description

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 SUTI 1a:

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 (>38ºC): Reminder: To use fever in a patient >65 years of age, the IUC need to be in place for more than 2 consecutive days in an inpatient location on date of event and is either still in place OR was removed the day before the DOE.
    - Suprapubic tenderness
    - Costovertebral angle pain or tenderness
    - Urinary urgency
    - Urinary frequency
    - Dysuria
3. Patient has a urine culture with no more than two species of organisms identified, at least one of which is a bacterium >10^5 CFU/ml.

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 (>38.0ºC)
    - hypothermia (<36.0ºC)
    - 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 $\geq 10^5$ CFU/ml.

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 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
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)

Rule ID	Level	Message
18901	1	Value is not a valid menu option
18903	2	Element cannot be blank
18904	2	Element cannot be "Not Applicable"
18940	1	Single Entry Max exceeded

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 (e.g., not Active Surveillance Culture/Testing (ASC/AST.)

AND

Organism(s) identified in blood is not related to an infection at another site.

OR

January 2016 CDC Criterion LCBI 2:

Patient has at least one of the following signs or symptoms: fever (>38^{0}C), chills, or hypotension

AND

Organism(s) identified from blood is not related to an infection at another site.

AND

The same common commensal (i.e., diphtheroids [Corynebacterium spp. not C. diphtheriae], Bacillus spp. [not B. anthracis], Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., and Micrococcus spp.) is identified from two or more blood specimens drawn on separate occasions, by a culture or nonculture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST.) Criterion elements must occur within the Infection Window Period, the 7-day time period which includes the collection date of the positive blood, the 3 calendar days before and the 3 calendar days after.

OR

January 2016 CDC Criterion LCBI 3:

Patient ≤ 1 year of age has at least one of the following signs or symptoms: fever (>38⁰ C), hypothermia (<36⁰C), apnea, or bradycardia

AND

Organism(s) identified from blood is not related to an infection at another site

AND

The same common commensal (i.e., diphtheroids [Corynebacterium spp. not C. diphtheriae], Bacillus spp. [not B. anthracis], Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., Micrococcus spp.) is identified from two or more blood specimens drawn on separate occasions, by a culture or nonculture base microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST.) Criterion elements must occur within the Infection Window Period, the 7-day time period which includes the collection date of the positive blood, the 3 calendar days before and the 3 calendar days after.

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)

Rule ID	Level	Message
19001	1	Value is not a valid menu option
19003	2	Element cannot be blank
19004	2	Element cannot be “Not Applicable”
19040	1	Single Entry Max exceeded

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 (e.g., fascial and muscle layers)

AND

patient has at least ***one*** of the following:

- Purulent drainage from the deep incision.
- A deep incision that spontaneously dehisces, or is deliberately opened or aspirated by a surgeon, attending physician** or other designee and organism is identified by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST) or culture or non-culture based microbiologic testing method is not performed).

AND

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.

- 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 surgical site infections (SSIs):

- Deep Incisional Primary (DIP) – a deep incisional SSI that is identified in a primary incision in a patient that has had an operation with one or more incisions (e.g., C-section incision or chest incision for CBGB)
- Deep Incisional Secondary (DIS) – a deep incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (e.g., donor site 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.

30 DAY SURVEILLANCE			
Code	**Operative Procedure**	**Code**	**Operative Procedure**
AAA	Abdominal aortic aneurysm repair	LAM	Laminectomy
AMP	Limb amputation	LTP	Liver transplant
APPY	Appendix surgery	NECK	Neck surgery
AVSD	Shunt for dialysis	NEPH	Kidney surgery
BILI	Bile duct, liver or pancreatic surgery	OVRY	Ovarian surgery
CEA	Carotid endarterectomy	PRST	Prostate surgery
CHOL	Gallbladder surgery	REC	Rectal surgery
COLO	Colon surgery	SB	Small bowel surgery
CSEC	Cesarean section	SPLE	Spleen surgery
GAST	Gastric surgery	THOR	Thoracic surgery
HTP	Heart transplant	THUR	Thyroid and/or parathyroid surgery
HYST	Abdominal hysterectomy	VHYS	Vaginal hysterectomy
KTP	Kidney transplant	XLAP	Exploratory Laparotomy

90 DAY SURVEILLANCE	
Code	**Operative Procedure**
BRST	Breast surgery
CARD	Cardiac surgery
CBGB	Coronary artery bypass graft with both chest and donor site incisions
CBGC	Coronary artery bypass graft with chest incision only
CRAN	Craniotomy
FUSN	Spinal fusion
FX	Open reduction of fracture
HER	Herniorrhaphy
HPRO	Hip prosthesis
KPRO	Knee prosthesis
PACE	Pacemaker surgery
PVBY	Peripheral vascular bypass surgery
VSHN	Ventricular shunt

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 an 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

Associated Edit Checks (NTDB)

Rule ID	Level	Message
19101	1	Value is not a valid menu option
19103	2	Element cannot be blank
19104	2	Element cannot be "Not Applicable"
19140	1	Single Entry Max exceeded

Hospital Events TR23.1 – Deep Vein Thrombosis

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)

Rule ID	Level	Message
19201	1	Value is not a valid menu option
19203	2	Element cannot be blank
19204	2	Element cannot be "Not Applicable"
19240	1	Single Entry Max exceeded

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)

Rule ID	Level	Message
21601	1	Value is not a valid menu option
21603	2	Element cannot be blank
21604	2	Element cannot be "Not Applicable"
21640	1	Single Entry Max exceeded

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)

Rule ID	Level	Message
19401	1	Value is not a valid menu option
19403	2	Element cannot be blank
19404	2	Element cannot be "Not Applicable"
19440	1	Single Entry Max exceeded

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:

- Purulent drainage from a drain that is placed into the organ/space (e.g., closed suction drainage system, open drain, T-tube drain, CT guided drainage).
- Organisms are identified from fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)).
- An abscess or other evidence of infection involving the organ/space that is detected on gross anatomical or histopathologic exam, or imaging test 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.

30 DAY SURVEILLANCE			
Code	**Operative Procedure**	**Code**	**Operative Procedure**
AAA	Abdominal aortic aneurysm repair	LAM	Laminectomy
AMP	Limb amputation	LTP	Liver transplant
APPY	Appendix surgery	NECK	Neck surgery
AVSD	Shunt for dialysis	NEPH	Kidney surgery
BILI	Bile duct, liver or pancreatic surgery	OVRY	Ovarian surgery
CEA	Carotid endarterectomy	PRST	Prostate surgery
CHOL	Gallbladder surgery	REC	Rectal surgery
COLO	Colon surgery	SB	Small bowel surgery
CSEC	Cesarean section	SPLE	Spleen surgery
GAST	Gastric surgery	THOR	Thoracic surgery
HTP	Heart transplant	THUR	Thyroid and/or parathyroid surgery
HYST	Abdominal hysterectomy	VHYS	Vaginal hysterectomy
KTP	Kidney transplant	XLAP	Exploratory Laparotomy

90 DAY SURVEILLANCE	
Code	**Operative Procedure**
BRST	Breast surgery
CARD	Cardiac surgery
CBGB	Coronary artery bypass graft with both chest and donor site incisions
CBGC	Coronary artery bypass graft with chest incision only
CRAN	Craniotomy
FUSN	Spinal fusion
FX	Open reduction of fracture
HER	Herniorrhaphy
HPRO	Hip prosthesis
KPRO	Knee prosthesis
PACE	Pacemaker surgery
PVBY	Peripheral vascular bypass surgery
VSHN	Ventricular shunt

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

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

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)

Rule ID	Level	Message
19501	1	Value is not a valid menu option
19503	2	Element cannot be blank
19504	2	Element cannot be "Not Applicable"
19540	1	Single Entry Max exceeded

Hospital Events TR23.1 – Osteomyelitis

Description

Osteomyelitis must meet at least one of the following criteria:

- 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, e.g., not Active Surveillance Culture/Testing (ASC/AST).
- Patient has evidence of osteomyelitis on gross anatomic or histopathologic exam.
- 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:

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

Associated Edit Checks (NTDB)

Rule ID	Level	Message
19601	1	Value is not a valid menu option
19603	2	Element cannot be blank
19604	2	Element cannot be "Not Applicable"
19640	1	Single Entry Max exceeded

Hospital Events TR23.1 – 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 NPUAP Stage II 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)

Rule ID	Level	Message
19801	1	Value is not a valid menu option
19803	2	Element cannot be blank
19804	2	Element cannot be "Not Applicable"
19840	1	Single Entry Max exceeded

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

Associated Edit Checks (NTDB)

Rule ID	Level	Message
19701	1	Value is not a valid menu option
19703	2	Element cannot be blank
19704	2	Element cannot be "Not Applicable"
19740	1	Single Entry Max exceeded

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

Associated Edit Checks (NTDB)

Rule ID	Level	Message
19901	1	Value is not a valid menu option
19903	2	Element cannot be blank
19904	2	Element cannot be "Not Applicable"
19940	1	Single Entry Max exceeded

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, e.g., progression of existing traumatic brain injury, seizure, tumor, metabolic or pharmacologic etiologies, is identified

AND

- Diagnosis is confirmed by neurology or neurosurgical specialist or neuroimaging procedure (MR,CT, angiography) or lumbar puncture (CSF demonstrating intracranial hemorrhage that was not present on admission)

Element Values

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

Additional Information

- 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 (e.g., blunt cerebrovascular injury, dysrhythmia) may be present on admission.

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)

Rule ID	Level	Message
20001	1	Value is not a valid menu option
20003	2	Element cannot be blank
20004	2	Element cannot be "Not Applicable"
20040	1	Single Entry Max exceeded

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:

- Purulent drainage from the superficial incision.
- Organisms identified from an aseptically-obtained specimen from the superficial incision or subcutaneous tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)).
- Superficial incision that is deliberately opened by a surgeon, attending physician** or other designee and culture or non-culture based testing is not performed.

AND

Patient has at least one of the following signs or symptoms: pain or tenderness; localized swelling; erythema; or heat. A culture or non-culture based test that has a negative finding does not meet this criterion.

- Diagnosis of a superficial incisional SSI by the surgeon or attending physician** or other designee.

** 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:

- Superficial Incisional Primary (SIP) – a superficial incisional SSI that is identified in the primary incision in a patient that has had an operation with one or more incisions (e.g., C-section incision or chest incision for CBGB)
- Superficial Incisional Secondary (SIS) – a superficial incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (e.g., donor site incision for CBGB)

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
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)

Rule ID	Level	Message
20101	1	Value is not a valid menu option
20103	2	Element cannot be blank
20104	2	Element cannot be "Not Applicable"
20140	1	Single Entry Max exceeded

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 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)

Rule ID	Level	Message
20201	1	Value is not a valid menu option
20203	2	Element cannot be blank
20204	2	Element cannot be "Not Applicable"
20240	1	Single Entry Max exceeded

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

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)

Rule ID	Level	Message
20301	1	Value is not a valid menu option
20303	2	Element cannot be blank
20304	2	Element cannot be "Not Applicable"
20340	1	Single Entry Max exceeded

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
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks (NTDB)

Rule ID	Level	Message
21701	1	Value is not a valid menu option
21703	2	Element cannot be blank
21704	2	Element cannot be "Not Applicable"
21740	1	Single Entry Max exceeded

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*):*		
IMAGING TEST EVIDENCE	**SIGNS/SYMPTOMS**	**LABORATORY**
Two or more serial chest imaging test results with at least **one** of the following:	At least **one** of the following:	At least **one** of the following:
• New and persistent **or** progressive and persistent • Infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1-year-old **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.	• Fever (>38°C or >100.4°F) • Leukopenia (<4000 WBC/mm³) or leukocytosis (≥12,000 WBC/mm³) • For adults ≥70 years old, altered mental status with no other recognized cause AND at least **one** of the following: • New onset of purulent sputum or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, or tachypnea • Rales or bronchial breath sounds • Worsening gas exchange (for example: O2 desaturations [for example: PaO2/FiO2 <240], increased oxygen requirements, or increased ventilator demand)	• Organism identified from blood • Organism identified from pleural fluid • Positive quantitative culture or corresponding semi-quantitative culture result from minimally-contaminated LRT specimen (specifically, BAL, protected specimen brushing or endotracheal aspirate) • ≥5% BAL-obtained cells contain intracellular bacteria on direct microscopic exam (for example: Gram's stain) • Positive quantitative culture or corresponding semi-quantitative culture result of lung tissue • Histopathologic exam shows at least **one** of the following evidences of pneumonia: – Abscess formation or foci of consolidation with intense PMN accumulation in bronchioles and alveoli – Evidence of lung parenchyma invasion by fungal hyphae or pseudohyphae

VAP Algorithm *(PNU2* Viral, Legionnella, and other Bacterial Pneumonias*)*:		
IMAGING TEST EVIDENCE	***SIGNS/SYMPTOMS***	***LABORATORY***
Two or more serial chest imaging test results with at least **one** of the following:	At least **one** of the following:	At least **one** of the following:
• New and persistent **or** progressive and persistent • Infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1-year-old **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.	• Fever (>38°C or >100.4°F) • Leukopenia (<4000 WBC/mm³) or leukocytosis (≥12,000 WBC/mm³) • For adults ≥70 years old, altered mental status with no other recognized cause AND at least **one** of the following: • New onset of purulent sputum or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, or tachypnea • Rales or bronchial breath sounds • Worsening gas exchange (for example: O2 desaturations [for example: PaO2/FiO2 <240], increased oxygen requirements, or increased ventilator demand)	• Virus, *Bordetella*, *Legionella*, *Chlamydia* or *Mycoplasma* identified from respiratory secretions or tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (for example: not Active Surveillance Culture/ Testing (ASC/AST). • Fourfold rise in paired sera (IgG) for pathogen (e.g., influenza viruses, *Chlamydia*) • Fourfold rise in *Legionella* pneumophila serogroup 1 antibody titer to ≥1:128 in paired acute and convalescent sera by indirect IFA. • Detection of L. *pneumophila* serogroup 1 antigens in urine by RIA or EIA

VAP Algorithm *(PNU3* Immunocompromised Patients*):*		
IMAGING TEST EVIDENCE	***SIGNS/SYMPTOMS***	***LABORATORY***
Two or more serial chest imaging test results with at least **one** of the following:	Patient who is immunocompromised (see definition in footnote) has at least ***one*** of the following:	At least **one** of the following:
• New and persistent **or** progressive and persistent • Infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1-year-old **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.	• Fever (>38°C or >100.4°F) • For adults ≥70 years old, altered mental status with no other recognized cause • New onset of purulent sputum or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, or tachypnea • Rales or bronchial breath sounds • Worsening gas exchange (for example: O2 desaturations [for example: PaO2/FiO2<240], increased oxygen requirements, or increased ventilator demand) • Hemoptysis • Pleuritic chest pain	• Identification of matching *Candida* spp. from blood and one of the following: sputum, endotracheal aspirate, BAL or protected specimen brushing. • Evidence of fungi from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing) from one of the following: – Direct microscopic exam – Positive culture of fungi – Non-culture diagnostic laboratory test **OR** • Any of the following from: **LABORATORY CRITERIA DEFINED UNDER PNU2**

VAP Algorithm ALTERNATE CRITERIA *(PNU1)*, for infant's ≤ 1 year old:	
IMAGING TEST EVIDENCE	**SIGNS/SYMPTOMS/LABORATORY**
Two or more serial chest imaging test results with at least **one** of the following: • New and persistent **or** progressive and persistent • Infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1-year-old **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:2 desaturations [for example pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand) And at least ***three*** of the following: • Temperature instability • Leukopenia (≤4000 WBC/mm3) or leukocytosis (>15,000 WBC/mm3) and left shift (>10% band forms) • New onset of purulent sputum or change in character of sputum, or increased respiratory secretions or increased suctioning requirements • Apnea, tachypnea, nasal flaring with retraction of chest wall or nasal flaring with grunting • Wheezing, rales, or rhonchi • Cough • Bradycardia (<100 beats/min) or tachycardia (>170 beats/min)

VAP Algorithm ALTERNATE CRITERIA *(PNU1)*, for children > 1 year old or ≤ 12 years old:	
IMAGING TEST EVIDENCE	**SIGNS/SYMPTOMS/LABORATORY**
Two or more serial chest imaging test results with at least **one** of the following: • New and persistent **or** progressive and persistent • Infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1-year-old **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.	ALTERNATE CRITERIA, for child >1 year old or ≤12 years old, at least ***three*** of the following: • Fever (>38. 0°C or >100. 4°F) or hypothermia (<36. 0°C or <96. 8°F) • Leukopenia (≤4000 WBC/mm3) or leukocytosis (≥15,000 WBC/mm3) • New onset of purulent sputum or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, apnea, or tachypnea • Rales or bronchial breath sounds • Worsening gas exchange (for example: O2 desaturations [for example pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand)

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
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)

Rule ID	Level	Message
20501	1	Value is not a valid menu option
20503	2	Element cannot be blank
20504	2	Element cannot be "Not Applicable"
20540	1	Single Entry Max exceeded

NTDS Outcome Information

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 *Total 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.

Example #1	Start Date	Start Time	Stop Date	Stop Time	LOS
A.	01/01/11	01:00	01/01/11	04:00	1 day (one calendar day)
B.	01/01/11	01:00	01/01/11	04:00	
	01/01/11	16:00	01/01/11	18:00	1 day (2 episodes within one calendar day)
C.	01/01/11	01:00	01/01/11	04:00	
	01/02/11	16:00	01/02/11	18:00	2 days (episodes on 2 separate calendar days)
D.	01/01/11	01:00	01/01/11	16:00	
	01/02/11	09:00	01/02/11	18:00	2 days (episodes on 2 separate calendar days)
E.	01/01/11	01:00	01/01/11	16:00	
	01/02/11	09:00	01/02/11	21:00	2 days (episodes on 2 separate calendar days)
F.	01/01/11	Unknown	01/01/11	16:00	1 day
G.	01/01/11	Unknown	01/02/11	16:00	2 days (patient was in ICU on 2 separate calendar days)
H.	01/01/11	Unknown	01/02/11	16:00	
	01/02/11	18:00	01/02/11	Unknown	2 days (patient was in ICU on 2 separate calendar days)
I.	01/01/11	Unknown	01/02/11	16:00	
	01/02/11	18:00	01/02/11	20:00	2 days (patient was in ICU on 2 separate calendar days)
J.	01/01/11	Unknown	01/02/11	16:00	
	01/03/11	18:00	01/03/11	20:00	3 days (patient was in ICU on 3 separate calendar days)
K.	Unknown	Unknown	01/02/11	16:00	
	01/03/11	18:00	01/03/11	20:00	Unknown (can't compute total)

Data Source Hierarchy Guide

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

Associated Edit Checks (NTDB)

Rule ID	Level	Message
7501	1	Value is not a valid menu option
7502	2	Element cannot be blank
7503	2	*Total ICU Length of Stay* is greater than the difference between *ED/Hospital Arrival Date* and *Hospital Discharge Date*
7504	3	The value is above 60
7505	2	The value submitted falls outside the valid range of 1 – 575
7540	1	Single Entry Max exceeded

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.

