Attachment L

OMB No. 0920-xxxx Exp. Date

Ambulatory Surgery Patient Record form

Ambulatory Care Pretest, National Hospital Care Survey

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

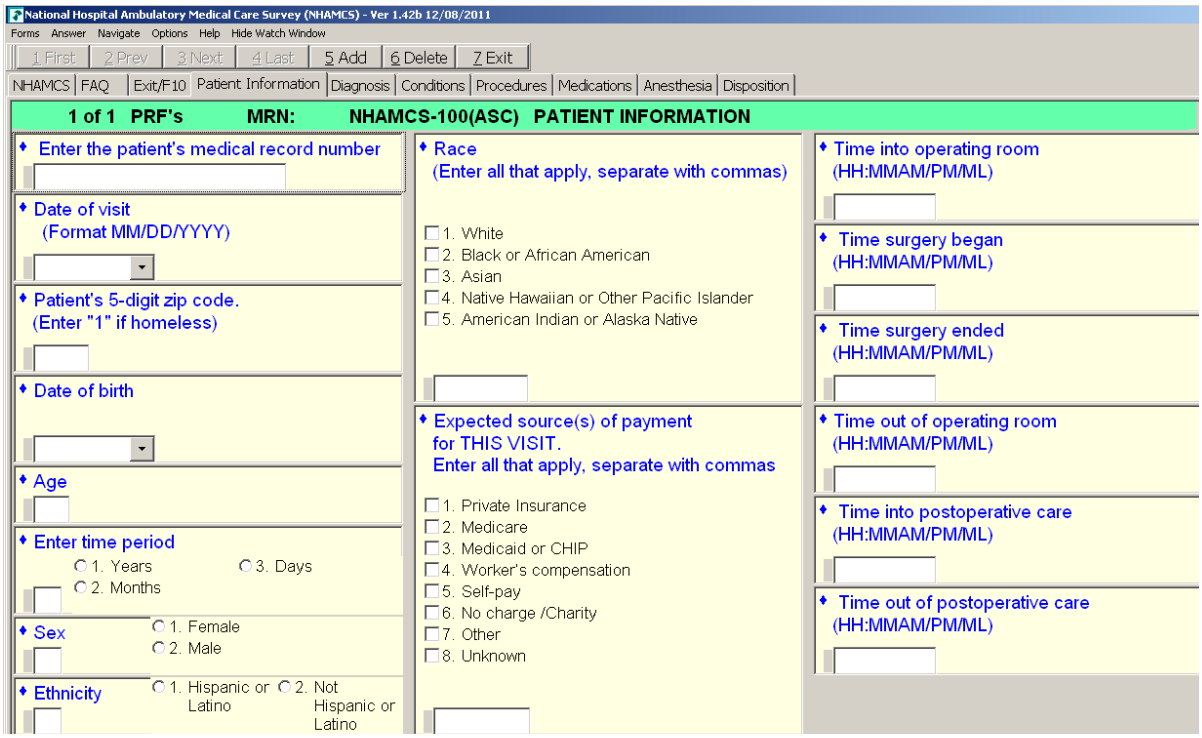
Patient's Social Security number _____

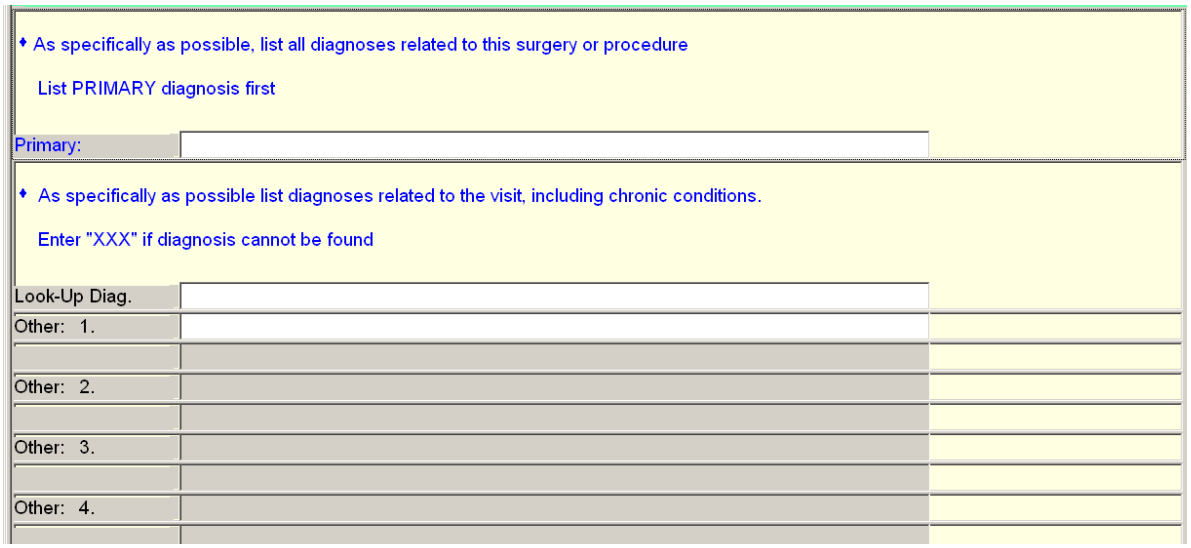
Patient's Control number _____

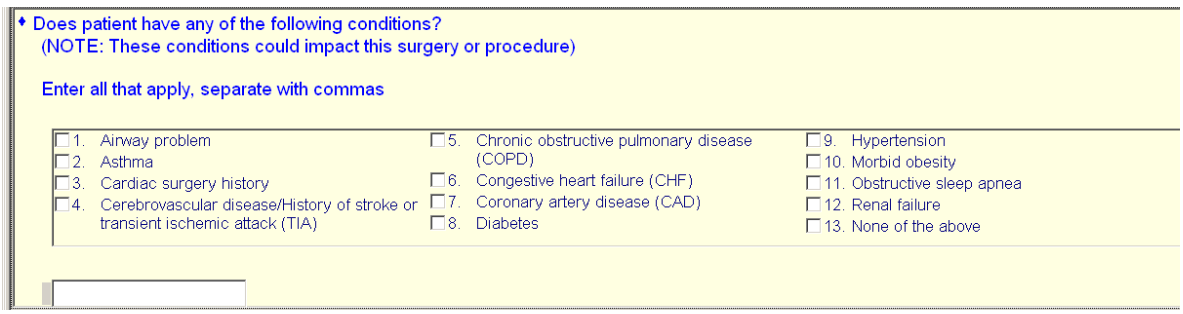
Medicare health insurance benefit/claim number _____

National Provider Identifier (NPI) - Attending _____

National Provider Identifier (NPI) - Operating _____


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 Diagnosis Conditions Procedures Medications Anesthesia Disposition
1 of 1 PRF's MRN: NHAMCS-100(ASC) 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
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
Time into operating room (HH:MMAM/PM/ML)
Time surgery began (HH:MMAM/PM/ML)
Time surgery ended (HH:MMAM/PM/ML)
Time out of operating room (HH:MMAM/PM/ML)
Time into postoperative care (HH:MMAM/PM/ML)
Time out of postoperative care (HH:MMAM/PM/ML)


As specifically as possible, list all diagnoses related to this surgery or procedure
List PRIMARY diagnosis first
Primary:
As specifically as possible list diagnoses related to the visit, including chronic conditions.
Enter "XXX" if diagnosis cannot be found
Look-Up Diag.
Other: 1.
Other: 2.
Other: 3.
Other: 4.


