NHDS Medical Abstract Form
Form HDS-1
### A. PATIENT IDENTIFICATION

1. Hospital number
   - [ ]

2. HDS number
   - [ ]

3. (Item deleted)

4. Date of admission
   - Month [ ]
   - Day [ ]
   - Year [ ]

5. Date of discharge
   - Month [ ]
   - Day [ ]
   - Year [ ]

6. Residence ZIP Code
   - [ ]

### B. PATIENT CHARACTERISTICS

7. Date of birth
   - Month [ ]
   - Day [ ]
   - Year [ ]

8. Age – Complete only if date of birth not given
   - Units [ ]
   - 1 [ ] Years
   - 2 [ ] Months
   - 3 [ ] Days

9. Sex – Mark (X) one
   - Male [ ]
   - Female [ ]
   - Not stated [ ]

10. Ethnicity – Mark (X) one
    - Hispanic or Latino [ ]
    - Not Hispanic or Latino [ ]
    - Not stated [ ]

11. Race – Mark all that apply
    - 1 [ ] White
    - 2 [ ] Black or African American
    - 3 [ ] American Indian or Alaska Native
    - 4 [ ] Asian
    - 5 [ ] Native Hawaiian or Other Pacific Islander
    - 6 [ ] Other – Specify [ ]

12. Marital status – Mark (X) one
    - Married [ ]
    - Widowed [ ]
    - Separated [ ]
    - Divorced [ ]
    - Single [ ]
    - Not stated [ ]

### C. ADMINISTRATIVE INFORMATION

13. Type of Admission – Mark (X) one
    - Emergency [ ]
    - Elective [ ]
    - Items not available/unknown [ ]

14. Source of Admission – Mark (X) one
    - Physician referral [ ]
    - Clinical referral [ ]
    - HMO referral [ ]
    - Transfer from hospital [ ]
    - Transfer from SNF [ ]
    - Transfer from other health facility [ ]

15. Status/Disposition of patient – Mark (X) appropriate box(es)
    - Alive [ ]
      - Routine discharge/discharged home [ ]
      - Left against medical advice [ ]
      - Discharged, transferred to another short-term hospital [ ]
      - Discharged, transferred to long-term care institution [ ]
      - Other disposition/not stated [ ]
    - Died [ ]
    - Status not stated [ ]

16. Expected source(s) of payment
    - Principal Mark one only
    - Other additional sources Mark all that apply
    - 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 – Specify [ ]

No source of payment indicated [ ]
### D. MEDICAL INFORMATION

**17.** Final Diagnoses (including E-code diagnoses) (Enter ICD-9-CM codes as well as narrative if available)

Principal: 

Other/additional: 

<table>
<thead>
<tr>
<th>Date of procedure(s)</th>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

**18.** Surgical and Diagnostic Procedures (Enter ICD-9-CM codes as well as narrative if available)

Principal: 

Other/additional: 

- NONE

Completed by

Date

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