

ATTACHMENT I

2009 NAMCS Lab Values Pretest Patient Record form



Form Approved, OMB No. 0930-0234



National Ambulatory Medical Care Survey 2009 Pretest Patient Record Folio


WEEK OF --		FROM		TO								
		Month	Day	Month	Day							
		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>							
SURVEY WEEK		Mon.	Tues.	Wed.	Thur.	Fri.	Sat.	Sun.	Total			
Complete a Patient Record for patient SW <input type="text"/> and every YE <input type="text"/> th patient thereafter.	Number of patient visits											
	Number of records completed											

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

Notice - Public reporting burden for this collection of information is estimated to average 9 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: COCIATSOR Information Collection Review Office, 1600 Clifton Road, NE D-74, Atlanta, GA 30333, ATTN: PRA (0920-0234).

FORM **NAMCS-30** (2/24/2009)
USCENSUSBUREAU

U.S. DEPARTMENT OF COMMERCE
Economic 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, <input type="text"/> through Sunday, <input type="text"/>
PATIENT SIGN-IN SHEET	Record the name of every patient seen during the Reporting Period on a Sign-In Sheet maintained by your office. Record each patient in the order registered by the 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 the provider 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 <input type="text"/> TAKE EVERY <input type="text"/> 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 office 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 office 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 during the entire Reporting Period, then the Take Every Number needs to be extended as new patient names are added to the list. Please refer to the NAMCS-26 Instruction Book for more detailed information on the sampling pattern.
DEFINITIONS	For purposes of this study: 1. An <i>ambulatory patient</i> 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/e-mail contacts with patients. 2. A <i>visit</i> is a direct, personal exchange between an ambulatory patient and a provider or medical staff member under a provider's direction for the purpose of seeking care and rendering personal health services. 3. Offices are premises that providers identify as locations for their ambulatory practices, customarily including consulting, examination, or treatment spaces their patients associate with the particular provider.
DISPOSITION OF MATERIALS	As each Patient Record is completed, place it in the pocket of the folio. 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. At the end of the Reporting Period, detach patient's name, return all Patient Records and all unused materials to the field representative as arranged. (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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Form Approved: OMB No. 0920-0234

PATIENT RECORD NO.:

PATIENT'S NAME:

