Appendix

NATIONAL CAPITAL POISON CENTER

202/784-208

GEORGETOWN UNIVERSITY HOSPITAL
3800 RESERVOIR ROAD, N.W. WASHINGTON, D.C. 20007

April 19, 1988

Dear AAPCC Data Collection Participants:

The enclosed pages in your AAPCC Data Collection Manual have been revised based on decisions made at the March 10-11 AAPCC Mid-year Board of Directors Meeting. Please insert these revised pages in your data collection manual and discard the old pages. A summary of the changes is provided below for your convenience:

1) PLEASE make sure your entire staff has reviewed and is using the CURRENT data collection manual which was sent to your center on December 15, 1987 and is labelled "effective January 1, 1988". There were significant changes in definitions of fields and requirements for participants incorporated in this manual.

2) Programs to scan the AAPCC data collection form are now available at no charge, and can be obtained from my office (National Capital Poison Center).

3) Center quality factors have demonstrated remarkable improvement over the years. In 1987, 42 of the 64 centers submitting data had a quality factor over 0.95; 54/64 had a quality factor over 0.90; and 58/64 had a quality factor over 0.80. Data submitted in 1988 and thereafter must have a quality factor of 0.80 or better to be included in the National Database. Centers with a quality factor less than 0.80 may still have their data processed by Micromedex for individual center reports, but will not be considered a participating center, and will not receive the rights, privileges, or reimbursements of participating centers.

4) Now that we have "cleaned up" our database from the perspective of completeness, we are obliged to assess the accuracy of the coded data. To accomplish this evaluation, AAPCC now requires all data collection participants to pull and submit copies of the medical record portion of 24 randomly selected cases within four weeks of the request for these records. This audit will be conducted annually (each spring), and will involve selected cases from the fourth quarter of the previous year. Centers concerned about medical record confidentiality may obscure patient identifying data on the chart prior to submitting the record. If you participated in the 1987 National Data Collection System, this list of cases is attached. Please pull the cases listed and send xerox copies (NOT ORIGINAL CHARTS) to the address below by May 25, 1988:

National Capital Poison Center
Georgetown University Hospital
3800 Reservoir Road, NW
Washington, DC 20007

Note that failure to submit these requested cases on time will compromise your center's status as a participant in the 1987 AAPCC Data Collection System. Submitted medical records will be compared with the computerized data, and an accuracy monitoring system will be developed and implemented. Feedback will be provided to each center. For 1987 data, the only requirement will be that you submit the cases on time (by May 25). In

subsequent years, minimum accuracy levels will be required for continued participation in the National Database.

After completion of the accuracy audit, charts will be forwarded to AAPCC's regional certification committee for review. This committee will review these records with an eye to the development of minimum performance/output standards for regional poison centers, and will assess the role of random chart audits in the regional poison center certification process. The results of this 1987 chart review will NOT affect a center's current regional certification in any way.

5) New deadlines are outlined in the revised sheets attached. These changes result from the 6 week process of begging, pleading, and cajoling required to get data and death verification reports submitted this year. In the future, center reimbursement will be decreased by 5% per day for every day data or fatality verification is delayed or incomplete. Absolute deadlines are also included in the attached pages beyond which we will not include your center's data in the National Database at all. Besides submitting your data ON TIME, please be sure your death abstracts have correct units provided for all drug levels. In addition, have your medical director review (or write) the abstracts, and either the director or medical director sign the fatality verifications. Verifications submitted with blank fields, levels without units, incorrect signatures, or inadequate abstracts will be considered incomplete. We recognize that postmortem reports may be delayed, and will be acceptable as pending for all deaths occurring after October 1 of the prior year. Nonetheless, fatality verifications must be submitted on time (received by February 1) for these cases, and revisions may be received up to the final February 21 deadline.

6) A preliminary copy of 1987 National Data is enclosed for your local use if your center submitted acceptable data in 1987. The final version of the annual report will be published in the September issue of the American Journal of Emergency Medicine. Four copies will be sent to each AAPCC institutional member at that time.

7) And finally, Barbara and I would like to thank all of you for your cooperation with the 1987 death verification system. In particular, we would like to commend a few individuals (or the ghost writers in their centers) for submitting unusually well-written, comprehensive abstracts in a timely manner. Other centers provided quality abstracts, but often after the deadline. Our special commendations to:

Gary Reed, M.D. and the North Texas Poison Center
John Trestrail, B.S.Pharm. and the Blodgett Regional Poison Center
Phil Johnson, Ph.D. and the Rhode Island Poison Center

As you can imagine, there was intense competition for the "most incredible excuse" award, and as yet, we have been unable to select the finalists.

Please feel free to contact me if you have any questions.

