ATTACHMENT J

Prototype of 2010 NAMCS Patient Record form

Form Approved: OMB No. 0920-0234

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

nchs

National Ambulatory Medical Care Survey

2010 Patient Record Folio

WEEK OF –	FROM Month Day				TO Month Day			
SURVEY WEEK	Mon.	Tues.	Wed.	Thur.	Fri.	Sat.	Sun.	**Total**
Complete a Patient Record for patient SW *and every* TE *nth 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!*

FORM **NAMCS-30** (2-4-2009)

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 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 _____ **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 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 *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/e-mail contacts with patients.
2. A *visit* 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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NATIONAL AMBULATORY MEDICAL CARE SURVEY
2010 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

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) one or more.*
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. Tobacco use
1 ☐ Not current 3 ☐ Unknown
2 ☐ Current

2. INJURY/POISONING/ ADVERSE EFFECT

Is this visit related to any of the following?
1 ☐ Unintentional injury/poisoning
2 ☐ Intentional injury/poisoning
3 ☐ Injury/poisoning – unknown intent
4 ☐ Adverse effect of medical/ surgical care or adverse effect of medicinal drug
5 ☐ None of the above

3. REASON FOR VISIT

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:

4. CONTINUITY OF CARE

a. Are you the patient's primary care physician/provider?
1 ☐ Yes –*SKIP to item 4b.*
2 ☐ No
3 ☐ Unknown

Was patient referred for this visit?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

b. Has the patient been seen in your practice before?
1 ☐ Yes, established patient – **How many past visits in the last 12 months?** *Exclude this visit.*
☐ Visits
1 ☐ Unknown
2 ☐ No, new patient

c. Major reason for this visit
1 ☐ New problem (<3 mos. onset)
2 ☐ Chronic problem, routine
3 ☐ Chronic problem, flare-up
4 ☐ Pre/Post surgery
5 ☐ 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 ☐ Arthritis
2 ☐ Asthma
3 ☐ Cancer
0 ☐ In situ
1 ☐ Stage I
2 ☐ Stage II
3 ☐ Stage III
4 ☐ Stage IV
5 ☐ Unknown
4 ☐ Cerebrovascular disease
5 ☐ Chronic renal failure
6 ☐ Congestive heart failure
7 ☐ COPD
8 ☐ Depression
9 ☐ Diabetes
10 ☐ Hyperlipidemia
11 ☐ Hypertension
12 ☐ Ischemic heart disease
13 ☐ Obesity
14 ☐ Osteoporosis
15 ☐ None of the above

6. VITAL SIGNS

(1) Height
☐ ft ☐ in OR ☐ cm

(2) Weight
☐ lb ☐ oz
OR
☐ kg ☐ gm

(3) Temperature
☐ ☐ °C ☐ °F

(4) Blood pressure
Systolic ☐ / Diastolic ☐

7. DIAGNOSTIC/SCREENING SERVICES

Mark (X) all ***ordered*** *or* ***provided*** *at this visit.*
1 ☐ NONE

Examinations:
2 ☐ Breast
3 ☐ Foot
4 ☐ Pelvic
5 ☐ Rectal
6 ☐ Retinal
7 ☐ Skin
8 ☐ Depression screening

Imaging:
9 ☐ X-ray
10 ☐ Bone mineral density
11 ☐ CT scan
12 ☐ Echocardiogram
13 ☐ Other ultrasound
14 ☐ Mammography
15 ☐ MRI
16 ☐ Other imaging

Blood tests:
17 ☐ CBC (complete blood count)
18 ☐ Glucose
19 ☐ HgbA1c (glycohemoglobin)
20 ☐ Lipids/Cholesterol
21 ☐ PSA (prostate specific antigen)
22 ☐ Other blood test

Scope:
23 ☐ Scope procedure (e.g., colonoscopy) - *Specify*

Other tests:
24 ☐ Biopsy – *Specify site*
25 ☐ Chlamydia test
26 ☐ EKG/ECG
27 ☐ HIV test
28 ☐ HPV DNA test
29 ☐ Pap test - conventional
30 ☐ Pap test - liquid-based
31 ☐ Pap test - unspecified
32 ☐ Pregnancy test
33 ☐ Urinalysis (UA)
34 ☐ Other exam/test/service - *Specify*

8. HEALTH EDUCATION

Mark (X) all ***ordered*** *or* ***provided*** *at this visit.*
1 ☐ NONE
2 ☐ Asthma education
3 ☐ Diet/Nutrition
4 ☐ Exercise
5 ☐ Family planning/ Contraception
6 ☐ Growth/Development
7 ☐ Injury prevention
8 ☐ Stress management
9 ☐ Tobacco use/ Exposure
10 ☐ Weight reduction
11 ☐ Other

9. NON-MEDICATION TREATMENT

Mark (X) all ***ordered*** *or* ***provided*** *at this visit.*
1 ☐ NONE
2 ☐ Complementary alternative medicine (CAM)
3 ☐ Durable medical equipment
4 ☐ Home health care
5 ☐ Physical therapy
6 ☐ Radiation therapy
7 ☐ Speech/Occupation therapy
8 ☐ Psychotherapy
9 ☐ Other mental health counseling
10 ☐ Excision of tissue
11 ☐ Wound care
12 ☐ Cast
13 ☐ Splint or wrap

Procedures:
14 ☐ Other non-surgical procedures – *Specify*
15 ☐ Other surgical procedures – *Specify*

10. MEDICATIONS & IMMUNIZATIONS

☐ NONE **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 ☐	2 ☐
(2)	1 ☐	2 ☐
(3)	1 ☐	2 ☐
(4)	1 ☐	2 ☐
(5)	1 ☐	2 ☐
(6)	1 ☐	2 ☐
(7)	1 ☐	2 ☐
(8)	1 ☐	2 ☐

11. PROVIDERS

Mark (X) all providers seen at this visit.
1 ☐ Physician
2 ☐ Physician assistant
3 ☐ Nurse practitioner/ Midwife
4 ☐ RN/LPN
5 ☐ Mental health provider
6 ☐ Other

12. VISIT DISPOSITION

Mark (X) all that apply.
1 ☐ Refer to other physician
2 ☐ Return at specified time
3 ☐ Refer to ER/Admit to hospital
4 ☐ 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	/ /	☐
2	High density lipoprotein (HDL)	mg/dl	/ /	☐
3	Low density lipoprotein (LDL)	mg/dl	/ /	☐
4	Triglycerides	mg/dl	/ /	☐
5	Glycohemoglobin A1c (HgbA1c)	% of HGb	/ /	☐
6	Fasting blood glucose (FBG)	mg/dl	/ /	☐