



**RELATIONAL TABLE FORMAT
DATA SUBMISSION FILE FORMAT**

(Formerly version 2.00)

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Intended Audience

This is a low-level reference for software developers (including Trauma Registry software vendors and hospital Information Systems departments) to implement data submission support to the National Trauma Data Bank (NTDB). Researchers or users of Trauma Registry software need not be concerned with this document, since they are only concerned with its byproduct- files that can be acceptably submitted to the NTDB. If you have any question pertaining to this list of data points, please call the National Trauma Data Bank Office of the American College of Surgeons at 312-202-5467.

File Format

You may submit your data file in the following format:

1. Standard DBF
2. Microsoft Access database
3. ASCII CSV (Standard Comma-Separated Values).
4. Fix Length ASCII.

Record Layout Definitions

In the pages that follow, each record layout definition will be presented in detail. For each definition, the following information will be provided:

1. File [Table] Name. Name of the file that explain the record type
2. Definition. Explains the category of information being captured by that record.
3. Required. Indicates whether a record of this type must be present somewhere in the file.
4. Frequency. Indicates the number of occurrences of records of its type are permitted in the file.
5. Layout. Each individual field in the record is defined. For each field, the following is defined:
 1. Position Number. The position the field should occupy in the file
 2. Field Name. Name of the data point – applied to DBF and MS Access only.
 3. Name. Title of the field.
 4. Definition. Detailed explanation of the field's intent.
 5. Required (Req). Indicates whether a value for this field is must be present in the record.
 6. Data Type. Indicates whether the value should be alphanumeric (AN) or numeric (N) or date(D).
 7. Format Required. Indicates whether the information in the file should have a specific format. The legend for the symbols used for

this are as follows:

9	=	Any numeric character, 0-9 only
X	=	Any character, including letters, numbers, symbols and punctuation
MM/DD/YYYY	=	Date as expressed with a two-digit month (including leading zero, if < 10), two-digit day (including leading zero, if <10), and full year including century (e.g., 1996, 2012). Slash characters must be included.
HH:MM	=	Time value, in military format, expressed as a two-digit hour (including leading zero) and two-digit minute.
Any other character	=	A literal character which must be included verbatim into the field at the position indicated.

8. Length. The maximum amount of characters accepted by the NTDB for this field. Any characters beyond this limit are ignored.
9. User-Defined Values OK (UDV Ok). Certain fields allow the submission of field values that not on the list of valid values (see next field). If this is permitted for a field (indicated with a "Yes"), the following conditions must be met before any custom value can be present for the field: a. The value is not a synonym for a value on the list or b. is not a cryptic code. If either case is true, the value must be translated to one in the Valid Values list before being inserted into the submission file.
10. Valid Values. Defines the list of all possible acceptable choices for the field.

Required Fields in NTDB:

- **DOB**
- **Gender**
- **ISS**
- **E-code**
- **LOS**
- **Discharge status and disposition**
- **Procedure codes (missing only)**
- **Diagnosis codes (missing only)**

Facility Information Record

File [Table] Name: *facility*

Definition: Includes information about the submitting facility and the file format version number.

Required: Yes

Frequency: Once per file

Layout:

Position Number	Field Name	Name	Definition	Req	Data Type	Format Required	Len	UDV Ok	Valid Values
1	ASCIVER	ASCII Template Version Number	The version number of this file format definition.	Yes	N	9.99	4	N/A	2.00
2	SUB_DATE	Submission Date	The date this file was created.	Yes	AN	MM/DD/YYYY	10	N/A	
3	AHA_NO	Facility AHA Number	American Hospital Association Number for your Facility.	Yes	AN		20	N/A	
4	FACILITY	Facility Name	Name of your facility.	Yes	AN		50	N/A	
5	ADRS1	Facility Address 1	First address line of your facility	Yes	AN		75	N/A	
6	ADRS2	Facility Address 2	Second address line of your facility. Use this field to record such things as suite numbers, floor numbers, etc.	Yes	AN		75	N/A	
7	CITY	Facility City	City in which your facility is located.	Yes	AN		50	N/A	
8	STATE	Facility State	State in which your facility is located.	Yes	AN		2	N/A	Any valid 2-letter U.S. postal abbreviation
9	ZIPCODE	Facility Zipcode	Zipcode in which your facility is located.	Yes	AN	99999-999999	12	N/A	At minimum, the five-digit zipcode. A nine and eleven-digit number may also be supplied.
10	FIRSTNM	Facility Contact Person First Name	First name of individual for ACS to contact to discuss issues with the submission file.	Yes	AN		50	N/A	
11	LASTNM	Facility Contact Person Last Name	Last name of individual for ACS to contact to discuss issues with the submission file.	Yes	AN		50	N/A	
12	PHONE	Facility Contact Person Telephone	Telephone number of individual for ACS to contact to discuss issues with the submission file.	Yes	AN	999-999-9999	12	N/A	

