

FORM NHAMCS-101(U) (6-12-2008)	U.S. DEPARTMENT OF COMMERCE Economics and Statistics Administration U.S. CENSUS BUREAU ACTING AS DATA COLLECTION AGENT FOR THE U.S. Department of Health and Human Services Centers for Disease Control and Prevention National Center for Health Statistics	NOTICE - Public reporting burden of this collection of information is estimated to average 60 minutes per response, including the 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 currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0278).
AMBULATORY UNIT RECORD National Hospital Ambulatory Medical Care Survey 2009 Panel		

Assurance of confidentiality - All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used by persons engaged in and for the purpose of the survey and will not be disclosed or released to other persons or used for any other purpose without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m).

COMPLETE THIS RECORD FOR EACH AMBULATORY UNIT SELECTED

Section A - AMBULATORY UNIT INFORMATION

a. Is this ambulatory unit part of an emergency or outpatient department?

1 ED - Mark (X) type → 1 General 2 Adult 3 PED 4 Urgi-/Fast track 5 PSYC 6 Trauma 7 Other

2 OPD - Mark (X) specialty → 1 GM 2 SURG 3 PED 4 OBG 5 Substance Abuse 6 Other

3 ASC

b. AU No. _____ of _____ Total AU's sampled within the ED or OPD or ASC	c. Hospital number	d. Hospital name
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1. Enter the name of the (emergency service area/clinic/ASC).	Name
2. Where is the (emergency service area/clinic/ASC) located?	Address (Number and street)
1 <input type="checkbox"/> Onsite at hospital 2 <input type="checkbox"/> Elsewhere - Specify →	City/State ZIP Code
3. What is the name and telephone number of the director of the (emergency service area/clinic/ASC)?	Name
	Telephone (Area code and number)

CHECK ITEM A-1 Is this an OPD Clinic whose specialty is **GM** or **OBG** or **PED**?
 1 Yes, Continue to Item 4 2 No, Skip to CHECK ITEM A-2

4. Does this clinic predominantly provide primary care?
 1 Yes 2 No 3 Unknown

CHECK ITEM A-2 Is this an OPD Clinic whose specialty is **GM** or **OBG**?
 1 Yes, Continue to Item 5 2 No, Skip to Section B

5. Does this clinic offer any type of cervical cancer screening?

906 Eligibility
1 <input type="checkbox"/> Yes - Leave NHAMCS-906 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown

Section B - SAMPLE INFORMATION

1. Take every number	4. Total estimated number of visits during reporting period for ENTIRE department	
2. Random start number	5. REPORTING PERIOD (Month/Day/Year) From: / / To: / /	
3. Estimated number of visits in this AU during reporting period		
From the Sampling Plan: <i>If a sampling plan is not required, item 6 is the AU No. from Section A, item b. Items 7 and 8 are each 1.</i>	6. SU number	7. Numerator
		8. Denominator

9. What was the total number of patient visits to this AU from (dates specified in B5)? (Refer to patient logs, etc. Ask if necessary. DO NOT LEAVE TOTAL BLANK. BE AS COMPLETE AND ACCURATE AS POSSIBLE.)	NUMBER OF VISITS				
	Week 1	Week 2	Week 3	Week 4	TOTAL
	/ - /	/ - /	/ - /	/ - /	

10. How many patient record forms were filled out for this AU (emergency service area/clinic/ASC)?	NUMBER OF FORMS				
	Week 1	Week 2	Week 3	Week 4	TOTAL

Section C – EMERGENCY SERVICES/OUTPATIENT CLINIC INFORMATION AND LOGS

1. What are the usual operating hours of this unit?

Day(s) (a)	Time (b)		Mark (X) ONLY one				
			Open 24 hours (c)	Not open (d)	Hours vary (e)		
Monday	FROM	a.m. p.m.	TO	a.m. p.m.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Tuesday	FROM	a.m. p.m.	TO	a.m. p.m.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Wednesday	FROM	a.m. p.m.	TO	a.m. p.m.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Thursday	FROM	a.m. p.m.	TO	a.m. p.m.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Friday	FROM	a.m. p.m.	TO	a.m. p.m.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Saturday	FROM	a.m. p.m.	TO	a.m. p.m.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Sunday	FROM	a.m. p.m.	TO	a.m. p.m.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

Section D – VERIFICATION OF ESTIMATED VISITS

Verify with ED/Clinic/ASC director BEFORE data collection begins (and records have been pulled).

