Serratus Anterior Plane Blocks for Rib Fractures in the Emergency Department- the SABRE study

Data Collection Form

Patient demographics					
Data variable number	**Data variable name**	**Type of data**	**Data variable categories or values**	**Definition of data variable**	**Source of data**
	Hospital	Nominal	1= Liverpool 2= St George 3= Orange Base 4= Northern Beaches 5= Campbelltown 6= Sutherland	Hospital patient admitted to	Electronic medical record (EMR)
	Medical record number	Ordinal	Number	Allocated hospital MRN	EMR (Patient information)
	Date of birth	Continuous	DD/MM/YYYY	Patient's date of birth	EMR (Patient information)
	Age	Continuous	YY	Years calculated from DOB (rounded down)	Calculated
	Gender	Nominal	1= Male 2= Female 99= Unknown	Patient gender	EMR (Patient information)
	Weight	Continuous	Number/Unknown	Weight of patient in kg, measured at enrolment	EMR (Patient information)
	Height	Continuous	Number/Unknown	Height of patient in cm, measured at enrolment	EMR (Patient information)
	BMI	Continuous	Number/Unknown	kg/m^2	Calculated
	Time of hospital arrival	Continuous	DD/MM/YY HH:MM	Date & time recorded of hospital arrival	EMR (Clinical notes)
	Time of study enrolment	Continuous	DD/MM/YY HH:MM	Date & time of enrolment	Clinician enrolment form
Past medical history & requirements for Charlson Comorbidity Index					
	Smoking status	Nominal	1= Yes 2= No 99= Unknown/not documented	Current smoker	Clinician enrolment form
	Myocardial infarction	Nominal	1= Yes 2= No 99= Unknown/not documented	History of definite or probable MI (ECG changes and/or enzyme changes)	Clinician enrolment form
	Congestive heart failure	Nominal	1= Yes 2= No 99= Unknown/not documented	Exertional or paroxysmal nocturnal dyspnea and has responded to digitalis, diuretics, or afterload reducing agents	Clinician enrolment form

	Peripheral vascular disease	Nominal	1= Yes 2= No 99= Unknown/not documented	Intermittent claudication or past bypass for chronic arterial insufficiency, history of gangrene or acute arterial insufficiency, or untreated thoracic or abdominal aneurysm (≥6 cm)	Clinician enrolment form
	CVA or TIA	Nominal	1= Yes 2= No 99= Unknown/not documented	History of a cerebrovascular accident with minor or no residua and transient ischemic attacks	Clinician enrolment form
	Dementia	Nominal	1= Yes 2= No 99= Unknown/not documented	Chronic cognitive deficit	Clinician enrolment form
	COPD	Nominal	1= Yes 2= No 99= Unknown/not documented	History of chronic obstructive lung disease	Clinician enrolment form
	Connective tissue disease	Nominal	1= Yes 2= No 99= Unknown/not documented	History of connective tissue disease	Clinician enrolment form
	Peptic ulcer disease	Nominal	1= Yes 2= No 99= Unknown/not documented	Any history of treatment for ulcer disease or history of ulcer bleeding	Clinician enrolment form
	Liver disease	Nominal	0= None 1= Mild 3= Moderate to Severe 99= Unknown/not documented	Severe = cirrhosis and portal hypertension with variceal bleeding history, moderate = cirrhosis and portal hypertension but no variceal bleeding history, mild = chronic hepatitis (or cirrhosis without portal hypertension). If details aren't available to determine severity - select ‘mild’.	Clinician enrolment form
	Diabetes mellitus	Nominal	0= None or diet-controlled 1= Uncomplicated 2= End-organ damage 99= Unknown/not documented	History of diabetes	Clinician enrolment form
	Hemiplegia	Nominal	0= No 2= Yes 99= Unknown/not documented	Established hemiplegia	Clinician enrolment form
	Moderate to severe CKD	Nominal	0= No 2= Yes 99= Unknown/not documented	Severe = on dialysis, status post kidney transplant, uremia, moderate = creatinine >270 umol/L. If details aren't available to determine severity - select ‘no’.	Clinician enrolment form
	Solid tumour	Nominal	0= No 2= Localised 6= Metastatic 99= Unknown/not documented	History of solid organ malignancy	Clinician enrolment form
	Leukaemia	Nominal	0= No	History of leukaemia	Clinician enrolment