Example #1	Start Date	Start Time	Stop Date	Stop Time	LOS
A.	01/01/11	01:00	01/01/11	04:00	1 day (one calendar day)
B.	01/01/11	01:00	01/01/11	04:00	
	01/01/11	16:00	01/01/11	18:00	1 day (2 episodes within one calendar day)
C.	01/01/11	01:00	01/01/11	04:00	
	01/02/11	16:00	01/02/11	18:00	2 days (episodes on 2 separate calendar days)
D.	01/01/11	01:00	01/01/11	16:00	
	01/02/11	09:00	01/02/11	18:00	2 days (episodes on 2 separate calendar days)
E.	01/01/11	01:00	01/01/11	16:00	
	01/02/11	09:00	01/02/11	21:00	2 days (episodes on 2 separate calendar days)
F.	01/01/11	Unknown	01/01/11	16:00	1 day
G.	01/01/11	Unknown	01/02/11	16:00	2 days (patient was in ICU on 2 separate calendar days)
H.	01/01/11	Unknown	01/02/11	16:00	
	01/02/11	18:00	01/02/11	Unknown	2 days (patient was in ICU on 2 separate calendar days)
I.	01/01/11	Unknown	01/02/11	16:00	
	01/02/11	18:00	01/02/11	20:00	2 days (patient was in ICU on 2 separate calendar days)
J.	01/01/11	Unknown	01/02/11	16:00	
	01/03/11	18:00	01/03/11	20:00	3 days (patient was in ICU on 3 separate calendar days)

Data Source Hierarchy Guide

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

Associated Edit Checks (NTDB)

Rule ID	Level	Message
7601	1	Invalid value
7602	2	Element cannot be blank
7603	2	*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*
7604	3	The value is above 60
7605	2	The value submitted falls outside the valid range of 1 – 575
7640	1	Single Entry Max exceeded

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 reported if *Hospital Discharge Disposition* is reported as "Not Applicable"
- 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)

Rule ID	Level	Message
7701	1	Date is not valid
7702	1	Date out of range
7703	2	Element cannot be blank
7707	2	*Hospital Discharge Date* cannot be earlier than *ED/Hospital Arrival Date*
7708	2	*Hospital Discharge Date* cannot be earlier than *ED Discharge Date*
7711	3	*Hospital Discharge Date* occurs more than 365 days after *ED/Hospital Arrival Date*
7713	2	Element must be and can only be "Not Applicable" when *Hospital Discharge Disposition* is "Not Applicable"
7714	3	*Hospital Discharge Date* is earlier than *Injury Incident Date*
7715	2	*Hospital Discharge Date* is earlier than *Hospital Procedure Start Date*
7716	2	*Hospital Discharge Date* is earlier than *Cerebral Monitor Date*
7717	2	*Hospital Discharge Date* is earlier than *Venous Thromboembolism Prophylaxis Date*
7718	2	*Hospital Discharge Date* is earlier than *Angiography Date*
7719	2	*Hospital Discharge Date* is earlier than *Surgery for Hemorrhage Control Date*
7720	2	*Hospital Discharge Date* is earlier than *Withdrawal of Life Supporting Treatment Date*
7721	3	*Hospital Discharge Date* is earlier than *Antibiotic Therapy Date*
7750	1	Date cannot be later than upload date
7740	1	Single Entry Max exceeded

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 *Hospital Discharge Date* is reported as "Not Applicable"
- The null value "Not Applicable" is reported 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 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)

Rule ID	Level	Message
7801	1	Time is not valid
7802	1	Time out of range
7803	2	Element cannot be blank
7807	2	*Hospital Discharge Time* cannot be earlier than *ED/Hospital Arrival Time*
7808	2	*Hospital Discharge Time* cannot be earlier than *ED Discharge Time*
7810	3	Element must be and can only be "Not Applicable" when *Hospital Discharge Date* is "Not Applicable"
7811	2	Element must be "Not Known/Not Recorded" when *Hospital Discharge Date* is "Not Known/Not Recorded"
7812	3	*Hospital Discharge Time* is earlier than the *Injury Incident Time*
7813	2	*Hospital Discharge Time* is earlier than the *Hospital Procedure Start Time*
7814	2	*Hospital Discharge Time* is earlier than the *Cerebral Monitor Time*
7815	2	*Hospital Discharge Time* is earlier than the *Venous Thromboembolism Prophylaxis Time*
7816	2	*Hospital Discharge Time* is earlier than the *Angiography Time*
7817	2	*Hospital Discharge Time* is earlier than the *Surgery for Hemorrhage Control Time*
7818	2	*Hospital Discharge Time* is earlier than the *Withdrawal of Life Supporting Treatment Time*
7819	3	*Hospital Discharge Time* is earlier than the *Antibiotic Therapy Time*
7840	1	Single Entry Max exceeded

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
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

- Element Values adapted from UB-04 disposition coding.
- Element Value "6. Home" refers to the patient's current place of residence (e.g., 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)."
- Disposition to any other medical facility must be reported as Element Value "14. Discharged/Transferred to another type of institution not defined elsewhere."
- Disposition to any Federal Health Care facility must be reported by selecting the option that most closely aligns to the needs of the patient (e.g., patients discharged to a Veteran's hospital skilled nursing facility must be reported as Element Value "7. Discharged/Transferred to Skilled Nursing Facility.")
- 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)

Rule ID	Level	Message
7901	1	Value is not a valid menu option
7902	2	Element cannot be blank
7907	2	Element must be and can only be "Not Applicable" when *ED Discharge Disposition* is 4,5,6,9,10, 11, or 13
7909	2	Element cannot be "Not Known/Not Recorded"
7940	1	Single Entry Max exceeded

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)

Rule ID	Level	Message
8001	1	Value is not a valid menu option
8002	2	Element cannot be blank
8003	2	Element cannot be "Not Applicable"
8040	1	Single Entry Max exceeded

SECTION B

Wisconsin Core Data Elements

WI Demographic Information

Demographics TR1.2 – Medical Record Number

Description

The facility medical record number that represents the patient.

Element Values

Relevant value for data element

Additional Information

This number will not change for the person regardless of changes to the account number of 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.

Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Discharge Summary
4. Admission Form

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

Description

The first name of the patient.

Element Values

Relevant value for data element

Additional Information

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

Data Source Hierarchy Guide

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

WI Injury Information

Injury 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_cause_matrix.ashx

Data Source Hierarchy Guide

NTDB External Cause of Injury Matrix.

WI Pre-Hospital Information

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

EMS Run Report

Associated Edit Checks (NTDB)

Rule ID	Level	Message
2801	1	Date is not valid
2802	1	Date out of range
2803	3	*EMS Dispatch Date* is earlier than *Date of Birth*
2804	3	*EMS Dispatch Date* is later than *EMS Unit Arrival on Scene Date*
2805	3	*EMS Dispatch Date* is later than *EMS Unit Scene Departure Date*
2806	3	*EMS Dispatch Date* is later than *ED/Hospital Arrival Date*
2807	3	*EMS Dispatch Date* is later than *ED Discharge Date*
2808	3	*EMS Dispatch Date* is later than *Hospital Discharge Date*
2809	2	Element cannot be blank
2840	1	Single Entry Max exceeded

Pre-Hospital TR9.10 – EMS Dispatch Time

Description

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

EMS Run Report

Associated Edit Checks (NTDB)

Rule ID	Level	Message
2901	1	Time is not valid
2902	1	Time out of range
2903	3	*EMS Dispatch Time* is later than *EMS Unit Arrival on Scene Time*
2904	3	*EMS Dispatch Time* is later than *EMS Unit Scene Departure Time*
2905	3	*EMS Dispatch Time* is later than *ED/Hospital Arrival Time*
2906	3	*EMS Dispatch Time* is later than *ED Discharge Time*
2907	3	*EMS Dispatch Time* is later than *Hospital Discharge Time*
2908	2	Element cannot be blank
2940	1	Single Entry Max exceeded

Pre-Hospital TR9.2 – EMS Unit Arrived on Scene Date

Description

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

EMS Run Report

Associated Edit Checks (NTDB)

Rule ID	Level	Message
3001	1	Date is not valid
3002	1	Date out of range
3003	3	*EMS Unit Arrival on Scene Date* is earlier than *Date of Birth*
3004	3	*EMS Unit Arrival on Scene Date* is earlier than *EMS Dispatch Date*
3005	3	*EMS Unit Arrival on Scene Date* is later than *EMS Unit Scene Departure Date*
3006	3	*EMS Unit Arrival on Scene Date* is later than *ED/Hospital Arrival Date*
3007	3	*EMS Unit Arrival on Scene Date* is later than *ED Discharge Date*
3008	3	*EMS Unit Arrival on Scene Date* is later than *Hospital Discharge Date*
3009	3	*EMS Unit Arrival on Scene Date* minus *EMS Dispatch Date* is greater than 7 days
3010	2	Element cannot be blank
3040	1	Single Entry Max exceeded

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

EMS Run Report

Associated Edit Checks (NTDB)

Rule ID	Level	Message
3101	1	Time is not valid
3102	1	Time out of range
3103	3	*EMS Unit Arrival on Scene Time* is earlier than *EMS Dispatch Time*
3104	3	*EMS Unit Arrival on Scene Time* is later than *EMS Unit Scene Departure Time*
3105	3	*EMS Unit Arrival on Scene Time* is later than *ED/Hospital Arrival Time*
3106	3	*EMS Unit Arrival on Scene Time* is later than *ED Discharge Time*
3107	3	*EMS Unit Arrival on Scene Time* is later than *ED Discharge Time*
3108	2	Element cannot be blank
3140	1	Single Entry Max exceeded

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

EMS Run Report

Associated Edit Checks (NTDB)

Rule ID	Level	Message
3201	1	Date is not valid
3202	1	Date out of range
3203	3	*EMS Unit Scene Departure Date* is earlier than *Date of Birth*
3204	3	*EMS Unit Scene Departure Date* is earlier than *EMS Dispatch Date*
3205	3	*EMS Unit Scene Departure Date* is earlier than *EMS Unit Arrival on Scene Date*
3206	3	*EMS Unit Scene Departure Date* is later than *ED/Hospital Arrival Date*
3207	3	*EMS Unit Scene Departure Date* is later than *ED Discharge Date*
3208	3	*EMS Unit Scene Departure Date* is later than *Hospital Discharge Date*
3209	3	*EMS Unit Scene Departure Date* minus *EMS Unit Arrival on Scene Date* is greater than 7 days
3210	2	Element cannot be blank
3240	1	Single Entry Max exceeded

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

EMS Run Report

Associated Edit Checks (NTDB)

Rule ID	Level	Message
3301	1	Time is not valid
3302	1	Time out of range
3303	3	*EMS Unit Scene Departure Time* is earlier than *EMS Dispatch Time*
3304	3	*EMS Unit Scene Departure Time* is earlier than *EMS Unit Arrival on Scene Time*
3305	3	*EMS Unit Scene Departure Time* is later than *ED/Hospital Arrival Time*
3306	3	*EMS Unit Scene Departure Time* is later than the *ED Discharge Time*
3307	3	*EMS Unit Scene Departure Time* is later than *Hospital Discharge Time*
3308	2	Element cannot be blank
3340	1	Single Entry Max exceeded

Pre-Hospital TR18.67– Initial Field Symbolic 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

EMS Run Report

Associated Edit Checks (NTDB)

Rule ID	Level	Message
3601	1	Invalid value
3602	1	Element cannot be blank
3603	3	The value is above 220
3606	2	The value submitted falls outside the valid range of 0-380
3607	3	The value is below 30
3640	1	Single Entry Max exceeded

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

EMS Run Report

Associated Edit Checks (NTDB)

Rule ID	Level	Message
3701	1	Invalid value
3702	1	Element cannot be blank
3703	3	The value submitted is above 220
3706	2	The value submitted falls outside the valid range of 0-300
3707	3	The value submitted is below 30
3740	1	Single Entry Max exceeded

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 TR18.80 *Pre-Hospital Respiratory Assistance*.

Data Source Hierarchy Guide

EMS Run Report

Associated Edit Checks (NTDB)

Rule ID	Level	Message
3801	1	Invalid value or Respiratory Rate exceeds 120
3802	1	Element cannot be blank
3806	2	The value submitted falls outside the valid range of 0-100
3807	3	The value is below 5
3808	3	The value is above 75
3840	1	Single Entry Max exceeded

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 TR18.70 *Pre-Hospital Respiratory Rate*.
- Respiratory Assistance is defined as mechanical and/or external support of respiration.
- Please note that first recorded hospital vitals do not need to be from the same assessment.
- When *Pre-Hospital Respiratory Rate* is "Not Known/Not Recorded," select "Not Applicable."

Data Source Hierarchy Guide

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

EMS Run Report

Associated Edit Checks (NTDB)

Rule ID	Level	Message
3901	1	Invalid value
3902	2	Element cannot be blank
3906	2	The value submitted falls outside the valid range of 0-100
3907	3	The value is below 40
3940	1	Single Entry Max exceeded

Pre-Hospital TR18.60 – Initial Field GCS - Eye

Description

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

Element Values

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

Additional Information

- The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no *EMS Run Report* from the scene of injury.
- If a patient does not have a numeric GCS 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. (e.g., 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 Eye was NOT measured at the scene of injury.
- The null value "Not Known/Not Recorded" is reported if Initial Field GCS-40 Eye is reported.

Data Source Hierarchy Guide

EMS Run Report

Associated Edit Checks (NTDB)

Rule ID	Level	Message
4001	1	Value is not a valid menu option
4003	2	Element cannot be blank
4006	2	Element must be "Not Applicable" when *Initial Field GCS-40 Eye* is reported
4040	1	Single Entry Max exceeded

Pre-Hospital TR18.61.2 & TR18.61.0 – Initial Field GCS - Verbal

Description

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

Element Values

Adult:

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

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

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. (e.g. 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

EMS Run Report

Associated Edit Checks (NTDB)

Rule ID	Level	Message
4101	1	Value is not a valid menu option
4103	2	Element cannot be blank
4106	2	Element must be "Not Applicable" when *Initial Field GCS-40 Verbal* is reported
4140	1	Single Entry Max exceeded

Pre-Hospital TR18.62.2 & TR18.62.0 – Initial Field GCS - Motor

Description

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

Element Values

Adult:

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

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

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. (E.g., the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation).
- The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- The null value "Not Known/Not Recorded" is reported if the patient's first recorded *Initial Field GCS Motor* was NOT measured at the scene of injury.
- The null value "Not Known/Not Recorded" is reported if *Initial Field GCS-40 Motor* is reported.
- Data elements automatically switched to Pediatrics for patients younger than 2 years.

Data Source Hierarchy Guide

EMS Run Report

Associated Edit Checks (NTDB)

Rule ID	Level	Message
4201	1	Value is not a valid menu option
4203	2	Element cannot be blank
4206	2	Element must be "Not Applicable" when *Initial Field GCS-40 Motor* is reported
4240	1	Single Entry Max exceeded

Pre-Hospital TR18.65 – Initial Field GCS - Total

Description

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 Eye, GCS Verbal, and GCS Motor are complete.
- The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- The null value "Not Known/Not Recorded" is reported if the patient's first recorded *Initial Field GCS Total* was NOT measured at the scene of injury.
- The null value "Not Known/Not Recorded" is reported if *Initial Field GCS-40* is reported.

Data Source Hierarchy Guide

EMS Run Report

Associated Edit Checks (NTDB)

Rule ID	Level	Message
4301	1	GCS Total is outside the valid range of 3 – 15
4303	3	*Initial Field GCS - Total* does not equal the sum of *Initial Field GCS - Eye, Initial Field GCS - Verbal*, and *Initial Field GCS – Motor*, unless any of these values are "Not Known/Not Recorded"
4304	2	Element cannot be blank
4306	2	Element must be "Not Known/Not Recorded" when *Initial Field GCS-40 Eye*, *Initial Field GCS-40 Verbal*, or *Initial Field GCS-40 Motor* are reported.
4340	1	Single Entry Max exceeded

Pre-Hospital TR18.90.2 & TR18.90.0 – Initial Field GCS-40 Eye

Description

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

Element Values

Adult:

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. E.g., the chart indicates: "patient's eyes open spontaneously," an Eye GCS-40 of 4 may be recorded, IF there is no other contradicting documentation.
- Report Field Value "0. Not Testable" if unable to assess (e.g., swelling to the eye(s)).
- The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- The null value "Not Known/Not Recorded" is reported if the patient's first recorded *Initial Field GCS-40 Eye* was NOT measured at the scene of injury.
- The null value "Not Known/Not Recorded" is reported if *Initial Field GCS – Eye* is reported.

Data Source Hierarchy Guide

EMS Run Report

Associated Edit Checks (NTDB)

Rule ID	Level	Message
15001	1	Value is not a valid menu option
15003	2	Element cannot be blank
15006	2	Element must be "Not Known/Not Recorded" when *Initial Field GCS – Eyes* is reported
15040	1	Single Entry Max exceeded

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

Adult:

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

Pediatric < 5 Years:

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

Additional Information

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

Data Source Hierarchy Guide

EMS Run Report

Associated Edit Checks (NTDB)

Rule ID	Level	Message
15101	1	Value is not a valid menu option
15103	2	Element cannot be blank
15106	2	Element must be "Not Known/Not Recorded" when *Initial Field GCS – Verbal* is reported
15140	1	Single Entry Max exceeded

Pre-Hospital TR18.92.2 & TR18.92.0 – Initial Field GCS-40 Motor

Description

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

Element Values

Adult:

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

Pediatric < 5 Years:

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

Additional Information

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

Data Source Hierarchy Guide

EMS Run Report

Associated Edit Checks (NTDB)

Rule ID	Level	Message
15201	1	Value is not a valid menu option
15203	2	Element cannot be blank
15205	2	Element must be "Not Applicable" when Transport Mode is "4. Private/Public Vehicle/Walk in"
15240	1	Single Entry Max exceeded

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 the head, neck, torso, and extremities proximal to elbow or knee
5. Chest wall instability or deformity (e.g., flail chest)
6. Two or more proximal long-bone fractures
7. Crushed, degloved, mangled, or pulseless extremity
8. Amputation proximal to wrist or ankle
9. Pelvic fracture
10. Open or depressed skull fracture
11. Paralysis
12. Not Applicable
13. Not Known/Not Recorded

Additional Information

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

Data Source Hierarchy Guide

EMS Run Report

Associated Edit Checks (NTDB)

Rule ID	Level	Message
9501	1	Value is not a valid menu option
9502	2	Element cannot be blank
9506	2	Element cannot be "Applicable" or "Not Known/Not Recorded" along with any other valid value
9550	1	Multiple Entry Max exceeded

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

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

Additional Information

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

Data Source Hierarchy Guide

EMS Run Report

Associated Edit Checks (NTDB)

Rule ID	Level	Message
9601	1	Value is not a valid menu option
9602	2	Element cannot be blank
9607	2	Element cannot be "Applicable" or "Not Known/Not Recorded" along with any other valid value
9650	1	Multiple Entry Max exceeded

WI Referring Facility Information

Referring Facility TR33.64 – Transfer In

Description

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

Element Values

1. Yes
2. No

Additional Information

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

Data Source Hierarchy Guide

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

Referring Facility TR33.1 – Referring 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 Report
2. Trauma/Triage/Hospital Flow Sheet
3. Referring facility paperwork

Referring Facility TR33.1.1 – Other Facility

Description

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

Element Values

Free text description of the facility that transferred the patient to your facility

Additional Information

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

Data Source Hierarchy Guide

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

Referring Facility TR33.1.2 – Other Facility Transferred From City

Description

The city the patent 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

1. EMS Run Report
2. 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

1. EMS Run Report
2. 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 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

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

WI Emergency Department Information

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

Additional Information

None

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

Relevant value for data element

Data Source Hierarchy Guide

1. Trauma/Triage/Hospital Flow Sheet
2. Nursing Notes
3. Access Center Record/Communication Center
4. EMS Run Sheet

ED/TTA TR17.44 – Reason for Transfer Delay

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. 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
10. Waiting for transporting EMS unit
11. Not Applicable
12. Not Known/Not Recorded
13. High ED census at receiving hospital/busy
14. High ED census at transferring hospital/busy
15. In-house imaging delay
16. Late requesting transporting EMS unit
17. Low patient acuity
18. Other
    a. Selecting this field will open a free-text field TR17.43
19. Patient status change/complication
20. Referring hospital Issue – Radiology
21. 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
22. Referring Physician Decision Making

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

1. Level 1
2. Level 2
3. Level 3
4. Not Activated
5. Consultation
6. 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. Physicians 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

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

Trauma/Triage/Hospital Flow Sheet

ED/TTA TR17.25 – ED Discharge Date

Description

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

Element Values

Relevant data values in MM/DD/YYYY

Additional Information

If date of discharge is not documented, leave blank.

