

2012 ASC

Form Approved: OMB No. 0920-0278; Expiration date 08/31/2012



PRETEST

National Hospital Ambulatory Medical Care Survey

2012 Ambulatory Surgery 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!

	Mon.	Tues.	Wed.	Thur.	Fri.	Sat.	Sun.	Total		Mon.	Tues.	Wed.	Thur.	Fri.	Sat.	Sun.	Total	
WEEK 1									WEEK 3									
Dates									Dates									
No. of patient visits									No. of patient visits									
No. of records filled									No. of records filled									
WEEK 2									WEEK 4									
Dates									Dates									
No. of patient visits									No. of patient visits									
No. of records filled									No. of records filled									

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 burden to: CDC/ATSDR Information Collection Review Office, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0278).

FORM NHAMCS-100(ASC) (4-12-2011)

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 ambulatory (outpatient) surgery patient seen during the Reporting Period on one or more Sign-In Sheets maintained by the in-scope ambulatory surgery locations. Record each patient in the order registered by your receptionist or seen by the provider. It is important to record every patient visit including those not seen by the provider but attended to by the staff. Patients who visit 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 ambulatory surgery center 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 ambulatory surgery center 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-126 Instruction Book for more detailed information on the sampling pattern.

DEFINITIONS For purposes of this study:

1. An *ambulatory surgery patient* is an individual presenting for one or more previously scheduled outpatient surgical or diagnostic procedure(s). **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**); and telephone/e-mail contacts with patients.
2. A *visit* is a direct, personal exchange between an ambulatory surgery patient and a physician or facility staff under a physician's supervision for the purpose of seeking ambulatory (outpatient) surgery.

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 the patient's name, and 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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PATIENT RECORD NO.:

PATIENT'S NAME:

**NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY
2012 AMBULATORY SURGERY 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

a. Date of visit			f. Race – Mark (X) all that apply.			h. Time						
Month	Day	Year	1 <input type="checkbox"/> White	(1) Time into operating room		Month	Day	Year	Time	a.m.	p.m.	Military
		1	2 <input type="checkbox"/> Black or African American					1				
b. ZIP Code			3 <input type="checkbox"/> Asian	(2) Time surgery began		Month	Day	Year	Time	a.m.	p.m.	Military
			4 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander					1				
c. Date of birth			5 <input type="checkbox"/> American Indian or Alaska Native	(3) Time surgery ended		Month	Day	Year	Time	a.m.	p.m.	Military
Month	Day	Year	g. Expected source(s) of payment for this visit – Mark (X) all that apply.					1				
			1 <input type="checkbox"/> Private insurance	(4) Time out of operating room		Month	Day	Year	Time	a.m.	p.m.	Military
d. Sex			2 <input type="checkbox"/> Medicare					1				
1 <input type="checkbox"/> Female	2 <input type="checkbox"/> Male		3 <input type="checkbox"/> Medicaid or CHIP	(5) Time into postoperative care		Month	Day	Year	Time	a.m.	p.m.	Military
e. Ethnicity			4 <input type="checkbox"/> Worker's compensation					1				
1 <input type="checkbox"/> Hispanic or Latino	2 <input type="checkbox"/> Not Hispanic or Latino		5 <input type="checkbox"/> Self-pay	(6) Time out of postoperative care		Month	Day	Year	Time	a.m.	p.m.	Military
			6 <input type="checkbox"/> No charge/Charity					1				
			7 <input type="checkbox"/> Other									
			8 <input type="checkbox"/> Unknown									

2. SURGICAL DIAGNOSIS

a. As specifically as possible, list all diagnoses related to this surgery or procedure.				Optional – ICD-9-CM Code			
Primary:	1.						
Other:	2.						
Other:	3.						
Other:	4.						
Other:	5.						

b. Other diagnoses that could impact this surgery or procedure – Mark (X) all that apply.

1 <input type="checkbox"/> Airway problem	5 <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD)	10 <input type="checkbox"/> Morbid obesity
2 <input type="checkbox"/> Asthma	6 <input type="checkbox"/> Congestive heart failure (CHF)	11 <input type="checkbox"/> Obstructive sleep apnea
3 <input type="checkbox"/> Cardiac surgery history	7 <input type="checkbox"/> Coronary artery disease (CAD)	12 <input type="checkbox"/> Renal failure
4 <input type="checkbox"/> Cerebrovascular disease/History of stroke or transient ischemic attack (TIA)	8 <input type="checkbox"/> Diabetes	13 <input type="checkbox"/> Other
	9 <input type="checkbox"/> Hypertension	

3. PROCEDURE(S)

As specifically as possible, list all diagnostic and surgical procedures performed during this visit.				Optional – CPT-4 Code				Optional – ICD-9-CM-Code			
<input type="checkbox"/> NONE											
Primary:	1.										
Other:	2.										
Other:	3.										
Other:	4.										
Other:	5.										
Other:	6.										
Other:	7.										

