Division of Trauma and Injury Prevention 2025

Trauma Data Dictionary 2025

Indiana Department of Health

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Indiana Inclusion Criteria

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

1) The patient must have sustained a traumatic injury no more than 14 days prior to presentation for initial treatment[1] **AND**
2) The patient must have **at least one** of the following International Classification of Diseases, Tenth Revision (ICD-10-CM) diagnostic codes:
    - S00-S99 with 7th character modifiers of A, B, or C ONLY. (Injuries to specific body parts – initial encounter);[2]
        - **EXCLUDING** the following isolated injuries (ICD-10-CM):
            - S00 (Superficial injuries of the head)
            - S10 (Superficial injuries of the neck)
            - S20 (Superficial injuries of the thorax)
            - S30 (Superficial injuries of the abdomen, pelvis, lower back and external genitals)
            - S40 (Superficial injuries of shoulder and upper arm)
            - S50 (Superficial injuries of elbow and forearm)
            - S60 (Superficial injuries of wrist, hand and fingers)
            - S70 (Superficial injuries of hip and thigh)
            - S80 (Superficial injuries of knee and lower leg)
            - S90 (Superficial injuries of ankle, foot and toes)
    - T07 (unspecified multiple injuries)
    - T14 (injury of unspecified body region); OR
    - T79.A1-T79.A9 with 7th character modifier of A ONLY (Traumatic Compartment Syndrome-initial encounter)

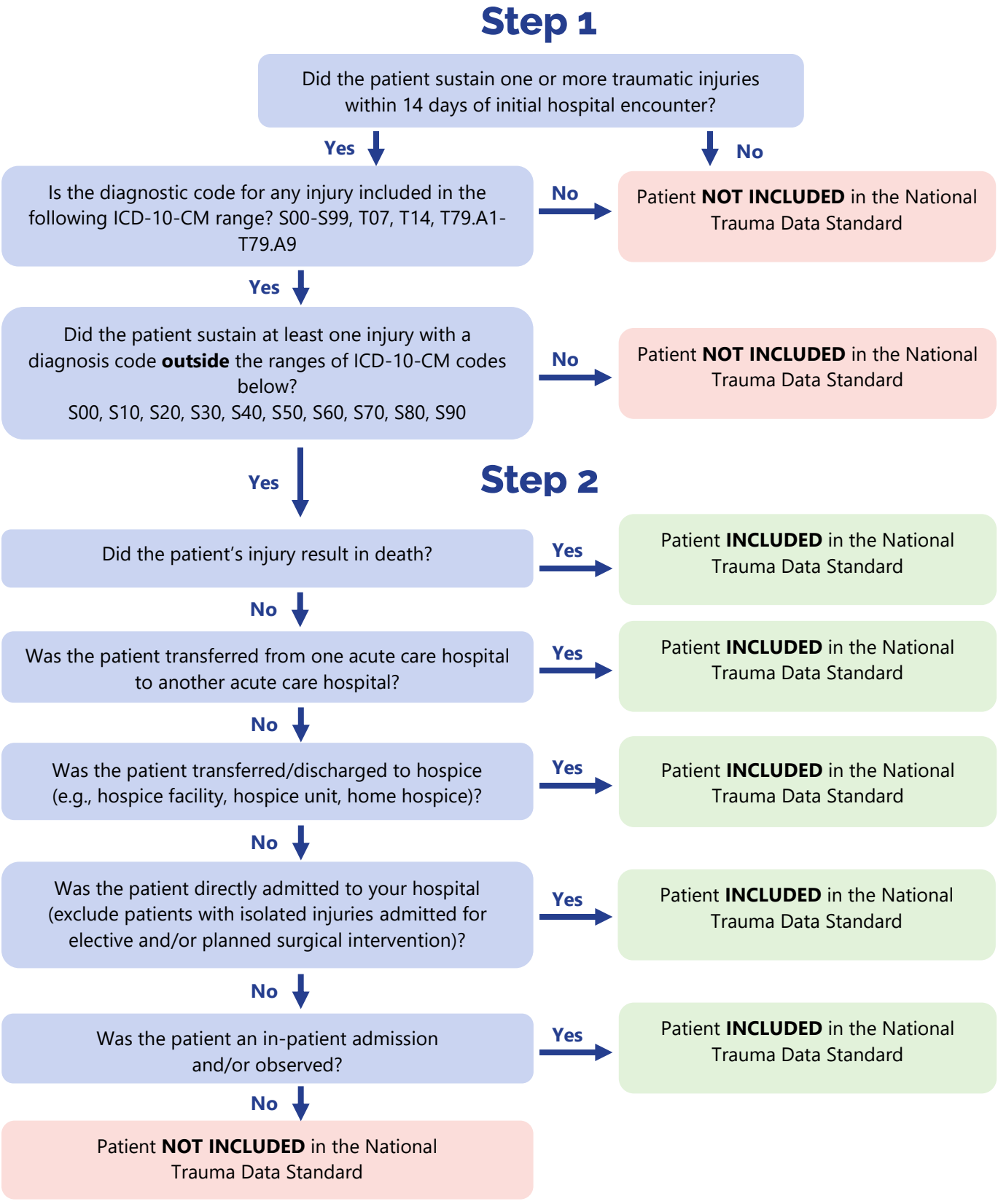
    AND
3) Must include one of the following:
    - Death resulting from the traumatic injury (independent of hospital admission or transfer status), **OR**
    - Patient transfer from one acute care hospital[3] to another acute care hospital, **OR**
    - Patients transferred/discharged to hospice (e.g.,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

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

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

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

Indiana Trauma Registry Inclusion Criteria Map



Common Null Values

Description

These values are to be used with each of the National Trauma Data Standard Data Elements and Indiana Trauma Data Standard Data Elements described in this document which have been defined to accept the null values.

Element Values

1. Not Applicable
2. Not Known / Not Recorded

Additional Information

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

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

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

Demographic Information

MEDICAL RECORD

TR 1.2 **Data Format**[text]

ImageTrend Description

The hospital's medical record number for the patient.

Element Values

- Relevant value for data element

Additional Information

- Auto-generated by the hospital

ACCOUNT NUMBER

TR 1.27 **Data Format**[text]

ImageTrend Description

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

Element Values

- Relevant value for data element

Additional Information

- Auto-generated by the hospital

PATIENT'S LAST NAME

TR 1.9 **Data Format**[text]

ImageTrend Description

The patient's last name.

Element Values

- Relevant value for data element

Data Source

- Face Sheet
- EMS Run Report
- Billing Sheet / Medical Records Coding Summary Sheet
- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation

PATIENT'S FIRST NAME

TR 1.8 **Data Format**[text]

ImageTrend Description

The patient's first name.

Element Values

- Relevant value for data element

Data Source

- Face Sheet
- EMS Run Report
- Billing Sheet / Medical Records Coding Summary Sheet
- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation

PATIENT'S MIDDLE INITIAL

TR 1.10 **Data Format**[text]

ImageTrend Description

The patient's middle initial.

Element Values

- Relevant value for data element

Data Source

- Face Sheet
- EMS Run Report
- Billing Sheet / Medical Records Coding Summary Sheet
- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation

PATIENT'S SOCIAL SECURITY

TR 1.11 **Data Format** [number]

ImageTrend Description
The patient's social security number.

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Face Sheet
- EMS Run Report
- Billing Sheet / Medical Records Coding Summary Sheet
- ED Nurses' Notes
- Other ED Documentation

DATE OF BIRTH*

TR 1.7

National & State Element
Data Format [date]

NTDB/ImageTrend Description

The patient's date of birth.

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Face Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- Admission Form
- Triage Form/Trauma Flow Sheet
- EMS Run Report

AGE (at date of incident)*

TR 1.12 National & State Element
Data Format [number]

NTDB/ImageTrend Description

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

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Face Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- Admission Form
- Triage Form/Trauma Flow Sheet
- EMS Run Report

AGE UNITS*

TR 1.14

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

NTDB/ ImageTrend Description

The units used to report the patient's age.

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

Element Values

Hours	Years
Days	Minutes
Months	Weeks

Additional Information

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

Data Source

- Face Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- Admission Form
- Triage Form/Trauma Flow Sheet
- EMS Run Report

RACE*

TR 1.16

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

NTDB/ImageTrend Description

The patient's race.

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

Element Values

Asian

Black or African American

Native Hawaiian or Other Pacific Islander

White

Other Race

American Indian

Additional Information

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

Data Source

- Face Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- Admission Form
- Triage Form/Trauma Flow Sheet
- EMS Run Report
- History & Physical

OTHER RACE

TR 1.28 **Data Format** [text]

ImageTrend Description

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

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

ETHNICITY*

TR 1.17

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

NTDB /ImageTrend Description

The patient's ethnicity.

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

Element Values

Hispanic or Latino Not Hispanic or Latino

Additional Information

- Patient ethnicity should be based upon self-report or identified by a family member.
- The maximum number of ethnicities that may be reported for an individual patient is 1.
- Based on the 2010 US Census Bureau.

Data Source

- Face Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- Admission Form
- Triage Form/Trauma Flow Sheet
- History & Physical
- EMS Run Report

SEX*

TR 1.56

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

Description
The patient's sex.

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

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

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

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

HEIGHT* (in)/HEIGHT* (cm)

TR 1.6.1/ TR 1.6

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

NTDB Description

First recorded height after ED/hospital arrival.

ImageTrend Description:

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

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet
- Pharmacy Record

WEIGHT* (kg)

TR 1.6.5

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

NTDB/ ImageTrend Description

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

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet
- Pharmacy Record

PATIENT'S HOME ADDRESS

TR 1.18 **Data Format** [text]

ImageTrend Description

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

Element Values

- Relevant value for data element

Data Source

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

ADDRESS LINE 2

TR 1.18.1 **Data Format** [text]

ImageTrend Description

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

Element Values

- Relevant value for data element

Data Source

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

PATIENT'S HOME COUNTRY*

TR 1.19

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

NTDB/ImageTrend Description

The country where the patient resides.

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Face Sheet
- Billing Sheet
- Admission Form

PATIENT'S HOME ZIP/POSTAL CODE*

TR 1.20

National & State Element
Data Format[text]

NTDB/ImageTrend Description

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

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Face Sheet
- Billing Sheet
- Admission Form

PATIENT'S HOME CITY*

TR 1.21

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

NTDB/ ImageTrend Description

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

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

Element Values

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

Additional Information

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

Data Source

- Face Sheet
- Billing Sheet
- Admission Form

PATIENT'S HOME COUNTY*

TR 1.22

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

NTDB/ ImageTrend Description

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

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

Element Values

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

Additional Information

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

Data Source

- Face Sheet
- Billing Sheet
- Admission Form

PATIENT'S HOME STATE*

TR 1.23

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

NTDB/ImageTrend Description

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

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

Element Values

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

Additional Information

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

Data Source

- Face Sheet
- Billing Sheet
- Admission Form

PATIENT'S ALTERNATE RESIDENCE*

TR 1.13 National & State Element

Data Format [combo] single-choice

NTDB/ImageTrend Description

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

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

Element Values

Homeless Migrant Worker

Undocumented Citizen

Additional Information

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

Data Source

- Face Sheet
- Billing Sheet
- Admission Form

PRIMARY METHOD OF PAYMENT*

TR 2.5

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

NTDB/ImageTrend Description

Primary source of payment for hospital care.

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

Element Values

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

Additional Information

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

Data Source

- Billing Sheet
- Admission Form
- Face Sheet

OTHER BILLING SOURCE

TR 2.13 **Data Format**[text]

ImageTrend Description

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Admission Form
- Face Sheet

REIMBURSED CHARGES

TR 2.8 **Data Format**[number]

ImageTrend Description

The amount the hospital was reimbursed for services.

Element Values

- Relevant value for data element

Data Source

- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Admission Form

SECONDARY METHOD OF PAYMENT

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

ImageTrend Description

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

Element Values

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

Data Source

- Billing Sheet / Medical Records Coding Summary Sheet
- Admission Form
- Face Sheet

SECONDARY OTHER BILLING SOURCE

TR 2.14 **Data Format**[text]

ImageTrend Description

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Billing Sheet / Medical Records Coding Summary Sheet
- Admission Form
- Face Sheet

THIRD METHOD OF PAYMENT

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

ImageTrend Description

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

Element Values

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

Data Source

- Billing Sheet / Medical Records Coding Summary Sheet
- Admission Form
- Face Sheet

THIRD OTHER BILLING SOURCE

TR 2.19 **Data Format**[text]

ImageTrend Description

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Billing Sheet / Medical Records Coding Summary Sheet
- Admission Form
- Face Sheet

BILLED HOSPITAL CHARGES

TR 2.9 **Data Format**[number]

ImageTrend Description

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

Element Values

- Relevant value for data element

Data Source

- Billing Sheet / Medical Records Coding Summary Sheet
- Admission Form

WORK-RELATED*

TR 2.10

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

NTDB/ImageTrend Description

Indication of whether the injury occurred during paid employment.

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

Element Values

Yes No

Additional Information

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

Data Source

- EMS Run Report
- Triage/Trauma Flow Sheet
- History & Physical
- Face Sheet
- Billing Sheet

PATIENT'S OCCUPATIONAL INDUSTRY*

TR 2.6

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

NTDB/ImageTrend Description

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

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

Element Values

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

Additional Information

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

Data Source

- Billing Sheet
- Face Sheet
- Case Management/Social Services Notes
- EMS Run Report
- Nursing Notes/Flow Sheet

PATIENT'S OCCUPATIONAL INDUSTRY DESCRIPTION

TR 2.27 **Data Format**[text]

ImageTrend Description

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

Element Values

- Relevant value for data element

Additional Information

- Only completed if injury is work-related

Data Source

- Triage Form / Trauma Flow Sheet
- EMS Run Report
- ED Nurses' Notes
- Other ED Documentation

PATIENT'S OCCUPATION*

TR 2.11

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

NTDB/ImageTrend Description

The occupation of the patient.

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

Element Values

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

Additional Information

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

Data Source

- Billing Sheet
- EMS Run Report
- Face Sheet
- Nursing Notes/Flow Sheet
- Case Management/Social Service Notes

PATIENT'S OCCUPATION DESCRIPTION

TR 2.12 **Data Format**[text]

ImageTrend Description

The description of the occupation of the patient.

Element Values

- Relevant value for data element

Additional Information

- Only completed if injury is work-related

Data Source

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED documentation
- EMS Run Report

Injury Information

INJURY INCIDENT DATE*

TR 5.1

National & State Element
Data Format[date]

NTDB/ImageTrend Description

The date the injury occurred.

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- EMS Run Report
- Triage Form / Trauma Flow Sheet
- History & Physical
- Face Sheet

INJURY INCIDENT TIME *

TR 5.18

National & State Element
Data Format[time]

NTDB/ImageTrend Description

The time the injury occurred.

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- EMS Run Report
- Triage Form / Trauma Flow Sheet
- History & Physical
- Face Sheet

INCIDENT LOCATION ZIP/POSTAL CODE*

TR 5.6 National & State Element

Data Format[text]

NTDB/ImageTrend Description

The ZIP/Postal code of the incident location.

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- EMS Run Report
- Triage Form/Trauma Flow Sheet

INCIDENT COUNTRY*

TR 5.11

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

NTDB/ImageTrend Description

The country where the incident occurred.

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

Element Values

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

Additional Information

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

Data Source

- EMS Run Report
- Triage Form/Trauma Flow Sheet

INCIDENT CITY

TR 5.10

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

NTDB/ ImageTrend Description

The city or township where the incident occurred.

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

Element Values

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

Additional Information

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

Data Source

- EMS Run Report
- Triage Form/Trauma Flow Sheet

INCIDENT COUNTY*

TR 5.9

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

NTDB// ImageTrend Description

The county or parish where the incident occurred.

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

Element Values

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

Additional Information

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

Data Source

- EMS Run Report
- Triage Form/Trauma Flow Sheet

INCIDENT STATE*

TR 5.7

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

NTDB/ImageTrend Description

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

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

Element Values

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

Additional Information

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

Data Source

- EMS Run Report
- Triage Form/Trauma Flow Sheet

ICD-10 LOCATION CODE*

TR 200.5.1

National & State Element
Data Format[number]

NTDB/ImageTrend Description

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

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

Element Values

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

Additional Information

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

Data Source

- EMS Run Report
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- History & Physical
- Progress Notes

(Complaint) SUPPLEMENTAL CAUSE OF INJURY

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

ImageTrend Description

The event that occurred to cause injury to the patient.

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

Data Source

- EMS Run Report
- Triage Form/Trauma Flow Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- ED Nurses' Notes
- Other ED Documentation

INJURY DESCRIPTION

TR 20.12 **Data Format**[text]

ImageTrend Description

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

Element Values

- Relevant value for data element

Data Source

- EMS Run Report
- History & Physical Documentation
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation

ICD-10 PRIMARY EXTERNAL CAUSE CODE*

TR 200.3 National & State Element

Data Format [number]

NTDB/ImageTrend Description

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

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

Element Values

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

Additional Information

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

Data Source

- EMS Run Report
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- History & Physical
- Progress Notes

ICD-10 ADDITIONAL EXTERNAL CAUSE CODE*

National & State Element
Data Format[number]

NTDB/ImageTrend Description

Additional External Cause Code used in conjunction with the Primary External Cause Code if multiple external cause codes are required to describe the injury event

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

Element Values

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

Additional Information

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

Data Source

- EMS Run Report
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- History & Physical
- Progress Notes

ICD-10 INTENTIONALITY

TR 200.3.2 **Data Format** [number]

ImageTrend Description

Intentionality.

Element Values

Relevant ICD-10-CM code value for intentionality.

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

ICD-10 TRAUMA TYPE

TR 200.3.3 **Data Format**[number]

ImageTrend Description

Type of injury.

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

Element Values

Relevant ICD-10-CM code value for intentionality.

- Blunt
- Penetrating
- Burn
- Other

BARRIERS TO PATIENT CARE

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

ImageTrend Description

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

Element Values

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

Data Source

- EMS Run Report
- Other ED Documentation

Pre-Hospital Information

ARRIVED FROM

TR 16.22 **Data Format**[combo] single choice

ImageTrend Description

Location the patient arrived from.

Element Values

Clinic / MD Office	Nursing Home
Home	Referring Hospital
Jail	Scene

Additional Information

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

Data Source

- EMS Run Report
- 911 or Dispatch Center
- Other ED Documentation

TRANSPORTED TO YOUR FACILITY BY (EMS Transport Party)*

TR 8.8

National & State Element
Data Format[combo] single choice

NTDB/ ImageTrend Description

The mode of transport delivering the patient to your hospital.

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

Element Values

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

Data Source

- EMS Run Report

OTHER TRANSPORT MODE

TR 8.9

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

NTDB/ImageTrend Description

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

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

Element Values

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

Additional Information

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

Data Source

- EMS Run Report

INTER-FACILITY TRANSFER*

TR 25.54

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

NTDB/ImageTrend Description

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

INCLUDE:

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

EXCLUDE:

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

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

Element Values

Yes No

Additional Information

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

Data Source

- EMS Run Report
- Triage/Trauma Flow Sheet
- History and Physical

INTUBATION PRIOR TO ARRIVAL*

TR60.1 National & State Element

Data Format [combo] single-choice

NTDB/ ImageTrend Description

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

INCLUDE:

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

EXCLUDE:

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

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

Element Values

1. Yes 2. No

Additional Information

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

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

Data Source

1. Triage/Trauma Flow Sheet 2. ED Record

3. Face Sheet 4. Billing Sheet

5. Discharge Summary

INTUBATION LOCATION*

TR60.2

National & State Element

Data Format [combo] single-choice

NTDB/ImageTrend Description

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

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

Element Values

1. Out of Hospital Intubation 2. Transferring Facility

Additional Information

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

Data Source

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

MASS CASUALTY INCIDENT

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

ImageTrend Description

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

Element Values

No Yes

Data Source

- EMS Run Report
- Trauma Flow Sheet
- 911 or Dispatch Center
- Other ED Documentation

PREGNANCY

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

ImageTrend Description

Indication of the possibility that the patient is currently pregnant.

Element Values

No Yes

Data Source

- EMS Run Report
- 911 or Dispatch Center
- Other ED Documentation

ESTIMATED BODY WEIGHT (Initial ED/Hospital Weight)*

TR 1.6.6 **Data Format**[combo] single-choice

NTDB/ ImageTrend Description

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Triage/Trauma/Hospital Flow Sheet
- Nursing Notes/Flow Sheet
- Pharmacy Record

LAW ENFORCEMENT / CRASH REPORT NUMBER

TR 14.40 **Data Format**[text]

ImageTrend Description

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

Element Values

- Relevant value for data element

Data Source

- EMS Run Report
- Other ED Documentation

VEHICULAR INJURY INDICATORS

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

ImageTrend Description

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

Element Values

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

Data Source

- EMS Run Report
- Other ED Documentation

SEAT ROW LOCATION (of Patient in Vehicle)

TR 14.43 **Data Format**[number]

ImageTrend Description

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

Element Values

- Relevant value for data element

Data Source

- EMS Run Report
- Other ED Documentation

POSITION OF PATIENT (in the seat of the vehicle)

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

ImageTrend Description

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

Element Values

Driver	Middle	Right
Left (Non-driver)	Other	

Data Source

- EMS Run Report
- Other ED Documentation

HEIGHT OF FALL IN FEET

TR 14.45 **Data Format**[number]

ImageTrend Description

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

Element Values

- Relevant value for data element

Data Source

- EMS Run Report
- Other ED Documentation

TRAUMA TRIAGE CRITERIA (Steps 1 and 2)*

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

ImageTrend Description

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

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

Element Values

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

Additional Information

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

Data Source

- EMS Run Report

TRAUMA TRIAGE CRITERIA (Steps 3 and 4)*

TR 17.47

National & State Element

Data Format[combo] single-choice

NTDB/ ImageTrend Description

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

Element Values

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

Additional Information

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

Data Source

- EMS Run Report

PROTECTIVE DEVICES (Safety Device Used)*

TR 29.24

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

NTDB/ ImageTrend Description

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

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

Element Values

1. None
2. Lap Belt – TR 29.11
3. Personal Floatation Device – TR29.8
4. Protective Non-Clothing Gear (e.g., shin guard) – TR29.12
5. Eye Protection – TR29.6
6. Child Restraint (booster seat or child car seat) – TR29.13
7. Helmet (e.g., bicycle, skiing, motorcycle) – TR29.2
8. Airbag Present – TR29.3
9. Protective Clothing (e.g., padded leather pants) – TR29.7
10. Shoulder Belt – TR29.14
11. Other – TR29.9

Additional Information

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

Data Source

- EMS Run Report
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes/Flow Sheet
- History & Physical

CHILD SPECIFIC RESTRAINT*

TR 29.31

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

NTDB/ImageTrend Description

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

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

Element Values

1. Not Applicable
2. Child Booster Seat (TR29.17)
3. Child Car Seat (TR29.15)
4. Infant Car Seat (TR29.16)
5. Not Known/Not Recorded

Additional Information

- Evidence of the use of a child restraint may be reported or observed.
- Only reported when Protective Devices include "6. Child Restraint (booster seat or child car seat)."
- The null value "Not Applicable" is reported if Element Value "6. Child Restraint" is NOT reported for Protective Devices.

Data Source

- EMS Run Report
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes/Flow Sheet
- History & Physical

AIRBAG DEPLOYMENT*

TR 29.32

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

NTDB/ImageTrend Description

Indication of airbag deployment during a motor vehicle crash.

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

Element Values

1. Not Applicable
2. Airbag Deployed Front (TR29.21)
3. Airbag Deployed Other (TR29.22)
4. Airbag Deployed Side (TR29.19)
5. Airbag Not Deployed (TR29.20)
6. Not Known/Not Recorded

Additional Information

- Only completed when 'Airbag Present' is marked "Yes"
- Evidence of the use of airbag deployment may be reported or observed
- The null value "Not Applicable" is used if no "Airbag Present" is reported under Protective Devices

Data Source

- EMS Run Report
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes/Flow Sheet
- History & Physical

SAFETY (Equipment) DESCRIPTION

TR 29.10 **Data Format**[text]

ImageTrend Description

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- EMS Run Report
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes/Flow Sheet

EMS RUN NUMBER

TR 7.1 **Data Format**[text]

ImageTrend Description

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

Element Values

- Relevant value for data element

Data Source

- EMS Run Report
- Other ED Documentation

EMS PATIENT CARE REPORT (PCR) NUMBER

TR 9.11 **Data Format**[text]

ImageTrend Description

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

Element Values

- Relevant value for data element

Data Source

- EMS Run Report
- Other ED Documentation

NAME OF EMS SERVICE

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

ImageTrend Description

The name of the EMS service that transferred the patient.

Element Values

- Relevant value for data element

Data Source

- EMS Run Report
- Other ED Documentation

EMS DISPATCH DATE*

TR 9.1 **Data Format**[date]

ImageTrend Description

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

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- EMS Run Report

EMS DISPATCH TIME*

TR 9.10 **Data Format**[time]

ImageTrend Description

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

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

Element Values

- Relevant value for data element

Additional Information

- Collected as HHMM military time
- For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility was notified by dispatch.
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene was dispatched.
- The null value "Not Applicable" is used for patients who were not transported by EMS

Data Source

- EMS Run Report

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

TR 9.2 **Data Format** [Date]

ImageTrend Description

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

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

Element Values

- Relevant value for data element
- Total EMS Time (elapsed time from EMS dispatch to hospital arrival)

Additional Information

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

Data Source

- EMS Run Report

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

TR 9.2.1 **Data Format**[time]

ImageTrend Description

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

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

Element Values

- Relevant value for data element
- Total EMS Time (elapsed time from EMS dispatch to hospital arrival)

Additional Information

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

Data Source

- EMS Run Report

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

TR 9.3 **Data Format** [Date]

ImageTrend Description

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

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- EMS Run Report

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

TR 9.3.1 **Data Format**[time]

ImageTrend Description

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

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

Element Values

- Relevant value for data element
- Total EMS Time (elapsed time from EMS dispatch to hospital arrival)

Additional Information

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

Data Source

- EMS Run Report

UNIT ARRIVED HOSPITAL DATE

TR 9.4 **Data Format** [Date]

ImageTrend Description

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- EMS Run Report
- 911 or Dispatch Center

UNIT ARRIVED HOSPITAL TIME

TR 9.4.1 **Data Format**[time]

ImageTrend Description

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

XSD Data Type	xs: string	**Element / Domain (Simple Type)**	Time Unit At Destination
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- EMS Run Report
- 911 or Dispatch Center

EMS PATIENT CARE REPORT UNIVERSALLY UNIQUE IDENTIFIER (UUID)

TR 7.7

National & State Element
Data Format[String]

NTDB/ImageTrend Description

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

Element Values

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

Additional Information

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

Data Source Hierarchy Guide

1. EMS Run Report

(Pre-Hospital) DESTINATION DETERMINATION

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

ImageTrend Description

Major reason for transferring the patient to the facility chosen.

Element Values

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

Data Source

- EMS Run Report
- Other ED Documentation

TRIAGE DESTINATION PROTOCOL

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

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

Element Values

- Relevant value for data element

Data Source

- EMS Run Report
- 911 or Dispatch Center

TRIAGE CRITERIA

TR 9.14 **Date Format**[Combo]multiple-choice

ImageTrend Description

Indicates criterion (a) used to triage patient criteria that may be selected are those in the adult out of hospital trauma triage criteria decision protocol of the EMS Bureau of the IDPH up to 20 criteria may be chosen (if EMS run sheet unavailable, give best estimate of circumstances of injury).