Data Source Hierarchy Guide

1. Referring facility documentation
2. Trauma/Transfer/Hospital Flow Sheet

ED/TTA TR17.26 – ED Discharge Time

Description

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

Element Values

Reported as HH: MM.

Additional Information

If date of discharge is not documented, leave blank.

Data Source Hierarchy Guide

1. Referring facility documentation
2. Trauma/Transfer/Hospital Flow Sheet

ED/TTA TR17.61 – Hospital Transferred To

Description

The name of the facility the patient was transferred to.

Element Values

1. Favorites
2. IA
3. MI
4. MN
5. WI
6. Other

Additional Information

- Relevant value for data element.
- Each option will show all facilities within that section.
- If hospital is not in list, contact trauma registry data manager to add to Patient Registry.

Data Source Hierarchy Guide

1. Referring facility documentation
2. Trauma/Transfer/Hospital Flow Sheet

ED/TTA TR17.60 – Discharge Transport Mode

Description

This type of transportation used to transfer the patient. Patient who are transferred by private vehicles are considered to have been discharged and referred. These cases need not be reported.

Element Values

1. Ambulance
2. Helicopter
3. Fixed wing
4. Private vehicle
5. Police
6. Public safety
7. Other
8. Not Applicable
9. Not Known/Not Recorded

Additional Information

None

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 TR18.99 – Admitting Service

Description

The service the patient was admitted to at your facility.

Element Values

1. Anesthesia/CRNA
2. Burn
3. Cardiology
4. Cardiovascular (CV) surgery
5. Critical Care Medicine
6. Emergency Medicine
7. ENT
8. Gastrointestinal
9. General Surgery
10. Gynecology
11. Hospitalist
12. Infection Control
13. Internal Medicine
14. Nephrology
15. Neurology
16. Neurosurgery
17. Non-Surgical
18. Not Applicable
19. Not Known/Not Recorded
20. OB
21. Ophthalmology
22. Oral Surgery
23. Oromaxillo Facial Service
24. Orthopedics
25. Other
26. Pediatric Surgery
27. Pediatrics
28. Plastic Surgery
29. Pulmonary Medicine
30. Radiology
31. Respiratory Therapy
32. Thoracic Surgery
33. Trauma
34. Trauma Nurse
35. Urology
36. Vascular

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 and 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

ED/TTA TR17.26 – ED Physical Discharge Time

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 Initial Assessment Information

Initial Assessment TR18.104 – Vitals Date

Description

The date the assessment was performed.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYYY.

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

Initial Assessment TR18.110 – Vitals Time

Description

The time the assessment was performed.

Element Values

Relevant value for data element

Additional Information

Reported as HH: MM.

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?

Description

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

Element Values

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

Additional Information

If the answer is "No," leave ICD-10 Procedures, Date performed, and Time blank.

Data Source Hierarchy Guide

1. Trauma/Triage/Hospital Flow Sheet

WI Diagnosis Information

Diagnosis – Injury Severity Score

Description

Injury Severity Score (ISS) that reflects the patient's injury.

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

Diagnosis – 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
3. Chest – TR21.3
5. Abdomen – TR21.6
6. Extremity – TR21.4
7. External – TR21.7

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

WI Outcome Information

Outcome TR25.33 – Hospital Admission Date

Description

The date the patient was admitted in the hospital.

Element Values

Relevant value for data element

Additional Information

- Reported as MM/DD/YYYY.
- 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

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

Outcome TR25.47– Hospital Admission Time

Description

The time patient was admitted in the hospital.

Element Values

Relevant value for data element

Additional Information

- Reported as HH: MM.
- 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 TR25.34– Hospital Physical Discharge Date

Description

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

Element Values

Relevant value for data element

Additional Information

- 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

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

Optional Elements

Optional Demographics Information

Demographics TR1.8.1 – Patient's Alias First Name

Description

The patient's first name.

Element Values

Relevant value for data element

Additional Information

Free text field.

Demographics TR1.9.1 – Patient's Alias Last Name

Description

The patient's last name.

Element Values

Relevant value for data element

Additional Information

Free text field.

Demographics TR1.28 –Other Race

Description

Patient race that is not specified in the race drop down.

Element Values

Relevant value for data element

Additional Information

Free text field.

Demographics TR1.18 –Patient Address

Description

The patient's home address.

Element Values

Relevant value for data element

Additional Information

Free text field.

Demographics TR1.18.1 – Address Line 2

Description

The patient's home address line 2.

Element Values

Relevant value for data element

Additional Information

Free text field.

Demographics TR1.24 –Patient's Primary Address

Description

The patient's primary address.

Element Values

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

Additional Information

Relevant value for data element.

Demographics TR1.25 –State of Residence

Description

The state the patient resides in.

Element Values

Relevant value for data element

Additional Information

Drop down option of U.S. states.

Optional Injury Information

Injury TR200.3.2 – Intentionality

Description

Intentionality.

Element Values

1. Assault
2. Not Applicable
3. Not Known/Not Recorded
4. Other
5. Self-inflicted
6. Undetermined
7. Unintentional

Additional Information

Relevant value for data element.

Injury TR200.12 – Cause of Injury

Description

Free text description of the mechanism of injury.

Element Values

Relevant value for data element

Additional Information

Free text field.

Injury TR200.12.2 – Activity Comments

Description

Activity comments.

Element Values

Relevant value for data element

Additional Information

Free text field.

Injury TR14.40 – Law Enforcement/Crash Report Number

Description

The unique number associated with the law enforcement or crash report which can be used for linkage at a later date.

Element Values

Relevant value for data element

Additional Information

Free text numeric field.

Injury TR14.37 – Mass Casualty Incident

Description

Indicator if this event would be considered a mass casualty incident (overwhelmed existing EMS resources).

Element Values

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

Additional Information

Relevant value for data element.

Injury TR5.8 – Supplemental Cause of Injury

Description

Injury complaint

Element Values

1. Accident
2. Aircraft
3. All terrain vehicle
4. Assault
5. Bicycle crash
6. Bite/sting
7. Boating
8. Burn
9. Child abuse
10. Crushing injury
11. Cut/pierce accidental
12. Dirt bike
13. Diving
14. Dog bite
15. Domestic abuse
16. Drowning
17. Electrical injury
18. Exposure/inhalation
19. Fall
20. Fall not further specified
21. Fall 1-6 meters (3.3-19.7 feet)
22. Fall over 6 meters (19.7 feet)
23. Fall under 1 meter (3.3 feet)
24. Farm/Heavy Equipment/Machine
25. Fire
26. Fireworks related
27. Frostbite
28. Gunshot wound
29. Hanging
30. Heat related
31. Homicide
32. Horse drawn carriage
33. Industrial accident
34. Injured by animal
35. Jetski
36. Lighting
37. Moped driver
38. Moped passenger
39. Moped crash
40. Motor pedestrian crash
41. Motor vehicle crash
42. Motor vehicle non-traffic
43. Motorcycle crash
44. Motorized stand-up scooter
45. Natural causes
46. Not Applicable
47. Not Known/Not Recorded
48. Other
49. Paddle boarding
50. Pending
51. Police
52. Power tools
53. Rape
54. Rollerblading
55. Rollerskating
56. Scooter
57. Skateboarding
58. Skiing
59. Skydiving
60. Sledding
61. Snowboarding
62. Snowmobile
63. Sport related
64. Stab wound
65. Struck by object
66. Suicide
67. Tornado
68. Train
69. Trampoline
70. Waterskiing

Additional Information

Relevant value for data element.

Injury TR29.10 – Safety Equipment Description

Description

Safety equipment description for other protective devices.

Element Values

Relevant value for data element

Additional Information

Free text field.

Injury TR2.12 – Occupation Description

Description

A description of the patient's occupation.

Element Values

Relevant value for data element

Additional Information

Free text field.

Injury TR5.14 – Vehicle Position

Description

The position of the patient in the motor vehicle at the time of the injury. Information gathered from EMS run sheet. This field only applies if the mechanism of injury is motor vehicle collision.

Element Values

1. Driver
2. Passenger back seat
3. Passenger front
4. Motorcycle driver
5. Motorcycle passenger
6. Other specified
7. Pedal cyclist
8. Pedestrian
9. Ride animal
10. Streetcar occupant
11. Passenger rear seat center
12. Not Applicable
13. Not Known/Not Recorded

Additional Information

Relevant value for data element.

Injury TR5.15 – Vehicle Position Other

Description

The position of the patient in the motor vehicle at the time of the injury.

Element Values

Relevant value for data element

Additional Information

Free text field.

Injury TR14.44 – Position of Patient in the Seat of the Vehicle

Description

The position of the patient in eat of the vehicle at the time of the crash.

Element Values

1. Driver
2. Left (non-driver)
3. Middle
4. Other
5. Right
6. Not Applicable
7. Not Known/Not Recorded

Additional Information

Relevant value for data element.

Injury TR14.43 – Seat Row Location of Patient in Vehicle

Description

The seat row location of the patient in vehicle at the time of the crash with the front seat numbered as 1.

Element Values

Relevant value for data element

Additional Information

Free numeric text field.

Injury TR14.42 – Area of the Vehicle Impacted by the Collision

Description

The area or location of impact on the vehicle.

Element Values

1. Center front
2. Center rear
3. Left front
4. Left rear
5. Left side
6. Right front
7. Right rear
8. Right side
9. Roll over
10. Not Applicable
11. Not Known/Not Recorded

Additional Information

- Relevant value for data element.
- Can select more than one with control + select.

Optional Pre-Hospital Information

Pre-Hospital TR5.33 – Was the Patient Extricated?

Description

Was the patient extricated?

Element Values

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

Additional Information

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

Pre-Hospital TR5.34 – Extrication Minutes

Description

The amount of time in minutes it took to extricate the patient.

Element Values

Relevant value for data element

Additional Information

- Free numeric text field.
- Entered in minutes.

Pre-Hospital TR18.106– Prehospital Vitals Date

Description

The date in which EMS took the patient's vitals.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYYY.

Pre-Hospital TR18.106.1– Prehospital Vitals Time

Description

The time in which EMS took the patient's vitals.

Element Values

Relevant value for data element

Additional Information

Reported as HH: MM.

Pre-Hospital TR18.68– EMS Diastolic Blood Pressure

Description

EMS diastolic blood pressure.

Element Values

Relevant value for data element

Additional Information

Free text numeric field.

Pre-Hospital TR18.59– EMS Temperature

Description

EMS temperature in Celsius.

Element Values

Relevant value for data element

Units:
1. C (Celsius) – TR18.59
2. F (Fahrenheit) – TR18.59.1

Additional Information

- Free text numeric field.
- Entry in one unit will auto-populate the other.

Pre-Hospital TR7.3 – Scene/Transport Agency Name

Description

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

Element Values

Relevant value for the data element.

Additional Information

- Picked from a drop-down menu after selecting agency state.
- If agency cannot be found, select "Out of State Agency," and inform trauma program by emailing DHSTrauma@dhs.wisconsin.gov.

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/Yes at Arrival
2. Missing/No
3. Not Applicable

Pre-Hospital TR7.1 – EMS Run Number

Description

The EMS run number is assigned by the EMS agency that generated the incident.

Element Values

Relevant value for data element

Additional Information

Free text numeric field.

Pre-Hospital TR9.11 – EMS Patient Care Report (PCR) Number

Description

EMS Patient Care Report (PCR) Number.

Element Values

Relevant value for data element

Additional Information

Free text numeric field.

Pre-Hospital TR9.17 – En Route Date

Description

The date the EMS agency started toward the injury scene.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYYY.

Pre-Hospital TR9.17.1 – En Route Time

Description

The time the EMS agency started toward the injury scene.

Element Values

Relevant value for data element

Additional Information

Reported as HH: MM.

Pre-Hospital TR9.6 – Patient Contact Date

Description

The date the service arrived at the patient at the injury scene.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYYY.

Pre-Hospital TR9.5 – Patient Contact Time

Description

The time the service arrived at the patient at the injury scene.

Element Values

Relevant value for data element

Additional Information

Reported as HH: MM.

Pre-Hospital TR9.16 – Trauma Notification Called in by EMS Date

Description

This field collects the date EMS contacted the hospital to provide information on the condition of their patient and estimated date of arrival at the hospital.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYYY.

Pre-Hospital TR9.16.1 – Trauma Notification Called in by EMS Time

Description

This field collects the time EMS contacted the hospital to provide information on the condition of their patient and estimated time of arrival at the hospital.

Element Values

Relevant value for data element

Additional Information

Reported as HH: MM.

Pre-Hospital TR9.4 – Unit Arrived Hospital Date

Description

The date the unit arrived at the hospital.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYYY.

Pre-Hospital TR9.4.1 – Unit Arrived Hospital Time

Description

The time the unit arrived at the hospital.

Element Values

Relevant value for data element

Additional Information

Reported as HH: MM.

Pre-Hospital TR8.12 – EMS Role

Description

The role EMS provider played in transport to facility.

Element Values

1. Transport from scene
2. Transport from rendezvous
3. Intercept
4. Non-transport
5. Not Applicable
6. Unknown

Additional Information

Relevant value for data element.

Pre-Hospital TR15.40 – Airway Management

Description

The management of the patient's airway.

Element Values

1. Airway cleared
2. Alternative Airway Device
3. Bag & mask
4. Combitube
5. Crico
6. LMA
7. Nasal ETT
8. Oral airway
9. Oral ETT
10. Trach
11. Not documented
12. Not performed
13. EOA
14. Nasal trumpet
15. Supplemental oxygen
16. Not Applicable
17. Not Known/Not Recorded

Additional Information

- Relevant value for data element.
- Can select more than one with control + select.

Pre-Hospital TR15.30 – Fluids

Description

Fluids given to the patient.

Element Values

1. Not performed
2. < 500
3. 500-2000
4. >2000
5. IVF attempted
6. IVF Unk Amount
7. Not Applicable
8. Not Known/Not Recorded

Additional Information

Relevant value for data element.

Pre-Hospital TR15.56 – Total Fluids Administered

Description

Prehospital total amount of fluids administered.

Element Values

Relevant value for data element

Additional Information

- Free numerical text field.
- Recorded in CC/ML.

Pre-Hospital TR15.60 – Prehospital Procedures

Description

Prehospital procedures.

Element Values

1. 12 lead ECG
2. Airway bag & mask
3. Airway nasal cannula
4. Airway non-rebreather mask
5. Airway supplemental oxygen
6. Cardio-pulmonary resuscitation (CPR)
7. Chest tube
8. Cricothyroidotomy
9. Defibrillation
10. External pacemaker
11. Hemorrhage hemostatic dressing
12. Hemorrhage pressure
13. Hemorrhage tourniquet
14. Laryngeal mask airway (LMA)
15. Lower extremity immobilization
16. Nasopharyngeal airways (NPA)
17. Needle decompression
18. Oral endotracheal tube (ETT)
19. Packed red blood cells
20. Pelvic wrap
21. Pericardiocentesis
22. Rapid sequence induction
23. Spinal immobilization
24. Upper extremity immobilization

Additional Information

- Relevant value for data element.
- Can select multiple options.

Pre-Hospital TR9.15 – Hospital Notified

Description

Indicates information used to identify patient as a trauma patient meriting a trauma service response by the EMS provider.

Element Values

1. Prehospital (direct from scene) notified receiving hospital of patient
2. Prehospital (direct from scene) did not notify receiving hospital
3. Not Applicable
4. Not Known/Not Recorded

Additional Information

Relevant value for data element.

Pre-Hospital TR15.31 – Medications

Description

Medications.

Element Values

1. ACLS drugs
2. Adenosine
3. Albuterol
4. Amiodarone
5. Ancef (Cefazolin)
6. Anectine (Succinylcholine)
7. Antibiotic
8. Artracurium
9. Aspirin (ASA)
10. Ativan (Lorazepam)
11. Atropine
12. Atrovent (Ipratropium)
13. Benadryl (Diphenhydramine)
14. Bretylium
15. Calcium chloride
16. Cardizem (Diltiazem)
17. Cerebyx (Fosphenytoin)
18. Chest tube
19. Cipro (Ciprofloxacin)
20. Claforan (Cefotaxime)
21. Colloid solution
22. Compazine (Prochlorperzine)
23. Crystalloid solution
24. Darvocet
25. Decadron (Dexamethasone)
26. Defibrillation
27. Demerol (Meperidine)
28. Dextrose (glucose)
29. Dilantin (Phenytoin)
30. Dilaudid (Hydromorphone)
31. Dobutamine
32. Dopamine
33. Epinephrine (aqueous)
34. Etomidate
35. External pacemaker
37. Flagyl (metronidazole)
38. Gentamicin
39. Geodon (ziprasidone)
40. Glucugon
41. Haldol (Haloperidol)
42. Heparin
43. Inderal (Propranolol)
44. Insulin
45. Isuprel (Isoproterenol)
46. Ketamine
47. Lasix (Furosemide)
48. Levaquin (Levofloxacin)
49. Levophed (Norepinephrine)
50. Lidocaine
51. Lovenox (Enoxaparin)
52. Magnesium sulfate
53. Mannitol
54. Methylprednisolone
55. Mivacron (Mivacurium)
56. Morphine sulfate
57. Motrin (Ibuprofen)
58. Narcan (Naloxene)
59. Nardil (Phenelzine)
60. Needle decompression of chest
61. Nifedipine
62. Nimbex (Cistracurium)
63. Nitroglycerin
64. Nitrous oxide
65. Norcuron (Vecuronium)
66. Not Applicable
67. Not Known/Not Recorded
68. Nubain (Nalbuphine)
69. Oxygen
70. Packed red blood cells
71. Pancuronium
73. Pelvic wrap
74. Pentothal (Thiopental)
75. Pepcid (Famotidine)
76. Pericardiocentesis
77. Phenergan (Promethazine)
78. Phenobarbital
79. Phytonadione (Vitamin K)
80. Prasugel
81. Procainamide
82. Propofol
83. Protonix (Pantaprozole)
84. Rapid sequence induction
85. Reglan (Metoclopramide)
86. Rocephin (Ceftriaxone)
87. Sodium bicarbonate
88. Sodium nitroprusside
89. Tetanus (TT, DT, or DPT)
90. Thiamine (Vitamin B1)
91. Tissue plasminogen activator (tPA)
92. Toradol (Ketorolac)
93.Tranexamic acid (TXA)
94. Tylenol (Acetaminophen)
95. Ultram (Tramadol)
96. Unasyn
97. Unknown
98. Valium (Diazepam)
99. Vancomycin
100. Verapamil
101. Versed (Midazolam)
102. Vistaril (Hydroxyzine)
103. Xanax (Alprazolam)
104. Zantac (Ramtidine)
105. Zemuron (Rocuronium)
106. Zofran (Ondansetron)

Additional Information

- Relevant value for data element.
- Can select multiple options.

Pre-Hospital TR15.61 – Provider's Primary Impression

Description

Provider's primary impression.

Element Values

Relevant value for data element

Additional Information

- Free text field.
- Can use lookup feature.

Optional Referring Facility Information

Referring Facility TR33.2 – 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.

Referring Facility TR33.3 – Referring Facility Arrival Time

Description

The time the patient arrived at the referring facility.

Element Values

Reported as HH: MM.

