Arkansas Department of Health

Arkansas Trauma Registry

Data Dictionary

Required Data Elements

Revision 3.0

Effective January 1, 2014

Contents

Introduction

Arkansas Trauma Registry Data Dictionary

The Arkansas Trauma Registry Data Dictionary details the requirements for the mandatory data elements submitted by Arkansas trauma centers.

This Dictionary provides a detailed description of each data point included in the Arkansas Trauma Registry.

For further information, please contact:

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Patient Definition Inclusion Criteria

Definition: To ensure consistent data collection across the state, a trauma patient is defined as a patient sustaining a traumatic injury and meeting the following criteria:

At least one of the following injury diagnostic codes defined in the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM): **800-959.9, 987.9 (Smoke Inhalation), 994.0 (Lightning), 994.1 (Drowning and nonfatal submersion), 994.7 (Asphyxiation and Strangulation, includes Hanging), 994.8 (Electrocution), E-code 905.0 (Snakebites, venomous), or E-code 906.0 (Dog bite).**

Excluding the following isolated injuries:

- 905-909.9 (late effects of injury)
- 910-924.9 (superficial injuries, including blisters, contusions, abrasions, and insect bites)
- 930-939.9 (foreign bodies)
- Same level fall in patients > 65 with isolated hip fracture (ICD-9 Codes 820.0 – 820.8)

AND MUST INCLUDE ONE OF THE FOLLOWING IN ADDITION TO ICD-9-CM:

- Hospital admission for injury. Hospital admission is defined as ED disposition other than out of hospital destination (home, jail, back to skilled nursing facility or other institutional care, etc.). Excludes ED disposition to L&D for monitoring. Excludes hospital admission for reasons other than trauma, i.e., diagnostic work-up for chest pain/syncope, medical management of medical condition (dehydration, diabetes, HTN, etc.), psychiatric related concerns
- Death resulting from the traumatic injury (independent of hospital admission or hospital transfer status)

EXCLUDES:

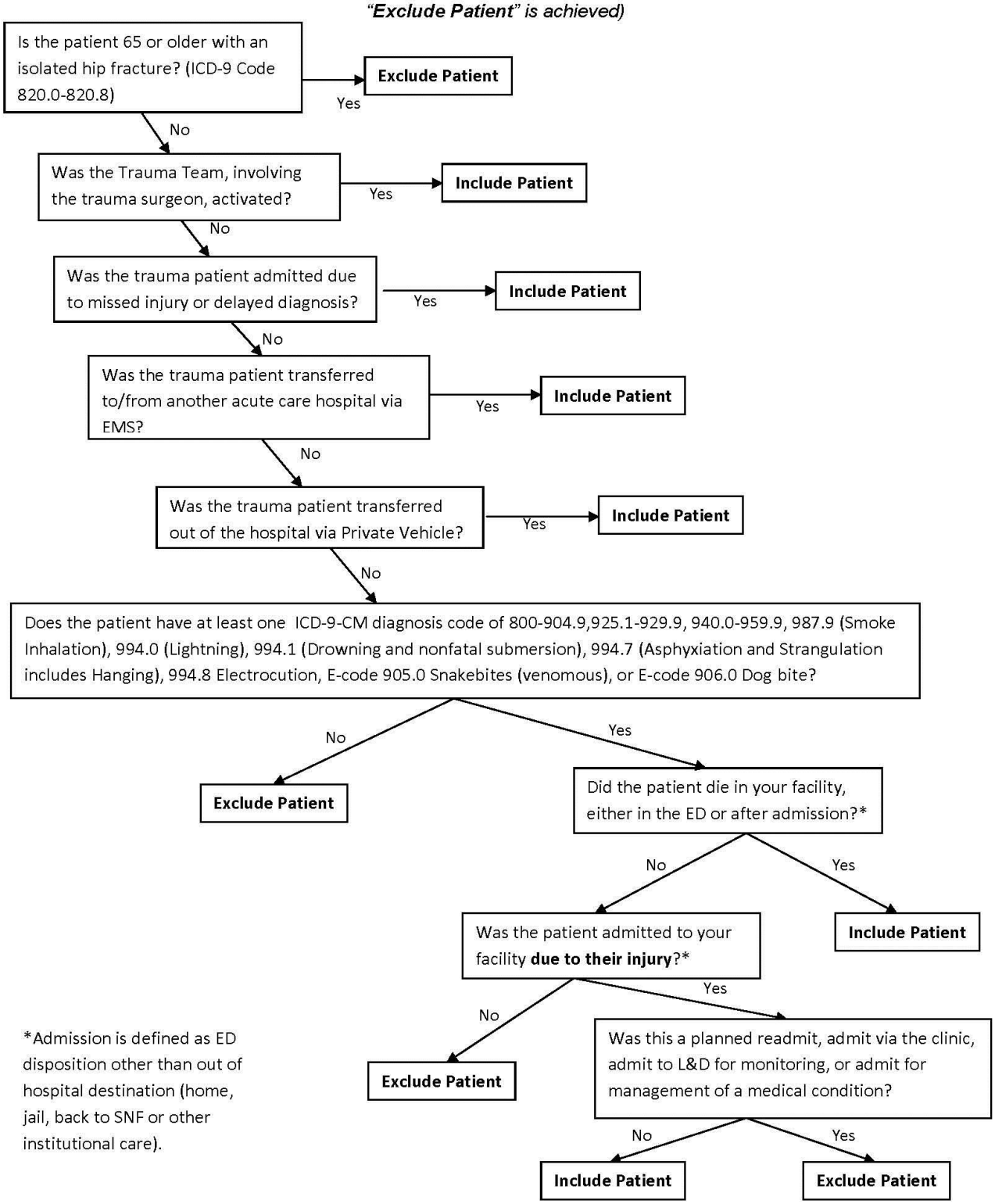
- Planned readmits or scheduled admits via the clinic

Other System Inclusion Criteria:

- All trauma team activations involving the trauma surgeon
- Any admission post ED/Hospital discharge that occurs as a result of missed injury or delayed diagnosis
- Any acute care hospital to acute care hospital trauma transfer via EMS
- Trauma transfers out via private vehicle

Inclusion Criteria picture

Trauma Registry Inclusion Criteria *(Follow downward until an "**Include Patient**" or "**Exclude Patient**" is achieved)*



*Admission is defined as ED disposition other than out of hospital destination (home, jail, back to SNF or other institutional care).

DATA DICTIONARY DEFINITION FORMAT

This section contains a description of each data point to be reported to the Arkansas Trauma Registry, organized by section of the data (demographics, diagnoses, etc.). At the end of the Data Dictionary, there is a glossary of all data elements.

COMMON NULL VALUES

Options:

/ = Not applicable

? = Not known/Not recorded

Definitions:

Not applicable - This null value code applies if, at the time of patient care documentation, the information requested was “Not applicable” to the patient, the hospitalization or the patient care event. For example, variables documenting EMS care would be “Not applicable” if a patient self-transports to the hospital.

Not known/Not recorded - This null value applies if, at the time of patient care documentation, information was “Not known” (to the patient, family, health care provider) or no value for the element was recorded for the patient. This documents that there was an attempt to obtain information but it was unknown by all parties or the information was missing at the time of documentation. For example, injury date and time may be documented in the hospital patient care report as “Unknown.” Another example: Not known/Not recorded should also be coded when documentation was expected, but none was provided (e.g., no EMS run sheet in the hospital record for patient transported by EMS).

Note:

In certain fields, common null values may be specified that are different from those outlined above. If such values are specified for some variables, those alternatives must be used instead of the common null values.

DEMOGRAPHIC INFORMATION

TRAUMA REGISTRY NUMBER

Data Format [assigned]

Definition

A unique identifier for a patient and trauma incident within a specific institution, this is a maximum 12 digit number.

Required in ATR Yes	**Required in NTDB** No
Web Field Name Trauma Registry Number	**NTDB Element Number** N/A
NTRACS Field Name Trauma Number	**NTDB Data Dictionary Page Number** N/A

Field Values

- Auto-generated

Additional Information

- Automatically assigned by the registry software
- This number may not be changed.

Data Source Hierarchy

References

TRAUMA BAND NUMBER

Data Format [text]

Definition

An alpha-numeric ID number printed on a plastic band is used to provide a link between entities (EMS, hospitals) within the State Trauma System. It is typically applied to the patient by the first agency involved, with the number recorded in the Trauma Band Number field.

Required in ATR Yes	**Required in NTDB** No
Web Field Name Trauma Band Number	**NTDB Element Number** N/A
NTRACS Field Name TBANDNUM	**NTDB Data Dictionary Page Number** N/A

Field Values

- Relevant value for data element
- Common null values

Additional Information

- Having an alpha character followed by a six (6) digit number, the letter and all numbers must be entered.

Data Source Hierarchy

1. EMS Run Sheet
2. ED Admission Form
3. Triage Form/Trauma Flow Sheet
4. ED Nurses Notes
5. Billing Sheet/Medical Records Coding Summary Sheet

References

HOSPITAL NUMBER

Data Format [text]

Definition

A seven-digit number for each hospital, consisting of the hospital's FIPS code and facility number within the hospital's county, is assigned by the Department of Health.

Required in ATR Yes	**Required in NTDB** No
Web Field Name Facility ID	**NTDB Element Number** N/A
NTRACS Field Name Hospital ID	**NTDB Data Dictionary Page Number** N/A

Field Values

- Relevant value for data element

Additional Information

- This number provides a unique identifier for the hospital in the Arkansas State Registry.
- Auto populated based on log-in information

Data Source Hierarchy

References

LAST FOUR DIGITS OF PATIENT'S SOCIAL SECURITY NUMBER

Data Format [text]

Definition

Last four digits of the patient's Social Security Number

Required in ATR Yes	**Required in NTDB** No
Web Field Name Last 4 digits of SSN	**NTDB Element Number** N/A
NTRACS Field Name SSN	**NTDB Data Dictionary Page Number** N/A

Field Values

- Relevant value for data element
- Common null values

Additional Information

- This field cannot be partially filled.

Data Source Hierarchy

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

References

PATIENT'S FIRST NAME

Data Format [text]

Definition

The patient's first given name

Required in ATR Yes	**Required in NTDB** No
Web Field Name First Name	**NTDB Element Number** N/A
NTRACS Field Name	**NTDB Data Dictionary Page Number** N/A

Field Values

- Relevant value for data element
- Common null values

Additional Information

- Alpha characters

Data Source Hierarchy

1. Billing Sheet/Medical Records Coding Summary Sheet
2. ED Admission Form
3. EMS Run Sheet
4. Triage Form/Trauma Flow Sheet
5. ED Nurses Notes

References

PATIENT'S MIDDLE INITIAL

Data Format [text]

Definition

The first letter of the patient's middle or second given name

Required in ATR Yes	**Required in NTDB** No
Web Field Name MI	**NTDB Element Number** N/A
NTRACS Field Name	**NTDB Data Dictionary Page Number** N/A

Field Values

- Relevant value for data element
- Common null values

Additional Information

- One (1) alpha character

Data Source Hierarchy

1. Billing Sheet/Medical Records Coding Summary Sheet
2. EMS Run Sheet
3. ED Admission Form
4. Triage Form/Trauma Flow Sheet
5. ED Nurses Notes

References

PATIENT'S LAST NAME

Data Format [text]

Definition

The patient's last or family name

Required in ATR Yes	**Required in NTDB** No
Web Field Name Last Name	**NTDB Element Number** N/A
NTRACS Field Name	**NTDB Data Dictionary Page Number** N/A

Field Values

- Relevant value for data element
- Common null values

Additional Information

- Alpha characters

Data Source Hierarchy

1. Billing Sheet/Medical Records Coding Summary Sheet
2. EMS Run Sheet
3. ED Admission Form
4. Triage Form/Trauma Flow Sheet
5. ED Nurses Notes

References

PATIENT'S STREET ADDRESS

Data Format [text]

Definition

The number and street name of the patient's primary residence is the street address.

Required in ATR Yes	**Required in NTDB** No
Web Field Name Street Address	**NTDB Element Number** N/A
NTRACS Field Name	**NTDB Data Dictionary Page Number** N/A

Field Values

- Relevant value for data element
- Common null values

Additional Information

- Alpha and numeric characters
- Street Address 2 field is available as needed for clarity or space.

Data Source Hierarchy

1. Billing Sheet/Medical Records Coding Summary Sheet
2. EMS Run Sheet
3. ED Admission Form
4. Triage Form/Trauma Flow Sheet
5. ED Nurses Notes

References

PATIENT'S HOME ZIP CODE

Data Format [text]

Definition

The patient's home ZIP code of primary residence.

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Zip	**NTDB Element Number** D_01
NTRACS Field Name Zip	**NTDB Data Dictionary Page Number** 2

Field Values

- Relevant value for data element
- Common null values

Additional Information

- Can be stored as a 5 or 9 digit code (XXXXX-XXXX)
- May require adherence to HIPAA regulations
- *If zip code is "Not Applicable," complete variable: Alternate Home Residence (pg. 27).*
- *If zip code is "Not Recorded/Not Known/Unknown," complete variables: Patient's Home Country (pg. 22), Patient's Home State (pg. 23), Patient's Home County (pg. 24) and Patient's Home City (pg. 25).*

Data Source Hierarchy

1. Billing Sheet/Medical Records Coding Summary Sheet
2. Ed Admission Form
3. EMS Run Sheet
4. Triage Form/Trauma Flow Sheet
5. ED Nurses Notes

References

PATIENT'S HOME COUNTRY

Data Format [combo] single choice

Definition

The country where the patient resides

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Country	**NTDB Element Number** D_02
NTRACS Field Name Country	**NTDB Data Dictionary Page Number** 3

Field Values

- Relevant value for data element
- Common null values

Additional Information

- *Only completed when ZIP code is "Not Recorded/Not Known"*
- Will auto populate when valid ZIP code is entered

Data Source Hierarchy

1. Billing Sheet/Medical Records Coding Summary Sheet
2. ED Admission Form
3. EMS Run Sheet
4. Triage Form/Trauma Flow Sheet
5. ED Nurses Notes

References

PATIENT'S HOME STATE

Data Format [combo] single choice

Definition

The state (territory, province, or District of Columbia) where the patient resides

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name State	**NTDB Element Number** D_03
NTRACS Field Name	**NTDB Data Dictionary Page Number** 4

Field Values

- Relevant value for data element (two digit numeric FIPS code)
- Common null values

Additional Information

- *Only completed when ZIP code is "Not Recorded/Not Known"*
- Used to calculate FIPS code

Data Source Hierarchy

1. ED Admission Form
2. Billing Sheet/Medical Records Coding Summary Sheet
3. EMS Run Sheet
4. Triage Form/Trauma Flow Sheet
5. ED Nurses Notes

References

PATIENT'S HOME COUNTY

Data Format [combo] single-choice

Definition

The patient's county (or parish) of residence

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name County	**NTDB Element Number** D_04
NTRACS Field Name County	**NTDB Data Dictionary Page Number** 5

Field Values

- Relevant value for data element
- Common null values

Additional Information

- *Only completed when ZIP code is "Not Recorded/Not Known"*
- Used to calculate FIPS code

Data Source Hierarchy

1. Billing Sheet/Medical Records Coding Summary Sheet
2. EMS Run Sheet
3. ED Admission Form
4. Triage Form/Trauma Flow Sheet
5. ED Nurses Notes

References

PATIENT'S HOME CITY

Data Format [combo] single-choice

Definition

The patient's city (or township or village) of residence

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name City	**NTDB Element Number** D_05
NTRACS Field Name City	**NTDB Data Dictionary Page Number** 6

Field Values

- Relevant value for data element
- Common null values

Additional Information

- *Only completed when ZIP code is "Not Recorded/Not Known"*
- Used to calculate FIPS code

Data Source Hierarchy

1. ED Admission Form
2. Billing Sheet/Medical Records Coding Summary Sheet
3. EMS Run Sheet
4. Triage Form/Trauma Flow Sheet
5. ED Nurses Notes

References

ALTERNATE HOME RESIDENCE

Data Format [text]

Definition

Documentation of the type of patient without a home zip code

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Alternate Home Residence	**NTDB Element Number** D_06
NTRACS Field Name Alternate Home Residence	**NTDB Data Dictionary Page Number** 7

Field Values

- Homeless
- Undocumented Citizen
- Migrant Worker
- Foreign Visitor
- Common null values

Additional Information

- *Only completed when ZIP code is "Not Recorded/Not Known"*
- **Homeless** - a person who lacks housing. The definition also includes a person living in transitional housing or a supervised public or private facility providing temporary living quarters.
- **Undocumented citizen** - a national of another country who has entered or stayed in another country without permission
- **Migrant worker** - a person who temporarily leaves his/her principal place of residence within a country in order to accept seasonal employment in the same country
- **Foreign visitor** - any person visiting a country other than his/her usual place of residence for any reason without intending to receive earnings *in the visited country*

Data Source Hierarchy

1. Billing Sheet/Medical Records Coding Summary Sheet
2. ED Admission Form
3. EMS Run Sheet
4. Triage Form/Trauma Flow Sheet
5. ED Nurses Notes

References

DATE OF BIRTH

Data Format [date]

Definition

The patient's date of birth

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Date Of Birth	**NTDB Element Number** D_07
NTRACS Field Name Date of Birth	**NTDB Data Dictionary Page Number** 8

Field Values

- Relevant value for data element
- Common null values

Additional Information

- Collected as MM/DD/YYYY
- *If age is less than 24 hours, complete variables: Age and Age Units.*
- *If "Not Recorded/Not Known" complete variables: Age and Age Units.*
- Used to calculate patient age in days, months, or years

Data Source Hierarchy

- ED Admission Form
- Billing Sheet/Medical Records Coding Summary Sheet
- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses Notes

References

AGE

Data Format [number]

Definition

The patient's age at time of injury (best approximation)

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Age	**NTDB Element Number** D_08
NTRACS Field Name Age	**NTDB Data Dictionary Page Number** 9

Field Values

- Minimum constraint: 0; Maximum constraint: 120
- Common null values

Additional Information

- Used to calculate patient age in hours, days, months, or years
- *Only completed when Date of Birth is "Not Recorded/Not Known" or age is less than 24 hours*
- *Must also complete variable: Age Units*

Data Source Hierarchy

- ED Admission Form
- Billing Sheet/Medical Records Coding Summary Sheet
- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses Notes

References

AGE UNITS

Data Format [combo] single -choice

Definition

The units used to document the patient's age (Hours, Days, Months, and Years)

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Age Unit	**NTDB Element Number** D_09
NTRACS Field Name Calculated Age	**NTDB Data Dictionary Page Number** 10

Field Values

- Hours
- Days
- Months
- Years
- Common null values

Additional Information

- Used to calculate patient age in hours, days, months, or years
- *Only completed when Date of Birth is "Not Recorded/Not Known" or age is less than 24 hours*
- *Must also complete variable: Age*

Data Source Hierarchy

1. ED Admission Form
2. Billing Sheet/Medical Records Coding Summary Sheet
3. Triage Form/Trauma Flow Sheet
4. EMS Run Sheet
5. ED Nurses Notes

References

RACE

Data Format [combo] multiple choice

Definition

The patient's race

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Race	**NTDB Element Number** D_10
NTRACS Field Name Race	**NTDB Data Dictionary Page Number** 11

Field Values

- Asian
- Native Hawaiian or Other Pacific Islander
- Other Race
- American Indian
- Black or African American
- White
- Common null values

Additional Information

- Patient race should be based upon self-report or identified by a family member.
- The maximum number of races that may be reported for an individual patient is two (2).

Data Source Hierarchy

1. ED Admission Form
2. Billing Sheet/Medical Records Coding Summary Sheet
3. Triage Form/Trauma Flow Sheet
4. EMS Run Sheet
5. ED Nurses Notes

References

ETHNICITY

Data Format [combo] single-choice

Definition

The patient's ethnicity

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Ethnicity	**NTDB Element Number** D_11
NTRACS Field Name Ethnicity	**NTDB Data Dictionary Page Number** 12

Field Values

- Hispanic or Latino
- Not Hispanic or Latino
- Common null values

Additional Information

- Patient ethnicity should be based upon self-report or identified by a family member.
- The maximum number of ethnicities that may be reported for an individual patient is one (1).

Data Source Hierarchy

1. ED Admission Form
2. Billing Sheet/Medical Records Coding Summary Sheet
3. Triage Form/Trauma Flow Sheet
4. EMS Run Sheet
5. ED Nurses Notes

References

SEX

Data Format [combo] single-choice

Definition

The patient's sex

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Gender	**NTDB Element Number** D_12
NTRACS Field Name Gender	**NTDB Data Dictionary Page Number** 13

Field Values

- Male
- Female
- Common null values

Additional Information

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

Data Source Hierarchy

- ED Admission Form
- Billing Sheet/Medical Records Coding Summary Sheet
- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses Notes

References

INJURY INFORMATION

INJURY INCIDENT DATE

Data Format [date]

Definition

The date the injury occurred.

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Injury Date	**NTDB Element Number** I_01
NTRACS Field Name Injury Date	**NTDB Data Dictionary Page Number** 15

Field Values

- Minimum: 1990; Maximum: 2030
- Common null values

Additional Information

- Collected as MM-DD-YYYY
- *Estimates of date of injury should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g., 911 call time) should not be used.*
- *Calendar pick box available*

Data Source Hierarchy

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

References

INJURY INCIDENT TIME

Data Format [time]

Definition

The time the injury occurred.

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Injury Time	**NTDB Element Number** I_02
NTRACS Field Name Injury Time	**NTDB Data Dictionary Page Number** 16

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM (midnight – 12:00 a.m.) through 23:59 (11:59 p.m.), valid military time
- *Estimates of time of injury should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g., 911 call time) should not be used.*

Data Source Hierarchy

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

References

INJURY TYPE

Data Format [character]

Definition

Blunt – non-penetrating injury, from an external force causing injury;

Burn – tissue injury from excessive exposure to chemical, thermal, electrical, or radioactive agents;

Penetrating – injury resulting from a projectile force, piercing instrument, entering deeply and causing tissue and/or organ injury.

Required in ATR Yes	**Required in NTDB** No
Web Field Name Injury Type	**NTDB Element Number N/A**
NTRACS Field Name Mechanism	**NTDB Data Dictionary Page Number** N/A

Field Values

- Blunt
- Burn
- Penetrating
- Common null values

Additional Information

- Pick list available

Data Source Hierarchy

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

References

WORK RELATED

Data Format [logic]

Definition

Indication of whether the injury occurred during paid employment

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Work Related	**NTDB Element Number** I_03
NTRACS Field Name Work Related	**NTDB Data Dictionary Page Number** 17

Field Values

- Yes
- No
- Common null values

Additional Information

- If 1 (No) is chosen, system skips the field identifying occupation.
- If work related, two additional data fields must be completed: Patient's Occupational Industry and Patient's Occupation.
- Pick list available

Data Source Hierarchy

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

References

PATIENT'S OCCUPATION

Data Format [character]

Definition

Occupation of the patient

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Patient's Occupation	**NTDB Element Number** I_05
NTRACS Field Name Patient's Occupation	**NTDB Data Dictionary Page Number** 19

Field Values

- Business and Financial Operations
- Architecture and Engineering
- Community and Social Services
- Education, Training, and Library
- Healthcare Practitioners and Technical
- Protective Service
- Building and Grounds Cleaning and Maintenance
- Sales and Related
- Farming, Fishing, and Forestry
- Installation, Maintenance, and Repair
- Transportation and Material Moving
- Management
- Computer and Mathematical
- Life, Physical, and Social Science
- Legal Occupations
- Arts, Design, Entertainment, Sports, and Media
- Healthcare Support
- Food Preparation and Serving Related
- Personal Care and Service
- Office and Administrative Support
- Construction and Extraction
- Production
- Military Specific
- Student
- Common null values

Additional Information

- If field WORK RELATED is No, Not Applicable, or Unknown, field will not be available for entry.
- If work related, also complete Patient's Occupational Industry.
- Pick list available

Data Source Hierarchy

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

References

1999 US Bureau of Labor Statistics Standard Occupational Classification (SOC)

PATIENT'S OCCUPATIONAL INDUSTRY

Data Format [character]

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Patient's Occupational Industry	**NTDB Element Number** I_04
NTRACS Field Name Patient's Occupational Industry	**NTDB Data Dictionary Page Number** 18

Field Values

- Finance, Insurance, and Real Estate
- Manufacturing
- Retail Trade
- Transportation and Public Utilities
- Agriculture, Forestry, Fishing
- Professional and Business Services
- Education and Health Services
- Construction
- Government
- Natural Resources and Mining
- Information Services
- Wholesale Trade
- Leisure and Hospitality
- Other Services
- Common null values

Additional Information

- If field WORK RELATED is No, Not Applicable, or Unknown, field will not be available for entry.
- If work related, also complete Patient's Occupation.
- Pick list available

Data Source Hierarchy

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

References

1999 US Bureau of Labor Statistics Standard Occupational Classification (SOC)

ICD-9 PRIMARY EXTERNAL CAUSE CODE

Data Format [combo] single-choice

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Primary E-Code	**NTDB Element Number** I_06
NTRACS Field Name Primary E-Code	**NTDB Data Dictionary Page Number** 20

Field Values

- Relevant ICD-9-CM code value for injury event
- Common null values

Additional Information

- The Primary E-Code should describe the main reason a patient is admitted to the hospital.
- ICD-9-CM codes were retained over ICD-10 due to CMS's continued use of ICD-9.
- Pick list available

Data Source Hierarchy

1. EMS Run Sheet
2. Triage Form/Trauma Flow Sheet
3. Billing Sheet/Medical Records Coding Summary Sheet
4. ED Nurses Note

References

ICD-10 PRIMARY EXTERNAL CAUSE CODE

Data Format [combo] single-choice

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Primary ICD-10 E-Code	**NTDB Element Number** I_07
NTRACS Field Name Primary ICD-10 E-Code	**NTDB Data Dictionary Page Number** 21

Field Values

- Relevant ICD-10-CM code value for injury event
- Common null values

Additional Information

- The Primary E-Code should describe the main reason a patient is admitted to the hospital.
- E-codes are used to auto-generate two calculated fields: Trauma Type (Blunt, Penetrating, Burn) and Intentionality (based up CDC matrix)
- ICD-10-CM codes will be accepted for this data element. Activity codes should not be reported in this field.
- Pick list available

Data Source Hierarchy

1. EMS Run Sheet
2. Triage Form/Trauma Flow Sheet
3. Billing Sheet/Medical Records Coding Summary Sheet
4. ED Nurses Note

References

ICD-9 PLACE OF OCCURRENCE EXTERNAL CAUSE CODE

Data Format [number]

Definition

Place of occurrence external cause code used to describe the place/site/location of the injury event (E-849.X).

