# Attachment T: Ambulatory Surgery Patient Record form

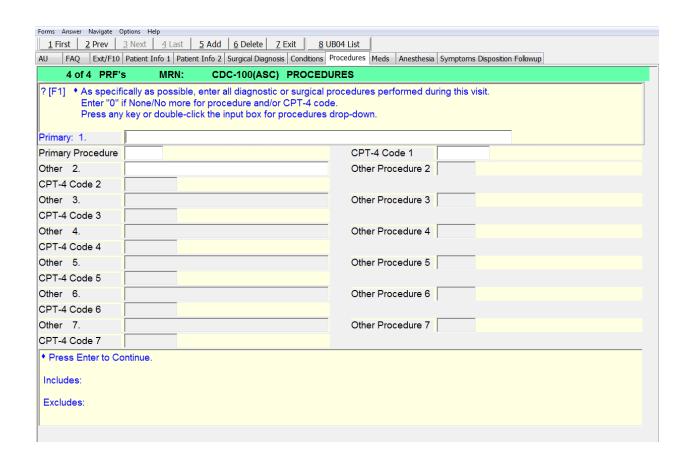## Ambulatory Component, National Hospital Care Survey

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**4 of 4  PRF's          MRN:          CDC-100(ASC)  PATIENT INFORMATION**

♦ Enter the patient's name

♦ Is the patient's Social Security Number documented?
  ○ 1. Yes     ○ 2. No

♦ Enter the patient's Social Security Number
  ___-__-____

? [F1]  ♦ Is the patient's Control Number documented?
  ○ 1. Yes     ○ 2. No

♦ Enter the patient's Control Number

♦ Is the patient's address documented?
  ○ 1. Yes     ○ 2. No

♦ What is the patient's address? Enter the number and street.

♦ Enter the second line of the address

♦ Enter the city

♦ Enter the state

♦ Patient's 5-digit zip code. (Enter "1" if homeless)

? [F1]  ♦ Is the patient's Medical Record Number documented?
  ○ 1. Yes     ○ 2. No

♦ Enter the patient's Medical Record Number.

? [F1]  ♦ Is the patient's Medicare Health Insurance Benefit/Claim Number documented?
  ○ 1. Yes     ○ 2. No

♦ Enter the patient's Medicare Health Insurance Benefit/Claim Number.

? [F1]  ♦ Is the National Provider Identifier - Attending documented?
  ○ 1. Yes     ○ 2. No

♦ Enter the National Provider Identifier - Attending.

? [F1]  ♦ Is the National Provider Identifier - Operating documented?
  ○ 1. Yes     ○ 2. No

♦ Enter the National Provider Identifier - Operating.

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◆ Date of visit
(Format MM/DD/YYYY)

[          ] [▾]

◆ Date of birth. Enter mm/dd/yyyy.

[          ] [▾]

◆ Age

[     ]

◆ Enter time       ○ 1. Years        ○ 3. Days
period           ○ 2. Months
[  ]

◆ Sex       ○ 1. Female
[  ]        ○ 2. Male

?[F1]   ◆ Ethnicity
○ 1. Hispanic or      ○ 2. Not Hispanic or
Latino                Latino
[  ]

? [F1]
◆ 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

[          ]

? [F1]
◆ 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

[          ]

? [F1]   ◆ Time into operating room
(HH:MMAM/PM/ML)

[          ]

? [F1]   ◆ Time surgery began
(HH:MMAM/PM/ML)

[          ]

? [F1]   ◆ Time surgery ended
(HH:MMAM/PM/ML)

[          ]

? [F1]   ◆ Time out of operating room
(HH:MMAM/PM/ML)

[          ]

? [F1]   ◆ Time into postoperative care
(HH:MMAM/PM/ML)

[          ]

? [F1]   ◆ Time out of postoperative care
(HH:MMAM/PM/ML)

[          ]

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**4 of 4  PRF's        MRN:        CDC-100(ASC)  SURGICAL DIAGNOSIS**

? [F1]
♦ As specifically as possible, list all diagnoses related to this surgery or procedure.

   List PRIMARY diagnosis first

| Primary: | |
| --- | --- |

? [F1]
♦ As specifically as possible list diagnoses related to the visit, including chronic conditions.

   Enter "XXX" if diagnosis cannot be found
   Enter the ICD9 Code. Enter 0 if None.

| Look-Up Diag. | |
| --- | --- |
| ICD9 Code | |
| Other:  1. | |
| Look-Up Diag. | |
| ICD9 Code | |
| Other:  2. | |
| Look-Up Diag. | |
| ICD9 Code | |
| Other:  3. | |
| Look-Up Diag. | |
| ICD9 Code | |
| Other:  4. | |
| Look-Up Diag. | |
| ICD9 Code | |

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**4 of 4  PRF's        MRN:        CDC-100(ASC)  CONDITIONS**

? [F1]  ♦ Does the patient have any of the following conditions that 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
☐ 14. Not documented

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? [F1]  ♦ As specifically as possible, enter all diagnostic or surgical procedures performed during this visit.
Enter "0" if None/No more for procedure and/or CPT-4 code.
Press any key or double-click the input box for procedures drop-down.

Primary:  1.

| Primary Procedure | | | CPT-4 Code 1 | | |
| Other   2. | | | Other Procedure 2 | | |
| CPT-4 Code 2 | | | | | |
| Other   3. | | | Other Procedure 3 | | |
| CPT-4 Code 3 | | | | | |
| Other   4. | | | Other Procedure 4 | | |
| CPT-4 Code 4 | | | | | |
| Other   5. | | | Other Procedure 5 | | |
| CPT-4 Code 5 | | | | | |
| Other   6. | | | Other Procedure 6 | | |
| CPT-4 Code 6 | | | | | |
| Other   7. | | | Other Procedure 7 | | |
| CPT-4 Code 7 | | | | | |

♦ Press Enter to Continue.

Includes:

Excludes:

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? [F1]
♦ 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 (Ondansetron) |
| ○ 2.  Fentanyl | ○ 6.  Pentothal | ○ 10. Other, please specify |
| ○ 3.  Lidocaine | ○ 7.  Propofol | |
| ○ 4.  Nitrous oxide | ○ 8.  Versed (Midazolam) | |

| Medicati | Drug | Drug Lookup | When | |
| | | | | |

? [F1]
♦ What is the other drug?

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? [F1]
♦ Type(s) of anesthesia administered.

  Enter all that apply, separate with commas

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

? [F1]
♦ Anesthesia administered by

  Enter all that apply, separate with commas

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

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**4 of 4   PRF's        MRN:        CDC-100(ASC)   SYMPTOMS, DISPOSITION, AND FOLLOWUP**

? [F1]
♦ Symptoms present during or after procedure. Enter all that apply, separate with commas

- ☐ 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

? [F1]
♦ Enter Disposition

- ○ 1. Routine discharge to customary residence
- ○ 2. Patient was moved to observation/post-surgical /recovery care area in same facility, i.e., not admitted as an inpatient.
- ○ 3. Admitted to hospital as inpatient
- ○ 4. Referred to ED
- ○ 5. Surgery terminated
- ○ 6. Procedure canceled on arrival to ambulatory surgery unit
- ○ 7. Other
- ○ 8. Unknown

♦ 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

? [F1] ♦ Did someone attempt to follow-up with the patient within 24 hours after the surgery?
- ○ 1. Yes
- ○ 2. No
- ○ 3. Unknown

? [F1]
♦ What was learned from this follow-up?

  Enter all that apply, separate with commas

- ☐ 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