

**REVSTAT**  
 REVIEW STATUS (not abstracted)  
 0. Abstraction has not begun  
 1. Abstraction in progress  
 2. Abstraction completed w/o errors  
 3. TVG failure (exclusion)  
 4. Record contains missing required answers (error record)  
 5. Administrative exclusion from all measures

**CATNUM**  
 Sample category  
 10. Inpt AMI primary dx  
 29. Inpt Heart Failure  
 41. Inpt Pneumonia  
 42. Inpt AMI primary/prin dx  
 53. Inpt Surgery  
 55. Inpt Surgery - type 10

**LEFTDATE** (PN Validation)  
 Discharge date: (rcvd on pull list).

**LEFTIME** (PN Validation)  
 Time of Discharge

**ADMDT** (PN Validation)  
 Date of admission to acute inpatient care

**PNEADMTM** (PN Validation)  
 Time of admission to acute inpatient care:

**DTOFDC** (IHF)  
 Discharge date:  
 (rcv'd on pull list)

**WHATIME** (IHF)  
 Discharge time:

**ENTRADM** (IHF)  
 Admission date:

**HFADMTIME** (q4 IHF)  
 Admission time:

**DCDATE** (ACS Validation)  
 Enter the date of discharge (rcvd on pull list).

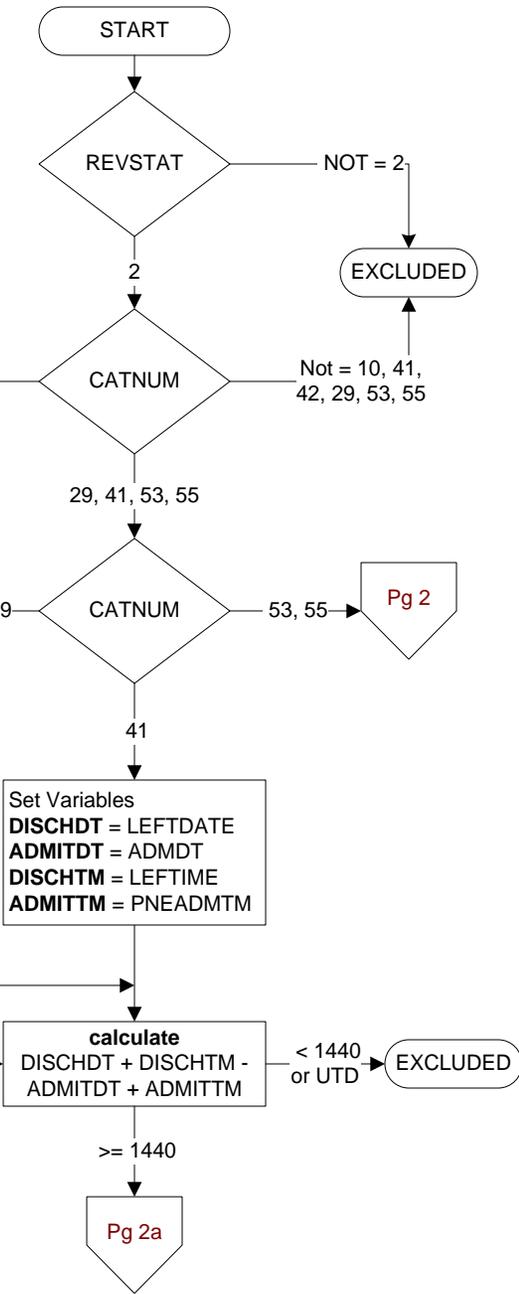
**DCTIME** (ACS Validation)  
 Enter the time of discharge.

