

2012 OPD



PRETEST

# 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!*

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

**Notice** – Public reporting burden for this collection of information is estimated to average 9 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(OPD)** (4-15-2011)  
U.S. CENSUS BUREAU

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.*

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**REPORTING DATES** Your reporting dates are:  
Monday, \_\_\_\_\_ through Sunday, \_\_\_\_\_

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**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.

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**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.**

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**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.

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**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**).

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**FIELD REP** In case of questions or difficulty, please call the Field Representative collect:  
Name \_\_\_\_\_  
Phone Number \_\_\_\_\_

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National Center for Health Statistics

PATIENT RECORD NO.:

PATIENT'S NAME:

**NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY  
2012 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 _____ 1 _____		<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 or CHIP 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>b. ZIP Code</b> _____		<b>e. Ethnicity</b> 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino		<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>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		<b>h. Tobacco use</b> 1 <input type="checkbox"/> Not current 3 <input type="checkbox"/> Unknown 2 <input type="checkbox"/> Current	
3. REASON FOR VISIT			4. CONTINUITY OF CARE		
<b>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 Was patient referred for this visit? 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 – How many past visits in the last 12 months? Exclude this visit. _____ 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 2 <input type="checkbox"/> Asthma <b>Asthma severity:</b> 1 <input type="checkbox"/> Intermittent 2 <input type="checkbox"/> Mild persistent 3 <input type="checkbox"/> Moderate persistent 4 <input type="checkbox"/> Severe persistent 5 <input type="checkbox"/> Other → _____ 6 <input type="checkbox"/> None recorded 3 <input type="checkbox"/> Cancer 1 <input type="checkbox"/> In situ 2 <input type="checkbox"/> Stage I 3 <input type="checkbox"/> Stage II 4 <input type="checkbox"/> Stage III 5 <input type="checkbox"/> Stage IV 6 <input type="checkbox"/> Unknown stage 4 <input type="checkbox"/> Cerebrovascular disease/History of stroke or transient ischemic attack (TIA) 5 <input type="checkbox"/> Chronic renal failure 6 <input type="checkbox"/> Congestive heart failure 7 <input type="checkbox"/> COPD 8 <input type="checkbox"/> Depression 9 <input type="checkbox"/> Diabetes 10 <input type="checkbox"/> Hyperlipidemia 11 <input type="checkbox"/> Hypertension 12 <input type="checkbox"/> Ischemic heart disease 13 <input type="checkbox"/> Obesity 14 <input type="checkbox"/> Osteoporosis 15 <input type="checkbox"/> None of the above					
6. VITAL SIGNS					
<b>(1) Height</b> _____ ft _____ in OR _____ cm		<b>(2) Weight</b> _____ lb _____ oz OR _____ kg _____ gm		<b>(3) Temperature</b> _____ °C _____ °F	<b>(4) Blood pressure</b> Systolic Diastolic _____ / _____
7. SERVICES					
Mark (X) all services <b>ordered</b> or <b>provided</b> at this visit. 1 <input type="checkbox"/> NONE <b>Examinations:</b> 2 <input type="checkbox"/> Breast 3 <input type="checkbox"/> Depression screening 4 <input type="checkbox"/> Foot 5 <input type="checkbox"/> General medical exam 6 <input type="checkbox"/> Neurologic 7 <input type="checkbox"/> Pelvic 8 <input type="checkbox"/> Rectal 9 <input type="checkbox"/> Retinal 10 <input type="checkbox"/> Skin <b>Blood tests:</b> 11 <input type="checkbox"/> CBC 12 <input type="checkbox"/> Glucose 13 <input type="checkbox"/> HgbA1c (glycohemoglobin A1C) 14 <input type="checkbox"/> Lipid profile 15 <input type="checkbox"/> PSA (prostate specific antigen) <b>Imaging:</b> 16 <input type="checkbox"/> Bone mineral density 17 <input type="checkbox"/> CT scan 18 <input type="checkbox"/> Echocardiogram 19 <input type="checkbox"/> Other ultrasound 20 <input type="checkbox"/> Mammography 21 <input type="checkbox"/> MRI 22 <input type="checkbox"/> X-ray <b>Other tests:</b> 23 <input type="checkbox"/> Audiometry 24 <input type="checkbox"/> Biopsy 1 <input type="checkbox"/> Provided 25 <input type="checkbox"/> Cardiac stress test 26 <input type="checkbox"/> Colonoscopy 1 <input type="checkbox"/> Provided 27 <input type="checkbox"/> Chlamydia test 28 <input type="checkbox"/> EEG 29 <input type="checkbox"/> EKG/ECG 30 <input type="checkbox"/> EMG 31 <input type="checkbox"/> Excision of tissue 1 <input type="checkbox"/> Provided 32 <input type="checkbox"/> Fetal monitoring 33 <input type="checkbox"/> HIV test 34 <input type="checkbox"/> HPV DNA test 35 <input type="checkbox"/> PAP test 36 <input type="checkbox"/> PAP flow 37 <input type="checkbox"/> Pregnancy/HCG test 38 <input type="checkbox"/> Sigmoidoscopy 1 <input type="checkbox"/> Provided 39 <input type="checkbox"/> Spirometry 40 <input type="checkbox"/> Tonometry 41 <input type="checkbox"/> Urinalysis <b>Non-medication treatment:</b> 42 <input type="checkbox"/> Cast/splint/wrap 43 <input type="checkbox"/> Complementary alternative medicine (CAM) 44 <input type="checkbox"/> Durable medical equipment 45 <input type="checkbox"/> Home health care 46 <input type="checkbox"/> Mental health counseling 47 <input type="checkbox"/> Physical therapy 48 <input type="checkbox"/> Psychotherapy 49 <input type="checkbox"/> Radiation therapy 50 <input type="checkbox"/> Wound care 51 <input type="checkbox"/> Asthma 1 <input type="checkbox"/> Asthma action plan given to patient 52 <input type="checkbox"/> Diet/Nutrition 53 <input type="checkbox"/> Exercise 54 <input type="checkbox"/> Family planning/Contraception 55 <input type="checkbox"/> Growth/Development 56 <input type="checkbox"/> Injury prevention 57 <input type="checkbox"/> Stress management 58 <input type="checkbox"/> Tobacco use/Exposure 59 <input type="checkbox"/> Weight reduction 60 <input type="checkbox"/> Other service – Specify → _____ 61 <input type="checkbox"/> Other service – Specify → _____ 62 <input type="checkbox"/> Other service – Specify → _____ 63 <input type="checkbox"/> Other service – Specify → _____ 64 <input type="checkbox"/> Other service – Specify → _____					

