Attachment K

Outpatient Department Patient Record form

Ambulatory Care Pretest, National Hospital Care Survey

OMB No. 0920-xxxx Exp. Date

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).

Patient's name: _____

Patient's address: _____ Street

_____ City _____ State

Patient's Social Security number _____

Patient's Control number _____

Medicare health insurance benefit/claim number _____

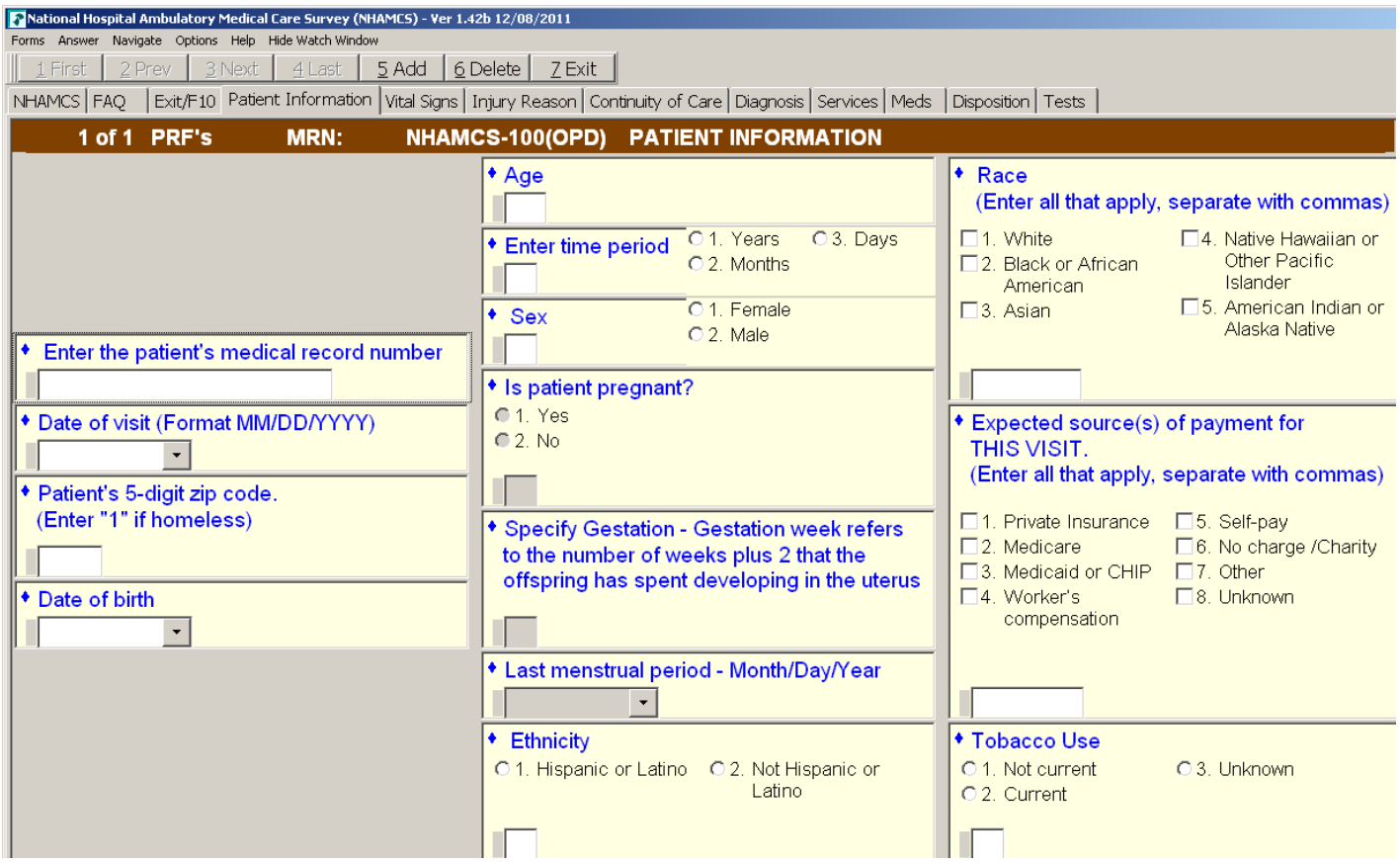
National Provider Identifier (NPI) - Attending _____

