Division of Trauma and Injury Prevention 2026

Trauma Data Dictionary 2026

Indiana Department of Health

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Introduction

The Indiana State Trauma Data Dictionary serves as the official reference document that defines and standardizes all data elements collected within the Indiana Trauma Registry. It ensures uniformity in data collection, interpretation, and reporting across submitting facilities. This helps strengthen data quality, facilitates benchmarking, and supports statewide injury prevention and trauma systems improvement efforts. Indiana's trauma inclusion criteria and data dictionary are based on the American College of Surgeons (ACS) National Trauma Data Standards (NTDS), with additional state-added and optional data elements.

Organization of the Data Dictionary

The data dictionary is organized into domains that follow the patient's continuum of care, from the time of injury through hospital discharge. Each section and its corresponding data elements are organized to reflect the workflow within the trauma registry, corresponding to the ordering of form tabs and data elements as they appear within the Indiana Trauma Registry. The domains include:

- Demographics
- Injury
- Pre-hospital
- ED/acute care
- Initial assessment
- Diagnosis
- Procedures
- NTDB hospital events
- NTDB pre-existing conditions
- Outcome
- Performance improvement
- TQIP data elements

Because the data elements are organized according to their placement within the Indiana Trauma Registry trauma form, some elements may not exactly follow the organization and sequencing of the NTDS data dictionary.

Required vs. Optional Data Elements

Throughout the data dictionary, required elements are denoted with an asterisk (*) next to the data element name. A list of all data elements, including an indication of which elements are required, is available in Appendix 5. This appendix also provides a reference to the location of the data element in the NTDS data dictionary, where applicable. Some elements are required only for manually entered cases, which is noted on the data element page as well as in Appendix 5.

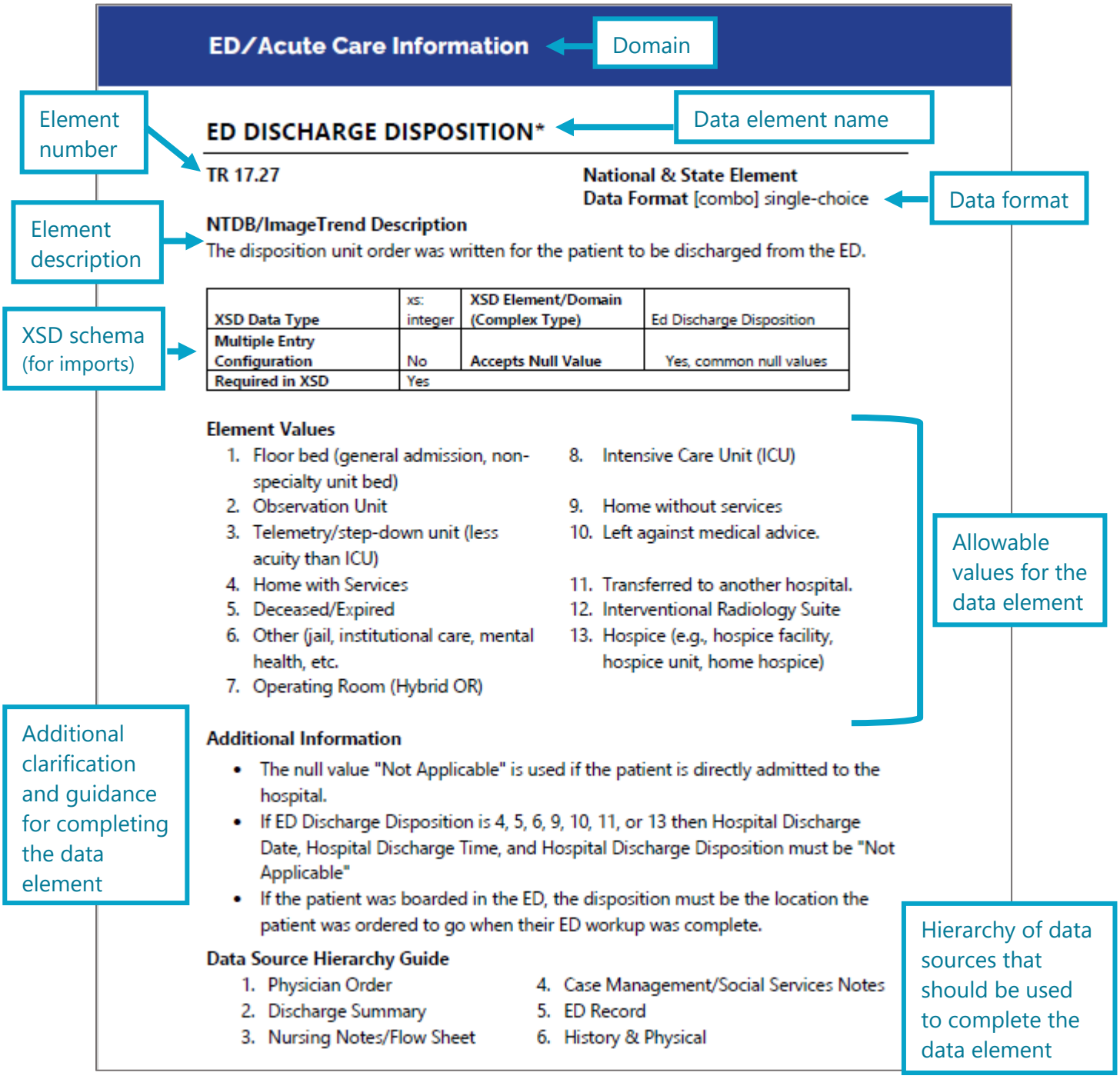
Additional Dictionary Resources

Additional resources within the data dictionary to help users better understand submission of trauma data include:

- Trauma inclusion criteria (page 16)
- Common null values (page 18)
- Glossary of terms (page 441)
- Data element edit checks (page 481)

Data Element Contents

Each data element in the registry is accompanied by detailed content that describes its meaning, structure and rules of entry. This information or "metadata" is organized in a consistent manner for each data element, following the example below:



Change Log

Updates to the 2026 Indiana trauma data dictionary compared to the previous year are noted below.

NTDS Updates

Changes to NTDS data elements for 2026 have been incorporated. Users should refer to the NTDS data dictionary change log for a summary of relevant national element changes.

Newly Required Elements

The following data elements were previously included in the Indiana data dictionary as optional elements. These elements are now required for facilities that manually enter data into the trauma registry. These elements are not yet required for importing facilities to allow for additional time to explore the feasibility of necessary registry modifications to support import of these data elements.

- Pre-hospital Information: Arrived from (TR16.22)
- Pre-hospital Information: EMS Status (TR15.38)
- ED/Acute Care Information: Hospital transferred to (for patients transferred from the ED) (TR 17.61)
- Procedures Information: Procedure Performed (TR 22.30)
- Outcome Information: Hospital transferred to (for patients transferred after admission) (TR 25.35)

Newly Added Elements

The data elements below are present in the Indiana Trauma Registry but did not appear in previous years' data dictionaries. They have been added to provide more complete documentation for registry users.

Pre – Hospital

- Area of the Vehicle Impacted (TR14.42)
- EMS EN Route Date (TR9.17)
- EMS EN Route Time (TR9.17.1)
- Patient Contact Date (TR9.6)
- Patient Contact Time (TR9.5)
- Temperature Maintained (TR15.36)
- Pre-Hospital Pediatric Trauma score (PTS) (TR18.81)
- Pre-Hospital GCS-40 Manual Total (TR 18.94)
- Pre-Hospital AVPU (TR18.107)

ED/Acute Care

- Hospital Transferred To (TR17.61)
- Reason for Transfer Delay (TR17.44)

Initial Assessment

- Blood Ordered Time (TR22.17)
- Cross Match Time (TR22.18)
- Blood Administered Time (TR22.19)

- Abdominal Ultrasound (TR18.75)
- Initial ED/Hospital GCS 40 Manual Total (TR18.44)

Diagnosis

- Diagnosis Comments (TR200.120)

Complications/Performance Improvement

- Multiple data elements added or modified to correspond with elements as listed on the "New Comp PI" tab in ImageTrend

Deleted Data Elements:

- National Provider Identifier
- All referring facility data elements
  - Note: To retain prior data, users who manually enter data will still see the "Referring" facility tab within the registry, but it is not required to be completed.
- Trauma Criteria (TR9.14)
- Pre-hospital Estimated Body Weight

Modifications to Element Descriptions

- Pre-hospital Pregnancy (TR14.38): Modified to clarify that this data element should reflect pregnancy status as assessed during the pre-hospital phase of patient care.

Additional Changes

- Added additional information for manually adding null values (i.e., not values) in the registry (page 18).
- Added a new appendix (Appendix 6) to provide an overview of edit checks conducted by IDOH.
- General reorganization of the order of data elements with the data dictionary to correspond to the organization of data elements within ImageTrend.

Indiana Inclusion Criteria

To ensure consistent data collection across the state and with the National Trauma Data Standard, a trauma patient is defined as a patient sustaining a traumatic injury and meeting the following criteria:

1) The patient must have sustained a traumatic injury no more than 14 days prior to presentation for initial treatment[1] **and**
2) The patient must have **at least one** of the following International Classification of Diseases, 10th Revision (ICD-10-CM) diagnostic codes:
    - S00-S99 with seventh character modifiers of A, B, or C ONLY. (Injuries to specific body parts – initial encounter);[2]
        - **EXCLUDING** the following isolated injuries (ICD-10-CM):
            - S00 (Superficial injuries of the head)
            - S10 (Superficial injuries of the neck)
            - S20 (Superficial injuries of the thorax)
            - S30 (Superficial injuries of the abdomen, pelvis, lower back and external genitals)
            - S40 (Superficial injuries of shoulder and upper arm)
            - S50 (Superficial injuries of elbow and forearm)
            - S60 (Superficial injuries of wrist, hand and fingers)
            - S70 (Superficial injuries of hip and thigh)
            - S80 (Superficial injuries of knee and lower leg)
            - S90 (Superficial injuries of ankle, foot and toes)
    - T07 (unspecified multiple injuries)
    - T14 (injury of unspecified body region); or
    - T79.A1-T79.A9 with seventh character modifier of A only (Traumatic Compartment Syndrome-initial encounter)

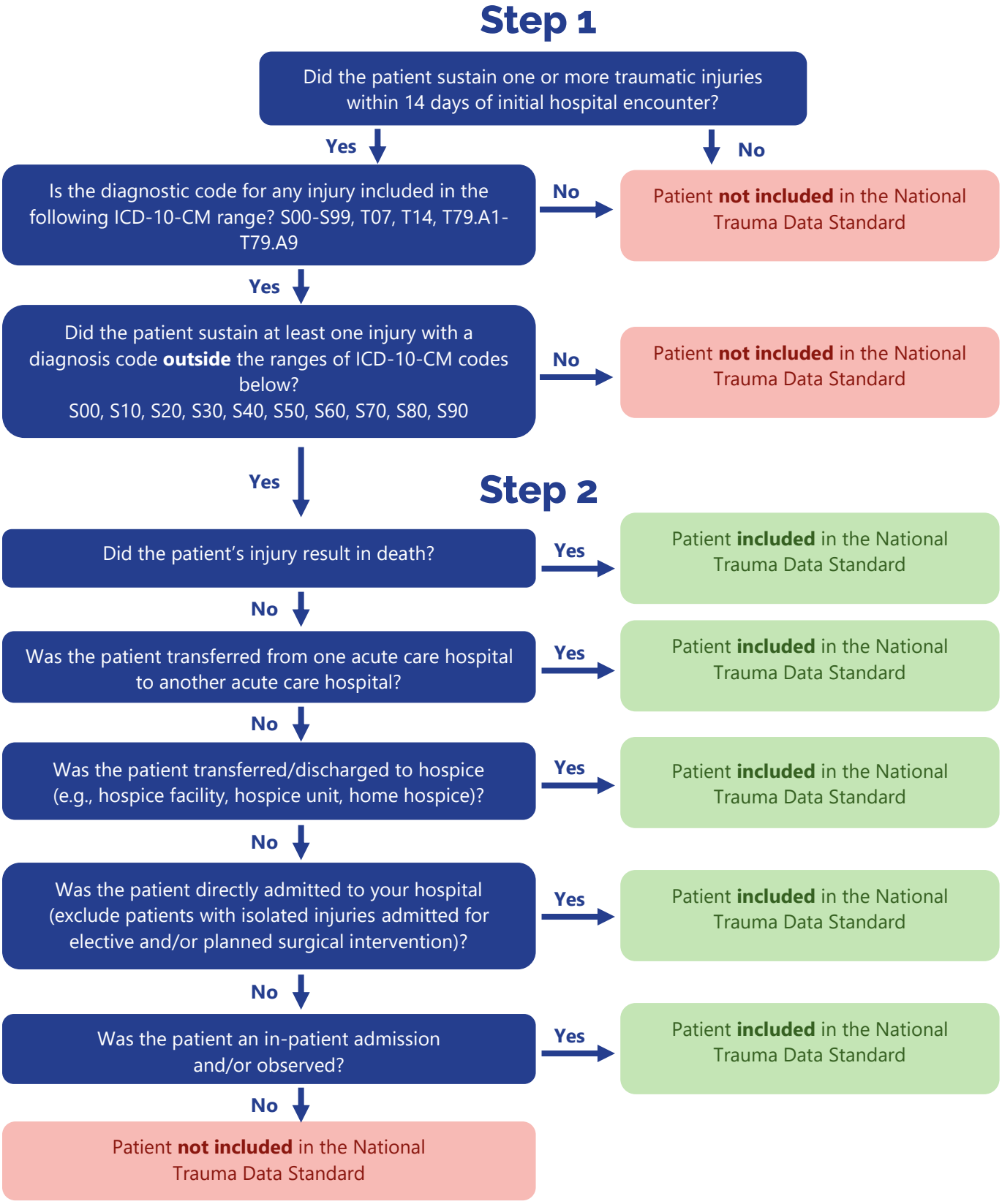
    and
3) Must include one of the following:
    - Death resulting from the traumatic injury (independent of hospital admission or transfer status), **or**
    - Patient transfer from one acute care hospital[3] to another acute care hospital, **or**
    - Patients transferred/discharged to hospice (e.g., hospice facility, hospice unit, home hospice), **or**
    - Patients directly admitted to your hospital (exclude patients with isolated injuries admitted for elective and/or planned surgical intervention), **or**
    - Patients who were an in-patient admission and/or observed.

[1] Exclude patient injuries sustained at your facility after initial ED/hospital arrival and before hospital discharge, and all data associated with that injury event.

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

[3] Acute Care Hospital is defined as a hospital that provides inpatient medical care and other related services for surgery, acute medical conditions or injuries (usually for a short-term illness or condition).

Indiana Trauma Registry Inclusion Criteria Map



Common Null Values

Description

Null values (sometimes referred to as “not values”) provide an indication of why information is not provided for a given data element (for example, when the information is unknown due to lack of documentation). These values are to be used with each data element which has been defined to accept null values. When information for a given data element is not available, users should enter the appropriate null value, rather than leaving the data element blank.

Element Values

1. Not Applicable
2. Not Known/Not Recorded

Additional Information

- For any collection of data to be of value and to reliably represent what was intended, a strong commitment must be made to ensure the correct documentation of incomplete data. When data elements associated with the National Trauma Data Standard and Indiana Trauma Data Standard are to be electronically stored in a database or moved from one database to another using XML, the indicated null values should be applied.

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

- Not Known/Not Recorded (NK/NR): This null value applies if, at the time of patient care documentation, information was "not known" (to the patient, family, or 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 (i.e., no EMS run sheet in the hospital record for patient transported by EMS). Leaving required fields blank without entering appropriate null values will trigger data validation errors.

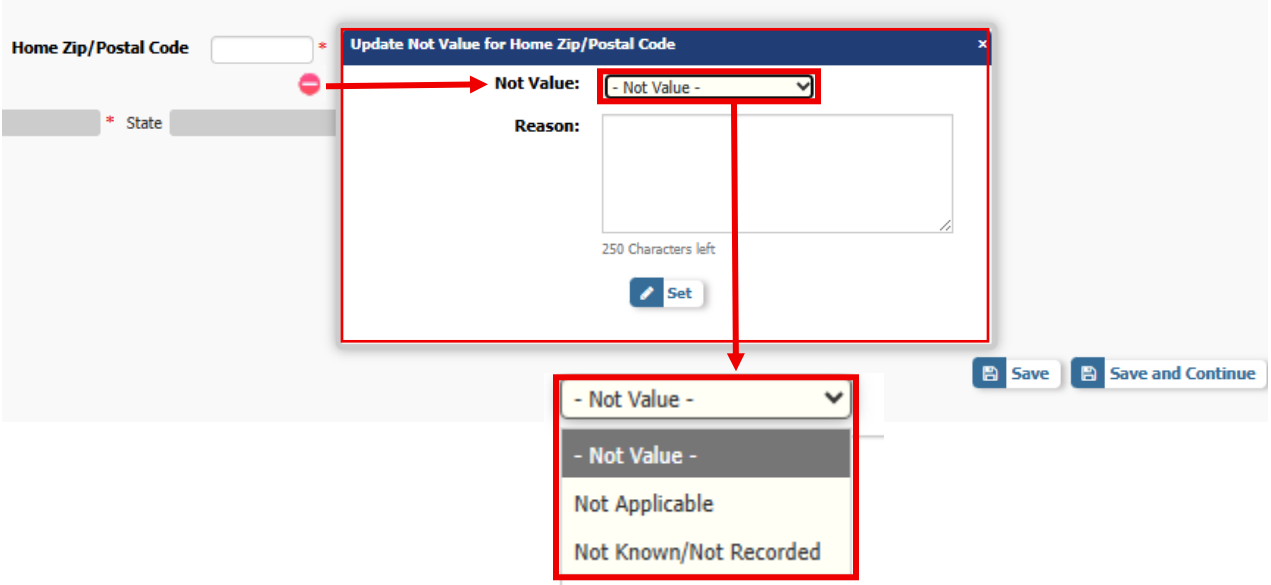
How to Add Null Values During Manual Data Entry

For fields that are completed via drop-down lists, users should select an appropriate null value from the list when information is not known or not applicable for a patient. For fields that are not entered via drop-down menus (for example, dates, times, or other numeric fields), an icon

shaped like a red circle (⛔) will be displayed next to the field. If the field value is not known, clicking this icon will allow you to add an appropriate null value (or "not value") for the data element.

In the box that appears, click the drop-down arrow next to the "Not Value" field to see a list of allowable not values for that data element. In most cases, users would select "Not Known/Not Recorded." If there is a known reason why the data is not available, please feel free to document it in the "reason" section.

Figure 1: Recording Not Values



Demographic Information

MEDICAL RECORD

TR 1.2 **Data Format** [text]

ImageTrend Description

The hospital's medical record number for the patient.

Element Values

- Relevant value for data element

Additional Information

- Auto-generated by the hospital

ACCOUNT NUMBER

TR 1.27 **Data Format** [text]

ImageTrend Description

The hospital's encounter number for the patient, that is unique to this visit.

Element Values

- Relevant value for data element

Additional Information

- Auto-generated by the hospital

INJURY INCIDENT DATE*

TR 5.1

National & State Element
Data Format [date]

NTDB/ImageTrend Description

The date the injury occurred.

XSD Data Type	xs: date	**XSD Element / Domain (Complex Type)**	Incident Date
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1,990	**Max. Constraint:** 2,030

Element Values

- Relevant value for data element

Additional Information

- Reported as MM/DD/YYYY.
- Estimated injury date must be based on patient, witness, family, or healthcare provider report. Other proxy measures (e.g., 911 call times) must not be reported.
- If date of injury is "Not Known/Not Recorded", the null value is unknown.

Data Source Hierarchy Guide

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

INJURY INCIDENT TIME *

TR 5.18

National & State Element
Data Format [time]

NTDB/ImageTrend Description

The time the injury occurred.

XSD Data Type	xs: time	**XSD Element/Domain (Complex Type)**	Incident Time
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 00:00	**Max. Constraint:** 23:59

Element Values

- Relevant value for data element

Additional Information

- Reported as HHMM military time.
- Estimates of time of injury should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g., 911 call times) should not be used.
- If time of injury is unknown, the not value is Not Known/Not Recorded.

Data Source Hierarchy Guide

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

PATIENT'S LAST NAME

TR 1.9 **Data Format** [text]

ImageTrend Description

The patient's last name.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. Face Sheet
2. EMS Run Report
3. Billing Sheet/Medical Records Coding Summary Sheet
4. Triage Form/Trauma Flow Sheet
5. ED Nurses' Notes
6. Other ED Documentation

PATIENT'S FIRST NAME

TR 1.8 **Data Format** [text]

ImageTrend Description

The patient's first name.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. Face Sheet
2. EMS Run Report
3. Billing Sheet/Medical Records Coding Summary Sheet
4. Triage Form/Trauma Flow Sheet
5. ED Nurses' Notes
6. Other ED Documentation

PATIENT'S MIDDLE INITIAL

TR 1.10 **Data Format** [text]

ImageTrend Description

The patient's middle initial.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. Face Sheet
2. EMS Run Report
3. Billing Sheet/Medical Records Coding Summary Sheet
4. Triage Form/Trauma Flow Sheet
5. ED Nurses' Notes
6. Other ED Documentation

PATIENT'S SOCIAL SECURITY

TR 1.11 **Data Format** [number]

ImageTrend Description
The patient's social security number.

Element Values

- Relevant value for data element

Additional Information

- Collected as ###-##-####

Data Source Hierarchy Guide

1. Face Sheet
2. EMS Run Report
3. Billing Sheet/Medical Records Coding Summary Sheet
4. ED Nurses' Notes
5. Other ED Documentation

DATE OF BIRTH*

TR 1.7

National & State Element
Data Format [date]

NTDB/ImageTrend Description

The patient's date of birth.

XSD Data Type	xs: date	**XSD Element/Domain (Complex Type)**	DateOfBirth
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1,890	**Max. Constraint:** 2,030

Element Values

- Relevant value for data element

Additional Information

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

Data Source Hierarchy Guide

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

AGE (at date of incident)*

TR 1.12 **National & State Element**
Data Format [number]

NTDB/ImageTrend Description

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

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Age
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 0	**Max. Constraint:** 120

Element Values

- Relevant value for data element

Additional Information

- Auto calculated to patient's age in years when "Date of Birth" is entered.
- Must also report Age Units.
- If date of birth is equal to the ED/Hospital Arrival date, then the Age & Age Units variables must be completed.
- If date of birth is "Not Known/Not Recorded" complete variables: Age and Age Units.
- The null value “Not Applicable” is reported if Date of Birth is reported.

Data Source Hierarchy Guide

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

AGE UNITS*

TR 1.14

National & State Element
Data Format [combo] single-choice

NTDB/ ImageTrend Description

The units used to report the patient's age.

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	AgeUnits
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Hours	Years
Days	Minutes
Months	Weeks

Additional Information

- If date of birth is equal to the ED/Hospital Arrival date, then the Age & Age Units variables must be completed.
- If date of birth is "Not Known/Not Recorded" complete variables: Age and Age Units
- Must also complete variable: Age
- The null value "Not Applicable" is reported if Date of Birth is reported.

Data Source Hierarchy Guide

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

RACE*

TR 1.16

National & State Element
Data Format [combo] multiple-choice

NTDB/ImageTrend Description

The patient's race.

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Race
Multiple Entry Configuration	Yes, max 2	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Asian
Black or African American
Native Hawaiian or Other Pacific Islander
White
Other Race
American Indian

Additional Information

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

Data Source Hierarchy Guide

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

OTHER RACE

TR 1.28 **Data Format** [text]

ImageTrend Description

The patient's secondary race (if the first race field is insufficient).

Element Values

- Relevant value for data element

Additional Information

- Patient race should be based upon self-report or identified by a family member.
- Only completed if Race is "Other Race"

Data Source Hierarchy Guide

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

ETHNICITY*

TR 1.17

National & State Element
Data Format [combo] single-choice

NTDB /ImageTrend Description

The patient's ethnicity.

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Ethnicity
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Hispanic or Latino Not Hispanic or Latino

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 1.
- Based on the 2010 US Census Bureau.

Data Source Hierarchy Guide

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

SEX*

TR 1.56

National & State Element
Data Format [combo] multiple-choice

Description
The patient's sex.

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Sex
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values
1. Male.
2. Female
3. Intersex

Additional Information
• Also referred to as birth sex, natal sex, biological sex.

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

HEIGHT* (in)/HEIGHT* (cm)

TR 1.6.1/ TR 1.6

National & State Element
Data Format [combo] single-choice

NTDB Description

First recorded height after ED/hospital arrival.

ImageTrend Description:

1. Height in inches: First recorded height upon ED/hospital arrival.
2. Height in centimeters: Indicate the patient's height in centimeters

XSD Data Type	xs: Decimal	**XSD Element/Domain (Complex Type)**	Height
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 0	**Max. Constraint:** 244 (cm)

Element Values

- Relevant value for data element

Additional Information

- Recorded in centimeters.
- May be based on family or self-report.
- Please note that the first recorded/hospital vitals do not need to be from the same assessment.
- The null value “Not Known/Not Recorded” is reported if the patient’s Initial ED/Hospital Height was not measured prior to discharge.

Data Source Hierarchy Guide

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

WEIGHT* (kg)

TR 1.6.5

National & State Element
Data Format [combo] single-choice

NTDB/ ImageTrend Description

First recorded weight within 24 hours of ED/hospital arrival.

XSD Data Type	xs: decimal	**XSD Element/Domain (Complex Type)**	Weight
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 0	**Max. Constraint:** 907 (kg)

Element Values

- Relevant value for data element

Additional Information

- Recorded in kilograms.
- May be based on family or self-report.
- Please note that first recorded/hospital visits do not need to be from the same assessment.
- Report the null value "Not Known/Not Recorded" if the patient's Initial ED/Hospital Weight was not measured within 24 hours of ED/hospital arrival.

Data Source Hierarchy Guide

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

PATIENT'S HOME ADDRESS

TR 1.18 **Data Format** [text]

ImageTrend Description

The home street address of the patient's primary residence.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

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

ADDRESS LINE 2

TR 1.18.1 **Data Format** [text]

ImageTrend Description

The continuation of the street address of the patient's primary residence.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

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

PATIENT'S HOME COUNTRY*

TR 1.19

National & State Element
Data Format [combo] single-choice

NTDB/ImageTrend Description

The country where the patient resides.

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Home Country
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- When completed with ZIP code, city, county, and state auto-calculate
- Values are two characters FIPS codes representing the country (e.g., US)
- If Patient's Home Country is not US, then the null value "Not Applicable" is used for: Patient's Home State, Patient's Home County and Patient's Home City
- The null value "Not Applicable" is reported for non-US hospitals.

Data Source Hierarchy Guide

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

PATIENT'S HOME ZIP/POSTAL CODE*

TR 1.20 **National & State Element**
Data Format [text]

NTDB/ImageTrend Description

The patient's home ZIP/Postal code of primary residence.

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Home Zip
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- May require adherence to HIPAA regulations.
- Can be stored as a 5 or 9-digit code (XXXXX-XXXX) for US or can be stored in the postal code format of the applicable country.
- When completed with Country the city, county, and state auto-calculate.
- If ZIP code is "Not Applicable", complete variable: Alternate Home Residence
- If ZIP code is "Not Recorded/Not Known", complete variables: Patient's Home State (US only); Patient's Home County (US only); Patient's Home City (US only)
- If ZIP code is reported, must also complete Patient’s Home Country

Data Source Hierarchy Guide

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

PATIENT'S HOME CITY*

TR 1.21

National & State Element
Data Format [combo] single-choice

NTDB/ ImageTrend Description

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

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Home City
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element (five-digit FIPS code)

Additional Information

- Auto Calculated if ZIP code and Country are completed.
- Only complete when ZIP code is "Not Known/Not Recorded" and country is US
- Used to calculate FIPS code.
- The null value "Not Applicable" is used if Patient's Home Zip/Postal Code is reported.
- The null value "Not Applicable" is reported for non-US hospitals.

Data Source Hierarchy Guide

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

PATIENT'S HOME COUNTY*

TR 1.22

National & State Element
Data Format [combo] single-choice

NTDB/ ImageTrend Description

The patient's county (or parish) of residence.

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Home County
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

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

Additional Information

- Auto Calculated if ZIP code and Country are completed.
- Only reported when Patient's Home ZIP/Postal Code is "Not Known/Not Recorded", and the country is the US.
- Used to calculate the FIPS code.
- The null value "Not Applicable" is reported if Patient's Home ZIP/Postal Code is reported.
- The null value "Not Applicable" is reported for non-US hospitals.

Data Source Hierarchy Guide

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

PATIENT'S HOME STATE*

TR 1.23

National & State Element
Data Format [combo] single-choice

NTDB/ImageTrend Description

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

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Home State
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

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

Additional Information

- Auto Calculated if ZIP code and Country are completed.
- Only reported when Patient's Home ZIP/Postal Code is "Not Known/Not Recorded", and country is US.
- Used to calculate FIPS code.
- The null value "Not Applicable" is reported if Patient's Home ZIP/Postal Code is reported.
- The null value "Not Applicable" is reported for non-US hospitals.

Data Source Hierarchy Guide

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

PATIENT'S ALTERNATE RESIDENCE*

TR 1.13

National & State Element
Data Format [combo] single-choice

NTDB/ImageTrend Description

Documentation of the type of patient without a home ZIP/Postal Code.

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Home Residence
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Homeless
Migrant Worker
Undocumented Citizen

Additional Information

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

Data Source Hierarchy Guide

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

PRIMARY METHOD OF PAYMENT*

TR 2.5

National & State Element
Data Format [combo] single-choice

NTDB/ImageTrend Description

Primary source of payment for hospital care.

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Primary Method Payment
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Medicaid
Medicare
Not Billed (for any reason)
Other Government
Self-Pay
Other
Private/Commercial Insurance

Additional Information

- No Fault Automobile, Workers Compensation, and Blue Cross/Blue Shield should be captured as "4. Private/Commercial Insurance".
- Primary methods of payments which were retired greater than 2 years before the current NTDS version are no longer listed under Element Values above. Refer to the NTDS Change Log for a full list of retired Primary Method of Payments.

Data Source Hierarchy Guide

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

OTHER BILLING SOURCE

TR 2.13 **Data Format** [text]

ImageTrend Description

Other billing source that is not specific in the Primary Method of Payment drop-down menu.

Element Values

- Relevant value for data element

Additional Information

- Only completed if Primary Method of Payment is "Other"

Data Source Hierarchy Guide

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

REIMBURSED CHARGES

TR 2.8 **Data Format** [number]

ImageTrend Description

The amount the hospital was reimbursed for services.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

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

SECONDARY METHOD OF PAYMENT

TR 2.7 **Data Format** [combo] single-choice

ImageTrend Description

Any known secondary source of finance expected to assist in payment of medical bills.

Element Values

Medicare Supp	Private/Commercial Insurance
Managed Care	Workers Compensation
No Fault Automobile	Other
Not Billed (for any reason)	Self-Pay
Medicare	Other Government
Medicaid	

Data Source Hierarchy Guide

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

SECONDARY OTHER BILLING SOURCE

TR 2.14 **Data Format** [text]

ImageTrend Description

Secondly, other billing source that is not specific in the Secondary Method of Payment drop-down menu.

Element Values

- Relevant value for data element

Additional Information

- Only completed if Primary Method of Payment is "Other"

Data Source Hierarchy Guide

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

THIRD METHOD OF PAYMENT

TR 2.18 **Data Format** [combo] single choice

ImageTrend Description

Any known third source of finance expected to assist in payment of medical bills.

Element Values

Medicare Supp	Private/Commercial Insurance
Managed Care	Workers Compensation
No Fault Automobile	Other
Not Billed (for any reason)	Self Pay
Medicare	Other Government
Medicaid	

Data Source Hierarchy Guide

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

THIRD OTHER BILLING SOURCE

TR 2.19 **Data Format** [text]

ImageTrend Description

Third other billing source that is not specific in the Third Method of Payment drop-down menu.

Element Values

- Relevant value for data element

Additional Information

- Only completed if Third Method of Payment is "Other"

Data Source Hierarchy Guide

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

BILLED HOSPITAL CHARGES

TR 2.9 **Data Format** [number]

ImageTrend Description

The total amount the hospital charged for the patient's care.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

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

WORK-RELATED*

TR 2.10

National & State Element
Data Format [combo] single-choice

NTDB/ImageTrend Description
Indication of whether the injury occurred during paid employment.

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Work Related
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Yes No

Additional Information

- If work related, two additional data elements must be completed: Patient's Occupational Industry and Patient's Occupation.

Data Source Hierarchy Guide

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

PATIENT'S OCCUPATIONAL INDUSTRY*

TR 2.6

National & State Element
Data Format [combo] single-choice

NTDB/ImageTrend Description
The occupational industry associated with the patient's work environment.

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Patients Occupational Industry
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

1. Finance, Insurance, and Real Estate
2. Manufacturing
3. Retail Trade
4. Transportation and Public Utilities
5. Agriculture, Forestry, Fishing
6. Professional and Business Services
7. Education and Health Services
8. Construction
9. Government
10. Natural Resources and Mining
11. Information Services
12. Wholesale Trade
13. Leisure and Hospitality
14. Other Services

Additional Information

- If work related, also complete Patient's Occupation.
- Based upon US Bureau of Labor Statistics Industry Classification.
- The null value "Not Applicable" is used if Work Related is 2. No.

Data Source Hierarchy Guide

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

PATIENT'S OCCUPATIONAL INDUSTRY DESCRIPTION

TR 2.27 **Data Format** [text]

ImageTrend Description
A description of the occupational industry associated with the patient's work environment.

Element Values

- Relevant value for data element

Additional Information

- Only completed if injury is work-related

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. EMS Run Report
3. ED Nurses' Notes
4. Other ED Documentation

PATIENT'S OCCUPATION*

TR 2.11

National & State Element
Data Format [combo] single-choice

NTDB/ImageTrend Description
The occupation of the patient.

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Patients Occupation
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

1. Business and Financial Operations Ocp
2. Architecture and Engineering Ocp
3. Community and Social Services Ocp
4. Education, Training, and Library Ocp
5. Healthcare Practitioners and Technical Ocp
6. Protective Service Ocp
7. Building and Grounds Cleaning and Maintenance
8. Sales and Related Ocp
9. Farming, Fishing, and Forestry Ocp
10. Installation, Maintenance, and Repair Ocp
11. Transportation and Material Moving Ocp
12. Management Ocp
13. Computer and Mathematical Ocp
14. Life, Physical, and Social Science Ocp
15. Legal Ocp
16. Arts, Design, Entertainment, Sports, and Media
17. Healthcare Support Ocp
18. Food Prep & Serving Related
19. Personal Care & Service Ocp
20. Office & Admin Support Ocp
21. Construction and Extraction Ocp
22. Production Ocp
23. Military Specific Ocp

Additional Information

- Only completed if injury is work-related.
- If work related, also complete Patient's Occupational Industry
- Based upon 1999 US Bureau of Labor Statistics Standard Occupational Classification (SOC).
- The null value "Not Applicable" is used if Work Related is 2. No.

Data Source Hierarchy Guide

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

PATIENT'S OCCUPATION DESCRIPTION

TR 2.12 **Data Format** [text]

ImageTrend Description
The description of the occupation of the patient.

Element Values

- Relevant value for data element

Additional Information

- Only completed if injury is work-related

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. ED Nurses' Notes
3. Other ED documentation
4. EMS Run Report

Injury Information

INCIDENT COUNTRY*

TR 5.11

National & State Element
Data Format [combo] single-choice

NTDB/ImageTrend Description

The country where the incident occurred.

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Incident Country
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

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

Additional Information

- Values are two characters FIPS codes representing the country (e.g., US)
- If Incident Country is not US, then the null value "Not Applicable" is used for: Incident State, Incident County, and Incident Home City

Data Source Hierarchy Guide

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

INCIDENT LOCATION ZIP/POSTAL CODE*

TR 5.6

National & State Element
Data Format [text]

NTDB/ImageTrend Description

The ZIP/Postal code of the incident location.

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Injury Zip
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- Stored as a 5- or 9-digit code for US and CA or can be stored in the postal code format of the applicable country
- If "Not Known/Not Recorded," complete variables: Incident Country, Incident State (US ONLY) and Incident City (US ONLY)
- May require adherence to HIPAA regulations
- If ZIP/Postal code is reported, then must complete Incident Country
- When completed with Country, the city, county, and state auto-calculate

Data Source Hierarchy Guide

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

INCIDENT CITY*

TR 5.10

National & State Element
Data Format [combo] single-choice

NTDB/ ImageTrend Description

The city or township where the incident occurred.

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Incident City
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

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

Additional Information

- Only completed when Incident Location ZIP/Postal Code is "Not Known/Not Recorded," and country is US
- Used to calculate FIPS code
- If incident location resides outside of formal city boundaries, report nearest city/town
- The null value "Not Applicable" is used if Incident Location ZIP/Postal Code is reported
- If Incident Country is not US, report the null value "Not Applicable"
- Auto-Calculated if ZIP code and Country are completed

Data Source Hierarchy Guide

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

INCIDENT COUNTY*

TR 5.9

National & State Element
Data Format [combo] single-choice

NTDB// ImageTrend Description

The county or parish where the incident occurred.

