NCTR Data Dictionary 2024

For Trauma Registrars

Version 2024-04-22

Effective 01 Jan 2024

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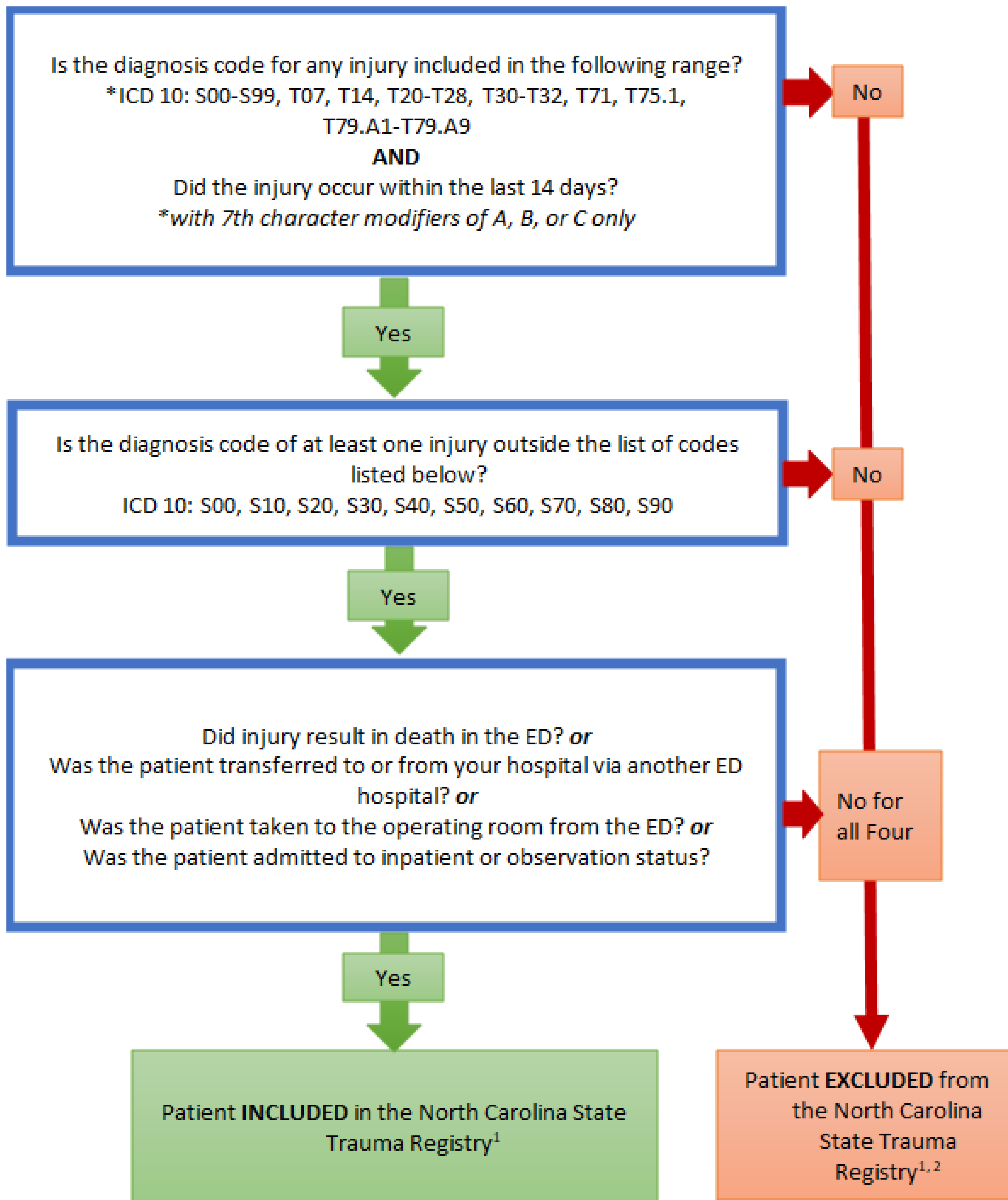
NCTR Inclusion Criteria



[1]Readmissions: See the Readmissions section below for patients experiencing an unplanned readmission to your facility within 30 days of discharge.

[2]Exclude patient if the patient's qualifying injury occurred while admitted to your facility

Sample Inclusion/Exclusion Scenarios

1. A patient arrives to your ED via private vehicle. The patient was seen at an urgent care facility earlier the same day where she was diagnosed with rib fractures and a shoulder dislocation and was told to go to an ED for further evaluation. The patient indicates the onset of pain was after a syncopal fall experienced 8 days ago. Pt was admitted to observation status at your facility for injury related pain management and syncopal workup.

   Outcome: **INCLUDE** in NCTR.
   Rationale: The patient meets inclusion criteria because their qualifying injury occurred within the last 14 days and the patient was admitted to observation status.

2. A patient arrives to your ED via private vehicle. The patient indicates they suffered a syncopal fall 5 days ago in another state and at that time was admitted as an inpatient there for 3 days for syncopal workup and pain management for an acute right proximal humerus fracture with no surgical intervention. The patient's family brought the patient home with them to NC to provide care after the injury. The patient presents to your ED with continued weakness as well as continued pain in their arm since they were discharged from the previous hospital. The patient receives an Ortho consult in the ED indicating no surgical management. The pt is admitted to observation status by the Hospitalist for medical evaluation and pain management of humerus fx.

   Outcome: **INCLUDE** in NCTR.
   Rationale: The patient meets inclusion criteria because their qualifying injury occurred within the last 14 days and the patient was admitted to observation status.

3. A patient had the onset of pain after falling off their bicycle 2 days ago. The patient arrives via EMS to your facility directly from Orthopedic MD office. Imaging at the Orthopedic office indicated a R femoral neck fx and the patient is directly admitted as an inpatient for additional imaging and urgent surgical intervention. Operative notes and imaging at your facility confirm R femoral neck fx.

   Outcome: **INCLUDE** in NCTR.
   Rationale: Patient's directly admitted to your hospital as inpatient or observation (i.e. not admitted from the ED) meet inclusion criteria as long as all other inclusion criteria are met. Note: Patients admitted as outpatient for planned surgical interventions are not included.

4. A patient arrives via EMS to your ED after suffering a fall immediately prior to arrival. The patient is diagnosed with a scalp hematoma. The patient also indicates tripping and falling about 2.5 weeks prior, after which they suffered foot pain. The patient did not seek medical attention for the fall 2.5 weeks ago. Imaging now reveals patient has a subacute metatarsal fx. The patient is admitted for syncopal workup and pain management related to metatarsal fx.

   Outcome: **EXCLUDE** from NCTR.
   Rationale: The patient's scalp hematoma ICD-10 diagnosis (S00.03XA) does not fall into the diagnosis code range for inclusion. The fall resulting in the metatarsal fracture occurred over 14 days ago. To be included in the NCTR, the injury must have occurred within the previous 14 days.

5. A patient arrives via EMS to your ED as a transfer from a standalone ED facility. The patient fell from a ladder 15 days prior. The patient has also been seen 2 times at Urgent care since the fall with no injury diagnosis. The standalone ED's imaging today indicates a subacute L1 compression fx. The patient is admitted as an inpatient to your facility for back pain management and severe hyponatremia management.

Outcome: EXCLUDE from NCTR.
Rationale: Although the patient has been transferred from another facility, their injury occurred more than 14 days ago, therefore they are excluded.

6. A patient arrives via EMS to your ED as a transfer from a referring hospital. The patient was involved in a MVC earlier in the day. The patient takes a daily anticoagulant for atrial fibrillation. The patient suffered a superficial forehead laceration in the MVC. The patient is transferred to your facility due to low hemoglobin and is admitted to observation from the ED. No other traumatic injuries are diagnosed.

Outcome: INCLUDE in NCTR.
Rationale: The ICD 10 diagnosis code for the patient's superficial forehead laceration (S01.81XA) meets inclusion criteria, therefore the patient should be included.

7. A patient, currently admitted as an inpatient at your facility for acute colitis, experiences a mechanical fall in their inpatient room. The patient is diagnosed with a R patella fx as a result of the fall.

Outcome: EXCLUDE from NCTR.
Rationale: If the patient's injury occurs while admitted to your hospital, they are excluded. Note: If a patient is injured while admitted to a facility other than yours and is then admitted to your facility (TXF, ED admit, or direct admit) then the patient should be included.

8. A patient, currently admitted as an inpatient at your facility for a traumatic T2 compression fracture, experiences a fall during Physical Therapy and is diagnosed with a new right ulna fracture as a result of this fall.

Outcome: EXCLUDE from NCTR.
Rationale: If the patient is already in the Trauma Registry for their T2 compression fracture, do not include the right ulna fracture diagnosis in the patient's injuries; If the patient is not already in the Trauma Registry (for example, the pt's T2 compression fx occurred 15 days prior to admission), do not enter the patient into the Trauma Registry due to the injury that occurred while admitted.

9. A patient presents to your ED with complaints of surgical site redness and pain. The patient was discharged from your facility 5 days prior after an ED to inpatient admission for surgical intervention for a traumatic femur fracture (this admission is included in the NCTR). The patient is readmitted as an inpatient to your hospital for infection management.

Outcome: Enter the patient's readmission in the Readmission Tab of the previous admission. Do not create a new/second Trauma Registry record for the patient.

10. A patient presents to your ED with complaints of surgical site redness and pain. The patient was discharged from your facility 5 days prior after a planned outpatient surgical intervention for a traumatic femur fracture. The patient's injury occurred 12 days ago. The patient is admitted as an inpatient to your hospital for infection management related to the outpatient surgery. The patient's admission for the outpatient surgery is not included in the Trauma Registry.

Outcome: INCLUDE in NCTR.

Rationale: The patient's inpatient admission for infection management should be included as the patient suffered an injury meeting inclusion criteria within 14 days prior to their inpatient admission.

11. Peri-prosthetic fxs resulting from traumatic mechanism (fall,MVC,etc) within 14 days prior to admission or TXF from your ED to another facility.

Outcome: INCLUDE in NCTR.
Rationale: The patient's fracture was caused by a traumatic injury mechanism. The patient should have 2 ICD-10 diagnosis codes. One is the M97 code that describes the periprosthetic nature of the fracture. The second is the S code that describes the fracture, e.g., S72 for femur fx.

12. A pediatric patient presents to your ED after a copperhead bite to their hand just prior to arrival. The patient is transferred to another acute inpatient facility for observation after treatment with anti-venom therapy.

Outcome: INCLUDE in NCTR.
Rationale: Snake bites are to be captured if the patient is admitted for treatment of the bite or transferred for treatment of the bite (including anti-venom therapy), as is any other trauma patient. M-code is used to describe snake type. For venomous snakes: (1) Use the appropriate T63.nnnA code to identify what type of snake (coral snake vs rattlesnake, etc) and intentionality. (2) Code the injury location using the appropriate S or T code. (3) Code the external cause code of X58 (Exposure to other specified factors).
For non-venomous snakes: Use the appropriate W59.1 code to identify whether the snake bit, struck, crushed, or had other contact with the patient. (a) W59.11—bitten by nonvenomous snake, (b) W59.12—struck by nonvenomous snake, (c) W59.13—crushed by nonvenomous snake.

13. A patient presents to your ED after Dog bite to the face just prior to arrival. The patient's wound is treated and they are discharged from the ED. The patient returns to ED 5 days later and is admitted as an inpatient for IV antibiotic treatment of developed cellulitis from the dog bite.

Outcome: EXCLUDE from NCTR.
Rationale: The patient is being admitted for sequalae of the traumatic injury (ICD 10 7th character S). NCTR inclusion criteria indicates to only include ICD 10 diagnosis codes with an ICD 10 7th character of A,B or C.

14. General Exclusion information. The following patients should not be sent to the state:
   a. Patients who are discharged from ED with planned return for outpatient surgery.
   b. Age-indeterminant injuries: if the patient's ONLY injuries are classified by the radiologist as age-indeterminant.
   c. Injuries due to in-hospital falls that occur when they are an inpatient in that facility

Demographic/Record info

RECORD COMPLETE?

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: Completeness status of the record.

FIELD VALUES:

<Y> Yes
<N> No
Blank

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Change flag to 'Y' once all pertinent data fields have been entered and validated.
- Analysis and quality check datasets will include all records flagged with Y or blank in this field.

HISTORY:

PATIENT INITIAL LOCATION

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Initial location patient was admitted to at submitting facility.

FIELD VALUES:

<2> Emergency Department
<3> Operating Room
<4> Intensive Care
<5> Step-Down Unit
<7> Telemetry Unit
<8> Floor
<9> Observation Unit
<10> Radiology
<11> Post Anesthesia Care Unit
<12> Special Procedure Room
<13> Labor and Delivery
<14> Pediatric ICU
</> Not Applicable
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

</> Not Applicable should never be used.

HISTORY:

TRAUMA NUMBER

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: Record identifier, unique to a patient admission/record at a specific facility.

FIELD VALUES:

DEFAULT: Auto-populated. Grayed out, unable to modify.

ADDITIONAL INFORMATION:

- This field is auto-generated by the software displayed in sequential numbering. However, the software does allow for the ability to modify the registry number interrupting the sequential numbering. It will not allow the user to duplicate registry numbers through a validation check.

HISTORY:

FACILITY ARRIVAL DATE/TIME

State Required	Available for State Research	NTDB Required
Yes	Yes*	Yes

DEFINITION: Arrival date-time at facility - either through ED or direct admit.

FIELD VALUES:

Date/Time

DEFAULT: Blank

ADDITIONAL INFORMATION:

- If the patient was brought to the ED, enter the time the patient arrived at the ED. If a direct admission, enter the time the patient was admitted to the hospital.
- In the DI software, this field will auto-populate patient date and time on ED Resuscitation screen provided the initial location field choice selected is <2> Emergency Department or if the initial location field is not used and left blank.
- Time (HH:MM) should be collected in military time.
- Used to auto-calculate the total ED LOS and Hospital LOS.
- </> (Not applicable) is not a valid option for this field.

HISTORY:

PATIENT ORIGIN

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Where did patient come from for this admission?

FIELD VALUES:

Field Values	Definition / Notes
<1> Clinic	Outpatient clinic. Includes free-standing diagnostic facility (such as radiology), "minute clinic". Assumes Clinic is not the scene.
<2> EMS Station	Includes fire stations, law enforcement buildings. Assumes EMS station is not the scene.
<3> MD Office	Any private physician's office. Assumes MD Office is not the scene.
<4> Home	Use if patient leaves the scene to go home then arrives at the ED, i.e., there is a delay between time of injury and when patient chooses to seek definitive care. Home includes foster care, group home, assisted living facilities, independent living facilities at independent living continuous care retirement communities. Assumes Home is not the Scene.
<5> Nursing Home	Skilled Nursing Facility (SNF), nursing home, or long term care facility where patient resides. Does not include LTAC. Assumes Nursing Home is not the scene.
<6> Referring hospital / facility	Referring hospital (including ED) that patient was treated at prior to arrival at your facility. Assumes referring hospital is not the scene.
<7> Scene	Use if patient arrives at your facility directly from scene of injury. Includes LTACs (Long Term Acute Care facilities) if patient was injured at LTAC. Also includes patient injured at home who arrives from home.
<8> Urgent Care	Facility that identifies itself as an urgent care facility. Assumes the Urgent Care facility is not the scene.
<9> Other Acute Facility	Free-standing ED.
<10> Correctional Facility	Jail, prison, or other place of incarceration. Assumes the Correctional Facility is not the scene.
<11> Other	
<?> Unknown	

DEFAULT: Blank

ADDITIONAL INFORMATION:

HISTORY:

2024 Change: changed name in dictionary from "Arrived from".

REGISTRY INCLUSION

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: Inclusion information: is record to be sent to state or NTDB?

FIELD VALUES:

1=NTDB
2=State

DEFAULT: Blank

ADDITIONAL INFORMATION:

- If record is to be sent to the state, this field is required if the trauma registry software requires this field to identify which records are to be sent to the state.
- Depending on trauma registry software, field values may be <Y>Yes or <N> No

HISTORY:

Demographic/Patient

PATIENT FIRST NAME/LAST NAME/MIDDLE INITIAL

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: The last, first and middle name of the patient.

FIELD VALUES:

Free Text
<?>=Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- No restriction as to whether the names should be entered in UPPER CASE, lower case, or Proper Case.
- </> N/A: used if no middle initial.
- In the DI software, the name fields will auto-populate the name fields within the Demographic/Patient screen. Conversely, these name fields will auto-populate should the patient’s name be entered initially within the Demographic/Patient Screen.
- Jr/Sr should follow last name with no commas.

HISTORY:

DATE OF BIRTH

State Required	Available for State Research	NTDB Required
Yes	No	Yes

DEFINITION: Month, day, and year of patient's birth.

FIELD VALUES:

Date value

DEFAULT: Blank

ADDITIONAL INFORMATION:

Use mm/dd/yyyy format.

HISTORY:

GENDER

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Patient's current gender.

FIELD VALUES:

<1> Male
<2> Female
<3> Non-binary (Added Jan2021)
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- If patient is transgender, enter the gender stated by the patient

HISTORY:

GENDER IDENTITY

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Patient's gender identify.

FIELD VALUES:

<1> Transgender-Female (the patient identifies as transgender male-to-female)
<2> Transgender-Male (the patient identifies as transgender female-to-male)
<3> Non-Binary (the patient does not identify as exclusively male or female)
<4> Male (the patient identifies as male)
<5> Female (the patient identifies as female)
<6> Other (other gender identity)
<7> Non-Disclosed (the patient does not wish to disclose gender identity)
</> Not Applicable
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- If patient is transgender, enter the gender stated by the patient.

HISTORY:
Added Jun-2021

RACE

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: The races of the patient based upon self-report or by a family member. Use primary race as the one that the patient predominantly identifies as.

FIELD VALUES:

<1> Asian
<2> Black
<3> American Indian
<4> Native Hawaiian or Other Pacific Islander
<5> White
<6> Other Race
<?> Unknown
</> n/a (for Race2 through Race4 only)

DEFAULT: Blank

ADDITIONAL INFORMATION:

- If no second-fourth race, use </> or blank.
- Use current census definitions for field values.
- Race should be recorded for all patients. Do not follow NTDB instructions to record race as "n/a" for outof-country residents. The NTDB edit check is in reference only to patients admitted to non-US hospitals where race is not collected.
- N/A is not a valid option for the Race1 field. N/A is valid for fields Race2-Race4 if the person identifies only as one race.
- If multiple, different races are reported through different sources (e.g., MD, EMS run sheet, patient/family), choose the patient/family report as the first option. Go with the value reported by hospital registration if it's not documented what the patient or family reports.

HISTORY:

ETHNICITY

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Hispanic ethnicity status of patient based on self-report or report by family member.

FIELD VALUES:

<1> Hispanic or Latino
<2> Not Hispanic or Latino
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- The maximum number of ethnicities that can be reported is 1.
- Use <?> for records where ethnicity is not recorded in medical record, or patient or family declined to provide ethnicity.
- Use current census definitions for field values.
- Do not follow NTDB instructions to record race as “n/a” for out-of-country residents.
- N/A is not a valid option for the Ethnicity field.

HISTORY:

PATIENT ADDRESS ZIPCODE

State Required	Available for State Research	NTDB Required
Yes	Yes*	Yes

DEFINITION: Zipcode of patient's home address.

FIELD VALUES:

Five-digit zipcode

</> Homeless (including living in a homeless shelter) or primary address is out of the country

<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- If zipcode is unknown, complete as many related fields as possible, e.g., Residence State, Residence County, Residence City, and Residence Country.

HISTORY:

HOMELESS

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Does patient have a home to live in?

FIELD VALUES:

<Y> Yes
<N> No
<?> Unknown

DEFAULT: <N>

ADDITIONAL INFORMATION:

- Homeless - A person who lacks housing. The definition also includes a person living in transitional housing or in a supervised public or private facility providing temporary living quarters.
- In ESO's V5 software: When a zip code is entered into the zip field, the Homeless field defaults to <N>.

HISTORY:

PATIENT ADDRESS CITY

State Required	Available for State Research	NTDB Required
Yes	No	Yes

DEFINITION: City of patient's home address.

FIELD VALUES:

<?> = Unknown

</> Patient is from country other than US or homeless

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Auto-populates by the software, based on the zip code.
- If zip code is unknown but city known, manually enter. The DI software NCv5 is currently not set up to search for city/FIPS code within the database. You will have to use the search option within the NTDB module to populate this field correctly. Reported to DI.

HISTORY:

PATIENT ADDRESS STATE

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: State of patient's home address.

FIELD VALUES:

Two-letter initials for states
<?> Unknown
</> Patient is from country other than US or homeless

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Auto-populated by the software, based on the zip code.
- If zip code is unknown but State is known, manually enter state. If zipcode and state are unknown, enter <?>.

HISTORY:

PATIENT ADDRESS COUNTY

State Required	Available for State Research	NTDB Required
Yes	No	Yes

DEFINITION: County of patient's home address.

FIELD VALUES:

Choose NC county from field menu.
<?> Unknown
</> Patient is from country other than US or homeless

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Auto-populated by the software, based on the zip code.
- If zip code is unknown but county is known, enter the county name. If county and zipcode are unknown, enter <?> for county.
- Do not guess or approximate.

HISTORY:

PATIENT ADDRESS COUNTRY

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Country of patient's home address.

FIELD VALUES:

<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Auto-populated by ESO's NCv5 software, based on the zip code
- If zip code is unknown but country is known then choose country value from picklist. If country also is unknown, enter <?> for country.
- Do not guess or approximate.

HISTORY:

PATIENT ADDRESS CITY FIPS CODE

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: FIPS code of city of patient's home address.

FIELD VALUES:
FIPS codes

DEFAULT: Blank

ADDITIONAL INFORMATION:
- FIPS is the Federal Information Processing Standards code. It is Auto-populated by ESO's NCv5 software, based on the zip code
- If registry software does not autopopulate FIPS code, refer to https://transition.fcc.gov/oet/info/maps/census/fips/fips.txt
- Do not guess or approximate.

HISTORY:
New in 2024

PATIENT ADDRESS COUNTY FIPS CODE

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: FIPS code of county of patient's home address

FIELD VALUES:

FIPS codes

DEFAULT: Blank

ADDITIONAL INFORMATION:

- FIPS is the Federal Information Processing Standards code. It is Auto-populated by ESO's NCv5 software, based on the zip code
- If registry software does not autopopulate FIPS code, refer to https://transition.fcc.gov/oet/info/maps/census/fips/fips.txt
- Do not guess or approximate.

HISTORY:

New in 2024

PATIENT ADDRESS STATE FIPS CODE

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: FIPS code of state of patient's home address

FIELD VALUES:

FIPS codes

DEFAULT: Blank

ADDITIONAL INFORMATION:

- FIPS is the Federal Information Processing Standards code. It is Auto-populated by ESO's NCv5 software, based on the zip code
- If registry software does not autopopulate FIPS code, refer to https://transition.fcc.gov/oet/info/maps/census/fips/fips.txt
- Do not guess or approximate.

HISTORY:

New in 2024

ALTERNATE HOME RESIDENCE

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Documentation of patient type for patients without a zipcode.

