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Section: Demographic/Record Info/Patient/Relative-Guardian

1. The trauma number will auto-populate when the chart is created.
2. Record Tab: The “Record Created By” will auto-populate to user logged in and creating the chart.
3. Record Tab: The facility name and number will auto-populate
4. Patient tab: The name of the patient will transfer over from the Record Info Tab.
5. Patient Tab: City FIPS, state, county and country are auto-populated after entering the zip code.
**MANDATORY NTDS definition fields denoted with BLUE FONT**

Additional clarification from NTDS:

**COMMON NULL VALUES**

<table>
<thead>
<tr>
<th>Definition</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field Values</td>
<td></td>
</tr>
<tr>
<td>1 Not Applicable</td>
<td></td>
</tr>
<tr>
<td>2 Not Known/Not Recorded</td>
<td></td>
</tr>
</tbody>
</table>

Additional Information:
- For any collection of data to be of value and reliability represent what was intended, a strong commitment must be made to ensure the correct documentation of incomplete data. When data elements are encoded with the National 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: This null value applies if, at the time of patient care documentation, information was "Not Known" to the patient, family, health care provider(s), 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).

References to Other Databases:
- Compare with NHTSA V.2.10 - E00
Initial Location

**Definition**

Where the patient was initially treated when they arrived to the facility.

**Element Values: DI Dropdown Menu**

1. Resuscitation room
2. Emergency Department
3. Operating Room
4. Intensive Care Unit
5. Step-Down Unit
6. Floor
7. Telemetry Unit
8. Observation Unit
9. Burn Unit
10. This number missing an element
11. Post Anesthesia Care Unit
12. Special Procedure Unit
13. Labor and Delivery
14. Unknown

**Data Source Hierarchy Guide**

1. ADT Events
2. Encounter Report (EMR)
3. Nursing Notes
4. Triage – Arrival information
5. H&P
Patient Arrival Date: **MANDATORY BLUE FIELD; NTDS Definition rules follow.**

**Definition**

The date that the patient arrived to your facility.

**Element Values**

1. Relevant value for data element

**Data source Hierarchy Guide**

1. ADT Events
2. Triage – Arrival information
3. Face Sheet
4. EMS Run Sheet
5. ED Patient Care Timeline
6. H&P
7. Billing sheet
Additional Information
- If the patient was brought to the ED, report date patient arrived at ED. If patient was directly admitted to the hospital, report date patient was admitted to the hospital.
- Reported as YYYY-MM-DD.

Associated Edit Checks

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>4501</td>
<td>1</td>
<td>Date is not valid</td>
</tr>
<tr>
<td>4502</td>
<td>1</td>
<td>Date out of range</td>
</tr>
<tr>
<td>4503</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>4505</td>
<td>2</td>
<td>Element cannot be “Not Known/Not Recorded”</td>
</tr>
<tr>
<td>4506</td>
<td>3</td>
<td>ED/Hospital Arrival Date is earlier than EMS Dispatch Date</td>
</tr>
<tr>
<td>4507</td>
<td>3</td>
<td>ED/Hospital Arrival Date is earlier than EMS Unit Arrival on Scene Date</td>
</tr>
<tr>
<td>4508</td>
<td>3</td>
<td>ED/Hospital Arrival Date is earlier than EMS Unit Scene Departure Date</td>
</tr>
<tr>
<td>4509</td>
<td>2</td>
<td>ED/Hospital Arrival Date is later than ED Discharge Date</td>
</tr>
<tr>
<td>4510</td>
<td>2</td>
<td>ED/Hospital Arrival Date is later than Hospital Discharge Date</td>
</tr>
<tr>
<td>4511</td>
<td>2</td>
<td>ED/Hospital Arrival Date is earlier than Date of Birth</td>
</tr>
<tr>
<td>4513</td>
<td>3</td>
<td>ED/Hospital Arrival Date minus Injury Incident Date is more than 14 days</td>
</tr>
<tr>
<td>4515</td>
<td>2</td>
<td>Element cannot be “Not Applicable”</td>
</tr>
<tr>
<td>4540</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
**Patient Arrival Time:** Mandatory Blue Field; NTDS Definition rules follow.

**Definition**

The time that the patient arrived to your facility.

**Note:** If the patient was brought to the ED, report time patient arrived at ED. If patient was directly admitted to the hospital, report time patient was admitted to the hospital.

**Element Values**

1. Relevant value for data element

**Data Source Hierarchy Guide**

1. ADT Events
2. Triage – Arrival Information
3. Face Sheet
4. ED Patient Care Timeline
5. EMS Run Sheet
6. H&P
<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>4601</td>
<td>1</td>
<td>Time is not valid</td>
</tr>
<tr>
<td>4602</td>
<td>1</td>
<td>Time out of range</td>
</tr>
<tr>
<td>4603</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>4604</td>
<td>3</td>
<td>ED/Hospital Arrival Time is earlier than EMS Dispatch Time</td>
</tr>
<tr>
<td>4605</td>
<td>3</td>
<td>ED/Hospital Arrival Time is earlier than EMS Unit Arrival on Scene Time</td>
</tr>
<tr>
<td>4606</td>
<td>3</td>
<td>ED/Hospital Arrival Time is earlier than EMS Unit Scene Departure Time</td>
</tr>
<tr>
<td>4607</td>
<td>3</td>
<td>ED/Hospital Arrival Time is later than ED Discharge Time</td>
</tr>
<tr>
<td>4608</td>
<td>2</td>
<td>ED/Hospital Arrival Time is later than Hospital Discharge Time</td>
</tr>
<tr>
<td>4609</td>
<td>2</td>
<td>Element cannot be &quot;Not Applicable&quot;</td>
</tr>
<tr>
<td>4640</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Medical Record Number

**Definition**

Number assigned to patient (MRN): Every patient’s number is unique to them and is the same for every visit.

**Element Values**

- Relevant value for data element

**Data Source Hierarchy Guide:**

1. Face Sheet
2. EMR Banner
Account Number

Definition

Patient number assigned for that specific encounter: primarily used for billing and coding.

Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Face Sheet
Patient Name

Definition

Patient’s legal name.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

- Face Sheet
- Snapshot – Demographics
- EMR Patient Banner
Patient Origin

Definition

Where the patient came from prior to being transported to your facility

Element Values - DI dropdown screen

1. Scene
2. Referring Hospital
3. Physician’s Office/Urgent Care
4. Extended Care Facility
5. Unknown

Data Source Hierarchy Guide

1. H&P
2. Nursing notes
3. Media tab
4. Scanned documents
5. EMS Run Sheet
6. Referring hospital information
Inclusion Source:

Definition

Reason why the patient was included in the trauma registry: where or how it was determined that the patient should be included in the organization’s trauma registry. These may be based off the NTDS Patient Inclusion Criteria or organizational registry criteria.

Element Values: DI dropdown screen

1. Dead on scene
2. Prehospital
3. Emergency Department
4. Acute Care Facility Transfer
5. Service Transfer
6. Retrospective Review
7. Not Applicable
8. Unknown

Data Source Hierarchy Guide

- Hierarchy of Evidence depends on the type of patient. Some examples are:
  - Dead on Scene – Prehospital/coroner report
  - Prehospital – Prehospital Run Report
  - Emergency Department – ED physician note, ED nurses note
  - Acute Care Facility Transfer – H&P, Nurses note, Media tab
  - Service Transfer – Progress note and Hospital Injury
  - Retrospective Review – Audit filters
Inclusion Information

Definition

Patient meets inclusion criteria for the **box checked**: NTDS and is eligible to be submitted to the NTDS and/or Illinois Trauma Registry. (As of 2019 and forward, the Illinois box is auto-populated and inclusion criteria are identical and follow below.)

Element Values

- Yes
- No

Data Source Hierarchy Guide

1. National Trauma Data Standard Patient Inclusion Criteria for that admission year.
2020 NTDS Patient Inclusion Criteria:

Definition: To ensure consistent data collection across states into the National Trauma Data Standard (NTDS), a trauma patient is defined as a patient sustaining a traumatic injury within 14 days of initial hospital encounter and meeting the following criteria:

At least one of the following injury diagnostic codes defined as follows:

International Classification of Diseases, Tenth Revision (ICD-10-CM):
- S00-S99 with 7th character modifier of A, B, or C ONLY. (Injuries to specific body parts – initial encounter)
- T00-T29 (including T50-T59)
- T30-T49 (burns by specific body parts – initial encounter)
- T50-T52 (burn by TBSA percentages)
- T84.0-T84.9 with 7th character modifier of A ONLY (Traumatic Compartment Syndrome – initial encounter)

EXCLUDING the following isolated injuries:
- ICD-10-CM:
  - S00 (Superficial injuries of the head)
  - S01 (Superficial injuries of the neck)
  - S02 (Superficial injuries of the thorax)
  - S03 (Superficial injuries of the abdomen, pelvis, lower back, and external genitalia)
  - S10 (Superficial injuries of the shoulder and upper arm)
  - S11 (Superficial injuries of the elbow and forearm)
  - S12 (Superficial injuries of the wrist, hand, and fingers)
  - S20 (Superficial injuries of the hip and thigh)
  - S21 (Superficial injuries of the knee and lower leg)
  - S22 (Superficial injuries of ankle, foot, and toes)

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

AND MUST INCLUDE ONE OF THE FOLLOWING IN ADDITION TO (ICD-10-CM S00-S99, T01, T14, T20-T28, T30-T52 and T84.0-T84.9):
- Death resulting from the traumatic injury (independent of hospital admission or hospital transfer status).
- OR
- Patient transfer from one acute care hospital to another acute care hospital.
- OR
- Patients directly admitted to your hospital (exclude patients with isolated injuries admitted for elective and/or planned surgical interventions).
- OR
- Patients who were an in-patient admission and/or observed.

*Acute Care Hospital is defined as a hospital that provides inpatient medical care and other related services for surgery, acute medical conditions or injuries (usually for a short-term illness or condition).* [CMS Data Navigator Glossary of Terms](https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/Medicare-Facts/DataBooks/DataBook_Glossary_Alphe.pdf) (accessed January 15, 2019).
**2020 NTDS Inclusion Criteria Algorithm**

**NTDS PATIENT INCLUSION CRITERIA**

**STEP #1:**
- Did the patient sustain one or more traumatic injuries within 24 days of initial hospital encounter?  
  - NO: Patient NOT INCLUDED in the National Trauma Data Standard
- Is the diagnostic code for any injury included in the following ICD-10-CM range?  
  - 500-599, T07, T14, T20-T28, T30-T32, T79 A1 - T79 A9  
  - NO: Patient NOT INCLUDED in the National Trauma Data Standard
- Did the patient sustain at least one injury with a diagnosis code outside the ranges of ICD-10-CM codes below?  
  - 500, 512, 520, 530, 540, 550, 560, 570, 580, 590  
  - NO: Patient NOT INCLUDED in the National Trauma Data Standard

**CONTINUE TO STEP #2**

**STEP #2:**
- Did the patient's injury result in death?  
  - YES: Patient INCLUDED in the National Trauma Data Standard
- Was the patient transferred from one acute care hospital to another acute care hospital?  
  - YES: Patient INCLUDED in the National Trauma Data Standard
  - NO: Patient NOT INCLUDED in the National Trauma Data Standard
- Was the patient directly admitted to your hospital (exclude patients with isolated injuries admitted for elective and/or planned surgical intervention)?  
  - YES: Patient INCLUDED in the National Trauma Data Standard
  - NO: Patient NOT INCLUDED in the National Trauma Data Standard
- Was the patient an inpatient admission and/or observed?  
  - YES: Patient INCLUDED in the National Trauma Data Standard
**Alias**

**Definition**

-Known alternate names that the patient uses when seeking medical care.
- May also be alternate name given by hospital if patient’s identity/name unknown at time of arrival and patient is registered initially under an alternate name. Example: Trauma 12 Male.

**Element Values**

- Relevant Value for data element

**Data Source Hierarchy Guide**

1. Demographics
2. Insurance section
**Date of Birth:** BLUE FIELD; NTDS Definition rules follow.

**Definition**

The patient’s date of birth.

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

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

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

**Associated Edit Checks**

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>0601</td>
<td>1</td>
<td>Invalid value</td>
</tr>
<tr>
<td>0602</td>
<td>1</td>
<td>Date out of range</td>
</tr>
<tr>
<td>0603</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>0604</td>
<td>2</td>
<td>Date of Birth is later than Injury Incident Date</td>
</tr>
<tr>
<td>0605</td>
<td>2</td>
<td>Date of Birth is later than ED Discharge Date</td>
</tr>
<tr>
<td>0606</td>
<td>2</td>
<td>Date of Birth is later than Hospital Discharge Date</td>
</tr>
<tr>
<td>0607</td>
<td>2</td>
<td>Date of Birth + 120 years must be less than Injury Incident Date</td>
</tr>
<tr>
<td>0608</td>
<td>2</td>
<td>Element cannot be “Not Applicable”</td>
</tr>
<tr>
<td>0609</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>

**NOTE:** Age will auto-fill based on Date of Birth entered.
AGE

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

Element Values
- Relevant value for data element

Additional Information
- If Date of Birth is "Not Known/Not Recorded," report data elements: Age and Age Units.
- If Date of Birth is the same as the ED/Hospital Arrival Date, then the Age and Age Units data elements must be reported.
- Must also report data element: 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
3. Admission Form
4. Triage/Trauma Flow Sheet
5. EMS Run Report

Associated Edit Checks

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>0701</td>
<td>1</td>
<td>Age is outside the valid range of 0 - 120</td>
</tr>
<tr>
<td>0703</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>0705</td>
<td>3</td>
<td>Age is greater than expected for the Age Units specified. Age should not exceed 60 minutes, 24 hours, 30 days, 24 months, or 120 years. Please verify this is correct.</td>
</tr>
<tr>
<td>0708</td>
<td>2</td>
<td>Element must be &quot;Not Known/Not Recorded&quot; when Age Units is &quot;Not Known/Not Recorded&quot;</td>
</tr>
<tr>
<td>0709</td>
<td>2</td>
<td>Element must be &quot;Not Applicable&quot; if Date of Birth is reported</td>
</tr>
<tr>
<td>0740</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
NOTE: Age Units will auto-fill based on Date of Birth

DI dropdown screen:

AGE UNITS

Definition
The units used to report the patient's age (Minutes, Hours, Days, Months, Years, Weeks).

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

Additional Information
- If Date of Birth is "Not Known/Not Recorded," report data elements: Age and Age Units.
- If Date of Birth is the same as the ED/Hospital Arrival Date, then the Age and Age Units data elements must be reported.
- Must also report data element: Age.
- The null value "Not Applicable" is reported if Date of Birth is reported.

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

Associated Edit Checks

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>0801</td>
<td>1</td>
<td>Value is not a valid menu option</td>
</tr>
<tr>
<td>0803</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>0806</td>
<td>2</td>
<td>Element must be &quot;Not Known/Not Recorded&quot; when Age is &quot;Not Known/Not Recorded&quot;</td>
</tr>
<tr>
<td>0809</td>
<td>2</td>
<td>Element must be &quot;Not Applicable&quot; when Date of Birth is reported</td>
</tr>
<tr>
<td>0840</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
**Gender:** BLUE FIELD; NTDS Definition rules follow.

**DI dropdown screen element values:**

1. Male
2. Female
3. Unknown

**SEX**

**Definition**
The patient's sex.

**Element Values**
1. Male
2. Female

**Additional Information**
- Patients who have undergone a surgical and/or hormonal sex reassignment should be reported using their current assignment.

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

**Associated Edit Checks**

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>1101</td>
<td>1</td>
<td>Value is not a valid menu option</td>
</tr>
<tr>
<td>1102</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>1103</td>
<td>2</td>
<td>Element cannot be &quot;Not Applicable&quot;</td>
</tr>
<tr>
<td>1140</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
**Race:** BLUE FIELD; NTDS Definition rules follow.

**DI dropdown screen element values:**

<table>
<thead>
<tr>
<th>Race (Choose up to 8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Asian</td>
</tr>
<tr>
<td>African</td>
</tr>
<tr>
<td>Black or African-American</td>
</tr>
<tr>
<td>Native Hawaiian or Other Pacific Islander</td>
</tr>
</tbody>
</table>

**RACE**

**Definition**
The patient's race.

**Element Values**

1. Asian
2. Native Hawaiian or Other Pacific Islander
3. Other Race
4. American Indian
5. Black or African American
6. White

**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
3. Admission Form
4. Triage/Trauma Flow Sheet
5. EMS Run Report
6. History & Physical

**Associated Edit Checks**

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>0901</td>
<td>1</td>
<td>Value is not a valid menu option</td>
</tr>
<tr>
<td>0902</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>0903</td>
<td>2</td>
<td>Element cannot be &quot;Not Applicable&quot; (excluding CA hospitals)</td>
</tr>
<tr>
<td>0905</td>
<td>2</td>
<td>If any Element Value is reported, neither &quot;Not Applicable&quot; or &quot;Not Known/Not Recorded&quot; can also be reported</td>
</tr>
<tr>
<td>0950</td>
<td>1</td>
<td>Multiple Entry Max exceeded</td>
</tr>
</tbody>
</table>
**Ethnicity:** MANDATORY BLUE FIELD; NTDS Definition rules follow.

**DI dropdown screen element values:**

<table>
<thead>
<tr>
<th>ETHNICITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition</td>
</tr>
<tr>
<td>The patient's ethnicity.</td>
</tr>
</tbody>
</table>

**Element Values**

1. Hispanic or Latino
2. 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/Thema Flow Sheet
5. History & Physical
6. EMS Run Report

**Associated Edit Checks**

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>1001</td>
<td>1</td>
<td>Value is not a valid menu option</td>
</tr>
<tr>
<td>1002</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>1003</td>
<td>2</td>
<td>Element cannot be “Not Applicable” (excluding CA hospitals)</td>
</tr>
<tr>
<td>1040</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
**Patient's Home Zip / Postal Code:** MANDATORY BLUE FIELD; NTDS Definition rules follow.

**PATIENT'S HOME ZIP/POSTAL CODE**

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

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

**Additional Information**
- Can be stored as a 5 or 9-digit code (XXXXX-XXXX) for US or can be stored in the postal code format of the applicable country.
- May require adherence to HIPAA regulations.
- If ZIP/Postal code is "Not Applicable," report data element: Alternate Home Residence.
- If ZIP/Postal code is "Not Known/Not Recorded," report data elements: Patient's Home Country, Patient's Home State (US only), Patient's Home County (US only) and Patient's Home City (US only).
- If ZIP/Postal code is reported, must also report Patient's Home Country.

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

**Associated Edit Checks**

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>0001</td>
<td>1</td>
<td>Invalid value</td>
</tr>
<tr>
<td>0002</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>0040</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Patient Address - Street 1, Street 2

Definition

Address where the patient currently resides. Street 2 is used for apartment numbers and PO Boxes

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. Face Sheet
2. Snapshot – Demographic information
3. EMS Run Sheet
Alternate Home Residence: MANDATORY BLUE FIELD; NTDS Definition rules follow.

DI dropdown screen data elements:                             Homeless dropdown:

1. Undocumented Citizen                                          1. Yes
2. Migrant Worker                                               2. No
3. Foreign Visitor                                               ? Unknown
/. Not Applicable                                               N/A Not Applicable
?. Unknown

ALTERNATE HOME RESIDENCE

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

Element Values
1. Homeless                                                    3. Migrant Worker
2. Undocumented Citizen

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

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

Associated Edit Checks

<table>
<thead>
<tr>
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<td>Multiple Entry Max exceeded</td>
</tr>
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</table>

NOTE: Alternate Residence and the Homeless option will only open if you N/A for both the Zip and Postal Code.
Patient’s Home State: **MANDATORY BLUE FIELD; NTDS Definition rules follow.**

**DI dropdown screen:**

**PATIENT’S HOME STATE**

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

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

**Additional Information**
- Only reported when 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

**Associated Edit Checks**

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</table>
Patient's Home County and Country: MANDATORY BLUE FIELD; NTDS Definition rules follow.

DI dropdown screen:

PATIENT'S HOME COUNTY

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

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

Additional Information
- Only reported when ZIP-Postal code is "Not Known/Not Recorded" and county 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

Associated Edit Checks

<table>
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<td>Element must be &quot;Not Applicable&quot; when Patient's Home Zip/Postal Code is reported</td>
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<tr>
<td>0040</td>
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</table>

DI dropdown screen:
Relative/Guardian Information

**Definition**
Either a relative, guardian or emergency contact’s address and phone number

**Element Values – Relationship to Patient - DI dropdown screen:**

1. Spouse
2. Child
3. Parent
4. Grandparent
5. Grandchild
6. Aunt or Uncle
7. Step Parent
8. Foster Parent
9. Sibling
10. Other Family Member
11. Unrelated Caregiver
12. Not Applicable
13. Unknown

**Element Values – Guardian - DI dropdown screen:**

- Yes
- No
- ? Unknown
- N/A Not Applicable

**Element Values – All Other Fields:**
- Relevant value for data element

**Data Source Hierarchy Guide**
1. Face Sheet
2. Demographics
3. Scanned documents for legal papers
Injury Information

- The City, City FIPS, State, County, and Country will auto-populate based on the injury zip code that is entered.
- Injury Type, blunt or penetrating, is auto-populated when the Primary ICD-10 injury code is entered.
- Much of the Injury information can be garnered from the EMS Run Report. Please note that EMS agencies use different run reports and the information may be in different spots for different agencies. These images are just used as a reference, please follow the data source hierarchy guide to find the correct information.
INJURY INCIDENT DATE: MANDATORY BLUE FIELD; NTDS Definition rules follow.

### Definition
The date the injury occurred.

### Element Values
- Relevant value for data element

### Additional Information
- Reported as YYYY-MM-DD
- Estimates of date of injury should be based upon report by patient, witness, family, or healthcare provider. Other proxy measures (e.g., 911 call times) should not be reported.

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

### Associated Edit Checks

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<tr>
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<td>Injury Incident Date is earlier than Date of Birth</td>
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<td>3</td>
<td>Injury Incident Date is later than EMS Desert Date</td>
</tr>
<tr>
<td>1206</td>
<td>3</td>
<td>Injury Incident Date is later than EMS Unit Arrival on Scene Date</td>
</tr>
<tr>
<td>1207</td>
<td>3</td>
<td>Injury Incident Date is later than EMS Unit Scene Departure Date</td>
</tr>
<tr>
<td>1208</td>
<td>3</td>
<td>Injury Incident Date is later than ED/Hospital Arrival Date</td>
</tr>
<tr>
<td>1209</td>
<td>3</td>
<td>Injury Incident Date is later than ED Discharge Date</td>
</tr>
<tr>
<td>1210</td>
<td>2</td>
<td>Injury Incident Date is later than Hospital Discharge Date</td>
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<td>2</td>
<td>Element cannot be &quot;Not Applicable&quot;</td>
</tr>
<tr>
<td>1212</td>
<td>3</td>
<td>Injury Incident Date is greater than 14 days earlier than ED/Hospital Arrival Date</td>
</tr>
</tbody>
</table>
**INJURY INCIDENT TIME:** MANDATORY BLUE FIELD; NTDS Definition rules follow.

**Definition**
The time the injury occurred.

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

**Additional Information**
- Reported as HH:MM military time.
- Estimates of time of injury should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g., 911 call times) should not be reported.

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

**Associated Edit Checks**

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</tr>
<tr>
<td>1303</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>1304</td>
<td>3</td>
<td>Injury Incident Time is later than EMS Dispatch Time</td>
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<tr>
<td>1305</td>
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<td>Injury Incident Time is later than EMS Unit Arrival on Scene Time</td>
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<td>1307</td>
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<td>Injury Incident Time is later than ED/Hospital Arrival Time</td>
</tr>
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<td>Injury Incident Time is later than ED Discharge Time</td>
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<td>1309</td>
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<td>Element cannot be ‘Not Applicable’</td>
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<tr>
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</tbody>
</table>
ICD-10 PLACE OF OCCURRENCE EXTERNAL CAUSE CODE

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

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

Additional Information
- Only ICD-10-CM codes are accepted for ICD-10 Place of Occurrence External Cause Code.

Data Source Hierarchy Guide
1. EMS Run Report
2. Trauma/Trauma Flow Sheet
3. Nursing Notes/Flow Sheet
4. History & Physical
5. Progress Notes

Associated Edit Checks

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<tr>
<td>9003</td>
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<td>Place of injury code should be Y92.XY92.XXY92.XXX (where X is A-Z [excluding 1,0] or 0-9) (ICD-10-CM only)</td>
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</tbody>
</table>
Injury Information

PROTECTIVE DEVICES: MANDATORY BLUE FIELD; NTDS Definition rules follow.

Restraints, Airbags, and Equipment in DI correspond to Protective Devices, Child Specific Restraint, and Airbag Deployment for the NTDS. The following are the Element Values for DI for each category. The pages following that will be the NTDS definitions and then EPIC Screen shots.