Element Values

- GCS < 13, SBP <90, RR 29
- Penetration, head/neck/torso/groin/axilla
- Flail Chest
- Suspected fractures, 2 or more long bones (humerus, femur)
- Amputation, proximal to wrist or ankle
- Suspected pelvic fx
- Neck or spinal cord injury with extremity paralysis or paresis
- Suspected alcohol/drug intoxication
- Not Known/Not Recorded/Not Performed/Not Available

Data Source

- EMS Run Report
- 911 or Dispatch Center

(Pre-Hospital Thoracentesis)/TUBE THORACOSTOMY

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

ImageTrend Description

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

Element Values

Not Performed	Performed

Data Source

- EMS Run Report
- Other ED Documentation

(Pre-Hospital) CPR PERFORMED

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

ImageTrend Description

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

Element Values

Performed Not Performed

Data Source

- EMS Run Report
- Other ED Documentation

EMS STATUS

TR 15.38 **Data Format** [combo] single-choice

ImageTrend Description

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

Element Values

Complete	Missing
Incomplete	Pending

Data Source

- EMS Run Report
- Other ED Documentation

PRE-HOSPITAL CARDIAC ARREST*

TR 15.53

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

NTDB/ ImageTrend Description

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

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

Element Values

Yes No

Additional Information

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

Data Source

- EMS Run Report
- Other ED Documentation

(Pre-Hospital) NEEDLE THORACOSTOMY

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

ImageTrend Description

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

Element Values

Not Performed Performed

Data Source

- EMS Run Report
- Other ED Documentation

(Pre-Hospital) AIRWAY MANAGEMENT

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

ImageTrend Description

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

Element Values

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

Data Source

- EMS Run Report
- Other ED Documentation

(Pre-Hospital) FLUIDS

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

ImageTrend Description

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

Element Values

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

Data Source

- EMS Run Report
- Other ED Documentation

(Pre-Hospital) MEDICATIONS

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

ImageTrend Description

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

Element Values

- Relevant value for data element

Data Source

- EMS Run Report
- Other ED Documentation

(Pre-Hospital) VITALS DATE

TR 18.106 **Data Format** [date]

ImageTrend Description

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

Element Values

- Collected as MM/DD/YYYY

Data Source

- EMS Run Report
- Other ED Documentation

(Pre-Hospital) VITALS TIME

TR 18.110 **Data Format** [time]

ImageTrend Description

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

Element Values

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

Data Source

- EMS Run Report
- Other ED Documentation

INITIAL FIELD GCS - EYE*

TR 18.60 **Data Format** [number]

ImageTrend Description

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

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

Element Values

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

Additional Information

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

Data Source

- EMS Run Report

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

INITIAL FIELD GCS - VERBAL*

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

ImageTrend Description

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

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

Element Values

Pediatric (≤ 2 years):

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

Adult:

No vocal response
Incomprehensible sounds
Inappropriate words
Confused
Oriented

Additional Information

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

Data Source

- EMS Run Report

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

INITIAL FIELD GCS - MOTOR*

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

ImageTrend Description

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

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

Element Values

Pediatric (≤ 2 years):

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

Adult:

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

Additional Information

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

Data Source

- EMS Run Report

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

(Initial Field) GCS QUALIFIER (UP TO 3)

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

ImageTrend Description

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

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

Element Values

- Patient chemically sedated or paralyzed
- Obstruction to the Patient's Eye
- Patient Intubated
- Valid GCS: Patient was not sedated, not intubated, and did not have obstruction to the eye

Additional Information

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

Data Source

- EMS Run Report

(Initial Field) SYSTOLIC BLOOD PRESSURE*

TR 18.67 **Data Format**[number]

ImageTrend Description

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

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- EMS Run Report

(Initial Field) DIASTOLIC BLOOD PRESSURE

TR 18.68 **Data Format**[number]

ImageTrend Description

First recorded diastolic blood pressure in the pre-hospital setting.

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- EMS Run Report

(Initial Field) PULSE RATE*

TR 18.69 **Data Format**[number]

ImageTrend Description

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

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- EMS Run Report

(Initial Field) RESPIRATORY RATE*

TR 18.70 **Data Format**[number]

ImageTrend Description

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

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- EMS Run Report

(Initial Field) SP02 (Oxygen Saturation) *

TR 18.82 **Data Format**[number]

ImageTrend Description

First recorded oxygen saturation at the scene of injury.

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- EMS Run Report

INITIAL FIELD GCS - TOTAL*

TR 18.64 **Data Format**[number]

ImageTrend Description

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

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- EMS Run Report

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

INITIAL FIELD GCS 40- EYE*

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

ImageTrend Description

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

XSD Data Type	xs: integer	**XSD Element / Domain (Complex Type)**	EmsGcs40Eye
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 3	**Max. Constraint:** 15

Element Values

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

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

Additional Information

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

Data Source :

- EMS Run Report

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

INITIAL FIELD GCS 40- VERBAL*

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

ImageTrend Description

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

XSD Data Type	xs: integer	**XSD Element / Domain (Complex Type)**	EmsGcs40Verbal
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 3	**Max. Constraint:** 15

Element Values

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

Additional Information

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

Data Source

- EMS Run Report

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

INITIAL FIELD GCS 40- MOTOR*

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

ImageTrend Description

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

XSD Data Type	xs: integer	**XSD Element / Domain (Complex Type)**	EmsGcs40Motor
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 3	**Max. Constraint:** 15

Element Values

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

Additional Information

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

Data Source

- EMS Run Report

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

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

TR 18.66 **Data Format**[number]

ImageTrend Description

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

Element Values

- Relevant value for data element

Data Source

- EMS Run Report

(Pre-Hospital) RESPIRATORY ASSISTANCE

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

ImageTrend Description

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

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

Element Values

Unassisted Respiratory Rate

Assisted Respiratory Rate

Additional Information

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

Data Source

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet
- Respiratory Therapy Notes/Flow Sheet

Referring Hospital Information

TRANSPORTED TO REFERRING FACILITY BY

TR 33.48 **Data Format**[combo] single-choice

ImageTrend Description

The mode of transport delivering the patient to the referring hospital

Element Values

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

Data Source

- Referring Hospital Medical Record Information

REFERRING HOSPITAL NAME

TR 33.1 **Data Format**[combo] single-choice

ImageTrend Description

Name of the referring hospital.

Element Values

- Relevant value for data element

Data Source

- Referring Hospital Medical Record Information

REFERRING HOSPITAL ARRIVAL DATE

TR 33.2 **Data Format**[date]

ImageTrend Description

The date the patient arrived at the referring hospital.

Element Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY

Data Source

- Referring Hospital Medical Record Information

REFERRING HOSPITAL ARRIVAL TIME

TR 33.3 **Data Format**[time]

ImageTrend Description

The time the patient arrived at the referring hospital

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Referring Hospital Medical Record Information

REFERRING HOSPITAL DISCHARGE DATE

TR 33.30 **Data Format**[date]

Description

The date the patient was discharged from the referring hospital.

Element Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY

Data Source

- Referring Hospital Medical Record Information

REFERRING HOSPITAL DISCHARGE TIME

TR 33.31 **Data Forma**t[time]

ImageTrend Description

The time the patient was discharged from the referring hospital.

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Referring Hospital Medical Record Information

REFERRING HOSPITAL PHYSICIAN NAME

TR 33.4 **Data Format** [text]

ImageTrend Description

The name of the patient's referring physician.

Element Values

- Relevant value for data element

Data Source

- Referring Hospital Medical Record Information

REFERRING HOSPITAL VITALS DATE

TR 33.54 **Data Format**[date]

ImageTrend Description

The referring hospital vitals date.

Element Values

- Relevant value for data element

(Referring Hospital) GCS - MOTOR

TR 33.14.2 / TR 33.14.0 (ped) **Data Format**[number]

ImageTrend Description

First recorded Glasgow Coma Score (Motor) at the referring hospital.

XSD Data Type	xs: VarChar		
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 6

. **Element Values**

Pediatric (≤ 2 years):

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

Adult:

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

Additional Information

- Used to calculate Overall GCS - Referring Hospital Score
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of function within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus", a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation

Data Source

- Referring Hospital Medical Record Information

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

(Referring Hospital) GCS - EYE

TR 33.12 **Data Format**[number]

ImageTrend Description

First recorded Glasgow Coma Score (Eye) at the referring hospital.

XSD Data Type	xs: integer		
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 4

Element Values

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

Additional Information

- Used to calculate Overall GCS - Referring Hospital Score
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of function within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus", a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation

Data Source

- Referring Hospital Medical Record Information

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

(Referring Hospital) GCS - VERBAL

TR 33.13.2/TR 33.13.0(ped) **Data Format**[number]

ImageTrend Description

First recorded Glasgow Coma Score (Verbal) at the referring hospital

XSD Data Type	xs: integer		
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 5

Element Values

Pediatric (≤ 2 years):

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

Adult:

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

Additional Information

- Used to calculate Overall GCS - Referring Hospital Score
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of function within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus", a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation

Data Source

- Referring Hospital Medical Record Information

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

(Referring Hospital) GCS ASSESSMENT QUALIFIERS (UP TO 3)

TR 33.16 **Data Format**[combo]multiple-choice

ImageTrend Description

Documentation of factors potentially affecting the first assessment of GCS upon arrival to the referring hospital.

Element Values

- Patient chemically sedated
- Patient Intubated
- Valid GCS: Patient was not sedated, not intubated, and did not have obstruction to the eye
- Obstruction to the Patient's Eye

Additional Information

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

Data Source

- Referring Hospital Medical Record Information

(Referring Hospital) MANUAL GCS TOTAL

TR 33.15 **Data Format**[number]

ImageTrend Description

First recorded Glasgow Coma Score (total) at the referring hospital.

Element Values

- Relevant value for data element

Additional Information

- Use only if total score is available without component score
- Used to auto-generate an additional calculated element: Revised Trauma Score - Referring Hospital (adult and pediatric)
- If a patient does not have a numeric GCS score recorded, but with documentation related to their level of consciousness such as "AAOx3", "awake alert and oriented", or "patient with normal mental status", interpret this as GCS of 15, IF there is no other contradicting documentation
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of function within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus", a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation

Data Source

- Referring Hospital Medical Record Information

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

(Referring Hospital) TEMPERATURE

TR 33.7 **Data Format**[number]

ImageTrend Description

Referring Temp Celsius.

Element Values

- Relevant value for data element
- Used to auto-generate an additional calculated element: Temperature in degrees Fahrenheit

Data Source

- Referring Hospital Medical Record Information

(Referring Hospital) SYSTOLIC BLOOD PRESSURE

TR 33.5 **Data Format**[number]

ImageTrend Description

Referring Systolic Blood Pressure.

Element Values

- Relevant value for data element

Additional Information

- Used to auto-generate an additional calculated element: Revised Trauma Score - Referring Hospital (adult and pediatric)

Data Source

- Referring Hospital Medical Record Information

(Referring Hospital) PULSE RATE

TR 33.6 **Data Format**[number]

ImageTrend Description

First recorded pulse at the referring hospital (palpated or auscultated), expressed as a number per minute.

Element Values

- Relevant value for data element

Data Source

- Referring Hospital Medical Record Information

(Referring Hospital) RESPIRATORY RATE

TR 33.8 **Data Format**[number]

ImageTrend Description

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

Element Values

- Relevant value for data element

Additional Information

- Used to auto-generate an additional calculated element: Revised Trauma Score - Referring Hospital (adult and pediatric)

Data Source

- Referring Hospital Medical Record Information

(Referring Hospital) SP02 (Oxygen Saturation)

TR 33.11 **Data Format**[number]

ImageTrend Description

Referring Oxygen Saturation.

Element Values

- Relevant value for data element

Data Source

- Referring Hospital Medical Record Information

(Referring Hospital Revised Trauma Score) MANUAL RTS

TR 33.17 **Data Format**[number]

ImageTrend Description

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Referring Hospital Medical Record Information

(Referring Hospital) Supplemental Oxygen

TR 33.10 **Data Format**[combo] single-choice

ImageTrend Description

Supplemental Oxygen.

Element Values

No Yes

Data Source

- Referring Hospital Medical Record Information

(Referring) HOSPITAL ICU

TR 33.18 **Data Format**[combo] single-choice

ImageTrend Description

Determination of whether or not the patient went to the ICU at the referring hospital.

Element Values

Yes No

Data Source

- Referring Hospital Medical Record Information
- Other ICU Documentation

(Referring) HOSPITAL OR

TR 33.19 **Data Format**[combo] single-choice

ImageTrend Description

Referring Operating Room.

Element Values

Yes No

Data Source

- Referring Hospital Medical Record Information
- Other OR Documentation

(Referring) CPR PERFORMED

TR 33.20 **Data Format**[combo] single-choice

ImageTrend Description

Indication as to if CPR management was conducted while under the care of the referring hospital.

Element Values

Yes No

Data Source

- Referring Hospital Medical Record Information

(Referring Hospital) CT HEAD (Results)

TR 33.21 **Data Format**[combo] single-choice

ImageTrend Description

Indication as to if this procedure was performed while under the care of the referring hospital.

Element Values

Positive Negative Not Performed

Data Source

- Referring Hospital Medical Record Information
- Radiology Report

(Referring Hospital) CT CERVICAL (Results)

TR 33.33 **Data Format**[combo] single-choice

ImageTrend Description

Indication as to if this procedure was performed while under the care of the referring hospital.

Element Values

Positive Negative Not Performed

Data Source

- Referring Hospital Medical Record Information
- Radiology Report

(Referring Hospital) CT ABD/PELVIS (Results)

TR 33.22 **Data Format**[combo] single-choice

ImageTrend Description

Indication as to if this procedure was performed while under the care of the referring hospital.

Element Values

Positive Negative Not Performed

Data Source

- Referring Hospital Medical Record Information
- Radiology Report

(Referring Hospital) CT CHEST (Results)

TR 33.23 **Data Format** [combo] single-choice

ImageTrend Description

Indication as to if this procedure was performed while under the care of the referring hospital.

Element Values

Positive Negative Not Performed

Data Source

- Referring Hospital Medical Record Information
- Radiology Report

(Referring Hospital) ABDOMINAL ULTRASOUND (Results)

TR 33.24 **Data Format** [combo] single-choice

ImageTrend Description

Indication as to if this procedure was performed while under the care of the referring hospital.

Element Values

Positive Negative Not Performed

Data Source

- Referring Hospital Medical Record Information
- Radiology Report

(Referring Hospital) AORTOGRAM (Results)

TR 33.25 **Data Format** [combo] single-choice

ImageTrend Description

Indication as to if this procedure was performed while under the care of the referring hospital.

Element Values

Positive Negative

Data Source

- Referring Hospital Medical Record Information
- Radiology Report

(Referring Hospital) AIRWAY MANAGEMENT

TR 33.27 **Data Format** [combo] single-choice

ImageTrend Description

Indication as to whether a device or procedure was used to prevent or correct an obstructed airway passage while under the care of the referring hospital.

Element Values

Bag & Mask	LMA
CPAP	Nasal ETT
King Airway	Not Performed
Nasal Cannula	Oral Airway
Non-Rebreather Mask	Oral ETT
Combi tube	Supplemental Oxygen
Crico	Trach

Data Source

- Referring Hospital Medical Record Information

(Referring Hospital) MEDICATIONS

TR 33.28 **Data Format** [combo] multiple-choice

ImageTrend Description

Indication as to which, if any, medications were administered to the patient while under the care of the referring hospital

Element Values

- Relevant value for data element

Data Source

- Referring Hospital Medical Record Information
- Other ED Documentation

(Referring Hospital) DESTINATION DETERMINATION

TR 33.29 **Data Format** [combo] single-choice

ImageTrend Description

The reason the facility transferred this patient to another acute care hospital.

Element Values

- Hospital of Choice
- Specialty Resource Center

Data Source

- Referring Hospital Medical Record Information

ED/Acute Care Information

DIRECT ADMIT TO HOSPITAL

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

ImageTrend Description

Indicates if the patient was a direct admission.

Element Values

No Yes

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Registration
- Hospital Discharge Summary

DATE ARRIVED IN ED/ACUTE CARE*

TR 18.55

National & State Element
Data Format [date]

NTDB/ImageTrend Description

The date the patient arrived in the ED/Hospital.

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

Element Values

- Relevant value for data element
- Total EMS Time: (elapsed time from EMS dispatch to hospital arrival) and Total Length of Hospital Stay (elapsed time from ED/Hospital Arrival to ED/Hospital Discharge)

Additional Information

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

Data Source:

- Triage Form/Trauma Flow Sheet
- Other ED Documentation
- Ed Record
- Face Sheet
- Billing Sheet
- Discharge Summary

TIME ARRIVED IN ED/ACUTE CARE*

TR 18.56

National & State Element
Data Format [Time]

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

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

Element Values

- Relevant value for data element
- Total EMS Time: (elapsed time from EMS dispatch to hospital arrival) and Total Length of Hospital Stay (elapsed time from ED/Hospital Arrival to ED/Hospital Discharge).

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- ED Record
- Fact Sheet
- Billing Sheet
- Discharge Summary

TRAUMA TEAM ACTIVATED

TR 17.21 **Data Format** [radio]

ImageTrend Description

Level of Trauma Team activated.

Element Values

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

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

HIGHEST ACTIVATION*

TR 17.21.1 National & State Element

Data Format[combo] single-choice

NTDB/ImageTrend Description

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

INCLUDE:

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

EXCLUDE:

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

Element Values

Yes No

Additional Information

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

Data Source

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

DATE TRAUMA TEAM ACTIVATED

TR 17.31 **Data Format** [date]

ImageTrend Description

The date the trauma team was activated.

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

TIME TRAUMA TEAM ACTIVATED

TR 17.34 **Data Format** [time]

ImageTrend Description

The time the trauma team was activated

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

ADMITTING MD/STAFF

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

ImageTrend Description

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

Element Values

- Relevant value for data element

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

TEAM MEMBER

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

ImageTrend Description

Name of the team member called when trauma team was activated

Element Values

- Relevant value for data element

Additional Information

- Only completed if Trauma Team is activated

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

ADMITTING SERVICE

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

ImageTrend Description

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

Element Values

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

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

(Trauma Team Member) SERVICE TYPE

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

ImageTrend Description

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

Element Values

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

Additional Information

- Only completed if Trauma Team is activated

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

DATE (Trauma Team Member) CALLED

TR 17.10 **Data Format** [date]

ImageTrend Description

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

TIME (Trauma Team Member) CALLED

TR 17.14 **Data Format** [time]

ImageTrend Description

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

DATE (Trauma Team Member) ARRIVED

TR 17.15 **Data Format** [date]

ImageTrend Description

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

TIME (Trauma Team Member) ARRIVED

TR 17.11 **Data Format** [time]

ImageTrend Description

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

(Trauma Team) TIMELY ARRIVAL

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

ImageTrend Description

Was the (ED physician) respond to the call to see the patient in a timely manner?

Element Values

Yes No

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

TRAUMA SURGEON ARRIVAL DATE*

TR 17.15.1 National & State Element

Data Format[Date]

NTDB/ImageTrend Description

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

XSD Data Type	xs: date	**XSD Element Name:**	Trauma Surgeon Highest Activation Arrival Date
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**XSD ComplexType:**	Date19902030
Minimum Value:	1990-01-01	**Maximum Value:**	2030-01-01

Element Values

Relevant value for data element

Additional Information

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

Data Source

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

TRAUMA SURGEON ARRIVAL TIME*

TR 17.15.2 National & State Element

Data Format[Time]

NTDB/ImageTrend Description

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

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

Element Values

Relevant value for data element

Additional Information

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

Data Source

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

CONSULTING SERVICES

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

ImageTrend Description

The determination that consulting services were provided.

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

Element Values

Yes No

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

(Consulting) SERVICE TYPE

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

ImageTrend Description

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

Element Values

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

Additional Information

- Only completed if Consulting Services is "Yes"

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

CONSULTING STAFF

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

ImageTrend Description

Name of staff member that consulted on the patient.

Element Values

- Relevant value for data element

Additional Information

- Only completed if Consulting Services is "Yes"

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

DATE (Consulting Practitioner Requested)

TR 17.7 **Data Format**[date]

ImageTrend Description

The date the consultant was called.

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

TIME (Consulting Practitioner Requested)

TR 17.8 **Data Format**[time]

ImageTrend Description

The time the consultant was called.

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

DATE DISCHARGED FROM ED (ORDERS WRITTEN) *

TR 17.41

National & State Element
Data Format[date]

NTDB/ImageTrend Description

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

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Physician Order
- ED Record
- Triage/Trauma/Hospital Flow Sheet
- Nursing Notes/Flow Sheet
- Discharge Summary
- Billing Sheet
- Progress Notes

TIME DISCHARGED FROM ED (ORDERS WRITTEN) *

TR 17.42 National & State Element

Data Format[time]

NTDB/ImageTrend Description

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

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Physician Order
- ED Record
- Triage/Trauma/Hospital Flow Sheet
- Nursing Notes/Flow Sheet
- Discharge Summary
- Billing Sheet
- Progress Notes

DATE DISCHARGED FROM ED (PHYSICAL EXIT)*

TR 17.25 **Data Format**[date]

ImageTrend Description

The date the patient physically left the ED.

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

Element Values

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

Additional Information

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

Data Source

- ED Record
- Triage/Trauma/Hospital Flow Sheet
- Nursing Notes/Flow Sheet
- Discharge Summary
- Billing Sheet
- Progress Notes

TIME DISCHARGED FROM ED (PHYSICAL EXIT)*

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

ImageTrend Description

The time the patient physically left the ED.

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

Element Values

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

Additional Information

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

Data Source

- ED Record
- Triage/Trauma/Hospital Flow Sheet
- Nursing Notes/Flow Sheet
- Discharge Summary
- Billing Sheet
- Progress Notes

ED DISCHARGE DISPOSITION*

TR 17.27

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

NTDB/ImageTrend Description

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

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

Element Values

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

Additional Information

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

Data Source

- Physician Order
- Discharge Summary
- Nursing Notes/Flow Sheet
- Case Management/Social Services Notes
- ED Record
- History & Physical

DISCHARGE TRANSPORT MODE*

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

ImageTrend Description

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

Element Values

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

Additional Information

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

Data Source

- EMS Run Report

**Patients transferred from one acute care hospital to another acute care hospital by private vehicle are to be included in the trauma registry per the 2021 NTDS Data Dictionary. **

PRIMARY TRAUMA SERVICE TYPE*

TR 18.205

National & State Element
Data Format [combo] single choice

NTDB/ImageTrend Description

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

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

Element Values

Adult Pediatric

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- History and Physical
- Discharge Summary

PRIMARY MEDICAL EVENT*

TR 18.220

National & State Element

Data Format [combo] single-choice

NTDB Description

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

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

Element Values

1. Yes
2. No

Additional Information

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

Data Source

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

TRANSFER DELAY*

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

ImageTrend Description

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

Element Values

No Yes

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet

REASON FOR TRANSFER DELAY - Communication Issue

TR 17.44.Communication

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

ImageTrend Description

Communication Issue - Detailed Reason for Transfer Delay.

Element Values

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

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet

REASON FOR TRANSFER DELAY - Delay Issue

TR 17.44.Delay

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

ImageTrend Description

Delay Issue - Detailed Reason for Transfer Delay.

Element Values

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

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet

REASON FOR TRANSFER DELAY - EMS Issue

TR 17.44.EMS

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

ImageTrend Description

EMS Issue - Detailed Reason for Transfer Delay.

Element Values

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

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet

REASON FOR TRANSFER DELAY - Equipment Issue

TR 17.44.Equipment

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

ImageTrend Description

Equipment Issue - Detailed Reason for Transfer Delay.

Element Values

Equipment broken

Equipment missing/unavailable

Not Known

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet

REASON FOR TRANSFER DELAY - Error Issue

TR 17.44.Error

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

ImageTrend Description

Error Issue - Detailed Reason for Transfer Delay.

Element Values

Error in judgement

Error in technique

Error in treatment

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet

REASON FOR TRANSFER DELAY - Patient Issue

TR 17.44.Patient

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

ImageTrend Description

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

Element Values

Change in patient condition

Child Protective Services (CPS)

Family requested transfer

Patient requested transfer

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet

REASON FOR TRANSFER DELAY - Receiving Facility Issue

TR 17.44.Receiving

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

ImageTrend Description

Receiving Facility Issue - Detailed Reason for Transfer Delay.

Element Values

Bed availability

Difficulty obtaining accepting facility/hospital

New ED staff

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet

REASON FOR TRANSFER DELAY - Referring Facility Issue

TR 17.44.Referring

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

ImageTrend Description

Referring Facility Issue - Detailed Reason for Transfer Delay.

Element Values

Physician decision making

Priority of transfer

Radiology workup delay

Surgeon availability

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet

REASON FOR TRANSFER DELAY - Transportation Issue

TR 17.44.Transportation

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

ImageTrend Description

Transportation Issue - Detailed Reason for Transfer Delay.

Element Values

Transportation issue

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet

REASON FOR TRANSFER DELAY - Weather or Natural Issue

TR 17.44.Weather

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

ImageTrend Description

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

Element Values

- Flooding
- Rain
- Snow
- Tornado

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet

OTHER REASON FOR TRANSFER DELAY

TR 17.43

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

ImageTrend Description

Reason for delay in transferring the patient.

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet

Initial Assessment Information

(Initial ED/Hospital) VITALS DATE

TR 18.104 **Data Format**[date]

ImageTrend Description

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

Element Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY

Data Source

- Triage Form/Trauma Flow Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- ED Nurses' Notes
- Other ED Documentation

(Initial ED/Hospital) VITALS TIME

TR 18.110 **Data Format**[time]

ImageTrend Description

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Triage Form/Trauma Flow Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- ED Nurses' Notes
- Other ED Documentation

(Initial ED/Hospital) SYSTOLIC BLOOD PRESSURE*

TR 18.11

National & State Element
Data Format[number]

NTDB/ImageTrend Description

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

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet
- Physician Notes
- History & Physical

(Initial ED/Hospital) DIASTOLIC BLOOD PRESSURE

TR 18.13 **Data Format**[number]

ImageTrend Description

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

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Nurses' notes

(Initial ED/Hospital) PULSE RATE*

TR 18.2

National & State Element
Data Format [number]

NTDB/ImageTrend Description

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

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet

(Initial ED/Hospital) TEMPERATURE*

TR 18.30

National & State Element
Data Format[number]

NTDB/ImageTrend Description

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

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet

(Initial ED/Hospital) TEMPERATURE ROUTE

TR 18.147 **Data Format**[number]

ImageTrend Description

Indicates the initial emergency department/hospital temperature measurement route.

Element Values

Axillary	Rectal
Foley	Temporal Artery
Oral	Tympanic
Other	

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Nurses' notes

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

TR 18.31

National & State Element
Data Format[number]

NTDB/ImageTrend Description

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

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet
- Respiratory Therapy Notes/Flow Sheet

(Initial ED/Hospital) RESPIRATORY RATE*

TR 18.7

National & State Element
Data Format[number]

NTDB/ImageTrend Description

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

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet
- Respiratory Therapy Notes/Flow Sheet

(Initial ED/Hospital) SUPPLEMENTAL OXYGEN*

TR 18.109

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

NTDB/ImageTrend Description

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

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

Element Values

- No Supplemental Oxygen
- Supplemental Oxygen

Additional Information

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

Data Source

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet

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

TR 18.28 **Data Format**[number]

ImageTrend Description

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

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

TR 21.10 **Data Format**[number]

ImageTrend Description

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

Element Values

- Relevant value for data element

Additional Information

- Use only if total score is available without component score

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

(Initial ED/Hospital) GCS - EYE*

TR 18.14 National & State Element

Data Format [number]

NTDB/ImageTrend Description

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

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

Element Values

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

Additional Information

- The null value "Not Known/Not Recorded" is reported if Initial Field GCS 40 – Eye is documented.
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient's pupils are PERRL," an Eye GCS of 4 may be recorded, IF there is no other contradicting documentation.
- Please note that first recorded hospital vitals do not need to be from the same assessment
- The null value "Not Known/Not Recorded" is reported if the patient's Initial ED/Hospital GCS - Eye was not measured within 30 minutes or less of ED/hospital arrival.