Does patient have any of the following conditions?
(NOTE: These conditions could impact this surgery or procedure)
Enter all that apply, separate with commas
1. Airway problem
2. Asthma
3. Cardiac surgery history
4. Cerebrovascular disease/History of stroke or transient ischemic attack (TIA)
5. Chronic obstructive pulmonary disease (COPD)
6. Congestive heart failure (CHF)
7. Coronary artery disease (CAD)
8. Diabetes
9. Hypertension
10. Morbid obesity
11. Obstructive sleep apnea
12. Renal failure
13. None of the above

♦ As specifically as possible, enter the PRIMARY diagnostic or surgical procedures performed during this visit.
Enter "0" if None/No more

Primary: 1.	
Other 2.	
Other 3.	
Other 4.	
Other 5.	
Other 6.	
Other 7.	

♦ Enter all drugs and anesthetics that were administered and whether they were administered preoperatively, intraoperatively, and/or postoperatively.

○ 1. None/no more	○ 5. Oxygen	○ 9. Zofran (Odansetron)
○ 2. Fentanyl	○ 6. Pentothal	○ 10. Other, please specify
○ 3. Lidocaine	○ 7. Propofol	
○ 4. Nitrous oxide	○ 8. Versed (Midazolam)	

♦ Type(s) of anesthesia listed in the VDRUG fields

Enter all that apply, separate with commas

☐ 1. None	☐ 5. Topical/Local	☐ 10. Other Regional block
☐ 2. General	☐ 6. Regional Epidural	☐ 11. Other
☐ 3. IV sedation	☐ 7. Regional Spinal	
☐ 4. MAC (Monitored Anesthesia Care)	☐ 8. Regional Retrobulbar block	
	☐ 9. Regional Peribulbar block	

♦ Anesthesia administered by

Enter all that apply, separate with commas

☐ 1. Anesthesiologist	☐ 5. Other provider
☐ 2. CRNA (Certified Registered Nurse Anesthetist)	☐ 6. Unknown
☐ 3. Surgeon/Other physician	
☐ 4. Resident	

♦ Symptoms present during or after procedure
Enter all that apply, separate with commas

☐ 1. NONE	☐ 6. Hypotension/Low blood pressure - >20% change from baseline	☐ 11. Surgical complications- unanticipated
☐ 2. Airway problem or aspiration	☐ 7. Hypoxia	☐ 12. Urinary retention
☐ 3. Arrhythmia- significant	☐ 8. Nausea- moderate to severe	☐ 13. Vomiting- moderate to severe
☐ 4. Bleeding (post-operative) - moderate to severe	☐ 9. Pain- moderate to severe	☐ 14. Other
☐ 5. Hypertension/High blood pressure - >20% change from baseline	☐ 10. Sedation- excessive	

♦ Enter Disposition

○ 1. Routine discharge to customary residence	○ 4. Admitted to hospital as inpatient	○ 8. Other
○ 2. Discharge to observation status	○ 5. Referred to ED	○ 9. Unknown
○ 3. Discharge to post-surgical/recovery care facility	○ 6. Surgery terminated	
	○ 7. Procedure canceled on arrival to ambulatory surgery unit	

♦ Reason for surgery termination:

○ 1. Allergic reaction
○ 2. Unable to intubate
○ 3. Other

♦ Reason for cancellation:

○ 1. Patient not n.p.o.
○ 2. Incomplete or inadequate medical evaluation
○ 3. Surgical issue
○ 4. Other

♦ Did someone attempt to follow-up with the patient within 24 hours after the surgery?

○ 1. Yes
○ 2. No
○ 3. Unknown

♦ What was learned from this follow-up?

Enter all that apply, separate with commas

☐ 1. Unable to reach patient	☐ 4. Patient reported problems and was advised by ASC staff to seek medical care	☐ 6. Other
☐ 2. Patient reported no problems	☐ 5. Patient reported problems, but no follow-up medical care was needed	☐ 7. Unknown
☐ 3. Patient reported problems and sought medical care		