FIELD VALUES:

<1> Undocumented citizen
<2> Migrant Worker
<3> Foreign Visitor (Retired Jan 2016)
</> Not Applicable
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Complete only when the residence zipcode is n/a.
- <Undocumented citizen> - Defined as a national of another country who has entered or stayed in another country without permission.
- <Migrant Worker> - Defined as a person who temporarily leaves his/her personal place of residence within a country in order to accept seasonal employment in the same or different country
- Prior to January 2016, <Foreign Visitor> -was defined as any person legally visiting a country other than his/her usual place of residence for any reason.
- Use </> for this field if residence zip code field contains a valid value.
- Use </> for a patient who is homeless. Note: NTDB includes Homeless as a value in this field as of 2024.

HISTORY:
July 2016: NTDS added that value should be n/a if Home Zip field is completed with valid zipcode.

INJURY DATE/TIME

State Required	Available for State Research	NTDB Required
Yes	Yes*	Yes

DEFINITION: Date-time that injury occurred.

FIELD VALUES:

Date/Time

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Estimates of date of injury should be based upon report by patient, witness, family, or healthcare provider. Other proxy measures (e.g. 911 called time) should not be used.
- The date is documented as MM/DD/YYYY
- The time is documented in military time (HH:MM)
- <?> ‘Unknown’ can be used in this field if injury date/time is unknown
- “Not applicable” is not a valid value.

HISTORY:

INJURY PLACE (ICD-10)

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Location where injury occurred (ICD-10 format for injuries occurring Oct-2015 or later.)

Place of occurrence external cause code used to describe the place/site/location of the injury

event

FIELD VALUES:

Too numerous to list. See https://www.icd10data.com/ICD10CM/Codes/V00-Y99/Y90-Y99/Y92- for a list of values.

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Refer to the ICD-10 CM manual to assign appropriate place of injury code.
- “Not applicable” is not a valid option for patients admitted on or after 01 Oct 2015.

HISTORY:

PROTECTIVE DEVICES - RESTRAINTS

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Type of motor vehicle restraint used by patient.

FIELD VALUES:

Field values	Definitions
~~<1> None~~ Retired 1/1/2017	
<2> Seatbelt-Lap and Shoulder	Same as 3-point restraint
<3> Seatbelt-Lap Only	
<4> Seatbelt-Shoulder Only	
<5> Seatbelt-NFS	Should be used to include those patients that are restrained but not further specified
<6> Child Booster Seat	
<7> Child Car Seat	
<8> Infant Car Seat	
<9> Child Seat Not Secure	Covers any instance where child seat in use, but not used appropriately
<10> Not Belted	Use only if it is known that no seatbelt was used
</> Not Applicable	This value may not be used when patient involved in MVC, but may be used for MCCs.
<?> Unknown	

DEFAULT: Blank

ADDITIONAL INFORMATION:

- The use of <1>None was retired in 2017; Use <10> <Not Belted> instead.
- Evidence of child restraint may be reported or observed.
- For research/data analysis purposes, 6, 7, and 8 are combined since Registrars generally don't have the information required to distinguish between these options.
- <11> Truck bed restraint: Do not use.

HISTORY:

PROTECTIVE DEVICES - AIRBAG DEPLOYMENT

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Indication of an airbag deployment during a motor vehicle crash.

FIELD VALUES:

<1> Airbag Did Not Deploy
<2> Front (Deployed)
<3> Side (Deployed)
<4> Airbag Deployed Other (knee, airbelt, curtain, etc.)
<5> Airbag Type Unknown (Deployed)
<6> No Airbag in Vehicle
</> Not Applicable
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Evidence of the use of airbag deployment may be reported or observed.
- <Airbag Type Unknown (Deployed)> should be used for patients with documented airbag deployments, for whom the airbag type is not further specified.
- Multiple entry field, choose all that apply. May choose up to four.
- Required only for motor vehicle collisions.

HISTORY:

PROTECTIVE DEVICES - EQUIPMENT

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Protective equipment used by patient (other than motor vehicle-related equipment).

FIELD VALUES:

1=None
2=Helmet *(Examples: for bicycling, skiing, riding motorcycle)*
3=Eye protection
4=Protective clothing
5=Protective non-clothing gear *(e.g., shin guard, padding)*
6=Hard hat
7=Safety harness
8=Other
9=No helmet *(Examples: for motorcycle, ATV, skateboard, and bicycle)*
10=Personal flotation device
/=Not applicable *(Do not use for MCC, ATV, or bicycle events)*
?=Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- <1> 'None' – Use this value only if it is documented that the patient was wearing no safety or protective equipment. If this information was not documented, use <Unknown>.
- <4> 'Protective Clothing' – includes any type of clothing used for protection during an activity, skateboarding, etc., as well as bullet-proof vests, steel-toed shoes, etc.
- Multiple entry field, choose all that apply.

HISTORY:

INJURY ADDRESS ZIP

State Required	Available for State Research	NTDB Required
Yes	Yes*	Yes

DEFINITION: Zipcode where injury occurred.

FIELD VALUES:

Five-digit zipcode
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

*Available for research as part of large region definition

- Enter <?> if zip is unknown, then complete as many of the location variables as possible: Incident State, Incident County, Incident City, and Incident Country.

HISTORY:

INJURY ADDRESS CITY

State Required	Available for State Research	NTDB Required
Yes	No	Yes

DEFINITION: Injury address city.

FIELD VALUES:

Auto-populated, based on zipcode
<?> Unknown
</> Patient is from country other than US

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Auto-populates by the software, based on the zip code Use <?> 'Unknown' city where injury occurred is unknown.
- If zip code is unknown but city known, manually enter. The DI software NCv5 is currently not set up to search for city/FIPS code within the database. You will have to use the search option within the NTDB module to populate this field correctly. Reported to DI.
- If incident country is not "US", then enter "Not Applicable" for Incident State, Incident County, and Incident City.

HISTORY:

INJURY ADDRESS STATE

State Required	Available for State Research	NTDB Required
Yes	Yes*	Yes

DEFINITION: State where injury occurred.

FIELD VALUES:

Two-letter initials for states

<?> Unknown

</> Patient is from country other than US

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Auto-populated by the software, based on the zip code
- If known but no zip code, manually enter.
- If unknown, enter <?>. Do not approximate.

HISTORY:

INJURY ADDRESS COUNTY

State Required	Available for State Research	NTDB Required
Yes	No	Yes

DEFINITION: County where injury occurred.

FIELD VALUES:

Choose NC county from field menu.
<?> Unknown
</> Patient is from country other than US

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Auto-populated by the software, based on the zip code.
- If zip code is unknown but county is known, use the search option for the field.
- If unknown, enter <?>.
- If out of country, use </>.

HISTORY:

INJURY ADDRESS COUNTRY

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Country where injury occurred.

FIELD VALUES:

<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Auto-populated by the software, based on the zip code
- If zip code is unknown but country is known then manually enter value.
- If incident country is not “US”, then enter “Not Applicable” for Incident State, Incident County, and Incident City.

HISTORY:

INJURY ADDRESS: CITY FIPS CODE

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: FIPS code for city where injury occurred

FIELD VALUES:

FIPS codes

DEFAULT: Blank

ADDITIONAL INFORMATION:

- FIPS is the Federal Information Processing Standards code. It is Auto-populated by ESO's NCv5 software, based on the zip code
- If registry software does not autopopulate FIPS code, refer to https://transition.fcc.gov/oet/info/maps/census/fips/fips.txt
- Do not guess or approximate.

HISTORY:

New in 2024

INJURY ADDRESS: COUNTY FIPS CODE

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: FIPS code for county where injury occurred

FIELD VALUES:

FIPS codes

DEFAULT: Blank

ADDITIONAL INFORMATION:

- FIPS is the Federal Information Processing Standards code. It is Auto-populated by ESO's NCv5 software, based on the zip code
- If registry software does not autopopulate FIPS code, refer to https://transition.fcc.gov/oet/info/maps/census/fips/fips.txt
- Do not guess or approximate.

HISTORY:

New in 2024

INJURY ADDRESS: STATE FIPS CODE

State Required	Available for State Research	NTDB Required
Yes	Yes*	No

DEFINITION: FIPS code for state where injury occurred

FIELD VALUES:

FIPS codes

DEFAULT: Blank

ADDITIONAL INFORMATION:

- FIPS is the Federal Information Processing Standards code. It is Auto-populated by ESO's NCv5 software, based on the zip code
- If registry software does not autopopulate FIPS code, refer to https://transition.fcc.gov/oet/info/maps/census/fips/fips.txt
- Do not guess or approximate.

HISTORY:

New in 2024

WORK RELATED

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Was the injury work-related? Indication of whether the injury occurred during paid employment.

FIELD VALUES:

<Y> Yes
<N> No
</> Not Applicable *Do not use
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- "Not Applicable" is not a valid value.

HISTORY:

- Pre-2023 (specific date unknown): Used to require that if injury was work related, then the Patient's Occupation Industry and Patient's Occupation fields must be completed. Registrars noted that these occupation fields were difficult to obtain and cate

ICD-10 MOI EXTERNAL CAUSE CODES - PRIMARY AND SECONDARY

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: ICD-10 code describing the primary cause or mechanism of injury (MOI)

FIELD VALUES:

Too numerous to list. Resource for ecode definitions: https://www.icd10data.com/ICD10CM/Codes/V00-Y99

DEFAULT: Blank

ADDITIONAL INFORMATION:

- The Primary MOI (aka cause) code should describe the main mechanism that resulted in the patient's injury.
- The Secondary MOI code should describe the secondary mechanism for the injury.
- Multiple Cause Coding Hierarchy: If two or more events cause separate injuries, an external cause code should be assigned for each cause. The first-listed external cause code will be selected in the following order:

    o Refer to the CDC Hierarchy Matrix to determine primary and secondary E-codes when more than one ecode applies.

    o External cause codes for child and adult abuse take priority over all other external cause codes. o External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse. Use codes T74* (confirmed) and T76* (suspected) - adult/child abuse, as the primary MOI for non-accidental trauma and abuse cases. Use codes X92-Y09 (assault codes) as the secondary MOI.

    o External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse, and terrorism.

    o External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, and child and adult abuse, and terrorism.

    o The first listed external cause code should correspond to the cause of the most serious diagnosis due to an assault, accident or self-harm, following the order of hierarchy listed above.

    o Secondary MOI code may not equal primary E-code.

HISTORY:

INJURY TYPE CODES 1 & 2

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Type of injury.

FIELD VALUES:

1=Blunt
2=Penetrating
3=Burn
4=Other
/=Not applicable
?=Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

Some trauma registry software packages may auto-generate this field value based on ECode, but user may be able to change value. Auto-generated value does not automatically change if you change the ECode. Please be sure that this value matches the appropriate mapping based on the CDC Injury Mechanism/Intentionality Matrix.

- Blunt: Non-penetrating injury, from an external force causing injury.
- Burn injury: Exposure to chemical, thermal, electrical or radioactive agents
- Penetrating injury: Injury resulting from a projectile force, piercing instrument of impalement entering into the body
- Other: Chosen for drowning/submersions, over-exertions, suffocations, hanging, and asphyxiations.
- Based upon the CDC intentionality matrix.

HISTORY:

PRIMARY AND SECONDARY COMPLAINT / MECHANISM OF INJURY

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Mechanism of injury.

FIELD VALUES:

Field Values	Definitions
<2> Aircraft	
<3> Animal	Injured by animal ; includes snake bites
<4> Assault	Includes suicide, rape
<5> ATV	Includes 3 & 4 wheelers and go-carts
<6> Bicycle	Includes non-motorized bikes such as mountain or trail bikes.
<7> Burn	
<8> Dirt bike	Motorized bike used off-road (includes motor-cross).
<9> Electrical	
<10> Fall	Includes falls from non-moving motor vehicles, and falls from wheelchairs, beds, and disability scooters.
<11> Golf cart	Be sure to document intended use through E-code as off-road recreation or on street for public use.
<12> GSW	
<13> Machine:	Farming equipment, heavy-duty machinery (i.e. construction, manufacturing, industrial, etc.). Any item that has its own power source. Includes hand-held power tools. Machine's primary purpose should not be human transport. Includes rolling over foot with lawnmower.
<14> Moped	
<15> Motorcycle crash	
<16> MVC	Includes patients who fall from moving vehicle (i.e. car, van, bus, etc.). Includes rider on riding lawn mower that is hit by car.
<17> Pedestrian	Includes pedestrian hit by a motor vehicle, person on skates, person changing a tire or working on a parked car.
<18> Sports	Injury occurred while engaged in an organized sporting activity.
<19> Stab	Includes cutting y ourself with a knife.
<20> Struck	Struck by an object – non motor vehicle related. Use for object thrown out from under a lawnmower. Includes putting your hand through a window.
<21> Asphyxiation	

<22> Drowning	
<23> Other	Replaces <'Accident> in early versions.
<24> Skin disorder	
<25> E-Scooter	(Added Jan2021) Includes Segways.
<26> Skateboard	(Added Jan2021)
<27> Fall from deer-stand	(Added Jan2021) – Any stand/structure that elevates a hunter. Aka tripod stand.
<28> Watercraft	Includes boat, jet-ski. Added-Jan2021)
</> Not applicable	
<?> Unknown	

DEFAULT: Blank

ADDITIONAL INFORMATION:

- May also be called "Chief Complaint"
- Enter primary reason for admission to your facility as first field. Enter any secondary complaint in second field or, if there is no secondary complaint, either enter </>.
- <NAT>: Choose Assault for primary complaint. Use mechanism for secondary complaint field.
- 8/15/2022: "Animal" complaints involving snake bite - Snake bites are to be captured if the patient is admitted for treatment of the bite (including anti-venom therapy), as is any other trauma patient. M-code is used to describe snake type.
  - For venomous snakes: (1) Use the appropriate T63.nnnA code to identify what type of snake (coral snake vs rattlesnake, etc) and intentionality. (2) Code the injury location using the appropriate S or T code. (3) Code the external cause code of X58 (Exposure to other specified factors).
  - For non-venomous snakes: Use the appropriate W59.1 code to identify whether the snake bit, struck, crushed, or had other contact with the patient. (a) W59.11—bitten by nonvenomous snake, (b) W59.12—struck by nonvenomous snake, (c) W59.13—crushed by nonvenomous snake.

HISTORY:

4/23/2012: Added Asphyxiation, Drowning. Removed Accident.
6/17/2013: Added Skin disorder for Burn users.

COMPLAINT/MOI SPECIFY

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: Injury mechanism - free text option to be used only if mechanism does not appear on Injury mechanism picklist.

FIELD VALUES:

Free text

DEFAULT: Blank

ADDITIONAL INFORMATION:

None

HISTORY:

PREHOSPITAL PROVIDER AGENCY ID/ DESCRIPTION

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: Agency represented by the pre-hospital transport provider. Enter for each agency providing transport from scene.

FIELD VALUES:

All NC EMS agencies

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Contact the NCOEMS Trauma Systems Manager should you need to add an agency not found within the picklist.
- Use <Other EMS Agency, OOS> for out of state agencies not already defined within the picklist.

HISTORY:

PCRUUID

State Required	Available for State Research	NTDB Required
Yes	No	Yes

DEFINITION: Linkage used by NEMSIS and OEMS to link trauma and EMS records.

FIELD VALUES:

- If value is unknown, enter “Unknown”.
- Structure must be exact for the UUID to be entered in to the field.
    - o An example UUID: e48cd734-01cc-4da4-ae6a-915b0b1290f6.

DEFAULT: Blank

ADDITIONAL INFORMATION:

Added Jun-2021.
*Field cannot be populated unless the hospital (trauma center) has purchased the ESO HDE (health data exchange).

HISTORY:

PREHOSPITAL MODE

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Mode used by the pre-hospital provider to transport patient from the scene.

FIELD VALUES:

<1> Ground Ambulance
<2> Helicopter Ambulance
<3> Fixed-Wing Ambulance
<4> Private/Public Vehicle/Walk-In
<5> Police
<6> Other
</> Not applicable (Not a valid option)
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- If <4>, <5>, or <6> options are applicable, no other pre-hospital fields should be filled in (since all are not applicable).

HISTORY:

PREHOSPITAL MODE SPECIFY

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Free text

FIELD VALUES:

Free Text

DEFAULT: Blank

ADDITIONAL INFORMATION:

None

HISTORY:

PREHOSPITAL PCR NUMBER

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: Pre-hospital care record (PCR) number

FIELD VALUES:

Free Text

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Will be used to link NCTR and NTDB records to pre-hospital records (Continuum, NEMSIS).

HISTORY:

PREHOSPITAL TRANSPORT REPORT STATUS

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Is the prehospital provider's report complete?

FIELD VALUES:

<1> Complete: There is an EMS report and all
NCTR required data is present
<2> Incomplete: There is an EMS report, but not all NCTR required data is present or legible
<3> Missing: There is no EMS report and all NCTR required data is missing or mode of arrival is unknown.
<4> Unreadable:

DEFAULT: Blank

ADDITIONAL INFORMATION:

Blank

HISTORY:

PREHOSPITAL TRANSPORT DISPATCH DATE-TIME

State Required	Available for State Research	NTDB Required
Yes	Yes*	No

DEFINITION: Date-time pre-hospital provider was dispatched to the patient.

FIELD VALUES:

Date/time value

DEFAULT: Blank

ADDITIONAL INFORMATION:

- The date is documented as MM/DD/YYYY
- The time is documented in military time (HH:MM)
- Date field will auto-populate from the Injury Date field. Be sure to verify date.
- Use </> (for Not applicable) for patients not transported by EMS.

HISTORY:

PREHOSPITAL TRANSPORT ARRIVED LOCATION (SCENE) DATE-TIME

State Required	Available for State Research	NTDB Required
Yes	Yes*	No

DEFINITION: Date-time of pre-hospital arrival at location (scene).

FIELD VALUES:
Date/Time

DEFAULT: Blank

ADDITIONAL INFORMATION:
- The date is documented as MM/DD/YYYY
- The time is documented in military time (HH:MM)
- In ESO's NCv5, the date field will auto-populate from the Injury Date field. Be sure to verify date.
- In ESO's NCv5, this field is used to auto-generate the calculated field: Transport Time Elapsed
- Use </> (for Not applicable) for patients not transported by EMS.

HISTORY:

PREHOSPITAL TRANSPORT LEFT LOCATION DATE-TIME

State Required	Available for State Research	NTDB Required
Yes	Yes*	No

DEFINITION: Date-time prehospital provider left the scene.

FIELD VALUES:
Date/Time

DEFAULT: Blank

ADDITIONAL INFORMATION:
- The date is documented as MM/DD/YYYY
- The time is documented in military time (HH:MM)
- Date field will auto-populate from Injury Date field. Be sure to verify date.
- Used to auto-generate calculated field: Scene Time Elapsed.
- Use </> (for Not applicable) for patients not transported by EMS.

HISTORY:

PREHOSPITAL TRANSPORT ARRIVED DESTINATION DATE-TIME

State Required	Available for State Research	NTDB Required
Yes	Yes*	No

DEFINITION: Date-time of pre-hospital arrival at ED (or rendevous point).

FIELD VALUES:

Date/time value

DEFAULT: Blank

ADDITIONAL INFORMATION:

- The date is documented as MM/DD/YYYY
- The time is documented in military time (HH:MM)
- Date field will auto-populate from Injury Date field. Be sure to verify date.
- Used to auto-generate calculated field: Transport Time Elapsed.

HISTORY:

PREHOSPITAL TRANSPORT NATIONAL FIELD TRIAGE

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Criteria used by EMS providers to help identify risk for serious injury and determine the appropriate type of destination (e.g., trauma center vs non-trauma center) for an injured patient.

FIELD VALUES:

<1> Penetrating injuries to head, neck, torso, and proximal extremities (Injury Pattern)
<2>Skull deformity, suspected skull fracture (Injury Pattern)
<3> Suspected spinal injury with new motor or sensory loss (Injury Pattern)
<4> Chest wall instability, deformity, or suspected flail chest (Injury Pattern)
<5> Suspected pelvic fracture (Injury Pattern)
<6> Suspected fracture of two or more proximal long bones (Injury Pattern)
<7> Crushed, degloved, mangled, or pulseless extremity (Injury Pattern)
<8> Amputation proximal to wrist or ankle (Injury Pattern)
<9> Active Bleeding requiring a tourniquet or wound packing with continuous pressure (Injury Pattern)
<10> Hight Risk Auto Crash (MOI)
<11> Partial or complete ejection (MOI)
<12> Significant intrusion (including roof) (MOI)
<13> Significant intrusion, > 12 inches occupant site (MOI)
<14> Significant intrusion, > 18 inches occupant site (MOI)
<15> Significant intrusion, need for extrication for entrapped patient (MOI)
<16> Death in passenger compartment (MOI)
<17> Child (Age 0-9) unrestrained or in unsecured child safety seat (MOI)
<18> Vehicle Telemetry data consistent with severe injury (MOI)
<19> Rider separated from transport vehicle with significant impact (MOI)
<20> Pedestrian/bicycle rider thrown, run over, or with significant impact (MOI)
<21> Fall from height > 10 feet (all ages) (MOI)
<22> All patients unable to follow commands motor GCS < 6 (MS & VS)
<23> All patients RR < 10 or > 29 breaths/min
<24> All patients respiratory distress or need for respiratory support (MS & VS)
<25> All patients room-air pulse oximetry < 90% (MS & VS)
<26> Age 0-9 years SBP < 70 mmHg + 2 x age years (MS & VS)
<27> Age 10-64 SBP < 90 mmHg (MS&VS) <28> Age 10-64 years HR > SBP (MS & VS)
<29> Age >= 65 years SP< 110 mmHg (MS & VS)
<30> Age >= 65 years HR > SBP (MS & VS)
<31> Low-level falls in young children (age <=5 years) or older adults (age >=65 years) with significant head impact (EMS Judgment)
<32> Anticoagulant use (EMS Judgment)
<33> Suspicion of child abuse (EMS Judgment)

<34> Special, high-resource healthcare needs (EMS Judgment)
<35> Pregnancy > 20 weeks (EMS Judgment)
<36> Burns in conjunction with trauma (EMS Judgment)
<37> Pediatric capable center (EMS Judgment)
/, Not Applicable
?, Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

*Required if completed by EMS agency

HISTORY:

New field 2024

AGENCY DESCRIPTION/ID (PRE-HOSPITAL ASSESSMENT)

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: Agency represented by the provider doing the pre-hospital assessment.

FIELD VALUES:

See EMS list

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Can gray out the agency number and select by name only, or user can click on the button above the field to auto fill the data element.
- Depending on registry software, this field may autopopulate if only one prehospital agency used; if more than one prehospital agency transported the patient, check to make sure the correct agency has been selected.

HISTORY:

PREHOSPITAL ASSESSMENT RECORDED DATE-TIME

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: Date-time on which pre-hospital assessment was done by the pre-hospital provider

FIELD VALUES:

Date/Time

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Date is documented as MM/DD/YYYY.
- Time is documented in military format (24-hour clock) as HH:MM.

HISTORY:

PARALYZED (PREHOSPITAL)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Had patient been given paralytic agents at the time prehospital vitals were taken?