Data Source

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet
- Physician Notes/Flow Sheet

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

(Initial ED/Hospital) GCS - VERBAL*

TR 18.15.2 National & State Element

Data Format[number]

NTDB/ImageTrend Description

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

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

Element Values

Pediatric (≤ 2 years):

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

Adult:

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

Additional Information

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

Data Source

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet
- Physician Notes/Flow Sheet

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

(Initial ED/Hospital) GCS - MOTOR*

TR 18.16.2 /TR 18.16.0 (ped) National & State Element

Data Format[number]

NTDB/ImageTrend Description

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

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

Element Values

Pediatric (≤ 2 years):

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

Adult:

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

Additional Information

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

Data Source

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet
- Physician Notes/Flow Sheet

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

(Initial ED/Hospital) MANUAL GCS TOTAL*

TR 18.19 National & State Element
Data Format[number]

NTBD/ImageTrend Description

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

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Nursing notes
- Physician Notes

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

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

TR 18.21 National & State Element

Data Format [combo] multiple-choice

NTDB/ ImageTrend Description

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

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

Element Values

- Patient Chemically Sedated or Paralyzed
- Obstruction to the Patient's Eye
- Patient Intubated
- Valid GCS: Patient was not sedated, not intubated, and did not have obstruction to the eye

Additional Information

- Identifies treatments given to the patient that may affect the first assessment of GCS. This element does not apply to self-medications the patient may administer (i.e., ETOH, prescriptions, etc.)
- If an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible, then the patient should be considered to have an exam that is not reflective of their neurologic status and the chemical sedation modifier should be selected
- Neuromuscular blockade is typically induced following the administration of agent like succinylcholine, mivacurium, rocuronium, (cis) atracurium, vecuronium, or pancuronium. While these are the most common agents, please review what might be typically used in your center so it can be identified in the medical record
- Each of these agents has a slightly different duration of action, so their effect on the GCS depends on when they were given. For example, succinylcholine's effects last for only 5-10 minutes
- Please note that the first recorded hospital vitals do not need to be from the same assessment
- The null value "Not Known/Not Recorded" is reported if Initial ED/Hospital GCS 40 is reported.
- The null value "Not Known/Not Recorded" is reported if the Initial ED/Hospital GCS Assessment Qualifiers are not documented within 30 minutes or less of ED/Hospital arrival.

- Report all that apply

Data Source

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet
- Physician Notes/Flow Sheet

(Initial ED/Hospital) GCS 40 – EYE*

TR 18.40.2 National & State Element

Data Format[number]

NTDB/ImageTrend Description

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

XSD Data Type	xs: integer	**XSD Element / Domain (Complex Type)**		Gcs40Eye
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values	
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 4	

Element Values

Adult:

- None
- To Pressure
- To Sound
- Spontaneous
- Not Testable

Pediatric <5 years:

- None
- To Pain
- To Sound
- Spontaneous
- Not Testable

Additional Information

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

Data Source

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet
- Physician Notes/Flow Sheet

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

(Initial ED/Hospital) GCS 40 – VERBAL*

TR 18.41.2 National & State Element

Data Format[number]

NTDB/ImageTrend Description

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

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

Element Values

Adult:

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

Pediatric <5 years:

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

Additional Information

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

Data Source

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet
- Physician Notes/Flow Sheet

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

(Initial ED/Hospital) GCS 40 – MOTOR*

TR 18.42.2 National & State Element

Data Format[number]

NTDB/ImageTrend Description

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

XSD Data Type	xs: integer	**XSD Element / Domain (Complex Type)**	Gcs40Motor
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 6

Element Values

Adult:

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

Pediatric <5 years:

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

Additional Information

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

Data Source

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet
- Physician Notes/Flow Sheet

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

(Initial ED/Hospital) RESPIRATORY ASSISTANCE*

TR 18.10

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

NTDB/ ImageTrend Description

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

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

Element Values

- Unassisted Respiratory Rate
- Assisted Respiratory Rate

Additional Information

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

Data Source

- Triage/Trauma/Hospital Flow Sheet
- Nurses Notes/Flow Sheet
- Respiratory Therapy Notes/Flow Sheet

(Initial ED/Hospital) AIRWAY MANAGEMENT

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

ImageTrend Description

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

Element Values

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

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

(Initial ED/Hospital) CPR PERFORMED

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

ImageTrend Description

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

Element Values

CPR in Progress, continued Not Performed Performed

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

UNITS OF BLOOD

TR 22.13 **Data Format**[number]

ImageTrend Description

Total units of blood given.

Element Values

- Relevant value for data element

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

BLOOD ORDERED DATE

TR 22.14 **Data Format**[date]

ImageTrend Description

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

Element Values

- Collected as MM/DD/YYYY

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

CROSSMATCH DATE

TR 22.15 **Data Format**[date]

ImageTrend Description

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

Element Values

- Collected as MM/DD/YYYY

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

BLOOD ADMINISTERED DATE

TR 22.16 **Data Format** [date]

ImageTrend Description

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

Element Values

- Collected as MM/DD/YYYY

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

(Initial ED/Hospital) CT HEAD (Results)

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

ImageTrend Description

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

Element Values

Positive Negative Not Performed

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Radiology Report

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

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

ImageTrend Description

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

Element Values

Positive Negative Not Performed

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Radiology Report

(Initial ED/Hospital) CT CHEST (Results)

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

ImageTrend Description

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

Element Values

Positive Negative Not Performed

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Radiology Report

(Initial ED/Hospital) CT CERVICAL (Results)

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

ImageTrend Description

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

Element Values

Positive Negative Not Performed

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Radiology Report

(Initial ED/Hospital) DATE SENT TO CT

TR 18.101 **Data Format** [date]

ImageTrend Description

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

Element Values

- Collected as MM/DD/YYYY

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

(Initial ED/Hospital) TIME SENT TO CT

TR 18.111 **Data Format** [time]

ImageTrend Description

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

(Initial ED/Hospital) ABDOMINAL ULTRASOUND DATE

TR 18.102 **Data Format** [date]

ImageTrend Description

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

Element Values

- Collected as MM/DD/YYYY

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

(Initial ED/Hospital) ABDOMINAL ULTRASOUND TIME

TR 18.112 **Data Format** [time]

ImageTrend Description

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

Element Values

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

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

(Initial ED/Hospital) ARTERIOGRAM (Results)

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

ImageTrend Description

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

Element Values

Positive Negative

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Radiology Report

(Initial ED/Hospital) AORTOGRAM (Results)

TR 18.77 **Data Format**[combo] single-choice

ImageTrend Description

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

Element Values

Positive Negative

Additional Information

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

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Radiology Report

ALCOHOL SCREEN*

TR 18.46

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

NTDB/ImageTrend Description

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

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

Element Values

Yes No

Additional Information

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

Data Source

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

ALCOHOL SCREEN RESULTS (Blood Alcohol Content)*

TR 18.46

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

NTDB/ ImageTrend Description

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

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source

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

(Initial ED / Hospital) BASE DEFICIT

TR 18.93 **Data Format** [number]

ImageTrend Description

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

Element Values

- Relevant value for data element

Data Source

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

DRUG SCREEN*

TR 18.91

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

NTDB/ ImageTrend Description

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

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

Element Values

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

Additional Information

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

Data Source

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

Diagnosis Information

ICD-10 INJURY DIAGNOSIS*

TR 200.1

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

NTDB/ ImageTrend Description

Diagnoses related to all identified injuries.

XSD Data Type	xs: string	**XSD Element / Domain (Complex Type)**	DiagnosisIcd10
Multiple Entry Configuration	Yes, max 100	**Accepts Null Value** Yes, common null values	
Required in XSD	Yes		

Element Values

- Injury diagnoses as defined by ICD-10-CM code range S00-S99, T07, T14, T79.A1-T79.A9 OR compatible ICD-10-CA code range
- The maximum number of diagnoses that may be reported for an individual patient is 50

Additional Information

- ICD-10-CM codes pertaining to other medical conditions (e.g., CVA, MI, co-morbidities, etc.) may also be included in this element.

Data Source

- Autopsy/Medical Examiner Report
- Operative Reports
- Radiology Reports
- Physician's Notes
- Trauma Flow Sheet
- History & Physical
- Nursing Notes/Flow Sheet
- Progress Notes
- Discharge Summary

AIS CODE*

TR 200.14.1 **Data Format**[combo] multiple-choice

NTDB/ ImageTrend Description

The Abbreviated Injury Scale (AIS) code(s) that reflect the patient's injuries.

XSD Data Type	xs: integer	**XSD Element / Domain (Complex Type)**	AISCODE
Multiple Entry Configuration	Yes, max 50	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- The code is the 8-digit AIS code.

Data Source

- AIS Coding Manual

AIS VERSION*

TR 21.25 **Data Format** [text]

NTDB Description

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

ImageTrend Description

AIS Version

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

Element Values

- AIS 05, Update 08
- AIS 2015

ISS (Body) REGION

Data Format [number]

Description

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

ImageTrend Location

This information may be found under the ImageTrend Diagnosis tab.

XSD Data Type	xs: integer	**XSD Element / Domain (Simple Type)**	IssRegion
Multiple Entry Configuration	Yes, max 50	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 6

Element Values

Head or Neck	Abdominal or pelvic contents
Face	Extremities or pelvic girdle
Chest	External

Additional Information

- Auto-calculated once AIS code is typed in
- This variable is considered optional and is not required as part of the State dataset
- Head or neck injuries include injury to the brain or cervical spine, skull or cervical spine fractures
- Facial injuries include those involving mouth, ears, nose and facial bones
- Chest injuries include all lesions to internal organs. Chest injuries also include those to the diaphragm, rib cage, and thoracic spine
- Abdominal or pelvic contents injuries include all lesions to internal organs. Lumbar spine lesions are included in the abdominal or pelvic region
- Injuries to the extremities or to the pelvic or shoulder girdle include sprains, fractures, dislocations, and amputations, except for the spinal column, skull, and rib cage
- External injuries include lacerations, contusions, abrasions, and burns, independent of their location on the body surface

Data Source

- Hospital Discharge Summary
- History and Physical
- Physician's Documentation / Nurses' Notes
- Other Hospital Documentation

AIS BASED INJURY SEVERITY SCORES BY DIAGNOSIS*

Data Format [number]

Description

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

ImageTrend Location

This information may be found in a table under the ImageTrend Diagnosis tab.

XSD Data Type	xs: integer	**XSD Element / Domain (Simple Type)**	AisSeverity
Multiple Entry Configuration	Yes, max 50	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 9

Element Values

Minor Injury	Severe Injury
Moderate Injury	Critical Injury
Serious Injury	Maximum Injury, Virtually Not Survivable
Not Possible to Assign	

Additional Information

- The element value (9) "Not Possible to Assign" would be chosen if it is not possible to assign a severity to an injury

Data Source

- Hospital Discharge Summary
- History and Physical
- Physician's Documentation
- Nurses' Notes
- Other Hospital Documentation

MANUAL (Locally Calculated ISS)*

Data Format [number]

Description

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

ImageTrend Location

This information may be found under the ImageTrend Diagnosis tab.

XSD Data Type	xs: integer	**XSD Element / Domain (Simple Type)**		IssLocal
Multiple Entry Configuration	No	**Accepts Null Value**		Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 75	

Element Values

- Auto-calculated once AIS scores are typed in
- Relevant ISS value for the constellation of injuries

Additional Information

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

Data Source

- Hospital Discharge Summary
- History and Physical
- Physician's Documentation
- Nurses' Notes
- Other Hospital Documentation

Comorbidity Information

(Pre-existing Conditions) ADVANCED DIRECTIVE LIMITING CARE*

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

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

Element Values

Yes No

Additional Information

- Present prior to arrival at your center.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available
- Report Element Value "2. No" for patients with Advanced Directives that did not limit life-sustaining treatments during this patient care event.
- The written request was signed/dated by the patient and/or his/her designee prior to arrival at your center
- Life-sustaining treatments include but are not limited to intubation, ventilator support, CPR, transfusion of blood products, dialysis or other forms of renal support, institution of medications to support blood pressure or cardiac function, or a specific surgical, interventional or radiological procedure (e.g. decompressive craniectomy, operation for hemorrhage control, angiography)

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) ALCOHOL USE DISORDER*

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

NTDB Description

Descriptors documented in the medical record consistent with the diagnostic criteria of alcohol use disorder or a diagnosis of alcohol use disorder documented in the patient's medical record.

Element Values

Yes No

Additional Information

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

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) ANTICOAGULANT THERAPY*

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

NTDB Description

Documentation in the medical record of the administration of medication (anticoagulants, antiplatelet agents, thrombin inhibitors, thrombolytic agents) that interferes with blood clotting.

EXCLUDE:

- Patients whose only anticoagulant therapy is chronic Aspirin.

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

Element Values

Yes No

Additional Information

- Present prior to injury
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.
- Anticoagulant must be part of the patient's active medication

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) ATTENTION DEFICIT DISORDER/ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADD/ADHD)*

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

NTDB Description

A disorder involving inattention, hyperactivity, or impulsivity requiring medication for treatment.

Element Values

Yes No

Additional Information

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

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) AUTISM SPECTRUM DISORDER (ASD)*

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

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

Element Values
1. Yes 2. No

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

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

(Pre-existing Conditions) BIPOLAR I/II DISORDER*

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

NTDB Description

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

Element Values

Yes No

Additional Information

- Present prior to injury.
- Based on the patient's age on the day of arrival at your hospital.
- Only report on patients ≥15 years-of-age.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15 years-of-age.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services Notes
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) BLEEDING DISORDER*

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

NTDB Description

A group of conditions that result when the blood cannot clot properly.

Element Values

Yes No

Additional Information

- Present prior to injury.
- A Bleeding Disorder diagnosis must be documented in the patient's medical record (e.g. Hemophilia, von Willebrand Disease, Factor V Leiden).
- Consistent with American Society of Hematology, 2015.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) BRONCHOPULMONARY DYSPLASIA/CHRONIC LUNG DISEASE*

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

NTDB Description

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

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

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

Element Values

1. Yes 2. No

Additional Information

- Present prior to injury.
- Based on the patient's age on the day of arrival at your hospital.
- Only report on patients < 15 years-of-age.
- The null value "Not Applicable" must be reported for patients ≥ 15 years-of-age.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available for patients < 15 years-of-age.
- Examples of evidence of Cystic Fibrosis-associated pulmonary disease include, but are not limited to:
    - Use of Chest Physiotherapy (CPT) or other airway clearing techniques.
    - Vest therapy or intrapulmonary percussive ventilator.
    - Intravenous, inhaled, or oral antibiotics to treat chronic respiratory infections related to Cystic Fibrosis.
- Consistent with the ncbi.nlm.nih.gov.

Data Source

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

(Pre-existing Conditions) CEREBRAL VASCULAR ACCIDENT (CVA)*

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

NTDB Description

A history prior to injury of a cerebrovascular accident (embolic, thrombotic, or hemorrhagic) with persistent residual motor sensory or cognitive dysfunction (e.g., hemiplegia, hemiparesis, aphasia, sensory deficit, impaired memory).

Element Values

Yes No

Additional Information

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

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)*

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

NTDB Description

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

- Functional disability from COPD (e.g., dyspnea, inability to perform activities of daily living [ADLs]).
- Hospitalization in the past for treatment of COPD.
- Requires chronic bronchodilator therapy with oral or inhaled agents.
- A Forced Expiratory Volume in 1 second (FEV1) of < 75% or predicted on pulmonary function testing

EXCLUDE:

- Patients whose only pulmonary disease is acute asthma.
- Patients with diffuse interstitial fibrosis or sarcoidosis.

Element Values

Yes No

Additional Information

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

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) CHRONIC RENAL FAILURE*

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

NTDB Description

Chronic renal failure prior to injury that was requiring periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration.

Element Values

Yes No

Additional Information

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

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) CIRRHOSIS*

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

NTDB Description

Cirrhosis is the replacement of normal liver tissue with non-living scar tissue related to other liver diseases. Must have documentation in the medical record of cirrhosis, which might also be referred to as end-stage liver disease.

EXCLUDE:

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

Element Values

Yes No

Additional Information

- Present prior to injury.
- Documentation in the medical record may include CHILD or MELD scores that support evidence of cirrhosis.
- A diagnosis of Cirrhosis, or documentation of Cirrhosis by diagnostic imaging studies or a laparotomy/laparoscopy, must be in the patient's medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source

- History & Physical
- Physician's Notes/ Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) CONGENITAL ANOMALIES*

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

NTDB Description

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

Element Values

Yes No

Additional Information

- Present prior to injury.
- A diagnosis of a Congenital Anomaly must be documented in the patient's medical record.
- Based on the patient's age on the day of arrival at your hospital.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients <15 years-of-age.
- Only report on patients < 15 years-of-age.
- The null value "Not Applicable" must be reported for patients ≥ 15-years-of-age.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) CONGESTIVE HEART FAILURE (CHF)*

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

NTDB Description

The inability of the heart to pump a sufficient quantity of blood to meet the metabolic needs of the body or can do so only at an increased ventricular filling pressure.

Element Values

Yes No

Additional Information

- Present prior to injury.
- A diagnosis of CHF must be documented in the patient's medical record.
- To be included, this condition must be noted in the medical record as CHF, congestive heart failure, or pulmonary edema with onset of increasing symptoms within 30 days prior to injury.
- Common manifestations are:
- Abnormal limitation in exercise tolerance due to dyspnea or fatigue
- Orthopnea (dyspnea or lying supine)
- Paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea)
- Increased jugular venous pressure
- Pulmonary rales on physical examination
- Cardiomegaly
- Pulmonary vascular engorgement
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source

- History & Physical
- Physician's Notes / Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) CURRENT SMOKER*

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

NTDB Description

A patient who reports smoking cigarettes every day or some days within the last 12 months.

EXCLUDE:

Patients who report smoke cigars or pipes or smokeless tobacco (chewing tobacco or snuff).

Element Values

Yes No

Additional Information

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

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) CURRENTLY RECEIVING CHEMOTHERAPY FOR CANCER*

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

NTDB Description

A patient who is currently receiving any chemotherapy treatment for cancer prior to injury.

Element Values

Yes No

Additional Information

- Present prior to injury.
- Chemotherapy may include, but is not restricted to, oral and parenteral treatment with chemotherapeutic agents for malignancies such as colon, breast, lung, head and neck, and gastrointestinal solid tumors as well as lymphatic and hematopoietic malignancies such as lymphoma, leukemia, and multiple myeloma.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) DEMENTIA*

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

NTDB Description

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

Element Values

Yes No

Additional Information

- Present prior to injury.
- A diagnosis of dementia including Alzheimer's Lewy Body Dementia, frontotemporal dementia (Pick's Disease) and vascular dementia must be documented in the patient's medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.
- Consistent with the National Institute on Aging December 2017.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) DIABETES MELLITUS*

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

NTDB Description

Diabetes mellitus that requires exogenous parenteral insulin or an oral hypoglycemic agent.

Element Values

Yes	No

Additional Information

- Present prior to injury.
- A diagnosis of Diabetes Mellitus must be documented in the patient's medical record.
- Report *Element Value* "1. Yes" for patients who were non-compliant with their prescribed exogenous parenteral insulin or oral hypoglycemic agent.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) DISSEMINATED CANCER*

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

NTDB Description

Cancer that has spread to one or more sites in addition to the primary site and in the presence of multiple metastases indicates the cancer is widespread, fulminant, or near terminal.

Element Values

Yes No

Additional Information

- Present prior to injury.
- Another term describing disseminated cancer is "metastatic cancer".
- Common sites of metastases include major organs, (e.g., brain, lung, liver, meninges, abdomen, peritoneum, pleura, bone).
- A diagnosis of Cancer that has spread to one or more sites must be documented in the patient's medical record.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) FUNCTIONALLY DEPENDENT HEALTH STATUS*

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

NTDB Description

Pre-injury functional status may be represented by the ability of the patient to complete age-appropriate activities of daily living (ADL).

Element Values

Yes No

Additional Information

- Present prior to injury.
- Activities of daily living include: bathing, feeding, dressing, toileting, and walking.
- Include patients whom prior to injury, and as a result of cognitive or physical limitations relating to a pre-existing medical condition, was partially dependent or completely dependent upon equipment, devices or another person to complete some or all activities of daily living.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) HYPERTENSION*

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

NTDB Description

History of persistent elevated blood pressure requiring antihypertensive medication.

Element Values

Yes No

Additional Information

- Present prior to injury.
- A diagnosis of Hypertension must be documented in the patient's medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.
- Report Element Value ‘1. Yes’ for patients who were non-compliant with their prescribed antihypertensive medication.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) MAJOR DEPRESSIVE DISORDER*

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

NTDB Description

A major depressive disorder diagnosis documented in the medical record.

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

Element Values

Yes No

Additional Information

- Present prior to injury.
- Based on the patient's age on the day of arrival at your hospital.
- Only report on patients ≥15 years-of-age.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15 years-of-age.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services Notes
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) MYOCARDIAL INFARCTION (MI)*

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

NTDB Description

History of myocardial infarction (MI) in the six months prior to injury.

Element Values

Yes No

Additional Information

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

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) OTHER MENTAL/PERSONALITY DISORDERS*

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

NTDB Description

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

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

Element Values

Yes No

Additional Information

- Present prior to injury.
- Based on the patient's age on the day of arrival at your hospital.
- Only report on patients ≥15 years-of-age.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15 years-of-age.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet /Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) PERIPHERAL ARTERIAL DISEASE (PAD)*

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

NTDB Description

The narrowing or blockage of the vessels that carry blood from the heart to the legs. It is primarily caused by the buildup of fatty plaque in the arteries, which is called atherosclerosis. Peripheral Arterial Disease (PAD) can occur in any blood vessel, but it is more common in the legs than the arms.

Element Values

Yes No

Additional Information

- Present prior to injury.
- Consistent with Centers for Disease Control, 2014 Fact Sheet.
- A diagnosis of PAD must be documented in the patient's medical record.
- Based on the patient's age on the day of arrival at your hospital.
- Only report on patients ≥15 years-of-age.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15 years-of-age.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) POST-TRAUMATIC STRESS DISORDER*

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

NTDB Description

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

Element Values

Yes No

Additional Information

- Present prior to injury.
- Based on the patient's age on the day of arrival at your hospital.
- Only report on patients ≥15 years-of-age.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15 years-of-age.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services Notes
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) PREGNANCY*

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

NTDB Description

Pregnancy confirmed by lab, ultrasound, or other diagnostic tool or diagnosis of pregnancy documented in the patient's medical record.

Element Values

Yes No

Additional Information

- Present prior to arrival at your center.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) PREMATURITY*

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

NTDB Description

Babies born before 37 weeks of pregnancy are completed.

Element Values

Yes No

Additional Information

- Present prior to injury.
- Based on the patient's age on the day of arrival at your hospital.
- Only report on patients <15 years-of-age.
- A diagnosis of Prematurity, or delivery before 37 weeks of pregnancy are completed, must be documented in the patient's medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients <15 years-of-age.
- The null value "Not Applicable" must be reported for patients ≥ 15 years-of-age.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) SCHIZOAFFECTIVE DISORDER*

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

NTDB Description

A schizoaffective disorder diagnosis documented in the medical record.

Element Values

Yes No

Additional Information

- Present prior to injury.
- Based on the patient's age on the day of arrival at your hospital.
- Only report on patients ≥15 years-of-age.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15 years of age.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services Notes
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) SCHIZOPHRENIA*

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

NTDB Description

A schizophrenia diagnosis documented in the medical record.

Element Values

Yes	No

Additional Information

- Present prior to injury.
- Based on the patient's age on the day of arrival at your hospital.
- Only report on patients ≥15 years-of-age.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15 years-of-age.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services Notes
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) STEROID USE*

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

NTDB Description

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

EXCLUDE:

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

Element Values

Yes No

Additional Information

- Present prior to injury.
- Examples of oral or parenteral corticosteroid medications are prednisone and dexamethasone.
- Examples of chronic medical conditions are Chronic Obstructive Pulmonary Disease (COPD), asthma, rheumatologic disease, rheumatoid arthritis, and inflammatory bowel disease.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) SUBSTANCE USE DISORDER*

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

NTDB Description

Descriptors documented in the patient's medical record consistent with the diagnostic criteria of substance use disorders specifically cannabis, hallucinogens, inhalants, opioids, sedative/hypnotics, and stimulants (e.g. patient has a history of drug use; patient has a history of opioid use) OR diagnosis of any of the following documented in the patient's medical record:

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

Element Values

Yes No

Additional Information

- Present prior to injury.
- Based on the patient's age on the day of arrival at your hospital.
- Only report on patients ≥15 years-of-age.
- Consistent with the American Psychiatric Association (APA) DSM 5, 2013.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.

- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15 years-of-age.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Pre-existing Conditions) VENTILATOR DEPENDENCE*

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

NTDB Description

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

Element Values

1. Yes 2. No

Additional Information

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

Data Source

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

CO-MORBID CONDITION NOTES

TR 21.23 **Data Format**[text]

ImageTrend Description

Additional information about the pre-existing medical conditions.

Element Values

- Relevant value for data element

Data Source

- History and Physical
- Physician's Documentation
- Nurses' Notes
- Other Hospital Documentation

Procedures Information

ICD-10 HOSPITAL PROCEDURES*

TR 200.2 National & State Element

Data Format[combo] multiple-choice

NTDB/ImageTrend Description

Operative and selected non-operative procedures conducted during hospital stay. Operative and selected non-operative procedures are those that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or complications. The list of procedures below should be used as a guide to non-operative procedures that should be provided to NTDB.

XSD Data Type	xs: string	**XSD Element / Domain (Complex Type)**	HospitalProcedureIcd10
Multiple Entry Configuration	Yes, max 200	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Major and minor procedure ICD-10 PCS procedure codes
- The maximum number of procedures that may be reported for a patient is 200.

Additional Information

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

Diagnostic & Therapeutic Imaging	Musculoskeletal
Computerized tomographic Head *	Soft tissue / bony debridements *
Computerized tomographic Chest *	Closed reduction of fractures
Computerized tomographic Abdomen *	Skeletal and halo traction
Computerized tomographic Pelvis *	Fasciotomy
Diagnostic ultrasound (includes FAST) *	
Doppler ultrasound of extremities*	**Transfusion**
	Transfusion of red cells * (only capture first 24 hours
Angiography	after hospital arrival)
	Transfusion of platelets * (only capture first 24 hours
Angioembolization	after hospital arrival)
	Transfusion of plasma * (only capture first 24 hours
	after hospital arrival)
IVC filter	
	Respiratory
Cardiovascular	Insertion of endotracheal tube * (exclude intubations
	performed in the OR)
Open cardiac massage	Continuous mechanical ventilation *
CPR	Chest tube *
	Bronchoscopy *
CNS	Tracheostomy
Insertion of ICP monitor *	
Ventriculostomy *	**Gastrointestinal**
Cerebral oxygen monitoring *	Endoscopy (includes gastroscopy, sigmoidoscopy,
	colonoscopy)
Genitourinary	
Ureteric catheterization (i.e. Ureteric	Gastrostomy / jejunostomy (percutaneous or
stent)	endoscopic)
Suprapubic cystostomy	Percutaneous (endoscopic) gastrojejunoscopy

Data Source

- Operative Reports
- Nursing Notes/Flow Sheet
- Procedure Notes
- Radiology Reports
- Trauma Flow Sheet
- Discharge Summary
- ED Record

PROCEDURE PERFORMED

TR 22.30 **Data Format**[combo] single-choice

Description

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

Element Values

No Yes

Data Source

- Operative Reports
- Triage Form / Trauma Flow Sheet
- Nurses' Documentation
- Physician Documentation
- Anesthesia Record
- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Discharge Summary

(Procedure Performed) LOCATION

TR 22.11 **Data Format**[combo] single-choice

ImageTrend Description

The hospital location where the procedure was performed.