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Incident County
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

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

Additional Information

- Only complete when Incident Location Zip/Postal Code is "Not Applicable", or "Not Known/Not Recorded"
- Used to calculate FIPS code
- The null value "Not Applicable" is used if Incident Location Zip/Postal Code is reported
- If Incident Country is not US, report the null value "Not Applicable"
- Auto-Calculated if ZIP code and Country are completed

Data Source Hierarchy Guide

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

INCIDENT STATE*

TR 5.7

National & State Element
Data Format [combo] single-choice

NTDB/ImageTrend Description

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

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Incident State
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

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

Additional Information

- Only complete when Incident Location Zip Code is "Not Applicable", or "Not Known/Not Recorded" and country is US
- Used to calculate FIPS code
- The null value "Not Applicable" is used if Incident Location Zip/Postal Code is reported
- If Incident Country is not US, report the null value "Not Applicable"
- Auto-Calculated if ZIP code and Country are completed

Data Source Hierarchy Guide

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

ICD-10 LOCATION CODE*

TR 200.5.1 **National & State Element**
Data Format [number]

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

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Place Of Injury Code
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

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

Additional Information

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

Data Source Hierarchy Guide

1. EMS Run Report
2. Triage Form/Trauma Flow Sheet
3. ED Nurses' Notes
4. History & Physical
5. Progress Notes

(Complaint) SUPPLEMENTAL CAUSE OF INJURY

TR 5.8 **Data Format** [combo] single-choice

ImageTrend Description

The event that occurred to cause injury to the patient.

Element Values

Accident	Fire	Rollerblading
Aircraft	Fireworks Related	Roller-skating
All-Terrain Vehicle	Frostbite	Scooter
Assault	Gunshot Wound	Skateboarding
Bicycle Crash	Hanging	Skydiving
Boating	Heat Related	Sledding
Burn	Industrial Incident	Snowboarding
Child Abuse	Injured by Animal	Snowmobile
Cut/Pierce	Jet Ski	Sport Related
Dirt Bike	Lightning	Stab Wound
Diving	Motor Pedestrian Crash	Struck By/Against
Domestic Abuse	Motor Vehicle Crash	Tornado
Drowning	Motorcycle Crash	Train
Electrical Injury	Police	Waterskiing
Fall	Rape	
Farm/Heavy Equipment/Machine	Recreational	

Data Source Hierarchy Guide

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

INJURY DESCRIPTION

TR 20.12 **Data Format** [text]

ImageTrend Description

The description of the injury. This can be any supporting or supplemental data about the injury, other circumstances, etc.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report
2. History & Physical Documentation
3. Triage Form/Trauma Flow Sheet
4. ED Nurses' Notes
5. Other ED Documentation

ICD-10 PRIMARY EXTERNAL CAUSE CODE*

TR 200.3 **National & State Element**
Data Format [number]

NTDB/ImageTrend Description

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

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	PrimaryECodeIcd10
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

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

Additional Information

- The primary external cause code should describe the main reason a patient is admitted to the hospital
- External cause codes are used to auto-generate two calculated elements: Trauma Type (Blunt, Penetrating, Burn) and Intentionality (based upon CDC matrix)
- ICD-10-CM or ICD 10-CA codes are accepted for this data element. Activity codes are not reported under the NTDS and should not be reported for this data element.
- Multiple Cause Coding Hierarchy: If two or more events cause separate injuries, an external cause code should be assigned for each cause. The first-listed external cause code will be selected in the following order:
    - External cause codes for child and adult abuse take priority over all other external cause codes
    - External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse
    - External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse, and terrorism
    - External cause codes for transport accidents take priority over all external cause codes except cataclysmic events, and child and adult abuse, and terrorism
    - The first listed external cause code should correspond to the cause of the most serious diagnosis due to an assault, accident or self-harm, following the order of hierarchy listed above.

Data Source Hierarchy Guide

1. EMS Run Report
2. Triage Form/Trauma Flow Sheet
3. ED Nurses' Notes
4. History & Physical
5. Progress Notes

ICD-10 ADDITIONAL EXTERNAL CAUSE CODE*

National & State Element
Data Format [number]

NTDB/ImageTrend Description

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

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	AdditionalECodeIcd10
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

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

Additional Information

- Only ICD-10-CM or ICD-10-CA codes will be accepted for ICD-10 Additional External Cause Code.
- Activity codes should not be reported in this element or under the NTDS and should not be reported for this data element.
- The null value "Not Applicable" is used if no additional external cause codes are used
- Report all that apply (maximum two)
- The first-listed external cause code will be selected in the following order:
  - External cause codes for child and adult abuse take priority over all other external cause codes
  - External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse
  - External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse, and terrorism
  - External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, child and adult abuse, and terrorism
  - The first listed external cause code should correspond to the cause of the most serious diagnosis due to an assault, accident or self-harm, following the order of hierarchy listed above

Data Source Hierarchy Guide

1. EMS Run Report
2. Triage Form/Trauma Flow Sheet
3. ED Nurses' Notes
4. History & Physical
5. Progress Notes

ICD-10 INTENTIONALITY

TR 200.3.2 **Data Format** [number]

ImageTrend Description
Intentionality.

Element Values
Relevant ICD-10-CM code value for intentionality.

- Assault
- Other
- Self-Inflicted
- Unintentional
- Undetermined

Data Source Hierarchy Guide

1. EMS Run Report
2. Triage Form/Trauma Flow Sheet
3. ED Nurses' Notes
4. History & Physical
5. Progress Notes

ICD-10 TRAUMA TYPE

TR 200.3.3 **Data Format** [number]

ImageTrend Description
Type of injury.

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	TraumaType
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values
Relevant ICD-10-CM code value for intentionality.

- Blunt
- Penetrating
- Burn
- Other

Data Source Hierarchy Guide
1. EMS Run Report
2. Triage Form/Trauma Flow Sheet
3. ED Nurses' Notes
4. History & Physical
5. Progress Notes

BARRIERS TO PATIENT CARE

TR 14.46 **Data Format** [combo] multiple-choice

ImageTrend Description
Indication of whether or not there were any patient specific barriers to serving the patient at the scene.

Element Values

Developmentally Impaired	Unattended or Unsupervised (including minors)
Physically Impaired	Not Known
Speech Impaired	Language
Not Applicable	Physically Restrained
Hearing Impaired	Unconscious
None	Not Known/Not Recorded

Data Source Hierarchy Guide

1. EMS Run Report
2. Other ED Documentation

Pre-hospital Information

ARRIVED FROM *

TR 16.22

Required for manually entered cases
Data Format [combo] single choice

ImageTrend Description
Location the patient arrived from.

Element Values

Clinic/MD Office	Nursing Home
Home	Referring Hospital
Jail	Scene

Additional Information

- Used to auto-generate an additional calculated element: Inter-Facility Transfer (patient transferred from another acute care facility to your facility)

Data Source Hierarchy Guide

1. EMS Run Report
2. 911 or Dispatch Center
3. Other ED Documentation

TRANSPORTED TO YOUR FACILITY BY (EMS Transport Party)*

TR 8.8

National & State Element
Data Format [combo] single choice

NTDB/ ImageTrend Description
The mode of transport delivering the patient to your hospital.

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Transport Mode
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Ground Ambulance	Private/Public Vehicle/Walk-In
Helicopter Ambulance	Police
Fixed-wing Ambulance	Other

Data Source Hierarchy Guide

1. EMS Run Report

OTHER TRANSPORT MODE

TR 8.9

National & State Element
Data Format [combo] single-choice

NTDB/ImageTrend Description

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

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Other Transport Mode
Multiple Entry Configuration	Yes, max 5	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Ground Ambulance	Private/Public Vehicle/Walk-In
Helicopter Ambulance	Police
Fixed-wing Ambulance	Other

Additional Information

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

Data Source Hierarchy Guide

1. EMS Run Report
2. Transfer Facility Records

INTUBATION PRIOR TO ARRIVAL*

TR60.1 **National & State Element**

Data Format [combo] single-choice

NTDB/ ImageTrend Description

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

INCLUDE:

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

EXCLUDE:

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

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Intubation Prior To Arrival
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

1. Yes 2. No

Additional Information

• If *Element Value* "1. Yes" is reported, report ***Intubation Location***.

• The null value "Not Applicable" is reported for patients who had an established airway prior to this injury event (e.g., Chronic Ventilator Dependence).

Data Source Hierarchy Guide

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

INTUBATION LOCATION*

TR60.2 **National & State Element**

Data Format [combo] single-choice

NTDB/ImageTrend Description

The location the patient was intubated prior to hospital arrival.

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Intubation Location
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

1. Out of Hospital Intubation 2. Transferring Facility

Additional Information

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

Data Source Hierarchy Guide

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

INTER-FACILITY TRANSFER*

TR 25.54 **National & State Element**
Data Format [combo] single-choice

NTDB/ImageTrend Description

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

INCLUDE:

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

EXCLUDE:

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

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Inter Facility Transfer
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Yes No

Additional Information

- Outlying facilities purporting to provide emergency care services or utilized to stabilize a patient are considered acute care facilities.
- Acute Care Hospital is defined as a hospital that provides inpatient medical care and other related services for surgery, acute medical conditions, or injuries (usually for a short-term illness or condition). "CMS Data Navigator Glossary of Terms" (accessed Mar. 19, 2025).

Data Source Hierarchy Guide

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

MASS CASUALTY INCIDENT

TR 14.37 **Data Format** [combo] single-choice

ImageTrend Description

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

Element Values

No Yes

Data Source Hierarchy Guide

1. EMS Run Report
2. Trauma Flow Sheet
3. 911 or Dispatch Center
4. Other ED Documentation

PREGNANCY (Pre-hospital)

TR 14.38 **Data Format** [combo] single-choice

ImageTrend Description

Indication of the possibility that the patient is currently pregnant, as assessed in the pre-hospital phase of patient care

Element Values

No Yes

Data Source Hierarchy Guide

1. EMS Run Report
2. 911 or Dispatch Center
3. Other ED Documentation

LAW ENFORCEMENT/CRASH REPORT NUMBER

TR 14.40 **Data Format** [text]

ImageTrend Description

The unique number associated with the law enforcement or crash report.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report
2. Other ED Documentation

VEHICULAR INJURY INDICATORS

TR 14.41 **Data Format** [combo] multiple-choice

ImageTrend Description

The risk factor predictors associated with the vehicle involved in the incident.

Element Values

Dash Deformity	Side Post Deformity
DOA Same Vehicle	Space Intrusion > 1 Foot
Ejection	Steering Wheel Deformity
Fire	Windshield Spider/Star
Rollover/Roof Deformity	

Data Source Hierarchy Guide

1. EMS Run Report
2. Other ED Documentation

AREA OF THE VEHICLE IMPACTED

TR 14.42 **Data Format** [combo] multiple-choice

ImageTrend Description

The area or location of initial impact on the vehicle involved in the incident.

Element Values

Center Front	Right Front
Center Rear	Right Rear
Left Front	Right Side
Left Rear	Roll Over
Left Side	

Data Source Hierarchy Guide

1. EMS Run Report
2. Other ED Documentation

SEAT ROW LOCATION (of Patient in Vehicle)

TR 14.43 **Data Format** [number]

ImageTrend Description

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

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report
2. Other ED Documentation

POSITION OF PATIENT (in the seat of the vehicle)

TR 14.44 **Data Format** [combo] single-choice

ImageTrend Description

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

Element Values

Driver	Middle	Right
Left (Non-driver)	Other	

Data Source Hierarchy Guide

1. EMS Run Report
2. Other ED Documentation

HEIGHT OF FALL IN FEET

TR 14.45 **Data Format** [number]

ImageTrend Description
The distance in feet the patient fell, measured from the lowest point to the ground.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report
2. Other ED Documentation

TRAUMA TRIAGE CRITERIA (Steps 1 and 2)*

TR 17.22 **Data Format** [combo] multiple-choice

ImageTrend Description

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

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Trauma Center Criterion
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Glasgow Coma Score <=13
- Systolic blood pressure < 90 mmHg
- Respiratory rate < 10 or > 29 breaths per minute (<20 in infants aged < 1 year) or need for ventilatory support.
- All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
- Paralysis
- Chest wall instability or deformity (e.g. flail chest).
- Two or more proximal long-bone fractures
- Pelvic fracture
- Open or depressed skull fracture
- Crushed, degloved, mangled, or pulseless extremity.
- Amputation proximal to wrist or ankle

Additional Information

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

Data Source Hierarchy Guide

1. EMS Run Report

TRAUMA TRIAGE CRITERIA (Steps 3 and 4) *

TR 17.47 **Data Format** [combo] multiple-choice

NTDB/ ImageTrend Description

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

Element Values

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

Additional Information

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

Data Source Hierarchy Guide

1. EMS Run Report

PROTECTIVE DEVICES (Safety Device Used)*

TR 29.24

National & State Element
Data Format [combo] multiple-choice

NTDB/ ImageTrend Description

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

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Protective Device
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

1. None
2. Lap Belt
3. Personal Floatation Device
4. Protective Non-Clothing Gear (e.g., Shin guard)
5. Eye Protection
6. Child Restraint (child car seat, infant car seat, or child booster seat)
7. Helmet (e.g., bicycle, skiing, motorcycle) –
8. Airbag Present
9. Protective Clothing (e.g., padded leather pants)
10. Shoulder Belt
11. Other

Additional Information

- Report all that apply.
- Evidence of the use of safety equipment may be reported or observed.
- If Element Value "6. Child Restraint" is reported, report Child Specific Restraint.
- If Element Value "8. Airbag" is reported, report Airbag Deployment.
- Lap Belt should be reported to include those patients that are restrained but not further specified.
- If the documentation indicates "3-point-restraint," report Element Values "2. Lap Belt" and "10. Shoulder Belt."
- If documented that a "Child Restraint (booster seat or child/infant car seat)" was used or worn, but not properly fastened, either on the child or in the car, report Element Value "1. None."

Data Source Hierarchy Guide

2. EMS Run Report
3. Triage Form/Trauma Flow Sheet
4. ED Nurses' Notes/Flow Sheet
5. History & Physical

CHILD SPECIFIC RESTRAINT*

TR 29.31

National & State Element
Data Format [combo] single-choice

NTDB/ImageTrend Description

Protective child restraint devices used by patients at the time of the injury.

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Child Specific Restraint
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

1. Child Car Seat (TR29.15)
2. Infant Car Seat (TR29.16)
3. Child Booster Seat (TR29.17)

Additional Information

- Evidence of the use of a child restraint may be reported or observed.
- Only reported when Protective Devices include "6. Child Restraint (booster seat or child car seat)."
- The null value "Not Applicable" is reported if Element Value "6. Child Restraint" is NOT reported for Protective Devices.
- Report Element Value "1. Child Car Seat" for forward-facing child seats.
- Report Element Value "2. Infant Car Seat" for rear-facing child seats.

Data Source Hierarchy Guide

1. EMS Run Report
2. Triage Form/Trauma Flow Sheet
3. ED Nurses' Notes/Flow Sheet
4. History & Physical

AIRBAG DEPLOYMENT*

TR 29.32

National & State Element
Data Format [combo] multiple-choice

NTDB/ImageTrend Description

Indication of airbag deployment during a motor vehicle crash.

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Airbag Deployment
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

1. Airbag Not Deployed (TR29.20)
2. Airbag Deployed Front (TR29.21)
3. Airbag Deployed Side (TR29.19)
4. Airbag Deployed Other (Knee, airbelt, curtain, etc. TR29.22)

Additional Information

- Report all that apply.
- Evidence of the use of airbag deployment may be reported or observed.
- Only report when Protective Devices include “8. Airbag Present.”
- Report Element Value "2. Airbag Deployed Front" for patients with documented airbag deployments but are not further specified.
- The null value "Not Applicable" is used if "Airbag Present" is NOT reported under Protective Devices

Data Source Hierarchy Guide

1. EMS Run Report
2. Triage Form/Trauma Flow Sheet
3. ED Nurses' Notes/Flow Sheet
4. History & Physical

SAFETY (Equipment) DESCRIPTION

TR 29.10 **Data Format** [text]

ImageTrend Description
Other protective equipment in use or worn by the patient at the time of the injury

Element Values

- Relevant value for data element

Additional Information

- Evidence of the use of safety equipment may be reported or observed
- Only completed if Other is "Yes"

Data Source Hierarchy Guide

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

EMS RUN NUMBER

TR 7.1 **Data Format** [text]

ImageTrend Description

The EMS Run number is assigned by the EMS agency that generated the incident. The NEMSIS data section is eResponse.03 (Incident Number).

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report
2. Other ED Documentation

EMS PATIENT CARE REPORT (PCR) NUMBER

TR 9.11 **Data Format** [text]

ImageTrend Description

The run number assigned and entered on the run sheet of the primary emergency service, specific to the individual run/patient.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report
2. Other ED Documentation

EMS PATIENT CARE REPORT UNIVERSALLY UNIQUE IDENTIFIER (UUID)

TR 7.7 **National & State Element**
Data Format [String]

NTDB/ImageTrend Description

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

Element Values

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

Additional Information

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

Data Source Hierarchy Guide

1. EMS Run Report

NAME OF EMS SERVICE

TR 7.3 **Data Format** [combo] single-choice

ImageTrend Description
The name of the EMS service that transferred the patient.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report
2. Other ED Documentation

EMS DISPATCH DATE*

TR 9.1 **Data Format** [date]

ImageTrend Description

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

XSD Data Type	xs: date	**XSD Element/Domain (Complex Type)**	EMS Notify Date
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1990	**Max. Constraint:** 2030

Element Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY
- For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility was notified by dispatch or assigned to this transport.
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene was dispatched.
- The null value "Not Applicable" is used for patients who were not transported by EMS

Data Source Hierarchy Guide

1. EMS Run Report

EMS DISPATCH TIME*

TR 9.10 **Data Format** [time]

ImageTrend Description

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

XSD Data Type	xs: time	**XSD Element/Domain (Complex Type)**	EMS Notify Time
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 00:00	**Max. Constraint:** 23:59

Element Values

- Relevant value for data element

Additional Information

- Collected as HHMM military time
- 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.
- 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.
- The null value "Not Applicable" is used for patients who were not transported by EMS

Data Source Hierarchy Guide

1. EMS Run Report

EMS EN ROUTE DATE

TR 9.17 **Data Format** [date]

ImageTrend Description

The date the EMS Agency began travel to the place where patient EMS transport was to begin.

XSD Data Type	xs: date	**XSD Element/Domain (Complex Type)**	EMS En Route Date
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1990	**Max. Constraint:** 2030

Element Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY
- For inter-facility transfer patients, this is the date at which the EMS agency transporting the patient to your facility began travelling to the transferring facility.
- For patients transported from the scene of injury to your hospital, this is the date at which the EMS agency transporting the patient to your facility began travel to place where patient EMS transport was to begin (scene).
- The null value "Not Applicable" is used for patients who were not transported by EMS.

Data Source Hierarchy Guide

1. EMS Run Report

EMS EN ROUTE TIME

TR 9.17.1 **Data Format** [time]

ImageTrend Description

The time the EMS Agency began travel to the place where patient EMS transport was to begin.

XSD Data Type	xs: time	**XSD Element/Domain (Complex Type)**	EMS En Route Time
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 00:00	**Max. Constraint:** 23:59

Element Values

- Relevant value for data element

Additional Information

- Collected as HHMM military time
- For inter-facility transfer patients, this is the time at which the EMS agency transporting the patient to your facility from the transferring facility started travelling.
- For patients transported from the scene of injury to your hospital, this is the time at which the EMS agency transporting the patient to your facility began travel to place where patient EMS transport was to begin (scene).
- The null value "Not Applicable" is used for patients who were not transported by EMS

Data Source Hierarchy Guide

1. EMS Run Report

(EMS Unit) ARRIVAL DATE AT SCENE OR TRANSFERRING FACILITY*

TR 9.2 **Data Format** [Date]

ImageTrend Description

The date the unit transporting to the hospital arrived on the scene (the date the vehicle stopped moving).

XSD Data Type	xs: date	**XSD Element/Domain (Complex Type)**	EMS Arrival Date
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1990-01-01	**Max. Constraint:** 2030-01-01

Element Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY military time
- For inter facility transfer patients, this is the date at 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 at which the unit transporting the patient to your facility from the scene arrived at the scene (arrival is defined as date/time when the vehicle stopped moving)
- The null value “Not Applicable” is used for patients who were not transported by EMS.

Data Source Hierarchy Guide

1. EMS Run Report

(EMS Unit) ARRIVAL TIME AT SCENE OR TRANSFERRING FACILITY*

TR 9.2.1 **Data Format** [time]

ImageTrend Description

The time the unit transporting to the hospital arrived on the scene (the time the vehicle stopped moving).

XSD Data Type	xs: time	**XSD Element/Domain (Complex Type)**	EMS Arrival Time
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 00:00	**Max. Constraint:** 23:59

Element Values

- Relevant value for data element

Additional Information

- Collected as HH:MM military time
- For interfacility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility arrived at the transferring facility (arrival is defined as date/time when the vehicle stopped moving).
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene arrived at the scene (arrival is defined as date/time when the vehicle stopped moving).
- The null value “Not Applicable” is used for patients who were not transported by EMS.

Data Source Hierarchy Guide

1. EMS Run Report

PATIENT CONTACT DATE

TR 9.6 **Data Format** [Date]

ImageTrend Description

The date the unit transporting to the hospital contacted the patient.

XSD Data Type	xs: date	**XSD Element/Domain (Complex Type)**	EMS Patient Contact Date
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	No	**Min. Constraint:** 1990	**Max. Constraint:** 2030

Element Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY military time
- For inter facility transfer patients, this is the date at which the unit transporting the patient to your facility from the transferring facility contacted the patient.
- For patients transported from the scene of injury to your hospital, this is the date at which the unit transporting the patient to your facility from the scene contacted the patient.
- The null value “Not Applicable” is used for patients who were not transported by EMS.

Data Source Hierarchy Guide

1. EMS Run Report

PATIENT CONTACT TIME

TR 9.5 **Data Format** [time]

ImageTrend Description

The time the unit transporting to the hospital contacted the patient on the scene.

XSD Data Type	xs: time	**XSD Element/Domain (Complex Type)**	EMS Patient Contact Time
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	No	**Min. Constraint:** 00:00	**Max. Constraint:** 23:59

Element Values

- Relevant value for data element

Additional Information

- Collected as HH:MM military time
- For interfacility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility contacted the patient.
- 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 contacted the patient.
- The null value “Not Applicable” is used for patients who were not transported by EMS.

Data Source Hierarchy Guide

1. EMS Run Report

(EMS Unit) DEPARTURE DATE FROM SCENE OR TRANSFERRING FACILITY*

TR 9.3 **Data Format** [Date]

ImageTrend Description

The date the unit transporting to the hospital left the scene.

XSD Data Type	xs: date	**XSD Element/Domain (Complex Type)**	EMS Left Date
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1990-01-01	**Max. Constraint:** 2030-01-01

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD
- For inter-facility transfer patients, this is the date at which 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 at which 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).
- The null value "Not Applicable" is used for patients who were not transported by EMS

Data Source Hierarchy Guide

1. EMS Run Report

(EMS Unit) DEPARTURE TIME FROM SCENE OR TRANSFERRING FACILITY*

TR 9.3.1 **Data Format** [time]

ImageTrend Description

The time the unit transporting to the hospital left the scene.

XSD Data Type	xs: time	**XSD Element/Domain (Complex Type)**	EMS Left Time
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 00:00	**Max. Constraint:** 23:59

Element Values

- Relevant value for data element

Additional Information

- Collected as HH:MM military time
- For inter facility transfer patients, this is the time at which 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 at which 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).
- The null value "Not Applicable" is used for patients who were not transported by EMS

Data Source Hierarchy Guide

1. EMS Run Report

UNIT ARRIVED HOSPITAL DATE

TR 9.4 **Data Format** [Date]

ImageTrend Description

The date the EMS Agency arrived with the patient at the destination of EMS transport.

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD
- Scene may be defined as "initial hospital" for inter-facility transfers.

Data Source Hierarchy Guide

1. EMS Run Report
2. 911 or Dispatch Center

UNIT ARRIVED HOSPITAL TIME

TR 9.4.1 **Data Format** [time]

ImageTrend Description
The time the EMS Agency arrived with the patient at the destination of EMS transport.

Element Values

- Relevant value for data element

Additional Information

- Collected as HH:MM
- Scene may be defined as "initial hospital" for inter-facility transfers.
- HH:MM should be collected as military time.

Data Source Hierarchy Guide

1. EMS Run Report
2. 911 or Dispatch Center

(Pre-Hospital) DESTINATION DETERMINATION

TR 15.32 **Data Format** [combo] single-choice

ImageTrend Description

Major reason for transferring the patient to the facility chosen.

Element Values

Closest Facility	On-Line Medical Direction
Diversion	Other
Hospital of Choice	Specialty Resource Center

Data Source Hierarchy Guide

1. EMS Run Report
2. Other ED Documentation

TRIAGE DESTINATION PROTOCOL

TR 9.13 **Data Format** [Combo] single-choice

ImageTrend Description
Indicates whether the out of hospital triage destination protocol was used to determine patient needed resources of this trauma care facility.

Element Values

- Relevant value for data element.

Data Source Hierarchy Guide

1. EMS Run Report
2. 911 or Dispatch Center

EMS STATUS *

TR 15.38

Required for manually entered cases
Data Format [combo] single-choice

ImageTrend Description
Status of the EMS run sheet or Patient Care Report (PCR).

Element Values

Complete	Missing
Incomplete	Pending

Data Source Hierarchy Guide

1. EMS Run Report
2. Other ED Documentation

PRE-HOSPITAL CARDIAC ARREST*

TR 15.53

National & State Element
Data Format [combo] single-choice

NTDB/ ImageTrend Description
Indication of whether the patient experienced cardiac arrest prior to ED/hospital arrival.

XSD Data Type	xs: integer	**Element/Domain (Simple Type)**	Cardiac Arrest
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Yes No

Additional Information

- A patient who experienced a sudden cessation of cardiac activity. The patient was unresponsive with no normal breathing and no signs of circulation.
- The event must have occurred outside of the index hospital.
- Pre-hospital cardiac arrest could occur at a transferring institution.
- Any component of basic and/or advanced cardiac life support must have been initiated.

Data Source Hierarchy Guide

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

(Pre-Hospital) CPR PERFORMED

TR 15.39 **Data Format** [combo] single-choice

ImageTrend Description
Indication if CPR management was conducted while under the care of EMS.

Element Values

Performed	Not Performed

Data Source Hierarchy Guide

1. EMS Run Report
2. Other ED Documentation

(Pre-Hospital Thoracentesis)/TUBE THORACOSTOMY

TR 18.97 **Data Format** [combo] single-choice

ImageTrend Description
Indication as to if this procedure was performed while under the care of EMS.

Element Values

Not Performed	Performed

Data Source Hierarchy Guide

1. EMS Run Report
2. Other ED Documentation

(Pre-Hospital) NEEDLE THORACOSTOMY

TR 18.96 **Data Format** [combo] single-choice

ImageTrend Description
Indication as to if this procedure was performed while under the care of EMS.

Element Values

Not Performed	Performed

Data Source Hierarchy Guide

1. EMS Run Report
2. Other ED Documentation

(Pre-Hospital) AIRWAY MANAGEMENT

TR 15.40 **Data Format** [combo] single-choice

ImageTrend Description
Indication as to whether a device or procedure was used to prevent or correct obstructed respiratory passage while under the care of EMS.

Element Values

CPAP	Cricoid	EOA
Nasal Cannula	LMA	Nasal Trumpet
Non-rebreather mask	Nasal ETT	Supplemental Oxygen
Bag & Mask	Oral Airway	King Airway
Combitube	Oral ETT	Airway cleared
	Trach	Alternative Airway Device

Data Source Hierarchy Guide

1. EMS Run Report
2. Other ED Documentation

(Pre-Hospital) FLUIDS

TR 15.30 **Data Format** [combo] single-choice

ImageTrend Description
Indication as to the amount of IV fluids that were administered to the patient while under the care of EMS.

Element Values

- Saline lock
- < 500
- 500-2000
- IVF Attempted
- IVF Unknown Amount

Data Source Hierarchy Guide

1. EMS Run Report
2. Other ED Documentation

(Pre-Hospital) MEDICATIONS

TR 15.31 **Data Format** [combo] multiple-choice

ImageTrend Description
Medications given to the patient while under the care of EMS.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report
2. Other ED Documentation

TEMPERATURE MAINTAINED

TR 15.36 **Data Format** [combo] Single-choice

ImageTrend Description
Whether or not the temperature of the patient was maintained while under the care of EMS.

Element Values

- Yes
- No

Data Source Hierarchy Guide

1. EMS Run Report
2. Other ED Documentation

APPROPRIATE WOUND MANAGEMENT

TR 15.37 **Data Format** [combo] multiple-choice

ImageTrend Description
Whether or not the wounds of the patient were managed appropriately while under the care of EMS.

Element Values

- Yes
- No

Data Source Hierarchy Guide

1. EMS Run Report
2. Other ED Documentation

(Pre-Hospital) VITALS DATE

TR 18.106 **Data Format** [date]

ImageTrend Description
Date of first recorded vital signs in the Pre-Hospital setting.

Element Values

- Collected as MM/DD/YYYY

Data Source Hierarchy Guide

1. EMS Run Report
2. Other ED Documentation

(Pre-Hospital) VITALS TIME

TR 18.110 **Data Format** [time]

ImageTrend Description
Time of first recorded vital signs in the Pre-Hospital setting.

Element Values

- Collected as HHMM
- HHMM should be collected as military time

Data Source Hierarchy Guide

1. EMS Run Report
2. Other ED Documentation

(Initial Field) SYSTOLIC BLOOD PRESSURE*

TR 18.67 **Data Format** [number]

ImageTrend Description

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

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Ems SBP
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 0	**Max. Constraint:** 300

Element Values

- Relevant value for data element

Additional Information

- The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury
- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- Used to auto-generate an additional calculated element: Revised Trauma Score - EMS (adult & pediatric)
- The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial element systolic blood pressure was NOT measured at the scene of injury

Data Source Hierarchy Guide

1. EMS Run Report

(Initial Field) DIASTOLIC BLOOD PRESSURE

TR 18.68 **Data Format** [number]

ImageTrend Description

First recorded diastolic blood pressure at the scene of injury.

XSD Data Type	xs: Numeric	**Element/Domain (Complex Type)**	EMS DBP
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- If the patient is transferred to your facility with no EMS run sheet from the scene of the injury, leave blank to record as "Not Known/Not Recorded"

Data Source Hierarchy Guide

1. EMS Run Report

(Initial Field) PULSE RATE*

TR 18.69 **Data Format** [number]

ImageTrend Description

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

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Ems Pulse Rate
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 0	**Max. Constraint:** 300

Element Values

- Relevant value for data element

Additional Information

- The null value "Not Known/Not Recorded" is used if the patient is transferred to (Initial ED/Hospital) SP02 (Oxygen Saturation). *
- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field pulse rate was NOT measured at the scene of injury.

Data Source Hierarchy Guide

1. EMS Run Report

(Initial Field) SP02 (Oxygen Saturation) *

TR 18.82 **Data Format** [number]

ImageTrend Description

First recorded oxygen saturation at the scene of injury.

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Ems Pulse Oximetry
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 0	**Max. Constraint:** 100

Element Values

- Relevant value for data element

Additional Information

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

Data Source Hierarchy Guide

1. EMS Run Report

(Initial Field) RESPIRATORY RATE*

TR 18.70 **Data Format** [number]

ImageTrend Description

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

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Ems Respiratory Rate
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 0	**Max. Constraint:** 100

Element Values

- Relevant value for data element

Additional Information

- The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field respiratory rate was NOT measured at the scene of injury.

Data Source Hierarchy Guide

1. EMS Run Report

(Pre-Hospital) RESPIRATORY ASSISTANCE

TR 18.80 **Data Format** [combo] single-choice

ImageTrend Description

The determination of mechanical and/or external support of respiration.

XSD Data Type	xs: integer	**Element/Domain (Complex Type)**	Respiratory Assistance
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Unassisted Respiratory Rate
Assisted Respiratory Rate

Additional Information

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

Data Source Hierarchy Guide

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

(Pre-Hospital Revised Trauma Score) RTS (Total)

TR 18.66 **Data Format** [number]

ImageTrend Description

A physiological scoring system used to predict death from injury or need for trauma center care. It is scored based upon the initial vital signs obtained from the patient in the pre-hospital setting.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report

(Pre-Hospital) Pediatric Trauma Score (PTS) (Total)

TR 18.81 **Data Format** [number]

ImageTrend Description

A physiological scoring system used to predict death from injury or need for trauma center care. It is scored based upon the initial vital signs obtained from the patient at the EMS setting for a pediatric patient.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report

INITIAL FIELD GCS - EYE*

TR 18.60 **Data Format** [number]

ImageTrend Description

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

XSD Data Type	xs: integer	**XSD Element/Domain (Simple Type)**	EMS GCS Eye
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 4

Element Values

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

Additional Information

- The null value “Not Known/Not Recorded” is reported if Initial Field GCS 40 - Eye is reported.
- The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- If patient 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. For example, if the chart indicates: "patient’s pupils are PERRL," an Eye GCS of 4 may be recorded, IF there is no other contradicting documentation.
- The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded initial field GCS - Eye was NOT measured at the scene of injury.

Data Source Hierarchy Guide

1. EMS Run Report

**Facility can report <u>EITHER</u> GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*

INITIAL FIELD GCS - VERBAL*

TR 18.61.2/TR 18.61.0(ped) **Data Format** [number]

ImageTrend Description

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

XSD Data Type	xs: integer	**XSD Element/Domain (Simple Type)**	EMS GCS Verbal
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 5

Element 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

Adult:

No vocal response
Incomprehensible sounds
Inappropriate words
Confused
Oriented

Additional Information

- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: “patient is oriented to person place and time," a Verbal GCS of 5 may be recorded, IF there is no other contradicting documentation. The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury
- If a patient is intubated, then the GCS Verbal score is equal to 1.
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded initial field GCS - Verbal was NOT measured at the scene of injury.
- The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in
- The null value “Not Known/Not Recorded” is reported if Initial Field GCS 40 - Verbal is reported.

Data Source Hierarchy Guide

1. EMS Run Report

**Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*

INITIAL FIELD GCS - MOTOR*

TR 18.62.2/TR 18.62.0 (ped) **Data Format** [number]

ImageTrend Description

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

XSD Data Type	xs: integer	**XSD Element/Domain (Simple Type)**	EMS GCS Motor
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 6

Element Values

Pediatric (≤ 2 years):

No motor response	Withdrawal from pain
Extension to pain	Localizing pain
Flexion to pain	Appropriate response to stimulation

Adult:

No motor response	Flexion to pain	Localizing pain
Extension to pain	Withdrawal from pain	Obeys commands

Additional Information

- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded initial field GCS - Motor was NOT measured at the scene of injury.
- The null value "Not Known/Not Recorded" is 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 function within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus", a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation.
- The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- The null value “Not Known/Not Recorded” is reported if Initial Field GCS 40 - Motor is reported.

Data Source Hierarchy Guide

1. EMS Run Report

**Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*

(Initial Field) GCS QUALIFIER (UP TO 3)

TR 18.63 **Data Format** [combo] multiple-choice

ImageTrend Description
Documentation of factors potentially affecting the first assessment of GCS before arrival in the ED/hospital.

XSD Data Type	xs: integer	**XSD Element/Domain (Simple Type)** EMS GCS Qualifier	
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element 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

Additional Information

- To select more than 1, hold down the Shift Key.
- Identifies treatments given to the patient that may affect the first assessment of GCS. This element does not apply to self-medications the patient may administer (i.e., ETOH, prescriptions, etc.).

Data Source Hierarchy Guide

1. EMS Run Report

INITIAL FIELD GCS – TOTAL (Manual GCS)*

TR 18.64 **Data Format** [number]

ImageTrend Description

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

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	EmsTotalGCS
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 3	**Max. Constraint:** 15

Element Values

- Relevant value for data element

Additional Information

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

Data Source Hierarchy Guide

1. EMS Run Report

**Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*

INITIAL FIELD GCS 40- EYE*

TR 18.90.2/TR 18.90.0 (ped) **Data Format** [number]

ImageTrend Description

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

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	EmsGCS40Eye
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 3	**Max. Constraint:** 15

Element Values

Adults**:**
None
To Pressure
To Sound
Spontaneous
Not Testable

Pediatric <5 years:
None
To Pain
To Sound
Spontaneous
Not Testable

Additional Information

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

Data Source Hierarchy Guide:

1. EMS Run Report

**Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*

INITIAL FIELD GCS 40- VERBAL*

TR 18.91.2/TR 18.91.0 (ped) **Data Format** [number]

ImageTrend Description

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

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Ems GCS40 Verbal
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 3	**Max. Constraint:** 15

Element Values

Adults:	Pediatric <5 years:
None	None
Sounds	Cries
Words	Vocal Sounds
Confused	Words
Oriented	Talks Normally
Not Testable	Not Testable

Additional Information

- The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- If a patient does not have a numeric GCS 40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS 40 scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient correctly gives name, place and date" a Verbal GCS of 5 may be recorded, IF there is no other contradicting documentation.
- The null value "Not Applicable" is reported for patients who arrive by "4. Private/Public Vehicle/Walk-in".
- Report Field Value "6. Not Testable" if unable to assess (e.g. patient is intubated).
- The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field GCS 40-Verbal was not measured at the scene of injury.
- The null value "Not Known/Not Recorded" is reported if Initial Field GCS – Verbal is reported.

