2012 OPD

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

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

nchs

National Hospital Ambulatory Medical Care Survey

2012 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!		

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

FORM **NHAMCS-100(OPD)** (4-15-2011)

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 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** _____

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.

DEFINITIONS

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)**; 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.

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:

Name

Phone Number

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

FORM **NHAMCS-100(OPD)**
(4-15-2011)

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

NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY
2012 OUTPATIENT DEPARTMENT 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 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

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 3 ☐ Unknown
2 ☐ Current

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. Is this clinic the patient's primary care 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 this clinic 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
Asthma severity:
1 ☐ Intermittent
2 ☐ Mild persistent
3 ☐ Moderate persistent
4 ☐ Severe persistent
5 ☐ Other
6 ☐ None recorded
Asthma control:
1 ☐ Well controlled
2 ☐ Not well controlled
3 ☐ Very poorly controlled
4 ☐ Other
3 ☐ Cancer
1 ☐ In situ
2 ☐ Stage I
3 ☐ Stage II
4 ☐ Stage III
5 ☐ Stage IV
6 ☐ Unknown stage
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. SERVICES

Mark (X) all services ***ordered*** *or* ***provided*** *at this visit.*

1 ☐ NONE

Examinations:
2 ☐ Breast
3 ☐ Depression screening
4 ☐ Foot
5 ☐ General medical exam
6 ☐ Neurologic
7 ☐ Pelvic
8 ☐ Rectal
9 ☐ Retinal
10 ☐ Skin

Blood tests:
11 ☐ CBC
12 ☐ Glucose
13 ☐ HgbA1c (glycohemoglobin A1C)
14 ☐ Lipid profile
15 ☐ PSA (prostate specific antigen)

Imaging:
16 ☐ Bone mineral density
17 ☐ CT scan
18 ☐ Echocardiogram
19 ☐ Other ultrasound
20 ☐ Mammography
21 ☐ MRI
22 ☐ X-ray

Other tests:
23 ☐ Audiometry
24 ☐ Biopsy
1 ☐ Provided
25 ☐ Cardiac stress test
26 ☐ Colonoscopy
1 ☐ Provided
27 ☐ Chlamydia test
28 ☐ EEG
29 ☐ EKG/ECG
30 ☐ EMG
31 ☐ Excision of tissue
1 ☐ Provided
32 ☐ Fetal monitoring
33 ☐ HIV test
34 ☐ HPV DNA test
35 ☐ PAP test
36 ☐ Peak flow
36 ☐ Peak flow
37 ☐ Pregnancy/HCG test
38 ☐ Sigmoidoscopy
1 ☐ Provided
39 ☐ Spirometry
40 ☐ Tonometry
41 ☐ Urinalysis

Non-medication treatment:
42 ☐ Cast/splint/wrap
43 ☐ Complementary alternative medicine (CAM)
44 ☐ Durable medical equipment
45 ☐ Home health care
46 ☐ Mental health counseling
47 ☐ Physical therapy
48 ☐ Psychotherapy
49 ☐ Radiation therapy
50 ☐ Wound care

Health education:
51 ☐ Asthma
1 ☐ Asthma action plan given to patient
52 ☐ Diet/Nurtrition
53 ☐ Exercise
54 ☐ Family planning/ Contraception
55 ☐ Growth/Development
56 ☐ Injury prevention
57 ☐ Stress management
58 ☐ Tobacco use/Exposure
59 ☐ Weight reduction

Other services not listed:
60 ☐ Other service – *Specify*
61 ☐ Other service – *Specify*
62 ☐ Other service – *Specify*
63 ☐ Other service – *Specify*
64 ☐ Other service – *Specify*

Continue on reverse side ➜

8. 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 ☐

9. 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

10. 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

11. LABORATORY TEST RESULTS

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 1 ☐ Yes → 2 ☐ None found within 12 months – *Skip to next item*	_____ mg/dl 1 ☐ Data not available	/ / 1 ☐ Data not available
2	High density lipoprotein (HDL) 1 ☐ Yes → 2 ☐ None found within 12 months – *Skip to next item*	_____ mg/dl 1 ☐ Data not available	/ / 1 ☐ Data not available
3	Low density lipoprotein (LDL) 1 ☐ Yes → 2 ☐ None found within 12 months – *Skip to next item*	_____ mg/dl 1 ☐ Data not available	/ / 1 ☐ Data not available
4	Triglycerdes 1 ☐ Yes → 2 ☐ None found within 12 months – *Skip to next item*	_____ mg/dl 1 ☐ Data not available	/ / 1 ☐ Data not available
5	Glycohemoglobin A1c (HgbA1c) 1 ☐ Yes → 2 ☐ None found within 12 months – *Skip to next item*	_____ mg/dl 1 ☐ Data not available	/ / 1 ☐ Data not available
6	Fasting blood glucose (FBG) 1 ☐ Yes → 2 ☐ None found within 12 months	_____ mg/dl 1 ☐ Data not available	/ / 1 ☐ Data not available