Restraints
- None
- Seatbelt – Lap and Shoulder
- Seatbelt – Lap Only
- Seatbelt – Shoulder Only
- Seatbelt – NFS
- Child Booster Seat
- Child Car Seat
- Infant Car Seat
- Truck Bed Restraint
- Not Applicable
- Unknown

Airbags
1. No Airbags in Vehicle
2. Airbags Did Not Deploy
3. Front (Deployed)
4. Side (Deployed)
5. Airbag Deployed Other (Knee, Air Belt, Curtain, etc.)
6. Airbag Type Unknown
   - Not Applicable
   - Unknown

Equipment
1. None
2. Helmet
3. Eye Protection
4. Protective Clothing
5. Protective Non-Clothing Gear (e.g. Shin Guard, Padding)
6. Hard Hat
7. Personal Flotation Device
8. Window Bars
9. Other
   - Not Applicable
   - Unknown
Data Source Hierarchy Guide

- EMS Run Report
- ED Trauma Summary
- History and Physical
- Nursing Notes

PROTECTIVE DEVICES

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

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 (booster seat or child car 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.
- If "Child Restraint" is present, must report data element Child Specific Restraint.
- If "Airbag" is present, must report data element Airbag Deployment.
- Evidence of the use of safety equipment may be reported or observed.
- Lap Belt should be reported to include those patients that are restrained but not further specified.
- If chart indicates "3-point restraint," report Element Values "2. Lap Belt" and "10. Shoulder Belt."
- If documented that a "Child Restraint (booster seat or child 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

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

Associated Edit Checks

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<td>Element cannot be &quot;Not Known/Not Recorded&quot; along with any other valid value</td>
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<tr>
<td>2550</td>
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<td>Multiple Entry Max exceeded</td>
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</tbody>
</table>
CHILD SPECIFIC RESTRAINT

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

Element Values
1. Child Car Seat
2. Infant Car Seat
3. Child Booster Seat

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)."
- If the null value "Not Applicable" must be reported if Element Value "6. Child Restraint" is NOT reported for Protective Devices.

Data Source Hierarchy Guide
1. EMS Run Report
2. Trauma/Injury Flow Sheet
3. Nursing Notes/Flow Sheet
4. History & Physical

Associated Edit Checks

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</tr>
<tr>
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<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Injury Information

AIRBAG DEPLOYMENT

Definition
Indication of airbag deployment during a motor vehicle crash.

Element Values
1. Airbag Not Deployed
2. Airbag Deployed Front
3. Airbag Deployed Side
4. Airbag Deployed Other (knee, airbell, curtain, etc.)

Additional Information
- Report all that apply.
- Evidence of airbag deployment may be reported or observed.
- Only report when Protective Devices include "9. Airbag Present."
- Airbag Deployed Front should be reported for patients with documented airbag deployments but are not further specified.
- The null value "Not Applicable" must be reported if Element Value 8. "Airbag Present" is NOT reported for Protective Devices.

Data Source Hierarchy Guide
1. EMS Run Report
2. Triage/Injury Flow Sheet
3. Nursing Notes/Flow Sheet
4. History & Physical

Associated Edit Checks

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Injury Information

**Incident Location Zip / Postal Code:** MANDATORY BLUE FIELD; NTDS Definition rules follow.

**INCIDENT LOCATION ZIP/POSTAL CODE**

**Definition**
The ZIP/Postal code of the incident location.

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

**Additional Information**
- Can be stored as a 5 or 9-digit code (XXXXX-XXXXX) for US and CA, or can be stored in the postal code format of the applicable country.
- If "Unknown/Not Recorded," report data elements: Incident Country, Incident State (US Only), Incident County (US Only) and Incident City (US Only).
- May require adherence to HIPAA regulations.
- If ZIP/Postal code is reported, then must report Incident Country.

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

**Associated Edit Checks**

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<tr>
<td>2040</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
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</tbody>
</table>
Injury Information

Injury: Street 1, Street 2

Definition
Address where the injury occurred. Street 2 is used for apartment numbers and PO boxes.

Element Values
1. Relevant value for data element

Data Source Hierarchy Guide
1. EMS Run Sheet
2. ED Trauma Narrator Event Log
Work Related Injury: **MANDATORY BLUE FIELD; NTDS Definition rules follow.**

**Injury Information**

**Place of Injury/CEDR**
- Patient Information
- Street
- City
- State
- Postal Code

**Injury Address:** Where the patient was injured

**Work Related:**

**Definition:**
Indication of whether the injury occurred during paid employment.

**Element Values**
1. Yes
2. No

**Additional Information**
- If work-related, two additional data elements must be reported: 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

**Associated Edit Checks**

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</tr>
<tr>
<td>1410</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>

**Additional DI Element Values**

/ Not Applicable
? Unknown

Injury Address: Where the patient was injured
### Occupation: MANDATORY BLUE FIELD; NTDS Definition rules follow. Opens if Work-Related.

#### PATIENT'S OCCUPATION

**Definition**
The occupation of the patient.

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

**Additional Information**
- Only reported if injury is work-related.
- If work-related, must also report Patient’s Occupational Industry.
- The null value “Not Applicable” is reported if Work-Related is “2. No”.

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

**Associated Edit Checks**

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<td>If Work-Related is “1. Yes”, Patient’s Occupation cannot be “Not Applicable”</td>
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<td>“Not Applicable” must be reported if Work-Related is “2. No”</td>
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<tr>
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</tr>
</tbody>
</table>
**Patient’s Occupational Industry:**  
**MANDATORY BLUE FIELD; NTDS Definition rules follow.**

**PATIENT's OCCUPATIONAL INDUSTRY**

**Definition**

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

**Element Values**

1. Finance, Insurance, and Real Estate
2. Manufacturing
3. Retail Trade
4. Transportation and Public Utilities
5. Agriculture, Forestry, Fishing, and Hunting
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, must also report Patient's Occupation.
- The null value "Not Applicable" is reported 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/Patients Sheet

**Associated Edit Checks**

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>1501</td>
<td>1</td>
<td>Value is not a valid menu option</td>
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<td>1504</td>
<td>2</td>
<td>Element cannot be blank</td>
</tr>
<tr>
<td>1505</td>
<td>2</td>
<td>If Work-Related is &quot;1. Yes&quot;, Patient’s Occupational Industry cannot be &quot;Not Applicable&quot;</td>
</tr>
<tr>
<td>1506</td>
<td>2</td>
<td>&quot;Not Applicable&quot; must be reported if Work-Related is &quot;2. No&quot;</td>
</tr>
<tr>
<td>1540</td>
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<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
### Injury Information

**NOTE:** Found in Print Forms – Face Sheet

Will only generate if you click yes to “Work Related.”

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
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<tbody>
<tr>
<td>Address</td>
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<tr>
<td>City, State, and Zip</td>
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</tr>
<tr>
<td>Phone, Home</td>
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</tr>
<tr>
<td>Medical Office</td>
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<tr>
<td>Religion</td>
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<tr>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>DOB</td>
<td>1/31/1960 (19 yrs)</td>
</tr>
<tr>
<td>Sex</td>
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</tr>
<tr>
<td>Race</td>
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<td>Language</td>
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<tr>
<td>Place of Worship</td>
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<tr>
<td>PCP Phone, Home</td>
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<table>
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<td>Occupation</td>
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<td>Employment Status</td>
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</tr>
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</table>

**Guarantor**
Domestic Violence

Definition
Domestic violence includes behaviors that physically harm, arouse fear, prevent a partner from doing what they wish or force them to behave in ways they do not want. It includes the use of physical and sexual violence, threats and intimidation, emotional abuse and economic deprivation.

Element Values
2. Yes
3. No
4. N/A – Not Applicable
5. ? - Unknown

Data Source Hierarchy Guide
- History and Physical
- ED Nursing Note
- Case Management/Social Work Note
- EMS Run Sheet
Report of Physical Abuse

Definition
A report of physical abuse made to the correct authorities.

Element Values
1. Yes
2. No
3. N/A – Not Applicable
4. ? - Unknown

Data Source Hierarchy Guide
1. Physician Progress Note
2. ED Nursing Note
3. Case Management/Social Work Note
4. Child Abuse Specialist
5. EMS Run Report
Investigation of Physical Abuse

Definition

An investigation of physical abuse was conducted by the correct authorities.

Element Values

5. Yes
6. No
7. N/A – Not Applicable
8. ? - Unknown

Data Source Hierarchy Guide

1. Physician Progress Note
2. ED Nursing Note
3. Case Management/Social Work Note
4. Child Abuse Specialist
5. EMS Run Report
ICD-10 Primary & Add'l E-Code: MANDATORY BLUE FIELD; NTDS Definition rules follow.

ICD-10 PRIMARY EXTERNAL CAUSE CODE

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

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

Additional Information
- The primary external cause code should describe the main reason a patient is admitted to the hospital.
- ICD-10-CM 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 reported 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 catastrophic 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 catastrophic 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. Trauma/Truma Flow Sheet
3. Nursing Notes/Flow Sheet
4. History & Physical
5. Progress Notes

Associated Edit Checks

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<thead>
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<tr>
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<td>ICD-10 External Cause Code should not be Y93.X/Y93.XX (where X is A-Z or 0-9) (ICD-10 CM only)</td>
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<td>8906</td>
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<td>8940</td>
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<td>Single Entry Max exceeded</td>
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</table>
ICD-10 ADDITIONAL EXTERNAL CAUSE CODE

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

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

Additional Information
- Only ICD-10-CM codes will be accepted for ICD-10 Additional External Cause Code.
- Activity codes are not reported under the NTDS and should not be reported for this data element.
- The null value “Not Applicable” is reported if no additional external cause codes are reported.
- Report all that apply (maximum 2)
- 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 catastrophic 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 catastrophic 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. Trauma/Injury Flow Sheet
3. Nursing Notes/Flow Sheet
4. History & Physical
5. Progress Notes

Associated Edit Checks

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<thead>
<tr>
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<th>Level</th>
<th>Message</th>
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<tbody>
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<td>E-Code is not a valid ICD-10-CM code (ICD-10-CM only)</td>
</tr>
<tr>
<td>9102</td>
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<td>Additional External Cause Code ICD-10 should not be equal to Primary External Cause Code ICD-10</td>
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<td>Element cannot be blank</td>
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<tr>
<td>9104</td>
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<td>E-Code is not a valid ICD-10-CA code (ICD-10-CA only)</td>
</tr>
<tr>
<td>9105</td>
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<td>ICD-10-CM TT4 and TT6 codes cannot be submitted as Additional External Cause Codes</td>
</tr>
<tr>
<td>9140</td>
<td>1</td>
<td>Multiple Entry Max exceeded</td>
</tr>
</tbody>
</table>
Activity Code

Definition
What the patient was doing while the injury occurred.

Element Values
- Relevant ICD-10 code value for activity.

Data Source Hierarchy Guide
- EMS Run Report
- H&P
- Trauma Flowsheet
- ED Nursing Note
- Progress Notes
Alcohol Involvement

Definition
Patient blood alcohol level at the time of injury

Element Values
- Relevant ICD-10 code for blood alcohol level

Data Source Hierarchy Guide
1. Lab Values
2. Lab Values from transferring facility
Injury Information

Injury Mechanism

Definition
Description of the mechanism (external event) that caused the injury.

Element Values

1. MVC (see ANSI definition below)
2. Fall Under 1m (3.3 ft) (Use this response for Standing Height Falls regardless of pt’s physical height and actual drop from head to surface).
3. Fall 1m – 6m (3.3 – 19.7 ft)
4. Fall over 6m (19.7 ft)
5. Fall – NFS
6. Assault
7. Motorcycle
8. Pedestrian
9. Bicycle
10. Other Blunt Mechanism
11. Knife
12. Handgun
13. Shotgun
14. Other gun
15. Glass
16. Biting
17. Other Penetrating Mechanism
18. Chemical Burn
19. Inhalation Burn
20. Thermal Burn
21. Electrical Burn
22. Other Burn Mechanism
/. Not Applicable
?. Unknown

According to ANSI D16-2017, a motor vehicle is defined as the following:

1. Automobile (See 2.2.12)
   • Van, passenger or cargo (See 2.2.14.1-2)
• Van-based motorhome (See 2.2.14.3)
• Other automobile
  o Utility vehicle (See 2.2.11)
• Bus (See 2.2.10)
  o School (See 2.8)
  o Van-based (See 2.2.14.4)
  o Other
• Motorcycle (has its own response (#7) in the Registry)
  o Moped (See 2.2.9.4)
  o Autocycle (See 2.2.9.7)
• Single Unit Truck (See 2.2.19)
  o Truck tractor (See 2.2.20)
• Truck combination (See 2.2.21)
  o Single unit truck and full trailer
  o Single unit truck and semitrailer
  o Truck tractor and semitrailer
  o Truck tractor, semitrailer and full trailer(s) (double or triple)
• Other Motor Vehicle
  o ATV
  o Low speed vehicle (ex, riding lawnmower)
  o Golf cart
  o Snowmobile

**Data Source Hierarchy Guide**

1. EMS Run Report
2. H&P
3. Trauma Flowsheet
4. ED Nursing Note
Position in Vehicle

Definition

Where the patient was located in the vehicle during the motor vehicle crash. Will auto populate “driver” if driver is used for the ICD-10 Primary Mechanism.

NOTE: Data does not need to be a precise match. It can be taken from narrative notes (EMS Run Sheet, ED Notes, or Inpt Notes when clarity is ultimately determined that may not be possible in the Resuscitation Phase of care.)

Element Values

1. Driver
2. Front Seat Middle
3. Front Seat Passenger
4. Second Row Left
5. Second Row Middle
6. Second Row Right
7. Third Row Left
8. Third Row Middle
9. Third Row Right
10. Station Wagon Rear
11. Truck/Van Rear
12. Truck Bed
13. Bus Passenger
14. Passenger NFS
/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. EMS Run Report
2. H&P
3. Trauma Flowsheet
4. IDOT Mandated Elements: Point of Impact and Seat Position:
5. ED Nursing Note
Impact Location

Definition
The side of the vehicle that impacted with another object.

NOTE: Data does not need to be a precise match. It can be taken from narrative notes (EMS Run Sheet, ED Notes, or Inpt Notes when clarity is ultimately determined that may not be possible in the Resuscitation Phase of care.)

Element Values
1. Frontal
2. Nearside
3. Far side
4. Side NOS
5. Rear
6. Rollover
7. Roof
8. Broadside
9. Other
1/ Not Applicable
? Unknown

Data Source Hierarchy Guide
1. EMS Run Report
2. H&P
3. Trauma Flowsheet
4. ED Nursing Note

**Police Report Number**

**Definition**

The number assigned to the report taken by a police officer.

**Data Element**

1. Relevant value for data element

**Data Source Hierarchy Guide**

1. ED Nursing Note
2. Media Scan
Injury Information

Disaster Casualty

Definition
Denotes if the patient is injured due to a multiple or mass causality event

Element Values
- Not Multiple or Mass
- Multiple
- Mass
- Not Applicable
- Unknown

Data Source Hierarchy Guide
1. EMS Run Report
2. H&P
3. Triage Flowsheet
4. Trauma Flowsheet
5. ED Nursing Note
6. Progress Notes
Casualty Event

Definition
Name of the Mass Casualty or Disaster event.

Element Values
- Relevant values for data element

Data Source Hierarchy Guide
1. EMS Run Report
2. Incident Action Plan
3. History & Physical
4. ED Nursing Note
5. Progress Notes
Prehospital Information

- Disclaimer: Prehospital agencies all have different charting systems that are used to document prehospital care. The data may be found in different places for different agencies.
- The inclusion source at the top of the page is auto-populated based on the selection in the demographics section.
- You may add multiple agencies if there were several on scene. For example a fire department that does not transport and a different transporting EMS agency. Make sure to delineate which one is the transporting agency when entering that data.
- Scene time and transport time will auto-populate based on the data entered regarding the scene arrival, departure, and arrival at destination information.
- When entering vitals, procedures, and medications the agencies that you have entered on the first tab will auto-populate at the top of the box. If you have multiple agencies please make sure to click the one that performed the intervention. If you only have one agency it will automatically populate in the top three boxes.
- Within the vitals section, the RTS and Triage RTS will auto-populate once the systolic blood pressure, pulse rate, unassisted respiratory rate and GCS are entered.
- The pediatric trauma score will only open if the patient is under the age of 18. The PTS total will auto-populate once all 6 boxes of the PTS are filled out.
Extrication

Definition
A period of time spent removing a patient from where they were injured.

Data Elements

- **Was Patient Extricated?**
  - Yes
  - No
  - N/A – Not Applicable
  - ? – Unknown

- **Time Required/Minutes**
  - Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report
Fluid Amount

Definition
The amount of fluid given prehospital before arriving to your facility

Element Values
- Relevant value for data element

Data Source Hierarchy Guide
1. EMS Run Report
Prehospital Information

Trauma Alert Called in by EMS

Definition
The date and time that EMS called into their medical control or your facility if you are not the resource hospital to activate a trauma.

Element Values
- Relevant value for data element

Data Source Hierarchy Guide
1. EMS Run Report
Prehospital Triage Rationale: MANDATORY BLUE FIELD; NTDS Definition rules follow.

NOTE: NTDS Data Dictionary requires a precise data match with the EMS Run Sheet. However, NTDB/TQIP review approved using the truncated version of the triage criteria listed on the IL EMS Run Sheets given the confidence from our IL EMS Data Coordinator that they are accurately mapped to the NEMSIS 3.4 criteria by our IL EMS database vendors. (8/25/2020)
TRAUMA TRIAGE CRITERIA (Steps 1 and 2)

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

Element Values
1. Glasgow Coma Score <= 13 7. Crushed, degloved, mangled, or pulseless extremity
2. Systolic blood pressure < 90 mmHg 8. Amputation proximal to wrist or ankle
3. Respiratory rate < 10 or > 29 breaths per minute 9. Pelvic fracture 10. Open or depressed skull fracture
4. All penetrating injuries to head, neck, torso, and 11. Paralysis
5. Chest wall instability or deformity (e.g., flail chest)
6. Two or more proximal long-bone fractures

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

Associated Edit Checks

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
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<td>9506</td>
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<td>Element cannot be &quot;Not Applicable&quot; or &quot;Not Known/Not Recorded&quot; along with any other valid value</td>
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<tr>
<td>9550</td>
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<td>Multiple Entry Max exceeded</td>
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</table>
TRAUMA TRIAGE CRITERIA (Steps 3 and 4)

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

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

Additional Information
- The null value "Not Applicable" should be 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

Associated Edit Checks
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<thead>
<tr>
<th>Rule ID</th>
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</tr>
<tr>
<td>9650</td>
<td>1</td>
<td>Multiple Entry Max exceeded</td>
</tr>
</tbody>
</table>
Prehospital Information

**Transport Mode**: MANDATORY BLUE FIELD; NTDS Definition rules follow.

**NOTE**: (#8 in DI) should be entered if the patient was not directly transported to your facility from the scene of injury. Entering that will open the ‘Mode if Other’ dialogue boxes to enter details of the scene to initial hospital transport. The details of that inter-agency transport will then be collected in the Referring Facility tab.

**DI Element Values**

1. Ground Ambulance
2. Helicopter Ambulance
3. Fixed-Wing Ambulance
4. Private/Public Vehicle/Walk-in
5. Police
6. Public Safety
7. Water Ambulance
8. Other
9. Not Applicable
10. Unknown
Prehospital Information

**Agency**

**Definition**

The prehospital agency that is responsible for some or all aspects of the patient’s care prior to arrival at the hospital. There may be multiple agencies added based on who has responded to the scene.

**Element Values**

- Relevant Value for Data Element

**Data Source Hierarchy Guide**

1. EMS Run Report
**Unit**

**Definition**

Call sign used by the specific unit responding to the scene.

**Element Values**

- Relevant Value for Data Element

**Data Source Hierarchy Guide**

1. EMS Run Report
NOTE: If the patient is transported to the hospital per this agency then *Transport Role* corresponds to *Transport Mode* in the NTDS data dictionary. All others involved in the transport correspond to the NTDS data dictionary’s “Other Transport Mode.” If the agency does not transport the patient, please mark the agency as non-transport.

**OTHER TRANSPORT MODE**

Definition

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

**Element Values**

1. Ground Ambulance
2. Helicopter Ambulance
3. Fixed-Wing Ambulance
4. Private/Public Vehicle/Walk-in
5. Police
6. Other

Additional Information

- Include in “Other” unspecified modes of transport.
- The null value “Not Applicable” is reported to indicate that a patient had a single mode of transport.
- Report all that apply with a maximum of 5.

Data Source Hierarchy Guide

1. EMR Run Report

**Associated Edit Checks**

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</tr>
<tr>
<td>3550</td>
<td>1</td>
<td>Multiple Entry Max exceeded</td>
</tr>
</tbody>
</table>

**DI Data Elements**

1. Non-Transport 5. Transport to Other
2. Transport from Scene to Facility 6. Transport from Non-Scene Location
3. Transport from Scene to Rendezvous 7. Not Applicable
4. Transport from Rendezvous to Facility 8. Unknown
Care Level

Definition

The level of care the agency is able to provide to the patient based on Illinois State EMS regulations.

Element Values

1. Advanced Life Support
2. Basic Life Support
   /. Not Applicable
2. Unknown

Data Source Hierarchy Guide

1. EMS Run Report
**Prehospital Information**

**Call Received Date and Time**

**Definition**

The date and time that the call was received by the dispatcher

**Data Elements**

- Relevant value for data element

**Data Source Hierarchy Guide**

1. EMS Run Report
**EMS Dispatch Date:** MANDATORY BLUE FIELD; NTDS Definition rules follow.

**EMS DISPATCH DATE**

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

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

**Additional Information**
- Reported as YYYY-MM-DD.
- 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 reported for patients who were not transported by EMS.

**Data Source Hierarchy Guide**
1. EMS Run Report

**Associated Edit Checks**

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<th>Message</th>
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<td>2602</td>
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<tr>
<td>2603</td>
<td>3</td>
<td>EMS Dispatch Date is earlier than Date of Birth</td>
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</tr>
<tr>
<td>2604</td>
<td>3</td>
<td>EMS Dispatch Date is later than EMS Unit Arrival on Scene Date</td>
<td></td>
</tr>
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<td>EMS Dispatch Date is later than EMS Unit Scene Departure Date</td>
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<tr>
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<td>EMS Dispatch Date is later than ED/Hospital Arrival Date</td>
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</table>
EMS Dispatch Time: MANDATORY BLUE FIELD; NTDS Definition rules follow.

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

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

**Additional Information**
- Reported 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 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 reported for patients who were not transported by EMS.

**Data Source Hierarchy Guide**
1. EMS Run Report

**Associated Edit Checks**

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<tr>
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</tbody>
</table>
Prehospital Information

**En-Route Date and Time**

**Definition**

The date and time that unit was en-route to the scene.

**Date Elements**

- Relevant value for data element

**Data Source Hierarchy Guide**

1. EMS Run Report
Rendezvous Pickup Location

Definition

Will only populate if the pt. was transported to a rendezvous point to be transported by a different agency. The location where the transporting agency intercepted the patient.

Date Elements

- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report
**EMS UNIT ARRIVAL DATE AT SCENE OR TRANSFERRING FACILITY**

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

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

**Additional Information**
- Reported as YYYY-MM-DD.
- For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility arrived at the transferring facility (arrival is defined at date/time when the vehicle stopped moving).
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene arrived at the scene (arrival is defined at date/time when the vehicle stopped moving).
- The null value “Not Applicable” is reported for patients who were not transported by EMS.

**Data Source Hierarchy Guide**
1. EMS Run Report

**Associated Edit Checks**

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</table>
PREHOSPITAL INFORMATION

EMS UNIT ARRIVAL TIME AT SCENE OR TRANSFERRING FACILITY

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

Element Values
- Relevant value for data element

Additional Information
- Reported 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 arrived at the transferring facility (arrival is defined at date/time when the vehicle stopped moving).
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene arrived at the scene (arrival is defined at date/time when the vehicle stopped moving).
- The null value “Not Applicable” is reported for patients who were not transported by EMS.

Data Source Hierarchy Guide
1. EMS Run Report

Associated Edit Checks

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</table>
Arrived at Patient Date and Time

Definition

The date and time that the prehospital personnel made contact with the patient.

Date Elements

- Relevant value for data element

Data Source Hierarchy Guide

1. EMS Run Report
**EMS UNIT DEPARTURE DATE FROM SCENE OR TRANSFERRING FACILITY**

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

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

**Additional Information**  
- Reported as YYYY-MM-DD.
  - For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined at date/time when the vehicle started moving).
  - For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene departed from the scene (departure is defined at date/time when the vehicle started moving).
  - The null value “Not Applicable” is reported for patients who were not transported by EMS.