National Provider Identifier (NPI) - Operating _____

The current question on page 8 "Is patient allergic to any medication, e.g., bleeding from aspirin?" will be changed to the following:

Is the patient allergic to any medication?
Yes – Enter up to 3
No or no known allergies
Unknown

Has the patient had any adverse reaction to any medication (e.g., bleeding from aspirin)?
Yes – Enter up to 3
No or no known adverse reactions
Unknown


National Hospital Ambulatory Medical Care Survey (NHAMCS) - Ver 1.42b 12/08/2011
Forms Answer Navigate Options Help Hide Watch Window
1 First 2 Prev 3 Next 4 Last 5 Add 6 Delete 7 Exit
NHAMCS FAQ Exit/F10 Patient Information Vital Signs Injury Reason Continuity of Care Diagnosis Services Meds Disposition Tests
1 of 1 PRF's MRN: NHAMCS-100(OPD) PATIENT INFORMATION
Enter the patient's medical record number
Date of visit (Format MM/DD/YYYY)
Patient's 5-digit zip code. (Enter "1" if homeless)
Date of birth
Age
Enter time period
1. Years
2. Months
3. Days
Sex
1. Female
2. Male
Is patient pregnant?
1. Yes
2. No
Specify Gestation - Gestation week refers to the number of weeks plus 2 that the offspring has spent developing in the uterus
Last menstrual period - Month/Day/Year
Ethnicity
1. Hispanic or Latino
2. Not Hispanic or Latino
Race
(Enter all that apply, separate with commas)
1. White
2. Black or African American
3. Asian
4. Native Hawaiian or Other Pacific Islander
5. American Indian or Alaska Native
Expected source(s) of payment for THIS VISIT.
(Enter all that apply, separate with commas)
1. Private Insurance
2. Medicare
3. Medicaid or CHIP
4. Worker's compensation
5. Self-pay
6. No charge /Charity
7. Other
8. Unknown
Tobacco Use
1. Not current
2. Current
3. Unknown

♦ Height (feet)

♦ Height (centimeters)

♦ Weight (pounds)

♦ Weight (kilograms)

♦ Weight (ounces)

♦ Weight (gm)

♦ Temperature

♦ Temperature type

1. Celsius
2. Fahrenheit

♦ Blood Pressure - SYSTOLIC
Refers to the top number of the blood pressure measurement.

♦ Blood pressure - DIASTOLIC
Refers to the bottom number of the blood pressure measurement.
Enter 998 for P, PALP, DOPP, or DOPPLER

♦ 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
- 4. No
- 5. Unknown

♦ Is this injury/poisoning unintentional or intentional?

- 1. Unintentional
- 2. 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

♦ Is this clinic the patient's primary care provider?

- 1. Yes
- 2. No
- 3. Unknown

♦ Was patient referred for this visit?

- 1. Yes
- 2. No
- 3. Unknown

♦ Has the patient been seen in this clinic before?

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

♦ How many past visits to this clinic in the last 12 months? (Exclude this visit) Enter CTRL-D if data is not available.

♦ 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)

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

♦ As specifically as possible, list diagnoses related to this visit , including chronic conditions.
Enter "XXX" if diagnosis cannot be found

