Form Approved: OMB No. 0920-0234 Exp. Date 02/28/2013

# National Ambulatory Medical Care Survey

## 2011 Patient Record Folio

Physician ID:

| WEEK OF – | FROM Month ☐☐ Day ☐☐ | | | | TO Month ☐☐ Day ☐☐ | | | |
|---|---|---|---|---|---|---|---|---|
| SURVEY WEEK | Mon. | Tues. | Wed. | Thur. | Fri. | Sat. | Sun. | **Total** |
| Number of patient visits | | | | | | | | |
| Number of records completed | | | | | | | | |

*Complete a Patient Record for patient* **SW** ☐ *and every* **TE** ☐ *nth patient thereafter.*

*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 11 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).

**Complete Item 14:** 1 ☐ Yes 2 ☐ No

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

FORM **NAMCS-30** (2-4-2011)

USCENSUSBUREAU

# GENERAL INSTRUCTIONS

***See card in pocket for instructions on how to complete Patient Record.***

| | |
|---|---|
| **REPORTING DATES** | Your reporting dates are:<br>**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.<br>**START WITH** ________ **TAKE EVERY** ________<br>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.<br>**Please refer to the NAMCS-26 Instruction Book for more detailed information on the sampling pattern.** |
| **DEFINITIONS** | For purposes of this study:<br>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.<br>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.<br>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, review 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:<br>Name<br>Phone Number |

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# NATIONAL AMBULATORY MEDICAL CARE SURVEY
## 2011 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 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) marks inside of boxes* ➜ ☒ Correct ✗ Incorrect

Office Location ________

### 1. PATIENT INFORMATION

**a. Date of visit**

Month | Day | Year 1

**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 or CHIP
4 ☐ Worker's compensation
5 ☐ Self-pay
6 ☐ No charge/Charity
7 ☐ Other
8 ☐ Unknown

**h. Tobacco use**
1 ☐ Not current
2 ☐ Current
3 ☐ Unknown

### 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
4 ☐ Cerebrovascular disease/History of stroke or transient ischemic attack (TIA)
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
30 ☐ Pregnancy/HCG test
31 ☐ Urinalysis (UA)
32 ☐ 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/Occupational 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

***Continue on reverse side*** ➜

### 13. TIME SPENT WITH PROVIDER

Minutes | *Enter zero if no provider seen*

## 14. LABORATORY TEST RESULTS

*If the "Complete Item 14" box is checked YES on the front of this folio, please provide the test results requested below. If neither box is checked, please see Appendix E in the NAMCS-26 Instruction Booklet.*

| Item number (a) | Were the following laboratory tests drawn within 12 months of this visit? (b) | Most recent result (c) | Date of the most recent result (mm/dd/yyyy) (d) |
|---|---|---|---|
| 1 | Total Cholesterol<br>1 ☐ Yes →<br>2 ☐ None found within 12 months – *Skip to next item* | ______ mg/dl<br>1 ☐ Data not available | / /<br>1 ☐ Data not available |
| 2 | High density lipoprotein (HDL)<br>1 ☐ Yes →<br>2 ☐ None found within 12 months – *Skip to next item* | ______ mg/dl<br>1 ☐ Data not available | / /<br>1 ☐ Data not available |
| 3 | Low density lipoprotein (LDL)<br>1 ☐ Yes →<br>2 ☐ None found within 12 months – *Skip to next item* | ______ mg/dl<br>1 ☐ Data not available | / /<br>1 ☐ Data not available |
| 4 | Triglycerdes<br>1 ☐ Yes →<br>2 ☐ None found within 12 months – *Skip to next item* | ______ mg/dl<br>1 ☐ Data not available | / /<br>1 ☐ Data not available |
| 5 | Glycohemoglobin A1c (HgbA1c)<br>1 ☐ Yes →<br>2 ☐ None found within 12 months – *Skip to next item* | ______ mg/dl<br>1 ☐ Data not available | / /<br>1 ☐ Data not available |
| 6 | Fasting blood glucose (FBG)<br>1 ☐ Yes →<br>2 ☐ None found within 12 months | ______ mg/dl<br>1 ☐ Data not available | / /<br>1 ☐ Data not available |