**Data Source Hierarchy Guide**

1. EMS Run Report

**Associated Edit Checks**

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</table>
**Prehospital Information**

---

**EMS UNIT DEPARTURE TIME FROM SCENE OR TRANSFERRING FACILITY**

**Definition**
The time the unit transporting to your hospital left the scene/transfering facility.

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

**Additional Information**
- Reported 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 at dot 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 at dot time when the vehicle started moving).
- The null value "Not Applicable" is reported for patients who were not transported by EMS.

**Data Source Hierarchy Guide**
1. EMS Run Report

**Associated Edit Checks**

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<tr>
<td>3340</td>
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</tbody>
</table>
Arrived at Destination Date and Time

**Definition**

The date and time that the transporting unit arrived to the hospital.

**Date Elements**

- Relevant value for data element

**Data Source Hierarchy Guide**

1. EMS Run Report
Scene EMS Report

Definition
The prehospital report and its level of completion/hospital’s access to the report.

Element Values
1. Complete
2. Incomplete
3. Missing
4. Unreadable
5. Not Applicable
6. Unknown

Data Source Hierarchy Guide
1. EMS Run Report
2. Media or Scanned Documents
PCR Number

**Definition**

The unique number assigned to the patient and the EMS call by the EMS agency.

**Element Values**

- Relevant Value for Data Element

**Data Source Hierarchy Guide**

1. EMS Run Report
Prehospital Vitals Date and Time Recorded

**Definition**

The date and time that the prehospital vitals were obtained.

**Element Values**

- Relevant Values for data element

**Data Source Hierarchy Guide**

1. EMS Run Report
Paralytic Agents

Definition
Patient was given paralytic agents prior to vitals being obtained and within their duration of effect.

Element Values
- Yes
- No
- ? Unknown
- N/A Not Applicable

Data Source Hierarchy Guide
1. EMS Run Report
Sedated

Definition

Patient was given sedative agents prior to vitals being obtained and within their duration of effect.

Element Values

- Yes
- No
- ? Unknown
- N/A Not Applicable

Data Source Hierarchy Guide

1. EMS Run Report
Eye Obstruction

Definition
Injury or other condition that causes the patient to be unable to open their eyes or obstructs their vision at the time the vitals were taken.

Element Values

- Yes
- No
- ? Unknown
- N/A Not Applicable

Data Source Hierarchy Guide

1. EMS Run Report
Intubated

Definition

Patient had an airway device in place when the vitals were taken.

Element Values

Intubated

- Yes
- No
- ? Unknown
- N/A Not Applicable

If Yes, Method:

1. Combitube
2. Cricothyrotomy
3. Cricothyrotomy – Needle
4. Endotracheal Tube – Nasal
5. Endotracheal Tube – Oral
6. Endotracheal Tube – Route NFS
7. Esophageal Obturator Airway
8. Laryngeal Mask Airway
9. LT Blind Insertion Airway Device
10. Tracheostomy

Data Source Hierarchy Guide

1. EMS Run Report
Respiration Assisted

Definition

Patient’s respirations were being assisted by an external device while vitals were taken.

Element Values

Respiration Assisted
- Yes
- No
- ? Unknown
- N/A Not Applicable

If Yes, Type
1. Bag Valve Mask
2. Nasal Airway
3. Oral Airway
4. Ventilator
5. ? Unknown

Data Source Hierarchy Guide

1. EMS Run Report
**Initial Field Systolic BP:** MANDATORY BLUE FIELD; NTDS Definition rules follow.

**INITIAL FIELD SYSTOLIC BLOOD PRESSURE**

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

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

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

**Data Source Hierarchy Guide**
1. EMS Run Report

**Associated Edit Checks**

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</table>

**NOTE:** First recorded diastolic blood pressure measured at the scene of injury
Diastolic Blood Pressure

Definition
The first recorded diastolic blood pressure recorded at the scene of injury

Element Values
- Relevant value for data element

Data Source Hierarchy Guide
1. EMS Run Report
**Initial Field Pulse Rate**: MANDATORY BLUE FIELD; NTDS Definition rules follow.

**INITIAL FIELD PULSE RATE**

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

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

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

**Data Source Hierarchy Guide**
1. EMS Run Report

**Associated Edit Checks**

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</table>
**Initial Field Resp Rate:** MANDATORY BLUE FIELD; NTDS Definition rules follow.

**INITIAL FIELD RESPIRATORY RATE**

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

**Element Values**
- Relevant value for data element.

**Additional Information**
- The null value “Not Known/Not Recorded” is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- The null value “Not Applicable” is reported for patients who arrive by “4. Private/Public Vehicle/Walk-in.”
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded Initial Field Respiratory Rate was NOT measured at the scene of injury.

**Data Source Hierarchy Guide**
1. EMS Run Report

**Associated Edit Checks**

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<tr>
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</table>

**NOTE:** Unassisted Resp. Rate should be used if patient is breathing on their own. Assisted Resp. Rate should be used if patient’s respirations are being supported by an external device.
**Initial Field O2 Saturation:** MANDATORY BLUE FIELD; NTDS Definition rules follow.

### INITIAL FIELD OXYGEN SATURATION

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

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

**Additional Information**
- The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- Value should be based upon assessment before administration of supplemental oxygen.
- The null value "Not Applicable" is reported for patients who arrive by 4. Private/Public Vehicle/ Walk-in.
- The null value "Not 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

**Associated Edit Checks**

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<td>The value submitted falls outside the valid range 0-100</td>
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<td>The value is below 40</td>
</tr>
<tr>
<td>3940</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Supplemental O2

Definition
Patient was being administered oxygen at the time that vitals were taken. Note – Initial Field Oxygen Saturation must be entered prior to oxygen administration.

Element Values
- Yes
- No
- ? Unknown
- N/A Not Applicable

Data Source Hierarchy Guide
1. EMS Run Report
INITIAL FIELD GCS - EYE

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

Element Values
1. No eye movement when assessed
2. Opens eyes in response to pain stimuli
3. Opens eyes in response to verbal stimulation
4. Opens eyes spontaneously

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 clearly (or directly) relates to verbal describing a specific level of functioning within the GCS scale, the appropriate numeric score may be reported. E.g. the chart indicates, "patient's pupils are PERRL, an Eye GCS of 4 may be reported, if there is no other contradicting documentation.
- The null value "Not Applicable" is reported for patients who arrive by 4. Private/Public Vehicle Walk-in.
- The null value "Not Known/Not Recorded" is reported if the patient's first recorded Initial Field GCS - Eye was NOT measured at the scene of injury.
- The null value "Not Known/Not Recorded" is reported if Initial Field GCS 40 – Eye is reported.

Data Source Hierarchy Guide
1. EMS Run Report

Associated Edit Checks
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<tr>
<td>4040</td>
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<td>Single Entry Max exceeded</td>
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</table>
INITIAL FIELD GCS - VERBAL

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

**Element Values:**

**Pediatric (≤ 2 years):**
1. No vocal response
2. Inconsolable, agitated
3. Inconsistently consolable, moaning
4. Cries but is consolable, inappropriate interactions
5. Smiles, oriented to sounds, follows objects, interacts

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

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

**Data Source Hierarchy Guide:**
1. EMS Run Report

**Associated Edit Checks:**

<table>
<thead>
<tr>
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<td>4140</td>
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</tbody>
</table>
INITIAL FIELD GCS - MOTOR

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

Element Values

**Pediatric (6 years or less):**
1. No motor response
2. Extension to pain
3. Flexion to pain
4. Withdrawal from pain
5. Localizing pain
6. Appropriate response to stimulation

**Adult:**
1. No motor response
2. Extension to pain
3. Flexion to pain
4. Withdrawal from pain
5. Localizing pain
6. Obey's commands

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

Data Source Hierarchy Guide
1. EMS Run Report

Associated Edit Checks

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<tr>
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<td>4240</td>
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</table>
**Pediatric Trauma Score: Weight**

**Definition**
The weight of the patient at the time of injury. Will only populate if patient is under the age of 18.

**Element Values**
- 2. Greater than 20kg (44 lbs.)
- 1. Between 10 and 20kg (22-44 lbs.)
- -1. Less than 10kg (22 lbs.)

- / Not Applicable
- ?. Unknown

**Data Source Hierarchy Guide**

1. EMS Run Report
**Pediatric Trauma Score: Airway**

**Definition**

The status of the patient’s airway upon EMS assessment. Will only populate if patient is under the age of 18.

**Element Values**

1. Normal
2. Maintainable
3. Unmaintainable or Intubated

/. Not Applicable
?

**Data Source Hierarchy Guide**

1. EMS Run Report
**Pediatric Trauma Score: Skeletal**

**Definition**

The presence or absence of known fractures on EMS assessment will only populate if patient is under the age of 18.

**Element Values**

1. None
2. Closed Fracture
3. Open or Multiple Fractures

**Data Source Hierarchy Guide**

1. EMS Run Report
**Pediatric Trauma Score: Cutaneous**

**Definition**
The presence or absence of open wounds on EMS assessment. Will only populate if patient is under the age of 18.

**Element Values**
- 2. No Open Wounds
- 1. Minor Open Wounds
- . Not Applicable
- ?. Unknown
- 1. Major or Penetrating Open Wounds

**Data Source Hierarchy Guide**
- 1. EMS Run Report
Pediatric Trauma Score: CNS

Definition
The mental status of the patient upon EMS assessment. Will only populate if patient is under the age of 18.

Element Values
2. Awake
1. Altered Mental Status or Obtunded
   - 1. Coma or Abnormal Flexion
   ?. Not Applicable
   ?. Unknown

Data Source Hierarchy Guide
1. EMS Run Report
Pediatric Trauma Score: Pulse Palp

Definition
The presence or absence of pulses in different anatomical areas upon EMS assessment. Will only populate if patient is under the age of 18.

Element Values
1. Pulse Palpable at Groin (SBP Btwn 50 and 90 mmHg)
2. Pulse Palpable at Wrist (SBP over 90 mmHg)
1. Pulse Not Palpable (SBP under 50 mmHg)
/. Not Applicable
?. Unknown

Data Source Hierarchy Guide
1. EMS Run Report
Prehospital Procedure

**Definition**

Medical interventions performed by EMS or first responders either on scene or en-route to the initial treatment facility.

**NOTE:** Illinois consensus is to enter only those invasive prehospital procedures essential to the diagnosis, stabilization, or treatment of the patient’s specific injuries. Facilities may choose to enter more, but entering ALL interventions is no longer encouraged as the EMS database is a robust resource to gather that information now.

**DI Element Values**

<p>| | | |</p>
<table>
<thead>
<tr>
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<tr>
<td><strong>0. None</strong></td>
<td><strong>16. Cricothyrotomy-Needle</strong></td>
<td><strong>28. Intravenous Fluids</strong></td>
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<td><strong>1. Airway-Nasal</strong></td>
<td><strong>17. Decontamination</strong></td>
<td><strong>29. Laryngeal Mask Airway</strong></td>
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<td><strong>2. Airway Opened or Cleared</strong></td>
<td><strong>18. Defibrillation-Automated</strong></td>
<td><strong>30. LT Blind Insertion</strong></td>
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<td><strong>8. Blood Glucose Analysis</strong></td>
<td><strong>Note Recorded</strong></td>
<td><strong>36. Rapid Sequence</strong></td>
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<td><strong>9. Cardiac Monitor</strong></td>
<td><strong>Airway</strong></td>
<td><strong>37. Rescue</strong></td>
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<td><strong>10. Chest Tube</strong></td>
<td><strong>24. Esophageal Obturator</strong></td>
<td><strong>38. Spinal Immobilization</strong></td>
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<td><strong>12. CNS Catheter</strong></td>
<td><strong>26. Intra-Aortic Balloon</strong></td>
<td><strong>40. Thoracostomy-Needle</strong></td>
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<td><strong>13. Combitube</strong></td>
<td><strong>27. Intraosseous Access or Infusion</strong></td>
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</tbody>
</table>

**Data Source Hierarchy Guide**

1. EMS Run Report
Referring Facility Information

- Disclaimer: Referring facilities may have different electronic health records and therefore paperwork and modes of transfer of information may be different. Due to this there is not pictures of where to find the information because the documentation can be so vastly different.
- For example if a patient is in the same hospital system, the chart can be accessed from our electronic health record.
- Some facilities have the same electronic health record and the information maybe be viewed through the care everywhere button.
- Other facilities may not be compatible with our system and may send their paperwork with the patient which will be scanned into the system and found under the media tab.
- Referring facility length of stay will be calculated once the arrival and departure time are documented.
- Referring facilities vitals, medications, procedures, and inter-facility transport will auto-populate the name of the referring facility at the top of the box. Please note if there are more than one referring facility then you need to choose which intervention was done at which facility.
- In the inter-facility transport section, the transport time will auto-populate based on departure date and time from the referring facility and arrival to the receiving facility date and time.
Inter-Facility Transfer: MANDATORY BLUE FIELD; NTDS Definition rules follow.

INTER-FACILITY TRANSFER

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

Element Values
1. Yes
2. No

Additional Information
- Patients transferred from a private doctor's office or a stand-alone ambulatory surgery center are not considered inter-facility transfers.
- Outlying facilities purporting to provide emergency care services or utilized to stabilize a patient are considered acute care facilities.

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

Associated Edit Checks

<table>
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<td>4440</td>
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</tbody>
</table>
**Referring Facility Information**

**Definition**

The name and ID number of the facility that referred emergency are for the patient prior to being transported to your facility.

**Element Values**

1. Relevant Value for Data Element

Element values can be found in numbers or names. A name will auto-populate the number and the number will auto-populate the name.

**Data Source Hierarchy**

a. Access Center Triage Note (Trauma Triage flowsheet)
b. Referring Facility Record
c. EMS Run Record
Referring Facility: Departure Date and Time

**Definition**

The time and date the patient left the facility that rendered emergency care for the patient prior to being transported to your facility.

**Element Values**

1. Relevant Value for Data Element.

**Data Source Hierarchy**

1. Referring Facility Record
2. EMS Run Record
Facility Level

Definition
The state designation of the facility that rendered emergency care for the patient prior to being transported to your facility.

Element Values
1. Non-Designated
2. Level I
3. Level II
4. Level III
5. Level IV
6. Level V
7. Not Applicable
8. Unknown
9. Other Specialty

Data Source Hierarchy Guide
4. Referring Facility Paperwork
Late Referral

Definition

The reason why transport from the referring facility to your facility was delayed.

Element Values

- Over 6 hours in ED or Resus
- Surgery Performed
- Admissions
- ICU
- Radiology
- Referring Physician Decisions
- Admitted
- Surgery
- > 6 Hours
- Not Applicable
- Unknown
- Weather or Natural Forces
- Mass Casualty Incident
- EMS Transfer Issues
- Destination Facility Issues

Data Source Hierarchy Guide

0. Referring Facility Paperwork
Transfer Rationale

Definition

The reason why the patient needed to be transferred to your facility.

Element Values

1. Economic / Not Applicable
2. Level of Care / Unknown
3. Personal
4. System Protocol
5. Other

Data Source Hierarchy Guide

1. Referring Facility Paperwork
**Transfer Rationale By**

**Definition**

The individual at the referring facility that made the decision to transfer the patient to your facility.

**Element Values**

1. Physician
2. Patient
3. Payor

**Data Source Hierarchy Guide**

1. Referring Facility Paperwork
**Additional Referring Facilities**

**Definition**

Was the patient transported to an additional facility, other than the referring facility that transported the patient to your facility?

**Element Values**

3. Relevant Value for Data Element.

**Data Source Hierarchy Guide**

1. Referring Facility Paperwork
2. Trauma/ Triage flowsheet
**Additional Referring Facility**

**Definition**

The name and ID number of the facility that rendered emergency care for the patient prior to being transported to the hospital that referred the patient to your facility.

**Element Values**

4. Relevant Value for Data Element
5. Element Values can be found in numbers or names. A name will auto-populate the number and the number will auto-populate the name.

**Data Source Hierarchy Guide**

1. Referring Facility Paperwork
2. EMS Run Sheet
Additional Referring Facility Arrival Date and Time

Definition
The time and date the patient arrived at the facility that rendered emergency care for the patient, prior to being transported to the hospital that referred the patient to your facility.

Element Values
6. Relevant Value for Data Element.

Data Sourced Hierarchy Guide
1. Additional Referring Facility Paperwork
2. Referring Facility Paperwork
Additional Referring Facility Departure Date and Time

**Definition**

The time and date the patient left the facility that rendered emergency care for the patient, prior to being transported to the hospital that referred the patient to your facility.

**Element Values**

1. Relevant Value for Data Element

**Data Source Hierarchy Guide**

1. Additional Referring Facility Paperwork
2. Referring Facility Paperwork
Additional Referring Facility: Facility Level

Definition
The state designation of the facility that rendered emergency care for the patient prior to being transported to the hospital that referred the patient to your facility

Element Values

- Non-Designated
- Level I
- Level II
- Level III
- Level IV
- Level V
- Other Specialty
- Not Applicable
- Unknown

Data Source Hierarchy Guide

1. Additional Referring Facility
2. Referring Facility Paperwork
Additional Referring Facility: Late Referral

Definition

The reason why transport from the referring facility to the hospital that transferred the patient to your facility is delayed.

Element Values

0. Over 6 hours in ED or Resus
1. Surgery Performed
2. Admissions
3. ICU
4. Radiology
5. Referring Physician Decisions
6. Unknown
7. Weather or Natural Forces
8. Mass Casualty Incident
9. EMS Transfer Issues
10. Destination Facility Issues

Data Source Hierarchy Guide

1. Additional Referring Facility Paperwork
2. Referring Facility Paperwork
**Additional Referring Facility: Transfer Rationale**

**Definition**

The reason why the patient needed to be transferred to the hospital that transferred the patient to your facility.

**Element Values**

1. Economic
2. Level of Care
3. Personal
4. System Protocol
5. Other
6. Not Applicable
7. Unknown

**Data Source Hierarchy Guide**

1. Additional Referring Facility Paperwork
2. Referring Facility Paperwork
Additional Referreing Facility: Transfer Rational By

Definition

The individual at the referring facility that made the decision to transfer the patient to your facility, or the individual that referred the patient to your facility.

Element Values

1. Physician / Not Applicable
2. Patient / Unknown
3. Payor

Data Source Hierarchy Guide

1. Additional Referring Facility Paperwork
2. Referring Facility Paperwork
Referring Facility Information

Referring Facility: Initial Vitals Recorded Date and Time

Definition
The date and time that the first set of vitals were recorded at the referring facility

Element Values
2. Relevant Value for Data Element

Data Source Hierarchy Guide
1. Referring Facility
**Referring Facility Information**

**Referring Facility: Initial Temperature/Unit/Route**

**Definition**

The first temperature recorded upon arrival within 30 minutes to the referring facility. Recorded as the degree, unit and route the temperature was taken.

**Element values**

3. Relevant Value for Data Element

**Unit**

- F. Fahrenheit
- C. Celsius

**Route**

1. Oral
2. Rectal
3. Rectal
4. Axillary
5. Core
6. Other
7. Temporal
8. Unknown

**Data Source Hierarchy Guide**

1. Referring Facility Paperwork
Referring Facility Information

Referring Facility: Paralytic Agents

Definition
Were paralytic agents affecting the patient at the time the vitals were taken?

Element Values
Y. Yes / N. No / . Not applicable / ?. Unknown

Data Source Hierarchy Guide
1. Referring Facility Paperwork
Referring Facility: Sedated

**Definition**

Were sedative agents affecting the patient at the time the vitals were taken?

**Element Values**

- **Y.** Yes
- **N.** No
- **/.** Not Applicable
- **?.** Unknown

**Data Source Hierarchy Guide**

1. Referring Facility Paperwork
Referring Facility Information

Referring Facility: Eye Obstruction

Definition
Was there an eye obstruction affecting the patient at the time the vitals were taken?

Element Values
Y. Yes  / . Not Applicable
N. No  ?. Unknown

Data Source Hierarchy Guide
1. Referring Facility Paperwork
Referring Facility Information

Referring Facility: Intubated

Definition
Was the Patient intubated at the time the vitals were taken?

Element Values
- Y. Yes
- N. No
- / Not Applicable
- ? Unknown

Data Source Hierarchy Guide
1. Referring Facility Paperwork
Referring Facility: Intubation Method

Definition
The device or method used to intubate the patient.

NOTE: Will only populate if you answer yes to the referring facility intubated questions.

Element Values
1. Combitube
2. Cricothyrotomy
3. Cricothyrotomy-Needle
4. Endotracheal Tube-Needle
5. Endotracheal Tube-Oral
6. Endotracheal Tube-Route NFS
7. Esophageal Obturator Airway
8. Laryngeal Mask Airway
9. LT Blind Insertion Device
10. Tracheostomy

Unknown

Data Source Hierarchy Guide
1. Referring Facility Paperwork
Referring Facility: Respiration Assisted

Definition
Did the patient require assisted respirations at the time the vitals were taken?

Element Values

Y. Yes
N. No
?. Unknown

Data Source Hierarchy Guide

1. Referring Facility Paperwork
Referring Facility Information

Referring Facility: Respiration Assisted Type

Definition

The Device used to assist the patient’s respirations.

**NOTE**: Will only populate if you answer **YES** to the referring facility respiration assisted question.

Element Values

1. Bag Valve mask
2. Nasal Airway
3. Oral Airway
4. Ventilator
5. Unknown

Data Source Hierarchy Guide

1. Referring Facility Paperwork
Referring Facility Information

Referring Facility: Initial Systolic and Diastolic Blood Pressure

Definition

The first recorded systolic and diastolic blood pressure at the referring facility within 30 minutes or less of the patient's arrival at ED/Hospital.

Element Values

4. Relevant Value for Data Element

NOTE: The first recorded referring facility vitals do not need to be from the same assessment. Measurement reported must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.

Data Source Hierarchy Guide

1. Referring Facility Paperwork
Referring Facility Information

Referring Facility: Initial Pulse Rate

Definition

The first recorded pulse in the ED/Hospital (palpated or auscultated) within 30 minutes or less of ED/Hospital arrival (expressed as number per minute).

Element Values

5. Relevant Value for Data Element

NOTE: The first recorded referring facility vitals do not need to be from the same assessment. Measurement reported must be without the assistance of CPR or any type of mechanical chest compressions; report the value obtained while compressions are paused.

Data Source Hierarchy Guide

1. Referring Facility Paperwork
Referring Facility Information

Referring Facility: Unassisted Respiratory Rate

Definition
The first recorded unassisted respiratory rate in the ED/Hospital within 30 minutes or less of ED/Hospital arrival (expressed as a number per minute).

Element Value

6. Relevant Data for data Element

NOTE: The first recorded referring facility vitals do not need to be from the same assessment. The box will only auto-populate if you check YES to the respiration assisted questions.

Data Source Hierarchy Guide

1. Referring Facility Paperwork
Referring Facility Information

Referring Facility: Oxygen Saturation

Definition
The first recorded oxygen saturation in the ED/Hospital within 30 Minutes or less of ED/Hospital arrival (expressed as a percentage).

Element Values

7. Relevant Value for Data Element

NOTE: The first recorded referring facility vitals do not need to be from the same assessment.
If reported, report additional data element: Supplemental Oxygen.

Data Source Hierarchy Guide

1. Referring Facility Paperwork
Referring Facility: Supplemental Oxygen

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

Element Values
8. Relevant Value for Data Element

NOTE: The first recorded referring facility vitals do not need to be from the same assessment. The box will only auto-populate if you record an oxygen saturation.

Data Source Hierarchy Guide
1. Referring Facility Paperwork
Referring Facility: GCS Eye

Definition

The first recorded Glasgow Coma Scale Eye in the ED/Hospital within 30 minutes or less of ED/Hospital arrival.

Element Values

1. No Eye Movement when Assessed / Not Applicable
2. Opens Yes in Response to Painful Stimulation ? Unknown
3. Opens Eyes in Response to Verbal Stimulation
4. Opens Eyes Spontaneously

NOTE: 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 number score may be reported. The null value “Not Known/Not Recorded” is reported if the patient’s initial GCS Eye was not measured within 30 minutes or less of ED/Hospital arrival.

Data Arrival Hierarchy Guide

1. Referring Facility Paperwork
Referring Facility: GCS Verbal

Definition

The first recorded Glasgow Coma Scale Verbal in the ED/Hospital within 30 minutes or less of ED/Hospital arrival.

Element Values

1. No Verbal Response (Pediatric ≤ 2 years: No vocal response)
2. Incomprehensible Sounds (Pediatric ≤ 2 years: Inconsolable, Agitated)
3. Inappropriate Words (Pediatric ≤ 2 years: Inconsistently Consolable, Moaning)
4. Confused (Pediatric ≤ 2 years: Cries but is consolable, Inappropriate Interactions)
5. Oriented Pediatric (Pediatric ≤ 2 years: Smiles, Oriented to sounds, Interacts)

/. Not Applicable
?

NOTE: 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 number score may be reported.
The null value “Not Known/Not Recorded” is reported if the patient’s initial GCS Eye was not measured within 30 minutes or less of ED/Hospital arrival.