Position Number	Field Name	Name	Definition	Req	Data Type	Format Required	Len	UDV Ok	Valid Values
13	PHONE_EXT	Facility Contact Person Telephone Extension	Telephone extension, if any, of individual for ACS to discuss issues with the submission file.	Yes	AN	9999	4	N/A	Populate this field only in the instance that the contact person has a telephone extension
14	SOURCE	Facility Source System Name	The name of the software product from where the data in this file originated.	Yes	AN		50	Yes	"Cales/HTR/STR" "Clinical Data Management/Trauma Base" "NATIONAL TRACS" "Lancet/Trauma One" "The San Diego Registry" "Hospital Mainframe" "TriAnalytics Collector" "Other"
15	SOURCVER	Facility Source System Version Number	The version number of the software product where the data in this file originated.	Yes	AN		10	N/A	
16	ACS_VER	ACS Verification Level	The American College of Surgeons trauma level designated for the submitting trauma facility.	Yes	AN		3	No	"I" "II" "III" "IV" "N/A"
17	STATEDES	State Designation	Definition to be obtained.	Yes	AN		30	No	None pre-defined
18	ADULTBED	Number of Adult Hospital Beds	The number of beds at your facility designated for adult patient use.	Yes	N	9999	4	N/A	Any integer between 0 and 9999
19	PEDBED	Number of Pediatric Hospital Beds	The number of beds at your facility designated for pediatric patient use.	Yes	N	9999	4	N/A	Any integer between 0 and 9999
20	BURNBED	Number of Burn Hospital Beds	The number of beds at your facility designated for Burn patient use.	Yes	N	9999	4	N/A	Any integer between 0 and 9999
21	TRICUBED	Number of ICU Beds Available for Trauma Patients	The number of ICU beds at your facility designated for trauma patient use.	Yes	N	9999	4	N/A	Any integer between 0 and 9999
22	BRICUBED	Number of ICU Beds Available for Burn Patients.	The number of ICU beds at your facility designated for burn patient use.	Yes	N	9999	4	N/A	Any integer between 0 and 9999
23	TEACHSTAT	Hospital Teaching Status.	Indicates the type of teaching your facility performs.	Yes	AN		12	NO	"University" "Community" "Non-Teaching"
24	HOSPTYPE	Hospital Type.	Designates whether your facility's teaching is conducted at a public or private institution.	Yes	AN		7	NO	"Public" "Private"

Position Number	Field Name	Name	Definition	Req	Data Type	Format Required	Len	UDV Ok	Valid Values

Incident Record

File [Table] Name: *Incident*

Definition: Identifies incident information.

Required: Yes

Frequency: Unlimited per file / One per incident

Layout:

Position Number	Field Name	Name	Definition	Req	Data Type	Format Required	Len	UDV Ok	Valid Values
1	Inc_key	Incident key	Primary Key to identify an incident. This data point will be used to link to child tables information.	Yes	N		10	N/A	
2	Pat_ID	Patient Identifier	Number that uniquely identifies a patient in this file. Once assigned, this number must remain constant for the patient, which means it must be identical across all future file submissions to the National Trauma Data Bank. This field may be the patient's existing Medical Record Number or some other uniquely generated identifier. The format of this field is facility-defined. Formatting characters are allowed (such as '-', '.', '/') for this field.	No	AN		25	N/A	
3	Rev_date	Incident Revision Date	Date the information for this trauma incident was last modified. If this date is not available, use the creation date for this file.	No	D	MM/DD/YYYY	10	N/A	
4	DOB	Date of Birth	The patient's date of birth.	Yes	D	MM/DD/YYYY	10	N/A	
5	GENDER	Gender	The patient's gender at injury date.	Yes	AN		1	No	"M" = Male "F" = Female "D" = Not Done/Not Documented "U" = Gender is Unknown
6	RACE	Race/Ethnicity	The patient's race/ethnic group.	No	AN		3	Yes	"B" = Black, not of Hispanic origin "D" = Not Done/ Not Documented "H" = Hispanic "NA" = Native American or Alaskan Native "A" = Asian or Pacific Islander "W" = White, not of Hispanic Origin "OTH" = Other
7	PAYMENT	Principal Payment Source	Indicates the primary source of payment to the hospital for this visit.	No	AN		50	Yes	"Blue Cross/Blue Shield" "Managed Care Organization"

Position Number	Field Name	Name	Definition	Req	Data Type	Format Required	Len	UDV Ok	Valid Values
	T		for this visit.						"Other Commercial Indemnity Plan" "Medicare" "Medicaid" "MCH and Crippled Children's" "CHAMPUS" "Worker's Compensation" "Government/Military Insurance" "Automobile Insurance" "Organ Donor Subsidy" "No Charge" "Other" "Liability Insurance/Under Litigation" "No Fault Insurance" "None" "Not Done/Not Doc" "Private Charity" "Pending" "Shriners" "Self Pay"
8	INJSITE	Site at Which Injury Occurred	The type of place of occurrence of the injury.	No	AN	E999.9	6	No	E849.0 = Home E849.1 = Farm E849.2 = Mine and Quarry E849.3 = Industrial Places and Premises E849.4 = Place for Recreation and Sport E849.5 = Street and Highway E849.6 = Public Building E849.7 = Residential Institution E849.8 = Other Specified Places E849.9 = Unspecified Places
9	WORK_REL	Work Relatedness of Injury	A marker that an injury-producing event or illness-producing exposure at work precipitated the patient's visit to the Emergency Department.	No	N	9	2	N/A	3 = Paid Work (Work Related) 4 = Unpaid Work (Non-work related) 99 = Unknown
10	ECODE	E-Code	A code for the ICD-9-CM external cause of injury that permits classification of environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects.	Yes	AN	999.9	6	N/A	Any valid ICD-9-CM E-Code.
11	GCS_EYE	Lowest Glasgow Eye Component at the Scene	The Glasgow Coma Scale for Eye Opening.	No	N	9	1	No	Values for Adults (> 5 years old): 4 = Spontaneous 3 = Voice 2 = Pain