Data Source Hierarchy Guide

1. EMS Run Report

**Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*

INITIAL FIELD GCS 40- MOTOR*

TR 18.92.2/TR 18.92.0 (ped) **Data Format** [number]

ImageTrend Description

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

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Ems GCS40 Motor
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 3	**Max. Constraint:** 15

Element Values

Adults	Pediatric <5 years
None	None
Extension	Extension to Pain
Abnormal Flexion	Flexion to Pain
Normal Flexion	Localizing Pain
Localizing	Talks Normally
Obeys Commands	Obeys Commands
Not Testable	Not Testable

Additional Information

- The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- If a patient does not have a numeric GCS 40 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 opened mouth and stuck out tongue when asked" for adult patient's, a Motor GCS 40 of 6 may be recorded, IF there is no other contradicting documentation.
- The null value "Not Applicable" is reported for patients who arrive by "4. Private/Public Vehicle/Walk-in".
- Report Field Value "7. Not Testable" if unable to assess (e.g. neuromuscular blockade).
- The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field GCS 40 – motor was NOT measured at the scene of injury.
- The null value "Not Known/Not Recorded" is reported if Initial Field GCS – Motor is reported.

Data Source Hierarchy Guide

1. EMS Run Report

**Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*

(Pre-Hospital) GCS 40 MANUAL TOTAL

TR 18.94 **Data Format** [number]

ImageTrend Description

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

Element Values

- Relevant value for data element

Additional Information

- Use only if total score is available without component score
- Used to auto-generate an additional calculated element: Revised Trauma Score – pre-hospital Hospital (adult and pediatric)
- If a patient does not have a numeric GCS score recorded, but with 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
- 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 function 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 Guide

1. EMS Run Report

**Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*

(Pre-Hospital) AVPU

TR 18.107 **Data Format** [combo] single-choice

ImageTrend Description

A scale used to assess a patient's level of consciousness in the pre-hospital setting.

Element Values

- Alert
- Responds to pain
- Unresponsive
- Verbal stimuli

Data Source Hierarchy Guide

1. EMS Run Report

ED/Acute Care Information

DIRECT ADMIT TO HOSPITAL

TR 17.30 **Data Format** [combo] single-choice

ImageTrend Description

Indicates if the patient was a direct admission.

Element Values

No Yes

Data Source Hierarchy Guide

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

DATE ARRIVED IN ED/ACUTE CARE*

TR 18.55

National & State Element
Data Format [date]

NTDB/ImageTrend Description

The date patient arrived in the ED/Hospital.

XSD Data Type	xs: date	**XSD Element/Domain (Complex Type)**	Hospital Arrival Date
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1990	**Max. Constraint:** 2030

Element Values

- Relevant value for data element
- 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)

Additional Information

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

Data Source Hierarchy Guide:

1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation
3. Ed Record
4. Face Sheet
5. Billing Sheet
6. Discharge Summary

TIME ARRIVED IN ED/ACUTE CARE (ED/Hospital Arrival Time)*

TR 18.56

National & State Element
Data Format [Time]

NTDB/ImageTrend Description
The time patient arrived at the ED/Hospital.

XSD Data Type	xs: time	**XSD Element/Domain (Complex Type)**	Hospital Arrival Time
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 00:00	**Max. Constraint:** 23:59

Element Values
- Relevant value for data element
- 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).

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

Data Source Hierarchy Guide
1. Triage Form/Trauma Flow Sheet
2. ED Record
3. Face Sheet
4. Billing Sheet
5. Discharge Summary

TRAUMA TEAM ACTIVATED

TR 17.21 **Data Format** [radio]

ImageTrend Description
Level of Trauma Team activated.

Element Values
- Not Activated
- Level 1
- Level 2
- Level 3
- Level 4

Data Source Hierarchy Guide
1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation

HIGHEST ACTIVATION*

TR 17.21.1

National & State Element
Data Format [combo] single-choice

NTDB/ImageTrend Description

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

INCLUDE:

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

EXCLUDE:

- Patients who received the highest level of trauma activation after emergency department (ED) discharge.

Element Values

Yes No

Additional Information

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

Data Source Hierarchy Guide

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

DATE TRAUMA TEAM ACTIVATED

TR 17.31 **Data Format** [date]

ImageTrend Description
The date trauma team was activated.

Element Values
- Relevant value for data element

Additional Information
- Collected as MM/DD/YYYY
- Only completed if Trauma Team is activated

Data Source Hierarchy Guide
1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation
3. Hospital Registration
4. Hospital Discharge Summary

TIME TRAUMA TEAM ACTIVATED

TR 17.34 **Data Format** [time]

ImageTrend Description
The time trauma team was activated

Element Values
- Relevant value for data element

Additional Information
- Collected as HHMM
- HHMM should be collected as military time
- Only completed if Trauma Team is activated

Data Source Hierarchy Guide
1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation
3. Hospital Registration
4. Hospital Discharge Summary

TEAM MEMBER

TR 17.9 **Data Format** [combo] single-choice

ImageTrend Description
Name of the team member called when trauma team was activated

Element Values
- Relevant value for data element

Additional Information
- Only completed if Trauma Team is activated

Data Source Hierarchy Guide
1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation
3. Hospital Registration
4. Hospital Discharge Summary

(Trauma Team Member) SERVICE TYPE

TR 17.13 **Data Format** [combo] single-choice

ImageTrend Description
The specialty of the team member (physician) called for the Trauma Team Activation.

Element Values

Anesthesia	Internal Medicine	Pediatric Surgery
Crisis RN	Maxillofacial Surgery	Pediatric Hospitalist
CRNA	Nephrologist	Pediatric Intensivist
Dental	Nephrology	Physician Assistant
Emergency Medicine	Neurosurgery	Plastic Surgery
ENT	Nurse Practitioner	Pulmonology
Family Practice	Obstetrics & Gyn	Social Work
Hospitalist	Ophthalmology	Surgery Senior Resident
Infectious Diseases	Organ Retrieval	Surgery/Trauma
Intensive Care Unit	Orthopedic Surgery Urology	Vascular Surgery

Additional Information

- Only completed if Trauma Team is activated

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation
3. Hospital Registration
4. Hospital Discharge Summary

DATE (Trauma Team Member) CALLED

TR 17.10 **Data Format** [date]

ImageTrend Description
The date team member (physician) was called when the trauma team was activated.

Element Values
- Relevant value for data element

Additional Information
- Collected as MM/DD/YYYY
- Only completed if Trauma Team is activated

Data Source Hierarchy Guide
1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation

TIME (Trauma Team Member) CALLED

TR 17.14 **Data Format** [time]

ImageTrend Description
The time team member (physician) was called when the trauma team was activated.

Element Values
- Relevant value for data element

Additional Information
- Collected as HHMM
- HHMM should be collected as military time
- Only completed if Trauma Team is activated

Data Source Hierarchy Guide
1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation

DATE (Trauma Team Member) ARRIVED

TR 17.15 **Data Format** [date]

ImageTrend Description
The date team member (physician) arrived when the trauma team was activated.

Element Values
- Relevant value for data element

Additional Information
- Collected as MM/DD/YYYY
- Only completed if Trauma Team is activated

Data Source Hierarchy Guide
1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation

TIME (Trauma Team Member) ARRIVED

TR 17.11 **Data Format** [time]

ImageTrend Description
The time team member (physician) arrived when the trauma team was activated.

Element Values
- Relevant value for data element

Additional Information
- Collected as HHMM
- HHMM should be collected as military time
- Only completed if Trauma Team is activated

Data Source Hierarchy Guide
1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation

(Trauma Team) TIMELY ARRIVAL

TR 17.12 **Data Format** [combo] single-choice

ImageTrend Description
Was the (ED physician) response to the call to see the patient in a timely manner?

Element Values

Yes	No

Additional Information

- Only completed if Trauma Team is activated
- Criteria for timely arrival is defined by the facility

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation
3. Hospital Registration
4. Hospital Discharge Summary

TRAUMA SURGEON ARRIVAL DATE*

TR 17.15.1 **National & State Element**
Data Format [Date]

NTDB/ImageTrend Description

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

XSD Data Type	xs: date	**XSD Element Name:**	Trauma Surgeon Highest Activation Arrival Date
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**XSD Complex Type:**	Date1990 - 2030
Minimum Value:	1990-01-01	**Maximum Value:**	2030-01-01

Element Values

Relevant value for data element

Additional Information

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

Data Source Hierarchy Guide

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

TRAUMA SURGEON ARRIVAL TIME*

TR 17.15.2 **National & State Element**
Data Format [Time]

NTDB/ImageTrend Description

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

XSD Data Type	xs: time	**XSD Element Name:**	Trauma Surgeon Highest Activation Arrival Time
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**XSD Complex Type:** Time	

Element Values

Relevant value for data element

Additional Information

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

Data Source Hierarchy Guide

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

PRIMARY TRAUMA SERVICE TYPE*

TR 18.205

National & State Element
Data Format [combo] single choice

NTDB/ImageTrend Description

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

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Primary Trauma Service Type
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Adult Pediatric

Additional Information

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

Data Source Hierarchy Guide

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

PRIMARY MEDICAL EVENT*

TR 18.220

National & State Element
Data Format [combo] single-choice

NTDB Description

The patient experienced a documented primary medical event (e.g. stroke, myocardial infarction, cardiac arrest, intracranial bleeding, sepsis) that immediately preceded the traumatic injury.

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Primary Medical Event
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

1. Yes
2. No

Additional Information

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

Data Source Hierarchy Guide

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

ADMITTING MD/STAFF

TR 18.98 **Data Format** [combo] single-choice

ImageTrend Description
Physician or staff member's name to which the patient is designated upon admission to the facility

Element Values
- Relevant value for data element

Data Source Hierarchy Guide
1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation
3. Hospital Registration
4. Hospital Discharge Summary

ADMITTING SERVICE

TR 18.99 **Data Format** [combo] single-choice

ImageTrend Description
The department within the hospital that admitted the patient after being discharged from the ED.

Element Values
Cardiology
Cardiovascular Surgery
Ears, Nose, Throat (ENT)
Family Practice
Gastrointestinal (GI)
General Surgery
Hem-Onc
Hospitalist
Infection Control
Internal Medicine
Medicine
Nephrology
Ophthalmology
Orthopedics
Pediatric Surgery
Plastic Surgery
Surgery Subspecialty
Trauma

Additional Information
- Burn, OMFS, Hand, etc. fall under "Surgery Subspecialty"

Data Source Hierarchy Guide
1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation
3. Hospital Registration
4. Hospital Discharge Summary

CONSULTING SERVICES

TR 17.29 **Data Format** [combo] single-choice

ImageTrend Description

The determination that consulting services were provided.

XSD Data Type	xs: integer	**XSD Element/Domain (Simple Type)**	Consulting Service
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Yes No

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation
3. Hospital Registration
4. Hospital Discharge Summary

(Consulting) SERVICE TYPE

TR 17.32 **Data Format** [combo] single-choice

ImageTrend Description

The specialty of any consults made during the patient's time at the hospital.

Element Values

Acute Rehabilitation Medicine	Infectious Disease	Pediatric Hospitalist
Anesthesia	Internal Medicine	Pediatric Infectious Disease
Bariatric	Interventional Radiology	Pediatric Intensivist
Burn	Kidney Transplant	Pediatric Nephrology
Cardiology	Liver	Pediatric Neurology
Cardiothoracic Surgery	Neonatal	Pediatric Orthopedic
Chemical Dependency	Nephrology	Pediatric Pulmonary
Colo-Rectal	Neurointensive Care	Pediatric Surgery
Critical Care Medicine	Neurology	Physical Med & Rehab
Critical Care Surgery	Neurosurgery	Plastic Surgeon
Dentistry	Obstetric	Psychiatry
Dermatology	Oculoplastic	Psychology
Electrophysiology	Oncology	Rheumatology
Endocrinology	Ophthalmology	Social Work
Ear Nose Throat	Oral Maxilla Facial Surgery	Trauma Surgeon
Family Medicine	Orthopedic Surgeon	Urology
Gastroenterology	Pain	Vascular Surgery
General Surgery	Pediatric Cardiology	
Geriatric	Pediatric Critical Care Medicine	
Gynecology	Pediatric Dentistry	
Hand Pediatric	Gastroenterology	
Hematology Oncology	Pediatric Hematology Oncology	

Additional Information

- Only completed if Consulting Services is "Yes"

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation
3. Hospital Registration
4. Hospital Discharge Summary

CONSULTING STAFF

TR 17.33 **Data Format** [combo] single-choice

ImageTrend Description
Name of staff member that consulted on the patient.

Element Values

- Relevant value for data element

Additional Information

- Only completed if Consulting Services is "Yes"

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation
3. Hospital Registration
4. Hospital Discharge Summary

DATE (Consulting Practitioner Requested)

TR 17.7 **Data Format** [date]

ImageTrend Description

The date the consultant was called.

Element Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY
- Only completed if Consulting Services is "Yes"

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation
3. Hospital Registration
4. Hospital Discharge Summary

TIME (Consulting Practitioner Requested)

TR 17.8 **Data Format** [time]

ImageTrend Description
The time the consultant was called.

Element Values

- Relevant value for data element

Additional Information

- Collected as HHMM
- HHMM should be collected as military time
- Only completed if Consulting Services is "Yes"

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation
3. Hospital Registration
4. Hospital Discharge Summary

DATE DISCHARGED FROM ED (ORDERS WRITTEN) *

TR 17.41 **National & State Element**
Data Format [date]

NTDB/ImageTrend Description
The date order was written for the patient to be discharged from the ED.

XSD Data Type	xs: date	**XSD Element/Domain (Complex Type)**	Ed Discharge Orders Written Date
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- Reported as MM/DD/YYYY.
- Used to auto-generate an additional calculated element: Total ED Time: (elapsed time from ED admit to ED discharge).
- The null value "Not Applicable" is used if the patient is directly admitted to the hospital.
- If ED Discharge Disposition is 5 Deceased/Expired, then ED Discharge Date is the date of death as indicated on the patient's death certificate.

Data Source Hierarchy Guide

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

TIME DISCHARGED FROM ED (ORDERS WRITTEN) *

TR 17.42 **National & State Element**
Data Format [time]

NTDB/ImageTrend Description
The time order was written for the patient to be discharged from the ED.

XSD Data Type	xs: time	**XSD Element/Domain (Complex Type)**	Ed Discharge Orders Written Time
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- Reported as HHMM military time.
- Used to auto-generate an additional calculated element: Total ED Time (elapsed time from ED admit to ED discharge)
- The null value "Not Applicable" is used if the patient is directly admitted to the hospital.
- If ED Discharge Disposition is 5 Decreased/Expired, then ED Discharge Time is the time of death as indicated on the patient's death certificate.

Data Source Hierarchy Guide

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

DATE DISCHARGED FROM ED (PHYSICAL EXIT) *

TR 17.25 **Data Format** [date]

ImageTrend Description

The date patient physically left the ED.

XSD Data Type	xs: date	**XSD Element/Domain (Complex Type)**		Ed Discharge Physical Date
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values	
Required in XSD	Yes	**Min. Constraint:** 1990		**Max. Constraint:** 2030

Element Values

- Relevant value for data element
- Total ED Time (elapsed time from ED admit to ED discharge)

Additional Information

- Collected as MM/DD/YYYY
- The null value "Not Applicable" is used if the patient is directly admitted to the hospital.

Data Source Hierarchy Guide

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

TIME DISCHARGED FROM ED (PHYSICAL EXIT) *

TR17.26 **Data Format** [time]

ImageTrend Description

The time patient physically left the ED.

XSD Data Type	xs: time	**XSD Element/Domain (Complex Type)**	Ed Discharge Physical Time
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 00:00	**Max. Constraint:** 23:59

Element Values

- Relevant value for data element
- Total ED Time (elapsed time from ED admit to ED discharge)

Additional Information

- Collected as HH:MM military time
- The null value "Not Applicable" is used if the patent is directly admitted to the hospital

Data Source Hierarchy Guide

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

ED DISCHARGE DISPOSITION*

TR 17.27

National & State Element
Data Format [combo] single-choice

NTDB/ImageTrend Description
The disposition unit order was written for the patient to be discharged from the ED.

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Ed Discharge Disposition
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

1. Floor bed (general admission, non-specialty unit bed)
2. Observation Unit
3. Telemetry/step-down unit (less acuity than ICU)
4. Home with Services
5. Deceased/Expired
6. Other (jail, institutional care, mental health, etc.
7. Operating Room (Hybrid OR)
8. Intensive Care Unit (ICU)
9. Home without services
10. Left against medical advice.
11. Transferred to another hospital.
12. Interventional Radiology Suite
13. Hospice (e.g., hospice facility, hospice unit, home hospice)

Additional Information

- The null value "Not Applicable" is used if the patient is directly admitted to the hospital.
- If ED Discharge Disposition is 4, 5, 6, 9, 10, 11, or 13 then Hospital Discharge Date, Hospital Discharge Time, and Hospital Discharge Disposition must be "Not Applicable"
- If the patient was boarded in the ED, the disposition must be the location the patient was ordered to go when their ED workup was complete.

Data Source Hierarchy Guide

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

HOSPITAL TRANSFERRED TO*

TR17.61

Required for manually entered cases
Format [combo] single-choice

ImageTrend Description
Name of the receiving facility the patient was transferred to from ED.

Element Values
- Relevant value for data element

Additional Information
- Only completed if ED Discharge Disposition is "Transferred to Another Hospital" is selected.

Data Source Hierarchy Guide
1. Hospital Records
2. Billing Sheet/Medical Records Coding Summary Sheet
3. Physician Discharge Summary
4. ED Report

DISCHARGE TRANSPORT MODE*

TR17.60 **Data Format** [combo] single-choice

ImageTrend Description

The type of transportation used to transfer the patient. For 2020 per NTDS, patients who are transferred by private vehicle are included in the trauma registry.

Element Values

- Ground Ambulance
- Helicopter Ambulance
- Fixed Wing Ambulance
- Private/Public Vehicle/Walk-In
- Police
- Other

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 element does not apply to the patient.
- Check all that apply with a maximum of 5.

Data Source Hierarchy Guide

1. EMS Run Report

**Patients transferred from one acute care hospital to another acute care hospital by private vehicle are to be included in the trauma registry. **

TRANSFER DELAY*

TR 17.45 **State Element (Only for Non-Trauma Centers)**
Data Format [combo] single-choice

ImageTrend Description
Indicate whether or not there was a delay transferring a patient to a hospital.

Element Values

No Yes

Additional Information

- Only completed if ED Disposition is "Transferred to another Hospital"

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. ED Nurses' Notes
3. Other ED Documentation
4. Hospital Discharge Summary
5. Billing Sheet/Medical Records Summary Sheet

REASON FOR TRANSFER DELAY*

TR 17.44

State Element (Only for Non-Trauma Centers)
Data Format [combo] multiple-choice

ImageTrend Description
Indicate the reason for delay in transferring a patient to a hospital.

Element Values

- Communication Issue
- Delayed Identification that the patient needed trauma center resources
- High ED census at receiving hospital/busy
- High ED census at transferring hospital/busy
- In-house imaging delay
- Late requesting transporting EMS unit
- Low patient acuity
- Patient status change/complication
- Religious/community/complication
- Waiting for transporting EMS unit
- Delay Issue
- EMS Issue
- Equipment Issue
- Error Issue
- Family, Legal Guardian, or Patient Issue
- Receiving Facility Issue
- Referring Facility Issue
- Referring Physician Decision making
- Transportation Issue
- Referring Hospital Issue - Radiology
- Weather or Natural Factors Issue
- Other

Additional Information

- Only completed if ED Disposition is "Transferred to another Hospital"

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. ED Nurses' Notes
3. Other ED Documentation
4. Hospital Discharge Summary
5. Billing Sheet/Medical Records Summary Sheet

REASON FOR TRANSFER DELAY - Communication Issue

TR 17.44.Communication **State Element (Only for Non-Trauma Centers)**
Data Format [combo] multiple-choice

ImageTrend Description
Communication Issue - Detailed Reason for Transfer Delay.

Element Values

- Miscommunication between sending and receiving facility
- Nursing delay in calling for/arranging transportation
- Nursing delay in contacting EMS
- Physician response delay

Additional Information

- Only completed if ED Disposition is "Transferred to another Hospital"

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. ED Nurses' Notes
3. Other ED Documentation
4. Hospital Discharge Summary
5. Billing Sheet/Medical Records Summary Sheet

REASON FOR TRANSFER DELAY - Delay Issue

TR 17.44.Delay

State Element (Only for Non-Trauma Centers)
Data Format [combo] multiple-choice

ImageTrend Description
Delay Issue - Detailed Reason for Transfer Delay.

Element Values

- Delay in diagnosis
- Delay in Emergency Department disposition decision
- Delay in trauma team activation

Additional Information

- Only completed if ED Disposition is "Transferred to another Hospital"

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. ED Nurses' Notes
3. Other ED Documentation
4. Hospital Discharge Summary
5. Billing Sheet/Medical Records Summary Sheet

REASON FOR TRANSFER DELAY - EMS Issue

TR 17.44.EMS

State Element (Only for Non-Trauma Centers)
Data Format [combo] multiple-choice

ImageTrend Description
EMS Issue - Detailed Reason for Transfer Delay.

Element Values

- Air transport ETA greater than ground transport ETA
- Air transport not available due to weather
- ALS transportation delay
- No ALS available
- No hospital staff available to accompany BLS EMS personnel
- Out of county
- Shortage of available ground transportation

Additional Information

- Only completed if ED Disposition is "Transferred to another Hospital"

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. ED Nurses' Notes
3. Other ED Documentation
4. Hospital Discharge Summary
5. Billing Sheet/Medical Records Summary Sheet

REASON FOR TRANSFER DELAY - Equipment Issue

TR 17.44.Equipment **State Element (Only for Non-Trauma Centers)**
Data Format [combo] multiple-choice

ImageTrend Description

Equipment Issue - Detailed Reason for Transfer Delay.

Element Values

Equipment broken
Equipment missing/unavailable
Not Known

Additional Information

- Only completed if ED Disposition is "Transferred to another Hospital"

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. ED Nurses' Notes
3. Other ED Documentation
4. Hospital Discharge Summary
5. Billing Sheet/Medical Records Summary Sheet

REASON FOR TRANSFER DELAY - Error Issue

TR 17.44.Error

State Element (Only for Non-Trauma Centers)
Data Format [combo] multiple-choice

ImageTrend Description
Error Issue - Detailed Reason for Transfer Delay.

Element Values

Error in judgement
Error in technique
Error in treatment

Additional Information

- Only completed if ED Disposition is "Transferred to another Hospital"

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. ED Nurses' Notes
3. Other ED Documentation
4. Hospital Discharge Summary
5. Billing Sheet/Medical Records Summary Sheet

REASON FOR TRANSFER DELAY - Patient Issue

TR 17.44.Patient **State Element (Only for Non-Trauma Centers)**
Data Format [combo] multiple-choice

ImageTrend Description

Family, Legal Guardian, or Patient Issue - Detailed Reason for Transfer Delay.

Element Values

Change in patient condition
Child Protective Services (CPS)
Family requested transfer
Patient requested transfer

Additional Information

- Only completed if ED Disposition is "Transferred to another Hospital"

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. ED Nurses' Notes
3. Other ED Documentation
4. Hospital Discharge Summary
5. Billing Sheet/Medical Records Summary Sheet

REASON FOR TRANSFER DELAY - Receiving Facility Issue

TR 17.44.Receiving **State Element (Only for Non-Trauma Centers)**
Data Format [combo] multiple-choice

ImageTrend Description
Receiving Facility Issue - Detailed Reason for Transfer Delay.

Element Values

Bed availability
Difficulty obtaining accepting facility/hospital
New ED staff

Additional Information

- Only completed if ED Disposition is "Transferred to another Hospital"

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. ED Nurses' Notes
3. Other ED Documentation
4. Hospital Discharge Summary
5. Billing Sheet/Medical Records Summary Sheet

REASON FOR TRANSFER DELAY - Referring Facility Issue

TR 17.44.Referring **State Element (Only for Non-Trauma Centers)**
Data Format [combo] multiple-choice

ImageTrend Description

Referring Facility Issue - Detailed Reason for Transfer Delay.

Element Values

Physician decision making
Priority of transfer
Radiology workup delay
Surgeon availability

Additional Information

- Only completed if ED Disposition is "Transferred to another Hospital"

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. ED Nurses' Notes
3. Other ED Documentation
4. Hospital Discharge Summary
5. Billing Sheet/Medical Records Summary Sheet

REASON FOR TRANSFER DELAY - Transportation Issue

TR 17.44.Transportation **State Element (Only for Non-Trauma Centers)**
Data Format [combo] multiple-choice

ImageTrend Description
Transportation Issue - Detailed Reason for Transfer Delay.

Element Values
Transportation issue

Additional Information

- Only completed if ED Disposition is "Transferred to another Hospital"

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. ED Nurses' Notes
3. Other ED Documentation
4. Hospital Discharge Summary
5. Billing Sheet/Medical Records Summary Sheet

REASON FOR TRANSFER DELAY - Weather or Natural Issue

TR 17.44.Weather **State Element (Only for Non-Trauma Centers)**
Data Format [combo] multiple-choice

ImageTrend Description

Weather or Natural Factors Issue - Detailed Reason for Transfer Delay.

Element Values

- Flooding
- Rain
- Snow
- Tornado

Additional Information

- Only completed if ED Disposition is "Transferred to another Hospital"

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. ED Nurses' Notes
3. Other ED Documentation
4. Hospital Discharge Summary
5. Billing Sheet/Medical Records Summary Sheet

OTHER REASON FOR TRANSFER DELAY

TR 17.43 **State Element (Only for Non-Trauma Centers)**
Data Format [text]

ImageTrend Description
Reason for delay in transferring the patient.

Element Values

- Relevant value for data element

Additional Information

- Only completed if Reason for Transfer Delay is "Other"

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. ED Nurses' Notes
3. Other ED Documentation
4. Hospital Discharge Summary
5. Billing Sheet/Medical Records Summary Sheet

Initial Assessment Information

(Initial ED/Hospital) VITALS DATE

TR 18.104 **Data Format** [date]

ImageTrend Description
The date of the first recorded vitals in the ED/Hospital setting.

Element Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. Billing Sheet/Medical Records Coding Summary Sheet
3. ED Nurses' Notes
4. Other ED Documentation

(Initial ED/Hospital) VITALS TIME

TR 18.110 **Data Format** [time]

ImageTrend Description
The time of the first recorded vitals in the ED/Hospital setting.

Element Values

- Relevant value for data element

Additional Information

- Collected as HHMM
- HHMM should be collected in military time

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. Billing Sheet/Medical Records Coding Summary Sheet
3. ED Nurses' Notes
4. Other ED Documentation

(Initial ED/Hospital) SYSTOLIC BLOOD PRESSURE*

TR 18.11 **National & State Element**
Data Format [number]

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

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	SBP
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 0	**Max. Constraint:** 300

Element Values

- Relevant value for data element

Additional Information

- Please note that the first recorded hospital vitals do not need to be from the same assessment
- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.

Data Source Hierarchy Guide

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

(Initial ED/Hospital) DIASTOLIC BLOOD PRESSURE

TR 18.13 **Data Format** [number]

ImageTrend Description

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

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	DBP
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 0	**Max. Constraint:** 299

Element Values

- Relevant value for data element

Additional Information

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

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation
3. Nurses' notes

(Initial ED/Hospital) PULSE RATE*

TR 18.2 **National & State Element**
Data Format [number]

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

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Pulse Rate
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 0	**Max. Constraint:** 300

Element Values

- Relevant value for data element

Additional Information

- Please note that the first recorded hospital vitals do not need to be from the same assessment
- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.

Data Source Hierarchy Guide

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

(Initial ED/Hospital) TEMPERATURE*

TR 18.30 **National & State Element**
Data Format [number]

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

XSD Data Type	xs: decimal	**XSD Element/Domain (Complex Type)**	Temperature
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 0	**Max. Constraint:** 45.0°C

Element Values

- Relevant value for data element

Additional Information

- Please note that the first recorded hospital vitals do not need to be from the same assessment
- Used to auto-generate an additional calculated element: Temperature in degrees Fahrenheit

Data Source Hierarchy Guide

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

(Initial ED/Hospital) TEMPERATURE ROUTE

TR 18.147 **Data Format** [number]

ImageTrend Description
Indicates the initial emergency department/hospital temperature measurement route.

Element Values

Axillary	Rectal
Foley	Temporal Artery
Oral	Tympanic
Other	

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation
3. Nurses' notes

(Initial ED/Hospital) SP02 (Oxygen Saturation) *

TR 18.31 **National & State Element**
Data Format [number]

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

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Pulse Oximetry
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 0	**Max. Constraint:** 100

Element Values
- Relevant value for data element

Additional Information
- If reported, complete additional element: "Initial ED/Hospital Supplemental Oxygen"
- Please note that the first recorded hospital vitals do not need to be from the same assessment

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

(Initial ED/Hospital) RESPIRATORY RATE*

TR 18.7

National & State Element
Data Format [number]

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

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Respiratory Rate
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 0	**Max. Constraint:** 120

Element Values

- Relevant value for data element

Additional Information

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

Data Source Hierarchy Guide

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

(Initial ED/Hospital) RESPIRATORY ASSISTANCE*

TR 18.10

National & State Element
Data Format [combo] single-choice

NTDB/ ImageTrend Description
Determination of respiratory assistance associated with the Initial ED/hospital respiratory rate within 30 minutes of ED/hospital arrival.

XSD Data Type	xs: integer	**XSD Element/Domain (Simple Type)**	Respiratory Assistance
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values
- Unassisted Respiratory Rate
- Assisted Respiratory Rate

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

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

(Initial ED/Hospital) SUPPLEMENTAL OXYGEN*

TR 18.109

National & State Element

Data Format [combo] single-choice

NTDB/ImageTrend Description

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

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Supplemental Oxygen
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- No Supplemental Oxygen
- Supplemental Oxygen

Additional Information

- The null value "Not Applicable" is reported if the Initial ED/Hospital Oxygen Saturation is "Not Known/Not Recorded"
- Please note that the first recorded hospital vitals do not need to be from the same assessment

Data Source Hierarchy Guide

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

(Initial ED/hospital Revised Trauma Score) RTS (Total)

TR 18.28 **Data Format** [number]

ImageTrend Description
A physiological scoring system used to predict death from injury or need for trauma center care. It is scored based upon the initial vital signs obtained from the patient in the ED or hospital setting.

Element Values
- Relevant value for data element

Additional Information
- Use only if total score is available without component score
- Auto-generated if Manual GCS - Total is entered

Data Source Hierarchy Guide
1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation

(Initial ED/hospital Pediatric Trauma Score) PTS (Total)

TR 21.10 **Data Format** [number]

ImageTrend Description
A physiological scoring system used to predict death from injury or need for trauma center care. It is scored based upon the initial vital signs obtained from the patient in the ED or hospital setting for a pediatric patient.

Element Values
- Relevant value for data element

Additional Information
- Use only if total score is available without component score

Data Source Hierarchy Guide
1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation

(Initial ED/Hospital) GCS - EYE*

TR 18.14 **National & State Element**
Data Format [number]

NTDB/ImageTrend Description
First recorded Glasgow Coma Scale (GCS) Eyes in the ED/hospital within 30 minutes of ED/hospital arrival.

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	GCS Eye
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 4

Element Values
- No eye movement when assessed
- Opens eyes in response to painful stimulation
- Opens eyes in response to verbal stimulation
- Opens eyes spontaneously

Additional Information
- The null value "Not Known/Not Recorded" is reported if Initial Field GCS 40 – Eye is documented.
- 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's pupils are PERRL," an Eye GCS of 4 may be recorded, IF there is no other contradicting documentation.
- Please note that first recorded hospital vitals do not need to be from the same assessment
- The null value "Not Known/Not Recorded" is reported if the patient's Initial ED/Hospital GCS - Eye was not measured within 30 minutes or less of ED/hospital arrival.

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

Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.

(Initial ED/Hospital) GCS - VERBAL*

TR 18.15.2 **National & State Element**
Data Format [number]

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

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	GCS Verbal
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 6

Element Values
Pediatric (≤ 2 years):

- No vocal response
- Inconsolable, agitated
- Inconsistently consolable, moaning
- Cries but is consolable, inappropriate interactions
- Smiles, oriented to sounds, follow objects, interacts

Adult:

- No verbal response
- Incomprehensible sounds
- Inappropriate words
- Confused
- Oriented

Additional Information

- If the patient is intubated, the GCS Verbal is equal to 1.
- If a patient does not have a numeric GCS recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS, the appropriate numeric score may be reported. (e.g. the chart indicates: "patient is oriented to person place and time," a GCS Verbal of 5 may be reported, if there is no other contradicting documentation).
- The null value "Not Known/Not Recorded" is reported if Initial ED/Hospital GCS-40 Verbal is reported.
- The null value "Not Known/Not Recorded" is reported if the patient's Initial ED/Hospital GCS – Verbal was not measured within 30 minutes of ED/hospital arrival.
- Please note that the first recorded hospital vitals do not need to be from the same assessment.

Data Source Hierarchy Guide

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

**Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*

(Initial ED/Hospital) GCS - MOTOR*

TR 18.16.2 /TR 18.16.0 (ped) **National & State Element**
Data Format [number]

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

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	GCS Motor
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 6

Element Values

Pediatric (≤ 2 years):

- No motor response
- Extension to pain
- Flexion to pain
- Withdrawal from pain
- Localizing pain
- Appropriate response to stimulation

Adult:

- No motor response
- Extension to pain
- Flexion to pain
- Withdrawal from pain
- Localizing pain
- Obeys commands

Additional Information

- The null value "Not Known/Not Recorded" is reported if Initial ED/Hospital GCS 40 – Motor is reported.
- 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 function within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus", a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation
- Please note that the first recorded hospital vitals do not need to be from the same assessment
- The null value "Not Known/Not Recorded" is reported if the patient's Initial ED/Hospital GCS – Motor was not measured within 30 minutes or less of ED/Hospital arrival.

Data Source Hierarchy Guide

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

**Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*

(Initial ED/Hospital) GCS ASSESSMENT QUALIFIERS (UP TO 3)*

TR 18.21 **National & State Element**

Data Format [combo] multiple-choice

NTDB/ ImageTrend Description

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

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	GCS Qualifier
Multiple Entry Configuration	Yes, max 3	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element 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

Additional Information

- Identifies treatments given to the patient that may affect the first assessment of GCS. This element does not apply to self-medications the patient may administer (i.e., ETOH, prescriptions, etc.)
- If an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible, then the patient should be considered to have an exam that is not reflective of their neurologic status, and the chemical sedation modifier should be selected
- Neuromuscular blockade is typically induced following the administration of agents 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 the first recorded hospital vitals do not need to be from the same assessment
- The null value "Not Known/Not Recorded" is reported if Initial ED/Hospital GCS 40 is reported.
- The null value "Not Known/Not Recorded" is reported if the Initial ED/Hospital GCS Assessment Qualifiers are not documented within 30 minutes or less of ED/Hospital arrival.
- Report all that apply

Data Source Hierarchy Guide

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

(Initial ED/Hospital) MANUAL GCS TOTAL*

TR 18.19 **National & State Element**
Data Format [number]

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

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Total GCS
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 15

Element Values
- Relevant value for data element

Additional Information
- If a patient does not have a numeric GCS score recorded but there is documentation related to their level of consciousness such as "AAOx3", "awake alert and oriented", or "patient with normal mental status", interpret this as GCS of 15, IF there is no other contradicting documentation.
- Please note that the first recorded hospital vitals do not need to be from the same assessment.
- The null value "Not Known/Not Recorded" is reported if Initial ED/Hospital GCS 40 is reported.
- The null value "Not Known/Not Recorded" is reported if Initial ED/Hospital GCS – Eye, Initial ED/Hospital GCS – Motor, Initial ED/Hospital GCS – Verbal was not measured within 30 minutes or less of ED/Hospital arrival.

Data Source Hierarchy Guide
1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation
3. Nursing notes
4. Physician Notes

**Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*

(Initial ED/Hospital) GCS 40 – EYE*

TR 18.40.2 **National & State Element**
Data Format [number]

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

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**		GCS 40Eye
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values	
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 4	

Element Values
Adult:
- None
- To Pressure
- To Sound
- Spontaneous
- Not Testable

Pediatric <5 years:
- None
- To Pain
- To Sound
- Spontaneous
- Not Testable

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

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

**Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*

(Initial ED/Hospital) GCS 40 – VERBAL*

TR 18.41.2 **National & State Element**

Data Format [number]

NTDB/ImageTrend Description

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

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	GCS 40 Verbal
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 5

Element Values

Adult:

- None
- Sounds
- Words
- Confused
- Oriented
- Not Testable

Pediatric <5 years:

- None
- Cries
- Vocal Sound
- Words
- Talks Normally
- Not Testable

Additional Information

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

Data Source Hierarchy Guide

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

**Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*

(Initial ED/Hospital) GCS 40 – MOTOR*

TR 18.42.2 **National & State Element**

Data Format [number]

NTDB/ImageTrend Description

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

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	GCS 40Motor
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 6

Element Values

Adult:

- None
- Extension
- Abnormal Flexion
- Normal Flexion
- Localizing
- Obeys Commands
- Not Testable

Pediatric <5 years:

- None
- Extension to Pain
- Flexion to Pain
- Localizing Pain
- Talks Normally
- Obeys Commands
- Not Testable

Additional Information

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

Data Source Hierarchy Guide

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

**Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.* (Initial ED/Hospital) RESPIRATORY ASSISTANCE*

(Initial ED/Hospital) GCS 40 MANUAL TOTAL*

TR 18.44 **Data Format** [number]

NTBD/ImageTrend Description
First recorded Glasgow Coma Scale 40 (GCS 40) total score within 30 minutes of ED/hospital arrival.