Data Source Hierarchy Guide

1. Referring Facility Paperwork
Referring Facility: GCS Motor

Definition
The first recorded Glasgow Coma Motor Verbal in the ED/Hospital within 30 minutes or less of ED/Hospital arrival.

Element Values
1. No Motor Response
2. Extension to Pain
3. Flexion to Pain
4. Withdrawal from Pain
5. Locating Pain
6. Obeys Commands (Pediatric ≤ 2 years: Appropriate Response to Stimulation).
/. Not Applicable
?. Unknown

NOTE: 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 number score may be reported. The null value “Not Known/Not Recorded” is reported if the patient’s initial GCS Eye was not measured within 30 minutes or less of ED/Hospital arrival.

Data Source Hierarchy Guide
1. Referring Facility Paperwork
**Pediatric Trauma Score: Weight**

**Definition**

The weight of the patient at the time of injury.

**NOTE:** Will only auto-populate if patient is under the age of 18.

**Element Values**

2. Greater Than 20kg (44 lbs.)
1. Between 10 and 20kg (22–44 lbs.)
-1. Less than 10kg (22 lbs.)
/-. Not applicable
?-. Unknown

**Data Source Hierarchy Guide**

1. Referring Facility Paperwork
Pediatric Trauma Score: Airway

Definition
The status of the patient’s airway upon ED/Hospital initial assessment.

NOTE: Will only auto-populate if patient is under the age of 18.

Element Values
2. Normal  
1. Maintainable  
  -1. Unmaintainable or Intubated  
  /. Not applicable  
  ?. Unknown

Data Source Hierarchy Guide
1. Referring Facility Paperwork
Pediatric Trauma Score: Skeletal

Definition

The presence or absence of known fractures on ED/Hospital known assessment.

NOTE: Will only auto-populate if patient is under the age of 18.

Element Values

2. None
1. Closed Fractures
-1. Open or Multiple Fractures
/. Not applicable
?/. Unknown

Data Source Hierarchy Guide

1. Referring Facility Paperwork
Pediatric Trauma Score: Cutaneous

**Definition**

The presence or absence of open wounds on ED/Hospital initial assessment

**NOTE:** Will only auto-populate if patient is under the age of 18.

**Element Values**

2. No open wounds
1. Minor open wounds
-1. Major or penetrating open wounds
/. Not applicable
?. Unknown

**Data Source Hierarchy Guide**

1. Referring Facility Paperwork
Pediatric Trauma Score: CNS

Definition
The mental status of the patient upon ED/Hospital initial assessment.

NOTE: Will only auto-populate if patient is under the age of 18.

Element Values
2. Awake
1. Altered mental status or obtunded
-1. Coma or abnormal flexion
/. Not applicable
?. Unknown

Data Source Hierarchy Guide
1. Referring Facility Paperwork
**Pediatric Trauma Score: Pulse Palp**

**Definition**

The presence or absence of pulses in different anatomical areas upon ED/Hospital initial assessment.

**NOTE:** Will only auto-populate if patient is under the age of 18.

**Element Values**

- 2. Pulse Palpable at Wrist (SBP over 90 mmHg)
- 1. Pulse Palpable at groin (SBP between 50 and 90 mmHg)
- -1. Pulse not palpable (SBP under 50 mmHg)
- -. Not applicable
- ?. Unknown

**Data Source Hierarchy Guide**

1. Referring Facility Paperwork
Referring Facility ETOH Use:  **MANDATORY BLUE FIELD; NTDS Definition rules follow.**

**Referring Facility: Alcohol Use Indicator**

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

**Element Values**
1. No (not tested)
2. No (confirmed by test)
3. Yes (confirmed by test)
4. Yes (confirmed by test: beyond legal limit)
. Not applicable
? Unknown

**Data Source Hierarchy Guide**
1. Referring Facility Paperwork
Referring Facility: Drug Use Indicator

**Definition**

A Drug Test was performed on the patient within 24 hours after the first hospital encounter.

**Element Values**

1. No (not tested)
2. No (confirmed by test)
3. Yes (confirmed by test: prescription drugs)
4. Yes (confirmed by test: illegal drug use)
   /: Not applicable
   ?: Unknown

**Data Source Hierarchy Guide**

1. Referring Facility Paperwork
MANDATORY BLUE FIELD; NTDS Definition rules follow.

Referring Facility: ETOH/BAC Level

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

Elemental Values

9. Relevant value for data element.

NOTE: Reported as grams per deciliter.
Alcohol screen may be administered at any facility, unit or setting treating this patient event.

Data Source Hierarchy Guide

1. Referring Facility Paperwork
Referring Facility Information

Referring Facility Drug Screen: **MANDATORY BLUE FIELD; NTDS Definition rules follow.**

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

**Element Values**
1. AMP (Amphetamine)  
2. BAR (Barbiturate)  
3. BZO (Benzodiazepines)  
4. COC (Cocaine)  
5. mAMP (Methamphetamine)  
6. MDMA (Ecstasy)  
7. MTD (Methadone)  
8. OPI (Opioid)  
9. OXY (Oxycodone)  
10. PCP (Phencyclidine)  
11. TCA (Tricyclic Antidepressant)  
12. THC (Cannabinoid)  
13. Other  
14. Not Tested  
15. Not Tested

**NOTE:** Drug Screen may be administered at any facility, unit or setting treating the patient event.

**Data Source Hierarchy Guide**

1. Referring Facility Paperwork
Referring Facility: Clinician Administered

MANDATORY BLUE FIELD; NTDS Definition rules follow.

**Definition**

Was the drug screen positive because that particular medication was administered by a clinician?

**Element Values**

- Y. Yes
- . Not Applicable
- N. No
- ?. Unknown

**Data Source Hierarchy Guide**

1. Referring Facility Paperwork
Referring Facility Information

Additional Referring Facility: Vitals

Definition
Any additional vitals recorded at the referring facility prior to transfer to your facility.

Element Values
10. Refer to previous vitals for specific information regarding the documentation of the vital signs.

NOTE: These vitals do not have to be performed within the first 30 minutes of arrival to the ED/Hospital.

Data Source Hierarchy Guide
1. Referring Facility Paperwork
Referring Facility Information

Referring Facility: Medications

Definition
All medications given at the referring facility prior to transfer to your facility.

Element Values
11. Relevant Value for data element.
12. DI has multiple medications that can be picked.

Data Source Hierarchy Guide
1. Referring Facility Paperwork
Referring Facility: Procedures

Definition
Operative and selective non-operative procedures conducted during the referring facility 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.

Element Values
1. Major and minor procedures ICD-10 codes.

NOTE: Only report procedures performed at the referring facility

Data Source Hierarchy Guide
1. Referring Facility Paperwork
Referring Facility Information

Referring Facility: Procedure – Start Date and Time

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

Element Values
Relevant value for data element.

NOTE: Procedure start time is defined as the time the incision was made (or the procedure was started).

Data Source Hierarchy Guide
1. Referring Facility Paperwork
Referring Facility Information

Referring Facility: Procedure – Diagnostic Result

**Definition**

The operative or selected non-operative procedure had diagnostic capabilities

**Element Values**

- Positive / Not Applicable
- Negative / Unknown
- Intermediate

**NOTE:** We do not input this field because we do not have a clear definition on positive or negative results. This is very difficult to determine at times. It would be more beneficial if noted normal or abnormal imaging results

**Data Source Hierarchy Guide**

1. Referring Facility Paperwork
**Transport Mode**: MANDATORY BLUE FIELD; NTDS Definition rules follow.

### Data Source Hierarchy Guide:

1. EMS Run Record

### DI Elements:

1. Ambulance
2. Helicopter
3. Police
4. Public Safety
5. Private Vehicle
6. Walk-In
7. Other
8. Not Applicable
9. Unknown
10. Fixed/Wing Ambulance
Agency

Definition
The prehospital agency that is responsible for transporting the patient from the referring facility to your facility

Element Value
2. Relevant Value for Date Element

Data Source Hierarchy Guide
1. EMS Run Report
Referring Facility Information

Unit

Definition

Call sign used by the specific unit who is transferring the patient to your facility.

Element Values

3. Relevant Value for Data Element

Data Source Hierarchy Guide

1. EMS Run Report
If the patient is transported to the hospital per this agency then **Transport Role** corresponds to **Transport Mode** in the NTDS data dictionary. All others involved in the transport correspond to the NTDS data dictionary’s “Other Transport Mode.”
DI Data Elements

1. Non-Transport
2. Transport from Scene to Facility
3. Transport from Scene to Rendezvous
4. Transport from Scene to Rendezvous Facility
5. Transport to Other
6. Transport from Non-Scene Location
   / Not Applicable
? Unknown
Care Level

Definition

The level of care the agency is able to provide to the patient based on Illinois State EMS Regulations.

Element Values

1. Advanced Life Support
2. Basic Life Support
   /. Not Applicable
   ?. Unknown

Data Source Hierarchy Guide

1. EMS Run Report
Call Received: Date and Time

**Definition**

The date and time that the call was received by the dispatcher.

**Element Values**

4. Relevant Value for Data Element

**Data Source Hierarchy Guide**

1. EMS Run Report
Inter-facility EMS Dispatch Date: **MANDATORY BLUE FIELD; NTDS Definition rules follow.**

**EMS DISPATCH DATE**

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

*Element Values*
- Relevant value for data element

*Additional Information*
- Reported as YYYY-MM-DD.
- 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 reported for patients who were not transported by EMS.

*Data Source Hierarchy Guide*
1. EMS Run Report
Inter-facility EMS Dispatch Time: MANDATORY BLUE FIELD; NTDS Definition rules follow.

**EMS Dispatch Time**

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

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

**Additional Information**
- Reported 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 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 reported for patients who were not transported by EMS.

**Data Source Hierarchy Guide**
1. EMS Run Report
En-Route: Date and Time

Definition
The date and time the unit was en route to the referring facility.

Element Values
5. Relevant value for data element.

Data Source Hierarchy Guide
1. EMS Run Report
Inter-Facility EMS Arrival Date: **MANDATORY BLUE FIELD; NTDS Definition rules follow.**

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

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

**Additional Information**
- Reported as YYYY-MM-DD.
- For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility arrived at the transferring facility (arrival is defined at datetime when the vehicle stopped moving).
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene arrived at the scene (arrival is defined at date/time when the vehicle stopped moving).
- The null value "Not Applicable" is reported for patients who were not transported by EMS.

**Data Source Hierarchy Guide**
1. EMS Run Report
Arrived at Patient: Date and Time

**Definition**
The date and time that the prehospital personnel made contact with the patients.

**Element Values**
6. Relevant Value for Data Element

**Data Source Hierarchy Guide**
1. EMS Run Report
Inter-Facility EMS Departure Date: **MANDATORY BLUE FIELD; NTDS Definition rules follow.**
**Referring Facility Information**

**Arrived at Destination: Date and Time**

**Definition**
The date and time that the transporting unit arrived to your hospital.

**Element Values**
1. Relevant Value for Data Element

**Data Source Hierarchy Guide**
1. EMS Run Report
Scene EMS Report

Definition
The prehospital report and its level of completion or the hospital’s access to the report

Element Values
1. Complete
2. Incomplete
3. Missing
4. Unreadable
5. Not Applicable
6. Unknown

Data Source Hierarchy Guide
1. EMS Run Report
PCR Number

Definition

The unique number assigned to the patient and the EMS call by the EMS agency.

Element Values

8. Relevant Value for Data Element

Data Source Hierarchy Guide

1. EMS Run Report
**Dispatch Number**

**Definition**

Number assigned to this transport by the dispatch center, if provided.

**Note**: Given the elective versus emergent nature of the inter-facility transport, this # will likely be Unavailable.

**Element Values:**

9. Relevant value for data element

**Data Source Hierarchy Guide:**

1. EMS Run Sheet
Prehospital Vitals: Date and Time Recorded

Definition
The date and time vitals were taken during the inter-facility transport recorded.

Element Values
10. Relevant Value for Data Element

Data Source Hierarchy Guide
1. EMS Run Report
Paralytic Agents

Definition
Patient was given paralytic agents prior to vitals being obtained and within their duration of effect.

Element Values

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tr>
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</tr>
<tr>
<td>?</td>
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<tr>
<td>N.</td>
<td>No</td>
</tr>
<tr>
<td>N/A</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

Data Source Hierarchy Guide

3. EMS Run Report
Sedated

Definition
Patient was given sedative agent prior to vitals being obtained and within their duration of effect.

Element Values
- Y. Yes
- ?. Unknown
- N. No
- N/A Not Applicable

Data Source Hierarchy Guide
1. EMS Run Report
Eye Obstruction

**Definition**

Injury or other condition that causes the patient to be unable to open their eyes, or obstructs their vision at the time the vitals were taken.

**Element Values**

- Y. Yes
- N. No
- N/A Not Applicable

**Data Source Hierarchy Guide**

1. EMS Run Record
**Intubated**

**Definition**

Patient had an airway device in place when the vitals were taken.

**Element Values**

11. Combitube
12. Cricothyrotomy
13. Cricothyrotomy – Needle
14. Endotracheal Tube – Nasal
15. Endotracheal Tube – Oral
16. Endotracheal Tube – Route NFS
17. Esophageal Obturator Airway
18. Laryngeal Mask Airway
19. LT Blind Insertion Airway Device
20. Tracheostomy

/r. Unknown

**Data Source Hierarchy Guide**

1. EMS Run Record
Referring Facility Information

**Respiration Assisted**

**Definition**

Patient’s respirations were being assisted by an external device while vitals were taken.

**Element Values**

- **Respiration Assisted:**
  - i. Yes
  - ii. No

- **If yes, Type:**
  - 5. Bag Valve Mask
  - 6. Nasal Airway
  - 7. Oral Airway
  - 8. Ventilator
  - . Unknown

**Data Source Hierarchy Guide**

1. Ems Run Report
Systolic Blood Pressure/Diastolic Blood Pressure

Definition
Systolic and diastolic blood pressure measurements recorded during transport to your facility.

Element Values
11. Relevant Value for Data Element

Data Source Hierarchy Guide
1. EMS Run Report
Pulse Rate

Definition
Pulse rate recorder during transport to your facility

Element Values
12. Relevant Value for Data Element

Data Source Hierarchy Guide
1. EMS Run Report
Unassisted/Assisted Respiratory Rate

**Definition**

Unassisted or Assisted Respiratory rates recorded during transport to your facility.

**Element Values**

13. Relevant Value for Data Element

**Data Source Hierarchy Guide**

1. EMS Run Report
Oxygen Saturation

Definition
The oxygen saturation measurements of the patient during transport to your facility.

Element Values
14. Relevant Value for Data Element

Data Source Hierarchy Guide
1. EMS Run Report
Inter-Facility Transport: Supplemental O2

Definition
Patient was being administered oxygen at the time that vitals were taken.

Element Values
15. Yes  ?  Unknown
16. No  N/A  Not Applicable

Data Source Hierarchy Guide
1. EMS Run Report
Inter-Facility Transport: GCS - Eye

Definition

The patients recorded Glasgow Coma Score Eye at the time that the vitals were taken during transport to your facility.

Element Values

1. No Eye Movement When Assessed
2. Opens Eyes in Response to Painful Stimulation
3. Opens Eyes in Response to Verbal Stimulation
4. Opens Eyes Spontaneously
5. Not Applicable
6. Unknown

NOTE: 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 number score may be replaced.

Data Source Hierarchy Guide

1. EMS Run Record
Inter-Facility Transport: GCS - Verbal

Definition
The patients recorded Glasgow Coma Score Verbal at the time that the vitals were taken during transport to your facility.

Element Values
1. No verbal Response (Pediatrics ≤ 2 years: No Vocal Response)
2. Incomprehensible Sounds (Pediatrics ≤ 2 years: Inconsolable, Agitated)
3. Inappropriate Words (Pediatrics ≤ 2 years: Inconsistently Consolable, Moaning)
4. Confused (Pediatrics ≤ 2 years: Cries but is Consolable, Inappropriate Interactions)
5. Oriented (Pediatrics ≤ 2 years: Smiles, Oriented to Sounds, Interacts)
/. Not Applicable
?. Unknown

NOTE: 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 number score may be replaced.

Data Source Hierarchy Guide
1. EMS Run Record
Inter-Facility Transport: GCS - Motor

Definition

The patients recorded Glasgow Coma Score Motor at the time that the vitals were taken during transport to your facility.

Element Values

1. No Motor Response
2. Extension to Pain
3. Flexion to Pain
4. Withdrawal from Pain
5. Localizing Pain
6. Obey Commands (Pediatric ≤ 2 years: Appropriate Response to Stimulation)

/. Not Applicable
?

NOTE: 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 number score may be replaced.

Data Source Hierarchy Guide

1. EMS Run Record
Pediatric Trauma Score: Weight

**Definition**
The weight of the patient at the time of injury.

**NOTE:** Will only auto-populate if patient is under the age of 18.

**Element Values**
1. Greater Than 20kg (44 lbs.)
2. Between 10 and 20kg (22-44 lbs.)
3. Less than 10kg (22 lbs.)
4. Not applicable
5. Unknown

**Data Source Hierarchy Guide**
1. Referring Facility Paperwork

Pediatric Trauma Score: Airway

**Definition**
The status of the patient’s airway upon ED/Hospital initial assessment.

**NOTE:** Will only auto-populate if patient is under the age of 18.

**Element Values**
1. Normal
2. Maintainable
3. Unmaintainable or Intubated
4. Not applicable
5. Unknown

**Data Source Hierarchy Guide**
1. Referring Facility Paperwork
Pediatric Trauma Score: Skeletal

**Definition**
The presence or absence of known fractures on ED/Hospital known assessment.

**NOTE:** Will only auto-populate if patient is under the age of 18.

**Element Values**
- 2. None
- 1. Closed Fractures
- -1. Open or Multiple Fractures
- /. Not applicable
- ?. Unknown

**Data Source Hierarchy Guide**
1. Referring Facility Paperwork

----

Pediatric Trauma Score: Cutaneous

**Definition**
The presence or absence of open wounds on ED/Hospital initial assessment

**NOTE:** Will only auto-populate if patient is under the age of 18.

**Element Values**
- 2. No open wounds
- 1. Minor open wounds
- -1. Major or penetrating open wounds
- /. Not applicable
- ?. Unknown

**Data Source Hierarchy Guide**
1. Referring Facility Paperwork
**Pediatric Trauma Score: CNS**

**Definition**
The mental status of the patient upon ED/Hospital initial assessment.

**NOTE:** Will only auto-populate if patient is under the age of 18.

**Element Values**
1. Awake
2. Altered mental status or obtunded
   - 1. Coma or abnormal flexion
   - / Not applicable
3. Comatose
4. Unknown

**Data Source Hierarchy Guide**
1. Referring Facility Paperwork

---

**Pediatric Trauma Score: Pulse Palp**

**Definition**
The presence or absence of pulses in different anatomical areas upon ED/Hospital initial assessment.

**NOTE:** Will only auto-populate if patient is under the age of 18.

**Element Values**
1. Pulse Palpable at Wrist (SBP over 90 mmHg)
2. Pulse Palpable at groin (SBP between 50 and 90 mmHg)
3. Pulse not palpable (SBP under 50 mmHg)
4. Not applicable
5. Unknown

**Data Source Hierarchy Guide**
1. Referring Facility Paperwork:
Inter-facility: Transport Procedure

Definition
Medical Intervention performed by EMS or first responder’s en-route to transfer facility.

NOTE: DI has a multiple procedures list that can be picked.

Data Source Hierarchy Guide
1. EMS Run record
Referring Facility Information

Inter-facility Transport: Medication Administration

Definition
Medications that were given to the patient en-route to referring facility.

NOTE: DI has multiple medication lists that can be picked.

Data Source Hierarchy Guide
1. EMS Run Report
Prehospital Procedure Start Date and Time

**Definition**

The date and time that medical interventions were performed by EMS or first responders either on scene or en-route to the initial treatment facility.

**Element Values**

- Relevant Value for Data Element

**Data Source Hierarchy Guide**

1. EMS Run Report
Prehospital: Medication Administration

Definition
Medications that were given to the patient either on scene or en-route to the initial treatment facility

Element Values
- Relevant Value for Data Element
- Multiple Values in DI

Data Source Hierarchy Guide
1. EMS Run Report
ED Arrival/Resuscitation

- The ED/Hospital Arrival date will auto-populate based on the demographics.
- The mode of arrival will auto-populate based on information placed in the prehospital section.
- The elapsed time for response activation and revised response activation will generate based on arrival and activation date and time.
- Please note the box at the top to denote if it is a direct admit or not.
**MANDATORY NTDS definition fields denoted with BLUE FONT**

**ED Arrival =ED or Hospital Arrival Date (see below)**

**Definition**

The date the patient arrived in the Emergency Department …OR… was admitted to your hospital. The patient may not enter your facility via ED, e.g., Direct Admission to the floor or ICU.
ED/HOSPITAL ARRIVAL DATE

Definition
The date the patient arrived to the ED/hospital.

Element Values
- Relevant value for data element

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

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

Associated Edit Checks

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<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
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<td>ED/Hospital Arrival Date is earlier than EMS Unit Arrival on Scene Date</td>
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<tr>
<td>4540</td>
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<td>Single Entry Max exceeded</td>
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</table>
**MANDATORY NTDS definition fields denoted with BLUE FONT**

**ED Arrival Time**

**Definition**

The time the patient arrived in the Emergency Department or into your Facility. The patient may not enter your facility via ED, e.g., Direct Admission to the floor, ICU. Enter the time the patient entered into the facility.
ED/HOSPITAL ARRIVAL TIME

Definition
The time the patient arrived to the ED/hospital.

Element Values
- Relevant value for data element

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

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

Associated Edit Checks

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</table>
ED Departure Order: **MANDATORY BLUE FIELD; NTDS Definition rules follow.**

**MANDATORY NTDS definition fields denoted with BLUE FONT**

**ED Discharge Date = ED Departure Order**

**ED DISCHARGE DATE**

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

Element Values
- Relevant value for data element

Additional Information
- Reported as YYYY-MM-DD.
- The null value “Not Applicable” is reported if the patient was 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. Trauma/Trauma/Hospital Flow Sheet
4. Nursing Notes/Flow Sheet
5. Discharge Summary
6. Billing Sheet
7. Progress Notes

Associated Edit Checks

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<td>ED Discharge Date is earlier than EMS Unit Arrival on Scene Date</td>
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<td>ED Discharge Date is earlier than EMS Unit Scene Departure Date</td>
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<td>ED Discharge Date is later than Hospital Discharge Date</td>
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<td>6309</td>
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<td>ED Discharge Date is earlier than Date of Birth</td>
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<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
**NOTE:** if no ED DC Order written: First Choice = Date Admit Orders entered; Second Choice = Date of ED discharge

**ED Departure Order Time** = BLUE FIELD; NTDS Definition rules.
ED DISCHARGE TIME

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

Element Values
- Relevant value for data element

Additional Information
- Reported as HH:MM military time.
- The null value "Not Applicable" is reported if the patient was directly admitted to the hospital.
- If ED Discharge Disposition is "5. Deceased/Expired," then ED Discharge Time is the time of
deed as indicated on the patient's death certificate.

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

Associated Edit Checks

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>6401</td>
<td>1</td>
<td>Time is not valid</td>
</tr>
<tr>
<td>6402</td>
<td>1</td>
<td>Time out of range</td>
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<td>6403</td>
<td>2</td>
<td>Element cannot be blank</td>
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<tr>
<td>6404</td>
<td>3</td>
<td>ED Discharge Time is earlier than EMS Dispatch Time</td>
</tr>
<tr>
<td>6405</td>
<td>3</td>
<td>ED Discharge Time is earlier than EMS Unit Arrival on Scene Time</td>
</tr>
<tr>
<td>6406</td>
<td>3</td>
<td>ED Discharge Time is earlier than EMS Unit Scene Departure Time</td>
</tr>
<tr>
<td>6407</td>
<td>2</td>
<td>ED Discharge Time is earlier than ED/Hospital Arrival Time</td>
</tr>
<tr>
<td>6408</td>
<td>2</td>
<td>ED Discharge Time is later than Hospital Discharge Time</td>
</tr>
<tr>
<td>6440</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>

**NOTE:** if no ED DC Order written: First Choice= Time Admit Orders entered; Second Choice = Time of ED discharge
**ED Departure / Admitted:** MANDATORY BLUE FIELD; NTDS Definition rules.

**ED/Resus ED Departure/Admitted**

**Definition**

The date and time the patient left the Emergency Department either for admission or discharge.

**Element Values**

- Relevant Value for Data Element

**Data Source Hierarchy Guide**

1. Physician admission/discharge orders
2. Progress Notes
3. Trauma Flowsheet
**ED Arrival/Resuscitation**

**Signs of Life:** MANDATORY BLUE FIELD; NTDS Definition rules.

**Definition**

Indication of whether the patient arrived at the ED/Hospital with signs of life. (**NOTE:** It is no longer required with the 2020 Admission NTDS data dictionary). The patient will have none of the following if they arrived with no signs of life: organized EKG activity, pupillary responses, spontaneous respiratory attempts or movement, and unassisted blood pressure. This generally means the patient was brought in with CPR in progress.