Position Number	Field Name	Name	Definition	Req	Data Type	Format Required	Len	UDV Ok	Valid Values
									1 = None Values for Children and Infants: 4 = Spontaneous 3 = Verbal Stimuli 2 = Pain 1 = No Response
12	GCS_VRB	Lowest Glasgow Verbal Component at the Scene	The Glasgow Coma Scale for Best Verbal Response.	No	N	9	1	No	Values for Adults (>5 years old): 5 = Oriented 4 = Confused 3 = Inappropriate Words 2 = Incomprehensible words 1 = None Values for Child: 5 = Oriented 4 = Confused 3 = Inappropriate Cries 2 = Incomprehensible sounds 1 = No Response Values for Infant: 5 = Coos, Babbles 4 = Irritable Cries 3 = Cries to Pain 2 = Moans to Pain 1 = No Response
13	GCS_MOT	Lowest Glasgow Motor Component at the Scene	The initial Glasgow Coma Scale Motor Response at the scene.	No	N	9	1	No	Values for Adults (>5 years old): 9 = Not Done/Not Documented 6 = Obeys commands with appropriate motor response 5 = Localization of painful stimulation 4 = General withdrawal in response to painful stimulation 3 = Flexor posturing in response to painful stimulation 2 = Extensor posturing in response to painful stimulation 1 = None Values for Infants and Children: 9 = Not Done/Not Documented 6 = Normal Spontaneous Movement 5 = Withdraws to touch 4 = Withdraws to pain 3 = Abnormal flexion (decerebrate)

Position Number	Field Name	Name	Definition	Req	Data Type	Format Required	Len	UDV Ok	Valid Values
									2 = Abnormal flexion (decerebrate) 1 = None
14	GCS_AQ	GCS Assessment Qualifier at the Scene	See options.	No	AN	XX	2	No	"T" = Patient intubated when GCS components assessed at scene. "TP" = Patient intubated and chemically paralyzed when GCS components assessed at scene "S" = Patient chemically sedated when initial GCS components assessed at scene. "L" = Initial GCS components at scene are legitimate values, without interventions such as intubation and sedation.
15	GCS_TOT	Glasgow Coma Scale Total at the Scene	Patient's Total Glasgow Coma Scale score assessed at the scene. The valid range is 3 to 15. The GCS is used to determine a score based on the total of three readings on the patient.	No	N	99	2	N/A	Any integer between 3 and 15. Blank for unknown
16	INJDATE	Date on Which Injury Occurred	The day, month and year on which the injury occurred.	No	D	MM/DD/YYYY	10	N/A	
17	INJSTATE	State in Which Injury Occurred	The name of the state in which the injury occurred.	No	AN	XX	2	No	Any valid 2-letter U.S. postal abbreviation.
18	INJCNTY	County in Which Injury Occurred	The name of the county within the state where the injury occurred.	No	AN		50	Yes	
19	INJCNTRY	Country in Which Injury Occurred	The country in which the injury occurred.	No	AN		30	Yes	"USA"
20	INJTYPE	Injury Type	Broad categorization of primary injury type.	No	AN		11	No	"Blunt" = Blunt injury, primarily "Burn" = Burn injury "Penetrating" = Penetrating injury, primarily Blank for unknown
21	HOSPTRAN	Inter-Hospital Transfer	If the patient arrived at your hospital as an inter-hospital transfer from another acute care facility, this indicates the type of facility from where the patient was transferred. This should exclude satellite and other free-standing emergency care sites.	No	AN		50	No	"Emergency: NOS" "Emergency: Trauma Level 1" "Emergency: Trauma Level 2" "Emergency: Trauma Level 3" "Emergency: Trauma Level 4" "Inpatient: Acute/Rehabilitation Facility" "Home Health: NOS" "Not Done/Not Documented"

Position Number	Field Name	Name	Definition	Req	Data Type	Format Required	Len	UDV Ok	Valid Values
22	ADMDATE	First Recorded Date of Patient's Arrival at Reporting Hospital ED	Date patient actually arrived at your hospital.	Yes	D	MM/DD/YYYY	10	N/A	Blank for unknown
23	ADMTIME	First Recorded Time of Patient's Arrival at Reporting Hospital ED	Time patient actually arrived at your hospital in military format.	No	C	HH:MM	5	N/A	Blank for unknown
24	TSTIMELY	Was Trauma Surgeon Arrival in ED Timely	Indicates whether the Trauma Surgeon arrived in the ED in an acceptable amount of time. This is a judgement call for the submitting facility.	No	AN		1	No	"Y" = Yes "N" = No "P" = Pending "D" = Not Done/Not Documented
25	ED_SBP	First Systolic Blood Pressure in ED	The initial assessment in the ED of the systolic blood pressure in either arm by auscultation or palpation measured in mm (Hg) by manual or automatic method.	No	N		3	N/A	Any integer between 0 and 300.
26	ED_RESP	First Unassisted Respiratory Rate in ED	The first unassisted patient respiratory rate expressed as number per minute assessed in the Emergency Department.	No	N		3	N/A	Any integer between 0 and 99. OR 666 = Agonal 777 = Respiratory assistance with manual or mechanical ventilation 888 = Not obtained 999 = Unknown
27	ED_RR_AQ	Respiratory Rate Assessment Qualifier in ED	See options.	No	AN		2	No	"T" = Patient intubated when initially assessed in ED. "TP" = Patient intubated and chemically paralyzed when initially assessed in ED. "S" = Patient chemically sedated when initially assessed in ED. "L" = Initial respiratory rate in ED is a legitimate value, without interventions such as intubation and sedation.
28	ED_TEMP	First Temperature in ED	The patient's initial temperature measured in the ED.	No	N	999.9	5	N/A	Any real number between 0 and 110.
29	TEMP_SC	Temperature Scale	The scale of measurement represented in the value of the First Temperature in ED field. * If a value is present in the previous field, then this field is required.	No	AN		1	No	"C" = Celsius "F" = Fahrenheit
30	HCT	Head CT Results	The results of a diagnostic procedure done in ED of the reporting hospital that utilizes a computer to analyze x-	No	AN		1	No	"P" = Positive "N" = Negative

