



National Ambulatory Medical Care Survey 2010 Patient Record Folio

WEEK OF -		FROM	Month [Day		ТО	Month E	Day	
SURVEY WEEK		Mon.	Tues.	Wed.	Thur.	Fri.	Sat.	Sun.	Total
Complete a Patient Record for patient SW	Number of patient visits								
every TE nth patient thereafter.	Number of records completed								
Please return the entire Folio with both the completed and blank									

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: CDC/ATSDR Information Collection Review Office, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0234).

forms at the completion of the survey week. Thank you!

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 da							
	Monday,		through Sunday	<i>I</i> ,				
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.							
			MCS-26 Instru n the sampling	ction Book for more 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.							
	patient and provider's	d a provider or	r medical staff me ne purpose of see					
 	ambulator examination	practices, cu	stomarily includir	fy as locations for their ng consulting, atients associate with				
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 qu Representati		culty, please call	the Field				
	Name							
	Phone Numb	er						

FORM **NAMCS-30B** (10-15-2009)

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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 I

PATIENT'S NAME:

PATIENT RECORD NO.:

NATIONAL AMBULATORY MEDICAL CARE SURVEY 2010 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 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).									
(Provider: Detach and keep upper portion)									
Please keep (X) ma	irks inside of b		ATIENT INFORM	ATION			2. INJURY/POISO	NING/	
a. Date of visit		d. Sex	ATIENT INFORM	g. Expec		(s) of payment	ADVERSE EFFI	ECT	
Month Day	Year	1 Female	2 Male		s visit – <i>Ma</i> ⁄ate insurand	rk (X) all that applyce	Is this visit related to any of the following?		
		e. Ethnicity 1 Hispanic	or Latino	2 Me	dicare		1 Unintentional inj	□ Unintentional injury/poisoning	
b. ZIP Code		2 Not Hispa		4 WC	dicaid or CH rker's compe		2 🗌 Intentional injury	/poisoning	
		f. Race – Mark	(X) one or more.	5 Sel	f-pay charge/Chai	ritv	3 Injury/poisoning – unknown intent		
a Data of hinth		2 Black or	African American	7 🗆 Otl	ner	,	4 Adverse effect of medical/		
C. Date of birth Month Day	Year	☐ 3 ☐ Asian 4 ☐ Native Ha	awaiian or	h. Tobac			surgical care or effect of medicin	adverse ial drug	
			cific Islander ı Indian or Alaska Nati [,]		t current	з Unknown	5 None of the abo	ve	
3. RE	ASON FOR	VISIT		2 2 3		FINUITY OF C	ARE		
Patient's comp reason(s) for th	laint(s), syn	nptom(s), or oth	ner a. Are you th			patient been practice before		or this visit	
(1) Most importan		e palient's own wo	physician	/provider?		, established pati	1 ∐ New problem	n (<3 mos.	
(1) Wost Important			1 ☐ Yes -5 2 ☐ No	SKIP to item 4b.	Hov	w many past v he last 12 mor	isits 2 Chronic prob	*	
(2) Other:			3 ☐ Unkno	wn }		lude this visit.	3 ☐ Chronic prob 4 ☐ Pre/Post surg		
				atient referred s visit?		Visits	5 Preventive ca	are (e.g.,	
(3) Other:			1 🗆 Ye		1 🔲	Unknown	routine prena well-baby, so	reening,	
			2 No 3 U	o nknown	2 🗌 No,	new patient	insurance, ge	eneral exams)	
			5. PROVIDER'S D	DIAGNOSIS FO	R THIS V	ISIT			
a. As specifically related to this	as possible,	, list diagnoses ng chronic condit	ions.	b. Regardless now have	of the di	agnoses writt	en in 5a, does the patie	nt	
(1) Primary diagn		.9 0 0 0 00		1 Arthritis	3 Cano	er 4 🗆 C		yperlipidemia	
				2 Asthma		stage I 5 C	Chronic renal failure 12 Is	ypertension chemic heart	
(2) Other:					2 🔲 5	stage II 6 □ C	ailure 13 □ OI	sease besitv	
(3) Other:			3 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \						
Other: 4 Stage IV 7 COPD 14 Osteoporosis 5 Unknown stage 9 Diabetes the above									
					5 🗌 l	Jnknown ⁸ 📙 L	Depression 15 No Diabetes th	one of e above	
6. VI	TAL SIGNS	S		7. DIAGI	5 🔲 l	Jnknown ⁸ 📙 L	Diabetes the	one of e above	
	TAL SIGNS	S	Mark (X) all ordered	d or provided at th	5 USTIC/S	Jnknown 8 L L stage 9 CREENING SI	Diabetes the ERVICES Other tests:	one of e above	
	OR	S cm	1 NONE Examinations:	d or provided at th 14	5 Use State of the	Jnknown 8 ☐ I stage 9 ☐ I	Diabetes the ERVICES Other tests: 24 Biopsy - Specify site	one of e above	
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NAMCS-30 Pre-Test (10-15-2009) NAMCS-30

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

NAMCS-30B (10-15-2009)