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name E-849x	**NTDB Element Number** I_08
NTRACS Field Name Location E-Code E849x	**NTDB Data Dictionary Page Number** 22

Field Values

- Relevant ICD-9-CM code value for injury event
- Home
- Farm
- Mine
- Industry
- Recreation
- Street
- Public Building
- Residential Institution
- Other
- Unspecified
- Common null values

Additional Information

- ICD-9-CM codes were retained over ICD-10 due to CMS's continued use of ICD-9.
- Only ICD-9-CM codes will be accepted for ICD-9 Place of Occurrence External Cause Code
- Pick list available

Data Source Hierarchy

1. EMS Run Sheet
2. Triage Form/Trauma Flow Sheet
3. Billing Sheet/Medical Records Coding Summary Sheet
4. ED Nurses Note

References

ICD-10 PLACE OF OCCURRENCE EXTERNAL CAUSE CODE

Data Format [number]

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name ICD 10 Location E-code	**NTDB Element Number** I_09
NTRACS Field Name ICD 10 Location E-code	**NTDB Data Dictionary Page Number** 23

Field Values

- Relevant ICD-10-CM code value for injury event
- Common null values

Additional Information

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

Data Source Hierarchy

1. EMS Run Sheet
2. Triage Form/Trauma Flow Sheet
3. Billing Sheet/Medical Records Coding Summary Sheet
4. ED Nurses Note

References

ICD-9 ADDITIONAL EXTERNAL CAUSE CODE

Data Format [combo] single-choice

Definition

Additional external cause code used in conjunction with the primary external cause code if multiple external cause codes are required to describe the injury event.

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name ICD-9 Additional E-Code	**NTDB Element Number** I_10
NTRACS Field Name ICD-9 Additional E-Code	**NTDB Data Dictionary Page Number** 24

Field Values

- Relevant ICD-9-CM code value for injury event
- Common null values

Additional Information

- Only ICD-9-CM codes will be accepted for ICD-9 Additional External Cause Code
- Activity codes should not be reported in this field.
- External cause codes are used to auto-generate two calculated fields: Trauma Type (Blunt, Penetrating, Burn) and Intentionality (based upon CDC matrix).
- Pick list available

Data Source Hierarchy

1. EMS Run Sheet
2. Triage Form/Trauma Flow Sheet
3. Billing Sheet/Medical Records Coding Summary Sheet
4. ED Nurses Note

References

ICD-10 ADDITIONAL EXTERNAL CAUSE CODE

Data Format [combo] single-choice

Definition

Additional external cause code used in conjunction with the primary external cause code if multiple external cause codes are required to describe the injury event.

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name ICD-10 Additional E-Code	**NTDB Element Number** I_11
NTRACS Field Name ICD-10 Additional E-Code	**NTDB Data Dictionary Page Number** 25

Field Values

- Relevant ICD-10-CM code value for injury event
- Common null values

Additional Information

- E-codes are used to auto-generate two calculated fields: Trauma Type (Blunt, Penetrating, Burn) and Intentionality (based upon CDC matrix).
- ICD-9-CM codes were retained over ICD-10 due to CMS's continued use of ICD-9.
- Activity codes should not be reported in this field.
- Pick list available

Data Source Hierarchy

1. EMS Run Sheet
2. Triage Form/Trauma Flow Sheet
3. Billing Sheet/Medical Records Coding Summary Sheet
4. ED Nurses Note

References

INCIDENT CITY

Data Format [character]

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Incident City	**NTDB Element Number** I_16
NTRACS Field Name City	**NTDB Data Dictionary Page Number** 30

Field Values

- Relevant value for data element
- Common null values

Additional Information

- Will auto-populate when valid zip code is entered
- Only completed when injury ZIP code is “Not recorded/Not known”
- If incident location resides outside of formal city boundaries, report nearest city/town.

Data Source Hierarchy

1. EMS Run Sheet
2. Triage Form/Trauma Flow Sheet
3. ED Nurses Note

References

INCIDENT COUNTY

Data Format [character]

Definition

The county or parish where the patient was found or to which the unit responded (or best approximation)

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Incident County	**NTDB Element Number** I_15
NTRACS Field Name County	**NTDB Data Dictionary Page Number** 29

Field Values

- Relevant value for data element (County Name)
- Common null values

Additional Information

- Will auto-populate when valid zip code is entered
- Only completed when ZIP code is “Not recorded/Not known”
- If the injury occurred in a country outside the United States, see “Out of Country.”

Data Source Hierarchy

1. EMS Run Sheet
2. Triage Form/Trauma Flow Sheet
3. ED Nurses Note

References

INCIDENT STATE

Data Format [character]

Definition

The state, territory, province where the patient was found or to which the unit responded (or best approximation)

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Incident State	**NTDB Element Number** I_14
NTRACS Field Name State	**NTDB Data Dictionary Page Number** 28

Field Values

- Relevant value for data element (two digit numeric FIPS code)
- For web portal users, relevant value for data element (two-character state abbreviation)
- Common null values

Additional Information

- Will auto-populate when valid zip code is entered
- Only completed when incident location Zip code is “Not Applicable” or “Not Recorded/Not Known”.

Data Source Hierarchy

1. EMS Run Sheet
2. Triage Form/Trauma Flow Sheet
3. ED Nurses Note

References

INCIDENT COUNTRY

Data Format [character]

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Incident Country	**NTDB Element Number** I_13
NTRACS Field Name Country	**NTDB Data Dictionary Page Number** 27

Field Values

- Relevant value for data element (incident country name)
- Common null values

Additional Information

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

Data Source Hierarchy

1. EMS Run Sheet
2. Triage Form/Trauma Flow Sheet
3. ED Nurses Note

References

INCIDENT ZIP CODE

Data Format [character]

Definition

The ZIP code of the incident location

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Incident Zip	**NTDB Element Number** I_12
NTRACS Field Name Zip	**NTDB Data Dictionary Page Number** 26

Field Values

- Relevant value for data element
- Common null values

Additional Information

- Patient zip code can be stored as a 5 or 9 digit code (XXXXX-XXXX).
- May require adherence to HIPAA regulations
- *If zip code is "Not Applicable," complete variable: Alternate Home Residence (pg 26).*
- *If zip code is "Not Recorded/Not Known/Unknown," complete variables: Patient's Home Country (pg 22), Patient's Home State (pg 23), Patient's Home County (pg 24), and Patient's Home City (pg 25).*

Data Source Hierarchy

1. EMS Run Sheet
2. Triage Form/Trauma Flow Sheet
3. ED Nurses Note

References

PROTECTIVE DEVICES

Data Format [character]

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Protective Devices	**NTDB Element Number** I_17
NTRACS Field Name Protective Devices	**NTDB Data Dictionary Page Number** 31

Field Values

- None
- Lap Belt
- Personal Flotation Device
- Protective Non-Clothing Gear (e.g., shin guard)
- Eye Protection
- Child Restraint (booster seat or child car seat)
- Helmet (e.g., bicycle, skiing, motorcycle)
- Airbag Present
- Protective Clothing (e.g., padded leather pants)
- Shoulder Belt
- Other
- Common null values

Additional Information

- Check all that apply.
- *If "Child Restraint" is present, complete variable "Child Specific Restraint."*
- *If "Airbag" is present, complete variable "Airbag Deployment."*
- Evidence of the use of safety equipment may be reported or observed.
- Lap Belt should be used to include those patients who are restrained, but not further specified.
- Pick list available

Data Source Hierarchy

1. EMS Run Sheet
2. Triage Form/Trauma Flow Sheet
3. ED Nurses Note

References

CHILD SPECIFIC RESTRAINT

Data Format [character]

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Child Specific Restraint	**NTDB Element Number** I_18
NTRACS Field Name Child Specific Restraint	**NTDB Data Dictionary Page Number** 32

Field Values

- Child Car Seat
- Infant Car Seat
- Child Booster Seat
- Common null values

Additional Information

- Evidence of the use of safety equipment may be reported or observed.
- *Only completed when Protective Devices include "Child Restraint"*
- Pick list available

Data Source Hierarchy

1. EMS Run Sheet
2. Triage Form/Trauma Flow Sheet
3. ED Nurses Note

References

AIRBAG DEPLOYMENT

Data Format [character]

Definition

Indication of an airbag deployment during a motor vehicle crash

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Airbag Deployment	**NTDB Element Number** I_19
NTRACS Field Name Airbag Deployment	**NTDB Data Dictionary Page Number** 33

Field Values

- Airbag Not Deployed
- Airbag Deployed Front
- Airbag Deployed Side
- Airbag Deployed Other (knee, air belt, curtain, etc.)
- Common null values

Additional Information

- Check all that apply.
- Evidence of the use of airbag deployment may be reported or observed.
- *Only completed when Protective Devices include "Airbag"*
- Airbag Deployed front should be used for patients with documented airbag deployments, but are not further specified.
- Pick list available

Data Source Hierarchy

1. EMS Run Sheet
2. Triage Form/Trauma Flow Sheet
3. ED Nurses Note

References

INJURY DETAILS

Data Format [character]

Definition

Narrative details of the injury, including any supporting or supplemental data about the injury, environmental conditions, other circumstances, etc.

Required in ATR Yes	**Required in NTDB** No
Web Field Name Injury Details	**NTDB Element Number** N/A
NTRACS Field Name Comments	**NTDB Data Dictionary Page Number** N/A

Field Values

- All values are allowed.
- Common null values

Additional Information

- Enter the details of the injury.
- This information should not repeat information contained in other fields.

Data Source Hierarchy

1. EMS Run Sheet
2. Triage Form/Trauma Flow Sheet
3. ED Nurses Note

References

REPORT OF PHYSICAL ABUSE

Data Format [character]

Definition

A report of suspected physical abuse was made to law enforcement and/or protective services.

Required in ATR No	**Required in NTDB** Yes
Web Field Name Report of Physical Abuse	**NTDB Element Number** I_20
NTRACS Field Name Report of Physical Abuse	**NTDB Data Dictionary Page Number** 34

Field Values

- Yes
- No
- Common null values

Additional Information

- This includes, but is not limited to, a report of child, elder, spouse, or intimate partner physical abuse.
- Not Applicable cannot be used.

Data Source Hierarchy

1. EMS Run Sheet
2. ED Records
3. H and P
4. Nursing Notes
5. Case Manager / Social Services' Notes
6. Physician Discharge Summary

References

INVESTIGATION OF PHYSICAL ABUSE

Data Format [character]

Definition

An investigation by law enforcement and/or protective services was initiated because of the suspected physical abuse.

Required in ATR No	**Required in NTDB** Yes
Web Field Name Investigation of Physical Abuse	**NTDB Element Number** I_21
NTRACS Field Name Investigation of Physical Abuse	**NTDB Data Dictionary Page Number** 35

Field Values

- Yes
- No
- Common null values

Additional Information

- This includes, but is not limited to, a report of child, elder, spouse, or intimate partner physical abuse.
- Only complete when Report of Physical abuse is Yes.
- The null value “Not Applicable” should be used for patients where Report of Physical abuse is No.

Data Source Hierarchy

1. EMS Run Sheet
2. ED Records
3. Case Manager / Social Services’ Notes
4. H and P
5. Nursing Notes
6. Physician Discharge Summary

References

CAREGIVER AT DISCHARGE

Data Format [character]

Definition

The patient was discharged to a caregiver different than the caregiver at admission due to suspected physical abuse.

Required in ATR No	**Required in NTDB** Yes
Web Field Name Caregiver at Discharge	**NTDB Element Number** I_22
NTRACS Field Name Caregiver at Discharge	**NTDB Data Dictionary Page Number** 36

Field Values

- Yes
- No
- Common null values

Additional Information

- Only complete when Report of Physical abuse is Yes.
- Only complete for minors as determined by state/local definition, excluding emancipated minors.
- The null value “Not Applicable” should be used for patients where Report of Physical abuse is No or where older than the state/local age definition of a minor.

Data Source Hierarchy

1. Case Manager / Social Services’ Notes
2. Physician Discharge Summary
3. Nursing Notes
4. Progress Notes

References

PRE-HOSPITAL INFORMATION

EMS AGENCY

Data Format [numeric]

Definition

The code for each EMS agency involved in transporting the patient from the scene of injury to arrival in your hospital

Required in ATR Yes	**Required in NTDB** No
Web Field Name EMS Agency	**NTDB Element Number** N/A
NTRACS Field Name EMS Agency	**NTDB Data Dictionary Page Number** N/A

Field Values

- Relevant value for data element
- Unique Arkansas-assigned license number
- Common null values

Additional Information

- Only numeric entry allowed

Data Source Hierarchy

1. Billing Sheet/Medical Records Coding Summary Sheet
2. ED Admission Form
3. EMS Run Sheet
4. Triage Form/Trauma Flow Sheet
5. ED Nurses Notes

References

TRANSPORT MODE

Data Format [character]

Definition

The mode of transport delivering the patient to your hospital

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Transport Mode	**NTDB Element Number** P_07
NTRACS Field Name Transport Mode	**NTDB Data Dictionary Page Number** 44

Field Values

- Ground Ambulance
- Helicopter Ambulance
- Fixed-Wing Ambulance
- Private/Public Vehicle/Walk-in
- Police
- Other
- Common null values

Additional Information

- When other is selected, make sure that the mode of transport is specified in the appropriate box labeled Transport Mode Specify.

Data Source Hierarchy

1. EMS Run Sheet

References

OTHER TRANSPORT MODE

Data Format [character]

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Other Transport Mode	**NTDB Element Number** P_08
NTRACS Field Name Other Transport Mode	**NTDB Data Dictionary Page Number** 45

Field Values

- Ground Ambulance
- Helicopter Ambulance
- Fixed-Wing Ambulance
- Private/Public Vehicle/Walk-in
- Police
- Other
- Common null values

Additional Information

- Include in “Other” unspecified modes of transport.
- The null value “Not Applicable” is used to indicate that a patient had a single mode of transport and therefore this field does not apply to the patient.
- Check all that apply with a maximum of 5.

Data Source Hierarchy

1. EMS Run Sheet

References

EMS TRIP REPORT RECEIVED

Data Format [logic]

Definition

Indicator of availability of the EMS responder's report in the medical record from the EMS responder who transports the patient for each leg of an EMS Agency patient transport

Required in ATR Yes	**Required in NTDB** No
Web Field Name Trip Form	**NTDB Element Number** N/A
NTRACS Field Name Trip Form	**NTDB Data Dictionary Page Number** N/A

Field Values

- Yes
- No
- Common null values

Additional Information

Data Source Hierarchy

1. EMS Run Sheet

References

EMS LEVEL OF PROVIDER

Data Format [character]

Definition

The CMS service level for this provider

Required in ATR Yes	**Required in NTDB** No
Web Field Name EMS Level of Provider	**NTDB Element Number** N/A
NTRACS Field Name EMS Level of Provider	**NTDB Data Dictionary Page Number** N/A

Field Values

- EMT
- Advanced EMT
- Paramedic
- EMS Instructor
- Nurse
- Doctor
- First Responder (Unlicensed Pre-hospital Provider)
- Common null values

Additional Information

- This may not be located on the EMS Trip Form.

Data Source Hierarchy

1. EMS Run Sheet

References

EMS NOTIFY DATE

Data Format [date]

Definition

The date EMS was notified for the possibility of treating and/or transporting a patient

Required in ATR Yes	**Required in NTDB** No
Web Field Name EMS Notify Date	**NTDB Element Number** N/A
NTRACS Field Name EMS Notify Date	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum: 1990; Maximum: 2030
- Common null values

Additional Information

- Collected as MM-DD-YYYY

Data Source Hierarchy

1. EMS Run Sheet

References

EMS NOTIFY TIME

Data Format [time]

Definition

The time the unit was notified of the possibility of treating and/or transporting a patient

Required in ATR Yes	**Required in NTDB** No
Web Field Name EMS Notify Time	**NTDB Element Number** N/A
NTRACS Field Name EMS Notify Time	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time

Data Source Hierarchy

1. EMS Run Sheet

References

EMS DISPATCH DATE

Data Format [date]

Definition

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

- 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.

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name EMS Dispatch Date	**NTDB Element Number** P_01
NTRACS Field Name EMS Dispatch Date	**NTDB Data Dictionary Page Number** 38

Field Values

- Minimum: 1990; Maximum: 2030
- Common null values

Additional Information

- Collected as YYYY-MM-DD
- Used to auto-generate an additional calculated field: Total EMS Time (elapsed time from EMS dispatch to hospital arrival).

Data Source Hierarchy

1. EMS Run Sheet

References

EMS DISPATCH TIME

Data Format [time]

Definition

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

- For inter-facility transfer patients, this is the time at 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 time at which the unit transporting the patient to your facility from the scene was dispatched.

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name EMS Dispatch Time	**NTDB Element Number** P_02
NTRACS Field Name EMS Dispatch Time	**NTDB Data Dictionary Page Number** 39

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time
- Used to auto-generate an additional calculated field: Total EMS Time (elapsed time from EMS dispatch to hospital arrival).

Data Source Hierarchy

1. EMS Run Sheet

References

EMS RESPOND DATE

Data Format [date]

Definition

The date on which unit responded to the call

- For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility responded to the call.
- 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 responded.

Required in ATR Yes	**Required in NTDB** No
Web Field Name EMS Respond Date	**NTDB Element Number** N/A
NTRACS Field Name EMS Respond Date	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum: 1990; Maximum: 2030
- Common null values

Additional Information

- Collected as MM-DD-YYYY

Data Source Hierarchy

1. EMS Run Sheet

References

EMS RESPOND TIME

Data Format [time]

Definition

The time the unit responded to the call

- For inter-facility transfer patients, this is the time the unit transporting the patient to your facility from the transferring facility responded to the call.
- For patients transported from the scene of injury to your hospital, this is the time the unit transporting the patient to your facility from the scene responded.

Required in ATR Yes	**Required in NTDB** No
Web Field Name EMS Respond Time	**NTDB Element Number** N/A
NTRACS Field Name EMS Respond Time	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time

Data Source Hierarchy

1. EMS Run Sheet

References

EMS UNIT ARRIVAL DATE

Data Format [date]

Definition

The date the unit transporting to your hospital arrived on the scene/transferring facility (the time the vehicle stopped moving)

- 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 as 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.)

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name EMS Unit Arrival Date	**NTDB Element Number** P_03
NTRACS Field Name EMS Unit Arrival Date	**NTDB Data Dictionary Page Number** 40

Field Values

- Minimum: 1990; Maximum: 2030
- Common null values

Additional Information

- Collected as MM-DD-YYYY
- Used to auto-generate two additional calculated fields: Total EMS Response Time (elapsed time from EMS dispatch to scene arrival) and Total EMS Scene Time (elapsed time from EMS scene arrival to scene departure).

Data Source Hierarchy

1. EMS Run Sheet

References

EMS UNIT ARRIVAL TIME

Data Format [time]

Definition

The time the unit transporting to your hospital arrived on the scene/transferring facility (the time the vehicle stopped moving)

- For inter-facility transfer patients, this is the time the unit transporting the patient to your facility from the transferring facility arrived at the transferring facility. (Arrival is defined as date/time when the vehicle stopped moving.)
- For patients transported from the scene of injury to your hospital, this is the time 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.)

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name EMS Unit Arrival Time	**NTDB Element Number** P_04
NTRACS Field Name EMS Unit Arrival Time	**NTDB Data Dictionary Page Number** 41

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time
- Used to auto-generate two additional calculated fields: Total EMS Response Time (elapsed time from EMS dispatch to scene arrival) and Total EMS Scene Time (elapsed time from EMS scene arrival to scene departure).

Data Source Hierarchy

1. EMS Run Sheet

References

EMS DEPARTURE DATE

Data Format [date]

Definition

The date the unit transporting to your hospital departed from the scene/transferring facility (the time the vehicle started moving)

- For inter-facility transfer patients, this is the date the unit transporting the patient to your facility from the transferring facility departed from the transferring facility. (Departure is defined as date/time when the vehicle started moving.)
- For patients transported from the scene of injury to your hospital, this is the date the unit transporting the patient to your facility from the scene departed from the scene. (Departure is defined as date/time when the vehicle started moving.)

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name EMS Departure Date	**NTDB Element Number** P_05
NTRACS Field Name EMS Departure Date	**NTDB Data Dictionary Page Number** 42

Field Values

- Minimum: 1990; Maximum: 2030
- Common null values

Additional Information

- Collected as MM-DD-YYYY

Data Source Hierarchy

1. EMS Run Sheet

References

EMS DEPARTURE TIME

Data Format [time]

Definition

The time the unit *transporting to your hospital* departed from the scene/transferring facility (the time the vehicle started moving)

- For inter-facility transfer patients, this is the time the unit transporting the patient to your facility from the transferring facility departed from the transferring facility. (Departure is defined as date/time when the vehicle started moving.)
- For patients transported from the scene of injury to your hospital, this is the time the unit transporting the patient to your facility from the scene departed from the scene. (Departure is defined at date/time when the vehicle started moving.)

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name EMS Departure Time	**NTDB Element Number** P_06
NTRACS Field Name EMS Departure Time	**NTDB Data Dictionary Page Number** 43

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time
- Used to auto-generate an additional calculated field: Total EMS Time (elapsed time from EMS dispatch to hospital arrival).

Data Source Hierarchy

1. EMS Run Sheet

References

EMS ARRIVAL DESTINATION DATE

Data Format [date]

Definition

The date unit arrived at its specific destination

Required in ATR Yes	**Required in NTDB** No
Web Field Name EMS Arrival Destination Date	**NTDB Element Number** N/A
NTRACS Field Name	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum: 1990; Maximum: 2030
- Common null values

Additional Information

- Collected as MM-DD-YYYY

Data Source Hierarchy

1. EMS Run Sheet

References

EMS ARRIVAL DESTINATION TIME

Data Format [time]

Definition

The time at which unit arrived at its specific destination

Required in ATR Yes	**Required in NTDB** No
Web Field Name EMS Arrival Destination Time	**NTDB Element Number** N/A
NTRACS Field Name	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time

Data Source Hierarchy

1. EMS Run Sheet

References

REASON FOR DESTINATION HOSPITAL

Data Format [character]

Definition

Major reason for transferring the patient to the specified hospital

Required in ATR Yes	**Required in NTDB** No
Web Field Name Reason For Destination Hospital	**NTDB Element Number** N/A
NTRACS Field Name	**NTDB Data Dictionary Page Number** N/A

Field Values

- Protocol
- Insurance
- Specialty Care/Higher Level Care
- Resources Unavailable (Beds, Equipment, Staff, MD)
- Patient Request
- Patient's Physician
- Family Request
- Law Enforcement
- Online Medical Direction
- Lower Level of Care
- Common null values

Additional Information

Data Source Hierarchy

1. EMS Run Sheet

References

SCENE RELATED DELAYS

Data Format [character]

Definition

Reason(s) for delay in transferring the patient

Required in ATR Yes	**Required in NTDB** No
Web Field Name Scene Related Delays	**NTDB Element Number** N/A
NTRACS Field Name	**NTDB Data Dictionary Page Number** N/A

Field Values

- Crowd
- Directions
- Distance
- Diversion
- Extrication > than 15 minutes
- HazMat
- Language Barrier
- Terrain
- Equipment
- Safety
- Staff Delay
- Traffic
- Vehicle Crash
- Vehicle Failure
- Weather
- Multiple Patients
- Other
- Common null values

Additional Information

- Pick list available

Data Source Hierarchy

1. EMS Run Sheet

References

INITIAL FIELD SYSTOLIC BLOOD PRESSURE

Data Format [number]

Definition

The first recorded systolic blood pressure measured at the scene of injury.

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name SBP	**NTDB Element Number** P_09
NTRACS Field Name SBP	**NTDB Data Dictionary Page Number** 46

Field Values

- Field value range 0-300
- Common null values

Additional Information

- The null value “Not Known/Not Recorded” is used if the patient is transferred to your facility with no EMS run sheet from the scene of injury.

Data Source Hierarchy

1. EMS Run Sheet

References

INITIAL FIELD PULSE RATE

Data Format [number]

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Pulse Rate	**NTDB Element Number** P_10
NTRACS Field Name Pulse Rate	**NTDB Data Dictionary Page Number** 47

Field Values

- Field value range 0-299
- Common null values

Additional Information

- The null value “Not Known/Not Recorded” is used if the patient is transferred to your facility with no EMS run sheet from the scene of injury.