♦ Enter 0 if no other diagnoses

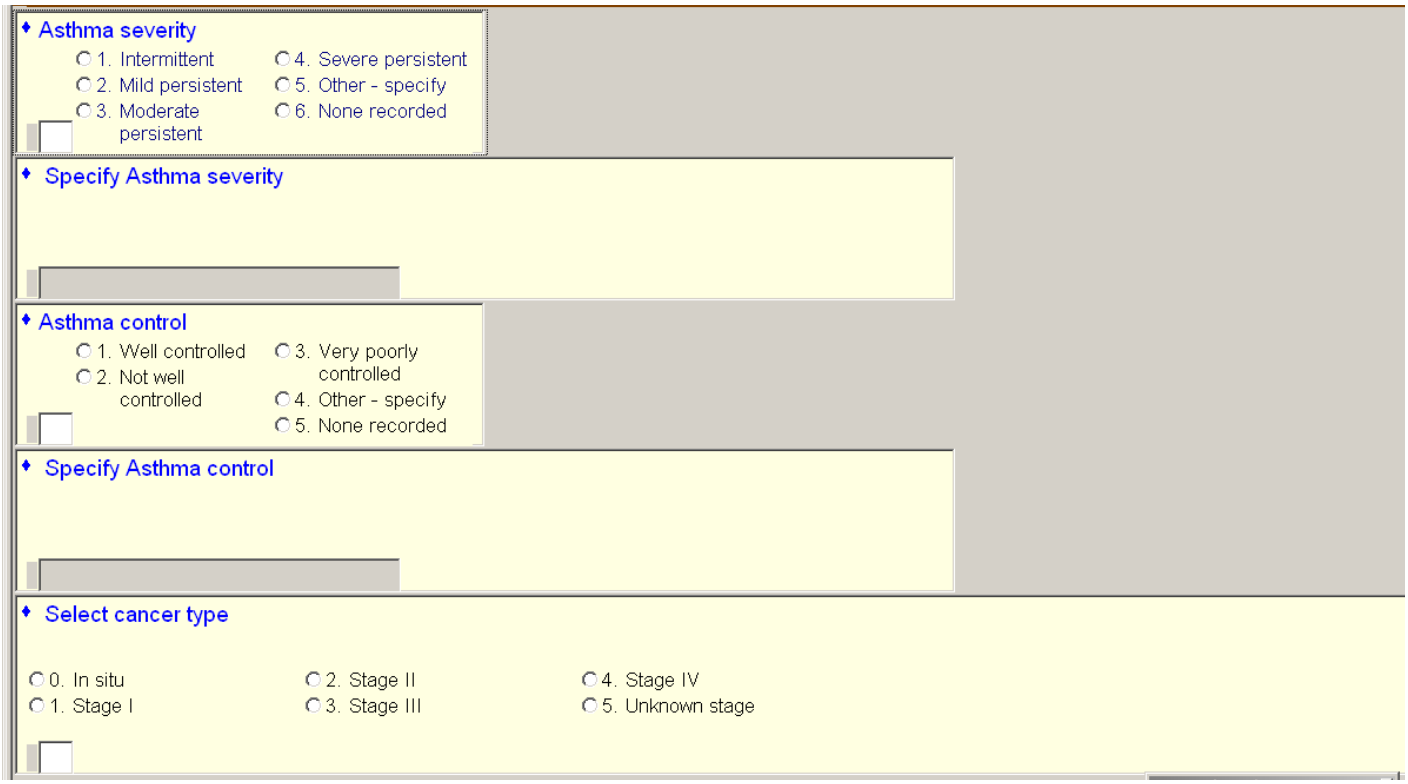
♦ As specifically as possible, list diagnoses related to this visit , including chronic conditions.
Enter "XXX" if diagnosis cannot be found