Position Number	Field Name	Name	Definition	Req	Data Type	Format Required	Len	UDV Ok	Valid Values
			ray data of the skull and cranial contents.						"D" = Not Done / Not Documented
31	ABDEVAL	Abdominal Evaluation	The results from the peritoneal lavage done in the ED.	No	AN		1	No	"P" = Positive "N" = Negative "D" = Not Done / Not Documented
32	ABDETYPE	Abdominal Evaluation Type	See options.	No	AN		25	Yes	"CT" "DPL" "Ultrasound"
33	ED_BASED	Base Deficit/Excess in ED	Arterial blood gas component showing the degree of acid/base imbalance with a normal range being +/- 2 mEq/L.	No	N	-99.9 or 99.9	5	N/A	Any integer between -80 and +80.
34	ED_EYE	Lowest Glasgow Eye Component in ED	Glasgow Coma Scale for Eye Opening.	No	N		1	N/A	Values for Adults (>5 years old): 4 = Spontaneous Eye Opening 3 = Opens Eyes to Commands 2 = Opens Eyes to Pain 1 = Does Not Open Eyes Values for Infants and Children: 4 = Spontaneous 3 = Verbal Stimuli 2 = Pain 1 = No Response
35	ED_VERB	Lowest Glasgow Verbal Component in ED	Glasgow Coma Scale for Best Verbal Response.	No	N		1	N/A	Values for Adults (>5 years old): 5 = Oriented 4 = Confused 3 = Inappropriate Words 2 = Incomprehensible words 1 = None Values for Child: 5 = Oriented 4 = Confused 3 = Inappropriate Cries 2 = Incomprehensible sounds 1 = No Response Values for Infant: 5 = Coos, Babbles 4 = Irritable Cries 3 = Cries to Pain 2 = Moans to Pain 1 = No Response
36	ED_MOTOR	Lowest Glasgow Motor Component in ED	The initial Glasgow Coma Scale Motor Response in ED.	No	N	9	1	No	Values for Adults (>5 years old): 9 = Not Done/Not Documented

Position Number	Field Name	Name	Definition	Req	Data Type	Format Required	Len	UDV Ok	Valid Values
	OR	Component in ED							<p>6 = Obeys commands with appropriate motor response 5 = Localization of painful stimulation 4 = General withdrawal in response to painful stimulation 3 = Flexor posturing in response to painful stimulation 2 = Extensor posturing in response to painful stimulation 1 = None</p> <p>Values for Infants and Children: 9 = Not Done/Not Documented 6 = Normal Spontaneous Movement 5 = Withdraws to touch 4 = Withdraws to pain 3 = Abnormal flexion (decerebrate) 2 = Abnormal flexion (decerebrate) 1 = None</p>
37	EDGCS_AQ	GCS Assessment Qualifier in ED	See options.	No	AN	XX	2	No	<p>"T" = Patient intubated when GCS components assess in ED. "TP" = Patient intubated and chemically paralyzed when GCS components assessed in ED. "S" = Patient chemically sedated when initial GCS components assessed in ED. "L" = Initial GCS components in ED are legitimate values, without interventions such as intubation and sedation.</p>
38	EDGCSTOT	Glasgow Coma Scale Total in ED	Patient's Total Glasgow Coma Scale score assessed in ED. The valid range is 3 to 15. The GCS is used to determine a score based on the total of three readings on the patient.	No	N	99	2	N/A	Any integer between 3 and 15.
39	ED_RTS	Revised Trauma Score in ED	<p>Based on the values of the Glasgow Coma Scale, systolic blood pressure and respiratory rate. Raw values are used for triage; coded values are weighted and summed for outcome evaluation (RTS).</p> <p>Glasgow Coma Scale total points (GCSc): 13-15 = 4 4-5 = 1 9-12 = 3 3 = 0 6-8 = 2</p>	No	N	9.9999	6	N/A	Any real number between 0 and 8. Use a 9 for Not Done / Not Documented.

Position Number	Field Name	Name	Definition	Req	Data Type	Format Required	Len	UDV Ok	Valid Values
			Respiratory Rate (RRc): 10-29 = 4 1-5 = 1 >29 = 3 0 = 0 6-9 = 2 Systolic Blood Pressure (SBPc): >89 = 4 1-49 = 1 76-89 = 3 0 = 0 50-75 = 2 Calculated values for use in Ps equation: RTS = 0.9368*GCS _c +0.7326*SBP _c +0.2908*RR _c						
40	ALCOHOL	Alcohol Present in Blood	The presence of any ethyl alcohol in any biological specimen obtained from patient for laboratory examination.	No	AN		2	No	"Y" = Yes "N" = No "D" = Not Done / Not Documented "NA" = Not Applicable
41	DRUGS	Drugs Present	Indicates if drugs were present in the blood by a laboratory test used to detect the presence of controlled substances other than alcohol in the patient's blood or urine. Do not include drugs given to the patient during any phase of resuscitation.	No	AN		1	No	"Y" = Yes "N" = No "D" = Not Done / Not Documented
42	ADMSERV	Admitting Service	The service to which the patient is designated upon admission to your hospital or, in the case of death in the ED, the service which gives the patient primary care in the ED.	No	AN		20	Yes	"Burn" = Burn "Pediatric" = Pediatric Surgery "Neuro" = Neurosurgery "Ortho" = Orthopedic Surgery "Other" = All Other Surgical Services "Trauma" = Trauma Surgery "Medical" = Nonsurgical Services
43	ED_DISP	Emergency Department Disposition	The location or status of the patient following treatment in the ED.	No	AN		25	Yes	"ED Observation" = Admitted to ED for 23 hour observation "DOA (Death)" = Expired (DOA) "Die in ED" = Expired, Death in ED after any treatment "Floor" = Admitted to hospital floor bed "ICU" = Admitted to ICU "Not Done/Doc" = Not Done/Not Documented "OR" = Admitted to OR "Telemetry" = Admitted to monitored telemetry floor bed "Transfer" = Transferred to other hospital "Other" = Other