FIELD VALUES:

<1> Yes
<2> No
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Qualifier for GCS.
- If an intubated patient has recently received an agent that results in neuromuscular blockade such that motor or eye response is not possible, then the patient should be considered to have an exam that is not reflective of their neurological status and chemical sedation and/or paralytic sedation should be selected.
- These agents do not include those administered by the patient (e.g., alcohol, prescription).
- Refer to drug list in Appendix A for further information regarding paralytics.
- Do not use </>.

HISTORY:

SEDATED (PREHOSPITAL)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Was patient sedated when prehospital GCS was evaluated?

FIELD VALUES:

<1> Yes
<2> No
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Qualifier for GCS.
- Because TQIP reclassifies GCS as <8 for any patient flagged as sedated, NC will no longer flag patients as sedated if they have a GCS of 8 or greater. If GCS is > 8: don't flag patients as sedated, regardless of any medication given. (Added 01Jan2021)
- For patients with a GCS<8, patients will be flagged as sedated if they have been given any drug on the approved NCCOT sedation list (see Appendix A) within 6 hours of when GCS was measured. No consideration of half-life, dose, or intent of the medication will be used. (Added 01Jan2021)
- Do not use </>.

HISTORY:

The following text was removed as of 01Jan2021: If an intubated patient has recently received an agent that results in neuromuscular blockade such that motor or eye response is not possible, then the patient should be considered to have an exam that is no

EYE OBSTRUCTION (PREHOSPITAL)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Indicates if the patient did or did not have an obstruction to both eyes that affected the GCS at the time GCS was obtained at your facility. An obstruction is a physical reason that prevents the patient from opening their eyes.

FIELD VALUES:

<1> Yes
<2> No
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Qualifier for GCS.
- Do not use </>.

HISTORY:

INTUBATED (PREHOSPITAL)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Indicates the use of a device for the purpose of assisted ventilation of patient to maintain an airway at the time pre-hospital vitals were taken.

FIELD VALUES:

<1> Yes
<2> No
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Qualifier for GCS.
- Must be active, not passive delivery of oxygen. Non-rebreather mask and nasal cannula are supplemental oxygen and not to be considered airway management.
- Base response on most active airway adjunct in use at time of GCS assessment.
- Do not use </>.

HISTORY:

INTUBATION METHOD (PREHOSPITAL)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Method used to intubate patient during pre-hospital care.

FIELD VALUES:

<1> Blind Insertion Airway Device(Combitube, I-Gel, King Airway, Laryngeal Mask Airway)
<2> Cricothyrotomy – Open
<3> Cricothyrotomy - Needle
<4> Endotracheal Tube – Nasal
<5> Endotracheal Tube – Oral
<6> Endotracheal Tube – Route NFS
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Record the most invasive airway adjunct used by the pre-hospital EMS provider.
- Only complete this field if the patient was intubated.

HISTORY:

4/23/2012: Changed wording of #1 from Combitube to Blind Insertion Airway Device. Removed Tracheostomy and Laryngeal Mask Airway from the active choices for this field.. Tracheostomy left in field value list for research purposes.

RESPIRATION ASSISTED (PREHOSPITAL)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Indicates whether the patient required respiration assistance at the time prehospital EMS vitals were taken.

FIELD VALUES:

<Y> Yes
<N> No
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Qualifier for GCS.
- Do not use </>.
- All EMS vital signs should be included in the registry, even if EMS picks up the patient hours after an injury. If your site participates in NTDS and the vital signs don't fit NTDS definition of "scene vitals", put question marks in the first vital sign position, then add the EMS vital signs as additional "scene" vitals.

HISTORY:

ASSISTED RESPIRATION TYPE (PREHOSPITAL)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: The type of device used for respiratory assistance during prehospital EMS care.

FIELD VALUES:

<1> Bag Valve Mask
<2> Nasal Airway
<3> Oral Airway
<4> Ventilator
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Must select "yes" in "Respiration Assisted" field to open "Type" field

HISTORY:

SBP (PREHOSPITAL)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Prehospital systolic blood pressure.

FIELD VALUES:

Numeric

DEFAULT: Blank

ADDITIONAL INFORMATION:

- All EMS vital signs should be included in the registry, even if EMS picks up the patient hours after an injury.
- Prior to 2021, NTDS had a different requirement for EMS vital signs than the NCTR. To meet the needs of NTDS, we asked Registrars, for sites participating in NTDS to put question marks in the first vital sign position, then add the EMS vital signs as additional "scene" vitals - if the vital signs didn't fit NTDS definition of "scene vitals".
- </> (Not applicable) is not a valid option for this field..

HISTORY:

PULSE RATE (PREHOSPITAL)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Puse rate measured during pre-hospital care.

FIELD VALUES:
Numeric

DEFAULT: Blank

ADDITIONAL INFORMATION:
- The pulse rate can be palpated or auscultated, expressed as a number per minute.
- All EMS vital signs should be included in the registry, even if EMS picks up the patient hours after an injury.
- Prior to 2021, NTDS had a different requirement for EMS vital signs than the NCTR. To meet the needs of NTDS, we asked Registrars, for sites participating in NTDS to put question marks in the first vital sign position, then add the EMS vital signs as additional “scene” vitals - if the vital signs didn’t fit NTDS definition of “scene vitals”.

HISTORY:

UNASSISTED RESPIRATORY RATE (PREHOSPITAL)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Unassisted respiratory rate during prehospital care.

FIELD VALUES:

Numeric

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Expressed as number per minute.
- All EMS vital signs should be included in the registry, even if EMS picks up the patient hours after an injury.
- Prior to 2021, NTDS had a different requirement for EMS vital signs than the NCTR. To meet the needs of NTDS, we asked Registrars, for sites participating in NTDS to put question marks in the first vital sign position, then add the EMS vital signs as additional “scene” vitals - if the vital signs didn’t fit NTDS definition of “scene vitals”,

HISTORY:

ASSISTED RESPIRATORY RATE (PREHOSPITAL)

State Required	Available for State Research	NTDB Required
Yes	Yes*	No

DEFINITION: The assisted respiratory rate measured during prehospital EMS care.

FIELD VALUES:

Numeric

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Expressed as number per minute.
- All EMS vital signs should be included in the registry, even if EMS picks up the patient hours after an injury.
- Prior to 2021, NTDS had a different requirement for EMS vital signs than the NCTR. To meet the needs of NTDS, we asked Registrars, for sites participating in NTDS to put question marks in the first vital sign position, then add the EMS vital signs as additional "scene" vitals - if the vital signs didn't fit NTDS definition of "scene vitals",

HISTORY:

SPO2 (PREHOSPITAL)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Prehospital pulse oximetry reading.

FIELD VALUES:

0 to 100

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Expressed as percentage
- All EMS vital signs should be included in the registry, even if EMS picks up the patient hours after an injury.
- Prior to 2021, NTDS had a different requirement for EMS vital signs than the NCTR. To meet the needs of NTDS, we asked Registrars, for sites participating in NTDS to put question marks in the first vital sign position, then add the EMS vital signs as additional “scene” vitals - if the vital signs didn’t fit NTDS definition of “scene vitals”,

HISTORY:

SUPPLEMENTAL O2 GIVEN (PREHOSPITAL)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Was patient receiving supplemental O2 during prehospital care?

FIELD VALUES:

<1> Yes
<2> No
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

Do not use </> (Not applicable).

HISTORY:

GCS-EYE (PREHOSPITAL)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: GCS-eye value measured by pre-hospital provider.

FIELD VALUES:

<1> No Eye Movement when Assessed
<2> Opens Eyes in Response to Painful Stimulation
<3> Opens Eyes in Response to Verbal Stimulation
<4> Opens Eyes Spontaneously
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Used to auto-calculate Total GCS.
- If anyone of the three GCS components is missing a value, the total GCS will not automatically calculate.
- If the GCS total is not recorded, but written documentation relates to verbiage describing a specific level of functioning with the GCS scale, the appropriate numeric score may be listed. e.g., the chart indicates: "the patient opens his eyes when spoken to", an Eye GCS of 3 may be recorded IF there is no other contradicting documentation.
- Do not use </>.
- All EMS vital signs should be included in the registry, even if EMS picks up the patient hours after an injury.
- Prior to 2021, NTDS had a different requirement for EMS vital signs than the NCTR. To meet the needs of NTDS, we asked Registrars, for sites participating in NTDS to put question marks in the first vital sign position, then add the EMS vital signs as additional "scene" vitals - if the vital signs didn't fit NTDS definition of "scene vitals",

HISTORY:

1/31/2013: DI added </> and <?> options

GCS-VERBAL (PREHOSPITAL)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: GCS-verbal value measured by pre-hospital provider.

FIELD VALUES:

<1> No Vocal Response
<2> Incomprehensible (adult) or Moans to Pain (infant/child)
<3> Inappropriate (adult) or Cries to Pain
(infant/child)
<4> Confused (adult) or Irritable/Cries
<5> Oriented (adult) or Coos/Babbles
(infant/child)
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Used to auto calculate the Total GCS.
- If anyone of the three GCS components is missing a value, the total GCS will not automatically calculate.
- If the GCS total is not recorded, but written documentation relates to verbiage describing a specific level of functioning with the GCS scale, the appropriate numeric score may be listed. For example, the chart indicates: “the patient responds verbally and appropriately when spoken to”, a Verbal GCS of 5 may be recorded IF there is no other contradicting documentation.
- Do not use </>.
- All EMS vital signs should be included in the registry, even if EMS picks up the patient hours after an injury.
- Prior to 2021, NTDS had a different requirement for EMS vital signs than the NCTR. To meet the needs of NTDS, we asked Registrars, for sites participating in NTDS to put question marks in the first vital sign position, then add the EMS vital signs as additional “scene” vitals - if the vital signs didn’t fit NTDS definition of “scene vitals”,

HISTORY:

1/31/2013: DI added </> and <?> options

GCS-MOTOR (PREHOSPITAL)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: GCS-motor value measured by pre-hospital provider.

FIELD VALUES:

<1> No Motor Response
<2> Extension to Pain
<3> Flexion to Pain
<4> Withdraws from Pain (adult) or Withdraws to Pain (infant/child)
<5> Localizing Pain (adult) or
Withdraws to Touch (infant/child)
<6> Obeys Command (adult) or
Spontaneous Movements (infant/child)
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Used to auto calculate the Total GCS.
- If anyone of the three GCS components is missing a value, the total GCS will not automatically calculate.
- Do not use </>.
- If the GCS total is not recorded, but written documentation relates to verbiage describing a specific level of functioning with the GCS scale, the appropriate numeric score may be listed. For example, the chart indicates: “the patient withdraws from a painful stimulus”, a Motor GCS of 4 may be recorded IF there is no other contradicting documentation.
- All EMS vital signs should be included in the registry, even if EMS picks up the patient hours after an injury.
- Prior to 2021, NTDS had a different requirement for EMS vital signs than the NCTR. To meet the needs of NTDS, we asked Registrars, for sites participating in NTDS to put question marks in the first vital sign position, then add the EMS vital signs as additional “scene” vitals - if the vital signs didn’t fit NTDS definition of “scene vitals”,

HISTORY:

1/31/2013: DI added </> and <?> options

GCS-TOTAL (PREHOSPITAL)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: GCS-total value calculated by pre-hospital provider.

FIELD VALUES:

Auto-calculated (3-15)
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- This field is auto-calculated by the software when the Eye, Verbal, and Motor fields contained values.
- If any one of the three components is missing a value, the GCS will not automatically calculate, but the total GCS can be entered manually ONLY if the documentation states “alert and oriented x 3” or “alert and oriented x 4”.
- The GCS is a scale used to determine a score based on the total of 3 components on a patient involving an assessment of eye, motor, verbal responses of the patient.

HISTORY:

PREHOSPITAL TREATMENT AGENCY DESCRIPTION/ID

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: Agency represented by the provider doing the pre-hospital intervention/treatment,

FIELD VALUES:

See EMS list

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Depending on registry software, this field may autopopulate if only one prehospital agency used; if more than one prehospital agency transported the patient, check to make sure the correct agency has been selected.

HISTORY:

PREHOSPITAL TREATMENT CODE

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: What was the Treatment/ intervention provided by the pre-hospital provider?

FIELD VALUES:

0= None
1=Airway-Nasal
2=Airway Opened or cleared
3=Airway - Oral
4=Arterial Line Maintenance
5=Assisted ventilation
6=Bag Valve Mask
7=Blood Draw
8=Blood glucose analysis
9=Cardiac monitor
10=Chest tube
11=Childbirth
12=CNS Catheter
13=Combitube/King airway
14=CPR
15=Cricothyrotomy
16=Cricothyrotomy - needle
17=Decontamination
18=Defibrillation - automated
19=Defibrillation - manual
20=Defibrillation - NFS
21=Endotrach-Nasal
22=Endotrach-Oral
23=Endotrach-Route NR
24=Esophageal Obturator Airway
25=Extrication
25=Intra-Aortic Baloon Pump
27=Intraosseous access or infusion
28=IV fluids
29=Laryngeal Mask Airway
30=LT Blind Insertion Airway Device
31=MAST
32=Nasogastric Tube

33=Pericadiocentesis
34=Pharmocological Restraints
35=Physical Restraitns
36=Rapid Dequence Intubation
37=Rescue
38=Spinal immobilization
39=Splinting
40=Thoracostomy - needle
41=Tracheostomy
42=Traction
43=Urinary Catheterization
44=Venous Access
45=Ventilator
46=Wound care
47=Other
48=Unsuccessful intubation
49=Unsuccessful IV
50=EKG, 12 lead
52=Oral gastric tube
53=Tourniquet
54=Pelvic Binder
/=Not applicable
?=Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

HISTORY:

Referring Facility/Referral hx

INTERFACILITY /HOSPITAL TRANSFER

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Was patient transferred from another hospital?

FIELD VALUES:

<1> Yes
<2> No
</> Not Applicable – do not use.
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Outlying facilities providing emergency care services or utilized to stabilize a patient are considered acute care facilities (e.g., free-standing EDs).
- Patients transferred from a private doctor's office, stand-alone ambulatory surgery center, or delivered to your hospital by a non-EMS transport are not considered an inter-facility transfer.
- Do not use </>.

HISTORY:

REFERRING FACILITY ID/NAME

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: Name (description) and id of referring facility.

FIELD VALUES:

All NC hospitals

DEFAULT: Blank

ADDITIONAL INFORMATION:

- If the facility is not in the picklist and is located within the State of NC, select <Other Hospital, NC>.
    - Contact the State Trauma Systems Manager to request the facility be added to the picklist.
- If the facility is not in the picklist and is located outside the State of NC, select <Other Hospital, OOS>.

HISTORY:

REFERRING FACILITY ADDRESS: CITY

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: City where referring facility is located

FIELD VALUES:

Blank

DEFAULT:

ADDITIONAL INFORMATION:

- If registry software does not autopopulate from Referring Facility ID, populate manually
- Do not guess or approximate.

HISTORY:

New in 2024

REFERRING FACILITY ADDRESS: COUNTRY

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Country where referring facility is located

FIELD VALUES:

Blank

DEFAULT:

ADDITIONAL INFORMATION:

- If registry software does not autopopulate from Referring Facility ID, populate manually
- Do not guess or approximate.

HISTORY:

New in 2024

REFERRING FACILITY ADDRESS: COUNTY

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: County where referring facility is located

FIELD VALUES:

Blank

DEFAULT:

ADDITIONAL INFORMATION:

- If registry software does not autopopulate from Referring Facility ID, populate manually
- Do not guess or approximate.

HISTORY:

New in 2024

REFERRING FACILITY ADDRESS: CITY FIPS CODE

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: FIPS code for city where referring facility is located

FIELD VALUES:

FIPS codes

DEFAULT: Blank

ADDITIONAL INFORMATION:

- FIPS is the Federal Information Processing Standards code. It is Auto-populated by ESO's NCv5 software, based on the zip code
- If registry software does not autopopulate FIPS code, refer to https://transition.fcc.gov/oet/info/maps/census/fips/fips.txt
- Do not guess or approximate.

HISTORY:

New in 2024

REFERRING FACILITY ADDRESS: COUNTY FIPS CODE

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: FIPS code for county where referring facility is located

FIELD VALUES:
FIPS codes

DEFAULT: Blank

ADDITIONAL INFORMATION:
- FIPS is the Federal Information Processing Standards code. It is Auto-populated by ESO's NCv5 software, based on the zip code
- If registry software does not autopopulate FIPS code, refer to https://transition.fcc.gov/oet/info/maps/census/fips/fips.txt
- Do not guess or approximate.

HISTORY:
New in 2024

REFERRING FACILITY ADDRESS: STATE FIPS CODE

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: FIPS code for state where referring facility is located

FIELD VALUES:

FIPS codes

DEFAULT: Blank

ADDITIONAL INFORMATION:

- FIPS is the Federal Information Processing Standards code. It is Auto-populated by ESO's NCv5 software, based on the zip code
- If registry software does not autopopulate FIPS code, refer to https://transition.fcc.gov/oet/info/maps/census/fips/fips.txt
- Do not guess or approximate.

HISTORY:
New in 2024

REFERRING FACILITY ADDRESS: STATE

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: State where referring facility is located

FIELD VALUES:

US State 2-letter codes

DEFAULT: Blank

ADDITIONAL INFORMATION:

- If registry software does not autopopulate from Referring Facility ID, populate manually
- Do not guess or approximate.

HISTORY:

New in 2024

REFERRING FACILITY STREET ADDRESS

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: Street address of referring facility

FIELD VALUES:

See Referring Facility list

DEFAULT: Blank

ADDITIONAL INFORMATION:

- If registry software does not autopopulate from Referring Facility ID, populate manually
- Do not guess or approximate.

HISTORY:

New in 2024

REFERRING FACILITY ADDRESS: ZIP

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: Zipcode of referring facility

FIELD VALUES:

Zip codes

DEFAULT: Blank

ADDITIONAL INFORMATION:

- If registry software does not autopopulate from Referring Facility ID, populate manually
- Do not guess or approximate.

HISTORY:

New in 2024

REFERRING FACILITY SPECIFY

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: Free-text field for entry of referring facility name if the name is not on the picklist.

FIELD VALUES:

Free text

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Required only if <Other Hospital, NC> or <Other Hospital, OOS> are chosen in the Referring Facility field

HISTORY:

REFERRING FACILITY ARRIVAL DATE-TIME

State Required	Available for State Research	NTDB Required
Yes	Yes*	No

DEFINITION: Referring hospital arrival date-time.

FIELD VALUES:

Date/time

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Date is documented as MM/DD/YYYY.
- Time is documented in military format (24-hour clock) as HH:MM.

HISTORY:

REFERRING FACILITY DEPARTURE DATE/TIME

State Required	Available for State Research	NTDB Required
Yes	Yes*	No

DEFINITION: Date-time patient departed from referring facility.

FIELD VALUES:

Date/Time

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Date is documented as MM/DD/YYYY.
- Time is documented in military format (24-hour clock) as HH:MM.

HISTORY:

REFERRING FACILITY LENGTH OF STAY (LOS)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Time between arrival and departure from referring facility in hours.

FIELD VALUES:

DEFAULT: Blank

ADDITIONAL INFORMATION:

This field is auto-calculated from the arrival date/time fields and the departure date/time fields. Be sure that field value is greater than 0.

HISTORY:

REFERRING FACILITY ICU

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Was patient admitted to ICU at referring facility?

FIELD VALUES:

<1> Yes
<2> No
</> Not Applicable
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

None

HISTORY:

REFERRING FACILITY DESCRIPTION (NAME)

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: Name and id number of referring facility where assesment performed

FIELD VALUES:

See Referring Facility list

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Depending on registry software, this field may autopopulate; if not, select referring facility name from dropdown.

HISTORY:

REFERRING FACILITY PARALYZED

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Had patient been given paralytic agents at the time referring facility vitals were taken?

FIELD VALUES:

<1> Yes
<2> No
</> Not Applicable
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Qualifier for GCS.
- If an intubated patient has recently received an agent that results in neuromuscular blockage such that motor or eye response is not possible, then the patient should be considered to have an exam that is not reflective of their neurological status and chemical sedation and/or paralytic sedation should be selected.
- These agents do not include those administered by the patient (e.g., alcohol, prescription).
- Refer to the drug list in Appendix A for further information regarding paralytics.
- Do not use </>.

HISTORY:

REFERRING FACILITY SEDATED

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Was patient sedated at time GCS was measured?

FIELD VALUES:

<1> Yes
<2> No
</> Not Applicable
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Qualifer for GCS.
- Because TQIP reclassifies GCS as <8 for any patient flagged as sedated, NC will no longer flag patients as sedated if they have a GCS of 8 or greater. If GCS is > 8: don't flag patients as sedated, regardless of any medication given. (Added 01Jan2021)
- For patients with a GCS<8, patients will be flagged as sedated if they have been given any drug on the approved NCCOT sedation list (see Appendix A) within 6 hours of when GCS was measured. No consideration of half-life, dose, or intent of the medication will be used. (Added 01Jan2021)
- Do not use </>.

HISTORY:

The following text was removed as of 01Jan2021: If an intubated patient has recently received an agent that results in neuromuscular blockade such that motor or eye response is not possible, then the patient should be considered to have an exam that is no

REFERRING FACILITY EYE OBSTRUCTION

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Indicates if the patient did or did not have an obstruction to both eyes that affected the GCS at the time GCS was obtained at the referring facility. An obstruction is a physical reason that prevents the patient from opening their eyes.

FIELD VALUES:

<1> Yes
<2> No
</> Not Applicable
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Qualifier for GCS.
- Do not use </>.

HISTORY:

REFERRING FACILITY INTUBATED

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Indicates the use of a device for the purpose of assisted ventilation of patient to maintain an airway at the time referring facility ED vitals were taken.

FIELD VALUES:

<1> Yes
<2> No
</> Not Applicable
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Qualifier for GCS.
- Must be active, not passive delivery of oxygen. Non-rebreather mask and nasal cannula are supplemental oxygen and not to be considered airway management.
- Base response on most active airway adjunct in use at time of GCS assessment.
- Do not use </>.

HISTORY:

REFERRING FACILITY INTUBATION METHOD

State Required	Available for State Research	NTDB Required
Yes	Yes	no

DEFINITION: Method of intubation at time referring facility ED vitals were taken.

FIELD VALUES:

<1> Blind Insertion Airway Device (Combitube, I-Gel, King Airway, Laryngeal Mask Airway)
<2> Cricothyrotomy - Open
<3> Cricothyrotomy - Needle
<4> Endotracheal Tube - Nasal
<5> Endotracheal Tube - Oral
<6> Endotracheal Tube – Route NFS
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Record the most invasive airway adjunct used by the referring facility provider.
- Only complete this field if the patient was intubated.

HISTORY:
4/23/2012: Changed wording of #1 from Combitube to Blind Insertion Airway Device. Removed Tracheostomy and Laryngeal Mask Airway from the active choices for this field.. Tracheostomy left in field value list for research purposes.

REFERRING FACILITY RESPIRATION ASSISTED

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Indicates whether the patient required respiration assistance at the time initial vital signs were assessed at the referring facility.

FIELD VALUES:

<1> Yes
<2> No
</> Not Applicable
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Qualifier for GCS.
- Do not use </>.