Sincerely,

Toby Litovitz

Toby Litovitz, M.D.
Chairperson, AAPCC Data Collection Committee

AAPCC National Data Collection System DEADLINES

January 20	All data submitted on floppy diskette to the National Capital Poison Center for conversion to nine-track tape must be RECEIVED by this date. Data received after January 20 will cause a decrease in the center's data reimbursement of 5% per day for every day receipt is delayed. Data received after February 3 will not be included in the National Database.
January 20	All of the previous year's data which is submitted to Data Recognition for scanning must be RECEIVED by this date. Centers using Data Recognition are urged to submit data in small batches throughout the year so that errors may be corrected. There will NOT be time to correct errors of any data submitted to Data Recognition in January. All error corrections must also be received by January 20. Error corrections received after January 20 will not be incorporated into AAPCC or individual center reports. Data received after January 20 will cause a decrease in the center's data reimbursement of 5% per day for every day receipt is delayed. Data received after February 3 will not be included in the National Database.
February 1	All of the previous year's data which is submitted to Micromedex directly (on nine track tape) must be RECEIVED by this date. Data received after February 1 will cause a decrease in the center's data reimbursement of 5% for every day receipt is delayed. Data received after February 3 will not be included in the National Database.
February 1	All death verification forms (H-2) for fatalities occurring during the previous year must be RECEIVED by this date. Please request postmortem verification as the deaths occur. Deaths awaiting postmortem verification should have a preliminary H-2 submitted by February 1 and a revision provided by February 21. Death abstracts or revisions received after February 21 will not be accepted, and the entire center's data will be deleted from the National Database. A center which has incomplete or missing abstracts after the February 1 deadline will have its data reimbursement decreased by 5% per day for every day these abstracts remain incomplete or missing.
March 5	Final, revised H-2 reports must be RECEIVED by this date. Revisions submitted after this date cannot be corrected and will appear as errors in the annual report.
May	Distribution of preliminary microfiche version of AAPCC National Data to participating centers that comply with data submission requirements.
July	Voluntary submission of data from first half of year. If you do not require quarterly or semi-annual reports, we urge you to send your data along anyway so we may get a head start on processing. Send tapes to Micromedex, diskettes to the National Capital Poison Center or scan sheets to Data Recognition.

September	Publication of AAPCC Annual Report of the National Database in the American Journal of Emergency Medicine. Reprints are distributed to all AAPCC members (4 copies to each institutional member; 1 copy to each individual member).
September 1	Submission of all fatality verifications (H-2 form) for all deaths occurring January 1 to June 30 of the same year. Send fatality verifications to: National Capital Poison Center Georgetown University Hospital 3800 Reservoir Road, N.W. Washington, DC 20007 Please submit fatality verifications as soon as possible after each death occurs. Submission is required by September 1 for all deaths occurring in the first half of the year and by February 1 for all the remaining deaths. Please request postmortem verification as the deaths occur. Deaths awaiting postmortem verification which is pending on February 1 should have a preliminary H-2 submitted and a revision provided by February 21.
September 1	Notification of upcoming nationwide form order.
September 25	Deadline for form orders for the next calendar year. (you will receive a written request for your form order by September 1).
December 1	Payment for forms ordered in September due. Send payment to AAPCC Treasurer.
December 15	Forms shipped to centers if payment is received.

revised 04/01/88

INSTRUCTIONS FOR THE AMERICAN ASSOCIATION OF POISON CONTROL CENTERS NATIONAL DATA COLLECTION SYSTEM

EFFECTIVE JANUARY 1, 1988

The following guidelines are intended to maintain uniformity among poison centers participating in the AAPCC National Data Collection System.

The AAPCC Cooperative Poison Center Report Form incorporates both medical record and data collection functions in a single sheet. The form is perforated vertically and separates into an 8.5" x 11" medical record and a $5^3/_8$" x 11" machine readable data form. The two portions of the form have an identical unique serial number which is also presented as a machine readable litho-code. Therefore, the medical record number is automatically entered into the database when the form is scanned.

The **medical record portion** of the form provides ample space for written comments and case documentation. It should be completed by the staff person taking the call as it is received. Prompts appear on this portion of the form; however, you may alter the way the medical record portion is used to meet the needs of your staff or your case management philosophy. It is suggested that you file the forms *numerically* and maintain them as you would any other type of medical record. (From time to time AAPCC will ask you to retrieve cases by case number).

The data collection portion of the form must be used in the method outlined below. Any deviation from these guidelines or definitions will result in inaccurate or invalid data. No patient identifiers are entered, thus patient confidentiality is maintained. The data collection portion of the form is compatible with any National Computer System (NCS) trans-optic scanner (except the model 7015). You may choose one of three scanning options:

1. **In-Center Scanning with an NCS Model 3000 Desk Top Scanner**

   A 50-sheet automatic feeder is recommended and an IBM PC, XT or AT is required to drive the scanner. A scanner and 50-sheet feeder can be obtained for approximately $4,150. Information on scanners can be obtained from:

   Dennis Johnson
   National Computer System
   7600 France Avenue South
   P.O. Box 9365
   Minneapolis, MN 55440

   800-328-6172, ext. 7700 or 612-830-7627

   Programs to scan the AAPCC data collection form can be obtained at no extra charge from National Capital Poison Center, Georgetown University Hospital, 3800 Reservoir Road, N.W., Washington, DC 20007, phone 202/784-2087.

2. **Local Scanning Service**

   High speed NCS scanners may be available to you locally through a school, testing or data processing center. You will need to locate, contact and price these services

yourself, but AAPCC can provide a Dossier program for most NCS scanners. Dossier programs are also available from National Capital Poison Center.

3. Central Scanning Service

AAPCC has provided Data Recognition Corporation with a copy of the Dossier program for scanning the data collection form. Data Recognition will scan your forms for approximately $0.05 per form. For further information contact:

Russ or Lu Hagen
Data Recognition Corporation
7550 Market Place Drive
Eden Prairie, MN 55344
612-944-3623

Data Recognition will scan your forms, send a tape of the data to Micromedex for processing and will return any forms containing errors. There may be an extra charge for returned forms if there is a large number of forms with errors. See Appendix I for interpretation of error codes which appear in the margin of your returned forms. Please correct these forms immediately, and submit the corrected forms for re-scanning. Corrected forms must be received by Data Recognition for rescanning by January 20 to be incorporated in the prior year's data.