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Total GCS 40
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 15

Element Values
- Relevant value for data element

Additional Information
- Please note that the first recorded hospital vitals do not need to be from the same assessment
- The null value "Not Known/Not Recorded" is reported if Initial ED/Hospital GCS is reported.
- The null value "Not Known/Not Recorded" is reported if Initial ED/Hospital GCS 40 – Eye, Initial ED/Hospital GCS 40 – Motor, Initial ED/Hospital GCS 40 – Verbal was not measured within 30 minutes or less of ED/Hospital arrival.

Data Source Hierarchy Guide
1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation
3. Nursing notes
4. Physician Notes

**Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*

(Initial ED/Hospital) ED AVPU

TR 18.53 **Data Format** [combo] single-choice

ImageTrend Description
A scale used to assess a patient's level of consciousness.

Element Values
- Alert
- Responds to pain
- Unresponsive
- Verbal stimuli

Data Source Hierarchy Guide
1. Triage Form/ Trauma Flow sheet
2. Other ED Documentation
3. Nursing Notes
4. Physician Notes

(Initial ED/Hospital) AIRWAY MANAGEMENT

TR 14.36 **Data Format** [combo] single-choice

ImageTrend Description
Indication as to whether a device or procedure was performed to prevent or correct an obstructed respiratory passage while under the care of the ED/Hospital.

Element Values

1 Bag & Mask	Oral Airway
BiPAP	Oral ETT
Combitube	Trach
Cricoid	Not Performed
King Airway	Supplemental Oxygen
LMA	Simple Mask
Nasal Cannula	
Non-rebreather mask	
Nasal ETT	

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation

(Initial ED/Hospital) CPR PERFORMED

TR 18.71 **Data Format** [combo] single-choice

ImageTrend Description
Indication as to if CPR management was conducted while under the care of the ED/Hospital.

Element Values

CPR in Progress, continued	Not Performed	Performed

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation

UNITS OF BLOOD

TR 22.13 **Data Format** [number]

ImageTrend Description
Total units of blood given.

Element Values
- Relevant value for data element

Data Source Hierarchy Guide
1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation

BLOOD ORDERED DATE

TR 22.14 **Data Format** [date]

ImageTrend Description
Date the blood was ordered for the patient in the ED/Hospital

Element Values
- Collected as MM/DD/YYYY

Data Source Hierarchy Guide
1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation

BLOOD ORDERED TIME

TR 22.17 **Data Format** [time]

ImageTrend Description
Time the blood was ordered for the patient in the ED/Hospital

Element Values
- Collected as HH:MM

Data Source Hierarchy Guide
1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation

CROSSMATCH DATE

TR 22.15 **Data Format** [date]

ImageTrend Description
Date the blood was crossmatched for the patient in the ED/Hospital.

Element Values
- Collected as MM/DD/YYYY

Data Source Hierarchy Guide
1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation

CROSSMATCH TIME

TR 22.18 **Data Format** [Time]

ImageTrend Description
Time the blood was crossmatched for the patient in the ED/Hospital.

Element Values
- Collected as HH:MM

Data Source Hierarchy Guide
1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation

BLOOD ADMINISTERED DATE

TR 22.16 **Data Format** [date]

ImageTrend Description
Date the blood was administered to the patient in the ED/Hospital.

Element Values
- Collected as MM/DD/YYYY

Data Source Hierarchy Guide
1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation

BLOOD ADMINISTERED TIME

TR 22.19 **Data Format** [time]

ImageTrend Description
Time the blood was administered to the patient in the ED/Hospital.

Element Values
- Collected as HH:MM

Data Source Hierarchy Guide
1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation

ALCOHOL SCREEN*

TR 18.46

National & State Element
Data Format [combo] single-choice

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

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Alcohol Screen
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Yes

No

Additional Information

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

Data Source Hierarchy Guide

1. Lab results (facility specific; inter-facility data not valid)
2. Transferring Facility Records

ALCOHOL SCREEN RESULTS (Blood Alcohol Content)*

TR 18.46 **National & State Element**

Data Format [combo] single-choice

NTDB/ ImageTrend Description

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

XSD Data Type	xs: decimal	**XSD Element/Domain (Complex Type)**	Alcohol Screen Result
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- Collect as X.XX grams per deciliter (g/dl).
- Report BAC results within 24 hours after first hospital encounter, at either your facility or the transferring facility.
- Report the null value "Not Applicable" for those patients who were not tested.

Data Source Hierarchy Guide

1. Lab results (facility specific; inter-facility data not valid)
2. Transferring Facility Records

DRUG SCREEN*

TR 18.91

National & State Element
Data Format [combo] multiple-choice

NTDB/ ImageTrend Description
First recorded positive drug screen results within 24 hours after first hospital encounter.

XSD Data Type	xs: integer	**XSD Element/Domain (Simple Type)**	Drug Screen
Multiple Entry Configuration	Yes, max 2	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

AMP (Amphetamine)
BAR (Barbiturate)
BZO (Benzodiazepines)
COC (Cocaine)
mAMP (Methamphetamine)
MDMA (Ecstasy)
MTD (Methadone)
OPI (Opioid)
OXY (Oxycodone)
PCP (Phencyclidine)
TCA (Tricyclic Antidepressant)
THC (Cannabinoid)
Other
None
Not Tested

Additional Information

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

Data Source Hierarchy Guide

1. Lab results (facility specific; inter-facility data not valid)
2. Transferring Facility Records

Initial ED/Hospital) BASE DEFICIT

TR 18.93 **Data Format** [number]

ImageTrend Description
The first recorded base deficit (the arterial blood gas component showing the degree of acid/base imbalance), measured in mEq/L.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. Lab results (facility specific; inter-facility data not valid)

(Initial ED/Hospital) DATE SENT TO CT

TR 18.101 **Data Format** [date]

ImageTrend Description
The date the patient had a CT performed while under the care of the ED/Hospital.

Element Values

- Collected as MM/DD/YYYY

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation

(Initial ED/Hospital) TIME SENT TO CT

TR 18.111 **Data Format** [time]

ImageTrend Description
The time the patient had a CT performed while under the care of the ED/Hospital.

Element Values

- Relevant value for data element

Additional Information

- Collected as HHMM
- HHMM should be collected in military time

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation

(Initial ED/Hospital) CT HEAD (Results)

TR 18.72 **Data Format** [combo] single-choice

ImageTrend Description
Indication as to if the procedure was performed while under the care of the ED/Hospital.

Element Values

Positive	Negative	Not Performed

Additional Information

- "Positive" is defined as “any traumatic injury”
- "Negative" is defined as “no traumatic injury”

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation
3. Radiology Report

(Initial ED/Hospital) CT ABD/PELVIS (Results)

TR 18.73 **Data Format** [combo] single-choice

ImageTrend Description
Indication as to if the procedure was performed while under the care of the ED/Hospital.

Element Values

Positive	Negative	Not Performed

Additional Information

- "Positive" is defined as “any traumatic injury”
- "Negative" is defined as “no traumatic injury”

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation
3. Radiology Report

(Initial ED/Hospital) CT CHEST (Results)

TR 18.74 **Data Format** [combo] single-choice

ImageTrend Description
Indication as to if the procedure was performed while under the care of the ED/Hospital.

Element Values

Positive	Negative	Not Performed

Additional Information

- "Positive" is defined as “any traumatic injury”
- "Negative" is defined as “no traumatic injury”

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation
3. Radiology Report

(Initial ED/Hospital) CT CERVICAL (Results)

TR 18.105 **Data Format** [combo] single-choice

ImageTrend Description
Indication as to if the procedure was performed while under the care of the ED/Hospital.

Element Values

Positive	Negative	Not Performed

Additional Information

- "Positive" is defined as “any traumatic injury”
- "Negative" is defined as “no traumatic injury”

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation
3. Radiology Report

(Initial ED/Hospital) ABDOMINAL ULTRASOUND DATE

TR 18.102 **Data Format** [date]

ImageTrend Description
The date abdominal ultrasound was performed on the patient while under the care of the ED/Hospital.

Element Values

- Collected as MM/DD/YYYY

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation

(Initial ED/Hospital) ABDOMINAL ULTRASOUND TIME

TR 18.112 **Data Format** [time]

ImageTrend Description
The time the abdominal ultrasound was performed on the patient while under the care of the ED/Hospital.

Element Values

- Collected as HHMM
- HHMM should be collected in military time

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation

(Initial ED/Hospital) ABDOMINAL ULTRASOUND (Results)

TR 18.75 **Data Format** [combo] single-choice

ImageTrend Description
Indication as to if the procedure was performed while under the care of the ED/Hospital.

Element Values
Positive Negative

Additional Information

- "Positive" is defined as “any traumatic injury”
- "Negative" is defined as “no traumatic injury”

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation
3. Radiology Report

(Initial ED/Hospital) ARTERIOGRAM (Results)

TR 18.76 **Data Format** [combo] single-choice

ImageTrend Description
Indication as to if the procedure was performed while under the care of the ED/Hospital.

Element Values

Positive	Negative

Additional Information

- "Positive" is defined as “any traumatic injury”
- "Negative" is defined as “no traumatic injury”

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation
3. Radiology Report

(Initial ED/Hospital) AORTOGRAM (Results)

TR 18.77 **Data Format** [combo] single-choice

ImageTrend Description
Indication as to if the procedure was performed while under the care of the ED/Hospital.

Element Values

Positive	Negative

Additional Information

- "Positive" is defined as “any traumatic injury”
- "Negative" is defined as “no traumatic injury”

Data Source Hierarchy Guide

1. Triage Form/Trauma Flow Sheet
2. Other ED Documentation
3. Radiology Report

Diagnosis Information

ICD-10 INJURY DIAGNOSIS*

TR 200.1

National & State Element
Data Format [combo] multiple-choice

NTDB/ ImageTrend Description
Diagnoses related to all identified injuries.

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	DiagnosisIcd10
Multiple Entry Configuration	Yes, max 100	**Accepts Null Value** Yes, common null values	
Required in XSD	Yes		

Element Values

- Injury diagnoses as defined by ICD-10-CM code range S00-S99, T07, T14, T79.A1-T79.A9 OR compatible ICD-10-CA code range
- The maximum number of diagnoses that may be reported for an individual patient is 50

Additional Information

- ICD-10-CM codes pertaining to other medical conditions (e.g., CVA, MI, co-morbidities, etc.) may also be included in this element.

Data Source Hierarchy Guide

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

AIS CODE*

TR 200.14.1 **Data Format** [combo] multiple-choice

NTDB/ ImageTrend Description

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

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	AISCODE
Multiple Entry Configuration	Yes, max 50	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- The code is the 8-digit AIS code.

Data Source Hierarchy Guide

1. AIS Coding Manual

DIAGNOSIS COMMENTS

TR 200.120 **Data Format** [text]

ImageTrend Description
Diagnosis comments related to all identified injuries.

Data Source Hierarchy Guide

1. Hospital Discharge Summary
2. History and Physical
3. Physician's Documentation
4. Nurses' Notes
5. Other Hospital Documentation

AIS VERSION*

TR 21.25 **Data Format** [text]

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

ImageTrend Description
AIS Version

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	AISVersion
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- AIS 05, Update 08
- AIS 2015

ISS (Body) REGION

Data Format [number]

Description

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

XSD Data Type	xs: integer	**XSD Element/Domain (Simple Type)**	ISSRegion
Multiple Entry Configuration	Yes, max 50	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 6

Element Values

Head or Neck	Abdominal or pelvic contents
Face	Extremities or pelvic girdle
Chest	External

Additional Information

- Auto-calculated once AIS code is typed in
- This variable is considered optional and is not required as part of the State 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 Guide

1. Hospital Discharge Summary
2. History and Physical
3. Physician's Documentation/Nurses' Notes
4. Other Hospital Documentation

AIS BASED INJURY SEVERITY SCORES BY DIAGNOSIS*

Data Format [number]

Description

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

XSD Data Type	xs: integer	**XSD Element/Domain (Simple Type)**	AISSeverity
Multiple Entry Configuration	Yes, max 50	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 9

Element Values

Minor Injury	Severe Injury
Moderate Injury	Critical Injury
Serious Injury	Maximum Injury, Virtually Not Survivable
Not Possible to Assign	

Additional Information

- The element value (9) "Not Possible to Assign" would be chosen if it is not possible to assign a severity to an injury

Data Source Hierarchy Guide

1. Hospital Discharge Summary
2. History and Physical
3. Physician's Documentation
4. Nurses' Notes
5. Other Hospital Documentation

MANUAL (Locally Calculated ISS)*

Data Format [number]

Description

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

XSD Data Type	xs: integer	**XSD Element/Domain (Simple Type)**		ISSLocal
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values	
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 75	

Element Values

- Auto-calculated once AIS scores are typed in
- Relevant ISS value for the constellation of injuries

Additional Information

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

Data Source Hierarchy Guide

1. Hospital Discharge Summary
2. History and Physical
3. Physician's Documentation
4. Nurses' Notes
5. Other Hospital Documentation

Procedures Information

PROCEDURE PERFORMED*

TR 22.30

Required for manually entered cases
Data Format [combo] single-choice

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

Element Values

No Yes

Data Source Hierarchy Guide

1. Operative Reports
2. Triage Form/Trauma Flow Sheet
3. Nurses' Documentation
4. Physician Documentation
5. Anesthesia Record
6. Billing Sheet/Medical Records Coding Summary Sheet
7. Hospital Discharge Summary

ICD-10 HOSPITAL PROCEDURES*

TR 200.2 **National & State Element**

Data Format [combo] multiple-choice

NTDB/ImageTrend Description

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

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	HospitalProcedureIcd10
Multiple Entry Configuration	Yes, max 200	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

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

Additional Information

- The null value "Not Applicable" is used if the patient did not have procedures.
- Include only procedures performed at your institution.
- Capture all procedures performed in your operating room.
- Capture all procedures performed 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.
- Plain radiography of whole body, Plain radiography of whole skeleton, and Plain radiography of infant whole body to the Diagnostic and Therapeutic Imaging.
- Note that the hospital may capture additional procedures.

Procedures Information

Diagnostic & Therapeutic Imaging	Musculoskeletal
Computerized tomographic Head *	Soft tissue/bony debridements *
Computerized tomographic Chest *	Closed reduction of fractures
Computerized tomographic Abdomen *	Skeletal and halo traction
Computerized tomographic Pelvis *	Fasciotomy
Diagnostic ultrasound (includes FAST) *	
Doppler ultrasound of extremities*	**Transfusion**
	Transfusion of red cells * (only capture first 24 hours after hospital arrival)
Angiography	Transfusion of platelets * (only capture first 24 hours after hospital arrival)
Angioembolization	Transfusion of plasma * (only capture first 24 hours after hospital arrival)
IVC filter	
	Respiratory
Cardiovascular	Insertion of endotracheal tube * (exclude intubations performed in the OR)
Open cardiac massage	Continuous mechanical ventilation *
CPR	Chest tube *
	Bronchoscopy *
CNS	Tracheostomy
Insertion of ICP monitor *	
Ventriculostomy *	**Gastrointestinal**
Cerebral oxygen monitoring *	Endoscopy (includes gastroscopy, sigmoidoscopy, colonoscopy)
Genitourinary	
Ureteric catheterization (i.e. Ureteric stent)	Gastrostomy/jejunostomy (percutaneous or endoscopic)
Suprapubic cystostomy	Percutaneous (endoscopic) gastrojejunoscopy

Data Source Hierarchy Guide

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

(Procedure Performed) LOCATION

TR 22.11 **Data Format** [combo] single-choice

ImageTrend Description
The hospital location where the procedure was performed.

Element Values

- Minor Surgery Unit
- Nuclear Medicine
- Observation
- Other
- Outpatient Clinic
- Recovery
- Rehabilitation
- Scene
- Special Procedure Unit
- Step-Down
- Transport from Scene
- Catheterization Lab
- ED
- Floor
- GI Lab
- ICU
- OR
- Other
- Radiology
- Readmit OR (planned OR)
- Tele

Data Source Hierarchy Guide

1. Operative Reports
2. Triage Form/Trauma Flow Sheet
3. Nurses' Documentation
4. Physician Documentation
5. Anesthesia Record
6. Billing Sheet/Medical Records Coding Summary Sheet
7. Hospital Discharge Summary

(Physician Performing the Procedure) STAFF

TR 200.10 **Data Format** [combo] single-choice

ImageTrend Description
Physician performing the procedure.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. OR Nurses' Notes
2. Operative Reports
3. Anesthesia Record

(Hospital Procedure) DATE PERFORMED*

TR 200.8 **National & State Element**

Data Format [date]

NTDB/ImageTrend Description

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

XSD Data Type	xs: date	**XSD Element/Domain (Complex Type)**	Hospital Procedure Start Date
Multiple Entry Configuration	Yes	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1990	**Max. Constraint:** 2030

Element Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY

Data Source Hierarchy Guide

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

(Hospital Procedure Start) TIME PERFORMED*

TR 200.9 **National & State Element**
Data Format [time]

NTDB/ImageTrend Description
The time operative and selected non-operative procedures were performed.

XSD Data Type	xs: time	**XSD Element/Domain (Complex Type)**	Hospital Procedure Start Time
Multiple Entry Configuration	Yes	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 00:00	**Max. Constraint:** 23:59

Element Values

- Relevant value for data element

Additional Information

- Reported as HH:MM military time.
- Procedure start time is defined as the time the incision was made (or the procedure started).
- If distinct procedures with the same procedure code are performed, their start times must be different

Data Source Hierarchy Guide

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

SERVICE TYPE (of the Physician)

TR 200.6 **Data Format** [combo] single-choice

ImageTrend Description
Service type of the physician.

Element Values

- Cardiology
- Critical Care Medicine
- Ear Nose Throat
- Emergency Medicine
- Gastroenterology
- General Surgery
- Gynecology
- Hand Surgery
- Medicine
- Neurosurgery
- Obstetrics
- Ophthalmology
- Oral Maxillo Facial Surgery
- Orthopedic Surgery
- Pediatric Orthopedic
- Pediatric Surgery
- Plastic Surgery
- Radiology
- Thoracic Surgery
- Trauma Surgery
- Urology
- Vascular Surgery

Data Source Hierarchy Guide

1. OR Nurses' Notes
2. Operative Reports
3. Anesthesia Record

(Procedure) COMMENTS

TR 200.7 **Data Format** [text]

ImageTrend Description
Additional information about the procedure

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. OR Nurses' Notes
2. Operative Reports
3. Anesthesia Record

RESOURCE UTILIZATION

TR 26.59 **Data Format** [combo] multiple-choice

ImageTrend Description
A list of the resources utilized during the treatment and care of the patient.

Element Values

Adult Protective Service
Bi-Pap
Case Management
Cerebral Brain Flow Studies
Child Protective Service
CRRT
Dialysis
Epidural Catheter
Exceeds LOS
Factor VIIa (Novoseven)
High dose methylprednisolone
Hypertonic Saline
Level-1 Blood/Fluid Warmer
LiCox Monitor
Massive Blood Transfusion
Miama J Collar
MRI
None
Nutritionist
Occupational Therapy
Pentobarbital Coma
Peripheral Parenteral Nutrition (PPN)
Physical Therapy
PICC line
PRISMA (CVVHD)
Respiratory Therapy
RN accompanied transfer
Specialized Bed
Speech Therapy
TLSO Brace
Total Parenteral Nutrition (TPN)
Traction
Transfusion of FFP
Transfusion of Platelets
Transfusion of PRBC
Tube Feeding
Uncrossmatched Blood
Vaccine Post-Splenectomy
Venous Doppler
Wound Care RN
Wound Vacuum

Data Source Hierarchy Guide

1. OR Nurses' Notes
2. Operative Reports
3. Anesthesia Record

NTDB Hospital Events

(Hospital Events) ACUTE KIDNEY INJURY (AKI)*

National & State Element
Data Format [combo] single-choice

NTDB/ ImageTrend Description

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

KDIGO (Stage 3) Table:

(SCr) 3 times baseline

or

Increase in SCr to ≥ 4.0 mg/dl (≥ 353.6 µmol/l)

or

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

or

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

or

Anuria for ≥ 12 hours

EXCLUDE:

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

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Hospital Complication
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Yes No

Additional Information

- Onset of AKI Stage 3 began after arrival to your ED/hospital.
- A diagnosis of AKI must be documented in the patient's medical record.
- Consistent with the March 2012 Kidney Disease Improving Global Outcome (KDIGO) guideline.
- Refer to guidance and algorithms on pages 141-142 of the.

Data Source Hierarchy Guide

1. History & Physical
2. Physician's Notes/Flow Sheet

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

(Hospital Events) ACUTE RESPIRATORY DISTRESS SYNDROME (ARDS)*

National & State Element
Data Format [combo] single-choice

NTDB/ImageTrend Description

Timing: Within 1 week of known clinical insult or new or worsening respiratory symptoms.
Chest imaging: Bilateral opacities – not fully explained by effusions, lobar/lung collage, or nodules.
Origin of edema: Respiratory failure not fully explained by cardiac failure of fluid overload. Need objective assessment (e.g., echocardiography) to exclude hydrostatic edema if no risk factor present.
Oxygenation:

- Mild: 200 mm Hg < PaO2/FIO2 < 300 mm Hg with PEEP or CPAP >= 5 cm H2O
- Moderate: 100 mm Hg < PaO2/FIO2 < 200 mm Hg with PEEP >5 cm H2O
- Severe: PaO2/FIO2 < 100 mm Hg with PEEP or CPAP >5 cm H2O
-

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Hospital Complication
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of ARDS must be documented in the patient's medical record.
- Consistent with the 2012 New Berlin Definition.
- Refer to guidance and algorithms on pages 143-144 of the 2026 NTDS Data Dictionary.

Data Source Hierarchy Guide

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

(Hospital Events) ALCOHOL WITHDRAWAL SYNDROME*

National & State Element
Data Format [combo] single-choice

NTDB/ ImageTrend Description
Characterized by tremors, sweating, anxiety, agitation, depression, nausea, and malaise. It occurs 6-48 hours after cessation of alcohol consumption and, when uncomplicated, abates after 2-5 days. It may be complicated by grand mal seizures and may progress to delirium (known as delirium tremens).

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Hospital Complication
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of ARDS must be documented in the patient's medical record.
- Consistent with the 2019 World Health Organization (WHO) definition of Alcohol Withdrawal Syndrome.
- Refer to guidance and algorithms on pages 145-146 of the 2026 NTDS Data Dictionary.

Data Source Hierarchy Guide

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

(Hospital Events) CARDIAC ARREST WITH CPR*

National & State Element
Data Format [combo] single-choice

NTDB/ ImageTrend Description

Cardiac arrest is the sudden cessation of cardiac activity after hospital arrival. The patient becomes unresponsive with no normal breathing and no signs of circulation. If corrective measures are not taken rapidly, this condition progresses to sudden death.
INCLUDE:

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

EXCLUDE:

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

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Hospital Complication
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival at your ED/hospital
- Cardiac Arrest must be documented in the patient's medical record.
- Refer to guidance and algorithms on pages 147-148 of the 2026 NTDS Data Dictionary.

Data Source Hierarchy Guide

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

(Hospital Events) CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI)*

National & State Element
Data Format [combo] single-choice

NTDB/ImageTrend Description

UPDATED TO: A urinary tract infection (UTI) where an indwelling urinary catheter was in place for > 2 calendar days on the date of event, with day of device placement being Day 1,
AND
An indwelling urinary catheter was in place on the date of event or the day before. If an indwelling urinary catheter was in place for more than 2 consecutive days in an inpatient location and then removed, the date of event for the UTI must be the day of device discontinuation or the next day for the UTI to be catheter-associated.

January 2019 CDC CAUTI Criterion SUTI 1a**:**
Patient must meet 1, 2, and 3 below:

1. Patient had an indwelling urinary catheter in place for the entire day on the date of event and such catheter had been in place for >2 calendar days, on that date (day of device placement = Day 1) AND was either:
    - Present for any portion of the calendar day on the date of event, OR
    - Removed the day before the date of event
2. Patient has at least one of the following signs or symptoms:
    - Fever (>38^{0}C): Reminder: To use fever in a patient > 65 years of age, the IUC needs to be in place for more than 2 consecutive days in an inpatient location on date of event and is either still in place or was removed the day before the DOE
    - Suprapubic tenderness with no other recognized cause
    - Costovertebral angle pain or tenderness
    - Urinary urgency
    - Urinary frequency
    - Dysuria
3. Patient has a urine culture with no more than two species of organisms, at least one of which is a bacterium >10^5 CFU/ml.

January 2019 CDC CAUTI Criterion SUTI 2:

Patient must meet 1, 2 and 3 below:

1. Patient is ≤1 year of age
2. Patient has at least one of the following signs or symptoms:
   - fever (>38.0^{0}C) hypothermia (<36.0^{0}C)
   - apnea with no other recognized cause
   - bradycardia with no other recognized cause
   - lethargy with no other recognized cause
   - vomiting with no other recognized cause
   - suprapubic tenderness with no other recognized cause
3. Patient has a urine culture with no more than two species of organisms, at least one of which is bacteria of ≥10^5 CFU/ml.

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Hospital Complication
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of UTI must be documented in the patient's medical record.
- Consistent with the January 2019 CDC defined CAUTI.
- Refer to guidance and algorithms on pages 149-154 of the 2026 NTDS Data Dictionary.

Data Source Hierarchy Guide

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

(Hospital Events) CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION (CLABSI)*

National & State Element
Data Format [combo] single-choice

NTDB/ ImageTrend Description

A laboratory-confirmed bloodstream infection (LCBI) where central line (CL) or umbilical catheter (UC) was in place for > 2 calendar days on the date of event, with day of device placement being Day 1,

AND

The line was also in place on the date of event or the day before. If a CL or UC was in place for > 2 calendar days and then removed, the date of event of the LCBI must be the day of discontinuation or the next day to be a CLABSI. If the patient is admitted or transferred into a facility with an implanted central line (port) in place, and that is the patient's only central line, day of first access in an inpatient location is considered Day 1. "Access" is defined as line placement, infusion or withdrawal through the line. Such lines continue to be eligible for CLABSI once they are accessed until they are either discontinued or the day after patient discharge (as per the Transfer Rule.) Note that the "de-access" of a port does not result in the patient's removal from CLABSI surveillance.

<u>January 2016 CDC Criterion LCBI 1:</u>

Patient has a recognized pathogen identified from one or more blood specimens by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).

AND

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

OR

<u>January 2016 CDC Criterion LCBI 2:</u>

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

AND

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

AND

The same common commensal (i.e., diphtheroids [Corynebacterium spp. not C. diphtheriae], Bacillus spp. [not B. anthracis], Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., and Micrococcus spp.) is identified from two or more blood specimens drawn on separate occasions, by a culture or non-culture based

microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). Criterion elements must occur within the Infection Window Period, the seven-day time period which includes the collection date of the positive blood, the three calendar days before and the three calendar days after.

OR

January 2016 CDC Criterion LCBI 3:

Patient ≤ 1 year of age have at least one of the following signs or symptoms: fever (>38^0 C), hypothermia (<36^{0}C), apnea, or bradycardia

AND

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

AND

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

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Hospital Complication
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of central line-associated bloodstream infection (CLABSI) must be documented in the patient's medical record.
- Consistent with the January 2016 CDC defined CLABSI.
- Refer to guidance and algorithms on pages 155-159 of the 2026 NTDS Data Dictionary.

Data Source Hierarchy Guide

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

(Hospital Events) DEEP SURGICAL SITE INFECTION*

National & State Element
Data Format [combo] single-choice

NTDB/ ImageTrend Description
Must meet the following criteria:

The date of event occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) according to list in Table 2 in the 2026 NTDS Data Dictionary (page 161).
AND
Involves deep soft tissues of the incision (e.g., fascial and muscle layers)
AND
Patient has at least one of the following:

a. Purulent drainage from the deep incision.
b. A deep incision that spontaneously dehisces, or is deliberately opened or aspirated by a surgeon, attending physician* or other designee
   AND
   Organism(s) identified from the deep soft tissues of the incision by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing (ASC/AST)) or culture or non-culture based microbiologic testing method is not performed. A culture or non-culture based test from the deep soft tissues of the incision that has a negative finding does not meet this criterion.
   AND
   Patient has at least one of the following signs or symptoms: fever (>38°C); localized pain or tenderness.
c. An abscess or other evidence of infection involving the deep incision that is detected on gross anatomical or histopathologic exam, or imaging test

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

COMMENTS: There are two specific types of deep incisional SSIs:

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

2 Deep Incisional Secondary (DIS) – a deep incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (e.g., donor site incision for CBGB)

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Hospital Complication
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of a surgical site infection (SSI) must be documented in the patient's medical record.
- Consistent with the January 2024 CDC defined SSI.
- Refer to guidance and algorithms on pages 160-164 of the 2026 NTDS Data Dictionary.

Data Source Hierarchy Guide

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

(Hospital Events) DEEP VEIN THROMBOSIS (DVT)*

National & State Element
Data Format [combo] single-choice

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

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Hospital Complication
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival at your ED/hospital
- The patient must be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava.
- A diagnosis of DVT must be documented in the patient's medical record, which may be confirmed by venogram, ultrasound, or CT.
- Refer to guidance and algorithms on pages 165-166 of the 2026 NTDS Data Dictionary.

Data Source Hierarchy Guide

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

(Hospital Events) DELIRIUM*

National & State Element
Data Format [combo] single-choice

NTDB/ ImageTrend Description

Acute onset of behaviors characterized by restlessness, illusions, and incoherence of thought and speech. Delirium can often be traced to one or more contributing factors, such as a severe or chronic medical illness, changes in your metabolic balance (such as low sodium), medication, infection, surgery, alcohol or drug withdrawal.

OR

Patient tests positive after using an objective screening tool like the Confusion Assessment Method (CAM or the Intensive Care Delirium Screening Checklist (ICDSC).

OR

A diagnosis of delirium documented in the patient's medical record.

EXCLUDE:

- Patients whose delirium is due to alcohol withdrawal.

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- Refer to guidance and algorithms on pages 167-168 of the 2026 NTDS Data Dictionary.

Data Source Hierarchy Guide

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

(Hospital Events) MYOCARDIAL INFARCTION (MI)*

National & State Element
Data Format [combo] single-choice

NTDB/ImageTrend Description

An acute myocardial infarction (MI) must be noted with documentation of ECG changes indicative of an acute MI
AND
New elevation in troponin greater than three times upper level of the reference range in the setting of suspected myocardial ischemia
AND
Physician diagnosis of an acute myocardial infarction that occurred subsequent to arrival at your center

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Hospital Complication
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- Refer to guidance and algorithms on pages 169-170 of the 2026 NTDS Data Dictionary.

Data Source Hierarchy Guide

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

(Hospital Events) ORGAN/SPACE SURGICAL SITE INFECTION*

National & State Element
Data Format [combo] single-choice

NTDB/ImageTrend Description

Must meet the following criteria:
Infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) according to the list in Table 2 on page 171 of the 2026 NTDS Data Dictionary.
AND
Infection involves any part of the body deeper than the fascial/muscle layers, that is opened or manipulated during the operative procedure
AND
Patient has at least **one** of the following:

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

AND
Meets at least **one** criterion for a specific organ/space infection site listed in Table 3 on page 172 of the 2026 NTDS Data Dictionary. These criteria are found in the Surveillance Definitions for Specific Types of Infections chapter.

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Hospital Complication
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of a surgical site infection (SSI) must be documented in the patient's medical record.
- Consistent with the January 2019 CDC defined SSI.
- Refer to guidance and algorithms on pages 171-174 of the 2026 NTDS Data Dictionary.

Data Source Hierarchy Guide

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

(Hospital Events) OSTEOMYELITIS*

National & State Element
Data Format [combo] single-choice

NTDB/ImageTrend Description

Osteomyelitis must meet at least one of the following criteria:

1 Patient has organisms identified from bone by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)).
2 Patient has evidence of osteomyelitis on gross anatomic or histopathologic exam.
3 Patient has at least **two** of the following localized signs or symptoms: fever (>38.0°C), swelling*, pain or tenderness*, heat*, or drainage*

And at least **one** of the following:

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

* With no other recognized cause

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Hospital Complication
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of osteomyelitis must be documented in the patient's medical record.
- Consistent with the January 2020 CDC definition of Bone and Joint infection.
- Refer to guidance and algorithms on pages 175-176 of the 2026 NTDS Data Dictionary.

Data Source Hierarchy Guide

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

(Hospital Events) PRESSURE ULCER*

National & State Element
Data Format [combo] single-choice

NTDB/ ImageTrend Description
A localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated. Equivalent to NPUAP Stages II-IV, Unstageable/Unclassified, and Suspected Deep Tissue Injury.

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Hospital Complication
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Yes No

Additional Information

- Onset of NPUAP Stage II began after arrival to your ED/hospital.
- Pressure Ulcer documentation must be in the patient's medical record.
- Consistent with the NPUAP 2014.
- Refer to guidance and algorithms on pages 177-178 of the 2026 NTDS Data Dictionary.

Data Source Hierarchy Guide

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

(Hospital Events) PULMONARY EMBOLISM (PE)*

National & State Element
Data Format [combo] single-choice

NTDB/ ImageTrend Description
A lodging of a blood clot in a pulmonary artery with subsequent obstruction of blood supply to the lung parenchyma. The blood clots usually originate from the deep leg veins or the pelvic venous system.
EXCLUDE:

- Subsegmental PEs.

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Hospital Complication
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- Consider the condition present if the patient has a VQ scan interpreted as high probability of pulmonary embolism or a positive pulmonary arteriogram, or positive CT angiogram and/or a diagnosis of PE is documented in the patient's medical record.
- Refer to guidance and algorithms on pages 179-180 of the 2026 NTDS Data Dictionary.

Data Source Hierarchy Guide

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

(Hospital Events) SEVERE SEPSIS*

National & State Element
Data Format [combo] single-choice

NTDB/ ImageTrend Description
Severe sepsis: Sepsis plus organ dysfunction, hypotension (low blood pressure), or hypoperfusion (insufficient blood flow) to 1 or more organs.
Septic shock: Sepsis with persisting arterial hypotension or hypoperfusion despite adequate fluid resuscitation.

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Hospital Complication
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of Sepsis must be documented in the patient's medical record.
- Consistent with the American College of Chest Physicians and the Society of Critical Care Medicine October 2010.
- Refer to guidance and algorithms on pages 181-182 of the 2026 NTDS Data Dictionary.

Data Source Hierarchy Guide

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

(Hospital Events) STROKE/CVA*

National & State Element
Data Format [combo] single-choice

NTDB/ImageTrend Description

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

- Change in level of consciousness
- Hemiplegia
- Hemiparesis
- Numbness or sensory loss affecting one side of the body
- Dysphasia or aphasia
- Hemianopia
- Amaurosis fugax
- Other neurological signs or symptoms consistent with stroke

AND:

- Duration of neurological deficit ≥24 h OR:
- Duration of deficit <24 hrs, if neuroimaging (MR, CT, or cerebral angiography) documents a new hemorrhage or infarct consistent with stroke, or therapeutic intervention(s) were performed for stroke, or the neurological deficit results in death.

AND:

- No other readily identifiable non-stroke cause, e.g., progression of existing traumatic brain injury, seizure, tumor, metabolic or pharmacologic etiologies, is identified.

AND:

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

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Hospital Complication
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of stroke/CVA must be documented in the patient's medical record.
- Although the neurologic deficit must not present on admission, risk factors predisposing to stroke (e.g., blunt cerebrovascular injury, dysrhythmia) may be present on admission.
- Refer to guidance and algorithms on pages 183-184 of the 2026 NTDS Data Dictionary.

Data Source Hierarchy Guide

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

(Hospital Events) SUPERFICIAL INCISIONAL SURGICAL SITE INFECTION*

National & State Element
Data Format [combo] single-choice

NTDB/ ImageTrend Description

Must meet the following criteria:
Infection occurs within 30 days after any NHSN operative procedure (where day 1 = the procedure date)

AND

involves only skin and subcutaneous tissue of the incision

AND

Patient has at least one of the following:

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

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

d) diagnosis of a superficial incisional SSI by the surgeon or attending physician** or other designee.

COMMENTS: There are two specific types of superficial incisional SSIs:

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

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Hospital Complication
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Yes
No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of a surgical site infection (SSI) must be documented in the patient's medical record.
- Consistent with the January 2019 CDC defined SSI.
- Refer to guidance and algorithms on pages 185-187 of the 2026 NTDS Data Dictionary.

Data Source Hierarchy Guide

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

(Hospital Events) UNPLANNED ADMISSION TO ICU*

National & State Element
Data Format [combo] single-choice

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

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

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

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Hospital Complication
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Yes No

Additional Information
- Must have occurred during the patient's initial stay at your hospital.
- Refer to guidance and algorithms on pages 188-189 of the 2026 NTDS Data Dictionary.

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

(Hospital Events) UNPLANNED INTUBATION*

National & State Element
Data Format [combo] single-choice

NTDB/ImageTrend Description
Patient requires placement of an endotracheal tube and mechanical or assisted ventilation manifested by severe respiratory distress, hypoxia, hypercarbia, or respiratory acidosis.

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Hospital Complication
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Yes No

Additional Information

- Must occur during the patient's initial stay at your hospital.
- In patients who were intubated in the element or Emergency Department, or those intubated for surgery, unplanned intubation occurs if they require reintubation > 24 hours after they were extubated.
- Refer to guidance and algorithms on pages 190-191 of the 2026 NTDS Data Dictionary.

Data Source Hierarchy Guide

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

(Hospital Events) UNPLANNED RETURN TO THE OPERATING ROOM*

National & State Element
Data Format [combo] single-choice

NTDB/ImageTrend Description

The patient underwent a subsequent operative procedure at the same operative site as the initial operative procedure. Both procedures must have been performed in the operating room at your center.
EXCLUDE:

- Planned return to the operating room after damage control surgery or staged surgical interventions.
- Procedures performed in an interventional radiology suite.
- Procedures performed in a hybrid operating room where the intervention is limited to a percutaneous approach.
- Pre-planned multiple-stage approach procedures.