HISTORY:

REFERRING FACILITY ASSISTED RESPIRATION TYPE

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: The type of device used for respiratory assistance at the time the initial vitals were taken at the referring facility.

FIELD VALUES:

<1> Bag Valve Mask
<2> Nasal Airway
<3> Oral Airway
<4> Ventilator
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Must select "yes" in "Respiration Assisted" field to open "Type" field

HISTORY:

REFERRING FACILITY SBP

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: The first recorded systolic blood pressure measured within 30 minutes of arrival at the referring facility.

FIELD VALUES:

Numeric

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Initial vital signs must be those taken within 30 minutes of arrival. If you'd like to record post-30 minute vital signs, add vital signs values in the non-initial fields. If no vital signs are taken within 30 minutes of arrival, then code initial values as unknown (<?>).
- </> (Not applicable) is not a valid option for this field.

HISTORY:

REFERRING FACILITY PULSE RATE

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Pulse rate measured within first 30 minutes of patient's arrival at referring facility.

FIELD VALUES:

Numeric

DEFAULT: Blank

ADDITIONAL INFORMATION:

- The pulse rate can be palpated or auscultated, expressed as a number per minute.
- Prior to 2021, NTDS had a different requirement for EMS vital signs than the NCTR. To meet the needs of NTDS, we asked Registrars, for sites participating in NTDS to put question marks in the first vital sign position, then add the EMS vital signs as additional “scene” vitals - if the vital signs didn’t fit NTDS definition of “scene vitals”.

HISTORY:

REFERRING FACILITY UNASSISTED RESPIRATORY RATE

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Unassisted respiratory rate measured within first 30 minutes of patient's arrival at the referring facility.

FIELD VALUES:

Numeric

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Expressed as number per minute.

HISTORY:

REFERRING FACILITY ASSISTED RESPIRATORY RATE

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: The first recorded assisted respiratory rate measured within the first 30 minutes of patient's arrival at the referring facility.

FIELD VALUES:

Numeric

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Expressed as number per minute.

HISTORY:

REFERRING FACILITY SPO2

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Referring facility pulse oximetry reading.

FIELD VALUES:

0 to 100

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Expressed as percentage

HISTORY:

REFERRING FACILITY SUPPLEMENTAL O2 GIVEN

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Was supplemental O2 provided to the patient in the referring facility?

FIELD VALUES:

<1> Yes
<2> No
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

Do not use </> (Not applicable).

HISTORY:

REFERRING FACILITY GCS-EYE

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: GCS-eye value measured within first 30 minutes of patient's arrival at referring facility recording this datapoint.

FIELD VALUES:

<1> No Eye Movement when Assessed
<2> Opens Eyes in Response to Painful Stimulation
<3> Opens Eyes in Response to Verbal Stimulation
<4> Opens Eyes Spontaneously
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Use to auto-calculate Total GCS.
- If anyone of the three GCS components is missing a value, the total GCS will not automatically calculate.
- If the GCS total is not recorded, but written documentation relates to verbiage describing a specific level of functioning with the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: “the patient opens his eyes when spoken to”, an Eye GCS of 3 may be recorded IF there is no other contradicting documentation.
- Do not use </>.

HISTORY:
1/31/2013: DI added </> and <?> options

REFERRING FACILITY GCS-VERBAL

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: GCS-verbal value measured within first 30 minutes of patient's arrival at referring facility recording this datapoint.

FIELD VALUES:

<1> No Vocal Response
<2> Incomprehensible (adult) or Moans to Pain (infant/child)
<3> Inappropriate (adult) or Cries to Pain
(infant/child)
<4> Confused (adult) or Irritable/Cries
<5> Oriented (adult) or Coos/Babbles
(infant/child)
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Used to auto calculate the Total GCS.
- If any one of the three GCS components is missing a value, the total GCS will not automatically calculate.
- If the GCS total is not recorded, but written documentation relates to verbiage describing a specific level of functioning with the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: “the patient responds verbally and appropriately when spoken to”, a Verbal GCS of 5 may be recorded IF there is no other contradicting documentation.
- Do not use </>.

HISTORY:
1/31/2013: DI added </> and <?> options

REFERRING FACILITY GCS-MOTOR

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: GCS-motor value measured within first 30 minutes of patient's arrival at referring facility recording this datapoint.

FIELD VALUES:

<1> No Motor Response
<2> Extension to Pain
<3> Flexion to Pain
<4> Withdraws from Pain (adult) or Withdraws to Pain (infant/child)
<5> Localizing Pain (adult) or
Withdraws to Touch (infant/child)
<6> Obeys Command (adult) or
Spontaneous Movements (infant/child)
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Used to auto calculate the Total GCS.
- If anyone of the three GCS components is missing a value, the total GCS will not automatically calculate.
- If the GCS total is not recorded, but written documentation relates to verbiage describing a specific level of functioning with the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "the patient withdraws from a painful stimulus", a Motor GCS of 4 may be recorded IF there is no other contradicting documentation.
- Do not use </>.

HISTORY:
1/31/2013: DI added </> and <?> options

REFERRING FACILITY GCS-TOTAL

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: GCS-total value measured within first 30 minutes of patient's arrival at referring facility recording this datapoint.

FIELD VALUES:

Blank; 3-15 (Autocalculated); <?>=Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- This field is auto-calculated by the software when the Eye, Verbal, and Motor fields contained values.
- If any one of the three components is missing a value, the GCS will not automatically calculate, but the total GCS can be entered manually ONLY if the documentation states "alert and oriented x 3" or "alert and oriented x 4".
- The GCS is a scale used to determine a score based on the total of 3 components involving an assessment of eye, motor, verbal responses of the patient.

HISTORY:

REFERRING FACILITY WEIGHTED RTS

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: The calculated weighted revised trauma score based on components measured within the first 30 minutes of patient's arrival at the referring facility.

FIELD VALUES:

Auto-calcuated; 0-7.841

DEFAULT: Blank

ADDITIONAL INFORMATION:

RTS components are GCS, Sys BP, or RR. The coded values are weighted often using standard vectors as follows: RTS = 0.9368 GCS + 0.7326 SBP + 0.2908 RR. If any values of the GCS, SBP or respiratory rate are missing, the weighted revised trauma score cannot be calculated.

HISTORY:

REFERRING FACILITY PROCEDURE FACILITY NAME AND ID

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: The name and ID number of the referring facility where procedure performed.

FIELD VALUES:

Refer to field menu for options

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Choose the button with the appropriate referring facility that performed the procedure or you can manually enter the facility from the picklist (may autopopulatee if only one referring facility).
- Enter the immediate facility first if patient required multiple transfers.

HISTORY:

REFERRING FACILITY PROCEDURE ICD10 CODE

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: ICD-10 code for procedure done at referring facility.

FIELD VALUES:

Refer to ICD-10 references for field options.

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Enter the procedures from the immediate facility first if patient required multiple transfers.

HISTORY:

REFERRING FACILITY DIAGNOSTIC RESULT

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Results of diagnositic procedures. Not required for non-diagnostic procedures.

FIELD VALUES:

<1> Positive
<2> Negative
<3> Indeterminate
</> Not Applicable
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Positive results in a FAST exam include free fluid in the abdomen
- Positive Peritoneal Lavage results: Gross blood (>20cc) or 100K RBCs per cc or >500 WBCs per cc
- Positive Aortogram: the aorta has identifiable injuries as a result of trauma Positive Arteriogram/Angiogram: report states “positive for acute changes” Negative plain film: no injuries identified.
- Indeterminate: report indicates exam results are inconclusive.

HISTORY:

REFERRING FACILITY (FOR IFT)

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: The name and ID number of the immediate referring facility where this IFT provider picked up the patient being transferred to your facility.

FIELD VALUES:

DEFAULT: Blank

ADDITIONAL INFORMATION:
- Depending on registry software, this may be autopopulated if only one referring facility
- If the facility is not in the picklist and is located within the State of NC, select <Other Hospital, NC>.
- If the facility is not in the picklist and is located outside the State of NC, select <Other Hospital, OOS>.
- Contact the State Trauma Systems Manager to request the facility be added to the picklist.

HISTORY:

AGENCY ID/ NAME (IFT PROVIDER)

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: The provider name of the EMS agency used to transfer the patient between healthcare facilities.

FIELD VALUES:

See EMS agency list

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Contact the NCOEMS Trauma Systems Manager should you need to add an agency not found within the picklist.
- Use <Other EMS Agency, OOS> for out of state agencies not already defined within the picklist.

HISTORY:

PCRUUID (IFT PROVIDER)

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: Linkage used by NEMSIS and OEMS to link trauma and EMS records

FIELD VALUES:

- If value is unknown, enter "Unknown".
- Structure must be exact for the UUID to be entered in to the field.
    - o An example UUID: e48cd734-01cc-4da4-ae6a-915b0b1290f6.

DEFAULT: Blank

ADDITIONAL INFORMATION:

Added Jun-2021.
*Field cannot be populated unless the hospital (trauma center) has purchased the ESO HDE (health data exchange).

HISTORY:

MODE (IFT PROVIDER)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: The mode of transport used by the IFT provider to deliver the patient to the facility recording these data.

FIELD VALUES:

<1> Ground Ambulance
<2> Helicopter Ambulance
<3> Fixed-wing Ambulance
<4> Private Vehicle or Walk-in
<5> Police
<6> Other
<?> Unknown
</> Not Applicable – Do not use.

DEFAULT: Blank

ADDITIONAL INFORMATION:

None

HISTORY:

MODE SPECIFY (IFT PROVIDER)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: IFT mode of transport - specify when appropriate choice is not in the IFT mode picklist and/or <Other> is chosen.

FIELD VALUES:

Free text

DEFAULT: Blank

ADDITIONAL INFORMATION:

None

HISTORY:

EMS REPORT (IFT PROVIDER)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Is interfacility transport provider's report complete?

FIELD VALUES:

<1>=Complete (There is an EMS report and all NCTR required data are present.)
<2>=Incomplete (There is an EMS report, but not all NCTR required data are present or legible.)
<3>=Missing (There is no EMS report and all NCTR required data are missing or mode of arrival is unknown.)
<4>=Unreadable

DEFAULT: Blank

ADDITIONAL INFORMATION:

None

HISTORY:

DISPATCH DATE-TIME (IFT PROVIDER)

State Required	Available for State Research	NTDB Required
Yes	Yes*	No

DEFINITION: Date-time IFT provider was dispatched to the patient.

FIELD VALUES:

Date/time

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Date is documented as MM/DD/YYYY.
- Time is documented in military format (24-hour clock) as HH:MM.

HISTORY:

ARRIVED LOCATION DATE-TIME (IFT PROVIDER)

State Required	Available for State Research	NTDB Required
Yes	Yes*	No

DEFINITION: The date-time the transporting unit arrived at the scene. Arrival is defined as the date/time when the vehicle stopped moving.

FIELD VALUES:

Date/time

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Date is documented as MM/DD/YYYY.
- Time is documented in military format (24-hour clock) as HH:MM.

HISTORY:

LEFT LOCATION DATE-TIME (IFT PROVIDER)

State Required	Available for State Research	NTDB Required
Yes	Yes*	No

DEFINITION: The date and time the transporting unit departed the referring facility. Departure is defined as the date/time when the vehicle started moving.

FIELD VALUES:

Date/time

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Date is documented as MM/DD/YYYY.
- Time is documented in military format (24-hour clock) as HH:MM.

HISTORY:

ARRIVED DESTINATION DATE-TIME (IFT PROVIDER)

State Required	Available for State Research	NTDB Required
Yes	Yes*	No

DEFINITION: The date-time the transporting unit arrived at the facility. Arrival is defined as the date/time when the EMS responder arrived in the ED/floor/unit.

FIELD VALUES:
Date/time

DEFAULT: Blank

ADDITIONAL INFORMATION:
- Date is documented as MM/DD/YYYY.
- Time is documented in military format (24-hour clock) as HH:MM.

HISTORY:

AGENCY NAME/ID (IFT)

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: The provider name of the EMS agency used to transfer the patient between healthcare facilities.

FIELD VALUES:

See EMS agency list

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Depending on registry software, may be autopopulated if only one EMS agency used
- Contact the NCOEMS Trauma Systems Manager should you need to add an agency not found within the picklist.
- Use <Other EMS Agency, OOS> for out of state agencies not already defined within the picklist.

HISTORY:

PARALYZED (IFT)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Had patient been given paralytic agents at the time IFT vitals were taken?

FIELD VALUES:

<1> Yes
<2> No
</> Not Applicable
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

HISTORY:
Added page in 2024 dictionary for variable (prior to 2024 the variable was listed in the summary table but there was not a page for it in the dictionary)

SEDATED (IFT)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Was patient sedated at time GCS was measured?

FIELD VALUES:

<1> Yes
<2> No
</> Not Applicable
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Qualifer for GCS.
- Because TQIP reclassifies GCS as <8 for any patient flagged as sedated, NC will no longer flag patients as sedated if they have a GCS of 8 or greater. If GCS is > 8: don't flag patients as sedated, regardless of any medication given. (Added 01Jan2021)
- For patients with a GCS<8, patients will be flagged as sedated if they have been given any drug on the approved NCCOT sedation list (see Appendix A) within 6 hours of when GCS was measured. No consideration of half-life, dose, or intent of the medication will be used. (Added 01Jan2021)
- Do not use </>.

HISTORY:

Added page in 2024 dictionary for variable (prior to 2024 the variable was listed in the summary table but there was not a page for it in the dictionary)

EYE OBSTRUCTION (IFT)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Indicates if the patient did or did not have an obstruction to both eyes at the time the IFT GCS was obtained. An obstruction is a physical reason that prevents the patient from opening their eyes.

FIELD VALUES:

<1> Yes
<2> No
</> Not Applicable
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

Do not use </> (not applicable).

HISTORY:
Added page in 2024 dictionary for variable (prior to 2024 the variable was listed in the summary table but there was not a page for it in the dictionary)

INTUBATED (IFT)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Indicates the use of a device for the purpose of assisted ventilation of patient to maintain an airway at the time IFT vitals were taken.

FIELD VALUES:

<1> Yes
<2> No
</> Not Applicable
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Qualifier for GCS.
- Must be active, not passive delivery of oxygen. Non-rebreather mask and nasal cannula are supplemental oxygen and not to be considered airway management.
- Base response on most active airway adjunct in use at time of GCS assessment.
- Do not use </>.

HISTORY:
Added page in 2024 dictionary for variable (prior to 2024 the variable was listed in the summary table but there was not a page for it in the dictionary)

INTUBATION METHOD (IFT)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Method used to intubate patient during IFT.

FIELD VALUES:

1= Blind Insertion Airway Device
2=Cricothyrotomy
3=Cricothyrotomy needle
4=Endotrachael tube - nasal
5=Endotrachael tube - oral
6=Endotrachael tube NFS
?=Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Record the most invasive airway adjunct used by the IFT provider.
- Only complete this field if the patient was intubated.

HISTORY:
Added page in 2024 dictionary for variable (prior to 2024 the variable was listed in the summary table but there was not a page for it in the dictionary)

RESPIRATION ASSISTED (IFT)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Indicates whether the patient required respiration assistance at the time IFT EMS vitals were taken.

FIELD VALUES:

<1>=Yes
<2>=No

DEFAULT: Blank

ADDITIONAL INFORMATION:

HISTORY:
Added page in 2024 dictionary for variable (prior to 2024 the variable was listed in the summary table but there was not a page for it in the dictionary)

ASSISTED RESPIRATORY RATE (IFT)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: The first recorded assisted respiratory rate measured during IFT EMS care.

FIELD VALUES:

Numeric

DEFAULT: Blank

ADDITIONAL INFORMATION:

HISTORY:

Added page in 2024 dictionary for variable (prior to 2024 the variable was listed in the summary table but there was not a page for it in the dictionary)

SBP (IFT)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: The first recorded IFT systolic blood pressure.

FIELD VALUES:

Numeric

DEFAULT: Blank

ADDITIONAL INFORMATION:

</> (Not applicable) is not a valid option for this field.

HISTORY:

Added page in 2024 dictionary for variable (prior to 2024 the variable was listed in the summary table but there was not a page for it in the dictionary)

PULSE RATE (IFT)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: The first recorded Pulse rate measured during IFT care.

FIELD VALUES:

Numeric

DEFAULT: Blank

ADDITIONAL INFORMATION:

- The pulse rate can be palpated or auscultated, expressed as a number per minute.

HISTORY:

Added page in 2024 dictionary for variable (prior to 2024 the variable was listed in the summary table but there was not a page for it in the dictionary)

UNASSISTED RESPIRATORY RATE (IFT)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Unassisted respiratory rate during IFT.

FIELD VALUES:

Numeric

DEFAULT: Blank

ADDITIONAL INFORMATION:

HISTORY:

Added page in 2024 dictionary for variable (prior to 2024 the variable was listed in the summary table but there was not a page for it in the dictionary)

ASSISTED RESPIRATION TYPE (IFT)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: The type of device used for respiratory assistance during IFT EMS care.

FIELD VALUES:

1=BVM
2=Nasal airway
3=Oral airway
4=Ventilator
?=Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

HISTORY:
Added page in 2024 dictionary for variable (prior to 2024 the variable was listed in the summary table but there was not a page for it in the dictionary)

SUPPLEMENTAL O2 GIVEN (IFT)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Was patient receiving supplemental O2 during IFT?

FIELD VALUES:

<1>=Yes
<2>=No
<?>Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

Do not use </> (Not applicable).

HISTORY:

Added page in 2024 dictionary for variable (prior to 2024 the variable was listed in the summary table but there was not a page for it in the dictionary)

GCS-EYE (IFT)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: GCS-eye value measured during IFT.

FIELD VALUES:

<1> No eye movement
<2> Opens e*Yes

DEFAULT: Blank

ADDITIONAL INFORMATION:

HISTORY:
Added page in 2024 dictionary for variable (prior to 2024 the variable was listed in the summary table but there was not a page for it in the dictionary)

GCS-VERBAL (IFT)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: GCS-verbal value measured during IFT.

FIELD VALUES:

<1> No vocal response
<2> Incomprehensible (adult) or Moans to pain (infant/child)
<3> Inappropriate adult) or Cries to pain (infant/child)
<4> Confused (adult) or Irritable/Cries
<5> Oriented (adult) or Coos/babbles (infant/child)
<?> Unknown
</> Not applicable

DEFAULT: Blank

ADDITIONAL INFORMATION:

HISTORY:
Added page in 2024 dictionary for variable (prior to 2024 the variable was listed in the summary table but there was not a page for it in the dictionary)

GCS-MOTOR (IFT)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: GCS-motor value measured during IFT.

FIELD VALUES:

<1> No motor response
<2> Extension to pain
<3> Flexion to pain
<4> Withdraws from pain (adult)
or Withdraws to pain (infant/child)
<5> Localizing pain (adult) or
Withdraws to touch (infant/child)
<6> Obeys command (adult) or
Spontaneous movements (infant/child)
<?> Unknown
</> = Not applicable

DEFAULT: Blank

ADDITIONAL INFORMATION:

HISTORY:
Added page in 2024 dictionary for variable (prior to 2024 the variable was listed in the summary table but there was not a page for it in the dictionary)

GCS-TOTAL (IFT)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Total GCS = sum of eye, motor, and verbal GCS values measured during IFT.

FIELD VALUES:

Blank
3-15 (Autocalculated)

DEFAULT: Blank

ADDITIONAL INFORMATION:

HISTORY:
Added page in 2024 dictionary for variable (prior to 2024 the variable was listed in the summary table but there was not a page for it in the dictionary)

AGENCY NAME/DESCRIPTION (IFT TREATMENT)

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: Name and ID of EMS agency of provider performing procedure/intervention.

FIELD VALUES:

See EMS agency list

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Depending on registry software, may be autopopulated if only one EMS agency used
- Contact the NCOEMS Trauma Systems Manager should you need to add an agency not found within the picklist.
- Use <Other EMS Agency, OOS> for out of state agencies not already defined within the picklist.

HISTORY:

PROCEDURE DESCRIPTION (IFT TREATMENT)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: IFT interventions or procedures (code and description).

FIELD VALUES:

<0> None
<1>=Airway - Nasal
<2>=Airway opened or cleared
<3>=Airway - Oral
<4> Aterial Line Maintenance
<5>=Assisted ventilation (unknown type)
<6>=Bag Valve Mask
<7> Blood Draw
<8>=Blood glucose analysis
<9>=Cardiac monitor
<10>=Chest tube
<11>=Childbirth
<12> CNS Catheter
<13>=Combitube/King airway
<14>=CPR
<15>=Cricothyrotomy
<16>=Cricothyrotomy-needle
<17>=Decontamination
<18>=Defibrillation - automated
<19>=Defibrillation - manual
<20>=Defibrillation - not further specified (NFS)
<21>=Endotrach-Nasal
<22>=Endotrach-Oral
<23>=Endotrach-Route unknown (NR)
<25>=Extrication
<26>Intra-Aortic Balloon Pump
<27>=Intraosseous access or infusion
<28>=IV fluids
<29>=Laryngeal Mask Airway
<30>=LT Blind Insertion Airway Device
<31>=MAST
<32>=Nasogastric Tube
<33> =Pericardiocentesis

<34>=Pharmacological Restraints
<35>=Physical Restraints
<36>=Rapid Sequence Intubation
<37>=Rescue
<38>=Spinal immobilization
<39>=Splinting
<40>=Thoracostomy - needle
<41>=Trach
<42>=Traction
<43>Urinary Catherization
<44>Venous Access
<45>=Ventilator
<46>=Wound care
<47>=Other
<55>=Unsuccessful intubation
<56>=Unsuccessful IV
<50>=EKG, 12 lead
<53>=Tourniquet
<54>=Pelvic Binder
</>=Not applicable
<?>=Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

HISTORY:

CODE SPECIFY (IFT INTERVENTION)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: IFT intervention code for interventions not listed on picklist.

FIELD VALUES:

Free text

DEFAULT: Blank

ADDITIONAL INFORMATION:

*This field not available in DI/ESO v5

HISTORY:

ED ARRIVAL DATE/TIME

State Required	Available for State Research	NTDB Required
Yes	Yes*	No

DEFINITION: Date/time patient arrives at ED (enters the doors of the ED).

FIELD VALUES:

Date/Time

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Date is documented as MM/DD/YYYY.
- Time is documented in military format (24-hour clock) as HH:MM.

HISTORY:

ED DISCHARGE ORDER DATE-TIME

State Required	Available for State Research	NTDB Required
Yes	Yes*	Yes

DEFINITION: Date-time ED discharge order was written.

FIELD VALUES:

Date/Time

DEFAULT: Blank

ADDITIONAL INFORMATION:

*Available for research as part of an interval calculation.

-If the patient was a direct admit enter </> for "Not Applicable".

-If patient dies in ED, enter date/time from death certificate.

HISTORY:

Required as of July-2016

ED DEPARTURE DATE/TIME

State Required	Available for State Research	NTDB Required
Yes	Yes*	No

DEFINITION: Date-time the patient physically left the ED.

FIELD VALUES:

Date/Time

DEFAULT: Blank

ADDITIONAL INFORMATION:

Date is documented as MM/DD/YYYY. Time is documented in military format (24-hour clock) as HH:MM.
*Available for research as part of an interval calculation.

