

Attachment H:

National Ambulatory Medical Care Survey 2012: Patient Record Form

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OMB No. 0920-0234: Approval expires 03/31/2013

National Ambulatory Medical Care Survey (NAMCS) - version 1.33

Forms Answer Navigate Options Help Show Watch Window

1 First 2 Prev 3 Next 4 Last 5 Add 6 Delete 7 Exit

NAMCS FAQ Exit/F10 Practice Care_Visits EMR Rev_Cont NewPat_Comp Pat_Appts Asthma CAMs PRF Patient Information Vital Signs Injury or Poisoning Continuity

1 of 1 PRF's MRN: NAMCS PATIENT INFORMATION

<p>♦ Enter Office Number <input type="radio"/> 1. 1</p> <p>♦ Enter the patient's medical record number</p> <p>♦ Date of visit (arrival) (Format MM/DD/YYYY)</p> <p>♦ Patient's 5 digit zip code. (Enter "1" if homeless)</p> <p>♦ Date of birth</p>	<p>♦ Age</p> <p>♦ Enter time period <input type="radio"/> 1. Years <input type="radio"/> 3. Days <input type="radio"/> 2. Months</p> <p>♦ Sex <input type="radio"/> 1. Female <input type="radio"/> 2. Male</p> <p>♦ Is patient pregnant? <input type="radio"/> 1. Yes <input type="radio"/> 2. No</p> <p>♦ Specify Gestation - Gestation week refers to the number of weeks plus 2 that the offspring has spent developing in the uterus</p> <p>♦ Last menstrual period - Month/Day/Year</p> <p>♦ Ethnicity <input type="radio"/> 1. Hispanic or Latino <input type="radio"/> 2. Not Hispanic or Latino</p>	<p>♦ Race (Enter all that apply, separate with commas)</p> <p><input type="checkbox"/> 1. White <input type="checkbox"/> 4. Native Hawaiian/ Other Pacific Islander <input type="checkbox"/> 2. Black/ African-American <input type="checkbox"/> 5. American Indian/ Alaska Native <input type="checkbox"/> 3. Asian</p> <p>♦ Expected source(s) of payment for THIS VISIT. (Enter all that apply, separate with commas)</p> <p><input type="checkbox"/> 1. Private Insurance <input type="checkbox"/> 5. Self-pay <input type="checkbox"/> 2. Medicare <input type="checkbox"/> 6. No charge /Charity <input type="checkbox"/> 3. Medicaid <input type="checkbox"/> 7. Other <input type="checkbox"/> 4. Worker's compensation <input type="checkbox"/> 8. Unknown</p> <p>♦ Tobacco Use <input type="radio"/> 1. Not current <input type="radio"/> 3. Unknown <input type="radio"/> 2. Current</p>
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<input type="button" value="1 First"/> <input type="button" value="2 Prev"/> <input type="button" value="3 Next"/> <input type="button" value="4 Last"/> <input type="button" value="5 Add"/> <input type="button" value="6 Delete"/> <input type="button" value="7 Exit"/>	
NAMCS FAQ Exit/F10 Practice Care_Visits EMR Rev_Cont NewPat_Comp Pat_Appnts Asthma CAMs PRF Patient Information Vital Signs Injury or Poisoning Continuity	
1 of 1 PRF's	MRN: NAMCS Vital signs
<p>♦ Height (feet) <input style="width: 50px;" type="text"/></p>	<p>♦ Height (centimeters) <input style="width: 50px;" type="text"/></p>
<p>♦ Height (inches) <input style="width: 50px;" type="text"/></p>	
<p>♦ Weight (pounds) <input style="width: 50px;" type="text"/></p>	<p>♦ Weight (kilograms) <input style="width: 50px;" type="text"/></p>
<p>♦ Weight (ounces) <input style="width: 50px;" type="text"/></p>	<p>♦ Weight (gm) <input style="width: 50px;" type="text"/></p>
<p>♦ Temperature</p> <input style="width: 50px;" type="text"/>	<p>♦ Temperature type</p> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> <input checked="" type="radio"/> 1. Celsius <input type="radio"/> 2. Fahrenheit </div>
<p>♦ Blood Pressure - SYSTOLIC Refers to the top number of the blood pressure measurement.</p> <input style="width: 50px;" type="text"/>	<p>♦ Blood pressure - DIASTOLIC Refers to the bottom number of the blood pressure measurement. Enter 998 for P, PAL, DOPP, or DOPPLER</p> <input style="width: 50px;" type="text"/>

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1 of 1 PRF's MRN: NAMCS INJURY/POISONING/ADVERSE EFFECT

♦ Is this visit related to an injury, poisoning, or adverse effect of medical treatment?