Data Source Hierarchy

1. EMS Run Sheet

References

INITIAL FIELD RESPIRATORY RATE

Data Format [number]

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Respiration Rate	**NTDB Element Number** P_11
NTRACS Field Name Respiratory Rate	**NTDB Data Dictionary Page Number** 48

Field Values

- Field value range 0-120
- Common null values

Additional Information

- The null value “Not Known/Not Recorded” is used if the patient is transferred to your facility with no EMS run sheet from the scene of injury.

Data Source Hierarchy

1. EMS Run Sheet

References

INITIAL FIELD RESPIRATORY ASSISTANCE

Data Format [logic]

Definition

The presence of mechanical and/or external support of respiration

Required in ATR Yes	**Required in NTDB** No
Web Field Name Respiration Assistance	**NTDB Element Number** N/A
NTRACS Field Name	**NTDB Data Dictionary Page Number** N/A

Field Values

- Yes
- No
- Common null values

Additional Information

Data Source Hierarchy

1. EMS Run Sheet

References

INITIAL FIELD OXYGEN SATURATION

Data Format [number]

Definition

The first recorded oxygen saturation measured at the scene of injury (expressed as a percentage)

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Oxygen Saturation	**NTDB Element Number** P_12
NTRACS Field Name Oxygen Saturation	**NTDB Data Dictionary Page Number** 49

Field Values

- Field value range 0-100
- Common null values

Additional Information

- The null value “Not Known/Not Recorded” is used if the patient is transferred to your facility with no EMS run sheet from the scene of injury.
- Value should be based upon assessment before administration of supplemental oxygen.

Data Source Hierarchy

1. EMS Run Sheet

References

INITIAL FIELD SUPPLEMENTAL OXYGEN

Data Format [logic]

Definition

The use of a storage tank of oxygen or a machine which provides an extra supply of oxygen to the patient

Required in ATR Yes	**Required in NTDB** No
Web Field Name Supplemental Oxygen	**NTDB Element Number** N/A
NTRACS Field Name	**NTDB Data Dictionary Page Number** N/A

Field Values

- Supplemental oxygen
- No supplemental oxygen
- Common null values

Additional Information

Data Source Hierarchy

1. EMS Run Sheet

References

INITIAL FIELD GCS - EYE

Data Format [number]

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name GCS Eye	**NTDB Element Number** P_13
NTRACS Field Name Eye	**NTDB Data Dictionary Page Number** 50

Field Values

- No eye movement when assessed
- Opens eyes in response to painful stimulation
- Opens eyes in response to verbal stimulation
- Opens eyes spontaneously
- Common null values

Additional Information

- Used to calculate overall GCS – EMS Score
- The null value “Not Known/Not Recorded” is used if the patient is transferred to your facility with no EMS run sheet from the scene of injury.
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation.

Data Source Hierarchy

1. EMS Run Sheet

References

- Adult: Glasgow Coma Scale, as quoted by Champion, Sacco, and Copes, “Trauma Scoring”, Trauma, edited by Feliciano, Moore, and Mattox, ed. 3, Stamford, CT, Appleton and Lange, 1996

- Pediatric: Modified from Davis RJ et al: head and Spinal Cord Injury. In: Rogers MC, Textbook of Pediatric Intensive Care, Baltimore, MD, Williams and Wilkins, 1987

INITIAL FIELD GCS - VERBAL

Data Format [number]

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name GCS Verbal	**NTDB Element Number** P_14
NTRACS Field Name Verbal	**NTDB Data Dictionary Page Number** 51

Field Values

- Adult
  - No verbal response
  - Incomprehensible sounds
  - Inappropriate words
  - Confused
  - Oriented
  - Common null values

- Pediatric (<= 2 years old)
  - No vocal response
  - Inconsolable, agitated
  - Inconsistently consolable, moaning
  - Cries, but is consolable, inappropriate interactions
  - Smiles, oriented to sounds, follows objects, interacts
  - Common null values

Additional Information

- Used to calculate overall GCS – EMS Score
- The null value “Not Known/Not Recorded” is used if the patient is transferred to your facility with no EMS run sheet from the scene of injury.
- If patient is intubated then the GCS Verbal score is equal to 1.
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation.

Data Source Hierarchy

1. EMS Run Sheet

References

- Adult: Glasgow Coma Scale, as quoted by Champion, Sacco, and Copes, “Trauma Scoring”, Trauma, edited by Feliciano, Moore, and Mattox, ed. 3, Stamford, CT, Appleton and Lange, 1996

- Pediatric: Modified from Davis RJ et al: head and Spinal Cord Injury. In: Rogers MC, Textbook of Pediatric Intensive Care, Baltimore, MD, Williams and Wilkins, 1987.

INITIAL FIELD GCS - MOTOR

Data Format [number]

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name GCS Motor	**NTDB Element Number** P_15
NTRACS Field Name Motor	**NTDB Data Dictionary Page Number** 52

Field Values

- Adult
  - No motor response
  - Extension to pain
  - Flexion to pain
  - Withdrawal from pain
  - Localizing pain
  - Obeys commands
  - Common null values

- Pediatric (<= 2 years old)
  - No motor response
  - Extension to pain
  - Flexion to pain
  - Withdrawal from pain
  - Localizing pain
  - Appropriately responds to stimulation
  - Common null values

Additional Information

- Used to calculate overall GCS – EMS Score
- The null value “Not Known/Not Recorded” is used if the patient is transferred to your facility with no EMS run sheet from the scene of injury.
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation..

Data Source Hierarchy

1. EMS Run Sheet

References

- Adult: Glasgow Coma Scale, as quoted by Champion, Sacco, and Copes, “Trauma Scoring”, Trauma, edited by Feliciano, Moore, and Mattox, ed. 3, Stamford, CT, Appleton and Lange, 1996

- Pediatric: Modified from Davis RJ et al: head and Spinal Cord Injury. In: Rogers MC, Textbook of Pediatric Intensive Care, Baltimore, MD, Williams and Wilkins, 1987

INITIAL FIELD GCS - TOTAL

Data Format [number]

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name GCS Total	**NTDB Element Number** P_16
NTRACS Field Name Total	**NTDB Data Dictionary Page Number** 53

Field Values

- Relevant value for data element, minimum 3, maximum 15
- Common null values

Additional Information

- Used to calculate overall GCS – EMS Score
- If the patient is transferred to your facility with no EMS run sheet from the scene of injury, record as *Not Known/Not Recorded*.
- 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

Data Source Hierarchy

1. EMS Run Sheet

References

- Adult: Glasgow Coma Scale, as quoted by Champion, Sacco, and Copes, “Trauma Scoring”, Trauma, edited by Feliciano, Moore, and Mattox, ed. 3, Stamford, CT, Appleton and Lange, 1996

- Pediatric: Modified from Davis RJ et al: head and Spinal Cord Injury. In: Rogers MC, Textbook of Pediatric Intensive Care, Baltimore, MD, Williams and Wilkins, 1987

INITIAL FIELD GCS ASSESSMENT QUALIFIERS

Data Format [character]

Definition

Documentation of factors potentially affecting the first assessment of GCS upon arrival at the scene of injury

Required in ATR Yes	**Required in NTDB** No
Web Field Name GCS Assessment Qualifiers	**NTDB Element Number** N/A
NTRACS Field Name	**NTDB Data Dictionary Page Number** N/A

Field Values

- Patient intubated
- Obstruction to the patient's eye
- Patient chemically sedated
- Common null values

Additional Information

- Pick list available
- Check all that apply.
- While identifying treatments given to the patient that may affect the first assessment of GCS, this field does not apply to self-medications the patient may have administered (i.e., ETOH, prescriptions, etc.).
- *If the patient was not chemically sedated, intubated, and did not have eye obstruction then code as Not Applicable*.

Data Source Hierarchy

1. EMS Run Sheet

References

TRAUMA CENTER CRITERIA

Data Format [character]

Definition

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

Required in ATR Yes	**Required in NTDB** YES
Web Field Name Trauma Center Criteria	**NTDB Element Number** P_18
NTRACS Field Name Trauma Center Criteria	**NTDB Data Dictionary Page Number** 55

Field Values

- Glasgow Coma Score < 14
- Systolic blood pressure < 90 mmHg
- Respiratory rate <10 or >29 breaths per minute (<20 in infants aged <1 year) or need for ventilator support.
- All penetrating injuries to head, neck torso, and extremities proximal to elbow or knee
- Chest wall instability or deformity (e.g., flail chest)
- Two or more proximal long-bone fractures
- Crushed, degloved, mangled, or pulseless extremity
- Amputation proximal to wrist or ankle
- Pelvic fracture
- Open or depressed skull fracture
- Paralysis

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 Sheet indicates patient did not meet any Trauma Center Criteria.
- The null value “Not Known/Not Recorded” should be used if this information is not indicated on the EMS Run Sheet or if the EMS Run Sheet is not available.
- Check all that apply

Data Source Hierarchy

1. EMS Run Sheet

References

VEHICULAR, PEDESTRIAN, OTHER RISK INJURY

Data Format [character]

Definition

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

Required in ATR Yes	**Required in NTDB** YES
Web Field Name Vehicular, Pedestrian, Other Risk	**NTDB Element Number** P_19
NTRACS Field Name Vehicular, Pedestrian, Other Risk	**NTDB Data Dictionary Page Number** 56

Field Values

- Fall adults: > 20 ft. (one story is equal to 10 ft.)
- Fall children: > 10 ft. or 2-3 times the height of the child
- Crash intrusion, including roof: > 12 in. occupant site; > 18 in. any site
- Crash ejection (partial or complete) from vehicle
- Crash death in same passenger compartment
- Crash vehicle telemetry data (AACN) consistent with high risk injury
- Auto v. pedestrian/bicyclist thrown, run over, or > 20 MPH impact
- Motorcycle crash > 20 MPH

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 Sheet indicates patient did not meet any Trauma Center Criteria.
- The null value “Not Known/Not Recorded” should be used if this information is not indicated on the EMS Run Sheet or if the EMS Run Sheet is not available.
- Check all that apply

Data Source Hierarchy

1. EMS Run Sheet

References

REFERRING FACILITY

INTERFACILITY TRANSFER

Data Format [logic]

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Inter-facility Transfer	**NTDB Element Number** P_17
NTRACS Field Name Inter-facility Transfer	**NTDB Data Dictionary Page Number** 54

Field Values

- Y – Yes, indicates that the patient was transferred to this hospital from another acute care hospital.
- N – No, indicates that the patient was NOT transferred to this hospital from another hospital OR the patient was transferred to this hospital from a doctor's office, clinic, or stand-alone ambulatory surgery center.
- Common null values

Additional Information

- Patients transferred from a private doctor's office, stand-alone ambulatory surgery center, or delivered to your hospital by a non-EMS transport are not considered an inter-facility transfer.
- Outlying facilities purporting to provide emergency care services or utilized to stabilize a patient are considered acute care facilities.

Data Source Hierarchy

1. EMS Run Sheet

References

REFERRING HOSPITAL

Data Format [combo] single-choice

Definition

Referring hospital's name

Required in ATR Yes	**Required in NTDB** No
Web Field Name Referring Hospital	**NTDB Element Number** N/A
NTRACS Field Name Referring Hospital	**NTDB Data Dictionary Page Number** N/A

Field Values

- Relevant value for field

Additional Information

- Complete only if the patient was transferred from another acute care hospital to your hospital.
- Choose from listed facilities.

Data Source Hierarchy

1. ED Discharge/Transfer Sheet
2. EMS Run Sheet

References

TRANSFER MODE

Data Format [text]

Definition

Indicator of the mode of transport to the referring hospital

Required in ATR Yes	**Required in NTDB** No
Web Field Name Transfer Mode	**NTDB Element Number** N/A
NTRACS Field Name	**NTDB Data Dictionary Page Number** N/A

Field Values

- Basic Life Support and Ground Ambulance (Class 1-A and Class 1-B)
- Advanced Life Support Ground Ambulance (Advance EMT or Paramedic)
- Helicopter Ambulance
- Fixed-Wing Ambulance
- Private/Public Vehicle/Walk-in
- Police
- Specialty Air Transport (does not include Fixed-Wing)
- Specialty Ground Transport
- Other
- Common null values

Additional Information

- Pick list available

Data Source Hierarchy

1. EMS Run Sheet

References

REFERRING HOSPITAL ARRIVAL DATE

Data Format [date]

Definition

The date the patient arrived at the referring hospital

Required in ATR Yes	**Required in NTDB** No
Web Field Name Arrival Date	**NTDB Element Number** N/A
NTRACS Field Name Arrival Date	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum: 1990; Maximum: 2030
- Common null values

Additional Information

- Collected as MM-DD-YYYY

Data Source Hierarchy

1. ED Discharge/Transfer Sheet
2. EMS Run Sheet

References

REFERRING HOSPITAL ARRIVAL TIME

Data Format [time]

Definition

Time the patient arrived at the referring hospital

Required in ATR Yes	**Required in NTDB** No
Web Field Name Arrival Time	**NTDB Element Number** N/A
NTRACS Field Name Arrival Time	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time

Data Source Hierarchy

1. ED Discharge/Transfer Sheet
2. EMS Run Sheet

References

REFERRING HOSPITAL DISCHARGE DATE

Data Format [date]

Definition

The date the patient was discharged from the referring facility

Required in ATR Yes	**Required in NTDB** No
Web Field Name Discharge Date	**NTDB Element Number** N/A
NTRACS Field Name Discharge Date	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum: 1990; Maximum: 2030
- Common null values

Additional Information

- Collected as MM-DD-YYYY

Data Source Hierarchy

1. ED Discharge/Transfer Sheet
2. EMS Run Sheet

References

REFERRING HOSPITAL DISCHARGE TIME

Data Format [time]

Definition

The time the patient was discharged from the referring facility

Required in ATR Yes	**Required in NTDB** No
Web Field Name Discharge Time	**NTDB Element Number** N/A
NTRACS Field Name Discharge Time	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time

Data Source Hierarchy

1. ED Discharge/Transfer Sheet
2. EMS Run Sheet

References

REFERRING HOSPITAL SYSTOLIC BLOOD PRESSURE

Data Format [number]

Definition

First recorded systolic blood pressure measured in the referring hospital

Required in ATR Yes	**Required in NTDB** No
Web Field Name SBP	**NTDB Element Number** N/A
NTRACS Field Name Sys BP	**NTDB Data Dictionary Page Number** N/A

Field Values

- Field value range 0-300
- Common null values

Additional Information

- If the patient was transferred to you without an ED Discharge/Transfer sheet, record as *Not Known/Not Recorded.*

Data Source Hierarchy

1. ED Discharge/Transfer Sheet

References

REFERRING HOSPITAL PULSE RATE

Data Format [number]

Definition

First recorded pulse measured in the referring hospital (palpated or auscultated), expressed as number per minute

Required in ATR Yes	**Required in NTDB** No
Web Field Name Pulse Rate	**NTDB Element Number** N/A
NTRACS Field Name Pulse	**NTDB Data Dictionary Page Number** N/A

Field Values

- Field value range 0-299
- Common null values

Additional Information

- If the patient was transferred to you without an ED Discharge/Transfer sheet, record as *Not Known/Not Recorded.*

Data Source Hierarchy

1. ED Discharge/Transfer Sheet

References

REFERRING HOSPITAL RESPIRATION RATE

Data Format [number]

Definition

First respiratory rate recorded at the referring hospital (expressed as number per minute)

Required in ATR Yes	**Required in NTDB** No
Web Field Name Respiration Rate	**NTDB Element Number** N/A
NTRACS Field Name Respiration Rate	**NTDB Data Dictionary Page Number** N/A

Field Values

- Field value range 0-99
- Common null values

Additional Information

- If the patient was transferred to you without an ED Discharge/Transfer sheet, record as *Not Known/Not Recorded.*

Data Source Hierarchy

1. ED Discharge/Transfer Sheet

References

REFERRING HOSPITAL GCS - EYE

Data Format [combo] single-choice

Definition

First recorded GCS – Eye measured at the referring hospital ED

Required in ATR Yes	**Required in NTDB** No
Web Field Name GCS: Eye	**NTDB Element Number** N/A
NTRACS Field Name Eye	**NTDB Data Dictionary Page Number** N/A

Field Values

- No eye movement when assessed
- Opens eyes in response to painful stimulation
- Opens eyes in response to verbal stimulation
- Opens eyes spontaneously
- Common null values

Additional Information

- Used to calculate Overall GCS Score
- If the patient was transferred to you without an ED Discharge/Transfer sheet, record as *Not Known/Not Recorded.*
- If a patient does not have a numeric GCS score recorded, but there is written documentation closely (or directly) related to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g., if the chart indicates “patient withdraws from a painful stimulus,” a Motor GCS may be recorded, IF there is no other contradicting documentation.

Data Source Hierarchy

1. ED Discharge/Transfer Sheet

References

REFERRING HOSPITAL GCS - VERBAL

Data Format [combo] single-choice

Definition

First recorded GCS – Verbal measured at the referring hospital ED

Required in ATR Yes	**Required in NTDB** No
Web Field Name GCS: Verbal	**NTDB Element Number** N/A
NTRACS Field Name Verbal	**NTDB Data Dictionary Page Number** N/A

Field Values

- Adult
  - No verbal response
  - Incomprehensible sounds
  - Inappropriate words
  - Confused
  - Oriented
  - Common null values

- Pediatric (<= 2 years old)
  - No vocal response
  - Inconsolable, agitated
  - Inconsistently consolable, moaning
  - Cries, but is consolable, inappropriate interactions
  - Smiles, oriented to sounds, follows objects, interacts
  - Common null values

Additional Information

- Used to calculate Overall GCS Score
- If the patient was transferred to you without an ED Discharge/Transfer sheet, record as *Not Known/Not Recorded.*
- If a patient does not have a numeric GCS score recorded, but there is written documentation closely (or directly) related to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g., if the chart indicates “patient withdraws from a painful stimulus,” a Motor GCS may be recorded, IF there is no other contradicting documentation.

Data Source Hierarchy

1. ED Discharge/Transfer Sheet

References

REFERRING HOSPITAL GCS - MOTOR

Data Format [combo] single-choice

Definition

First recorded GCS – Motor measured at the referring hospital ED

Required in ATR Yes	**Required in NTDB** No
Web Field Name GCS: Motor	**NTDB Element Number** N/A
NTRACS Field Name Motor	**NTDB Data Dictionary Page Number** N/A

Field Values

- Adult
  - No motor response
  - Extension to pain
  - Flexion to pain
  - Withdrawal from pain
  - Localizing pain
  - Obeys commands
  - Common null values

- Pediatric (<= 2 years old)
  - No motor response
  - Extension to pain
  - Flexion to pain
  - Withdrawal from pain
  - Localizing pain
  - Appropriately responds to stimulation
  - Common null values

Additional Information

- Used to calculate Overall GCS Score
- If the patient was transferred to you without an ED Discharge/Transfer sheet, record as *Not Known/Not Recorded.*
- If a patient does not have a numeric GCS score recorded, but there is written documentation closely (or directly) related to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g., if the chart indicates “patient withdraws from a painful stimulus,” a Motor GCS may be recorded, IF there is no other contradicting documentation.

Data Source Hierarchy

1. ED Discharge/Transfer Sheet

References

REFERRING HOSPITAL GCS - TOTAL

Data Format [number]

Definition

First recorded GCS – Motor measured at the referring hospital ED

Required in ATR Yes	**Required in NTDB** No
Web Field Name GCS: Total	**NTDB Element Number** N/A
NTRACS Field Name Calculated GCS	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum: 3; Maximum: 15
- Common null values

Additional Information

- If the patient was transferred to you without an ED Discharge/Transfer sheet, record as *Not Known/Not Recorded.*
- If the three GCS components are completed, the relevant value will be auto-calculated. If the three component values are Not Known/Not Recorded, but a total is provided, it may be entered into the field.

Data Source Hierarchy

1. ED Discharge/Transfer Sheet

References

EMERGENCY DEPARTMENT INFORMATION

ED ARRIVED FROM

Data Format [combo] single choice

Definition

The location of the patient before their transport to your hospital

Required in ATR Yes	**Required in NTDB** No
Web Field Name Arrived From	**NTDB Element Number** N/A
NTRACS Field Name Arrived From	**NTDB Data Dictionary Page Number** N/A

Field Values

- Doctor's office
- Clinic
- Stand-alone ambulatory surgery center
- Acute care hospital
- Scene of injury
- Other
- Home
- Jail
- Common null vales

Additional Information

Data Source Hierarchy

1. Billing Sheet/Medical Records Coding Summary Sheet
2. ED Records
3. Triage Form/Trauma Flow Sheet
4. Hospital Discharge Summary

References

ED ARRIVAL MODE

Data Format [combo] single-choice

Definition

Indicator of the mode of transport to the ED

Required in ATR Yes	**Required in NTDB** No
Web Field Name Mode	**NTDB Element Number** N/A
NTRACS Field Name Transport	**NTDB Data Dictionary Page Number** N/A

Field Values

- Basic Life Support and Ground Ambulance (Class 1-A and Class 1-B)
- Advance Life Support Ground Ambulance (Advance EMT or Paramedic)
- Helicopter Ambulance
- Fixed-Wing Ambulance
- Private/Public Vehicle/Walk-in
- Police
- Specialty Air Transport (does not include Fixed-Wing)
- Specialty Ground Transport
- Other
- Common null values

Additional Information

Data Source Hierarchy

1. Billing Sheet/Medical Records Coding Summary Sheet
2. ED Records
3. Triage Form/Trauma Flow Sheet
4. Hospital Discharge Summary

References

ED DIRECT ADMIT

Data Format [checkbox]

Definition

Identifies a patient who was admitted to the hospital without going through the ED

Required in ATR Yes	**Required in NTDB** No
Web Field Name Direct Admit	**NTDB Element Number** N/A
NTRACS Field Name Direct Admit	**NTDB Data Dictionary Page Number** N/A

Field Values

- Yes
- No

Additional Information

- Null values are not accepted for this variable.

Data Source Hierarchy

1. Billing Sheet/Medical Records Coding Summary Sheet
2. ED Records
3. Triage Form/Trauma Flow Sheet
4. Hospital Discharge Summary

References

ED READMISSION

Data Format [checkbox]

Definition

Indicator that the patient was readmitted to the hospital for follow-up care from a trauma

Required in ATR Yes	**Required in NTDB** No
Web Field Name Readmission	**NTDB Element Number** N/A
NTRACS Field Name	**NTDB Data Dictionary Page Number** N/A

Field Values

- Relevant value for data element

Additional Information

- Null values are not accepted for this variable.

Data Source Hierarchy

1. Billing Sheet/Medical Records Coding Summary Sheet
2. ED Records
3. Triage Form/Trauma Flow Sheet
4. Hospital Discharge Summary

References

ED/HOSPITAL ARRIVAL DATE

Data Format [date]

Definition

The date the patient arrived at the ED/hospital

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name ED Arrival Date	**NTDB Element Number** ED_01
NTRACS Field Name Arrival/Admit Date	**NTDB Data Dictionary Page Number** 58

Field Values

- Minimum: 1990; Maximum: 2030
- Common null values

Additional Information

- If the patient was brought to the ED, enter date patient arrived at ED. If the patient was directly admitted to the hospital, enter date patient was admitted to the hospital.
- Collected as MM/DD/YYYY
- Used to auto-generate two additional calculated fields: Total EMS Time (elapsed time from EMS dispatch to hospital arrival) and Total Length of Hospital Stay (elapsed time from ED/Hospital Arrival to ED/Hospital Discharge)

Data Source Hierarchy

1. Triage Form/Trauma Flow Sheet
2. ED Records
3. Billing Sheet/Medical Records Coding Summary Sheet
4. Hospital Discharge Summary

References

ED/HOSPITAL ARRIVAL TIME

Data Format [time]

Definition

The time the patient arrived at the ED/hospital

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name ED Arrival Time	**NTDB Element Number** ED_02
NTRACS Field Name Arrival/Admit Time	**NTDB Data Dictionary Page Number** 59

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- If the patient was brought to the ED, enter time patient arrived at ED. If the patient was directly admitted to the hospital, enter time patient was admitted to the hospital.
- Collected as HH:MM, military time
- Used to auto-generate two additional calculated fields: Total EMS Time (elapsed time from EMS dispatch to hospital arrival) and Total Length of Hospital Stay (elapsed time from ED/Hospital Arrival to ED/Hospital Discharge)

Data Source Hierarchy

1. Triage Form/Trauma Flow Sheet
2. ED Records
3. Billing Sheet/Medical Records Coding Summary Sheet
4. Hospital Discharge Summary

References

INITIAL ED/HOSPITAL SYSTOLIC BLOOD PRESSURE

Data Format [number]

Definition

First recorded systolic blood pressure in the ED/hospital

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name SBP	**NTDB Element Number** ED_03
NTRACS Field Name SBP	**NTDB Data Dictionary Page Number** 60

Field Values

- Field value range 0-300
- Common null values

Additional Information

- Please note that first recorded/hospital vitals do not need to be from the same assessment.

Data Source Hierarchy

1. Triage Form/Trauma Flow Sheet
2. ED Records
3. Nurses Notes

References

INITIAL ED/HOSPITAL PULSE RATE

Data Format [number]

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Pulse Rate	**NTDB Element Number** ED_04
NTRACS Field Name Pulse	**NTDB Data Dictionary Page Number** 61

Field Values

- Field value range 0-299
- Common null values

Additional Information

- Please note that first recorded/hospital vitals do not need to be from the same assessment.