Additional Information

If time of arrival is not documented, leave blank.

Referring Facility TR33.54– Referring Hospital Vitals Date

Description

The date in which vitals were taken at the referring hospital.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYYY.

Referring Facility TR33.56– Referring Hospital Vitals Time

Description

The time in which vitals were taken at the referring hospital.

Element Values

Relevant value for data element

Additional Information

Reported as HH: MM.

Referring Facility TR33.30 – Discharge Date

Description

The date the patient was discharged from the referring facility.

Element Values

Relevant data values in MM/DD/YYYY

Additional Information

If date of discharge is not documented, leave blank.

Data Source Hierarchy Guide

1. Referring facility documentation
2. Trauma/Transfer/Hospital Flow Sheet

Referring Facility TR33.31 – Discharge Time

Description

The time the patient was discharged from the referring facility.

Element Values

Reported as HH: MM.

Additional Information

If date of discharge is not documented, leave blank.

Data Source Hierarchy Guide

1. Referring facility documentation
2. Trauma/Transfer/Hospital Flow Sheet

Referring Facility TR33.48– Transported to Referring Facility By

Description

The mode of transportation to referring facility.

Element Values

1. Ground ambulance
2. Helicopter ambulance
3. Fixed-wing ambulance
4. Private/Public vehicle/Walk-In
5. Police
6. Other
7. Not Applicable
8. Not Known/Not Recorded

Additional Information

Relevant value for data element.

Referring Facility TR33.45 – Referring Medical Record Number

Description

The patient's medical record number from the referring facility.

Element Values

Relevant value for data element

Additional Information

Free numeric text field.

Referring Facility TR33.46 – Referring Incident Number

Description

The patient's incident number from the referring facility.

Element Values

Relevant value for data element

Additional Information

Free numeric text field.

Referring Facility TR33.5– Referring Systolic Blood Pressure

Description

Referring systolic blood pressure.

Element Values

Relevant value for data element

Additional Information

Free text numeric field.

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Referring Facility TR33.40– Referring Diastolic Blood Pressure

Description

Referring diastolic blood pressure.

Element Values

Relevant value for data element

Additional Information

Free text numeric field.

Referring Facility TR33.6– Referring Hospital Pulse Rate

Description

Patient's pulse rate.

Element Values

Relevant value for data element

Additional Information

Free text numeric field.

Referring Facility TR33.7– Referring Temperature

Description

Referring temperature in Celsius.

Element Values

Relevant value for data element

Units:
1. C (Celsius) – TR33.7
2. F (Fahrenheit) – TR33.7.1

Additional Information

- Free text numeric field.
- Entry in one unit will auto-populate the other.

Referring Facility TR33.8– Referring Hospital Respiratory Rate

Description

Patient's respiratory rate in the referring facility.

Element Values

Relevant value for data element

Additional Information

Free text numeric field.

Referring Facility TR33.9– Referring 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

Relevant value for data element.

Referring Facility TR33.10– Referring Hospital Supplemental Oxygen

Description

Did patient receive supplemental oxygen at referring hospital?

Element Values

1. Yes
2. No
3. Not Applicable
4. Not Recorded
5. Not Known
6. Not Available
7. Not Known/Not Recorded

Additional Information

Relevant value for data element.

Referring Facility TR33.11– Referring Oxygen Saturation

Description

Referring oxygen saturation.

Element Values

Relevant value for data element

Additional Information

Free text numeric field.

Referring Facility TR33.12– Referring Hospital GCS - Eye

Description

First recorded GCS eye score measured at the facility.

Element Values

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

Additional Information

Relevant value for data element.

Referring Facility TR33.13.2– Referring Hospital GCS - Verbal

Description

First recorded GCS verbal score measured at the facility.

Element Values

1. No verbal response
2. Incomprehensible sounds
3. Inappropriate words
4. Confused
5. Oriented
6. Not Applicable
7. Not Known/Not Recorded

Additional Information

Relevant value for data element.

Referring Facility TR33.14.2– Referring Hospital GCS - Motor

Description

First recorded GCS motor score measured at the facility.

Element Values

1. No motor response
2. Extension to pain
3. Flexion to pain
4. Withdrawal from pain
5. Localizing pain
6. Obeys commands
7. Not Applicable
8. Not Known/Not Recorded

Additional Information

Relevant value for data element.

Referring Facility TR33.16– Referring Hospital GCS Assessment Qualifier

Description

Was the patient intubated, sedated, have eye obstruction, or receive paralytic agents in the referring facility?

Element Values

1. Patient chemically sedated
2. Obstruction to the patient eye
3. Patient intubated
4. Intubated and chemically paralyzed
5. Valid GCS: Patient was not sedated, not intubated, and did not have obstruction to the eye
6. Not Applicable
7. Not Known/Not Recorded

Additional Information

- Relevant value for data element.
- Hold the control key to select multiple items within the software.

Referring Facility TR33.50– Referring GCS Total Calc

Description

Referring GCS Total (Calculated).

Element Values

Value is generated by ImageTrend after GCS Eye, GCS Verbal, GCS Motor are entered.

Referring Facility TR33.32– Referring Hospital PTS

Description

Pediatric trauma score from the referring hospital.

Element Values

Relevant value for data element

Referring Facility TR33.62– Delay of Departure at Referring Hospital

Description

The reason for the delay of the departure at the referring hospital.

Element Values

Relevant value for data element

Additional Information

Free text field.

Referring Facility TR33.82– Transfer Rationale

Description

What is the reason for transferring to another hospital?

Element Values

1. Cardiac
2. General surgery
3. Neurosurgery
4. OB/GYN
5. Operating room
6. Orthopedics
7. Pediatrics
8. Thoracic
9. Not Applicable
10. Unknown

Additional Information

Relevant value for data element.

Referring Facility TR33.28– Referring Hospital Medication Given

Description

Medication given to the patient at the referring hospital.

Element Values

1. ACLS drugs
2. Adenosine
3. Albuterol
4. Amiodarone
5. Ancef (Cefazolin)
6. Anectine (Succinylcholine)
7. Antibiotic
8. Artracurium
9. Aspirin (ASA)
10. Ativan (Lorazepam)
11. Atropine
12. Atrovent (Ipratropium)
13. Benadryl (Diphenhydramine)
14. Bretylium
15. Calcium chloride
16. Cardizem (Diltiazem)
17. Cerebyx (Fosphenytoin)
18. Chest tube
19. Cipro (Ciprofloxacin)
20. Claforan (Cefotaxime)
21. Colloid solution
22. Compazine (Prochlorperazine)
23. Darvocet
24. Decadron (Dexamethasone)
25. Defibrillation
26. Demerol (Meperidine)
27. Dextrose (glucose)
28. Dilantin (Phenytoin)
29. Dilaudid (Hydromorphone)
30. Dobutamine
31. Dopamine
32. Epinephrine (aqueous)
33. Etomidate
34. External pacemaker
35. Fentanyl
36. Flagyl (metronidazole)
37. Gentamicin
38. Geodon (ziprasidone)
39. Glucagon
40. Haldol (Haloperidol)
41. Heparin
42. Inderal (Propranolol)
43. Insulin
44. Isuprel (Isoproterenol)
45. Ketamine
46. Lasix (Furosemide)
47. Levaquin (Levofloxacin)
48. Levophed (Norepinephrine)
49. Lidocaine
50. Lovenox (Enoxaparin)
51. Magnesium sulfate
52. Mannitol
53. Methylprednisolone
54. Mivacron (Mivacurium)
55. Morphine sulfate
56. Motrin (Ibuprofen)
57. Narcan (Naloxene)
58. Nardil (Phenelzine)
59. Needle decompression of chest
60. Nifedipine
61. Nimbex (Cistracurium)
62. Nitroglycerin
63. Nitrous oxide
64. Norcuron (Vecuronium)
65. Not Applicable
66. Not Known/Not Recorded
67. Nubain (Nalbupine)
68. Oxygen
69. Packed red blood cells
70. Pancuronium
71. Paxil (Paroxetene)
72. Pelvic wrap
73. Pentothal (Thiopental)
74. Pepcid (Famotidine)
75. Pericardiocentesis
76. Phenergan (Promethazine)
77. Phytonadione (Vitamin K)
78. Prasugrel
79. Procainamide
80. Propofol
81. Protonix (Pantaprozole)
82. Rapid sequence induction

83. Reglan (Metoclopramide)
84. Rocephin (Ceftriaxone)
85. Sodium bicarbonate
86. Tetanus (TT, DT, or DPT)
87. Thiamine (Vitamin B1)
88. Tissue plasminogen activator(tPA)
89. Toradol (Ketorolac)
90. Tylenol (Acetaminophen)
91. Ultram (Tramadol)
92. Unknown
93. Valium (Diazepam)
94. Vancomycin
95. Verapamil
96. Versed (Midazolam)
97. Vistaril (Hydroxyzine)
98. Xanax (Alprazolam)
99. Zantac (Ramtidine)
100. Zemuron (Rocuronium)
101. Zofran (Ondansetron)

Additional Information

Relevant value for data element.

Optional ED/TTA Information

ED/TTA TR8.9 – Other Mode

Description

Free text field for other mode of transport.

Element Values

Relevant value for data element

Additional Information

Free text field.

ED/TTA TR25.36– Date of Death

Description

Date the patient died.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYYY.

ED/TTA TR25.36.1– Time of Death

Description

Time the patient died.

Element Values

Relevant value for data element

Additional Information

Reported as HH: MM.

ED/TTA TR25.53– Circumstances of Death

Description

Circumstances of death comment.

Element Values

Relevant value for data element

Additional Information

Free text field.

ED/TTA TR25.69– Organs/Tissue Donation Requested

Description

Was there a documented request of the next of kin to donate organs or tissues?

Element Values

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

Additional Information

Relevant value for data element.

ED/TTA TR25.29– Organ Donation

Description

Was organ tissue donated?

Element Values

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

Additional Information

Relevant value for data element.

ED/TTA TR25.70– Organs Donated

Description

If the patient was an organ donor, what organs were recovered?

Element Values

1. Adrenal glands
2. Bone
3. Bone marrow
4. Cartilage
5. Cornea
6. Dura mater
7. Fascialata
8. Heart
9. Kidney
10. Large intestines
11. Liver
12. Lung
13. Nerve
14. Other
15. Pancreas
16. Skin
17. Small intestines
18. Stomach
19. Tendons
20. Unknown
21. Valve
22. Whole eye

Additional Information

- Relevant value for data element.
- Select that all are appropriate.
- Hold the control key to select multiple items within the software.

ED/TTA TR25.37– Autopsy Performed

Description

Was an autopsy performed or does the chart indicate that one will be performed?

Element Values

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

Additional Information

Relevant value for data element.

ED/TTA TR17.59– ED Destination Determination

Description

The reason the facility was chosen as the destination.

Element Values

1. Specialty Care/Higher Level Care
2. Patient/family request
3. Other-specify
4. Hospital of choice
5. Specialty- burns
6. Specialty – cardiac (bypass)
7. Specialty – facial trauma
8. Specialty – hand
9. Specialty – neurosurgery
10. Specialty- orthopedics – pelvic ring/acetabular fxs
11. Specialty – orthopedics – soft tissue coverage
12. Specialty – other orthopedics
13. Specialty – pediatrics
14. Specialty – replantation
15. Specialty – spine
16. Specialty – vascular/aortic injuries
17. Not Known/Not Recorded

Additional Information

Relevant value for data element.

ED/TTA TR17.28– OR Discharge Disposition

Description

The operating room discharge disposition.

Element Values

1. Died
2. Floor bed
3. Home with services
4. Home without services
5. Intensive care unit
6. Left against medical advice
7. Not Applicable
8. Not Known/Not Recorded
9. Observation unit (unit that provides < 24 hour stay)
10. Other (jail, institution, etc.)
11. Telemetry/step-down unit (less acuity than ICU)
12. Transferred to another hospital

Additional Information

Relevant value for data element.

ED/TTA TR25.99– Discharge Physician

Description

The physician responsible for the discharge summary or discharge orders from the ED.

Element Values

Relevant value for data element

Additional Information

Physicians can be added in the staff section of Patient Registry by hospital administrators or system administrators.

ED/TTA TR18.98– Admitting MD/Staff

Description

Admitting MD/staff.

Element Values

Relevant value for data element

Additional Information

Physicians can be added in the staff section of Patient Registry by hospital administrators or system administrators.

ED/TTA TR17.29– Consulting Service

Description

Did the patient see a consulting service?

Element Values

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

Additional Information

Relevant value for data element.

ED/TTA TR17.32– Consulting Service Type

Description

Type of the consulting service.

Element Values

1. Hyperbaric medicine
2. Acute rehabilitation medicine
3. Anesthesia
4. Bariatric
5. Burn
6. Cardiology
7. Cardiothoracic surgery
8. Chemical dependency
9. Colo-rectal
10. Critical care medicine
11. Critical care surgery
12. Dentistry
13. Dermatology
14. Electrophysiology
15. Endocrinology
16. ENT
17. Family practice
18. Gastroenterology
19. General surgery
20. Geriatrics
21. Gynecology
22. Hand
23. Hematology oncology
24. Hospitalist
25. Infectious disease
26. Intensive care unit
27. Internal medicine
28. Interventional radiology
29. Kidney transplant
30. Liver
31. Neonatal
32. Nephrology
33. Neurointensive care
34. Neurointerventional radiology
35. Neurology
36. Neurosurgery
37. Neurosurgery – spine
38. Obstetrics
39. Occuloplastics
40. Oncology
41. Ophthalmology
42. Oral Maxillo Facial Surgery
43. Ortho-spine
44. Orthopedic surgery
45. Pain
46. Palliative care
47. Plastic surgery
48. Podiatry
49. Psychiatry
50. Psychology
51. Pulmonary medicine
52. Rheumatology
53. Trauma surgeon
54. Urology
55. Vascular surgery
56. Not applicable
57. Not known/not recorded

Additional Information

Relevant value for data element.

ED/TTA TR17.33– Consulting Staff

Description

Staff consulted for the service.

Element Values

Relevant value for data element

Additional Information

Physicians can be added in the staff section of Patient Registry by hospital administrators or system administrators.

ED/TTA TR17.7– Date Consulting Practioner Requested

Description

The date the consulting practioner was requested.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYYY.

ED/TTA TR17.8- Time Consulting Practioner Requested

Description

The time the consulting practioner was requested.

Element Values

Relevant value for data element

Additional Information

Reported as HH: MM.

ED/TTA TR17.75– Date Arrived

Description

The date the consulting practioner arrived.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYYY.

ED/TTA TR17.76– Time Arrived

Description

The time the consulting practioner arrived.

Element Values

Relevant value for data element

Additional Information

Reported as HH: MM.

ED/TTA TR18.131– Attending MD/Staff

Description

Attending MD/staff member.

Element Values

Relevant value for data element

Additional Information

Physicians can be added in the staff section of Patient Registry by hospital administrators or system administrators.

ED/TTA TR18.132– Attending Service

Description

Attending MD/staff service type.

Element Values

1. Burn
2. Cardiology
3. ENT
4. General surgery
5. Hand
6. Medicine
7. Neurosurgery
8. Not Applicable
9. Not Known/Not Recorded
10. OB
11. Ophthalmology
12. Orthopedics
13. Pediatric surgery
14. Plastics
15. Podiatry
16. Surgery subspecialty
17. Trauma
18. Urology
19. Emergency medicine

Additional Information

Relevant value for data element.

ED/TTA TR17.9– ED Physician

Description

ED physician.

Element Values

Relevant value for data element

Additional Information

Physicians can be added in the staff section of Patient Registry by hospital administrators or system administrators.

ED/TTA TR17.13– ED Physician Service Type

Description

The responding trauma team member's service type.

Element Values

1. Anesthesia
2. Dentistry
3. ED RN
4. Emergency department technician
5. Emergency medicine
6. Endocrinology
7. ENT
8. Family practice
9. Infectious diseases
10. Intensive care unit
11. Internal medicine
12. Laboratory
13. Maxillofacial surgery
14. Nephrology
15. Neurosurgery
16. Not Applicable
17. Not Known/Not Recorded
18. Nurse practitioner
19. Obstetrics & gynecology
20. Ophthalmology
21. Organ retrieval
22. Orthopedic surgery
23. Pediatric surgery
24. Physician assistant
25. Plastic surgery
26. Pulmonology
27. Radiology
28. Respiratory therapy
29. Social work
30. Surgery senior resident
31. Surgery/trauma
32. Trauma nurse
33. Urology
34. Vascular surgery

Additional Information

Relevant value for data element.

ED/TTA TR17.10– Date Physician Called

Description

The date physician was called.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYYY.

ED/TTA TR17.14– Time Physician Called

Description

The time physician was called.

Element Values

Relevant value for data element

Additional Information

Reported as HH: MM.

ED/TTA TR17.15– Date Physician Arrived

Description

The date physician arrived.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYYY.

ED/TTA TR17.11 – Time Physician Arrived

Description

The time physician arrived.

Element Values

Relevant value for data element

Additional Information

Reported as HH: MM.

ED/TTA TR17.12– Was Trauma Surgeon Arrival in ED Timely?

Description

Was the trauma team member arrival timely?

Element Values

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

Additional Information

Relevant value for data element.

ED/TTA TR17.79– Response Time

Description

Calculated by difference between team member called and team member arrived in minutes.

Element Values

Auto calculation

Additional Information

Relevant value for data element.

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. Physicians Notes

ED/TTA TR17.78.1– Date Activation Level Was Changed

Description

The date the activation level was upgraded or downgraded.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYYY.

ED/TTA TR17.78.1.1 – Time Activation Level Was Changed

Description

The time the activation level was upgraded or downgraded.

Element Values

Relevant value for data element

Additional Information

Reported as HH: MM.

ED/TTA TR17.78.4– Old Activation Level

Description

Old 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

Relevant value for data element.

Optional Initial Assessment Information

Initial Assessment TR18.13 – Initial Assessment Diastolic Blood Pressure

Description

Initial assessment diastolic blood pressure of patient.

Element Values

Relevant value for data element

Additional Information

Free numeric text field.

Initial Assessment TR21.10 – Initial ED/Hospital PTS Total

Description

Initial ED/hospital pediatric trauma score (PTS) total.

Element Values

Relevant value for data element

Additional Information

Free numeric text field.

Initial Assessment TR18.95 – Initial ED/Hospital Hematocrit

Description

Hematocrit.

Element Values

Relevant value for data element

Additional Information

Free numeric text field.

Initial Assessment TR18.93 – Base deficit

Description

Defined as a value greater than 4 at a time during admission. This number is reported as a component or arterial or venous blood gases. The number may be reported by the lab as base deficit, or as base excess with a negative value.

Element Values

Relevant value for data element

Additional Information

Free numeric text field.

Initial Assessment TR18.47 – Prothrombin Time

Description

The time, in seconds, that it takes for the patient's blood to clot.

Element Values

Relevant value for data element

Additional Information

- Free numeric text field.
- Recorded in seconds.

Initial Assessment TR18.48 – Partial Thromboplastin Time

Description

The time, in seconds, that it takes for the patient's blood to coagulate.

Element Values

Relevant value for data element

Additional Information

- Free numeric text field.
- Recorded in seconds.

Initial Assessment TR18.182– ABGs drawn

Description

Were arterial blood gases drawn?

Element Values

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

Additional Information

Relevant value for data element.

Initial Assessment TR18.179– ABGs pH

Description

Initial ABG pH.

Element Values

Relevant value for data element

Additional Information

Free numeric text field.

Initial Assessment TR18.180– Pa02

Description

Initial Pa02.

Element Values

Relevant value for data element

Additional Information

Free numeric text field.

Initial Assessment TR18.181– PaC02

Description

Initial PaC02.