HISTORY:

ED LENGTH OF STAY

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: ED LOS as calculated by trauma registry software.

FIELD VALUES:

Numeric (calculated)

DEFAULT: Blank

ADDITIONAL INFORMATION:

- This field is auto-calculated when arrival date/time and discharge date/time are entered.
- The field is blank if patient is a direct admit.
- Check values to ensure that the value is greater than 0.

HISTORY:

SIGNS OF LIFE

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Did the patient arrive with signs of life?

FIELD VALUES:

<1> Arrived with no signs of life
<2> Arrived with signs of life
</> Not applicable> Do not use!
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- A patient with no signs of life is defined as having none of the following: organized EKG activity, pupillary responses, spontaneous respiratory attempts or movement, and unassisted blood pressure. This usually implies the patient was brought to the ED with CPR in progress. PEA is considered to be organized EKG activity, and, thus, is a sign of life.
- Do not use "/" (not applicable)

HISTORY:

FACILITY ARRIVAL MODE

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Mode of transport from scene to trauma center

DUPLICATE of Php_Mode

FIELD VALUES:

<1> Ground Ambulance
<2> Helicopter Ambulance
<3> Fixed-wing Ambulance
<4> Private Vehicle or Walk-in
<5> Police
<6> Other
<?> Unknown

DEFAULT:

ADDITIONAL INFORMATION:

- Depending on registry software, this field maybe autopopulated from prehospital screen.

HISTORY:

TRAUMA ACTIVATION TYPE

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: The initial trauma team activation level prior to the patient's arrival or on arrival to your ED.

FIELD VALUES:

<1> Level 1 (highest level of care)
<2> Level 2
<3> Level 3
<4> or </> No trauma activation

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Some facilities do not define a Level 3 for activations.

HISTORY:

TRAUMA ACTIVATION DATE/TIME 2

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: Trauma activation date-time (initial activation).

FIELD VALUES:

Date/Time

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Date is documented as MM/DD/YYYY.
- Time is documented in military format (24-hour clock) as HH:MM.

HISTORY:

ACTIVATION RESPONSE ELAPSED TIME: INITIAL

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: The time between patient's arrival at your facility and initial trauma team activation notification time.

FIELD VALUES:

Auto-calculated

DEFAULT:

ADDITIONAL INFORMATION:

HISTORY:

TRAUMA ACTIVATION 2

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Identifies if the patient's activation level was modified prior to patient's arrival to the ED or any time during the patient's ED stay.

FIELD VALUES:

<1> Level 1
<2> Level 2
<3> Level 3
<4> or </> No trauma activation

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Some facilities do not define a Level 3 for activations.

HISTORY:

TRAUMA ACTIVATION DATE/TIME 2

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: Trauma activation date-time (2nd activation).

FIELD VALUES:

Date/Time

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Date is documented as MM/DD/YYYY.
- Time is documented in military format (24-hour clock) as HH:MM.

HISTORY:

ACTIVATION RESPONSE ELAPSED TIME: 2

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Calculated time between patient's arrival at your facility and the revised trauma team activation notification time.

FIELD VALUES:

Auto-calculated

DEFAULT:

ADDITIONAL INFORMATION:

HISTORY:

TRAUMA ACTIVATION 3

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Identifies if the patient's activation level was modified prior to patient's arrival to the ED or any time during the patient's ED stay.

FIELD VALUES:

<1> Level 1
<2> Level 2
<3> Level 3
<4> or </> No trauma activation

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Some facilities do not define a Level 3 for activations.

HISTORY:

TRAUMA ACTIVATION DATE/ TIME 3

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: Trauma activation date-time (3rd activation).

FIELD VALUES:

Date/Time

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Date is documented as MM/DD/YYYY.
- Time is documented in military format (24-hour clock) as HH:MM.

HISTORY:

ACTIVATION RESPONSE ELAPSED TIME: 3

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Calculated time between patient's arrival at your facility and the second revised trauma team activation notification time.

FIELD VALUES:

Auto-calculated

DEFAULT:

ADDITIONAL INFORMATION:

HISTORY:

ED DISPOSITION

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: ED disposition

FIELD VALUES:

<3> OR
<4> ICU
<5> Step down unit
<7> Telemetry
<8> Floor
<9> Observation unit
<12> Special procedure room (includes cath lab)
<13> Labor & delivery
<14> PICU
<40> Morgue: ED death
<41> AMA
<42> Correctional facility
<43> Home
<44> Home with services
<70> Acute Care Facility: (retired 01 Jan 2019)
<72> SNF: usually temporary, to solve a specific medical need or to allow recovery outside a hospital
<73> Hospice: includes home hospice
<75> Mental health
<76> Rehab
<77> Nursing home: permanent custodial assistance
<78> Burn center
<79> Trauma center
<99> Transferred: Transfer to Acute Care Facility. Discharged/transferred to nontrauma center or non-burn center hospital
<15> Interventional radiology
</> Not applicable (n/a)

DEFAULT: Blank

ADDITIONAL INFORMATION:

- If patient is directly admitted to the hospital, code as </> Not Applicable.
- If a patient lives in a nursing home and returns back there from your facility, use <Home> as the disposition, due to NTDB mandate

- If the patient lives in a Skilled Nursing Facility (SNF) and returns to a SNF, use <Home> as the disposition, due to NTDB mandate.25
- If the patient comes from Jail and returns to jail, use Home per NTDB mandate.
- If the patient lives in a retirement center/community or assisted living facility and returns to said facility from the ED, use <43> Home or <44> Home with Services as appropriate.
- Movement of a patient to Obs from the ED is considered a discharge from the ED – no matter where the physical location of the bed is. If patient is discharged from ED to Obs:
- Disposition from Obs will be a hospital disposition.
- ED discharge date and time will reflect the move to Obs.
- Admitting service will reflect the team caring for the patient in the Obs bed.

HISTORY:

ADMITTING SERVICE

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: The name of the service responsible for admitting the patient to your facility.

FIELD VALUES:

1=Trauma
2=Neurosurg
3=Ortho
4=General surg
5=Peds surg
6=Cardiothoracic surg
7=Burn Services;
9=Pediatrics
11=Cardiology
23=ENT
25=Medicine
28=Hand
33=Internal med
36=Nephrology
37=Neurology
39=Not admitted
43=OB/Gyn
45=Opthalmology;
53=Pediatric critical care;
58=Plastic surgery;
76=Urology;
77=Vascular surgery
80=Intensivist
98=Other surgical
99=Other non-surg;
/=n/a
Values that aren't state approved: 16=Dental; 31=Hospitalist; 46=Oral surgery; 59=Psychiatry. 63=Rehab

DEFAULT: Blank

ADDITIONAL INFORMATION:

<39> Not Admitted: Use for patients discharged to home from the ED.

HISTORY:

Oct 2014: Request made to DI to change field values so they match those of Discharge Service.
Jan 2021: Gerontology changed to Geriatrics.

POST IR DISPOSITION

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Interventional radiology (IR) disposition

FIELD VALUES:

<3> OR
<4> ICU
<5> Step down unit
<7> Telemetry
<8> Floor
<9> Observation unit
<12> Special procedure room (includes cath lab)
<13> Labor & delivery
<14> PICU
<40> Morgue: ED death
<41> AMA
<42> Correctional facility
<43> Home
<44> Home with services
<70> Acute Care Facility: (retired 01 Jan 2019)
<72> SNF: usually temporary, to solve a specific medical need or to allow recovery outside a hospital
<73> Hospice: includes home hospice
<75> Mental health
<76> Rehab
<77> Nursing home: permanent custodial assistance
<78> Burn center
<79> Trauma center
<99> Transferred: Transfer to Acute Care Facility. Discharged/transferred to nontrauma center or non-burn center hospital
</> Not applicable (n/a)

DEFAULT: Blank

ADDITIONAL INFORMATION:

HISTORY:

POST OR DISPOSITION

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Disposition from operating room

FIELD VALUES:

<4> ICU
<5> Step down unit
<7> Telemetry
<8> Floor
<9> Observation unit
<12> Special procedure room (includes cath lab)
<13> Labor & delivery
<14> PICU
<40> Morgue: ED death
<41> AMA
<42> Correctional facility
<43> Home
<44> Home with services
<70> Acute Care Facility: (retired 01 Jan 2019)
<72> SNF: usually temporary, to solve a specific medical need or to allow recovery outside a hospital
<73> Hospice: includes home hospice
<75> Mental health
<76> Rehab
<77> Nursing home: permanent custodial assistance
<78> Burn center
<79> Trauma center
<99> Transferred: Transfer to Acute Care Facility. Discharged/transferred to nontrauma center or non-burn center hospital
</> Not applicable (n/a)

DEFAULT: Blank

ADDITIONAL INFORMATION:

HISTORY:

SBIRT DONE? (ED)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Was SBIRT (Screening, Brief Intervention and Referral to Treatment) completed for this patient? SBIRT is an evidence-based approach to identify individuals who use alcohol and other drugs (substances) at risky levels.

FIELD VALUES:

<1>=Yes
<2>=No

DEFAULT: Blank

ADDITIONAL INFORMATION:

HISTORY:
New in 2024

ALCOHOL MISUSE TEAM (Y/N)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Brief intervention should be providedby a hospital staff member who is specially trained in how to do a brief intervention.

FIELD VALUES:

<1>=Yes
<2>=No
</>=n/a
<?>=Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

HISTORY:
New in 2024

ASSESSMENT DATE-TIME (ED)

State Required	Available for State Research	NTDB Required
Yes	Yes*	No

DEFINITION: Date/time ED assessment done

FIELD VALUES:

Date/time

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Initial vital signs must be those taken within 30 minutes of arrival. If you'd like to record post-30 minute
- vital signs, add vital signs values in the non-initial fields. If no vital signs are taken within 30 minutes of
- arrival, then code initial values with </>
- The date is documented as MM/DD/YYYY
- The time is documented in military time (HH:MM)

HISTORY:

WEIGHT (ED) VALUE /UNIT OF MEASURE

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Patient's weigh - value

FIELD VALUES:

Numeric

DEFAULT: Blank

ADDITIONAL INFORMATION:

- May be measured or estimated.
- May be based on patient or family report.
- May record in either lbs. or kg. Software will convert to other unit of measurement.
- </> (Not applicable) is not a valid option for this field.

HISTORY:

HEIGHT (ED) VALUE/UNIT OF MEASURE

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Height value: how tall is the patient (with the units designated in the Height unit field)?

FIELD VALUES:

0 to 268

DEFAULT: Blank

ADDITIONAL INFORMATION:

- If recorded in centimeters, software auto calculates to inches and vice versa.
- May be based on family or self-report.
- </> (Not applicable) is not a valid option for this field.

HISTORY:

TEMPERATURE VALUE /UNIT/ROUTE (ED)

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Initial ED temperature value measured within first 30 minutes of patient's arrival at facility recording this datapoint

FIELD VALUES:

Value: Numeric
Unit: F,C
Route:
<1>Oral
<2>Tympanic
<3>Rectal
<4>Axillary>
<5>Core
<6>Other
<7>Temporal
? Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Initial vital signs must be those taken within 30 minutes of arrival. If you'd like to record post-30 minute vital signs, add vital signs values in the non-initial fields. If no vital signs are taken within 30 minutes of arrival, then code initial values with ?
- If recorded in Fahrenheit, software auto converts to Celsius and vice versa.
- </> (Not applicable) is not a valid option for this field.

HISTORY:

PARALYZED (ED)

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Had patient been given paralytic agents at the time ED vitals were taken?

FIELD VALUES:

<Y> Yes
<N> No
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Qualifier for GCS.
- If an intubated patient has recently received an agent that results in neuromuscular blockade such that motor or eye response is not possible, then the patient should be considered to have an exam that is not reflective of their neurological status and chemical sedation and/or paralytic sedation should be selected.
- These agents do not include those administered by the patient (e.g., alcohol, prescription).
- Refer to drug list in Appendix A for further information regarding paralytics.
- Do not use </>.

HISTORY:

SEDATED (ED)

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Was patient sedated at time GCS was measured?

FIELD VALUES:

<Y> Yes
<N> No
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Qualifer for GCS.
- Because TQIP reclassifies GCS as <8 for any patient flagged as sedated, NC will no longer flag patients as sedated if they have a GCS of 8 or greater. If GCS is > 8: don't flag patients as sedated, regardless of any medication given. (Added 01Jan2021)
- For patients with a GCS<8, patients will be flagged as sedated if they have been given any drug on the approved NCCOT sedation list (see Appendix A) within 6 hours of when GCS was measured. No consideration of half-life, dose, or intent of the medication will be used. (Added 01Jan2021)
- Do not use </>.

HISTORY:
The following text was removed as of 01Jan2021: If an intubated patient has recently received an agent that results in neuromuscular blockade such that motor or eye response is not possible, then the patient should be considered to have an exam that is no

EYE OBSTRUCTION (ED)

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Indicates if the patient did or did not have an obstruction to both eyes that affected the GCS at the time GCS was obtained at your facility. An obstruction is a physical reason that prevents the patient from opening their eyes.

FIELD VALUES:

<Y> Yes
<N> No
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Qualifier for GCS
- Do not use </>.

HISTORY:

INTUBATED? (ED)

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Indicates the use of a device for the purpose of assisted ventilation of patient to maintain an airway at the time ED vitals were taken.

Only if patient was intubated in the ED.

FIELD VALUES:

<Y> Yes
<N> No
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Qualifier for GCS.
- Must be active, not passive delivery of oxygen. Non-rebreather mask and nasal cannula are supplemental oxygen and not to be considered airway management.
- Base response on most active airway adjunct in use at time of GCS assessment.
- Do not use </>.

HISTORY:

INTUBATION METHOD (ED)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Method of intubation at time ED vitals were taken.

FIELD VALUES:

<1> Blind Insertion Airway Device
(Combitube, I-Gel, King Airway, Laryngeal Mask Airway
<2> Cricothyrotomy – Open
<3> Cricothyrotomy - Needle
<4> Endotracheal Tube – Nasal
<5> Endotracheal Tube – Oral
<6> Endotracheal Tube – Route NFS
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Record the most invasive airway adjunct used by the ED provider.
- Only complete this field if the patient was intubated.

HISTORY:
4/23/2012: Changed wording of #1 from Combitube to Blind Insertion Airway Device. Removed Tracheostomy and Laryngeal Mask Airway from the active choices for this field.. Tracheostomy left in field value list for research purposes.

RESPIRATION ASSISTED (ED)

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Indicates whether the patient required respiration assistance at the time initial vital signs were assessed at the facility recording these data.

FIELD VALUES:

<Y> Yes
<N> No
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Qualifier for GCS
- Do not use </>.

HISTORY:

ASSISTED RESPIRATION TYPE (ED)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: The type of device used for respiratory assistance at the time the initial vitals were taken at the facility recording these data.

FIELD VALUES:

<1> Bag Valve Mask
<2> Nasal Airway
<3> Oral Airway
<4> Ventilator
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Should only be complete if "Respiration assisted" field value is <Yes>

HISTORY:

SYSTOLIC BLOOD PRESSURE (SBP) (ED)

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Systolic blood pressure (SBP) measured within first 30 minutes of patient's arrival at facility recording this datapoint.

FIELD VALUES:

Numeric

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Initial vital signs must be those taken within 30 minutes of arrival. If you'd like to record post-30 minute vital signs, add vital signs values in the non-initial fields. If no vital signs are taken within 30 minutes of arrival, then code initial values as unknown (<?>).
- </> (Not applicable) is not a valid option for this field.

HISTORY:

PULSE RATE (ED)

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Pulse rate measured within first 30 minutes of patient's arrival at facility recording this datapoint.

FIELD VALUES:

Numeric

DEFAULT: Blank

ADDITIONAL INFORMATION:

- The pulse rate can be palpated or auscultated, expressed as a number per minute.
- Prior to 2021, NTDS had a different requirement for EMS vital signs than the NCTR. To meet the needs of NTDS, we asked Registrars, for sites participating in NTDS to put question marks in the first vital sign position, then add the EMS vital signs as additional “scene” vitals - if the vital signs didn’t fit NTDS definition of “scene vitals”.

HISTORY:

UNASSISTED RESPIRATORY RATE (ED)

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Unassisted respiratory rate measured within first 30 minutes of patient's arrival at the facility recording these data.

FIELD VALUES:

Numeric

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Expressed as number per minute.
- Initial vital signs must be those taken within 30 minutes of arrival. If you'd like to record post-30 minute vital signs, add vital signs values in the non-initial fields. If no vital signs are taken within 30 minutes of arrival, then code initial values as unknown (<?>).

HISTORY:

ASSISTED RESPIRATORY RATE (ED)

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: The first recorded assisted respiratory rate measured within the first 30 minutes of patient's arrival at the facility recording these data.

FIELD VALUES:

0 to 98

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Expressed as number per minute.
- Initial vital signs must be those taken within 30 minutes of arrival. If you'd like to record post-30 minute vital signs, add vital signs values in the non-initial fields. If no vital signs are taken within 30 minutes of arrival, then code initial values as unknown (<?>).

HISTORY:

O2 SATURATION (ED)

State Required	Available for State Research	NTDB Required
Yes	No	Yes

DEFINITION: O2 saturation (aka pulse ox) measured within first 30 minutes of patient's arrival at this facility

FIELD VALUES:

Numeric

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Expressed as percentage
- Initial vital signs must be those taken within 30 minutes of arrival. If you'd like to record post-30 minute vital signs, add vital signs values in the non-initial fields. If no vital signs are taken within 30 minutes of arrival, then code initial values as unknown (<?>).
- </> (Not applicable) is not a valid option for this field.

HISTORY:

SUPPLEMENTAL O2 GIVEN (ED)

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Was supplemental O2 provided to the patient in the ED during the initial assessment within 30 minutes of arrival at your facility?

FIELD VALUES:

<1>=Yes
<2>=No
<?>Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

Do not use </> (Not applicable).

HISTORY:

ED GCS-EYE

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: GCS-eye value measured within first 30 minutes of patient's arrival at facility recording this datapoint.

FIELD VALUES:

<1> No Eye Movement when Assessed
<2> Opens Eyes in Response to Painful Stimulation
<3> Opens Eyes in Response to Verbal Stimulation
<4> Opens Eyes Spontaneously
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Initial vital signs must be those taken within 30 minutes of arrival. If you'd like to record post-30 minute vital signs, add vital signs values in the non-initial fields. If no vital signs are taken within 30 minutes of arrival, then code initial values with ?
- Use to auto-calculate Total GCS.
- If anyone of the three GCS components is missing a value, the total GCS will not automatically calculate.
- If the GCS total is not recorded, but written documentation relates to verbiage describing a specific level of functioning with the GCS scale, the appropriate numeric score may be listed. For example, the chart indicates: "the patient opens his eyes when spoken to", an Eye GCS of 3 may be recorded IF there is no other contradicting documentation.
- </> (Not applicable) is not a valid option for this field.

HISTORY:

1/31/2013: DI added </> and <?> options

GCS-VERBAL (ED)

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: GCS-verbal measured within first 30 minutes of patient's arrival at facility recording this datapoint.

FIELD VALUES:

<1> No Vocal Response
<2> Incomprehensible (adult) or Moans to Pain (infant/child)
<3> Inappropriate (adult) or Cries to Pain
(infant/child)
<4> Confused (adult) or Irritable/Cries
<5> Oriented (adult) or Coos/Babbles
(infant/child)
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Initial vital signs must be those taken within 30 minutes of arrival. If you'd like to record post-30 minute vital signs, add vital signs values in the non-initial fields. If no vital signs are taken within 30 minutes of arrival, then code initial values with ?
- Used to auto calculate the Total GCS.
- If anyone of the three GCS components is missing a value, the total GCS will not automatically calculate.
- If the GCS total is not recorded, but written documentation relates to verbiage describing a specific level of functioning with the GCS scale, the appropriate numeric score may be listed. For example, if the chart indicates: "the patient responds verbally and appropriately when spoken to", a Verbal GCS of 5 may be recorded IF there is no other contradicting documentation.
- </> (Not applicable) is not a valid option for this field.

HISTORY:

1/31/2013: DI added </> and <?> options

GCS-MOTOR (ED)

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: The first recorded Glasgow Coma Scale (GCS)-motor value measured within 30 minutes of patient's arrival at facility recording this datapoint.

FIELD VALUES:

<1> No Motor Response
<2> Extension to Pain
<3> Flexion to Pain
<4> Withdraws from Pain (adult) or Withdraws to Pain (infant/child)
<5> Localizing Pain (adult) or
Withdraws to Touch (infant/child)
<6> Obeys Command (adult) or
Spontaneous Movements (infant/child)
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

Initial vital signs must be those taken within 30 minutes of arrival. If you'd like to record post-30 minute vital signs, add vital signs values in the non-initial fields. If no vital signs are taken within 30 minutes of arrival, then code initial values as unknown (<?>).
Used to auto calculate the Total GCS
If anyone of the three GCS components is missing a value, the total GCS will not automatically calculate.
If the GCS total is not recorded, but written documentation relates to verbiage describing a specific level of functioning with the GCS scale, the appropriate numeric score may be listed. e.g., the chart indicates: "the patient withdraws from a painful stimulus", a Motor GCS of 4 may be recorded IF there is no other contradicting documentation.
</> (Not applicable) is not a valid option for this field.

HISTORY:
1/31/2013: DI added </> and <?> options

GCS-TOTAL (ED)

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: GCS-total measured within first 30 minutes of patient's arrival at facility recording this datapoint.

FIELD VALUES:

3-15 (Autocalculated)
<?>Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- This field is auto-calculated by the software when the Eye, Verbal, and Motor fields contained values.
- If any one of the three components is missing a value, the GCS will not automatically calculate, but the total GCS can be entered manually ONLY if the documentation states “alert and oriented x 3” or “alert and oriented x 4”.
- The GCS is a scale used to determine a score based on the total of 3 components on a patient involving an assessment of eye, motor, verbal responses of the patient.

HISTORY:

ED ABG DRAWN?

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Indicates whether blood gas laboratory studies were drawn on the patient at facility recording this datapoint. First recorded in ED within 30 minutes of arrival for patients who come in through ED (non-direct-admits). For direct admits, use first drawn

FIELD VALUES:

<Y> Yes
<N> No
</> Not applicable> - Do not use this value
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- In DI's NCv5, you must select <Y> in this field in order to enter ABG lab value fields.

HISTORY:

ED ABG TYPE

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Indicates whether blood gas drawn was arterial or venous.

FIELD VALUES:

<1> ABG (Arterial Blood Gas)
<2> VBG (Venous Blood Gas)
</> Not applicable>
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

None

HISTORY:

ED BASE DEFICIT (ABG)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: The initial Base Deficit/Excess measured at your facility drawn within 30 minutes of patient arrival at facility recording this datapoint.

FIELD VALUES:

Up to 2 decimal pts; Pos and neg values

DEFAULT: Blank

ADDITIONAL INFORMATION:

- A negative base (deficit) is equivalent to an acid excess.
- A positive base (excess) indicates an insufficient level of bicarbonate in the system

HISTORY:

ED HEMATOCRIT

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: The patient's initial hematocrit value obtained at the trauma center - drawn within 30 minutes of patient arrival at facility recording this datapoint.