Position Number	Field Name	Name	Definition	Req	Data Type	Format Required	Len	UDV Ok	Valid Values
									"Home" = Home "Burn" = Transfer to Acute Burn Fac. "Unknown" = Unknown
44	ISS	Total Injury Severity Score	The ISS is a sum of the squares of the highest AIS code in each of the three most severely injured ISS body regions. The six body regions of injury used in the ISS are: those for Head, Face, Chest, Abdominal or Pelvic contents, Extremities or Pelvic girdle and External. (The Abbreviated Injury Scale, 1990 Revision. Association for the Advancement of Automotive Medicine. Des Plaines, IL) Use this field only if no AIS-90 codes can be provided in the <i>Diagnosis</i> records. If AIS-90 codes are provided, this value is calculated in the NTDB™.	Yes	N	99	2	N/A	An integer between 0 and 75.
45	PROBOFS URV	TRISS Survival Probability	Using the TRISS methodology, Ps is calculated using ED admission values of the Revised Trauma Score (RTS), the Injury Severity Score (ISS) based on the final diagnoses, patient age and the type of injury (blunt or penetrating).	No	N	9.99	4	N/A	Any real number between 0.00 and 1.00 OR 9 = Not Done/Not Documented
46	LOS	Length of Stay in Hospital	The total number of patient days for an inpatient episode, calculated by subtracting the date of admission from the date of discharge. If a patient is admitted and discharged on the same date, the LOS is one day.	Yes	N	999	3	N/A	Any integer between 0 and 999. -1 for Unknown blank for unknown NULL for unknown
47	ICU_DAYS	Days of Total Stay in ICU	The total number of patient days for an ICU episode, calculated by subtracting the date of admission from the date of discharge. If a patient is admitted and discharged on the same date, the LOS is one day.	No	N	999	3	N/A	Any integer between 0 and 999. -1 for Unknown blank for unknown NULL for unknown
48	VENT_DAYS	Ventilator Support Days	The total number of ventilator support days calculated by subtracting the start date from the end date. If a patient starts and ends on the same date, the ventilator support days is one day.	No	N	999	3	N/A	Any integer between 0 and 999. -1 for Unknown blank for unknown NULL for unknown
49	FIM_FEE D	FIM Self-Feeding Score at Discharge	Assessed as close to discharge as possible, includes using suitable utensils to bring food to mouth, chewing, and swallowing (once meal is appropriately prepared). Opening containers, cutting meat, buttering bread and pouring liquids are not included as they are often part of meal preparation.	No	N	9	1	No	4 = Independent 3 = Independent with Device 2 = Dependent-Partial Help Required 1 = Dependent-Total Help Required 8 = Not Applicable (e.g., pat < 7 yrs. old or died) 9 = Unknown

Position Number	Field Name	Name	Definition	Req	Data Type	Format Required	Len	UDV Ok	Valid Values
50	STAT_FE ED	Status of FIM Self-Feeding Score	<p>Indication whether the Self-Feeding component of the FIM score is temporary, permanent or not done/not documented.</p> <p>FIM only applies to those patients greater than 7 years of age and that "D" should be used for those patient under 7 years of age or those patients that died. These assumptions will be updated as additional clarifications are obtained from the CDC.</p> <p><i>Related Definitions:</i> <u>Temporary:</u> Likely to improve. <u>Permanent:</u> Unlikely to improve.</p>	No	AN		1	No	"T" = Temporary "P" = Permanent "D" = Not Done / Not Documented
51	FIM_LOCOM	FIM Locomotion Score at Discharge	<p>Assessed as close to discharge as possible. Includes walking once in a standing position, or using a wheelchair, once in a seated position, indoors. Also referred to as Independence.</p>	No	N	9	1	No	4 = Independent 3 = Independent with Device 2 = Dependent-Partial Help Required 1 = Dependent-Total Help Required 8 = Not Applicable (e.g., patient < 7 yrs. old or died) 9 = Unknown
52	STAT_LOCOM	Status of FIM Locomotion Score	<p>Indication whether the Locomotion component of the FIM Score is temporary, permanent or not done/not documented.</p> <p>FIM only applies to those patients greater than 7 years of age and that "D" should be used for those patient under 7 years of age or those patients that died. These assumptions will be updated as additional clarifications are obtained from the CDC.</p> <p><i>Related Definitions:</i> <u>Temporary:</u> Likely to improve. <u>Permanent:</u> Unlikely to improve.</p>	No	AN		1	No	"T" = Temporary "P" = Permanent "D" = Not Done / Not Documented
53	FIM_EXPRESSION	FIM Expression Score at Discharge	<p>Assessed as close to discharge as possible. Includes clear expression of verbal or nonverbal language. This means expressing linguistic information verbally or graphically with appropriate and accurate meaning and grammar. Also referred to as the Motor component.</p>	No	N	9	1	No	4 = Independent 3 = Independent with Device 2 = Dependent-Partial Help Required 1 = Dependent-Total Help Required 8 = Not Applicable (e.g., patient < 7 yrs. old or died) 9 = Unknown
54	STAT_EXPRESSION	Status of FIM Expression Score	<p>Indication whether the expression component of the FIM Score is temporary, permanent or not done/not documented.</p>	No	AN		1	No	"T" = Temporary "P" = Permanent "D" = Not Done/Not Documented

