1. Main specialty (choose only one)
- [ ] Internal Medicine / General
- [ ] Internal Medicine / Cardiology
- [ ] Internal Medicine / Gastroenterology & Hepatology
- [ ] Internal Medicine / Geriatrics
- [ ] Internal Medicine / Infectious Diseases
- [ ] Internal Medicine / Nephrology
- [ ] Internal Medicine / Oncology (incl. radiotherapy)
- [ ] Interdisciplinary
- [ ] Long term care
- [ ] Neurology
- [ ] Surgery / General
- [ ] Surgery / Cardiac/Vascular/Thoracic
- [ ] Surgery / Neurosurgery
- [ ] Surgery / Orthopedic
- [ ] Trauma
- [ ] Ear Nose Throat (ENT)
- [ ] Gynecology / Obstetrics
- [ ] Pediatrics
- [ ] Psychiatry
- [ ] Others

2. Number of registered inpatients at noon

3. Total bed capacity of the unit

4. Number of each type of staff in the unit for TODAY’s morning shift (excluding cleaning and temporary nDay staff)

<table>
<thead>
<tr>
<th>Staff Type</th>
<th>Fully trained</th>
<th>In training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical doctors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical students</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Nursing aides</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dieticians</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritionists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other staff involved in patient care</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

5. Is there a nutrition support team in your hospital available?  
- [ ] Yes  
- [ ] No

6. Does the unit have a nutrition care strategy?  
- [ ] Yes  
- [ ] No

7. Is there a person in your unit responsible for nutrition care?  
- [ ] Yes  
- [ ] No

8. Is there a dietician, nutritionist or dietetic assistant available for your unit?  
- [ ] Yes  
- [ ] No

9. Is specific staff responsible for providing feeding assistance to patients during meal times?  
- [ ] Yes  
- [ ] No

10. How do you MAINLY screen/monitor patients for malnutrition? (choose only one answer per column)

   - **At admission**
     - [ ] No routine screening
     - [ ] No fixed criteria
     - [ ] Experience / visual assessment only
     - [ ] Weighing / BMI only
     - [ ] Nutritional Risk Screening (NRS) 2002
     - [ ] Malnutrition Universal Screening Tool (MUST)
     - [ ] Malnutrition Screening tool (MST)
     - [ ] SNAQ
     - [ ] Other formal tool
     - [ ] Please specify:

   - **During hospital stay**
     - [ ] No routine monitoring
     - [ ] No fixed criteria
     - [ ] Experience / visual assessment only
     - [ ] Weighing / BMI only
     - [ ] Other formal tool
     - [ ] Please specify:

Please continue with sheet 1b
11a. Do you routinely use guidelines or standards for nutrition care? **Yes**  **No**

11b. If yes, which one is mainly used?
- International guidelines
- National guidelines
- Standards on unit level
- Standards on hospital level
- Other

12. What is routinely done in your unit for given patient groups? (mark all that apply)

<table>
<thead>
<tr>
<th>Activity</th>
<th>At risk</th>
<th>Malnourished</th>
<th>Every patient</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Watchful waiting</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>Never</td>
</tr>
<tr>
<td>Discuss nutrition care activities during ward rounds</td>
<td>✔️</td>
<td>✔️</td>
<td>Every patient</td>
<td>Never</td>
</tr>
<tr>
<td>Develop an individual nutrition care plan</td>
<td>✔️</td>
<td>✔️</td>
<td>Every patient</td>
<td>Never</td>
</tr>
<tr>
<td>Initiate treatment / nutrition intervention</td>
<td>✔️</td>
<td>✔️</td>
<td>Every patient</td>
<td>Never</td>
</tr>
<tr>
<td>Consult a nutrition expert (dietician, nutritionist, etc.)</td>
<td>✔️</td>
<td>✔️</td>
<td>Every patient</td>
<td>Never</td>
</tr>
<tr>
<td>Consult a medical professional</td>
<td>✔️</td>
<td>✔️</td>
<td>Every patient</td>
<td>Never</td>
</tr>
<tr>
<td>Calculate energy requirements</td>
<td>✔️</td>
<td>✔️</td>
<td>Every patient</td>
<td>Never</td>
</tr>
<tr>
<td>Calculate protein requirements</td>
<td>✔️</td>
<td>✔️</td>
<td>Every patient</td>
<td>Never</td>
</tr>
</tbody>
</table>

