

2012 ASC

National Hospital Ambulatory Medical Care Survey

2012 Ambulatory Surgery Patient Record Folio

Hospital ID
Ambulatory Unit Nun

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

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

USCENSUSBUREAU

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



PRETEST

	REPORTING PERIOD	FROM:	Day	TO:	Day
ımber					
	Start with the	Patient.	Take every	Patient.	
Pl an	ease return the d blank forms a	whole Folio with bo t the completion of Thank vou!	th the comple the survey pe	eted priod.	

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).

> 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



See	GENE		TRUCTIONS	
	-	Patient R	ecord.	
REPORTING DATES	Your reporting dates	s are:		
	Monday,		through Sunday	l,
PATIENT Sign-in Sheet	patient seen of Sheets mainta Record each or seen by the visit including the staff. Patie	luring the Re ained by the patient in the provider. It those not se ents who visi	nscope ambulat order registered is important to re en by the provid t more than once	patient) surgery n one or more Sign-In ory surgery locations. I by your receptionist ecord every patient er but attended to by during the Reporting Sheet at each visit.
PATIENT RECORD	Follow the Sa Patient Recor			rmine for which visit(s) a
	START WITH:		TAKE EVERY:	
	designates ev should be con Every of 3, a patient listed of every third pa that the Take Sheet to anot uses a new S has to be extended the new list or entire Reporting extended as r	rery patient the npleted. For a Patient Reco- pon the ambul tient listed the Every Numb her. For exar ign-In Sheet anded from the n Tuesday. If ng Period, the new patient nor r to the NH	example, for a S rd will be comple- atory surgery ce ereafter (e.g., 2, er is extended ea nple, if your amb each day, then t he last patient vis a single Sign-In en the Take Eve ames are added	m a Patient Record tart With of 2 and Take ated for the second nter Sign-In Sheet and 5, 8, etc.). It is essential ach day from one Sign-In pulatory surgery center he Take Every Number sit selected on Monday to Sheet is used during the ry Number needs to be
DEFINITIONS	or more pre procedure(s the physician a persons wh complete a services (e persons cu (nursing l telephone/e surgery pat	tory surgery eviously sche s). Include an does not s ssistant, nurs no visit only fo n insurance f .g., pick up a rrently admitt home patic e-mail contact direct, person tient and a pl	batient is an indi- duled outpatient patients the phy- see but who rece- se, nurse practiti or administrative form; patients who prescription or I ted as inpatients ents should be ts with patients. nal exchange be hysician or facilit	oner, etc. Exclude reasons, such as to no do not seek care or eave a specimen); to the hospital b included ; and tween an ambulatory y staff under a
DISPOSITION OF MATERIALS	As each Patie folio. At the er properly comp Patient Recor completed Pa detach the pa unused mater RETURN THE	nt Record is nd of each da pleted, verify ds equals the tient Record. tient's name, ials to the fie DETACHEI	completed, plac ay, review all forr that the total nur number appear At the end of th and return all P Id representative	e it in the pocket of the ms to be sure they are mber of completed ring on the last e Reporting Period, atient Records and all e as arranged. (DO <i>NOT</i> HE PATIENT RECORD
FIELD REP	In case of que		iculty, please ca	ll the Field
	Name			
	Phone Numbe	ər		