			2= Yes 99= Unknown/not documented		form
	Lymphoma	Nominal	0= No 2= Yes 99= Unknown/not documented	History of lymphoma	Clinician enrolment form
	AIDS	Nominal	0= No 6= Yes 99= Unknown/not documented	History of HIV/AIDS	Clinician enrolment form
	Charlson Comorbidity index	Continuous	Number/Unknown	Score	Calculated
	Prior/chronic opiate use	Nominal	1= Yes 2= No 99= Unknown/not documented	Daily use of opiate medications	Clinician enrolment form
Details of injury					
	Time of injury	Continuous	DD/MM/YY HH:MM	Date & time of injury	Clinician enrolment form
	Mechanism of injury	Nominal	1= Fall (standing) 2= Fall (from height) 3= Road traffic collision 4= Pedestrian 5= Pedal cyclist 6= Assault 7= Sport/Recreational 8= Industrial 99= Unknown/not documented	Predominant mechanism of injury. 'Road traffic collision' = any mechanism where patient was driver/passenger of car/motorbike/bus/truck. 'Pedestrian' = person struck by vehicle. 'Pedal cyclist' = patient riding push-bike at time of injury. 'Assault' = injury relating to interpersonal violence. 'Sport/Recreational' = injury relating to organised sport or recreational activity incl. struck by bat/racket/ball, non-powered aircraft, horse/equestrian. 'Industrial' = non-fall, workplace injuries including crush, explosion, machines-related, electrical/gas-powered equipment.	EMR (Clinical history)
	Side of chest injury	Nominal	1= Left 2= Right 3= Bilateral 99= Unknown/not documented	Reported side of chest injury (pain, tenderness, radiological abnormality)	EMR (Clinical history)
	Rib fractures visible on CXR	Nominal	1= Yes 2= No 3= Not reported 4= CXR not performed	Based on consultant radiologist report on initial CXR	EMR (Medical imaging)
	Chest CT performed	Nominal	1= Yes 2= No	CT scan of the chest performed from the emergency department	EMR (Medical imaging)
	Side of radiological injury	Nominal	1= Left 2= Right 3= Bilateral 99= Unknown/not documented	Reported side of chest injury on CT report	EMR (Medical imaging)

	Number of LEFT rib fractures on CT	Ordinal	0-12	Based on consultant radiologist report on initial Chest CT	EMR (Medical imaging)
	Number of RIGHT rib fractures on CT	Ordinal	0-12	Based on consultant radiologist report on initial Chest CT	EMR (Medical imaging)
	Flail segment	Nominal	1= Yes 2= No 99= Not reported	Based on consultant radiologist report on initial Chest CT	EMR (Medical imaging)
	Pneumothorax	Nominal	1= Yes 2= No 99= Not reported	Based on consultant radiologist report on initial Chest CT	EMR (Medical imaging)
	Haemothorax	Nominal	1= Yes 2= No 99= Not reported	Based on consultant radiologist report on initial Chest CT	EMR (Medical imaging)
	Atelectasis	Nominal	1= Yes 2= No 99= Not reported	Based on consultant radiologist report on initial Chest CT	EMR (Medical imaging)
	Injury Severity Score (ISS)	Ordinal	1-75	As recorded in local trauma registry (leave *blank* if not available locally)	Collector (Trauma registry)
	AIS (thoracic injuries)	Nominal	1= Mild 2= Moderate 3= Serious 4= Severe 5= Critical 6= Maximal	Final score recorded in local trauma registry	Collector (Trauma registry)
	Tube thoracostomy	Nominal	1= Yes 2= No 99= Unknown/not documented	Chest drain placed in the emergency department	EMR (Clinical history)
	Pneumothorax size estimate	Ordinal	1-100	As reported by Collins method % = 4.2 + 4.7 (A + B + C) A is the maximum apical interpleural distance B is the interpleural distance at midpoint of upper half of lung C is the interpleural distance at midpoint of lower half of lung	EMR (Medical imaging)
Details of SAPB					
	Serratus anterior plane block performed	Nominal	1= Yes 2= No	SAPB performed in the Emergency Department	Clinician enrolment form
	Reason for SAPB not being performed	Nominal	1= Patient declined 2= Trained clinician not available 3= Overwhelmed department 4= Clinician thought SAPB not suitable or appropriate 5= Other	The reason why a SAPB was not performed in Emergency Department	Clinician enrolment form
	Time of block	Continuous	DD/MM/YY HH:MM	Date & time of SAPB	Clinician enrolment form or EMR (pre-completed
	Hemithorax	Nominal	1= Left 2= Right 3= Both	Side of thorax receiving SAPB	EMR (pre-completed note)