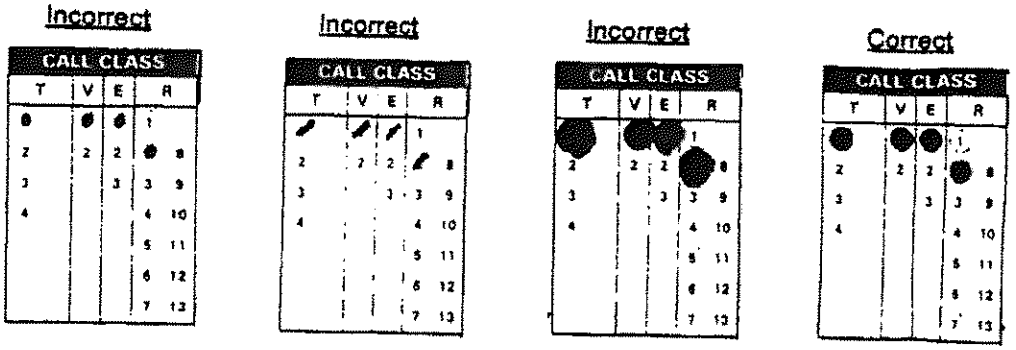
Once programmed the scanner "reads" both sides of the form simultaneously and enters the data to either magnetic tape (9 track 1600 BPI EBCDIC) or floppy disk (if you have a desk top scanner). The optical scanning method of data compilation is rapid and accurate, however, the quality of the forms presented to the scanner impacts on the speed and accuracy of the data output. Your cooperation and care in completing the data portion of the form are essential to the collection of high quality data. No stray marks should intrude onto the right side (the data collection portion) of the report form. Stray marks may result in rejection of the data or tabulation of inappropriate data. Take special care not to damage or mark either the skunk marks (two black squares at the top of the form) or the timing marks (black rectangles along the right side of the form). Any stray mark, cut or mutilation of the skunk or timing marks will cause the form to be rejected.

Data are tabulated by darkening circles with a Sanford Sharpie, Expo Marker or a #2 pencil. The markers are available from most office supply companies. Only a Sharpie or Expo Marker contain ink of high enough carbon content to be "read" by the scanner. If errors are made with the markers they are easily corrected by using a paper punch to remove the incorrectly marked circle. Punches with a 3", 4" or 6" reach are available from:

Carol Casey Multicounter Mfg. Co., Inc.
P.J. Mieth Mfg. Co.
Stround Road
North Branford, CT 06471
203-488-1800

Approximate cost: 3" - $39.00; 4" - $71.00: 6" - $102.00. You must specify 1/8" die. The punch with the 6" reach will allow you access to any circle on the data collection portion

without separating the data collection portion. If a pencil is used to darken the circle and an error is made you must erase the mark completely. We recommend that you use a marker rather than a #2 pencil to record data on the form because of the inherent speed and consistency of the markers. Remember, only markers with ink of high carbon content are "readable" by the scanner: most black markers will not work. When filling in the data tabulation portion of the report form completely darken the appropriate circles. At least 2/3 of the circle must be darkened including the center of the circle for the scanner to "read" the data.



At a minimum, all calls involving an exposure require complete reporting. **Each patient should have a separate form.** Centers may also submit data on drug, poison or medical information calls for inclusion in individual center reports. However AAPCC utilizes only actual exposures.

Data Processing

Micromedex is the current Data Compiling Organization (DCO) for AAPCC. They maintain the National Database for AAPCC and will prepare reports for participating centers who contract with them for that service. All centers contracting with Micromedex for reports will have the choice of laser printed or microfiche output. Prices are outlined in Appendix II. For additional information, contact:

George Ward
Micromedex, Inc.
660 Bannock Street
Suite 350
Denver, CO 80204-4506
800-525-9083

Data ownership and access

The National Database will remain the property of AAPCC. Each poison center submitting data to the National Database will maintain ownership of its data and may access its own database at any time with the following restrictions:

1. The poison center may not withdraw its data after it has been submitted to the National Database.

2. Selected portions of the National Database may be accessed without prior approval of the individual participating poison center. This subset of the National Database is defined below and can only be accessed with prior approval of three members of the Data Access Subcommittee (DAS). More detailed searches of the center's data can only be performed with the written approval of the center's director.

3. The following selected items of the National Database may be accessed without prior approval of the submitting center; however, each request must be approved by DAS.

substance code	call type	type of victim
exposure type	reason for exposure	date
month	symptom assessment	hour
age and sex of the victim	route of exposure	year
patient flow (excluding HCF) codes	therapies provided	medical outcome
whether the patient was pregnant	exposure and caller site	

Any participating center may search or analyze its own portion of the National Database without prior approval of DAS. Each computer search, compilation or analysis will be provided at cost (including cost of programming, computer time, supplies and administrative costs) by the DCO. Such requests may be initiated and negotiated directly between the participating center and the DCO without consultation or approval of DAS. However, all requests to search, compile or analyze the National Database must be approved by DAS. Routine requests must be submitted in writing to Dr. Litovitz. Appendix III contains a complete copy of AAPCC's approved Data Access Policy Statement.