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Hospital Complication
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Yes No

Additional Information

- The same operative site usually (but not exclusively) implies there was a need to re-open the previous incision.
- *Element Value* "1. Yes" is reported whether the initial intervention was related to the injuries (e.g., anastomotic leak after laparotomy, hardware failure/infection after ORIF of fractures) **OR** if there is a return to the operating room for an unplanned intervention related to a secondary procedure (e.g., return to the OR for bleeding after tracheostomy).
- *Element Value* "2. No" is reported if there is intent to return to the operating room for a two-stage approach.
- Refer to guidance and algorithms on pages 192-193 of the 2026 NTDS Data Dictionary.

Data Source Hierarchy Guide

1. Operative report
2. Physician Notes/Flow Sheet
3. Progress Notes
4. Nursing Notes/Flow Sheet
5. Discharge Summary

(Hospital Events) VENTILATOR-ASSOCIATED PNEUMONIA (VAP)*

National & State Element
Data Format [combo] single-choice

NTDB/ImageTrend Description

A pneumonia where the patient is on mechanical ventilation for > 2 calendar days on the date of event, with day of ventilator placement being Day 1,
AND
The ventilator was in place on the date of event or the day before.
Note: Refer to VAP algorithms on pages 194-207 of the 2026 NTDS Data Dictionary.

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Hospital Complication
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of pneumonia must be documented in the patient's medical record.
- Consistent with the January 2019 CDC defined VAP.
- Refer to guidance and algorithms on pages 194-207 of the 2026 NTDS Data Dictionary.

Data Source Hierarchy Guide

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

NTDB Pre-existing Conditions

(Pre-existing Conditions) ATTENTION DEFICIT DISORDER/ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADD/ADHD)*

National & State Element
Data Format [combo] single-choice

NTDB Description
A disorder involving inattention, hyperactivity, or impulsivity requiring medication for treatment.

Element Values

Yes	No

Additional Information

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

Data Source Hierarchy Guide

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

(Pre-existing Conditions) ADVANCED DIRECTIVE LIMITING CARE*

National & State Element
Data Format [combo] single-choice

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

Element Values

Yes No

Additional Information

- The written request was signed/dated by the patient and/or his/her designee prior to arrival at your center
- Life-sustaining treatments include but are not limited to intubation, ventilator support, CPR, transfusion of blood products, dialysis or other forms of renal support, institution of medications to support blood pressure or cardiac function, or a specific surgical, interventional or radiological procedure (e.g. decompressive craniectomy, operation for hemorrhage control, angiography)
- Report Element Value "2. No" for patients with Advanced Directives that did not limit life-sustaining treatments during this patient care event.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

(Pre-existing Conditions) ANTICOAGULANT THERAPY*

National & State Element
Data Format [combo] single-choice

NTDB Description

Documentation in the medical record of the administration of medication (anticoagulants, antiplatelet agents, thrombin inhibitors, thrombolytic agents) that interferes with blood clotting.

EXCLUDE:

- Patients whose only anticoagulant therapy is chronic Aspirin.

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

Element Values

Yes No

Additional Information

- Present prior to injury
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.
- Anticoagulants must be part of the patient's active medication

Data Source Hierarchy Guide

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

(Pre-existing Conditions) AUTISM SPECTRUM DISORDER (ASD)*

National & State Element
Data Format [combo] single-choice

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

Element Values
1. Yes 2. No

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

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

(Pre-existing Conditions) BLEEDING DISORDER*

National & State Element
Data Format [combo] single-choice

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

Element Values

Yes	No

Additional Information

- Present prior to injury.
- A bleeding disorder diagnosis must be documented in the patient's medical record (e.g. Hemophilia, von Willebrand Disease, Factor V Leiden).
- Consistent with American Society of Hematology, 2015.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available

Data Source Hierarchy Guide

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

(Pre-existing Conditions) CEREBRAL VASCULAR ACCIDENT (CVA)*

National & State Element
Data Format [combo] single-choice

NTDB Description
A history prior to injury of a cerebrovascular accident (embolic, thrombotic, or hemorrhagic) with persistent residual motor sensory or cognitive dysfunction (e.g., hemiplegia, hemiparesis, aphasia, sensory deficit, impaired memory).

Element Values

Yes No

Additional Information

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

Data Source Hierarchy Guide

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

(Pre-existing Conditions) CHRONIC RENAL FAILURE*

National & State Element
Data Format [combo] single-choice

NTDB Description
Chronic renal failure prior to injury that required periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration.

Element Values

Yes	No

Additional Information

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

Data Source Hierarchy Guide

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

(Pre-existing Conditions) CIRRHOSIS*

National & State Element
Data Format [combo] single-choice

NTDB Description
Cirrhosis is the replacement of normal liver tissue with non-living scar tissue related to other liver diseases. Must have documentation in the medical record of cirrhosis, which might also be referred to as end-stage liver disease.
EXCLUDE:

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

Element Values

Yes No

Additional Information

- Present prior to injury.
- Documentation in the medical record may include CHILD or MELD scores that support evidence of cirrhosis.
- A diagnosis of Cirrhosis, or documentation of Cirrhosis by diagnostic imaging studies or a laparotomy/laparoscopy, must be in the patient's medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

(Pre-existing Conditions) MYOCARDIAL INFARCTION (MI)*

National & State Element
Data Format [combo] single-choice

NTDB Description
History of myocardial infarction (MI) in the six months prior to injury.

Element Values

Yes	No

Additional Information

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

Data Source Hierarchy Guide

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

(Pre-existing Conditions) CONGESTIVE HEART FAILURE (CHF)*

National & State Element
Data Format [combo] single-choice

NTDB Description
The inability of the heart to pump a sufficient quantity of blood to meet the metabolic needs of the body or can do so only at an increased ventricular filling pressure.

Element Values

Yes No

Additional Information

- Present prior to injury.
- A diagnosis of CHF must be documented in the patient's medical record.
- To be included, this condition must be noted in the medical record as CHF, congestive heart failure, or pulmonary edema with onset of increasing symptoms within 30 days prior to injury.
- Common manifestations are:
- Abnormal limitation in exercise tolerance due to dyspnea or fatigue
- Orthopnea (dyspnea or lying supine)
- Paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea)
- Increased jugular venous pressure
- Pulmonary rales on physical examination
- Cardiomegaly
- Pulmonary vascular engorgement
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

(Pre-existing Conditions) CURRENTLY RECEIVING CHEMOTHERAPY FOR CANCER*

National & State Element
Data Format [combo] single-choice

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

Element Values

Yes	No

Additional Information

- Present prior to injury.
- Chemotherapy may include, but is not restricted to, oral and parenteral treatment with chemotherapeutic agents for malignancies such as colon, breast, lung, head and neck, and gastrointestinal solid tumors as well as lymphatic and hematopoietic malignancies such as lymphoma, leukemia, and multiple myeloma.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

(Pre-existing Conditions) CURRENT SMOKER*

National & State Element
Data Format [combo] single-choice

NTDB Description
A patient who reports inhaling nicotine by smoking cigars, pipes, cigarettes, e-cigarettes, vaping, or juuling every day or some days within the last 30 days.
EXCLUDE:

Patients who chew tobacco or snuff.

Element Values

Yes	No

Additional Information

- Present prior to injury.
- Vaping and juuling includes vape pens, dab pens, dab rings, mods, pod-mods, or any other electronic delivery system to inhale nicotine.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

(Pre-existing Conditions) DEMENTIA*

National & State Element
Data Format [combo] single-choice

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

Element Values

Yes	No

Additional Information

- Present prior to injury.
- A diagnosis of dementia including Alzheimer's Lewy Body Dementia, frontotemporal dementia (Pick's Disease) and vascular dementia must be documented in the patient's medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.
- Consistent with the National Institute on Aging December 2017.

Data Source Hierarchy Guide

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

(Pre-existing Conditions) DIABETES MELLITUS*

National & State Element
Data Format [combo] single-choice

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

Element Values

Yes	No

Additional Information

- Present prior to injury.
- A diagnosis of Diabetes Mellitus must be documented in the patient's medical record.
- Report *Element Value* "1. Yes" for patients who were non-compliant with their prescribed exogenous parenteral insulin or oral hypoglycemic agent.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

(Pre-existing Conditions) DISSEMINATED CANCER*

National & State Element
Data Format [combo] single-choice

NTDB Description
Cancer that has spread to one or more sites in addition to the primary site and in the presence of multiple metastases indicates the cancer is widespread, fulminant, or near terminal.

Element Values

Yes	No

Additional Information

- Present prior to injury.
- Another term describing disseminated cancer is "metastatic cancer".
- Common sites of metastases include major organs, (e.g., brain, lung, liver, meninges, abdomen, peritoneum, pleura, bone).
- A diagnosis of Cancer that has spread to one or more sites must be documented in the patient's medical record.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

(Pre-existing Conditions) FUNCTIONALLY DEPENDENT HEALTH STATUS*

National & State Element
Data Format [combo] single-choice

NTDB Description

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

Element Values

Yes No

Additional Information

- Present prior to injury.
- If **Ventilator Dependence** is *Element Value* "1. Yes," **Functionally Dependent Health Status** must be *Element Value* "1. Yes."
- Activities of daily living include bathing, feeding, dressing, toileting, and walking.
- Include patients whom prior to injury, and as a result of cognitive or physical limitations relating to a pre-existing medical condition, were partially dependent or completely dependent upon equipment, devices or another person to complete some or all activities of daily living.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

(Pre-existing Conditions) HYPERTENSION*

National & State Element
Data Format [combo] single-choice

NTDB Description
History of persistent elevated blood pressure requiring antihypertensive medication.

Element Values

Yes	No

Additional Information

- Present prior to injury.
- A diagnosis of Hypertension must be documented in the patient's medical record.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.
- Report Element Value "1. Yes" for patients who were non-compliant with their prescribed antihypertensive medication.

Data Source Hierarchy Guide

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

(Pre-existing Conditions) PREGNANCY*

National & State Element
Data Format [combo] single-choice

NTDB Description
Pregnancy confirmed by lab, ultrasound, or other diagnostic tool or diagnosis of pregnancy documented in the patient's medical record.

Element Values

Yes	No

Additional Information

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

Data Source Hierarchy Guide

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

(Pre-existing Conditions) STEROID USE*

National & State Element
Data Format[combo] single-choice

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

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

Element Values

Yes	No

Additional Information

- Present prior to injury.
- Examples of oral or parenteral corticosteroid medications are prednisone and dexamethasone.
- Examples of chronic medical conditions are Chronic Obstructive Pulmonary Disease (COPD), asthma, rheumatologic disease, rheumatoid arthritis, and inflammatory bowel disease.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

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

(Pre-existing Conditions) VENTILATOR DEPENDENCE*

National & State Element
Data Format[combo] single-choice

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

Element Values

Yes No

Additional Information

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

Data Source Hierarchy Guide

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

(Pre-existing Conditions) ALCOHOL USE DISORDER*

National & State Element
Data Format [combo] single-choice

NTDB Description

Descriptors documented in the medical record consistent with the diagnostic criteria of alcohol use disorder or a diagnosis of alcohol use disorder documented in the patient's medical record.

Element Values

Yes No

Additional Information

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

Data Source Hierarchy Guide

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

(Pre-existing Conditions) BIPOLAR I/II DISORDER*

National & State Element
Data Format [combo] single-choice

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

Element Values

Yes	No

Additional Information

- Present prior to injury.
- Based on the patient's age on the day of arrival at your hospital.
- Only report on patients ≥15 years-of-age.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15 years-of-age.

Data Source Hierarchy Guide

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

(Pre-existing Conditions) CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)*

National & State Element
Data Format [combo] single-choice

NTDB Description

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

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

EXCLUDE:

- Patients whose only pulmonary disease is acute asthma.
- Patients with diffuse interstitial fibrosis or sarcoidosis.

Element Values

Yes No

Additional Information

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

Data Source Hierarchy Guide

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

(Pre-existing Conditions) MAJOR DEPRESSIVE DISORDER*

National & State Element
Data Format [combo] single-choice

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

XSD Data Type	xs: integer	**XSD Element/Domain (Simple Type)**	Comorbid Condition
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Yes No

Additional Information

- Present prior to injury.
- Based on the patient's age on the day of arrival at your hospital.
- Only report on patients ≥15 years-of-age.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15 years-of-age.

Data Source Hierarchy Guide

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

(Pre-existing Conditions) OTHER MENTAL/PERSONALITY DISORDERS*

National & State Element
Data Format [combo] single-choice

NTDB Description

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

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

Element Values

Yes	No

Additional Information

- Present prior to injury.
- Based on the patient's age on the day of arrival at your hospital.
- Only report on patients ≥15 years-of-age.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15 years-of-age.

Data Source Hierarchy Guide

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

(Pre-existing Conditions) PERIPHERAL ARTERIAL DISEASE (PAD)*

National & State Element
Data Format [combo] single-choice

NTDB Description

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

Element Values

Yes No

Additional Information

- Present prior to injury.
- A diagnosis of peripheral Arterial Disease or Peripheral Vascular Disease must be documented in the patient's medical record.
- Based on the patient's age on the day of arrival at your hospital.
- Only report on patients ≥15 years-of-age.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15 years-of-age.
- Consistent with Centers for Disease Control, 2014 Fact Sheet.

Data Source Hierarchy Guide

1. History & physical
2. Physician notes/Flow sheet
3. Progress Notes
4. Case management/Social Services Notes
5. Nursing Notes/Flow sheet
6. Triage/Trauma Flow sheet
7. Discharge Summary

(Pre-existing Conditions) POST-TRAUMATIC STRESS DISORDER*

National & State Element
Data Format[combo] single-choice

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

Element Values

Yes	No

Additional Information

- Present prior to injury.
- Based on the patient's age on the day of arrival at your hospital.
- Only report on patients ≥15 years-of-age.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15 years-of-age.

Data Source Hierarchy Guide

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

(Pre-existing Conditions) SCHIZOAFFECTIVE DISORDER*

National & State Element
Data Format[combo] single-choice

NTDB Description
A schizoaffective disorder diagnosis documented in the medical record.

Element Values

Yes	No

Additional Information

- Present prior to injury.
- Based on the patient's age on the day of arrival at your hospital.
- Only report on patients ≥15 years-of-age.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15 years of age.

Data Source Hierarchy Guide

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

(Pre-existing Conditions) SCHIZOPHRENIA*

National & State Element
Data Format[combo] single-choice

NTDB Description
A schizophrenia diagnosis documented in the medical record.

Element Values

Yes	No

Additional Information

- Present prior to injury.
- Based on the patient's age on the day of arrival at your hospital.
- Only report on patients ≥15 years-of-age.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15 years of age.

Data Source Hierarchy Guide

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

(Pre-existing Conditions) SUBSTANCE USE DISORDER*

National & State Element
Data Format[combo] single-choice

NTDB Description

Descriptors documented in the patient's medical record consistent with the diagnostic criteria of substance use disorders specifically cannabis, hallucinogens, inhalants, opioids, sedative/hypnotics, and stimulants (e.g. patient has a history of drug use; patient has a history of opioid use) OR diagnosis of any of the following documented in the patient's medical record:

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

Element Values

Yes No

Additional Information

- Present prior to injury.
- Based on the patient's age on the day of arrival at your hospital.
- Only report on patients ≥15 years-of-age.
- Consistent with the American Psychiatric Association (APA) DSM 5, 2013.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.

- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15 years-of-age.

Data Source Hierarchy Guide

1. History & Physical
2. Physician's Notes/Flow Sheet

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

(Pre-existing Conditions) BRONCHOPULMONARY DYSPLASIA/CHRONIC LUNG DISEASE*

National & State Element
Data Format [combo] single-choice

NTDB Description

The disorders which constitute Chronic Lung Disease (CLD) generally have a slow tempo of progression over many months or even years. The most common causes of CLD in children are Cystic Fibrosis (CF), and other causes of bronchiectasis (such as immunodeficiency, and in the third world, post-infective bronchiectasis (e.g., measles), Bronchopulmonary Dysplasia (BPD), or lung disease of prematurity).
INCLUDE: Patients with a diagnosis of Cystic Fibrosis with pulmonary involvement.
EXCLUDE: Patients with a diagnosis of Cystic Fibrosis with no documentation of lung disease.

Element Values

Yes No

Additional Information

- Present prior to injury.
- Based on the patient's age on the day of arrival at your hospital.
- Only report on patients < 15 years-of-age.
- The null value "Not Applicable" must be reported for patients ≥ 15 years-of-age.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available for patients < 15 years-of-age.
- Examples of evidence of Cystic Fibrosis-associated pulmonary disease include, but are not limited to:
    - Use of Chest Physiotherapy (CPT) or other airway clearing techniques.
    - Vest therapy or intrapulmonary percussive ventilator.
    - Intravenous, inhaled, or oral antibiotics to treat chronic respiratory infections related to Cystic Fibrosis.
- Consistent with the ncbi.nlm.nih.gov.

Data Source Hierarchy Guide

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

(Pre-existing Conditions) CONGENITAL ANOMALIES*

National & State Element
Data Format [combo] single-choice

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

Element Values

Yes	No

Additional Information

- Present prior to injury.
- A diagnosis of a Congenital Anomaly must be documented in the patient's medical record.
- Based on the patient's age on the day of arrival at your hospital.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients <15 years-of-age.
- Only report on patients < 15 years-of-age.
- The null value "Not Applicable" must be reported for patients ≥ 15-years-of-age.

Data Source Hierarchy Guide

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

(Pre-existing Conditions) PREMATURITY*

National & State Element
Data Format[combo] single-choice

NTDB Description
Babies born before 37 weeks of pregnancy are completed.

Element Values

Yes	No

Additional Information

- Present prior to injury.
- Based on the patient's age on the day of arrival at your hospital.
- Only report on patients <15 years-of-age.
- A diagnosis of Prematurity, or delivery before 37 weeks of pregnancy are completed, must be documented in the patient's medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients <15 years-of-age.
- The null value "Not Applicable" must be reported for patients ≥ 15 years-of-age.

Data Source Hierarchy Guide

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

Outcome Information

HOSPITAL DISCHARGE SERVICE

TR 25.31 **Data Format** [combo] single-choice

ImageTrend Description

The department that discharged the patient from the hospital.

Element Values

Acute Rehabilitation Medicine
Anesthesia
Bariatric
Burn
Cardiology
Cardiothoracic Surgery
Chemical Dependency
Critical Care Medicine
Critical Care Surgery
Dentistry
Dermatology
Ear Nose Throat
Emergency Medicine
Endocrinology
Family Medicine
Gastroenterology
General Pediatrics
General Surgery
Geriatric
Hand
Hematology Oncology
Infectious Disease
Internal Medicine
Kidney Transplant
Liver
Neonatal
Nephrology
Neurology
Neurosurgery
Obstetric
Oculoplastic
Ophthalmology
Oral Maxillo Facial Surgery
Orthopedic Surgery
Pain
Pediatric Cardiology
Pediatric Critical Care Medicine
Pediatric Dentistry
Pediatric Gastroenterology
Pediatric Hematology Oncology
Pediatric Hospitalist
Pediatric Infectious Disease
Pediatric Neurology
Pediatric Orthopedic
Pediatric Pulmonary
Plastic Surgeon
Psychiatry
Psychology
Pulmonary
Rheumatology
Trauma Surgeon
Urology
Vascular Surgery

Data Source Hierarchy Guide

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

HOSPITAL ADMISSION DATE

TR 25.33 **Data Format**[date]

ImageTrend Description

Date patient was discharged from the ED (or arrived at the facility if the patient was a direct admit).

XSD Data Type	xs: date	**XSD Element/Domain (Simple Type)**	Admission Date
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY
- Used to auto-generate an additional calculated element: Total Length of Hospital Stay (time from hospital admission to hospital discharge)

Data Source Hierarchy Guide

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

HOSPITAL ADMISSION TIME

TR 25.47 **Data Format** [time]

ImageTrend Description

Time patient was discharged from the ED (or arrived at the facility if the patient was a direct admit).

XSD Data Type	xs: time	**XSD Element/Domain (Simple Type)**	Admission Time
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- Collected as HHMM
- HHMM should be collected as military time
- Used to auto-generate an additional calculated element: Total Length of Hospital Stay (time from hospital admission to hospital discharge)

Data Source Hierarchy Guide

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

HOSPITAL DISCHARGE DATE (ORDERS WRITTEN) *

TR 25.93 **National & State Element**
Data Format [date]

NTDB/ImageTrend Description
The date the order was written for the patient to be discharged from the hospital.

XSD Data Type	xs: date	**XSD Element/Domain (Complex Type)**	Hospital Discharge Orders Written Date
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element
- Total Length of Hospital Stay (elapsed time from ED/Hospital arrival to hospital discharge)

Additional Information

- Reported as YYYY-MM-DD.
- The null value "Not Applicable" is reported if Hospital Discharge Disposition is reported as "Not Applicable"
- If Hospital Discharge Disposition is 5 Deceased/Expired, then Hospital Discharge Date is the date of death as indicated on the patient's death certificate.

Data Source Hierarchy Guide

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

HOSPITAL DISCHARGE TIME (ORDERS WRITTEN) *

TR 25.94 **National & State Element**
Data Format [time]

NTDB/ImageTrend Description
The time the order was written for the patient to be discharged from the hospital.

XSD Data Type	xs: time	**XSD Element/Domain (Complex Type)**	Hospital Discharge Orders Written time
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element
- Total Length of Hospital Stay (elapsed time from ED/Hospital arrival to hospital discharge)

Additional Information

- Reported as HHMM military time.
- The null value "Not Applicable" is reported if Hospital Discharge Date is reported as "Not Applicable"
- If Hospital Discharge Disposition is 5 Deceased/Expired, then Hospital Discharge Time is the time of death as indicated on the patient's death certificate.

Data Source Hierarchy Guide

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

HOSPITAL DISCHARGE DATE (PHYSICAL EXIT)

TR 25.34 **Data Format** [date]

ImageTrend Description

The date the patient physically left the hospital.

XSD Data Type	xs: date	**XSD Element/Domain (Complex Type)**	Hospital Physical Discharge Date
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1990	**Max. Constraint:** 2030

Element Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY
- The null value "Not Applicable" is used if ED Discharge Disposition = 4,5, 6,9,10 or 11
- If Hospital Discharge Disposition is 5 Deceased/Expired, then Hospital Discharge Date is the date of death as indicated on the patient's death certificate

Data Source Hierarchy Guide

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

HOSPITAL DISCHARGE TIME (PHYSICAL EXIT)

TR 25.48 **Data Format** [time]

ImageTrend Description

The time the patient physically left the hospital.

XSD Data Type	xs: time	**XSD Element/Domain (Complex Type)**	Hospital Physical Discharge Time
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 00:00	**Max. Constraint:** 23:59

Element Values

- Relevant value for data element

Additional Information

- Collected as HH:MM military time
- Used to auto-generate an additional calculated element: Total Length of Hospital Stay (elapsed time from ED/hospital arrival to hospital discharge)
- The null value "Not Applicable" is used if ED Discharge Disposition = 5 (Deceased/expired)
- The null value "Not Applicable" is used if ED Discharge Disposition = 4,6,9,10 or 11
- If Hospital Discharge Disposition is 5 Deceased/Expired, then Hospital Discharge Time is the time of death as indicated on the patient's death certificate

Data Source Hierarchy Guide

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

TOTAL ICU DAYS*

TR 26.9

National & State Element
Data Format [number]

NTDB/ ImageTrend Description

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

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Total ICU Los
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 400

Element Values

- Relevant value for data element

Additional Information

- Recorded in full day increments with any partial day listed 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.
- The null value "Not Known/Not Recorded" is used if any dates are missing.
- If patient has multiple ICU episodes on the same calendar day, count that day as one calendar day.
- At no time should the Total ICU LOS exceed the Hospital LOS
- The null value "Not Applicable" is used if the patient had no ICU days according to the above definition.

Data Source Hierarchy Guide

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

TOTAL VENTILATOR DAYS*

TR 26.58 **National & State Element**
Data Format [number]

NTDB/ ImageTrend Description
The cumulative amount of time spent on the ventilator. Each partial or full day must be measured as one calendar day.

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Total Vent Days
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 400

Element Values

- Relevant value for data element

Additional Information

- Excludes mechanical ventilation time associated with OR procedures.
- Non-invasive means of ventilator support (CPAP or BIPAP) should not be considered in the calculation of ventilator hours.
- Recorded in full day increments with any partial calendar day county as a full calendar day.
- The calculation assumes that the date and time of starting and stopping Ventilator episode are recorded in the patient's chart.
- The null value "Not Known/Not Recorded" is used if any dates are missing.
- At no time should the Total Vent Days exceed the Hospital LOS
- The null value "Not Applicable" is used if the patient was not on the ventilator according to the above definition.

Data Source Hierarchy Guide

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

DISABILITY AT DISCHARGE - FEEDING

TR 26.54 **Data Format** [combo] single-choice

ImageTrend Description
A score calculated to derive a baseline of trauma patient feeding disability at discharge from an acute care facility.

Element Values

Dependent - Total Help	Dependent - Partial Help
Independent with Device	Independent

Additional Information

- Used to auto-generate an additional calculated element: FIM Score (combination of Feeding, Locomotion, and Motor scores)
- Assess as close to discharge as possible. Includes using suitable utensils to bring food to mouth, chewing, and swallowing (once meal is appropriately prepared). Opening containers, cutting meat, buttering bread and pouring liquids are not included as they are often part of meal preparation.
- Dependent-total help required: Either performs less than half of feeding tasks or does not eat or drink full meals by mouth and relies at least in part on other means of alimentation, such as parenteral or gastrostomy feedings.
- Dependent-partial help required: Performs half or more of feeding tasks but requires supervision (e.g., standby, cueing, or coaxing) setup (application of Orthopedics), or other help.
- Independent with device: Uses an adaptive or assisting device such as a straw, spork, or rocking knifes, or requires more than a reasonable time to eat.
- Independent: Eats from a dish and drinks from a cup or glass presented in the customary manner on table or tray. Uses ordinary knife, fork, and spoon.
- Not applicable: (e.g., patient less than 7 years old, patient died, etc.)

Data Source Hierarchy Guide

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

DISABILITY AT DISCHARGE - LOCOMOTION

TR 26.55 **Data Format** [combo] single-choice

ImageTrend Description
A score calculated to derive a baseline of trauma patient locomotion (independence) disability at discharge from an acute care facility.

Element Values

Dependent - Total Help	Dependent - Partial Help
Independent with Device	Independent

Additional Information

- Used to auto-generate an additional calculated element: FIM Score (combination of Feeding, Locomotion, and Motor scores)
- Includes walking once in a standing position, or using a wheelchair, once in a seated position, indoors
- Dependent - total help required: Performs less than half of locomotion effort to go a minimum of 50 feet or does not walk or wheel a minimum of 50 feet. Requires assistance of one or more persons.
- Dependent - partial help required: If walking requires standby supervision, cueing, or coaxing to go a minimum of 150 feet, or walks independently only short distances (a minimum of 50 feet). If not walking, requires standby supervision, cueing, or coaxing to go a minimum of 150 feet in wheelchair, or operates manual or electric wheelchair independently only short distances (a minimum of 50 feet).
- Independent with Device: Walks a minimum of 150 feet but uses a brace or prosthesis on leg, special adaptive shoes, cane, crutches, or walker; takes more than a reasonable time; or there are safety considerations. If not walking, operates manual or electric wheelchair independently for a minimum of 150 feet; turns around; maneuvers the chair to a table, bed, toilet; negotiates at least a 3% grade; maneuvers on rugs and over doorsills.
- Independent: Walks a minimum of 150 feet without assisting devices. Does not use a wheelchair. Performs safely.
- Not applicable: (e.g., patient less than 7 years old, patient died, etc.)

Data Source Hierarchy Guide

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

DISABILITY AT DISCHARGE - EXPRESSION (MOTOR)

TR 26.56 **Data Format** [combo] single-choice

ImageTrend Description
A score calculated to derive a baseline of trauma patient motor (expression) disability at discharge from an acute care facility.

Element Values

Dependent - Total Help	Dependent - Partial Help
Independent with Device	Independent

Additional Information

- Used to auto-generate an additional calculated element: FIM Score (combination of Feeding, Locomotion, and Motor scores)
- Includes clear expression of verbal or nonverbal language. This means expressing linguistic information verbally or graphically with appropriate and accurate meaning and grammar
- Dependent - total help required: Expresses basic needs and ideas less than half of the time. Needs prompting more than half the time or does not express basic needs appropriately or consistently despite prompting
- Dependent - partial help required: Expresses basic needs and ideas about everyday situations half (50%) or more than half of the time. Requires some prompting, but requires that prompting less than half (50%) of the time
- Independent with Device: Expresses complex or abstract ideas with mild difficulty. May require an augmentative communication device or system
- Independent: Expresses complex or abstract ideas intelligibly and fluently, verbal or nonverbal, including signing or writing
- Not applicable: (e.g., patient less than 7 years old, patient died, etc.)

Data Source Hierarchy Guide

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

DISABILITY AT DISCHARGE - FIM SCORE

TR 26.61 **Data Format** [number]

ImageTrend Description
A score calculated (by adding together the Feeding, Independence, and Motor scores) to derive a baseline of trauma patient disability at discharge from an acute care facility, using three components: Feeding, Locomotion (Independence), and Motor (Expression)

Element Values

- Relevant value for data element
- Auto-calculated by combining Feeding, Locomotion, and Motor scores when entered

Data Source Hierarchy Guide

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

HOSPITAL DISCHARGE DISPOSITION*

TR 25.27

National & State Element

Data Format [combo] single-choice

NTDB/ImageTrend Description

The disposition of the patient when discharged from the hospital.

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type):** Hospital Discharge Disposition	
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

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

Additional Information

- Element value = 6, "Home" refers to the patient's current place of residence (e.g., prison, Child Protective Services, etc.)
- Element Values adapted from UB-04 disposition coding.
- Disposition to any other non-medical facility must be reported as Element Value "6. Discharged to home or self-care (routine discharge)."
- Disposition to any other medical facility must be reported as Element Value "14. Discharged/ Transferred to another type of institution not defined elsewhere."
- Disposition to any Federal Health Care facility must be reported by selecting the option that most closely aligns to the needs of the patient (e.g., patients discharged to a Veteran's hospital skilled nursing facility must be reported as Element Value "7. Discharged/Transferred to Skilled Nursing Facility.")
- The null value "Not Applicable" is reported if ED Discharge Disposition is reported as Element Value 4, 5, 6, 9, 10, or 11.

- Hospital Discharge Dispositions which were retired more than two years before the current NTDS version are no longer listed under Element Values above, which is why there are number gaps. Refer to the NTDS Change Log for a full list of retired Hospital Discharge Dispositions.

Data Source Hierarchy Guide

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

HOSPITAL DESTINATION DETERMINATION

TR 25.42 **Data Format** [combo] single-choice

ImageTrend Description
Major reason for transferring the patient to the facility or the specialty chosen.

Element Values

- Hospital of Choice
- Other - Specify
- Specialty - Burns
- Specialty – Cardiac (bypass)
- Specialty – Facial Trauma
- Specialty - Hand
- Specialty - Neurosurgery
- Specialty – Orthopedics -Pelvic ring/Acetabular fxs
- Specialty – Orthopedics – Soft tissue Coverage
- Specialty – Other- Orthopedics
- Specialty - Pediatrics
- Specialty - Replantation
- Specialty - Spine
- Specialty – Vascular or Aortic Injuries
- Specialty Resource Center

Data Source Hierarchy Guide

1. Physician Order
2. Discharge Instructions
3. Nursing Notes/Flow Sheet
4. Discharge Summary

HOSPITAL TRANSFERRED TO*

TR 25.35

Required for manually entered cases
Data Format [combo] single-choice

ImageTrend Description
Name of the receiving facility the patient was transferred to.

Element Values

- Relevant value for data element

Additional Information

- Only completed if Hospital Disposition "Acute Care Hospital," "Burn Care Facility," or "Rehab or long-term facility" is selected.

Data Source Hierarchy Guide

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

(Other) FACILITY (Transferred to)

TR 25.39 **Data Format** [text]

ImageTrend Description
Any other receiving facility that is not found on the available list of options to which the patient was discharged.

Element Values

- Relevant value for data element

Additional Information

- Only completed if Hospital Transferred to "Other" is selected

Data Source Hierarchy Guide

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

(Other) CITY (Transferred to)

TR 25.40 **Data Format** [text]

ImageTrend Description
The city in which the transfer facility is located.

Element Values

- Relevant value for data element

Additional Information

- Only completed if Hospital Transferred to "Other" is selected

Data Source Hierarchy Guide

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

(Other) STATE (Transferred to)

TR 25.41 **Data Format** [text]

ImageTrend Description
The state in which the transfer facility is located.

Element Values

- Relevant value for data element

Additional Information

- Only completed if Hospital Transferred to "Other" is selected

Data Source Hierarchy Guide

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

(Discharge) TRANSPORT MODE

TR 25.43 **Data Format** [combo] single-choice

ImageTrend Description
Hospital discharge transportation mode.

Element Values

- Ambulance
- Helicopter
- Fixed Wing
- Police
- Private Vehicle

Additional Information

- Only completed if Hospital Disposition "Acute Care Hospital" is selected

Data Source Hierarchy Guide

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

DATE OF DEATH

TR 25.36 **Data Format** [Date]

ImageTrend Description
Date the patient died.

Element Values

- Relevant value for data element

Additional Information

- Only completed if Hospital Disposition is "Expired"

Data Source Hierarchy Guide

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

TIME OF DEATH

TR 25.36.1 **Data Format** [Time]

ImageTrend Description
Time the patient died.

Element Values

- Relevant value for data element

Additional Information

- Only completed if Hospital Disposition is "Expired"

Data Source Hierarchy Guide

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

LOCATION OF DEATH

TR 25.30 **Data Format** [combo] single-choice

ImageTrend Description
The location where the patient died.

Element Values

- ICU
- OR
- Floor
- Prior to Arrival
- ER

Additional Information

- Only completed if Hospital Disposition is "Expired"

Data Source Hierarchy Guide

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

DEATH CIRCUMSTANCE

TR 25.32 **Data Format** [combo] single-choice

ImageTrend Description
Indicates patient's primary cause of death.

Element Values

Brain Injury	Thoracic Aortic Transection
Burn Shock	Trauma Shock
Cardio Failure	Treatment Withheld
Drowning	Brain Death
Electrocution	Sepsis
Heart Laceration	Cardiac Arrest due to
Liver Laceration	Strangulation
Multiple Organ	Cardiac Arrest
Failure/Metabolic	Family D/C Life Support
Other	Medical
Pre-Existing Illness	Multisystem Trauma
Pulmonary Failure	Trauma Wound
Pulmonary Failure/Sepsis	

Additional Information

- Only completed if Hospital Disposition is "Expired"

Data Source Hierarchy Guide

1. Hospital Records
2. Billing Sheet/Medical Records Coding Summary Sheet
3. Physician Discharge Summary
4. Autopsy Report

OTHER (Death Circumstance) DESCRIPTION

TR 25.45 **Data Format** [text]

ImageTrend Description
The circumstance under which the patient died.

Element Values

- Relevant value for data element

Additional Information

- Only completed if Death Circumstance is "Other"

Data Source Hierarchy Guide

1. Hospital Records
2. Billing Sheet/Medical Records Coding Summary Sheet
3. Physician Discharge Summary
4. Autopsy Report

ORGAN DONATION

TR 25.29 **Data Format** [combo] single-choice

ImageTrend Description
Were organs/tissue donated? - To make a gift of a differentiated structure (as a heart, kidney, leaf, or stem) consisting of cells and tissues and performing some specific function in an organism.

Element Values

Yes
No
Tissue Donation

Additional Information

- Only completed if Hospital Disposition is "Expired"

Data Source Hierarchy Guide

1. Hospital Documentation

AUTOPSY PERFORMED

TR 25.37 **Data Format** [combo] single-choice

ImageTrend Description
Was an autopsy performed? - An examination of a body after death to determine the cause of death or the character and extent of changes produced by disease.

Element Values

Yes	No

Additional Information

- Only completed if Hospital Disposition is "Expired"

Data Source Hierarchy Guide

1. Hospital Documentation

ADVANCED DIRECTIVE

TR 25.28 **Data Format** [combo] single-choice

ImageTrend Description
Determination whether the patient had an Advanced Directive.

Element Values

Yes	No

Additional Information

- Only completed if Hospital Disposition is "Expired"

Data Source Hierarchy Guide

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

Complications/Performance Improvement

(Complication PI Overview) PI NURSE

TR 31.54 **Data Format** [combo] single-choice

ImageTrend Description
Staff who works PI and complications

Element Values
Relevant value from the list.

(Complication PI Overview) MEDICAL RECORD INJURY CATEGORIES

TR 31.5 **Data Format** [combo] multiple-choice

ImageTrend Description
Injury categories for record review.