FIELD VALUES:

Numeric

DEFAULT: Blank

ADDITIONAL INFORMATION:

HISTORY:

Blood products

BLOOD TYPE

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: The type of blood product given to the patient during the initial visit at the facility recording these data.

FIELD VALUES:

<1> Packed Red Blood Cells (PRBCs)
<2> Plasma/FFP
<3> Platelets
<4> Cryo
<5> Other Blood Substitute
<6> Whole blood (added Jan 2021)
</> Not Applicable
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Enter PRBC option for each separate timeframe. Timeframe options include, but are not exclusive to, prehospital, referring facility, and within 1 hour of arrival.
- The packed red blood cells given within the first 24 hours of the patient's injury are required by the state of North Carolina. Any other blood products are optional.

HISTORY:

BLOOD UNITS: NUMBER

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: The total number of units given to the patient within the first 24 hours.

FIELD VALUES:

Numeric

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Separate events for each episode within the 1st 24 hours.
- The packed red blood cells given within the first 24 hours of the patient's injury are required by the state of North Carolina. Any other blood products are optional.

HISTORY:

BLOOD UNIT OF MEASURE

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: The unit of measure of the blood product given.

FIELD VALUES:

<1> L (DO NOT USE)
<2> mL
<3> Units
</> Not Applicable
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- The volume measurement type for packed red blood cells given within the first 24 hours of the patient's injury are required by the state of North Carolina. Any other blood products are optional.
- Separate event for each episode within the 1st 24 hours

HISTORY:
1/15/2013: "Units" added as a value. Blank was used in lieu of units prior to this date.

BLOOD TIME PERIOD

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Blood timeframe: Time frame when a specific "unit" of blood was started.

FIELD VALUES:

<0> Referring facility prior to arrival
<1> Transport prior to facility arrival
<2> Within 1st hour after facility arrival
<3> Between 1 and 4 hours after facility arrival
<4> Between 5 and 24 hours after facility arrival
<5> Between 24 and 48 hours after facility arrival
<6> Between 48 and 72 hours after facility arrival
<7> More than 72 hours after facility arrival
<8> Within first 24 hours of facility arrival – NFS
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- The packed red blood cells given within the first 24 hours of the patient's injury are required by the state of North Carolina. Any other blood products are optional.
- Separate episode for each event within the 1st 24 hours.
- Option <1> refers to blood given during any transport
- Vidant uses option 3 to include patients meeting options 2 or 3.

HISTORY:

ED PROVIDER CALLED DATE-TIME

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: Date-time ED provider was called in response to activation or ED consult.

FIELD VALUES:

Date/time

DEFAULT: Blank

ADDITIONAL INFORMATION:

Date is documented as MM/DD/YYYY. Time is documented in military format (24-hour clock) as HH:MM.

HISTORY:

ED PROVIDER RESPONDED DATE-TIME

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: Date-time ED provider responded by phone to call in response to activation or ED consult. Required if provider responded only by phone.

FIELD VALUES:

Date/time

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Optional field. Included in dictionary because it may be used to account for providers who respond only by phone and do not come to patient's bedside in ED.
- For neuro and ortho: documentation of arrival and response times can include those of attendings, residents, and midlevels, if they arrive first.

HISTORY:

New in 2024

ED PROVIDER ARRIVAL DATE/TIME

State Required	Available for State Research	NTDB Required
Yes	No	Yes (for Trauma Surgeon highest activation only)

DEFINITION: The date-time the ED provider arrived at the patient's bedside. Providers include ED physicians, neurosurgeons, orthopedists, trauma surgeons, etc. See ED provider type field for a complete list. Does not include virtual/phone responses.

FIELD VALUES:

Date/time

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Date is documented as MM/DD/YYYY.
- Time is documented in military format (24-hour clock) as HH:MM.

HISTORY:

ED PROVIDER ARRIVAL TIMELY

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: Was ED provider's arrival timely?

FIELD VALUES:

<1> Timely
<2> Not timely
<3> Absent
<?> Unknown
</> Do not use this value.

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Timely is based on the earliest documented date/time the Trauma Attending arrived at the patient's bedside.
- The date is documented as MM/DD/YYYY
- The time is documented in military time (HH:MM)

HISTORY:

ED PROVIDER TYPE

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes (to identify Trauma Service)

DEFINITION: ED provider type.

FIELD VALUES:

<1> Trauma
<2> Neurosurgery
<3> Orthopedics
<4> General surgery
<5> Pediatric surgery
<6> Cardiothoracic surgery
<7> Burn services
<8> Emergency medicine
<9> Pediatrics
<10> Anesthesiology
<11> Cardiology
<14> Child protective team
<15> Critical care
<16> Dental
<17> Dermatology
<20> Drug/alcohol counselor
<22> Endocrinology
<23> ENT
<24> Ethics committee
<25> Medicine
<26> Geriatrics (renamed from Gerontology Jun-2021)
<27> GI
<28> Hand
<29> Hematology/Oncology
<31> Hospitalist
<32> Infectious disease
<33> Internal medicine
<34> Interventional radiology
<36> Nephrology
<37> Neurology
<38> Neuro-psych
<42> Nutrition

<43> OB/Gyn
<45> Opthalmology
<46> Oral surgery
<47> Organ donation
<49> Spine
<50> SCI (spinal cord injury)
<51> Pain management
<52> Palliative care
<53> Pediatric critical care
<54> Pharmacy
<55> Physiatry
<56> Physical therapy
<58> Plastic surgery
<59> Psychiatry
<60> Pulmonary
<61> Radiology
<62> Recreation therapy
<63> Rehab
<64> Respiratory therapy
<65> Risk management
<66> Social services
<67> Social work
<68> Speech therapy
<72> TBI
<73> Thoracic surgery
<76> Urology
<77> Vascular surgery
<78> Wound care
<79> Hyperbarics
<80> Intensivist
<98> Other surgical service
<99> Other non-surgical service

DEFAULT: Blank

ADDITIONAL INFORMATION:

- For trauma surgeon, include only the attending. Fellows and residents do not count for the time requirement (per Gray Book).
- For neuro and ortho: documentation of arrival and response times can include those of attendings, residents, and midlevels, if they arrive first.

HISTORY:

Provider/In-House Consult

IN-HOUSE CONSULT TYPE

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: What service does the in-house consult represent?

FIELD VALUES:

<1> Trauma
<2> Neurosurgery
<3> Orthopedics
<4> General surgery
<5> Pediatric surgery
<6> Cardiothoracic surgery
<7> Burn services
<8> Emergency medicine
<9> Pediatrics
<10> Anesthesiology
<11> Cardiology
<14> Child protective team
<15> Critical care
<16> Dental
<17> Dermatology
<20> Drug/alcohol counselor
<22> Endocrinology
<23> ENT
<24> Ethics committee
<25> Medicine
<26> Geriatrics (renamed from Gerontology
Jun-2021)
<27> GI
<28> Hand
<29> Hematology/Oncology
<31> Hospitalist
<32> Infectious disease
<33> Internal medicine
<34> Interventional radiology
<36> Nephrology
<37> Neurology
<38> Neuro-psych
<42> Nutrition
<43> OB/Gyn

<45> Opthalmology
<46> Oral surgery
<47> Organ donation
<49> Spine
<50> SCI (spinal cord injury)
<51> Pain management
<52> Palliative care
<53> Pediatric critical care
<54> Pharmacy
<55> Physiatry
<56> Physical therapy
<58> Plastic surgery
<59> Psychiatry
<60> Pulmonary
<61> Radiology
<62> Recreation therapy
<63> Rehab
<64> Respiratory therapy
<65> Risk management
<66> Social services
<67> Social work
<68> Speech therapy
<72> TBI
<73> Thoracic surgery <76> Urology
<77> Vascular surgery
<78> Wound care
<79> Hyperbarics
<80> Intensivist
<98> Other surgical service
<99> Other non-surgical service

DEFAULT: Blank

ADDITIONAL INFORMATION:

HISTORY:
Required as of Jan2019

IN-HOUSE CONSULT CALLED DATE-TIME

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Date-time the in-house (non-ED) consult service was called (requested).

FIELD VALUES:

Date/Time value

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Date is documented as MM/DD/YYYY.
- Time is documented in military format (24-hour clock) as HH:MM.

HISTORY:

Required as of Jan2019

IN-HOUSE CONSULT ARRIVED DATE-TIME

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Date-time the in-house (non-ED) consult service arrived at the patient's bedside.

FIELD VALUES:

Date/Time value

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Date is documented as MM/DD/YYYY.
- Time is documented in military format (24-hour clock) as HH:MM.

HISTORY:

Required as of Jan2019

ICD-10 PROCEDURE CODE

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: ICD-10 code that describes the procedure done on the patient.

FIELD VALUES:

Too many values to list. See https://www.icd10data.com/ICD10PCS/Codes.

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Major and minor procedures performed at your facility, including CPR for all locations.
- In DI V5 software, the maximum number of procedures that may be recorded for a patient is 200.
- Capture all procedures performed in the operating room except for intubation solely for the operation.
    - Ignore NTDB instructions to capture only first incidence of certain procedures.
- Diagnostic and supplemental (non-operative) procedures have the potential to be performed multiple times during one hospitalization event. In this case, capture only the first event.
- </> (Not applicable) not valid for ICD-10 codes for patients arriving on 01Oct2015 or later.

HISTORY:

PROCEDURE LOCATION

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Location where procedure was done.

FIELD VALUES:

<2> Emergency department
<3> Operating room
<4> Intensive care unit
<5> Step-down unit
<8> Floor
<10> Radiology
<12> Special procedure room
<14> Pediatric ICU
<15> Interventional radiology
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

None

HISTORY:

OPERATIONNUMBER

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: Provides information on the order of procedures done. First procedure should have operation number 1.

FIELD VALUES:

Numeric

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Start the count at your facility. Whether or not the patient has had procedures at another facility, the first procedure at your facility is OR Visit #1.
- If multiple procedures are performed during the one trip to the OR, those procedures will share the same OR visit number.
- If a procedure is performed anywhere other than the OR, the OR visit number can be left as the default value <blank> or </> Not Applicable.
- First visit to OR should be recorded as #1.

HISTORY:

PROCEDURE START DATE-TIME

State Required	Available for State Research	NTDB Required
Yes	Yes*	Yes

DEFINITION: Date-time that procedure started.

FIELD VALUES:

Date/Time

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Date is documented as MM/DD/YYYY.
- Time is documented in military format (24-hour clock) as HH:MM.

HISTORY:

PROCEDURE RESULT

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Results of diagnositic procedures. Not required for non-diagnostic procedures.

FIELD VALUES:

<1> Positive
<2> Negative
<3> Indeterminate
</> Not Applicable
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

Procedure result required for all diagnostic studies.

HISTORY:

RADIOLOGIC BIG

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: The portion of the brain injury guideline (BIG) score assigned by the radiologist. No interpretation is to be done by anyone other than radiologists. They're supposed to assign the Radiologic BIG 1, 2, or 3 value based only imaging findings.

FIELD VALUES:

1=BIG-1
2=BIG-2
3=BIG-3
4 = Not reported. Patient has a brain injury, CT done, but no BIG score reported by radiologist
/ = Not applicable. Patient does not have a brain injury
? = Unknown. Patient diagnosed with brain injury, but no CT done

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Required for patients with head injuries who get CTs.
- No interpretation is to be done by anyone other than radiologists. Radiologists are to assign the BIG 1, 2, or 3 value based only on imaging (head CT) findings.
- If radiology reports more than one value, use the highest score (3 is the highest possible score; 1 is the lowest).
- Use results only from the first CT done on the patient, as this first CT is the one that determines their subsequent care, such as whether or not they need additional CTs.
- Registrars should enter only the value assigned by a radiologist based on the template provided by the STAC/NCCOT Research Committee.
- Report only for CTs done at your facility. This field is not meant for transfer facility BIG classifications.
- Training has been written for radiologists by the STAC Research Committee, and we've designed a template for the EMR for radiology.

HISTORY:
New in 2024

MEDICAL IMAGING ORDER (Y/N)

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Was medical imaging (CT or MRI) ordered on this patient during this hospital stay?

FIELD VALUES:

<1>=Yes
<2>=No

DEFAULT: Blank

ADDITIONAL INFORMATION:

Check "yes" if any CT or MRI was ordered for this patient during this hospital stay - for any reason. If the imaging was ordered, but not completed, still check "yes". Only check "no" if no MRI or CT was ordered or if the order was cancelled.

HISTORY:
New in 2024

AIS VERSION

State Required	Available for State Research	NTDB Required
Yes	No	Yes

DEFINITION: The software version used to calculate the AIS (Abbreviated Injury Scale) severity codes

FIELD VALUES:

AIS 2005

- **DEFAULT:** AIS2005
- </> (Not applicable) is not a valid option for this field.

ADDITIONAL INFORMATION:

- All facilities submitting data to the State of NC trauma registry are required to use the AIS 2005 version. Starting in 2016, NTDS will accept AIS2005. NTDS used to accept AIS 80, 85, 90, 95, 98 and AIS2005.

HISTORY:

ISS

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Injury severity score

FIELD VALUES:

Auto-calculated

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Sum of squares of highest AIS code in each of the three most severely injured AIS body regions.
- This field auto calculates based on injury coding.

HISTORY:

NISS

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: The New Injury Severity Score is the sum of the squares of the three highest AIS in any ISS body region. This score is used as a predictor of mortality.

FIELD VALUES:

Auto-calculated

DEFAULT: Blank

ADDITIONAL INFORMATION:

Autocalculated based on injury coding as the sum of squares of 3 highest AIS scores, regardless of body region.

HISTORY:

TRISS

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Trauma and injury severity score

FIELD VALUES:

Auto-calculated

DEFAULT: Blank

ADDITIONAL INFORMATION:

TRISS is a based on revised trauma score (RTS), injury severity score (ISS) and patient's age.

HISTORY:

ICD-10 DIAGNOSIS CODE

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: ICD-10 diagnosis codes for all injuries

FIELD VALUES:

Refer to ICD-10 reference texts.

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Required for admissions post Oct-2015.
- Values required for diagnoses made at your facility. Diagnoses recorded at a referring facility should be recorded in the referring facility diagnoses field.
- For ICD-9: for drowning – use 994.1. For asphyxia/suffocation use 994.7.

HISTORY:

Required for admissions post Oct-2015.

AIS PREDOT

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Pre-dot: Digits before decimal point of AIS code. The Abbreviated Injury Scale (AIS) Predot codes that reflect the patient's injuries.

FIELD VALUES:

Auto-generated

DEFAULT: Blank

ADDITIONAL INFORMATION:

- The predot code is the 6 digits preceding the decimal point in an associated AIS Code.
- Refer to most recent AIS coding book for further coding detail.
- </> (Not applicable) is not a valid option for this field.

HISTORY:

AIS SEVERITY

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Digit after decimal point of the AIS code. The AIS single digit severity number indicates the relative severity of injury in an "average patient" who sustains the coded injury as their only injury.

FIELD VALUES:

Auto-calculated

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Auto populates based on AIS 6-digit predot.

HISTORY:

ISS BODY REGION

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: AIS body region: The body regions used for generation of the injury severity scores.

FIELD VALUES:

Auto-calculated

DEFAULT: Blank

ADDITIONAL INFORMATION:

1) This field is auto populated based on AIS 6-digit predot.
2) Head or neck injuries include the brain, skull, cervical cord, and cervical spine.
3) Facial injuries include those involving the mouth, ears, e*Yes

HISTORY:

OIS SEVERITY

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Organ injury severity scale.

FIELD VALUES:

<1> Grade 1
<2> Grade 2
<3> Grade 3
<4> Grade 4
<5> Grade 5
<6> Grade 6
</> Not Applicable
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- The OIS is for organs only. Organs include all organs in the thoracic and abdominal cavities as well as thoracic vascular and abdominal vascular.

HISTORY:

NON-TRAUMA DIAGNOSIS ICD-10 CODE

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: ICD-10 codes identified during the patient's stay for non-trauma diagnoses not coded elsewhere.

FIELD VALUES:

Refer to ICD-10 reference texts.

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Any diagnosis that is hospital acquired should go into the non-trauma diagnosis (NTD) list. If you have a NTD that is present on admission (POA) and is listed in the comorbidity list, then you can enter it in the comorbidity list. If you have NTDs that are POA and are not listed in the comorbidity list (or don't meet the NTDB's strict definitions), then enter them in the NTD section. Comorbidities that are entered in to the "Comorbidity" field do not need to also be entered in to the NTD field.
- D62 (acute blood loss anemia) should not be used for pre-existing (chronic) anemia. D62 represents acute post-hemorrhagic anemia.

HISTORY:

NON-TRAUMA DIAGNOSIS TYPE

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Indicates whether comorbidity or complication was present on arrival (POA) or hospital acquired.

FIELD VALUES:

<1> Present on Arrival
<2> Hospital Acquired
</> Not Applicable
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Obtained from medical records coding
- Not required for ED discharges

HISTORY:

COMORBIDITY

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Pre-existing co-morbid factors present before patient arrival at the ED/Hospital.

FIELD VALUES:

0=None
2=Alcoholism
4=Bleeding disorder
5=Currently receiving chemo for cancer
6=Congenital abnormalities
7=CHF
8=Current smoker
9=Chronic renal failure
10=CVA
11=Diabetes mellitus
12=Disseminated cancer
13=Advanced directive limiting care
15=Functionally dependent health status
19=Hypertension
21=Prematurity
23=Respiratory disease
24=Steroid use
25=Cirrhosis
26=Dementia
30=ADD/ADHD
31=Anticoagulant therapy
32=Angina pectoris
33=Mental/personality disorder
34=MI
35=Peripheral arterial disease
36=Substance use disorder
20=Impaired sensorium (NTDB retired 2012)
3=Ascites within 30 days (NTDB retired 2015)
14=Esoph varices (NTDB retired 2015)
22=Obesity (NTDB retired 2015)
29=Pre-hosp cardiac arrest with resus efforts by h/c provider (NTDB retired 2015)
16=Hx of angina w/in 30 days (NTDB retired 2017)
17=Hx of MI (NTDB retired 2017)
18=Hx of PAD (NTDB retired 2017)

0=None
A01=Hx of cardiac surgery
A02=Coronary artery disease
A04=Cor pulmonale
B01=Diabetes mellitus-insulin-dep
B02=Diabetes mellitus-non-insulin-dep
C01=Peptic ulcer disease
C03=Pancreatitis
C04=Inflammatory bowel disease
D01=Acquired coagulopathy
D02=Coumadin tx
D04=Pre-existing anemia
F01=HIV/AIDS
F03=Transplant
G01=Bilirubin>2mg% on admission
H01=Undergoing current therapy
I01=Rheumatoid arthritis
I02=SLE
J01=SCI
J02=MS
J04=Alzheimer's disease
J04=Seizures
J05=Chronic demyelinating disease
J07=Organic brain syndrome
J08=Parkinson's disease
L01=Documented prior hx of pulmonary disease w/ ongoing active tx
L02=Asthma
L03=COPD
L04=Chronic pulmonary condition
M01=Serum creatinine>2mg% on admission
M02=Dialysis non-transplant
N01=Osteoporosis / osteopenia
P00=Pregnancy

DEFAULT: Blank

ADDITIONAL INFORMATION:

See NTDB data dictionary for field value definitions with the following exceptions:

- Congenital anomalies: enter for all ages. ESO is setting up a mapping so that a "yes" value is sent to TQIP/NTDB only if patient is a child. The State should get all values regardless of age.
- Alcohol and substance abuse disorder fields: entry for all ages. ESO is setting up a mapping so that a "yes" value is sent to TQIP/NTDB only if patient is age 15+. The State should get all values regardless of age.

If no comorbidities are reported, choose <0> (None).
Definitions:
Osteoporsis/osteopenia:

Note: medication use does not count as criteria for flagging a patient as having osteoporosis or osteopenia. Requires at least one of the following:
1) Diagnosis or documentation of medical history of osteoporosis or osteopenia noted medical record by MD, DO, PA, or NP
2) Report of presence of osteoporosis or osteopenia on the radiology report.

HISTORY:

Outcome/Initial Discharge

DISCHARGE STATUS

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Status of patient (alive or dead) at time of discharge from trauma center.

FIELD VALUES:

<1> Alive
<2> Dead

DEFAULT: Blank

ADDITIONAL INFORMATION:

None

HISTORY:

DISCHARGE ORDER DATE-TIME (HOSPITAL)

State Required	Available for State Research	NTDB Required
Yes	Yes*	Yes

DEFINITION: Date-time hospital discharge order was written

FIELD VALUES:

DEFAULT: Blank

ADDITIONAL INFORMATION:

- If death, enter n/a.

HISTORY:

DISCHARGE DATE/TIME

State Required	Available for State Research	NTDB Required
Yes	Yes*	No

DEFINITION: Date/time that patient physically left the trauma center or was declared brain dead.

FIELD VALUES:

Date/Time

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Date is documented as MM/DD/YYYY.
- Time is documented in military format (24-hour clock) as HH:MM.

HISTORY:

ICU DAYS

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: ICU LOS in days

FIELD VALUES:

Numeric

DEFAULT: Blank

ADDITIONAL INFORMATION:

HISTORY:

VENT DAYS

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

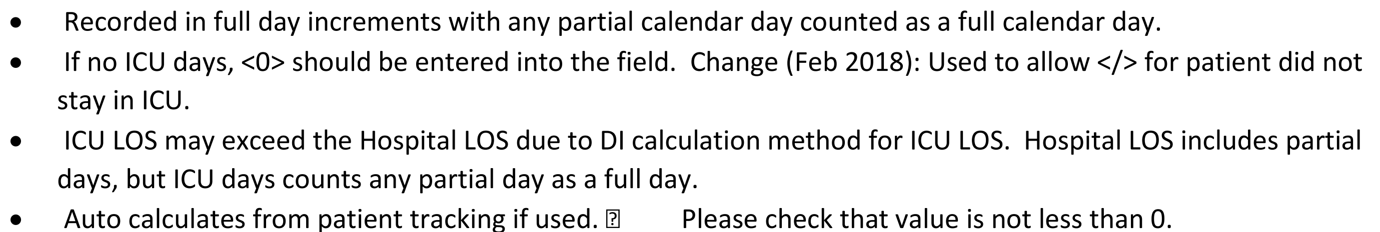
DEFINITION: Number of days a patient was on a ventilator

FIELD VALUES:

Numeric

DEFAULT: Blank

ADDITIONAL INFORMATION:



- Recorded in full day increments with any partial calendar day counted as a full calendar day.
- If no ICU days, <0> should be entered into the field. Change (Feb 2018): Used to allow </> for patient did not stay in ICU.
- ICU LOS may exceed the Hospital LOS due to DI calculation method for ICU LOS. Hospital LOS includes partial days, but ICU days counts any partial day as a full day.
- Auto calculates from patient tracking if used. Please check that value is not less than 0.

HISTORY:

HOSPITAL DAYS

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Hospital (in-patient) LOS in days

FIELD VALUES:

Numeric

DEFAULT: Blank

ADDITIONAL INFORMATION:

- This field is auto-calculated by the software from the arrival date/time and the hospital discharge date/time.

HISTORY:

DISCHARGE SERVICE

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: The service that handled the discharge from the trauma center.