Data Source Hierarchy

1. Triage Form/Trauma Flow Sheet
2. ED Records
3. Nurses Notes

References

INITIAL ED/HOSPITAL TEMPERATURE

Data Format [number]

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Temperature	**NTDB Element Number** ED_05
NTRACS Field Name Temp	**NTDB Data Dictionary Page Number** 62

Field Values

- Minimum constraint: 0.0; Maximum constraint: 45.0
- Common null values

Additional Information

- Please note that first recorded/hospital vitals do not need to be from the same assessment.

Data Source Hierarchy

1. Triage Form/Trauma Flow Sheet
2. ED Records
3. Nurses Notes

References

TEMPERATURE UNITS

Data Format [combo] single choice

Definition

Indicator of whether the temperature was captured in Fahrenheit or Celsius (centigrade)

Required in ATR Yes	**Required in NTDB** No
Web Field Name Units	**NTDB Element Number** N/A
NTRACS Field Name N/A	**NTDB Data Dictionary Page Number** N/A

Field Values

- Relevant value for data element
- Common null values

Additional Information

- Variable is captured only in the web registry.

Data Source Hierarchy

1. Triage Form/Trauma Flow Sheet
2. ED Records

References

INITIAL ED/HOSPITAL RESPIRATORY RATE

Data Format [number]

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Respiration Rate	**NTDB Element Number** ED_06
NTRACS Field Name Respiration Rate	**NTDB Data Dictionary Page Number** 63

Field Values

- Minimum constraint: 0; Maximum constraint: 120
- Common null values

Additional Information

- *If available, complete additional field: "Initial ED/Hospital Respiratory Assistance."*
- Please note that first recorded hospital vitals do not need to be from the same assessment.

Data Source Hierarchy

1. Triage Form/Trauma Flow Sheet
2. ED Records
3. Nurses Notes

References

INITIAL ED/HOSPITAL RESPIRATORY ASSISTANCE

Data Format [combo] single-choice

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Respiratory Assistance	**NTDB Element Number** ED_07
NTRACS Field Name Respiratory Assistance	**NTDB Data Dictionary Page Number** 64

Field Values

- Web
  - Yes
  - No
  - Common null values

- NTRACS
  - Unassisted Respiratory Rate
  - Assisted Respiratory Rate
  - Common null values

Additional Information

- Only complete if a value is provided for “Initial ED/Hospital Respiratory Rate”.
- Respiratory Assistance is defined as mechanical and/or external support of respiration.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.

Data Source Hierarchy

1. Triage Form/Trauma Flow Sheet
2. ED Records
3. Nurses Notes

References

INITIAL ED/HOSPITAL OXYGEN SATURATION

Data Format [number]

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Oxygen Saturation	**NTDB Element Number** ED_08
NTRACS Field Name Oxygen Saturation	**NTDB Data Dictionary Page Number** 65

Field Values

- Minimum constraint: 0; Maximum constraint: 100
- Common null values

Additional Information

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

Data Source Hierarchy

1. Triage Form/Trauma Flow Sheet
2. ED Records
3. Nurses Notes

References

INITIAL ED/HOSPITAL SUPPLEMENTAL OXYGEN

Data Format [combo] single-choice

Definition

Determination of the presence of supplemental oxygen during assessment of initial ED/hospital oxygen saturation level

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Supplemental Oxygen	**NTDB Element Number** ED_09
NTRACS Field Name Supplemental Oxygen	**NTDB Data Dictionary Page Number** 66

Field Values

- No supplemental oxygen
- Supplemental oxygen
- Common null values

Additional Information

- Only completed if a value is provided for “Initial ED/Hospital Oxygen Saturation”
- Please note that first recorded/hospital vitals do not need to be from the same assessment

Data Source Hierarchy

1. Triage Form/Trauma Flow Sheet
2. ED Records
3. Nurses Notes

References

INITIAL ED/HOSPITAL HCT (HEMATOCRIT)

Data Format [number]

Definition

First recorded hematocrit in the ED/hospital (expressed as a percentage)

Required in ATR Yes	**Required in NTDB** No
Web Field Name HCT	**NTDB Element Number** N/A
NTRACS Field Name HCT	**NTDB Data Dictionary Page Number** N/A

Field Values

- Field value range 0-99
- Common null values

Additional Information

Data Source Hierarchy

1. Triage Form/Trauma Flow Sheet
2. ED Records

References

INITIAL ED/HOSPITAL BASE DEFICIT

Data Format [number]

Definition

First recorded base deficit measured in the ED/hospital

Required in ATR Yes	**Required in NTDB** No
Web Field Name Base Deficit	**NTDB Element Number** N/A
NTRACS Field Name Base Deficit	**NTDB Data Dictionary Page Number** N/A

Field Values

- Relevant value for data element
- Common null values

Additional Information

- Field accepts positive and negative values.

Data Source Hierarchy

1. Triage Form/Trauma Flow Sheet
2. ED Records

References

INITIAL ED/HOSPITAL HEIGHT

Data Format [number]

Definition

First recorded height of patient in ED/hospital

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Height	**NTDB Element Number** ED_15
NTRACS Field Name Height	**NTDB Data Dictionary Page Number** 72

Field Values

- Minimum constraint: 0; Maximum constraint: 244
- Common null values

Additional Information

- May be captured in centimeters
- May be based on family or self-report.
- In Web Registry, additional variable “Height Units” must be completed.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.

Data Source Hierarchy

1. Triage Form/Trauma Flow Sheet
2. ED Records
3. EMS Run Sheet
4. Nurses Notes
5. Self-report
6. Family report

References

INITIAL ED/HOSPITAL HEIGHT UNITS

Data Format [combo] single-choice

Definition

Indicator of whether the height was captured in centimeters or inches

Required in ATR Yes	**Required in NTDB** No
Web Field Name Units	**NTDB Element Number** N/A
NTRACS Field Name	**NTDB Data Dictionary Page Number** N/A

Field Values

- Centimeters
- Inches
- Common null values

Additional Information

- In Web Registry, only completed if a value is provided for “Height”

Data Source Hierarchy

1. Triage Form/Trauma Flow Sheet
2. ED Records

References

INITIAL ED/HOSPITAL WEIGHT

Data Format [number]

Definition

First recorded weight of patient in ED/hospital

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Weight	**NTDB Element Number** ED_16
NTRACS Field Name Weight	**NTDB Data Dictionary Page Number** 73

Field Values

- Minimum constraint: 0; Maximum constraint: 907 (kg)
- Common null values

Additional Information

- Recorded in kilograms (kg)
- In Web Registry, additional variable “Weight Units” must be completed.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.

Data Source Hierarchy

1. Triage Form/Trauma Flow Sheet
2. ED Records
3. EMS Run Sheet
4. Nurses Notes
5. Self-report
6. Family report

References

INITIAL ED/HOSPITAL WEIGHT UNITS

Data Format [combo] single-choice

Definition

Indicator of whether the weight was captured in pounds (lb) or kilograms (kg)

Required in ATR Yes	**Required in NTDB** No
Web Field Name Units	**NTDB Element Number** N/A
NTRACS Field Name	**NTDB Data Dictionary Page Number** N/A

Field Values

- lb
- kg
- Common null values

Additional Information

- In Web Registry, only completed if a value is provided for “Weight”

Data Source Hierarchy

1. Triage Form/Trauma Flow Sheet
2. ED Records

References

INITIAL ED/HOSPITAL GLASGOW COMA SCALE (GCS) - EYE

Data Format [combo] single-choice

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name GCS: Eye	**NTDB Element Number** ED_10
NTRACS Field Name GCS: Eye	**NTDB Data Dictionary Page Number** 67

Field Values

- No eye movement when assessed
- Opens eyes in response to painful stimulation
- Opens eyes in response to verbal stimulation
- Opens eyes spontaneously
- Common null values

Additional Information

- Used to calculate Overall GCS - ED Score
- Minimum constraint: 1; Maximum constraint: 4
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g., if the chart indicates “patient withdraws from a painful stimulus,” a Motor GCS may be recorded, IF there is no other contradicting documentation.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.

Data Source Hierarchy

1. Triage Form/Trauma Flow Sheet
2. ED Records
3. Nurses Notes

References

INITIAL ED/HOSPITAL GLASGOW COMA SCALE (GCS) - VERBAL

Data Format [combo] single-choice

Definition

First recorded GCS – Verbal measured in the ED/hospital

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name GCS: Verbal	**NTDB Element Number** ED_11
NTRACS Field Name GCS: Verbal	**NTDB Data Dictionary Page Number** 68

Field Values

- Adult
  - No verbal response
  - Incomprehensible sounds
  - Inappropriate words
  - Confused
  - Oriented
  - Common null values

- Pediatric (≤ 2 years)
  - No vocal response
  - Inconsolable, agitated
  - Inconsistently consolable, moaning
  - Cries but is consolable, inappropriate interactions
  - Smiles, oriented to sounds, follows objects, interacts
  - Common null values

Additional Information

- Used to calculate Overall GCS – ED Score
- Minimum constraint: 1; Maximum constraint: 5
- If patient is intubated, then the GCS Verbal score is equal to 1 (No vocal response).
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g., if the chart indicates “patient withdraws from a painful stimulus,” a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.

Data Source Hierarchy

1. Triage Form/Trauma Flow Sheet
2. ED Records
3. Nurses Notes

References

INITIAL ED/HOSPITAL GLASGOW COMA SCALE (GCS) - MOTOR

Data Format [number]

Definition

First recorded Glasgow Coma Score – Motor in the ED/hospital within 30 minutes or less of ED/hospital arrival

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name GCS: Motor	**NTDB Element Number** ED_12
NTRACS Field Name GCS: Motor	**NTDB Data Dictionary Page Number** 69

Field Values

- **Adult**
  - No motor response
  - Extension to pain
  - Flexion to pain
  - Withdrawal from pain
  - Localizing pain
  - Obeys commands
  - Common null values

- **Pediatric (≤ 2 years)**
  - No motor response
  - Extension to pain
  - Flexion to pain
  - Withdrawal from pain
  - Localizing pain
  - Appropriate response to stimulation
  - Common null values

Additional Information

- Used to calculate Overall GCS – ED Score
- Minimum constraint: 1; Maximum constraint: 6
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g., if the chart indicates “patient withdraws from a painful stimulus,” a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.

Data Source Hierarchy

1. Triage Form/Trauma Flow Sheet
2. ED Records
3. Nurses Notes

References

INITIAL ED/HOSPITAL GLASGOW COMA SCALE (GCS) - TOTAL

Data Format [number]

Definition

First recorded Glasgow Coma Scale – Total in the ED/hospital within 30 minutes or less of ED/hospital arrival

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name GCS: Total	**NTDB Element Number** ED_13
NTRACS Field Name GCS: Total	**NTDB Data Dictionary Page Number** 70

Field Values

- Minimum constraint: 3; Maximum constraint: 15
- Common null values

Additional Information

- *Utilize only if total score is available without component scores.*
- 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.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.

Data Source Hierarchy

1. Triage Form/Trauma Flow Sheet
2. ED Records
3. Nurses Notes

References

INITIAL ED/HOSPITAL GLASGOW COMA SCALE ASSESSMENT QUALIFIERS

Data Format [combo] multiple-choice

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name GCS Assessment Qualifiers	**NTDB Element Number** ED_14
NTRACS Field Name GCS Assessment Qualifiers	**NTDB Data Dictionary Page Number** 71

Field Values

- Patient chemically sedated or paralyzed
- Obstruction to the patient's eye
- Patient intubated
- Valid GCS: Patient was not sedated, not intubated, and did not have obstruction to the eye.
- Common null values

Additional Information

-
- Identifies medical treatments given to the patient that may affect the best assessment of GCS. This field does not apply to self-medication the patient may have administered (i.e., ETOH, prescriptions, etc.).
- If an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible, then the patient should be considered to have an exam that is not reflective of their neurologic status. The chemical sedation modifier should be selected.
- Neuromuscular blockade is typically induced following the administration of an agent like succinylcholine, mivacurium, rocuronium, (cis)atracurium, vecuronium, or pancuronium. While these are the most common agents, please review what might be typically used in your center so it can be identified in the medical record.
- Each of these agents has a slightly different duration of action, so their effect on the GCS depends on when they were given. For example, succinylcholine's effects last for only 5-10 minutes.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.

Data Source Hierarchy

1. Triage Form/Trauma Flow Sheet
2. ED Records
3. EMS Run Sheet
4. Nurses Notes

References

INITIAL ED/HOSPITAL ALCOHOL USE INDICATOR

Data Format [combo] single-choice

Definition

Use of alcohol by the patient

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Alcohol Use Indicator	**NTDB Element Number** ED_17
NTRACS Field Name Alcohol Use Indicator	**NTDB Data Dictionary Page Number** 74

Field Values

- No (not tested)
- No (confirmed by test)
- Yes (confirmed by test [trace levels])
- Yes (confirmed by test [beyond legal limit])
- Common null values

Additional Information

- Blood alcohol concentration (BAC) may be documented at any facility (or setting) treating this patient event.
- “Trace levels” is defined as any alcohol level below the legal limit, but not zero.
- “Beyond legal limit” is defined as a blood alcohol concentration above the legal limit for the state in which the treating institution is located. Above any legal limit, DUI, DWI, or DWAI, would apply here.
- If alcohol use is suspected, but not confirmed by test, record null value “Not Known/Not Recorded.”

Data Source Hierarchy

1. Lab Results
2. ED Physician Notes

References

INITIAL ED/HOSPITAL DRUG USE INDICATOR

Data Format [combo] single-choice

Definition

Use of drugs by the patient

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Drug Use Indicator	**NTDB Element Number** ED_18
NTRACS Field Name Drug Use Indicator	**NTDB Data Dictionary Page Number** 75

Field Values

- No (not tested)
- No (confirmed by test)
- Yes (confirmed by test [prescription drug])
- Yes (confirmed by test [illegal use drug])
- Common null values

Additional Information

- Drug use may be documented at any facility (or setting) treating this patient event.
- "Illegal drug use" includes illegal use of prescription drugs.
- If drug use is suspected, but not confirmed by test, record null value "Not Known/Not Recorded."
- This data element refers to drug use by the patient and does not include medical treatment.

Data Source Hierarchy

1. Lab Results
2. ED Physician Notes

References

ED DISCHARGE DISPOSITION

Data Format [combo] single-choice

Definition

The disposition of the patient at the time of discharge from the ED

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name ED Discharge Disposition	**NTDB Element Number** ED_19
NTRACS Field Name ED Discharge Disposition	**NTDB Data Dictionary Page Number** 76

Field Values

- Floor bed (general admission, non-specialty unit bed)
- Observation unit (unit that provides < 24 hour stays)
- Telemetry/step-down unit (less acuity than ICU)
- Home with services
- Died/expired
- Other (jail, institutional care, mental health, etc.)
- Operating room
- Intensive care unit (ICU)
- Home without services
- Left against medical advice
- Transferred to another hospital
- Common null values

Additional Information

- If the patient is directly admitted to the hospital, code as N/A.
- If ED Discharge Disposition is 4, 5, 6, 9, 10, 11, then Hospital Discharge Date, Time, and Disposition should be N/A.

Data Source Hierarchy

1. Discharge Sheet
2. Nursing Progress Notes
3. Social Worker notes

References

SIGNS OF LIFE

Data Format [combo] single-choice

Definition

Indication of whether patient arrived at ED/Hospital with signs of life.

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name ED Discharge Disposition	**NTDB Element Number** ED_20
NTRACS Field Name ED Discharge Disposition	**NTDB Data Dictionary Page Number** 76

Field Values

- Arrived with NO signs of life
- Arrived with sings of life

Additional Information

- A patient with no signs of life is defined as having none of the following: organized EKG activity, pupillary responses, spontaneous respiratory attempts or movement, and unassisted blood pressure. This usually implies the patient was brought to the ED with CPR in progress.

Data Source Hierarchy

1. Discharge Sheet
2. Nursing Progress Notes
3. Social Worker notes

References

ED DISCHARGE DATE

Data Format [date]

Definition

The date the patient was discharged from the ED

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name ED Discharge Date	**NTDB Element Number** ED_21
NTRACS Field Name ED Discharge Date	**NTDB Data Dictionary Page Number** 78

Field Values

- Minimum: 1990; Maximum: 2030
- Common null values

Additional Information

- Collected as YYYY-MM-DD
- Used to auto-generate additional calculated fields: Total EMS Time (elapsed time from EMS dispatch to hospital arrival) and Total ED Time (elapsed time from ED/Hospital Arrival to ED Discharge)
- If the patient was directly admitted to the hospital, code as “Not Applicable.”

Data Source Hierarchy

1. Hospital Discharge Summary
2. Billing Sheet/Medical Records Coding Summary Sheet
3. Physician’s Progress Notes

References

ED DISCHARGE TIME

Data Format [time]

Definition

The time the patient was discharged from the ED

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name ED Discharge Time	**NTDB Element Number** ED_22
NTRACS Field Name ED Discharge Time	**NTDB Data Dictionary Page Number** 79

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time
- Used to auto-generate additional calculated field: Total ED Time (elapsed time from ED admit to ED discharge)
- If the patient was directly admitted to the hospital, code as “Not Applicable.”

Data Source Hierarchy

1. Hospital Record
2. Billing Sheet/Medical Records Coding Summary Sheet
3. Physician’s Progress Notes

References

TRAUMA TEAM ACTIVATION

Data Format [combo] single-choice

Definition

Indicator that an announcement was made of an incoming trauma patient via pager system to assemble appropriate members of the trauma team in the ED

Required in ATR Yes	**Required in NTDB** No
Web Field Name Trauma Team Activation	**NTDB Element Number** N/A
NTRACS Field Name Trauma Team Activation	**NTDB Data Dictionary Page Number** N/A

Field Values

- Yes, trauma team activated
- No, trauma team not activated
- Common null values

Additional Information

- 1 – Yes, trauma team activated should be selected by the corresponding activation level.
- If the trauma team was not activated at any level, all three activation levels should reflect 2 – No, trauma team not activated.

Data Source Hierarchy

1. Trauma Flow Sheet
2. ED Records

References

PHYSICIAN CALLED TIME

Data Format [time]

Definition

The time the first physician was called

Required in ATR Yes	**Required in NTDB** No
Web Field Name Physician Called Time	**NTDB Element Number** N/A
NTRACS Field Name Physician Time (Called)	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time

Data Source Hierarchy

1. Trauma Flow Sheet
2. ED Records

References

PHYSICIAN ARRIVED TIME

Data Format [time]

Definition

The time the first physician called arrived

Required in ATR Yes	**Required in NTDB** No
Web Field Name Physician Arrived Time	**NTDB Element Number** N/A
NTRACS Field Name Physician Time (Arrived)	**NTDB Data Dictionary Page Number** N/A

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time

Data Source Hierarchy

1. Trauma Flow Sheet
2. ED Records

References

DISCHARGE DESTINATION HOSPITAL

Data Format [combo] single-choice

Definition

The name of the receiving hospital of the patient transferred from the ED to another acute care hospital

Required in ATR Yes	**Required in NTDB** No
Web Field Name Discharge Destination Hospital	**NTDB Element Number** N/A
NTRACS Field Name	**NTDB Data Dictionary Page Number** N/A

Field Values

- Relevant value for data element
- Common null values

Additional Information

Data Source Hierarchy

1. Hospital Discharge Summary
2. Trauma Flow Sheet
3. ED Records
4. Billing Sheet/Medical Records Coding Summary Sheet

References

HOSPITAL ADMITTING SERVICE

Data Format [combo] single choice

Definition

Indicator of the section of the hospital to which the patient was sent for care

Required in ATR Yes	**Required in NTDB** No
Web Field Name Admitting Service	**NTDB Element Number** N/A
NTRACS Field Name Admit Service	**NTDB Data Dictionary Page Number** N/A

Field Values

- Trauma
- Neurosurgery
- Orthopedic Surgery
- ENT/Plastic Surgery
- Thoracic Surgery
- Pediatric Surgery
- Pediatrics
- Other Surgical Service
- Other Non-Surgical Service
- ER Physician
- Hospitalist
- Family Practice
- General Medicine
- Common null values

Additional Information

Data Source Hierarchy

1. ED Discharge/Transfer Sheet
2. Nursing Progress Notes

References

ED/HOSPITAL CARE ISSUES

Data Format [combo] multiple choice

Definition

These broad categories or specific events may warrant review, or may be used to note a question or concern surrounding, for example, the patient's transport to the most appropriate facility, the call to a specialty, or the OR's acceptance; or may serve as an opportunity for further research or improvement.

Required in ATR Yes	**Required in NTDB** No
Web Field Name ED Care Issues	**NTDB Element Number** N/A
NTRACS Field Name N/A	**NTDB Data Dictionary Page Number** N/A

Field Values

- Transport to appropriate facility
- ER physician availability
- Trauma team activation
- Trauma team arrival
- General surgeon availability
- General surgeon arrival
- Specialist call
- Specialist arrival
- Transfer out to appropriate facility
- Delay in transfer out
- Met transfer criteria & not transferred out
- Blood availability
- CT scan availability
- MRI availability
- Diagnostic test results availability
- Equipment not readily available
- Indicated procedure not performed
- Indicated diagnostic test not ordered or not performed
- OR acceptance
- Delay of pain medication
- Critical care bed not available
- Ward bed not available
- Missed injury
- Unrecognized or untreated hypothermia
- Unrecognized or untreated hypovolemia
- Aspiration due to c-spine restraints
- Cardiac arrest outside of ED
- Chest tube displacement
- Intubation - esophageal
- Intubation – mainstem
- Intubation - tube displacement
- Medication not available
- Neurovascular changes after splinting
- Patient refused lab/x-ray
- Other
- No ED care issues identified

Additional Information

- Up to five (5) may be selected.

Data Source Hierarchy

1. ED Record
2. Nursing Progress Notes
3. Triage Form/Trauma Flow Sheet

References

HOSPITAL PROCEDURES

ICD-9 HOSPITAL PROCEDURES

Data Format [text]

Definition

Operative and selected non-operative procedures conducted during hospital stay. Operative and selected non-operative procedures are those that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or complications. The list of procedures below should be used as a guide to non-operative procedures that should be provided to NTDB. This list is based on procedures sent to NTDB with a high frequency. Not all hospitals capture all procedures listed below. Please transmit those procedures that you do capture to NTDB.

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name ICD-9 Hospital Procedures	**NTDB Element Number** HP_01
NTRACS Field Name ICD-9 Hospital Procedures	**NTDB Data Dictionary Page Number** 81-82

Field Values

- Major and minor procedure (ICD 9-CM) procedure codes.
- The maximum number of procedures that may be reported for a patient is 200.
- Common null values

Additional Information

. The null value "Not Applicable" is used if the patient did not have procedures.
• Include only procedures performed at your institution.
• Capture all procedures performed in the operating room.
• Capture all procedures in the ED, ICU, ward, or radiology department that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or their complications.
• Procedures with an asterisk have the potential to be performed multiple times during one episode of hospitalization. In this case, capture only the first event. If there is no asterisk, capture each event even if there is more than one.
• Note that the hospital may capture additional procedures.
• The null value "Not Known/Not Recorded" is used if not coding ICD-9.

Diagnostic and Therapeutic Imaging:
Computerized tomographic studies
Diagnostic ultrasound (includes FAST)
Doppler ultrasound of extremities *
Angiography
Angioembolization
Echocardiography
Cystogram
IVC Filter
Urethrogram

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

Transfusion:
The following blood products should be captured over first 24 hours after hospital arrival:
Transfusion of red cells *
Transfusion of platelets *
Transfusion of plasma *
In addition to coding the individual blood products listed above assign the appropriate procedure code

on patients that receive > 10 units of blood products
over first 24 hours following hospital arrival *
For pediatric patients (age 14 and under), assign the
appropriate procedure code on patients that receive
40cc/kg of blood products over first 24 hours following hospital arrival*

Cardiovascular:
Central venous catheter
Pulmonary artery catheter
Cardiac output monitoring
Open cardiac massage
CPR

Respiratory:
Insertion of endotracheal tube
Continuous mechanical ventilation
Chest tube
Bronchoscopy
Tracehostomy

CNS
Insertion of ICP monitor
Ventriculostomy
Cerebral oxygen monitoring

Gastroinetstinal
Endoscopy (includes gastroscopy, sigmoidoscopy, colonoscopy)
Gastrostomy/Jejunostomy (percutaneous or endoscopic)
Percutaneous (endoscipic) gastrojejunoscopy

Musculoskeletal:
Soft tissue/bony debridements
Closed reduction of fractures
Skeletal and halo traction
Fasciotomy

Other:
Hyperbaric Oxygen
Decompression Chamber
TPN

Data Source Hierarchy

1. Operative Records
2. ER and ICU Records
3. Trauma Flow Sheet
4. Anesthesia Record
5. Billing Sheet/Medical Records Coding Summary Sheet
6. Hospital Discharge Summary

References

ICD-10 HOSPITAL PROCEDURES

Data Format [text]

Definition

Operative and selected non-operative procedures conducted during hospital stay. Operative and selected non-operative procedures are those that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or complications. The list of procedures below should be used as a guide to non-operative procedures that should be provided to NTDB. This list is based on procedures sent to NTDB with a high frequency. Not all hospitals capture all procedures listed below. Please transmit those procedures that you do capture to NTDB.