Position Number	Field Name	Name	Definition	Req	Data Type	Format Required	Len	UDV Ok	Valid Values
			FIM only applies to those patients greater than 7 years of age and that "D" should be used for those patient under 7 years of age or those patients that died. These assumptions will be updated as additional clarifications are obtained from the CDC. <i>Related Definitions:</i> <u>Temporary</u> : Likely to improve. <u>Permanent</u> : Unlikely to improve.						
55	FIM_SCORE	Total FIM Score	A score calculated to derive a baseline of trauma patient disability at discharge from an acute care facility, using three components; Feeding, Locomotion (Independence) and Motor (Expression)	No	N	99	2	N/A	Any integer between 1 and 12. -1 for Unknown blank for unknown NULL for unknown
56	DC_DATE	Date of Discharge or Death	The date of patient discharge or death from your hospital.	No	D	MM/DD/YYYY	10	N/A	
57	HOSP_DISP	Discharge Disposition	The place to which the patient was released when discharged from your hospital.	Yes	AN		30	Yes	"Burn" = Transfer to Acute Burn Fac. "Death" = Death in Hospital "Death (DOA)" = Dead on Arrival in ED "Died During Treatment" "Discharged, SNF" = Discharged, Extended Care Facility "Home" "Home Health" "Hosp Transfer" = Transferred to Other Hospital "Jail" = Jail or Prison "Nursing Home" "Rehab" = Rehabilitation Center "Unable to Complete Treatment"
58	HOSP_CHRG	Billed Hospital Charges	The final billed amount charged for this admission, excluding professional fees, at the acute care facility, expressed in a whole dollar figure.	No	N	9999999	7	N/A	Any integer between 0 and 9999999. -1 for Unknown blank for unknown NULL for unknown
59	DC_STATUS	Discharge Status	Identifies whether the patient was deceased at moment of discharge.	Yes	AN		5	No	"Alive" "Dead" Blank for unknown

Complication Record

File [Table] Name: *COMPLIC*

Definition: Information pertaining to any complications that arose during the course of patient treatment at your facility.

Required: No

Frequency: Unlimited per Incident.

Notes: See Appendix B for a listing of valid factors.

Layout:

Position Number	Field Name	Name	Definition	Req	Data Type	Format Required	Len	UDV Ok	Valid Values
1	INC_KEY	Incident key	Foreign Key to identify an incident. This data point will be used to identify an incident in incident record.	Yes	N		10	N/A	
2	COMPCODE	Complication Code	The code from Appendix B that identifies the complication.	No	AN	XXXXX	4	No	A valid code as listed in Appendix B.

Diagnosis Record

File [Table] Name: *DIAGNOS*

Definition: Information pertaining to a diagnosis made about the trauma incident.

Required: Yes

Frequency: Unlimited per Incident.

Layout:

Position Number	Field Name	Name	Definition	Req	Data Type	Format Required	Len	UDV Ok	Valid Values
1	INC_KEY	Incident key	Foreign Key to identify an incident. This data point will be used to identify an incident in incident record.	Yes	N		10	N/A	
2	DCODE	ICD-9-CM Code of Diagnosis	The ICD-9-CM code that describes the diagnosis * Both the ICD-9-CM and the AIS Full Code need not be supplied, but at least one or the other must be present.	Yes*	AN	X999.99	7	N/A	A defined ICD-9-CM diagnosis code. If the diagnosis represents a pre-existing condition, this code must be prefixed with a "V". Otherwise, no prefix is necessary.

Position Number	Field Name	Name	Definition	Req	Data Type	Format Required	Len	UDV Ok	Valid Values
			<i>Related Definitions:</i> ICD-9-CM Code: Issued by the U.S. Department of Health and Human Services to describe why services were rendered.						Blank for unknown
3	AISCODE	AIS Full Code of Diagnosis	If the diagnosis represents a trauma, this represents the AIS Full Code that describes the diagnosis. * Both the ICD-9-CM and the AIS Full Code need not be supplied, but at least one or the other must be present.	No	N	For AIS 85: 99999.9 For AIS 90: 999999.9	8	N/A	A defined AIS numerical injury identifier. Blank for unknown
4	AISSCORE	AIS Severity Score	This represents the severity portion of the AIS Full Code. Use this field only if the Full Code is not provided in the previous field.	No	N	9	1	N/A	Any integer between 1 and 6, or 9. 0 for unknown -1 for unknown NULL for unknown

Intubation Record

File [Table] Name: *INTUBAT*

Definition: Information indicates whether intubation was performed either at the scene or in the ED.

Required: No

Frequency: No more than twice per Incident. Once per scene intubation and once per ED intubation.

Layout:

Position Number	Field Name	Name	Definition	Req	Data Type	Format Required	Len	UDV Ok	Valid Values
1	INC_KEY	Incident key	Foreign Key to identify an incident. This data point will be used to identify an incident in incident record.	Yes	N		10	N/A	
2	LOCATION	Intubation Location Indicator	Indicates whether the intubation took place at the scene or in the ED.	No	AN		5	No	"Scene" "ED"
3	INTUB_TYPE	Intubation Type	Indicates the type of mechanical or surgical airway placed.	No	AN		40	Yes	"Nasal ETT" "Oral ETT" "ETT Route Not Recorded" "Tracheostomy"

Position Number	Field Name	Name	Definition	Req	Data Type	Format Required	Len	UDV Ok	Valid Values
									"Cricothyrotomy" "Unintentional Esophageal Intubation" "No Airway Placed" "Not Done/Not Documented"

Pre-Existing Comorbidity Factors Record

File [Table] Name: *COMORBID*

Definition: Information pertaining to any pre-existing comorbidity diseases the patient had upon arrival in your ED.

Required: No

Frequency: Unlimited per Incident.

Notes: See Appendix A for a listing of valid factors.