13. When do you routinely weigh your patients? (mark all that apply)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>When requested</th>
<th>At discharge</th>
<th>Occasionally</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>at admission</td>
<td>✔️</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within 48 hours</td>
<td>✔️</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Every week</td>
<td>✔️</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At discharge</td>
<td>✔️</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within 72 hours</td>
<td>✔️</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occasionally</td>
<td>✔️</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>✔️</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

14. What do you do to support adequate food intake of patients? (mark all that apply)

<table>
<thead>
<tr>
<th>Activity</th>
<th>At risk</th>
<th>Malnourished</th>
<th>Every patient</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offer additional meals or in between snacks</td>
<td>✔️</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Offer meal choices</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Offer different portion sizes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider food presentation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change food texture/consistency as needed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider patient problems with eating and drinking</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

15. Which nutrition-related standards or routine activities exist in your unit? (mark all that apply)

- Nutrition training is available
- Reporting of nutrition related information to hospital managers
- Quality indicators are recorded and reported to national or regional level
- Quality indicators are used for internal benchmarking
- Patient feedback about food and food service is collected using a questionnaire

16. At admission what is asked and documented? (mark all that apply)

<table>
<thead>
<tr>
<th>Activity</th>
<th>At risk</th>
<th>Malnourished</th>
<th>Every patient</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in weight</td>
<td>✔️</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating habits/difficulties</td>
<td>✔️</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutrition before admission</td>
<td>✔️</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

17. On what forms is there a specific part about eating, nutrition or malnutrition? (mark all that apply)

a. Patient Record has a section for...
- ✔️ indicating if the patient is malnourished or at risk of malnutrition
- ✔️ nutrition treatment

b. Discharge Letter...
- ✔️ summarizes nutrition treatment received during stay
- ✔️ makes future nutrition-related recommendations

18. Do you provide brochures about malnutrition to at risk/malnourished patients? **Yes**  **No**

19. Who filled in this sheet? (mark all that apply)
- Head staff
- Nurse
- Administrative staff
- Dietericlan
- Physician
- Other

THANK YOU!
1. Total number of beds in hospital

2. Total number of admissions in the hospital last year

3. Total number of staff in the hospital

<table>
<thead>
<tr>
<th>Total number doctors</th>
<th>Full time equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total medical doctors</td>
<td></td>
</tr>
<tr>
<td>Medical specialists</td>
<td></td>
</tr>
<tr>
<td>Medical non-specialists</td>
<td></td>
</tr>
<tr>
<td>Nurses</td>
<td></td>
</tr>
<tr>
<td>Dieticians</td>
<td></td>
</tr>
<tr>
<td>Nutritionists</td>
<td></td>
</tr>
<tr>
<td>Pharmacists</td>
<td></td>
</tr>
<tr>
<td>Kitchen staff</td>
<td></td>
</tr>
</tbody>
</table>

4. Does the hospital have a nutrition care strategy?
   - Yes
   - No
   - I do not know

5. Which nutrition-related standards or routine activities exist in your hospital?
   - Nutrition training is available
   - Nutrition steering committee is available
   - Quality indicators are recorded and reported to national or regional level
   - Quality indicators are used for internal benchmarking
   - Patient feedback about food and food service is collected using a questionnaire