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name ICD-10 Hospital Procedures	**NTDB Element Number** HP_02
NTRACS Field Name ICD-10 Hospital Procedures	**NTDB Data Dictionary Page Number** 83-84

Field Values

- Major and minor procedure (ICD 10-CM) procedure codes.
- The maximum number of procedures that may be reported for a patient is 200.
- Common null values

Additional Information

. The null value "Not Applicable" is used if the patient did not have procedures.
• Include only procedures performed at your institution.
• Capture all procedures performed in the operating room.
• Capture all procedures in the ED, ICU, ward, or radiology department that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or their complications.
• Procedures with an asterisk have the potential to be performed multiple times during one episode of hospitalization. In this case, capture only the first event. If there is no asterisk, capture each event even if there is more than one.
• Note that the hospital may capture additional procedures.
• The null value "Not Known/Not Recorded" is used if not coding ICD-10.

Diagnostic and Therapeutic Imaging:
Computerized tomographic studies
Diagnostic ultrasound (includes FAST)
Doppler ultrasound of extremities *
Angiography
Angioembolization
Echocardiography
Cystogram
IVC Filter
Urethrogram

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

Transfusion:
The following blood products should be capturedover first 24 hours after hospital arrival:

- Transfusion of red cells *
- Transfusion of platelets *
- Transfusion of plasma *

In addition to coding the individual blood products
listed above assign the appropriate procedure code

on patients that receive > 10 units of blood products
over first 24 hours following hospital arrival *
For pediatric patients (age 14 and under), assign the
appropriate procedure code on patients that receive
40cc/kg of blood products over first 24 hours following hospital arrival*

Cardiovascular:
Central venous catheter
Pulmonary artery catheter
Cardiac output monitoring
Open cardiac massage
CPR

Respiratory:
Insertion of endotracheal tube
Continuous mechanical ventilation
Chest tube
Bronchoscopy
Tracehostomy

CNS
Insertion of ICP monitor
Ventriculostomy
Cerebral oxygen monitoring

Gastroinetstinal
Endoscopy (includes gastroscopy, sigmoidoscopy, colonoscopy)
Gastrostomy/Jejunostomy (percutaneous or endoscopic)
Percutaneous (endoscipic) gastrojejunoscopy

Musculoskeletal:
Soft tissue/bony debridements
Closed reduction of fractures
Skeletal and halo traction
Fasciotomy

Other:
Hyperbaric Oxygen
Decompression Chamber
TPN

Data Source Hierarchy

1. Operative Records
2. ER and ICU Records
3. Trauma Flow Sheet
4. Anesthesia Record
5. Billing Sheet/Medical Records Coding Summary Sheet
6. Hospital Discharge Summary

HOSPITAL PROCEDURE START DATE

Data Format [date]

Definition

The beginning date for each included procedure

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Procedure Start Date	**NTDB Element Number** HP_03
NTRACS Field Name Procedure Start Date	**NTDB Data Dictionary Page Number** 85

Field Values

- Relevant value for data element
- Common null values

Additional Information

- Collected as YYYY-MM-DD

Data Source Hierarchy

1. OR Nurse's Notes
2. Operative Records
3. Anesthesia Record

References

HOSPITAL PROCEDURE START TIME

Data Format [time]

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Procedure Start Time	**NTDB Element Number** HP_04
NTRACS Field Name Procedure Start Time	**NTDB Data Dictionary Page Number** 86

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM (midnight – 12:00 a.m.) through 23:59 (11:59 p.m.), valid military time
- Procedure start time is defined as the time the incision was made (or the procedure started).
- If distinct procedures with the same procedure code are performed, their start times must be different.

Data Source Hierarchy

1. OR Nurse's Notes
2. Operative Records
3. Anesthesia Record

References

OR DISPOSITION

Data Format [character]

Definition

The disposition of the patient following post-anesthesia recovery.

Required in ATR Yes	**Required in NTDB** No
Web Field Name OR Disposition	**NTDB Element Number** N/A
NTRACS Field Name	**NTDB Data Dictionary Page Number** N/A

Field Values

- WARD/Floor
- ICU/CCU
- Short stay/discharged
- Expired
- Other in-house
- Other
- Other acute care facility
- Pediatrics
- Pediatric ICU
- Progressive care unit
- Jail
- Common null values

Additional Information

Data Source Hierarchy

1. OR Nurse's Notes
2. Operative Records

References

DIAGNOSES INFORMATION

ICD-9 INJURY DIAGNOSIS

Data Format [combo] multiple-choice

Definition

Diagnoses related to all identified injuries

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name ICD-9 Injury Diagnosis	**NTDB Element Number** DG_02
NTRACS Field Name ICD-9 Injury Diagnosis	**NTDB Data Dictionary Page Number** 89

Field Values

- Injury diagnoses as defined by ICD-9-CM codes (code range: 800-959.9), except for 905-909.0, 910-924.9,930-939.9.
- The maximum number of diagnoses that may be reported for an individual patient is 50.
- Common null values

Additional Information

- ICD-9-CM codes pertaining to other medical conditions (e.g., CVA, MI, co-morbidities, etc.) may also be included in the field.
- Used to auto-generate additional calculated fields: Abbreviated Injury Scale (six body regions) and Injury Severity Score
- The null value “Not Applicable” is used if not coding ICD-9.

Data Source Hierarchy

1. Hospital Discharge Summary
2. Billing Sheet/Medical Records Coding Summary Sheet
3. Triage Form/Trauma Flow Sheet
4. ER and ICU Records

References

ICD-10 INJURY DIAGNOSIS

Data Format [combo] multiple-choice

Definition

Diagnoses related to all identified injuries

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name ICD-10 Injury Diagnosis	**NTDB Element Number** DG_03
NTRACS Field Name ICD-10 Injury Diagnosis	**NTDB Data Dictionary Page Number** 90

Field Values

- Injury diagnoses as defined by ICD-10-CM code range S00-S99, T07, T14, T20-T28, and T30-T32.
- The maximum number of diagnoses that may be reported for an individual patient is 100.
- *If not coding ICD-10 then enter Not Applicable.*
- Common null values

Additional Information

- ICD-10-CM codes pertaining to other medical conditions (e.g., CVA, MI, co-morbidities, etc.) may also be included in the field.
- Used to auto-generate additional calculated fields: Abbreviated Injury Scale (six body regions) and Injury Severity Score

Data Source Hierarchy

1. Hospital Discharge Summary
2. Billing Sheet/Medical Records Coding Summary Sheet
3. Triage Form/Trauma Flow Sheet
4. ER and ICU Records

References

ICD-9 CODE

Data Format [number] single choice

Definition

The ICD-9-CM code which categorized the injury diagnosis

Required in ATR Yes	**Required in NTDB** No
Web Field Name ICD-9 Code	**NTDB Element Number** N/A
NTRACS Field Name	**NTDB Data Dictionary Page Number** N/A

Field Values

- Relevant value for data element
- Valid injury diagnosis codes range from 800-959.9
- Common null values

Additional Information

- Format - ###.## (fifth digit may not be required)
- DI Coder or TriCoder will auto generate ICD-9 Codes.
- If the specific diagnosis entered does not have a corresponding ICD-9 code (e.g., loss of consciousness codes for AIS), record as *Not Known/Not Recorded.*
- If the specific diagnosis does not have enough detail to determine a specific ICD-9 code, record as *Unknown.*

Data Source Hierarchy

1. Hospital Discharge Summary
2. Billing Sheet/Medical Records Coding Summary Sheet
3. Triage Form/Trauma Flow Sheet
4. ER and ICU Records

References

AIS PREDOT CODE

Data Format [combo] multiple-choice

Definition

The Abbreviated Injury Scale (AIS) PreDot codes that reflect the patient's injuries

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Predot	**NTDB Element Number** IS_01
NTRACS Field Name	**NTDB Data Dictionary Page Number** 92

Field Values

- The predot code is the 6 digits preceding the decimal point in an associated AIS code.
- Multiple entries are allowed, with a maximum of 50.
- Common null values

Additional Information

- This variable is considered optional and is not required as part of the NTDS dataset.

Data Source Hierarchy

References

AIS SEVERITY

Data Format [combo] multiple choice

Definition

The Abbreviated Injury Scale (AIS) severity codes that reflect that patient's injuries

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name AIS Severity	**NTDB Element Number** IS_02
NTRACS Field Name AIS	**NTDB Data Dictionary Page Number** 93

Field Values

- Minor injury (1)
- Moderate injury (2)
- Serious injury (3)
- Severe injury (4)
- Critical injury (5)
- Maximum injury, virtually unsurvivable (6)
- Not possible to assign (9)
- Common null values

Additional Information

- This variable is considered optional and is not required as part of the NTDS dataset.
- The field value (9) "Not Possible to Assign" would be chosen if it is not possible to assign a severity to an injury.

Data Source Hierarchy

References

ISS BODY REGION

Data Format [combo] multiple-choice

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name ISS Body Region	**NTDB Element Number** IS_03
NTRACS Field Name Body Region	**NTDB Data Dictionary Page Number** 94

Field Values

- Head or neck (1)
- Face (2)
- Chest (3)
- Abdominal or pelvic contents (4)
- Extremities or pelvic girdle (5)
- External (6)
- Common null values

Additional Information

- This variable is considered optional and is not required as part of the NTDS dataset.
- Head or neck injuries include injury to the brain or cervical spine, skull or cervical spine fractures.
- Facial injuries include those involving 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 include 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

References

AIS VERSION

Data Format [combo] single choice

Definition

The software (and version) used to calculate Abbreviated Injury Scale (AIS) severity codes.

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name AIS Version	**NTDB Element Number** IS_04
NTRACS Field Name AIS Version	**NTDB Data Dictionary Page Number** 95

Field Values

- AIS 80
- AIS 85
- AIS 90
- AIS 95
- AIS 98
- AIS 05
- Common null values

Additional Information

- The variable is considered optional and is not required as part of the NTDS dataset.

Data Source Hierarchy

References

LOCALLY CALCULATED ISS

Data Format [combo] single choice

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name ISS	**NTDB Element Number** IS_05
NTRACS Field Name ISS	**NTDB Data Dictionary Page Number** 96

Field Values

- Minimum constraint: 1; Maximum constraint: 75
- Relevant ISS value for the constellation of injuries
- Common null values

Additional Information

- The variable is considered optional and is not required as part of the NTDS dataset.
- Field is auto-calculated based on AIS Severity and ISS Body Region.

Data Source Hierarchy

References

QUALITY ASSURANCE INFORMATION

CO-MORBID CONDITIONS

Data Format [character]

Definition

Pre-existing co-morbid factors present before patient arrival at the ED/hospital

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Comorbidities	**NTDB Element Number** DG_01
NTRACS Field Name Co-morbidity	**NTDB Data Dictionary Page Number** 88

Field Values

- Alcoholism
- Ascites within 30 days
- Bleeding disorder
- Currently receiving chemotherapy for cancer
- Congenital anomalies
- Congestive heart failure
- Current smoker
- Chronic renal failure
- CVA/residual neurological deficit
- Diabetes mellitus
- Disseminated cancer
- Advanced directive limiting care
- Esophageal varices
- Functionally dependent health status
- History of angina within past 30 days
- History of myocardial infarction
- History of PVD
- Hypertension requiring medication
- Prematurity
- Obesity
- Respiratory disease
- Steroid use
- Cirrhosis
- Dementia
- Major psychiatric illness
- Drug abuse or dependence
- Pre-hospital cardiac arrest with resuscitative efforts by healthcare provider
- Other
- Common null values

Additional Information

- The value “Not Applicable” should be used for patients with no known co-morbid conditions.
- The field value “No NTDS co-morbidities are present” would be chosen if none of the pre-existing co-morbid factors listed above are present in the patient.
- This particular field value is available since individual state or hospital registries may track additional co-morbid factors not listed here.
- Multiple entries are allowed, with a maximum of 28.

Data Source Hierarchy

1. History and Physical
2. Discharge Sheet
3. Billing Sheet

References

HOSPITAL COMPLICATIONS

Data Format [character]

Definition

Any medical complication that occurred during the patient's stay at your hospital

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Complications	**NTDB Element Number** Q_01
NTRACS Field Name Complications	**NTDB Data Dictionary Page Number** 109

Field Values

- Acute renal failure
- Acute lung injury/Acute respiratory distress syndrome (ARDS)
- Cardiac arrest with CPR
- Decubitus ulcer
- Deep surgical site infection
- Drug or alcohol withdrawal syndrome
- Deep Vein Thrombosis (DVT)/ thrombophlebitis
- Extremity compartment syndrome
- Graft/prosthesis/flap failure
- Myocardial infarction
- Organ/space surgical site infection
- Pneumonia
- Pulmonary embolism
- Stroke/CVA
- Superficial surgical site infection
- Unplanned intubation
- Urinary tract infection
- Catheter-related blood stream infection
- Osteomyelitis
- Unplanned return to the OR
- Unplanned return to the ICU
- Severe sepsis
- Other
- Common null values

Additional Information

- The field value "No NTDS listed medical complications occurred" would be chosen if none of the hospital complications listed above is present in the patient.
- The "No NTDS …" field value is available because individual state or hospital registries may track hospital complications not listed here.
- The value "Not Applicable" should be used for patients with no complications.
- Multiple entries are allowed, with a maximum of 23.

Data Source Hierarchy

1. Discharge Sheet
2. History and Physical
3. Billing Sheet

References

OUTCOME INFORMATION

TOTAL ICU DAYS

Data Format [number]

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Total ICU Days	**NTDB Element Number** O_01
NTRACS Field Name Total ICU Days	**NTDB Data Dictionary Page Number** 98

Field Values

- Minimum constraint: 1; Maximum constraint: 400
- Relevant value for data element
- Common null values

Additional Information

- Recorded in full day increments, with any partial calendar day counted as a full calendar day
- The calculation assumes that the date and time of starting and stopping an ICU episode are recorded in the patient's chart.
- If any dates are missing, then a LOS cannot be calculated.
- If patient has multiple ICU episodes on the same calendar day, count that day as one calendar day.
- At no time should the ICU LOS exceed the hospital LOS.
- If the patient had no ICU days according to the above definition, code as 'Not Applicable.'

Data Source Hierarchy

1. ICU Nursing Flow Sheet
2. Calculate Based on Admission Form and Discharge Sheet
3. Nurses Progress Notes

References

- For examples, see page 98 of the NTDB 2013 Data Dictionary.

VENTILATOR SUPPORT DAYS

Data Format [number]

Definition

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

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Total Ventilator Days	**NTDB Element Number** O_02
NTRACS Field Name Vent Support Days	**NTDB Data Dictionary Page Number** 100

Field Values

- Minimum constraint: 1; Maximum constraint: 400
- Relevant value for data element
- Common null values

Additional Information

- Excludes mechanical ventilation time associated with OR procedures
- Non-invasive means of support (CPAP or BIPAP) should not be considered in the calculation of ventilator days.
- The calculation assumes that the date and time of starting and stopping any ventilator episode are recorded in the patient's chart.
- If any dates are missing, then a Total Vent Days cannot be calculated.
- At no time should the Total Vent Days exceed the hospital LOS.
- If the patient was not on the ventilator according to the above definition, code as 'Not Applicable.
- The null value "Not Applicable" is used if the patient was not on the ventilator according to the above definition.

Data Source Hierarchy

1. ICU Respiratory Therapy Flow sheet
2. ICU Nursing Flow Sheet
3. Physician's Daily Progress Notes
4. Calculate Based on Admission Form and Discharge Sheet

References

- For examples, see page 100 of the NTDB 2013 Data Dictionary

HOSPITAL DISCHARGE DATE

Data Format [date]

Definition

The date the patient was discharged from the hospital

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Discharge Date	**NTDB Element Number** O_03
NTRACS Field Name Discharge Date	**NTDB Data Dictionary Page Number** 102

Field Values

- Minimum constraint: 1990; Maximum constraint: 2030
- Relevant value for data element
- Common null values

Additional Information

- Collected as YYYY-MM-DD
- Used to auto-generate an additional calculated field: Total Length of Hospital Stay (elapsed time from ED/hospital arrival to hospital discharge)
- If ED Discharge Disposition = 5 (Died) then Hospital Discharge Date should be NA.
- If ED Discharge Disposition = 4, 6,9,10, or 11 then Hospital Discharge Date must be NA.

Data Source Hierarchy

1. Hospital Record
2. Billing Sheet/Medical Records Coding Summary Sheet
3. Physician Discharge Summary

References

HOSPITAL DISCHARGE TIME

Data Format [time]

Definition

The time the patient was discharged from the hospital

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Discharge Time	**NTDB Element Number** O_04
NTRACS Field Name Discharge Time	**NTDB Data Dictionary Page Number** 103

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Relevant value for data element
- Common null values

Additional Information

- Collected as HH:MM, military time
- Used to auto-generate an additional calculated field: Total Length of Hospital Stay (elapsed time from ED/hospital arrival to hospital discharge)
- If ED Discharge Disposition = 5 (Died) then Hospital Discharge Date should be NA.
- If ED Discharge Disposition = 4, 6,9,10, or 11 then Hospital Discharge Date must be NA.

Data Source Hierarchy

1. Hospital Record
2. Billing Sheet/Medical Records Coding Summary Sheet
3. Physician Discharge Summary

References

HOSPITAL DISPOSITION

Data Format [combo] single-choice

Definition

The disposition of the patient when discharged from the hospital

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Hospital Disposition	**NTDB Element Number** O_05
NTRACS Field Name Hospital Discharge Disposition	**NTDB Data Dictionary Page Number** 104

Field Values

- Discharged/Transferred to a short-term general hospital for inpatient care
- Discharged/Transferred to an Intermediate Care Facility (ICF)
- Discharged/Transferred to home under care of organized home health service
- Left against medical advice or discontinued care
- Expired
- Discharged home with no home services
- Discharged/Transferred to Skilled Nursing Facility
- Discharged/Transferred to hospice care (
- Discharged/Transferred to court/law enforcement
- Discharged/Transferred to inpatient rehab or designated unit
- Discharged/Transferred to Long Term Care Hospital (LTCH)
- Discharged/Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
- Common null values

Additional Information

- Field value = 6, “home” refers to the patient’s current place of residence (e.g., prison, Child Protective Services, etc.).
- Field values based upon UB-04 disposition coding
- Disposition to any other non-medical facility should be coded as 6.
- Disposition to any other medical facility should be coded as 9.
- Refer to the glossary for definitions of facility types.
- If ED Discharge Disposition = 5 (Died) then Hospital Discharge Date should be NA.
- If ED Discharge Disposition = 4, 6,9,10, or 11 then Hospital Discharge Date must be NA

Data Source Hierarchy

1. Hospital Discharge Summary Sheet
2. Nurses Notes
3. Case Manager / Social Services’ Notes

Uses

- Can be used to roughly characterize functional status at hospital discharge

Data Collection

- Hospital records or electronically through linkage with the EMS/medical record

Other Associated Elements

- ED Discharge Date
- ED Discharge Time

LIFE SUPPORT WITHDRAWN

Data Format [logic]

Definition

Indicator that a patient was removed from life support systems

Required in ATR Yes	**Required in NTDB** No
Web Field Name Life Support Withdrawn	**NTDB Element Number** N/A
NTRACS Field Name Circumstances of Death	**NTDB Data Dictionary Page Number** N/A

Field Values

- Yes, life support was withdrawn
- No, life support was NOT withdrawn
- Common null values

Additional Information

Data Source Hierarchy

1. Nurses Notes
2. Physician's Progress Notes

References

ORGAN DONATION

Data Format [logic]

Definition

Indicator that a gift was made, of a differentiated structure (as a heart or kidney) consisting of cells and tissues and performing some specific function in an organism

Required in ATR Yes	**Required in NTDB** No
Web Field Name Organ Donation	**NTDB Element Number** N/A
NTRACS Field Name Organ Donation	**NTDB Data Dictionary Page Number** N/A

Field Values

- Yes
- No
- Common null values

Additional Information

- Entry is required if Hospital Discharge Disposition = Expired (5).

Data Source Hierarchy

1. Nurses Notes
2. Physician's Progress Notes

References

ORGANS DONATED

Data Format [character]

Definition

Record of organ(s) donated

Required in ATR Yes	**Required in NTDB** No
Web Field Name Organs Donated	**NTDB Element Number** N/A
NTRACS Field Name ORGANDNTD	**NTDB Data Dictionary Page Number** N/A

Field Values

- Heart
- Lung
- Liver
- Kidney
- Cornea
- Pancreas
- Intestine
- Skin
- Other tissue
- Other organ
- Common null values

Additional Information

- Entry is required if Organ Donation = Yes.
- This field is a custom data element in the NTRACS system.

Data Source Hierarchy

1. Nurses Notes
2. Physician's Progress Notes

References

AUTOPSY DONE

Data Format [logic]

Definition

Indicator that an autopsy was performed

Required in ATR Yes	**Required in NTDB** No
Web Field Name Autopsy Done	**NTDB Element Number** N/A
NTRACS Field Name Autopsy	**NTDB Data Dictionary Page Number** N/A

Field Values

- Yes, autopsy done
- No, autopsy not done
- Common null values

Additional Information

- Entry is required when disposition is Death, DOA, or Died in NTRACS.

Data Source Hierarchy

References

AUTOPSY RESULTS REQUESTED

Data Format [logic]

Definition

Indicator that a report of autopsy results was requested

Required in ATR Yes	**Required in NTDB** No
Web Field Name Autopsy Results Requested	**NTDB Element Number** N/A
NTRACS Field Name	**NTDB Data Dictionary Page Number** N/A

Field Values

- Yes, autopsy results requested
- No, autopsy results not requested
- Common null values

Additional Information

Data Source Hierarchy

References

AUTOPSY RESULTS RECEIVED

Data Format [logic]

Definition

Indicator that a report of the autopsy was received, if an autopsy was requested

Required in ATR Yes	**Required in NTDB** No
Web Field Name Autopsy Results Received	**NTDB Element Number** N/A
NTRACS Field Name	**NTDB Data Dictionary Page Number** N/A

Field Values

- Yes, autopsy results received
- No, autopsy results not received
- Common null values

Additional Information

Data Source Hierarchy

References

CONSULTS

Data Format [character]

Definition

Record of other specialties consulted

Required in ATR Yes	**Required in NTDB** No
Web Field Name Consults	**NTDB Element Number** N/A
NTRACS Field Name Consult	**NTDB Data Dictionary Page Number** N/A

Field Values

- Social work
- Physical therapy
- Mental health
- Rehabilitation
- Family practice physician
- ER physician
- Hospitalist
- Physiatrist
- Other
- Common null values

Additional Information

- Multiple entries are allowed.

Data Source Hierarchy

1. Nurses' Notes
2. Social Services Notes

References

INITIAL REHABILITATION REFERRAL FACILITY

Data Format [combo] single-choice

Definition

The first rehabilitation hospital to which the patient was referred

Required in ATR Yes	**Required in NTDB** No
Web Field Name	**NTDB Element Number** N/A
NTRACS Field Name	**NTDB Data Dictionary Page Number** N/A

Field Values

- Relevant value for data element
- Common null values

Additional Information

Data Source Hierarchy

1. Physician Discharge Summary
2. Triage Form/Trauma Flow Sheet
3. Nurses Notes

References

DAYS FROM REFERRAL TO DISCHARGE

Data Format [number]

Definition

The number of days between the time the patient was referred to a rehabilitation hospital and the time the patient was discharged from the hospital to the rehabilitation facility

Required in ATR Yes	**Required in NTDB** No
Web Field Name	**NTDB Element Number** N/A
NTRACS Field Name	**NTDB Data Dictionary Page Number** N/A

Field Values

- Relevant value for data element
- Common null values

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 referral are recorded in the patient's chart.