**Element Values**

1. Arrived with No Signs of Life
2. Arrived with Signs of Life
3. Not Applicable
4. Unknown

**Data Source Hierarchy Guide**

1. History and Physical
2. Progress Note
3. Flowsheet
4. EMS Run Report
**Response Level**

**Definition**

The level of trauma activation for the patient arriving to your facility.

- **Full**: Inhouse Team Activation Criteria met for full team response (highest level activation)
- **Partial**: Inhouse Team Activation Criteria met for partial team response.
- **Consult**: Inhouse Team Activation Criteria NOT met. Trauma Surgeon activated for consultation. May or may not result in Trauma Service admission.
- **No Trauma Activation**: IL Trauma Registry Inclusion Criteria met. No Trauma Surgeon involvement. Admitted to Service other than Trauma Service.
- **N/A**: IL Trauma Registry Inclusion Criteria NOT met. Trauma Surgeon may / may not have been involved. Often will be used for Facility – specific cohort tracking identifier

**Element Values**

1. Full
2. Partial
3. Consult
4. No Trauma Activation
5. Not Applicable
6. Unknown

**Data Source Hierarchy Guide**
1. Progress notes
2. History and Physical
3. EMS run sheet
4. Trauma Flowsheet

Response Activation Date and Time

Definition
The date (MONTH/DATE/YEAR) and time that the trauma was activated at your facility.

Element Values
- Relevant value for data element

Data Source Hierarchy Guide
1. History and Physical
2. Progress Notes
3. EMS Run Sheet
4. Trauma Flowsheet
Revised Response Activation Date and Time

Definition

The date (MONTH/DATE/YEAR) and time that the trauma was re-categorized after being evaluated or consulting with a physician en-route at your facility.

Element Values

- Relevant value for data element

Data Source Hierarchy Guide

1. Flowsheets
2. History and Physical
3. Progress Notes
4. EMS Run Sheet
**MANDATORY NTDS definition fields denoted with BLUE FONT**

ED DISCHARGE DISPOSITION

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

Element Values
1. Floor bed (general admission, non-specialty unit)
2. Observation unit
3. Telemetry/step-down unit
4. Home without services
5. Deceased/expired
6. Other (e.g., institutional care, mental health, etc.)
7. Operating Room bed
8. Intensive Care Unit (ICU)
9. Home without services
10. Left against medical advice
11. Transferred to another hospital

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

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

Associated Edit Checks

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
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<td>Element cannot be “Not Applicable” when Hospital Discharge Date is “Not Applicable”</td>
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**Entry Title Changed to POST ED DISPOSITION**

**DI Element Values**

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<th>Description</th>
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<tr>
<td>3.</td>
<td>Operating Room</td>
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<td>Intensive Care Unit</td>
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<tr>
<td>5.</td>
<td>Step-Down Unit</td>
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<tr>
<td>6.</td>
<td>Floor</td>
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<tr>
<td>7.</td>
<td>Telemetry Unit</td>
</tr>
<tr>
<td>8.</td>
<td>Observation Unit</td>
</tr>
<tr>
<td>9.</td>
<td>Burn Unit</td>
</tr>
<tr>
<td>13.</td>
<td>Labor and Delivery</td>
</tr>
<tr>
<td>14.</td>
<td>Neonatal/Pediatric Care Unit</td>
</tr>
<tr>
<td>15.</td>
<td>Other (In Hospital)</td>
</tr>
<tr>
<td>40.</td>
<td>Home</td>
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<td>41.</td>
<td>Home with Services</td>
</tr>
<tr>
<td>42.</td>
<td>Left AMA</td>
</tr>
<tr>
<td>43.</td>
<td>Correctional Facility/Court/Law Enforcement</td>
</tr>
<tr>
<td>44.</td>
<td>Morgue</td>
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<td>45.</td>
<td>Child Protective Agency</td>
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<td>46.</td>
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<td>47.</td>
<td>Intermediate Care Facility</td>
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<tr>
<td>48.</td>
<td>Skilled Nursing Facility</td>
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<tr>
<td>49.</td>
<td>Rehab (Inpatient)</td>
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<tr>
<td>50.</td>
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<tr>
<td>51.</td>
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<tr>
<td>52.</td>
<td>76. Mental Health/Psychiatric Hospital (Inpatient)</td>
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<td>53.</td>
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<tr>
<td>54.</td>
<td>78. Other (Out of Hospital)</td>
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<tr>
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<td>79. Another Type of Inpatient Facility Not Defined Elsewhere</td>
</tr>
<tr>
<td>56.</td>
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<tr>
<td>57.</td>
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<td>58.</td>
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<tr>
<td>62.</td>
<td>73. Rehab (Inpatient)</td>
</tr>
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<td>63.</td>
<td>74. Long-Term Care</td>
</tr>
<tr>
<td>64.</td>
<td>75. Hospice</td>
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<tr>
<td>65.</td>
<td>76. Mental Health/Psychiatric Hospital (Inpatient)</td>
</tr>
<tr>
<td>66.</td>
<td>77. Nursing Home</td>
</tr>
<tr>
<td>67.</td>
<td>78. Other (Out of Hospital)</td>
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<tr>
<td>68.</td>
<td>79. Another Type of Inpatient Facility Not Defined Elsewhere</td>
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<td>69.</td>
<td>88. Burn Center</td>
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<td>70.</td>
<td>87. Not Applicable</td>
</tr>
<tr>
<td>71.</td>
<td>89. Unknown</td>
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<tr>
<td>72.</td>
<td>70. Acute Care Facility</td>
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<td>73.</td>
<td>71. Intermediate Care Facility</td>
</tr>
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<td>74.</td>
<td>72. Skilled Nursing Facility</td>
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<tr>
<td>75.</td>
<td>73. Rehab (Inpatient)</td>
</tr>
<tr>
<td>76.</td>
<td>74. Long-Term Care</td>
</tr>
<tr>
<td>77.</td>
<td>75. Hospice</td>
</tr>
<tr>
<td>78.</td>
<td>76. Mental Health/Psychiatric Hospital (Inpatient)</td>
</tr>
<tr>
<td>79.</td>
<td>77. Nursing Home</td>
</tr>
<tr>
<td>80.</td>
<td>78. Other (Out of Hospital)</td>
</tr>
<tr>
<td>81.</td>
<td>79. Another Type of Inpatient Facility Not Defined Elsewhere</td>
</tr>
<tr>
<td>82.</td>
<td>88. Burn Center</td>
</tr>
<tr>
<td>83.</td>
<td>87. Not Applicable</td>
</tr>
<tr>
<td>84.</td>
<td>89. Unknown</td>
</tr>
<tr>
<td>85.</td>
<td>70. Acute Care Facility</td>
</tr>
<tr>
<td>86.</td>
<td>71. Intermediate Care Facility</td>
</tr>
<tr>
<td>87.</td>
<td>72. Skilled Nursing Facility</td>
</tr>
<tr>
<td>88.</td>
<td>73. Rehab (Inpatient)</td>
</tr>
<tr>
<td>89.</td>
<td>74. Long-Term Care</td>
</tr>
</tbody>
</table>
**Admitting Service**

**Definition**

The provider service that admitted the patient.

**Element Values:**

1. Trauma
2. Neurosurgery
3. Orthopedics
4. General Surgery
5. Pediatric Surgery
6. Cardiothoracic Surgery
7. Burn Services
8. Emergency Medicine
9. Pediatrics
10. Hospitalist
11. Intensivist
12. Other Surgical

**Data Source Hierarchy Guide:**

1. Physician Order
2. History and Physical
3. Consult Note
4. Billing Sheets
**Admitting Physician**

**Definition**

The provider that is admitting the patient to the hospital

**Element Values**

- Relevant Value for Data Set

**Data Source Hierarchy Guide**

1. Physician Order
2. History and Physical
3. Progress Notes
4. Billing Sheets
**Surgeon**

**Definition**

Denotes whether or not the admitting physician is a surgeon.

**NOTE:** Data entry of Admitting Physician turns the Surgeon box white to indicate if the admitting physician is a surgeon.

**Element Values**

1. Yes, Surgeon
2. No, Not a Surgeon
3. Not Applicable
4. Unknown

**Data Source Hierarchy Guide**

1. Progress Notes
2. Billing Sheets
Post OR Disposition

Definition

If the patient went from the emergency department to the operating room, this designates where the person went post-operatively.

Element Values

- 4. Intensive Care Unit
- 5. Step-Down Unit
- 6. Floor
- 7. Telemetry Unit
- 8. Observation Unit
- 9. Burn Unit
- 11. Post Anesthesia Care Unit
- 14. Neonatal/Pediatric Care Unit
- 42. Left AMA
- 44. Morgue
- /, Not Applicable
- ?, Unknown

Data Source Hierarchy Guide

1. Operative Note
2. Progress Note
ED/Resus Initial Vitals Recorded Date and Time

Definition

The date and time that the first set of vitals was recorded within your facility.

**NOTE**: The initial values must be recorded within 30 minutes of patient arrival.

**Element Values**

- Relevant Value for Data Element

**Data Source Hierarchy Guide**

1. Trauma Flowsheet
2. Flowsheets
3. History and Physical
4. Progress Notes
Initial ED / Hospital Patient Weight: MANDATORY BLUE FIELD; NTDS Definition rules.

NOTE: Once weight is entered, you will be asked for pounds or kilograms. Then you will be asked if it was timely. Timely refers to weight being available within the 24 hour timeframe put forth by the NTDS.
Initial ED / Hospital Patient Weight: **MANDATORY BLUE FIELD; NTDS Definition rules.**

**INITIAL ED/HOSPITAL HEIGHT**

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

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

**Additional Information**
- Report in centimeters.
- May be based on family or self-report.
- Please note that first recorded hospital vital signs do not need to be from the same assessment.
- The null value “Not Known/Not Recorded” is reported if the patient’s Initial ED/Hospital Height was not measured within 24 hours or less of ED/hospital arrival.

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

**Associated Edit Checks**

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
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<td>3</td>
<td>The value is above 215</td>
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<tr>
<td>8506</td>
<td>3</td>
<td>The value is below 50</td>
</tr>
<tr>
<td>8540</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>

**NOTE:** Once entered, it will ask for centimeters or inches, and will then ask if it was timely. If it doesn’t meet the criteria of less than 24 hours after arrival, it is not timely.
**Initial ED / Hospital Temperature:** MANDATORY BLUE FIELD; NTDS Definition rules.

**NOTE:** Once entered it will ask for cc (centigrade) or ff (Fahrenheit). It also will open “source” – 1. Oral; 2. Tympanic; 3. Rectal; 4. Axillary; 5. Core; 6. Other; 7. Temporal; ? Unknown
ED Resus Paralytic Agents: MANDATORY BLUE FIELD; NTDS Definition rules.

ED Resus Paralytic Agents

Definition
Were paralytic agents affecting the patient at the time the initial set of vitals were taken?

Element Values

Y. Yes
N. No
/. Not Applicable
?. Unknown

Data Source Hierarchy Guide:
1. Medication Administration Record
2. Trauma Flowsheet / Nurse’s Notes
3. ED Timeline
4. History and Physical
5. Progress Notes
**ED Resus Sedated:** MANDATORY BLUE FIELD; NTDS Definition rules.

**Definition**
Were sedative agents affecting the patient at the time the initial set of vitals were taken?

**Element Values**
- Y. Yes
- / . Not Applicable
- N. No
- ?. Unknown

**Data Source Hierarchy Guide**
1. Medication Administration Record
2. Trauma Flowsheet / Nurse’s Notes
3. ED Timeline
4. History and Physical
5. Progress Notes
**Eye Obstruction:** MANDATORY BLUE FIELD; NTDS Definition rules.

**ED/Resus Eye Obstruction**

**Definition**
Was there an eye obstruction affecting the patient at the time the initial set of vitals were taken?

**Element Values**
- Y. Yes
- N. No
- / Not Applicable
- ?. Unknown

**Data Source Hierarchy Guide**
1. Medication Administration Record
2. Trauma Flowsheet / Nurse’s Notes
3. ED Timeline
4. History and Physical
5. Progress Notes
ED / Resus Intubated

Definition
Was the patient intubated at the time the initial set of vitals were taken?

Element Values
Y. Yes
N. No
/. Not Applicable
?. Unknown

Data Source Hierarchy Guide
1. History and Physical / Procedure Notes
2. Progress Notes
3. Flowsheets
ED/Resus Intubation Method

Definition

The device or method used to intubate the patient.

NOTE: Will only populate if you answer yes to the referring facility intubated question.

Element Values

1. Combitube
2. Cricothyrotomy
3. Cricothyrotomy- Needle
4. Endotracheal Tube-Nasal
5. Endotracheal Tube-Oral
6. Endotracheal Tube-Route
7. Esophageal Obturator
8. Laryngeal Mask Airway
9. LT Blind Insertion Device
10. Tracheostomy

Data Source Hierarchy Guide

1. History and Physical / Procedure Notes
2. Flowsheets
3. Progress Notes
ED Resus Respiration Assisted: MANDATORY BLUE FIELD; NTDS Definition rules.

**Definition**

Did the patient required assisted respirations at the time the initial set of vitals were taken?

**Element Values**

- Y. Yes
- N. No
- / Not Applicable
- ?. Unknown

**Data Source Hierarchy Guide**

1. History and Physical
2. Flowsheets
3. Progress Notes
**ED/Resus Respiration Assisted Type**

**Definition**
The device used to assist the patient’s respirations.

**NOTE:** Will only populate if you answer yes.

**Element Values**
1. Bag Value Mask
2. Nasal Airway
3. Oral Airway
4. Ventilator
5. Unknown

**Data Source Hierarchy Guide**
1. History and Physical
2. Flowsheets
3. Progress Notes
**Initial ED / Hospital Systolic BP:**  MANDATORY BLUE FIELD; NTDS Definition rules.

**INITIAL ED/HOSPITAL SYSTOLIC BLOOD PRESSURE**

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

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

**Additional Information**
- Please note that first recorded hospital vitals do not need to be from the same assessment.
  - Measurement reported 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. Trauma/Neurosurgical/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes
4. History & Physical

**Associated Edit Checks**

<table>
<thead>
<tr>
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<th>Level</th>
<th>Message</th>
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<td>The value is below 30</td>
</tr>
<tr>
<td>4740</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
**Initial ED / Hospital Diastolic BP:** MANDATORY BLUE FIELD; NTDS Definition rules.

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

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

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

**Data Source Hierarchy Guide**
1. Flowsheets
2. ED Trauma Summary
3. History and Physical
4. Progress Notes
INITIAL ED/HOSPITAL PULSE RATE

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

Element Values
- Relevant value for data element:

Additional Information
- Please note that first recorded hospital vitals do not need to be from the same assessment.
- Measurement reported 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

Associated Edit Checks

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<thead>
<tr>
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<th>Level</th>
<th>Message</th>
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<td>4840</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
INITIAL ED/HOSPITAL RESPIRATORY RATE

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

Element Values
- Relevant value for data element

Additional Information
- If reported, report additional data element: Initial ED/Hospital Respiratory Assistance.
- Please note that first recorded hospital vitals do not need to be from the same assessment.

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

Associated Edit Checks

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<tr>
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<th>Level</th>
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</tbody>
</table>
NOTE: Only opens if auto-populated by entering data into the Respiratory Assisted element.
INITIAL ED/HOSPITAL OXYGEN SATURATION

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

Element Values
- Relevant value for data element

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

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

Associated Edit Checks

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</table>
INITIAL ED/HOSPITAL SUPPLEMENTAL OXYGEN

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

Element Values
1. No Supplemental Oxygen
2. 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 first recorded hospital vitals do not need to be from the same assessment.

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

Associated Edit Checks

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</table>

230
INITIAL ED/HOSPITAL GCS - EYE

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

**Element Values**
1. No eye movement when assessed
2. Opens eyes in response to painful stimulation
3. Opens eyes in response to verbal stimulation
4. Opens eyes spontaneously

**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 reported. E.g. the chart indicates “patient’s pupils are PERRL,” or Eye GCS of 4 may be reported, if there is no other contradicting documentation.
- Please note that first recorded hospital vitals do not need to be from the same assessment.
- The null value “Not Known/Not Recorded” is reported if Initial ED/Hospital GCS 40 = Eye is documented.
- The null value “Not Known/Not Recorded” is reported if the patient’s Initial ED/Hospital GCS - Eye was not measured within 30 minutes or less of ED/hospital arrival.

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

**Associated Edit Checks**

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<tr>
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</table>
**INITIAL ED/HOSPITAL GCS - VERBAL**

**Definition**
First recorded Glasgow Coma Score (Verbal) within 30 minutes or less of ED/Hospital arrival.

**Element Values**

**Pediatric (≤ 2 years):**
1. No vocal response
2. Incomprehensible sounds
3. Inconsistently consolable, meaning
4. Confused
5. Oriented

**Adult:**
1. No vocal response
2. Incomprehensible sounds
3. Inconsistently consolable, meaning
4. Confused
5. Oriented

**Additional Information**
- If patient is intubated, then the GCS Verbal score is equal to 1.
- If patient does not have a numeric GCS score recorded, but written documentation clearly (or directly) relates to verbal describing a specific level of functioning within the GCS scale, the appropriate numeric score may be reported. e.g., the chart indicates “patient is oriented to person, places and time.” A Verbal GCS of 5 may be reported, IF there is no other contradicting documentation.
- Please note that if first recorded hospital vitals do not need to be from the same assessment.
- The null value “Not Known/Not Recorded” is reported if Initial ED/Hospital GCS 40 – Verbal is 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 or less of ED/Hospital arrival.

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

**Associated Edit Checks**

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</table>
INITIAL ED/HOSPITAL GCS - MOTOR

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

Element Values

Pediatric (≤ 2 years)
1. No motor response
2. Extension to pain
3. Flexion to pain

Infants
1. No motor response
2. Extension to pain
3. Flexion to pain

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

Data Source Hierarchy Codes
1. Trauma/Trauma/hospital Flow Sheet
2. Nurse Notes/Prior Sheet
3. Physician Notes/Prior Sheet

Associated Edit Checks

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</table>
**Pediatric Trauma Score: Weight**

**Definition**
The weight of the patient at the time of injury. Will only populate if patient is under the age of 18.

**Element Values**

1. Less than 10kg (22 lbs.)
2. Between 10 and 20kg (22-44 lbs.)
3. Greater than 20kg (44 lbs.)
4. Not Applicable
5. Unknown

**Data Source Hierarchy Guide**

1. Flowsheets
2. History and Physical
**Pediatric Trauma Score: Airway**

**Definition**

The status of the patient’s airway upon ED/Hospital initial assessment. Will only populate if patient is under the age of 18.

**Element Values**

1. Normal
2. Maintainable
3. Unmaintainable or Intubated
4. /, Not Applicable
5. ?, Unknown

**Data Source Hierarchy Guide**

1. Flowsheets
2. History and Physical
3. Progress Notes
**Pediatric Trauma Score: Skeletal**

**Definition**

The presence or absence of known fractures on ED/Hospital known assessment. Will only populate if patient is under the age of 18.

**Element Values**

1. Closed Fracture
2. None
3. Open or Multiple Fractures
4. Not Applicable
5. Unknown

**Data Source Hierarchy Guide**

1. Flowsheets
2. Radiology Reports
3. History and Physical
4. Progress Notes
Pediatric Trauma Score: Cutaneous

**Definition**

The presence or absence of open wounds on ED/Hospital initial assessment. Will only populate if patient is under the age of 18.

**Element Values**

2. No Open Wounds
1. Minor Open Wounds
   - Major or Penetrating Open Wounds
   . Not Applicable
   ?. Unknown

**Data Source Hierarchy Guide**

1. Flowsheets
2. History and Physical
3. Progress Notes
Pediatric Trauma Score: CNS

**Definition**
The mental status of the patient upon ED/Hospital initial assessment. Will only populate if patient is under the age of 18.

**Element Values**
- 2. Awake
- 1. Altered Mental Status or Obtunded
  - 1. Coma or Abnormal Flexion
  - / Not Applicable
  - ?. Unknown

**Data Source Hierarchy Guide**
1. Flowsheets
2. History and Physical
3. Progress Notes
Pediatric Trauma Score: Pulse Palp

**Definition**

The presence or absence of pulses in different anatomical areas upon ED/Hospital initial assessment. Will only populate if patient is under the age of 18.

**Element Values**

1. Pulse Palpable at Groin (SBP Btwn 50 and 90 mmHg)
2. Pulse Palpable at Wrist (SBP over 90 mmHg)
3. Pulse Not Palpable (SBP under 50 mmHg)
4. Not Applicable
5. Unknown

**Data Source Hierarchy Guide**

1. Flowsheets
2. History and Physical
3. Progress Notes
ALCOHOL SCREEN

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

Element Values
1. Yes
2. No

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

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

Associated Edit Checks

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</table>
ALCOHOL SCREEN RESULTS

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

Element Values
• Relevant value for data element.

Additional Information
• Reported as XXX grams per deciliter (g/dl).
• Report BAC results within 24 hours after first hospital encounter, at either your facility or the transferring facility.
• The null value "Not Applicable" is reported for those patients who were not tested.

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

Associated Edit Checks

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<tr>
<td>5936</td>
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NOTE: A positive alcohol result will activate an opening for entry of ETOH/BAC Level.
**ED/Resus: Drug Use Indicator**

**Definition**
A drug test was performed on the patient within 24 hours after the first hospital encounter.

**Element Values**
1. No (Not Tested)
2. No (Confirmed by Test)
3. Yes (Confirmed by Test: Prescription Drug)
4. Yes (Confirmed by Test: Illegal Drug Use)
   / Not Applicable
   ?. Unknown

**NOTE:** Drug screen may be administered at any facility, unit, or setting treating this patient event.

**NOTE:** Cannabis is ILLEGAL…regardless of medical Rx or IL legislation. TOIP has ruled on this already.

**Data Source Hierarchy Guide**
1. Lab Results
2. Transferring Facility Records
3. Progress Notes
DRUG SCREEN

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

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

Additional Information
- Report 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 selected, only report drugs that were NOT administered at any facility (or setting) treating this patient event.

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

Associated Edit Checks

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<td>D050</td>
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</table>
ED/Resus Drug Specify

**Definition**
What drug was positive within 24 hours after the first hospitalization encounter?

**Element Values**
1. Amphetamine
2. Barbiturate
3. Benzodiazepine
4. Cannabis
5. Cocaine
6. Methamphetamine
7. Opiates
8. PCP
9. Other
? Unknown

**Data Source Hierarchy Guide**
1. 1. Lab Results
2. Transfer Center Records
**ED/Resus: Clinician Administered**

**Definition**

Was the drug screen positive because that particular medication was administered by a clinician?

**Element Values**

- Y. Yes
- N. No
- . Not Applicable
- ?. Unknown

**Data Source Hierarchy Guide**

1. Medication Administration Record
2. Transferring Facility Paperwork
3. Flowsheets / ED Timeline
4. History and Physical
5. Progress Notes
**ED/Resus: ABGs Drawn**

**Definition**

Arterial Blood Gases were drawn on the patient within 24 hours of arrival.

**Element Values**

- Y. Yes
- N. No
- /, Not Applicable
- ?, Unknown

**Data Source Hierarchy Guide**

1. Lab Results
**ED/Resus: pH**

**Definition**

The measurement of the acidity of arterial blood. Found in the lab results for ABG within the first 24 hours.

**Element Values**

- Relevant value for data element

**Data Source Hierarchy Guide**

1. Lab Results
ED/Resus: PaO2

**Definition**

The measurement of the oxygen levels of arterial blood. Found in the lab results for ABG within the first 24 hours.

**Element Values**

- Relevant value for data element

**Data Source Hierarchy Guide**

1. Lab Results
ED/Resus: PaCO2

**Definition**

The measurement of the carbon dioxide levels of arterial blood. Found in the lab results for ABG within the first 24 hours.

**Element Values**

- Relevant value for data element

**Data Source Hierarchy Guide**

1. Lab Results
**ED/Resus: Base Deficit / Excess**

**Definition**

The measurement of the excess or deficit of base present in arterial blood. Found in the lab results for ABG within the first 24 hours.

**Element Values**

- Relevant value for data element

**Data Source Hierarchy Guide**

1. Lab Results
**ED/Resus: Hematocrit**

**Definition**

The proportion, by volume, of the blood that consists of red blood cells. Measured from the first lab test drawn with that particular result.

**Element Values**

- Relevant value for data element

**Data Source Hierarchy Guide**

1. Lab Results
**ED/Resus: INR**

**Definition**

A result that helps to evaluate the body’s ability to appropriately form blood clots, it is derived from the pro-time results. Results of the first lab test drawn with that particular result.