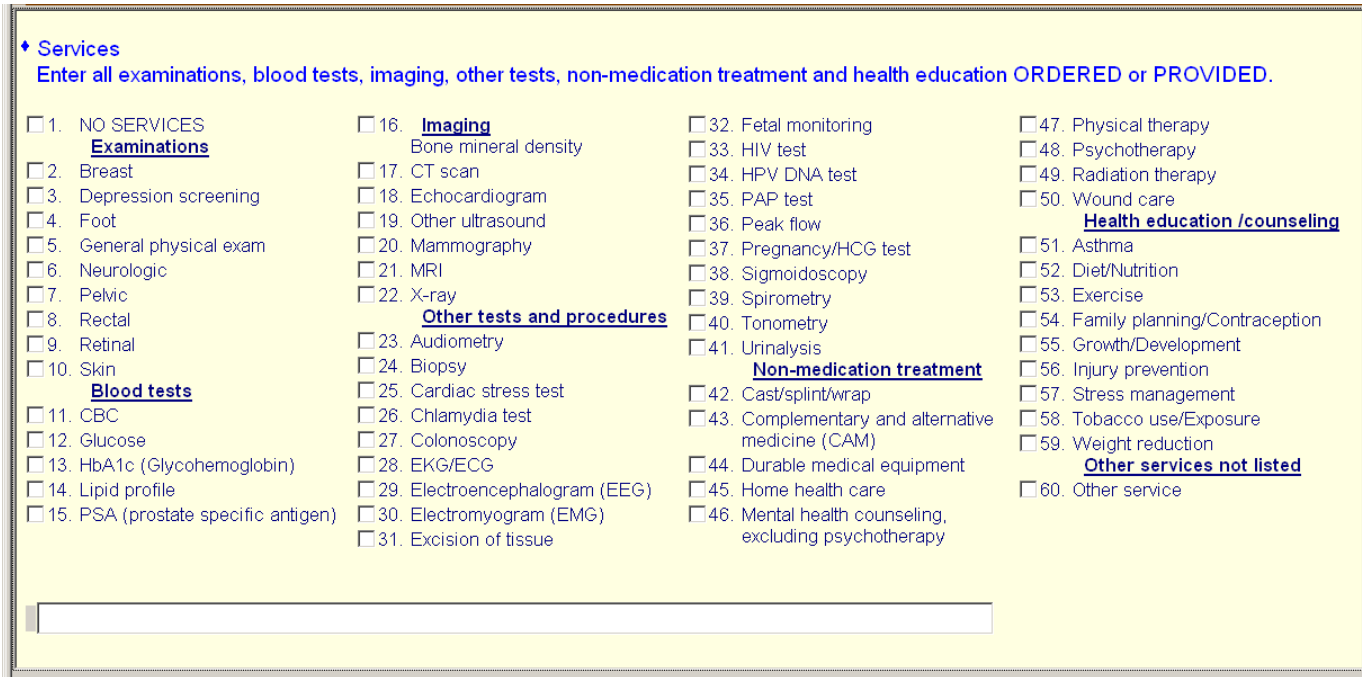
♦ Enter 0 if no other diagnoses

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

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


Asthma severity
1. Intermittent
2. Mild persistent
3. Moderate persistent
4. Severe persistent
5. Other - specify
6. None recorded
Specify Asthma severity
Asthma control
1. Well controlled
2. Not well controlled
3. Very poorly controlled
4. Other - specify
5. None recorded
Specify Asthma control
Select cancer type
0. In situ
1. Stage I
2. Stage II
3. Stage III
4. Stage IV
5. Unknown stage


Services
Enter all examinations, blood tests, imaging, other tests, non-medication treatment and health education ORDERED or PROVIDED.
1. NO SERVICES
Examinations
2. Breast
3. Depression screening
4. Foot
5. General physical exam
6. Neurologic
7. Pelvic
8. Rectal
9. Retinal
10. Skin
Blood tests
11. CBC
12. Glucose
13. HbA1c (Glycohemoglobin)
14. Lipid profile
15. PSA (prostate specific antigen)
16. Imaging
Bone mineral density
17. CT scan
18. Echocardiogram
19. Other ultrasound
20. Mammography
21. MRI
22. X-ray
Other tests and procedures
23. Audiometry
24. Biopsy
25. Cardiac stress test
26. Chlamydia test
27. Colonoscopy
28. EKG/ECG
29. Electroencephalogram (EEG)
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
Non-medication treatment
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
Health education /counseling
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
Other services not listed
60. Other service

♦ 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

♦ Were any prescription or non-prescription drugs ORDERED or PROVIDED (by any route of administration) at this visit?
Include Rx and OTC drugs, immunizations, allergy shots, oxygen, anesthetics, chemotherapy, and dietary supplements that were ordered, supplied, administered, or continued during this visit.
Include drugs prescribed at a previous visit if the patient was instructed at THIS VISIT to continue with the medication.

- 1. Yes
- 2. No

Drugs Ordered

♦ 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

	Drug	Drug Lookup	New/Continued
[1]			
[2]			
[3]			

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

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

♦ 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

♦ 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	

Lookback

♦ Collect the following data for each prior visit in the previous 12 months.

Collect up to 10 prior visits, starting with the oldest. (Exclude telephone calls, emails, and faxes).

Reference Time: 5/4/2010 - 5/4/2011

Reference Time: 5/4/2010 - 5/4/2011

♦ Date of visit (Format MM/DD/YYYY)

♦ Smoke cigarettes

○ 1. Not current
○ 2. Current
○ 3. Unknown

♦ Does the patient now have

Enter all that apply, separate with commas

- ☐ 1. NONE
- ☐ 2. Cerebrovascular disease/history of stroke or transient ischemic attack (TIA)
- ☐ 3. Congestive heart failure (CHF)
- ☐ 4. Diabetes
- ☐ 5. Hypertension
- ☐ 6. Hyperlipidemia
- ☐ 7. Ischemic heart disease

♦ Does the patient have a family history of premature coronary heart disease (CHD), coronary artery disease (CAD), or ischemic heart disease (IHD)...