Data Source Hierarchy

1. Physician Discharge Summary
2. Triage Form/Trauma
3. ED Nurses Notes

References

DELAYS TO REHAB FACILITY

Data Format [combo] single choice

Definition

Indicator of any delays that prevented the patient from being discharge and transferred to the rehabilitation facility

Required in ATR Yes	**Required in NTDB** No
Web Field Name	**NTDB Element Number** N/A
NTRACS Field Name	**NTDB Data Dictionary Page Number** N/A

Field Values

- Relevant value for data element
- Common null values

Additional Information

Data Source Hierarchy

1. Physician Discharge Summary
2. Triage Form/Trauma
3. ED Nurses Notes

References

RECEIVING REHABILITATION FACILITY

Data Format [combo] single-choice

Definition

The rehabilitation facility to which the patient was transferred after hospital discharge

Required in ATR Yes	**Required in NTDB** No
Web Field Name	**NTDB Element Number** N/A
NTRACS Field Name	**NTDB Data Dictionary Page Number** N/A

Field Values

- Relevant value for data element
- Common null values

Additional Information

Data Source Hierarchy

1. Physician Discharge Summary
2. Triage Form/Trauma Flow Sheet
3. Nurses Notes

References

GOS: GLASGOW OUTCOME SCALE

Data Format [combo] single-choice

Definition

An indicator of the general functioning of a patient who suffered a traumatic brain injury

Required in ATR Yes	**Required in NTDB** No
Web Field Name	**NTDB Element Number** N/A
NTRACS Field Name	**NTDB Data Dictionary Page Number** N/A

Field Values

- Dead
- Vegetative state
- Severely disabled
- Moderately disabled
- Good recovery
- Common null values

Additional Information

Data Source Hierarchy

1. Physician Discharge Summary
2. Triage Form/Trauma Flow Sheet
3. Nurses Notes

References

GOS-E: EXTENDED GLASGOW OUTCOME SCALE

Data Format [number]

Definition

An adaptation of the GOS to provide more detail

Required in ATR Yes	**Required in NTDB** No
Web Field Name	**NTDB Element Number** N/A
NTRACS Field Name	**NTDB Data Dictionary Page Number** N/A

Field Values

- Dead
- Vegetative state
- Lower severely disabled
- Upper severely disabled
- Lower moderately disabled
- Upper moderately disabled
- Lower good recovery
- Upper good recovery
- Common null values

Additional Information

Data Source Hierarchy

1. Physician Discharge Summary
2. Triage Form/Trauma Flow Sheet
3. Nurses Notes

References

FINANCIAL INFORMATION

FINANCIAL INFORMATION AVAILABLE

Data Format [logic]

Definition

An indicator of the availability of financial information at the time the record is entered

Required in ATR Yes	**Required in NTDB** No
Web Field Name Financial Information Available	**NTDB Element Number** N/A
NTRACS Field Name	**NTDB Data Dictionary Page Number** N/A

Field Values

- Yes – available at this time
- No – not available at this time
- Common null values

Additional Information

Data Source Hierarchy

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

References

HOSPITAL CHARGES

Data Format [number]

Definition

The total amount charged for this admission at the acute care facility

Required in ATR Yes	**Required in NTDB** No
Web Field Name Charges	**NTDB Element Number** N/A
NTRACS Field Name Hospital Charges	**NTDB Data Dictionary Page Number** N/A

Field Values

- Numerical dollar amount
- Common null values

Additional Information

- 8 digit dollar amount, followed by a period and a 2 digit cents amount

Data Source Hierarchy

1. Billing Sheet/Medical Records Coding Summary Sheet

References

ACTUAL REIMBURSEMENT

Data Format [character]

Definition

The total amount received for admission at the acute care facility

Required in ATR Yes	**Required in NTDB** No
Web Field Name Actual Reimbursement	**NTDB Element Number** N/A
NTRACS Field Name Reimbursed Charges	**NTDB Data Dictionary Page Number** N/A

Field Values

- Numeric dollar amount
- Common null values

Additional Information

- 8 digit dollar amount, followed by a period and a 2 digit cents amount

Data Source Hierarchy

1. Billing Sheet/Medical Records Coding Summary Sheet

References

PRIMARY METHOD OF PAYMENT

Data Format [character]

Definition

The primary source of payment for hospital care

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Primary Method of Payment	**NTDB Element Number** F_01
NTRACS Field Name Primary Payor Source	**NTDB Data Dictionary Page Number** 107

Field Values

- Medicaid
- Not billed (for any reason)
- Self-Pay
- Private/Commercial Insurance
- No Fault Automobile
- Medicare
- Other government
- Workers Compensation
- Blue Cross/Blue Shield
- Other
- Common null values

Additional Information

- Pick list available

Data Source Hierarchy

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

References

SECONDARY METHOD OF PAYMENT

Data Format [character]

Definition

Any known secondary source of finance expected to assist in payment of medical bills, usually a health insurance or vehicle insurance policy

Required in ATR Yes	**Required in NTDB** No
Web Field Name Secondary Payment Method	**NTDB Element Number** N/A
NTRACS Field Name Secondary Payor Source	**NTDB Data Dictionary Page Number** N/A

Field Values

- Medicaid
- Not billed – no bill was sent to any source
- Self pay
- Commercial – private/commercial insurance, HMO, managed care
- Auto – no-fault automobile insurance
- Medicare
- Other government (e.g., Military/CHAMPUS)
- Workers Compensation
- Blue Cross/Blue Shield
- Other
- No secondary source of payment
- Common null values

Additional Information

- Pick list available

Data Source Hierarchy

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

References

MEASURES FOR PROCESSES OF CARE INFORMATION

The fields in this section should be collected and transmitted by TQIP participating centers only.

HIGHEST GCS TOTAL

Data Format [number]

Definition

Highest total GCS within 24 hours of ED/hospital arrival

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Highest GCS Total	**NTDB Element Number** PM_01
NTRACS Field Name Highest GCS Total	**NTDB Data Dictionary Page Number** 111

Field Values

- Relevant value for data element
- Minimum constraint: 3; Maximum constraint: 15
- Common null values

Additional Information

- Refers to highest total GCS within 24 hours after ED/hospital arrival to index hospital where index hospital is the hospital abstracting the data
- To obtain the highest GCS total, review all data sources. In many cases, the highest GCS total may occur **after** ED discharge.
- If patient is intubated, then the GCS Verbal score is equal to 1.
- Best obtained when sedatives or paralytics are withheld as part of sedation holiday
- If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness, such as “AAOx3,” “awake alert and oriented,” or “patient with normal mental status,” interpret this as GCS of 15 IF there is no other contradicting documentation.
- Collect on patients with at least one injury in AIS head region

Data Source Hierarchy

1. Physician (NS) notes
2. Nursing Unit/ICU Flow Sheet
3. Triage Form/Trauma Flow Sheet

Uses

- Significant indicator of degree of head injury. Provides estimate of GCS used to guide interventions. As an example, a persistently low GCS might lead to intervention, but a GCS that has improved might lead to continued observation.

GCS MOTOR COMPONENT OF HIGHEST GCS TOTAL

Data Format [number]

Definition

Highest motor GCS within 24 hours of ED/hospital arrival

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name GCS Motor	**NTDB Element Number** PM_02
NTRACS Field Name GCS Motor	**NTDB Data Dictionary Page Number** 112

Field Values

- Pediatric (≤ 2 years)
  - No motor response (1)
  - Extension to pain (2)
  - Flexion to pain (3)
  - Withdrawal from pain (4)
  - Localizing pain (5)
  - Appropriate response to stimulation (6)
  - Common null values

- Adult
  - No motor response (1)
  - Extension to pain (2)
  - Flexion to pain (3)
  - Withdrawal from pain (4)
  - Localizing pain (5)
  - Obeys commands (6)
  - Common null values

Additional Information

- Refers to highest GCS motor score within 24 hours after ED/hospital arrival to index hospital where index hospital is the hospital abstracting the data
- To obtain the highest GCS total, review all data sources. In many cases, the highest GCS total may occur **after** ED discharge.
- Must be the motor component of Highest GCS Total
- Best obtained when sedatives or paralytics are withheld as part of sedation holiday
- 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 scale, the appropriate numeric score may be listed. E.g., the chart indicates: “patient withdraws from a painful stimulus,” a Motor GCS of 4 may be recorded IF there is no other contradicting information.
- Collect on patients with at least one injury in AIS head region

Data Source Hierarchy

1. Physician (NS) notes
2. Nursing Unit/ICU Flow Sheet
3. Triage Form/Trauma Flow Sheet

Uses

- Significant indicator of degree of head injury. Provides estimate of GCS used to guide interventions. As an example, a persistently low GCS might lead to intervention, but a GCS that has improved might lead to continued observation.

GCS ASSESSMENT QUALIFIER COMPONENT OF HIGHEST GCS TOTAL

Data Format [number]

Definition

Documentation of factors potentially affecting the highest GCS within 24 hours of ED/hospital arrival

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name GCS Qualifier	**NTDB Element Number** PM_03
NTRACS Field Name GCS Qualifier	**NTDB Data Dictionary Page Number** 113

Field Values

- Patient chemically sedated or paralyzed
- Obstruction to the patient's eyes
- Patient intubated
- Valid GCS: patient was not sedated, not intubated, and did not have obstruction to the eye.
- Common null values

Additional Information

- Refers to highest GCS assessment qualifier score after arrival to index hospital, where index hospital is the hospital abstracting the data
- Requires review of all data sources to obtain the highest GCS assessment qualifier score, which might occur after the ED phase of care
- This field identifies medical treatments given to the patient that may affect the best assessment of GCS, but does not apply to self-medication the patient may have administered (i.e., ETOH, prescriptions, etc.).
- Must be the assessment qualifier for the Highest GCS Total
- If an intubated patient has recently received an agent that results in neuromuscular blockade, such that a motor or eye response is not possible, then the patient should be considered to have an exam that is not reflective of their neurologic status. The chemical sedation modifier should be selected.
- Neuromuscular blockade is typically induced following the administration of an agent like succinylcholine, mivacurium, rocuronium, (cis)atracurium, vecuronium, or pancuronium. While these are the most common agents, please review what might be typically used in your center so it can be identified in the medical record.
- Each of these agents has a slightly different duration of action, so their effect on the GCS depends on when they were given. For example, succinylcholine's effects last for only 5-10 minutes.
- Collect on patients with at least one injury in AIS head region

. **Data Source Hierarchy**

1. Trauma Flow Sheet
2. Nursing Unit / ICU Flow Sheet
3. Physician / Progress notes

Uses

- Provides documentation of assessment and care
- Used to determine validity of GCS total or motor component

CEREBRAL MONITOR

Data Format [combo] multiple-choice

Definition

Indicates all cerebral monitors that were placed, including any of the following: ventriculostomy, subarachnoid bolt, camino bolt, external ventricular drain (EVD), Licox monitor, jugular venous bulb

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Cerebral Monitor	**NTDB Element Number** PM_04
NTRACS Field Name Cerebral Monitor	**NTDB Data Dictionary Page Number** 114

Field Values

- Intraventricular drain/catheter (e.g., ventriculostomy, external ventricular drain)
- Intraparenchymal pressure monitor (e.g., Camion bolt, subarachnoid bolt, intraparenchymal catheter)
- Intraparenchymal oxygen monitor (e.g., Licox)
- Jugular venous bulb
- Common null values

Additional Information

- Refers to insertion of an intracranial pressure (ICP) monitor (or other measures of cerebral perfusion) for the purposes of managing severe TBI
- Choose *Not Applicable* if the patient did not have a cerebral monitor.
- Check all that apply.
- Collect on patients with at least one injury in AIS head region.

Data Source Hierarchy

1. Procedure note
2. Nursing Unit Flow Sheet
3. Operative Note
4. Physician/Progress notes
5. Anesthesia Record

Uses

- Evaluate process of care for patients with severe TBI.

CEREBRAL MONITOR DATE

Data Format [date]

Definition

Date of first cerebral monitor placement

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Date	**NTDB Element Number** PM_05
NTRACS Field Name Date	**NTDB Data Dictionary Page Number** 115

Field Values

- Relevant value for data element
- Minimum constraint: 2010; Maximum constraint: 2030
- Common null values

Additional Information

- Collected as YYYY-MM-DD
- If no cerebral monitor then code as “Not Applicable”
- Collect on patients with at least one injury in AIS head region.
- The null value “Not Applicable” is used for patients that do not meet the collection criterion.

Data Source Hierarchy

1. Procedure note
2. Anesthesia record
3. Nursing unit Flow sheet
4. Operation Note
5. Physician / Progress note

Uses

- Documents when cerebral monitor was placed

CEREBRAL MONITOR TIME

Data Format [time]

Definition

Time of first cerebral monitor placement

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Time	**NTDB Element Number** PM_06
NTRACS Field Name Time	**NTDB Data Dictionary Page Number** 116

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time
- If no cerebral monitor then code as “Not Applicable”
- Collect on patients with at least one injury in AIS head region.
- The null value “Not Applicable” is used for patients that do not meet the collection criterion.

Data Source Hierarchy

1. Procedure note
2. Anesthesia record
3. Nursing unit Flow sheet
4. Operation time
5. Physician / Progress notes

Uses

- Documents when cerebral monitor was placed

VENOUS THROMBOEMBOLISM PROPHYLAXIS TYPE

Data Format [combo] single-choice

Definition

Type of first dose of VTE prophylaxis administered to patient

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name VTE Type	**NTDB Element Number** PM_07
NTRACS Field Name VTE Type	**NTDB Data Dictionary Page Number** 117

Field Values

- Heparin
- None
- LMWH (Dalteparin, Enoxaparin, etc.)
- Direct Thrombin Inhibitor (Dabigatran, etc.)
- Oral Xa Inhibitor (Rivaroxaban, etc.)
- Coumadin
- Other
- Common null values

Additional Information

- Collect on all patients

Data Source Hierarchy

1. Pharmacy Record
2. Charted Medications

Uses

- Used to determine type of pharmacologic prophylaxis

VENOUS THROMBOEMBOLISM PROPHYLAXIS DATE

Data Format [date]

Definition

Date of administration to patient of first prophylactic dose of Heparin or other anticoagulants.

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name VTE Date	**NTDB Element Number** PM_08
NTRACS Field Name VTE Date	**NTDB Data Dictionary Page Number** 118

Field Values

- Minimum constraint: 2010: Maximum constraint: 2030
- Common null values

Additional Information

- Collected as MM/DD/YYYY
- Refers to date upon which patient first received the prophylactic agent indicated in VTE Prophylaxis Type field
- The null value “Not Applicable” is used if Venous Thromboembolism Prophylaxis Type = “5 none”.
- Collect on all patients.

Data Source Hierarchy

1. Pharmacy Record

2. Charted Medications

VENOUS THROMBOEMBOLISM PROPHYLAXIS TIME

Data Format [time]

Definition

Time of administration to patient of first prophylactic dose of Heparin or other anticoagulants.

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name VTE Time	**NTDB Element Number** PM_09
NTRACS Field Name VTE Time	**NTDB Data Dictionary Page Number** 119

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time
- Refers to time at which patient first received the prophylactic agent indicated in VTE Prophylaxis Type field
- The null value “Not Applicable” is used if Venous Thromboembolism Prophylaxis Type = “5 none”.
- Collect on all patients.

Data Source Hierarchy

1. Pharmacy Record
2. Charted Medications

LOWEST ED SBP

Data Format [number]

Definition

Lowest sustained (>5 min) systolic blood pressure measured in ED.

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Lowest ED SBF	**NTDB Element Number** PM_26
NTRACS Field Name Lowest ED SBF	**NTDB Data Dictionary Page Number** 136

Field Values

- Relevant value for data element
- Minimum constraint: 0; Maximum constraint: 300
- Common null values

Additional Information

- Refers to lowest sustained (> 5 min) SBP in the ED of the index hospital, where index hospital is the hospital abstracting the data
- Collect on all patients with transfusion blood within first 4 hours after ED/hospital arrival.

Data Source Hierarchy

1. Trauma Flow Sheet
2. Medical records

Uses

- Identifies patients with shock

Data Collection

- Hospital records

TRANSFUSION BLOOD (4 HOURS)

Data Format [number]

Definition

Volume of packed red blood cell transfusion (units) **within first 4 hours** after ED/hospital arrival

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Transfusion Blood (4 hrs)	**NTDB Element Number** PM_10
NTRACS Field Name Transfusion Blood (4 hrs)	**NTDB Data Dictionary Page Number** 120

Field Values

- Minimum constraint: 0; Maximum constraint: 80
- Common null values

Additional Information

- Refers to amount of transfused packed red blood cells in units within first 4 hours after arrival to index hospital, where index hospitals is the hospital abstracting the data
- If no blood given, then volume should be 0 (zero).
- 1 unit of blood = 350ml
- Must also complete the fields Transfusion Blood Measurement and Transfusion Blood Conversion.
- Collect on all patients with transfusion blood within first 4 hours after ED/hospital arrival.

Data Source Hierarchy

1. ED Flow Sheet
2. Nursing unit sheet
3. Anesthesia records
4. Transfusion records

Uses

- Identifies patients with active bleeding

TRANSFUSION BLOOD (24 HOURS)

Data Format [number]

Definition

Volume of packed red blood cell transfusion (units) **within first 24 hours** after ED/hospital arrival

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Transfusion Blood (24 hrs)	**NTDB Element Number** PM_11
NTRACS Field Name Transfusion Blood (24 hrs)	**NTDB Data Dictionary Page Number** 121

Field Values

- Minimum constraint: 0; Maximum constraint: 120
- Common null values

Additional Information

- Refers to amount of transfused packed red blood cells in units within first 24 hours after arrival to index hospital, where index hospital is the hospital abstracting the data
- The null value “Not Applicable” is used if not blood was given
- The null value “Not Applicable” is used for patients that do not meet the collection criterion.
- Collect on all patients with transfusion blood within first 4 hours after ED/hospital arrival.

Data Source Hierarchy

1. ED flow sheet
2. Nursing unit sheet
3. Anesthesia records
4. Transfusion records

Uses

- Identifies patients with active bleeding

TRANSFUSION BLOOD MEASUREMENT

Data Format [number]

Definition

The measurement used to document the patient's blood transfusion (Units, CCs [MLs]).

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Transfusion Blood Measurement	**NTDB Element Number** PM_12
NTRACS Field Name Transfusion Blood Measurement	**NTDB Data Dictionary Page Number** 122

Field Values

- Units
- CCs (MLs)
- Common null values

Additional Information

- Complete if fields Transfusion Blood (4hours) or Transfusion Blood (24 Hours) are valued.
- Must also complete field Transfusion Blood Conversion
- The null value "Not Applicable" is used for patients that do not meet the collection criterion.

Data Source Hierarchy

1. Blood Bank Records

TRANSFUSION BLOOD CONVERSION

Data Format [number]

Definition

The quantity of CCs [MLs] constituting a “unit” for blood transfusions at your hospital.

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Transfusion Blood Conversion	**NTDB Element Number** PM_13
NTRACS Field Name Transfusion Blood Conversion	**NTDB Data Dictionary Page Number** 123

Field Values

- Relevant value for data element
- Common null values

Additional Information

- Complete if fields Transfusion Blood (4hours) or Transfusion Blood (24 Hours) are valued.
- Must also complete field Transfusion Blood Measurement
- The null value “Not Applicable” is used for patients that do not meet the collection criterion.

Data Source Hierarchy

1. Blood Bank Records

TRANSFUSION PLASMA (4 HOURS)

Data Format [number]

Definition

Volume of fresh frozen or thawed plasma (units or CCs) **within first 4 hours** after ED/hospital arrival

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Transfusion Plasma (24 hrs)	**NTDB Element Number** PM_14
NTRACS Field Name Transfusion Plasma (24 hrs)	**NTDB Data Dictionary Page Number** 124

Field Values

- Minimum constraint: 0; Maximum constraint: 120
- Accepts common null values, except should never be “not applicable”

Additional Information

- Refers to amount of transfused fresh frozen or thawed plasma in units within first 24 hours after arrival to index hospital, where index hospital is the hospital abstracting the data
- The null value “Not Applicable” is used for patients that do not meet the collection criterion.
- Must also complete the fields Transfusion Plasma Measurement and Transfusion Plasma Conversion
- Collect on all patients with transfusion blood within first 4 hours after ED/hospital arrival.

Data Source Hierarchy

1. ED flow sheet
2. Nursing unit sheet
3. Anesthesia records
4. Transfusion records

TRANSFUSION PLASMA (24 HOURS)

Data Format [number]

Definition

Volume of fresh frozen or thawed plasma (units) **within first 24 hours** after ED/hospital arrival

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Transfusion Plasma (24 hrs)	**NTDB Element Number** PM_15
NTRACS Field Name Transfusion Plasma (24 hrs)	**NTDB Data Dictionary Page Number** 125

Field Values

- Minimum constraint: 0; Maximum constraint: 120
- Accepts common null values, except should never be “not applicable”

Additional Information

- Refers to amount of transfused fresh frozen or thawed plasma in units within first 24 hours after arrival to index hospital, where index hospital is the hospital abstracting the data
- The null value “Not Applicable” is used for patients that do not meet the collection criterion.
- Collect on all patients with transfusion blood within first 4 hours after ED/hospital arrival.

Data Source Hierarchy

1. ED flow sheet
2. Nursing unit sheet
3. Anesthesia records
4. Transfusion records

Uses

- Identifies treatment for presumed coagulopathy

TRANSFUSION PLASMA MEASUREMENT

Data Format [number]

Definition

The measurement used to document the patient's plasma transfusion (Units, CCs [MLs]).

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Transfusion Plasma Measurement	**NTDB Element Number** PM_16
NTRACS Field Name Transfusion Plasma Mearsurment	**NTDB Data Dictionary Page Number** 126

Field Values

- Units
- CCs (MLs)
- Common null values

Additional Information

- Complete if fields Transfusion Plasma (4hours) or Transfusion Plasma (24 Hours) are valued.
- Must also complete field Transfusion Plasma Conversion
- The null value "Not Applicable" is used for patients that do not meet the collection criterion.

Data Source Hierarchy

1. Blood Bank Records

TRANSFUSION PLASMA CONVERSION

Data Format [number]

Definition

The quantity of CCs [MLs] constituting a “unit” for plasma transfusions at your hospital.

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Transfusion Plasma Conversion	**NTDB Element Number** PM_17
NTRACS Field Name Transfusion Plasma Conversion	**NTDB Data Dictionary Page Number** 127

Field Values

- Relevant value for data element
- Common null values

Additional Information

- Complete if fields Transfusion Plasma (4hours) or Transfusion Plasma (24 Hours) are valued.
- Must also complete field Transfusion Plasma Measurement
- The null value “Not Applicable” is used for patients that do not meet the collection criterion.

Data Source Hierarchy

1. Blood Bank Records

TRANSFUSION PLATELETS (4 HOURS)

Data Format [number]

Definition

Volume of platelets (units or CCs) **within first 4 hours** after ED/hospital arrival

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Transfusion Platelets (4 hrs)	**NTDB Element Number** PM_18
NTRACS Field Name Transfusion Platelets (4 hrs)	**NTDB Data Dictionary Page Number** 128

Field Values

- Relevant value for data element
- Common null values

Additional Information

- Refers to amount of transfused platelets in units within first 24 hours after arrival to index hospital, where index hospital is the hospital abstracting the data
- The null value “Not Applicable” is used for patients that do not meet the collection criterion.
- Must also complete the fields Transfusion Platelets Measurement and Transfusion Platelets Conversion
- Collect on all patients with transfusion blood within first 4 hours after ED/hospital arrival.

Data Source Hierarchy

1. ED flow sheet
2. Nursing unit sheet
3. Anesthesia records
4. Transfusion records

TRANSFUSION PLATELETS (24 HOURS)

Data Format [number]

Definition

Volume of platelets (units) transfused **within first 24 hours** after ED/hospital arrival.

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Transfusion Platelets (24 hrs)	**NTDB Element Number** PM_19
NTRACS Field Name Transfusion Platelets (24 hrs)	**NTDB Data Dictionary Page Number** 129

Field Values

- Minimum constraint: 0; Maximum constraint: 120
- Relevant value for data element
- Common null values

Additional Information

- Refers to amount of transfused platelets in milliliters (ml) within first 24 hours after arrival to index hospital, where index hospital is the hospital abstracting the data
- The null value “Not Applicable” is used for patients that do not meet the collection criterion.
- Must also complete the fields Transfusion Platelets Measurement and Transfusion Platelets Conversion.
- Collect on all patients with transfusion blood within first 4 hours after ED/hospital arrival.

Data Source Hierarchy

1. ED flow sheet
2. Nursing unit sheet
3. Anesthesia records
4. Transfusion records

Uses

- Identifies treatment for presumed coagulopathy

TRANSFUSION PLATLETS MEASUREMENT

Data Format [number]

Definition

The measurement used to document the patient's platelets transfusion (Units, CCs [MLs]).

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Transfusion Plasma Measurement	**NTDB Element Number** PM_20
NTRACS Field Name Transfusion Plasma Measurement	**NTDB Data Dictionary Page Number** 130

Field Values

- Units
- CCs (MLs)
- Common null values

Additional Information

- Complete if fields Transfusion Platelets (4hours) or Transfusion Platelets (24 Hours) are valued.
- Must also complete field Transfusion Platelets Conversion
- The null value "Not Applicable" is used for patients that do not meet the collection criterion.

Data Source Hierarchy

1. Blood Bank Records

TRANSFUSION PLATELETS CONVERSION

Data Format [number]

Definition

The quantity of CCs [MLs] constituting a “unit” for platelets transfusions at your hospital.

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Transfusion Platelets Conversion	**NTDB Element Number** PM_21
NTRACS Field Name Transfusion Platelets Conversion	**NTDB Data Dictionary Page Number** 131

Field Values

- Relevant value for data element
- Common null values

Additional Information

- Complete if fields Transfusion Platelets (4hours) or Transfusion Platelets (24 Hours) are valued.
- Must also complete field Transfusion Platelets Measurement
- The null value “Not Applicable” is used for patients that do not meet the collection criterion.

Data Source Hierarchy

1. Blood Bank Records

CRYOPRECIPITATE (4 HOURS)

Data Format [number]

Definition

Volume of solution enriched with clotting factors transfused (units) **within first 4 hours** after ED/hospital arrival.

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Cryoprecipitate (4 hours)	**NTDB Element Number** PM_22
NTRACS Field Name Cryoprecipitate (4 hours)	**NTDB Data Dictionary Page Number** 132

Field Values

- Relevant value for data element

Additional Information

- Refers to amount of transfused cryoprecipitate in units within first 4 hours after arrival to index hospital, where index hospital is the hospital abstracting the data
- The null value “Not Applicable” is sued for patients that do not meet the collection criterion.
- Must also complete the fields Cryoprecipitate measurement and Cryoprecipitate conversion.
- Collect on all patients with transfusion blood within first 4 hours after ED/hospital arrival.