	Plane of block	Nominal	1= Superficial 2= Deep	Plane utilised by clinician during SAPB	EMR (pre-completed note)
	Local anaesthetic agent used	Nominal	1= Ropivacaine 2= Bupivacaine 3= Other	Agent used in SAPB	Clinician enrolment form or EMR (pre-completed note)
	Local anaesthetic dose	Continuous	Number	Number of milligrams of local anaesthetic administered	Clinician enrolment form or EMR (pre-completed note)
	Volume administered	Continuous	Number	Total volume administered in block (mL)	Clinician enrolment form or EMR (pre-completed note)
Pain management details					
	Regular paracetamol prescribed	Nominal	1= Yes 2= No 99= Unknown/not documented	Regular paracetamol ordered by treating physician	Medication chart
	Regular NSAID prescribed	Nominal	1= Yes 2= No 99= Unknown/not documented	Regular NSAID ordered by treating physician	Medication chart
	Other analgesics prescribed	Nominal	0= None 1= Pregabalin 2= Gabapentin 3= Other 99= Unknown/not documented	Other regular analgesic medication ordered by treating physician	Medication chart
	Non-PCA opiate prescribed	Nominal	1= Yes 2= No	Regular non-PCA opiate ordered by treating physician	Medication chart
	Opiate medications chosen	Nominal	1= Oxycodone (Endone) 2= Oxycontin (slow-release) 3= Morphine (MS Contin) 4= Targin 5= Tapentadol 6= Tramadol	Choose all that apply	Medication chart
	Cumulative Non-PCA opiate dose (4 hours)	Continuous	Number	Cumulated dose of *each* non-PCA opiate for first four hours of use (milligrams)	Medication chart
	Converted Non-PCA opiate dose (4 hours)	Continuous	Number	Converted (MME) dose of *each* non-PCA opiate and overall total for first four hours of use (milligrams of oral morphine) utilising https://www.eviq.org.au/clinical-resources/eviq-calculators/3201-opioid-conversion-calculator	Medication chart
	Cumulative Non-PCA opiate dose (12 hours)	Continuous	Number	Cumulated dose of *each* non-PCA opiate for first 12 hours of use (milligrams)	Medication chart
	Converted Non-PCA	Continuous	Number	Converted (MME) dose of *each*	Medication chart

	opiate dose (12 hours)			non-PCA opiate and overall total for first 12 hours of use (milligrams of oral morphine) utilising https://www.eviq.org.au/clinical-resources/eviq-calculators/3201-opioid-conversion-calculator	
	Cumulative Non-PCA opiate dose (24 hours)	Continuous	Number	Cumulated dose of *each* non-PCA opiate for first 24 hours of use (milligrams)	Medication chart
	Converted Non-PCA opiate dose (24 hours)	Continuous	Number	Converted (MME) dose of *each* non-PCA opiate and overall total for first 24 hours of use (milligrams of oral morphine) utilising https://www.eviq.org.au/clinical-resources/eviq-calculators/3201-opioid-conversion-calculator	Medication chart
	PCA prescribed	Nominal	1= Yes 2= No	PCA prescribed by treating physician	PCA chart (SMR130025)
	PCA drug chosen	Nominal	1= Fentanyl 2= Morphine 3= Oxycodone 4= Other	Drug used in PCA syringe	PCA chart (SMR130025)
	Time PCA commenced	Continuous	DD/MM/YY HH:MM	Date & time PCA commenced	PCA chart (SMR130025)
	Baseline pain score	Ordinal	0-10	Verbally administered numerical rating scale or PAINAD score in setting of dementia (out of 10) at time of study enrolment	Clinician enrolment form or PCA chart (SMR130025) or observation chart
	Pain score (PCA commenced)	Ordinal	0-10	Verbally administered numerical rating scale or PAINAD score in setting of dementia (out of 10) at time PCA commenced	Clinician enrolment form or PCA chart (SMR130025) or observation chart
	Pain score (time of SAPB)	Ordinal	0-10	Verbally administered numerical rating scale or PAINAD score in setting of dementia (out of 10) at time SAPB administered	Clinician enrolment form or PCA chart (SMR130025) or observation chart
	Time (30 minutes post enrolment)	Continuous	DD/MM/YY HH:MM	Date & time (30 minutes post-enrolment)	Clinician enrolment form or PCA chart (SMR130025) or observation chart
	Pain score (30 minutes post enrolment)	Ordinal	0-10	Verbally administered numerical rating scale or PAINAD score in setting of dementia (out of 10) 30 minutes post study enrolment	Clinician enrolment form or PCA chart (SMR130025) or observation chart
	Time (1 hour post enrolment)	Continuous	DD/MM/YY HH:MM	Date & time (1 hour post-enrolment)	Clinician enrolment form or PCA chart (SMR130025) or observation chart
	Pain score (1 hour post enrolment)	Ordinal	0-10	Verbally administered numerical rating scale or PAINAD score in setting of dementia (out of 10) one hour post study enrolment	Clinician enrolment form or PCA chart (SMR130025) or observation chart
	Time (2 hour post enrolment)	Continuous	DD/MM/YY HH:MM	Date & time (2 hour post-enrolment)	Clinician enrolment form or PCA chart (SMR130025) or

