

FORM **HDS-1**  
(10-31-2006)

U.S. DEPARTMENT OF COMMERCE  
Economics and Statistics Administration  
U.S. CENSUS BUREAU  
ACTING AS COLLECTING AGENT FOR  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR DISEASE CONTROL AND PREVENTION  
NATIONAL CENTER FOR HEALTH STATISTICS

**012345**

# MEDICAL ABSTRACT NATIONAL HOSPITAL DISCHARGE SURVEY

**Notice** – All information which would permit identification of an individual or an establishment will be held confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to other persons or used for any other purpose. Public reporting burden of this collection of information is estimated to average 4 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0212).

## A. PATIENT IDENTIFICATION

<b>1.</b> Hospital number . . . . .	<input type="text"/>	<b>4.</b> Date of admission . . . . .	Month <input type="text"/> <input type="text"/> – Day <input type="text"/> <input type="text"/> – Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<b>2.</b> HDS number . . . . .	<input type="text"/>	<b>5.</b> Date of discharge . . . . .	Month <input type="text"/> <input type="text"/> – Day <input type="text"/> <input type="text"/> – Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<b>3.</b> (Item deleted)		<b>6.</b> Residence ZIP Code . . . . .	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

## B. PATIENT CHARACTERISTICS

<b>7.</b> Date of birth	Month <input type="text"/> <input type="text"/> – Day <input type="text"/> <input type="text"/> – Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<b>11.</b> Race – <i>Mark all that apply</i>
<b>8.</b> Age – Complete only if date of birth not given	Units <input type="text"/> <input type="text"/> <input type="text"/> { 1 <input type="checkbox"/> Years, 2 <input type="checkbox"/> Months, 3 <input type="checkbox"/> Days	
<b>9.</b> Sex – <i>Mark (X) one</i>	1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female 3 <input type="checkbox"/> Not stated	4 <input type="checkbox"/> Asian
<b>10.</b> Ethnicity – <i>Mark (X) one</i>	1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino 3 <input type="checkbox"/> Not stated	5 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander
		6 <input type="checkbox"/> Other – <i>Specify</i> <input type="text"/>
		7 <input type="checkbox"/> Not stated
		<b>12.</b> Marital status – <i>Mark (X) one</i>
		1 <input type="checkbox"/> Married 2 <input type="checkbox"/> Single 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced 5 <input type="checkbox"/> Separated 6 <input type="checkbox"/> Not stated

## C. ADMINISTRATIVE INFORMATION

<b>13.</b> Type of Admission – <i>Mark (X) one</i>	1 <input type="checkbox"/> Emergency 2 <input type="checkbox"/> Urgent 3 <input type="checkbox"/> Elective 4 <input type="checkbox"/> Newborn 5 <input type="checkbox"/> Items not available/unknown	<b>16.</b> Expected source(s) of payment	Principal	Other additional sources	
<b>14.</b> Source of Admission – <i>Mark (X) one</i>	1 <input type="checkbox"/> Physician referral 2 <input type="checkbox"/> Clinical referral 3 <input type="checkbox"/> HMO referral 4 <input type="checkbox"/> Transfer from a hospital 5 <input type="checkbox"/> Transfer from SNF 6 <input type="checkbox"/> Transfer from other health facility 7 <input type="checkbox"/> Emergency room 8 <input type="checkbox"/> Court/Law enforcement 9 <input type="checkbox"/> Other – <i>Specify</i> <input type="text"/> 10 <input type="checkbox"/> Item not available		<i>Mark one only</i>	<i>Mark all that apply</i>	
<b>15.</b> Status/Disposition of patient – <i>Mark (X) appropriate box(es)</i>	Status 1 <input type="checkbox"/> Alive 2 <input type="checkbox"/> Died 3 <input type="checkbox"/> Status not stated	Disposition a. <input type="checkbox"/> Routine discharge/discharged home b. <input type="checkbox"/> Left against medical advice c. <input type="checkbox"/> Discharged, transferred to another short-term hospital d. <input type="checkbox"/> Discharged, transferred to long-term care institution e. <input type="checkbox"/> Other disposition/not stated	1. Worker's compensation . . . . . 2. Medicare . . . . . 3. Medicaid . . . . . 4. Other government payments . . . . . 5. Blue Cross/Blue Shield . . . . . 6. HMO/PPO . . . . . 7. Other private or commercial insurance . . . . . 8. Self pay . . . . . 9. No charge . . . . . 10. Other – <i>Specify</i> <input type="text"/> <input type="checkbox"/> No source of payment indicated	<input type="checkbox"/>	<input type="checkbox"/>

(Over)

**D. MEDICAL INFORMATION**

**17. Admitting Diagnosis**

Admitting diagnosis	ICD-9-CM Code	Description

**18. Final diagnoses** (up to 7 diagnoses including E-codes) *(Enter ICD-9-CM codes as well as narrative if available.)*

Diagnosis	ICD-9-CM Code	Description	Present on admission
Principal diagnosis			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Clinically undetermined <input type="checkbox"/> No information on face sheet
Diagnosis 2			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Clinically undetermined <input type="checkbox"/> No information on face sheet
Diagnosis 3			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Clinically undetermined <input type="checkbox"/> No information on face sheet
Diagnosis 4			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Clinically undetermined <input type="checkbox"/> No information on face sheet
Diagnosis 5			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Clinically undetermined <input type="checkbox"/> No information on face sheet
Diagnosis 6			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Clinically undetermined <input type="checkbox"/> No information on face sheet
Diagnosis 7			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Clinically undetermined <input type="checkbox"/> No information on face sheet

**19. Surgical and Diagnostic Procedures** (up to 4 procedures) *(Enter ICD-9-CM codes as well as narrative if available.)*

Procedure	ICD-9-CM Code	Description	Date of Procedure(s)		
			Month	Day	Year
Principal procedure					
Procedure 2					
Procedure 3					
Procedure 4					

**No procedures**

Comments

Completed by

Date