

Technical Specifications: Retrospective Data Collection Flowsheet

This form is intended to be used for patients who were discharged from the emergency department (ED) to ambulatory care (home/self care) or home health care, does not include patients that left against medical advice (AMA) or patients that expired during their ED visit.

Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)

Patient Name:

Medical Record Number or other patient identifier:

Date of Discharge:

Numerator:

		Yes	No	Instructions
Transition Record with all of the specified elements				If yes, answer questions (1-5) to determine that all appropriate elements were included in the Transition Record.
Did patient or their caregiver(s) receive a <u>Transition Record</u> at discharge? (Underlined terms are defined below)				
Are the following elements included in Transition Record?		Yes	No	
	1. Summary of major procedures and tests performed during ED visit			
	2. Principal clinical diagnosis at discharge which may include the presenting chief complaint			
	3. Patient Instructions			
	4. Plan for Follow-Up Care (or statement that none required), including primary physician, other health care professional, or site designated for follow-up care			
	5. List of new medications and changes to continued medications that patient should take after ED discharge, with quantity prescribed and/or dispensed (OR intended duration) and instructions for each			
Transition Record with all of the specified elements	Were ALL of the specified elements included in the transition record?			<i>Review responses above to determine if all were elements were included in Transition Record</i>

Definition of Terms

Transition record (for ED discharges):	A core, standardized set of data elements related to patient's diagnosis, treatment, and care plan that is discussed with and provided to patient in written, printed, or electronic format. Electronic format may be provided only if acceptable to patient.
Primary physician or other health care professional designated for follow-up care	May be primary care physician (PCP), medical specialist, or other physician or health care professional. If no physician, other health care professional, or site designated or available, patient may be provided with information on alternatives for obtaining follow-up care needed, which may include a

Technical Specifications: Sample Transition Records

Sample Transition Record #1

Principal Diagnosis: Patient presented to hospital emergency department (ED) complaining of ankle and foot pain likely due to sprain from injury. At the time of discharge, the patient's principal diagnosis was ankle sprain.

The following **major tests and procedures** were conducted in the ED prior to discharge:

- Seen by a physician in the ED and given a complete physical and examination
- Complete Radiologic examination ("X-Ray") of Ankle
- Ankle control orthosis for support, with fitting and adjustment
- Crutches underarm
- Injection of XXXX (medication) for pain and swelling

Patient instructions, Plan for follow up care and New or changed medications: Patient and/or caregiver was given instructions for self care at home and advised to follow up with primary care physician on next business day. Patient was given dosage and administration instructions for any new medications that were prescribed and informed of any changes to current medications.

Sample Transition Record #2

Principal Diagnosis: Patient presented to hospital emergency department (ED) complaining of abdominal pain. At the time of ED discharge, the patient's principal diagnosis was chlamydial infection in the lower genital tract and pelvic inflammatory disease.

The following **major tests and procedures** were conducted during the patient's ED visit:

- ED physician completed a problem-based physical and examination
- Blood test: Complete Blood Count and Metabolic Panel
- Computed Tomography ("CT Scan") of Pelvis
- Urine sample obtained for urinalysis and bacterial culture
- Urine pregnancy test
- Culture testing for *C. trachomatis* (Chlamydia) and *N. gonorrhoeae* (Gonorrhea)

Patient instructions, Plan for follow up care and New or changed medications: Patient and/or caregiver was given instructions for self care at home and advised to follow up with primary care physician on next business day. Patient was given dosage and administration instructions for any new medications that were prescribed and informed of any changes to current medications.

New Medications: Ofloxacin (Floxin) 400 mg orally twice daily for 14 days or levofloxacin (Levaquin) 500 mg orally once daily for 14 days; with or without metronidazole (Flagyl) 500 mg orally twice daily for 14 days.