CASE #: ______________________________

Facility Name: ____

Facility Contact: Phone #: ________________________

1. **Administrative Communication** (NQF 291): Does the medical record documentation indicate that the following communication occurred ***prior to the departure of the patient from the ED to another healthcare facility*** ?	Yes	No	NA
a. Evidence of communication between the transferring ED and the receiving hospital (this does not need to be a full report, acceptable communication includes assuring the availability of appropriate bed and staff for the patient).			
b. evidence of the Physician/Advanced, Practice Nurse/Physician, Assistant, (Physician/APN/PA) to Physician/APN/PA communication			
2. **Patient Information** (NQF # 294): Does the medical record documentation indicate that the following patient information went with the patient or was communicated via fax or phone or internet/Electronic Health Record within 60 minutes of the patient's discharge?	Yes	No	NA
a. patient name			
b. patient address			
c. patient age or date of birth			
d. patient gender			
e. patient contact information (family member/significant other/friend)			
f. patient health insurance information			
3. **Vital Signs** (NQF # 292) Does the medical record documentation indicate that the following patient's vital signs were taken and the information went with the patient or was communicated via fax or phone or internet/Electronic Health Record within 60 minutes of the patient's discharge?	Yes	No	NA
a. pulse			
b. respiratory rate			
c. blood pressure			
d. oxygen saturation			
e. temperature			
f. glasgow coma scale or other neurologic assessment (trauma, cognitively altered, or neurology patients only)			
4. **Medication Information** (NQF # 293): Does the medical record documentation indicate that the following patient's medication information went with the patient or was communicated via fax or phone or internet/Electronic Health Record within 60 minutes of the patient's discharge? *note: if it is **documented** that patient is not on any home medications, no ED medications were perscribed or does not have any allergies select "yes" Also: if it is **documented** that it is unknown if patient is on home medication or has allergies/reactions select "yes"*	Yes	No	NA
a. medications administered in the ED			
b. allergies/reactions (includes food, medication, other and allergic reactions)			
c. home medications (including home scripts, PRN, OTC, herbals,etc)			
5. **Physician Information** (NQF # 295): Does the medical record documentation indicate that the following physician or practitioner generated information went with the patient or was communicated via fax or phone or internet/Electronic Health Record within 60 minutes of the patient's discharge?	Yes	No	NA
a. history and physical (Must minimally include history of the current ED episode, a focused physical exam and relevant chronic conditions. Chronic conditions may be excluded if the patient is neurologically altered)			
b. reason for transfer and/or plan of care			
6. **Nurse Generated Information** (NQF # 296): Does the medical record documentation indicate that the following nurse generated information went with the patient or was communicated via fax or phone or internet/Electronic Health Record within 60 minutes of the patient's discharge?	Yes	No	NA
a. nursing notes (examples: assessments/interventions/patient response or SOAP notes			
b. sensory status (impairments) (includes mental, speech,lllhearing, vision, sensation)			
c. catheters/ IV			
d. immobilizations			
e. respiratory support			
f. oral restrictions			
7. **Procedures and Tests Information** (NQF # 297): Does the medical record documentation indicate that the following procedures and tests information went with the patient or was communicated via fax or phone or internet/Electronic Health Record within 60 minutes of the patient's discharge?	Yes	No	NA
a. tests and procedures performed			
b. tests and procedure results			

Complete one extraction form per chart reviewed. See Guidelines for number of cases to submit or sample for each month of the reporting period.