6. Which codes are available / routinely used in your hospital for billing and reimbursement purposes?

<table>
<thead>
<tr>
<th>Codes available</th>
<th>Codes routinely used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition Support</td>
<td>Nutrition Support</td>
</tr>
<tr>
<td>Oral nutrition supplements</td>
<td>Oral nutrition supplements</td>
</tr>
<tr>
<td>Parenteral nutrition</td>
<td>Parenteral nutrition</td>
</tr>
<tr>
<td>Enteral nutrition</td>
<td>Enteral nutrition</td>
</tr>
<tr>
<td>Dietary counseling</td>
<td>Dietary counseling</td>
</tr>
<tr>
<td>Specific dietary interventions</td>
<td>Specific dietary interventions</td>
</tr>
<tr>
<td>Screening for malnutrition</td>
<td>Screening for malnutrition</td>
</tr>
<tr>
<td>Risk of malnutrition</td>
<td>Risk of malnutrition</td>
</tr>
<tr>
<td>Malnutrition (in general)</td>
<td>Malnutrition (in general)</td>
</tr>
<tr>
<td>Severity of malnutrition (i.e. mild, moderate, severe)</td>
<td>Severity of malnutrition (i.e. mild, moderate, severe)</td>
</tr>
<tr>
<td>No information available from billing/finance/controlling</td>
<td>No information available from billing/finance/controlling</td>
</tr>
</tbody>
</table>

THANK YOU!
### ABOUT YOUR PATIENT

**SHEET 2a**

<table>
<thead>
<tr>
<th>Patient number</th>
<th>Patient Initials</th>
<th>Year of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>Male</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Weight</th>
<th>Height</th>
<th>Patient consent</th>
</tr>
</thead>
<tbody>
<tr>
<td>kg</td>
<td>cm</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Date

**Date**

**Center-Code**

**Unit-Code**

### PLEASE CONTINUE ONLY IF PATIENT GAVE CONSENT!

1. **This hospital admission was...**

   - planned
   - an emergency
   - I do not know

2a. **Diagnosis at admission (mark all that apply)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>0100</td>
<td>Infectious and parasitic diseases</td>
</tr>
<tr>
<td>0200</td>
<td>Neoplasms</td>
</tr>
<tr>
<td>0300</td>
<td>Blood and bloodforming organs and the immune mechanism</td>
</tr>
<tr>
<td>0400</td>
<td>Endocrine, nutritional and metabolic diseases</td>
</tr>
<tr>
<td>0500</td>
<td>Mental health</td>
</tr>
<tr>
<td>0600</td>
<td>Nervous system</td>
</tr>
<tr>
<td>0700</td>
<td>Eye and adnexa</td>
</tr>
<tr>
<td>0800</td>
<td>Ear and mastoid process</td>
</tr>
<tr>
<td>0900</td>
<td>Circulatory system</td>
</tr>
<tr>
<td>1000</td>
<td>Respiratory system</td>
</tr>
<tr>
<td>1100</td>
<td>Digestive system</td>
</tr>
<tr>
<td>1200</td>
<td>Skin and subcutaneous tissue</td>
</tr>
<tr>
<td>1300</td>
<td>Musculoskeletal system and connective tissue</td>
</tr>
<tr>
<td>1400</td>
<td>Genitourinary system</td>
</tr>
<tr>
<td>1500</td>
<td>Pregnancy, childbirth and the puerperium</td>
</tr>
<tr>
<td>1600</td>
<td>Conditions originating in the perinatal period</td>
</tr>
<tr>
<td>1700</td>
<td>Congenital/chromosomal abnormalities</td>
</tr>
<tr>
<td>1800</td>
<td>Symptoms, signs, abnormal clinical/lab findings</td>
</tr>
<tr>
<td>1900</td>
<td>Injury, poisoning</td>
</tr>
<tr>
<td>2000</td>
<td>External causes of morbidity and mortality (e.g. transport accidents, assaults)</td>
</tr>
<tr>
<td>2100</td>
<td>Factors influencing health status and contact with health services</td>
</tr>
</tbody>
</table>

2b. **Main reason for admission (choose only one code from above)**

3. **Which conditions/comorbidities does this patient have? (mark an answer for each)**

   - Cardiac insufficiency
   - Myocardial infarction
   - Chronic lung disease
   - Cerebral vascular disease
   - Peripheral vascular disease
   - Chronic liver disease
   - Chronic kidney disease

