2009 ASC

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

Form Approved: OMB No. 0920-0278

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National Hospital Ambulatory Medical Care Survey

2009 Ambulatory Surgery Center Patient Record Folio

Hospital ID	REPORTING PERIOD	FROM: Month ☐☐ Day ☐☐ TO Month ☐☐ Day ☐☐
Ambulatory Unit Number	Start with the ☐☐ Patient. Take every ☐☐ Patient.	

Please return the whole Folio with both the completed and blank forms at the completion of the survey period. Thank you!

		Mon.	Tues.	Wed.	Thur.	Fri.	Sat.	Sun.	Total
WEEK 1	Dates								
	No. of patient visits								
	No. of records filled								
WEEK 2	Dates								
	No. of patient visits								
	No. of records filled								
WEEK 3	Dates								
	No. of patient visits								
	No. of records filled								
WEEK 4	Dates								
	No. of patient visits								
	No. of records filled								

Notice – Public reporting burden for this collection of information is estimated to average 6 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a current valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing burden to: CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road, MS E-11, Atlanta, GA 30333, ATTN: PRA (0920-XXXX).

FORM **NHAMCS-100(ASC)** (7-11-2008)

USCENSUSBUREAU

U. S. DEPARTMENT OF COMMERCE
Economics and Statistics Administration
U.S. CENSUS BUREAU
ACTING AS DATA COLLECTION AGENT FOR
U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for Health Statistics

GENERAL INSTRUCTIONS

See card in pocket for instructions on how to complete Patient Record.

REPORTING DATES

Your reporting dates are:

Monday, _____ **through Sunday,** _____

PATIENT SIGN-IN SHEET

Record the name of every patient seen during the Reporting Period on a Sign-In Sheet maintained in each area of the ambulatory surgery center. Record each patient in the order registered by your receptionist or seen by the provider. If two or more patients are seen during a single provider visit, the patients should be listed in the sequence registered or the sequence seen. It is important to record every patient visit including those not seen by the provider but attended to by the staff. Patients who visit more than once during the reporting period should be recorded on the Sign-In Sheet at each visit.

PATIENT RECORD

Follow the Sampling Pattern below to determine for which visit(s) a Patient Record should be completed.

START WITH: _____ **TAKE EVERY:** _____

The START WITH designates the FIRST PATIENT for whom a patient record should be completed. The TAKE EVERY designates every patient thereafter for whom a patient record should be completed. For example, for a Start With of 2 and Take Every of 3, a patient record will be completed for the second patient listed on the ambulatory surgery center Sign-In Sheet and every third patient listed thereafter (e.g., 2, 5, 8, etc.). It is essential that the Take Every Number is extended each day from one Sign-In Sheet to another. For example, If your ambulatory surgery center uses a new Sign-In Sheet each day, then the Take Every Number has to be extended from the last patient visit selected on Monday to the new list on Tuesday. If a single Sign-In Sheet is used the entire reporting period, then the Take Every simply needs to be extended as new patient names are added to the list.

Please refer to the NHAMCS-126 Instruction Book for more detailed information on the sampling pattern.

DEFINITIONS

For purposes of this study:

1. An *ambulatory patient* is an individual presenting for personal health services, not currently admitted to any health care institution on the premises. **Include** patients the physician sees; and patients the physician does not see but who receive care from a physician assistant, nurse, nurse practitioner, etc. **Exclude** persons who visit only for administrative reasons, such as to complete an insurance form; patients who do not seek care or services (e.g., pick up a prescription or leave a specimen); persons currently admitted as inpatients to the hospital **(nursing home patients should be included, however)**; and telephone contacts with patients.
2. A *visit* is a direct, personal exchange between an ambulatory patient and a physician or hospital staff under a physician's supervision for the purpose of seeking care and rendering personal health services.

DISPOSITION OF MATERIALS

As each Patient Record is completed, place the combined form (Patient Log and Patient Record) in the pocket of the kit. At the end of each day scan all forms to be sure they are properly completed, verify that the total number of completed Patient Records equals the number appearing on the last completed Patient Record. Check pages of the Patient Log against other record(s) (e.g., appointment book, billing records) to assure that every patient visit was recorded on the Patient Log. At the end of the period, detach patient's name, place all Patient Records and all unused materials in the postage paid envelope provided and mail to the interviewer. (DO *NOT* RETURN THE DETACHED PAGES OF THE PATIENT RECORD THAT CONTAIN THE PATIENT'S NAME).

FIELD REP

In case of questions or difficulty, please call the Field Representative collect:

Name

Phone Number

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NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY
2009 AMBULATORY SURGERY CENTER PATIENT RECORD

PATIENT RECORD NO.:

PATIENT'S NAME:

Assurance of confidentiality – All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used only by NCHS staff, contractors, and agents only when required and with necessary controls, and will not be disclosed or released to other persons without the consent of the individual or establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347).