					observation chart
	Pain score (2 hours post enrolment)	Ordinal	0-10	Verbally administered numerical rating scale or PAINAD score in setting of dementia (out of 10) two hours post study enrolment	Clinician enrolment form or PCA chart (SMR130025) or observation chart
	Time (3 hour post enrolment)	Continuous	DD/MM/YY HH:MM	Date & time (3 hour post-enrolment)	Clinician enrolment form or PCA chart (SMR130025) or observation chart
	Pain score (3 hours post enrolment)	Ordinal	0-10	Verbally administered numerical rating scale or PAINAD score in setting of dementia (out of 10) three hours post study enrolment	Clinician enrolment form or PCA chart (SMR130025) or observation chart
	Time (4 hour post enrolment)	Continuous	DD/MM/YY HH:MM	Date & time (4 hour post-enrolment)	Clinician enrolment form or PCA chart (SMR130025) or observation chart
	Pain score (4 hours post enrolment)	Ordinal	0-10	Verbally administered numerical rating scale or PAINAD score in setting of dementia (out of 10) four hours post study enrolment	Clinician enrolment form or PCA chart (SMR130025) or observation chart
	Time (6 hour post enrolment)	Continuous	DD/MM/YY HH:MM	Date & time (6 hour post-enrolment)	Clinician enrolment form or PCA chart (SMR130025) or observation chart
	Pain score (6 hours post enrolment)	Ordinal	0-10	Verbally administered numerical rating scale or PAINAD score in setting of dementia (out of 10) six hours post study enrolment	Clinician enrolment form or PCA chart (SMR130025) or observation chart
	Time (8 hour post enrolment)	Continuous	DD/MM/YY HH:MM	Date & time (8 hour post-enrolment)	Clinician enrolment form or PCA chart (SMR130025) or observation chart
	Pain score (8 hours post enrolment)	Ordinal	0-10	Verbally administered numerical rating scale or PAINAD score in setting of dementia (out of 10) eight hours post study enrolment	Clinician enrolment form or PCA chart (SMR130025) or observation chart
	Time (10 hour post enrolment)	Continuous	DD/MM/YY HH:MM	Date & time (10 hour post-enrolment)	Clinician enrolment form or PCA chart (SMR130025) or observation chart
	Pain score (10 hours post enrolment)	Ordinal	0-10	Verbally administered numerical rating scale or PAINAD score in setting of dementia (out of 10) ten hours post study enrolment	Clinician enrolment form or PCA chart (SMR130025) or observation chart
	Time (12 hour post enrolment)	Continuous	DD/MM/YY HH:MM	Date & time (12 hour post-enrolment)	Clinician enrolment form or PCA chart (SMR130025) or observation chart
	Pain score (12 hours post enrolment)	Ordinal	0-10	Verbally administered numerical rating scale or PAINAD score in setting of dementia (out of 10) twelve hours post study enrolment	Clinician enrolment form or PCA chart (SMR130025) or observation chart
	Time (16 hour post	Continuous	DD/MM/YY HH:MM	Date & time (16 hour	Clinician enrolment