Element Values

Minor Surgery Unit	Catheterization Lab
Nuclear Medicine	ED
Observation	Floor
Other	GI Lab
Outpatient Clinic	ICU
Recovery	OR
Rehabilitation	Other
Scene	Radiology
Special Procedure Unit	Readmit OR (planned OR)
Step-Down	Tele
Transport from Scene	

Data Source

- Operative Reports
- Triage Form / Trauma Flow Sheet
- Nurses' Documentation
- Physician Documentation
- Anesthesia Record
- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Discharge Summary

(Hospital Procedure) DATE PERFORMED*

TR 200.8 National & State Element
Data Format[date]

NTDB/ImageTrend Description

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

XSD Data Type	xs: date	**XSD Element / Domain (Complex Type)**	HospitalProcedureStartDate
Multiple Entry Configuration	Yes	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1990	**Max. Constraint:** 2030

Element Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY

Data Source

- Operative Reports
- Procedure Notes
- Trauma Flow Sheet
- ED Record
- Nursing Notes/Flow Sheet
- Radiology Reports
- Discharge Summary

(Hospital Procedure Start) TIME PERFORMED*

TR 200.9

National & State Element
Data Format[time]

NTDB/ImageTrend Description

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

XSD Data Type	xs: time	**XSD Element / Domain (Complex Type)**	HospitalProcedureStartTime
Multiple Entry Configuration	Yes	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 00:00	**Max. Constraint:** 23:59

Element Values

- Relevant value for data element

Additional Information

- Reported as HH:MM military time.
- Procedure start time is defined as the time the incision was made (or the procedure started).
- If distinct procedures with the same procedure code are performed, their start times must be different

Data Source

- Operative Reports
- Anesthesia Reports
- Procedure Notes
- Trauma Flow Sheet
- ED Record
- Nursing Notes/Flow Sheet
- Radiology Reports
- Discharge Summary

(Physician Performing the Procedure) STAFF

TR 200.10 **Data Format**[combo] single-choice

ImageTrend Description

Physician performing the procedure.

Element Values

- Relevant value for data element

Data Source

- OR Nurses' Notes
- Operative Reports
- Anesthesia Record

SERVICE TYPE (of the Physician)

TR 200.6 **Data Format**[combo] single-choice

ImageTrend Description

Service type of the physician.

Element Values

Cardiology	Ophthalmology
Critical Care Medicine	Oral Maxillo Facial Surgery
Ear Nose Throat	Orthopedic Surgery
Emergency Medicine	Pediatric Orthopedic
Gastroenterology	Pediatric Surgery
General Surgery	Plastic Surgery
Gynecology	Radiology
Hand Surgery	Thoracic Surgery
Medicine	Trauma Surgery
Neurosurgery	Urology
Obstetrics	Vascular Surgery

Data Source

- OR Nurses' Notes
- Operative Reports
- Anesthesia Record

(Procedure) COMMENTS

TR 200.7 **Data Format**[text]

ImageTrend Description

Additional information about the procedure

Element Values

- Relevant value for data element

Data Source

- OR Nurses' Notes
- Operative Reports
- Anesthesia Record

RESOURCE UTILIZATION

TR 26.59 **Data Format** [combo] single-choice

ImageTrend Description

A list of the resources utilized during the treatment and care of the patient.

Element Values

Adult Protective Service
Bi-Pap
Case Management
Cerebral Brain Flow Studies
Child Protective Service
CRRT
Dialysis
Epidural Catheter
Exceeds LOS
Factor VIIa (Novoseven)
High dose methylprednisolone
Hypertonic Saline
Level-1 Blood/Fluid Warmer
LiCox Monitor
Massive Blood Transfusion
Miama J Collar
MRI
None
Nutritionist
Occupational Therapy
Pentobarbital Coma
Peripheral Parenteral Nutrition (PPN)
Physical Therapy
PICC line
PRISMA (CVVHD)
Respiratory Therapy
RN accompanied transfer
Specialized Bed
Speech Therapy
TLSO Brace
Total Parenteral Nutrition (TPN)
Traction
Transfusion of FFP
Transfusion of Platelets
Transfusion of PRBC
Tube Feeding
Uncrossmatched Blood
Vaccine Post-Splenectomy
Venous Doppler
Wound Care RN
Wound Vacuum

Data Source

- OR Nurses' Notes
- Operative Reports
- Anesthesia Record

Hospital Events

(Hospital Events) ACUTE KIDNEY INJURY (AKI)*

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

NTDB/ ImageTrend Description

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

KDIGO (Stage 3) Table:

(SCr) 3 times baseline

or

Increase in SCr to ≥ 4.0 mg/dl (≥ 353.6 µmol/l)

or

Initiation of renal replacement therapy OR In patient < 18 years decrease in eGFR to <35 ml/min per 1.73m2

or

Urine output <0.3 ml/kg/h for ≥ 24 hours

or

Anuria for ≥ 12 hours

EXCLUDE:

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

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

Element Values

Yes No

Additional Information

- Onset of AKI Stage 3 began after arrival to your ED/hospital.
- A diagnosis of AKI must be documented in the patient's medical record.
- Consistent with the March 2012 Kidney Disease Improving Global Outcome (KDIGO) guideline.
- Refer to guidance and algorithms on pages 142-143 of the 2025 NTDS Data Dictionary.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Hospital Events) ACUTE RESPIRATORY DISTRESS SYNDROME (ARDS)*

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

NTDB/ImageTrend Description

Timing: Within 1 week of known clinical insult or new or worsening respiratory symptoms.
Chest imaging: Bilateral opacities – not fully explained by effusions, lobar/lung collage, or nodules.
Origin of edema: Respiratory failure not fully explained by cardiac failure of fluid overload. Need objective assessment (e.g., echocardiography) to exclude hydrostatic edema if no risk factor present.
Oxygenation:

- Mild: 200 mm Hg < PaO2/FIO2 < 300 mm Hg with PEEP or CPAP >= 5 cm H2O
- Moderate: 100 mm Hg < PaO2/FIO2 < 200 mm Hg with PEEP >5 cm H2O
- Severe: PaO2/FIO2 < 100 mm Hg with PEEP or CPAP >5 cm H2O

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

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of ARDS must be documented in the patient's medical record.
- Consistent with the 2012 New Berlin Definition.
- Refer to guidance and algorithms on pages 144-146 of the 2025 NTDS Data Dictionary.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Hospital Events) ALCOHOL WITHDRAWAL SYNDROME*

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

NTDB/ ImageTrend Description

Characterized by tremor, sweating, anxiety, agitation, depression, nausea, and malaise. It occurs 6-48 hours after cessation of alcohol consumption and, when uncomplicated, abates after 2-5 days. It may be complicated by grand mal seizures and may progress to delirium (known as delirium tremens).

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

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of ARDS must be documented in the patient's medical record.
- Consistent with the 2019 World Health Organization (WHO) definition of Alcohol Withdrawal Syndrome.
- Refer to guidance and algorithms on pages 147-148 of the 2025 NTDS Data Dictionary.

Data Source Hierarchy Guide

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services Notes
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Hospital Events) CARDIAC ARREST WITH CPR*

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

NTDB/ ImageTrend Description

Cardiac arrest is the sudden cessation of cardiac activity after hospital arrival. The patient becomes unresponsive with no normal breathing and no signs of circulation. If corrective measures are not taken rapidly, this condition progresses to sudden death.
INCLUDE:

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

EXCLUDE:

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

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

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival at your ED/hospital
- Cardiac Arrest must be documented in the patient's medical record.
- Refer to guidance and algorithms on pages 149-150 of the 2025 NTDS Data Dictionary.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Hospital Events) CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI)*

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

NTDB/ImageTrend Description

UPDATED TO: A urinary tract infection (UTI) where an indwelling urinary catheter was in place for > 2 calendar days on the date of event, with day of device placement being Day 1,
AND
An indwelling urinary catheter was in place on the date of event or the day before. If an indwelling urinary catheter was in place for more than 2 consecutive days in an inpatient location and then removed, the date of event for the UTI must be the day of device discontinuation or the next day for the UTI to be catheter-associated.

January 2019 CDC CAUTI Criterion SUTI 1a**:**

Patient must meet 1, 2, and 3 below:

1. Patient had an indwelling urinary catheter in place for the entire day on the date of event and such catheter had been in place for >2 calendar days, on that date (day of device placement = Day 1) AND was either:
    - Present for any portion of the calendar day on the date of event, OR
    - Removed the day before the date of event
2. Patient has at least one of the following signs or symptoms:
    - Fever (>38^{0}C): Reminder: To use fever in a patient > 65 years of age, the IUC needs to be in place for more than 2 consecutive days in an inpatient location on date of event and is either still in place or was removed the day before the DOE
    - Suprapubic tenderness with no other recognized cause
    - Costovertebral angle pain or tenderness
    - Urinary urgency
    - Urinary frequency
    - Dysuria
3. Patient has a urine culture with no more than two species of organisms, at least one of which is a bacterium >10^5 CFU/ml.

January 2019 CDC CAUTI Criterion SUTI 2:

Patient must meet 1, 2 and 3 below:

1. Patient is ≤1 year of age
2. Patient has at least one of the following signs or symptoms:
   - fever (>38.0^{0}C) hypothermia (<36.0^{0}C)
   - apnea with no other recognized cause
   - bradycardia with no other recognized cause
   - lethargy with no other recognized cause
   - vomiting with no other recognized cause
   - suprapubic tenderness with no other recognized cause
3. Patient has a urine culture with no more than two species of organisms, at least one of which is bacteria of ≥10^5 CFU/ml.

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

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of UTI must be documented in the patient's medical record.
- Consistent with the January 2019 CDC defined CAUTI.
- Refer to guidance and algorithms on pages 151-154 of the 2025 NTDS Data Dictionary.

Data Source

- History & Physical
- Physician's Notes
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Hospital Events) CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION (CLABSI)*

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

NTDB/ ImageTrend Description

A laboratory-confirmed bloodstream infection (LCBI) where central line (CL) or umbilical catheter (UC) was in place for > 2 calendar days on the date of event, with day of device placement being Day 1,

AND

The line was also in place on the date of event or the day before. If a CL or UC was in place for > 2 calendar days and then removed, the date of event of the LCBI must be the day of discontinuation or the next day to be a CLABSI. If the patient is admitted or transferred into a facility with an implanted central line (port) in place, and that is the patient's only central line, day of first access in an inpatient location is considered Day 1. "Access" is defined as line placement, infusion or withdrawal through the line. Such lines continue to be eligible for CLABSI once they are accessed until they are either discontinued or the day after patient discharge (as per the Transfer Rule.) Note that the "de-access" of a port does not result in the patient's removal from CLABSI surveillance.

<u>January 2016 CDC Criterion LCBI 1:</u>

Patient has a recognized pathogen identified from one or more blood specimens by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).

AND

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

OR

<u>January 2016 CDC Criterion LCBI 2:</u>

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

AND

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

AND

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

OR

<u>January 2016 CDC Criterion LCBI 3:</u>

Patient ≤ 1 year of age has at least one of the following signs or symptoms: fever (>38^0 C), hypothermia (<36^{0}C), apnea, or bradycardia

AND

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

AND

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

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

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of central line-associated bloodstream infection (CLABSI) must be documented in the patient's medical record.
- Consistent with the January 2016 CDC defined CLABSI.
- Refer to guidance and algorithms on pages 155-159 of the 2025 NTDS Data Dictionary.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Hospital Events) DEEP SURGICAL SITE INFECTION*

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

NTDB/ ImageTrend Description

Must meet the following criteria:

Infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) according to list in Table 2 in the 2025 NTDS Data Dictionary (page 161).

AND

involves deep soft tissues of the incision (e.g., fascial and muscle layers)

AND

patient has at least one of the following:

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

AND

patient has at least one of the following signs or symptoms: fever (>38°C); localized pain or tenderness. A culture or non-culture-based test that has a negative finding does not meet this criterion.

- an abscess or other evidence of infection involving the deep incision that is detected on gross anatomical or histopathologic exam, or imaging test

COMMENTS: There are two specific types of deep incisional SSIs:

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

2 Deep Incisional Secondary (DIS) – a deep incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (e.g., donor site incision for CBGB)

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

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of a surgical site infection (SSI) must be documented in the patient's medical record.
- Consistent with the January 2019 CDC defined SSI.
- Refer to guidance and algorithms on pages 160-164 of the 2025 NTDS Data Dictionary.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Hospital Events) DEEP VEIN THROMBOSIS (DVT)*

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

NTDB/ImageTrend Description

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

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

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- The patient must be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava.
- A diagnosis of DVT must be documented in the patient's medical record, which may be confirmed by venogram, ultrasound, or CT.
- Refer to guidance and algorithms on pages 165-166 of the 2025 NTDS Data Dictionary.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Hospital Events) DELIRIUM*

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

NTDB/ ImageTrend Description

Acute onset of behaviors characterized by restlessness, illusions, and incoherence of thought and speech. Delirium can often be traced to one or more contributing factors, such as a severe or chronic medical illness, changes in your metabolic balance (such as low sodium), medication, infection, surgery, or alcohol or drug withdrawal.

OR

Patient tests positive after using an objective screening tool like the Confusion Assessment Method (CAM or the Intensive Care Delirium Screening Checklist (ICDSC).

OR

A diagnosis of delirium documented in the patient's medical record.

EXCLUDE:

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

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- Refer to guidance and algorithms on pages 167-168 of the 2025 NTDS Data Dictionary.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Hospital Events) MYOCARDIAL INFARCTION (MI)*

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

NTDB/ImageTrend Description

An acute myocardial infarction (MI) must be noted with documentation of ECG changes indicative of an acute MI
AND
New elevation in troponin greater than three times upper level of the reference range in the setting of suspected myocardial ischemia
AND
Physician diagnosis of an acute myocardial infarction that occurred subsequent to arrival at your center

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

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- Refer to guidance and algorithms on pages 169-170 of the 2025 NTDS Data Dictionary.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Hospital Events) ORGAN/SPACE SURGICAL SITE INFECTION*

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

NTDB/ImageTrend Description

Must meet the following criteria:

Infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) according to the list in Table 2 on page 171 of the 2025 NTDS Data Dictionary.

AND

Infection involves any part of the body deeper than the fascial/muscle layers, that is opened or manipulated during the operative procedure

AND

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

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

AND

Meets at least **one** criterion for a specific organ/space infection site listed in Table 3 on page 172 of the 2025 NTDS Data Dictionary. These criteria are found in the Surveillance Definitions for Specific Types of Infections chapter.

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

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of a surgical site infection (SSI) must be documented in the patient's medical record.
- Consistent with the January 2019 CDC defined SSI.
- Refer to guidance and algorithms on pages 171-174 of the 2025 NTDS Data Dictionary.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Hospital Events) OSTEOMYELITIS*

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

NTDB/ImageTrend Description

Osteomyelitis must meet at least one of the following criteria:

1 Patient has organisms identified from bone by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)).
2 Patient has evidence of osteomyelitis on gross anatomic or histopathologic exam.
3 Patient has at least **two** of the following localized signs or symptoms: fever (>38.0°C), swelling*, pain or tenderness*, heat*, or drainage*

And at least **one** of the following:

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

* With no other recognized cause

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

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of osteomyelitis must be documented in the patient's medical record.
- Consistent with the January 2020 CDC definition of Bone and Joint infection.
- Refer to guidance and algorithms on pages 175-176 of the 2025 NTDS Data Dictionary.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Hospital Events) PRESSURE ULCER*

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

NTDB/ ImageTrend Description

A localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated. Equivalent to NPUAP Stages II-IV, Unstageable/Unclassified, and Suspected Deep Tissue Injury.

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

Element Values

Yes No

Additional Information

- Onset of NPUAP Stage II began after arrival to your ED/hospital.
- Pressure Ulcer documentation must be in the patient's medical record.
- Consistent with the NPUAP 2014.
- Refer to guidance and algorithms on pages 177-178 of the 2025 NTDS Data Dictionary.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Hospital Events) PULMONARY EMBOLISM (PE)*

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

NTDB/ ImageTrend Description

A lodging of a blood clot in a pulmonary artery with subsequent obstruction of blood supply to the lung parenchyma. The blood clots usually originate from the deep leg veins or the pelvic venous system.

EXCLUDE:

- Subsegmental PE's.

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

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- Consider the condition present if the patient has a VQ scan interpreted as high probability of pulmonary embolism or a positive pulmonary arteriogram or positive CT angiogram and/or a diagnosis of PE is documented in the patient's medical record.
- Refer to guidance and algorithms on pages 179-180 of the 2025 NTDS Data Dictionary.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Hospital Events) SEVERE SEPSIS*

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

NTDB/ ImageTrend Description
Severe sepsis: sepsis plus organ dysfunction, hypotension (low blood pressure), or hypoperfusion (insufficient blood flow) to 1 or more organs.
Septic shock: sepsis with persisting arterial hypotension or hypoperfusion despite adequate fluid resuscitation.

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

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of Sepsis must be documented in the patient's medical record.
- Consistent with the American College of Chest Physicians and the Society of Critical Care Medicine October 2010.
- Refer to guidance and algorithms on pages 181-182 of the 2025 NTDS Data Dictionary.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Hospital Events) STROKE/CVA*

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

NTDB/ImageTrend Description

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

- Change in level of consciousness
- Hemiplegia
- Hemiparesis
- Numbness or sensory loss affecting on side of the body
- Dysphasia or aphasia
- Hemianopia
- Amaurosis fugax
- Other neurological signs or symptoms consistent with stroke

AND:

- Duration of neurological deficit ≥24 h OR:
- Duration of deficit <24 h, if neuroimaging (MR, CT, or cerebral angiography) documents a new hemorrhage or infarct consistent with stroke, or therapeutic intervention(s) were performed for stroke, or the neurological deficit results in death

AND:

- No other readily identifiable non-stroke cause, e.g., progression of existing traumatic brain injury, seizure, tumor, metabolic or pharmacologic etiologies, is identified

AND:

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

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

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of stroke/CVA must be documented in the patient's medical record.
- Although the neurologic deficit must not present on admission, risk factors predisposing to stroke (e.g., blunt cerebrovascular injury, dysrhythmia) may be present on admission.
- Refer to guidance and algorithms on pages 183-186 of the 2025 NTDS Data Dictionary.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Hospital Events) SUPERFICIAL INCISIONAL SURGICAL SITE INFECTION*

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

NTDB/ ImageTrend Description

Must meet the following criteria:

Infection occurs within 30 days after any NHSN operative procedure (where day 1 = the procedure date)

AND

involves only skin and subcutaneous tissue of the incision

AND

patient has at least one of the following:

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

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

d) diagnosis of a superficial incisional SSI by the surgeon or attending physician** or other designee.

COMMENTS: There are two specific types of superficial incisional SSIs:

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

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

Element Values

Yes

No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of a surgical site infection (SSI) must be documented in the patient's medical record.
- Consistent with the January 2019 CDC defined SSI.
- Refer to guidance and algorithms on pages 187-189 of the 2025 NTDS Data Dictionary.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Hospital Events) UNPLANNED ADMISSION TO ICU*

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

NTDB/ImageTrend Description

Patients admitted to the ICU after initial transfer to the floor, and/or patients with an unplanned return to the ICU after initial ICU discharge.

INCLUDE:

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

EXCLUDE:

- Patients with a planned post-operative ICU stay.

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

Element Values

Yes No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- Refer to guidance and algorithms on pages 190-191 of the 2025 NTDS Data Dictionary.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Hospital Events) UNPLANNED INTUBATION*

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

NTDB/ImageTrend Description

Patient requires placement of an endotracheal tube and mechanical or assisted ventilation manifested by severe respiratory distress, hypoxia, hypercarbia, or respiratory acidosis.

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

Element Values

Yes No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- In patients who were intubated in the element or Emergency Department, or those intubated for surgery, unplanned intubation occurs if they require reintubation > 24 hours after they were extubated.
- Refer to guidance and algorithms on pages 192-193 of the 2025 NTDS Data Dictionary.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Hospital Events) UNPLANNED VISIT TO THE OPERATING ROOM*

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

NTDB/ImageTrend Description

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

EXCLUDE:

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

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

Element Values

Yes No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- Refer to guidance and algorithms on pages 194-195 of the 2025 NTDS Data Dictionary.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

(Hospital Events) VENTILATOR-ASSOCIATED PNEUMONIA (VAP)*

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

NTDB/ImageTrend Description

A pneumonia where the patient is on mechanical ventilation for > 2 calendar days on the date of event, with day of ventilator placement being Day 1,

AND

The ventilator was in place on the date of event or the day before.

Note: Refer to VAP algorithms on pages 196-209 of the 2025 NTDS Data Dictionary.

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

Element Values

Yes No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of pneumonia must be documented in the patient's medical record.
- Consistent with the January 2019 CDC defined VAP.
- Refer to guidance and algorithms on pages 196-209 of the 2025 NTDS Data Dictionary.

Data Source

- History & Physical
- Physician's Notes/Flow Sheet
- Progress Notes
- Case Management/Social Services
- Nursing Notes/Flow Sheet
- Triage/Trauma Flow Sheet
- Discharge Summary

Complications/Performance Improvement

(Complication) STATUS

TR 23.15 **Data Format**[radio]

ImageTrend Description

The status of the complication.

Element Values

Open	Close

(Complication) OCCURRENCE DATE

TR 23.13 **Data Format** [date]

ImageTrend Description

The date that the complication was first documented.

Element Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY

(Complication) OCCURRENCE TIME

TR 23.20 **Data Format**[time]

ImageTrend Description

The time that the complication was first documented.

Element Values

- Relevant value for data element

Additional Information

- Collected as HHMM

(Complication) LOCATION OF OCCURRENCE

TR 23.19 **Data Format**[combo] single-choice

ImageTrend Description

The location that the complication occurred.

Element Values

Burn Unit	OR
Catheterization Lab	Pre-Hospital
ED	PTA (Referring Hospital)
Floor Bed	Radiology
GI Lab	Readmit OR (planned OR)
ICU	Telemetry / Step-Down Unit

(Complication) STAFF INVOLVED

TR 23.46 **Data Format**[combo] multiple-choice

ImageTrend Description

Staff involved with the complication.

Element Values

- Relevant value for data element

Additional Information

- Press and hold "CTRL" key to select multiple values

(Complication) PR DATE

TR 23.6 **Data Format**[date]

ImageTrend Description

Complications peer review date.

Element Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY

(Complication) PR TIME

TR 23.18 **Data Format** [time]

ImageTrend Description

Complications peer review time.

Element Values

- Relevant value for data element

Additional Information

- Collected as HHMM

(Complication) CORRECTIVE ACTION

TR 23.9 **Data Format**[combo] single-choice

ImageTrend Description

The action taken based on the complication.

Element Values

Counseling	Privilege/Credentialing
Education	Process Improvement Team
Guideline / Protocol	Resource Enhancement
Not Indicated	Trend
Other	Unnecessary
Peer Review Presentation	

(Complication) OTHER CORRECTIVE ACTION

TR 23.10 **Data Format**[text]

ImageTrend Description

Any other action taken based on the complication.

Element Values

- Relevant value for data element

Additional Information

- Only completed if Correction Action is "Other"

(Complication) DETERMINATION

TR 23.11 **Data Format**[combo] single-choice

ImageTrend Description

Indication as to what was determined to be cause the complication.

Element Values

- Cannot be Determined
- Disease-Related
- Procedure-Related
- Provider-Related
- System-Related

FURTHER EXPLANATION/ACTION (of Complication)

TR 23.8 **Data Format**[text]

ImageTrend Description

Further explanation of the complication.

Element Values

- Relevant value for data element

PREVENTABILITY (of Complication)

TR 23.12 **Data Format**[combo] single-choice

ImageTrend Description

Is the complication preventable?

Element Values

- Cannot Be Determined
- Non-preventable
- Potentially Preventable
- Preventable

FINDINGS (of Complication)

TR 23.14 **Data Format**[combo] single-choice

ImageTrend Description

Outcome of peer review of a complication.

Element Values

- Acceptable
- Acceptable with Reservations
- Defer Peer Review
- Unacceptable
- Will Never Undergo PR

(Complication Correspondence) STAFF

TR 23.1.14 **Data Format**[combo] single-choice

ImageTrend Description

Staff involved with the complication correspondence.

Element Values

- Relevant value for data element

(Complication Correspondence) NOTE

TR 23.1.15 **Data Format**[text]

ImageTrend Description

Complication correspondence note.

Element Values

- Relevant value for data element

(Complication Correspondence) SOURCE

TR 23.1.13 **Data Format**[combo] single-choice

ImageTrend Description

Complication correspondence source.

Element Values

- Autopsy
- Patient/Family Concern/Comment
- Conversation
- PI Comm
- Daily Rounds
- Referrals
- EMS Run Sheet
- Risk Management Variance report
- Hospital Quality Department
- Staff Concern
- Medical Record

(Complication Correspondence) TYPE

TR 23.1.12 **Data Format**[combo] single-choice

ImageTrend Description

Complication correspondence type.

Element Values

- Action Plan
- Process Concern
- Care Concern
- Primary Review
- Secondary Review
- Tertiary Review

(Complication Correspondence) GROUP

TR 23.1.16 **Data Format**[combo] single-choice

ImageTrend Description

Complication correspondence group.

Element Values

- Neuro
- Peds
- Ortho
- Trauma
- Other

(Performance Improvement) STATUS

TR 31.9 **Data Format**[radio]

ImageTrend Description

The status of the QA peer review judgement.

Element Values

Open	Close

(Performance Improvement) OCCURRENCE DATE

TR 31.7 **Data Format**[date]

ImageTrend Description

The date that the performance improvement audit occurred.

Element Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY

(Performance Improvement) OCCURRENCE TIME

TR 31.18 **Data Format**[time]

ImageTrend Description

The time that the performance improvement audit occurred.

Element Values

- Relevant value for data element

Additional Information

- Collected as HHMM

(Performance Improvement) PR DATE

TR 31.8 **Data Format**[date]

ImageTrend Description

The QA indicator peer review date.

Element Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY

(Performance Improvement) PR TIME

TR 31.19 **Data Format** [time]

ImageTrend Description

The QA indicator peer review time.

Element Values

- Relevant value for data element

Additional Information

- Collected as HHMM

FURTHER EXPLANATION/ACTION (of PI)

TR 31.10 **Data Format** [text]

ImageTrend Description

Further explanation of the Performance Improvement.

Element Values

- Relevant value for data element

(PI Correspondence) STAFF

TR 31.14 **Data Format**[combo] single-choice

ImageTrend Description

Staff involved with the performance improvement audit correspondence.

XSD Data Type	xs: string	**XSD Element/Domain (Simple Type)**	Correspondence_Staff
Multiple Entry Configuration	No	**Accepts Null Value**	No
Required in XSD	Yes		

Element Values

- Relevant value for data element

(PI Correspondence) NOTE

TR 31.15 **Data Format** [text]

ImageTrend Description

Performance Improvement audit correspondence note.

Element Values

- Relevant value for data element

(PI Correspondence) SOURCE

TR 31.13 **Data Format**[combo] single-choice

ImageTrend Description

Performance Improvement audit correspondence source.

Element Values

- Autopsy
- PI Comm
- Conversation
- Referrals
- Daily Rounds
- Risk Management Variance
- EMS Run Sheet
- Report
- Hospital Quality Department
- Staff Concern
- Medical Record
- Patient/Family Concern/Comment

(PI Correspondence) TYPE

TR 31.12 **Data Format**[combo] single-choice

ImageTrend Description

Performance Improvement audit correspondence type.

Element Values

- Action Plan
- Process Concern
- Care Concern
- Primary Review
- Secondary Review
- Tertiary Review

(PI Correspondence) GROUP

TR 31.16 **Data Format**[combo] single-choice

ImageTrend Description

Performance Improvement audit correspondence group.

Element Values

- Neuro
- Peds
- Ortho
- Trauma
- Other

Outcome Information

HOSPITAL DISCHARGE SERVICE

TR 25.31 **Data Format**[combo] single-choice

ImageTrend Description

The department that discharged the patient from the hospital.

Element Values

Acute Rehabilitation Medicine	Neurology
Anesthesia	Neurosurgery
Bariatric	Obstetric
Burn	Oculoplastic
Cardiology	Ophthalmology
Cardiothoracic Surgery	Oral Maxillo Facial Surgery
Chemical Dependency	Orthopedic Surgery
Critical Care Medicine	Pain
Critical Care Surgery	Pediatric Cardiology
Dentistry	Pediatric Critical Care Medicine
Dermatology	Pediatric Dentistry
Ear Nose Throat	Pediatric Gastroenterology
Emergency Medicine	Pediatric Hematology Oncology
Endocrinology	Pediatric Hospitalist
Family Medicine	Pediatric Infectious Disease
Gastroenterology	Pediatric Neurology
General Pediatrics	Pediatric Orthopedic
General Surgery	Pediatric Pulmonary
Geriatric	Plastic Surgeon
Hand	Psychiatry
Hematology Oncology	Psychology
Infectious Disease	Pulmonary
Internal Medicine	Rheumatology
Kidney Transplant	Trauma Surgeon
Liver	Urology
Neonatal	Vascular Surgery
Nephrology	

Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

HOSPITAL ADMISSION DATE

TR 25.33 **Data Format** [date]

ImageTrend Description

Date patient was discharged from the ED (or arrived at the facility if the patient was a direct admit).