1. According to our information, about (Number from B-3) patient visits are expected during the reporting period. Do you agree with this estimate?

- 1 Yes – SKIP to section F, page 3
2 No

2. About how many visits do you expect during the reporting period, _____ to _____?

Revised estimate

Determine if new Take Every and Random Start numbers must be calculated for this ESA/clinic/ASC.

3a. Divide the revised estimate by the original estimate from B-3.

$$\frac{\text{Revised estimate}}{\text{Original estimate}} = \frac{\boxed{}}{\boxed{}} = \boxed{} \text{ (Result)}$$

b. Is the result of (a) between 0.7 and 1.3?

- 1 Yes – SKIP to section F, page 3
2 No

Section E – CALCULATE NEW TAKE EVERY AND RANDOM START NUMBERS FOR THIS ESA/CLINIC/ASC

1. Calculate new sampling Take Every, using the appropriate table (page 2 or 4) of the NHAMCS-124. (Use the revised estimate of visits from D-2 and the original total visits from B-4).

New Take Every

2. Calculate new Random Start, using the next available row on the label affixed to the back of the NHAMCS-101.

New Random Start

Section F – DATA COORDINATOR AND HOSPITAL STAFF

Enter the name, title, and telephone number of the data coordinator and hospital staff involved in the data collection.

Line No. (a)	Name (b)	Title (c)	Telephone number (d)	
			Area code	Number
1				
2				
3				
4				
5				
6				
7				
8				

Section G – PATIENT RECORD FORM INFORMATION

1. Enter the range of Patient Record Forms that were **ACTUALLY** used by the unit.

FIRST FOLIO	FROM:	<input type="text"/>	TO:	<input type="text"/>
SECOND FOLIO	FROM:	<input type="text"/>	TO:	<input type="text"/>
THIRD FOLIO	FROM:	<input type="text"/>	TO:	<input type="text"/>

CHECK ITEM B

This NHAMCS-101(U) is being completed for:

- 1 ED – Continue with Item 2
- 2 OPD } SKIP to Section H, page 4
- 3 ASC }

2. Of the completed PRF's in this ESA, how many had a visit disposition (item 11) of "Admit to hospital?"

Number of PRFs with visit disposition of "Admit to hospital"

If the number of PRFs given above is 0, then return to the ED for an explanation and write it in the "NOTES" section below. If an error was found in sampling or recording the disposition, then make the correction and note it below.

3. Did you complete a NHAMCS-105, Hospital Admission Log for any PRFs where the patient was admitted to the hospital?

- 1 Yes
- 2 No

NOTE – On average, about 12 percent of ED visits result in hospital admission; therefore, it would be unusual to have no PRFs with this disposition during the 4-week reporting period.

NOTES

Section H - FINAL DISPOSITION

1. FINAL DISPOSITION

Ambulatory unit

- 1 Participated
 - a Patients seen, *Continue to Item 2*
 - b No patients seen
- 2 Refused
- 3 Closed
 - a Temporary
 - b Permanent
- 4 Ineligible *z*
 - a AU not under auspices of hospital
 - b Only ancillary services provided
 - c Care not provided by or under the direct supervision of a physician
 - d Clinic classified as out-of-scope
 - e Other – *Specify z*

} *SKIP to Item 3*

2. Who completed the patient record forms?

Mark (X) all that apply

- 1 Hospital staff
- 2 FR – abstraction DURING reporting period
- 3 FR – abstraction AFTER reporting period
- 4 Other – *Specify z*

**3. DISPOSITION OF NHAMCS-906
Cervical Cancer Screening Supplement**

- 1 Completed
- 2 Refused
- 3 Not applicable – Clinic not eligible for CCSS

NOTES