Element Values

Relevant value for data element

Additional Information

Free numeric text field.

Initial Assessment TR45.1– Was SBIRT Completed?

Description

Was the process of screening, brief intervention and referral to treatment completed?

Element Values

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

Additional Information

Relevant value for data element.

Initial Assessment TR45.2– SBIRT Provided By?

Description

If alcohol is indicated, who provided the screening, brief intervention and referral to treatment?

Element Values

1. Trauma program manager
2. Trauma program coordinator
3. Student
4. Social worker
5. Physician
6. Nurse
7. Other

Additional Information

Relevant value for data element.

Initial Assessment TR45.4– Were the Screening Results Positive?

Description

SBIRT screening results are considered positive when the results indicate a brief intervention should be performed.

Element Values

1. Yes/positive
2. No/negative
3. Not applicable
4. Not known

Additional Information

Relevant value for data element.

Initial Assessment TR45.5– Was SBIRT brief intervention initiated?

Description

Following a screening result indicating moderate risk, brief intervention is provided. This involves motivational discussion on raising awareness of their substance use and its consequences and motivating them toward behavioral change.

Element Values

1. Yes/brief intervention performed
2. No/brief intervention not performed
3. Not applicable
4. Not known

Additional Information

Relevant value for data element.

Initial Assessment TR45.7– Was referral to treatment provided?

Description

Following a screening result of severe or dependence, a referral to treatment is provided. This is a proactive process that facilitates access to care for individuals requiring more extensive treatment.

Element Values

5. Yes/referral to treatment provided
6. No/referral to treatment not provided
7. Not applicable
8. Not known

Additional Information

Relevant value for data element.

Optional Ventilator/Blood Information

Ventilator/Blood TR26.74– Placed on Ventilator Date

Description

The date the patient was placed on a ventilator.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYYY.

Ventilator/Blood TR26.74.1 – Placed on Ventilator Time

Description

The time the patient was placed on a ventilator.

Element Values

Relevant value for data element

Additional Information

Reported as HH: MM.

Ventilator/Blood TR26.75– Taken Off Ventilator Date

Description

The date the patient was taken off of the ventilator.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYYY.

Ventilator/Blood TR26.75.1 – Taken Off Ventilator Time

Description

The time the patient was taken off the ventilator.

Element Values

Relevant value for data element

Additional Information

Reported as HH: MM.

Ventilator/Blood TR26.58.1–Count of Each Calendar Day the Patient Has Been on the Ventilator

Description

The count of each calendar day the patient has been on the ventilator.

Element Values

Auto calculation

Additional Information

Relevant value for data element.

Ventilator/Blood TR26.58.2 – Total Computed Time on Ventilator

Description

Total computed time on ventilator.

Element Values

Auto calculation

Additional Information

Relevant value for data element.

Ventilator/Blood TR22.45– Date Blood was Administered

Description

Date blood was administered.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYYY.

Ventilator/Blood TR22.45.1 – Time Blood was Administered

Description

Time blood was administered.

Element Values

Relevant value for data element

Additional Information

Reported as HH: MM.

Ventilator/Blood TR22.20– Blood Product Location

Description

Blood product location.

Element Values

1. Critical care unit
2. Elsewhere
3. Emergency department
4. Floor
5. ICU
6. Operating room
7. Prehospital
8. Referring hospital
9. Unspecified

Additional Information

Relevant value for data element.

Ventilator/Blood TR22.21– Blood Product

Description

Blood product.

Element Values

1. Cryoprecipitate
2. Fresh frozen plasma
3. Massive blood transfusion protocol initiated
4. Packed red blood cells
5. Platelets
6. Crystalloids
7. Not Known/Not Recorded

Additional Information

Relevant value for data element.

Ventilator/Blood TR22.22– Total Units of Blood Given

Description

The volume of blood reported to the NTDB will be in CCs. The trauma exports will take the actual value recorded for blood products administered within the first four hours. (Note: the system does not convert units to CCs).

Element Values

Relevant value for data element

Additional Information

Free numeric text field.

Ventilator/Blood TR22.14 – First Unit of Blood Ordered Date

Description

The date the order was placed for blood products.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYYY.

Ventilator/Blood TR22.17– First Unit of Blood Ordered Time

Description

The time the order was placed for blood products.

Element Values

Relevant value for data element

Additional Information

Reported as HH: MM.

Ventilator/Blood TR22.15 – Crossmatch Date

Description

The date of the crossmatch.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYYY.

Ventilator/Blood TR22.18– Crossmatch Time

Description

The time of the crossmatch.

Element Values

Relevant value for data element

Additional Information

Reported as HH: MM.

Ventilator/Blood TR22.16 – First Unit of Blood Administered Date

Description

The date of the first unit of blood administered.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYYY.

Ventilator/Blood TR22.19– First Unit of Blood Administered Time

Description

The time of the first unit of blood administered.

Element Values

Relevant value for data element

Additional Information

Reported as HH: MM.

Optional Procedures Information

Procedures TR200.11– Procedure Performed Location

Description

The hospital location where the procedure was performed.

Element Values

1. Catheterization lab
2. ED
3. Endoscopy
4. Floor
5. GI lab
6. ICU
7. Minor surgery unit
8. Not Applicable
9. Not Known/Not Recorded
10. Nuclear medicine
11. Observation
12. Operating room
13. Other
14. Outpatient clinic
15. PTA(referring hospital)
16. Radiology
17. Readmit OR (planned OR)
18. Recovery
19. Rehabilitation
20. Scene
21. Special procedure unit
22. Step-down
23. Tele
24. Transport from scene

Additional Information

Relevant value for data element.

Procedures TR200.10– Physician Performing the Procedures

Description

The physician performing the procedures.

Element Values

Relevant value for data element

Additional Information

Physicians can be added in the staff section of Patient Registry by hospital administrators or system administrators.

Procedures TR200.7– Physician Comments

Description

Procedure comments.

Element Values

Relevant value for data element

Additional Information

Free text field.

Procedures TR200.6– Service Type of the Physician

Description

Service type of the physician.

Element Values

1. Anesthesia
2. Cardiology
3. Critical care medicine
4. Ear nose throat
5. Emergency medicine
6. General surgery
7. Gynecology
8. Hand surgery
9. Medicine
10. Neurosurgery
11. Not Applicable
12. Not Known/Not Recorded
13. Obstetrics
14. Ophthalmology
15. Oral maxilla facial surgery
16. Orthopedic surgery
17. Pediatric surgery
18. Plastic surgery
19. Podiatry
20. Radiology
21. Thoracic surgery
22. Trauma surgery
23. Urology
24. Vascular surgery

Additional Information

Relevant value for data element.

Procedures TR200.2.2.1– Operation Number

Description

Operation number.

Element Values

Relevant value for data element

Additional Information

Free text numeric field.

Procedures TR200.2.2.3 – Date in OR/Time in OR

Description

The date the patient was in the OR and time the patient was in the OR.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYYY and HH: MM.

Procedures TR200.2.2.4– Date out of OR/Time out of OR

Description

The date the patient was out of the OR and time the patient was out of the OR.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYY and HH: MM.

Procedures TR200.2.2.9– Staff Involved with Procedure

Description

The staff that are involved with the procedure.

Element Values

Relevant value for data element

Additional Information

Staff can be added in the staff section of Patient Registry by hospital administrators or system administrators.

Procedures TR200.2.1.2– Accession Number

Description

The ID/order number associated with this procedure.

Element Values

Relevant value for data element

Additional Information

Free text numeric field.

Procedures TR200.2.1.6 – Exam Arrival

Description

The date the patient was sent to radiology for the procedure.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYYY.

Procedures TR200.2.1.6.1– Exam Arrival Time

Description

The time the patient was sent to radiology for the procedure.

Element Values

Relevant value for data element

Additional Information

Reported as HH: MM.

Procedures TR200.2.1.8 – Exam Finished

Description

The date the patient left radiology following the procedure.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYYY.

Procedures TR200.2.1.8.1– Exam Finished Time

Description

The time the patient left radiology following the procedure.

Element Values

Relevant value for data element

Additional Information

Reported as HH: MM.

Procedures TR200.2.1.4 – Request Date

Description

The date the radiology procedure was requested.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYYY.

Procedures TR200.2.1.4.1 – Request Time

Description

The time the radiology procedure was requested.

Element Values

Relevant value for data element

Additional Information

Reported as HH: MM.

Procedures TR200.15 – Procedure Arterial Puncture Date

Description

The date the procedure arterial puncture was performed.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYYY.

Procedures TR200.15.1 – Procedure Arterial Puncture Time

Description

The time the procedure arterial puncture was performed.

Element Values

Relevant value for data element

Additional Information

Reported as HH: MM.

Procedures TR200.2.3.2 – Radiology Results Read Date

Description

The date the radiology procedure was read by radiologist.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYYY.

Procedures TR200.2.3.3–Radiology Results Read Time

Description

The time the radiology procedure was read by radiologist.

Element Values

Relevant value for data element

Additional Information

Reported as HH: MM.

Procedures TR200.2.3.1– Radiology Results

Description

Enter the results of the radiology procedures as recorded by the radiologist.

Element Values

1. Inconclusive result
2. Negative
3. Not Known/Not Recorded
4. Positive

Additional Information

Relevant value for data element.

Procedures TR200.2.1.3– Requesting Staff

Description

The staff member who wrote the orders for this procedure.

Element Values

Relevant value for data element

Additional Information

Staff can be added in the staff section of Patient Registry by hospital administrators or system administrators.

Procedure TR18.190 – Date of First Antibiotic Administration

Description

Date of first antibiotic administration. Recommended antibiotics > 60 min from time of arrival to ED on an open fracture.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYYY.

Procedure TR18.190.1– Time of First Antibiotic Administration

Description

Time of first antibiotic administration. Recommended antibiotics > 60 min from time of arrival to ED on an open fracture.

Element Values

Relevant value for data element

Additional Information

Reported as HH: MM.

Optional Diagnosis Information

Diagnosis TR200.120– Comments

Description

Diagnosis comments.

Element Values

Relevant value for data element

Additional Information

Free text.

Optional Outcome Information

Outcome TR25.42– Hospital Discharge Destination Determination

Description

Hospital discharge destination determination.

Element Values

1. Obstetrics
2. Ophthalmology
3. Oral maxilla facial surgery
4. Orthopedic surgery
5. Pediatric surgery
6. Plastic surgery
7. Podiatry
8. Radiology
9. Thoracic surgery
10. Trauma surgery
11. Urology
12. Vascular surgery
13. Obstetrics
14. Ophthalmology
15. Oral maxilla facial surgery
16. Orthopedic surgery
17. Pediatric surgery
18. Plastic surgery
19. Podiatry

Additional Information

Relevant value for data element.

Outcome TR25.42.Other– Other Destination Determination

Description

Other destination determination.

Element Values

Relevant value for data element

Additional Information

Free text.

Outcome TR25.35 – Hospital Transferred To

Description

The name of the facility the patient was transferred to.

Element Values

1. Favorites
2. IA
3. MI
4. MN
5. WI
6. Other

Additional Information

- Relevant value for data element.
- Each option will show all facilities within that section.

Outcome TR25.43– Hospital Discharge Transport Mode

Description

The mode of transport by which the patient was transported from your facility to the facility that you transferred the patient to.

Element Values

1. Ambulance
2. Helicopter
3. Fixed wing
4. Private vehicle
5. Police
6. Public safety
7. Other
8. Not Applicable
9. Not Known/Not Recorded

Additional Information

Relevant value for data element.

Outcome TR25.36 – Date of Death

Description

The date the patient died.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYYY.

Outcome TR25.36.1– Time of Death

Description

The time the patient died.

Element Values

Relevant value for data element

Additional Information

Reported as HH: MM.

Outcome TR25.30– Location of Death

Description

The location where the patient died.

Element Values

1. ED
2. Floor
3. ICU
4. Not Applicable
5. Not Known/Not Recorded
6. Not recorded
7. Operating room
8. PICU
9. Prior to arrival

Additional Information

Relevant value for data element

Outcome TR25.53 – Circumstances of death

Description

The circumstances of the patient's death comment.

Element Values

Relevant value for data element

Additional Information

Free text field.

Outcome TR25.69– Organs/Tissue Donation Requested

Description

Was there a documented request of the next of kin to donate organs or tissues?

Element Values

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

Additional Information

Relevant value for data element.

Outcome TR25.29– Organ Donation

Description

Was there a donation of patient's organs?

Element Values

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

Additional Information

Relevant value for data element.

Outcome TR25.70– Organs Donated

Description

If the patient was an organ donor, what organs were recovered?

Element Values

1. Adrenal glands
2. Bone
3. Bone marrow
4. Cartilage
5. Cornea
6. Dura mater
7. Fascialata
8. Heart
9. Kidney
10. Large intestines
11. Liver
12. Lung
13. Nerve
14. Other
15. Pancreas
16. Skin
17. Small intestines
18. Stomach
19. Tendons
20. Unknown
21. Valve
22. Whole eye

Additional Information

- Relevant value for data element.
- Select that all are appropriate.
- Hold the control key to select multiple items within the software.

Outcome TR25.37– Autopsy Performed

Description

Was an autopsy performed or does the chart indicate that one will be performed?

Element Values

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

Additional Information

Relevant value for data element.

Outcome TR25.46– General Condition at Discharge

Description

The general condition of the patient at discharge.

Element Values

1. Good, return to previous level of function
2. Temporary disability, expected to return to previous level of function
3. Moderate disability with self care
4. Severe disability, dependent
5. Persistent vegetative state
6. Not Applicable
7. Not Known/Not Recorded

Additional Information

Relevant value for data element.

Outcome TR25.99– Discharge Physician

Description

The physician responsible for the discharge summary or discharge orders from the ED.

Element Values

Relevant value for data element

Additional Information

Staff can be added in the staff section of Patient Registry by hospital administrators or system administrators.

Outcome TR2.7– Secondary Method of Payment

Description

The secondary source of payment for hospital care.

Element Values

1. Auto
2. Blue Cross/Blue Shield
3. HMO
4. Managed care
5. Medicaid
6. Medicare
7. Military/champus
8. No fault automobile
9. None
10. Not Applicable
11. Not billed (for any reason)
12. Not Known/Not Recorded
13. Other
14. Other government
15. PPO
16. Private charity
17. Private/commercial insurance
18. Self pay
19. Shriners
20. Worker's compensation

Additional Information

Relevant value for data element.

Outcome TR2.14– Secondary Other Billing Source

Description

Specify the other secondary billing source.

Element Values

Relevant value for data element

Additional Information

Free text field.

Outcome TR25.49 – DRG Codes

Description

Diagnosis related group codes.

Element Values

Relevant value for data element

Additional Information

- Free text field.
- Can use lookup feature.

Outcome TR2.9 – Billed Hospital Charges

Description

The total charges the patient was billed for the hospital stay.

Element Values

Relevant value for data element

Additional Information

Free numeric text field.

Outcome TR5.27– Note Type

Description

The type of the notes related to the injury of the patient which are significant to the care of the patient.

Element Values

1. Trauma program notes
2. Registry notes
3. Quality notes

Additional Information

Relevant value for data element.

Outcome TR5.24– Note

Description

Notes related to the injury of a patient which are significant to the care of the patient.

Element Values

Relevant value for data element

Additional Information

Free text field.

Outcome TR5.26– Notes Entered By

Description

Who creates the notes related to the injury of a patient which are significant to the care of the patient.

Element Values

Auto entry field

Outcome TR5.25 – Notes Date/Time

Description

The date and time when notes related to the injury of a patient which are significant to the care of the patient are taken.

Element Values

Auto entry field

Additional Information

Reported as MM/DD/YYYY and HH: MM.

Outcome TR25.100 – Discharge Summary

Description

A comprehensive narrative of any information you feel should be detailed for this patient's record.

Element Values

Relevant value for data element

Additional Information

Free text field.

Optional Log of Admission Information

Log of Admission TR44.1 – Admission Log Date

Description

The date of patient admission.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYYY.

Log of Admission TR44.2– Admission Log Time

Description

The time of patient admission.

Element Values

Relevant value for data element

Additional Information

Reported as HH: MM.

Log of Admission TR44.7 – Discharge Date

Description

The date of patient discharge.

Element Values

Relevant value for data element

Additional Information

Reported as MM/DD/YYYY.

Log of Admission TR44.8 – Discharge Time

Description

The time of patient discharge.

Element Values

Relevant value for data element

Additional Information

Reported as HH: MM.

Log of Admission TR44.3– Admission Ward

Description

The type of ward that the patient was admitted to.

Element Values

1. Burn unit
2. ED
3. Floor
4. ICU
5. Not Applicable
6. Not Known/Not Recorded
7. OR
8. Other
9. Readmit OR (planned OR)

Additional Information

Relevant value for data element.

Log of Admission TR44.4 – Bed Number

Description

The bed number the patient is in.

Element Values

Relevant value for data element

Additional Information

Free text numeric field.

Log of Admission TR44.5– Consultant

Description

The staff that consulted with the patient.

Element Values

Relevant value for data element

Additional Information

Staff can be added in the staff section of Patient Registry by hospital administrators or system administrators.

Log of Admission TR44.6– Medical Specialty

Description

The medical specialty of the area of patient admission.

Element Values

1. Acute Rehabilitation Medicine
2. Anesthesia
3. Bariatric
4. Burn
5. Cardiology
6. Cardiothoracic Surgery
7. Cardiovascular Surgery
8. Case Manager
9. Chemical Dependency
10. Colon & Rectal Surgery
11. Critical Care Medicine
12. Critical Care Surgery
13. Dentistry
14. Dermatology
15. Electrophysiology
16. Emergency Medicine
17. Endocrinology
18. Family Medicine
19. Gastroenterology
20. General Surgery
21. Geriatric
22. Gynecology
23. Hand
24. Hematology Oncology
25. Hospitalist
26. Infection Control
27. Infectious Disease
28. Intensive Care Unit
29. Internal Medicine
30. Interventional Radiology
31. Kidney Transplant
32. Laboratory
33. Liver
34. Medicine
35. Nephrology
36. Neurointensive Care
37. Neurointerventional Radiology
38. Neurology
39. Neurosurgery
40. Neurovascular
41. Non-Surgical
42. Not Applicable
43. Not Done/Not Documented
44. Not Known/Not Recorded
45. Not Performed
46. Nutrition
47. Obstetric
48. Occuloplastic
49. Occupational Therapy
50. On Call Nurse
51. Oncology
52. Opthalmology
53. Oral Maxillo Facial Surgery
54. Orthopedic Surgeon
55. Orthopedics
56. Other
57. Other Non-Surgeon
58. Other Surgeon
59. Otolaryngology
60. Pain
61. Palliative care
62. Pending
63. Physical medicine & rehab
64. Physical therapy
65. Plastic surgery
66. Podiatry
67. Psychology
68. Pulmonary medicine
69. Radiation oncology
70. Radiology
71. Rehab
72. Respiratory therapy
73. Rheumatology
74. Social work
75. Speech therapy
76. Surgery subspecialty
77. Thoracic surgeon
78. Trauma
79. Trauma nurse
80. Trauma surgeon
81. Urology
82. Vascular
83. Vascular surgery

Additional Information

Relevant value for data element.

Log of Admission TR44.10.1–Count of Each Calendar Day the Patient Within the Log of Admissions

Description

The count of each calendar day the patient was within the log of admissions.

Element Values

Auto calculation

Additional Information

Relevant value for data element.

Log of Admission TR44.10 – Total Computed Log of Admission Time

Description

Total computed time of log of admission.

Element Values

Auto calculation

Additional Information

Relevant value for data element.

SECTION D

Element Intents

Pre-Existing Conditions – Advance Directive Limiting Care

Element Intent

Implementation of a previously signed advanced directive impacts care and influences outcomes.