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

Element Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY
- Used to auto-generate an additional calculated element: Total Length of Hospital Stay (time from hospital admission to hospital discharge)

Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

HOSPITAL ADMISSION TIME

TR 25.47 **Data Format**[time]

ImageTrend Description

Time patient was discharged from the ED (or arrived at the facility if the patient was a direct admit).

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

Element Values

- Relevant value for data element

Additional Information

- Collected as HHMM
- HHMM should be collected as military time
- Used to auto-generate an additional calculated element: Total Length of Hospital Stay (time from hospital admission to hospital discharge)

Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

HOSPITAL DISCHARGE DATE (ORDERS WRITTEN) *

TR 25.93

National & State Element
Data Format[date]

NTDB/ImageTrend Description

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

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

Element Values

- Relevant value for data element
- Total Length of Hospital Stay (elapsed time from ED/Hospital arrival to hospital discharge)

Additional Information

- Collected as YYYY-MM-DD.
- The null value "Not Applicable" is reported if Hospital Discharge Disposition is reported as "Not Applicable"
- If Hospital Discharge Disposition is 5 Deceased/Expired, then Hospital Discharge Date is the date of death as indicated on the patient's death certificate.

Data Source

- Physician Order
- Discharge Instructions
- Nursing Notes/Flow Sheet
- Case Management/Social Services Notes
- Discharge Summary

HOSPITAL DISCHARGE TIME (ORDERS WRITTEN) *

TR 25.94

National & State Element
Data Format [time]

NTDB/ImageTrend Description

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

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

Element Values

- Relevant value for data element
- Total Length of Hospital Stay (elapsed time from ED/Hospital arrival to hospital discharge)

Additional Information

- Collected as HHMM
- The null value "Not Applicable" is reported if Hospital Discharge Date is reported as "Not Applicable"
- If Hospital Discharge Disposition is 5 Deceased/Expired, then Hospital Discharge Time is the time of death as indicated on the patient's death certificate.

Data Source

- Physician Order
- Discharge Instructions
- Nursing Notes/Flow Sheet
- Case Management/Social Services Notes
- Discharge Summary

HOSPITAL DISCHARGE DATE (PHYSICAL EXIT)

TR 25.34 **Data Format**[date]

ImageTrend Description

The date the patient physically left the hospital.

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

Element Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY
- The null value "Not Applicable" is used if ED Discharge Disposition = 4,5, 6,9,10 or 11
- If Hospital Discharge Disposition is 5 Deceased/Expired, then Hospital Discharge Date is the date of death as indicated on the patient's death certificate

Data Source

- Physician Order
- Discharge Instructions
- Nursing Notes/Flow Sheet
- Case Management/Social Services Notes
- Discharge Summary

HOSPITAL DISCHARGE TIME (PHYSICAL EXIT)

TR 25.48 **Data Format**[time]

ImageTrend Description

The time the patient physically left the hospital.

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

Element Values

- Relevant value for data element

Additional Information

- Collected as HH:MM military time
- Used to auto-generate an additional calculated element: Total Length of Hospital Stay (elapsed time from ED/hospital arrival to hospital discharge)
- The null value "Not Applicable" is used if ED Discharge Disposition = 5 (Deceased/expired)
- The null value "Not Applicable" is used if ED Discharge Disposition = 4,6,9,10 or 11
- If Hospital Discharge Disposition is 5 Deceased/Expired, then Hospital Discharge Time is the time of death as indicated on the patient's death certificate

Data Source

- Physician Order
- Discharge Instructions
- Nursing Notes/Flow Sheet
- Case Management/Social Services Notes
- Discharge Summary

TOTAL ICU DAYS*

TR 26.9

National & State Element
Data Format [number]

NTDB/ ImageTrend Description

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

XSD Data Type	xs: integer	**XSD Element / Domain (Complex Type)**	TotalIcuLos
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 400

Element Values

- Relevant value for data element

Additional Information

- Recorded in full day increments with any partial day listed as a full calendar day
- The calculation assumes that the date and time of starting and stopping an ICU episode are recorded in the patient's chart.
- The null value "Not Known/Not Recorded" is used if any dates are missing.
- If patient has multiple ICU episodes on the same calendar day, count that day as one calendar day.
- At no time should the Total ICU LOS exceed the Hospital LOS
- The null value "Not Applicable" is used if the patient had no ICU days according to the above definition.

Data Source

- ICU Flow Sheet
- Nursing Notes/Flow Sheet

TOTAL VENTILATOR DAYS*

TR 26.58

National & State Element
Data Format [number]

NTDB/ ImageTrend Description

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

XSD Data Type	xs: integer	**XSD Element / Domain (Complex Type)**	TotalVentDays
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 400

Element Values

- Relevant value for data element

Additional Information

- Excludes mechanical ventilation time associated with OR procedures.
- Non-invasive means of ventilator support (CPAP or BIPAP) should not be considered in the calculation of ventilator hours.
- Recorded in full day increments with any partial calendar day county as a full calendar day.
- The calculation assumes that the date and time of starting and stopping Ventilator episode are recorded in the patient's chart.
- The null value "Not Known/Not Recorded" is used if any dates are missing.
- At no time should the Total Vent Days exceed the Hospital LOS
- The null value "Not Applicable" is used if the patient was not on the ventilator according to the above definition.

Data Source

- Respiratory Therapy Notes/Flow Sheet
- ICU Flow Sheet
- Progress Notes

DISABILITY AT DISCHARGE - FEEDING

TR 26.54 **Data Format**[combo] single-choice

ImageTrend Description

A score calculated to derive a baseline of trauma patient feeding disability at discharge from an acute care facility.

Element Values

Dependent - Total Help	Dependent - Partial Help
Independent with Device	Independent

Additional Information

- Used to auto-generate an additional calculated element: FIM Score (combination of Feeding, Locomotion, and Motor scores)
- Assess as close to discharge as possible. Includes using suitable utensils to bring food to mouth, chewing, and swallowing (once meal is appropriately prepared). Opening containers, cutting meat, buttering bread and pouring liquids are not included as they are often part of meal preparation.
- Dependent-total help required: Either performs less than half of feeding tasks or does not eat or drink full meals by mouth and relies at least in part on other means of alimentation, such as parenteral or gastrostomy feedings.
- Dependent-partial help required: Performs half or more of feeding tasks but requires supervision (e.g., standby, cueing, or coaxing) setup (application of Orthopedics), or other help.
- Independent with device: Uses an adaptive or assisting device such as a straw, spork, or rocking knifes, or requires more than a reasonable time to eat.
- Independent: Eats from a dish and drinks from a cup or glass presented in the customary manner on table or tray. Uses ordinary knife, fork, and spoon.
- Not applicable: (e.g., patient less than 7 years old, patient died, etc.)

Data Source

- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Admission Form

DISABILITY AT DISCHARGE - LOCOMOTION

TR 26.55 **Data Format**[combo] single-choice

ImageTrend Description

A score calculated to derive a baseline of trauma patient locomotion (independence) disability at discharge from an acute care facility.

Element Values

Dependent - Total Help	Dependent - Partial Help
Independent with Device	Independent

Additional Information

- Used to auto-generate an additional calculated element: FIM Score (combination of Feeding, Locomotion, and Motor scores)
- Includes walking once in a standing position, or using a wheelchair, once in a seated position, indoors
- Dependent - total help required: Performs less than half of locomotion effort to go a minimum of 50 feet or does not walk or wheel a minimum of 50 feet. Requires assistance of one or more persons.
- Dependent - partial help required: If walking, requires standby supervision, cueing, or coaxing to go a minimum of 150 feet, or walks independently only short distances (a minimum of 50 feet). If not walking, requires standby supervision, cueing, or coaxing to go a minimum of 150 feet in wheelchair, or operates manual or electric wheelchair independently only short distances (a minimum of 50 feet).
- Independent with Device: Walks a minimum of 150 feet but uses a brace or prosthesis on leg, special adaptive shoes, cane, crutches, or walker; takes more than a reasonable time; or there are safety considerations. If not walking, operates manual or electric wheelchair independently for a minimum of 150 feet; turns around; maneuvers the chair to a table, bed, toilet; negotiates at least a 3% grade; maneuvers on rugs and over doorsills.
- Independent: Walks a minimum of 150 feet without assisting devices. Does not use a wheelchair. Performs safely.
- Not applicable: (e.g., patient less than 7 years old, patient died, etc.)

Data Source

- Billing Sheet/Medical Records Coding Summary Sheet
- Hospital Admission Form

DISABILITY AT DISCHARGE - EXPRESSION (MOTOR)

TR 26.56 **Data Format**[combo] single-choice

ImageTrend Description

A score calculated to derive a baseline of trauma patient motor (expression) disability at discharge from an acute care facility.

Element Values

Dependent - Total Help	Dependent - Partial Help
Independent with Device	Independent

Additional Information

- Used to auto-generate an additional calculated element: FIM Score (combination of Feeding, Locomotion, and Motor scores)
- Includes clear expression of verbal or nonverbal language. This means expressing linguistic information verbally or graphically with appropriate and accurate meaning and grammar
- Dependent - total help required: Expresses basic needs and ideas less than half of the time. Needs prompting more than half the time or does not express basic needs appropriately or consistently despite prompting
- Dependent - partial help required: Expresses basic needs and ideas about everyday situations half (50%) or more than half of the time. Requires some prompting, but requires that prompting less than half (50%) of the time
- Independent with Device: Expresses complex or abstract ideas with mild difficulty. May require an augmentative communication device or system
- Independent: Expresses complex or abstract ideas intelligibly and fluently, verbal or nonverbal, including signing or writing
- Not applicable: (e.g., patient less than 7 years old, patient died, etc.)

Data Source

- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Admission Form

HOSPITAL DISCHARGE DISPOSITION*

TR 25.27

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

NTDB/ImageTrend Description

The disposition of the patient when discharged from the hospital.

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

Element Values

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

Additional Information

- Element value = 6, "Home" refers to the patient's current place of residence (e.g., prison, Child Protective Services, etc.)
- Element Values adapted from UB-04 disposition coding.
- Disposition to any other non-medical facility must be reported as Element Value "6. Discharged to home or self-care (routine discharge)."
- Disposition to any other medical facility must be reported as Element Value "14. Discharged/ Transferred to another type of institution not defined elsewhere."
- Disposition to any Federal Health Care facility must be reported by selecting the option that most closely aligns to the needs of the patient (e.g., patients discharged to a Veteran's hospital skilled nursing facility must be reported as Element Value "7. Discharged/Transferred to Skilled Nursing Facility.")
- The null value "Not Applicable" is reported if ED Discharge Disposition is reported as Element Value 4, 5, 6, 9, 10, or 11.

- Hospital Discharge Dispositions which were retired more than two years before the current NTDS version are no longer listed under Element Values above, which is why there are number gaps. Refer to the NTDS Change Log for a full list of retired Hospital Discharge Dispositions.

Data Source

- Physician Order
- Discharge Instructions
- Nursing Notes/Flow Sheet
- Case Management/Social Services Notes
- Discharge Summary

HOSPITAL TRANSFERRED TO

TR 25.35 **Data Format**[combo] single-choice

ImageTrend Description

Name of the receiving facility the patient was transferred to.

Element Values

- Relevant value for data element

Additional Information

- Only completed if Hospital Disposition "Acute Care Hospital," "Burn Care Facility," or "Rehab or long-term facility" is selected.

Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

(Other) FACILITY (Transferred to)

TR 25.39 **Data Format** [text]

ImageTrend Description

Any other identifying facility not found on the available list of options to which the patient was discharged.

Element Values

- Relevant value for data element

Additional Information

- Only completed if Hospital Transferred to "Other" is selected

Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

(Other) CITY (Transferred to)

TR 25.40 **Data Format**[text]

ImageTrend Description

The city in which the transfer facility is located.

Element Values

- Relevant value for data element

Additional Information

- Only completed if Hospital Transferred to "Other" is selected

Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

(Other) STATE (Transferred to)

TR 25.41 **Data Format**[text]

ImageTrend Description

The state in which the transfer facility is located.

Element Values

- Relevant value for data element

Additional Information

- Only completed if Hospital Transferred to "Other" is selected

Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

(Discharge) TRANSPORT MODE

TR 25.43 **Data Format**[combo] single-choice

ImageTrend Description

Hospital discharge transport mode.

Element Values

- Ambulance
- Helicopter
- Fixed Wing
- Police
- Private Vehicle

Additional Information

- Only completed if Hospital Disposition "Acute Care Hospital" is selected

Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

DISABILITY AT DISCHARGE - FIM SCORE

TR 26.61 **Data Format**[number]

ImageTrend Description

A score calculated (by adding together the Feeding, Independence, and Motor scores) to derive a baseline of trauma patient disability at discharge from an acute care facility, using three components: Feeding, Locomotion (Independence), and Motor (Expression)

Element Values

- Relevant value for data element
- Auto-calculated by combining Feeding, Locomotion, and Motor scores when entered

Data Source

- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Admission Form

LOCATION OF DEATH

TR 25.30 **Data Format**[combo] single-choice

ImageTrend Description

The location where the patient died.

Element Values

- ICU
- OR
- Floor
- Prior to Arrival
- ER

Additional Information

- Only completed if Hospital Disposition is "Expired"

Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

DATE & TIME OF DEATH

TR 25.36 **Data Format**[Date] [Time]

ImageTrend Description

Date and time the patient died.

Element Values

- Relevant value for data element

Additional Information

- Only completed if Hospital Disposition is "Expired"

Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

DEATH CIRCUMSTANCE

TR 25.32 **Data Format**[combo] single-choice

ImageTrend Description

Indicates patient's primary cause of death.

Element Values

Brain Injury	Thoracic Aortic Transection
Burn Shock	Trauma Shock
Cardio Failure	Treatment Withheld
Drowning	Brain Death
Electrocution	Sepsis
Heart Laceration	Cardiac Arrest due to
Liver Laceration	Strangulation
Multiple Organ	Cardiac Arrest
Failure/Metabolic	Family D/C Life Support
Other	Medical
Pre-Existing Illness	Multisystem Trauma
Pulmonary Failure	Trauma Wound
Pulmonary Failure/Sepsis	

Additional Information

- Only completed if Hospital Disposition is "Expired"

Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary
- Autopsy Report

OTHER (Death Circumstance) DESCRIPTION

TR 25.45 **Data Format**[text]

ImageTrend Description

The circumstance under which the patient died.

Element Values

- Relevant value for data element

Additional Information

- Only completed if Death Circumstance is "Other"

Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary
- Autopsy Report

ORGAN DONATION

TR 25.29 **Data Format**[combo] single-choice

ImageTrend Description

Were organs/tissue donated? - To make a gift of a differentiated structure (as a heart, kidney, leaf, or stem) consisting of cells and tissues and performing some specific function in an organism.

Element Values

Yes

No

Tissue Donation

Additional Information

- Only completed if Hospital Disposition is "Expired"

Data Source

- Hospital Documentation

AUTOPSY PERFORMED

TR 25.37 **Data Format**[combo] single-choice

ImageTrend Description

Was an autopsy performed? - An examination of a body after death to determine the cause of death or the character and extent of changes produced by disease.

Element Values

Yes No

Additional Information

- Only completed if Hospital Disposition is "Expired"

Data Source

- Hospital Documentation

ADVANCED DIRECTIVE

TR 25.28 **Data Format**[combo] single-choice

ImageTrend Description

Determination whether the patient had an Advanced Directive.

Element Values

Yes No

Additional Information

- Only completed if Hospital Disposition is "Expired"

Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

TRAUMA QUALITY IMPROVEMENT PROGRAM
Measures for Processes of Care

The elements in this section should be reported by Level 1 and Level 2 TQIP participating centers **ONLY**. Please contact us at indianatrauma@isdh.IN.gov if you have question or at tqip@facs.org for information about joining TQIP.

HIGHEST GCS TOTAL

TR 39.1 **Data Format** [combo] single-choice

NTDB Description

Highest total GCS score on calendar day after ED/hospital arrival.

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

Element Values

- Relevant value for data element

Additional Information

- Refers to highest total GCS on calendar day after ED/hospital arrival to index hospital, where index hospital is the hospital abstracting the data.
- Requires review of all data sources to obtain the highest GCS total on the calendar day after ED/hospital arrival.
- If patient is intubated, then the GCS Verbal score is equal to 1.
- Best obtained when sedatives or paralytics are withheld as part of sedation holiday.
- If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as "AAOx3", "awake alert and oriented", or "patient with normal mental status", report this as GCS of 15 IF there is no other contradicting documentation.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- The null value “Not Known/Not Recorded” is reported if reporting Highest GCS Motor 40.
- If reporting Highest GCS Total, the null value “Not Applicable” is reported if the patient is discharged from your hospital prior to the next calendar day

Data Source

- Neuro Assessment Flow Sheet
- Triage/Trauma/ICU Flow Sheet
- Nursing Notes/Flow Sheet
- Progress Notes

HIGHEST GCS MOTOR

TR 39.2 **Data Format** [combo] single-choice

NTDB Description

Highest GCS motor on calendar day after ED/hospital arrival.

** Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). **

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

Element Values

Pediatric (≤ 2 years):

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

Adult

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

Additional Information

- Refers to highest GCS motor on calendar day after ED/hospital arrival to index hospital, where index hospital is the hospital abstracting the data.
- Requires review of all data sources to obtain the highest GCS motor on the calendar day after ED/hospital arrival.
- Best obtained when sedatives or paralytics are withheld as part of sedation holiday.
- If a patient does not have a numeric GCS recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be reported. For example, the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be reported, IF there is no other contradicting documentation.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion. The null value “Not Known/Not Recorded” is reported if reporting Highest GCS Motor 40.
- If reporting Highest GCS Motor, the null value “Not Applicable” is reported if the patient’s ED Discharge Date or Hospital Discharge Date is prior to the next calendar day.

Data Source

- Neuro Assessment Flow Sheet
- Triage/Trauma/ICU Flow Sheet
- Nursing Notes/Flow Sheet
- Progress Notes

GCS Assessment (Qualifier Component) of Highest GCS TOTAL

TR 39.3 **Data Format** [combo] single-choice

NTDB Description

Documentation of factors potentially affecting the highest GCS on calendar day after ED/hospital arrival.

** Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). **

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

Element Values

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

Additional Information

- Refers to highest GCS assessment qualifier score on calendar day after ED/hospital arrival to index hospital, where index hospital is the hospital abstracting the data.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Requires review of all data sources to obtain the highest GCS motor score on calendar day after ED/hospital arrival, which might occur after the ED phase of care.
- Identifies medical treatments given to the patient that may affect the best assessment of GCS. This element does not apply to self-medication the patient may have administered (i.e. ETOH, prescriptions, etc.).
- Must be the assessment qualifier for the Highest GCS Total on calendar day after ED/hospital arrival.
- If an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible, then

the patient should be considered to have an exam that is not reflective of their neurologic status and the chemical sedation modifier should be reported.

- Neuromuscular blockade is typically induced following the administration of agents like succinylcholine, mivacurium, rocuronium, (cis)atracurium, vecuronium, or pancuronium. While these are the most common agents, please review what might be typically used in your center so it can be identified in the medical record.
- Each of these agents has a slightly different duration of action, so their effect on the GCS depends on when they were given. For example, succinylcholine's effects last for only 5-10 minutes.
- Report all that apply.
- The null value "Not Known/Not Recorded" is reported if reporting Highest GCS Motor 40.
- If reporting GCS Assessment Qualifier Component of Highest GCS Total, the null value "Not Applicable" is reported if the patient is discharged from your hospital prior to the next calendar day.

Data Source

- Neuro Assessment Flow Sheet
- Triage/Trauma/ICU Flow Sheet
- Nursing Notes/Flow Sheet
- Progress Notes
- Medication Summary

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

HIGHEST GCS 40 - MOTOR

TR 39.40.2 **Data Format** [combo] single-choice

NTDB Description

Highest GCS 40 motor on calendar day after ED/hospital arrival.

** Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). **

XSD Data Type	xs: integer	**XSD Element / Domain (Complex Type)**	TBIGcs40Motor
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Adult:

None	Normal Flexion
Extension	Localizing
Abnormal Flexion	Obeys commands
	Not Testable

Pediatric < 5 years:

None	Localizes Pain
Extension to Pain	Obeys Commands
Flexion to Pain	Not Testable

Additional Information

- Refers to highest GCS 40 motor on calendar day after arrival to index hospital, where index hospital is the hospital abstracting the data.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Requires review of all data sources to obtain the highest GCS 40 motor score on the calendar day after ED/hospital arrival.
- If a patient does not have a numeric GCS 40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be reported. (E.g. the chart indicates: "patient opened mouth and stuck out tongue

when asked" for adult patient's, a Motor GCS 40 of 6 may be reported, IF there is no other contradicting documentation.)

- Report Element Value "0. Not Testable" if unable to assess (e.g. neuromuscular blockade).
- The null value "Not Known/Not Recorded" is reported if Highest GCS – Motor is reported.
- If reporting Highest GCS 40 – Motor, the null value "Not Applicable" is reported if the patient's ED Discharge Date or Hospital Discharge Date is prior to the next calendar day.

Data Source

- Neuro Assessment Flow Sheet
- Triage/Trauma/ICU Flow Sheet
- Nursing Notes/Flow Sheet
- Progress Notes

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

INITIAL ED/HOSPITAL PUPILLARY RESPONSE

TR 40.32 **Data Format** [combo] single-choice

NTDB Description

Physiological response of the pupil size within 30 minutes or less of ED/hospital arrival.

** Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). **

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

Element Values

Both reactive
Neither reactive
One reactive

Additional Information

- Please note that first recorded hospital vitals do not need to be from the same assessment.
- If a patient does not have a listed element value recorded, but there is documentation related to their pupillary response such as PERRL "Pupils Equal Round Reactive to Light" report Element Value “1. Both reactive” IF there is no other contradicting documentation.
- The null value "Not Known/Not Recorded" should be reported if this information is not documented or if assessment is unable to be obtained due to facial trauma and/or foreign object in the eye.
- Element value “2. One reactive” should be reported for patients who have a prosthetic eye.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.

Data Source Hierarchy Guide

1. Triage/Trauma Flow Sheet
2. Progress Notes/ Nursing Notes
3. History and Physical

MIDLINE SHIFT

TR 40.33 **Data Format** [combo] single-choice

NTDB Description

>5mm shift of the brain past its center line within 24 hours after time of injury

** Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). **

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

Element Values

Yes Not Imaged (e.g. CT Scan, MRI) No

Additional Information

- If there is documentation of "massive" midline shift in lieu of >5mm shift measurement, report element value “1. Yes.”
- Radiological and surgical documentation from transferring facilities should be considered for this data element.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- The null value "Not Known/Not Recorded" is reported if both the injury date and injury time are unknown.
- If the injury time is unknown, but there is supporting documentation that the injury occurred within 24-hours of any CT measuring a >5mm shift, report the element value "1. Yes" if there is no other contradicting documentation.
- If the patient was not imaged within 24 hours from the time of injury, report the element value "3. Not Imaged (e.g. CT Scan, MRI)."

Data Source Hierarchy Guide

1. Radiology Reports
2. Operative Reports
3. Physician Notes/Flow Sheet
4. Nursing Notes/Flow Sheet
5. Hospital Discharge Summary

CEREBRAL MONITOR

TR 39.4 **Data Format** [combo] single-choice

NTDB Description

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

** Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). **

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

Element Values

- Intraventricular drain/catheter (e.g. ventriculostomy; external ventricular drain)
- Intraparenchymal pressure monitor (e.g. Camino bolt, subarachnoid bolt, intraparenchymal catheter)
- Intraparenchymal oxygen monitor (e.g. Licox)
- Jugular venous bulb
- None

Additional Information

- Refers to insertion of an intracranial pressure (ICP) monitor (or other measures of cerebral perfusion) for the purposes of managing severe TBI.
- Cerebral monitor placed at a referring facility would be acceptable if such a monitor was used by receiving facility to monitor the patient.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Report all that apply.

Data Source Hierarchy Guide

1. Operative Reports
2. Procedure Notes
3. Triage/Trauma/ICU Flow Sheet
4. Nursing Notes/Flow Sheet
5. Progress Notes
6. Anesthesia Record

CEREBRAL MONITOR DATE

TR 39.5 **Data Format** [combo] single-choice

NTDB Description

Date of first cerebral monitor placement.

** Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). **

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

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD.
- The null value "Not Applicable" is reported if the data element Cerebral Monitor is "5. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- If the cerebral monitor was placed at the referring facility, cerebral monitor date must be the date of insertion at the referring facility.

Data Source Hierarchy Guide

1. Operative Reports
2. Procedure Notes
3. Triage/Trauma/ICU Flow Sheet
4. Nursing Notes/Flow Sheet
5. Progress Notes
6. Anesthesia Record

CEREBRAL MONITOR TIME

TR 39.6 **Data Format** [combo] single-choice

NTDB Description

Time of first cerebral monitor placement.

** Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). **

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

Element Values

- Relevant value for data element

Additional Information

- Reported as HH:MM military time.
- The null value "Not Applicable" is reported if the data element Cerebral Monitor is "5. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- If the cerebral monitor was placed at the referring facility, cerebral monitor time must be the time of insertion at the referring facility.

Data Source Hierarchy Guide

1. Operative Reports
2. Procedure Notes
3. Triage/Trauma/ICU Flow Sheet
4. Nursing Notes/Flow Sheet
5. Progress Notes
6. Anesthesia Record

VENOUS THROMBOEMBOLISM PROPHYLAXIS TYPE

TR40.1 **Data Format** [combo] single-choice

NTDB Description

Type of first dose of venous thromboembolism prophylaxis administered to patient at your hospital.

EXCLUDE:

- Sequential compression devices

** Reporting Criterion: Report on all patients**

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

Element Values

Xa Inhibitor (Rivaroxaban, etc.)
None
LMWH (Daktarin, Enoxaparin, etc.)
Direct Thrombin Inhibitor (Dabigatran, etc.)
Other
Unfractionated Heparin (UH)

Additional Information

- Element Value “5. None” is reported if the first dose of Venous Thromboembolism Prophylaxis is administered post discharge order date/time.
- Element Value "5. None" is reported for patients who refuse VTE prophylaxis
- Venous Thromboembolism Prophylaxis Types which were retired greater than 2 years before the current NTDS version are no longer listed under Element Values above, which is why there are numbering gaps. Refer to the NTDS Change Log for a full list of retired Venous Thromboembolism Prophylaxis Types.
- Element Value “10. Other” is reported if “Coumadin” and/or “aspirin” are given as Venous Thromboembolism Prophylaxis.

Data Source Hierarchy Guide

1. Medication Summary
2. Nursing Notes/Flow Sheet
3. Pharmacy Record

VENOUS THROMBOEMBOLISM PROPHYLAXIS DATE

TR40.2 **Data Format** [combo] single-choice

NTDB Description

Date of administration of first dose of VTE prophylaxis administered to patient at your hospital

** Reporting Criterion: Report on all patients**

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

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD.
- Refers to date upon which patient first received the prophylactic agent indicated in VTE Prophylaxis Type element.
- The null value "Not Applicable" is reported if Venous Thromboembolism Prophylaxis Type is "5. None."

Data Source

1. Medication Summary
2. Nursing Notes/Flow Sheet

VENOUS THROMBOEMBOLISM PROPHYLAXIS TIME

TR40.3 **Data Format** [combo] single-choice

NTDB Description

Time of administration of first dose of VTE prophylaxis administered to patient at your hospital

** Reporting Criterion: Report all on patients**

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

Element Values

- Relevant value for data element

Additional Information

- Reported as HH:MM military time.
- Refers to date upon which patient first received the prophylactic agent indicated in Venous Thromboembolism Prophylaxis Type.
- The null value "Not Applicable" is reported if Venous Thromboembolism Prophylaxis Type is "5. None."