...in a father, son, or brother less than age 55

- ○ 1. Yes
- ○ 2. No
- ○ 3. Unknown

♦ Does the patient have a family history of premature coronary heart disease (CHD), coronary artery disease (CAD), or ischemic heart disease (IHD)...

...in a mother, daughter, or sister less than age 55?

- ○ 1. Yes
- ○ 2. No
- ○ 3. Unknown

Skipping height through BP systolic screens- simply asks to fill in the number

♦ Blood pressure - DIASTOLIC

Enter 998 for P, PAL, DOPP, or DOPPLER

♦ Services

Enter all that apply, separate with commas

- ☐ 1. NONE
- ☐ 2. Lipids/cholesterol
- ☐ 3. HgbA1c (Glycohemoglobin A1c)
- ☐ 4. Fasting blood glucose (FBG)
- ☐ 5. Creatinine
- ☐ 6. Potassium
- ☐ 7. Sodium
- ☐ 8. AST/ALT
- ☐ 9. Basic metabolic panel
- ☐ 10. Comprehensive metabolic panel (CMP)

♦ Health education/counseling

Enter all that apply, separate with commas

- ☐ 1. NONE
- ☐ 2. Diet/Nutrition-Reduce fat/Cholesterol
- ☐ 3. Diet/Nutrition-Reduce salt/sodium
- ☐ 4. Weight or caloric reduction
- ☐ 5. Exercise
- ☐ 6. Smoking cessation

♦ Assessment and plan

Enter all that apply, separate with commas

- ☐ 1. NONE
- ☐ 2. Blood pressure assessment and plan
- ☐ 3. Cholesterol assessment and plan
- ☐ 4. Blood glucose assessment and plan
- ☐ 5. Referral

♦ Assessment and plan - blood pressure

Enter all that apply, separate with commas

- ☐ 1. Controlled
- ☐ 2. Elevated or uncontrolled
- ☐ 3. Medication being titrated
- ☐ 4. Ambulatory/home blood pressure monitoring normal
- ☐ 5. Patient nonadherence

♦ Assessment and plan - cholesterol

Enter all that apply, separate with commas

- ☐ 1. Controlled
- ☐ 2. Elevated or uncontrolled
- ☐ 3. Medication being titrated
- ☐ 4. Patient nonadherence

♦ Assessment and plan - blood glucose

Enter all that apply, separate with commas

- ☐ 1. Controlled
- ☐ 2. Elevated or uncontrolled
- ☐ 3. Medication being titrated
- ☐ 4. Patient nonadherence

♦ Assessment and plan - referral

Enter all that apply, separate with commas

- ☐ 1. Nurse management
- ☐ 2. Nutritionist
- ☐ 3. Smoking-cessation program
- ☐ 4. Weight loss program
- ☐ 5. Other physician, including primary care provider

♦ Is patient allergic to any medication, e.g., bleeding from aspring?

- ○ 1. Yes
- ○ 2. No
- ○ 3. Unknown

Date of visit: 1/1/2011

- List all prescription and over-the-counter (OTC) medications and immunizations ordered, administered, or continued during this visit.

  Enter 0 for no more

- Now you will be collecting labortory test results for certain tests performed within the 15 months before the sampled visit (5/4/2011).

  Collect up to 15 results for each type of test, starting with the oldest.

  Reference Time: 1/29/2010 - 5/4/2011

- Was a total cholesterol test performed within the 15 months before 5/4/2011?

  Reference Time: 1/29/2010 - 5/4/2011

○ 1. Yes
○ 2. No / not found

- Total cholesterol result (Start with the oldest test)

  Enter '999' for no more

	Visit Date	Reference Time	Chol Results	Chol Date
[1]	5/4/2011	1/29/2010		
[2]				
[3]				

- Was a high density lipoprotein (HDL) test performed within the 15 months before 5/4/2011?

  Reference Time: 1/29/2010 - 5/4/2011

○ 1. Yes
○ 2. No / not found

Total test result screens for each test is the same as cholesterol screen except with different wording to indicate the respective test, so did not copy those in.