   - Diabetes
   - Cancer
   - Infection
   - Dementia
   - Major depressive disorder
   - Other chronic mental disorder
   - Other chronic disease

4a. **Previous operation during this hospital stay**

   - Yes, planned
   - No
   - Yes, acute

   **days since operation**

4b. **Planned operation during this hospital stay**

   - Yes, today or tomorrow
   - Yes, later
   - No

5. **Previous ICU admission during this hospital stay?**

   - Yes
   - No

6. **Is this patient terminally ill?**

   - Yes
   - No
   - I do not know

7. **Fluid status (TODAY)**

   - Normal
   - Overloaded
   - Dehydrated
   - I do not know

8. **Number of different medications planned (TODAY)**

   - oral
   - other

9. **Was this patient identified as malnourished or at risk of malnutrition?**

   - Malnourished
   - At risk
   - No
   - I do not know

Please continue with Sheet 2b
### About Your Patient Sheet 2b

#### 10. IV Fluids (TODAY)
- Electrolyte solution (NaCl, Ringers lactate, etc)
- 5% Glucose solution

#### 11. Number of ONS drinks planned (TODAY)

#### 12. Nutrition intake (TODAY) (mark an answer for each)
- Regular hospital food
- Fortified/enriched hospital food
- Protein/energy supplement (e.g. ONS drinks)
- Enteral nutrition
- Parenteral nutrition
- Special diet

#### 13a. All lines and tubes (TODAY) (mark an answer for each)
- Central Venous
- Peripheral venous access
- Nasogastric
- Nasojejunal
- Nasoduodenal
- Enterostoma
- Percutaneous endoscopy/surgical gastrostomy
- Percutaneous endoscopy/surgical jejunostomy

#### 13b. Were there complications with nutrition related lines and tubes since admission? (infections /obstructions)
- Yes, previously
- Yes, ongoing
- No
- I do not know

#### 14. Please indicate if any of the following was done for this patient since admission (mark an answer for each)
- Energy requirements were determined
- Protein requirements were determined
- Food/Nutrition intake was recorded in the patient record
- Nutrition treatment plan was developed
- Nutrition expert was consulted
- Malnutrition status is recorded in the patient record

#### 15a. Energy goal (YESTERDAY)
- <500 kcal
- 500-999 kcal
- 1000-1499 kcal
- 1500-1999 kcal
- >=2000 kcal
- Not determined
- I do not know

#### 15b. Energy intake (YESTERDAY)
- <500 kcal
- 500-999 kcal
- 1000-1499 kcal
- 1500-1999 kcal
- >=2000 kcal
- Not determined
- I do not know

#### 16. Since admission, this patient's health status has…
- Improved
- Deteriorated
- Remained the same
- This patient has just been admitted
- I do not know

Thank you!
### Patient Sheet 3a

**1. What are your typical dietary habits? (mark all that apply)**
- [ ] No special dietary habits
- [ ] I am vegetarian
- [ ] I adhere to a vegan diet
- [ ] I eat gluten-free diet
- [ ] I avoid added sugars
- [ ] I avoid carbohydrates
- [ ] I eat a low-fat diet
- [ ] I am lactose intolerant
- [ ] Other special diet due to intolerances/allergies
- [ ] Other

**2. Where did you live before your current hospital admission?**
- [ ] At home
- [ ] In a nursing home or other live-in facility
- [ ] I was transferred from another hospital
- [ ] Other

**3. In general, are you able to walk?**
- [ ] Yes
- [ ] Yes, with someone’s help
- [ ] Yes, independently using a cane, walker, or crutches
- [ ] No, I have a wheelchair
- [ ] No, I am bedridden

**4. In general, how would you say your health is?**
- [ ] Very good
- [ ] Good
- [ ] Fair
- [ ] Poor
- [ ] Very poor

**5. Over the last 12 months prior to your current hospital admission approximately…**
- … how many times have you seen a doctor? __________ times
- … how many times have you been admitted to the hospital (Emergency room, any ward)? __________ times
- … how many nights in total have you spent in hospital? __________ nights

