

Attachment BB- National Ambulatory Medical Care Survey 2012: Patient Record Form – CPT Code Pretest

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OMB No. 0920-0234: Approval expires 03/31/2013

National Ambulatory Medical Care Survey (NAMCS) - version 1.33

Forms Answer Navigate Options Help Show Watch Window

1 First 2 Prev 3 Next 4 Last 5 Add 6 Delete 7 Exit

NAMCS FAQ Exit/F10 Practice Care_Visits EMR Rev_Cont NewPat_Comp Pat_Appts Asthma CAMs PRF Patient Information Vital Signs Injury or Poisoning Continuity

1 of 1 PRF's MRN: NAMCS PATIENT INFORMATION

<p>♦ Enter Office Number <input type="radio"/> 1. 1</p> <p>♦ Enter the patient's medical record number</p> <p>♦ Date of visit (arrival) (Format MM/DD/YYYY)</p> <p>♦ Patient's 5 digit zip code. (Enter "1" if homeless)</p> <p>♦ Date of birth</p>	<p>♦ Age</p> <p>♦ Enter time period <input type="radio"/> 1. Years <input type="radio"/> 3. Days <input type="radio"/> 2. Months</p> <p>♦ Sex <input type="radio"/> 1. Female <input type="radio"/> 2. Male</p> <p>♦ Is patient pregnant? <input type="radio"/> 1. Yes <input type="radio"/> 2. No</p> <p>♦ Specify Gestation - Gestation week refers to the number of weeks plus 2 that the offspring has spent developing in the uterus</p> <p>♦ Last menstrual period - Month/Day/Year</p> <p>♦ Ethnicity <input type="radio"/> 1. Hispanic or Latino <input type="radio"/> 2. Not Hispanic or Latino</p>	<p>♦ Race (Enter all that apply, separate with commas)</p> <p><input type="checkbox"/> 1. White <input type="checkbox"/> 4. Native Hawaiian/ Other Pacific Islander <input type="checkbox"/> 2. Black/ African-American <input type="checkbox"/> 5. American Indian/ Alaska Native <input type="checkbox"/> 3. Asian</p> <p>♦ Expected source(s) of payment for THIS VISIT. (Enter all that apply, separate with commas)</p> <p><input type="checkbox"/> 1. Private Insurance <input type="checkbox"/> 5. Self-pay <input type="checkbox"/> 2. Medicare <input type="checkbox"/> 6. No charge /Charity <input type="checkbox"/> 3. Medicaid <input type="checkbox"/> 7. Other <input type="checkbox"/> 4. Worker's compensation <input type="checkbox"/> 8. Unknown</p> <p>♦ Tobacco Use <input type="radio"/> 1. Not current <input type="radio"/> 3. Unknown <input type="radio"/> 2. Current</p>
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1 of 1 PRF's MRN: NAMCS Vital signs

<p>♦ Height (feet) <input type="text"/></p>	<p>♦ Height (centimeters) <input type="text"/></p>
<p>♦ Height (inches) <input type="text"/></p>	
<p>♦ Weight (pounds) <input type="text"/></p>	<p>♦ Weight (kilograms) <input type="text"/></p>
<p>♦ Weight (ounces) <input type="text"/></p>	<p>♦ Weight (gm) <input type="text"/></p>
<p>♦ Temperature <input type="text"/></p>	<p>♦ Temperature type <input type="radio"/> 1. Celsius <input type="radio"/> 2. Fahrenheit</p>
<p>♦ Blood Pressure - SYSTOLIC Refers to the top number of the blood pressure measurement. <input type="text"/></p>	<p>♦ Blood pressure - DIASTOLIC Refers to the bottom number of the blood pressure measurement. Enter 998 for P, PAL, DOPP, or DOPPLER <input type="text"/></p>

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1 of 1 PRF's MRN: NAMCS INJURY/POISONING/ADVERSE EFFECT

♦ 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

♦ Is this injury/poisoning unintentional or intentional?
 1. Yes, unintentional 2. Yes, intentional

<p>♦ 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 <input type="text"/></p>	<p>♦ Locate the reason for visit in the look-up table. Enter XXX if reason cannot be found <input type="text"/></p>
<p>♦ <input type="text"/></p>	<p>♦ Locate the reason for visit in the look-up table. Enter XXX if reason cannot be found <input type="text"/></p>
<p>♦ <input type="text"/></p>	<p>♦ Locate the reason for visit in the look-up table. Enter XXX if reason cannot be found <input type="text"/></p>

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1 of 1 PRF's MRN: NAMCS Continuity of care

♦ Are you the patient's primary care physician?

1. Yes 2. No 3. Unknown

♦ Was patient referred for this visit?

1. Yes 2. No 3. Unknown

♦ Has the patient been seen in your practice before?