**NATIONAL AMBULATORY MEDICAL CARE SURVEY
2009 PRETEST PATIENT RECORD**

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 306(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		2. INJURY/POISONING/ADVERSE EFFECT	
a. Date of visit Month Day Year	d. Sex 1 <input type="checkbox"/> Female 2 <input type="checkbox"/> Male	g. Expected source(s) of payment for this visit - Mark (X) all that apply. 1 <input type="checkbox"/> Private insurance 2 <input type="checkbox"/> Medicare 3 <input type="checkbox"/> Medicaid/SCHIP 4 <input type="checkbox"/> Worker's compensation 5 <input type="checkbox"/> Self-pay 6 <input type="checkbox"/> No charge/Charity 7 <input type="checkbox"/> Other 8 <input type="checkbox"/> Unknown	Is this visit related to any of the following? 1 <input type="checkbox"/> Unintentional injury/poisoning 2 <input type="checkbox"/> Intentional injury/poisoning 3 <input type="checkbox"/> Injury/poisoning - unknown intent 4 <input type="checkbox"/> Adverse effect of medical/surgical care or adverse effect of medicinal drug 5 <input type="checkbox"/> None of the above
b. ZIP Code	e. Ethnicity 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino	h. Tobacco use 1 <input type="checkbox"/> Not current 3 <input type="checkbox"/> Unknown 2 <input type="checkbox"/> Current	
c. Date of birth Month Day Year	f. Race - Mark (X) one or more. 1 <input type="checkbox"/> White 2 <input type="checkbox"/> Black or African American 3 <input type="checkbox"/> Asian 4 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 5 <input type="checkbox"/> American Indian or Alaska Native		
3. REASON FOR VISIT		4. CONTINUITY OF CARE	
a. Patient's complaint(s), symptom(s), or other reason(s) for this visit - Use patient's own words. (1) Most important: (2) Other: (3) Other:		a. Are you the patient's primary care physician/provider? 1 <input type="checkbox"/> Yes -SKIP to item 4b. 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown Was patient referred for this visit? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown	b. Has the patient been seen in your practice before? 1 <input type="checkbox"/> Yes, established patient - How many past visits in the last 12 months? Exclude this visit. _____ Visits 1 <input type="checkbox"/> Unknown 2 <input type="checkbox"/> No, new patient
		c. Major reason for this visit 1 <input type="checkbox"/> New problem (<3 mos. onset) 2 <input type="checkbox"/> Chronic problem, routine 3 <input type="checkbox"/> Chronic problem, flare-up 4 <input type="checkbox"/> Pre/Post surgery 5 <input type="checkbox"/> Preventive care (e.g., routine prenatal, well-baby, screening, insurance, general exams)	
5. PROVIDER'S DIAGNOSIS FOR THIS VISIT			
a. As specifically as possible, list diagnoses related to this visit including chronic conditions. (1) Primary diagnosis: (2) Other: (3) Other:		b. Regardless of the diagnoses written in 5a, does the patient now have - Mark (X) all that apply. 1 <input type="checkbox"/> Arthritis 3 <input type="checkbox"/> Cancer 4 <input type="checkbox"/> Cerebrovascular disease 10 <input type="checkbox"/> Hyperlipidemia 2 <input type="checkbox"/> Asthma 4 <input type="checkbox"/> In situ 5 <input type="checkbox"/> Chronic renal failure 11 <input type="checkbox"/> Hypertension 1 <input type="checkbox"/> Stage I 6 <input type="checkbox"/> Congestive heart failure 12 <input type="checkbox"/> Ischemic heart disease 2 <input type="checkbox"/> Stage II 7 <input type="checkbox"/> COPD 13 <input type="checkbox"/> Obesity 3 <input type="checkbox"/> Stage III 8 <input type="checkbox"/> Depression 14 <input type="checkbox"/> Osteoporosis 4 <input type="checkbox"/> Stage IV 9 <input type="checkbox"/> Diabetes 15 <input type="checkbox"/> None of the above 5 <input type="checkbox"/> Unknown	
6. VITAL SIGNS		7. DIAGNOSTIC/SCREENING SERVICES	
(1) Height _____ ft _____ in OR _____ cm	(2) Weight _____ lb _____ oz OR _____ kg _____ gm	(3) Temperature _____ °C _____ °F	(4) Blood pressure Systolic _____ Diastolic _____
8. HEALTH EDUCATION		9. NON-MEDICATION TREATMENT	
Mark (X) all ordered or provided at this visit. 1 <input type="checkbox"/> NONE 7 <input type="checkbox"/> Injury prevention 2 <input type="checkbox"/> Asthma education 8 <input type="checkbox"/> Stress management 3 <input type="checkbox"/> Diet/Nutrition 9 <input type="checkbox"/> Tobacco use/Exposure 4 <input type="checkbox"/> Exercise 10 <input type="checkbox"/> Weight reduction 5 <input type="checkbox"/> Family planning/Contraception 11 <input type="checkbox"/> Other 6 <input type="checkbox"/> Growth/Development		Mark (X) all ordered or provided at this visit. 1 <input type="checkbox"/> NONE 8 <input type="checkbox"/> Psychotherapy 2 <input type="checkbox"/> Complementary alternative medicine (CAM) 9 <input type="checkbox"/> Other mental health counseling 3 <input type="checkbox"/> Durable medical equipment 10 <input type="checkbox"/> Excision of tissue 4 <input type="checkbox"/> Home health care 11 <input type="checkbox"/> Wound care 5 <input type="checkbox"/> Physical therapy 12 <input type="checkbox"/> Cast 6 <input type="checkbox"/> Radiation therapy 13 <input type="checkbox"/> Splint or wrap 7 <input type="checkbox"/> Speech/Occupation therapy	
10. MEDICATIONS & IMMUNIZATIONS		11. PROVIDERS	
Include Rx and OTC drugs, immunizations, allergy shots, oxygen, anesthetics, chemotherapy, and dietary supplements that were ordered, supplied, administered or continued during this visit. New Continued (1) _____ 1 <input type="checkbox"/> 2 <input type="checkbox"/> (2) _____ 1 <input type="checkbox"/> 2 <input type="checkbox"/> (3) _____ 1 <input type="checkbox"/> 2 <input type="checkbox"/> (4) _____ 1 <input type="checkbox"/> 2 <input type="checkbox"/> (5) _____ 1 <input type="checkbox"/> 2 <input type="checkbox"/> (6) _____ 1 <input type="checkbox"/> 2 <input type="checkbox"/> (7) _____ 1 <input type="checkbox"/> 2 <input type="checkbox"/> (8) _____ 1 <input type="checkbox"/> 2 <input type="checkbox"/>		Mark (X) all providers seen at this visit. 1 <input type="checkbox"/> Physician 2 <input type="checkbox"/> Physician assistant 3 <input type="checkbox"/> Nurse practitioner/Midwife 4 <input type="checkbox"/> RN/LPN 5 <input type="checkbox"/> Mental health provider 6 <input type="checkbox"/> Other	
		12. VISIT DISPOSITION Mark (X) all that apply. 1 <input type="checkbox"/> Refer to other physician 2 <input type="checkbox"/> Return at specified time 3 <input type="checkbox"/> Refer to ER/Admit to hospital 4 <input type="checkbox"/> Other	
		13. TIME SPENT WITH PROVIDER Minutes _____ Enter zero if no provider seen	

14. LABORATORY VALUES

- All laboratory results are more than 12 months prior to sampled visit.
 No laboratory tests were ordered.

Item number (a)	Laboratory test (b)	Result (c)	Date Lab Was Drawn (mm/dd/yyyy) (d)	Missing (e)
1	Total Cholesterol	mg/dl	/ /	<input type="checkbox"/>
2	High density lipoprotein (HDL)	mg/dl	/ /	<input type="checkbox"/>
3	Low density lipoprotein (LDL)	mg/dl	/ /	<input type="checkbox"/>
4	Triglycerides	mg/dl	/ /	<input type="checkbox"/>
5	Glycohemoglobin A1c (HgbA1c)	% of HGb	/ /	<input type="checkbox"/>
6	Fasting blood glucose (FBG)	mg/dl	/ /	<input type="checkbox"/>