FIELD VALUES:

<1> Trauma
<2> Neurosurgery
<3> Orthopedics
<4> General Surgery
<5> Pediatric Surgery
<6> Cardiothoracic Surgery
<7> Burn Services
<9> Pediatrics
<11> Cardiology
<16> Dental
<23> ENT
<25> Medicine
<26> Geriatrics
<28> Hand
<31> Hospitalist
<33> Internal Medicine
<80> Intensivist
<36> Nephrology
<37> Neurology
<39> Not Admitted
<43> OB-GYN
<45> Ophthalmology
<46> Oral Surgery
<53> Pediatric Critical Care
<58> Plastic Surgery
<59> Psychiatry
<63> Rehab
<76> Urology
<77> Vascular Surgery
<98> Other Surgical
<99> Other Non-Surgical
</> Not Applicable

DEFAULT: Blank

ADDITIONAL INFORMATION:

- If patient is discharged from ED, use “Not Admitted”
- List still does not match admitting service list. Requested of DI in approx. 2014.

HISTORY:

DISCHARGE DISPOSITION

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Hospital disposition, i.e., where the patient went after leaving the trauma center.

FIELD VALUES:

<40> Morgue
<41> Left AMA
<42> Correctional Facility
<43> Home
<44> Home with Services
<72> Skilled Nursing Facility (SNF): usually temporary, to solve a specific medical need or to allow recovery outside a hospital
<73> Hospice: includes home hospice
<74> Long-term care: includes assisted living, and nursing home. Use this value when it is unclear what level of care a patient is discharged to.
<75> Mental Health Facility
<76> Rehab
<77> Nursing Home: permanent custodial assistance
<78> Burn Center: Transferred to Burn Center
<79> Trauma Center: Transferred to Trauma Center
<99> Transferred: Discharged/transferred to nontrauma center or non-burn center hospital. Includes LTAC.

DEFAULT: Blank

ADDITIONAL INFORMATION:

- If a patient lives in a nursing home and returns back there from your facility, use <Home> as the disposition, due to NTDB mandate
- If the patient lives in a Skilled Nursing Facility (SNF) and returns to a SNF, use <Home> as the disposition, due to NTDB mandate.
- If the patient comes from Jail and returns to jail, use Home per NTDB mandate.
- If a patient lives in a retirement center or assisted nursing facility and returns there from your facility, use <Home> as the disposition.

HISTORY:

DISCHARGE FACILITY DESCRIPTION / ID

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: The description of the facility receiving the patient after they were discharged from the trauma center for transfer to another facility.

FIELD VALUES:

Standardized list of hospital names

DEFAULT: Blank

ADDITIONAL INFORMATION:

- If the facility is not in the picklist and is located within the State of NC, select <Other Hospital, NC>. Contact the State Trauma Systems Manager to request the facility be added to the picklist.
- If the facility is not in the picklist and is located outside the State of NC, select <Other Hospital, OOS>

HISTORY:

DEATH LOCATION

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Location of patient's death

FIELD VALUES:

<2> Emergency Department
<3> Operating Room
<4> Intensive Care Unit
<5> Step-down Unit
<7> Telemetry
<8> Floor
<12> Special Procedure Unit
<14> Pediatric ICU
<15> Interventional Radiology
<45> DOA

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Place or site in which patient's vital functions ceased permanently.

HISTORY:

AUTOPSY TYPE AND NUMBER

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Type of autopsy performed

FIELD VALUES:

<1> Full
<2> Partial
</> Not Applicable
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- <Full> - The ME does a complete exam, both external and internal. Incisions are made into the body as part of the examination process.
- <Partial> - The ME conducts an outside examination of the body only, no incision was made.
- Autopsy Number is a free-text field for the Autopsy ID Number.

HISTORY:

ORGAN DONATION REQUESTED

State Required	Available for State Research	NTDB Required
Yes	Yes*	No

DEFINITION: Was organ donation requested?

FIELD VALUES:

<Y> Yes
<N> No
<?> Unknown
</> Not Applicable

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Use <Y> if family is approached. Does not include phone call to organ donor services, unless family is contacted.

HISTORY:
Previous name: Organ Donation Requested/Granted

ORGANS PROCURED

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Organ donation - Organs procured.

FIELD VALUES:

<0> None
<1> Adrenal Glands
<2> Bone
<3> Bone Marrow
<4> Cartilage
<5> Corneas
<6> Dura Mater
<7> Fascialata
<8> Heart
<9> Heart Valves
<10> Intestines
<11> Kidney
<12> Liver
<13> Lungs
<14> Nerves
<15> Pancreas
<16> Skin
<17> Stomach
<18> Tendons
<19> Whole Eyes
<20> Tissue
<21> Other
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

HISTORY:
Required by State as of 1/1/2014.

ORGANS PROCURED SPECIFY

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: If the organs procured were not on the "Organs procured" field list, use this field to record the organ(s) procured.

FIELD VALUES:

Free text

DEFAULT: Blank

ADDITIONAL INFORMATION:

HISTORY:
Required by State as of 1/1/2014.

ORGAN DONATION DECLINED-REASON

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: Why was organ donation declined?

FIELD VALUES:

<1> Not Brain Dead
<2> No Legal Brain Death Documentation Noted
<3> No ME Consent
<4> Medically Unsuitable,
Clinical Condition
<5> Medically Unsuitable,
Social History
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

HISTORY:
Required by State as of 1/1/2014.

ORGAN DONATION DONOR STATUS

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: The status of the patient at the time the the patient's organs were donated at the facility recording these data.

FIELD VALUES:

<1> Brain Death
<2> Non-beating heart
Donor after Cardiac Death
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

HISTORY:
Required by State as of 1/1/2014.

ORGAN PROCURED DATE-TIME

State Required	Available for State Research	NTDB Required
Yes	No	No

DEFINITION: Organ donation - procurement date-time.

FIELD VALUES:
Date/Time

DEFAULT: Blank

ADDITIONAL INFORMATION:
- The date is documented as MM/DD/YYYY
- The time is documented in military time (HH:MM)

HISTORY:

PAYOR CODE

State Required	Available for State Research	NTDB Required
Yes	Yes	Yes

DEFINITION: Primary and secondary payors (insurance).

FIELD VALUES:

Field Values	Definitions
<1> Medicaid	
<2> Not Billed for Any Reason	
<3> Self Pay	Patients with no primary insurance
<5> Commercial	Includes automobile/liability, worker's compensation, BCBS, HMO, PPO, State Employee, and Managed Care
<4> Medicare	Use this value for any type of Medicare, including 3rd party payors (e.g., United Healthcare Medicare).
<7> Government	Includes Military, Champus, TriCare, Veteran's insurance (Mar2016)
<10> Other	Includes insurance from out of country, out of state, (not otherwise categorized), and tour insurance
<?> Unknown	
Retired values	
<6> Automobile/Liability	Code as Commercial (2014)
<8> Workers Compensation	Code as Commercial (2014)
<9> BCBS	Code as Commercial (2014)
<11> HMO	Code as Commercial (2014)
<12> PPO	Code as Commercial (2014)
<13> Military/Champus	Should be coded as <Government> (Mar2016)
<14> State Employee	Code as Commercial (2014)
<15> Charity	
<16> Managed Care	Code as Commercial (2014)

DEFAULT: Blank

ADDITIONAL INFORMATION:

Multi-entry field

HISTORY:

RELATED ADMISSION ADMISSION DATE-TIME

State Required	Available for State Research	NTDB Required
Yes	Yes*	No

DEFINITION: Date-time that patient was readmitted for the same injury.

FIELD VALUES:

Date/Time

DEFAULT: Blank

ADDITIONAL INFORMATION:

- The date is documented as MM/DD/YYYY
- The time is documented in military time (HH:MM)

HISTORY:

RELATED ADMISSION ADMITTING SERVICE

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Admitting service for patient's readmission

FIELD VALUES:

<1> Trauma
<2> Neurosurgery
<3> Orthopedics
<4> General Surgery
<5> Pediatric Surgery
<6> Cardiothoracic Surgery
<7> Burn Services
<9> Pediatrics
<11> Cardiology
<16> Dental
<23> ENT
<25> Medicine
<26> Geriatrics (Renamed from Gerontology Jun-2021)
<28> Hand
<31> Hospitalist
<33> Internal Medicine
<36> Nephrology
<37> Neurology
<39> Not Admitted
<43> OB-GYN
<45> Ophthalmology
<46> Oral Surgery
<53> Pediatric Critical Care
<58> Plastic Surgery
<59> Psychiatry
<63> Rehab
<76> Urology
<77> Vascular Surgery
<98> Other Surgical
<99> Other Non-Surgical
</> Not Applicable

DEFAULT: Blank

ADDITIONAL INFORMATION:

None

HISTORY:

RELATED ADMISSION ADMISSION TYPE

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Indicates whether readmissoin was planned or not.

FIELD VALUES:

<1> Planned
<2> Unplanned
</> Not Applicable
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Planned readmissions are optional. If entered, be sure to indicate that they are planned.

HISTORY:

UNPLANNED REASON

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: If readmission was not planned, what was the reason for the patient's readmission?

FIELD VALUES:

<1> Infection
<2> Diagnosis Missed
<3> Pain
<4> Progression of Disease
<5> Other
<6> Complication
</> Not applicable
<?> Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

None

HISTORY:

RELATED ADMISSION DISCHARGE DATE

State Required	Available for State Research	NTDB Required
Yes	Yes*	No

DEFINITION: Discharge date for patient's readmission.

FIELD VALUES:

Date/time

DEFAULT: Blank

ADDITIONAL INFORMATION:

- The date is documented as MM/DD/YYYY
- The time is documented in military time (HH:MM)
- If death, report the date and time the patient pronounced dead. Use the time when the patient is declared brain dead. From a clinical/legal standpoint the time of death is the time when patient is declared brain dead. All of the tracking should end at that point as far as vent and ICU days. Death certificates always reflect, if completed correctly, the time of death as the time declared brain dead.

HISTORY:

RELATED ADMISSION DISCHARGE DISPOSITION

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Discharge disposition for patient's readmission.

FIELD VALUES:

Field values	Definitions for researchers
<40> Morgue	
<41> Left AMA	
<42> Correctional Facility	
<43> Home	
<44> Home with Services	
<70> Acute Care Facility	Discontinued as of 19 Feb 2019.
<72> Skilled Nursing Facility (SNF)	To provide a specific medical need or to allow recovery outside a hospital.
<73> Hospice	Includes home hospice
<74> Long term care	Includes assisted living, and nursing home. Use this value when it is unclear what level of care a patient is discharged to.
<75> Mental Health Facility	
<76> Rehab	If patient goes to SNF for rehab, use rehab.
<77> Nursing Home	Retired February 2019.
<78> Burn Center	
<79> Trauma Center	
<99> Transferred	Equivalent of “Acute Care Facility”. Discharged/transferred to non-trauma center or non-burn center hospital

DEFAULT: Blank

ADDITIONAL INFORMATION:

- If a patient lives in a nursing home and returns back there from your facility, use <Home> as the disposition, due to NTDB mandate
- If the patient lives in a Skilled Nursing Facility (SNF) and returns to a SNF, use <Home> as the disposition, due to NTDB mandate.
- If the patient comes from Jail and returns to jail, use Home per NTDB mandate.

- If a patient lives in a retirement center or assisted nursing facility and returns there from your facility, use <Home> as the disposition.
- Ignore instructions from DI to complete details on the If Death screen if “Morgue” is chosen

HISTORY:

RELATED ADMISSION ICU DAYS

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Patient's ICU LOS during readmission.

FIELD VALUES:

Numeric

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Recorded in full day increments with any partial calendar day counted as a full calendar day. If no ICU days, <0> should be entered into the field
- ICU LOS may exceed the Hospital LOS due to DI calculation method for ICU LOS. Hospital LOS includes partial days, but ICU days counts any partial day as a full day.

HISTORY:

RELATED ADMISSION VENTILATOR DAYS

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Number of days patient was on a ventilator for this readmission.

FIELD VALUES:

Numeric

DEFAULT: Blank

ADDITIONAL INFORMATION:

- Recorded in full day increments with any partial calendar day counted as a full calendar day.
- Excludes mechanical ventilation time associated with OR procedures.
- Non-invasive means of ventilator support (CPAP or BIPAP) should not be considered in the calculation of ventilator days.
- If no vent days, <0> should be entered into the field.
- Total Vent Days may exceed the Hospital LOS due to DI calculation method for Total Vent Days. Hospital LOS includes partial days, but Total Vent Days counts any partial day as a full day.

HISTORY:

RELATED ADMISSION HOSPITAL DAYS

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Patient's LOS in hospital for readmission.

FIELD VALUES:

Numeric

DEFAULT: Blank

ADDITIONAL INFORMATION:

- This field is auto-calculated by the software from the patient arrival date/time and the hospital discharge date/time.

HISTORY:

RELATED ADMISSION PATIENT ORIGIN

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Where did patient come from for this readmission?

FIELD VALUES:

1=Clinic
2=EMS Station
3=MD Office
4=Home
5=Nursing home
6=Refer facility
7=Scene
8=Urgent care
9=Other acute facility
10=Correctional facility
11=Other
?=Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

- <9> Other Acute Facility – Outlying facilities that provide emergency care services are considered acute care facilities, i.e., free standing ED
- Patients arriving from an LTAC: Use <9> for other acute facility.

HISTORY:

RELATED ADMISSION ARRIVAL MODE

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: Arrival mode for patient's readmission

FIELD VALUES:

1=GroundAmbulance
2=Helicopter
3=Fixed-wing
4=Private vehicle/Walk-in
5=Police
6=Other
?=Unknown

DEFAULT: Blank

ADDITIONAL INFORMATION:

None

HISTORY:

RELATED ADMISSION ED DEPARTURE DATE-TIME

State Required	Available for State Research	NTDB Required
Yes	Yes*	No

DEFINITION: Date-time that patient left the hospital after readmission

FIELD VALUES:

Date/Time

DEFAULT: Blank

ADDITIONAL INFORMATION:

- The date is documented as MM/DD/YYYY
- The time is documented in military time (HH:MM)

HISTORY:

RELATED ADMISSION ED DISPOSITION

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: ED disposition for readmission

FIELD VALUES:

3=OR
4=ICU
5=Step-down unit
7=Telemetry unit
8=Floor
9=Observation unit
13=L&D
14=PICU
40=Morgue
41=AMA
42=Correctional facility
43=Home
44=Home with services
72=SNF
73=Hospice
75=Mental health facility
77=Nursing home
78=Burn Center
79=Trauma Center
99=Transferred
/=n/a
Non-state approved values: 12=Special procedure room
76=Rehab

DEFAULT: Blank

ADDITIONAL INFORMATION:

- If patient is directly admitted to the hospital, code as </> Not Applicable.
- If a patient lives in a nursing home and returns back there from your facility, use <Home> as the disposition, due to NTDB mandate
- If the patient lives in a Skilled Nursing Facility (SNF) and returns to a SNF, use <Home> as the disposition, due to NTDB mandate.
- If the patient comes from Jail and returns to jail, use Home per NTDB mandate.

- If the patient lives in a retirement center/community or assisted living facility and returns to said facility from the ED, use <43> Home or <44> Home with Services as appropriate.

HISTORY:

RELATED ADMISSION ED LENGTH OF STAY

State Required	Available for State Research	NTDB Required
Yes	Yes	No

DEFINITION: ED LOS for related admission (readmission)

FIELD VALUES:

Numeric

DEFAULT: Blank

ADDITIONAL INFORMATION:

- This is a calculated field in V5 in hours and tenths of an hour.
- If the patient was a direct admit and the dates and times have been entered as previously outlined, the ED LOS will NOT calculate.

HISTORY:

Complications

COMPLICATION CODE

State Required	Available for State Research	NTDB Required
Yes	No	Yes

DEFINITION: An unanticipated problem that occurs as a result of a procedure, treatment, or illness.

FIELD VALUES:

1=Other
2= Abdominal compartment syndrome
(retired 2011)
4= Acute kidney injury
5= Acute respiratory distress syndrome (ARDS)
7=Bleeding (retired 2011)
8= Cardiac arrest with CPR
9= Coagulopathy (retired 2011)
11= Decubitus ulcer (retired 2017)
12= Deep surgical site infection
13=Drug/alcohol withdrawal (retired 2017)
14=DVT
15=Extremity compartment syndrome;
16=Graft/prosthesis/flap failure (retired 2016)
18=MI (definition change Jan2020)
19=Organ/space surgical site infection
20=Pneumonia (retired 2016)
21=Pulmonary embolism
22=Stroke/CVA
23=Superficial surgical site infection (retired
2017)
24=Systemic sepsis (retired 2011)
25=Unplanned intubation
26= Wound disruption (retired 2011)
27=UTI (retired 2016)
28=Catheter-related blood stream infection
(retired 2016)
29=Osteomyelitis
30=Unplanned return to OR (retired Jan2020)
39=Delirium (added Jan2020)
40=Unplanned visit to OR (added Jan2020)
31=Unplanned admission to ICU
32=Severe sepsis
33=CAUTI

34=Central line=associated blood stream infection (CLABSI)
35=Ventilator-associated pneumonia
36=Alcohol withdrawal syndrome
37=Pressure ulcer
38=Superficial incisional surgical site infection
Not applicable = no complications
39=Delirium (added Jan2020)

DEFAULT: Blank

ADDITIONAL INFORMATION:

- North Carolina Trauma Registry complications are listed on this page.
- For information on the NTDS complications, see the NTDS data dictionary.

HISTORY:

VARIABL LIST TABLE

Section/Subsection(s)	Variable	Required by State	Available for Research	NTDB Required
Demographic/Record info	Record complete?	Yes	No	No
Demographic/Record info	Patient initial location	Yes	Yes	No
Demographic/Record info	Trauma number	Yes	No	No
Demographic/Record info	Facility arrival date/time	Yes	Yes*	Yes
Demographic/Record info	Patient origin	Yes	Yes	No
Demographic/Record info	Registry inclusion	Yes	No	No
Demographic/Patient	Patient first name/last name/middle initial	Yes	No	No
Demographic/Patient	Date of birth	Yes	No	Yes
Demographic/Patient	Gender	Yes	Yes	Yes
Demographic/Patient	Gender identity	Yes	Yes	No
Demographic/Patient	Race	Yes	Yes	Yes
Demographic/Patient	Ethnicity	Yes	Yes	Yes
Demographic/Patient	Patient address zipcode	Yes	Yes*	Yes
Demographic/Patient	Homeless	Yes	Yes	Yes
Demographic/Patient	Patient address city	Yes	No	Yes
Demographic/Patient	Patient address state	Yes	Yes	Yes
Demographic/Patient	Patient address county	Yes	No	Yes
Demographic/Patient	Patient address country	Yes	Yes	Yes
Demographic/Patient	Patient address city FIPS code	Yes	No	No
Demographic/Patient	Patient address county FIPS code	Yes	No	No
Demographic/Patient	Patient address state FIPS code	Yes	Yes	No
Demographic/Patient	Alternate home residence	Yes	Yes	Yes
Injury/Injury information	Injury date/time	Yes	Yes*	Yes
Injury/Injury information	Injury place (ICD-10)	Yes	Yes	Yes
Injury/Injury Information	Protective Devices - Restraints	Yes	Yes	Yes
Injury/Injury information	Protective Devices - Airbag deployment	Yes	Yes	Yes
Injury/Injury information	Protective Devices - Equipment	Yes	Yes	Yes
Injury/Injury information	Injury address zip	Yes	Yes*	Yes
Injury/Injury information	Injury address city	Yes	No	Yes
Injury/Injury information	Injury address state	Yes	Yes*	Yes
Injury/Injury information	Injury address county	Yes	No	Yes
Injury/Injury information	Injury Address country	Yes	Yes	Yes
Injury/Injury information	Injury address: City FIPS code	Yes	No	No
Injury/Injury information	Injury address: County FIPS code	Yes	No	No
Injury/Injury information	Injury address: State FIPS code	Yes	Yes*	No

Injury/Injury information	Work Related	Yes	Yes	Yes
Injury/MOI	ICD-10 MOI External Cause Codes - Primary and Secondary	Yes	Yes	Yes
Injury/MOI	Injury type codes 1 & 2	Yes	Yes	No
Injury/MOI	Primary and secondary complaint / mechanism of injury	Yes	Yes	No
Injury/MOI	Complaint/MOI specify	Yes	No	No
PreHospital/Scene-Transport	Prehospital provider agency ID/ description	Yes	No	No
PreHospital/Scene-Transport	PCRUUID	Yes	No	Yes
PreHospital/Scene-Transport	Prehospital mode	Yes	Yes	Yes
PreHospital/Scene-Transport	Prehospital mode specify	Yes	Yes	Yes
PreHospital/Scene-Transport	Prehospital PCR number	Yes	No	No
PreHospital/Scene-Transport	Prehospital transport report status	Yes	Yes	No
PreHospital/Scene-Transport	Prehospital transport dispatch date-time	Yes	Yes*	No
PreHospital/Scene-Transport	Prehospital transport arrived location (scene) date-time	Yes	Yes*	No
PreHospital/Scene-Transport	Prehospital transport left location date-time	Yes	Yes*	No
PreHospital/Scene-Transport	Prehospital transport arrived destination date-time	Yes	Yes*	No
PreHospital/Assessment	Prehospital transport national field triage	Yes	Yes	No
PreHospital/Assessment	Agency description/id (Pre-hospital assessment)	Yes	No	No
PreHospital/Assessment	Prehospital assessment recorded date-time	Yes	No	No
PreHospital/Assessment	Paralyzed (PreHospital)	Yes	Yes	No
PreHospital/Assessment	Sedated (PreHospital)	Yes	Yes	No
PreHospital/Assessment	Eye Obstruction (PreHospital)	Yes	Yes	No
PreHospital/Assessment	Intubated (PreHospital)	Yes	Yes	No
PreHospital/Assessment	intubation method (PreHospital)	Yes	Yes	No
PreHospital/Assessment	Respiration assisted (PreHospital)	Yes	Yes	No
PreHospital/Assessment	Assisted respiration type (PreHospital)	Yes	Yes	No
PreHospital/Assessment	SBP (PreHospital)	Yes	Yes	No
PreHospital/Assessment	Pulse rate (PreHospital)	Yes	Yes	No
PreHospital/Assessment	Unassisted respiratory rate (PreHospital)	Yes	Yes	No
PreHospital/Assessment	Assisted respiratory rate (PreHospital)	Yes	Yes*	No
PreHospital/Assessment	SpO2 (PreHospital)	Yes	Yes	No
PreHospital/Assessment	Supplemental O2 given (PreHospital)	Yes	Yes	No
PreHospital/Assessment	GCS-eye (PreHospital)	Yes	Yes	No
PreHospital/Assessment	GCS-verbal (PreHospital)	Yes	Yes	No