Element Values
Select all that apply:

- **Abdominal and Thoracic**
  - Penetrating neck, torso, proximal extremity trauma, with ISS >=9, or requiring intervention
  - Solid organ injuries: spleen, liver, kidney, and pancreas, >=Grade III or requiring intervention
  - Thoracic/cardiac injuries (include aortic), AIS >=3 or requiring intervention
- **Adverse Events**
  - Any major complication, or unexpected return to the SICU/PICU or the operating room
  - ISS >25 with survival, without severe TBI (head AIS <3)
- **Deaths**
  - Mortality with opportunity for improvement
  - Mortality without opportunity for improvement
  - Unanticipated death with opportunity for improvement
- **Hospice**
  - Care provided up to the time of transfer will be evaluated
- **Massive Transfusion Protocol (MTP)**
  - MTP (Activation criteria, timing of hemorrhage control, prehospital interventions and timing, resources in the ED, time in the ED with hypotension prior to hemorrhage control, outcomes and timing of consults)
- **Neurosurgical**
  - Epidural/subdural hematoma taken to the operating room
  - Severe TBI (GCS<=8) admitted to an ICU, excluding the mechanism of physical child abuse
  - Spinal cord injury with neurologic deficit
- **Non-surgical Admission and Transfers**
  - Patients admitted to non-surgical services with an ISS >=9
  - Patients admitted to non-surgical services with an ISS >=9 for geriatric hip fractures

  - Physical child abuse (suspected and/or confirmed) with an ISS >=9
  - Transfer out for the management of acute injury
- **Orthopedic**
  - Acetabular fractures and any pelvic fractures requiring embolization, transfusion or surgery/ORIF
  - Any amputations excluding digits
  - Open femur or tibia fractures
  - Supracondylar elbow fractures with neurovascular compromise

(Complication PI Overview) INCIDENT OVERVIEW

TR 31.53 **Data Format** Text

ImageTrend Description
Overview review of the incident.

Element Values
A brief overview of the incident.

(Complication Hospital Events) COMPLICATION

TR 23.1 **Data Format** [combo] multiple-choice

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

Element Values
Relevant value from the list of categories.

- Burn
- Cardiovascular
- Gastrointestinal
- Hematologic
- Hepatic, Pancreatic, Biliary, Splenic
- Hospital Airway
- Infection (Nonpulmonary, Nonorthopedic)
- Miscellaneous
- Musculoskeletal/Integumentary
- Neurologic
- No complications
- Other
- Prehospital Airway
- Prehospital Fluids
- Prehospital miscellaneous
- Provider Errors/Delays
- Psychiatric
- Pulmonary
- Renal/Genitourinary
- Vascular

(Complication Hospital Events Overview) OCCURRENCE DATE

TR 23.13 **Data Format** [date]

ImageTrend Description
The date that the complication was first documented.

Element Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY

(Complication Hospital Events Overview) OCCURRENCE TIME

TR 23.20 **Data Format** [time]

ImageTrend Description
The time that the complication was first documented.

Element Values

- Relevant value for data element

Additional Information

- Collected as HHMM

(Complication Hospital Events Overview) LOCATION OF OCCURRENCE

TR 23.19 **Data Format** [combo] single-choice

ImageTrend Description
The location where the complication occurred.

Element Values

Burn Unit	OR
Catheterization Lab	Pre-Hospital
ED	PTA (Referring Hospital)
Floor Bed	Radiology
GI Lab	Readmit OR (planned OR)
ICU	Telemetry/Step-Down Unit

(Complication Hospital Events Overview) COMPLICATION STAFF INVOLVED

TR 23.46 **Data Format** [combo] multiple-choice

ImageTrend Description
Staff involved with the complication.

Element Values

- Relevant value for data element

Additional Information

- Press and hold "CTRL" key to select multiple values

(Complication Hospital Events Overview) SOURCE

TR 23.63 **Data Format** [combo] single-choice

ImageTrend Description
Complication correspondence source.

Element Values

- Autopsy
- Conversation
- Daily Rounds
- EMS Run Sheet
- Hospital Quality Department
- Medical Record
- Patient/Family Concern/Complaint
- PI Comm
- Referrals
- Risk Management Variance Report
- Staff Concern

(Complication Hospital Events Overview) GROUP

TR 23.64 **Data Format** [combo] single-choice

ImageTrend Description
Group for complication.

Element Values

- Burn
- Cardiology
- Medical Audit Committee (MAC)
- Neuro
- Ortho
- Other
- Peds
- Trauma

(Complication Hospital Events Overview) FURTHER EXPLANATION/ACTION

TR 23.8 **Data Format** [text]

ImageTrend Description
Further explanation of the complication.

Element Values

- Relevant value for data element

(Complication Hospital Events Overview) LAST REVIEW TYPE

TR 23.1.12 **Data Format** [combo] single-choice

ImageTrend Description
Complication correspondence type.

Element Values

- Action Plan
- Process Concern
- Care Concern
- Primary Review
- Secondary Review
- Tertiary Review

(Hospital Event Review Notes) STAFF

TR 23.1.14 **Data Format** [combo] single-choice

ImageTrend Description
Staff involved with the complication correspondence.

Element Values

- Relevant value for data element

(Hospital Event Review Notes) TYPE

TR 23.1.12 **Data Format** [combo] single-choice

ImageTrend Description
Complication correspondence type.

Element Values

- Action Plan
- Care Concern
- Process Concern

(Hospital Event Review Notes) SOURCE

TR 23.1.13 **Data Format** [combo] single-choice

ImageTrend Description
Complication correspondence source.

Element Values

- Autopsy
- Conversation
- Daily Rounds
- EMS Run Sheet
- Hospital Quality Department
- Medical Record
- Patient/Family Concern/Complaint
- PI Comm
- Referrals
- Risk Management Variance Report
- Staff Concern

(Hospital Event Review Notes) GROUP

TR 23.1.16 **Data Format** [combo] single-choice

ImageTrend Description
Complication correspondence group.

Element Values

- Burn
- Neuro
- Ortho
- Other
- Peds
- Trauma

(Hospital Event Review Notes) NOTE

TR 23.1.15 **Data Format** [text]

ImageTrend Description
Complication correspondence note.

Element Values

- Relevant value for data element

(Hospital Event Decisions) DETERMINATION

TR 23.11 **Data Format** [combo] single-choice

ImageTrend Description
Indication as to what was determined to cause the complication.

Element Values

- Cannot be Determined
- Disease-Related
- Procedure-Related
- Provider-Related
- System-Related

(Hospital Event Decisions) PREVENTABILITY

TR 23.12 **Data Format** [combo] single-choice

ImageTrend Description
Is the complication preventable?

Element Values

- Cannot Be Determined
- Non-preventable
- Potentially Preventable
- Preventable

(Hospital Event Decisions) FINDINGS

TR 23.14 **Data Format** [combo] single-choice

ImageTrend Description
Outcome of peer review of a complication.

Element Values

- Acceptable
- Acceptable with Reservations
- Defer Peer Review
- Unacceptable
- Will Never Undergo PR

(Hospital Event Decisions) ACTIONS

TR 23.9 **Data Format** [combo] single-choice

ImageTrend Description
The action taken based on the complication.

Element Values

- Counseling
- Education
- Guideline/Protocol
- Not Indicated
- Other
- Peer Review Presentation
- Privilege/Credentialing
- Process Improvement Team
- Resource Enhancement
- Trend
- Unnecessary

(Hospital Event Decisions) OTHER ACTIONS

TR 23.10 **Data Format** [text]

ImageTrend Description
Any other action taken based on the complication.

Element Values

- Relevant value for data element

Additional Information

- Only completed if Correction Action is "Other"

(Hospital Event Decisions) STATUS

TR 23.15 **Data Format** [radio]

ImageTrend Description
The status of the complication.

Element Values

Open	Closed

(Performance Improvement Audit) NO PI AUDIT FILTERS

TR 31.4.1 **Data Format** [radio]

ImageTrend Description
No PI audit filters.

Element Values

- Relevant value for data element

(Performance Improvement Audit) AUDIT

TR 31.4 **Data Format** [combo] multiple-choice

ImageTrend Description
The performance improvement audit.

Element Values
Relevant value(s) from the list of categories in ImageTrend. Hospitals may select from all pre-existing audit options in ImageTrend or may create hospital-specific PI audit filters.

(Performance Improvement Audit) LAST REVIEW TYPE

TR 31.12 **Data Format** [combo] single-choice

ImageTrend Description
Performance Improvement audit correspondence type.

Element Values

- Action Plan
- Process Concern
- Care Concern
- Primary Review
- Secondary Review
- Tertiary Review

(Performance Improvement Audit Overview) OCCURRENCE DATE

TR 31.7 **Data Format** [date]

ImageTrend Description
The date that the performance improvement audit occurred.

Element Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY

(Performance Improvement Audit Overview) OCCURRENCE TIME

TR 31.18 **Data Format** [time]

ImageTrend Description
The time that the performance improvement audit occurred.

Element Values

- Relevant value for data element

Additional Information

- Collected as HHMM

(Performance Improvement Audit Overview) LOCATION OF OCCURRENCE

TR 31.17 **Data Format** [combo] single-choice

ImageTrend Description
The location where the performance improvement occurred.

Element Values

- Catheterization Lab
- ED
- Floor
- GI Lab
- ICU
- Operating Room
- Prehospital
- PTA (referring to hospital)
- Radiology
- Readmit OR (planned OR)
- Tele

(Performance Improvement Audit Overview) AUDIT STAFF INVOLVED

TR 31.55.9 **Data Format** [combo] multiple-choice

ImageTrend Description
Staff who work on the performance improvement audit.

Element Values

- Relevant value for data element

Additional Information
Press and hold "CTRL" key to select multiple values

(Performance Improvement Audit Overview) SOURCE

TR 31.57 **Data Format** [combo] single-choice

ImageTrend Description
Source of PI audit information.

Element Values

- Autopsy
- Conversation
- Daily Rounds
- EMS Run Sheet
- Hospital Quality Department
- Medical Record
- Patient/Family Concern/Complaint
- Peer Review
- PI Comm
- Referrals
- Risk Management Variance Report
- Staff Concern
- Systems Committee

(Performance Improvement Audit Overview) GROUP

TR 31.58 **Data Format** [combo] single-choice

ImageTrend Description
Complication correspondence group.

Element Values

- Burn
- Cardiology
- Medical Audit Committee (MAC)
- Neuro
- Ortho
- Other
- Peds
- Trauma

(Performance Improvement Audit Overview) FURTHER EXPLANATION/ACTION

TR 31.10 **Data Format** [text]

ImageTrend Description
Further explanation of the Performance Improvement.

Element Values

- Relevant value for data element

(Performance Improvement Notes) STAFF

TR 31.14 **Data Format** [combo] multiple-choice

ImageTrend Description
Staff involved with the performance improvement audit correspondence.

Element Values

- Relevant value for data element

(Performance Improvement Notes) TYPE

TR 31.12 **Data Format** [combo] single-choice

ImageTrend Description
Complication correspondence type.

Element Values

- Action Plan
- Care Concern
- Process Concern

(Performance Improvement Notes) GROUP

TR 31.16 **Data Format** [combo] single-choice

ImageTrend Description
Performance Improvement audit correspondence group.

Element Values

- Burn
- Neuro
- Ortho
- Other
- Peds
- Trauma

(Performance Improvement Notes) SOURCE

TR 31.13 **Data Format** [combo] single-choice

ImageTrend Description
Performance Improvement audit correspondence source.

Element Values

- Autopsy
- Conversation
- Daily Rounds
- EMS Run Sheet
- Hospital Quality Department
- Medical Record
- Patient/Family Concern/Complaint
- PI Comm
- Referrals
- Risk Management Variance Report
- Staff Concern

(Performance Improvement Notes) NOTE

TR 31.15 **Data Format**[text]

ImageTrend Description
Performance Improvement audit correspondence note.

Element Values

- Relevant value for data element

(Performance Improvement Decisions) DETERMINATION

TR 31.3 **Data Format** [combo] multiple-choice

ImageTrend Description
Indication as to what was determined to cause the need for a performance improvement audit.

Element Values

- Cannot be Determined
- Disease-Related
- Provider-Related
- System-Related

(Performance Improvement Decisions) PREVENTABILITY

TR 31.5 **Data Format** [combo] single-choice

ImageTrend Description
Is the performance improvement preventable?

Element Values

- Cannot Be Determined
- Non-preventable
- Potentially Preventable
- Preventable

(Performance Improvement Decisions) FINDINGS

TR 31.6 **Data Format** [combo] single-choice

ImageTrend Description
Outcome of peer review judgment of a QA indicator.

Element Values

- Acceptable
- Acceptable with Reservations
- Defer Peer Review
- Unacceptable
- Will Never Undergo PR

(Performance Improvement Decisions) ACTIONS

TR 31.1 **Data Format** [combo] multiple-choice

ImageTrend Description
The action taken based on the quality indicator.

Element Values

Counseling
Education
Guideline/Protocol
Other
Peer Review Presentation
Privilege/Credentialing
Process Improvement Team
Resource Enhancement
Trend
Unnecessary

(Performance Improvement Decisions) MORTALITY

TR 23.30.1 **Data Format** [combo] single-choice

ImageTrend Description
Mortality Category

Element Values

- Mortality with opportunity for improvement
- Mortality without opportunity for improvement

(Performance Improvement Decisions) STATUS

TR 31.9 **Data Format** [radio]

ImageTrend Description
The status of QA peer review judgment.

Element Values

Open	Closed

TRAUMA QUALITY IMPROVEMENT PROGRAM
Measures for Processes of Care

The elements in this section should be reported by Level 1 and Level 2 TQIP participating centers **ONLY**. Please contact us at indianatrauma@isdh.IN.gov if you have question or at tqip@facs.org for information about joining TQIP.

HIGHEST GCS TOTAL

TR 39.1 **Data Format** [combo] single-choice

NTDB Description

Highest total GCS score on calendar day after ED/hospital arrival.

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	TBI Highest Total GCS
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- Refers to highest total GCS on calendar day after ED/hospital arrival to index hospital, where index hospital is the hospital abstracting the data.
- For patients who were discharged from your hospital prior to the next calendar day after ED/hospital arrival, the null value “Not Applicable” is reported.
- For patients who were at your hospital on the calendar day after ED/hospital arrival, the null value “Not Known/Not Recorded” is reported if reporting ***Highest GCS-40 Motor***.
- The null value "Not Applicable" is reported for patients who do not meet the reporting criterion.
- Requires review of all data sources to obtain the highest GCS total on the calendar day after ED/hospital arrival.
- If patient is intubated, then the GCS Verbal 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," report this as GCS of 15 IF there is no other contradicting documentation.

Data Source Hierarchy Guide

1. Neuro Assessment Flow Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Nursing Notes/Flow Sheet
4. Progress Notes

HIGHEST GCS MOTOR

TR 39.2 **Data Format** [combo] single-choice

NTDB Description

Highest GCS motor on calendar day after ED/hospital arrival.

** Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). **

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	TBI GCS Motor
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Pediatric (≤ 2 years):

- No motor response
- Extension to pain
- Flexion to pain
- Withdrawal from pain
- Localizing pain
- Appropriate response to stimulation

Adult

- No motor response
- Extension to pain
- Flexion to pain
- Withdrawal from pain
- Localizing pain
- Obeys commands

Additional Information

- Refers to highest GCS motor on calendar day after ED/hospital arrival to index hospital, where index hospital is the hospital abstracting the data.
- For patients who were discharged from your hospital prior to the next calendar day after ED/hospital arrival, the null value "Not Applicable" is reported.
- For patients who were at your hospital on the calendar day after ED/hospital arrival, the null value "Not Known/Not Recorded" is reported if reporting ***Highest GCS-40 Motor***.
- The null value "Not Applicable" is reported for patients who do not meet the reporting criterion.
- Requires review of all data sources to obtain the highest GCS motor on calendar day after ED/hospital arrival.
- Best obtained when sedatives or paralytics are withheld as part of sedation holiday.
- 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 reported. For example, the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be reported, IF there is no other contradicting documentation.

Data Source Hierarchy Guide

1. Neuro Assessment Flow Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Nursing Notes/Flow Sheet
4. Progress Notes

GCS ASSESSMENT (QUALIFIER COMPONENT) OF HIGHEST GCS TOTAL

TR 39.3 **Data Format** [combo] single-choice

NTDB Description

Documentation of factors potentially affecting the highest GCS on calendar day after ED/hospital arrival.

** Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). **

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	TBI GCS Qualifier
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element 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

Additional Information

- Report all that apply.
- Refers to highest GCS assessment qualifier score on calendar day after ED/hospital arrival to index hospital, where index hospital is the hospital abstracting the data.
- For patients who were discharged from your hospital prior to the next calendar day after ED/hospital arrival, the null value “Not Applicable” is reported.
- For patients who were at your hospital on the calendar day after ED/hospital arrival, the null value “Not Known/Not Recorded” is reported if reporting ***Highest GCS-40 Motor***.
- The null value "Not Applicable" is reported for patients who do not meet the reporting criterion.
- Requires review of all data sources to obtain the highest GCS motor score on calendar day after ED/hospital arrival, which might occur after the ED phase of care.
- Identifies medical treatments given to the patient that may affect the best assessment of GCS. This element 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*** on calendar day after ED/hospital arrival.
- 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 must be considered to have an exam that is not reflective of their neurologic status and the chemical sedation modifier must be reported.
- Neuromuscular blockade is typically induced following the administration of agents 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.

Data Source Hierarchy Guide

1. Neuro Assessment Flow Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Nursing Notes/Flow Sheet
4. Progress Notes
5. Medication Summary

**Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*

HIGHEST GCS 40 - MOTOR

TR 39.40.2 **Data Format** [combo] single-choice

NTDB Description

Highest GCS 40 motor on calendar day after ED/hospital arrival.

** Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). **

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	TBI GCS40 Motor
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Adult:

None
Extension
Abnormal Flexion
Normal Flexion
Localizing
Obeys commands
Not Testable

Pediatric < 5 years:

None
Extension to Pain
Flexion to Pain
Localizes Pain
Obeys Commands
Not Testable

Additional Information

- Refers to highest GCS 40 motor on calendar day after arrival to index hospital, where index hospital is the hospital abstracting the data.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Requires review of all data sources to obtain the highest GCS 40 motor score on the calendar day after ED/hospital arrival.
- If a patient does not have a numeric GCS 40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be reported. (E.g. the chart indicates: "patient opened mouth and stuck out tongue when asked" for adult patient's, a Motor GCS 40 of 6 may be reported, IF there is no other contradicting documentation.)
- Report Element Value "0. Not Testable" if unable to assess (e.g. neuromuscular blockade).

- The null value "Not Known/Not Recorded" is reported if Highest GCS – Motor is reported.
- If reporting Highest GCS 40 – Motor, the null value "Not Applicable" is reported if the patient's ED Discharge Date or Hospital Discharge Date is prior to the next calendar day.

Data Source Hierarchy Guide

1. Neuro Assessment Flow Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Nursing Notes/Flow Sheet
4. Progress Notes

**Facility can report EITHER GCS or GCS40. Facility must stay consistent for each patient from admission to discharge.*

INITIAL ED/HOSPITAL PUPILLARY RESPONSE

TR 40.32 **Data Format** [combo] single-choice

NTDB Description

Physiological response of the pupil size within 30 minutes or less of ED/hospital arrival.

** Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). **

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	TBI Pupillary Response
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Both reactive
One reactive
Neither reactive

Additional Information

- Please note that first recorded hospital vitals do not need to be from the same assessment.
- If a patient does not have a listed element value recorded, but there is documentation related to their pupillary response such as PERRL "Pupils Equal Round Reactive to Light" report Element Value “1. Both reactive” IF there is no other contradicting documentation.
- The null value "Not Known/Not Recorded" should be reported if this information is not documented or if assessment is unable to be obtained due to facial trauma and/or foreign object in the eye.
- Element value “2. One reactive” should be reported for patients who have a prosthetic eye.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.

Data Source Hierarchy Guide

1. Triage/Trauma Flow Sheet
2. Nursing Notes/ Flow sheet
3. Progress Notes
4. History and Physical

MIDLINE SHIFT

TR 40.33 **Data Format** [combo] single-choice

NTDB Description

>5mm shift of the brain past its center line within 24 hours after time of injury

** Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). **

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	TBI Midline Shift
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Yes No Not Imaged (e.g. CT scan, MRI)

Additional Information

- If there is documentation of "massive" midline shift in lieu of >5mm shift measurement, report element value “1. Yes.”
- Radiological and surgical documentation from transferring facilities should be considered for this data element.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- The null value "Not Known/Not Recorded" is reported if both the injury date and injury time are unknown.
- If the injury time is unknown, but there is supporting documentation that the injury occurred within 24-hours of any CT measuring a >5mm shift, report the element value "1. Yes" if there is no other contradicting documentation.
- If the patient was not imaged within 24 hours from the time of injury, report the element value "3. Not Imaged (e.g. CT Scan, MRI)."

Data Source Hierarchy Guide

1. Radiology Reports
2. Operative Reports
3. Physician Notes/Flow Sheet
4. Nursing Notes/Flow Sheet
5. Hospital Discharge Summary
6. Transfer Facility Records

CEREBRAL MONITOR

TR 39.4 **Data Format** [combo] single-choice

NTDB Description

Indicate 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.

** Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). **

XSD Data Type	xs: integer		**XSD Element/Domain (Complex Type)**	TBI Cerebral Monitor
Multiple Entry Configuration		No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes			

Element Values

- Intraventricular drain/catheter (e.g. ventriculostomy; external ventricular drain)
- Intraparenchymal pressure monitor (e.g. Camino bolt, subarachnoid bolt, intraparenchymal catheter)
- Intraparenchymal oxygen monitor (e.g. Licox)
- Jugular venous bulb
- None

Additional Information

- Report all that apply.
- Refers to insertion of an intracranial pressure (ICP) monitor (or other measures of cerebral perfusion) for the purposes of managing severe TBI.
- Cerebral monitor placed at a referring facility would be acceptable if such a monitor was used by receiving facility to monitor the patient.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.

Data Source Hierarchy Guide

1. Operative Reports
2. Procedure Notes
3. Triage/Trauma/ICU Flow Sheet
4. Nursing Notes/Flow Sheet
5. Progress Notes
6. Anesthesia Record
7. Transfer Facility Records

CEREBRAL MONITOR DATE

TR 39.5 **Data Format** [combo] single-choice

NTDB Description

Date of first cerebral monitor placement.

** Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). **

XSD Data Type	xs: date	**XSD Element/Domain (Complex Type)**	TBI Cerebral Monitor Date
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD.
- The null value "Not Applicable" is reported if the data element Cerebral Monitor is "5. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- If the cerebral monitor was placed at the referring facility, cerebral monitor date must be the date of insertion at the referring facility.

Data Source Hierarchy Guide

1. Operative Reports
2. Procedure Notes
3. Triage/Trauma/ICU Flow Sheet
4. Nursing Notes/Flow Sheet
5. Progress Notes
6. Anesthesia Record
7. Transfer Facility Records

CEREBRAL MONITOR TIME

TR 39.6 **Data Format** [combo] single-choice

NTDB Description

Time of first cerebral monitor placement.

** Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). **

XSD Data Type	xs: time	**XSD Element/Domain (Complex Type)**	TBI Cerebral Monitor Time
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- Reported as HHMM military time.
- The null value "Not Applicable" is reported if the data element Cerebral Monitor is "5. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- If the cerebral monitor was placed at the referring facility, cerebral monitor time must be the time of insertion at the referring facility.

Data Source Hierarchy Guide

1. Operative Reports
2. Procedure Notes
3. Triage/Trauma/ICU Flow Sheet
4. Nursing Notes/Flow Sheet
5. Progress Notes
6. Anesthesia Record
7. Transfer Facility Records

VENOUS THROMBOEMBOLISM PROPHYLAXIS TYPE

TR40.1 **Data Format** [combo] single-choice

NTDB Description

Type of first dose of venous thromboembolism prophylaxis administered to patient at your hospital.
EXCLUDE:

- Therapeutic anticoagulants initiated to treat DVT or PE that developed after admission.
- Sequential compression devices

** Reporting Criterion: Report on all patients**

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	VTE Prophylaxis Type
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- None
- LMWH (Dalteparin, Enoxaparin, etc.)
- Direct Thrombin Inhibitor (Dabigatran, etc.)
- Xa Inhibitor (Rivaroxaban, etc.)
- Unfractionated Heparin (UH)
- Other
- Aspirin
- Warfarin (Coumadin)

Additional Information

- Element Value “5. None” is reported if the first dose of Venous Thromboembolism Prophylaxis is administered post discharge order date/time.
- Element Value "5. None" is reported for patients who refuse VTE prophylaxis
- For patients who were fully anticoagulated prior to this injury event, report the Venous Thromboembolism Prophylaxis Type that was administered after arrival, regardless of if the dosage was therapeutic or prophylaxis.
- For therapeutic anticoagulants administered for other reasons, report the Element Value aligned with the anticoagulant administered.
- Venous Thromboembolism Prophylaxis Types which were retired greater than 2 years before the current NTDS version are no longer listed under Element Values above, which is why there are numbering gaps. Refer to the NTDS Change Log for a full list of retired Venous Thromboembolism Prophylaxis Types.

Data Source Hierarchy Guide

1. Medication Summary
2. Nursing Notes/Flow Sheet
3. Pharmacy Record

VENOUS THROMBOEMBOLISM PROPHYLAXIS DATE

TR40.2 **Data Format** [combo] single-choice

NTDB Description

Date of administration of first dose of VTE prophylaxis administered to patient at your hospital

** Reporting Criterion: Report on all patients**

XSD Data Type	xs: date	**XSD Element/Domain (Complex Type)**	VTE Prophylaxis Date
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD
- Refers to date upon which patient first received the prophylactic agent indicated in VTE Prophylaxis type element.
- The null value "Not Applicable" is reported if Venous Thromboembolism Prophylaxis type is "5. None."

Data Source Hierarchy Guide

1. Medication Summary
2. Nursing Notes/Flow Sheet

VENOUS THROMBOEMBOLISM PROPHYLAXIS TIME

TR40.3 **Data Format** [combo] single-choice

NTDB Description

Time of administration of first dose of VTE prophylaxis administered to patient at your hospital

** Reporting Criterion: Report all on patients**

XSD Data Type	xs: time	**XSD Element/Domain (Complex Type)**	VTE Prophylaxis Time
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- Reported as HH:MM military time.
- Refers to date upon which patient first received the prophylactic agent indicated in Venous Thromboembolism Prophylaxis type.
- The null value "Not Applicable" is reported if Venous Thromboembolism Prophylaxis type is "5. None."

Data Source Hierarchy Guide

1. Medication Summary
2. Nursing Notes/Flow Sheet

PACKED RED BLOOD CELLS

Data Format [combo] single-choice

NTDB Description

Volume of packed red blood cells transfused (CCs [mLs]) within first 4 hours after ED/hospital arrival

EXCLUDE:

- Packed red blood cells transfusing upon patient arrival.
- Cell saver blood.

** Reporting Criterion: Report on all patients**

XSD Data Type	xs: integer	**XSD Element/Domain (Comple Type)**	Transfusion Blood 4Hours
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- Refers to amount of transfused packed red blood cells (CCs [mLs]) within first 4 hours after arrival to your hospital.
- If no packed red blood cells were given, then volume reported must be 0 (zero).

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. Anesthesia Record
3. Operative Reports
4. Nursing Notes/Flow Sheet
5. Blood Bank

WHOLE BLOOD

TR 40.4 **Data Format** [combo] single-choice

NTDB Description

Volume of whole blood transfused (CCs [mLs]) within first 4 hours after ED/hospital arrival

EXCLUDE:

- Whole blood transfusing upon patient arrival.
- Cell saver blood

** Reporting Criterion: Report on all patients**

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Whole Blood 4Hours
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- Refers to amount of transfused whole blood (CCs [mLs]) within first four hours after arrival to your hospital.
- If no whole blood was given, then volume reported must be 0 (zero).

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. Anesthesia Record
3. Operative Reports
4. Nursing Notes/Flow Sheet
5. Blood Bank

PLASMA

TR40.5 **Data Format** [combo] single-choice

NTDB Description

Volume of plasma (CCs [mLs]) transfused within first four hours after ED/hospital arrival
EXCLUDE:

- Plasma transfusing upon patient arrival.
- Cell saver blood.

** Reporting Criterion: Report on all patients**

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Transfusion Plasma 4Hours
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- Refers to amount of transfused fresh frozen, thawed, or never frozen plasma (CCs [mLs]) within first 4 hours after arrival to your hospital.
- If no plasma was given, then volume reported must be 0 (zero).

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. Anesthesia Record
3. Operative Reports
4. Nursing Notes/Flow Sheet
5. Blood Bank

PLATELETS

TR40.6 **Data Format** [combo] single-choice

NTDB Description

Volume of platelets (CCs [mLs]) transfused within first 4 hours after ED/hospital arrival
EXCLUDE:

- Platelets transfusing upon patient arrival.
- Cell saver blood.

** Reporting Criterion: Report on all patients**

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Transfusion Platelets 4Hours
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- Refers to amount of transfused platelets (CCs [mLs]) within first four hours after arrival to your hospital.
- If no platelets were given, then volume reported must be 0 (zero).

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. Anesthesia Record
3. Operative Reports
4. Nursing Notes/Flow Sheet
5. Blood Bank

CRYOPRECIPTIATE (4 Hours)

TR 40.7 **Data Format** [combo] single-choice

NTDB Description
Volume of solution enriched with clotting factors transfused (CCs [mLs]) within first four hours after ED/hospital arrival

EXCLUDE:
- Cryoprecipitate transfusing upon patient arrival.
- Cell saver blood.

** Reporting Criterion: Report on all patients**

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Cryoprecipitate 4Hours
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- Refers to amount of transfused cryoprecipitate (CCs [mLs]) within first four hours after arrival to your hospital.
- If no cryoprecipitate was given, then volume reported must be 0 (zero).

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. Anesthesia Record
3. Operative Reports
4. Nursing Notes/Flow Sheet
5. Blood Bank

ANGIOGRAPHY

TR 40.12 **Data Format** [combo] single-choice

NTDB Description

First interventional angiogram for hemorrhage control within first 24 hours of ED/hospital arrival

EXCLUDE:

- Computerized tomographic angiography (CTA).

** Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival**

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Angiography
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

None
Angiogram only
Angiogram with embolization
Angiogram with stenting

Additional Information

- Limit reporting angiography data to the first 24 hours following ED/hospital arrival.
- Only report Element Value "4. Angiogram with stenting" if stenting was performed specifically for hemorrhage control.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.

Data Source Hierarchy Guide

1. Radiology Reports
2. Operative Reports
3. Progress Notes

EMBOLIZATION SITE

TR 40.18 **Data Format** [combo] single-choice

NTDB Description

Organ/site of embolization for hemorrhage control.

** Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival**

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Embolization Site
Multiple Entry Configuration	Yes, max 7	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Liver
Spleen
Kidneys
Pelvic (iliac, gluteal, obturator)
Retroperitoneum (lumbar, sacral)
Peripheral vascular (neck, extremities)
Other

Additional Information

- Report all that apply.
- The null value "Not Applicable" is reported if Angiography is Element Value "1. None," "2. Angiogram only," or "4. Angiogram with stenting."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Embolization Sites which were retired more than two years before the current NTDS version are no longer listed under Element Values above, which is why there are numbering gaps. Refer to the NTDS Change Log for a full list of retired Embolization Sites.

Data Source Hierarchy Guide

1. Radiology Reports
2. Operative Reports
3. Progress Notes

ANGIOGRAPHY DATE

TR 40.13 **Data Format** [combo] single-choice

NTDB Description

Date the first angiogram with or without embolization was performed.

** Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival**

XSD Data Type	xs: date	**XSD Element/Domain (Complex Type)**	Angiography Date
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD.
- The null value "Not Applicable" is reported if the data element Angiography is Element Value "1. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Procedure start date is the date of needle insertion in the groin.

Data Source Hierarchy Guide

1. Radiology Reports
2. Operative Reports
3. Progress Notes

ANGIOGRAPHY TIME

TR 40.14 **Data Format** [combo] single-choice

NTDB Description

Time the first angiogram with or without embolization was performed.

** Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival**

XSD Data Type	xs: time	**XSD Element/Domain (Complex Type)**	Angiography Time
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- Reported as HH:MM military time.
- The null value "Not Applicable" is reported if the data element Angiography is Element Value "1. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Procedure start time is the time of needle insertion in the groin.

Data Source Hierarchy Guide

1. Radiology Reports
2. Operative Reports
3. Progress Notes

SURGERY FOR HEMORRHAGE CONTROL TYPE

TR 40.19 **Data Format** [combo] single-choice

NTDB Description

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

** Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival**

XSD Data Type	xs: integer	**XSD Element/Domain (Complex Type)**	Hemorrhage Control Surgery Type
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

None
Laparotomy
Thoracotomy
Sternotomy
Extremity
Neck
Mangled extremity/traumatic amputation
Other skin/soft tissue (e.g. scalp laceration)
Extraperitoneal Pelvic Packing

Additional Information

- If unclear if surgery was for hemorrhage control, then consult TMD or operating/consulting/relevant surgeon
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Element Value "1. None" is reported if Surgery for Hemorrhage Control Type is not a listed Element Value option.

Data Source Hierarchy Guide

1. Radiology Reports
2. Operative Reports
3. Progress Notes

SURGERY FOR HEMORRHAGE CONTROL DATE

TR 40.20 **Data Format** [combo] single-choice

NTDB Description

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

** Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival**

XSD Data Type	xs: Date	**XSD Element/Domain (Complex Type)**	Hemorrhage Control Surgery Date
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD
- If unclear if surgery was for hemorrhage control, then consult TMD or operating/consulting/relevant surgeon.
- The null value "Not Applicable" is reported, if surgery for Hemorrhage Control type is "1. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criteria.
- Procedure start date is defined as the date the incision was made (or the procedure started).

Data Source Hierarchy Guide

1. Radiology Reports
2. Operative Reports
3. Progress Notes

SURGERY FOR HEMORRHAGE CONTROL TIME

TR 40.21 **Data Format** [combo] single-choice

NTDB Description

Time of first surgery for hemorrhaged control within the first 24 hours of ED/hospital arrival.

** Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival**

XSD Data Type	xs: Time	**XSD Element/Domain (Complex Type)**	Hemorrhage Control Surgery Time
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- Reported as HH:MM military time.
- If unclear, surgery was for hemorrhage control, then consult TMD or operating/consulting/relevant surgeon.
- The null value "Not Applicable" is reported if Surgery for Hemorrhage Control Type is "1. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criteria.
- Procedure start time is defined as the time the incision was made (or the procedure started).

Data Source Hierarchy Guide

1. Radiology Reports
2. Operative Reports
3. Progress Notes

WITHDRAWAL OF LIFE SUPPORTING TREATMENT

TR 40.15 **Data Format** [combo] single-choice

NTDB Description

Treatment was withdrawn based on a decision to either remove or withhold further life supporting 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.

** Reporting Criterion: Report on all patients **

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Withdrawal Of Life Supporting Treatment
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Yes No

Additional Information

- Do-not-resuscitate (DNR) order not a requirement.
- A note to limit escalation of treatment qualifies as a withdrawal of life supporting treatment. 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-supporting intervention (e.g. intubation).
- Excludes the discontinuation of CPR and typically involves prior planning.
- DNR order is not the same as withdrawal of life supporting treatment.
- Element Value ”2. No” should be reported for patients whose time of death, according to your hospital's definition, was prior to the removal of any interventions or escalation of care.

Data Source Hierarchy Guide

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

WITHDRAWAL OF LIFE SUPPORTING TREATMENT DATE

TR 40.16 **Data Format** [combo] single-choice

NTDB Description

The date treatment was withdrawn

** Reporting Criterion: Report on all patients **

XSD Data Type	xs: Date	**XSD Element/Domain (Complex Type)**	Withdrawal Of Life Supporting Treatment Date
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD
- The null value "Not Applicable" is reported for patients when Withdrawal of Life Supporting Treatment is "2. No."
- Report the date the first of any existing life-supporting 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 supporting intervention(s) occurs (e.g. intubation).

Data Source Hierarchy Guide

1. Physician Order
2. Progress Order
3. Respiratory Therapy Notes/Flow Sheet
4. Case Manager/Social Services Notes
5. Nursing Notes/Flow Sheet
6. Discharge Summary

WITHDRAWAL OF LIFE SUPPORTING TREATMENT TIME

TR 40.17 **Data Format** [combo] single-choice

NTDB Description

The time treatment was withdrawn

** Reporting Criterion: Report on all patients **

XSD Data Type	xs: time	**XSD Element/Domain (Complex Type)**	Withdrawal Of Life Supporting Treatment Time
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- Reported as HH:MM military time.
- The null value "Not Applicable" is reported for patients when Withdrawal of Life Supporting Treatment is "2. No."
- Report the time the first of any existing life-supporting 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 supporting intervention(s) occurs (e.g. intubation).

Data Source Hierarchy Guide

1. Physician Order
2. Progress Order
3. Respiratory Therapy Notes/Flow Sheet
4. Case Manager/Social Services Notes
5. Nursing Notes/Flow Sheet
6. Discharge Summary

ANTIBIOTIC THERAPY

TR 18.189 **Data Format** [combo] single-choice

NTDB Description

Intravenous antibiotic therapy was administered to the patient within 24 hours after injury.

** Reporting Criterion: Report on all patients with any open fracture(s)**

XSD Data Type	xs: string	**XSD Element/Domain (Complex Type)**	Antibiotic Therapy
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Yes No

Additional Information

- The null value “Not Applicable” is reported for patients that do not meet the reporting criterion.
- Open fractures as defined by the Association of Advancement of Automotive Medicine AIS Coding Rules and Guidelines and includes all AIS code descriptors that contain "open" and all AIS extremity/limb code descriptors that contain "amputation."

Data Source Hierarchy Guide

1. EMS Run Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Medication Summary
4. Anesthesia Record
5. Nursing Notes/Flow Sheet
6. Pharmacy Record
7. Transfer Facility Records

ANTIBIOTIC THERAPY DATE

TR 18.190 **Data Format** [combo] single-choice

NTDB Description

The date of first recorded intravenous antibiotic therapy administered to the patient within 24 hours after injury.