Generic code

AAPCC maintains a copyrighted list of 800-900 generic (category) codes. The more than 100,000 Poisindex product specific codes have been matched to the generic category codes. AAPCC requests that participating centers submit product specific data utilizing the Poisindex product code; however, centers may submit generic category data. If your center uses generic codes exclusively you may be ineligible to share revenues generated by the sale of data in the National Database.

Quality control

Maximum acceptable error rates have been set by the AAPCC Executive Committee for 15 fields on the data collection form, Appendix IV. For each of these fields the maximum acceptable rates of invalid, missing and unknown data have been specified. Each participating center receives a quality control report at least annually, with a summary quality factor. High error rates lead to a reduction in a center's quality factor. Submission of data containing <75% product specific data likewise leads to a reduction of this factor. In order to facilitate the submission of high quality data, edit programs have been developed for both desk-top and high speed scanners. These programs will reject forms with invalid and missing data in certain fields. Data from centers with a quality factor less than 0.8 (maximum possible is 1.0) will not be included in the National Database. Poison information specialists should note that the average national quality factor was 0.994 in 1987. High quality factors are easily obtained by meticulous history-taking and coding and by editing and re-scanning rejected sheets. Please code accurately. Never distort data to achieve a higher quality factor.

Data scanned centrally (Data Recognition Corp.) will be returned to the submitting center if errors are noted. AAPCC anticipates that these centers will correct the forms and re-submit them for scanning. This will cost an additional scanning fee. The new record will be merged with the original record by the DCO so that the quality of the data will be maintained at a high level. Forms that have been returned with errors in the T and V fields of the call class section were rejected without extracting any data from the record. These forms must be corrected and resubmitted, or the case will not be entered into the database.

At the beginning of each year, participating centers will be required to pull and submit the medical record portion of 24 randomly selected cases from the prior year's data within four weeks of request. These will be compared with the computer data submitted by the center to determine coding accuracy. Feedback will be provided to the centers, and eventually, a minimum accuracy score will be required.

Death verification

Death verification forms must be completed for each fatality, including an abstract of the case. Please send these forms as each fatality is closed to:

Toby Litovitz, M.D.
National Capital Poison Center
Georgetown University Hospital
3800 Reservoir Road, N.W.
Washington, DC 20007

Additional copies may be produced by xeroxing the form in Appendix V.

Record layout

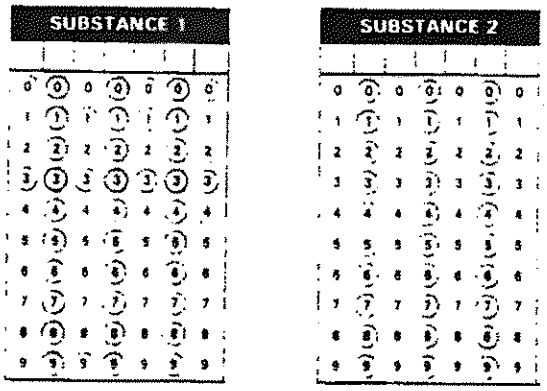
Centers submitting compatible data on 9-track tape should refer to the record layout provided in Appendix VI. These data must be submitted either 1) in EBCDIC, on 9-track tape or 2) in ASCII on floppy diskettes with 1,000 records per file. No delimiters are utilized between fields on records. Any blocking factor may be utilized (preferably 1 or 10), but the blocking factor must be specified. Fields with multiple possible entries (route of exposure, age, decontamination, therapies, free areas) must be filled with spaces (blanks, not zeros). Center code numbers and serial numbers must be zero-filled.

Ordering forms

A year's supply of data collection forms can be ordered at a cost of $0.05 per form in September of each year. Midyear form orders may cost substantially more due to the small volume ordered. Please order forms through Dr. Toby Litovitz (at address above).

Deadlines

Appendix VII lists deadlines for data submission, form orders, etc. for Database participants. Please recognize that these deadlines are not negotiable.



SUBSTANCE CODES: Product specific data will be captured on the data collection form by using the Poisindex code which appears on the product fiche of Poisindex. In the fiche system, this number if found after the ingredients list and is preceded by (PRODUCT REF.) The seven digits immediately preceding a hyphen (-) is the code. See example below:

ANTI-DANDRUFF HAIR TONIC. FROM J.B.
BENZOIC ACID 0.1%
DEHYDROACETIC ACID 0.1%
QUATERNIUM-23 & QUATERNIUM 0.05%
(PRODUCT REF 1799413-0482-L-WIL7)

In the computerized system, this number appears in reverse video at the lower right of the product screen.

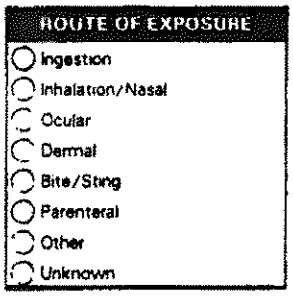
If a product is not found in the Poisindex System, then enter the seven digit generic code found in the AAPCC Generic Code Manual. All generic codes begin with the number zero. Use the generic code that best fits the product involved. Product specific codes should be used in preference to generic codes whenever possible. Be careful not to use the product specific codes of outdated, discontinued or foreign products unless you are certain that this is the product involved. DO NOT use specific INGREDIENT codes if the specific PRODUCT code is unavailable. Use the appropriate AAPCC generic code. A maximum of two products may be entered on a single report. If more than one product is involved, you may enter two Poisindex codes, or two generic codes, or one Poisindex code and one generic code in the substance areas. Enter the numbers from left to right. You may use the boxes above the columns on the data collection portion of the form to write the number on the form but you must be careful not to write outside of the boxes provided. If more than one substance is implicated in an exposure, the substances should be prioritized by relative contribution to the patient's clinical condition or relative toxic hazard to the patient. Using the following 3 generic codes for exposure cases results in invalid data:

poison information
drug information
medical information

SUBSTANCE 1: This area is used to code the first substance. Darken circles corresponding to the numbers on the code. Enter the number from left to right. Darken only one circle per column; more than one mark per column is invalid. **ALL NUMBERS INCLUDING ZERO MUST BE CODED.**

SUBSTANCE 2: This area is used to code the second substance if more than one substance is involved in the exposure.