Pre-Existing Conditions – Alcohol Use Disorder

Element Intent

Consumption of high levels of alcohol can affect the immune system, negatively affect wound healing, and increase the risk of developing infection, which could impact care decisions, increase the risk of adverse outcomes and prolong the length of stay.

Pre-Existing Conditions – Anticoagulant Therapy

Element Intent

Anticoagulants could induce greater risk of bleeding and increase the risk of adverse outcomes.

Pre-Existing Conditions – Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Element Intent

Patients with ADD/ADHD experience impulsiveness, restlessness, and difficulty focusing on tasks which could impact care decisions, increase the risk of adverse outcomes and prolong the length of stay.

Pre-Existing Conditions – Autism Spectrum Disorder (ASD)

Element Intent

Patients with ASD experience problems with social communications and interaction, restricted or repetitive behaviors or interest, and/or different ways of learning, moving, or paying attention, which could impact care decisions and increase the risk of adverse outcomes.

Pre-Existing Conditions – Bipolar I/II Disorder

Element Intent

Patient with Bipolar Disorder experience severe mood disturbances that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning, which could impact care decisions and increase the risk of adverse outcomes.

Pre-Existing Conditions – Bleeding Disorder

Element Intent

Underlying hematologic disorders result in a greater risk of bleeding which could increase the risk of adverse outcomes.

Pre-Existing Conditions – Bronchopulmonary Dysplasia/Chronic Lung Disease

Element Intent

Bronchopulmonary Dysplasia/Chronic Lung Disease could induce negative respiratory and pulmonary function, which could impact care decisions and increase the risk of adverse outcomes.

Pre-Existing Conditions – Cerebral Vascular Accident

Element Intent

Persistent residual motor sensory or cognitive deficits could impact care decisions and increase the risk of adverse outcomes.

Pre-Existing Conditions – Chronic Obstructive Pulmonary Disorder (COPD)

Element Intent

COPD limits respiratory reserve and prolongs the duration of mechanical ventilation, which could increase the risk of adverse outcomes.

Pre-Existing Conditions – Chronic Renal Failure

Element Intent

Chronic renal failure reflects limited renal reserve, which increases the risk of adverse outcomes.

Pre-Existing Conditions – Cirrhosis

Element Intent

Cirrhosis/end stage liver disease reflects limited hepatic reserve, which could impact care decisions and increase the risk of adverse outcomes.

Pre-Existing Conditions – Congenital Anomalies

Element Intent

Congenital anomalies have a multitude of risks, which could impact care decisions and increase the risk of adverse outcomes.

Pre-Existing Conditions – Congestive Heart Failure (CHF)

Element Intent

CHF reflects limited cardiac reserve, leading to a higher risk of adverse outcomes.

Pre-Existing Conditions – Current Smoker

Element Intent

Inhaling nicotine could induce negative cardiopulmonary effects, increase risk for stroke, negatively affect wound healing, increase anesthesia risk and the development of a venous thromboembolism (VTE), which could impact care decisions and increase the risk of adverse outcomes.

Pre-Existing Conditions – Currently Receiving Chemotherapy for Cancer

Element Intent

The effects of chemotherapy increase the risk of infection, and could limit physiologic reserve,

which together increases the risk of adverse outcomes.

Pre-Existing Conditions – Dementia

Element Intent

Patients with dementia experience forgetfulness, limited social skills and impaired thinking that could impact care decisions and prolong the length of stay.

Pre-Existing Conditions – Diabetes Mellitus

Element Intent

Diabetes can increase risk for infection, negatively affect wound healing, and contribute to renal and cardiac dysfunction, which could impact care decisions and increase the risk of adverse outcomes.

Pre-Existing Conditions – Disseminated Cancer

Element Intent

Advanced malignancy reflecting serious physiologic compromise has a multitude of risks, which could impact care decisions and increase the risk of adverse outcomes.

Pre-Existing Conditions – Functionally Dependent Health Status

Element Intent

Pre-injury functional status could indicate a chronic/underlying disease state, which could impact care decisions and increase the risk of adverse outcomes.

Pre-Existing Conditions – Hypertension

Element Intent

Hypertension that requires medication increases risk for cerebrovascular, renal, and cardiac disease, which could impact care decisions and increase the risk of adverse outcomes.

Pre-Existing Conditions – Major Depressive Disorder

Element Intent

Patients with Major Depressive Disorder experience depressed mood, loss of interest/pleasure, weight issues, fatigue, insomnia or hypersomnia, psychomotor agitation or retardation, decreased concentration, delusional guilt, and suicidal ideation which cause clinically significant distress or impairment in social, occupational, or other important areas of functioning, which could impact care decisions and increase the risk of adverse outcomes.

Pre-Existing Conditions – Myocardial Infarction (MI)

Element Intent

Myocardial infarction causes damage or death to the heart muscle, which could impact care decisions and increase the risk of adverse outcomes.

Pre-Existing Conditions – Other Mental/Personality Disorder

Element Intent

Patients with these disorders experience significant distress or impairment in social, occupational, or other important areas of functioning, which could impact care decisions and increase the risk of adverse outcomes.

Pre-Existing Conditions – Peripheral Arterial Disease

Element Intent

PAD reflects cardiovascular risk, which itself is associated with adverse outcomes.

Pre-Existing Conditions – Post-Traumatic Stress Disorder

Element Intent

Patients with PTSD experience intrusive symptoms, avoidance, altered mood, altered reactivity, causing clinically significant distress or impairment in social, occupational, or other important areas of functioning, which could impact care decisions and increase the risk of adverse outcomes.

Pre-Existing Conditions – Pregnancy

Element Intent

Trauma during pregnancy could cause pre-term labor and/or placental abruption, which could impact care decisions and increase the risk of adverse outcomes.

Pre-Existing Conditions – Prematurity

Element Intent

Prematurity can induce a multitude of risks, which could impact care decisions and increase the risk of adverse outcomes.

Pre-Existing Conditions – Schizoaffective Disorder

Element Intent

Patients with Schizoaffective Disorder experience hallucinations, delusions, mania, depression and disorganized thinking causing clinically significant distress or impairment in social, occupational, or other important areas of functioning, which could impact care decisions and increase the risk of adverse outcomes.

Pre-Existing Conditions – Schizophrenia

Element Intent

Patients with Schizophrenia experience hallucinations, delusions, disorganized speech, grossly disorganized or catatonic behavior, diminished emotional expression or avolition causing clinically significant distress or impairment in social, occupation, or other important areas of functioning, which could impact care decisions and increase the risk of adverse outcomes.

Pre-Existing Conditions – Steroid Use

Element Intent

Steroids negatively affect wound healing and increase the risk of infection, which could impact care decisions and increase the risk of adverse outcomes.

Pre-Existing Conditions – Substance Use Disorder

Element Intent

Patients with substance use disorder are at increased risk of heart, lung, liver, and kidney diseases, as well as stroke, cancer, and mental health conditions, which could impact care decisions and increase the risk of adverse outcomes.

Pre-Existing Conditions – Ventilator Dependence

Element Intent

The need for ventilator-assisted respirations reflects limited pulmonary reserve, which increases the risk of adverse outcomes.

Hospital Events – Acute Kidney Injury (AKI)

Element Intent

A potentially preventable event often induced by sepsis, hypotension, drug toxicity and/or renal trauma; advancement to stage 3 requires treatment which could increase the hospital length of stay and the likelihood of mortality.

Hospital Events – Acute Respiratory Distress Syndrome (ARDS)

Element Intent

A potentially preventable event often induced by pneumonia, viral infection, sepsis, blood transfusion, pancreatitis, fat emboli, trauma, or other injuries, requiring treatment which could increase the hospital length of stay and the likelihood of mortality.

Hospital Events – Alcohol Withdrawal Syndrome

Element Intent

A potentially preventable event often associated with infectious complications, requiring treatment which could increase the hospital length of stay and the likelihood of mortality.

Hospital Events – Cardiac Arrest With CPR

Element Intent

A potentially preventable event often associated with either a medical or trauma-related condition, requiring treatment which could increase the hospital length of stay and the likelihood of mortality.

Hospital Events – Catheter-Associated Urinary Tract Infection (CAUTI)

Element Intent

A potentially preventable event often induced by bacteria entering the urinary tract through the catheter, requiring treatment which could increase the hospital length of stay and the likelihood of mortality.

Hospital Events – Central Line-Associated Bloodstream Infection (CLABSI)

Element Intent

A potentially preventable event, often induced by bacteria entering the bloodstream through the central line, requiring treatment which could increase the hospital length of stay and the likelihood of mortality.

Hospital Events – Deep Surgical Site Infection

Element Intent

A potentially preventable event often induced by bacteria, viruses, or endogenous flora contacting a surgical wound, requiring treatment which could increase the hospital length of stay and the likelihood of mortality.

Hospital Events – Deep Vein Thrombosis (DVT)

Element Intent

A potentially preventable event often induced by immobility, anesthesia, stroke, venous catheters, dehydration, and/or thrombocytosis, requiring treatment which could increase the hospital length of stay and the likelihood of mortality.

Hospital Events – Delirium

Element Intent

A potentially preventable event often induced by infection, stroke, lung or liver disease, medications, low sodium, low blood sugar, urinary retention, dehydration, low oxygen, or an unfamiliar environment, requiring treatment which could increase the hospital length of stay and the likelihood of mortality.

Hospital Events – Myocardial Infarction (MI)

Element Intent

A potentially preventable event often induced by coronary artery disease, medications, emotional stress, or pain, requiring treatment which could increase the hospital length of stay and the likelihood of mortality.

Hospital Events – Organ/Space Surgical Site Infection

Element Intent

A potentially preventable event often induced by bacteria or endogenous flora contacting a surgical wound, requiring treatment which could increase the hospital length of stay and the likelihood of mortality.

Hospital Events – Osteomyelitis

Element Intent

A potentially preventable event often induced by bacteria or fungi, diabetes, and/or a weakened immune system, requiring treatment which could increase the hospital length of stay and the likelihood of mortality.

Hospital Events – Pulmonary Embolism (PE)

Element Intent

A potentially preventable event requiring treatment which could increase the hospital length of stay and the likelihood of mortality.

Hospital Events – Pressure Ulcer

Element Intent

A potentially preventable event often induced by pressure or friction, moisture or other medical factors; advancement to stage II or greater requires treatment which could increase the hospital length of stay and the likelihood of mortality.

Hospital Events – Severe Sepsis

Element Intent

A potentially preventable event often induced by bacterial, viral or fungal infections, requiring treatment which could increase the hospital length of stay and the likelihood of mortality.

Hospital Events – Stroke/CVA

Element Intent

A potentially preventable event often induced by obstruction of blood flow or a ruptured blood vessel in the brain, requiring treatment which could increase the hospital length of stay and the likelihood of mortality.

Hospital Events – Superficial Incisional Surgical Site Infection

Element Intent

A potentially preventable event often induced by endogenous flora or exogenous contamination contacting a surgical site, requiring treatment which could increase the hospital length of stay.

Hospital Events – Unplanned Admission to the ICU

Element Intent

A potentially preventable event that highlights possible gaps in the assessment of the severity of the patient's condition or the application of appropriate treatment plans.

Hospital Events – Unplanned Intubation

Element Intent

A potentially preventable event that highlights possible gaps in the assessment of the severity of the patient's condition or the application of appropriate treatment plans.

Hospital Events – Unplanned Visit to the Operation Room

Element Intent

A potentially preventable event that highlights possible opportunities for improvements in care.

Hospital Events – Ventilator-Associated Pneumonia (VAP)

Element Intent

A potentially preventable event often induced by bacteria or virus entering the lungs, requiring treatment which could increase the hospital length of stay and the likelihood of mortality.

SECTION E

Report Writer 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, STATE, or OPTIONAL), 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 Report Writer Elements

Required	Data Element	Element Name	Transactional Report Name	Analytical Report Name
NTDB	TR1.20	ZIP	Patient Home Zip (TR1.20)	Patient Home Postal Code (TR1.20)
NTDB	TR1.19	Country	Patient Home Country (TR1.19)	Patient Home Country (TR1.19)
NTDB	TR1.23	State	Patient Home State (TR1.23)	Patient Home State (TR1.23)
NTDB	TR1.22	County	Patient Home County (TR1.22)	Patient Home County (TR1.22)
NTDB	TR1.21	City	Patient Home City (TR1.21)	Patient Home City (TR1.21)
NTDB	TR1.13	Alternate Residence	Patient Alternate Home Residence (TR1.13)	Patient Alternate Home Residence (TR1.13)
NTDB	TR1.7	Date of Birth	Patient Date of Birth (TR1.7)	Patient Date of Birth (TR1.7)
NTDB	TR1.12	Age	Patient Age (TR1.12)	Patient Age in Years (TR1.12)
NTDB	TR1.14	Age Units	Patient Age Units (TR1.14)	Patient Reported Age Units (TR1.14)
NTDB	TR1.16	Race	Patient Race (TR1.16)	Patient Race (TR1.16)
NTDB	TR1.17	Ethnicity	Patient Ethnicity (TR1.17)	Patient Ethnicity (TR1.17)
NTDB	TR1.56	Sex Assigned at Birth	Sex Assigned at Birth (TR1.56)	Sex Assigned at Birth (TR1.56)
NTDB	TR1.51	Gender	Patient Gender Identity (TR1.51)	Patient Gender Identity (TR1.51)
NTDB	TR1.5	Gender-Affirming Hormone Therapy	Gender-Affirming Hormone Therapy (TR1.55)	Gender-Affirming Hormone Therapy (TR1.55)
STATE	TR5.12	Registry Number	Incident Number (TR5.12)	Incident Number (TR5.12)
STATE	TR1.2	Medical Record Number	Patient Medical Record Number (TR1.2)	Patient Medical Record Number (TR1.2)
STATE	TR1.9	Last Name	Patient Last Name (TR1.9)	Patient Last Name (TR1.9)
STATE	TR1.8	First Name	Patient First Name (TR1.8)	Patient First Name (TR1.8)
STATE	TR1.10	Middle Initial	Patient Middle Initial (TR1.10)	Patient Middle Initial (TR1.10)
OPTIONAL	TR1.8.1	Patient's Alias First Name	Patient's First Name Alias (TR1.8.1)	N/A
OPTIONAL	TR1.9.1	Patient's Alias Last Name	Patient's Last Name Alias (TR1.9.1)	N/A
OPTIONAL	TR1.28	Other Race	Patient Race Other (TR1.28)	Patient Race – Other (TR1.28)
OPTIONAL	TR1.18	Patient Address	Patient Address (TR1.18)	N/A
OPTIONAL	TR1.18.1	Address Line 2	Patient Address Line 2 (TR1.18.1)	N/A

OPTIONAL	TR1.24	Patient's Primary Address	Patients Primary Address (TR1.24)	N/A
OPTIONAL	TR1.25	State of Residence	N/A	N/A

Injury Report Writer Elements

Required	Data Element	Element Name	Transactional Report Name	Analytical Report Name
NTDB	TR5.1	Injury Date	Incident Date (TR5.1)	Incident Date (TR5.1)
NTDB	TR5.18	Injury Time	Incident Time (TR5.18)	Incident Time (TR5.18)
NTDB	TR2.10	Work Related	Incident Work Related (TR2.10)	Incident Work Related (TR2.10)
NTDB	TR2.6	Occupational Industry	Patient Occupational Industry (TR2.6)	Patient Occupational Industry (TR2.6)
NTDB	TR2.11	Occupation	Patient Occupation (TR2.11)	Patient Occupation (TR2.11)
NTDB	TR200.3	ICD10 External Cause Code	ICD-10 Injury Code (TR200.3)	ICD-10 Injury Code (TR200.3)
NTDB	TR200.5	ICD10 Location	ICD-10 Location Code (TR200.5)	ICD-10 Location Code (TR200.5)
NTDB	TR5.6	Incident ZIP	Incident Location Zip Code (TR5.6)	Incident Location Zip Code (TR5.6)
NTDB	TR5.11	Incident Country	Incident Country (TR5.11)	Incident Country (TR5.11)
NTDB	TR5.7	Incident State	Injury State (TR5.7)	Incident State (TR5.7)
NTDB	TR5.9	Incident County	Incident County (TR5.9)	Incident County (TR5.9)
NTDB	TR5.10	Incident City	Incident City (TR5.10)	Incident City (TR5.10)
STATE	TR200.3.3	Injury Type	N/A	N/A
OPTIONAL	TR200.3.2	Intentionality	Injury Intentionality with ICD-10 COI codes	N/A
OPTIONAL	TR20.12	Cause of Injury	Injury Description (TR20.12)	Incident Injury Description (TR20.12)
OPTIONAL	TR200.12.2	Activity Comments	ICD-10 Activity Note (TR200.12.2)	N/A
OPTIONAL	TR14.40	Law Enforcement/Crash Report Number	Law Enforcement/Crash Report Number (TR14.40)	Incident Law Enforcement Crash Report Number (TR14.40)
OPTIONAL	TR14.37	Mass Casualty Incident	Mass Casualty Incident (TR14.37)	Incident Mass Casualty Incident-MCI (TR17.37)

OPTIONAL	TR5.8	Supplemental Cause of Injury	Injury Supplemental Cause (TR5.8)	Incident Supplemental Cause of Injury (TR5.8)
OPTIONAL	TR29.10	Safety Equipment Description	Safety Equipment – Safety Description (TR29.10)	Protective Devices – Safety Equipment Description (TR29.10)
OPTIONAL	TR2.12	Occupation Description	Occupation Text (TR2.12)	Facility Charges Occupation Description (TR2.12)
OPTIONAL	TR5.14	Vehicle Position	Vehicle Position (TR5.14)	Incident Vehicle Position (TR5.14)
OPTIONAL	TR5.15	Vehicle Position Other	Vehicle Position Other (TR5.15)	Incident Vehicle Position Other (TR5.14)
OPTIONAL	TR14.44	Position of Patient in the Seat of Vehicle	Position of Patient in the Seat of the Vehicle (TR14.44)	Incident Vehicle Position of Patient Seat (TR14.44)
OPTIONAL	TR14.43	Seat Row Location of Patient in Vehicle	Seat row location (TR14.43)	Incident Vehicle Seat Row Location (TR14.43)
OPTIONAL	TR14.42	Area of the Vehicle Impacted by the Collision	Vehicle Impact (TR14.42)	Incident Areas of Vehicle Impacted by Collision List (TR14.42)
NTDB	TR29.24	Protective Devices	Safety Device Used (TR29.24)	Protective Device – Safety Device Used (TR29.24)
	TR29.32	Airbag Deployed	Airbag Deployment (TR29.32)	N/A
	TR29.31	Child Specific Restraint	Child Specific Restraint (TR29.31)	N/A