**6. How many different medications do you take routinely each day (prior to hospitalisation)?**
- [ ] None
- [ ] 1-2
- [ ] 3-5
- [ ] More than 5
- [ ] I do not know

**7. Do you have health insurance?**
- [ ] Yes, private insurance only
- [ ] Yes, public insurance only
- [ ] Yes, both
- [ ] No
- [ ] I prefer not to answer

**8. What was your weight 5 years ago?** __________ kg
- [ ] I do not know

**9a. Have you lost weight within the last 3 months?**
- [ ] Yes, intentionally
- [ ] Yes, unintentionally
- [ ] No, my weight stayed the same
- [ ] I do not know

**9b. If yes, how many kg did you lose?** __________ kg
- [ ] I do not know

**10. Did you know about your hospitalisation two days before admission?**
- [ ] Yes
- [ ] No

**11. Please indicate if you …**
- [ ] … were weighed at admission
- [ ] … were informed about your nutrition status
- [ ] … were informed about nutrition care options
- [ ] … received special nutrition care
- [ ] I do not know
12. How well have you eaten in the week before you were admitted to the hospital?
- More than normal
- Normal
- About 3/4 of normal
- About half of normal
- About a quarter to nearly nothing

13. In general, how satisfied are you with the food at the hospital?
- Very satisfied
- Somewhat satisfied
- Neutral
- Dissatisfied
- Very dissatisfied

14. Did you get any help with eating TODAY?
- Yes, from family or friends
- Yes, from hospital staff
- No

15. Were you able to eat without interruption TODAY?
- Yes
- No

16a. Please indicate how much hospital food you ate for lunch or dinner TODAY:
- about all
- 1/2
- 1/4
- nothing

16b. The portion size of the meal I ordered TODAY was...
- standard
- smaller
- larger
- I do not know

17. If you did not eat everything of your meal, please tell us why: (mark all that apply)
- I did not like the type of food offered
- I have problems chewing/swallowing
- I did not like the smell/taste of the food
- I normally eat less than what was served
- The food did not fit my cultural/religious preferences
- I had nausea/vomiting
- The food was too hot
- I was too tired
- The food was too cold
- I cannot eat without help
- Due to food allergy/intolerance
- I was not allowed to eat
- I was not hungry at that time
- I had an exam, surgery, or test and missed my meal
- I do not have my usual appetite
- I did not get requested food

18. Enter the number of glasses/cups of the drinks you consumed in the last 24 hours
- Water
- Coffee
- Tea
- Fruit juice
- Milk
- Soft drinks
- Nutrition drink
- Other

19a. Did you eat any food apart from hospital food TODAY?
- Yes
- No

19b. If yes, what did you eat?
- Sweet snacks
- Dairy products
- Salty snacks
- Food delivered/restaurant
- Homemade food
- Sandwich
- Fruits
- Other

20. How has your food intake changed since your hospital admission?
- Increased
- Decreased
- Stayed the same
- I do not know

21. TODAY I feel...
- Stronger than at admission
- Weaker than at admission
- Same as at admission
- I was admitted today
- I do not know

22. Can you walk without assistance TODAY?
- Yes
- No, only with assistance
- No, I stay in bed

23. Did anyone help you complete this questionnaire?
- Yes
- No

THANK YOU!
### Patients list and outcomes (all ND-patients)

#### 30 days OUTCOMES

<table>
<thead>
<tr>
<th>Patient Number</th>
<th>Patient Initials</th>
<th>Discharge Date</th>
<th>Discharge Diagnosis</th>
<th>Outcome</th>
<th>Readmitted since ND</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MA</td>
<td>24.11.2015</td>
<td>J15.212 G89.3 T45.1X5 Z61.12</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

