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O Code Review SQI
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Review Form SQI

Record ID
_____**Patient demographics and admission information**Patient Encounter Number
_____Patient's age at the time of admission to the
emergency department (in years) _____Patient's sex
_____Admission date

(Please use mmddyyyy format.)

Date of injury
_____(The date the injury event occurred, if known.
Please use mmddyyyy format. If the exact date of
injury is not documented, please type "UKN".)The number of hours between the injury event and the
time of ED admission

- < 1 hours
 1-11 hours
 12-23 hours
 24-48 hours
 >48 hours
 Unknown

Signs and Symptoms of Injury

Does this encounter of care involve an injury?

- Yes
 No

Within the medical record, was there mention of the following signs and/or symptoms?

	Documented Yes	Documented No	No documentation
Abdominal pain/Cramping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Contractions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vaginal bleeding	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vaginal discharge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vaginal pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Facial pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Neck pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Chest pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Extremity pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Burn	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Abnormal fetal movement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Abnormal fetal heart rate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Spontaneous abortion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Threatened abortion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nausea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vomiting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cardiac arrest	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seizure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Why does this encounter not involve an injury?

External Cause of Injury

Does this case involve an overdose or poisoning? Yes
 No

Substance of overdose

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What was the external cause of injury?

	No	Yes, known	Yes, suspected	No documentation
Motor vehicle accidents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other vehicle accidents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poisoning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Accidental falls	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Accidents caused by fire and flames	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Accidents due to natural and environmental factors	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drowning and submersion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Choking, suffocation, and constriction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sports injuries	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Late effects of injury	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Suicide and self-inflicted injury (violence to self)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Homicide and injuries inflicted by others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Accidents caused by foreign bodies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Struck by objects, caught between objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Accidents caused by machinery, explosions, or electricity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Overexertion, strenuous movements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Injuries due to war operations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Injuries undetermined as accidental or purposefully inflicted	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other unspecified accidents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Body Part/Region of Injury

What body system and/or part was injured?

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Intentionality

What was the intention of this injury?

- Accidental
 Self-inflicted
 Assault
 Undetermined

Was this injury due to abuse?

- No
 Yes, known
 Yes, suspected
 No documentation

Assessment

Did this patient receive a consult by OBGYN or referral to OBGYN triage?

- Documented Yes
 Documented No
 No documentation

Additional info gained from OB consult.

What was the disposition of the patient upon discharge?

Based on the reviewer's assessment, does this encounter of care involve an injury that complicating pregnancy, delivery, or the puerperium?

- Yes
 No

Why does this encounter not involve an injury complicating pregnancy, delivery, or the puerperium?