Pre-Hospital Report Writer Elements

Required	Data Element	Element Name	Transactional Report Name	Analytical Report Name
NTDB	TR60.1	Intubation Prior to Arrival	Intubation Prior to Arrival (TR60.1)	Intubation Prior to Arrival (TR60.1)
NTDB	TR60.2	Intubation Location	Intubation Location (TR60.2)	Intubation Location (TR60.2)
STATE	TR9.1	EMS Dispatched Date	EMS Unit Notified Date (TR9.1)	Pre-Hospital EMS Unit Notified Date (TR9.1)
STATE	TR9.10	EMS Dispatch Time	EMS Unit Notified Time (TR9.10)	Pre-Hospital EMS Unit Notified Time (TR9.10)
STATE	TR9.2	EMS Arrive Scene	EMS Unit Arrived On Scene (TR9.2)	Pre-Hospital EMS Unit Arrived on Scene (TR9.2)
STATE	TR9.2.1	EMS Arrive Scene Time	EMS Unit Arrived On Scene Time (TR9.2.1)	N/A
STATE	TR9.3	EMS Leave Scene Date	EMS Unit Left Scene (TR9.3)	Pre-Hospital EMS Scene Departure Date Time (TR9.3)
STATE	TR9.3.1	EMS Leave Scene Time	EMS Unit Left Scene Time (TR9.3.1)	N/A
NTDB	TR8.10	Transport Mode	EMS Transport Mode From Scene (TR8.10)	Pre-Hospital EMS Transport Mode From Scene (TR8.10)
STATE	TR18.67	SBP	Prehospital Systolic Blood Pressure (TR18.67)	Prehospital Systolic Blood Pressure (TR18.67)
STATE	TR18.69	Pulse Rate	Prehospital Pulse Rate (TR18.69)	Prehospital Pulse Rate (TR18.69)
STATE	TR18.70	Respiratory Rate	Prehospital Respiratory Rate (TR18.70)	Prehospital Respiratory Rate (TR18.70)
STATE	TR18.82	02Sat	Prehospital Pulse Oximetry (TR18.82)	Prehospital Pulse Oximetry (TR18.82)
STATE	TR18.60	GCS Eye	Prehospital GCS Eye (TR18.60)	Prehospital GCS Eye (TR18.60)
STATE	TR18.61.2/ TR18.61.0	GCS Verbal	Prehospital GCS Verbal (TR18.61.2)	**Adult:** Prehospital GCS Verbal (TR18.61.2) **Pediatric:** Prehospital GCS Verbal - Pediatric (TR18.61.0)
STATE	TR18.62.2/ TR18.62.0	GCS Motor	Prehospital GCS Motor (TR18.62.2)	**Adult:** Prehospital GCS Motor (TR18.62.2) **Pediatric:** Prehospital GCS Motor – Pediatric (TR18.62.2)
STATE	TR18.65	GCS Total	Prehospital GCS Calculated (TR18.65)	Prehospital GCS Calculated (TR18.65)
STATE	TR18.90.2/ TR18.90.0	Glasgow Coma Score 40 (Eye)	Pre-Hospital GCS 40 Eye (TR18.90)	N/A
STATE	TR18.91.2/ TR18.91.0	Glasgow Coma Score (Verbal)	Pre-Hospital GCS 40 Verbal (TR18.81)	N/A

STATE	T18.92.2/ TR18.92.0	Glasgow Coma Score (Motor)	Pre-Hospital GCS 40 Motor (TR18.92)	N/A
NTDB	TR7.7	UUID	EMS Universally Unique Identifier (UUID) (TR7.7)	N/A
NTDB	TR25.54	Inter-Facility Transfer	InterFacility Transfer (TR25.54)	Facility Interfacility Transfer (TR25.54)
NTDB	TR17.22	Trauma Center Criteria (Steps 1 and 2)	Trauma Alert Type (TR17.22)	Incident Trauma Alert Type (TR17.22)
STATE	TR17.47	Trauma Triage Criteria (Steps 3 and 4)	Vehicular, Pedestrian, Other Risk Injury (TR17.47)	N/A
NTDB	TR46.11	Cardiac Arrest	Pre-Hospital Cardiac Arrest (TR15.53)	Pre-Hospital Cardiac Arrest Occurred (TR15.53)
STATE	TR5.33	Non-EMS Extrication	Pre-Hospital Extrication (TR5.33)	Non-EMS Extrication (TR5.33)
STATE	TR7.3	Agency Name	EMS Service Name (TR7.3)	Pre-Hospital EMS Service Name (TR7.3)
STATE	TR15.38	EMS Run Sheet Present	EMS Report Status (TR15.38)	Pre-Hospital EMS Report Status (TR15.38)
STATE	TR18.136	RTS	Prehospital Calculated RTS (TR18.136)	Prehospital Calculated RTS (TR18.136)
STATE	TR18.80	Respiratory Assistance	Prehospital Respiratory Assistance (TR18.80)	Prehospital Respiratory Assistance (TR18.80)
OPTIONAL	TR5.33	Was the Patient Extricated?	Pre-Hospital Extrication (TR5.33)	Non-EMS Extrication (TR5.33)
OPTIONAL	TR5.34	Extrication Minutes	Non-EMS Extrication Minutes (TR5.34)	N/A
OPTIONAL	TR18.106	Prehospital Vitals Date	Pre-Hospital Vitals Date (TR18.106)	Pre-Hospital Vitals Date
OPTIONAL	TR18.106.1	Prehospital Vitals Time	Pre-Hospital Vitals Time (TR18.106.1)	N/A
OPTIONAL	TR18.68	EMS Diastolic Blood Pressure	Pre-Hospital DBP (TR18.68)	Pre-Hospital Diastolic Blood Pressure (TR18.68)
OPTIONAL	TR18.59	EMS Temperature	Pre-Hospital Body Temperature Celsius (TR18.59)	Pre-Hospital Initial Temperature – Celsius (TR18.59)
OPTIONAL	TR7.3	Scene/Transport Agency Name	EMS Service Name (TR7.3)	Pre-Hospital Service Name (TR7.3)
OPTIONAL	TR15.38	EMS Run Sheet Present?	EMS Report Status (TR15.38)	Pre-Hospital EMS Report Status (TR15.38)

OPTIONAL	TR7.1	EMS Run Number	EMS Incident Number (TR7.1)	Pre-Hospital EMS Incident Number (TR7.1)
OPTIONAL	TR9.11	EMS Patient Care Report (PCR) Number	EMS PCR Num (TR9.11)	Pre-Hospital EMS Patient Care Report Number – PCR (TR9.11)
OPTIONAL	TR9.17	En Route Date	EMS Unit En Route Date (TR9.17)	N/A
OPTIONAL	TR9.17.1	En Route Time	EMS Unit En Route Time (TR9.17.1)	N/A
OPTIONAL	TR9.6	Patient Contact Date	EMS Patient Contact Date (TR9.6)	Pre-Hospital Patient Contact Date (TR9.6)
OPTIONAL	TR9.5	Patient Contact Time	EMS Patient Contact Time (TR9.5)	Pre-Hospital Patient Contact Time (TR9.5)
OPTIONAL	TR9.16	Trauma Notification Called in by EMS Date	Trauma Notification Called in by EMS Date (TR9.16)	N/A
OPTIONAL	TR9.16.1	Trauma Notification Called in by EMS Time	Trauma Notification Called in by EMS Time (TR9.16.1)	N/A
OPTIONAL	TR9.4	Unit Arrived Hospital Date	EMS Unit at Destination Date (TR9.4)	Pre-Hospital EMS ED Arrival Date Time (TR9.4)
OPTIONAL	TR9.4.1	Unit Arrived Hospital Time	EMS Unit at Destination Date (TR9.4.1)	N/A
OPTIONAL	TR8.12	EMS Role	EMS Role (TR8.12)	N/A
OPTIONAL	TR15.40	Airway Management	EMS Airway Management (TR15.40)	Pre-Hospital Airway Management Performed (TR15.40)
OPTIONAL	TR15.30	Fluids	EMS Fluids (TR15.30)	Pre-Hospital Fluids – Total Volume Given (TR15.30)
OPTIONAL	TR15.56	Total Fluids Administered	Total Fluid Administered (TR15.56)	N/A
OPTIONAL	TR15.60	Prehospital Procedures	EMS Procedure (TR15.60)	N/A
OPTIONAL	TR9.15	Hospital Notified	Facility Notified (TR9.15)	N/A
OPTIONAL	TR15.31	Medications	EMS Medication (TR15.31)	Pre-Hospital Medications Administered List (TR15.31)
OPTIONAL	TR15.61	Provider's Primary Impression	Provider's Primary Impression (TR15.61)	EMS Provider Primary Impression (TR15.61)

Referring Facility Report Writer Elements

Required	Data Element	Element Name	Transactional Report Name	Analytical Report Name
STATE	TR33.64	Transfer In	Referring Transferred from other ED (TR33.64)	N/A
STATE	TR33.1	Referring Hospital	Referring Hospital Name (TR33.1)	Previous Referring Facility Name (TR33.1)
STATE	TR33.1.1	Other Facility	Other Facility Transferred From (TR33.1.1)	N/A
STATE	TR33.78	Length of Stay	• Referring Hospital Length Of Stay Days • Referring Hospital Length Of Stay Hours • Referring Hospital Length Of Stay Minutes • Referring Hospital Length Of Stay Total Minutes	Previous Referring Facility Length Of Stay In Minutes/Previous Referring Facility Length Of Stay In Hours/Previous Referring Facility Length Of Stay In Days
OPTIONAL	TR33.2	Referring Facility Arrival Date	Referring Hospital Arrival Date (TR33.2)	Previous Referring Facility Patient Arrival Date (TR33.2)
OPTIONAL	TR33.3	Referring Facility Arrival Time	Referring Arrival Time (TR33.3)	N/A
OPTIONAL	TR33.54	Referring Hospital Vitals Date	Referring Facility Vitals Date (TR33.54)	Previous Referring Facility Vitals Date (TR33.54)
OPTIONAL	TR33.56	Referring Hospital Vitals Time	Referring Facility Vitals Time (TR33.56)	Referring Facility Vitals Time (TR33.56)
OPTIONAL	TR33.30	Discharge Date	Referring Hospital Discharge Date (TR33.30)	Previous Referring Facility Patient Discharge Date (TR33.30)
OPTIONAL	TR33.31	Discharge Time	Referring Hospital Discharge Time (TR33.31)	Referring Hospital Discharge Time (TR33.31)
OPTIONAL	TR33.48	Transported to Referring Facility By	Referring Transported By (TR33.48)	Referring Facility Transport Mode (TR33.48)
OPTIONAL	TR33.45	Referring Medical Record Number	Referring Medical Record Number (TR33.45)	N/A
OPTIONAL	TR33.46	Referring Incident Number	Referring Incident Number (TR33.46)	N/A
OPTIONAL	TR33.5	Referring Systolic Blood Pressure	Referring SBP (TR33.5)	Referring Facility Last Systolic Blood Pressure (TR33.5)
OPTIONAL	TR33.40	Referring Diastolic Blood Pressure	Referring DBP (TR33.40)	Referring Facility Last Diastolic Blood Pressure (TR33.40)

OPTIONAL	TR33.6	Referring Hospital Pulse Rate	Referring Pulse Rate (TR33.6)	Referring Facility Last Pulse Rate (TR33.6)
OPTIONAL	TR33.7	Referring Temperature	Referring Temperature Celsius (TR33.7)	Referring Facility Last Body Temperature – Celsius (TR33.7)
OPTIONAL	TR33.8	Referring Hospital Respiratory Rate	Referring Respiratory Rate (TR33.8)	Referring Facility Last Respiratory Rate (TR33.8)
OPTIONAL	TR33.9	Referring Hospital Respiratory Assistance	Referring Respiratory Assistance (TR33.9)	Referring Facility Respiratory Assistance (TR33.9)
OPTIONAL	TR33.10	Referring Hospital Supplemental Oxygen	Referring Supplemental Oxygen (TR33.10)	N/A
OPTIONAL	TR33.11	Referring Oxygen Saturation	Referring SPO2 (TR33.11)	Referring Facility Last Oxygen Saturation – SPO2 (TR33.11)
OPTIONAL	TR33.12	Referring Hospital GCS – Eye	Referring GCS Eye (TR33.12)	Referring Facility Last GCS – Eye (TR33.12)
OPTIONAL	TR33.13.2	Referring Hospital GCS – Verbal	Referring GCS Verbal (TR33.13.2)	Referring Facility Last GCS – Verbal (TR33.13.2)
OPTIONAL	TR33.14.2	Referring Hospital GCS – Motor	Referring GCS Motor (TR33.14.2)	Referring Facility Last GCS – Motor (TR33.14.2)
OPTIONAL	TR33.16	Referring Hospital GCS Assessment Qualifier	Referring GCS Qualifier (TR33.16)	Previous Referring Facility Last GCS Qualifier List (TR33.16)
OPTIONAL	TR33.50	Referring GCS Total Calc	Referring GCS Total Calc (TR33.50)	Previous Referring Facility Last GCS Total – Calculated (TR33.50)
OPTIONAL	TR33.32	Referring	Referring PTS (TR33.32)	Referring Facility Last Pediatric Trauma Score – PTS (TR33.32)
OPTIONAL	TR33.62	Delay of Departure at Referring Hospital	Referring Departure Delay Reason (TR33.62)	N/A
OPTIONAL	TR33.82	Transfer Rationale	Referring Transfer Rationale (TR33.82)	N/A
OPTIONAL	TR33.28	Referring Hospital Medications Given	Referring Medications (TR33.28)	Previous Referring Facility Medications Administered List (TR33.28)

ED/TTA & Initial Assessment Report Writer Elements

Required	Data Element	Element Name	Transactional Report Name	Analytical Report Name
NTDB	TR17.21.1	Highest Activation	Highest Activation Level (TR17.21.1)	Highest Activation Level (TR17.21.1)
NTDB	TR17.15.1	Trauma Surgeon Arrival Date	First Trauma Surgeon Arrival Date (TR17.15.1)	First Trauma Surgeon Arrival Date (TR17.15.1)
NTDB	TR17.15.2	Trauma Surgeon Arrival Time	First Trauma Surgeon Arrival Time (TR17.15.2)	First Trauma Surgeon Arrival Time (TR17.15.2)
NTDB	TR18.55	Arrival Date	ED Admission Date (TR18.55)	ED Admission Date (TR18.55)
NTDB	TR18.56	Arrival Time	ED Admission Time (TR18.56)	ED Admission Time (TR18.56)
NTDB	TR18.11	SBP	Initial Assessment Systolic Blood Pressure (TR18.11)	Initial Assessment Systolic Blood Pressure (TR18.11)
NTDB	TR18.2	Pulse Rate	Initial Assessment Pulse Rate (TR18.2)	Initial Assessment Pulse Rate (TR18.2)
NTDB	TR18.30/TR 18.30.1	Temperature	**Celsius:** Initial Assessment Body Temperature Celsius (TR18.30) **Fahrenheit:** Initial Assessment Body Temperature Fahrenheit (TR18.30.1)	**Celsius:** Initial Assessment Body Temperature Celsius (TR18.30) **Fahrenheit:** Initial Assessment Body Temperature Fahrenheit (TR18.30.1)
NTDB	TR18.7	Respiratory Rate	Initial Assessment Respiratory Rate (TR18.7)	Initial Assessment Respiratory Rate (TR18.7)
NTDB	TR18.10	Respiratory Assistance	Initial Assessment Respiratory Assistance (TR18.10)	Initial Assessment Respiratory Assistance (TR18.10)
NTDB	TR18.31	02Sat	Initial Assessment Pulse Oximetry (TR18.31)	Initial Assessment Pulse Oximetry (TR18.31)
NTDB	TR18.109	Supplemental 02	Initial Assessment Supplemental Oxygen (TR18.109)	Initial Assessment Supplemental Oxygen (TR18.109)
NTDB	TR18.14	GCS Eye	Initial Assessment GCS Eye (TR18.14)	Initial Assessment GCS Eye (TR18.14)
NTDB	TR18.15.2/ TR18.15.0	GCS Verbal	Initial Assessment GCS Verbal (TR18.15.2)	**Adult:** Initial Assessment GCS Verbal (TR18.15.2) **Pediatric:** Initial Assessment GCS Verbal - Pediatric (TR18.15.0)
NTDB	TR18.16.2/ TR18.16.0	GCS Motor	Initial Assessment GCS Motor (TR18.16.2)	**Adult:** Initial Assessment GCS Motor (TR18.16.2) **Pediatric:** Initial Assessment GCS Motor - Pediatric (TR18.16.2)
NTDB	TR18.22	GCS Total	Initial Assessment GCS Total (TR18.22)	ED-Hospital Initial GCS Total - Calculated (TR18.22)

NTDB	TR18.21	GCS Qualifier	Initial Assessment GCS Qualifier (TR18.21)	ED-Hospital Initial GCS Qualifier List (TR18.21)
NTDB	TR1.6.1/ TR1.6	Height	**Inches:** Patient Height In Inches (TR1.6.1) **Centimeters:** Patient Height In Centimeters (TR1.6)	**Inches:** Patient Height In Inches (TR1.6.1) **Centimeters:** Patient Height In Centimeters (TR1.6)
NTDB	TR1.6.5	Weight	**Kilograms:** Patient Weight In Kilograms (TR1.6.5) **Pounds:** Patient Weight In Pounds (TR1.6.6)	**Kilograms:** Patient Weight In Kilograms (TR1.6.5) **Pounds:** Patient Weight In Pounds (TR1.6.6)
NTDB	TR18.91	Drug Screen	Drug Screen (TR18.91)	Drug Screen (TR18.91)
NTDB	TR18.46	Alcohol Screen	Alcohol Screen (TR18.46)	Alcohol Screen (TR18.46)
NTDB	TR18.103	Alcohol Screen Results	ED/Acute Care Blood Alcohol Description (TR18.103)	ED/Acute Care Blood Alcohol Description (TR18.103)
NTDB	TR17.27	Discharge Disposition	ED Discharge Disposition (TR17.27)	ED Discharge Disposition (TR17.27)
NTDB	TR17.41	Discharge Order Date	ED Decision to Discharge/Transfer Date (TR17.41)	ED Decision to Discharge/Transfer Date (TR17.41)
NTDB	TR17.42	Discharge Order Time	ED Decision to Discharge/Transfer Time (TR17.42)	ED Decision to Discharge/Transfer Time (TR17.42)
NTDB	TR18.205	Primary Trauma Service Type	Primary Trauma Service Type (TR18.205)	N/A
NTDB	TR18.220	Primary Medical Event	Primary Medical Event (TR18.220)	Primary Medical Event (TR18.220)
STATE	TR17.65	Facility Access	Facility Access (TR17.65)	N/A
STATE	TR16.22	Arrived From	Arrived From (TR16.22)	Arrived From (TR16.22)
STATE	TR17.21	Trauma Team Activation	Trauma Team Activation Level (TR17.21)	Trauma Team Activation Level (TR17.21)
STATE	TR17.31	Activation Date	Trauma Team Activated Date (TR17.31)	Trauma Team Activated Date (TR17.31)
STATE	TR17.34	Activation Time	Trauma Team Activated Time (TR17.34)	Trauma Team Activated Time (TR17.34)
STATE	TR8.8	Mode of Arrival	Mode of Arrival (ED/TTA)	N/A
STATE	TR18.99	Admitting Service	Admitting Service (TR18.99)	Admitting Service (TR18.99)
STATE	TR18.135	RTS	Initial Assessment Calculated RTS (TR18.135)	N/A
STATE	TR17.25	Discharge Date	ED Discharge Date (TR17.25)	ED Discharge Date (TR17.25)
STATE	TR17.26	Discharge Time	ED Discharge Time (TR17.26)	ED Discharge Time (TR17.26)
STATE	TR17.61	Hospital Transferred to	Hospital Transferred To (TR17.61)	ED Facility Transferred To (17.61)
STATE	TR17.60	Transport Mode	ED Discharge Transport Mode (TR17.60)	N/A
STATE	TR17.45	Transfer Delay	Transfer Delay (TR17.45)	Transfer Delay (TR17.45)