1. Yes, injury/trauma
 2. Yes, poisoning
 3. Yes, adverse effect of medical treatment

♦ Is this injury/poisoning unintentional or intentional?

1. Yes, unintentional 2. Yes, intentional

♦ Enter the patient's complaint(s), symptom(s), or other reason(s) for this visit in the patient's own words. Enter the "most important" complaint/symptom/reason first	♦ Locate the reason for visit in the look-up table. Enter XXX if reason cannot be found
<input type="text"/>	<input type="text"/>
♦	♦ Locate the reason for visit in the look-up table. Enter XXX if reason cannot be found
<input type="text"/>	<input type="text"/>
♦	♦ Locate the reason for visit in the look-up table. Enter XXX if reason cannot be found
<input type="text"/>	<input type="text"/>

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1 of 1 PRF's MRN: NAMCS Continuity of care

♦ Are you the patient's primary care physician?

1. Yes 2. No 3. Unknown

♦ Was patient referred for this visit?

1. Yes 2. No 3. Unknown

♦ Has the patient been seen in your practice before?

1. Yes, established patient 2. No, new patient

♦ How many past visits to this clinic in the last 12 months? (Exclude this visit)

♦ Major reason for this visit

1. New problem (<3 mos. onset) 5. Preventive care (e.g., routine prenatal, well-baby, screening, insurance, general exams)
 2. Chronic problem, routine
 3. Chronic problem, flare-up
 4. Pre/Post surgery

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1 of 1 PRF's MRN: NAMCS Providers diagnosis for this visit

♦ As specifically as possible, list diagnoses related to this visit including chronic conditions.
♦ List PRIMARY diagnoses first

♦ Enter 0 if no other diagnoses

♦ Enter 0 if no other diagnoses

♦ Enter 0 if no other diagnoses

♦ Locate the diagnosis in the look-up table. Enter "XXX" if diagnosis cannot be found

♦ Locate the diagnosis in the look-up table. Enter "XXX" if diagnosis cannot be found

♦ Locate the diagnosis in the look-up table. Enter "XXX" if diagnosis cannot be found

♦ Regardless of the diagnoses previously entered, does the patient now have - Enter all that apply, separate with commas

<input type="checkbox"/> 1. Arthritis	<input type="checkbox"/> 5. Chronic obstructive pulmonary disease (COPD)	<input type="checkbox"/> 11. Hypertension
<input type="checkbox"/> 2. Asthma	<input type="checkbox"/> 6. Chronic renal failure	<input type="checkbox"/> 12. Ischemic heart disease
<input type="checkbox"/> 3. Cancer	<input type="checkbox"/> 7. Congestive heart failure	<input type="checkbox"/> 13. Obesity
<input type="checkbox"/> 4. Cerebrovascular disease/History of stroke or transient ischemic attack (TIA)	<input type="checkbox"/> 8. Depression	<input type="checkbox"/> 14. Osteoporosis
<input type="checkbox"/> 9. Diabetes	<input type="checkbox"/> 10. Hyperlipidemia	<input type="checkbox"/> 15. None of the above

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1 of 1 PRF's MRN: NAMCS Providers diagnosis for this visit

♦ **Asthma severity**

1. Intermittent 4. Severe persistent
 2. Mild persistent 5. Other - specify
 3. Moderate persistent 6. none recorded

♦ **Specify Asthma severity**

♦ **Asthma control**

1. Well controlled 3. Very poorly controlled
 2. Not well controlled 4. Other - specify
 5. None recorded

♦ **Specify Asthma control**

? [F1]
♦ **Select cancer type**

0. In situ 2. Stage II 4. Stage IV
 1. Stage I 3. Stage III 5. Unknown stage

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1 of 1 PRF's MRN: NAMCS Services

? [F1]
♦ **Services**
Enter all examinations, blood tests, imaging, other tests, non-medication treatment and health education ORDERED or PROVIDED.