Layout:

Position Number	Field Name	Name	Definition	Req	Data Type	Format Required	Len	UDV Ok	Valid Values
1	INC_KEY	Incident key	Foreign Key to identify an incident. This data point will be used to identify an incident in incident record.	Yes	N		10	N/A	
2	FAC_CODE	Factor Code	The code from Appendix A that identifies the pre-existing comorbid factor present at the point of patient arrival in the ED.	No	AN	X.99	4	No	A valid code as listed in Appendix A.

Prehospital Procedures Record

File [Table] Name: *PREHPROC*

Definition: Information pertaining to the procedures performed for a trauma incident.

Required: No

Frequency: Unlimited per Incident.

Layout:

Position Number	Field Name	Name	Definition	Req	Data Type	Format Required	Len	UDV Ok	Valid Values
1	INC_KEY	Incident key	Foreign Key to identify an incident. This data point will be used to identify an incident in incident record.	Yes	N		10	N/A	
2	PREH_PROC	Prehospital Procedure	See options.	No	AN		40	Yes	"CPR" "Chest Decompression" "MAST" "Intravenous Fluids" "None" "Not Done/Not Documented" "Thoracentesis/Thoracostomy"

Procedure Record

File [Table] Name: *PROCEDUR*

Definition: Information pertaining to the procedures performed for a trauma incident.

Required: No

Frequency: Unlimited per Incident.

Layout:

Position Number	Field Name	Name	Definition	Req	Data Type	Format Required	Len	UDV Ok	Valid Values
1	INC_KEY	Incident key	Foreign Key to identify an incident. This data point will be used to identify an incident in incident record.	Yes	N		10	N/A	
2	PCODE	ICD-9-CM Code of Procedure	The ICD-9-CM code that describes the procedure. * Both the ICD-9-CM and CPT-4 need not be supplied, but at least one or the other must be present. If a CPT-4 code is provided in this record, this field may be left null.	Yes *	AN	99.99	5	N/A	A defined ICD-9-CM procedure code.
3	CPT_CODE	CPT-4 Code of Procedure	The CPT-4 code that describes the procedure. * Both the ICD-9-CM and CPT-4 need not be supplied, but at least one or the other must be present. If an ICD-9 code is	No	N	99999	5	N/A	A defined CPT-4 code.

Position Number	Field Name	Name	Definition	Req	Data Type	Format Required	Len	UDV Ok	Valid Values
			provided in this record, this field may be left null.						
4	OPDATE	Date at Which Procedure Occurred	The date the patient underwent the operation or procedure.	No	D	MM/DD/YYYY	10	N/A	
5	OPTIME	Time at Which Procedure Occurred	The date and time the patient underwent the operation or procedure. (Military time format)	No	C	HH:MM	5	N/A	
6	ORVISITNO	OR Visit Number	If this procedure was performed in the Operating Room, this field indicates the sequential visit number to the OR.	No	N	99	2	N/A	Any number between 1 and 99.

Safety Equipment Record

File [Table] Name: *SAFETY*

Definition: Information pertaining to the safety equipment used or worn by the patient at the time of the injury.

Required: No

Frequency: Unlimited per Incident.

Layout:

Position Number	Field Name	Name	Definition	Req	Data Type	Format Required	Len	UDV Ok	Valid Values
1	INC_KEY	Incident key	Foreign Key to identify an incident. This data point will be used to identify an incident in incident record.	Yes	N		10	N/A	
2	SAFETY	Safety Equipment Used	Identifies the protective/safety device(s) in use or worn by the patient at the time of injury.	No	AN		25	Yes	"Seat Belt" "Air Bag Deployed" "Infant/Child Car Seat" "Helmet" "Eye Protection" "Protective Clothing" "Hard Hat" "Padding" "None Used" "Not Done/Not Documented" "Other"

Appendix A : Pre-Existing Comorbidity Factors

Below is the list of factors that are applicable for the *Incident Pre-Existing Comorbidity Factors* record (*I-COMBDTY*). ICD-9-CM codes are listed for each comorbid factor. These codes are provided in the event that your system records comorbidities in the form of ICD-9-CM codes. If this is the case, please translate each comorbid ICD-9-CM code (if present for the patient incident) to create a *Pre-Existing Comorbidity Factors* record with the associated Data Submission File Format code as indicated in the first column.

Code	Name	Related ICD-9-CM Codes
A.01	History of Cardiac Surgery	V45.0, P35.00-39.99, V42.1, V42.2, V42.2, V43.3
A.02	Coronary Artery Disease	414.9, 414.0
A.03	Congestive Heart Failure	428.0, 425.0-425.9
A.04	Cor Pulmonale	416.8, 415.0, 416.9
A.05	Myocardial Infarction	410.0-412.0, 428, 429.0-429.3, 429.8, 429.9
A.06	Hypertension	any 401, 402.00, 402.10, 402.90
B.01	Insulin Dependent	250 (5 th digit assignment for each comorbid factor)
B.02	Non-Insulin Dependent	250 (5 th digit assignment for each comorbid factor)
C.01	Peptic Ulcer Disease	any 533
C.02	Gastric or Esophageal Varices	456.0-456.2
C.03	Pancreatitis	577.0
C.04	Inflammatory Bowel Disease	558.9
D.01	Acquired Coagulopathy	286.7
D.02	Coumadin Therapy	
D.03	Hemophilia	286.0-286.4
D.04	Pre-existing Anemia	285.0, 285.8, 285.9
E.00	History of Psychiatric Disorders	any V11, V40.2
F.01	HIV/AIDS	079.53
F.02	Routine Steroid Use	