STATE	TR17.44	Transfer Delay Reason	Transfer Delay Reason (TR17.44)	Transfer Delay Reason (TR17.44)
OPTIONAL	TR8.9	Other Mode	Transport Mode Other (TR8.9)	Discharge Transport Mode (TR8.9)
OPTIONAL	TR25.36	Date of Death	Date of Death (TR25.36)	Patient Death Date (TR25.36)
OPTIONAL	TR25.36.1	Time of Death	Time of Death (TR25.36.1)	N/A
OPTIONAL	TR25.53	Circumstances of Death	Circumstances of Death (TR25.53)	N/A
OPTIONAL	TR25.69	Organs/Tissue Donation Requested	Indicates whether organ donation was requested (TR25.69)	N/A
OPTIONAL	TR25.29	Organ Donation	Organ Donation (TR25.29)	Patient Death Organ Donation Status (TR25.29)
OPTIONAL	TR25.70	Organs Donated	Organs Donated (TR25.70)	N/A
OPTIONAL	TR25.37	Autopsy Performed	Autopsy (TR25.37)	Patient Death Autopsy Performed (TR25.37)
OPTIONAL	TR17.59	ED Destination Determination	ED Destination Determination (TR17.59)	N/A
OPTIONAL	TR17.28	OR Discharge Disposition	OR Disposition (TR17.28)	ED-Facility OR Discharge Disposition (TR17.28)
OPTIONAL	TR25.99	Discharge Physician	Discharge Physician (T25.99)	N/A
OPTIONAL	TR18.98	Admitting MD/Staff	Admitting MD/Staff (TR18.98)	Facility Admitting Physician – Staff Member Name (TR18.98)
OPTIONAL	TR17.29	Consulting Service	Consulting Service (TR17.29)	Facility Services Or Specialists Consulted (TR17.29)
OPTIONAL	TR18.131	Attending MD/Staff	Attending MD/Staff (TR18.131)	N/A
OPTIONAL	TR18.132	Attending Service	ED Attending Service (TR18.132)	N/A
OPTIONAL	TR17.9	ED Physician	ED Physician (TR17.9)	ED Physician Name (TR17.9)
OPTIONAL	TR17.13	ED Physician Service Type	ED Physician Service Type (TR17.13)	N/A
OPTIONAL	TR17.10	Date Physician Called	Trauma Surgeon Called Date (TR17.10)	ED Physician Called Date (TR17.10)
OPTIONAL	TR17.14	Time Physician Called	Trauma Surgeon Called Time (TR17.14)	ED Physician Called Time (TR17.14)
OPTIONAL	TR17.15	Date Physician Arrived	Trauma Surgeon Date Arrived (TR17.15)	ED Physician Arrived Date (TR17.15)
OPTIONAL	TR17.11	Time Physician Arrived	Trauma Surgeon Time Arrived (TR17.11)	ED Physician Arrived Time (TR17.11)
OPTIONAL	TR17.12	Was Trauma Surgeon Arrived in ED Timely	Trauma Team Member Arrival (TR17.12)	ED Physician Arrived Within Established Time Parameters (TR17.12)
OPTIONAL	TR17.79	Response Time	Trauma Team Member Response Time in Minutes (TR17.79)	N/A
OPTIONAL	TR17.78.3	Activation Level Upgrade/Downgrade	New Activation Level (TR17.78.3)	N/A
OPTIONAL	TR17.78.1	Date Activation Level Was Changed	Activation Level was Changed Date (TR17.78.1)	N/A

OPTIONAL	TR17.78.1.1	Time Activation Level Was Changed	Activation Level was Changed Time (TR17.78.1.1)	N/A
OPTIONAL	TR17.78.4	Old Activation Level	Old Activation Level (TR17.78.4)	N/A
OPTIONAL	TR45.1	Was SBIRT Completed?	N/A	SBIRT Completed
OPTIONAL	TR45.2	SBIRT Provided by?	N/A	N/A
OPTIONAL	TR45.4	Were the SBIRT screening results positive?	Were the SBIRT screening results positive?	Were the SBIRT screening results positive?
OPTIONAL	TR45.5	Was SBIRT brief intervention initiated?	Was SBIRT brief intervention initiated?	Was SBIRT brief intervention initiated?
OPTIONAL	TR45.7	Was SBIRT referral to treatment provided?	Was SBIRT referral to treatment provided?	Was SBIRT referral to treatment provided?

Ventilator/Blood Report Writer Elements

Required	Data Element	Element Name	Transactional Report Name	Analytical Report Name
OPTIONAL	TR26.74	Placed on Ventilator Date	Placed on Ventilator Date (TR26.74)	N/A
OPTIONAL	TR26.74.1	Placed on Ventilator Time	Placed on Ventilator Time (TR26.74.1)	N/A
OPTIONAL	TR26.75	Taken Off Ventilator Date	Taken Off Ventilator Date (TR26.75)	N/A
OPTIONAL	TR26.75.1	Taken Off Ventilator Time	Taken Off Ventilator Time (TR26.75.1)	N/A
OPTIONAL	TR26.58.1	Count of Each Calendar Day the Patient Has Been on the Ventilator	N/A	N/A
OPTIONAL	TR26.58.2	Total Computed Time on Ventilator	N/A	N/A
OPTIONAL	TR22.45	Date Blood was Administered	Blood Product was Administered Date (TR22.45)	N/A
OPTIONAL	TR22.45.1	Time Blood was Administered	Blood Product was Administered Time (TR22.45.1)	N/A
OPTIONAL	TR22.20	Blood Product Location	Blood Product Location (TR22.20)	N/A
OPTIONAL	TR22.21	Blood Product	Blood Product (TR22.21)	N/A
OPTIONAL	TR22.22	Total Units of Blood Given	Units of Blood (TR22.22)	N/A
OPTIONAL	TR22.14	First Unit of Blood Ordered Date	ED/Acute Care Date Blood Ordered (TR22.14)	ED-Facility Blood Ordered Date (TR22.14)
OPTIONAL	TR22.17	First Unit of Blood Ordered Time	ED/Acute Care Blood Ordered Time (TR22.17)	N/A
OPTIONAL	TR22.15	Crossmatch Date	ED/Acute Care Crossmatch Date (TR22.15)	ED-Facility Blood Crossmatch Date (TR22.15)
OPTIONAL	TR22.18	Crossmatch Time	ED/Acute Care Crossmatch Time (TR22.18)	N/A
OPTIONAL	TR22.16	First Unit of Blood Administered Date	ED/Acute Care Date Blood Administered (TR22.16)	ED-Facility Blood Administered Date (TR22.16)
OPTIONAL	TR22.19	First Unit of Blood Administered Time	ED/Acute Care Blood Administered Time (TR22.19)	N/A

Procedures Report Writer Elements

Required	Data Element	Element Name	Transactional Report Name	Analytical Report Name
NTDB	TR200.2	ICD10 Procedure	ICD-10 Procedure Code (TR200.2)	ICD-10 Procedure Code (TR200.2)
NTDB	TR200.8	Date Performed	ICD-10 Procedure Performed Date (TR200.8)	ICD-10 Procedure Performed Date (TR200.8)
NTDB	TR200.9	Time Performed	ICD-10 Procedure Performed Time (TR200.9)	ICD-10 Procedure Performed Time (TR200.9)
NTDB	TR200.2	ICD10 Procedure	ICD-10 Procedure Code (TR200.2)	ICD-10 Procedure Code (TR200.2)
STATE	TR22.30	Procedure Performed	Procedure Performed (TR22.30)	ED-Facility Performed Procedure (TR22.30)
OPTIONAL	TR200.11	Procedure Performed Location	ICD-10 Procedure Performed Location (TR200.11)	ED-Facility ICD-10 Procedure Location (TR200.11)
OPTIONAL	TR200.10	Physician Performing the Procedures	ICD-10 Procedure Patient Care Staff (TR200.10)	ED-Facility ICD-10 Procedure Staff Name (TR200.10)
OPTIONAL	TR200.7	Physician Comments	ICD-10 Procedure Note (TR200.7)	N/A
OPTIONAL	TR200.6	Service Type of the Physician	ICD-10 Procedure Service Type (TR200.6)	ED-Facility ICD-10 Procedure Service Type (TR200.6)
OPTIONAL	TR200.2.2.1	Operation Number	Operation Number (TR200.2.2.1)	ED-Facility ICD-10 Operation Number (TR200.2.2.1)
OPTIONAL	TR200.2.2.3	Date in OR/Time in OR	In OR Date (TR200.2.2.3)	ED-Facility ICD-10 Operation Procedure In OR Date Time (TR200.2.2.3)
OPTIONAL	TR200.2.2.4	Date out of OR/Time out of OR	Out OR Date (TR200.2.2.4)	ED-Facility ICD-10 Operation Procedure Out OR Date Time (TR200.2.2.4)
OPTIONAL	TR200.2.2.9	Staff Involved with Procedures	Procedure Operating Staff (TR200.2.2.9)	ED-Facility ICD-10 Operation Procedures Staff Name List (TR200.2.2.9)
OPTIONAL	TR200.2.1.2	Accession Number	Radiological Accession Number (TR200.2.1.2)	ED-Facility ICD-10 Radiological Procedure Accession Number (TR200.2.1.2)
OPTIONAL	TR200.2.1.6	Exam Arrival	Radiological Exam Arrival Date (TR200.2.1.6)	ED-Facility ICD-10 Radiological Procedure Exam Arrival Date Time (TR200.2.1.6)
OPTIONAL	TR200.2.1.6.1	Exam Arrival Time	Radiological Exam Arrival Time (TR200.2.1.6.1)	N/A
OPTIONAL	TR200.2.1.8	Exam Finished	Radiological Exam Finished Date (TR200.2.1.8)	ED-Facility ICD-10 Radiological Procedures Exam Finished Date Time (TR200.2.1.8)
OPTIONAL	TR200.2.1.8.1	Exam Finished Time	Radiological Exam Finished Time (TR200.2.1.8.1)	N/A
OPTIONAL	TR200.15	Procedure Arterial Puncture Date	Procedure Arterial Puncture Date (TR200.15)	N/A

OPTIONAL	TR200.15.1	Procedure Arterial Puncture Time	Procedure Arterial Puncture Time (TR200.15.1)	N/A
OPTIONAL	TR200.2.1.4	Request Date	Radiological Request Date (TR200.2.1.4)	ED-Facility ICD-10 Radiological Procedure Request Date Time (TR200.2.1.4)
OPTIONAL	TR200.2.1.4.1	Request Time	Radiological Request Time (TR200.2.1.4.1)	N/A
OPTIONAL	TR200.2.3.2	Radiology Results Read Date	Radiology Results Read Date (TR200.2.3.2)	N/A
OPTIONAL	TR200.2.3.3	Radiology Results Read Time	Radiology Results Read Time (TR200.2.3.3)	N/A
OPTIONAL	TR200.2.3.1	Radiology Results	Radiology Results (TR200.2.3.1)	N/A
OPTIONAL	TR200.2.1.3	Requesting Staff	Radiological Requesting Staff (TR200.2.1.3)	ED-Facility ICD-10 Radiological Procedure Requesting Staff (TR200.2.1.3)
OPTIONAL	TR18.190	Date of First Antibiotic Administration	First Antibiotic Administration Date (TR18.190)	N/A
OPTIONAL	TR18.190.1	Time of First Antibiotic Administration	First Antibiotic Administration Time (TR18.190.1)	N/A

Diagnosis Report Writer Elements

Required	Data Element	Element Name	Transactional Report Name	Analytical Report Name
NTDB	Pre-Existing Conditions	Pre-Existing Conditions	Pre-Existing Condition (NAME OF CONDITION)	N/A
NTDB	TR200.1	ICD 10 Diagnosis	ICD-10 Diagnosis Code (TR200.1)	ICD-10 Diagnosis Code (TR200.1)/ ED-Hospital ICD-10 Diagnosis Description (TR200.1)
STATE	NA	ISS	ISS Calculated (TR21.8)	ISS Calculated (TR21.8)
STATE	NA	TRISS	TRISS Blunt TRISS Penetrating	ED-Hospital Probability Of Survival TRISS - Calculated (TR21.9)
STATE	1. Head TR21.2 2. Face TR21.5 3. Chest TR21.3 4. Abdomen TR21.6 5. Extremity TR21.4 6. 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)
OPTIONAL	TR200.130	Comments	N/A	N/A

Injury Severity Information Report Writer Elements

Required	Data Element	Element Name	Transactional Report Name	Analytical Report Name
NTDB	TR200.14.1	ICD10 AIS Codes	ICD-10 AIS 05 Code	ICD-10 AIS 05 Code

Outcome Report Writer Elements

Required	Data Element	Element Name	Transactional Report Name	Analytical Report Name
NTDB	TR26.9	Total ICU Days	Total ICU Length Of Stay - Days (TR26.9)	Total ICU Length Of Stay - Days (TR26.9)
NTDB	TR26.58	Total Ventilator Days	Total Ventilator Days (TR26.58)	Total Ventilator Days (TR26.58)
NTDB	TR25.93	Discharge Order Date	Hospital Discharge Orders Written Date (TR25.93)	N/A
NTDB	TR25.94	Discharge Order Time	Hospital Discharge Orders Written Time (TR25.94)	N/A
NTDB	TR25.27	Discharge Disposition	Facility Discharge Disposition (TR25.27)	Facility Discharge Disposition (TR25.27)
STATE	TR25.44	Length of Stay	Facility Length Of Stay - Calendar Days (Physical D/C) (TR25.44)	Hospital Length Of Stay (TR25.44)
STATE	TR25.34	Discharge Date	Facility Discharge Date (TR25.34)	Hospital Discharge Date (TR25.34)
STATE	TR25.48	Discharge Time	Facility Discharge Time (TR25.48)	Hospital Discharge Time (TR25.48)
STATE	TR25.92	Discharge Status	Discharge Status (Dead/Alive) (TR25.92)	N/A
OPTIONAL	TR25.42	Hospital Discharge Destination Determination	Facility Discharge Destination Determination (TR25.42)	Discharge Destination Determination Reason (TR25.42)
OPTIONAL	TR25.42Other	Other Destination Determination	Facility Discharge Destination Determination Other (TR25.42Other)	N/A
OPTIONAL	TR25.35	Hospital Transferred To	Hospital Transferred To (Outcome)(TR25.35)	Discharge Facility Transferred To (TR25.35)
OPTIONAL	TR25.43	Hospital Discharge Transport Mode	Discharge Transport Mode (TR25.43)	Discharge Transfer Transport Mode (TR25.43)
OPTIONAL	TR25.36	Date of Death	Date of Death	Date of Death (TR25.36)
OPTIONAL	TR25.36.1	Time of Death	Time of Death	Time of Death (TR25.36.1)
OPTIONAL	TR25.30	Location of Death	Death Location (TR25.30)	Patient Death Location (TR25.30)
OPTIONAL	TR25.53	Circumstances of Death	Circumstances of Death	Circumstances of Death (TR25.53)
OPTIONAL	TR25.69	Organs/Tissue Donation Requested	Organs/Tissue Donation Requested	Indicates whether organ donation was requested (TR25.69)
OPTIONAL	TR25.29	Organ Donation	Organ Donation	Organ Donation (TR25.29)
OPTIONAL	TR25.70	Organs Donated	Organs Donated	Organs Donated (TR25.70)
OPTIONAL	TR25.37	Autopsy Performed	Autopsy Performed	Autopsy (TR25.37)

OPTIONAL	TR25.46	General Condition at Discharge	Disability at Discharge (TR25.46)	N/A
OPTIONAL	TR25.99	Discharge Physician	Discharge Physician (TR25.99)	N/A
OPTIONAL	TR2.7	Secondary Method of Payment	Financial-Secondary Method of Payment (TR2.7)	Facility Charges Secondary Method of Payment (TR2.7)
OPTIONAL	TR2.14	Secondary Other Billing Source	Financial-Secondary Other Billing Source (TR2.14)	Facility Charges Secondary Other Billing Source (TR2.14)
OPTIONAL	TR25.49	DRG Codes	DRG Codes (TR25.49)	N/A
OPTIONAL	TR2.9	Billed Hospital Charge	Financial-Billing Charges (TR2.9)	Facility Charges Billed (TR2.9)
OPTIONAL	TR5.27	Note Type	Clinical Note Type (TR5.27)	N/A
OPTIONAL	TR5.24	Note	Clinical Note (TR5.24)	N/A
OPTIONAL	TR5.26	Notes Entered By	Clinical Note Creator (TR5.26)	N/A
OPTIONAL	TR5.25	Notes Date/Time	Clinical Note Date/Time (TR5.25)	N/A
OPTIONAL	TR25.100	Discharge Summary	Discharge Summary (TR25.100)	N/A

Financial Information Report Writer Elements

Required	Data Element	Element Name	Transactional Report Name	Analytical Report Name
NTDB	TR2.5	Primary Method of Payment	Primary Method Of Payment (TR2.5)	Primary Method Of Payment (TR2.5)

Log of Admission Report Writer Elements

Required	Data Element	Element Name	Transactional Report Name	Analytical Report Name
OPTIONAL	TR44.1	Admission Log Date	Log of Admission-Ward Admission Date (TR44.1)	Facility Admission Log Date (TR44.1)
OPTIONAL	TR44.2	Admission Log Time	Log of Admission – Ward Admission Time (TR44.2)	Facility Admission Log Time (TR44.2)
OPTIONAL	TR44.7	Discharge Date	Log of Admission – Ward Discharge Date (TR44.7)	N/A
OPTIONAL	TR44.8	Discharge Time	Log of Admission – Ward Discharge Time (TR44.8)	N/A
OPTIONAL	TR44.3	Admission Ward	Log of Admission – Ward (TR44.3)	Facility Admission Log Ward (TR44.3)
OPTIONAL	TR44.4	Bed Number	Log of Admission – Ward Bed Number (TR44.4)	Facility Admission Log Bed Number (TR44.4)
OPTIONAL	TR44.5	Consultant	Log of Admission – Ward Consultant (TR44.5)	Facility Admission Log Consultant Name (TR44.5)
OPTIONAL	TR44.6	Medical Specialty	Log of Admission – Ward Specialty (TR44.6)	Facility Admission Log Consultant Specialty (TR44.6)
OPTIONAL	TR44.10.1	Count of Each Calendar Day the Patient Within the Log of Admissions	Total Calendar Log of Admission Days (TR44.10.1)	N/A
OPTIONAL	TR44.10	Total Computed Log of Admission Time	Total Calendar Log of Admission Time (TR44.10)	N/A

Hospital Complications Report Writer Elements

Required	Data Element	Element Name	Transactional Report Name	Analytical Report Name
NTDB	TR23.1	Complications	Injury Complication Type (TR23.1)	Injury Complication Type (TR23.1)

In addition to the required elements above, the following options are commonly used within reports.

Other Common Report Writer Elements

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

SECTION F

Wisconsin NTDB Extension Import Mapping

If needed, contact the Trauma Registry Data Manager for a copy of the import schema.

Demographics Import Mapping

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 TR1.0 – 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

Referring Facility Import Mapping

Referring Facility TR33.1 – Referring Facility

Description

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

Schema Data Type

String

XSD Type

Xs:string

ED/TTA Import Mapping

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

Activation Level	3rd Party Upload Code
Level 1	1
Level 2	2
Level 3	3
Consultation	4
Not Activated	0
Not Known/Not Recorded	-45

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.

Schema Data Type

String

XSD Type

Xs:string

Element Values

Mode of Arrival	3rd Party Upload Code
Ground Ambulance	1
Helicopter Ambulance	2
Fixed Wing Ambulance	3
Private/Public Vehicle/Walk-In	4
Police	5
Other	6
Not Applicable	-25
Not Known/Not Recorded	-45

ED/TTA TR17.25 – ED Discharge Date

Description

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

Schema Data Type

String

XSD Type

Xs:string

ED/TTA TR17.26 – ED Discharge Time

Description

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

Schema Data Type

String

XSD Type

Xs:string

Outcome Import Mapping

Outcome TR25.34 – Hospital Discharge Date

Description

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

Schema Data Type

String

XSD Type

Xs:string

Outcome TR25.48 – Hospital Discharge Time

Description

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

Schema Data Type

String

XSD Type

Xs:string