<input type="checkbox"/> 1. NO SERVICES	<input type="checkbox"/> 16. Imaging	<input type="checkbox"/> 32. Fetal monitoring	<input type="checkbox"/> 47. Physical therapy
<input type="checkbox"/> 2. Breast	<input type="checkbox"/> 17. CT scan	<input type="checkbox"/> 33. HIV test	<input type="checkbox"/> 48. Psychotherapy
<input type="checkbox"/> 3. Depressing screening	<input type="checkbox"/> 18. Echocardiogram	<input type="checkbox"/> 34. HPV DNA test	<input type="checkbox"/> 49. Radiation therapy
<input type="checkbox"/> 4. Foot	<input type="checkbox"/> 19. Other ultrasound	<input type="checkbox"/> 35. PAP test	<input type="checkbox"/> 50. Wound care
<input type="checkbox"/> 5. General physical exam	<input type="checkbox"/> 20. Mammography	<input type="checkbox"/> 36. Peak flow	<input type="checkbox"/> 51. Asthma
<input type="checkbox"/> 6. Neurologic	<input type="checkbox"/> 21. MRI	<input type="checkbox"/> 37. Pregnancy/HCG test	<input type="checkbox"/> 52. Diet/Nutrition
<input type="checkbox"/> 7. Pelvic	<input type="checkbox"/> 22. X-ray	<input type="checkbox"/> 38. Sigmoidoscopy	<input type="checkbox"/> 53. Exercise
<input type="checkbox"/> 8. Rectal	<input type="checkbox"/> 23. Audiometry	<input type="checkbox"/> 39. Spirometry	<input type="checkbox"/> 54. Family planning/Contraception
<input type="checkbox"/> 9. Retinal	<input type="checkbox"/> 24. Biopsy	<input type="checkbox"/> 40. Tonometry	<input type="checkbox"/> 55. Growth/Development
<input type="checkbox"/> 10. Skin	<input type="checkbox"/> 25. Cardiac stress test	<input type="checkbox"/> 41. Urinalysis	<input type="checkbox"/> 56. Injury prevention
<input type="checkbox"/> 11. CBC	<input type="checkbox"/> 26. Chlamydia test	<input type="checkbox"/> 42. Cast/splint/wrap	<input type="checkbox"/> 57. Stress management
<input type="checkbox"/> 12. Glucose	<input type="checkbox"/> 27. Colonoscopy	<input type="checkbox"/> 43. Complementary and alternative medicine (CAM)	<input type="checkbox"/> 58. Tobacco use/Exposure
<input type="checkbox"/> 13. HgbA1c (Glycohemoglobin)	<input type="checkbox"/> 28. Electroencephalogram (EEG)	<input type="checkbox"/> 44. Durable medical equipment	<input type="checkbox"/> 59. Weight reduction
<input type="checkbox"/> 14. Lipid profile	<input type="checkbox"/> 29. EKG/ECG	<input type="checkbox"/> 45. Home health care	<input type="checkbox"/> 60. Other service
<input type="checkbox"/> 15. PSA (prostate specific antigen)	<input type="checkbox"/> 30. Electromyogram (EMG)	<input type="checkbox"/> 46. Mental health counseling, excluding psychotherapy	
	<input type="checkbox"/> 31. Excision of tissue		

16. **Imaging**
 Bone mineral density

17. CT scan

18. Echocardiogram

19. Other ultrasound

20. Mammography

21. MRI

22. X-ray

23. Audiometry

24. Biopsy

25. Cardiac stress test

26. Chlamydia test

27. Colonoscopy

28. Electroencephalogram (EEG)

29. EKG/ECG

30. Electromyogram (EMG)

31. Excision of tissue

32. Fetal monitoring

33. HIV test

34. HPV DNA test

35. PAP test

36. Peak flow

37. Pregnancy/HCG test

38. Sigmoidoscopy

39. Spirometry

40. Tonometry

41. Urinalysis

42. Cast/splint/wrap

43. Complementary and alternative medicine (CAM)

44. Durable medical equipment

45. Home health care

46. Mental health counseling, excluding psychotherapy

47. Physical therapy

48. Psychotherapy

49. Radiation therapy

50. Wound care

51. Asthma

52. Diet/Nutrition

53. Exercise

54. Family planning/Contraception

55. Growth/Development

56. Injury prevention

57. Stress management

58. Tobacco use/Exposure

59. Weight reduction

60. Other service

Examinations

Blood tests

Other tests and procedures

Non-medication treatment

Health education /counseling

Other services not listed

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1 of 1 PRF's MRN: NAMCS Services