Code	Name	Related ICD-9-CM Codes
F.03	Transplants	V42
F.04	Active Chemotherapy	V58.1
G.01	Bilirubin > 2 mg % (on Admission)	
G.02	Documented History of Cirrhosis	571.2, 571.5
H.01	Undergoing Current Therapy	
H.02	Concurrent or Existence of Metastasis	
I.01	Rheumatoid Arthritis	714.0-714.9
I.02	Systemic Lupus Erythematosus	710.0
J.01	Spinal Cord Injury	any 806, 952-954
J.02	Multiple Sclerosis	340
J.03	Alzheimers Disease	290.0-290.13, 331.0
J.04	Seizures	780.3
J.05	Chronic Demyelinating Disease	341.0-341.9
J.06	Chronic Dementia	290.10
J.07	Organic Brain Syndrome	310.9
J.08	Parkinsons Disease	332.0
J.09	CVA/Hemiparesis (Stroke with Residual)	342.0-342.9
K.00	Obesity	278.00-278.01
L.01	Documented Prior History of Pulmonary Disease with Ongoing Active Treatment	
L.02	Asthma	493.0-493.9
L.03	Chronic Obstructive Pulmonary Disease	493.2, 496
L.04	Chronic Pulmonary Condition	496
M.01	Serum Creatinine > 2 mg % (On Admission)	
M.02	Dialysis (Excludes Transplant Patients)	V56.0, V45.1, V56.8
N.01	Chronic Drug Abuse	304.0-304.9

Code	Name	Related ICD-9-CM Codes
N.02	Chronic Alcohol Abuse	303.9
P.00	Pregnancy	any V22

Appendix B : Complications

Below is a list of complications as defined by the Committee On Trauma Quality Improvement Subcommittee. Each complication has been tagged with its identifying code which is used in field position 2 in the *Incident Complication Record*. If your system records complications in another format (e.g., boolean Y/N fields), please translate each complication present for a patient incident to an *Incident Complication Record* that contains the appropriate complication code as defined in the table below.

COT Complication Name	File Format Complication Code	Definition	Related ICD-9-CM Codes
Acute Respiratory Distress Syndrome (ARDS)	"ARDS"	PaO ₂ /fIO ₂ >= 200, decreased compliance, diffuse pulmonary infiltrates associated with normal capillary wedge pressure in an appropriate setting. "Decreased compliance" is defined as abnormal per criteria established by institution.	518.5
Aspiration Pneumonia	"ASPP"	History of aspiration of gastric contents followed by clinical and new radiologic findings of pneumonitis within 48 hours.	507
Bacteremia	"BACT"	Any positive blood culture (<i>not</i> contaminants).	790.7
Cardiac Arrest	"CARA"	Sudden cessation of cardiac activity <i>after arrival</i> in ED, resulting in deprivation of sufficient oxygen to maintain viability of heart and brain.	427.5
Coagulopathy	"COAG"	Uncontrolled diffuse bleeding in the presence of coagulation abnormalities, e.g., increased PT or PTT, decreased platelets, or DIC.-requires treatment.	286.6
Compartment Syndrome	"COMS"	Clinical evidence of increased compartment pressure with or without development of sensory or motor deficit not present on admission in a patient following blunt or penetrating extremity injury.	958.8
DVT (Lower Extremity)	"DVTL"	Venous thrombosis proximal to or involving popliteal vein confirmed by autopsy, venogram, duplex scan or non-invasive vascular evaluation.	453.8
Disseminated Fungal Infection	"DFUI"	Clinical picture of sepsis with isolation of fungus from the blood, <i>or</i> two or more non-hematogenous sites, <i>or</i> tissue biopsy, <i>or</i> positive fundoscopic findings.	117.9
Dehiscence/+Evisceration	"DEEV"	Breakdown of fascial closure confirmed by discharge of preitoneal fluid, evisceration or palpable fascial defect.	998.3
Empyema	"EMPY"	Positive culture of purulent material from pleural space requiring thoracostomy tube drainage.	510.9

Esophageal Intubation	"ESOP"	Endotracheal tube in esophagus and not immediately repositioned. Esophageal location determined by physical examination, x-ray, capnography or endoscopy.	
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Hypothermia	"HPOT"	Temperature <= 35 C.	780.9
Intra-Abdominal Abscess	"INAA"	Localized collection of purulent material in the abdominal cavity confirmed by Gram stain or culture.	682.2
Jaundice	"JAUN"	Total bilirubin >= 2.5 and AST or ALT greater than twice normal.	774.4
Loss of Operative Reduction/Fixation	"LORF"	Configuration of reduced fracture changed enough to warrant reoperative reposition of fragments.	
Myocardial Infarction	"MYCI"	Acute, irreversible myocardial injury and necrosis documented by increased CK-MB isoenzyme and serial T wave, S-T segment; or Q wave ECG changes; or a diagnostic radionuclide scan.	410.9
Pancreatitis	"PANC"	Any hypermylasemia associated with ultrasound or CT findings compatible with pancreatic inflammation.	577.0
Pneumonia	"PNEU"	Presence of fever, leukocytosis, gram stain of sputum with a predominant organism and white blood cells, chest radiograph with a pneumonic infiltrate and culture of sputum demonstrating a pathogen.	482.9
Pneumothorax	"PNTH"	Presence of intra-pleural air.	512.0, 512.1, 512.8
Skin Breakdown	"SKBD"	Contact pressure induced skin breakdown	707
Progression Of Original Neurologic Insult	"PONI"	Deterioration of additional loss of function from that noted on arrival in ED.	
Pulmonary Embolus	"PEMB"	Embolus to the lungs documented by arteriography, nuclear scan or autopsy	415.1
Renal Failure	"RENF"	Creatine >= 3.5 mg/dl or BUN >= 100 mg/dl	584.8
Urinary Tract Infection	"UNTI"	Clean voided or catheter urine specimen with >= 10 WBC/hpf or >= 50K organisms/ml on C/S.	any 599
Wound Infection	"WNDI"	Drainage of purulent material from wound or active treatment of the wound, including opening a closed wound or antibiotics for the wound.	958.3