Continue on reverse side →

8. MEDICATIONS & IMMUNIZATIONS			9. PROVIDERS	10. VISIT DISPOSITION
<input type="checkbox"/> NONE	<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>	New   Continued	<i>Mark (X) all providers seen at this visit.</i>	<i>Mark (X) all that apply.</i>
(1)	_____	1 <input type="checkbox"/> 2 <input type="checkbox"/>	1 <input type="checkbox"/> Physician	1 <input type="checkbox"/> Refer to other physician
(2)	_____	1 <input type="checkbox"/> 2 <input type="checkbox"/>	2 <input type="checkbox"/> Physician assistant	2 <input type="checkbox"/> Return at specified time
(3)	_____	1 <input type="checkbox"/> 2 <input type="checkbox"/>	3 <input type="checkbox"/> Nurse practitioner/ Midwife	3 <input type="checkbox"/> Refer to ER/Admit to hospital
(4)	_____	1 <input type="checkbox"/> 2 <input type="checkbox"/>	4 <input type="checkbox"/> RN/LPN	4 <input type="checkbox"/> Other
(5)	_____	1 <input type="checkbox"/> 2 <input type="checkbox"/>	5 <input type="checkbox"/> Mental health provider	
(6)	_____	1 <input type="checkbox"/> 2 <input type="checkbox"/>	6 <input type="checkbox"/> Other	
(7)	_____	1 <input type="checkbox"/> 2 <input type="checkbox"/>		
(8)	_____	1 <input type="checkbox"/> 2 <input type="checkbox"/>		

**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 <input type="checkbox"/> Yes _____ → 2 <input type="checkbox"/> None found within 12 months – <i>Skip to next item</i>	_____ mg/dl  1 <input type="checkbox"/> Data not available	/ /  1 <input type="checkbox"/> Data not available
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>	_____ mg/dl  1 <input type="checkbox"/> Data not available	/ /  1 <input type="checkbox"/> Data not available
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>	_____ mg/dl  1 <input type="checkbox"/> Data not available	/ /  1 <input type="checkbox"/> Data not available
4	Triglycerdes  1 <input type="checkbox"/> Yes _____ → 2 <input type="checkbox"/> None found within 12 months – <i>Skip to next item</i>	_____ mg/dl  1 <input type="checkbox"/> Data not available	/ /  1 <input type="checkbox"/> Data not available
5	Glycohemoglobin A1c (HgbA1c)  1 <input type="checkbox"/> Yes _____ → 2 <input type="checkbox"/> None found within 12 months – <i>Skip to next item</i>	_____ mg/dl  1 <input type="checkbox"/> Data not available	/ /  1 <input type="checkbox"/> Data not available
6	Fasting blood glucose (FBG)  1 <input type="checkbox"/> Yes _____ → 2 <input type="checkbox"/> None found within 12 months	_____ mg/dl  1 <input type="checkbox"/> Data not available	/ /  1 <input type="checkbox"/> Data not available