Data Source

1. Medication Summary
2. Nursing Notes/Flow Sheet

PACKED RED BLOOD CELLS

Data Format [combo] single-choice

NTDB Description

Volume of packed red blood cells transfused (CCs [mLs]) within first 4 hours after ED/hospital arrival

EXCLUDE:

- Packed red blood cells transfusing upon patient arrival.
- Cell saver blood.

** Reporting Criterion: Report on all patients**

XSD Data Type	xs: integer	**XSD Element / Domain (Comple Type)**	TransfusionBlood4Hours
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- Refers to amount of transfused packed red blood cells (CCs [mLs]) within first 4 hours after arrival to your hospital.
- If no packed red blood cells were given, then volume reported must be 0 (zero).

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. Anesthesia Record
3. Operative Reports
4. Nursing Notes/Flow Sheet
5. Blood Bank

WHOLE BLOOD

TR 40.4 **Data Format** [combo] single-choice

NTDB Description

Volume of whole blood transfused (CCs [mLs]) within first 4 hours after ED/hospital arrival

EXCLUDE:

- Whole blood transfusing upon patient arrival..
- Cell saver blood

** Reporting Criterion: Report on all patients**

XSD Data Type	xs: integer	**XSD Element / Domain (Complex Type)**	WholeBlood4Hours
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- Refers to amount of transfused whole blood (CCs [mLs]) within first four hours after arrival to your hospital.
- If no whole blood was given, then volume reported must be 0 (zero).

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. Anesthesia Record
3. Operative Reports
4. Nursing Notes/Flow Sheet
5. Blood Bank

PLASMA

TR40.5 **Data Format** [combo] single-choice

NTDB Description

Volume of plasma (CCs [mLs]) transfused within first four hours after ED/hospital arrival
EXCLUDE:

- Plasma transfusing upon patient arrival.
- Cell saver blood.

** Reporting Criterion: Report on all patients**

XSD Data Type	xs: integer	**XSD Element / Domain (Complex Type)**	TransfusionPlasma4Hours
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- Refers to amount of transfused fresh frozen, thawed, or never frozen plasma (CCs [mLs]) within first 4 hours after arrival to your hospital.
- If no plasma was given, then volume reported must be 0 (zero).

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. Anesthesia Record
3. Operative Reports
4. Nursing Notes/Flow Sheet
5. Blood Bank

PLATELETS

TR40.6 **Data Format** [combo] single-choice

NTDB Description

Volume of platelets (CCs [mLs]) transfused within first 4 hours after ED/hospital arrival
EXCLUDE:

- Platelets transfusing upon patient arrival.
- Cell saver blood.

** Reporting Criterion: Report on all patients**

XSD Data Type	xs: integer	**XSD Element / Domain (Complex Type)**	TransfusionPlatelets4Hours
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- Refers to amount of transfused platelets (CCs [mLs]) within first four hours after arrival to your hospital.
- If no platelets were given, then volume reported must be 0 (zero).

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. Anesthesia Record
3. Operative Reports
4. Nursing Notes/Flow Sheet
5. Blood Bank

CRYOPRECIPTIATE (4 Hours)

TR 40.7 **Data Format** [combo] single-choice

NTDB Description
Volume of solution enriched with clotting factors transfused (CCs [mLs]) within first four hours after ED/hospital arrival

EXCLUDE:
- Cryoprecipitate transfusing upon patient arrival.
- Cell saver blood.

** Reporting Criterion: Report on all patients**

XSD Data Type	xs: integer	**XSD Element / Domain (Complex Type)**	Cryoprecipitate4Hours
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

- Relevant value for data element

Additional Information

- Refers to amount of transfused cryoprecipitate (CCs [mLs]) within first four hours after arrival to your hospital.
- If no cryoprecipitate was given, then volume reported must be 0 (zero).

Data Source

1. Trauma Flow Sheet
2. Anesthesia Record
3. Operative Reports
4. Nursing Notes/Flow Sheet
5. Blood Bank

ANGIOGRAPHY

TR 40.12 **Data Format** [combo] single-choice

NTDB Description

First interventional angiogram for hemorrhage control within first 24 hours of ED/hospital arrival

EXCLUDE:

- Computerized tomographic angiography (CTA).

** Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival**

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

Element Values

None	Angiogram with embolization
Angiogram only	Angiogram with stenting

Additional Information

- Limit reporting angiography data to the first 24 hours following ED/hospital arrival.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Only report Element Value “4. Angiogram with stenting” if stenting was performed specifically for hemorrhage control.

Data Source

1. Radiology Reports
2. Operative Reports
3. Progress Notes

EMBOLIZATION SITE

TR 40.18 **Data Format** [combo] single-choice

NTDB Description

Organ/site of embolization for hemorrhage control.

** Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival**

XSD Data Type	xs: integer	**XSD Element / Domain (Complex Type)**	EmbolizationSite
Multiple Entry Configuration	Yes, max 7	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Element Values

Liver

Spleen

Kidneys

Pelvic (iliac, gluteal, obturator)

Retroperitoneum (lumbar, sacral)

Peripheral vascular (neck, extremities)

Other

Additional Information

- Report all that apply.
- The null value "Not Applicable" is reported if Angiography is Element Value "1. None," "2. Angiogram only," or "4. Angiogram with stenting."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Embolization Sites which were retired more than two years before the current NTDS version are no longer listed under Element Values above, which is why there are numbering gaps. Refer to the NTDS Change Log for a full list of retired Embolization Sites.

Data Source

1. Radiology Reports
2. Operative Reports
3. Progress Notes

ANGIOGRAPHY DATE

TR 40.13 **Data Format** [combo] single-choice

NTDB Description

Date the first angiogram with or without embolization was performed.

** Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival**

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

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD.
- The null value "Not Applicable" is reported if the data element Angiography is Element Value "1. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Procedure start date is the date of needle insertion in the groin.

Data Source

1. Radiology Reports
2. Operative Reports
3. Progress Notes

ANGIOGRAPHY TIME

TR 40.14 **Data Format** [combo] single-choice

NTDB Description

Time the first angiogram with or without embolization was performed.

** Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival**

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

Element Values

- Relevant value for data element

Additional Information

- Reported as HH:MM military time.
- The null value "Not Applicable" is reported if the data element Angiography is Element Value "1. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Procedure start time is the time of needle insertion in the groin.

Data Source

1. Radiology Reports
2. Operative Reports
3. Progress Notes

SURGERY FOR HEMORRHAGE CONTROL TYPE

TR 40.19 **Data Format** [combo] single-choice

NTDB Description

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

** Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival**

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

Element Values

None	Extremity
Laparotomy	Neck
Thoracotomy	Mangled extremity/traumatic amputation
Sternotomy	Other skin/soft tissue (e.g. scalp laceration)
	Extraperitoneal Pelvic Packing

Additional Information

- If unclear if surgery was for hemorrhage control, then consult TMD or operating/consulting/relevant surgeon
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Element Value “1. None” is reported if Surgery for Hemorrhage Control Type is not a listed Element Value option.

Data Source

1. Operative Reports
2. Procedure Notes
3. Progress Notes

SURGERY FOR HEMORRHAGE CONTROL DATE

TR 40.20 **Data Format** [combo] single-choice

NTDB Description

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

** Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival**

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

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD.
- If unclear if surgery was for hemorrhage control, then consult TMD or operating/consulting/relevant surgeon.
- The null value "Not Applicable" is reported if Surgery for Hemorrhage Control Type is "1. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criteria.
- Procedure start date is defined as the date the incision was made (or the procedure started).

Data Source

1. Operative Reports
2. Procedure Notes
3. Progress Notes

SURGERY FOR HEMORRHAGE CONTROL TIME

TR 40.21 **Data Format** [combo] single-choice

NTDB Description

Time of first surgery for hemorrhaged control within the first 24 hours of ED/hospital arrival.

** Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival**

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

Element Values

- Relevant value for data element

Additional Information

- Reported as HH:MM military time.
- If unclear if surgery was for hemorrhage control, then consult TMD or operating/consulting/relevant surgeon.
- The null value "Not Applicable" is reported if Surgery for Hemorrhage Control Type is "1. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criteria.
- Procedure start time is defined as the time the incision was made (or the procedure started).

Data Source

1. Operative Reports
2. Procedure Notes
3. Progress Notes

WITHDRAWAL OF LIFE SUPPORTING TREATMENT

TR 40.15 **Data Format** [combo] single-choice

NTDB Description

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

** Reporting Criterion: Report on all patients **

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

Element Values

Yes No

Additional Information

- Do-not-resuscitate (DNR) order not a requirement.
- A note to limit escalation of treatment qualifies as a withdrawal of life supporting treatment. These interventions are limited to: ventilator support (with or without extubation), dialysis or other forms of renal support, institution of medications to support blood pressure or cardiac function, or a specific surgical, interventional or radiological procedure (e.g. decompressive craniectomy, operation for hemorrhage control, angiography). Note that this definition provides equal weight to the withdrawal of an intervention already in place (e.g. extubation) and a decision not to proceed with a life-supporting intervention (e.g. intubation).
- Excludes the discontinuation of CPR and typically involves prior planning.
- DNR order is not the same as withdrawal of life supporting treatment.
- Element Value ”2. No” should be reported for patients whose time of death, according to your hospital's definition, was prior to the removal of any interventions or escalation of care.

Data Source

1. Physician Order
2. Progress Order
3. Case Manager/Social Services Notes
4. Nursing Notes/Flow Sheet
5. Discharge Summary

WITHDRAWAL OF LIFE SUPPORTING TREATMENT DATE

TR 40.16 **Data Format** [combo] single-choice

NTDB Description

The date treatment was withdrawn

** Reporting Criterion: Report on all patients **

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

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD.
- The null value "Not Applicable" is reported for patients when Withdrawal of Life Supporting Treatment is "2. No."
- Report the date the first of any existing life-supporting intervention(s) is withdrawn (e.g. extubation). If no intervention(s) is in place, record the time the decision not to proceed with a life supporting intervention(s) occurs (e.g. intubation).

Data Source

1. Physician Order
2. Progress Order
3. Respiratory Therapy Notes/Flow Sheet
4. Case Manager/Social Services Notes
5. Nursing Notes/Flow Sheet
6. Discharge Summary

WITHDRAWAL OF LIFE SUPPORTING TREATMENT TIME

TR 40.17 **Data Format** [combo] single-choice

NTDB Description

The time treatment was withdrawn

** Reporting Criterion: Report on all patients **

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

Element Values

- Relevant value for data element

Additional Information

- Reported as HH:MM military time.
- The null value "Not Applicable" is reported for patients when Withdrawal of Life Supporting Treatment is "2. No."
- Report the time the first of any existing life-supporting intervention(s) is withdrawn (e.g. extubation). If no intervention(s) is in place, record the time the decision not to proceed with a life supporting intervention(s) occurs (e.g. intubation).

Data Source

1. Physician Order
2. Progress Order
3. Respiratory Therapy Notes/Flow Sheet
4. Case Manager/Social Services Notes
5. Nursing Notes/Flow Sheet
6. Discharge Summary

ANTIBIOTIC THERAPY

TR 18.189 **Data Format** [combo] single-choice

NTDB Description

Intravenous antibiotic therapy was administered to the patient within 24 hours after injury.

** Reporting Criterion: Report on all patients with any open fracture(s)**

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

Element Values

Yes No

Additional Information

- The null value “Not Applicable” is reported for patients that do not meet the reporting criterion.
- Open fractures as defined by the Association of Advancement of Automotive Medicine AIS Coding Rules and Guidelines and includes all AIS code descriptors that contain "open" and all AIS extremity/limb code descriptors that contain "amputation."

Data Source

1. EMS Run Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Medication Summary
4. Anesthesia Record
5. Nursing Notes/Flow Sheet
6. Pharmacy Record

ANTIBIOTIC THERAPY DATE

TR 18.190 **Data Format** [combo] single-choice

NTDB Description

The date of first recorded intravenous antibiotic therapy administered to the patient within 24 hours after injury.

** Reporting Criterion: Report on all patients with any open fracture(s)**

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

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD
- The null value “Not Applicable” is reported for patients that do not meet the reporting criterion.
- The null value “Not Applicable” is reported if Antibiotic Therapy is Element Value “2. No”.
- Open fractures as defined by the Association of Advancement of Automotive Medicine AIS Coding Rules and Guidelines and includes all AIS code descriptors that contain "open" and all AIS extremity/limb code descriptors that contain "amputation."

Data Source

1. EMS Run Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Medication Summary
4. Anesthesia Record
5. Nursing Notes/Flow Sheet
6. Pharmacy Record

ANTIBIOTIC THERAPY TIME

TR 18.190.1 **Data Format** [combo] single-choice

NTDB Description

The time of first recorded intravenous antibiotic therapy administered to the patient within 24 hours after injury.

** Reporting Criterion: Report on all patients with any open fracture(s)**

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

Element Values

- Relevant value for data element

Additional Information

- Reported HH:MM military time
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- The null value "Not Applicable" is reported if Antibiotic Therapy is Element Value "2. No".
- Open fractures as defined by the Association of Advancement of Automotive Medicine AIS Coding Rules and Guidelines and includes all AIS code descriptors that contain "open" and all AIS extremity/limb code descriptors that contain "amputation."

Data Source

1. EMS Run Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Medication Summary
4. Anesthesia Record
5. Nursing Notes/Flow Sheet
6. Pharmacy Record

Surgeon Specific Reporting - Optional

NATIONAL PROVIDER IDENTIFIER (NPI)

Data Format [combo] single-choice

NTDB Description

The National Provider Identifier (NPI) of the admitting surgeon.

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

Element Values

- Relevant value for data element

Additional Information

- Must be stored as a 10-digit numeric value.
- This variable is considered optional and is not required as part of the NTDS dataset.
- The null value "Not Applicable" is reported if this optional element is not being reported.

Data Source

1. Medical Record

Appendix 1: Regarding Injury Severity Score (ISS) and Abbreviated Injury Score (AIS)

In ImageTrend, the ISS is calculated from the AIS codes by using the AIS region and severity that is associated with the AIS code. The AIS codes are entered along with a corresponding ICD-10-CM diagnosis code.

When an ICD-10-CM diagnosis code is added to a patient on the "Diagnosis" tab, the ImageTrend Patient Registry can show the registrar the AIS code used frequently with the diagnosis. If the registrar agrees with the stated code, they can click the **add** button. When the Diagnosis and AIS are added, the system will automatically update the ISS and Probability of Survival.

The ImageTrend Patient Registry uses AIS 05 with updates from 2008. System updates to implement AIS 15 codes are anticipated in 2025. Also, in addition to calculating the ISS, the New Injury Severity Score (NISS) will also be calculated.

Appendix 2: Indiana Hospitals

See below for a list of Indiana's 128 acute care hospitals with emergency departments, as of 2025.

Zip Code	Facility Name	Trauma Level	District
46733	Adams Memorial Hospital	Non-Trauma Centers	3
46016	Ascension St. Vincent Anderson	Trauma Level III	6
46123	Ascension St. Vincent- Avon (Neighborhood Hospital)	Non-Trauma Centers	5
46250	Ascension St. Vincent- Castleton (Neighborhood Hospital)	Non-Trauma Centers	5
47714	Ascension St. Vincent Evansville	Trauma Levels I & II	10
46260	Ascension St. Vincent Hospital - Indianapolis	Trauma Levels I & II	5
46237	Ascension St. Vincent- Indianapolis South (Neighborhood Hospital)	Non-Trauma Centers	5
46901	Ascension St. Vincent Kokomo	Non-Trauma Centers	6
46036	Ascension St. Vincent Mercy Hospital	Non-Trauma Centers	6
46168	Ascension St. Vincent- Plainfield (Neighborhood Hospital)	Non-Trauma Centers	5
47394	Ascension St. Vincent Randolph	Non-Trauma Centers	6
47167	Ascension St. Vincent Salem Hospital	Non-Trauma Centers	8
47601	Ascension St. Vincent Warrick	Non-Trauma Centers	10
47993	Ascension St. Vincent Williamsport	Non-Trauma Centers	4
46032	Ascension St. Vincent-Carmel	Non-Trauma Centers	5
47834	Ascension St. Vincent-Clay	Non-Trauma Centers	7
46037	Ascension St. Vincent-Fishers	Non-Trauma Centers	5
47265	Ascension St. Vincent-Jennings	Non-Trauma Centers	9
47150	Baptist Health Floyd	Non-Trauma Centers	9
46530	Beacon Granger Hospital	Non-Trauma Centers	2
46714	Bluffton Regional Medical Center	Non-Trauma Centers	3
46703	Cameron Memorial Community Hospital	Non-Trauma Centers	3

Zip Code	Facility Name	Trauma Level	District
47201	Columbus Regional Hospital	Non-Trauma Centers	8
46219	Community EAST Health Network Comm Hosp	Non-Trauma Centers	5
46011	Community Hosp of Anderson and Madison Co	Trauma Level III	6
46321	Community Hospital Munster	Non-Trauma Centers	1
46506	Community Hospital of Bremen	Non-Trauma Centers	2
46902	Community Howard Regional Health	Non-Trauma Centers	6
46256	Community NORTH Health Network Comm Hosp	Non-Trauma Centers	5
46227	Community SOUTH Health Network Comm Hosp	Non-Trauma Centers	5
47501	Daviess Community Hospital	Non-Trauma Centers	10
47630	Deaconess Gateway Hospital	Non-Trauma Centers	10
47670	Deaconess Gibson Hospital	Non-Trauma Centers	10
47546	Deaconess Memorial Medical Center	Trauma Level III	10
47747	Deaconess Midtown Hospital	Trauma Levels I & II	10
47240	Decatur County Memorial Hospital	Non-Trauma Centers	9
46970	Dukes Memorial Hospital	Non-Trauma Centers	3
46825	Dupont Hospital	Non-Trauma Centers	3
46514	Elkhart General Hospital	Trauma Level III	2
46202	Eskenazi Health	Trauma Levels I & II	5
47933	Franciscan Health Crawfordsville	Non-Trauma Centers	4
46307	Franciscan Health Crown Point	Trauma Level III	1
46311	Franciscan Health Dyer	Non-Trauma Centers	1
46237	Franciscan Health Indianapolis	Trauma Level III	5
47095	Franciscan Health Lafayette East	Trauma Level III	4
46360	Franciscan Health Michigan City	Non-Trauma Centers	1
46350	Franciscan Health Michigan City at LaPorte	Non-Trauma Centers	1
46158	Franciscan Health Mooresville	Non-Trauma Centers	5
46321	Franciscan Health Munster	Non-Trauma Centers	1

Zip Code	Facility Name	Trauma Level	District
47978	Franciscan Health Rensselaer	Non-Trauma Centers	1
47591	Good Samaritan Hospital	Trauma Level III	10
46526	Goshen Health	Non-Trauma Centers	2
47441	Greene County General Hospital	Non-Trauma Centers	7
46140	Hancock Health	Non-Trauma Centers	5
47112	Harrison County Hospital	Non-Trauma Centers	9
46122	Hendricks Regional Health	Non-Trauma Centers	5
46112	Hendricks Regional Health – Brownsburg Hospital	Non-Trauma Centers	5
47362	Henry Community Health	Non-Trauma Centers	6
47905	IU Health Arnett Hospital	Trauma Level III	4
47303	IU Health Ball Memorial Hospital	Trauma Level III	6
47421	IU Health Bedford Hospital	Non-Trauma Centers	8
47403	IU Health Bloomington Hospital	Trauma Level III	8
46041	IU Health Frankfort Hospital	Non-Trauma Centers	4
47371	IU Health Jay	Non-Trauma Centers	6
46202	IU Health Methodist Hospital	Trauma Levels I & II	5
46151	IU Health Morgan Hospital	Non-Trauma Centers	5
46032	IU Health North Hospital	Non-Trauma Centers	5
47454	IU Health Paoli Hospital	Non-Trauma Centers	8
46202	IU Health Riley Hospital for Children	Trauma Levels I & II	5
46037	IU Health Saxony Hospital	Non-Trauma Centers	5
46072	IU Health Tipton Hospital	Non-Trauma Centers	6
46123	IU Health West Hospital	Non-Trauma Centers	5
47960	IU Health White Memorial Hospital	Non-Trauma Centers	4
46131	Johnson Memorial Hospital	Non-Trauma Centers	5
46802	Lutheran Downtown	Non-Trauma Centers	3
46804	Lutheran Hospital of Indiana	Trauma Levels I & II	3
46580	Lutheran Kosciusko Hospital	Non-Trauma Centers	2

Zip Code	Facility Name	Trauma Level	District
46176	Major Hospital	Non-Trauma Centers	5
47006	Margaret Mary Health	Non-Trauma Centers	9
46952	Marion Health	Non-Trauma Centers	6
46947	Memorial Hospital Logansport	Non-Trauma Centers	4
46601	Memorial Hospital of South Bend	Trauma Levels I & II	2
46402	Methodist Hospitals Inc Northlake Campus	Non-Trauma Centers	1
46410	Methodist Hospitals Inc Southlake Campus	Non-Trauma Centers	1
47403	Monroe Hospital	Non-Trauma Centers	8
46350	Northwest Health La Porte	Non-Trauma Centers	1
46368	Northwest Health Portage	Non-Trauma Centers	1
46383	Northwest Health Porter	Non-Trauma Centers	1
46383	Northwest Health Valparaiso Medical Center (VMC)	Non-Trauma Centers	1
47130	Norton Clark Hospital	Non-Trauma Centers	9
47250	Norton King's Daughters' Health	Non-Trauma Centers	9
47170	Norton Scott Hospital	Non-Trauma Centers	9
46706	Parkview DeKalb Hospital	Non-Trauma Centers	3
46750	Parkview Huntington Hospital	Non-Trauma Centers	3
46761	Parkview LaGrange Hospital	Non-Trauma Centers	3
46755	Parkview Noble Hospital	Non-Trauma Centers	3
46805	Parkview Randallia	Non-Trauma Centers	3
46845	Parkview Regional Medical Center	Trauma Levels I & II	3
46804	Parkview Southwest Outpatient Center	Non-Trauma Centers	3
46992	Parkview Wabash	Non-Trauma Centers	3
	Parkview Warsaw	Non-Trauma Centers	3
46725	Parkview Whitley	Non-Trauma Centers	3
47586	Perry County Memorial Hospital	Non-Trauma Centers	10
46260	Peyton Manning Children’s Hospital at St Vincent	Non-Trauma Centers	5

Zip Code	Facility Name	Trauma Level	District
46996	Pulaski Memorial Hospital	Non-Trauma Centers	2
46135	Putnam County Hospital	Non-Trauma Centers	7
47374	Reid Health	Trauma Level III	6
47331	Reid Health Connersville	Non-Trauma Centers	6
46060	Riverview Health	Non-Trauma Centers	5
46074	Riverview Health Westfield	Non-Trauma Centers	5
46077	Riverview Health Emergency Room & Urgent Care – West Carmel/Zionsville	Non-Trauma Centers	5
46033	Riverview Health Emergency Room & Urgent Care - Carmel	Non-Trauma Centers	5
46037	Riverview Health Emergency Room & Urgent Care - Fishers	Non-Trauma Centers	5
46173	Rush Memorial Hospital	Non-Trauma Centers	6
46545	Saint Joseph Regional Medical Center (Mishawaka)	Non-Trauma Centers	2
46563	Saint Joseph Regional Medical Center (Plymouth)	Non-Trauma Centers	2
47274	Schneck Medical Center	Non-Trauma Centers	8
46312	St. Catherine Hospital East Chicago	Non-Trauma Centers	1
47025	St. Elizabeth Dearborn	Non-Trauma Centers	9
46342	St. Mary Medical Center (Hobart)	Non-Trauma Centers	1
46534	Starke Hospital	Non-Trauma Centers	2
47882	Sullivan County Community Hospital	Non-Trauma Centers	7
47802	Terre Haute Regional Hospital	Non-Trauma Centers	7
47842	Union Hospital Clinton	Non-Trauma Centers	7
47804	Union Hospital Terre Haute	Trauma Level III	7
46052	Witham Health Services	Non-Trauma Centers	5
46077	Witham Health Services at Anson	Non-Trauma Centers	5
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Appendix 3: Glossary of Terms

Glossary

CO-MORBID CONDITIONS

Advanced Directive Limiting Care: The patient had a written request limiting life sustaining therapy, or similar advanced directive, present prior to arrival at your center.

Alcohol Use Disorder: (Consistent with the American Psychiatric Association (APA) DMS 5, 2013. Always use the most recent definition provided by the APA.) Diagnosis of alcohol use disorder documented in the patient's medical record, present prior t injury.

Angina Pectoris: (Consistent with the American Heart Association (AHA), May 2015. Always use the most recent definition provided by the AHA.) Chest pain or discomfort due to coronary heart disease present prior to injury. Usually causes uncomfortable pressure, fullness, squeezing or pain in the center of the chest. Patient may also feel the discomfort in the neck, jaw, shoulder, back or arm. Symptoms may be different in women than men. A diagnosis of angina or chest pain must be documented in the patient's medical record.

Anticoagulant Therapy: Documentation in the medical record of the administration of medication (anticoagulants, antiplatelet agents, thrombin inhibitors, thrombolytic agents) that interferes with blood clotting, present prior to injury. Exclude patients who are on chronic Aspirin therapy. Some examples are:

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

Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD): A disorder involving inattention, hyperactivity, or impulsivity requiring medication for

treatment, present prior to ED/Hospital arrival. A diagnosis of ADD/ADHD must be documented in the patient's medical record.

Bleeding Disorder: (Consistent with the American Society of Hematology, 2015. Always use the most recent definition provided by the American Society of Hematology.) A group of conditions that result when the blood cannot clot properly, present prior to injury. A Bleeding Disorder diagnosis must be documented in the patient's medical record (e.g. Hemophilia, von Willenbrand Disease, Factor V Leiden.)

Cerebral Vascular Accident (CVA): A history prior to injury of a cerebrovascular accident (embolic, thrombotic, or hemorrhagic) with persistent residual motor sensory or cognitive dysfunction (e.g. hemiplegia, hemiparesis, aphasia, sensory deficit, impaired memory). A diagnosis of CVA must be documented in the patient's medical record.

Chronic Obstructive Pulmonary Disease (COPD): (Consistent with World Health Organization (WHO), 2015. Always use the most recent definition provided by the WHO.) Lung ailment that is characterized by a persistent blockage of airflow from the lungs, present prior to injury. It is not one single disease, but an umbrella term used to describe chronic lung diseases that cause limitations in lung airflow. The more familiar terms "chronic bronchitis" and "emphysema" are no longer used, but are now included within the COPD diagnosis and result in any one or more of the following:

- Functional disability from COPD (e.g., dyspnea, inability to perform activities of daily living [ADLs]).
- Hospitalization in the past for treatment of COPD.
- Requires chronic bronchodilator therapy with oral or inhaled agents.
- A Forced Expiratory Volume in 1 second (FEV1) of < 75% or predicted on pulmonary function testing.

A diagnosis of COPD must be documented in the patient's medical record. Do not include patients whose only pulmonary disease is acute asthma, and/or diffuse interstitial fibrosis or sarcoidosis.

Chronic Renal Failure: Chronic renal failure prior to injury that was requiring periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration, present prior to injury. A diagnosis of chronic renal failure must be documented in the patient's medical record.

Cirrhosis: Documentation in the medical record of cirrhosis, which might also be referred to as end stage liver disease, present prior to injury. If there is documentation

of prior or present esophageal or gastric varices, portal hypertension, previous hepatic encephalopathy, or ascites with notation of liver disease, then cirrhosis should be considered present. A diagnosis of cirrhosis, or documentation of cirrhosis by diagnostic imaging studies or a laparotomy/laparoscopy, must be in the patient's medical record.

Congenital Anomalies: Documentation of a cardiac, pulmonary, body wall, CNS/spinal, GI, renal, orthopedic, or metabolic anomaly, present prior to injury. A diagnosis of a Congenital Anomaly must be documented in the patient's medical record.