**Element Values**

- Relevant value for data element

**Data Source Hierarchy Guide**

1. Lab Results
Additional ED/Resus: Vitals

Definition

Portions of the Initial Assessment will populate to the Vitals tab. Any additional vitals recorded during the patient’s initial ED stay or during the resuscitation phase.

NOTE: You can also EDIT and DELETE the information if needed.

Element Values

- Refer to previous vitals for specific information regarding the documentation of the vital signs

  NOTE: These vitals do not have to be performed within the first 30 minutes of arrival to the ED/Hospital. The American College of Surgeons suggests checking the vitals at least every hour.

Data Source Hierarchy Guide

1. Flowsheets
2. OR Records
3. Progress Notes
**ED/Resus: Medications**

**Definition**

Medications that were given during the initial ED stay or during the resuscitation phase. Note these can all be edited or deleted formally by the box to the right.

**Element Values**

- Relevant Value for Data Element

**Data Source Hierarchy Guide**

1. Medication Administration Record
2. Trauma Flowsheet / Flowsheets / ED Timeline
3. OR / Anesthesia Records
4. History and Physical
5. Progress Notes
6. Nursing Notes
**ED/Resus: Warming Measures**

**Definition**
The presence or absence of warming measures taken to maintain a patient’s temperature during the resuscitation phase.

**Element Values**
- 0. No Warming Measures
- 1. Warming Measures Applied
- /, Not Applicable
- ?, Unknown

**Data Source Hierarchy Guide**
1. Trauma Flowsheet
2. OR Records
3. History and Physical
4. Progress Notes
ED/Resus: Mass Blood Protocol

Definition
Was a massive blood transfusion protocol activated for the patient?

Element Values
- Y. Yes
- N. No
- /. Not Applicable
- ?. Unknown

Data Source Hierarchy Guide
1. Orders (EMR / Physician / Lab)
2. Trauma Flowsheet / Flowsheets / ED Timeline
3. Blood Bank / Lab Records
4. OR / Anesthesia Records
5. Operative Procedure Notes
6. History and Physical
7. Progress Notes
**ED/Resus: Mass Blood Protocol Time and Date Ordered**

**Definition**

The time and date that the massive transfusion protocol was ordered

**Element Values**

- Relevant Values for Data Element

**Data Source Hierarchy Guide**

1. Orders (EMR / Physician / Lab)
2. Trauma Flowsheet / Flowsheets / ED Timeline
3. Blood Bank / Lab Records
4. OR / Anesthesia Records
5. Operative Procedure Notes
6. History and Physical
7. Progress Notes
**ED/Resus: Mass Blood Protocol Time and Date Ordered**

**Definition**

The date and time that the massive transfusion protocol was initiated.

**Element Values**

- Relevant Values for Data Element

**Data Source Hierarchy Guide**

1. Orders (EMR / Physician / Lab)
2. Trauma Flowsheet / Flowsheets / ED Timeline
3. Blood Bank / Lab Records
4. OR / Anesthesia Records
5. Operative Procedure Notes
6. History and Physical
7. Progress Notes
**Location/Service/Blood/Ventilator Tracking**

- The elapsed time for each location will auto-populate based on the date and times that are placed. ICU and Step-Down days will automatically calculate based on the location option that you select.
- Service Tracking elapsed time will auto-populate after the date and times are entered for each service.
- Ventilator tracking will calculate the amount of days that the patient is on a ventilator automatically based on the dates and times that are entered.
- IL Consensus to enter blood components as UNITS statewide vs using the other quantity options.
Location Tracking: Location Code

**Definition**

The different units and procedural areas where the patient was admitted throughout their inpatient hospital stay.

**Element Values**

1. Resuscitation Room
2. Emergency Department
3. Operating Room
4. Intensive Care Unit
5. Step-Down Unit (Adv Care)
6. Floor
7. Telemetry Unit
8. Observation Unit
9. Burn Unit
10. Radiology
11. Post Anesthesia Care Unit
12. Special Procedure Unit
13. Labor and Delivery
14. Neonatal/Pediatric Care Unit

*FYI: if used for Peds ICU, it will not auto-calculate ICU days*

?. Unknown
/. Not Applicable

**Data Source Hierarchy Guide**

- ADT Events
- Encounter Report (EPIC)
- Nursing Notes
- Progress Notes
NOTE: Can enter the Peds ICU days as “4 “Intensive Care Unit. Then after entering arrival & departure dates / times and allowing it to auto calculate, return and edit that row entering “14” and the total times will remain.

**Location Tracking: Arrival Date and Time**

**Definition**

The date and time that a patient arrived to a particular unit or procedural area.

**Element Values**

- Relevant values for Data Element

**Data Source Hierarchy Guide**

1. ADT Events
2. Encounter Report (EPIC)
3. Nursing Notes
4. Progress Notes
Location Tracking: Departure Date and Time

Definition
The date and time that a patient departed a particular unit or procedural area.

Element Values
- Relevant values for Data Element

Data Source Hierarchy Guide
1. ADT Events
2. Encounter Report (EPIC)
3. Nursing Notes
4. Progress Notes
**IL Trauma Patient Categorization: Mandatory Illinois Element, if applicable**

**Definition**

The trauma acuity Category assigned to the patient based on the criteria specified in the IL Trauma Rules & Regulations.

Categorization Rules can be found in Section 515, Appendices C and F. (Screen shots follow on next 3 pages)

Patient can meet State Categorization anytime the Criteria is met prior to or within 10 minutes of hospital arrival. (For example: Prehospital Sustained SBP ≤90 on 2 consecutive measurements at least 5 minutes apart = Category I; ED first 10 minutes with confirmed SBP ≤90 = Category I; ICU or OR SBP ≤90 or ED Drop in SBP after evaluation has begun and the 10min clock has passed = sick patient, but no state categorization.)

**Element Values for Illinois:**

1. Category I
2. Category II

**NOTE:** Field Element Values in the DI Software are based on CDC Field and IL In-house criteria. Currently use only those IL approved elements as highlighted below:

This field is NOT MULTI-SELECT. You will need to ADD a new row for each new element.
INHOUSE ACTIVATION CRITERIA: TAC Approved 2015 but not yet in RULES
1. Cat I – Amputation Proximal to Wrist or Arm
2. Cat I – Blood infusing to Maintain Vital Signs
3. Cat I – Chest Wall Instability or Deformity (e.g., Flail chest)
4. Cat I – Confirmed SBP <90 in Adults; <80 in Peds (this would be Field Surgeon Activation)
5. Cat I – Crushed, De-gloved, Mangled or Pulseless Extremity
6. Cat I – Emergency Physician Discretion
7. Cat I – GCS ≤ 10
8. Cat I – Inability to Intubate with Anticipation of Surgical Airway
9. Cat I – Open or Depressed Skull Fracture
10. Cat I – Other (Facility Specific Criteria for Full Team Activation)

FIELD ACTIVATION CRITERIA: TAC Approved in 2012 but not yet in RULES
11. Cat I – Paralysis proximal to the Wrist or Ankle
12. Cat I – Pelvis Fractures (Unstable)
13. Cat I – Penetrating Injuries Excluding Distal Extremities (Head, Neck, Torso, Groin)
14. Cat I – Respiratory Rate <10 or >29 or requiring ventilator support
15. Cat I – Systolic BP <90mmHg (<80mmHg in Peds)
16. Cat I – Two or more Proximal Long Bone Fractures
17. Cat 2 – Auto Crash Death in Same Passenger Compartment
18. Cat 2 – Auto Crash Ejection
19. Cat 2 – Auto Crash Intrusion >18in (>12in for Occupant Site)
20. Cat 2 – Auto Crash Telemetry Data Indication
21. Cat 2 – Auto vs Cyclist Thrown, Run Over or >20mph Impact
22. Cat 2 – Auto vs Pedestrian Thrown, Run Over or >20mph Impact
23. Cat 2 – Fall; Adults >20ft (One Story = 10ft)
24. Cat 2 – Fall Children >10ft or 2-3 Times Height of Child
25. Cat 2 – GCS 11-13 with Mechanism Attributed to Trauma
26. Cat 2 – Motorcycle crash >20mph (also recreational vehicles)
27. Cat 2 – Other (Facility Specific Criteria for Partial Team Activation)

MISSING FROM DI ELEMENT CHOICES BUT APPROVED IN IDPH SET

XX Cat I – Combination Trauma with ≥ 20% TBSA Burns
XX Cat I – Two or more body regions with potential life or limb threat
XX Cat I - SUSTAINED Hypotension- BP ≤90 Systolic (Peds ≤80 Systolic) on 2 consecutive measurements 5min apart (USING Element #4 “Confirmed SBP <90…)

Data Source Hierarchy Guide
1. Trauma Flowsheet / Navigator
2. EMS Run Sheet
3. EMS Radio Report Sheet
4. Nursing Notes
5. Progress Notes
Section 515. APPENDIX C  Minimum Trauma Field Triage Criteria

- SUSTAINED HYPOTENSION — BP ≤ 90 SYSTOLIC (PEAK ≤ 80 SYSTOLIC) ON TWO CONSECUTIVE MEASUREMENTS FIVE MINUTES APART

  NO

  YES

  MANDATORY NOTIFICATION OF THE TRAUMA SURGEON FROM THE FIELD

  YES

  Category I
  Blast or Penetrating Trauma With Unstable
  Vital Signs And/or:
  - Hemodynamic Compromise As Evidenced By:
    - BP ≤ 90 systolic
    - (Peds – BP ≤ 80 systolic
  - Respiratory Compromise as Evidenced By:
    - Respiratory rate < 10 or > 29
  - Altered Mentation as Evidenced By:
    - Glasgow Coma Scale ≤ 10

  NO

  YES

  Anatomical Injury
  - Penetrating injury of head, neck, torso, groin
  - Two or more body regions with potential life or limb threat
  - Combination trauma with ≥ 20% TBSA Burn
  - Amputation above wrist or ankle
  - Limb paralysis and/or sensory deficit above the wrist and ankle
  - Flail chest

  NO

  YES

  Category II
  Mechanism of Injury
  - Ejection from motor vehicle
  - Death in same passenger compartment
  - Falls > 20 feet

  NO

  YES

  - Initiate Field Trauma Treatment Protocols
  - Rapid Transport To Trauma Center (I)

  Initiates Field Trauma Treatment Protocols
  And Transport to Closest Hospital
Section 515 APPENDIX F Template for In-House Triage for Trauma Centers

It is expected that each trauma center will expand upon the minimum triage set based on individual assessments, resources and outcomes. The criteria are consistent with the Minimum Trauma Field Triage Criteria for transport to a trauma center.

a) Patient Evaluation

1) Any EMS System transported patients who are classified under Category I in the Minimum Trauma Field Triage Criteria require rapid transport to a trauma center if less than 25 minutes from the trauma center; otherwise, follow Section 515 Appendix C. Mandatory field notification of a trauma surgeon will occur in cases of:

A) Sustained hypotension (blood pressure less than or equal to 90 Hg systolic for an adult and less than or equal to 60 Hg for a pediatric patient on two consecutive measures five minutes apart), or

B) Cavity penetration of the torso or neck.

2) Patients who are classified in the field or in any pre-hospital setting shall be evaluated by the ED’s attending emergency physician or designee immediately upon arrival. (Section 515:2060(a))

3) Patients who are not classified as trauma prior to arrival shall be evaluated to assess whether they should be classified as a trauma patient within 10 minutes after arrival. (Section 515:2060(b))

4) Within the above 10 minute evaluation period, the patient must be determined to be Category I or Category II. The response periods for both categories are described below.

5) Patients may be upgraded at any time during ED treatment. The surgeon response time requirements begin at the time of upgrade.

6) Once the patient has been assigned a Category I or II status that patient cannot be downgrade until the patient is evaluated by the trauma surgeon or appropriate subspecialist.

b) Category I

The trauma center must activate its trauma team response (which includes a trauma surgeon, resident or other surgical specialty in lieu of the trauma surgeon) for patients who meet these criteria. Level II trauma centers require a 30-minute response from the time of identification of need. If a back-up surgeon is used, the 30-minute time for response is based on the trauma patient identification time, not the time of the contact to the back-up surgeon. Any patient can be made a Category I based on the ED physician’s discretion.
Any patient meeting the definition of isolated injury requires consultation with the appropriate subspecialist within 60 minutes after trauma patient identification, except for neurosurgery and Level I OB/GYN, pediatric surgery and cardiovascular surgery. When neurosurgical intervention has been identified, the neurosurgeon must arrive and be available in a fully staffed operating room within 60 minutes after the identification of the need for operative intervention. In a Level I trauma center, the OB/GYN, pediatric surgery or cardiovascular surgical subspecialist must arrive within 30 minutes after notification of the subspecialist that his or her services are needed at the hospital. Where specialty services are provided by transfer agreement, a transfer to a specialty center shall commence within 30 minutes after the patient’s arrival, and shall be completed within two hours. An isolated injury refers to transfer of energy to a single anatomical body region with no potential for multisystem involvement.

c) Category II
Any other patient who is admitted for traumatic injury requires notification and consultation with the trauma surgeon or subspecialist at the time the decision to admit is made. The patient will be seen by the trauma surgeon or appropriate surgical subspecialist within 12 hours after emergency department arrival.

Any patient meeting the definition for isolated injury requires a telephone consultation with the appropriate subspecialist (within 60 minutes Level II and 30 minutes Level III) of identified need by the emergency department physician. When the need for neurosurgical intervention has been identified, the neurosurgeon must be available in a fully staffed operating room within 60 minutes after the identification of need for operative intervention. Where specialty services are provided by transfer agreement, a transfer to a specialty center shall commence within 30 minutes after the patient’s arrival, and the transfer shall be completed within two hours. An isolated injury refers to the transfer of energy to a single anatomical body region with no potential for multisystem involvement.

Category I criteria include at minimum but are not limited to items in the Category I box, Minimum Trauma Field Triage Criteria (Section 515 Appendix C).

Category II criteria include at minimum but are not limited to items in the Category II box, Minimum Field Triage Criteria (Section 515 Appendix C).

(Source: Amended at 22 Ill. Reg. 11835, effective June 25, 1998)
Definition

The actual trauma acuity Category criteria met by the patient as specified in the IL Trauma Rules & Regulations.

NOTE: Categorization Rules can be found in Section 515, Appendices C and F. (Screen shots on prior 3 pages). Patient can meet State Categorization anytime the Criteria is met prior to or within 10 minutes of hospital arrival.

Element Values

**CATEGORY I**
1. Sustained SBP ≤ 90 (≤80 Peds)
2. RR ≤10 or >29
3. GCS ≤ 10

**CATEGORY II**
4. Motor vehicle ejection
5. Death
6. Falls >20ft
7. 2 or more body regions life/limb threat
8. Combo trauma / Burns ≥20% TBSA
9. Amputation above wrist or ankle
10. Limb deficit above wrist or ankle
11. Flail chest

Data Source Hierarchy Guide
1. Trauma Flowsheet / Navigator
2. EMS Run Sheet
3. EMS Radio Report Sheet
4. Nursing Notes
5. Progress Notes
Location Tracking: Trauma Category Location

Definition

The location of the patient when IDPH Trauma Patient Categorization Criteria was/were identified.

NOTE: Prehospital is not an option in the DI List for this element. Please use ( ) ______ when the categorization criteria were met in the Prehospital setting. (IDPH to supply the missing clarity.)

Element Values

- Relevant values for Data Element

Data Source Hierarchy Guide

1. EMS Run Report
2. Trauma Flow Sheet / Navigator
3. Radio Report Log
4. Nursing Notes
5. Progress Notes
Location Tracking: Trauma Category Time / Date

Definition
The date when IDPH Trauma Patient Categorization Criteria was/were identified.
Stop Date can be entered as NA (/).

NOTE: There is no need to identify or track a STOP time for this element.

Element Values
- Relevant values for Data Element

Data Source Hierarchy Guide
1. EMS Run Report
2. Trauma Flow Sheet / Navigator
3. Radio Report Log
4. Nursing Notes
5. Progress Notes
**Location Tracking: Trauma Category Notes**

**Definition**

Free text opportunity to add notes pertinent to the IDPH Trauma Patient Categorization process.

**Examples**

- Specifying time that activation occurred and/or why.
- Specifying the Facility-specific criteria utilized if not present in the approved / highlighted lists.
- Specifying Prehospital as the location of criteria being met since not a dropdown item.

**Element Values**

- Relevant values for Data Element

**Data Source Hierarchy Guide:**

1. EMS Run Report
2. Trauma Flow Sheet / Navigator
3. Radio Report Log
4. Nursing Notes
5. Progress Notes
ICU Days – See next page for NTDS definitions. **MANDATORY BLUE FIELD: NTDS Definition rules.**

**NOTE:** ICU days will auto-populate based on location tracking
Use of location #14, Neonatal / Pediatric Care Unit, will not auto-populate ICU days. You CAN however, enter ICU location # 4 initially for the software to calculate the days and then switch location to #14 Neonatal / Pediatric Care Unit and the calculated days will remain in the reporting blue field.

Stepdown/IMC Days – These will also auto-populate based on location tracking.
TOTAL ICU LENGTH OF STAY

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

Element Values
- Relevant value for data element

Additional Information
- Reported in full day increments with any partial calendar day counted as a full calendar day.
- The calculation assumes that the date and time of starting and stopping an ICU episode are recorded in the patient's chart.
- If patient has multiple ICU episodes on the same calendar day, count that day as one calendar day.
- At no time should the ICU LOS exceed the hospital LOS.
- The null value "Not Applicable" is reported if the patient had no ICU days according to the above definition.

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

Data Source Hierarchy Guide
1. ICU Flow Sheet
2. Nursing Notes/Flow Sheet

Associated Edit Checks

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<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
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<td>7502</td>
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<tr>
<td>7503</td>
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<td>Total ICU Length of Stay is greater than the difference between ED/Hospital Arrival Date and Hospital Discharge Date</td>
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<tr>
<td>7504</td>
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<td>The value is above 80</td>
</tr>
<tr>
<td>7505</td>
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<td>The value submitted falls outside the valid range of 1-575</td>
</tr>
<tr>
<td>7540</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Service Tracking: Service Code

Definition
The physician specialty service(s) caring for the patient. Up to 8 services can be added. **NOTE:** Enter the Primary Service first if you enter multiples.

Useful to track service handoffs / assumption of care (such as Trauma Service handing isolated injury case to Orthopedics, who added Hospitalists, etc.).

Facility can determine if tracking only Primary Service, specific Service Lines, or every service involved with the patient.

Element Values
- Relevant values for Data Element
  (Specialty Provider Groups)

Data Source Hierarchy Guide
1. History and Physical
2. Consult Notes
3. Progress Notes
4. Treatment Team entries if doing concurrent abstraction
**Service Tracking: Start Date and Time**

**Definition**
The date and time that a physician subspecialty group begins to primarily care for a patient.

**Element Values**
- Relevant values for Data Element

**Data Source Hierarchy Guide**
1. History and Physical
2. Consult Notes
3. Progress Notes
4. Treatment Team entries if concurrent abstraction
Service Tracking: Stop Date and Time

Definition
The date and time that a physician subspecialty group stops primarily caring for a patient.

Element Values
- Relevant values for Data Element

Data Source Hierarchy Guide
1. History and Physical
2. Progress Notes
3. Treatment Team entries if concurrent abstraction
Ventilator Tracking: Start Date and Time: **MANDATORY BLUE FIELD**; follow NTDS Definition rules

**Definition:**
The date and time that a patient was placed on mechanical ventilation.
See next page for NTDS definitions.

**NOTE:** Ventilator days will auto-populate based on date/time entered.
Field will accept multiple episodes of ventilation (failed and required reintubation / ventilation).

**Element Values**
- Relevant values for Data Element

**Data Source Hierarchy Guide**
1. Respiratory Therapy Notes / Flowsheets
2. ICU Flowsheet
3. Progress Notes
4. Procedure Note
TOTAL VENTILATOR DAYS

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

Element Values
- Relevant value for data element

Additional Information
- Excludes mechanical ventilation time associated with OR procedures.
- Non-invasive means of ventilatory support (CPAP or BiPAP) should not be considered in the calculation of ventilator days.
- Reported in full day increments with any partial calendar day counted as a full calendar day.
- The calculation assumes that the date and time of starting and stopping ventilator episode are recorded in the patient’s chart.
- The null value "Not Known/Not Recorded" is reported if any dates are missing.
- At no time should the Total Ventilator Days exceed the hospital LOS.
- The null value "Not Applicable" is reported if the patient was not on the ventilator according to the above definition.

<table>
<thead>
<tr>
<th>Example #</th>
<th>Start Date</th>
<th>Start Time</th>
<th>Stop Date</th>
<th>Stop Time</th>
<th>LOS</th>
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</thead>
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<tr>
<td>A.</td>
<td>01/01/11</td>
<td>01:00</td>
<td>01/01/11</td>
<td>04:00</td>
<td>1 day (one calendar day)</td>
</tr>
<tr>
<td>B.</td>
<td>01/01/11</td>
<td>09:00</td>
<td>01/01/11</td>
<td>18:00</td>
<td>1 day (one calendar day)</td>
</tr>
<tr>
<td>C.</td>
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<td>09:00</td>
<td>01/02/11</td>
<td>18:00</td>
<td>2 days (episodes on 2 separate calendar days)</td>
</tr>
<tr>
<td>D.</td>
<td>01/02/11</td>
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<td>01/02/11</td>
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<td>01/03/11</td>
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<tr>
<td>F.</td>
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<td>01/04/11</td>
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<tr>
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<td>01/05/11</td>
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<tr>
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<td>01/08/11</td>
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Data Source Hierarchy Table
1. Respiratory Therapy Notes/Flow Sheet
2. ICU Flow Sheet
3. Progress Notes

Associated Edit Checks

<table>
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<th>Level</th>
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<td>7005</td>
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</tr>
<tr>
<td>7640</td>
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<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Ventilator Tracking: Stop Date and Time: MANDATORY BLUE FIELD; follow NTDS Definition rules.

Definition
The date and time that a patient was removed from mechanical ventilation

Element Values
- Relevant values for Data Element

Data Source Hierarchy Guide
1. Respiratory Therapy Notes / Flowsheets
2. ICU Flowsheet
3. Progress Notes
NOTE: The total ventilator days will auto-populate based on your ventilator tracking information.
<table>
<thead>
<tr>
<th>Example #</th>
<th>Start Date</th>
<th>Start Time</th>
<th>Stop Date</th>
<th>Stop Time</th>
<th>LOS</th>
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<td>1 day (one calendar day)</td>
</tr>
<tr>
<td>B.</td>
<td>01/01/11</td>
<td>01:00</td>
<td>01/01/11</td>
<td>04:00</td>
<td>1 day (2 episodes within one calendar day)</td>
</tr>
<tr>
<td>C.</td>
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<td>16:00</td>
<td>01/02/11</td>
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<td>2 days (episodes on 2 separate calendar days)</td>
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<td>D.</td>
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<td>01/02/11</td>
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<td>2 days (episodes on 2 separate calendar days)</td>
</tr>
<tr>
<td>E.</td>
<td>01/01/11</td>
<td>01:00</td>
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<td>01/02/11</td>
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<td>2 days (episodes on 2 separate calendar days)</td>
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<td>16:00</td>
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<td>01/02/11</td>
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<td>01/02/11</td>
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<td>2 days (patient was in on Vent on 2 separate calendar days)</td>
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<tr>
<td></td>
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<td>01/03/11</td>
<td>20:00</td>
<td>2 days (patient was on Vent on 3 separate calendar days)</td>
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Data Source Hierarchy Guide
1. Respiratory Therapy Notes/Flow Sheet
2. ICU Flow Sheet
3. Progress Notes

Associated Edit Checks

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<th>Level</th>
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</tr>
<tr>
<td>7640</td>
<td>1</td>
<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Blood Tracking: Blood Product

Definition
The type of blood product given to the patient.

Element Values
1. Packed Red Blood Cells
2. Plasma
3. Platelets
4. Other Blood Substitute (Cryoprecipitate)
5. Not Applicable
6. Unknown

NOTE: Whole blood should be an option in the Web Version.

Data Source Hierarchy Guide
1. Flowsheets (I&O, MTP, Blood Tracking, etc.)
2. Nursing Notes
3. Operative Report
4. Anesthesia Record
**Blood Tracking: Volume**

**Definition**

The volume of a particular blood product given to the patient reflected as # of units for red cells or # of packs for coagulation components

**Element Values**

- Relevant Data for Element Value

**Data Source Hierarchy Guide**

1. Flowsheets (I&O, MTP, Blood Tracking, etc.)
2. Nursing Notes
3. Operative Report
4. Anesthesia Record
Blood Tracking: Units

**Definition**

The units used to measure the volume of blood product given.

**NOTE:** Illinois will use UNITS as the standard measure for data entry.

**Element Values**

1. L
2. mL
3. Units (red cells) or Packs (coag components) / Not Applicable
4. Unknown / Unknown

**Data Source Hierarchy Guide**

1. Flowsheets (I&O, MTP, Blood Tracking, etc.)
2. Nursing Notes
3. Operative Report
4. Anesthesia Record
**Blood Tracking: Location**

**Definition**

Where the patient was located when they received the blood products.

