

**OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
HOSPITAL INPATIENT DATA RECORD
MANUAL ABSTRACT REPORTING FORM
Effective with discharges occurring on or after July 1, 2008**

Instructions: For a description of the data elements, refer to the appropriate section of the Patient Data Reporting Requirements
(Title 22, Sections 97216 through 97234)

TYPE OF CARE 1 Acute 5 Chem Dep <input type="checkbox"/> 3 SN/IC 6 Physical Rehab 4 Psychiatric	FACILITY ID NUMBER <input style="width:100%; height:20px;" type="text"/>	ABSTRACT RECORD NUMBER (Optional) <input style="width:100%; height:20px;" type="text"/>
DATE OF BIRTH <input style="width:100%; height:20px;" type="text"/> <i>Month Day Year (4 - Digit)</i>	PATIENT'S SOCIAL SECURITY NUMBER <input style="width:100%; height:20px;" type="text"/> <i>Report 000 00 0001 if SSN is Unknown</i>	SEX 1 Male 3 Other <input type="checkbox"/> 2 Female 4 Unknown
RACE ETHNICITY 1 Hispanic <input type="checkbox"/> 2 Non-Hispanic 3 Unknown	RACE 1 White 4 Asian/Pacific <input type="checkbox"/> 2 Black Islander 3 Native American/ 5 Other Eskimo/Aleut 6 Unknown	ZIP CODE <input style="width:100%; height:20px;" type="text"/>
ADMISSION DATE <input style="width:100%; height:20px;" type="text"/> <i>Month Day Year (4 - Digit)</i>	DISCHARGE DATE <input style="width:100%; height:20px;" type="text"/> <i>Month Day Year (4 - Digit)</i>	TOTAL CHARGES <input style="width:100%; height:20px;" type="text"/> <i>(Report whole dollars only, right justified)</i>
SOURCE OF ADMISSION SITE 1 Home 6 Other <u>Inpatient</u> 2 Residential Hospital Care Care Facility 7 Newborn <input type="checkbox"/> 3 Ambulatory 8 Prison/Jail Surgery 9 Other 4 SN/IC 5 Acute <u>Inpatient</u> Hospital Care	LICENSURE OF SITE 1 This Hospital 2 Another Hospital <input type="checkbox"/> 3 Not a Hospital	ROUTE 1 <u>Your</u> ER 2 Not <u>Your</u> ER (or no ER) <input type="checkbox"/>
TYPE OF ADMISSION 1 Scheduled 2 Unscheduled 3 Infant, under 24 hrs old <input type="checkbox"/> 4 Unknown		
EXPECTED SOURCE OF PAYMENT PAYER CATEGORY 01 Medicare 06 Other Government 02 Medi-Cal 07 Other Indigent <input type="checkbox"/> 03 Private Coverage 08 Self Pay 04 Workers' 09 Other Payer Compensation 05 County Indigent Programs	TYPE OF COVERAGE 1 Managed Care - Knox - Keene/ MCOHS <input type="checkbox"/> 2 Managed Care - Other 3 Traditional Coverage	NAME OF PLAN <input style="width:100%; height:20px;" type="text"/> (0001 - 9999 Plan Code Number)
DISPOSITION OF PATIENT: <input style="width:20px; height:20px;" type="text"/> 01 Routine (Home) 07 SN/IC Within This Hospital 08 Residential Care Facility 02 Acute Care 09 Prison/Jail 03 Other Care 10 Against Medical Advice 04 SN/IC 11 Died To Another Hospital 12 Home Health Service 05 Acute Care 13 Other 06 Other Care (Not SN/IC)	PREHOSPITAL CARE AND RESUSCITATION DNR orders at admission or within 24 hrs of admission Y = Yes <input type="checkbox"/> N = No	

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THIS SPACE RESERVED FOR PRINCIPAL LANGUAGE SPOKEN

PRINCIPAL EXTERNAL CAUSE OF INJURY E-CODE

E					
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PRESENT ON ADMISSION

Y = Yes

N = No

U = Unknown

W = Clinically Undetermined

blank = Exempt from POA reporting

OTHER EXTERNAL CAUSE OF INJURY E-CODES

E					
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PRESENT ON ADMISSION

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PRINCIPAL DIAGNOSIS

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PRESENT ON ADMISSION

Y = Yes
 N = No
 U = Unknown
 W = Clinically Undetermined
 blank = Exempt from POA reporting

OTHER DIAGNOSES

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PRESENT AT ADMISSION

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12. PRINCIPAL PROCEDURE AND DATE

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Month | Day | Year (4-Digit)

13. OTHER PROCEDURES AND DATES

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