Congestive Heart Failure (CHF): The inability of the heart to pump enough blood to meet the metabolic needs of the body or can do so only at an increased ventricular filling pressure, present prior to injury. To be included, this condition must be noted in the medical record as CHF, congestive heart failure, or pulmonary edema with onset of increasing symptoms within 30 days prior to injury.
Common manifestations are:

- Abnormal limitation in exercise tolerance due to dyspnea or fatigue
- Orthopnea (dyspnea or lying supine)
- Paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea)
- Increased jugular venous pressure
- Pulmonary rales on physical examination
- Cardiomegaly
- Pulmonary vascular engorgement

Current Smoker: A patient who reports smoking cigarettes every day or some days within the last 12 months, prior to injury. Excludes patients who smoke cigars or pipes or smokeless tobacco (chewing tobacco or snuff).

Currently Receiving Chemotherapy for Cancer: A patient who is currently receiving any chemotherapy treatment for cancer, prior to injury. Chemotherapy may include, but is not restricted to, oral and parenteral treatment with chemotherapeutic agents for malignancies such as colon, breast, lung, head and neck, and gastrointestinal solid tumors as well as lymphatic and hematopoietic malignancies such as lymphoma, leukemia, and multiple myeloma.

Dementia: Documentation in the patient's medical record of dementia including senile or vascular dementia (e.g., Alzheimer's) present prior to injury.

Diabetes Mellitus: Diabetes mellitus that requires exogenous parenteral insulin or an oral hypoglycemic agent, present prior to injury. A diagnosis of diabetes mellitus must be documented in the patient's medical record.

Disseminated Cancer: Patients who have cancer that has spread to one or more sites in addition to the primary site AND in whom the presence of multiple metastases indicates the cancer is widespread, fulminant, or near terminal, present prior to injury. Other terms describing disseminated cancer include: "diffuse," "widely metastatic," "widespread," or "carcinomatosis." Common sites of metastases include major organs, (e.g., brain, lung, liver, meninges, abdomen, peritoneum, pleura, and/or bone). A diagnosis of cancer that has spread to one or more sites must be documented in the patient’s medical record.

Functionally Dependent Health Status: Pre-injury functional status may be represented by the ability of the patient to complete age-appropriate activities of daily living (ADL). Activities of daily living include bathing, feeding, dressing, toileting, and walking. Include patients whom prior to injury, and as a result of cognitive or physical limitations relating to a pre-existing medical condition, were partially dependent or completely dependent upon equipment, devices or another person to complete some or all activities of daily living.

Hypertension: History of persistent elevated blood pressure requiring medical therapy, present prior to injury. A diagnosis of hypertension must be documented in the patient's medical record.

Mental/Personality Disorder: (Consistent with American Psychiatric Association (APA) DSM 5, 2013. Always use the most recent definition provided by the APA.) Documentation of the presence of pre-injury depressive disorder, bipolar disorder, schizophrenia, borderline or antisocial personality disorder, and/or adjustment disorder/post-traumatic stress disorder. A diagnosis of Mental/Personality Disorder must be documented in the patient's medical record.

Myocardial Infarction: History of a MI in the six months prior to injury. A diagnosis of MI must be documented in the patient's medical record.

Peripheral Arterial Disease (PAD): The narrowing or blockage of the vessels that carry blood from the heart to the legs, present prior to injury. It is primarily caused by the buildup of fatty plaque in the arteries, which is called atherosclerosis. PAD can occur in any blood vessel, but it is more common in the legs than the arms. A diagnosis of PAD must be documented in the patient's medical record. (Consistent with Centers for

Disease Control, 2014 Fact Sheet. Always use the most recent definition provided by the CDC.)

Prematurity: Infants delivered before 37 weeks from the first day of the last menstrual period, and a history of bronchopulmonary dysplasia, or ventilator support for greater than seven days after birth. A diagnosis of prematurity, or delivery before 37 weeks gestation, must be documented in the patient's medical record.

Steroid Use: Patients that require the regular administration of oral or parenteral corticosteroid medications within 30 days prior to injury for a chronic medical condition. Examples of oral or parenteral corticosteroid medications are prednisone and dexamethasone. Examples of chronic medical conditions include COPD, asthma, rheumatologic disease, rheumatoid arthritis, and inflammatory bowel disease. Exclude topical corticosteroids applied to the skin, and corticosteroids administered by inhalation or rectally.

Substance Abuse Disorder: (Consistent with American Psychiatric Association (APA) DSM 5, 2013.Always use the most recent definition provided by the APA.) Documentation of substance abuse disorder documented in the patient medical record, present prior to injury. A diagnosis of Substance Abuse Disorder must be documented in the patient's medical record.

HOSPITAL COMPLICATIONS

Acute Kidney Injury: (Consistent with the March 2012 Kidney Disease Improving Global Outcome (KDIGO) Guideline. Always use the most recent definition provided by the KDIGO.) Acute Kidney Injury, AKI (stage 3), is an abrupt decrease in kidney function that occurred during the patient’s initial stay at your hospital.

KDIGO (Stage 3) Table:

(SCr) 3 times baseline
OR
Increase in SCr to ≥ 4.0 mg/dl (≥ 353.6 µmol/l)
OR
Initiation of renal replacement therapy OR, in patients < 18 years, decrease in eGFR to <35 ml/min per 1.73 m^2
OR
Urine output <0.3 ml/kg/h for > 24 hours
OR

Anuria for > 12 hours
A diagnosis of AKI must be documented in the patient's medical record. If the patient or family refuses treatment (e.g., dialysis,) the condition is still considered to be present if a combination of oliguria and creatinine are present.
EXCLUDE patients with renal failure that were requiring chronic renal replacement therapy such as periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration prior to injury.

Acute Respiratory Distress Syndrome (ARDS):
Timing: Within one week of known clinical insult or new or worsening respiratory symptoms.
Chest imaging: Bilateral opacities – not fully explained by effusions, lobar/lung collage, or Nodules Origin of edema: Respiratory failure not fully explained by cardiac failure of fluid overload. Need objective assessment (e.g., echocardiography) to exclude hydrostatic edema if no risk factor present.
Oxygenation: 200<Pa02/Fi02<=300 (at a minimum) With PEEP or CPAP>=5 cmH20c
A diagnosis of ARDS must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital. (Consistent with the 2012 New Berlin Definition. Always use the most recent New Berlin definition provided.)

Alcohol Withdrawal Syndrome: Characterized by tremor, sweating, anxiety, agitation, depression, nausea, and malaise. It occurs six to 48 hours after cessation of alcohol consumption, and when uncomplicated, abates after two to five days. It may be complicated by grand mal seizures and may progress to delirium (known as delirium tremens). Must have occurred during the patient's initial stay at your hospital, and documentation of alcohol withdrawal must be in the patient's medical record. (Consistent with the 2016 World Health Organization (WHO) definition of Alcohol Withdrawal Syndrome. Always use the most recent definition provided by the WHO.)

Cardiac Arrest with CPR: Cardiac arrest is the sudden cessation of cardiac activity after hospital arrival. The patient becomes unresponsive with no normal breathing and no signs of circulation. If corrective measures are not taken rapidly, this condition progresses to sudden death. Cardiac arrest must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital.
EXCLUDE patients who are receiving CPR on arrival to your hospital.
INCLUDE patients who have had an episode of cardiac arrest evaluated by hospital personnel and received compressions or defibrillation or cardioversion or cardiac pacing to restore circulation.

Catheter-Associated Urinary Tract Infection (CAUTI) (Consistent with the January 2016 CDC defined CAUTI. Always use the most recent definition provided by the CDC.)
A UTI where an indwelling urinary catheter was in place for > 2 calendar days on the date of event, with day of device placement being Day 1, **AND**
An indwelling urinary catheter was in place on the date of event or the day before. If an indwelling urinary catheter was in place for > 2 calendar days and then removed, the date of event for the UTI must be the day of discontinuation or the next day for the UTI to be catheter-associated.)

January 2016 CDC CAUTI Criterion SUTI 1a:

Patient must meet 1, 2, **and** 3 below:
1. Patient had an indwelling urinary catheter in place for the entire day on the date of event and such catheter had been in place for >2 calendar days, on that date (day of device

- Placement = Day 1) AND was either:
- Present for any portion of the calendar day on the date of event, OR
- Removed the day before the date of event

2. Patient has at least **one** of the following signs or symptoms:

- Fever (>38^{0}C)
- Suprapubic tenderness with no other recognized cause
- Costovertebral angle pain or tenderness with no other recognized cause

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

January 2016 CDC CAUTI Criterion SUTI 2:

Patient must meet 1, 2 **and** 3 below:
1. Patient is ≤1 year of age
2. Patient has at least one of the following signs or symptoms:

- fever (>38.0^{0}C)
- hypothermia (<36.0^{0}C)
- apnea with no other recognized cause
- bradycardia with no other recognized cause
- lethargy with no other recognized cause
- vomiting with no other recognized cause
- suprapubic tenderness with no other recognized cause

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

A diagnosis of UTI must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

Central Line-Associated Bloodstream Infection (CLABSI): (Consistent with the January 2016 CDC defined CLABSI. Always use the most recent definition provided by the CDC.) A laboratory-confirmed bloodstream infection (LCBI) where central line (CL) or umbilical catheter (UC) was in place for > 2 calendar days on the date of event, with day of device placement being Day 1,

AND

The line was also in place on the date of event or the day before. If a CL or UC was in place for > 2 calendar days and then removed, the date of event of the LCBI must be the day of discontinuation or the next day to be a CLABSI. If the patient is admitted or transferred into a facility with an implanted central line (port) in place, and that is the patient's only central line, day of first access in an inpatient location is considered Day 1. "Access" is defined as line placement, infusion, or withdrawal through the line. Such lines continue to be eligible for CLABSI once they are accessed until they are either discontinued or the day after patient discharge (as per the Transfer Rule.) Note that the "de-access" of a port does not result in the patient's removal from CLABSI surveillance.

January 2016 CDC Criterion LCBI 1:

Patient has a recognized pathogen identified from one or more blood specimens by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not active surveillance culture/testing (ASC/AST.)

AND

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

OR

January 2016 CDC Criterion LCBI 2:

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

AND

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

AND

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

Infection Window Period, the seven-day time period which includes the collection date of the positive blood, the 3 calendar days before and the three calendar days after.
OR
January 2016 CDC Criterion LCBI 3:
Patient ≤ 1 year of age has at least one of the following signs or symptoms: fever (>38^0 C), hypothermia (<36^0C), apnea, or bradycardia
AND
Organism(s) identified from blood is not related to an infection at another site
AND
The same common commensal (i.e., diphtheroids [*Corynebacterium* spp. not *C. diphtheriae*], *Bacillus* spp. [not *B. anthracis*], *Propionibacterium* spp., coagulase-negative staphylococci [including *S. epidermidis*], viridans group streptococci, *Aerococcus* spp., and *Micrococcus* spp.) is identified from two or more blood specimens drawn on separate occasions, by a culture or nonculture base microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not active surveillance culture/testing (ASC/AST.) Criterion elements must occur within the Infection Window Period, the seven-day time period which includes the collection date of the positive blood, the three calendar days before and the three calendar days after.

A diagnosis of LCBSI must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

Deep Surgical Site Infection: (Consistent with the January 2016 CDC defined SSI. Always use the most recent definition provided by the CDC.) Must meet the following criteria: Infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) according to list in Table 2 in the 2025 NTDS Data Dictionary (page 161).
AND
involves deep soft tissues of the incision (e.g., fascial and muscle layers)
AND
patient has at least **one** of the following:

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

AND

patient has at least **one** of the following signs or symptoms: fever (>38°C); localized pain or tenderness. A culture or non-culture-based test that has a negative finding does not meet this criterion.
c. an abscess or other evidence of infection involving the deep incision that is detected on gross anatomical or histopathologic exam, or imaging test

COMMENTS: There are two specific types of deep incisional SSIs:

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

A diagnosis of SSI must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

Deep Vein Thrombosis (DVT): The formation, development, or existence of a blood clot or thrombus within the vascular system, which may be coupled with inflammation. The patient must be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava. A diagnosis of DVT must be documented in the patient's medical record. This diagnosis may be confirmed by a venogram, ultrasound, or CT, and must have occurred during the patient's initial stay at your hospital.

Extremity Compartment Syndrome: A condition does not present at admission in which there is documentation of tense muscular compartments of an extremity through clinical assessment or direct measurement of intracompartmental pressure requiring fasciotomy. Compartment syndromes usually involve the leg but can also occur in the forearm, arm, thigh, and shoulder. A diagnosis of extremity compartment syndrome must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital. Only record as a complication if it is originally missed, leading to late recognition, a need for late intervention, and has threatened limb viability.

Myocardial Infarction (MI): An acute myocardial infarction must be noted with documentation of any of the following:
Documentation of ECG changes indicative of acute MI (one or more of the following three):

1. ST elevation >1 mm in two or more contiguous leads
2. New left bundle branch block
3. New q-wave in two or more contiguous leads

OR

New elevation in troponin greater than three times upper level of the reference range in the setting of suspected myocardial ischemia

OR

Physician diagnosis of myocardial infarction

Must have occurred during the patient's initial stay at your hospital.

Organ/Space Surgical Site Infection: (Consistent with the January 2016 CDC defined SSI. Always use the most recent definition provided by the CDC.) Must meet the following criteria: Infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) according to the list in Table 2 on page 171 of the 2025 NTDS Data Dictionary.

AND

infection involves any part of the body deeper than the fascial/muscle layers, that is opened or manipulated during the operative procedure

AND

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

a. purulent drainage from a drain that is placed into the organ/space (e.g., closed suction drainage system, open drain, T-tube drain, CT guided drainage)

b. organisms are identified from an aseptically-obtained fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).

c. an abscess or other evidence of infection involving the organ/space that is detected on gross anatomical or histopathologic exam, or imaging test

AND

meets at least **one** criterion for a specific organ/space infection site listed in Table 3 on page 172 of the 2025 NTDS Data Dictionary. These criteria are found in the Surveillance Definitions for Specific Types of Infections chapter.

A diagnosis of SSI must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

Osteomyelitis: (Consistent with the January 2016 CDC definition of Bone and Joint infection. Always use the most recent definition provided by the CDC.) Osteomyelitis must meet at least **one** of the following criteria:
1. Patient has organisms identified from bone by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not active surveillance culture/testing (ASC/AST).
2. Patient has evidence of osteomyelitis on gross anatomic or histopathologic exam.
3. Patient has at least **two** of the following localized signs or symptoms: fever (>38.0°C), swelling*, pain or tenderness*, heat*, or drainage*

And at least one of the following:

a. organisms identified from blood by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not active surveillance culture/testing (ASC/AST) in a patient with imaging test evidence suggestive of infection (e.g., x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for osteomyelitis).

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

* With no other recognized cause

A diagnosis of osteomyelitis must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

Pulmonary Embolism: A lodging of a blood clot in a pulmonary artery with subsequent obstruction of blood supply to the lung parenchyma. The blood clots usually originate from the deep leg veins or the pelvic venous system. Consider the condition present if the patient has a V-Q scan interpreted as high probability of pulmonary embolism or a positive pulmonary arteriogram or positive CT angiogram and/or a diagnosis of PE is documented in the patient's medical record. Must have occurred during the patient's initial stay at your hospital.

Pressure Ulcer: (Consistent with the National Pressure Ulcer Advisory Panel (NPUAP) 2014. Always use the most recent definition provided by the NPUAP.) A localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated. Equivalent to NPUAP Stages II-IV,

Unstageable/Unclassified, and suspected deep tissue injury. Documentation of pressure ulcer must be in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

Severe Sepsis: (Consistent with the American College of Chest Physicians and the Society of Critical Care Medicine October 2010. Always use the most recent definition provided by the American College of Chest Physicians and the Society of Critical Care Medicine.)
Severe sepsis: sepsis plus organ dysfunction, hypotension (low blood pressure), or hypoperfusion (insufficient blood flow) to one or more organs.
Septic shock: sepsis with persisting arterial hypotension or hypoperfusion despite adequate fluid resuscitation. A diagnosis of sepsis must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

Stroke/CVA: A focal or global neurological deficit of rapid onset and NOT present on admission. The patient must have at least one of the following symptoms:

- Change in level of consciousness
- Hemiplegia
- Hemiparesis
- Numbness or sensory loss affecting on side of the body
- Dysphasia or aphasia
- Hemianopia
- Amaurosis fugax
- Other neurological signs or symptoms consistent with stroke

AND:

- Duration of neurological deficit ≥24 h

OR:

- Duration of deficit <24 h, if neuroimaging (MR, CT, or cerebral angiography) documents a new hemorrhage or infarct consistent with stroke, or therapeutic intervention(s) were performed for stroke, or the neurological deficit results in death

AND:

- No other readily identifiable non-stroke cause, e.g., progression of existing traumatic brain injury, seizure, tumor, metabolic or pharmacologic etiologies, is identified

AND:

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

Although the neurologic deficit must not present on admission, risk factors predisposing to stroke (e.g., blunt cerebrovascular injury, dysrhythmia) may be present on admission. A diagnosis of Stroke/CVA must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

Superficial Incisional Surgical Site Infection: (Consistent with the January 2016 CDC defined SSI. Always use the most recent definition provided by the CDC.) Must meet the following criteria: Infection occurs within 30 days after any NHSN operative procedure (where day 1 = the procedure date)

AND

involves only skin and subcutaneous tissue of the incision

AND

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

a. purulent drainage from the superficial incision.

b. organisms identified from an aseptically-obtained specimen from the superficial incision or subcutaneous tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).

c. superficial incision that is deliberately opened by a surgeon, attending physician** or other designee and culture or non-culture-based testing is not performed.

AND

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

d. diagnosis of a superficial incisional SSI by the surgeon or attending physician** or other designer.

COMMENTS: There are two specific types of superficial incisional SSIs:

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

A diagnosis of SSI must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

Unplanned Admission to ICU: Patients admitted to the ICU after initial transfer to the floor, and/or patients with an unplanned return to the ICU after initial ICU discharge. Must have occurred during the patient's initial stay at your hospital. EXCLUDE patients in which ICU care was required for postoperative care of a planned surgical procedure.

Unplanned Intubation: Patient requires placement of an endotracheal tube and mechanical or assisted ventilation because of the onset of respiratory or cardiac failure manifested by severe respiratory distress, hypoxia, hypercarbia, or respiratory acidosis. In patients who were intubated in the element or Emergency Department, or those intubated for surgery, unplanned intubation occurs if they require reintubation > 24 hours after extubating. Must have occurred during the patient's initial stay at your hospital.

Unplanned Return to the Operating Room: Unplanned return to the operating room after initial operation management for a similar or related previous procedure. Must have occurred during the patient's initial stay at your hospital.

Ventilator-Associated Pneumonia (VAP): (Consistent with the January 2016 CDC defined VAP. Always use the most recent definition provided by the CDC.) A pneumonia where the patient is on mechanical ventilation for > 2 calendar days on the date of event, with day of ventilator placement being Day 1,
AND
The ventilator was in place on the date of event or the day before. If the patient is admitted or transferred into a facility on a ventilator, the day of admission is considered Day 1.
Note: Refer to VAP algorithms on pages 196-209 of the 2025 NTDS Data Dictionary.

A diagnosis of Pneumonia must be documented in the patient's medical record and must have occurred during the patient's initial stay at your hospital.

Occupation and Industry Terms

Patient's Occupational Industry: The occupational history associated with the patient's work environment.

Value Elements and Definitions

Finance and Insurance - The finance and insurance sector comprises establishments primarily engaged in financial transactions (transactions involving the creation, liquidation, or change in ownership of financial assets) and/or in facilitating financial transactions. Three principal types of activities are identified:

- Raising funds by taking deposits and/or issuing securities and, in the process, incurring liabilities.
- Pooling of risk by underwriting insurance and annuities.
- Providing specialized services facilitating or supporting financial intermediation, insurance, and employee benefit programs.

Real Estate - Industries in the real estate subsector group establishments that are primarily engaged in renting or leasing real estate to others; managing real estate for others; selling, buying, or renting real estate for others; and providing other real estate related services, such as appraisal services.

Manufacturing - The manufacturing sector comprises establishments engaged in the mechanical, physical, or chemical transformation of materials, substances, or components into new products. Establishments in the manufacturing sector are often described as plants, factories, or mills and characteristically use power-driven machines and materials-handling equipment. However, establishments that make new products by hand, such as bakeries, candy stores, and custom tailors, may also be included in this sector.

Retail Trade - The retail trade sector comprises establishments engaged in retailing merchandise, generally without transformation, and rendering services incidental to the sale of merchandise. The retailing process is the final step in the distribution of merchandise; retailers are, therefore, organized to sell merchandise in small quantities to the general public. This sector comprises two main types of retailers:

- Store retailers operate fixed point-of-sale locations, located, and designed to attract a high volume of walk-in customers.
- Non-store retailers, like store retailers, are organized to serve the general public, but their retailing methods differ.

Transportation and Public Utilities - The transportation and warehousing sector

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

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

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

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

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

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

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

Information Services - The information sector comprises establishments engaged in the following processes: (a) producing and distributing information and cultural products, (b) providing the means to transmit or distribute these products as well as data or communications, and (c) processing data.

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

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

Other Services - The other services sector comprises establishments engaged in providing services not specifically provided for elsewhere in the classification system.

Establishments in this sector are primarily engaged in activities, such as equipment and machinery repairing, promoting, or administering religious activities, grantmaking, advocacy,

Patient's Occupation: The occupation of the patient.

Element Value Definitions:

Business and Financial Operations Occupations - Buyers and purchasing agents, accountants and auditors, claims adjusters, appraisers, examiners, and investigators; human resources workers, market research analysts and marketing specialists, business operations specialists

Architecture and Engineering Occupations - Landscape architects, surveyors, cartographers, and photogrammetrists; agricultural engineers, chemical engineers, civil engineers, electrical engineers

Community and Social Services Occupations - Marriage and family therapists, substance abuse and behavioral disorder counselors, healthcare social workers, probation officers, and correctional treatment specialists, clergy

Education, Training, and Library Occupations - Engineering and architecture teachers, postsecondary math and computer teachers, postsecondary nursing instructors and teachers, postsecondary law, criminal justice, and social work teachers; postsecondary preschool and kindergarten teachers, librarians

Healthcare Practitioners and Technical Occupations - Dentists, all other specialists, dietitians and nutritionists, physicians and surgeons, nurse practitioners, cardiovascular technologists and technicians, emergency medical technicians and paramedics

Protective Service Occupations – Firefighters, police officers, animal control workers, security guards, lifeguards, ski patrol, and other recreational protective service

Building and Grounds Cleaning and Maintenance - Building cleaning workers, landscaping and groundskeeping workers, pest control workers, pesticide handlers, sprayers and applicators, vegetation, tree trimmers and pruners.

Sales and Related Occupations - Advertising sales agents, retail salespersons, counter and rental clerks, door-to-door sales workers, news and street vendors and related workers, real estate brokers

Farming, Fishing, and Forestry Occupations - Animal breeders, fishers and related fishing workers, agricultural equipment operators, hunters and trappers, forest and conservation workers, logging workers

Installation, Maintenance, and Repair Occupations - Electric motor, power tool, and related repairers; aircraft mechanics and service technicians, automotive glass installers and repairers; heating, air conditioning, and refrigeration mechanics and installers; maintenance workers, machinery and industrial machinery installation, repair, and maintenance

Transportation and Material Moving Occupations - Rail transportation workers, all other subway and streetcar operators; packers and packagers, hand refuse and recyclable material collectors, material moving workers, all other driver/sales workers

Management Occupations - Public relations and fundraising managers, marketing and sales managers, administrative services managers; transportation, storage, and distribution managers, food service managers

Computer and Mathematical Occupations - Computer occupations, all other web developers, software developers and programmers, database administrators, statisticians

Life, Physical, and Social Science Occupations – Psychologists, economists, foresters, zoologists and wildlife biologists, political scientists, agricultural and food science technicians

Legal Occupations - Lawyers and judicial law clerks, paralegals and legal assistants, court reporters, administrative law judges, adjudicators, and hearing officers; arbitrators, mediators, and conciliators; title examiners, abstractors, and searchers

Arts, Design, Entertainment, Sports, and Media - Artists and related workers, all other athletes, coaches, umpires, and related workers; dancers and choreographers, reporters and correspondents, interpreters and translators, photographers

Healthcare Support Occupations - Nursing, psychiatric, and home health aides; physical therapist assistants and aides, veterinary assistants and laboratory animal caretakers, healthcare support workers, and all other medical assistants

Food Preparation and Serving-Related – Bartenders, cooks, institution and cafeteria cooks, fast food dishwashers, counter attendants; cafeteria, food concession, and coffee shop waiters and waitresses

Personal Care and Service Occupations - Animal trainers, amusement and recreation attendants, barbers, hairdressers, hairstylists and cosmetologists; baggage porters, bellhops; concierges tour guides and escorts; recreation and fitness workers

Office and Administrative Support Occupations - Bill and account collectors, gaming cage workers, payroll and timekeeping clerks, tellers; court, municipal, and license clerks; hotel, motel, and resort desk clerks

Construction and Extraction Occupations - Brick masons, block masons, and stonemasons; carpet, floor, and tile installers and finishers; construction laborers, electricians, pipelayers, plumbers, pipefitters, and steamfitters; roofers

Production Occupations - Electrical, electronics, and electromechanical assemblers; engine and other machine assemblers, structural metal fabricators, and fitters; butchers and meat cutters, machine tool cutting setters, operators, and tenders; metal and plastic welding, soldering, and brazing workers

Military-Specific Occupations - Air crew officers, armored assault vehicle officers, artillery and missile officers, infantry officers, military officer, special and tactical operations leaders

All Other Occupations - Dry cleaning and laundry services, personal care services, and death care services; pet care services, photofinishing services, temporary parking services, dating services, etc.

Foreign Visitor - Any person visiting a country other than his/her usual place of residence for any reason

Intermediate Care Facility - A facility providing a level of medical care that is less than the degree of care and treatment that a hospital or skilled nursing facility is designed to provide but greater than the level of room and board

Home Health Service - A certified service approved to provide care received at home as part-time skilled nursing care, speech therapy, physical or occupational therapy or part-time services of home health aides

Homeless - A person who lacks housing. The definition also includes a person living in transitional housing or a supervised public or private facility providing temporary living quarters.

Hospice - An organization which is primarily designed to provide pain relief, symptom management and supportive services for the terminally ill and their families

Migrant Worker - A person who temporarily leaves his/her principal place of residence within a country to accept seasonal employment in the same or different country.

Operative and/or Essential Procedures - Procedures performed in the Operating Room, Emergency Department, or Intensive Care Unit that were essential to the diagnoses, stabilization, or treatment of the patient's specific injuries. Repeated diagnostic procedures (e.g., repeated CT scan) should not be recorded (record only the first procedure).

Skilled Nursing Care - Daily nursing and rehabilitative care that is performed only by or under the supervision of skilled professional or technical personnel. Skilled care includes administering medication, medical diagnosis and minor surgery.