Data Source Hierarchy

1. ED flow sheet
2. Nursing unit sheet
3. Anesthesia records
4. Transfusion records

Uses

- Identifies treatment for presumed coagulopathy

CRYOPRECIPITATE (24 HOURS)

Data Format [combo] single-choice

Definition

Volume of solution enriched with clotting factors transfused (units) **within first 24 hours** after ED/hospital arrival

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Cryoprecipitate (24 hrs)	**NTDB Element Number** PM_23
NTRACS Field Name Cryoprecipitate (24 hrs)	**NTDB Data Dictionary Page Number** 133

Field Values

- Minimum constraint: 0; Maximum constraint: 120
- Accepts common null values, except should never be “not applicable”

Additional Information

- Refers to amount of transfused cryoprecipitate in units within first 24 hours after arrival to index hospital, where index hospital is the hospital abstracting the data
- The null value “Not Applicable” is sued for patients that do not meet the collection criterion
- Must also complete the fields Cryoprecipitate measurement and Cryoprecipitate conversion
- Collect on all patients with transfusion blood within first 4 hours after ED/hospital arrival.

Data Source Hierarchy

1. ED flow sheet
2. Nursing unit sheet
3. Anesthesia records
4. Transfusion records

Uses

- Identifies treatment for presumed coagulopathy

CRYOPRECIPITATE MEASUREMENT

Data Format [number]

Definition

The measurement used to document the patient's cryoprecipitate transfusion (Units, CCs [MLs]).

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Cryoprecipitate Measurement	**NTDB Element Number** PM_24
NTRACS Field Name Cryoprecipitate Measurement	**NTDB Data Dictionary Page Number** 134

Field Values

- Units
- CCs (MLs)
- Common null values

Additional Information

- Complete if fields Cryoprecipitate (4hours) or Cryoprecipitate (24 Hours) are valued.
- Must also complete field Cryoprecipitate Conversion
- The null value "Not Applicable" is used for patients that do not meet the collection criterion.
- Collect on all patients with transfusion blood within first 4 hours after ED/hospital arrival

Data Source Hierarchy

1. Blood Bank Records

CRYOPRECIPITATE CONVERSION

Data Format [number]

Definition

The quantity of CCs [MLs] constituting a “unit” for cryoprecipitate transfusions at your hospital.

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Cryoprecipitate Conversion	**NTDB Element Number** PM_25
NTRACS Field Name Cryoprecipitate Conversion	**NTDB Data Dictionary Page Number** 135

Field Values

- Relevant value for data element
- Common null values

Additional Information

- Complete if fields Cryoprecipitate (4hours) or Cryoprecipitate (24 Hours) are valued.
- Must also complete field Cryoprecipitate Measurement
- The null value “Not Applicable” is used for patients that do not meet the collection criterion.
- Collect on all patients with transfusion blood within first 4 hours after ED/hospital arrival

Data Source Hierarchy

1. Blood Bank Records

ANGIOGRAPHY (24 HOURS)

Data Format [combo] single-choice

Definition

First interventional angiogram with or without embolization **within first 48 hours** of ED/hospital arrival

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Angiography	**NTDB Element Number** PM_27
NTRACS Field Name Angiography	**NTDB Data Dictionary Page Number** 137

Field Values

- None
- Angiogram only
- Angiogram with embolization
- Common null values

Additional Information

- Limit collection of angiography data to first 48 hours following ED/hospital arrival.
- The null value “Not Applicable” is used for patients that do not meet the collection criterion
- Excludes CTA
- Collect on all patients with transfusion blood within first 4 hours after ED/hospital arrival.

Data Source Hierarchy

1. Procedure (radiology) notes
2. Trauma Flow Sheet
3. Nursing Unit Flow Sheet
4. Physician / Progress notes

Uses

- Identifies whether angiography has been used for hemorrhage control.

EMBOLIZATION SITE

Data Format [combo] multiple-choice

Definition

Organ / site of embolization for hemorrhage control

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Embolization Site	**NTDB Element Number** PM_28
NTRACS Field Name Embolization Site	**NTDB Data Dictionary Page Number** 138

Field Values

- Relevant value for data element
- Liver
- Spleen
- Kidneys
- Pelvic (iliac, gluteal, obturator)
- Retro peritoneum (lumbar, sacral)
- Peripheral vascular (neck, extremities)
- Aorta (thoracic or abdominal)
- Common null values

Additional Information

- It is possible to undergo embolization of more than one site (i.e., more than 1 choice is possible).
- Multiple entry, max. 8
- The null value “Not Applicable” is used if the data field ANGIOGRAPHY = None or Angiography only.
- The null value “Not Applicable” is used for patients that do not meet the collection criterion
- Collect on all patients with transfusion blood within first 4 hours after ED/hospital arrival.

Data Source Hierarchy

1. Procedure (radiology) notes
2. Nursing Unit/ ICU Flow Sheet
3. Physician / Progress notes
4. Trauma Flow Sheet

Uses

- Identifies site of control of hemorrhage using angiography

ANGIOGRAPHY DATE

Data Format [date]

Definition

Date the first angiogram with or without embolization was performed

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Angiography Date	**NTDB Element Number** PM_29
NTRACS Field Name Angiography Date	**NTDB Data Dictionary Page Number** 139

Field Values

- Minimum constraint: 2013; Maximum constraint: 2030
- Common null values

Additional Information

- Collected as YYYY-MM-DD
- The null value “Not Applicable” is used if the data field ANGIOGRAPHY = None.
- The null value “Not Applicable” is used for patients that do not meet the collection criterion
- Collect on all patients with transfusion blood within first 4 hours after ED/hospital arrival.

Data Source Hierarchy

1. Radiology / Procedure notes
2. Nursing unit / ICU flow sheets
3. Trauma flow sheet
4. Physician / Progress notes

Uses

- Identifies the timing of angiography to achieve hemorrhage control.

ANGIOGRAPHY

Data Format [time]

Definition

Time the first angiogram with or without embolization was performed.

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Angiography Time	**NTDB Element Number** PM_30
NTRACS Field Name Angiography Time	**NTDB Data Dictionary Page Number** 140

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time
- The null value “Not Applicable” is used for patients that do not meet the collection criterion
- The null value “Not Applicable” is used if the data field ANGIOGRAPHY = None.
- Collect on all patients with transfusion blood within first 4 hours after ED/hospital arrival.

Data Source Hierarchy

1. Radiology / Procedure notes
2. Nursing unit / ICU flow sheets
3. Trauma flow sheet
4. Physician / Progress notes

Uses

- Identifies the timing of angiography to achieve hemorrhage control.

SURGERY FOR HEMORRHAGE CONTROL TYPE

Data Format [combo] multiple-choice

Definition

First type of surgery for hemorrhage control within the first 24 hours of ED/hospital arrival

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Surgery Hemorrhage Control Type	**NTDB Element Number** PM_31
NTRACS Field Name Surgery Hemorrhage Control Type	**NTDB Data Dictionary Page Number** 141

Field Values

- Relevant value for data element
- None
- Laparotomy
- Thoracotomy
- Sternotomy
- Extremity (peripheral vascular)
- Neck
- Mangled extremity/traumatic amputation

Additional Information

- Multiple sites are possible.
- No choice should be duplicated.
- If unclear if surgery was for hemorrhage control, then consult TMD or operating/ consulting/relevant surgeon.
- The null value "Not Applicable" is used for patients that do not meet the collection criterion.
- Collect on all patients with transfusion blood within first 4 hours after ED/hospital arrival.

Data Source Hierarchy

1. OR records
2. Anesthesia records
3. Procedure notes
4. Physician / Progress notes
5. Nursing records

Uses

- Identifies what operative intervention was used for hemorrhage control.

SURGERY FOR HEMORRHAGE CONTROL DATE

Data Format [date]

Definition

Date of first surgery for hemorrhage control within first 24 hours of ED/hospital arrival.

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Surgery Hemorrhage Control Date	**NTDB Element Number** PM_32
NTRACS Field Name Surgery Hemorrhage Control Date	**NTDB Data Dictionary Page Number** 142

Field Values

- Minimum constraint: 2010; Maximum constraint: 2030
- Common null values
- Select Not Applicable if no surgery for hemorrhage control

Additional Information

- Collected as YYYY-MM-DD
- If unclear if surgery was for hemorrhage control, then consult TMD or operating/ consulting/relevant surgeon.
- Code as Not Applicable if surgery for hemorrhage control is None.
- The null value "Not Applicable" is used for patients that do not meet the collection criterion.
- Collect on all patients with transfusion blood within first 4 hours after ED/hospital arrival.

Data Source Hierarchy

1. OR records
2. Anesthesia records
3. Procedure notes
4. Physician / Progress notes
5. Nursing records

Uses

- Identifies whether operative intervention was used for hemorrhage control

SURGERY FOR HEMORRHAGE CONTROL TIME

Data Format [time]

Definition

Time of first surgery for hemorrhage control within first 24 hours of ED/hospital arrival

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Surgery Hemorrhage Control Time	**NTDB Element Number** PM_33
NTRACS Field Name Surgery Hemorrhage Control Time	**NTDB Data Dictionary Page Number** 143

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time
- The null value "Not Applicable" is used for patients that do not meet the collection criterion.
- The null value "Not Applicable" is used if the data field SURGERY FOR HEMORRHAGE CONTROL TYPE = "1 None".
- Collect on all patients with transfusion blood within first 4 hours after ED/hospital arrival.

Data Source Hierarchy

1. OR records
2. Anesthesia records
3. Procedure notes
4. Physician / Progress notes
5. Nursing records

Uses

- Identifies whether operative intervention was used for hemorrhage control

WITHDRAWAL OF CARE

Data Format [combo] single-choice

Definition

Care was withdrawn based on a decision to either remove or withhold further life sustaining intervention. This decision must be documented in the medical record and is often, but not always, associated with a discussion with the legal next of kin.

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Withdrawal of Care	**NTDB Element Number** PM_34
NTRACS Field Name Withdrawal of Care	**NTDB Data Dictionary Page Number** 144

Field Values

- Yes
- No
- Common null values

Additional Information

- DNR is not a requirement.
- A note to limit escalation of care qualifies as a withdrawal of care. These interventions are limited to: ventilator support (with or without extubation), dialysis or other forms of renal support, institution of medications to support blood pressure or cardiac function, or a specific surgical, interventional or radiological procedure (e.g., decompressive craniectomy, operation for hemorrhage control, angiography). Note that this definition provides equal weight to the withdrawal of an intervention already in place (e.g., extubation) and a decision not to proceed with a life-saving intervention (e.g., intubation).
- Note that this definition provides equal weight to the withdrawal of an intervention already in place (e.g. extubation) and a decision not to proceed with a life-saving intervention (e.g. intubation).
- Excludes the discontinuation of CPR and typically involves prior planning.
- DNR order is not the same as withdrawal of care.
- Collect on all patients.

Data Source Hierarchy

1. Hospital Discharge Summary Sheet
2. Nurses' notes
3. Case Manager / Social Services' Notes

WITHDRAWAL OF CARE DATE

Data Format [date]

Definition

The date care was withdrawn

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Withdrawal of Care Date	**NTDB Element Number** PM_35
NTRACS Field Name Withdrawal of Care Date	**NTDB Data Dictionary Page Number** 145

Field Values

- Minimum constraint: 1990; Maximum constraint: 2030
- Common null values

Additional Information

- Collected as YYYY-MM-DD
- The null value “Not Applicable” is used for patients where Withdrawal of Care is “No”.
- Record the time the first of any existing life-sustaining intervention(s) is withdrawn (e.g. extubation). If no intervention(s) is in place, record the time the decision not to proceed with a life-saving intervention(s) occurs (e.g. intubation).
- Collect on all patients.

Data Source Hierarchy

1. Hospital Record
2. Billing Sheet / Medical Records Coding Summary Sheet
3. Physician Discharge Summary

WITHDRAWAL OF CARE TIME

Data Format [time]

Definition

The time care was withdrawn

Required in ATR Yes	**Required in NTDB** Yes
Web Field Name Withdrawal of Care Time	**NTDB Element Number** PM_36
NTRACS Field Name Withdrawal of Care Time	**NTDB Data Dictionary Page Number** 146

Field Values

- Minimum constraint: 00:00; Maximum constraint: 23:59
- Common null values

Additional Information

- Collected as HH:MM, military time
- The null value “Not Applicable” is used for patients where Withdrawal of Care is “No”.
- Record the time the first of any existing life-sustaining intervention(s) is withdrawn (e.g. extubation). If no intervention(s) is in place, record the time the decision not to proceed with a life-saving intervention(s) occurs (e.g. intubation).
- Collect on all patients.

Data Source Hierarchy

1. Hospital Record
2. Billing Sheet / Medical Records Coding Summary Sheet
3. Physician Discharge Summary

Modified FIM

Modified FIM must be collected by designated Level I and II hospitals on patients with hospital length of stay greater than 72 hours and at least one injury with head/neck AIS greater than equal to 3.

SELF-FEEDING SCORE

Data Format [combo] multiple-choice

Definition

Self-feeding Score includes the use of suitable utensils to bring food to the mouth, chewing, and swallowing, once the meal is presented in the customary manner on a table or tray.

Required in ATR Yes	**Required in NTDB** No
Web Field Name Self-Feeding Score	**NTDB Element Number** n/a
NTRACS Field Name Self-Feeding Score	**NTDB Data Dictionary Page Number** n/a

Field Values

- ?, Unknown
- /, Inappropriate
- 1, Dependent – Total help required
- 2, Dependent – Partial help required
- 3, Independent with Device
- 4, Independent

Additional Information

- Independent level, the patient eats from a dish while managing all consistencies of food, and drink from a cup or glass with the meal presented in the customary manner on a table or tray.

- The patient uses suitable utensils to bring food to the mouth; food is chewed and swallowed. Performs independently and safely. If the activity requires total assistance, score as dependent – total help required.

Note

- Patient must have a hospital length of stay greater than 72 hours and at least one injury with head/neck AIS greater than equal to 3.

Data Source Hierarchy

SELF-FEEDING STATUS

Data Format [combo] multiple-choice

Definition

Self-feeding Status includes the use of suitable utensils to bring food to the mouth, chewing, and swallowing, once the meal is presented in the customary manner on a table or tray.

Required in ATR Yes	**Required in NTDB** No
Web Field Name Self-Feeding Status	**NTDB Element Number** n/a
NTRACS Field Name Self-Feeding Status	**NTDB Data Dictionary Page Number** n/a

Field Values

- P, Permanent
- T, Temporary
- ?, Unknown
- /, Inappropriate

Additional Information

- Independent level, the patient eats from a dish while managing all consistencies of food, and drink from a cup or glass with the meal presented in the customary manner on a table or tray.

- The patient uses suitable utensils to bring food to the mouth; food is chewed and swallowed. Performs independently and safely. If the activity requires total assistance, score as dependent – total help required.

Note

- Patient must have a hospital length of stay greater than 72 hours and at least one injury with head/neck AIS greater than equal to 3.

Data Source Hierarchy

LOCOMOTION SCORE

Data Format [combo] multiple-choice

Definition

Locomotion score includes walking, once in a standing position, on a level surface.

Required in ATR Yes	**Required in NTDB** No
Web Field Name Locomotion Score	**NTDB Element Number** n/a
NTRACS Field Name Locomotion Score	**NTDB Data Dictionary Page Number** n/a

Field Values

- ?, Unknown
- /, Inappropriate
- 1, Dependent – Total help required
- 2, Dependent – Partial help required
- 3, Independent with Device
- 4, Independent

Additional Information

- Independent level, the patient walks a minimum of 150 feet (50 meters), in a reasonable time, without assistance or assistive devices, independently and safely.

Note

- Patient must have a hospital length of stay greater than 72 hours and at least one injury with head/neck AIS greater than equal to 3.

Data Source Hierarchy

LOCOMOTION STATUS

Data Format [combo] multiple-choice

Definition

Locomotion status includes walking, once in a standing position, on a level surface.

Required in ATR Yes	**Required in NTDB** No
Web Field Name Locomotion Status	**NTDB Element Number** n/a
NTRACS Field Name Locomotion Status	**NTDB Data Dictionary Page Number** n/a

Field Values

- P, Permanent
- T, Temporary
- ?, Unknown
- /, Inappropriate

Additional Information

- Independent level, the patient walks a minimum of 150 feet (50 meters), in a reasonable time, without assistance or assistive devices, independently and safely.

Note

- Patient must have a hospital length of stay greater than 72 hours and at least one injury with head/neck AIS greater than equal to 3.

Data Source Hierarchy

EXPRESSION SCORE

Data Format [combo] multiple-choice

Definition

Expression score includes clear vocal or non-vocal expression of language. This includes either intelligible speech or clear expression of language using writing or a communication device.

Required in ATR Yes	**Required in NTDB** No
Web Field Name Expression Score	**NTDB Element Number** n/a
NTRACS Field Name Expression Score	**NTDB Data Dictionary Page Number** n/a

Field Values

- ?, Unknown
- /, Inappropriate
- 1, Dependent – Total help required
- 2, Dependent – Partial help required
- 3, Independent with Device
- 4, Independent

Additional Information

- At the independent level, the patient expresses complex or abstract ideas clearly and fluently.

Note

- Patient must have a hospital length of stay greater than 72 hours and at least one injury with head/neck AIS greater than equal to 3.

Data Source Hierarchy

EXPRESSION STATUS

Data Format [combo] multiple-choice

Definition

Expression status includes clear vocal or non-vocal expression of language. This includes either intelligible speech or clear expression of language using writing or a communication device.

Required in ATR Yes	**Required in NTDB** No
Web Field Name Expression Status	**NTDB Element Number** n/a
NTRACS Field Name Expression Status	**NTDB Data Dictionary Page Number** n/a

Field Values

- P, Permanent
- T, Temporary
- ?, Unknown
- /, Inappropriate

Additional Information

- At the independent level, the patient expresses complex or abstract ideas clearly and fluently.

Note

- Patient must have a hospital length of stay greater than 72 hours and at least one injury with a head/neck AIS greater than equal to 3.

Data Source Hierarchy

GROOMING SCORE

Data Format [combo] multiple-choice

Definition

Grooming score includes oral care, hair grooming (combing and brushing hair), washing the hands and face, and either shaving the face or applying make-up.

Required in ATR Yes	**Required in NTDB** No
Web Field Name Grooming Score	**NTDB Element Number** n/a
NTRACS Field Name Grooming	**NTDB Data Dictionary Page Number** n/a

Field Values

- ?, Unknown
- /, Inappropriate
- 1, Dependent – Total help required
- 2, Dependent – Partial help required
- 3, Independent with Device
- 4, Independent

Additional Information

- At the independent level, the patient cleans his or her own teeth or dentures, combs or brushes his or her own hair, washes his or her hands and face, and may shave or apply make-up, including all preparations.
- If patient neither shaves nor applies make-up, grooming only includes the first four tasks.

Note

- Patient must have a hospital length of stay greater than 72 hours and at least one injury with head/neck AIS greater than equal to 3.

Data Source Hierarchy

GROOMING STATUS

Data Format [combo] multiple-choice

Definition

Grooming status includes oral care, hair grooming (combing and brushing hair), washing the hands and face, and either shaving the face or applying make-up.

Required in ATR Yes	**Required in NTDB** No
Web Field Name Grooming Score	**NTDB Element Number** n/a
NTRACS Field Name GRMSTATUS	**NTDB Data Dictionary Page Number** n/a

Field Values

- P, Permanent
- T, Temporary
- ?, Unknown
- /, Inappropriate

Additional Information

- At the independent level, the patient cleans his or her own teeth or dentures, combs or brushes his or her own hair, washes his or her hands and face, and may shave or apply make-up, including all preparations.
- If patient neither shaves nor applies make-up, grooming only includes the first four tasks.

Note

- Patient must have a hospital length of stay greater than 72 hours and at least one injury with head/neck AIS greater than equal to 3.

Data Source Hierarchy

PROBLEM SOLVING SCORE

Data Format [combo] multiple-choice

Definition

Problem solving score includes skills related to making reasonable, safe, and timely decisions regarding financial, social, and personal affairs, and initiating, sequencing, and self-correcting tasks and activities to solve problems.

Required in ATR Yes	**Required in NTDB** No
Web Field Name Problem Solving Score	**NTDB Element Number** n/a
NTRACS Field Name PRBSOLVNG	**NTDB Data Dictionary Page Number** n/a

Field Values

- ?, Unknown
- /, Inappropriate
- 1, Dependent – Total help required
- 2, Dependent – Partial help required
- 3, Independent with Device
- 4, Independent

Additional Information

- At the independent level, the patient consistently recognizes a problem, makes appropriate decisions, initiates and carries out a sequence of steps to solve complex problems until the task is completed, and self-corrects if errors are made..

Note

- Patient must have a hospital length of stay greater than 72 hours and at least one injury with a head/neck AIS greater than equal to 3.

Data Source Hierarchy

PROBLEM SOLVING STATUS

Data Format [combo] multiple-choice

Definition

Problem solving status includes skills related to making reasonable, safe, and timely decisions regarding financial, social, and personal affairs, and initiating, sequencing, and self-correcting tasks and activities to solve problems.

Required in ATR Yes	**Required in NTDB** No
Web Field Name Problem Solving Status	**NTDB Element Number** n/a
NTRACS Field Name PRBSOLSTAT	**NTDB Data Dictionary Page Number** n/a

Field Values

- P, Permanent
- T, Temporary
- ?, Unknown
- /, Inappropriate

Additional Information

- At the independent level, the patient consistently recognizes a problem, makes appropriate decisions, initiates and carries out a sequence of steps to solve complex problems until the task is completed, and self-corrects if errors are made..

Note

- Patient must have a hospital length of stay greater than 72 hours and at least one injury with a head/neck AIS greater than equal to 3.

Data Source Hierarchy

APPENDICES

Appendix 1: Detailed Data Elements

This appendix includes elements that require more detail. The elements listed here will show what the menu choices are across all registry systems and data dictionaries. The data elements are child specific restraint, airbag deployment, GCS qualifiers, alternate home residence, and initial ED/Hospital GCS verbal.

Data Element	NTRACS Registry	ATR Data Dictionary/Web Portal	NTDB Data Dictionary
Child Specific Restraint	Infant/Child Car Seat Common null values	Child car seat Infant car seat Child booster seat Common null values	1 Child car seat 2 Infant car seat 3 Child booster seat Common null values
Air Bag Deployment	Air Bag, Air Bag Only Common null values	Airbag not deployed Airbag deployed front Airbag deployed side Airbag deployed other (knee, airbelt, curtain, etc.) Common null values	1 Airbag not deployed 2 Airbag deployed front 3 Airbag deployed side 4 Airbag deployed other (knee, airbelt, curtain, etc.) Common null values

Appendix 1 Cont'd…

Data Element	NTRACS Registry	ATR Data Dictionary/Web Portal	NTDB Data Dictionary
GCS Qualifiers	L, Legitimate value without intervention (intubate, paralytics) S, Chemically sedated T, Intubated TP, Intubated and chemically paralyzed V, Unknown Z, Inappropriate	Patient chemically sedated or paralyzed Obstruction to the patient's eye Patient intubated Valid GCS: patient was not sedated, not intubated, and did not have obstruction to the eye. Common null 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. Common null values
Alternate Home Residence	1, Homeless 2, Undocumented citizen 3, Migrant 4, Foreign visitor ?, Unknown /, Not applicable	Homeless Undocumented citizen Migrant worker Foreign visitor Common null values	1 Homeless 2 Undocumented citizen 3 Migrant worker 4 Foreign visitor Common null values
Initial ED/Hospital GCS Verbal	?, Unknown /, Inappropriate 1, No response 2, Incomprehensible sounds 3, Inappropriate words 4, Disoriented and converses 5, Oriented and converses	<u>Pediatric (<= 2 years)</u>: No vocal response Inconsolable, agitated Inconsistently consolable, moaning Cries but is consolable, inappropriate interactions Smiles, oriented to sounds, follows objects, interacts <u>Adult</u>: No verbal response Incomprehensible sounds Inappropriate words Confused Oriented Common null values	<u>Pediatric (<= 2 years)</u>: 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 <u>Adult</u>: 1 No verbal response 2 Incomprehensible sounds 3 Inappropriate words 4 Confused 5 Oriented Common null values

Appendix 2: Change Log

This appendix keeps record of what data elements have been added, deleted, or modified in the data dictionary. It will also reference changes between versions of the data dictionary.

- The following data points have been removed:
  - Referring hospital admission type
  - Referring hospital GCS assessment qualifiers
  - Referring hospital procedures

- The following elements have been modified:
  - Inclusion criteria sheet and diagram
  - Table of contents

- The following elements have been added:
  - Cross-reference to page numbers in NTDB
  - Showcase web field name and NTRACS field name for each data element
  - Change log

Appendix 3: Glossary

CO-MORBID CONDITIONS

Alcoholism: Evidence of chronic use, such as withdrawal episodes. Exclude isolated elevated blood alcohol level in absence of history of abuse.

Ascites within 30 days: The presence of fluid accumulation (other than blood) in the peritoneal cavity noted on physical examination, abdominal ultrasound, or abdominal CT/MRI.

Bleeding disorder: Any condition that places the patient at risk for excessive bleeding due to a deficiency of blood clotting elements (e.g., vitamin K deficiency, hemophilia, thrombocytopenia, chronic anticoagulation therapy with Coumadin, Plavix, or similar medications.) Do not include patients on chronic aspirin therapy.

Currently receiving chemotherapy for cancer: A patient who is currently receiving any chemotherapy treatment for cancer prior to admission. Chemotherapy may include, but is not restricted to, oral and parenteral treatment with chemotherapeutic agents for malignancies such as colon, breast, lung, head and neck, and gastrointestinal solid tumors as well as lymphatic and hematopoietic malignancies such as lymphoma, leukemia, and multiple myeloma.