** Reporting Criterion: Report on all patients with any open fracture(s)**

XSD Data Type	xs: Date	**XSD Element/Domain (Complex Type)**	Antibiotic Therapy Date
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD
- The null value “Not Applicable” is reported for patients that do not meet the reporting criterion.
- The null value “Not Applicable” is reported if Antibiotic Therapy is element value “2. No”.
- Open fractures as defined by the Association of Advancement of Automotive Medicine AIS Coding Rules and Guidelines and includes all AIS code descriptors that contain "open" and all AIS extremity/limb code descriptors that contain "amputation."

Data Source Hierarchy Guide

1. EMS Run Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Medication Summary
4. Anesthesia Record
5. Nursing Notes/Flow Sheet
6. Pharmacy Record
7. Transfer Facility Records

ANTIBIOTIC THERAPY TIME

TR 18.190.1 **Data Format** [combo] single-choice

NTDB Description

The time of first recorded intravenous antibiotic therapy administered to the patient within 24 hours after injury.

** Reporting Criterion: Report on all patients with any open fracture(s)**

XSD Data Type	xs: time	**XSD Element/Domain (Complex Type)**	Antibiotic Therapy Time
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- Reported HH:MM military time
- The null value “Not Applicable” is reported for patients that do not meet the reporting criterion.
- The null value “Not Applicable” is reported if Antibiotic Therapy is element value “2. No”.
- Open fractures as defined by the Association of Advancement of Automotive Medicine AIS Coding Rules and Guidelines and includes all AIS code descriptors that contain "open" and all AIS extremity/limb code descriptors that contain "amputation."

Data Source Hierarchy Guide

1. EMS Run Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Medication Summary
4. Anesthesia Record
5. Nursing Notes/Flow Sheet
6. Pharmacy Record
7. Transfer Facility Records

Appendix 1: Regarding Injury Severity Score (ISS) and Abbreviated Injury Score (AIS)

In ImageTrend, the ISS is calculated from the AIS codes by using the AIS region and severity that is associated with the AIS code. The AIS codes are entered along with a corresponding ICD-10-CM diagnosis code.

When an ICD-10-CM diagnosis code is added to a patient on the "Diagnosis" tab, the ImageTrend Patient Registry can show the registrar the AIS code used frequently with the diagnosis. If the registrar agrees with the stated code, they can click the **add** button. When the Diagnosis and AIS are added, the system will automatically update the ISS and Probability of Survival.

The ImageTrend Patient Registry uses AIS 15. In addition to calculating the ISS, the New Injury Severity Score (NISS) will also be calculated in ImageTrend.

Appendix 2: Indiana Hospitals

See below for a list of Indiana's 131 acute care hospitals with emergency departments, as of December 2025.

Zip Code	Facility Name	Trauma Level	District
46733	Adams Memorial Hospital	Non-Trauma Centers	3
46016	Ascension St. Vincent Anderson	Trauma Level III	6
46123	Ascension St. Vincent- Avon (Neighborhood Hospital)	Non-Trauma Centers	5
46250	Ascension St. Vincent- Castleton (Neighborhood Hospital)	Non-Trauma Centers	5
47714	Ascension St. Vincent Evansville	Trauma Levels I & II	10
46260	Ascension St. Vincent Hospital - Indianapolis	Trauma Levels I & II	5
46237	Ascension St. Vincent- Indianapolis South (Neighborhood Hospital)	Non-Trauma Centers	5
46901	Ascension St. Vincent Kokomo	Non-Trauma Centers	6
46036	Ascension St. Vincent Mercy Hospital	Non-Trauma Centers	6
46168	Ascension St. Vincent- Plainfield (Neighborhood Hospital)	Non-Trauma Centers	5
47394	Ascension St. Vincent Randolph	Non-Trauma Centers	6
47167	Ascension St. Vincent Salem Hospital	Non-Trauma Centers	8
47601	Ascension St. Vincent Warrick	Non-Trauma Centers	10
47993	Ascension St. Vincent Williamsport	Non-Trauma Centers	4
46032	Ascension St. Vincent-Carmel	Non-Trauma Centers	5
47834	Ascension St. Vincent-Clay	Non-Trauma Centers	7
46037	Ascension St. Vincent-Fishers	Non-Trauma Centers	5
47265	Ascension St. Vincent-Jennings	Non-Trauma Centers	9
47150	Baptist Health Floyd	Non-Trauma Centers	9
46530	Beacon Granger Hospital	Non-Trauma Centers	2
46714	Bluffton Regional Medical Center	Non-Trauma Centers	3
46703	Cameron Memorial Community Hospital	Non-Trauma Centers	3

Appendix 2: Indiana Hospitals

Zip Code	Facility Name	Trauma Level	District
47201	Columbus Regional Hospital	Non-Trauma Centers	8
46219	Community EAST Health Network Comm Hosp	Non-Trauma Centers	5
46011	Community Hosp of Anderson and Madison Co	Trauma Level III	6
46321	Community Hospital Munster	Non-Trauma Centers	1
46506	Community Hospital of Bremen	Non-Trauma Centers	2
46902	Community Howard Regional Health	Non-Trauma Centers	6
46256	Community NORTH Health Network Comm Hosp	Non-Trauma Centers	5
46227	Community SOUTH Health Network Comm Hosp	Non-Trauma Centers	5
47501	Daviess Community Hospital	Non-Trauma Centers	10
47630	Deaconess Gateway Hospital	Non-Trauma Centers	10
47670	Deaconess Gibson Hospital	Non-Trauma Centers	10
47546	Deaconess Memorial Medical Center	Trauma Level III	10
47747	Deaconess Midtown Hospital	Trauma Levels I & II	10
47240	Decatur County Memorial Hospital	Non-Trauma Centers	9
46970	Dukes Memorial Hospital	Non-Trauma Centers	3
46825	Dupont Hospital	Non-Trauma Centers	3
46514	Elkhart General Hospital	Trauma Level III	2
46202	Eskenazi Health	Trauma Levels I & II	5
47933	Franciscan Health Crawfordsville	Non-Trauma Centers	4
46307	Franciscan Health Crown Point	Trauma Level III	1
46311	Franciscan Health Dyer	Non-Trauma Centers	1
46237	Franciscan Health Indianapolis	Trauma Level III	5
47095	Franciscan Health Lafayette East	Trauma Level III	4
46360	Franciscan Health Michigan City	Non-Trauma Centers	1
46350	Franciscan Health Michigan City at LaPorte	Non-Trauma Centers	1
46158	Franciscan Health Mooresville	Non-Trauma Centers	5
46321	Franciscan Health Munster	Non-Trauma Centers	1

Appendix 2: Indiana Hospitals

Zip Code	Facility Name	Trauma Level	District
47978	Franciscan Health Rensselaer	Non-Trauma Centers	1
47591	Good Samaritan Hospital	Trauma Level III	10
46526	Goshen Health	Non-Trauma Centers	2
47441	Greene County General Hospital	Non-Trauma Centers	7
46140	Hancock Health	Non-Trauma Centers	5
47112	Harrison County Hospital	Non-Trauma Centers	9
46122	Hendricks Regional Health	Non-Trauma Centers	5
46112	Hendricks Regional Health – Brownsburg Hospital	Non-Trauma Centers	5
47362	Henry Community Health	Non-Trauma Centers	6
47905	IU Health Arnett Hospital	Trauma Level III	4
47303	IU Health Ball Memorial Hospital	Trauma Level III	6
47421	IU Health Bedford Hospital	Non-Trauma Centers	8
47403	IU Health Bloomington Hospital	Trauma Level III	8
46037	IU Health Fishers Hospital	Non-Trauma Centers	5
46041	IU Health Frankfort Hospital	Non-Trauma Centers	4
47371	IU Health Jay	Non-Trauma Centers	6
46202	IU Health Methodist Hospital	Trauma Levels I & II	5
46151	IU Health Morgan Hospital	Non-Trauma Centers	5
46032	IU Health North Hospital	Non-Trauma Centers	5
47454	IU Health Paoli Hospital	Non-Trauma Centers	8
46202	IU Health Riley Hospital for Children	Trauma Levels I & II	5
46072	IU Health Tipton Hospital	Non-Trauma Centers	6
46123	IU Health West Hospital	Non-Trauma Centers	5
47960	IU Health White Memorial Hospital	Non-Trauma Centers	4
46131	Johnson Memorial Hospital	Non-Trauma Centers	5
46802	Lutheran Downtown	Non-Trauma Centers	3
46804	Lutheran Hospital of Indiana	Trauma Levels I & II	3
46580	Lutheran Kosciusko Hospital	Non-Trauma Centers	2

Appendix 2: Indiana Hospitals

Zip Code	Facility Name	Trauma Level	District
46176	Major Hospital	Non-Trauma Centers	5
47006	Margaret Mary Health	Non-Trauma Centers	9
46952	Marion Health	Non-Trauma Centers	6
46947	Memorial Hospital Logansport	Non-Trauma Centers	4
46601	Memorial Hospital of South Bend	Trauma Levels I & II	2
46402	Methodist Hospitals Inc Northlake Campus	Non-Trauma Centers	1
46410	Methodist Hospitals Inc Southlake Campus	Non-Trauma Centers	1
47403	Monroe Hospital	Non-Trauma Centers	8
46350	Northwest Health La Porte	Non-Trauma Centers	1
46368	Northwest Health Portage	Non-Trauma Centers	1
46383	Northwest Health Porter	Non-Trauma Centers	1
46383	Northwest Health Valparaiso Medical Center (VMC)	Non-Trauma Centers	1
47130	Norton Clark Hospital	Non-Trauma Centers	9
47250	Norton King's Daughters' Health	Non-Trauma Centers	9
47130	Norton Medical Center – Jeffersonville Commons	Non-Trauma Centers	9
47170	Norton Scott Hospital	Non-Trauma Centers	9
46324	NW Indiana ER & Hospital	Non-Trauma Centers	1
46706	Parkview DeKalb Hospital	Non-Trauma Centers	3
46750	Parkview Huntington Hospital	Non-Trauma Centers	3
46761	Parkview LaGrange Hospital	Non-Trauma Centers	3
46755	Parkview Noble Hospital	Non-Trauma Centers	3
46805	Parkview Randallia	Non-Trauma Centers	3
46845	Parkview Regional Medical Center	Trauma Levels I & II	3
46804	Parkview Southwest Outpatient Center	Non-Trauma Centers	3
46992	Parkview Wabash	Non-Trauma Centers	3
46580	Parkview Warsaw	Non-Trauma Centers	2
46725	Parkview Whitley	Non-Trauma Centers	3

Zip Code	Facility Name	Trauma Level	District
47586	Perry County Memorial Hospital	Non-Trauma Centers	10
46260	Peyton Manning Children's Hospital at St Vincent	Non-Trauma Centers	5
46996	Pulaski Memorial Hospital	Non-Trauma Centers	2
46135	Putnam County Hospital	Non-Trauma Centers	7
47374	Reid Health	Trauma Level III	6
47331	Reid Health Connersville	Non-Trauma Centers	6
46060	Riverview Health	Non-Trauma Centers	5
46074	Riverview Health Westfield	Non-Trauma Centers	5
46077	Riverview Health Emergency Room & Urgent Care – West Carmel/Zionsville	Non-Trauma Centers	5
46033	Riverview Health Emergency Room & Urgent Care - Carmel	Non-Trauma Centers	5
46037	Riverview Health Emergency Room & Urgent Care - Fishers	Non-Trauma Centers	5
46173	Rush Memorial Hospital	Non-Trauma Centers	6
46545	Saint Joseph Regional Medical Center (Mishawaka)	Non-Trauma Centers	2
46563	Saint Joseph Regional Medical Center (Plymouth)	Non-Trauma Centers	2
47274	Schneck Medical Center	Non-Trauma Centers	8
46312	St. Catherine Hospital East Chicago	Non-Trauma Centers	1
47025	St. Elizabeth Dearborn	Non-Trauma Centers	9
46342	St. Mary Medical Center (Hobart)	Non-Trauma Centers	1
46534	Starke Hospital	Non-Trauma Centers	2
47882	Sullivan County Community Hospital	Non-Trauma Centers	7
47802	Terre Haute Regional Hospital	Non-Trauma Centers	7
46307	UChicago Medicine Crown Point	Non-Trauma Centers	1
47842	Union Hospital Clinton	Non-Trauma Centers	7
47804	Union Hospital Terre Haute	Trauma Level III	7

Zip Code	Facility Name	Trauma Level	District
46052	Witham Health Services	Non-Trauma Centers	5
46077	Witham Health Services at Anson	Non-Trauma Centers	5
46975	Woodlawn Hospital	Non-Trauma Centers	2

Appendix 3: Glossary of Terms

Glossary

CO-MORBID CONDITIONS

Advanced Directive Limiting Care: The patient had a written request limiting life sustaining therapy, or similar advanced directive, present prior to arrival at your center.

Alcohol Use Disorder: (Consistent with the American Psychiatric Association (APA) DMS 5, 2013. Always use the most recent definition provided by the APA.) Diagnosis of alcohol use disorder documented in the patient's medical record, present prior to injury.

Angina Pectoris: (Consistent with the American Heart Association (AHA), May 2015. Always use the most recent definition provided by the AHA.) Chest pain or discomfort due to coronary heart disease present prior to injury. Usually causes uncomfortable pressure, fullness, squeezing or pain in the center of the chest. Patient may also feel the discomfort in the neck, jaw, shoulder, back or arm. Symptoms may be different in women than men. A diagnosis of angina or chest pain must be documented in the patient's medical record.

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

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

Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD): A disorder involving inattention, hyperactivity, or impulsivity requiring medication for treatment, present prior to ED/Hospital arrival. A diagnosis of ADD/ADHD must be documented in the patient's medical record.

Bleeding Disorder: (Consistent with the American Society of Hematology, 2015. Always use the most recent definition provided by the American Society of Hematology.) A group of conditions that result when the blood cannot clot properly, present prior to injury. A Bleeding Disorder diagnosis must be documented in the patient's medical record (e.g. Hemophilia, von Willebrand Disease, Factor V Leiden.)

Cerebral Vascular Accident (CVA): A history prior to injury of a cerebrovascular accident (embolic, thrombotic, or hemorrhagic) with persistent residual motor sensory or cognitive dysfunction (e.g. hemiplegia, hemiparesis, aphasia, sensory deficit, impaired memory). A diagnosis of CVA must be documented in the patient's medical record.

Chronic Obstructive Pulmonary Disease (COPD): (Consistent with World Health Organization (WHO), 2015. Always use the most recent definition provided by the WHO.) Lung ailment that is characterized by a persistent blockage of airflow from the lungs, present prior to injury. It is not one single disease, but an umbrella term used to describe chronic lung diseases that cause limitations in lung airflow. The more familiar terms "chronic bronchitis" and "emphysema" are no longer used, but are now included within the COPD diagnosis and result in any one or more of the following:

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

A diagnosis of COPD must be documented in the patient's medical record. Do not include patients whose only pulmonary disease is acute asthma, and/or diffuse interstitial fibrosis or sarcoidosis.

Chronic Renal Failure: Chronic renal failure prior to injury that was requiring periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration, present prior to injury. A diagnosis of chronic renal failure must be documented in the patient's medical record.

Cirrhosis: Documentation in the medical record of cirrhosis, which might also be referred to as end stage liver disease, present prior to injury. If there is documentation of prior or present esophageal or gastric varices, portal hypertension, previous hepatic encephalopathy, or ascites with notation of liver disease, then cirrhosis should be considered present. A diagnosis of cirrhosis, or documentation of cirrhosis by diagnostic imaging studies or a laparotomy/laparoscopy, must be in the patient's medical record.

Congenital Anomalies: Documentation of a cardiac, pulmonary, body wall, CNS/spinal, GI, renal, orthopedic, or metabolic anomaly, present prior to injury. A diagnosis of a congenital anomaly must be documented in the patient's medical record.

Congestive Heart Failure (CHF): The inability of the heart to pump enough blood to meet the metabolic needs of the body or can do so only at an increased ventricular filling pressure, present prior to injury. To be included, this condition must be noted in the medical record as CHF, congestive heart failure, or pulmonary edema with onset of increasing symptoms within 30 days prior to injury.
Common manifestations are:

- Abnormal limitation in exercise tolerance due to dyspnea or fatigue
- Orthopnea (dyspnea or lying supine)
- Paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea)
- Increased jugular venous pressure
- Pulmonary rales on physical examination
- Cardiomegaly
- Pulmonary vascular engorgement

Current Smoker: A patient who reports smoking cigarettes every day or some days within the last 12 months, prior to injury. Excludes patients who smoke cigars or pipes or smokeless tobacco (chewing tobacco or snuff).

Currently Receiving Chemotherapy for Cancer: A patient who is currently receiving any chemotherapy treatment for cancer, prior to injury. Chemotherapy may include, but is not restricted to, oral and parenteral treatment with chemotherapeutic agents for malignancies such as colon, breast, lung, head and neck, and gastrointestinal solid tumors as well as lymphatic and hematopoietic malignancies such as lymphoma, leukemia, and multiple myeloma.

Dementia: Documentation in the patient's medical record of dementia including senile or vascular dementia (e.g., Alzheimer's) present prior to injury.

Diabetes Mellitus: Diabetes mellitus that requires exogenous parenteral insulin or an oral hypoglycemic agent, present prior to injury. A diagnosis of diabetes mellitus must be documented in the patient's medical record.

Disseminated Cancer: Patients who have cancer that has spread to one or more sites in addition to the primary site AND in whom the presence of multiple metastases indicates the cancer is widespread, fulminant, or near terminal, present prior to injury. Other terms describing disseminated cancer include: "diffuse," "widely metastatic," "widespread," or "carcinomatosis." Common sites of metastases include major organs, (e.g., brain, lung, liver, meninges, abdomen, peritoneum, pleura, and/or bone). A diagnosis of cancer that has spread to one or more sites must be documented in the patient's medical record.

Functionally Dependent Health Status: Pre-injury functional status may be represented by the ability of the patient to complete age-appropriate activities of daily living (ADL). Activities of daily living include bathing, feeding, dressing, toileting, and walking. Include patients whom prior to injury, and as a result of cognitive or physical limitations relating to a pre-existing medical condition, were partially dependent or completely dependent upon equipment, devices or another person to complete some or all activities of daily living.

Hypertension: History of persistent elevated blood pressure requiring medical therapy, present prior to injury. A diagnosis of hypertension must be documented in the patient's medical record.

Mental/Personality Disorder: (Consistent with American Psychiatric Association (APA) DSM 5, 2013. Always use the most recent definition provided by the APA.) Documentation of the presence of pre-injury depressive disorder, bipolar disorder, schizophrenia, borderline or antisocial personality disorder, and/or adjustment disorder/post-traumatic stress disorder. A diagnosis of Mental/Personality Disorder must be documented in the patient's medical record.

Myocardial Infarction: History of a MI in the six months prior to injury. A diagnosis of MI must be documented in the patient's medical record.

Peripheral Arterial Disease (PAD): The narrowing or blockage of the vessels that carry blood from the heart to the legs, present prior to injury. It is primarily caused by the buildup of fatty plaque in the arteries, which is called atherosclerosis. PAD can occur in any blood vessel, but it is more common in the legs than the arms. A diagnosis of PAD must be documented in the patient's medical record. (Consistent with Centers for

Disease Control, 2014 Fact Sheet. Always use the most recent definition provided by the CDC.)

Prematurity: Infants delivered before 37 weeks from the first day of the last menstrual period, and a history of bronchopulmonary dysplasia, or ventilator support for greater than seven days after birth. A diagnosis of prematurity, or delivery before 37 weeks gestation, must be documented in the patient's medical record.

Steroid Use: Patients that require the regular administration of oral or parenteral corticosteroid medications within 30 days prior to injury for a chronic medical condition. Examples of oral or parenteral corticosteroid medications are prednisone and dexamethasone. Examples of chronic medical conditions include COPD, asthma, rheumatologic disease, rheumatoid arthritis, and inflammatory bowel disease. Exclude topical corticosteroids applied to the skin, and corticosteroids administered by inhalation or rectally.

Substance Abuse Disorder: (Consistent with American Psychiatric Association (APA) DSM 5, 2013.Always use the most recent definition provided by the APA.) Documentation of substance abuse disorder documented in the patient medical record, present prior to injury. A diagnosis of Substance Abuse Disorder must be documented in the patient's medical record.

HOSPITAL COMPLICATIONS

Acute Kidney Injury: (Consistent with the March 2012 Kidney Disease Improving Global Outcome (KDIGO) Guideline. Always use the most recent definition provided by the KDIGO.) Acute Kidney Injury, AKI (stage 3), is an abrupt decrease in kidney function that occurred during the patient's initial stay at your hospital.

KDIGO (Stage 3) Table:

(SCr) 3 times baseline
OR
Increase in SCr to ≥ 4.0 mg/dl (≥ 353.6 µmol/l)
OR
Initiation of renal replacement therapy OR, in patients < 18 years, decrease in eGFR to <35 ml/min per 1.73 m^2
OR
Urine output <0.3 ml/kg/h for > 24 hours
OR

Anuria for > 12 hours
A diagnosis of AKI must be documented in the patient's medical record. If the patient or family refuses treatment (e.g., dialysis,) the condition is still considered to be present if a combination of oliguria and creatinine are present.
EXCLUDE patients with renal failure that were requiring chronic renal replacement therapy such as periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration prior to injury.

Acute Respiratory Distress Syndrome (ARDS):
Timing: Within one week of known clinical insult or new or worsening respiratory symptoms.
Chest imaging: Bilateral opacities – not fully explained by effusions, lobar/lung collage, or Nodules Origin of edema: Respiratory failure not fully explained by cardiac failure of fluid overload. Need objective assessment (e.g., echocardiography) to exclude hydrostatic edema if no risk factor present.
Oxygenation: 200<Pa02/Fi02<=300 (at a minimum) With PEEP or CPAP>=5 cmH20c
A diagnosis of ARDS must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital. (Consistent with the 2012 New Berlin Definition. Always use the most recent New Berlin definition provided.)

Alcohol Withdrawal Syndrome: Characterized by tremor, sweating, anxiety, agitation, depression, nausea, and malaise. It occurs six to 48 hours after cessation of alcohol consumption, and when uncomplicated, abates after two to five days. It may be complicated by grand mal seizures and may progress to delirium (known as delirium tremens). Must have occurred during the patient's initial stay at your hospital, and documentation of alcohol withdrawal must be in the patient's medical record. (Consistent with the 2016 World Health Organization (WHO) definition of Alcohol Withdrawal Syndrome. Always use the most recent definition provided by the WHO.)

Cardiac Arrest with CPR: Cardiac arrest is the sudden cessation of cardiac activity after hospital arrival. The patient becomes unresponsive with no normal breathing and no signs of circulation. If corrective measures are not taken rapidly, this condition progresses to sudden death. Cardiac arrest must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital.
EXCLUDE patients who are receiving CPR on arrival to your hospital.
INCLUDE patients who have had an episode of cardiac arrest evaluated by hospital personnel and received compressions or defibrillation or cardioversion or cardiac pacing to restore circulation.

Catheter-Associated Urinary Tract Infection (CAUTI) (Consistent with the January 2016 CDC defined CAUTI. Always use the most recent definition provided by the CDC.)
A UTI where an indwelling urinary catheter was in place for > 2 calendar days on the date of event, with day of device placement being Day 1, **AND**
An indwelling urinary catheter was in place on the date of event or the day before. If an indwelling urinary catheter was in place for > 2 calendar days and then removed, the date of event for the UTI must be the day of discontinuation or the next day for the UTI to be catheter-associated.)

January 2016 CDC CAUTI Criterion SUTI 1a:

Patients must meet 1, 2, **and** 3 below:
1. Patient had an indwelling urinary catheter in place for the entire day on the date of event and such catheter had been in place for >2 calendar days, on that date (day of device
   - Placement = Day 1) AND was either:
   - Present for any portion of the calendar day on the date of event, OR
   - Removed the day before the date of event
2. Patient has at least **one** of the following signs or symptoms:
   - Fever (>38^{0}C)
   - Suprapubic tenderness with no other recognized cause
   - Costovertebral angle pain or tenderness with no other recognized cause
3. Patient has a urine culture with no more than two species of organisms, at least one of which is a bacteria >10^5 CFU/ml.

January 2016 CDC CAUTI Criterion SUTI 2:

Patients must meet 1, 2 **and** 3 below:
1. Patient is ≤1 year of age
2. Patient has at least one of the following signs or symptoms:
   - fever (>38.0^{0}C)
   - hypothermia (<36.0^{0}C)
   - apnea with no other recognized cause
   - bradycardia with no other recognized cause
   - lethargy with no other recognized cause
   - vomiting with no other recognized cause
   - suprapubic tenderness with no other recognized cause

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

A diagnosis of UTI must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

Central Line-Associated Bloodstream Infection (CLABSI): (Consistent with the January 2016 CDC defined CLABSI. Always use the most recent definition provided by the CDC.) A laboratory-confirmed bloodstream infection (LCBI) where central line (CL) or umbilical catheter (UC) was in place for > 2 calendar days on the date of event, with day of device placement being Day 1,
AND
The line was also in place on the date of event or the day before. If a CL or UC was in place for > 2 calendar days and then removed, the date of event of the LCBI must be the day of discontinuation or the next day to be a CLABSI. If the patient is admitted or transferred into a facility with an implanted central line (port) in place, and that is the patient's only central line, day of first access in an inpatient location is considered Day 1. "Access" is defined as line placement, infusion, or withdrawal through the line. Such lines continue to be eligible for CLABSI once they are accessed until they are either discontinued or the day after patient discharge (as per the Transfer Rule.) Note that the "de-access" of a port does not result in the patient's removal from CLABSI surveillance.

January 2016 CDC Criterion LCBI 1:
Patient has a recognized pathogen identified from one or more blood specimens by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not active surveillance culture/testing (ASC/AST.)
AND
Organism(s) identified in blood is not related to an infection at another site.
OR
January 2016 CDC Criterion LCBI 2:
Patient has at least one of the following signs or symptoms: fever (>38^{0}C), chills, or hypotension
AND
Organism(s) identified from blood is not related to an infection at another site.
AND
The same common commensal (i.e., diphtheroids [*Corynebacterium* spp. not *C. diphtheriae*], *Bacillus* spp. [not *B. anthracis*], *Propionibacterium* spp., coagulase-negative staphylococci [including *S. epidermidis*], viridans group streptococci, *Aerococcus* spp., and *Micrococcus* spp.) is identified from two or more blood specimens drawn on separate occasions, by a culture or nonculture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST.) Criterion elements must occur within the

Infection Window Period, the seven-day time period which includes the collection date of the positive blood, the 3 calendar days before and the three calendar days after.
OR
January 2016 CDC Criterion LCBI 3:
Patient ≤ 1 year of age has at least one of the following signs or symptoms: fever (>38^0 C), hypothermia (<36^0C), apnea, or bradycardia
AND
Organism(s) identified from blood is not related to an infection at another site
AND
The same common commensal (i.e., diphtheroids [*Corynebacterium* spp. not *C. diphtheriae*], *Bacillus* spp. [not *B. anthracis*], *Propionibacterium* spp., coagulase-negative staphylococci [including *S. epidermidis*], viridans group streptococci, *Aerococcus* spp., and *Micrococcus* spp.) is identified from two or more blood specimens drawn on separate occasions, by a culture or nonculture base microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not active surveillance culture/testing (ASC/AST.) Criterion elements must occur within the Infection Window Period, the seven-day time period which includes the collection date of the positive blood, the three calendar days before and the three calendar days after.

A diagnosis of LCBSI must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

Deep Surgical Site Infection: (Consistent with the January 2016 CDC defined SSI. Always use the most recent definition provided by the CDC.) Must meet the following criteria: Infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) according to list in Table 2 in the 2026 NTDS Data Dictionary (page 161).
AND
involves deep soft tissues of the incision (e.g., fascial and muscle layers)
AND
patient has at least **one** of the following:

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

AND

patient has at least **one** of the following signs or symptoms: fever (>38°C); localized pain or tenderness. A culture or non-culture-based test that has a negative finding does not meet this criterion.
c. an abscess or other evidence of infection involving the deep incision that is detected on gross anatomical or histopathologic exam, or imaging test

COMMENTS: There are two specific types of deep incisional SSIs:

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

A diagnosis of SSI must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

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

Extremity Compartment Syndrome: A condition does 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. A diagnosis of extremity compartment syndrome must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital. Only record as a complication if it is originally missed, leading to late recognition, a need for late intervention, and has threatened limb viability.

Myocardial Infarction (MI): An acute myocardial infarction must be noted with documentation of any of the following:
Documentation of ECG changes indicative of acute MI (one or more of the following three):

1. ST elevation >1 mm in two or more contiguous leads
2. New left bundle branch block
3. New q-wave in two or more contiguous leads

OR

New elevation in troponin greater than three times upper level of the reference range in the setting of suspected myocardial ischemia

OR

Physician diagnosis of myocardial infarction

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

Organ/Space Surgical Site Infection: (Consistent with the January 2016 CDC defined SSI. Always use the most recent definition provided by the CDC.) Must meet the following criteria: Infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) according to the list in Table 2 on page 171 of the 2026 NTDS Data Dictionary.

AND

infection involves any part of the body deeper than the fascial/muscle layers, that is opened or manipulated during the operative procedure

AND

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

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

AND

meets at least **one** criterion for a specific organ/space infection site listed in Table 3 on page 172 of the 2026 NTDS Data Dictionary. These criteria are found in the Surveillance Definitions for Specific Types of Infections chapter.

A diagnosis of SSI must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

Osteomyelitis: (Consistent with the January 2016 CDC definition of Bone and Joint infection. Always use the most recent definition provided by the CDC.) Osteomyelitis must meet at least **one** of the following criteria:
1. Patient has organisms identified from bone by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not active surveillance culture/testing (ASC/AST).
2. Patient has evidence of osteomyelitis on gross anatomic or histopathologic exam.
3. Patient has at least **two** of the following localized signs or symptoms: fever (>38.0°C), swelling*, pain or tenderness*, heat*, or drainage*

And at least one of the following:

a. organisms identified from blood by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not active surveillance culture/testing (ASC/AST) in a patient with imaging test evidence suggestive of infection (e.g., x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for osteomyelitis).

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

* With no other recognized cause

A diagnosis of osteomyelitis must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

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 and/or a diagnosis of PE is documented in the patient's medical record. Must have occurred during the patient's initial stay at your hospital.

Pressure Ulcer: (Consistent with the National Pressure Ulcer Advisory Panel (NPUAP) 2014. Always use the most recent definition provided by the NPUAP.) A localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated. Equivalent to NPUAP Stages II-IV,

Unstageable/Unclassified, and suspected deep tissue injury. Documentation of pressure ulcer must be in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

Severe Sepsis: (Consistent with the American College of Chest Physicians and the Society of Critical Care Medicine October 2010. Always use the most recent definition provided by the American College of Chest Physicians and the Society of Critical Care Medicine.)
Severe sepsis: sepsis plus organ dysfunction, hypotension (low blood pressure), or hypoperfusion (insufficient blood flow) to one or more organs.
Septic shock: sepsis with persisting arterial hypotension or hypoperfusion despite adequate fluid resuscitation. A diagnosis of sepsis must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

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 one side of the body
- Dysphasia or aphasia
- Hemianopia
- Amaurosis fugax
- Other neurological signs or symptoms consistent with stroke

AND:

- Duration of neurological deficit ≥24 h

OR:

- Duration of deficit <24 h, if neuroimaging (MR, CT, or cerebral angiography) documents a new hemorrhage or infarct consistent with stroke, or therapeutic intervention(s) were performed for stroke, or the neurological deficit results in death

AND:

- No other readily identifiable non-stroke cause, e.g., progression of existing traumatic brain injury, seizure, tumor, metabolic or pharmacologic etiologies, is identified

AND:

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

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. A diagnosis of Stroke/CVA must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

Superficial Incisional Surgical Site Infection: (Consistent with the January 2016 CDC defined SSI. Always use the most recent definition provided by the CDC.) Must meet the following criteria: Infection occurs within 30 days after any NHSN operative procedure (where day 1 = the procedure date)
AND
involves only skin and subcutaneous tissue of the incision
AND
patient has at least **one** of the following:

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

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

d. diagnosis of a superficial incisional SSI by the surgeon or attending physician** or other designer.

COMMENTS: There are two specific types of superficial incisional SSIs:

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

A diagnosis of SSI must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

Unplanned Admission to ICU: Patients admitted to the ICU after initial transfer to the floor, and/or patients with an unplanned return to the ICU after initial ICU discharge. Must have occurred during the patient's initial stay at your hospital. EXCLUDE patients in which ICU care was required for postoperative care of a planned surgical procedure.

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 element or Emergency Department, or those intubated for surgery, unplanned intubation occurs if they require reintubation > 24 hours after extubating. Must have occurred during the patient's initial stay at your hospital.

Unplanned Return to the Operating Room: Unplanned return to the operating room after initial operation management for a similar or related previous procedure. Must have occurred during the patient's initial stay at your hospital.

Ventilator-Associated Pneumonia (VAP): (Consistent with the January 2016 CDC defined VAP. Always use the most recent definition provided by the CDC.) A pneumonia where the patient is on mechanical ventilation for > 2 calendar days on the date of event, with day of ventilator placement being Day 1,
AND
The ventilator was in place on the date of event or the day before. If the patient is admitted or transferred into a facility on a ventilator, the day of admission is considered Day 1.
Note: Refer to VAP algorithms on pages 194-207 of the 2026 NTDS Data Dictionary.

A diagnosis of Pneumonia must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

Occupation and Industry Terms

Patient's Occupational Industry: The occupational history associated with the patient's work environment.

Value Elements and Definitions

Finance and Insurance - The finance and insurance sector comprise 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:

- Raising funds by taking deposits and/or issuing securities and, in the process, incurring liabilities.
- Pooling of risk by underwriting insurance and annuities.
- 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:

- Store retailers operate fixed point-of-sale locations, located, and designed to attract a high volume of walk-in customers.
- 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 elements such as teaching, sanitation, health care, management, and administration for the federal, state, or local government. Legislatures establish basic prerequisites for employment such as compliance with minimal age and educational requirements and residency laws.

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

Information Services - The information sector comprises establishments engaged in the following processes: (a) producing and distributing information and cultural products, (b) providing the means to transmit or distribute these products as well as data or communications, 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, grantmaking, advocacy,

Patient's Occupation: The occupation of the patient.

Element 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

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, post-secondary math and computer teachers, post-secondary nursing instructors and teachers, post-secondary law, criminal justice, and social work teachers; post-secondary pre-school 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 groundskeeping workers, pest control workers, pesticide handlers, sprayers and applicators, vegetation, tree trimmers and pruners.

Sales and Related Occupations - Advertising sales agents, 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 and industrial machinery installation, repair, and maintenance

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 - Computer occupations, all other web developers, software developers and programmers, database administrators, statisticians

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; and all other medical assistants

Food Preparation and Serving-Related – Bartenders, cooks, institution and cafeteria cooks, fast food dishwashers, counter attendants; cafeteria, food concession, and coffee shop waiters and waitresses

Personal Care and Service Occupations - Animal trainers, amusement and recreation attendants, barbers, hairdressers, hairstylists and cosmetologists; baggage porters, bellhops; 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, pipelayers, plumbers, pipefitters, and steamfitters; 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 Occupations - Dry cleaning and laundry services, personal care services, and death care services; pet care services, photofinishing services, temporary parking services, dating services, etc.

Foreign Visitor - Any person visiting a country other than his/her usual place of residence for any reason

Intermediate Care Facility - A facility providing a level of medical care that is less than the degree of care and treatment that a hospital or skilled nursing facility is designed to provide but greater than the level of room and board

Home Health Service - A certified service approved to provide care received at home as part-time skilled nursing care, speech therapy, physical or occupational therapy or part-time services of home health aides

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.

Hospice - An organization which is primarily designed to provide pain relief, symptom management and supportive services for the terminally ill and their families

Migrant Worker - A person who temporarily leaves his/her principal place of residence within a country to accept seasonal employment in the same or different country.

Operative and/or Essential Procedures - Procedures performed in the Operating Room, Emergency Department, or Intensive Care Unit that were essential to the diagnoses, stabilization, or treatment of the patient's specific injuries. Repeated diagnostic procedures (e.g., repeated CT scan) should not be recorded (record only the first procedure).

Skilled Nursing Care - Daily nursing and rehabilitative care that is performed only by or under the supervision of skilled professional or technical personnel. Skilled care includes administering medication, medical diagnosis and minor surgery.

Undocumented Citizen - A national of another country who has entered or stayed in another country without permission

Appendix 4: Acronyms

- AIS: Abbreviated Injury Scale
- CDC: Centers for Disease Control and Prevention
- CPR: Cardiopulmonary resuscitation
- CT: Computerized tomography
- ED: Emergency department
- EMS: Emergency medical service
- GCS: Glasgow Coma Scale
- ICD-10: International Classification of Diseases, Tenth Revision
- ICD-10-CA: International Classification of Diseases, Tenth Revision, Canada
- ICD-10-CM: International Classification of Diseases, Tenth Revision, Clinical Modification
- ICD-10-PCS: International Classification of Diseases, Tenth Revision, Procedure Coding System
- ICU: Intensive care unit
- LOS: Length of stay
- NA: Not applicable
- NEMSIS: National Emergency Medical Services Information System
- NK/NR: Not known/not recorded
- NTDB: National Trauma Data Bank
- NTDS: National Trauma Data Standard
- OR: Operating room
- PACU: Post-anesthesia care unit
- TQIP: Trauma quality improvement program
- TQP: Trauma quality programs

Appendix 5: Indiana and NTDS Trauma Data Elements Comparison Table

Required elements are shaded in light blue.

