

# Attachment A:

## 2010 NHAMCS-100(OPD) with Proposed 2011-2012 Laboratory Values Questions Added

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

FORM <b>NHAMCS-100(OPD)</b> (9-2-2009)	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	PATIENT RECORD NO.:
		PATIENT'S NAME:

**NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY  
2010 OUTPATIENT DEPARTMENT 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		2. INJURY/POISONING/ADVERSE EFFECT	
<b>a. Date of visit</b> Month Day Year _____	<b>d. Sex</b> 1 <input type="checkbox"/> Female 2 <input type="checkbox"/> Male	<b>g. Expected source(s) of payment for this visit – Mark (X) all that apply.</b> 1 <input type="checkbox"/> Private insurance 2 <input type="checkbox"/> Medicare 3 <input type="checkbox"/> Medicaid/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>Is this visit related to any of the following?</b> 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
<b>b. ZIP Code</b> _____	<b>e. Ethnicity</b> 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino	<b>h. Tobacco use</b> 1 <input type="checkbox"/> Not current 3 <input type="checkbox"/> Unknown 2 <input type="checkbox"/> Current	
<b>c. Date of birth</b> Month Day Year _____	<b>f. Race – Mark (X) one or more.</b> 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		
3. REASON FOR VISIT		4. CONTINUITY OF CARE	
<b>a. Patient's complaint(s), symptom(s), or other reason(s) for this visit – Use patient's own words.</b> (1) Most important: _____ (2) Other: _____ (3) Other: _____	<b>a. Is this clinic the patient's primary care provider?</b> 1 <input type="checkbox"/> Yes –SKIP to item 4b. 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown <b>Was patient referred for this visit?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown	<b>b. Has the patient been seen in this clinic before?</b> 1 <input type="checkbox"/> Yes, established patient – <b>How many past visits in the last 12 months? Exclude this visit.</b> _____ Visits 1 <input type="checkbox"/> Unknown 2 <input type="checkbox"/> No, new patient	<b>c. Major reason for this visit</b> 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			
<b>a. As specifically as possible, list diagnoses related to this visit including chronic conditions.</b> (1) Primary diagnosis: _____ (2) Other: _____ (3) Other: _____	<b>b. Regardless of the diagnoses written in 5a, does the patient now have – Mark (X) all that apply.</b> 1 <input type="checkbox"/> Arthritis 4 <input type="checkbox"/> Cerebrovascular disease 10 <input type="checkbox"/> Hyperlipidemia 2 <input type="checkbox"/> Asthma 5 <input type="checkbox"/> Chronic renal failure 11 <input type="checkbox"/> Hypertension 3 <input type="checkbox"/> Cancer 6 <input type="checkbox"/> Congestive heart failure 12 <input type="checkbox"/> Ischemic heart disease 0 <input type="checkbox"/> In situ 7 <input type="checkbox"/> COPD 13 <input type="checkbox"/> Obesity 1 <input type="checkbox"/> Stage I 8 <input type="checkbox"/> Depression 14 <input type="checkbox"/> Osteoporosis 2 <input type="checkbox"/> Stage II 9 <input type="checkbox"/> Diabetes 15 <input type="checkbox"/> None of the above 3 <input type="checkbox"/> Stage III 4 <input type="checkbox"/> Stage IV		
6. VITAL SIGNS		7. DIAGNOSTIC/SCREENING SERVICES	
<b>(1) Height</b> _____ ft _____ in OR _____ cm <b>(2) Weight</b> _____ lb _____ oz OR _____ kg _____ gm <b>(3) Temperature</b> <b>(4) Blood pressure</b> _____ °C      Systolic Diastolic _____ °F      _____ / _____	<b>Mark (X) all ordered or provided at this visit.</b> 1 <input type="checkbox"/> NONE <b>Examinations:</b> 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 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		<b>Other tests:</b> 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	
<b>Mark (X) all ordered or provided at this visit.</b> 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	<b>Mark (X) all ordered or provided at this visit.</b> 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		
10. MEDICATIONS & IMMUNIZATIONS		11. PROVIDERS	12. VISIT DISPOSITION
_____ _____ _____ _____ _____ _____ _____ _____	<b>Include Rx and OTC drugs, immunizations, allergy shots, oxygen, anesthetics, chemotherapy, and dietary supplements that were ordered, supplied, administered or continued during this visit.</b> _____ _____ _____ _____ _____ _____ _____ _____	<b>Mark (X) all providers seen at this visit.</b> 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	<b>Mark (X) all that apply.</b> 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

**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>	<input type="text"/> mg/dl	<input type="text"/> / <input type="text"/> / <input type="text"/>
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>	<input type="text"/> mg/dl	<input type="text"/> / <input type="text"/> / <input type="text"/>
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>	<input type="text"/> mg/dl	<input type="text"/> / <input type="text"/> / <input type="text"/>
4	Triglycerides 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found within 12 months – <i>Skip to next item</i>	<input type="text"/> mg/dl	<input type="text"/> / <input type="text"/> / <input type="text"/>
5	Glycohemoglobin A1c (HgbA1c) 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found within 12 months – <i>Skip to next item</i>	<input type="text"/> % of Hgb	<input type="text"/> / <input type="text"/> / <input type="text"/>
6	Fasting blood glucose (FBG) 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found within 12 months	<input type="text"/> mg/dl	<input type="text"/> / <input type="text"/> / <input type="text"/>