**NOTE:** Location of the administration of blood can be configured by looking at the time and date it was given and comparing that to the pt.’s ADT events

**Element Values**

1. Resuscitation Room
2. Emergency Department
3. Operating Room
4. Intensive Care Unit
5. Step-Down Unit
6. Floor
7. Telemetry Unit
8. Observation Unit
9. Burn Unit
10. Radiology
11. Post Anesthesia Care Unit
12. Special Procedure Unit
13. Labor and Delivery
14. Neonatal/Pediatric Care Unit
90. Prehospital
91. Referring Facility
./ Not Applicable
?. Unknown

**Data Source Hierarchy Guide**

1. Flowsheets (I&O, MTP, Blood Tracking, etc.)
2. ADT Events
3. Encounter Report
4. Nursing Notes
**Blood Tracking: Time Period**

**Definition**

The time period during the patient’s stay when they received the blood

Determined by comparing the Date and Time that the blood was administered to the patient’s arrival date and time.

**Element Values**

1. Prior to Facility Arrival
2. First 4 Hours after Facility Arrival
3. Between 4 and 24 Hours after Facility Arrival
4. Between 24 and 48 Hours after Facility Arrival
5. More than 48 Hours after Facility Arrival
6. Not Applicable
7. Unknown
Data Source Hierarchy Guide

1. Blood Tracking Flowsheets
2. ADT Events
3. Nursing Notes
4. EMS Run Reports
5. Transferring Facility Documentation
Providers

- The provider elapsed time will auto-populate based on ED/Hospital arrival time and Provider arrived time.

- The Timeliness box is based on state or other certifying body’s time expectations for the different providers to arrive.
Resus: Provider

Definition

The providers who were involved with the patient’s initial resuscitation after arriving to your facility. Include as many choices as necessary to identify physicians participating with the trauma team response. Can include consults generated in the Emergency Department for expectant response IN the emergency department. All other consults are entered in the next tab (in-hospital section).

Element Values

- Relevant Data for Element Value

Data Source Hierarchy Guide

1. ED Trauma Summary
2. History and Physical
3. Nursing Notes
4. Consult Notes
Resus: Provider Called

Definition
The date and time that the particular provider was called or paged because their specialty was needed for the care of the patient.

Element Values
- Relevant Data for Element Value

Data Source Hierarchy Guide
1. ED Trauma Summary
2. History and Physical
3. Nursing Notes
4. Consult Notes
**Resus: Provider Responded**

**Definition**

The date and time that the particular provider responded to the page or call because their specialty was needed for the care of the patient.

**Element Values**

- Relevant Data for Element Value

**Data Source Hierarchy Guide**

1. History and Physical
2. Progress Notes
3. Trauma Flowsheet / Nursing Notes
4. Consult Notes
**Resus: Provider Arrived**

**Definition**

The date and time that the particular provider arrived to treat the patient, and makes actual verbal or physical contact with the patient.

**Element Values**

- Relevant Data for Element Value

**Data Source Hierarchy Guide**

1. ED Trauma Summary
2. History and Physical
3. Progress Notes
4. Nursing Notes / Trauma Flowsheet
5. Consult Notes
### Resus Team: Timeliness

**Definition**

Did the provider arrive within a specific timeframe that is designated by the appropriate governing body or hospital policy?

**Element Values**

1. Timely
2. Not Timely
3. Absent

### Data Source Hierarchy Guide

1. ED Trauma Summary
2. History and Physical
3. Progress Notes
4. Nursing Notes
5. Consult Notes
It is expected that each trauma center will expand upon the minimum triage set based on individual requirements, resources, and outcomes. The criteria are consistent with the Minimum Trauma Field Triage Criteria for transport to a trauma center.

1. **Patient Evaluation**

   a) Any Injury System transport a patient who is classified above Category I in the Minimum Trauma Field Triage Criteria requires rapid transport to a trauma center if less than 20 minutes from the trauma center, otherwise, follow Section 152 Appendix A, Mandatory field notification of a trauma surgeon will occur in cases of:

   A) Sustained hypotension (blood pressure less than or equal to 90 mm Hg systolic for an adult and less than or equal to 60 mm Hg for a pediatric patient on two consecutive measures five minutes apart) or

   B) Cardiac perforation of the retro or neck.

2. Patients who are classified in the field or in any pre-hospital setting shall be evaluated by the ED (if standing emergency physician designee) immediately upon arrival. (Seciton 515.2066(k))

3. Patients who are not classified in the field prior to arrival shall be evaluated to assess whether they should be classified as a trauma patient within 10 minutes after arrival. (Section 515.2066(k))

4. Within the 10 minute evaluation period, the patient must be determined to be Category I or Category II. The response periods for both categories are described below.

5. Patients may be upgraded at any time during ED treatment. The surgeon response time requirements begin at the time of upgrade.

6. Once the patient has been assigned a Category I or II status, the patient cannot be downgraded. If the patient is evaluated by the trauma surgeon or appropriate subspecialist.

b) **Category I**

   The trauma center must activate its trauma team response (which includes the trauma surgeon, residents or other surgical specialty in lieu of the trauma surgeon) for patients who meet these criteria. Level II trauma centers require a 30-minute response from the time of identification of severe. If a backup surgeon is used, the 20-minute response time is based on the patient's identification time, not the time of the contact to the backup surgeon. Any patient can be made a Category I based on the ED physician's discretion.
Any patient meeting the definition of isolated injury requires consultation with the appropriate subspecialist within 60 minutes after trauma patient identification, except for neurosurgery and Level I OB/GYN, pediatric surgery, and cardiothoracic surgery. When neurosurgical intervention has been identified, the neurosurgeon must arrive and be available in a fully staffed operating room within 60 minutes after the identification of the need for operative intervention. In a Level I trauma center, the OB/GYN, pediatric surgery, or cardiothoracic surgical subspecialist must arrive within 30 minutes after notification of the subspecialist that his or her services are needed at the hospital. Where specialty services are provided by transfer agreement, a transfer to a specialty center shall commence within 30 minutes after the patient’s arrival, and shall be completed within two hours. As isolated injury refers to transfer of energy to a single anatomic body region with no potential for multisystem involvement.

Category II

Any other patient who is admitted for traumatic injury requires notification/consultation with the trauma surgeon or subspecialist at the time the decision to admit is made. The patient will be seen by the trauma surgeon or appropriate surgical subspecialist within 12 hours after emergency department arrival.

Any patient meeting the definition for isolated injury requires a telephone consultation with the appropriate subspecialist (outside 60 minutes Level II and 30 minutes Level I) of identified need by the emergency department physician. When the need for neurosurgical intervention has been identified, the neurosurgeon must be available in a fully staffed operating room within 60 minutes after the identification of need for operative intervention. Where specialty services are provided by transfer agreement, a transfer to a specialty center shall commence within 30 minutes after the patient’s arrival, and the transfer shall be completed within two hours. An isolated injury refers to the transfer of energy to a single anatomic body region with no potential for multisystem involvement.

Category I criteria include at minimum but are not limited to items in the Category I box, Minimum Trauma Field Triage Criteria (Section 515. Appendix C).

Category II criteria include at minimum but are not limited to items in the Category II box, Minimum Field Triage Criteria (Section 515. Appendix C).

Source: Amended at 22 Ill. Reg. 11835, effective June 25, 1993
In-House Consults

Definition

The subspecialties consulted after the patient has been admitted to the hospital.

Element Values

1. Relevant Value for Data Element

   NOTE: The provider’s name should be attached to the consult note

Data Source Hierarchy Guide

1. Consult Notes
2. Progress Notes
3. Nursing Notes
**In-House Consult: Provider Called**

**Definition**

The date and time that the particular provider was called or paged because their specialty was needed for the care of the patient after the patient was admitted.

**Element Values**

- Relevant Data for Element Value

**Data Source Hierarchy Guide**

1. Consult Notes / Notes
2. Progress Notes
3. Nursing Notes
In-House Consults: Provider Arrived

Definition
The date and time that the particular provider arrived to treat the patient after the patient has been admitted to the hospital.

Element Values
- Relevant Data for Element Value

Data Source Hierarchy Guide
1. Consult Notes
2. Progress Notes
3. Nursing Notes
**In House Consults: Timeliness**

**Definition**
Did the provider arrive within a specific timeframe that is designated by the appropriate governing body or hospital policy?

**NOTE:** Refer to the IL Trauma Center Rules / Regulations in the Resus Team Consult Tab to assist in making this determination.

**Element Values**
1. Timely
2. Not Timely
3. Absent

**Data Source Hierarchy Guide**
1. ED Trauma Summary
2. History and Physical
3. Progress Notes
4. Nursing Notes
Procedures Information

- Procedures are entered using the very specific ICD-10 codes

- Procedures, based on the NTDS definition adopted by Illinois, are limited to those essential to the diagnosis, stabilization, or treatment of the patient’s specific injuries or complications. The NTDS has a recommended list and the IL CQI / Registry Committee has also created a standardized list of codes to assist in making these decisions and standardized entries. They are embedded in this Section.

- (Many of the procedures entered pre-2019 will no longer be needed. Each facility can enter as many as they want, but there is no longer a mandate to capture all of them, allowing you an opportunity to limit some of that historic work).
Hospital Procedures:  BLUE FIELD; NTDS Definition rules follow.
ICD-10 HOSPITAL PROCEDURES

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

Element Values
- Major and minor procedure ICD-10 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 reported if the patient did not have procedures.
- Only report procedures performed at your institution.
- Report all procedures performed in the operating room.
- Report 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, report only the first event. If there is no asterisk, report each event even if there is more than one.
- Note that the hospital may report additional procedures.

DIAGNOSTIC AND THERAPEUTIC IMAGING
- Computed tomographic Head *
- Computed tomographic Chest *
- Computed tomographic Abdomen *
- Computed tomographic Pelvis *
- Computed tomographic C-Spine *
- Computed tomographic T-Spine *
- Computed tomographic L-Spine *
- Diagnostic ultrasound (includes FAST) *
- Angiogramization
- Angiography
- IVC filter
- REBOA

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

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

RESPIRATORY
- Insertion of endotracheal tube *(excludes intubations performed in the OR)
- Continuous mechanical ventilation *

CARDIOVASCULAR
- Open cardiac massage
- CPR

CNS
- Insertion of ICP monitor *
NOTE: Please refer to the Commonly Used ICD-10 Procedure Codes Chart on the next page for standardization of the common procedures performed during trauma patient evaluation and treatment.

NOTE: Standardized codes for Blood and AntiCoag Administration:

- The blood admin codes for use in Procedures if you also track it there are:
  - PRBC: 30233N1
  - Plasma / FFP: 30233L1
  - Platelets: 30233R1
  - Cryoprecipitate: 30233M1
  - TXA: 30243T1
  - Whole Blood
- There is currently NO CODE for Massive Transfusion Protocol; use products
- AntiCoag Reversal
  - PCC (KCentra) - 30283B1
<table>
<thead>
<tr>
<th>Commonly Used ICD - 10 Procedure Codes</th>
<th>Resuscitation</th>
<th>Diagnostic X-rays</th>
<th>MRI</th>
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<tbody>
<tr>
<td>1WS2K5Z</td>
<td>Out-of-Office/Aspen Application</td>
<td>99050ZZZ</td>
<td>XR Pancreas</td>
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<tr>
<td>1W1E7XZ</td>
<td>Thoracoplasty Right Lower Leg</td>
<td>99601ZZZ</td>
<td>XR Skull</td>
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<td>Thoracoplasty Left Lower Leg</td>
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<td>XR C-Spine</td>
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<td>99672ZZZ</td>
<td>XR T-Spine</td>
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<tr>
<td>1W1IA3Z</td>
<td>Thoracoplasty Right Upper Arm</td>
<td>99702ZZZ</td>
<td>XR L-Spine</td>
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<tr>
<td>1A250Z</td>
<td>Pull/Arena Bag</td>
<td>89001ZZZ</td>
<td>XR Right Rib</td>
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<tr>
<td>0W847Z</td>
<td>Intubation</td>
<td>89040ZZZ</td>
<td>XR Right Rib</td>
</tr>
<tr>
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<td>King Airway/Comintube/Intub/IMA</td>
<td>89050ZZZ</td>
<td>XR Chest</td>
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<td>Exsufflation</td>
<td>89060ZZZ</td>
<td>XR Abdomen</td>
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<tr>
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<td>Circumcision</td>
<td>89070ZZZ</td>
<td>XR Hips</td>
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<td>LPR</td>
<td>89082ZZZ</td>
<td>XR Pelvis</td>
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<td>CFR - Lumen Device</td>
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<td>Diagnostic CT Scan</td>
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<td>Defibrillation</td>
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<td>CT Head</td>
</tr>
<tr>
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<td>Right Needle Decompression</td>
<td>89270ZZZ</td>
<td>CT Brain</td>
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<td>89272ZZZ</td>
<td>CT Facial Bones</td>
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<td>Paracentesis</td>
<td>89280ZZZ</td>
<td>CT Chest/Abdomen/Pelvis</td>
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<td>Right Thoracotomy</td>
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<td>CT Chest/Abdomen/Pelvis</td>
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<td>Right Thoracotomy (Clamshell)</td>
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<td>Open Cardiac Massage</td>
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<td>CT Abdomen/Pelvis</td>
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<td>CT Brain</td>
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<td>OPAP/BIPAP &lt; 24 hours</td>
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<td>CPAP</td>
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<td>CPAP</td>
</tr>
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<td>CPAP</td>
</tr>
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<td>CPAP</td>
</tr>
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<td>0A000Z</td>
<td>VENT &gt; 24 hours</td>
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<td>CPAP</td>
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<td>Nasal Airway</td>
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<td>Oral Airway</td>
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<td>Right Chest Tube - Perc</td>
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<td>Left Chest Tube - Perc</td>
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<td>Bronchoscopy</td>
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<td>0S000Z</td>
<td>Tracheotomy</td>
<td>89210ZZZ</td>
<td>Tracheotomy</td>
</tr>
</tbody>
</table>


- **Diagnostic X-rays**: XR Pancreas, XR Skull, XR C-Spine, XR T-Spine, XR L-Spine, XR Right Rib, XR Right Rib, XR Chest, XR Abdomen, XR Hips, XR Pelvis, Diagnostic CT Scan, CT Head, CT Brain, CT Facial Bones, CT Chest/Abdomen/Pelvis, CT Chest/Abdomen/Pelvis, CT Chest/Abdomen/Pelvis, CT Chest/Abdomen/Pelvis, CT Abdomen/Pelvis, CT Pelvis, CT Spine, CT Brain, CPAP, CPAP, CPAP, CPAP, Nasal Airway, Oral Airway, Right Chest Tube - Open, Left Chest Tube - Open, Right Chest Tube - Perc, Left Chest Tube - Perc, Bronchoscopy, Tracheotomy.


- **Ultrasound**: Ultrasonic, Ultrasound.

- **Sedation**: Sedation.


- **Other Procedures**: CP Monitoring, CP Monitoring, DVD Placement - Perc, DVD Placement - Perc, DVD Placement - Open, DVD Placement - Open, Lumbar Puncture, Lumbar Puncture, DDS.
Procedure Location

Definition

The area of the healthcare facility where the procedure was performed.

Element Values

1. Resuscitation Room
2. Emergency Department
3. Operative Room
4. Intensive Care
5. Step-Down Unit
6. Floor
7. Telemetry Unit
8. Observation Unit
9. Burn Unit
10. Radiology
11. Post Anesthesia Care Unit
12. Special Procedure Unit
13. Labor and Delivery
14. Neonatal/Pediatric Care Unit

Data Source Hierarchy Guide

1. Operative Notes
2. Procedure Notes
3. History and Physical
4. Progress Notes
5. Nursing Notes
Operation Number

Definition

Operations are valued in numerical order. This is the number of the operation where the particular procedure being entered was performed.

Element Values

1. Relevant Data for Element Values

Data Source Hierarchy Guide

1. Operative Notes
2. Procedure Notes
3. History and Physical
4. Progress Notes
5. Nursing Notes
6. ADT Events
**Hospital Procedure Start Date:** Mandatory **BLUE FIELD; NTDS Definition rules follow.**
**Procedure Stop Date and Time**

**Definition**

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

**NOTE:** Illinois recommendation to enter STOP times for *invasive procedures only*.

**Element Values**

1. Relevant Data for Element Value

**Data Source Hierarchy Guide**

1. Operative Notes
2. Procedure Notes
3. Anesthesia Notes
4. History and Physical
5. Progress Notes
6. Nursing Notes
7. ADT Events
### Diagnostic Result

**Definition**
Did the procedure result in a diagnosis of a new injury or other medical issue being managed by the Trauma Team?

**Element Values**
1. Positive (or abnormal / IL definition).
2. Negative (or normal / IL definition).
3. Indeterminate (or equivocal / IL definition).
4. /: Not Applicable
5. /: Unknown

**Data Source Hierarchy Guide**
- Operative Notes
- Procedure Notes
- Anesthesia Notes
- History and Physical
- Progress Notes
- Nursing Notes
Service

Definition

The subspecialty service that performed or ordered the procedure.

Element Values

2. Relevant Data for Element Value

Data Source Hierarchy Guide

1. Operative Notes
2. Procedure Notes
3. Progress Notes
4. History and Physical
5. Nursing Note
6. Radiology Reports
**Physician**

**Definition**

The physician responsible for performing the procedure.

**Element Values**

3. Relevant Data for Element Value

**Data Source Hierarchy Guide**

1. Operative Notes
2. Procedure Notes
3. Progress Notes
4. History and Physical
5. Nursing Note
6. Radiology Reports
Diagnosis Codes

- There are three different ways to code diagnosis codes in the trauma registry.
  - One is the Tri-Code feature where the narrative information is typed into the box and the computer will assign ICD-10 and AIS codes. These codes need to be checked after they populate to ensure that they are accurate and meet the AIS coding rules.
  - The second way is to enter the AIS codes and then have them converted to ICD-10 codes. These codes need to be checked as well because AIS is not as comprehensive as the ICD-10 system.
  - The final way is to enter the ICD-10 codes and convert them to AIS codes. These codes also need to be checked for accuracy.
    - **EDITOR NOTE:** Would be nice for DI to enter their ‘hierarchy insight’ here that they verbalized during training. Well said and would be helpful, but I didn’t write it down. MBV

- Once the diagnosis codes are in, along with the ED initial vitals, GCS, Age, and Mechanism of Injury, the ISS, TRISS, and NISS scores will auto-populate. ISS and NISS will populate just based off the severity of the AIS codes, TRISS scores need more information.
DIAGNOSES:  MANDATORY BLUE FIELD; NTDS Definition rules follow.

NTDS definitions for the mandated ICD-10 and AIS codes are on the next 2 pages.
ICD-10 INJURY DIAGNOSES

Definition
Diagnoses related to all identified injuries.

Element Values
- Injury diagnoses as defined by ICD-10-CM code range 500-599, T07, T14, T20-T28 and T30-T32.
- 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

Associated Edit Checks

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<td>Invalid value (ICD-10-CM only)</td>
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<tr>
<td>8702</td>
<td>2</td>
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<tr>
<td>8703</td>
<td>2</td>
<td>At least one diagnosis must be provided and meet inclusion criteria. (ICD-10-CM only)</td>
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<tr>
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<tr>
<td>8750</td>
<td>1</td>
<td>Multiple Entry Max exceeded</td>
</tr>
</tbody>
</table>
Diagnosis Codes

AIS CODE

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

Element Values
- The code is the 8 digit AIS code

Additional Information

Data Source Hierarchy Guide
1. AIS Coding Manual

Associated Edit Checks

<table>
<thead>
<tr>
<th>Rule ID</th>
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<td>AIS codes submitted are not valid AIS 05, Update 08, or AIS 2015 codes</td>
</tr>
<tr>
<td>21007</td>
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<tr>
<td>21008</td>
<td>2</td>
<td>Element cannot be &quot;Not Applicable&quot;</td>
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<tr>
<td>21060</td>
<td>1</td>
<td>Multiple Entry Max exceeded</td>
</tr>
</tbody>
</table>

AIS VERSION

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

Element Values
- 6. AIS 05, Update 08
- 16. AIS 2015

Additional Information

Data Source Hierarchy Guide
1. AIS Coding Manual

Associated Edit Checks

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<thead>
<tr>
<th>Rule ID</th>
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</tr>
<tr>
<td>7340</td>
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</tr>
</tbody>
</table>
Non-Trauma Diagnosis

**Definition**

All other medical diagnoses that are not related to the injury diagnoses.

No minimum entry requirement for IL Trauma Registry.

**Element Values**

- Relevant Data for Element Value

**Data Source Hierarchy Guide**

1. Progress Notes
2. Nursing Notes
3. Consult Notes
4. History and Physical
5. Radiology Reports
6. Autopsy Reports
7. Lab Values
Prehospital Cardiac Arrest: MANDATORY BLUE FIELD; NTDS Definition rules follow.
Diagnosis Codes

PRE-HOSPITAL CARDIAC ARREST

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

Element Values
1. Yes
2. 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 & Physical
4. Transfer Notes

Associated Edit Checks

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
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</tr>
<tr>
<td>9740</td>
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<td>Single Entry Max exceeded</td>
</tr>
</tbody>
</table>
Diagnosis Codes

Pre-Existing Conditions / Co Morbidities: MANDATORY BLUE FIELD; NTDS Definition rules follow.

Pre-Existing Conditions / Comorbidities:

Definition
Medical conditions that existed prior to the patient becoming injured.

NOTE: Please refer to the NTDS Data Dictionary for the specifics regarding pre-existing conditions. (Multiple page reference with very specific definitions).

Element Values
- Relevant Data for Element Value

Data Source Hierarchy Guide
1. History and Physical
2. Nursing Notes/Triage Flowsheet
3. Progress Notes
4. Consult Notes
5. Previous Patient Encounters
Outcome

- The total ICU, Ventilator, and Hospital days will calculate based on the information that has already been placed in the chart.
- Remember the NTDS Discharge Order date and time signify the end of the patient’s stay. Please make sure you are utilizing the final order if multiple orders are placed and cancelled. Anything documented after the discharge order date and time will not be included.
- The Death tab will only be accessible if the discharge status is marked as Dead. The Initial Discharge 2 tab will only be accessible if the discharge status is marked Alive.
- In the Billing Section, the account number will auto-populate from the initial demographics page.
- Total charges collected and last date collected will generate off of the information placed regarding payments and dates in the above section.
Outcome 321

Discharge Status

Definition
Is the patient alive or deceased at discharge?

Element Values
1. Alive
2. Dead

Data Source Hierarchy Guide
1. Discharge Summary
2. Post-Mortem Flowsheet
3. Nursing Notes
**Outcome**

**Discharge Condition**

**Definition**

The condition of the patient compared to previous health at discharge

**Element Values**

1. Discharge with Previous Level of Function
2. Temporary Disability Expected to Return to Previous Level of Function
3. Moderate Disability with Expected Ability for Self-Care
4. Severe Disability
5. Persistent Vegetative State
6. Dead

**Data Source Hierarchy Guide**

1. Discharge Summary
2. Therapy Notes
3. Post-Mortem Flowsheet
4. Nursing Notes
Patient Directive Applied

Definition
Did the patient have an advanced directive that was utilized during their hospital stay?

Element Values
1. Care Directive Applied
2. Care Directive Not Applied / Not Applicable
3. No Care Directive Provided ? Unknown

Data Source Hierarchy Guide
1. Discharge Summary
2. History and Physical
3. Progress Notes
4. Nursing Notes
5. Advanced Directives form or scanned document
Discharge / Death Time and Date: MANDATORY BLUE FIELD; NTDS Definition rules follow.

**Definition**
The actual time and date that the patient left your facility.

**NOTE:** Please note this is the actual date and time the patient left the facility or was pronounced.

**Element Values**
- Relevant Value for Data Element

**Data Source Hierarchy Guide**
1. ADT Events
2. Discharge Summary
3. Nursing Notes
4. Post – Mortem Flowsheet
**Discharge Order Date**: MANDATORY BLUE FIELD; NTDS Definition rules follow.