**ADMDT** (ACS Validation)  
 Enter the date the patient was formally admitted to inpatient status at this VAMC.

**ADMTIME** (ACS Validation)  
 Enter the time the patient was formally admitted to inpatient status at this VAMC.

Set Variables  
**DISCHDT** = DCDATE  
**ADMITDT** = ADMDT  
**DISCHTM** = DCTIME  
**ADMITTM** = ADMTIME

Set Variables  
**DISCHDT** = DTOFDC  
**ADMITDT** = ENTRADM  
**DISCHTM** = WHATIME  
**ADMITTM** = HFADMTIME



**DTOFDC** (SCIP)  
Discharge Date

**SIPDCTM** (SCIP)  
Time of discharge:.

**SIADMDT** (SCIP)  
Date of admission to inpatient care:

**SIPADMTM** (SCIP)  
Time of admission to inpatient care:

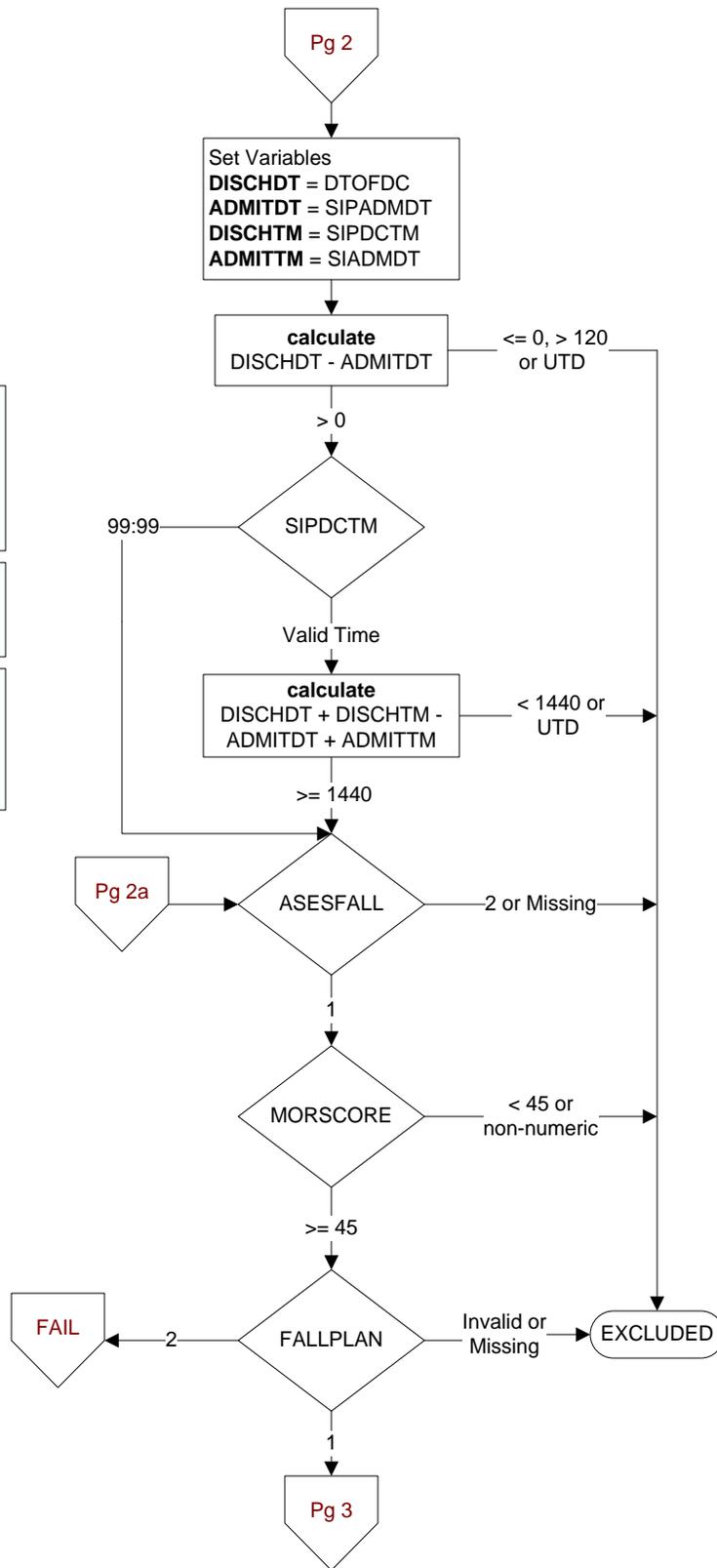
**ASESFALL** (Fall)  
Does the medical record document the patient was assessed for risk of falls using the Morse Fall Scale during this hospital stay?  
1. Yes  
2. No

**MORSCORE** (Fall)  
Enter the result of the Morse Fall Scale.  
(If the MFS score is not documented, enter default zzz.)

**FALLPLAN** (Fall)  
Does the record document a care plan to minimize the risk of fall/injury?  
1. Yes  
2. No

**FALPLNDT** (Fall)  
Enter the date the first fall/injury care plan was documented in the record.

**FALPLNTM** (Fall)  
Enter the time the first fall/injury care plan was documented in the record.



**FALPLNDT** (Fall)  
Enter the date the first fall/injury care plan was documented in the record.

**FALPLNTM** (Fall)  
Enter the time the first fall/injury care plan was documented in the record.