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



(4-12-2011) Economic	TMENT OF COMMERC s and Statistics Administrati U.S. CENSUS BUREA					5920-0278,	Expiration	date 08/31/	2012
U.S. Department of Centers for Di Nation NATIONAL HOSPITAL AMBULATORY MEDICAL	A COLLECTION AGENT FOR T of Health and Human Servic isease Control and Preventi hal Center for Health Statisti CARE SURVE		ENT'S NA	ME:					
2012 AMBULATORY SURGERY PATIENT Assurance of confidentiality – All information which wou confidential; will be used for statistical purposes only by NCHS not be disclosed or released to other persons without the cons Health Service Act (42 USC 242m) and the Confidential Inform	RECORD uld permit identification staff, contractors, a sent of the individual	on of an in nd agents or establis	only wher shment in a	n requir accorda	ed and wance with	vith neces	sary conti	rols; and v	vill
Please keep (X) marks inside of boxes → 🛛 Correct	r: <u>Detach and keep u</u>	ppe <u>r port</u> i	ion)						
	PATIENT INFORM	ATION							
a. Date of visit f. Race - Mark (X) all that apply. Month Day Year 1	h. Time	Month	Dav	Year	Time			n. p.m. N	Ailitary
2 Black or African American 3 Asian 4 Native Hawaiian or Other Pacific Islander	(1) Time into operating room			1		:			
5 American Indian or Alaska Native	(2) Time surgery	Month	Day	Year	Time		a.r		Ailitary
c. Date of birth g. Expected source(s) of payment for this visit – Mark (X) all that apply.	began	Month	Day	Year	Time		a.r		/ilitary
	(3) Time surgery ended			1					
d. Sex 3 Medicaid or CHIP 1 Female 2 Male 4 Worker's compensation	(4) Time out of operating	Month	Day	Year	Time].	a.r	n. p.m. N	/lilitary
5 Self-pay e. Ethnicity 6 No charge/Charity 1 Hispanic or Latino 7 Other	<u>room</u>	Month	Dav	Year			L	n. p.m. N	/ilitary
2 Not Hispanic or Latino 8 Unknown	(5) Time into postoperative care			1		:			
	(6) Time out of postoperative	Month	Day	Year	Time		a.r	n. p.m. N	Ailitary
2.	SURGICAL DIAG	NOSIS							
a. As specifically as possible, list all diagnoses related	d to this surgery o	or proce	dure.					ional – CM Code	_
Primary: 1.								•	
								•	
Other: 2.									
Other: 3.								•	
Other: 4.								•	
								•	
Other: 5. b. Other diagnoses that could impact this surgery or p	procedure – Mark (1	X) all that	apply.						
1 Airway problem 5 Chronic obstrue 2 Asthma 6 Congestive here 3 Cardiac surgery history 7 Coronary arter 4 Cerebrovascular disease/History of stroke or transient ischemic attack (TIA) 8 Diabetes		se (COPD	11 12		failure	ep apnea			
As specifically as possible, list all diagnostic and sur	3. PROCEDURI	E(S)							
performed during this visit.					ptional – T-4 Code	9	ICE	Optional –)-9-CM-Co	de
Primary: 1.								•	
Other: 2.								•	
Other: 3.								•	
Other: 4.								•	
Other: 5.								•	
Other: 6.								•	
Other: 7.								•	
PLEASE CONTINUE ON TH	E REVERSE	SIDE							
NHAMCS-100(ASC) (4-12-2011)									

	4. MED	ICATIO	N(S) &	ANESTHESIA			
. Mark (X) all drugs and anesthetics that were	e administo	ered and	whether	they were admini	istered	preoperatively,	
intraoperatively, and/or postoperatively.							
1 NONE – SKIP to item 6.	Preop	Intraop	Postop				
2 🗌 Fentanyl	1	2	3				
3 🗌 Midazolam	1	2	3				
4 🗌 Nitrous oxide	1	2	3				
5 🗖 Oxygen	1 🗌	2	3 🗌				
6 🗖 Pentathol	1 🗌	2	3 🗌				
7 🗖 Propofol	1 🗌	2	з 🗌				
8 🗌 Zofran	1 🗌	2	з 🗌				
9 🗌 Other – <i>Specify 📈</i>							
	1 🗖	2	3 🗌				
			3				
$_{10}$ Other – Specify \overrightarrow{V}							
	1	2	з 🗌				
11 🗌 Other – <i>Specify 📈</i>							
	1 🗖	2	3 🗌				
	. 🗆						
$_{12}$ Other – Specify \vec{k}							
	1 🗌	2	з 🗌				
 Type(s) of anesthesia listed in 4a - Mark (X) all 1 NONE - SKIP to item 6. 2 General 3 IV sedation 4 MAC (Monitored Anesthesia Care) 5 Topical/Local 	Regional 6 7 8	Epidural Spinal Retrobulk Peribulba		11 🗖 Othe	er.		
1 NONE – <i>SKIP to item 6.</i> 2 General 3 IV sedation	Regional 6 7 8 9	Spinal Retrobult	ar block	11 🗖 Othe	ər		
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