TOTAL NUMBER OF SUBSTANCES INVOLVED: This area is used to code the total number of substances involved in the exposure if more than two different substances were involved in a single exposure. In such cases enter the total number of products up to 12. Fixed combinations or single products of multiple ingredients are considered one substance.



ROUTE OF EXPOSURE: Multiple marks are acceptable in this area. Darken the circle(s) corresponding to the route(s) of exposure. Choose from the following definitions:

Ingestion: An exposure by the oral route. Exposures where the material was put in the mouth but unlikely to have reached the stomach should be classified as an ingestion. Ingestions accompanied by aspiration should be coded as both an ingestion and an inhalation.

Inhalation/Nasal: An exposure by the pulmonary route (tracheal or nasal). This route usually pertains to gaseous or vaporized agents. Record insufflation of cocaine here. Ingestions accompanied by aspiration should be coded as both an inhalation and an ingestion.

Ocular: An exposure involving the eyeball. DO NOT code peri-orbital exposures as ocular.

Dermal: An exposure involving the skin, hair or fingernails. Code peri-orbital exposures here.

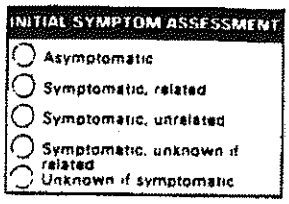
Bite/Sting: An exposure resulting from the bite or sting of an insect, arthropod or mammal.

Parenteral: An exposure resulting from the injection of a substance into the body.

Other: Any other routes of exposure not listed above.

Example: penetrating (stab, gunshot) injuries; foreign body in rectum, etc.

Unknown: If the route of exposure is unknown.



INITIAL SYMPTOM ASSESSMENT: For data collection purposes you must make a judgment about the patient's symptoms and then darken a single circle corresponding to the single category which best describes the patient's symptom status from the time of the exposure to the time of the call. Choose from the following definitions:

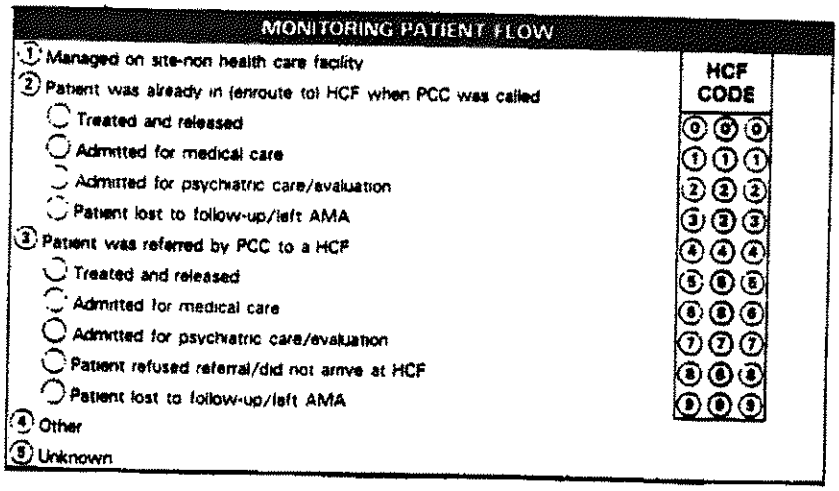
Asymptomatic: The patient has or had **no symptoms whatsoever** (subjective or objective).

Symptomatic, related: The patient is experiencing or has experienced symptoms which are (or reasonably may be) related to the exposure.

Symptomatic, unrelated: The patient is experiencing or has experienced symptoms which preceded the exposure or are of such a nature that they are unlikely to be related to the exposure. Use your best clinical judgment to make this determination.

Symptomatic, unknown if related: The patient is symptomatic or was symptomatic, but you do not have enough information to reasonably determine the relationship between the exposure history and the symptoms reported.

Unknown if symptomatic: It is unknown whether the patient is or was symptomatic.