(Provider: Detach and keep upper portion)

Please keep (X) marks inside of boxes ➜ ☒ Correct ☒ Incorrect

1. PATIENT INFORMATION

a. Date of visit

Month		Day		Year			
				2	0	0	

b. ZIP Code

c. Date of birth

Month		Day		Year			

d. Sex
1 ☐ Female 2 ☐ Male

e. Ethnicity
1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino

f. Race – *Mark (X) all that apply.*
1 ☐ White
2 ☐ Black or African American
3 ☐ Asian
4 ☐ Native Hawaiian or Other Pacific Islander
5 ☐ American Indian or Alaska Native

g. Expected source(s) of payment for this visit – *Mark (X) all that apply.*
1 ☐ Private insurance
2 ☐ Medicare
3 ☐ Medicaid/SCHIP
4 ☐ Worker's compensation
5 ☐ Self-pay
6 ☐ No charge/Charity
7 ☐ Other
8 ☐ Unknown

h. Time

(1) Time in to operating room . . . . . ☐☐:☐☐ ☐ a.m. ☐ p.m. ☐ Military

(2) Time surgery began . . . . . ☐☐:☐☐ ☐ a.m. ☐ p.m. ☐ Military

(3) Time surgery ended . . . . . ☐☐:☐☐ ☐ a.m. ☐ p.m. ☐ Military

(4) Time out of operating room . . . . ☐☐:☐☐ ☐ a.m. ☐ p.m. ☐ Military

(5) Time in to postoperative care . . ☐☐:☐☐ ☐ a.m. ☐ p.m. ☐ Military

(6) Time out of postoperative care . . ☐☐:☐☐ ☐ a.m. ☐ p.m. ☐ Military

2. FINAL DIAGNOSIS

As specifically as possible, list all diagnoses related to this visit.

Optional – ICD-9-CM Code

Primary: **1.**
Other: **2.**
Other: **3.**
Other: **4.**
Other: **5.**

3. EXTERNAL CAUSE OF INJURY

As specifically as possible, describe the injury that preceded the visit or adverse effect that occurred during the visit.

☐ NONE

Optional – E-Code

4. PROCEDURE(S)

As specifically as possible, list all diagnostic and surgical procedures performed during this visit.

☐ NONE

Optional – CPT-4 Codes

Optional – ICD-9-CM-Codes

Primary: **1.**
Other: **2.**
Other: **3.**
Other: **4.**
Other: **5.**

PLEASE CONTINUE ON THE REVERSE SIDE

5. MEDICATION(S) & ANESTHESIA

a. Include Rx and OTC drugs, anesthetics, and oxygen that were ordered, supplied, or administered during the visit or at discharge.

☐ NONE

		During this visit	At discharge
(1)		1 ☐	2 ☐
(2)		1 ☐	2 ☐
(3)		1 ☐	2 ☐
(4)		1 ☐	2 ☐
(5)		1 ☐	2 ☐
(6)		1 ☐	2 ☐
(7)		1 ☐	2 ☐
(8)		1 ☐	2 ☐

b. Types of anesthesia – *Mark (X) all that apply.*

1 ☐ NONE
2 ☐ General
3 ☐ IV sedation
4 ☐ MAC (Monitored Anesthesia Care)

Regional
5 ☐ Topical/Local
6 ☐ Epidural
7 ☐ Spinal
8 ☐ Retrobulbar block
9 ☐ Peribulbar block
10 ☐ Other block

11 ☐ Other

6. PROVIDER(S) OF ANESTHESIA

Anesthesia administered by – *Mark (X) all that apply.*

1 ☐ Anesthesiologist
2 ☐ CRNA (Certified Registered Nurse Anesthetist)
3 ☐ Surgeon/Other physician
4 ☐ Unknown

7. SYMPTOM(S) PRESENT DURING OR AFTER PROCEDURE

Mark (X) all that apply.

1 ☐ NONE
2 ☐ Apnea
3 ☐ Bleeding/Hemorrhage
4 ☐ Difficulty waking up
5 ☐ Dysrhythmia/Arrhythmia
6 ☐ Hypertension/High blood pressure
7 ☐ Hypotension/Low blood pressure
8 ☐ Hypoxia
9 ☐ Incontinence
10 ☐ Nausea
11 ☐ Vomiting
12 ☐ Other

8. DISPOSITION

Mark (X) the appropriate box.

1 ☐ Routine discharge to customary residence
2 ☐ Discharge to observation status
3 ☐ Discharge to post-surgical/recovery care facility
4 ☐ Admitted to hospital as inpatient
5 ☐ Referred to ED
6 ☐ Surgery terminated
7 ☐ Other
8 ☐ Unknown

9. FOLLOW-UP INFORMATION

	Yes	No	Unknown
a. Did someone attempt to follow-up with the patient within 24 hours after the surgery?	1 ☐	2 ☐	3 ☐

b. What was learned from this follow-up?
Mark (X) all that apply.

1 ☐ Unable to reach patient
2 ☐ Patient reported no problems
3 ☐ Patient reported problems and sought medical care
4 ☐ Patient reported problems and was advised by ASC staff to seek medical care
5 ☐ Patient reported problems, but no follow-up medical care was needed
6 ☐ Other
7 ☐ Unknown