Congenital Anomalies: Documentation of a cardiac, pulmonary, body wall, CNS/spinal, GI, renal, orthopaedic, or metabolic congenital anomaly.

Congestive Heart Failure: 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. 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 on lying supine)

• Paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea)

• Increased jugular venous pressure

• Pulmonary rales on physical examination

• Cardiomegaly

• Pulmonary vascular engorgement

Current Smoker: A patient who reports smoking cigarettes every day or some days. Excludes patients who smoke cigars or pipes or use smokeless tobacco (chewing tobacco or snuff.)

Chronic renal failure: Acute or chronic renal failure prior to injury that was requiring periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration.

CVA/residual neurological deficit: 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.)

Diabetes mellitus: Diabetes mellitus prior to injury that required exogenous parenteral insulin or an oral hypoglycemic agent.

Disseminated cancer: Patients who have cancer that has spread to one site or more sites in addition to the primary site and whom the presence of multiple metastases indicates the cancer is widespread, fulminant, or near terminal. Other terms describing disseminated cancer include: “diffuse,” “widely metastatic,” “widespread,” or “carcinomatosis.” Common sites of metastases include major organs, (e.g., brain, lung, liver, meninges, abdomen, peritoneum, pleura, bone.)

Advanced directive limiting care: The patient had a Do Not Resuscitate (DNR) document or similar advanced directive recorded prior to injury.

Esophageal varices: Esophageal varices are engorged collateral veins in the esophagus which bypass a scarred liver to carry portal blood to the superior vena cava. A sustained increase in portal pressure results in esophageal varices which are most frequently demonstrated by direct visualization at esophagoscopy.

Functionally dependent health status: Pre-injury functional status may be represented by the ability of the patient to complete activities of daily living (ADL) including: bathing, feeding, dressing, toileting, and walking. This item is marked YES if the patient, prior to injury, was partially dependent or completely dependent upon equipment, devices or another person to complete some or all activities of daily living.

Formal definitions of dependency are listed below:

*Partially dependent***:** The patient requires the use of equipment or devices coupled with assistance from another person for some activities of daily living. Any patient coming from a nursing home setting who is not totally dependent would fall into this category, as would any patient who requires kidney dialysis or home ventilator support that requires chronic oxygen therapy yet maintains some independent functions.

*Totally dependent***:** The patient cannot perform any activities of daily living for himself/herself. This would include a patient who is totally dependent upon nursing care, or a dependent nursing home patient. All patients with psychiatric illness should be evaluated for their ability to function with or without assistance with ADLs just as the non-psychiatric patient.

History of angina within past 1 month: Pain or discomfort between the diaphragm and the mandible resulting from myocardial ischemia. Typically angina is a dull, diffuse (fist sized or larger) sub sternal chest discomfort precipitated by exertion or emotion and relieved by rest or nitroglycerine. Radiation often occurs to the arms and shoulders and occasionally to the neck, jaw (mandible, not maxilla), or interscapular region. For patients on anti-angina medications, enter yes only if the patient has had angina within one month prior to admission.

History of myocardial infarction: The history of a non-Q wave, or a Q wave infarction in the six months prior to injury and diagnosed in the patient’s medical record.

History of Peripheral Vascular disease (PVD): Any type of operative (open) or interventional radiology angioplasty or revascularization procedure for atherosclerotic PVD (e.g., aorta-femoral, femoral-femoral, femoral-popliteal, balloon angioplasty, stenting, etc.) Patients who have had amputation from trauma or resection/repair of abdominal aortic aneurysms, including Endovascular Repair of Abdominal Aortic Aneurysm (EVAR,) would not be included.

Hypertension requiring medication: History of a persistent elevation of systolic blood pressure >140mm Hg and a diastolic blood pressure >90mm Hg requiring an antihypertensive treatment (e.g., diuretics, beta blockers, angiotensin-converting enzyme (ACE) inhibitors, calcium channel blockers.)

Prematurity: Documentation of premature birth, a history of bronchopulmonary dysplasia, or ventilator support for greater than 7 days after birth. Premature birth is defined as infants delivered before 37 weeks from the first day of the last menstrual period.

Obesity: A Body Mass Index of 30 or greater.

Respiratory Disease: Severe chronic lung disease, chronic obstructive pulmonary disease (COPD) such as emphysema and/or chronic bronchitis resulting in any one of more of the following:

• Functional disability from COPD (e.g., dyspnea, inability to perform activities of daily living [ADLs].)

• Hospitalization in the past for treatment of COPD.

• Requires chronic bronchodialator therapy with oral or inhaled agents.

• A Forced Expiratory Volume in 1 second (FEV1) of <75% of predicted on pulmonary function testing.

• Do not include patients whose only pulmonary disease is acute asthma. Do not include patients with diffuse interstitial fibrosis or sarcoidosis.

Steroid use: Patients that required the regular administration of oral or parenteral corticosteroid medications (e.g., prednisone, dexamethasone in the 30 days prior to injury for a chronic medical condition (e.g., COPD, asthma, rheumatologic disease, rheumatoid arthritis, inflammatory bowel disease.) Do not include topical corticosteroids applied to the skin or corticosteroids administered by inhalation or rectally.

Cirrhosis: Documentation in the medical record of cirrhosis, which might also be referred to as end stage liver disease. If there is documentation of prior or present esophageal or gastric varices, portal hypertension, previous hepatic encephalopathy, or ascites with notation of liver disease, then cirrhosis should be considered present. Cirrhosis should also be considered present if documented by diagnostic imaging studies or a laparotomy/laparoscopy.

Dementia: With particular attention to senile or vascular dementia (e.g., Alzheimer's.)

Major psychiatric illness: Documentation of the presence of pre-injury major depressive disorder, bipolar disorder, schizophrenia, anxiety/panic disorder, borderline or antisocial personality disorder, and/or adjustment disorder/post-traumatic stress disorder.

Drug abuse or dependency: With particular attention to opioid, sedative, amphetamine, cocaine, diazepam, alprazolam, or lorazepam dependence (excludes ADD/ADHD or chronic pain with medication use as prescribed.)

Pre-hospital cardiac arrest with CPR: A sudden, abrupt loss of cardiac function which occurs outside of the hospital, prior to admission at the center in which the registry is maintained, that results in loss of consciousness requiring the initiation of any component of basic and/or advanced cardiac life support by a health care provider.

COMPLICATIONS

Acute kidney injury: A patient who did not require chronic renal replacement therapy prior to injury, who has worsening renal dysfunction after injury requiring renal replacement therapy. If the patient or family refuses treatment (e.g., dialysis,) the condition is still considered to be present if a combination of oliguria and creatinine are present.

• *GFR criteria***:** Increase creatinine x3 or GFR decrease >75%

• *Urine output criteria***:** UO <0.3ml/kg/h x 24 hr or Anuria x 12 hrs

ALI/ARDS Acute Lung Injury/Adult (Acute) Respiratory Distress Syndrome: ALI/ARDS occurs in conjunction with catastrophic medical conditions, such as pneumonia, shock, sepsis (or severe infection throughout the body, sometimes also referred to as systemic infection, and may include or also be called a blood or blood-borne infection,) and trauma. It is a form of sudden and often severe lung failure that is usually characterized by a PaO2/Fi02 ratio of <300 mmHg, bilateral fluffy infiltrates seen on a frontal chest radiograph, and an absence of clearly demonstrable volume overload (as signified by pulmonary wedge pressure , 18mmHg, if measured, or other similar surrogates such as echocardiography which do not demonstrate analogous findings.)

Cardiac arrest with CPR: The sudden abrupt loss of cardiac function that results in loss of consciousness requiring the initiation of any component of basic and/or advanced cardiac life support. EXCLUDE patients that arrive at the hospital in full arrest.

Decubitus ulcer: Any partial or full thickness loss of dermis resulting from pressure exerted by the patient's weight against a surface. Deeper tissues may or may not be involved. Equivalent to NPUAP Stages II – IV and NPUAP "unstageable" ulcers. EXCLUDES intact skin with non-blanching redness (NPUAP Stage I,) which is considered reversible tissue injury.

Deep surgical site infection: A deep incisional SSI must meet one of the following criteria:

Infection occurs within 30 days after the operative procedure if no implant is left in place or within one year if implant is in place and the infection appears to be related to the operative procedure and involves deep soft tissues (e.g., fascial and muscle layers) of the incision; AND patient has at least one of the following:

• Purulent drainage from the deep incision but not from the organ/space component of the surgical site of the following:

• A deep incision spontaneously dehisces or is deliberately opened by a surgeon and is culture-positive or not cultured when the patient has at least one of the following signs or symptoms: fever (>38C,) or localized pain or tenderness. A culture negative finding does not meet this criterion.

• An abscess or other evidence of infection involving the deep incision is found on direct examination, during reoperation, or by histopathologic or radiologic examination.

• Diagnosis of a deep incisional SSI by a surgeon or attending physician.

NOTE: There are two specific types of deep incisional 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., Csection 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 [leg] incision for CBGB.)

REPORTING INSTRUCTION: Classify infection that involves both superficial and deep incision sites as deep incisional SSI.

Drug or alcohol withdrawal syndrome: A set of symptoms that may occur when a person who has been habitually drinking too much alcohol or habitually using certain drugs (e.g., narcotics, benzodiazepine) experiences physical symptoms upon suddenly stopping consumption. Symptoms may include: activation syndrome (i.e., tremulousness, agitation, rapid heartbeat and high blood pressure,) seizures, hallucinations or delirium tremens.

Deep Vein Thrombosis (DVT): The formation, development, or existence of a blood clot or thrombus within the vascular system, which may be coupled with inflammation. This diagnosis may be confirmed by a venogram, ultrasound, or CT. The patient must be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava.

Extremity compartment syndrome: A condition not present at admission in which there is documentation of tense muscular compartments of an extremity through clinical assessment or direct measurement of intracompartmental pressure requiring fasciotomy. Compartment syndromes usually involve the leg but can also occur in the forearm, arm, thigh, and shoulder. Record as a complication if it is originally missed, leading to late recognition, a need for late intervention, and has threatened limb viability.

Graft/prosthesis/flap failure: Mechanical failure of an extracardiac vascular graft or prosthesis including myocutaneous flaps and skin grafts requiring return to the operating room or a balloon angioplasty.

Myocardial infarction: A new acute myocardial infarction occurring during hospitalization (within 30 days of injury.)

Organ/space surgical site infection: An infection that occurs within 30 days after an operation and infection involves any part of the anatomy (e.g., organs or spaces) other than the incision, which was opened or manipulated during a procedure; and at least one of the following, including:

• Purulent drainage from a drain that is placed through a stab wound or puncture into the organ/space.

• Organisms isolated from an aseptically obtained culture of fluid or tissue in the organ/space.

• An abscess or other evidence of infection involving the organ/space that is found on direct examination, during reoperation, or by histopathologic or radiologic examination

• Diagnosis of an organ/space SSI by a surgeon or attending physician.

Pneumonia: Patients with evidence of pneumonia that develops during the hospitalization and meets at least one of the following two criteria:

• *Criterion #1:* Rales or dullness to percussion on physical examination of chest AND any of the following:

- New onset of purulent sputum or change in character of sputum.

- Organism isolated from blood culture.

- Isolation of pathogen from specimen obtained by transtracheal

aspirate, bronchial brushing, or biopsy.

• *Criterion #2:* Chest radiographic examination shows new or progressive infiltrate, consolidation, cavitation, or pleural effusion AND any of the following:

- New onset of purulent sputum or change in character of sputum.
- Organism isolated from the blood.
- Isolation of pathogen from specimen obtained by transtracheal aspirate, bronchial brushing, or biopsy
- Isolation of virus or detection of viral antigen in respiratory secretions
- Diagnostic single antibody titer (IgM) or fourfold increase in paired serum samples (IgG) for pathogen
- Histopathologic evidence of pneumonia

Pulmonary embolism: 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. Consider the condition present if the patient has a V-Q scan interpreted as high probability of pulmonary embolism or a positive pulmonary arteriogram or positive CT angiogram.

Stroke/CVA: A focal or global neurological deficit of rapid onset and NOT present on admission. The patient must have at least one of the following symptoms:

• Change in level of consciousness

• Hemiplegia

• Hemiparesis

• Numbness or sensory loss affecting on side of the body

• Dysphasia or aphasia

• Hemianopia

• Amaurosis fugax

• Other neurological signs or symptoms consistent with stroke

AND:

• Duration of neurological deficit ≥24 h

OR:

• Duration of deficit <24 h, if neuroimaging (MR, CT, or cerebral angiography)

documents a new hemorrhage or infact 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.) 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.

Superficial surgical site infection: An infection that occurs within 30 days after an operation and infection involves only skin or subcutaneous tissue of the incision and at least one of the following:

• Purulent drainage, with or without laboratory confirmation, from the superficial incision.

• Organisms isolated from an aseptically obtained culture of fluid or tissue from the superficial incision.

• At least one of the following signs or symptoms of infection: pain or tenderness, localized swelling, redness, or heat and superficial incision is deliberately opened by the surgeon, unless incision is culture-negative.

• Diagnosis of superficial incisional surgical site infection by the surgeon or attending physician.

Do not report the following conditions as superficial surgical site infection:

• Stitch abscess (minimal inflammation and discharge confined to the points of suture penetration.)

• Infected burn wound.

• Incisional SSI that extends into the fascial and muscle layers (see deep surgical site infection.)

Unplanned intubation: Patient requires placement of an endotracheal tube and mechanical or assisted ventilation because of the onset of respiratory or cardiac failure manifested by severe respiratory distress, hypoxia, hypercarbia, or respiratory acidosis. In patients who were intubated in the field or Emergency Department, or those intubated for surgery, unplanned intubation occurs if they require reintubation > 24 hours after extubation.

Urinary Tract Infection: An infection anywhere along the urinary tract with clinical evidence of infection, which includes at least one of the following symptoms with no other recognized cause:

• Fever $\geq$ 38^{0} C

• WBC > 10,000 or < 3,000 per cubic millimeter

• Urgency

• Frequency

• Dysuria

• Suprapubic tenderness

AND:

• Positive urine culture (≥ 100,000 microorganisms per cm3 of urine with no more than two species of microorganisms)

OR:

• At least two of the following signs or symptoms with no other recognized cause:

• Fever ≥ 38^0 C

• WBC >10,000 or <3,000 per cubic millimeter

• Urgency

• Frequency

• Dysuria

• Suprapubic tenderness

AND at least one of the following:

• Positive dipstick for leukocyte esterase and/or nitrate

• Pyuria (urine specimen with >10 WBC/mm3 or >3 WBC/high power field or unspun urine

• Organisms seen on Gram stain of unspun urine

• At least two urine cultures with repeated isolation of the same unopathogen (gram-negative bacteria or S. saprophyticus) with ≥102 colonies/ml in nonvoided specimens

• ≤105 colonies/ml of a single uropathogen (gram-negative bacteria or S. saprophyticus) in a patient being treated with an effective antimicrobial agent for a urinary tract infection

• Physician diagnosis of a urinary tract infection

• Physician institutes appropriate therapy for a urinary tract infection excludes asymptomatic bacteriuria and “other” UTIs that are more like deep space infections of the urinary tract.

Catheter-Related Blood Stream Infection: An organism cultured from the bloodstream that is not

related to an infection at another site but is attributed to a central venous catheter. Patients must have evidence of infection including at least one of the following:

• *Criterion #1:* Patient has a recognized pathogen cultured from one or more blood cultures and organism cultured from blood is not related to an infection at another site.

OR:

• *Criterion #2:* Patient has at least one of the following signs or symptoms:

o Fever ≥ 38⁰ C

o Chills

o WBC > 10,000 or < 3,000 per cubic millimeter

o Hypotension (SBP<90) or >25% drop in systolic blood pressure

o Signs and symptoms and positive laboratory results are not related to an infection at another site AND common skin contaminant (i.e., diphtheroids [Corynebacterium spp.], Baccillus [not B. anthracis] spp.,

Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis,] viridans group streptococcik, Aerococcus spp., Micrococcus spp.) is cultured from two or more blood cultures drawn on separate occasions.

OR:

• *Criterion #3:* Patient <1 year of age has at least one of the following signs or symptoms:

o Fever > 38⁰ C

o Hypothermia < 36⁰ C

o Apnea, or bradycardia

o Signs and symptoms and positive laboratory results are not related to an infection at another site and common skin contaminant (i.e., diptheroids [Corynebacterium sup.] Bacillus [not B. anthracis] spp.,

Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., Micrococcus spp.) is cultured from two or more blood cultures drawn

on separate occasions. Erythema at the entry site of the central line or positive cultures on the tip of the line in the absence of positive blood cultures is not considered a CRBSI.

Osteomyelitis: Defined as meeting at least one of the following criteria:

• Organisms cultured from bone.

• Evidence of osteomyelitis on direct examination of the bone during a surgical operation or histopathologic examination.

• At least two of the following signs or symptoms with no other recognized cause:

o Fever (38^0 C)

o Localized swelling at suspected site of bone infection

o Tenderness at suspected site of bone infection

o Heat at suspected site of bone infection

o Drainage at suspected site of bone infection

AND at least one of the following:

o Organisms cultured from blood positive blood antigen test (e.g., H. influenza, S. pneumonia)

o Radiographic evidence of infection, e.g., abnormal findings on x-ray, CT scan, magnetic resonance imaging (MRI,) radiolabel scan (gallium,technetium, etc.)

Unplanned return to the OR: Unplanned return to the operating room after initial operation

management for a similar or related previous procedure.

Unplanned return to the ICU: Unplanned return to the intensive care unit after initial ICU discharge. Does not apply if ICU care is required for postoperative care of a planned surgical procedure.

Severe sepsis: Sepsis and/or Severe Sepsis defined as an obvious source of infection with bacteremia and two or more of the following:

• Temp >38^0 C or <36^0 C

• WBC count >12,000/mm^3, or > 20%immature (source of infection)

• Hypotension – (Severe Sepsis)

• Evidence of hypo perfusion: (Severe Sepsis)

• Anion gap or lactic acidosis or Oliguria, or Altered mental status.

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

Field Value Definitions:

Finance and Insurance - The Finance and Insurance sector comprises establishments primarily engaged in financial transactions (transactions involving the creation, liquidation, or change in ownership of financial assets) and/or in facilitating financial transactions. Three principal types of activities are identified:

1. Raising funds by taking deposits and/or issuing securities and, in the process, incurring liabilities.
2. Pooling of risk by underwriting insurance and annuities.
3. Providing specialized services facilitating or supporting financial intermediation, insurance, and employee benefit programs.

Real Estate - Industries in the Real Estate subsector group establishments that are primarily engaged in renting or leasing real estate to others; managing real estate for others; selling, buying, or renting real estate for others; and providing other real estate related services, such as appraisal services.

Manufacturing - The Manufacturing sector comprises establishments engaged in the mechanical, physical, or chemical transformation of materials, substances, or components into new products. Establishments in the Manufacturing sector are often described as plants, factories, or mills and characteristically use power-driven machines and materials-handling equipment. However, establishments that make new products by hand, such as bakeries, candy stores, and custom tailors, may also be included in this sector.

Retail Trade - The Retail Trade sector comprises establishments engaged in retailing merchandise, generally without transformation, and rendering services incidental to the sale of merchandise. The retailing process is the final step in the distribution of merchandise; retailers are, therefore, organized to sell merchandise in small quantities to the general public. This sector comprises two main types of retailers:

1. Store retailers operate fixed point-of-sale locations, located and designed to attract a high volume of walk-in customers.
2. Non-store retailers, like store retailers, are organized to serve the general public, but their retailing methods differ.

Transportation and Public Utilities - The Transportation and Warehousing sector includes industries providing transportation of passengers and cargo, warehousing and storage for goods, scenic and sightseeing transportation, and support activities related to modes of transportation. The Utilities sector

comprises establishments engaged in the provision of the following utility services: electric power, natural gas, steam supply, water supply, and sewage removal.

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

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

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

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

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

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

PATIENT'S OCCUPATION: The occupation of the patient.

Field Value Definitions:

Business and Financial Operations Occupations:

Buyers and Purchasing Agents

Accountants and Auditors

Claims Adjusters, Appraisers, Examiners, and Investigators

Human Resources Workers

Market Research Analysts and Marketing Specialists

Business Operations Specialists, All Other

Architecture and Engineering Occupations

Landscape Architects

Surveyors, Cartographers, and Photogrammetrists

Agricultural Engineers

Chemical Engineers Civil

Engineers Electrical Engineers

Community and Social Services Occupations

Marriage and Family Therapists

Substance Abuse and Behavioral Disorder Counselors

Healthcare Social Workers

Probation Officers and Correctional Treatment Specialists

Clergy

Education, Training, and Library Occupations

Engineering and Architecture Teachers, Postsecondary Math and

Computer Teachers, Postsecondary

Nursing Instructors and Teachers, Postsecondary

Law, Criminal Justice, and Social Work Teachers, Postsecondary

Preschool and Kindergarten Teachers

Librarians

Healthcare Practitioners and Technical Occupations

Dentists, All Other Specialists Dietitians and Nutritionists Physicians and Surgeons Nurse

Practitioners Cardiovascular Technologists and Technicians

Emergency Medical Technicians and Paramedics

Protective Service Occupations

Firefighters

Police Officers

Animal Control Workers Security Guards

Lifeguards, Ski Patrol, and Other Recreational Protective Service

Building and Grounds Cleaning and Maintenance

Building Cleaning Workers

Landscaping and Grounds keeping Workers

Pest Control Workers

Pesticide Handlers, Sprayers, and Applicators, Vegetation

Tree Trimmers and Pruners

Sales and Related Occupations

Advertising Sales Agents

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Retail Salespersons

Counter and Rental Clerks

Door-to-Door Sales Workers, News and Street Vendors, and Related Workers

Real Estate Brokers

Farming, Fishing, and Forestry Occupations

Animal Breeders

Fishers and Related Fishing Workers Agricultural Equipment Operators Hunters and Trappers

Forest and Conservation Workers

Logging Workers

Installation, Maintenance, and Repair Occupations

Electric Motor, Power Tool, and Related Repairers Aircraft Mechanics and Service

Technicians Automotive Glass

Installers and Repairers

Heating, Air Conditioning, and Refrigeration Mechanics and Installers

Maintenance Workers, Machinery Industrial Machinery Installation, Repair, and Maintenance Workers

Transportation and Material Moving Occupations

Rail Transportation Workers, All Other Subway and Streetcar Operators Packers and Packagers, Hand Refuse and Recyclable Material Collectors Material Moving Workers, All Other Driver/Sales Workers

Management Occupations

Public Relations and Fundraising Managers Marketing and Sales Managers Administrative Services Managers

Transportation, Storage, and Distribution Managers Food Service Managers

Computer and Mathematical Occupations

Web Developers

Software Developers and Programmers

Database Administrators

Statisticians

Computer Occupations, All Other

Life, Physical, and Social Science Occupations

Psychologists

Economists Foresters

Zoologists and Wildlife Biologists

Political Scientists

Agricultural and Food Science Technicians

Legal Occupations

Lawyers and Judicial Law Clerks Paralegals and Legal Assistants Court Reporters

Administrative Law Judges, Adjudicators, and Hearing Officers

Arbitrators, Mediators, and Conciliators

Title Examiners, Abstractors, and Searchers

Arts, Design, Entertainment, Sports, and Media

Artists and Related Workers, All Other Athletes, Coaches, Umpires, and Related Workers

Dancers and Choreographers

Reporters and Correspondents

Interpreters and Translators

Photographers

Healthcare Support Occupations

Nursing, Psychiatric, and Home Health Aides

Physical Therapist Assistants and Aides

Veterinary Assistants and Laboratory Animal Caretakers

Healthcare Support Workers, All Other

Medical Assistants

Food Preparation and Serving Related

Bartenders, Cooks, Institution and Cafeteria

Cooks, Fast Food

Counter Attendants, Cafeteria, Food Concession, and Coffee Shop

Waiters and Waitresses, Dishwashers

Personal Care and Service Occupations

Animal Trainers

Amusement and Recreation Attendants

Barbers, Hairdressers, Hairstylists and Cosmetologists

Baggage Porters, Bellhops, and Concierges

Tour Guides and Escorts

Recreation and Fitness Workers

Office and Administrative Support Occupations

Bill and Account Collectors

Gaming Cage Workers

Payroll and Timekeeping Clerks, Tellers

Court, Municipal, and License Clerks

Hotel, Motel, and Resort Desk Clerks

Construction and Extraction Occupations

Brick masons, Block masons, and Stonemasons

Carpet, Floor, and Tile Installers and Finishers

Construction Laborers, Electricians

Pipe layers, Plumbers, Pipe fitters, Steam fitters and Roofers

Production Occupations

Electrical, Electronics, and Electromechanical Assemblers

Engine and Other Machine Assemblers

Structural Metal Fabricators and Fitters

Butchers and Meat Cutters

Machine Tool Cutting Setters, Operators, and Tenders, Metal and Plastic

Welding, Soldering, and Brazing Workers

Military Specific Occupations

Air Crew Officers

Armored Assault Vehicle Officers

Artillery and Missile Officers Infantry

Officers

Military Officer Special and Tactical Operations Leaders, All Other

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:

1. External cause codes for child and adult abuse take priority over all other external cause codes

2. External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse.

3. External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse, and terrorism.

4. External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, and child and adult abuse, and terrorism.

5. The first listed external cause code should correspond to the cause of the most serious diagnosis due to an assault, accident or self-harm, following the order of hierarchy listed above.