



CENTERS FOR DISEASE CONTROL AND PREVENTION



Form Approved: OMB No. 0920-0278

2010 OPD

National Hospital Ambulatory Medical Care Survey

2010 Outpatient Department 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!

WEEKLY No. of patient visits	Dates							Total
	Mon.	Tues.	Wed.	Thur.	Fri.	Sat.	Sun.	
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3								
4								
5								
6								
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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 this burden to: CDC/ATISDH Information Collection Review Office, 1600 Clifton Road, NE, Atlanta, GA 30333; ATTN: PRA (0920-0278).

FORM **NHAMCS-100(OPD)** (2-9-2009)
U S C E N S U S B U R E A U

U.S. DEPARTMENT OF COMMERCE
BUREAU OF ECONOMIC ANALYSIS
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 clinic. 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 _____
DEFINITIONS	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 clinic 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 clinic 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 NHAMCS-123 instruction Book for more detailed information on the sampling pattern.
DISPOSITION OF MATERIALS	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 physician or hospital staff member under a physician's supervision for the purpose of seeking care and rendering personal health services.
FIELD REP	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 _____

FORM NHAMCS-100(OPD) (2-9-2009)

FORM **NHAMCS-100(OPD)**
(2-9-2009)

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

PATIENT RECORD NO.:

PATIENT'S NAME:

**NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY
2010 OUTPATIENT DEPARTMENT 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 for statistical purposes 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				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	
b. ZIP Code _____		e. Ethnicity 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino		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	
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		h. Tobacco use 1 <input type="checkbox"/> Not current 3 <input type="checkbox"/> Unknown 2 <input type="checkbox"/> Current	
3. REASON FOR VISIT			4. CONTINUITY OF CARE		
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. Is this clinic the patient's primary care 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 this clinic 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 2 <input type="checkbox"/> Asthma 3 <input type="checkbox"/> Cancer 0 <input type="checkbox"/> In situ 1 <input type="checkbox"/> Stage I 2 <input type="checkbox"/> Stage II 3 <input type="checkbox"/> Stage III 4 <input type="checkbox"/> Stage IV 5 <input type="checkbox"/> Unknown 4 <input type="checkbox"/> Cerebrovascular disease 5 <input type="checkbox"/> Chronic renal failure 6 <input type="checkbox"/> Congestive heart failure 7 <input type="checkbox"/> COPD 8 <input type="checkbox"/> Depression 9 <input type="checkbox"/> Diabetes 10 <input type="checkbox"/> Hyperlipidemia 11 <input type="checkbox"/> Hypertension 12 <input type="checkbox"/> Ischemic heart disease 13 <input type="checkbox"/> Obesity 14 <input type="checkbox"/> Osteoporosis 15 <input type="checkbox"/> None of the above		
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 _____ / _____		Mark (X) all ordered or provided at this visit. 1 <input type="checkbox"/> NONE Examinations: 2 <input type="checkbox"/> Breast 3 <input type="checkbox"/> Foot 4 <input type="checkbox"/> Pelvic 5 <input type="checkbox"/> Rectal 6 <input type="checkbox"/> Retinal 7 <input type="checkbox"/> Skin 8 <input type="checkbox"/> Depression screening Imaging: 9 <input type="checkbox"/> X-ray 10 <input type="checkbox"/> Bone mineral density 11 <input type="checkbox"/> CT scan 12 <input type="checkbox"/> Echocardiogram 13 <input type="checkbox"/> Other ultrasound 14 <input type="checkbox"/> Mammography 15 <input type="checkbox"/> MRI 16 <input type="checkbox"/> Other imaging Blood tests: 17 <input type="checkbox"/> CBC (complete blood count) 18 <input type="checkbox"/> Glucose 19 <input type="checkbox"/> HgbA1c (glycohemoglobin) 20 <input type="checkbox"/> Lipids/Cholesterol 21 <input type="checkbox"/> PSA (prostate specific antigen) 22 <input type="checkbox"/> Other blood test Scope: 23 <input type="checkbox"/> Scope procedure (e.g., colonoscopy) - Specify → _____ Other tests: 24 <input type="checkbox"/> Biopsy – Specify site _____ 25 <input type="checkbox"/> Chlamydia test 26 <input type="checkbox"/> EKG/ECG 27 <input type="checkbox"/> HIV test 28 <input type="checkbox"/> HPV DNA test 29 <input type="checkbox"/> Pap test - conventional 30 <input type="checkbox"/> Pap test - liquid-based 31 <input type="checkbox"/> Pap test - unspecified 32 <input type="checkbox"/> Pregnancy test 33 <input type="checkbox"/> Urinalysis (UA) 34 <input type="checkbox"/> Other exam/test/service - Specify → _____			
8. HEALTH EDUCATION		9. NON-MEDICATION TREATMENT			
Mark (X) all ordered or provided at this visit. 1 <input type="checkbox"/> NONE 2 <input type="checkbox"/> Asthma education 3 <input type="checkbox"/> Diet/Nutrition 4 <input type="checkbox"/> Exercise 5 <input type="checkbox"/> Family planning/Contraception 6 <input type="checkbox"/> Growth/Development 7 <input type="checkbox"/> Injury prevention 8 <input type="checkbox"/> Stress management 9 <input type="checkbox"/> Tobacco use/Exposure 10 <input type="checkbox"/> Weight reduction 11 <input type="checkbox"/> Other		Mark (X) all ordered or provided at this visit. 1 <input type="checkbox"/> NONE 2 <input type="checkbox"/> Complementary alternative medicine (CAM) 3 <input type="checkbox"/> Durable medical equipment 4 <input type="checkbox"/> Home health care 5 <input type="checkbox"/> Physical therapy 6 <input type="checkbox"/> Radiation therapy 7 <input type="checkbox"/> Speech/Occupational therapy 8 <input type="checkbox"/> Psychotherapy 9 <input type="checkbox"/> Other mental health counseling 10 <input type="checkbox"/> Excision of tissue 11 <input type="checkbox"/> Wound care 12 <input type="checkbox"/> Cast 13 <input type="checkbox"/> Splint or wrap Procedures: 14 <input type="checkbox"/> Other non-surgical procedures – Specify → _____ 15 <input type="checkbox"/> Other surgical procedures – Specify → _____			
10. MEDICATIONS & IMMUNIZATIONS			11. PROVIDERS	12. VISIT DISPOSITION	
<input type="checkbox"/> 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. (1) _____ (2) _____ (3) _____ (4) _____ (5) _____ (6) _____ (7) _____ (8) _____			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	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	