Data Element Name	Required Element	Element Type	Page in 2026 NTDS Dictionary	Page in IDOH Dictionary
Demographic Information				
MEDICAL RECORD #	No	State		21
ACCOUNT NUMBER	No	State		22
INJURY INCIDENT DATE	Yes	National & State	15	23
INJURY INCIDENT TIME	Yes	National & State	16	24
PATIENT'S LAST NAME	No	State		25
PATIENT'S FIRST NAME	No	State		26
PATIENT'S MIDDLE INITIAL	No	State		27
PATIENT'S SOCIAL SECURITY #	No	State		28
DATE OF BIRTH	Yes	National & State	7	29
AGE (at date of incident)	Yes	National & State	8	30
AGE UNITS	Yes	National & State	9	31
RACE	Yes	National & State	10	32
OTHER RACE	No	State		33
ETHNICITY	Yes	National & State	11	34
SEX	Yes	National & State	12	35
HEIGHT	Yes	National & State	58	36
WEIGHT	Yes	National & State	59	37
PATIENT'S HOME ADDRESS	No	State		38
ADDRESS LINE 2	No	State		39
PATIENT'S HOME COUNTRY	Yes	National & State	2	40
PATIENT'S HOME ZIP/POSTAL CODE	Yes	National & State	1	41
PATIENT'S HOME CITY	Yes	National & State	5	42
PATIENT'S HOME COUNTY	Yes	National & State	4	43
PATIENT'S HOME STATE	Yes	National & State	3	44
PATIENT'S ALTERNATE RESIDENCE	Yes	National & State	6	45
PRIMARY METHOD OF PAYMENT	Yes	National & State	215	46
OTHER BILLING SOURCE	No	State		47
REIMBURSED CHARGES	No	State		48
SECONDARY METHOD OF PAYMENT	No	State		49

Appendix 5: List of Indiana and NTDB Data Elements

Data Element Name	Required Element	Element Type	Page in 2026 NTDS Dictionary	Page in IDOH Dictionary
SECONDARY OTHER BILLING SOURCE	No	State		50
THIRD METHOD OF PAYMENT	No	State		51
THIRD OTHER BILLING SOURCE	No	State		52
BILLED HOSPITAL CHARGES	No	State		53
WORK-RELATED	Yes	National & State	17	54
PATIENT'S OCCUPATIONAL INDUSTRY	Yes	National & State	18	55
PATIENT'S OCCUPATIONAL INDUSTRY DESCRIPTION	No	State		56
PATIENT'S OCCUPATION	Yes	National & State	19	57
PATIENT'S OCCUPATION DESCRIPTION	No	State		58
Injury Information				
INCIDENT COUNTRY	Yes	National & State	24	60
INCIDENT LOCATION ZIP/POSTAL CODE	Yes	National & State	23	61
INCIDENT CITY	Yes	National & State	27	62
INCIDENT COUNTY	Yes	National & State	26	63
INCIDENT STATE	Yes	National & State	25	64
ICD-10 LOCATION CODE	Yes	National & State	21	65
(Complaint) SUPPLEMENTAL CAUSE OF INJURY	No	State		66
INJURY DESCRIPTION	No	State		67
ICD-10 PRIMARY EXTERNAL CAUSE CODE	Yes	National & State	20	68
ICD-10 ADDITIONAL EXTERNAL CAUSE CODE	Yes	National & State	22	70
ICD-10 INTENTIONALITY	No	State		71
ICD-10 TRAUMA TYPE	No	State		72
BARRIERS TO PATIENT CARE	No	State		73
Pre-hospital Information				
ARRIVED FROM	Yes (manually entered cases)	State		75
TRANSPORTED TO YOUR FACILITY BY (EMS Transport Party)	Yes	National & State	31	76

Appendix 5: List of Indiana and NTDB Data Elements

Data Element Name	Required Element	Element Type	Page in 2026 NTDS Dictionary	Page in IDOH Dictionary
OTHER TRANSPORT MODE	No	National & State	32	77
INTUBATION PRIOR TO ARRIVAL	Yes	National & State	36	78
INTUBATION LOCATION	Yes	National & State	37	79
INTER-FACILITY TRANSFER	Yes	National & State	34	80
MASS CASUALTY INCIDENT	No	State		81
PREGNANCY (Pre-hospital)	No	State		82
LAW ENFORCEMENT/CRASH REPORT NUMBER	No	State		83
VEHICULAR INJURY INDICATORS	No	State		84
AREA OF THE VEHICLE IMPACTED	No	State		85
SEAT ROW LOCATION (of Patient in Vehicle)	No	State		86
POSITION OF PATIENT (in the seat of the vehicle)	No	State		87
HEIGHT OF FALL IN FEET	No	State		88
TRAUMA TRIAGE CRITERIA (Steps 1 and 2)	Yes	State		89
TRAUMA TRIAGE CRITERIA (Steps 3 and 4)	Yes	State		90
PROTECTIVE DEVICES (Safety Device Used)	Yes	National & State	28	91
CHILD SPECIFIC RESTRAINT	Yes	National & State	29	92
AIRBAG DEPLOYMENT	Yes	National & State	30	93
SAFETY (Equipment) DESCRIPTION	No	State		94
EMS RUN NUMBER	No	State		95
EMS PATIENT CARE REPORT (PCR) NUMBER	No	State		96
EMS PATIENT CARE REPORT UNIVERSALLY UNIQUE IDENTIFIER (UUID)	No	National & State	33	97
NAME OF EMS SERVICE	No	State		98
EMS DISPATCH DATE	Yes	State		99
EMS DISPATCH TIME	Yes	State		100
EMS EN ROUTE DATE	No	State		101
EMS EN ROUTE TIME	No	State		102

Appendix 5: List of Indiana and NTDB Data Elements

Data Element Name	Required Element	Element Type	Page in 2026 NTDS Dictionary	Page in IDOH Dictionary
(EMS Unit) ARRIVAL DATE AT SCENE OR TRANSFERRING FACILITY	Yes	State		103
(EMS Unit) ARRIVAL TIME AT SCENE OR TRANSFERRING FACILITY	Yes	State		104
PATIENT CONTACT DATE	No	State		105
PATIENT CONTACT TIME	No	State		106
(EMS Unit) DEPARTURE DATE FROM SCENE OR TRANSFERRING FACILITY	Yes	State		107
(EMS Unit) DEPARTURE TIME FROM SCENE OR TRANSFERRING FACILITY	Yes	State		108
UNIT ARRIVED HOSPITAL DATE	No	State		109
UNIT ARRIVED HOSPITAL TIME	No	State		110
(Pre-Hospital) DESTINATION DETERMINATION	No	State		111
TRIAGE DESTINATION PROTOCOL	No	State		112
EMS STATUS	Yes (manually entered cases)	State		113
PRE-HOSPITAL CARDIAC ARREST	Yes	National & State	35	114
(Pre-Hospital) CPR PERFORMED	No	State		115
(Pre-Hospital Thoracentesis)/TUBE THORACOSTOMY	No	State		116
(Pre-Hospital) NEEDLE THORACOSTOMY	No	State		117
(Pre-Hospital) AIRWAY MANAGEMENT	No	State		118
(Pre-Hospital) FLUIDS	No	State		119
(Pre-Hospital) MEDICATIONS	No	State		120
TEMPERATURE MAINTAINED	No	State		121
APPROPRIATE WOUND MANAGEMENT	No	State		122
(Pre-Hospital) VITALS DATE	No	State		123

Data Element Name	Required Element	Element Type	Page in 2026 NTDS Dictionary	Page in IDOH Dictionary
(Pre-Hospital) VITALS TIME	No	State		124
(Initial Field) SYSTOLIC BLOOD PRESSURE	Yes	State		125
(Initial Field) DIASTOLIC BLOOD PRESSURE	No	State		126
(Initial Field) PULSE RATE	Yes	State		127
(Initial Field) SP02 (Oxygen Saturation)	Yes	State		128
(Initial Field) RESPIRATORY RATE	Yes	State		129
(Pre-Hospital) RESPIRATORY ASSISTANCE	No	State		130
(Pre-Hospital Revised Trauma Score) RTS (Total)	No	State		131
(Pre-Hospital) Pediatric Trauma Score (PTS) (Total)	No	State		132
INITIAL FIELD GCS - EYE	Yes	State		133
INITIAL FIELD GCS - VERBAL	Yes	State		134
INITIAL FIELD GCS - MOTOR	Yes	State		135
(Initial Field) GCS QUALIFIER (UP TO 3)	No	State		136
INITIAL FIELD GCS - TOTAL	Yes	State		137
INITIAL FIELD GCS 40- EYE	Yes	State		138
INITIAL FIELD GCS 40- VERBAL	Yes	State		139
INITIAL FIELD GCS 40- MOTOR	Yes	State		140
GCS 40 MANUAL TOTAL	No	State		141
(Pre-Hospital) AVPU	No	State		142
ED/Acute Care Information				
DIRECT ADMIT TO HOSPITAL	No	State		144
DATE ARRIVED IN ED/ACUTE CARE	Yes	National & State	41	145
TIME ARRIVED IN ED/ACUTE CARE	Yes	National & State	42	146
TRAUMA TEAM ACTIVATED	No	State		147
HIGHEST ACTIVATION	Yes	National & State	38	148
DATE TRAUMA TEAM ACTIVATED	No	State		149
TIME TRAUMA TEAM ACTIVATED	No	State		150

Data Element Name	Required Element	Element Type	Page in 2026 NTDS Dictionary	Page in IDOH Dictionary
TEAM MEMBER	No	State		151
(Trauma Team Member) SERVICE TYPE	No	State		152
DATE (Trauma Team Member) CALLED	No	State		153
TIME (Trauma Team Member) CALLED	No	State		154
DATE (Trauma Team Member) ARRIVED	No	State		155
TIME (Trauma Team Member) ARRIVED	No	State		156
(Trauma Team) TIMELY ARRIVAL	No	State		157
TRAUMA SURGEON ARRIVAL DATE	Yes	National & State	39	158
TRAUMA SURGEON ARRIVAL TIME	Yes	National & State	40	159
PRIMARY TRAUMA SERVICE TYPE	Yes	National & State	66	160
PRIMARY MEDICAL EVENT	Yes	National & State	67	161
ADMITTING MD/STAFF	No	State		162
ADMITTING SERVICE	No	State		163
CONSULTING SERVICES	No	State		164
(CONSULTING) SERVICE TYPE	No	State		165
CONSULTING STAFF	No	State		166
DATE (Consulting Practitioner Requested)	No	State		167
TIME (Consulting Practitioner Requested)	No	State		168
DATE DISCHARGED FROM ED (ORDERS WRITTEN)	Yes	National & State	64	169
TIME DISCHARGED FROM ED (ORDERS WRITTEN)	Yes	National & State	65	170
DATE DISCHARGED FROM ED (PHYSICAL EXIT)	Yes	State		171
TIME DISCHARGED FROM ED (PHYSICAL EXIT)	Yes	State		172
ED DISCHARGE DISPOSITION	Yes	National & State	63	173
HOSPITAL TRANSFERRED TO	Yes	State		174

Data Element Name	Required Element	Element Type	Page in 2026 NTDS Dictionary	Page in IDOH Dictionary
DISCHARGE TRANSPORT MODE	Yes	State		175
TRANSFER DELAY	Yes (for non-trauma centers)	State		176
REASON FOR TRANSFER DELAY	No	State		177
REASON FOR TRANSFER DELAY – Communication Issue	No	State		178
REASON FOR TRANSFER DELAY - Delay Issue	No	State		179
REASON FOR TRANSFER DELAY - EMS Issue	No	State		180
REASON FOR TRANSFER DELAY - Equipment Issue	No	State		181
REASON FOR TRANSFER DELAY - Error Issue	No	State		182
REASON FOR TRANSFER DELAY - Patient Issue	No	State		183
REASON FOR TRANSFER DELAY - Receiving Facility Issue	No	State		184
REASON FOR TRANSFER DELAY - Referring Facility Issue	No	State		185
REASON FOR TRANSFER DELAY - Transportation Issue	No	State		186
REASON FOR TRANSFER DELAY - Weather or Natural Issue	No	State		187
OTHER REASON FOR TRANSFER DELAY	No	State		188
Initial Assessment Information				
(Initial ED/Hospital) VITALS DATE	No	State		190
(Initial ED/Hospital) VITALS TIME	No	State		191
INITIAL ED/HOSPITAL SYSTOLIC BLOOD PRESSURE	Yes	National & State	43	192
INITIAL ED/HOSPITAL DIASTOLIC BLOOD PRESSURE	No	State		193
INITIAL ED/HOSPITAL PULSE RATE	Yes	National & State	44	194

Data Element Name	Required Element	Element Type	Page in 2026 NTDS Dictionary	Page in IDOH Dictionary
INITIAL ED/HOSPITAL TEMPERATURE	Yes	National & State	45	195
INITIAL ED/HOSPITAL TEMPERATURE ROUTE	No	State		196
INITIAL ED/HOSPITAL SP02 (Oxygen Saturation)	Yes	National & State	48	197
INITIAL ED/HOSPITAL RESPIRATORY RATE	Yes	National & State	46	198
INITIAL ED/HOSPITAL RESPIRATORY ASSISTANCE	Yes	National & State	47	199
INITIAL ED/HOSPITAL SUPPLEMENTAL OXYGEN	Yes	National & State	49	200
(Initial ED/hospital Revised Trauma Score) RTS (Total)	No	State		201
(Initial ED/hospital Pediatric Trauma Score) PTS (Total)	No	State		202
INITIAL ED/HOSPITAL GCS - EYE	Yes	National & State	50	203
INITIAL ED/HOSPITAL GCS - VERBAL	Yes	National & State	51	204
INITIAL ED/HOSPITAL GCS - MOTOR	Yes	National & State	52	205
INITIAL ED/HOSPITAL GCS ASSESSMENT QUALIFIERS (UP TO 3)	Yes	National & State	54	206
INITIAL ED/HOSPITAL MANUAL GCS TOTAL	Yes	State		208
INITIAL ED/HOSPITAL GCS 40 – EYE	Yes	National & State	55	209
INITIAL ED/HOSPITAL GCS 40 – VERBAL	Yes	National & State	56	210
INITIAL ED/HOSPITAL GCS 40 – MOTOR	Yes	National & State	57	211
(Initial ED/Hospital) GCS 40 MANUAL TOTAL	No	State		213
(Initial ED/Hospital) ED AVPU	No	State		214
INITIAL ED/HOSPITAL AIRWAY MANAGEMENT	No	State		215
INITIAL ED/HOSPITAL CPR PERFORMED	No	State		216
UNITS OF BLOOD	No	State		217

Data Element Name	Required Element	Element Type	Page in 2026 NTDS Dictionary	Page in IDOH Dictionary
BLOOD ORDERED DATE	No	State		218
BLOOD ORDERED TIME	No	State		219
CROSSMATCH DATE	No	State		220
CROSSMATCH TIME	No	State		221
BLOOD ADMINISTERED DATE	No	State		222
BLOOD ADMINISTERED TIME	No	State		223
ALCOHOL SCREEN	Yes	National & State	61	224
ALCOHOL SCREEN RESULTS (Blood Alcohol Content)	Yes	National & State	62	225
DRUG SCREEN	Yes	National & State	60	226
(Initial ED/Hospital) BASE DEFICIT	No	State		227
(Initial ED/Hospital) DATE SENT TO CT	No	State		228
(Initial ED/Hospital) TIME SENT TO CT	No	State		229
(Initial ED/Hospital) CT HEAD (Results)	No	State		230
(Initial ED/Hospital) CT ABD/PELVIS (Results)	No	State		231
(Initial ED/Hospital) CT CHEST (Results)	No	State		232
(Initial ED/Hospital) CT CERVICAL (Results)	No	State		233
(Initial ED/Hospital) ABDOMINAL ULTRASOUND DATE	No	State		234
(Initial ED/Hospital) ABDOMINAL ULTRASOUND TIME	No	State		235
(Initial ED/Hospital) ABDOMINAL ULTRASOUND	No	State		236
(Initial ED/Hospital) ARTERIOGRAM (Results)	No	State		237
(Initial ED/Hospital) AORTOGRAM (Results)	No	State		238
Diagnosis Information				
ICD-10 INJURY DIAGNOSIS	Yes	National & State	138	240
AIS CODE	Yes	National & State	139	241
DIAGNOSIS COMMENTS	No	State		242

Appendix 5: List of Indiana and NTDB Data Elements

Data Element Name	Required Element	Element Type	Page in 2026 NTDS Dictionary	Page in IDOH Dictionary
AIS VERSION	Yes	National & State	140	243
ISS (Body) REGION	No	State		244
AIS BASED INJURY SEVERITY SCORES BY DIAGNOSIS	Yes	State		245
MANUAL (Locally Calculated ISS)	Yes	State		246
Procedures Information				
PROCEDURE PERFORMED	Yes (manually entered cases)	State		248
ICD-10 HOSPITAL PROCEDURES	Yes	National & State	68	249
(Procedure Performed) LOCATION	No	State		251
(Physician Performing the Procedure) STAFF	No	State		252
(Hospital Procedure) DATE PERFORMED	Yes	National & State	70	253
(Hospital Procedure Start) TIME PERFORMED	Yes	National & State	71	254
SERVICE TYPE (of the Physician)	No	State		255
(Procedure) COMMENTS	No	State		256
RESOURCE UTILIZATION	No	State		257
Hospital Events				
ACUTE KIDNEY INJURY (AKI)	Yes	National & State	141	259
ACUTE RESPIRATORY DISTRESS SYNDROME (ARDS)	Yes	National & State	143	261
ALCOHOL WITHDRAWAL SYNDROME	Yes	National & State	145	262
CARDIAC ARREST WITH CPR	Yes	National & State	147	263
CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI)	Yes	National & State	149	264
CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION (CLABSI)	Yes	National & State	155	266
DEEP SURGICAL SITE INFECTION	Yes	National & State	160	269
DEEP VEIN THROMBOSIS (DVT)	Yes	National & State	165	271

Appendix 5: List of Indiana and NTDB Data Elements

Data Element Name	Required Element	Element Type	Page in 2026 NTDS Dictionary	Page in IDOH Dictionary
DELIRIUM	Yes	National & State	167	272
MYOCARDIAL INFARCTION (MI)	Yes	National & State	169	273
ORGAN/SPACE SURGICAL SITE INFECTION	Yes	National & State	171	274
OSTEOMYELITIS	Yes	National & State	175	276
PRESSURE ULCER	Yes	National & State	177	278
PULMONARY EMBOLISM (PE)	Yes	National & State	179	279
SEVERE SEPSIS	Yes	National & State	181	280
STROKE/CVA	Yes	National & State	183	281
SUPERFICIAL INCISIONAL SURGICAL SITE INFECTION	Yes	National & State	185	283
UNPLANNED ADMISSION TO ICU	Yes	National & State	188	285
UNPLANNED INTUBATION	Yes	National & State	190	286
UNPLANNED RETURN TO THE OPERATING ROOM	Yes	National & State	192	287
VENTILATOR-ASSOCIATED PNEUMONIA (VAP)	Yes	National & State	194	288
Pre-existing Conditions				
ATTENTION DEFICIT DISORDER/ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADD/ADHD)	Yes	National & State	78	290
ADVANCE DIRECTIVE LIMITING CARE	Yes	National & State	72	291
ANTICOAGULANT THERAPY	Yes	National & State	76	292
AUTISM SPECTRUM DISCORDER (ASD)	Yes	National & State	80	293
BLEEDING DISORDER	Yes	National & State	84	294
CEREBRAL VASCULAR ACCIDENT (CVA)	Yes	National & State	88	295
CHRONIC RENAL FAILURE	Yes	National & State	92	296
CIRRHOSIS	Yes	National & State	94	297
MYOCARDIAL INFARCTION (MI)	Yes	National & State	116	298
CONGESTIVE HEART FAILURE (CHF)	Yes	National & State	98	299
CURRENTLY RECEIVING CHEMOTHERAPY FOR CANCER	Yes	National & State	102	300
CURRENT SMOKER	Yes	National & State	100	301

Data Element Name	Required Element	Element Type	Page in 2026 NTDS Dictionary	Page in IDOH Dictionary
DEMENTIA	Yes	National & State	104	302
DIABETES MELLITUS	Yes	National & State	106	303
DISSEMINATED CANCER	Yes	National & State	108	304
FUNCTIONALLY DEPENDENT HEALTH STATUS	Yes	National & State	110	305
HYPERTENSION	Yes	National & State	112	306
PREGNANCY	Yes	National & State	124	307
STEROID USE	Yes	National & State	132	308
VENTILATOR DEPENDENCE	Yes	National & State	137	309
ALCOHOL USE DISORDER	Yes	National & State	74	310
BIPOLAR I/II DISORDER	Yes	National & State	82	311
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)	Yes	National & State	90	312
MAJOR DEPRESSIVE DISORDER	Yes	National & State	114	313
OTHER MENTAL/PERSONALITY DISORDERS	Yes	National & State	118	314
PERIPHERAL ARTERIAL DISEASE (PAD)	Yes	National & State	120	315
POST-TRAUMATIC STRESS DISORDER	Yes	National & State	122	316
SCHIZOAFFECTIVE DISORDER	Yes	National & State	128	317
SCHIZOPHRENIA	Yes	National & State	130	318
SUBSTANCE USE DISORDER	Yes	National & State	134	319
BRONCHOPULMONARY DYSPLASIA/CHRONIC LUNG DISEASE	Yes	National & State	86	321
CONGENITAL ANOMALIES	Yes	National & State	96	322
PREMATURITY	Yes	National & State	126	323
Outcome Information				
HOSPITAL DISCHARGE SERVICE	No	State		325
HOSPITAL ADMISSION DATE	No	State		326
HOSPITAL ADMISSION TIME	No	State		327
HOSPITAL DISCHARGE DATE (ORDERS WRITTEN)	Yes	National & State	213	328
HOSPITAL DISCHARGE TIME (ORDERS WRITTEN)	Yes	National & State	214	329
HOSPITAL DISCHARGE DATE (PHYSICAL EXIT)	No	State		330

Data Element Name	Required Element	Element Type	Page in 2026 NTDS Dictionary	Page in IDOH Dictionary
HOSPITAL DISCHARGE TIME (PHYSICAL EXIT)	No	State		331
TOTAL ICU DAYS	Yes	National & State	208	332
TOTAL VENTILATOR DAYS	Yes	National & State	210	333
DISABILITY AT DISCHARGE - FEEDING	No	State		334
DISABILITY AT DISCHARGE - LOCOMOTION	No	State		335
DISABILITY AT DISCHARGE - EXPRESSION (MOTOR)	No	State		336
DISABILITY AT DISCHARGE - FIM SCORE	No	State		337
HOSPITAL DISCHARGE DISPOSITION	Yes	National & State	212	338
HOSPITAL DESTINATION DETERMINATION	No	State		340
HOSPITAL TRANSFERRED TO	Yes (manually entered cases)	State		341
(Other) FACILITY (Transferred to)	No	State		342
(Other) CITY (Transferred to)	No	State		343
(Other) STATE (Transferred to)	No	State		344
(Discharge) TRANSPORT MODE	No	State		345
DATE OF DEATH	No	State		346
TIME OF DEATH	No	State		347
LOCATION OF DEATH	No	State		348
DEATH CIRCUMSTANCE	No	State		349
OTHER (Death Circumstance) DESCRIPTION	No	State		350
ORGAN DONATION	No	State		351
AUTOPSY PERFORMED	No	State		352
ADVANCED DIRECTIVE	No	State		353
Complications/Performance Improvement				
(Complication PI Overview) PI NURSE	No	State		355
(Complication PI Overview) MEDICAL RECORD INJURY CATEGORIES	No	State		356

Data Element Name	Required Element	Element Type	Page in 2026 NTDS Dictionary	Page in IDOH Dictionary
(Complication PI Overview) INCIDENT OVERVIEW	No	State		358
(Complication Hospital Events) COMPLICATION	No	State		359
(Complication Hospital Events Overview) OCCURRENCE DATE	No	State		360
(Complication Hospital Events Overview) OCCURRENCE TIME	No	State		361
(Complication Hospital Events Overview) LOCATION OF OCCURRENCE	No	State		362
(Complication Hospital Events Overview) COMPLICATION STAFF INVOLVED	No	State		363
(Complication Hospital Events Overview) SOURCE	No	State		364
(Complication Hospital Events Overview) GROUP	No	State		365
(Complication Hospital Events Overview) FURTHER EXPLANATION/ACTION	No	State		366
(Complication Hospital Events) LAST REVIEW TYPE	No	State		367
(Hospital Event Review Notes) STAFF	No	State		368
(Hospital Event Review Notes) TYPE	No	State		369
(Hospital Event Review Notes) SOURCE	No	State		370
(Hospital Event Review Notes) GROUP	No	State		371
(Hospital Event Review Notes) NOTE	No	State		372
(Hospital Event Decisions) DETERMINATION	No	State		373
(Hospital Event Decisions) PREVENTABILITY	No	State		373
(Hospital Event Decisions) FINDINGS	No	State		375

Data Element Name	Required Element	Element Type	Page in 2026 NTDS Dictionary	Page in IDOH Dictionary
(Hospital Event Decisions) ACTIONS	No	State		376
(Hospital Event Decisions) OTHER ACTIONS	No	State		377
(Hospital Event Decisions) STATUS	No	State		378
(Performance Improvement Audit) NO PI AUDIT FILTERS	No	State		379
(Performance Improvement Audit) AUDIT	No	State		380
(Performance Improvement Audit) LAST REVIEW TYPE	No	State		381
(Performance Improvement Audit Overview) OCCURRENCE DATE	No	State		382
(Performance Improvement Audit Overview) OCCURRENCE TIME	No	State		383
(Performance Improvement Audit Overview) LOCATION OF OCCURRENCE	No	State		384
(Performance Improvement Audit Overview) AUDIT STAFF INVOLVED	No	State		385
(Performance Improvement Audit Overview) SOURCE	No	State		386
(Performance Improvement Audit Overview) GROUP	No	State		387
(Performance Improvement Audit Overview) FURTHER EXPLANATION/ACTION	No	State		388
(Performance Improvement Notes) STAFF	No	State		389
(Performance Improvement Notes) TYPE	No	State		390
(Performance Improvement Notes) GROUP	No	State		391
(Performance Improvement Notes) SOURCE	No	State		392

Data Element Name	Required Element	Element Type	Page in 2026 NTDS Dictionary	Page in IDOH Dictionary
(Performance Improvement Notes) NOTE	No	State		393
(Performance Improvement Decisions) DETERMINATION	No	State		394
(Performance Improvement Decisions) PREVENTABILITY	No	State		395
(Performance Improvement Decisions) FINDINGS	No	State		396
(Performance Improvement Decisions) ACTIONS	No	State		397
(Performance Improvement Decisions) MORTALITY	No	State		398
(Performance Improvement Decisions) STATUS	No	State		399
Trauma Quality Improvement Program (TQIP) Measures (Trauma Levels I and II Only)				
HIGHEST GCS TOTAL	No	National & State	216	401
HIGHEST GCS MOTOR	No	National & State	218	402
GCS ASSESSMENT QUALIFIER OF HIGHEST GCS TOTAL	No	National & State	220	403
HIGHEST GCS 40 – MOTOR	No	National & State	223	405
INITIAL ED/HOSPITAL PUPILLARY RESPONSE	No	National & State	226	407
MIDLINE SHIFT	No	National & State	228	408
CEREBRAL MONITOR	No	National & State	230	409
CEREBRAL MONITOR DATE	No	National & State	232	410
CEREBRAL MONITOR TIME	No	National & State	234	411
VENOUS THROMBOEMBOLISM PROPHYLAXIS TYPE	No	National & State	236	412
VENOUS THROMBOEMBOLISM PROPHYLAXIS DATE	No	National & State	238	414
VENOUS THROMBOEMBOLISM PROPHYLAXIS TIME	No	National & State	240	415
PACKED RED BLOOD CELLS	No	National & State	242	416
WHOLE BLOOD	No	National & State	244	417
PLASMA	No	National & State	246	418
PLATELETS	No	National & State	248	419
CRYOPRECIPITATE (4 HOURS)	No	National & State	250	420
ANGIOGRAPHY	No	National & State	252	421
EMBOLIZATION SITE	No	National & State	254	422

Data Element Name	Required Element	Element Type	Page in 2026 NTDS Dictionary	Page in IDOH Dictionary
ANGIOGRAPHY DATE	No	National & State	256	423
ANGIOGRAPHY TIME	No	National & State	258	424
SURGERY FOR HEMORRHAGE CONTROL TYPE	No	National & State	260	425
SURGERY FOR HEMORRHAGE CONTROL DATE	No	National & State	262	426
SURGERY FOR HEMORRHAGE CONTROL TIME	No	National & State	264	427
WITHDRAWAL OF LIFE SUPPORTING TREATMENT	No	National & State	266	428
WITHDRAWAL OF LIFE SUPPORTING TREATMENT DATE	No	National & State	268	429
WITHDRAWAL OF LIFE SUPPORTING TREATMENT TIME	No	National & State	270	430
ANTIBIOTIC THERAPY	No	National & State	272	431
ANTIBIOTIC THERAPY DATE	No	National & State	274	432
ANTIBIOTIC THERAPY TIME	No	National & State	276	433

Appendix 6: Data Element Edit Checks

Within the Indiana Trauma Registry, validity rules generate error messages that flag problems with the data, such as missingness for required data elements and values that are out of the valid range or logically impossible. For Indiana data elements that are also national data elements, users are also encouraged to refer to the NTDS edit checks documented in the 2026 NTDS Data Dictionary.

A list of additional edit checks conducted by IDOH is below. This list may be modified over time to reflect new or updated data quality priorities. Users should refer to the user guide sent along with quarterly data quality reports for the most up-to-date list of IDOH edit checks.

Table 1. Indiana Trauma Registry Edit Checks

Domain	Data Element	Tier 1 Edit Checks (Errors)	Tier 2 Edit Checks (Warnings)
Demographics	Patient date of birth	• Cannot be missing • Cannot be later than incident date, ED admission date, or facility admission date	
Demographics	Patient age	• Cannot be <0 or >120 years	• Age is greater than expected for the age units specified. Age should not exceed 60 minutes, 24 hours, 30 days, 24 months, or 120 years.
Demographics	Patient sex	• Cannot be missing • Cannot be "not applicable"	
Demographics	Patient race	• Cannot be missing • Cannot be "not applicable" • Patient race is marked as "not known" or "not applicable" along with another race value	
Demographics	Patient home zip code	• Cannot be missing	

Appendix 6: Data Element Edit Checks

Table 1. Indiana Trauma Registry Edit Checks

Domain	Data Element	Tier 1 Edit Checks (Errors)	Tier 2 Edit Checks (Warnings)
Demographics	Patient home state	• Patient has an Indiana home ZIP code but patient home state is not listed as Indiana. • Patient does not have an Indiana ZIP code but patient home state listed is Indiana.	
Demographics	Patient home county	• Patient state is Indiana but patient county listed is not an Indiana county.	
Demographics	Primary method of patient	• Cannot be missing • Cannot be "not applicable"	
Injury/incident information	Incident date	• Cannot be missing • Cannot be after ED/acute care admission date • Cannot be after facility admission date	• Incident date is >14 days before ED/acute care admission date
Injury/incident information	Incident time	• Cannot be after ED/acute care admission time • Cannot be after facility admission time	
Injury/incident information	External cause of injury ICD-10-CM code	• Cannot be missing • ICD-10-CM code must be a valid external cause of injury code	• ICD-10-CM code must be sufficiently specific to classify cause of injury
Pre-hospital	Arrived from	• Cannot be missing • Cannot be "not applicable"	
Pre-hospital	Transport to facility by	• Cannot be missing • Cannot be "not applicable"	
Pre-hospital	EMS notified date/time	• Cannot be later than EMS arrived on scene date/time • Cannot be later than ED admission date/time	• EMS notified date/time is equal to ED admission date/time • EMS notified date/time is >2 hours before ED admission date/time

Appendix 6: Data Element Edit Checks

Table 1. Indiana Trauma Registry Edit Checks

Domain	Data Element	Tier 1 Edit Checks (Errors)	Tier 2 Edit Checks (Warnings)
Pre-hospital	EMS arrived on scene date/time	• Cannot be earlier than EMS notified date/time • Cannot be later than EMS left scene date/time	• Time EMS arrived on scene is equal to time EMS notified • EMS arrived on scene date/time is >1 hour after EMS notified date/time
Pre-hospital	EMS left scene date/time	• Cannot be earlier than EMS arrival on scene date/time • Cannot be later than EMS arrival at destination date/time • Cannot be later than ED admission date/time	• Time EMS left scene is equal to time EMS arrived on scene • Time EMS left scene is >1 hour after EMS arrived on scene • Time EMS left scene is equal to time EMS arrived at destination • Time EMS left scene is equal to ED admission time • Time EMS left scene is >2 hours before ED admission time
Pre-hospital	EMS at destination	• Cannot be earlier than EMS left scene date/time • Cannot be later than ED/acute care admission date/time	• EMS arrival at destination date/time is >2 hours after EMS left scene date/time
Initial assessment	Glasgow Coma Scale (GCS)	• All components of GCS or GCS-40 are missing or not applicable, and the manual total GCS or GCS-40 is not reported (Note: Facilities should report GCS or GCS-40, not both.)	
Initial assessment	Pulse rate	• Cannot be missing • Cannot be outside of valid range (0-300)	• Pulse rate <30 • Pulse rate >220

Appendix 6: Data Element Edit Checks

Table 1. Indiana Trauma Registry Edit Checks

Domain	Data Element	Tier 1 Edit Checks (Errors)	Tier 2 Edit Checks (Warnings)
Initial assessment	Respiratory rate	• Cannot be missing • Cannot be outside of valid range (0-100)	• Respiratory rate <5 • Respiratory rate >75
Initial assessment	Systolic blood pressure (SBP)	• Cannot be missing • Cannot be outside of valid range (0-380)	• SBP < 30 • SBP >220
Injury diagnosis	Injury diagnosis ICD-10-CM code	• Cannot be missing • Must have at least one ICD10-CM diagnosis code corresponding to NTDS trauma inclusion criteria	
Injury diagnosis	AIS Codes/Injury severity score (ISS)	• AIS codes cannot be missing	• ISS is 0 (along with non-missing AIS codes)
ED information	ED/acute care admission date	• Cannot be missing • Cannot be earlier than incident date • Cannot be later than ED/acute care discharge date • Cannot be later than facility discharge date	• ED/acute care admission date is >14 days after incident date
ED information	ED/acute care admission time	• Cannot be missing • Cannot be earlier than incident date/time	
ED information	ED/acute care discharge date (orders written)	• Cannot be missing (unless patient was directly admitted) • Cannot be earlier than ED/acute care admission date	
ED information	ED/acute care discharge time (orders written)	• Cannot be missing (unless patient was directly admitted)	• Time from ED/acute care admission to ED discharge (orders written) is >24 hours

Appendix 6: Data Element Edit Checks

Table 1. Indiana Trauma Registry Edit Checks

Domain	Data Element	Tier 1 Edit Checks (Errors)	Tier 2 Edit Checks (Warnings)
		• Cannot be earlier than ED/acute care admission time	• Time of ED/acute care admission is equal to time of ED discharge (orders written)
ED information	ED/acute care discharge date (physical exit)	• Cannot be missing (unless patient was directly admitted) • Cannot be earlier than ED/acute care admission date	
ED information	ED/acute care discharge time (physical exit)	• Cannot be missing (unless patient was directly admitted) • Cannot be earlier than ED/acute care admission time • Cannot be earlier than ED/acute care discharge orders written time	• Time from ED/acute care admission to ED discharge (physical exit) is >24 hours • Time of ED/acute care admission is equal to time of ED discharge • (physical exit) • ED discharge (physical exit) time is equal to ED discharge orders written time
ED information	Facility transferred to		• Name of facility the patient was transferred to is missing (transferred patients only)
ED information	ED discharge disposition	• Cannot be missing • Cannot be "not applicable" (unless patient was directly admitted) • If patient was not an interfacility transfer, ED disposition should not be any of the following: o Home with services o Other (jail, institutional care, mental health, etc.) o Home without services	• ED discharge disposition is not known or not known/not recorded

Table 1. Indiana Trauma Registry Edit Checks

Domain	Data Element	Tier 1 Edit Checks (Errors)	Tier 2 Edit Checks (Warnings)
		o Left against medical advice	
Facility admission information	Facility admission date	• Cannot be missing (if patient was admitted and was not a direct admission) • Facility admission date is earlier than ED/acute care admission date	
Facility admission information	Facility admission time	• Cannot be missing (if patient was admitted and was not a direct admission) • Facility admission time is earlier than ED/acute care admission time	
Facility admission information	Facility discharge date	• Cannot be missing (if patient was admitted) • Cannot be earlier than ED/acute care admission date • Cannot be earlier than facility admission date	• Facility discharge date is >365 days after facility admission date • Facility discharge date is >365 days after ED admission date
Facility admission information	Facility discharge time	• Cannot be missing (if patient was admitted) • Cannot be earlier than ED/acute care admission time • Cannot be earlier than facility admission time	
Facility admission information	Facility discharge disposition	• Cannot be missing • Cannot be "not applicable" if patient was admitted • Must be "not applicable" if patient was transferred from the ED, discharged to home or another institution from the ED, left AMA from the ED, or died in the ED.	• Facility discharge disposition is "not known" or "not known/not recorded"