Undocumented Citizen - A national of another country who has entered or stayed in another country without permission

Appendix 4: Acronyms

- AIS: Abbreviated Injury Scale
- CDC: Centers for Disease Control and Prevention
- CPR: Cardiopulmonary resuscitation
- CT: Computerized tomography
- ED: Emergency department
- EMS: Emergency medical service
- GCS: Glasgow Coma Scale
- ICD-10: International Classification of Diseases, Tenth Revision
- ICD-10-CA: International Classification of Diseases, Tenth Revision, Canada
- ICD-10-CM: International Classification of Diseases, Tenth Revision, Clinical Modification
- ICD-10-PCS: International Classification of Diseases, Tenth Revision, Procedure Coding System
- ICU: Intensive care unit
- LOS: Length of stay
- NA: Not applicable
- NEMSIS: National Emergency Medical Services Information System
- NK/NR: Not known/not recorded
- NTDB: National Trauma Data Bank
- NTDS: National Trauma Data Standard
- OR: Operating room
- PACU: Post-anesthesia care unit
- TQIP: Trauma quality improvement program
- TQP: Trauma quality programs

Appendix 5: Indiana and NTDS Trauma Data Elements Comparison Table

Data Element Name	Required Element	Element Type	Page in 2025 NTDS Dictionary	Page in IDOH Dictionary
Demographic Information				
MEDICAL RECORD #	No	State		23
ACCOUNT NUMBER	No	State		24
PATIENT'S LAST NAME	No	State		25
PATIENT'S FIRST NAME	No	State		26
PATIENT'S MIDDLE INITIAL	No	State		27
PATIENT'S SOCIAL SECURITY #	No	State		28
DATE OF BIRTH	Yes	National & State	7	29
AGE (at date of incident)	Yes	National & State	8	30
AGE UNITS	Yes	National & State	9	31
RACE	Yes	National & State	10	32
OTHER RACE	No	State		33
ETHNICITY	Yes	National & State	11	34
SEX	Yes	National & State	12	35
HEIGHT	Yes	National & State	58	36
WEIGHT	Yes	National & State	59	37
PATIENT'S HOME ADDRESS	No	State		38
ADDRESS LINE 2	No	State		39
PATIENT'S HOME COUNTRY	Yes	National & State	2	40
PATIENT'S HOME ZIP/POSTAL CODE	Yes	National & State	1	41
PATIENT'S HOME CITY	Yes	National & State	5	42
PATIENT'S HOME COUNTY	Yes	National & State	4	43
PATIENT'S HOME STATE	Yes	National & State	3	44
PATIENT'S ALTERNATE RESIDENCE	Yes	National & State	6	45
PRIMARY METHOD OF PAYMENT	Yes	National & State	218	46
OTHER BILLING SOURCE	No	State		47
REIMBURSED CHARGES	No	State		48
SECONDARY METHOD OF PAYMENT	No	State		49
SECONDARY OTHER BILLING SOURCE	No	State		50
THIRD METHOD OF PAYMENT	No	State		51

Data Element Name	Required Element	Element Type	Page in 2025 NTDS Dictionary	Page in IDOH Dictionary
THIRD OTHER BILLING SOURCE	No	State		52
BILLED HOSPITAL CHARGES	No	State		53
WORK-RELATED	Yes	National & State	17	54
PATIENT'S OCCUPATIONAL INDUSTRY	Yes	National & State	18	55
PATIENT'S OCCUPATIONAL INDUSTRY DESCRIPTION	No	State		56
PATIENT'S OCCUPATION	Yes	National & State	19	57
PATIENT'S OCCUPATION DESCRIPTION	No	State		58
Injury Information				
INJURY INCIDENT DATE	Yes	National & State	15	60
INJURY INCIDENT TIME	Yes	National & State	16	61
INCIDENT LOCATION ZIP/POSTAL CODE	Yes	National & State	23	62
INCIDENT COUNTRY	Yes	National & State	24	63
INCIDENT CITY	Yes	National & State	27	64
INCIDENT COUNTY	Yes	National & State	26	65
INCIDENT STATE	Yes	National & State	25	66
ICD-10 LOCATION CODE	Yes	National & State	21	67
(Complaint) SUPPLEMENTAL CAUSE OF INJURY	No	State		68
INJURY DESCRIPTION	No	State		69
ICD-10 PRIMARY EXTERNAL CAUSE CODE	Yes	National & State	20	70
ICD-10 ADDITIONAL EXTERNAL CAUSE CODE	Yes	National & State	22	72
ICD-10 INTENTIONALITY	No	State		73
ICD-10 TRAUMA TYPE	No	State		74
BARRIERS TO PATIENT CARE	No	State		75
Pre-hospital Information				
ARRIVED FROM	No	State		77
TRANSPORTED TO YOUR FACILITY BY (EMS Transport Party)	Yes	National & State	31	78
OTHER TRANSPORT MODE	No	National & State	32	79
INTER-FACILITY TRANSFER	Yes	National & State	34	80
INTUBATION PRIOR TO ARRIVAL	Yes	National & State	36	81

Data Element Name	Required Element	Element Type	Page in 2025 NTDS Dictionary	Page in IDOH Dictionary
INTUBATION LOCATION	Yes	National & State	37	82
MASS CASUALTY INCIDENT	No	State		83
PREGNANCY	No	State		84
ESTIMATED BODY WEIGHT (Initial ED/Hospital Weight)	Yes	State		85
LAW ENFORCEMENT / CRASH REPORT NUMBER	No	State		86
VEHICULAR INJURY INDICATORS	No	State		87
SEAT ROW LOCATION (of Patient in Vehicle)	No	State		88
POSITION OF PATIENT (in the seat of the vehicle)	No	State		89
HEIGHT OF FALL IN FEET	No	State		90
TRAUMA TRIAGE CRITERIA (Steps 1 and 2)	Yes	State		91
TRAUMA TRIAGE CRITERIA (Steps 3 and 4)	Yes	State		92
PROTECTIVE DEVICES (Safety Device Used)	Yes	National & State	28	93
CHILD SPECIFIC RESTRAINT	Yes	National & State	29	93
SAFETY (Equipment) DESCRIPTION	No	State		96
EMS RUN NUMBER	No	State		97
EMS PATIENT CARE REPORT (PCR) NUMBER	No	State		98
NAME OF EMS SERVICE	No	State		99
EMS DISPATCH DATE	Yes	State		100
EMS DISPATCH TIME	Yes	State		101
(EMS Unit) ARRIVAL DATE AT SCENE OR TRANSFERRING FACILITY	Yes	State		102
(EMS Unit) ARRIVAL TIME AT SCENE OR TRANSFERRING FACILITY	Yes	State		103
(EMS Unit) DEPARTURE DATE FROM SCENE OR TRANSFERRING FACILITY	Yes	State		104

Data Element Name	Required Element	Element Type	Page in 2025 NTDS Dictionary	Page in IDOH Dictionary
(EMS Unit) DEPARTURE TIME FROM SCENE OR TRANSFERRING FACILITY	Yes	State		105
UNIT ARRIVED HOSPITAL DATE	No	State		106
UNIT ARRIVED HOSPITAL TIME	No	State		107
EMS PATIENT CARE REPORT UNIVERSALLY UNIQUE IDENTIFIER (UUID)	No	National & State	33	108
(Pre-Hospital) DESTINATION DETERMINATION	No	State		109
TRIAGE DESTINATION PROTOCOL	No	State		110
TRIAGE CRITERIA	No	State		111
(Pre-Hospital Thoracentesis) / TUBE THORACOSTOMY	No	State		112
(Pre-Hospital) CPR PERFORMED	No	State		113
EMS STATUS	No	State		114
PRE-HOSPITAL CARDIAC ARREST	Yes	National & State	35	115
(Pre-Hospital) NEEDLE THORACOSTOMY	No	State		116
(Pre-Hospital) AIRWAY MANAGEMENT	No	State		117
(Pre-Hospital) FLUIDS	No	State		118
(Pre-Hospital) MEDICATIONS	No	State		119
(Pre-Hospital) VITALS DATE	No	State		120
(Pre-Hospital) VITALS TIME	No	State		121
INITIAL FIELD GCS - EYE	Yes	State		122
INITIAL FIELD GCS - VERBAL	Yes	State		123
INITIAL FIELD GCS - MOTOR	Yes	State		124
(Initial Field) GCS QUALIFIER (UP TO 3)	No	State		125
(Initial Field) SYSTOLIC BLOOD PRESSURE	Yes	State		126
(Initial Field) DIASTOLIC BLOOD PRESSURE	No	State		127
(Initial Field) PULSE RATE	Yes	State		128
(Initial Field) RESPIRATORY RATE	Yes	State		129

Data Element Name	Required Element	Element Type	Page in 2025 NTDS Dictionary	Page in IDOH Dictionary
(Initial Field) SP02 (Oxygen Saturation)	Yes	State		130
INITIAL FIELD GCS - TOTAL	Yes	State		131
INITIAL FIELD GCS 40- EYE	Yes	State		132
INITIAL FIELD GCS 40- VERBAL	Yes	State		133
INITIAL FIELD GCS 40- MOTOR	Yes	State		134
(Pre-Hospital Revised Trauma Score) RTS (Total)	No	State		135
(Pre-Hospital) RESPIRATORY ASSISTANCE	No	State		136
Referring Hospital Information				
TRANSPORTED TO REFERRING FACILITY BY	No	State		138
REFERRING HOSPITAL NAME	No	State		139
REFERRING HOSPITAL ARRIVAL DATE	No	State		140
REFERRING HOSPITAL ARRIVAL TIME	No	State		141
REFERRING HOSPITAL DISCHARGE DATE	No	State		142
REFERRING HOSPITAL PHYSICIAN NAME	No	State		144
REFERRING HOSPITAL VITALS DATE	No	State		145
(Referring Hospital) GCS - MOTOR	No	State		146
(Referring Hospital) GCS - EYE	No	State		150
(Referring Hospital) GCS - VERBAL	No	State		148
(Referring Hospital) GCS ASSESSMENT QUALIFIERS (UP TO 3)	No	State		149
(Referring Hospital) MANUAL GCS TOTAL	No	State		150
(Referring Hospital) TEMPERATURE	No	State		151
(Referring Hospital) SYSTOLIC BLOOD PRESSURE	No	State		152
(Referring Hospital) PULSE RATE	No	State		153

Data Element Name	Required Element	Element Type	Page in 2025 NTDS Dictionary	Page in IDOH Dictionary
(Referring Hospital) RESPIRATORY RATE	No	State		154
(Referring Hospital) SP02 (Oxygen Saturation)	No	State		155
(Referring Hospital Revised Trauma Score) MANUAL RTS	No	State		156
(Referring Hospital) Supplemental Oxygen	No	State		157
(Referring) HOSPITAL ICU	No	State		158
(Referring) HOSPITAL OR	No	State		159
(Referring) CPR PERFORMED	No	State		160
(Referring Hospital) CT HEAD (Results)	No	State		161
(Referring Hospital) CT CERVICAL (Results)	No	State		162
(Referring Hospital) CT ABD/PELVIS (Results)	No	State		163
(Referring Hospital) CT CHEST (Results)	No	State		164
(Referring Hospital) ABDOMINAL ULTRASOUND (Results)	No	State		165
(Referring Hospital) AORTOGRAM (Results)	No	State		166
(Referring Hospital) AIRWAY MANAGEMENT	No	State		167
(Referring Hospital) MEDICATIONS	No	State		168
(Referring Hospital) DESTINATION DETERMINATION	No	State		169
ED/Acute Care Information				
DIRECT ADMIT TO HOSPITAL	No	State		171
DATE ARRIVED IN ED/ACUTE CARE	Yes	National & State	41	172
TIME ARRIVED IN ED/ACUTE CARE	Yes	National & State	42	173
TRAUMA TEAM ACTIVATED	No	State		174
HIGHEST ACTIVATION	Yes	National & State	38	175

Data Element Name	Required Element	Element Type	Page in 2025 NTDS Dictionary	Page in IDOH Dictionary
DATE TRAUMA TEAM ACTIVATED	No	State		176
TIME TRAUMA TEAM ACTIVATED	No	State		177
ADMITTING MD/STAFF	No	State		178
TEAM MEMBER	No	State		179
ADMITTING SERVICE	No	State		180
(Trauma Team Member) SERVICE TYPE	No	State		181
DATE (Trauma Team Member) CALLED	No	State		182
TIME (Trauma Team Member) CALLED	No	State		183
DATE (Trauma Team Member) ARRIVED	No	State		184
TIME (Trauma Team Member) ARRIVED	No	State		185
(Trauma Team) TIMELY ARRIVAL	No	State		186
TRAUMA SURGEON ARRIVAL DATE	Yes	National & State	39	187
TRAUMA SURGEON ARRIVAL TIME	Yes	National & State	40	188
CONSULTING SERVICES	No	State		189
CONSULTING STAFF	No	State		191
DATE (Consulting Practitioner Requested)	No	State		192
TIME (Consulting Practitioner Requested)	No	State		193
DATE DISCHARGED FROM ED (ORDERS WRITTEN)	Yes	National & State	64	194
TIME DISCHARGED FROM ED (ORDERS WRITTEN)	Yes	National & State	65	195
DATE DISCHARGED FROM ED (PHYSICAL EXIT)	Yes	State		196
TIME DISCHARGED FROM ED (PHYSICAL EXIT)	Yes	State		197
ED DISCHARGE DISPOSITION	Yes	National & State	63	198
DISCHARGE TRANSPORT MODE	Yes	State		199

Data Element Name	Required Element	Element Type	Page in 2025 NTDS Dictionary	Page in IDOH Dictionary
PRIMARY TRAUMA SERVICE TYPE	Yes	National & State	66	200
PRIMARY MEDICAL EVENT	Yes	National & State	67	201
TRANSFER DELAY	Yes	State		202
REASON FOR TRANSFER DELAY - Communication Issue	No	State		203
REASON FOR TRANSFER DELAY - Delay Issue	No	State		204
REASON FOR TRANSFER DELAY - EMS Issue	No	State		205
REASON FOR TRANSFER DELAY - Equipment Issue	No	State		206
REASON FOR TRANSFER DELAY - Error Issue	No	State		207
REASON FOR TRANSFER DELAY - Patient Issue	No	State		208
REASON FOR TRANSFER DELAY - Receiving Facility Issue	No	State		209
REASON FOR TRANSFER DELAY - Referring Facility Issue	No	State		210
REASON FOR TRANSFER DELAY - Transportation Issue	No	State		211
REASON FOR TRANSFER DELAY - Weather or Natural Issue	No	State		212
OTHER REASON FOR TRANSFER DELAY	No	State		213
Initial Assessment Information				
(Initial ED/Hospital) VITALS DATE	No	State		215
(Initial ED/Hospital) VITALS TIME	No	State		216
INITIAL ED/HOSPITAL SYSTOLIC BLOOD PRESSURE	Yes	National & State	43	217
INITIAL ED/HOSPITAL DIASTOLIC BLOOD PRESSURE	No	State		218
INITIAL ED/HOSPITAL PULSE RATE	Yes	National & State	44	219
INITIAL ED/HOSPITAL TEMPERATURE	Yes	National & State	45	220

Data Element Name	Required Element	Element Type	Page in 2025 NTDS Dictionary	Page in IDOH Dictionary
INITIAL ED/HOSPITAL TEMPERATURE ROUTE	No	State		221
INITIAL ED/HOSPITAL SP02 (Oxygen Saturation)	Yes	National & State	48	222
INITIAL ED/HOSPITAL RESPIRATORY RATE	Yes	National & State	46	223
INITIAL ED/HOSPITAL SUPPLEMENTAL OXYGEN	Yes	National & State	49	224
(Initial ED/hospital Revised Trauma Score) RTS (Total)	No	State		225
(Initial ED/hospital Pediatric Trauma Score) PTS (Total)	No	State		226
INITIAL ED/HOSPITAL GCS - EYE	Yes	National & State	50	227
INITIAL ED/HOSPITAL GCS - VERBAL	Yes	National & State	51	228
INITIAL ED/HOSPITAL GCS - MOTOR	Yes	National & State	52	229
INITIAL ED/HOSPITAL MANUAL GCS TOTAL	Yes	State		230
INITIAL ED/HOSPITAL GCS ASSESSMENT QUALIFIERS (UP TO 3)	Yes	National & State	54	231
INITIAL ED/HOSPITAL GCS 40 – EYE	Yes	National & State	55	233
INITIAL ED/HOSPITAL GCS 40 – VERBAL	Yes	National & State	56	234
INITIAL ED/HOSPITAL GCS 40 – MOTOR	Yes	National & State	57	235
INITIAL ED/HOSPITAL RESPIRATORY ASSISTANCE	Yes	National & State	47	237
INITIAL ED/HOSPITAL AIRWAY MANAGEMENT	No	State		238
INITIAL ED/HOSPITAL CPR PERFORMED	No	State		239
UNITS OF BLOOD	No	State		240
BLOOD ORDERED DATE	No	State		241
CROSSMATCH DATE	No	State		242
BLOOD ADMINISTERED DATE	No	State		243

Data Element Name	Required Element	Element Type	Page in 2025 NTDS Dictionary	Page in IDOH Dictionary
(Initial ED/Hospital) CT HEAD (Results)	No	State		244
(Initial ED/Hospital) CT ABD/PELVIS (Results)	No	State		245
(Initial ED/Hospital) CT CHEST (Results)	No	State		246
(Initial ED/Hospital) CT CERVICAL (Results)	No	State		247
(Initial ED/Hospital) DATE SENT TO CT	No	State		248
(Initial ED/Hospital) TIME SENT TO CT	No	State		249
(Initial ED/Hospital) ABDOMINAL ULTRASOUND DATE	No	State		250
(Initial ED/Hospital) ABDOMINAL ULTRASOUND TIME	No	State		251
(Initial ED/Hospital) ARTERIOGRAM (Results)	No	State		252
(Initial ED/Hospital) AORTOGRAM (Results)	No	State		253
ALCOHOL SCREEN	Yes	National & State	61	254
ALCOHOL SCREEN RESULTS (Blood Alcohol Content)	Yes	National & State	62	255
(Initial ED / Hospital) BASE DEFICIT	No	State		256
DRUG SCREEN	Yes	National & State	60	257
Diagnosis Information				
ICD-10 INJURY DIAGNOSIS	Yes	National & State	139	259
AIS CODE	Yes	National & State	140	260
AIS VERSION	Yes	National & State	141	261
ISS (Body) REGION	No	State		262
AIS BASED INJURY SEVERITY SCORES BY DIAGNOSIS	Yes	State		263
MANUAL (Locally Calculated ISS)	Yes	State		264
Pre-existing Conditions				
ADVANCED DIRECTIVE LIMITING CARE	Yes	National & State	72	266

Data Element Name	Required Element	Element Type	Page in 2025 NTDS Dictionary	Page in IDOH Dictionary
ALCOHOL USE DISORDER	Yes	National & State	74	267
ANTICOAGULANT THERAPY	Yes	National & State	76	268
ATTENTION DEFICIT DISORDER/ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADD/ADHD)	Yes	National & State	78	269
AUTISM SPECTRUM DISCORDER (ASD)	Yes	National & State	80	270
BIPOLAR I/II DISORDER	Yes	National & State	82	271
BLEEDING DISORDER	Yes	National & State	84	272
BRONCHOPULMONARY DYSPLASIA/CHRONIC LUNG DISEASE	Yes	National & State	86	273
CEREBRAL VASCULAR ACCIDENT (CVA)	Yes	National & State	88	274
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)	Yes	National & State	90	275
CHRONIC RENAL FAILURE	Yes	National & State	92	276
CIRRHOSIS	Yes	National & State	94	277
CONGENITAL ANOMALIES	Yes	National & State	96	278
CONGESTIVE HEART FAILURE (CHF)	Yes	National & State	98	279
CURRENT SMOKER	Yes	National & State	100	280
CURRENTLY RECEIVING CHEMOTHERAPY FOR CANCER	Yes	National & State	102	281
DEMENTIA	Yes	National & State	104	282
DIABETES MELLITUS	Yes	National & State	106	283
DISSEMINATED CANCER	Yes	National & State	108	284
FUNCTIONALLY DEPENDENT HEALTH STATUS	Yes	National & State	110	285
HYPERTENSION	Yes	National & State	112	286
MAJOR DEPRESSIVE DISORDER	Yes	National & State	114	287
MYOCARDIAL INFARCTION (MI)	Yes	National & State	116	288
OTHER MENTAL/PERSONALITY DISORDERS	Yes	National & State	118	289
PERIPHERAL ARTERIAL DISEASE (PAD)	Yes	National & State	120	290
POST-TRAUMATIC STRESS DISORDER	Yes	National & State	122	291

Data Element Name	Required Element	Element Type	Page in 2025 NTDS Dictionary	Page in IDOH Dictionary
PREGNANCY	Yes	National & State	124	292
PREMATURITY	Yes	National & State	126	293
SCHIZOAFFECTIVE DISORDER	Yes	National & State	128	294
SCHIZOPHRENIA	Yes	National & State	130	295
STEROID USE	Yes	National & State	132	296
SUBSTANCE USE DISORDER	Yes	National & State	134	297
CO-MORBID CONDITION NOTES	No	State		300
Procedures Information				
ICD-10 HOSPITAL PROCEDURES	Yes	National & State	68	302
PROCEDURE PERFORMED	No	State		304
(Procedure Performed) LOCATION	No	State		305
(Hospital Procedure) DATE PERFORMED	Yes	National & State	70	306
(Hospital Procedure Start) TIME PERFORMED	Yes	National & State	71	307
(Physician Performing the Procedure) STAFF	No	State		308
SERVICE TYPE (of the Physician)	No	State		309
(Procedure) COMMENTS	No	State		310
RESOURCE UTILIZATION	No	State		311
Hospital Events				
ACUTE KIDNEY INJURY (AKI)	Yes	National & State	142	313
ACUTE RESPIRATORY DISTRESS SYNDROME (ARDS)	Yes	National & State	144	315
ALCOHOL WITHDRAWAL SYNDROME	Yes	National & State	147	316
CARDIAC ARREST WITH CPR	Yes	National & State	149	317
CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI)	Yes	National & State	151	318
CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION (CLABSI)	Yes	National & State	155	320
DEEP SURGICAL SITE INFECTION	Yes	National & State	160	323
DEEP VEIN THROMBOSIS (DVT)	Yes	National & State	165	325

Data Element Name	Required Element	Element Type	Page in 2025 NTDS Dictionary	Page in IDOH Dictionary
DELIRIUM	Yes	National & State	167	326
MYOCARDIAL INFARCTION (MI)	Yes	National & State	169	327
ORGAN/SPACE SURGICAL SITE INFECTION	Yes	National & State	171	328
OSTEOMYELITIS	Yes	National & State	175	330
PRESSURE ULCER	Yes	National & State	177	332
PULMONARY EMBOLISM (PE)	Yes	National & State	179	333
SEVERE SEPSIS	Yes	National & State	181	334
STROKE/CVA	Yes	National & State	183	335
SUPERFICIAL INCISIONAL SURGICAL SITE INFECTION	Yes	National & State	187	337
UNPLANNED ADMISSION TO ICU	Yes	National & State	190	339
UNPLANNED INTUBATION	Yes	National & State	192	340
UNPLANNED VISIT TO THE OPERATING ROOM	Yes	National & State	194	341
VENTILATOR-ASSOCIATED PNEUMONIA (VAP)	Yes	National & State	196	342
Complications/Performance Improvement				
(Complication) STATUS	No	State		343
(Complication) OCCURRENCE DATE	No	State		345
(Complication) OCCURRENCE TIME	No	State		346
(Complication) LOCATION OF OCCURRENCE	No	State		347
(Complication) STAFF INVOLVED	No	State		348
(Complication) PR DATE	No	State		349
(Complication) PR TIME	No	State		350
(Complication) CORRECTIVE ACTION	No	State		351
(Complication) OTHER CORRECTIVE ACTION	No	State		352
(Complication) DETERMINATION	No	State		353
FURTHER EXPLANATION / ACTION (of Complication)	No	State		354
PREVENTABILITY (of Complication)	No	State		355

Data Element Name	Required Element	Element Type	Page in 2025 NTDS Dictionary	Page in IDOH Dictionary
JUDGMENT (of Complication)	No	State		356
(Complication Correspondence) STAFF	No	State		357
(Complication Correspondence) NOTE	No	State		358
(Complication Correspondence) SOURCE	No	State		359
(Complication Correspondence) TYPE	No	State		360
(Complication Correspondence) GROUP	No	State		361
(Performance Improvement) STATUS	No	State		362
(Performance Improvement) OCCURRENCE DATE	No	State		363
(Performance Improvement) OCCURRENCE TIME	No	State		364
(Performance Improvement) PR DATE	No	State		365
(Performance Improvement) PR TIME	No	State		366
FURTHER EXPLANATION / ACTION (of PI)	No	State		367
(PI Correspondence) STAFF	No	State		368
(PI Correspondence) NOTE	No	State		369
(PI Correspondence) SOURCE	No	State		370
(PI Correspondence) TYPE	No	State		371
(PI Correspondence) GROUP	No	State		372
Outcome Information				
HOSPITAL DISCHARGE SERVICE	No	State		374
HOSPITAL ADMISSION DATE	No	State		375
HOSPITAL ADMISSION TIME	No	State		376
HOSPITAL DISCHARGE DATE (ORDERS WRITTEN)	Yes	National & State	216	377
HOSPITAL DISCHARGE TIME (ORDERS WRITTEN)	Yes	National & State	217	378
HOSPITAL DISCHARGE DATE (PHYSICAL EXIT)	No	State		379
HOSPITAL DISCHARGE TIME (PHYSICAL EXIT)	No	State		380

Data Element Name	Required Element	Element Type	Page in 2025 NTDS Dictionary	Page in IDOH Dictionary
TOTAL ICU DAYS	Yes	National & State	210	381
TOTAL VENTILATOR DAYS	Yes	National & State	212	382
DISABILITY AT DISCHARGE - FEEDING	No	State		383
DISABILITY AT DISCHARGE - LOCOMOTION	No	State		384
DISABILITY AT DISCHARGE - EXPRESSION (MOTOR)	No	State		385
HOSPITAL DISCHARGE DISPOSITION	Yes	National & State	214	386
HOSPITAL TRANSFERRED TO	No	State		388
(Other) FACILITY (Transferred to)	No	State		389
(Other) CITY (Transferred to)	No	State		390
(Other) STATE (Transferred to)	No	State		391
(Discharge) TRANSPORT MODE	No	State		392
DISABILITY AT DISCHARGE - FIM SCORE	No	State		393
LOCATION OF DEATH	No	State		394
DATE & TIME OF DEATH	No	State		395
DEATH CIRCUMSTANCE	No	State		396
OTHER (Death Circumstance) DESCRIPTION	No	State		397
ORGAN DONATION	No	State		398
AUTOPSY PERFORMED	No	State		399
ADVANCED DIRECTIVE	No	State		400
Trauma Quality Improvement Program (TQIP) Measures (Trauma Levels I and II Only)				
HIGHEST GCS TOTAL	No	National & State	219	402
HIGHEST GCS MOTOR	No	National & State	222	403
GCS ASSESSMENT QUALIFIER OF HIGHEST GCS TOTAL	No	National & State	225	404
HIGHEST GCS 40 – MOTOR	No	National & State	228	406
INITIAL ED/HOSPITAL PUPILLARY RESPONSE	No	National & State	231	408
MIDLINE SHIFT	No	National & State	233	409
CEREBRAL MONITOR	No	National & State	235	410
CEREBRAL MONITOR DATE	No	National & State	237	411
CEREBRAL MONITOR TIME	No	National & State	239	412

Data Element Name	Required Element	Element Type	Page in 2025 NTDS Dictionary	Page in IDOH Dictionary
VENOUS THROMBOEMBOLISM PROPHYLAXIS TYPE	No	National & State	241	413
VENOUS THROMBOEMBOLISM PROPHYLAXIS DATE	No	National & State	243	414
VENOUS THROMBOEMBOLISM PROPHYLAXIS TIME	No	National & State	245	415
PACKED RED BLOOD CELLS	No	National & State	247	416
WHOLE BLOOD	No	National & State	249	417
PLASMA	No	National & State	251	418
PLATELETS	No	National & State	253	419
CRYOPRECIPITATE (4 HOURS)	No	National & State	255	420
ANGIOGRAPHY	No	National & State	257	421
EMBOLIZATION SITE	No	National & State	259	422
ANGIOGRAPHY DATE	No	National & State	261	423
ANGIOGRAPHY TIME	No	National & State	263	424
SURGERY FOR HEMORRHAGE CONTROL TYPE	No	National & State	265	425
SURGERY FOR HEMORRHAGE CONTROL DATE	No	National & State	267	426
SURGERY FOR HEMORRHAGE CONTROL TIME	No	National & State	269	427
WITHDRAWAL OF LIFE SUPPORTING TREATMENT	No	National & State	271	428
WITHDRAWAL OF LIFE SUPPORTING TREATMENT DATE	No	National & State	273	429
WITHDRAWAL OF LIFE SUPPORTING TREATMENT TIME	No	National & State	275	430
ANTIBIOTIC THERAPY	No	National & State	277	431
ANTIBIOTIC THERAPY DATE	No	National & State	279	432
ANTIBIOTIC THERAPY TIME	No	National & State	281	433
Surgeon-specific Reporting (Optional)				
NATIONAL PROVIDER IDENTIFIER (NPI)	No	National & State	283	435