PreHospital/Assessment	GCS-motor (PreHospital)	Yes	Yes	No
PreHospital/Assessment	GCS-total (PreHospital)	Yes	Yes	No
PreHospital/Treatment	Prehospital treatment agency description/id	Yes	No	No
PreHospital/Treatment	Prehospital treatment code	Yes	Yes	No
Referring Facility/Referral hx	InterFacility /Hospital Transfer	Yes	Yes	Yes
Referring Facility/Referral hx	Referring facility id/name	Yes	No	No
Referring Facility/Referral hx	Referring facility address: city	Yes	No	No
Referring Facility/Referral hx	Referring facility address: country	Yes	Yes	No
Referring Facility/Referral hx	Referring facility address: county	Yes	No	No
Referring Facility/Referral hx	Referring facility address: city FIPS code	Yes	No	No
Referring Facility/Referral hx	Referring facility address: county FIPS code	Yes	No	No
Referring Facility/Referral hx	Referring facility address: state FIPS code	Yes	Yes	No
Referring Facility/Referral hx	Referring facility address: state	Yes	Yes	No
Referring Facility/Referral hx	Referring facility street address	Yes	No	No
Referring Facility/Assessments	Referring facility description (name)	Yes	No	No
Referring Facility/Referral hx	Referring facility address: zip	Yes	No	No
Referring Facility/Referral hx	Referring facility specify	Yes	No	No
Referring facility/Referral hx	Referring facility arrival date-time	Yes	Yes*	No
Referring facility/Referral hx	Referring facility departure date/time	Yes	Yes*	No
Referring Facility/Referral hx	Referring facility length of stay (LOS)	Yes	Yes	No
Referring Facility/Referral hx	Referring Facility ICU	Yes	Yes	No
Referring Facility/Assessments	Referring facility paralyzed	Yes	Yes	No
Referring Facility/Assessments	Referring facility sedated	Yes	Yes	No
Referring Facility/Assessments	Referring facility eye obstruction	Yes	Yes	No
Referring Facility/Assessments	Referring facility Intubated	Yes	Yes	No
Referring Facility/Assessments	Referring facility Intubation Method	Yes	Yes	no
Referring Facility/Assessments	Referring facility respiration assisted	Yes	Yes	No
Referring Facility/Assessments	Referring facility assisted respiration type	Yes	Yes	No
Referring Facility/Assessments	Referring facility SBP	Yes	Yes	No
Referring Facility/Assessments	Referring facility pulse rate	Yes	Yes	No
Referring Facility/Assessments	Referring facility unassisted respiratory rate	Yes	Yes	No
Referring Facility/Assessments	Referring facility assisted respiratory rate	Yes	Yes	No
Referring Facility/Assessments	Referring facility SpO2	Yes	Yes	No
Referring Facility/Assessments	Referring facility supplemental O2 given	Yes	Yes	No
Referring Facility/Assessments	Referring facility GCS-eye	Yes	Yes	No

Referring Facility/Assessments	Referring facility GCS-verbal	Yes	Yes	No
Referring Facility/Assessments	Referring facility GCS-motor	Yes	Yes	No
Referring Facility/Assessments	Referring facility GCS-total	Yes	Yes	No
Referring Facility/Assessments	Referring facility weighted RTS	Yes	Yes	No
Referring Facility/Treatment/Procedures	Referring facility procedure Facility name and id	Yes	No	No
Referring Facility/Treatment/Procedures	Referring facility procedure ICD10 Code	Yes	Yes	No
Referring Facility/Treatment/Procedures	Referring Facility Diagnostic Result	Yes	Yes	No
Interfacility transport/Transport	Referring facility (for IFT)	Yes	No	No
Interfacility transport/Transport	Agency ID/ Name (IFT provider)	Yes	No	No
Interfacility transport/Transport	PcrUUID (IFT provider)	Yes	No	No
Interfacility transport/Transport	Mode (IFT provider)	Yes	Yes	No
Interfacility transport/Transport	Mode specify (IFT provider)	Yes	Yes	No
Interfacility transport/Transport	EMS report (IFT provider)	Yes	Yes	No
Interfacility transport/Transport	Dispatch date-time (IFT provider)	Yes	Yes*	No
Interfacility transport/Transport	Arrived location date-time (IFT provider)	Yes	Yes*	No
Interfacility transport/Transport	Left location date-time (IFT provider)	Yes	Yes*	No
Interfacility transport/Transport	Arrived destination date-time (IFT provider)	Yes	Yes*	No
Interfacility transport/Transport	Agency name/id (IFT)	Yes	No	No
Interfacility transport/Assessment	Paralyzed (IFT)	Yes	Yes	No
Interfacility transport/Assessment	Sedated (IFT)	Yes	Yes	No
Interfacility transport/Assessment	Eye obstruction (IFT)	Yes	Yes	No
Interfacility transport/Assessment	Intubated (IFT)	Yes	Yes	No
Interfacility transport/Assessment	Intubation method (IFT)	Yes	Yes	No
Interfacility transport/Assessment	Respiration assisted (IFT)	Yes	Yes	No
Interfacility transport/Assessment	Assisted respiratory rate (IFT)	Yes	Yes	No
Interfacility transport/Assessment	SBP (IFT)	Yes	Yes	No
Interfacility transport/Assessment	Pulse rate (IFT)	Yes	Yes	No
Interfacility transport/Assessment	Unassisted respiratory rate (IFT)	Yes	Yes	No
Interfacility transport/Assessment	Assisted respiration type (IFT)	Yes	Yes	No
Interfacility transport/Assessment	Supplemental O2 given (IFT)	Yes	Yes	No
Interfacility transport/Assessment	GCS-eye (IFT)	Yes	Yes	No
Interfacility transport/Assessment	GCS-verbal (IFT)	Yes	Yes	No
Interfacility transport/Assessment	GCS-motor (IFT)	Yes	Yes	No
Interfacility transport/Assessment	GCS-total (IFT)	Yes	Yes	No
Interfacility transport/Treatment	Agency Name/Description (IFT treatment)	Yes	No	No

Interfacility transport/Treatment	Procedure description (IFT treatment)	Yes	Yes	No
Interfacility transport/Treatment	Code specify (IFT intervention)	Yes	Yes	No
ED Resuscitation/Arrival-Admission	ED arrival date/time	Yes	Yes*	No
ED Resuscitation/Arrival-Admission	ED discharge order date-time	Yes	Yes*	Yes
ED Resuscitation/Arrival-Admission	ED departure date/time	Yes	Yes*	No
ED Resuscitation/Initial assessment	ED length of stay	Yes	Yes	No
ED Resuscitation/Arrival-Admission	Signs Of Life	Yes	Yes	No
ED Resuscitation/Arrival-Admission	Trauma Activation type	Yes	Yes	Yes
ED Resuscitation/Arrival-Admission	Trauma Activation Date/Time 2	Yes	No	No
ED Resuscitation/Arrival-Admission	Activation response elapsed time: initial	Yes	Yes	No
ED Resuscitation/Arrival-Admission	Trauma Activation 2	Yes	Yes	Yes
ED Resuscitation/Arrival-Admission	Trauma Activation Date/Time 2	Yes	No	No
ED Resuscitation/Arrival-Admission	Activation response elapsed time: 2	Yes	Yes	No
ED Resuscitation/Arrival-Admission	Trauma Activation 3	Yes	Yes	Yes
ED Resuscitation/Arrival-Admission	Trauma Activation Date/ Time 3	Yes	No	No
ED Resuscitation/Arrival-Admission	Activation response elapsed time: 3	Yes	Yes	No
ED Resuscitation/Arrival-Admission	ED disposition	Yes	Yes	Yes
ED Resuscitation/Arrival-Admission	Admitting service	Yes	Yes	No
ED Resuscitation/Arrival-Admission	Post IR disposition	Yes	Yes	No
ED Resuscitation/Arrival-Admission	Post Or Disposition	Yes	Yes	No
ED Resuscitation/Arrival-Admission	SBIRT done? (ED)	Yes	Yes	No
ED Resuscitation/Arrival-Admission	Alcohol misuse team (y/n)	Yes	Yes	No
ED Resuscitation/Initial assessment	Assessment date-time (ED)	Yes	Yes*	No
ED Resuscitation/Initial assessment	Weight (ED) value /unit of measure	Yes	Yes	Yes
ED Resuscitation/Initial assessment	Height (ED) value/unit of measure	Yes	Yes	Yes
ED Resuscitation/Initial assessment	Temperature value /unit/route (ED)	Yes	Yes	Yes
ED Resuscitation/Initial assessment	Paralyzed (ED)	Yes	Yes	Yes
ED Resuscitation/Initial assessment	Sedated (ED)	Yes	Yes	Yes
ED Resuscitation/Initial assessment	Eye obstruction (ED)	Yes	Yes	Yes
ED Resuscitation/Initial assessment	Intubated? (ED)	Yes	Yes	Yes
ED Resuscitation/Initial assessment	Intubation method (ED)	Yes	Yes	No
ED Resuscitation/Initial assessment	Respiration assisted (ED)	Yes	Yes	Yes
ED Resuscitation/Initial assessment	Assisted respiration type (ED)	Yes	Yes	No
ED Resuscitation/Initial assessment	Systolic blood pressure (SBP) (ED)	Yes	Yes	Yes
ED Resuscitation/Initial assessment	Pulse rate (ED)	Yes	Yes	Yes
ED Resuscitation/Initial assessment	Unassisted respiratory rate (ED)	Yes	Yes	Yes
ED Resuscitation/Initial assessment	Assisted respiratory rate (ED)	Yes	Yes	Yes
ED Resuscitation/Initial assessment	O2 saturation (ED)	Yes	No	Yes

ED Resuscitation/Initial assessment	Supplemental O2 given (ED)	Yes	Yes	Yes
ED Resuscitation/Initial assessment	ED GCS-eye	Yes	Yes	Yes
ED Resuscitation/Initial assessment	GCS-verbal (ED)	Yes	Yes	Yes
ED Resuscitation/Initial assessment	GCS-motor (ED)	Yes	Yes	Yes
ED Resuscitation/Initial assessment	GCS-total (ED)	Yes	Yes	Yes
ED Resuscitation/Initial assessment	ED ABG drawn?	Yes	Yes	No
ED Resuscitation/Initial assessment	ED ABG type	Yes	Yes	No
ED Resuscitation/Initial assessment	ED base deficit (ABG)	Yes	Yes	No
ED Resuscitation/Initial assessment	ED hematocrit	Yes	Yes	No
Blood products	Blood type	Yes	Yes	No
Blood products	Blood units: number	Yes	Yes	No
Blood products	Blood unit of measure	Yes	Yes	No
Blood products	Blood time period	Yes	Yes	No
Provider/Resus team	ED provider called date-time	Yes	No	No
Provider/Resus team	ED provider responded date-time	Yes	No	No
Provider/Resus team	ED provider arrival date/time	Yes	No	Yes (for Trauma Surgeon highest activation only)
Provider/Resus team	ED provider arrival timely	Yes	No	No
Provider/Resus team	ED provider type	Yes	Yes	Yes (to identify Trauma Service)
Provider/In-House Consult	In-house consult type	Yes	No	No
Provider/In-House Consult	In-house consult called date-time	Yes	Yes	No
Provider/In-House Consult	In-house consult arrived date-time	Yes	Yes	No
Procedure/Procedures	ICD-10 procedure code	Yes	Yes	Yes
Procedure/Procedures	Procedure location	Yes	Yes	No
Procedure/Procedures	OperationNumber	Yes	No	No
Procedure/Procedures	Procedure start date-time	Yes	Yes*	Yes
Procedure/Procedures	Procedure result	Yes	Yes	No
Procedure/Procedures	Radiologic BIG	Yes	Yes	No
Procedure/Procedures	Medical imaging order (y/n)	Yes	Yes	No
Diagnosis/Injury coding	AIS version	Yes	No	Yes
Diagnosis/Injury coding	ISS	Yes	Yes	No
Diagnosis/Injury coding	Niss	Yes	Yes	No
Diagnosis/Injury coding	TRISS	Yes	Yes	No
Diagnosis/Injury coding	ICD-10 diagnosis code	Yes	Yes	Yes

Diagnosis/Injury coding	AIS predot	Yes	Yes	Yes
Diagnosis/Injury coding	AIS severity	Yes	Yes	Yes
Diagnosis/Injury coding	ISS body region	Yes	Yes	No
Diagnosis/Injury coding	OIS severity	Yes	Yes	No
Diagnosis/Non-trauma diagnosis	Non-trauma diagnosis ICD-10 code	Yes	Yes	No
Diagnosis/Non-trauma diagnosis	Non-trauma diagnosis type	Yes	Yes	No
Diagnosis/Comorbidity	Comorbidity	Yes	Yes	Yes
Outcome/Initial Discharge	Discharge status	Yes	Yes	No
Outcome/Initial Discharge	Discharge order date-time (hospital)	Yes	Yes*	Yes
Outcome/Initial Discharge	Discharge date/time	Yes	Yes*	No
Outcome/Initial Discharge	Icu days	Yes	Yes	Yes
Outcome/Initial Discharge	Vent days	Yes	Yes	Yes
Outcome/Initial Discharge	Hospital days	Yes	Yes	No
Outcome/Initial Discharge	Discharge service	Yes	Yes	No
Outcome/Initial Discharge	Discharge disposition	Yes	Yes	Yes
Outcome/Initial Discharge	Discharge facility description / id	Yes	No	No
Outcome/If death	Death location	Yes	Yes	No
Outcome/If death	Autopsy type and Number	Yes	Yes	No
Outcome/If death	Organ donation requested	Yes	Yes*	No
Outcome/If death	Organs procured	Yes	Yes	No
Outcome/If death	Organs procured specify	Yes	Yes	No
Outcome/If death	Organ donation declined-reason	Yes	No	No
Outcome/If death	Organ donation donor status	Yes	No	No
Outcome/If death	Organ procured date-time	Yes	No	No
Outcome/Billing	Payor code	Yes	Yes	Yes
Outcome/Related admission	Related admission admission date-time	Yes	Yes*	No
Outcome/Related admission	Related admission admitting service	Yes	Yes	No
Outcome/Related admission	Related admission admission type	Yes	Yes	No
Outcome/Related admission	Unplanned reason	Yes	Yes	No
Outcome/Related admission	Related admission discharge date	Yes	Yes*	No
Outcome/Related admission	Related admission discharge disposition	Yes	Yes	No
Outcome/Related admission	Related Admission Icu Days	Yes	Yes	No
Outcome/Related admission	Related Admission Ventilator days	Yes	Yes	No
Outcome/Related admission	Related Admission hospital days	Yes	Yes	No
Outcome/Related admission	Related Admission Patient Origin	Yes	Yes	No
Outcome/Related admission	Related admission arrival mode	Yes	Yes	No
Outcome/Related admission	Related admission ED departure date-time	Yes	Yes*	No
Outcome/Related admission	Related Admission ED Disposition	Yes	Yes	No

Outcome/Related admission	Related admission ED length of stay	Yes	Yes	No
Complications	Complication code	Yes	No	Yes

Appendix A: Sedating and paralytic medications

Sedating medications (to be used to classify a patient as sedated when GCS was measured if given within 6-hours of when GCS was measured)		Paralytics
Alprazolam (Xanax)		RSI (procedure)
Diphenhydramine (Benadryl)		Atracurium, cis-Atracurium
Cisatracium (Nimbex)		Cisatracium
Demerol		Rocuronium
Diazepam (Valium)		Succinylcholine
Etomidate (Hypnomidate)		Vecuronium
Droperidol		
Fentanyl		
Haloperidol (Haldol)		
Hydromorphone		
Ketamine		
Clonazepam (Klonopin)		
Chlordiazepoxide (Librium)		
Dexmedetomidine		
Lorazepam (Ativan)		
Midazolam (Versed)		
Morphine		
Pentobarbital (Nembutal)		
Phenobarbital		
Propofol (Diprivan)		
Rocuronium		
Succinylcholine (Anectine)		
Vecuronium		
Zydone		

Appendix B: Record of changes

Summary of 2024 Changes

- Formatting Changes – changed look and feel of dictionary.
- Inclusion Criteria Changes
    - No longer include pts with injuries sustained more than 14 days prior to arrival
- Addition of FAQ/Inclusion Scenarios
- Changed names of some fields to not be registry software dependent (ex changed "Arrived From" to Patient Origin")
- Wording of some definitions changed – without impact to abstraction
- Additional information modified for some variables
- New required fields
    - Prehospital national field triage
    - SBIRT done? (ED)
    - Alcohol misuse team (y/n)
    - ED Resus Provider – Responded by Date/Time
    - Radiologic BIG
    - Medical Imaging Ordered
    - Interfacility transport Assessment fields (Note: these fields were previously listed in the summary table but there was not a corresponding page in the dictionary with definition. The 2024 dictionary includes a page for each of these fields)
    - Address FIPS codes (required to enter manually if registry software does not autopopulate)
- Updated Values available in Gender Identity Field
- Updated Values available in Prehospital and IFT treatment/procedures
- Fields no longer Required
    - ED Fluid Amount

Changes 2023 and prior

Admitting and discharge services

- Aligned (Dec-2021)

Airbag

- Added text to indicate that the Airbag field is not required unless the injury mechanism is a motor vehicle collision.

Alcohol use indicator

- Alcohol Use Indicator pages (RF, ED): removed from Data Dictionary and changed to not required because of discrepancy in time interval (30 min for NCTR vs 24 hours for NTDB). (Jan 2019)

Blood

- "Whole blood" was added as a value for type of blood product. (Jan 2021)

Chief complaint

- Chief complaint: Changed definition of “Pedestrian”: Includes standing motorized and non-motorized scooters, Segways, roller skates, and skateboards. (Jan 2019)
- Added “Watercraft”, which will cover “boat” and “jet ski”. (Jan 2021)
- Added “Skateboard”, “E-scooter”, and “Fall from deerstand. (Jan 2021). “Pedestrian” is no longer to be used for skateboard incidents.
- Pedestrian used to include standing motorized and non-motorized scooters, Segways, and skateboards. This part of the definition of this value was eliminated with the addition of Chief Complaint values of “Skateboard” and “E-scooter”.

Comorbidities

- Added instruction to enter “None” if no comorbidities are reported. (08Apr2019) Added Osteoporosis/osteopenia (Dec-2021). Criteria:
  - Diagnosis or documentation of medical history of osteoporosis or osteopenia noted medical record by MD, DO, PA, or NP, or report of presence of osteoporosis or osteopenia on the radiology report.
  - Note: medication use does not count as criteria for flagging a patient as having osteoporosis or osteopenia
- Preexisting illnesses: Two requests were sent to ESO for the Jan-2023 update with the goal o eliminating the Type 2 error received when submitting a record with a congenital anomaly for an adult or an alcohol/substance abuse history for a child.
  - Congenital anomalies: allow entry for all ages, but map so that a “yes” value is sent to TQIP/NTDB only if patient is a child. State should get all values regardless of age.
  - Alcohol and substance abuse disorder fields: allow entry for all ages, but map so that a “yes” value is sent to TQIP/NTDB only if patient is age 15+. State should get all values regardless of age. Alzheimer’s: hide value. We will use “Dementia” instead going forward. (Jan-2023) Angina: NTDB removed this value from their list in Jan-2023, but NCTR did not.

Complications

- Added values for several codes (2, 7, 9, 24 26, 39) (Oct-2022)

Drug screen

Drug Screen results pages (RF, ED): removed from Data Dictionary and changed to not required because of discrepancy in time interval (30 min for NCTR vs 24 hours for NTDB). (Jan 2019)

ED discharge order

Date/time: Added “If patient died, enter date and time from death certificate.” (Jan 2019)

ED disposition

- ED Disposition (original and readmission): Discontinued use of “<70> Acute Care Facility” and changed definition of “<99> Transferred” to “Acute Care Facility”. It was unclear how these values were different. (Jan 2019)
- Dec-2021: Clarified definition: Defined as the first change in status for the patient. Though it has generally represented a location, the increasing use of hallways, temporary beds, and other boarding areas has made the definition for this field more complex. So, the focus now is on the

change in status for the patient – ie, who is caring for them at what level of care. Observation (Obs): will stay on the menu.

i. Movement of a patient to Obs from the ED is considered a discharge from the ED – no matter where the physical location of the bed is.
ii. Disposition from Obs will be a hospital disposition. iii. ED discharge date and time will reflect the move to Obs.
iv. Admitting service will reflect the team caring for the patient in the Obs bed. b. Interventional radiology

i. Will be added to the ED disposition menu.
ii. A request will be made to ESO to have a post-OR-type box open up for patients going to the OR, special procedures, or IR so that the disposition from this location can be recorded. This information will provide a PI opportunity for sites that have frequent transfers from IR to OR for the same injury.

c. Definitions:

i. Cath lab: enter as "Special Procedure room"

EMS PCR number

Field added as a required field to match new NTDB requirement. (Jan 2021)

GCS-sedation

- Due to TQIP's decision to change GCS values to "≤8" if patients are flagged as sedated – regardless of the GCS recorded, NC decided to no longer flag any patient with GCS>8 as being sedated. Only patients with GCS≤8 will be considered for flagging as sedated. (Jan 2021)
- Patients will be flagged as sedated if and only if they've been given one of the drugs on the "Sedating medication" list in Appendix A of the data dictionary within 6 hours prior to when GCS was measured. No consideration of half-life, dose, or intent of the medication will be used. (Jan 2021) Sedation list updated, per NCCOT. (Jan 2021)

Gender

"Non-binary" was added to match the new NTDB values. (Jan 2021)

Hospital disposition

Discontinued use of "<70> Acute Care Facility" and changed definition of "<99> Transferred" to "Acute Care Facility". It was unclear how these values were different. (Jan 2019)

If Death, Location

- Instruction not to use "<45> DOA" field value removed in January 2019, because ACS has requested that this value be used. Added definition of DOA (Jan 2019).
- Added "Special Procedure Room" (code=12) to this menu. (Jan 2023)

Inclusion criteria

- In last row of decision points, “Was patient transferred to or from your facility via another ED or hospital using EMS or air ambulance?” was changed to “Was patient transferred to or from your facility via another ED or hospital”. Requirement for EMS or air ambulance removed from criteria. Purpose of change: to follow new NTDB requirements. (Feb 2020)
- “Send to state”: added recommendation to set the default to blank and leave this field blank until user is sure that a record is to be sent to the state. Many of our record mismatch issues appear to be caused by changing “Send to state” from Yes to No.

Medications

Antibiotics for open fractures: decision was made to capture this information for all open fractures using the ICD-10 procedure code 3E03329 (Dec-2021)

Non-trauma diagnoses

Added note that D62 (acute blood loss anemia) should not be used for pre-existing (chronic) anemia. D62 represents acute post-hemorrhagic anemia. (Jan-2023)

OR visit number

Added text to the “Additional information” section to clarify what number to start the OR visit count with. Text added was “Start the count at your facility. Whether or not the patient has had procedures at another facility, the first procedure at your facility is OR Visit #1.” (Jan 2019)

Pre-hospital treatment

- Added ventilator, pelvic binder.
- Pre-hospital and IFT menus aligned.

Provider types (for ED responses, consults, discharge/admitting services)

Values of Geriatrics and Gerontology were consolidated. Changed label for <26> to Geriatrics from Gerontology. Value <48> Geriatrics removed. (Jan 2021)

Referring facility

Several datapoints were changed to “not required” because of the complexity of locating the data. These datapoint include RF diagnoses and “clinician administered”. (Jan 2021)

UUID (aka PCR UUID or EMS UUID)

Collect this value for all EMS transports – not just for the transport to the trauma center. (Jan-2023)