PARAMEDIC TRANSPORT / HOSPITAL DISCHARGE DATA REPORT

I. AUTHORITY:

Policy #600.00, Section III, A-10: "Participation in data collection and evaluative studies conducted by Orange County Emergency Medical Services (OCEMS).

II. APPLICATION:

This policy establishes the procedure for the appropriate completion of the OCEMS Paramedic Transport/ Hospital Discharge Data Report.

III. DEFINITIONS:

"**Emergency Department Disposition Codes**" means those patient events that occur within the emergency department (ED).

"**Hospital Disposition Codes**" means those patient events that pertain to the in-patient (hospital admission) intervention.

"**Prehospital Care Log Number**" means the unique twelve (12) digit number assigned by a base hospital to identify each patient contact by an EMT-P.

IV. GENERAL:

A. The OCEMS Paramedic Transport/Hospital Discharge Data (PTHDD) report shall document each patient **ASSESSED IN THE FIELD BY AN EMT-P** and transported to a receiving hospital by an EMT-P, air ambulance service, or BLS transport.

B. The PTHDD report is due to the OCEMS office within sixty (60) days after the close of the current month.

C. The Prehospital Care Report is a legal document and shall be included in the patient's permanent medical record.

V. PROCEDURE:

A. Hospital/Date:

1. State the name of the hospital filing the report**.**

2. Record the month and year related to the patient event represented in the report.

B. Emergency Department Information:

Column 1: Record the 12 digit Prehospital Care Report log number. The identifying number represents the following data:

05	87	01	12	05	01
Base Hospital	Year	Month	Day	Paramedic Run	Patient No.

- In the absence of a log number use the date to identify the "no base hospital contact" EMT-P transported patient.

Column 2: Record the hospital's medical record number. (NOTE: This number will be referenced when the OCEMS requests individual patient hospital admission information.)

Column 3: Record the time the patient was admitted to the ED.

Column 4: Record the age of the patient.

Column 5: Check the appropriate box:

M (Male) F (Female).

Column 6: Record **one** applicable ED "Disposition Code Number":

01 General Medical/Surgical Admits (includes: Sub ICU, Step Down, Observation Unit, Etc.)
02 DOA or Died in E.D.
03 ICU
04 CCU
05 Burn Unit
06 Pediatric/Neonatal ICU
07 Trauma Unit
08 Acute Spinal Cord Unit
09 Acute Psychiatric Unit
10 Alcohol Detox. Unit
11 Drug Detox. Unit
12 Obstetrics

Record **one** applicable "transfer code number" transfers from the E.D. to another medical facility unit.

13 ICU
14 CCU
15 Burn Unit
16 Pediatric/Neonatal ICU
17 Trauma Center
18 Acute Spinal Cord Unit
19 Acute Psychiatric Unit
20 Alcohol Detox. Unit
21 Drug Detox. Unit
22 Obstetrics Unit
23 Neurosurgical Center
24 Other (patient or MD request)

Column 7: Use the comment column if needed to clarify the documented code. (e.g., Code 24 "other" clarification.)

- Use Code 25 (not on code list) in the comments column to indicate that the patient was examined and/or treated, then discharged from the E.D. (treated and released).
- Use AMA to indicate that a patient left against medical advice.

C. Medical Records Department Information:

Column 8: Fill in the date the patient was discharged, expired or was transferred.

NOTE: When the patient's final ICD-9 is not available due to the length of stay being greater than 60 days, complete the report with a explanation, (e.g., "Patient in house).

Column 9: Use the following medical record department, (hospital disposition codes) to identify the patient disposition.

01 Discharged home
02 Died in hospital
03 Transferred to an acute care hospital
04 Other (includes non-acute i.e., rehab., jail ward, nursing home, etc.)

Column 10: Use the comment column as needed for clarification of the documented code.

- Example: 03 and name of hospital
- This column may also be used to record additional pertinent information.

Column 11: Indicate the primary ICD-9 code for all patients including those patients who were transferred or died. Primary ICD-9 is not required for treated and released patients.

D. Code "00": This code may be used by either the ED or medical record department when the disposition of the patient is not available.