PLEASE CONTINUE ON THE REVERSE SIDE

4. MEDICATION(S) & ANESTHESIA

a. Mark (X) all drugs and anesthetics that were administered and whether they were administered preoperatively, intraoperatively, and/or postoperatively.

	Preop	Intraop	Postop
1 <input type="checkbox"/> NONE – SKIP to item 6.			
2 <input type="checkbox"/> Fentanyl	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
3 <input type="checkbox"/> Midazolam	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
4 <input type="checkbox"/> Nitrous oxide	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
5 <input type="checkbox"/> Oxygen	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
6 <input type="checkbox"/> Pentathol	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
7 <input type="checkbox"/> Propofol	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
8 <input type="checkbox"/> Zofran	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
9 <input type="checkbox"/> Other – Specify ↴ <input type="text"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
10 <input type="checkbox"/> Other – Specify ↴ <input type="text"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
11 <input type="checkbox"/> Other – Specify ↴ <input type="text"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
12 <input type="checkbox"/> Other – Specify ↴ <input type="text"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

b. Type(s) of anesthesia listed in 4a – Mark (X) all that apply.

- | | | |
|--|--|-----------------------------------|
| 1 <input type="checkbox"/> NONE – SKIP to item 6. | Regional | 11 <input type="checkbox"/> Other |
| 2 <input type="checkbox"/> General | 6 <input type="checkbox"/> Epidural | |
| 3 <input type="checkbox"/> IV sedation | 7 <input type="checkbox"/> Spinal | |
| 4 <input type="checkbox"/> MAC (Monitored Anesthesia Care) | 8 <input type="checkbox"/> Retrobulbar block | |
| 5 <input type="checkbox"/> Topical/Local | 9 <input type="checkbox"/> Peribulbar block | |
| | 10 <input type="checkbox"/> Other block | |

5. PROVIDER(S) OF ANESTHESIA

Anesthesia administered by –
Mark (X) all that apply.

- 1 Anesthesiologist
- 2 CRNA (Certified Registered Nurse Anesthetist)
- 3 Surgeon/Other physician
- 4 Resident
- 5 Unknown

6. SYMPTOM(S) PRESENT DURING OR AFTER PROCEDURE

Mark (X) all that apply.

- | | |
|---|--|
| 1 <input type="checkbox"/> NONE | 7 <input type="checkbox"/> Hypoxia |
| 2 <input type="checkbox"/> Airway problem or aspiration | 8 <input type="checkbox"/> Nausea – moderate to severe |
| 3 <input type="checkbox"/> Arrhythmia – significant | 9 <input type="checkbox"/> Pain – moderate to severe |
| 4 <input type="checkbox"/> Bleeding (post-operative) – moderate to severe | 10 <input type="checkbox"/> Sedation – excessive |
| 5 <input type="checkbox"/> Hypertension/High blood pressure – >20% change from baseline | 11 <input type="checkbox"/> Surgical complications – unanticipated |
| 6 <input type="checkbox"/> Hypotension/Low blood pressure – >20% change from baseline | 12 <input type="checkbox"/> Urinary retention |
| | 13 <input type="checkbox"/> Vomiting – moderate to severe |
| | 14 <input type="checkbox"/> Other |

7. DISPOSITION

Mark (X) one box.

- 1 Routine discharge to customary residence
- 2 Discharge to observation status
- 3 Discharge to post-surgical/recovery care facility
- 4 Admitted to hospital as inpatient
- 5 Referred to ED
- 6 Surgery terminated
Reason for termination
 Allergic reaction
 Unable to intubate
 Other
- 7 Procedure canceled on arrival to ambulatory surgery unit
Reason for cancellation
 Patient not n.p.o.
 Incomplete or inadequate medical evaluation
 Surgical issue
 Other
- 8 Other
- 9 Unknown

8. FOLLOW-UP INFORMATION

a. Did someone attempt to follow-up with the patient within 24 hours after the surgery?

Mark (X) one box.

- 1 Yes – Continue with Item 8b.
- 2 No
- 3 Unknown } END – Patient Record complete.

b. What was learned from this follow-up?

Mark (X) all that apply.

- 1 Unable to reach patient
- 2 Patient reported no problems
- 3 Patient reported problems and sought medical care
- 4 Patient reported problems and was advised by ASC staff to seek medical care
- 5 Patient reported problems, but no follow-up medical care was needed
- 6 Other
- 7 Unknown