



Common Hospital Information Form

FORM CODE: CHI 08/20/2014
VERSION: B

ID NUMBER:

CONTACT YEAR:

LAST NAME:

INITIALS:

INSTRUCTIONS: The Common Hospital Information Form is completed for any hospital record abstraction for CHD or HF.
Q. 1 – 10 are common to both the HRA and the HFA forms.

0.a. Hospital code number:

0.b. Medical Record Number:

0.c. Date of discharge (for nonfatal case) or death:
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Month Day Year

SECTION I: DISCHARGE CODES, TRANSFER STATUS, DEMOGRAPHIC DATA

1.a. Primary admission diagnosis:

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[Specify if diagnosis is not ICD coded]

1.b. Primary discharge diagnosis:

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[Specify if diagnosis is not ICD coded]

2. Record the ICD9-CM diagnoses and procedure codes from the hospital discharge index (or Eligibility Form):

a.

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b.

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c.

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d.

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e.

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f.

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g.

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h.

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i.

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u.

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v.

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w.

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x.

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y.

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z.

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3. Sex:

M.....Male
F..... Female

4. Race or ethnic group:

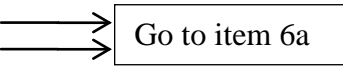
White.....W
Black/African American..... B
Native Hawaiian or Other Pacific Islander..... H
Asian.....S
American Indian/Native Alaskan....I
Other.....O (If other, specify)
Unknown/not recorded..... U

4.a. Hispanic or Latino origin?

Yes..... Y
No..... N
Unk..... U

5.a. Does this person have health insurance?

Yes..... Y
No..... N
Unk..... U



5b.3. Does this person have Medicaid insurance?

Yes..... Y
No..... N
Unk..... U

6.a. Date of arrival at this hospital (mm-dd-yyyy) :

□ □ - □ □ - □ □ □ □

b. Arrival time at this hospital (24-hr clock) :

□ □ : □ □

7. Did an emergency medical service unit transport the patient to this hospital?

Yes..... Y
No..... N
Unk..... U

Transfer information

8.a. Was the patient transferred from or to another acute care hospital? Yes.....Y
No..... N → Go to item 9.
Unk..... U →

8.b. Was this an in-catchment hospital? Yes.....Y
No..... N

b.1. Hospital Code: If 96 - 99, specify: →
Hospital Name: _____
City and State: _____

8.c. Date of admission to that hospital (mm-dd-yyyy):

<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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c.1. Was the patient transferred a second time? Yes No → Go to item 9.

8.d. Was this an in-catchment hospital? Yes.....Y
No..... N

d.1. Hospital Code: If 96 - 99, specify: →
Hospital Name: _____
City and State: _____

8.e. Date of admission to that hospital (mm-dd-yyyy):

<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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9. List the hospital discharge diagnosis and procedure codes exactly as they appear on the front sheet of the medical record and/or on the discharge summary:

a.

b.

c.

d.

e.

f.

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i.

j.

k.

l.

m.

n.

o.

p.

q.

r.

s.

t.

u.

v.

w.

x.

y.

z.

SECTION II: ADMINISTRATIVE INFORMATION

11. Abstractor number:

12. Date abstract completed (mm-dd-yyyy): --

13. Source of information abstracted:

- Medical Record (Paper chart)..... P
- Medical Record (Electronic chart)..... E
- Medical Record (Both paper and electronic chart)..... B