MONITORING PATIENT FLOW: This area is designed to gather information about the management site of patients. In this area five (5) circles are numbered 1 through 5. You must choose only one of these responses. If you darken more than one of the numbered circles the response is invalid. If you choose response #2 or #3, then you must also darken one additional circle under each area regarding the disposition of the patient from the HCF. Darken the circle corresponding to the single term which best describes the initial management site of the patient from the following:

(1) **MANAGED ON SITE - NON HEALTH CARE FACILITY:** Use this area to record your response if you treat the patient at home or any other non-health care site. School or workplace exposures are included here only if the school or occupational health nurse were NOT consulted. A hospital worker exposed on site is coded as "managed on site, non HCF" unless seen by a physician, or occupational health nurse. **If you plan to refer the patient to a HCF, or eventually refer the patient to a HCF, even unexpectedly, ignore this response and darken circle #3.**

(2) **PATIENT WAS ALREADY IN (ENROUTE TO) HCF WHEN PCC WAS CALLED:** At time of initial contact with the center the patient is already in or enroute to a primary health care facility such as an emergency department, clinic or physician's office. For the purposes of this field, health care facilities include only those sites where the patient is evaluated by a physician. Note that this differs from the definition of HCF used in the SITE OF CALLER and SITE OF EXPOSURE fields. Patients who go on to health care facilities after or despite poison center recommendations to stay at home should also be coded here. If this response is chosen then the specific health care facility should be identified by code in the HCF CODE area on the right side of this section. NOTE: Each center may develop its own HCF codes and HCF coding criteria. **If this response is chosen, a further determination should be made about the disposition of the patient from that HCF.** Choose from the following:

Treated and released: The patient is observed/treated then released to home. **HCF code required.**

Admitted for medical care: The patient is observed and/or treated and subsequently admitted as an inpatient primarily to receive medical care rather than psychiatric evaluation. **DARKEN THE "ADMITTED" CIRCLE EVEN IF THE PATIENT IS TRANSFERRED TO AND ADMITTED TO AN HCF OTHER THAN THE ORIGINAL HCF** so that the National Database will reflect the total number of admitted patients. HCF code required. Record the HCF code of an additional facility involved in a transfer in the "follow-up" area.

> Example: A patient is in the emergency department at HCF-A and is transferred to HCF-B and admitted to HCF-B for medical care. You may code HCF-A in the monitoring patient flow section and HCF-B in the follow-up section; or code these HCF's in any manner designated by your director. However, for the purposes of the National Database you must code "admitted for medical care" rather than "treated and released" and you must utilize one of the other HCF codes or this will be coded as an error during scanning.

Admitted for psychiatric care/evaluation: The patient is observed and/or treated and subsequently admitted as an inpatient in the same facility and the patient is admitted primarily to receive psychiatric care or evaluation. HCF code required. If the patient is transferred to another facility for psychiatric care, the primary HCF should be indicated here and the second facility recorded in the "follow-up" area.

Patient lost to follow-up/left AMA: You have lost the patient to follow-up or the patient has left the HCF against medical advice or the patient never arrived at the HCF. **HCF code not required.**

(3) **PATIENT WAS REFERRED BY PCC TO A HCF:** Any case where the patient is referred to a primary HCF (Emergency Department, physician's office) as part of your management recommendation. For the purposes of this field, health care facilities include only those sites where the patient is evaluated by a physician. Note that this differs from the definition of HCF used in the SITE OF CALLER and SITE OF EXPOSURE fields. If this response is chosen then the specific health care facility should be identified by code in the HCF CODE area in the right side of this section. NOTE: Each center may develop its own HCF codes and HCF coding criteria. **If this response is chosen, a further determination should be made regarding the disposition of the patient from that HCF.** Choose from the following:

Treated and released: The patient is observed/treated then released to home. **HCF code is required.**

Admitted for medical care: The patient is observed and/or treated and subsequently admitted as an inpatient primarily to receive medical care rather than psychiatric evaluation. **DARKEN THE "ADMITTED" CIRCLE EVEN IF THE PATIENT IS TRANSFERRED TO AND ADMITTED TO AN HCF OTHER THAN THE ORIGINAL HCF** so that the National Database will reflect the total number of admitted patients. HCF code required. Record the HCF code of an additional facility involved in a transfer in the "follow-up" area.

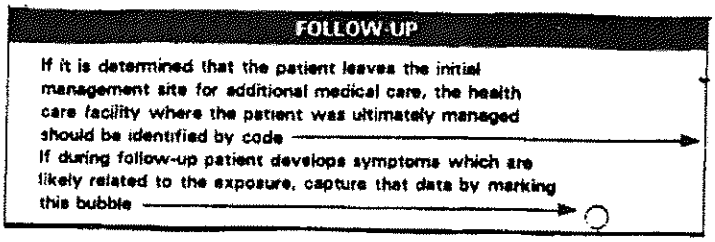
Admitted for psychiatric care/evaluation: The patient is observed and/or treated and subsequently admitted as an inpatient in the same facility and the patient is admitted primarily to receive psychiatric care or evaluation. HCF code required. If the patient is transferred to another facility for psychiatric care, the primary HCF should be indicated here, and the second facility recorded in the "follow-up" area.

Patient refused referral/did not arrive at HCF: Patient declined to follow your referral recommendation or failed to arrive at the HCF to which you referred him. **HCF code not required.**

Patient lost to follow-up/left AMA: You have lost the patient to follow-up or the patient has left the HCF against medical advice. HCF code not required.

(4) **OTHER:** Any management site not identified above. If a non-physician health care provider such as a nursing home, dentist's office, detox center, jail, mental health center, occupation health nurse or school nurse is involved in the patient's care, code this option.

