2012 ASC

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

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PRETEST

National Hospital Ambulatory Medical Care Survey

2012 Ambulatory Surgery 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!

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

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

USCENSUSBUREAU

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.

REPORTING DATES

Your reporting dates are:

Monday, _____ **through Sunday,** _____

PATIENT SIGN-IN SHEET

Record the name of every ambulatory (outpatient) surgery patient seen during the Reporting Period on one or more Sign-In Sheets maintained by the inscope ambulatory surgery locations. Record each patient in the order registered by your receptionist or seen by the provider. It is important to record every patient visit including those not seen by the provider but attended to by the staff. Patients who visit more than once during the Reporting Period should be recorded on the Sign-In Sheet at each visit.

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 ambulatory surgery center 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 ambulatory surgery center 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-126 Instruction Book for more detailed information on the sampling pattern.

DEFINITIONS

For purposes of this study:

1. An *ambulatory surgery patient* is an individual presenting for one or more previously scheduled outpatient surgical or diagnostic procedure(s). **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 surgery patient and a physician or facility staff under a physician's supervision for the purpose of seeking ambulatory (outpatient) surgery.

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 the patient's name, and 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).

FIELD REP

In case of questions or difficulty, please call the Field Representative collect:

Name

Phone Number

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NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY
2012 AMBULATORY SURGERY PATIENT RECORD

PATIENT RECORD NO.:

PATIENT'S NAME:

(Provider: Detach and keep upper portion)

Please keep (X) marks inside of boxes ➜ ☒ Correct ☒ Incorrect

1. PATIENT INFORMATION

a. Date of visit

Month		Day		Year	
				1	

b. ZIP Code

c. Date of birth

Month		Day		Year			

d. Sex
1 ☐ Female 2 ☐ Male

e. Ethnicity
1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino

f. Race – *Mark (X) all that apply.*
1 ☐ White
2 ☐ Black or African American
3 ☐ Asian
4 ☐ Native Hawaiian or Other Pacific Islander
5 ☐ American Indian or Alaska Native

g. Expected source(s) of payment for this visit – *Mark (X) all that apply.*
1 ☐ Private insurance
2 ☐ Medicare
3 ☐ Medicaid or CHIP
4 ☐ Worker's compensation
5 ☐ Self-pay
6 ☐ No charge/Charity
7 ☐ Other
8 ☐ Unknown

h. Time

	Month	Day	Year	Time	a.m.	p.m.	Military
(1) Time into operating room			1	:	☐	☐	☐
(2) Time surgery began . . .			1	:	☐	☐	☐
(3) Time surgery ended . . .			1	:	☐	☐	☐
(4) Time out of operating room			1	:	☐	☐	☐
(5) Time into postoperative care			1	:	☐	☐	☐
(6) Time out of postoperative care			1	:	☐	☐	☐

2. SURGICAL DIAGNOSIS

a. As specifically as possible, list all diagnoses related to this surgery or procedure.

		Optional – ICD-9-CM Code
Primary:	**1.**	
Other:	**2.**	
Other:	**3.**	
Other:	**4.**	
Other:	**5.**	

b. Other diagnoses that could impact this surgery or procedure – *Mark (X) all that apply.*

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 ☐ Other

3. PROCEDURE(S)

As specifically as possible, list all diagnostic and surgical procedures performed during this visit.

☐ NONE

		Optional – CPT-4 Code	Optional – ICD-9-CM-Code
Primary:	**1.**		
Other:	**2.**		
Other:	**3.**		
Other:	**4.**		
Other:	**5.**		
Other:	**6.**		
Other:	**7.**		

PLEASE CONTINUE ON THE REVERSE SIDE

4. MEDICATION(S) & ANESTHESIA

a. Mark (X) all drugs and anesthetics that were administered and whether they were administered preoperatively, intraoperatively, and/or postoperatively.

	Preop	Intraop	Postop
1 ☐ NONE – *SKIP to item 6.*			
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 ☐	3 ☐
8 ☐ Zofran	1 ☐	2 ☐	3 ☐
9 ☐ Other – *Specify*	1 ☐	2 ☐	3 ☐
10 ☐ Other – *Specify*	1 ☐	2 ☐	3 ☐
11 ☐ Other – *Specify*	1 ☐	2 ☐	3 ☐
12 ☐ Other – *Specify*	1 ☐	2 ☐	3 ☐

b. Type(s) of anesthesia listed in 4a – *Mark (X) all that apply.*

1 ☐ NONE – *SKIP to item 6.*
2 ☐ General
3 ☐ IV sedation
4 ☐ MAC (Monitored Anesthesia Care)
5 ☐ Topical/Local

Regional
6 ☐ Epidural
7 ☐ Spinal
8 ☐ Retrobulbar block
9 ☐ Peribulbar block
10 ☐ Other block

11 ☐ Other

5. PROVIDER(S) OF ANESTHESIA

Anesthesia administered by –
Mark (X) all that apply.

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

6. SYMPTOM(S) PRESENT DURING OR AFTER PROCEDURE

Mark (X) all that apply.

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

7. DISPOSITION

Mark (X) one box.

1 ☐ Routine discharge to customary residence
2 ☐ Discharge to observation status
3 ☐ Discharge to post-surgical/recovery care facility
4 ☐ Admitted to hospital as inpatient
5 ☐ Referred to ED
6 ☐ Surgery terminated
Reason for termination
☐ Allergic reaction
☐ Unable to intubate
☐ Other
7 ☐ Procedure canceled on arrival to ambulatory surgery unit
Reason for cancellation
☐ Patient not n.p.o.
☐ Incomplete or inadequate medical evaluation
☐ Surgical issue
☐ Other
8 ☐ Other
9 ☐ Unknown

8. FOLLOW-UP INFORMATION

a. Did someone attempt to follow-up with the patient within 24 hours after the surgery?
Mark (X) one box.

1 ☐ Yes – *Continue with Item 8b.*
2 ☐ No
3 ☐ Unknown
} *END – Patient Record complete.*

b. What was learned from this follow-up?
Mark (X) all that apply.

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