**HOSPITAL DISCHARGE DATE**

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

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

**Additional Information**
- Reported as YYYY-MM-DD.
- The null value "Not Applicable" is reported if ED Discharge Disposition is 4, 5, 6, 9, 10, or 11.
- If Hospital Discharge Disposition is "5, Decedent/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

**Associated Edit Checks**

<table>
<thead>
<tr>
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<td>7705</td>
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<td>Hospital Discharge Date is earlier than EMS Unit Arrival on Scene Date</td>
</tr>
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<td>7706</td>
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<td>Hospital Discharge Date is earlier than EMS Unit Scene Departure Date</td>
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<td>2</td>
<td>Hospital Discharge Date is earlier than ED/Hospital Arrival Date</td>
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<td>2</td>
<td>Hospital Discharge Date is earlier than ED Discharge Date</td>
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<td>Hospital Discharge Date is earlier than Date of Birth</td>
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<td>Hospital Discharge Date minus ED/Hospital Arrival Date is greater than 365 days</td>
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<tr>
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</table>

**Commented [FT1]**: Change title to Hospital Discharge Order Date

**Commented [M2R1]**: This is an NTDS field; No edits allowed ;)

MANDATORY BLUE FIELD; NTDS Definition rules follow.
Outcome

**Discharge Order Time:** **MANDATORY BLUE FIELD; NTDS Definition rules follow.**

**HOSPITAL DISCHARGE TIME**

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

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

**Additional Information**
- Reported as HH:MM military time.
- The null value 'Not Applicable' is reported if ED Discharge Disposition is 4, 5, 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

**Associated Edit Checks**

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<thead>
<tr>
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<th>Message</th>
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<tr>
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<td>Hospital Discharge Time is earlier than ED/Hospital Arrival Time</td>
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<tr>
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</tr>
</tbody>
</table>

Commented [FT3]: Change title to **Hospital Discharge Order Time**

Commented [M4R3]: Same as above. But I believe the definition is pretty clear re: Order vs physically leave the building which is captured in the prior elements.
NOTE: Total Days: ICU, Ventilator and Hospital will auto-populate from the Patient Tracking tab entries.
If you feel they are inaccurate, you need to return to that tab / screen to edit.
Discharging Physician

Definition
The provider that is discharging the patient from your facility.

Element Values
- Relevant Value for Data Element

Data Source Hierarchy Guide
1. Discharge Summary
2. Discharge Order
3. Nursing Notes
HOSPITAL DISCHARGE DISPOSITION

Definition
The disposition of the patient when discharged from the hospital.

Element Values
1. Discharged/Transferred to a short-term general hospital for inpatient care
2. Discharged/Transferred to an Intermediate Care Facility (ICF)
3. Discharged/Transferred to home under care of organized home health service
4. Left against medical advice or discontinued care
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., Ptown, Child Protective Services etc.).
- Element values based upon UB-04 disposition coding.
- Disposition to any other non-medical facility should be coded as 8.
- Disposition to any other medical facility should be reported as 14.
- The null value "Not Applicable" is reported if ED Discharge Disposition = 4, 5, 6, 9, 10, or 11.
- Hospital Discharge Dispositions which were retired greater than 2 years before the current NTDS version are no longer listed under Element Values above, which is why there are numbering gaps. Refer to the NTDS Change Log for a full list of retired Hospital Discharge Dispositions.
- If multiple orders were written, report the final disposition order.

Data Source Hierarchy Guide
1. Physician Order
2. Discharge Instructions
3. Nursing Notes/Flow Sheet
4. Case Management/Social Services Notes
5. Discharge Summary
<table>
<thead>
<tr>
<th>DI Data Element Numbers / Choices</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>40. Home or Self-Care (Routine Discharge)</td>
<td>72. Skilled Nursing Facility</td>
</tr>
<tr>
<td>41. Home with Services (Home Health Care)</td>
<td>73. Rehab (Inpatient)</td>
</tr>
<tr>
<td>42. Left AMA</td>
<td>74. Long-Term Care (LTAC Facility/Vent)</td>
</tr>
<tr>
<td>43. Correctional Facility/Court/Law Enforcement</td>
<td>75. Hospice</td>
</tr>
<tr>
<td>44. Morgue</td>
<td>76. Mental Health/Psychiatric Hospital (Inpatient)</td>
</tr>
<tr>
<td>45. Child Protective Agency</td>
<td>77. Nursing Home</td>
</tr>
<tr>
<td>70. Acute Care Facility (Hospital for Inpatient Care)</td>
<td>79. Another Type of Inpatient Facility Not Defined Elsewhere</td>
</tr>
<tr>
<td>71. Intermediate Care Facility (Step Down Hospital)</td>
<td>80. Burn Center</td>
</tr>
<tr>
<td></td>
<td>?. Unknown</td>
</tr>
</tbody>
</table>

**NOTES:**
- If the patient returns to the environment from which they came, that disposition is entered as #40 (home).
  - Example: Patient admitted from Skilled Nursing Facility (SNF, ECF) following fall and returns back to the SNF / ECF care setting. NTDS considers this a return HOME. If the patient came from Assisted Living (ALF) and is discharged to Skilled Nursing (SNF, ECF), that would be entered as 72 (Skilled Nursing Facility) since the level of care changed.
- Rehab (#73) references Inpatient, CARF-certified multidisciplinary Rehab Programs. Therapy programs at skilled care facilities do not meet this definition, regardless of facility name.
Discharge to Alternate Caregiver

Definition
Was the patient discharged with a different person than the person that primarily cares for them or lives with them?

NOTE: Will only populate if there is a Y (yes) in the report of physical abuse in the Injury Section

Element Values
- Y. Yes
- N. No
- /. Not Applicable
- ?. Unknown

Data Source Hierarchy Guide
1. Discharge Summary
2. Child Abuse Physician Notes
3. Case Management Notes
4. Child Protective Service Notes
5. Nursing Notes
If Transferred, Facility

Definition

The facility that the patient was transferred to, if the patient was transferred out of your hospital.

Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Discharge Summary
2. Case Management Notes
3. Progress Notes
4. Nursing Notes
**Transfer Rationale**

**Definition**

The reason why the patient was transferred out of your facility

**Element Values**

1. Economic
2. Level of Care
3. Personal
4. System Protocol
5. Other
6. Pediatrics/PICU
7. Neurosurgery
8. OB Care
9. Cardiothoracic Care
10. Orthopedic Care
11. Urology
12. Ophthalmology
13. Oral/dental care services
14. ENT
15. Plastics/maxillofacial services
16. Burn Unit
17. Replantation
18. Spinal Cord Injury
19. Other Specialty
/. Not Applicable
?. Unknown

**Data Source Hierarchy Guide**

1. Discharge Summary
2. Case Management Notes
3. Progress Notes
4. Nursing Notes
Transfer Rationale By

Definition
The person that made the decision to transfer the patient out of the facility.

Element Values
1. Physician
2. Patient
3. Payor

Data Source Hierarchy Guide
1. Discharge Summary
2. Case Management Notes
3. Progress Notes
4. Nursing Notes
Impediments to Discharge

Definition
Any issues or contributing factors to the patient’s discharge being delayed.

Element Values
0. None
1. Delay in Discharge Plan
2. Financial
3. Homeless
4. Legal
5. Non-availability of Transfer Facility
6. Psychiatric
7. Social
8. Other
?. Unknown

Data Source Hierarchy Guide
1. Discharge Summary
2. Case Management Notes
3. Progress Notes
4. Nursing Notes
**Outcome**

**336**

**Trauma Sign Off**

**Definition**

The date that trauma services handed over primary care to another service.

**Element Values**

- Relevant Value for Data Element

**Data Source Hierarchy Guide**

1. Progress Notes
2. Consult Notes
Disabilities: Pre-Existing Feeding

Definition

Feeding disabilities that are either temporary or permanent that the patient had prior to their injury admission.

Element Values

<table>
<thead>
<tr>
<th>Box 1</th>
<th>Box 2</th>
</tr>
</thead>
<tbody>
<tr>
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<td>1. Permanent</td>
</tr>
<tr>
<td>3. Independent</td>
<td>2. Temporary</td>
</tr>
<tr>
<td>2. Dependent – Partial Help Required</td>
<td>/. Not Applicable</td>
</tr>
<tr>
<td>1. Dependent – Total Help Required</td>
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</tr>
<tr>
<td>/. Not Applicable</td>
<td></td>
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<tr>
<td>?. Unknown</td>
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</tr>
</tbody>
</table>

Data Source Hierarchy Guide

1. Discharge Summary
2. Therapy Notes
3. Case Management Notes
4. Progress Notes
5. Nursing Notes
Disabilities: Pre-Existing Locomotion

Definition
Locomotion disabilities that are either temporary or permanent that the patient had prior to their injury admission

Element Values

<table>
<thead>
<tr>
<th>Box 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Independent</td>
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<tr>
<td>2. Dependent – Partial Help Required</td>
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<tr>
<td>1. Dependent – Total Help Required</td>
</tr>
<tr>
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</tr>
<tr>
<td>?. Unknown</td>
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</tbody>
</table>

<table>
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<tr>
<th>Box 2</th>
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</thead>
<tbody>
<tr>
<td>1. Permanent</td>
</tr>
<tr>
<td>2. Temporary</td>
</tr>
<tr>
<td>/. Not Applicable</td>
</tr>
<tr>
<td>?. Unknown</td>
</tr>
</tbody>
</table>

Data Source Hierarchy Guide

1. Discharge Summary
2. Therapy Notes
3. Case Management Notes
4. Progress Notes
5. Nursing Notes
Disabilities: Pre-Existing Expression

Definition

Expression disabilities that are either temporary or permanent that the patient had prior to their injury admission

Element Values

**Box 1**

- 4. Independent
- 3. Independent
- 2. Dependent – Partial Help Required
- 1. Dependent – Total Help Required
- / Not Applicable
- ?. Unknown

**Box 2**

- 1. Permanent
- 2. Temporary
- / Not Applicable
- ?. Unknown

Data Source Hierarchy Guide

1. Discharge Summary
2. Therapy Notes
3. Case Management Notes
4. Progress Notes
5. Nursing Notes
Disabilities: Discharge Feeding

Definition

Feeding disabilities that are either temporary or permanent that the patient had when being discharged from the facility

Element Values

Box 1
4. Independent
3. Independent
2. Dependent – Partial Help Required
1. Dependent – Total Help Required
/. Not Applicable
?. Unknown

Box 2
1. Permanent
2. Temporary
/. Not Applicable
?. Unknown

Data Source Hierarchy Guide

1. Discharge Summary
2. Therapy Notes
3. Case Management Notes
4. Progress Notes
5. Nursing Notes
Disabilities: Discharge Locomotion

Definition

Locomotion disabilities that are either temporary or permanent that the patient had when being discharged from the facility.

Element Values

**Box 1**

4. Independent
3. Independent
2. Dependent – Partial Help Required
1. Dependent – Total Help Required

**Box 2**

1. Permanent
2. Temporary
3. Not Applicable
4. Unknown

Data Source Hierarchy Guide

1. Discharge Summary
2. Therapy Notes
3. Case Management Notes
4. Progress Notes
5. Nursing Notes
**Disabilities: Discharge Expression**

**Definition**

Expression disabilities that are either temporary or permanent that the patient had when being discharged from the facility.

**Element Values**

**Box 1**

4. Independent  
3. Independent  
2. Dependent – Partial Help Required  
1. Dependent – Total Help Required  
/. Not Applicable  
?. Unknown

**Box 2**

1. Permanent  
2. Temporary  
/. Not Applicable  
?. Unknown

**Data Source Hierarchy Guide**

1. Discharge Summary  
2. Therapy Notes  
3. Case Management Notes  
4. Progress Notes  
5. Nursing Notes
Rehabilitation Potential

Definition
The likelihood that with rehabilitation, the patient will be independent with cares or return to their previous level of function.

Element Values
1. Discharged with Previous Level of Function
2. Probable Improvement
3. Possible Improvement
4. Improbable Improvement
5. Not Applicable
6. Unknown

Data Source Hierarchy Guide
1. Discharge Summary
2. Therapy Notes
3. Case Management Notes
4. Progress Notes
5. Nursing Notes
**Location**

**Definition**

The place where the patient expired while in the hospital.

**Element Values**

1. Resuscitation Room
2. Emergency Departments
3. Operating Room
4. Intensive Care Unit
5. Step-Down Unit
6. Floor
7. Telemetry Unit
8. Observation Unit
9. Burn Unit
10. Radiology
11. Post Anesthesia Care Unit
12. Special Procedure Unit
13. Labor and Delivery
14. Neonatal/Pediatric Care Unit

?. Unknown

**Data Source Hierarchy Guide**

1. Discharge Summary
2. Post-Mortem Flowsheet
3. Progress Notes
4. Nursing Notes
Manner (Suspected)

Definition
The suspected reason behind the patient’s death.

Element Values
1. Accidental
2. Homicide
3. Natural Causes
4. Suicide
5. Undetermined
6. Not Applicable
7. Unknown

Data Source Hierarchy Guide
1. Autopsy/Medical Examiner Reports
2. Discharge Summary
3. Progress / Consult Notes
Manner (Cause)

Definition
The suspected cause of the patient’s death.

Element Values
1. Accidental
2. Homicide
3. Natural Causes
4. Suicide
5. Undetermined
6. Not Applicable
7. Unknown

Data Source Hierarchy Guide
1. Autopsy/Medical Examiner Reports
2. Discharge Summary
Withdrawal of Care

Definition
Treatment was withdrawn based on a decision to either remove or withhold further life supporting interventions.

Element Values
Y. Yes
N. No
/. Not Applicable
?. Unknown

Data Source Hierarchy Guide
1. Discharge Summary
2. Progress Notes
3. Palliative Care Notes
4. Nursing Notes
**Was Autopsy Performed?**

**Definition**

Was an autopsy performed after the patient’s death?

**Element Values**

- Y. Yes
- N. No
- / . Not Applicable
- ? . Unknown

**Data Source Hierarchy Guide**

1. Autopsy/Medical Examiner Report
Medical Examiner Number

Definition

The number provided to the medical examiner within your registry.

Element Values

- Relevant Value for Data Element

Data Source Hierarchy Guide

1. Autopsy/Medical Examiner Report
**Autopsy Number**

**Definition**

The autopsy number given to the patient from the medical examiner.

**Element Values**

- Relevant Value for Data Element

**Data Source Hierarchy Guide**

1. Autopsy/Medical Examiner Report
**Was Organ Donation Requested?**

**Definition**
Was the possibility of organ donation requested of the patient’s healthcare power of attorney?

**Element Values**
- Y. Yes
- N. No
- /, Not Applicable
- ?, Unknown

**Data Source Hierarchy Guide**
1. Organ Procurement Coordinator Notes
2. Discharge Summary
3. Palliative Care Note
4. Progress Note
5. Nursing Note
Was Request Granted?

**Definition**

Was the request for organ donation granted by the patient’s healthcare power of attorney?

**Element Values**

- Y. Yes
- N. No
- . Not Applicable
- ?. Unknown

**Data Source Hierarchy Guide**

1. Organ Procurement Coordinator Notes
2. Discharge Summary
3. Palliative Care Note
4. Progress Note
5. Nursing Note
**Organs Procured**

**Definition**

The organs that were able to be procured for donation.

**Element Values**

0. None  
1. Adrenal Glands  
2. Bone  
3. Bone Marrow  
4. Cartilage  
5. Corneas  
6. Dura Mater  
7. Fascialata  
8. Heart  
9. Heart Valves  
10. Intestine  
11. Kidney  
12. Liver  
13. Lungs  
14. Nerves  
15. Pancreas  
16. Skin  
17. Stomach  
18. Tendons  
19. Whole Eyes  
20. Other  
?. Unknown

**Data Source Hierarchy Guide**

1. Organ Procurement OR Records  
2. Organ Procurement Coordinator Data  
3. Autopsy/Medical Examiners Report
If None, Reason

Definition
If organ donation request was granted, but no organs were procured, specify the reason organs were not donated.

Element Values
1. No Medical Examiner Consent
2. Medically Unsuitable – Clinical Condition
3. Medically Unsuitable – Social History
4. Unknown

Data Source Hierarchy Guide
1. Organ Procurement Coordinator Note
**Donor Status**

**Definition**
The type of organ donor the patient was classified.

**Element Values**
1. Brain Death
2. Non-Beating Heart
3. Unknown

**Data Source Hierarchy Guide**
1. Organ Procurement OR Records
2. Organ Procurement Coordinator Data
3. Discharge Summary
Date and Time Organs were Procured

Definition
The date and time that the organ procurement surgeon began the operative procedure.

Element Values
- Relevant Value for Data Element

Data Source Hierarchy Guide
1. Organ Procurement OR Records
2. Organ Procurement Coordinator Data
**Charges Billed $**

**Definition**

The total charges billed to the patient for their hospital stay.

**Element Value**

- Relevant Value for Data Element

**Data Source Hierarchy Guide**

1. Billing/Coding
2. Medical Records
ICD-10 DRG

Definition
The diagnosis related group which is how hospitalization costs are calculated through Medicare.

Element Value
- Relevant Value for Data Element

Data Source Hierarchy Guide
1. Billing/Coding
2. Medical Records
**Primary Payor**: MANDATORY BLUE FIELD; NTDS Definition rules follow.

**Definition**

The primary payor responsible for paying for the hospitalization costs.

**Note**: Organ Donor Payor: Per NDTS, Primary Payor = payor source at admission; NOT the organ procurement agency.

**Element Value**

1. Self-Pay  8. Medicare
2. HMO 9. Medicaid
3. PPO 10. Military (Tricare)
4. Blue Cross Blue Shield 11. Other Commercial
(including PPO and HMO, etc.) 12. Other Government
5. Not Billed for Any
6. Automobile 13. Not Billed for Any
7. Worker’s Compensation 14. Charity
8. Liability
9. Charity Pending
10. Not Applicable
11. Unknown

**Data Source Hierarchy Guide**

1. Billing/Coding
2. Medical Records
Primary Payor Amount $

**Definition**

The total amount of payment collected from the Primary Payor.

**Element Value**

- Relevant Value for Data Element

**Data Source Hierarchy Guide**

1. Billing/Coding
2. Medical Records
Primary Payor Date

Definition
The last date the primary payor made payments for the hospitalization.

Element Value
- Relevant Value for Data Element

Data Source Hierarchy Guide
1. Billing/Coding
2. Medical Records
**Additional Payors**

**Definition**
Secondary payors responsible for paying some of the hospital costs after the primary payor.

**Element Value**

1. Self-Pay
2. HMO
3. PPO
4. Medicare
5. Blue Cross Blue Shield
6. Automobile
7. Worker’s Compensation
8. Medicaid
9. Medicaid
10. Military (Tricare)
11. Other Commercial
12. Other Government
13. Not Billed for Any Reason
14. Charity
15. Other
16. Charity Pending
17. Liability
18. Not Applicable
19. Unknown

**Data Source Hierarchy Guide**

1. Billing/Coding
2. Medical Records
Additional Payor Amount $  

**Definition**  
The total amount of payment collected from the additional payor.

**Element Value**  
- Relevant Value for Data Element

**Data Source Hierarchy Guide**  
1. Billing/Coding  
2. Medical Records
Related Admission: Admission

**Definition**

The date that the patient was readmitted to the hospital

**NOTE:** Only collect on admissions within 30 days of original discharge. Only include admissions for an issue related to the original trauma admission. Admissions related to an alternate cause may be tracked here for PI purposes.

**Element Values**

1. Relevant Value for Data Element

**Data Source Hierarchy Guide**

1. Patient Encounter Events
2. ADT Events
3. History and Physical
4. Nursing Notes
Related Admission: Admitting Service

Definition

The service that readmitted the patient to the hospital

**NOTE:** Only collect on admissions within 30 days of original discharge

**Element Values**

1. Trauma
2. Neurosurgery
3. Orthopedics
4. General Surgery
5. Pediatric Surgery
6. Cardiothoracic Surgery
7. Burn Services
8. Emergency Medicine
9. Pediatrics
23. Hospitalist
65. Intensivist
98. Other Surgical
99. Other Non-Surgical

**Data Source Hierarchy Guide**

1. Physician Order
2. History and Physical
3. Consult Note
Related Admission: Type of Admission

**Definition**

Was the admission planned or unplanned

**NOTE:** Only collect on admissions within 30 days of original discharge

**Element Values**

1. Planned
2. Unplanned
3. / Not Applicable
4. ? Unknown

**Data Source Hierarchy Guide**

1. History and Physical
2. Consult Note
3. Nursing Note
**Related Admission: If Unplanned, Reason**

**Definition**
What was the reason the patient was readmitted.

**NOTE:** Only collect on admissions within 30 days of original discharge

**Element Values**
- 1. Infection
- 2. Missed Diagnosis
- 3. Pain
- 4. Progression of Disease
- 5. Other
- /: Not Applicable
- ?: Unknown
**Data Source Hierarchy Guide**

1. History and Physical
2. Consult Note
3. Nursing Note

**Related Admission: Account Number**

**Definition**

Patient number assigned for that specific encounter (HAR); primarily used for billing and coding

**Element Values**

- Relevant Value for Data Element

**Data Source Hierarchy Guide:**

1. Face Sheet
Related Admission: Total Charges

**Definition**
The total charges billed for the hospital encounter

**Element Values**
- Relevant Value for Data Element

**Data Source Hierarchy Guide:**
1. Billing/Coding
2. Medical Records
Related Admission: Discharge Date

**Definition**

The date that the patient was discharged from their readmission stay.

**NOTE**: Only collect on admissions within 30 days of original discharge

**Element Values**

- Relevant Value for Data Element

**Data Source Hierarchy Guide**

1. ADT Events
2. Discharge Summary
3. Nursing Notes
Related Admission: Discharged To

Definition
Where the patient was discharged to after their hospital stay was complete.

**NOTE:** Only collect on admissions within 30 days of original discharge. If the patient dies during the readmission, place the details on the “If Death” tab.

**Element Values / Choices in DI**
40. Home or Self-Care (Routine Discharge)
41. Home with Services
42. Left AMA
43. Correctional Facility/Court/Law Enforcement
44. Morgue
45. Child Protective Agency
46. Acute Care Facility
47. Intermediate Care Facility
48. Skilled Nursing Facility
49. Rehab (Inpatient)
50. Long-Term Care
51. Hospice
52. Mental Health/Psychiatric Hospital (Inpatient)
53. Nursing Home
54. Another Type of Inpatient Facility Not Defined Elsewhere
55. Burn Center
56. Unknown

**Data Source Hierarchy Guide**
1. ADT Events
2. Discharge Summary
3. Case Management Note
4. Nursing Notes
QA Items

1. There are multiple different QA items that you can enter into the registry.
2. Much of this work is often done in collaboration with the Trauma Program Manager/Coordinator, Trauma PI Nurse and Registrar(s). Each facility will determine the workflow appropriate for their facility.
3. Detailed definitions for the Mandatory NTDB hospital event (Events and Complications) can be found in your NTDS Data Dictionary. (Note that some NTDS definitions for complications differ from the CDC or other national definitions being used by your facility ID / HIM coders.)
4. The ACS hospital events have question marks that will display the definitions when you click on them.
5. The System QA has several items to choose from and generally look at hospital events from a system breakdown perspective.
6. The IL Trauma Registry has the additional DI Driller capability which is accessible to all IL Trauma Centers and provides both statistical data and graph capability for a variety of data points.
ACS List

Definition

American College of Surgeons’ recommended QI variances.

NOTE: The ACS hospital events have question marks that will display the definition of that variable when you click on them.

Element Values:

1. Yes  
2. No  
3. ? Unknown  
4. / Non-applicable

Data Source Hierarchy:

1. Variable sources based on element being reviewed.
User Defined List

Definition
Institution – defined QI variances being monitored.

(Editor Note: Unsure re: this functionality in the State system, but allows for specific variable monitoring in your system).

NOTE: The User-defined events also have question marks that will display the definition of that variable when you click on them.

Element Values:
1. Yes
2. No
3. ? Unknown
4. / Non-applicable

Data Source Hierarchy:
- Variable sources based on element being reviewed.
System List

Definition:

Speed access option to address defined system or Facility recommended QI variances.

(Editor Note: Don’t see this option on the Web-based State version. Server-based facilities already familiar with use).
NTDB Complications and Hospital Events: MANDATORY BLUE FIELD; NTDS Definition rules.

Definition:

NTDB – defined complications. (See Hospital Events Section of the NTDS Data Dictionary for the detailed definitions being used for this item). It is >20 pages long, so not incorporated into our IL Dictionary.)

NOTE: Each Complication / Hospital Event is further designated with the date it was identified / diagnosed. This list is multi-select for complications identified / diagnosed on the same date.

Element Values:

1. Yes
2. No
3. ? Unknown
4. / Non-applicable

Data Source Hierarchy:

1. Variable sources based on element being reviewed.
NTDS Complication Details:

Definition:
Detailed of the occurrence and/or PI actions related to each NTDB – defined complication.

NOTE: The Registry will populate a row for each Complication entered. Selecting that row will allow you to edit / add details of the review and/or actions associated with each complication.

Element Values:

1. Yes  
2. No  
3. ? Unknown  
4. / Non-applicable

Data Source Hierarchy:

1. Variable sources based on element being reviewed and your Trauma Center PI Plan.
Explicit Negatives

Definition

Verification that each NTDB–defined complication has been evaluated for/captured during the chart review process.

NOTE: The description paragraph on this page details the intent and process. NTDS Data Dictionary Hospital Events (Complications) section is the reference for this work. “NOT KNOWN” should be a RARE response given the detailed chart review that has occurred at this point of data entry.

Data Source Hierarchy

1. Variable sources based on element being reviewed.
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