**Outcome Code**

1. Either use full ICD-10 codes or the codes below

Enter up to 6 codes, in the same order as in your records

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0100</td>
<td>Infectious and parasitic diseases</td>
</tr>
<tr>
<td>0200</td>
<td>Neoplasms</td>
</tr>
<tr>
<td>0300</td>
<td>Blood and bloodforming organs and the immune mechanism</td>
</tr>
<tr>
<td>0400</td>
<td>Endocrine, nutritional and metabolic diseases</td>
</tr>
<tr>
<td>0500</td>
<td>Mental health</td>
</tr>
<tr>
<td>0600</td>
<td>Nervous system</td>
</tr>
<tr>
<td>0700</td>
<td>Eye and adnexa</td>
</tr>
<tr>
<td>0800</td>
<td>Ear and mastoid process</td>
</tr>
<tr>
<td>0900</td>
<td>Circulatory system</td>
</tr>
<tr>
<td>1000</td>
<td>Respiratory system</td>
</tr>
<tr>
<td>1100</td>
<td>Digestive system</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1200</td>
<td>Skin and subcutaneous tissue</td>
</tr>
<tr>
<td>1300</td>
<td>Musculoskeletal system and connective tissue</td>
</tr>
<tr>
<td>1400</td>
<td>Genitourinary system</td>
</tr>
<tr>
<td>1500</td>
<td>Pregnancy, childbirth and the puerperium</td>
</tr>
<tr>
<td>1600</td>
<td>Conditions originating in the perinatal period</td>
</tr>
<tr>
<td>1700</td>
<td>Congenital/chromosomal abnormalities</td>
</tr>
<tr>
<td>1800</td>
<td>Symptoms, signs, abnormal clinical/lab findings</td>
</tr>
<tr>
<td>1900</td>
<td>Injury, poisoning</td>
</tr>
<tr>
<td>2000</td>
<td>External causes of morbidity and mortality (e.g. transport accidents, assaults)</td>
</tr>
<tr>
<td>2100</td>
<td>Factors influencing health status and contact with health services</td>
</tr>
</tbody>
</table>

**Readmission Code**

1. No

2. Yes, same hospital planned

3. Yes, same hospital unplanned

4. Yes, different hospital planned

5. Yes, different hospital unplanned

6. Unknown

THANK YOU!
# Patients list and outcomes (all ND-patients)

## 30 days OUTCOMES

### Patients list and outcomes (all ND-patients)

<table>
<thead>
<tr>
<th>Patient Number</th>
<th>Patient Initials</th>
<th>Discharge Date</th>
<th>Discharge Diagnosis</th>
<th>Outcome</th>
<th>Readmitted since ND</th>
</tr>
</thead>
<tbody>
<tr>
<td>...or patient sticker</td>
<td></td>
<td></td>
<td>(see box 1. for codes)</td>
<td>(see box 2. for codes)</td>
<td>(see box 3. for codes)</td>
</tr>
</tbody>
</table>

#### 1. Either use full ICD-10 codes or the codes below

**Enter up to 6 codes, in the same order as in your records**

- 0100 Infectious and parasitic diseases
- 0200 Neoplasms
- 0300 Blood and bloodforming organs and the immune mechanism
- 0400 Endocrine, nutritional and metabolic diseases
- 0500 Mental health
- 0600 Nervous system
- 0700 Eye and adnexa
- 0800 Ear and mastoid process
- 0900 Circulatory system
- 1000 Respiratory system
- 1100 Digestive system
- 1200 Skin and subcutaneous tissue
- 1300 Musculoskeletal system and connective tissue
- 1400 Genitourinary system
- 1500 Pregnancy, childbirth and the puerperium
- 1600 Conditions originating in the perinatal period
- 1700 Congenital/chromosomal abnormalities
- 1800 Symptoms, signs, abnormal clinical/lab findings
- 1900 Injury, poisoning
- 2000 External causes of morbidity and mortality (e.g. transport accidents, assaults)

#### 2. Outcome Code

- 1= Still in the hospital
- 2= Transferred to another hospital
- 3= Transferred to long term care
- 4= Rehabilitation
- 5= Discharged home
- 6= Death
- 7= Others

#### 3. Readmission Code

- 1= No
- 2= Yes, same hospital planned
- 3= Yes, same hospital unplanned
- 4= Yes, different hospital planned
- 5= Yes, different hospital unplanned
- 6= Unknown

**THANK YOU!**