	enrolment)			post-enrolment)	form or PCA chart (SMR130025) or observation chart
	Pain score (16 hours post enrolment)	Ordinal	0-10	Verbally administered numerical rating scale or PAINAD score in setting of dementia (out of 10) sixteen hours post study enrolment	Clinician enrolment form or PCA chart (SMR130025) or observation chart
	Time (20 hour post enrolment)	Continuous	DD/MM/YY HH:MM	Date & time (20 hour post-enrolment)	Clinician enrolment form or PCA chart (SMR130025) or observation chart
	Pain score (20 hours post enrolment)	Ordinal	0-10	Verbally administered numerical rating scale or PAINAD score in setting of dementia (out of 10) twenty hours post study enrolment	Clinician enrolment form or PCA chart (SMR130025) or observation chart
	Time (24 hour post enrolment)	Continuous	DD/MM/YY HH:MM	Date & time (24 hour post-enrolment)	Clinician enrolment form or PCA chart (SMR130025) or observation chart
	Pain score (24 hours post enrolment)	Ordinal	0-10	Verbally administered numerical rating scale or PAINAD score in setting of dementia (out of 10) twenty four hours post study enrolment	Clinician enrolment form or PCA chart (SMR130025) or observation chart
	PCA use; attempts/successful (1 hour post enrolment)	Continuous	Number	Number of PCA attempts & successful doses administered, one hour post study enrolment	PCA chart (SMR130025)
	PCA use; attempts/successful (2 hour post enrolment)	Continuous	Number	Number of PCA attempts & successful doses administered, two hours post study enrolment	PCA chart (SMR130025)
	PCA use; attempts/successful (3 hour post enrolment)	Continuous	Number	Number of PCA attempts & successful doses administered, three hours post study enrolment	PCA chart (SMR130025)
	PCA use; attempts/successful (4 hour post enrolment)	Continuous	Number	Number of PCA attempts & successful doses administered, four hour post study enrolment	PCA chart (SMR130025)
	PCA use; attempts/successful (6 hour post enrolment)	Continuous	Number	Number of PCA attempts & successful doses administered, six hour post study enrolment	PCA chart (SMR130025)
	PCA use; attempts/successful (8 hour post enrolment)	Continuous	Number	Number of PCA attempts & successful doses administered, eight hour post study enrolment	PCA chart (SMR130025)
	PCA use; attempts/successful (10 hour post enrolment)	Continuous	Number	Number of PCA attempts & successful doses administered, ten hour post study enrolment	PCA chart (SMR130025)
	PCA use; attempts/successful (12 hour post enrolment)	Continuous	Number	Number of PCA attempts & successful doses administered, twelve hour post study enrolment	PCA chart (SMR130025)
	PCA use; attempts/successful (16 hour post enrolment)	Continuous	Number	Number of PCA attempts & successful doses administered, sixteen hour post study enrolment	PCA chart (SMR130025)
	PCA use; attempts/successful (20	Continuous	Number	Number of PCA attempts & successful doses administered,	PCA chart (SMR130025)

