

Attachment 1 – NAMCS & HNAMCS Patient Record form to be evaluated

The Public Health Service Act provides us with the authority to do this research (42 United States Code 242k). All information which would permit identification of any 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 the 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).

Public reporting burden for this collection of information is estimated to average 5 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-24, Atlanta, GA 30333, ATTN: PRA (0920-0222).

OMB #0920-0222; Expiration Date: 03/31/2013

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 or CHIP/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		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		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	
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 2 <input type="checkbox"/> Asthma 0 <input type="checkbox"/> In situ 5 <input type="checkbox"/> Chronic renal failure 1 <input type="checkbox"/> stage I 6 <input type="checkbox"/> Congestive heart failure 2 <input type="checkbox"/> stage II 7 <input type="checkbox"/> COPD 3 <input type="checkbox"/> stage III 8 <input type="checkbox"/> Depression 4 <input type="checkbox"/> stage IV 9 <input type="checkbox"/> Diabetes 5 <input type="checkbox"/> Unknown stage 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 (4) Blood pressure _____ °C Systolic Diastolic _____ °F _____ / _____		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/HCG 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 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/Occupational therapy		
			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
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) _____ New <input type="checkbox"/> Continued <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	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 Continue on reverse side →
				13. TIME SPENT WITH PROVIDER Minutes Enter zero if no provider seen	

14. LABORATORY TEST RESULTS

Item number (a)	Were the following laboratory tests drawn within 12 months of this visit? (b)	Most recent result (c)	Date most recent result was drawn (mm/dd/yyyy) (d)
1	Total Cholesterol 1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> None found within 12 months – <i>Skip to next item</i>	_____ mg/dl	/ /
2	High density lipoprotein (HDL) 1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> None found within 12 months – <i>Skip to next item</i>	_____ mg/dl	/ /
3	Low density lipoprotein (LDL) 1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> None found within 12 months – <i>Skip to next item</i>	_____ mg/dl	/ /
4	Triglycerides 1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> None found within 12 months – <i>Skip to next item</i>	_____ mg/dl	/ /
5	Glycohemoglobin A1c (HgbA1c) 1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> None found within 12 months – <i>Skip to next item</i>	_____ % of Hgb	/ /
6	Fasting blood glucose (FBG) 1 <input type="checkbox"/> Yes _____ 2 <input type="checkbox"/> None found within 12 months	_____ mg/dl	/ /