Biopsy provided?
 1. Yes
 2. No

Colonoscopy provided?
 1. Yes
 2. No

Excision of tissue provided?
 1. Yes
 2. No

Sigmoidoscopy provided?
 1. Yes
 2. No

Asthma action plan given to patient?
 1. Yes
 2. No

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1 of 1 PRF's MRN: NAMCS Services

Specify other exam/test/service

Specify other exam/test/service
Enter '0' if no other exam/test/services provided

Specify other exam/test/service
Enter '0' if no other exam/test/services provided

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1 of 1 PRF's MRN: NAMCS Medications & Immunization

♦ Were any prescription or non-prescription drugs ORDERED or PROVIDED (by any route of administration) at this visit? Include allergy shots and other biologicals. Also, include drugs prescribed at a previous visit if the patient was instructed at THIS VISIT to continue with the medication.

1. Yes 1. Yes 2. No

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♦ Enter drugs that were ordered, supplied, administered or continued during this visit. Include Rx and OTC drugs, immunizations, allergy shots, oxygen, anesthetics, chemotherapy, and dietary supplements. Enter XXX if medication cannot be found. Enter 0 for no more

Drugs 1	<input type="checkbox"/>	<input type="radio"/> 1. New	<input type="radio"/> 2. Continued
1 Other			
Drugs 2	<input type="checkbox"/>	<input type="radio"/> 1. New	<input type="radio"/> 2. Continued
2 Other			
Drugs 3	<input type="checkbox"/>	<input type="radio"/> 1. New	<input type="radio"/> 2. Continued
3 Other			
Drugs 4	<input type="checkbox"/>	<input type="radio"/> 1. New	<input type="radio"/> 2. Continued
4 Other			
Drugs 5	<input type="checkbox"/>	<input type="radio"/> 1. New	<input type="radio"/> 2. Continued
5 Other			
Drugs 6	<input type="checkbox"/>	<input type="radio"/> 1. New	<input type="radio"/> 2. Continued
6 Other			
Drugs 7	<input type="checkbox"/>	<input type="radio"/> 1. New	<input type="radio"/> 2. Continued
7 Other			
Drugs 8	<input type="checkbox"/>	<input type="radio"/> 1. New	<input type="radio"/> 2. Continued
8 Other			
Drugs 9	<input type="checkbox"/>	<input type="radio"/> 1. New	<input type="radio"/> 2. Continued
9 Other			
Drugs 10	<input type="checkbox"/>	<input type="radio"/> 1. New	<input type="radio"/> 2. Continued
10 Other			

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1 of 1 PRF's MRN: NAMCS Providers

♦ Enter all providers seen at this visit, separate with commas

1. Physician 5. Mental health provider
 2. Physician assistant 6. Other
 3. Nurse practitioner/Midwife 7. None
 4. RN/LPN

Enter time spent, in minutes, with provider

Enter 0 if no provider seen

♦ Visit Disposition (Enter all that apply, separate with commas)

1. Refer to other physician 4. Other
 2. Return at specified time
 3. Refer to ER/Admit to hospital

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1 of 1 PRF's MRN: NAMCS Providers

♦ Was blood for the following laboratory tests drawn on the day of the sampled visit or during the 12 months prior to the visit?

1. Enter 1 to Continue

	Most recent result	Date of Test
♦ Total cholesterol? (1 = yes 2 = none found)	♦ Total cholesterol mg/dl	
♦ High density lipoprotein (HDL)? (1 = yes 2 = none found)	♦ HDL mg/dl	
♦ Low density lipoprotein (LDL)? (1 = yes 2 = none found)	♦ LDL mg/dl	
♦ Triglycerides (TGS) ? (1 = yes 2 = none found)	♦ TGS mg/dl	
♦ HbA1c Glycohemoglobin ? (1 = yes 2 = none found)	♦ A1C %	
♦ Fasting blood glucose (FBG) ? (1 = yes 2 = none found)	♦ FBG mg/dl	