	hour post enrolment)			twenty hour post study enrolment	
	PCA use; attempts/successful (24 hour post enrolment)	Continuous	Number	Number of PCA attempts & successful doses administered, twenty four hour post study enrolment	PCA chart (SMR130025)
	Cumulative PCA dose (4 hours)	Continuous	Number	Cumulated dose of PCA opiate for first four hours of use	PCA chart (SMR130025)
	Converted PCA opiate dose (4 hours)	Continuous	Number	Converted (MME) dose of *each* non-PCA opiate for first four hours of use (milligrams of oral morphine) utilising https://www.eviq.org.au/clinical-resources/eviq-calculators/3201-opioid-conversion-calculator	PCA chart (SMR130025)
	Cumulative PCA dose (12 hours)	Continuous	Number	Cumulated dose of PCA opiate for first 12 hours of use	PCA chart (SMR130025)
	Converted PCA opiate dose (12 hours)	Continuous	Number	Converted (MME) dose of *each* non-PCA opiate for first 12 hours of use (milligrams of oral morphine) utilising https://www.eviq.org.au/clinical-resources/eviq-calculators/3201-opioid-conversion-calculator	PCA chart (SMR130025)
	Cumulative PCA dose (24 hours)	Continuous	Number	Cumulated dose of PCA opiate for first 24 hours of use	PCA chart (SMR130025)
	Converted PCA opiate dose (24 hours)	Continuous	Number	Converted (MME) dose of *each* non-PCA opiate for first 24 hours of use (milligrams of oral morphine) utilising https://www.eviq.org.au/clinical-resources/eviq-calculators/3201-opioid-conversion-calculator	PCA chart (SMR130025)
	Time PCA ceased	Continuous	DD/MM/YY HH:MM	Date & time PCA ceased	PCA chart (SMR130025)
	Time on PCA	Continuous	Number	No. of days (to 1 decimal place)	Calculated
	In-patient regional anaesthesia administered	Nominal	1= Yes 2= No 99= Unknown/not documented	Further regional anaesthesia provided by in-patient pain services (incl. catheter techniques)	EMR (Clinical notes)
	In-patient regional anaesthesia details	Nominal	1= SAPB 2= Erector spinae block 3= Paravertebral block 4= Other	Details of further regional anaesthesia provided by in-patient pain services (incl. catheter techniques)	EMR (Clinical notes)
	Naloxone use	Nominal	1= Yes 2= No 99= Unknown/not documented	Opiate reversal administered by treating clinicians	PCA chart (SMR130025)
	Local anaesthetic systemic toxicity (LAST)	Nominal	1= Yes 2= No 99= Unknown/not documented	LAST symptoms defined by severe neurologic or cardiovascular symptoms within one hour of local anaesthetic administration (eg. perioral tingling, twitching/seizures, agitation/coma, ventricular	Clinician enrolment form or EMR (pre-completed SAPB note or progress notes)

				dysrhythmias, heart block or cardiovascular collapse)	
	Delirium screening	Ordinal	0-12	4+: possible delirium +/- cognitive impairment; 1-3: possible cognitive impairment; 0: delirium or severe cognitive impairment unlikely	4AT delirium screening tool
Respiratory complications					
	Non-invasive ventilation	Nominal	1= Yes 2= No 99= Unknown/not documented	NIV commenced during first seven days of admission	EMR (Clinical notes)
	Time NIV commenced	Continuous	DD/MM/YY HH:MM	Date & time that non-invasive ventilation commenced	EMR (Clinical notes)
	Invasive mechanical ventilation	Nominal	1= Yes 2= No 99= Unknown/not documented	Intubated for respiratory failure (hypoxia, hypercarbia or fatigue) during first seven days of admission	EMR (Clinical notes)
	Time of intubation	Continuous	DD/MM/YY HH:MM	Date & time that patient is intubated	EMR (Clinical notes)
	Time of extubation	Continuous	DD/MM/YY HH:MM	Date & time that patient is extubated	EMR (Clinical notes)
	Ventilator free days	Continuous	Number	No. of days (to 1 decimal place)	Calculated
	New consolidation on CXR	Nominal	1= Yes 2= No 99= Unknown/not documented	During first seven days of admission, as reported by consultant radiologist	EMR (Medical imaging)
	Antibiotics	Nominal	1= Yes 2= No 99= Unknown/not documented	Prescribed by treating clinicians for presumed pneumonia	Medication charts
Outcomes					
	Time of ICU admission	Continuous	DD/MM/YY HH:MM	Date & time recorded of ICU admission	EMR (Clinical notes)
	Time of ICU discharge	Continuous	DD/MM/YY HH:MM	Date & time recorded of ICU discharge	EMR (Clinical notes)
	Time of hospital discharge	Continuous	DD/MM/YY HH:MM	Date & time recorded of hospital discharge	EMR (Clinical notes)
	ICU LOS	Continuous	Number	No. of days (to 1 decimal place)	Calculated
	Hospital LOS	Continuous	Number	No. of days (to 1 decimal place)	Calculated
	30-day mortality	Nominal	1= Alive 2= Dead 99= Unknown/not documented	Dead or alive at 30 days from hospital admission	EMR (Clinical notes)
	QOL at 30 days	Ordinal	As per EQ-5D-5L	Quality of Life at 30 days post-injury	EQ-5D-5L
	DRG list	List	Codes	Diagnostic Related Group listing for admission related to injury	EMR (Clinical notes)