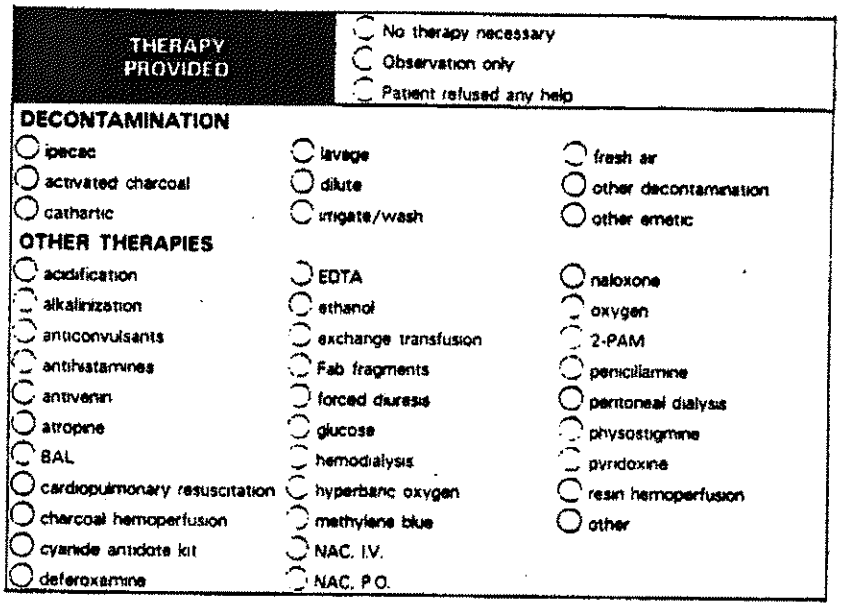
(5) **UNKNOWN:** The management site of the patient is unknown.



FOLLOW-UP: During follow-up if you determine that the patient leaves the initial management site or is transferred from the referral site for additional medical or psychiatric care, this response should be coded by entering the HCF code of the facility at which the patient was ultimately managed. Enter the code in the HCF CODE area to the right of the arrow. If more than one transfer facility is involved, the center may choose which facility is coded.

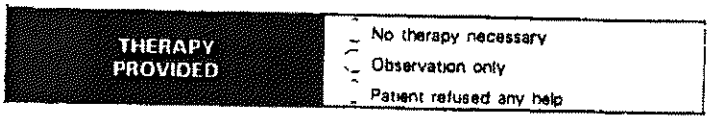
FOLLOW-UP/SYMPTOMS: This response applies only if you determine that the patient develops symptoms related to the exposure sometime after the initial call. If during follow-up, you determine that the patient has subsequently developed symptoms, document the time of onset on the medical record and darken the circle to the right of the arrow. NOTE: **THIS RESPONSE IS NOT VALID IF THE INITIAL SYMPTOM ASSESSMENT IS SYMPTOMATIC, RELATED.** PLEASE do not skip this field.

TERATOGENICITY: If you are able to determine that the patient is a pregnant female at the time of her exposure then darken the bubble to the right of the arrow.



THERAPY SECTION: On the medical record you should document any therapy which you recommend including those which you anticipate may be needed during the course of the exposure. You should also document any therapy which was provided which you did not recommend. In these latter cases be sure to document the circumstances on the medical record portion of the form. It is quite possible that you may not find all the therapies that you provided. The form is not intended to capture all possible therapies. Therefore, if your center finds therapies which they wish to have coded but are not on the form we encourage you to use one of the free areas to record that data.

On the data collection form you should code only those therapies which were actually provided including those you may not have recommended. Darken the circle corresponding to only those therapies which were actually used to treat the patient for the exposure or a medical complication associated with that exposure.



NO THERAPY NECESSARY: Darken the circle corresponding to "No therapy necessary" if you determine that the patient can be managed without any therapy.

OBSERVATION ONLY: Darken the circle corresponding to "Observation only" if you determine that the patient can be managed without any therapy other than observation (medical and nonmedical observation are included here).

PATIENT REFUSED ANY HELP: If you believe that the exposure is potentially toxic, but the caller or the patient refuses to accept your help or they will not give you a return phone number and you have no way to determine whether therapeutic intervention was provided, code this response.

DECONTAMINATION: Multiple responses are acceptable in this area. IF YOU LEAVE THIS AREA BLANK THE DATA FOR THIS CASE WILL BE INTERPRETED AS "NO DECONTAMINATION PROVIDED". Darken all the circles corresponding to the decontamination procedure(s) used to treat the patient. Darken all circles that apply. Choose all that apply from the following:

Ipecac: Ipecac syrup was administered.

Activated Charcoal: Activated charcoal was given.

Catharsis: The patient was given a laxative, cathartic or enema resulting in purgation of the gastrointestinal tract.

Lavage: Gastric lavage was used to decontaminate the stomach.

Dilute: The patient does something to decrease the concentration of a substance by ingesting water or other fluid.

Irrigate/wash: The substance is removed from the eye or skin by flooding the area with water or by cleansing with soap, detergent or similar substance. Nasal/aural irrigation are also coded here.

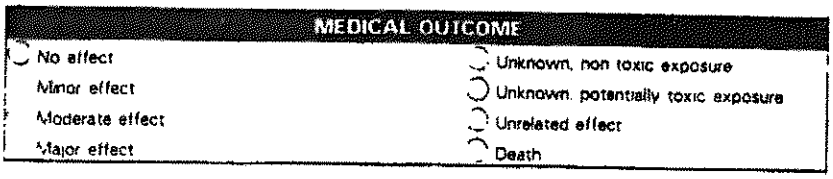
Example: acetone for cyanoacrylates; vegetable oil for dermal capsicum exposures

Fresh air: The patient was removed from a contaminated environment and provided a source of fresh air. This response will usually pertain to inhalation exposures.

Other decontamination: Any decontamination procedure not specifically listed above. Food administration should be listed here.

Other emetic: Emesis was induced with an agent other than syrup of ipecac. Mechanical stimulation, a detergent solution, apomorphine and the like should be coded here.

OTHER THERAPIES: Multiple entries are acceptable in this area. This area is provided to code procedures and chemical therapies which were actually used to treat the patient. Darken all the circles corresponding to the therapies which were actually used to treat the patient.



MEDICAL OUTCOME: This area is designed to record the medical effects experienced by the patient as a result of this exposure. Periodic follow-up should continue until a reasonably certain medical outcome can be documented. Darken the circle which best describes the medical outcome from the following:

No effect: The patient developed no symptoms as a result of the exposure. Follow-up is required to make this determination unless the initial poison center call occurs long after the exposure.

Minor effect: The patient exhibited some symptoms as a result of the exposure, but they were minimal or no treatment was provided. The symptoms resolved rapidly and usually involve skin or mucous membrane manifestations. The patient has returned to a pre-exposure state of well being and has no residual disability or disfigurement. Follow-up is required to make this determination unless the initial poison center call occurs long after the exposure. Some examples of minor symptoms are: mild GI symptoms, drowsiness, skin irritation or 1° burn, sinus tachycardia without hypotension.

Moderate effect: The patient exhibited symptoms as a result of the exposure which are more pronounced, more prolonged or more of a systemic nature than minor symptoms. Usually some form of treatment is or would have been indicated to treat the patient. Symptoms were not life threatening and the patient has returned to a pre-exposure state of well being with no residual disability or disfigurement. Follow-up is required to make this determination unless the initial poison center call occurs long after the exposure. Examples of moderate symptoms are: a corneal abrasion, acid-base disturbance, high fever, disorientation, hypotension which rapidly responds to treatment, and isolated brief seizures which resolve spontaneously or readily respond to treatment, transient renal failure not requiring dialysis, hepatic injury without encephalopathy, GI symptoms causing dehydration, caustic injury to esophagus without perforation or residual injury.

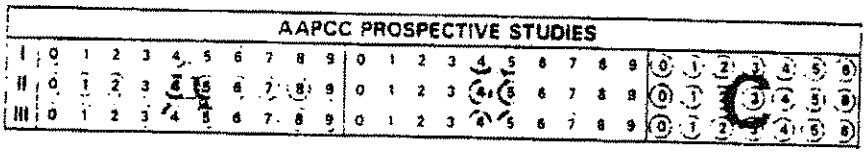
Major effect: The patient has exhibited some symptoms as a result of the exposure. The symptoms were life-threatening or resulted in residual disability or disfigurement. Follow-up is required to make this determination unless the initial poison center call occurs long after the exposure. Examples include patients who require intubation plus mechanical ventilation, who sustain repeated seizures, or experience ventricular tachycardia, cardiovascular instability or coma.

Unknown, nontoxic exposure: The patient was lost to follow-up or was not followed. However, in your estimation the exposure was likely to be non toxic because the agent involved was non toxic or the amount of the exposure, (or route) was insignificant and unlikely to result in toxicity.

Unknown, potentially toxic exposure: The patient was lost to follow-up and in your estimation the exposure was significant and may have resulted in toxic manifestations.

Unrelated effect: The patient exhibited symptoms which were ultimately diagnosed as not related to a toxic problem. Deaths which are clearly unrelated to a toxic exposure should also be coded here.

Death: The patient died as a result of the exposure or a direct complication of the exposure which was unlikely to have occurred had the toxic exposure not preceded the complication.



AAPCC PROSPECTIVE STUDIES: This area has been provided specifically for AAPCC sponsored studies. **DO NOT USE THIS AREA FOR YOUR CENTER'S INDIVIDUAL NEEDS.** If you wish to use this area for a national study please submit a brief proposal to the chairperson of the Data Collection Committee.

SINGLE CASES HANDLED BY 2 OR MORE CENTERS: When 2 or more centers that participate in the National Database consult on the same case, secondary centers must identify the case in AAPCC PROSPECTIVE STUDIES area or the case will be duplicated in the National Database. We will use **section C, row III, circle 6** for this purpose. Collaborating centers must decide between themselves which center will be the primary center and which will be the secondary center. Usually the center with the most information on a case will be the primary center. **The secondary center should darken circle C, III, 6 in the AAPCC Prospective Studies area. Those cases will be reported in the center's individual data but will be dropped from the National Database.**

FREE AREAS: The form has five areas (three on the front and two on the back) to gather data for individual center needs and special studies. If you choose to use the free areas you will receive a numeric tabulation of the codes which you enter from the DCO. Only specified Free Areas may be used for individual center purposes. Do not divert other fields for your center's special coding needs!

FREE AREA 1: Only a single response may be coded in this area; however, it provides for up to 100 choices (0-99). Enter codes from left to right and darken only one circle in each column.

FREE AREA 2: Only a single response may be coded in this area; however, it provides for up to 1,000 choices (0-999). Enter codes from left to right and darken only one circle in each column.

FREE AREA 3: Only a single response may be coded in this area; however, it provides for up to 100 choices (00-99). Enter codes from left to right and darken only one circle in each column.

FREE AREA 4: Multiple responses may be made in this area (up to 59). Darken all circles for which a response is appropriate.

FREE AREA 5: Multiple responses may be made in this area (up to 54). Darken all circles for which a response is appropriate.