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

♦ How many past visits to this clinic in the last 12 months? (Exclude this visit)

♦ Major reason for this visit

1. New problem (<3 mos. onset) 5. Preventive care (e.g., routine prenatal, well-baby, screening, insurance, general exams)

2. Chronic problem, routine

3. Chronic problem, flare-up

4. Pre/Post surgery

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1 of 1 PRF's MRN: NAMCS Providers diagnosis for this visit

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

♦ Enter 0 if no other diagnoses

♦ Enter 0 if no other diagnoses

♦ Locate the diagnosis in the look-up table.
Enter "XXX" if diagnosis cannot be found

♦ Locate the diagnosis in the look-up table.
Enter "XXX" if diagnosis cannot be found

♦ Locate the diagnosis in the look-up table.
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 5. Chronic obstructive pulmonary disease (COPD) 11. Hypertension

2. Asthma 6. Chronic renal failure 12. Ischemic heart disease

3. Cancer 7. Congestive heart failure 13. Obesity

4. Cerebrovascular disease/History of stroke or transient ischemic attack (TIA) 8. Depression 14. Osteoporosis

9. Diabetes 15. None of the above

10. Hyperlipidemia

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1 of 1 PRF's MRN: NAMCS Providers diagnosis for this visit

♦ Asthma severity

1. Intermittent 4. Severe persistent

2. Mild persistent 5. Other - specify

3. Moderate persistent 6. none recorded

♦ Specify Asthma severity

♦ Asthma control

1. Well controlled 3. Very poorly controlled

2. Not well controlled 4. Other - specify

5. None recorded

♦ Specify Asthma control

? [F1]

♦ Select cancer type

0. In situ 2. Stage II 4. Stage IV

1. Stage I 3. Stage III 5. Unknown stage

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1 of 1 PRF's MRN: NAMCS Services

? [F1]

♦ Services

Enter all examinations, blood tests, imaging, other tests, non-medication treatment and health education ORDERED or PROVIDED.

<input type="checkbox"/> 1. NO SERVICES	<input type="checkbox"/> 16. <u>Imaging</u>	<input type="checkbox"/> 32. Fetal monitoring	<input type="checkbox"/> 47. Physical therapy
<input type="checkbox"/> 2. Breast <u>Examinations</u>	<input type="checkbox"/> 17. CT scan	<input type="checkbox"/> 33. HIV test	<input type="checkbox"/> 48. Psychotherapy
<input type="checkbox"/> 3. Depressing screening	<input type="checkbox"/> 18. Echocardiogram	<input type="checkbox"/> 34. HPV DNA test	<input type="checkbox"/> 49. Radiation therapy
<input type="checkbox"/> 4. Foot	<input type="checkbox"/> 19. Other ultrasound	<input type="checkbox"/> 35. PAP test	<input type="checkbox"/> 50. Wound care
<input type="checkbox"/> 5. General physical exam	<input type="checkbox"/> 20. Mammography	<input type="checkbox"/> 36. Peak flow	<input type="checkbox"/> <u>Health education /counseling</u>
<input type="checkbox"/> 6. Neurologic	<input type="checkbox"/> 21. MRI	<input type="checkbox"/> 37. Pregnancy/HCG test	<input type="checkbox"/> 51. Asthma
<input type="checkbox"/> 7. Pelvic	<input type="checkbox"/> 22. X-ray	<input type="checkbox"/> 38. Sigmoidoscopy	<input type="checkbox"/> 52. Diet/Nutrition
<input type="checkbox"/> 8. Rectal	<input type="checkbox"/> <u>Other tests and procedures</u>	<input type="checkbox"/> 39. Spirometry	<input type="checkbox"/> 53. Exercise
<input type="checkbox"/> 9. Retinal	<input type="checkbox"/> 23. Audiometry	<input type="checkbox"/> 40. Tonometry	<input type="checkbox"/> 54. Family planning/Contraception
<input type="checkbox"/> 10. Skin	<input type="checkbox"/> 24. Biopsy	<input type="checkbox"/> 41. Urinalysis	<input type="checkbox"/> 55. Growth/Development
<input type="checkbox"/> <u>Blood tests</u>	<input type="checkbox"/> 25. Cardiac stress test	<input type="checkbox"/> <u>Non-medication treatment</u>	<input type="checkbox"/> 56. Injury prevention
<input type="checkbox"/> 11. CBC	<input type="checkbox"/> 26. Chlamydia test	<input type="checkbox"/> 42. Cast/splint/wrap	<input type="checkbox"/> 57. Stress management
<input type="checkbox"/> 12. Glucose	<input type="checkbox"/> 27. Colonoscopy	<input type="checkbox"/> 43. Complementary and alternative medicine (CAM)	<input type="checkbox"/> 58. Tobacco use/Exposure
<input type="checkbox"/> 13. HgbA1c (Glycohemoglobin)	<input type="checkbox"/> 28. Electroencephalogram (EEG)	<input type="checkbox"/> 44. Durable medical equipment	<input type="checkbox"/> 59. Weight reduction
<input type="checkbox"/> 14. Lipid profile	<input type="checkbox"/> 29. EKG/ECG	<input type="checkbox"/> 45. Home health care	<input type="checkbox"/> <u>Other services not listed</u>
<input type="checkbox"/> 15. PSA (prostate specific antigen)	<input type="checkbox"/> 30. Electromyogram (EMG)	<input type="checkbox"/> 46. Mental health counseling, excluding psychotherapy	<input type="checkbox"/> 60. Other service
	<input type="checkbox"/> 31. Excision of tissue		

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1 of 1 PRF's MRN: NAMCS Services

♦ 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

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1 of 1 PRF's MRN: NAMCS Services

♦ Specify other exam/test/service

♦ Specify other exam/test/service
Enter '0' if no other exam/test/services provided

♦ Specify other exam/test/service
Enter '0' if no other exam/test/services provided

♦ Specify other exam/test/service
Enter '0' if no other exam/test/services provided

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Enter '0' if no other exam/test/services provided

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1 of 1 PRF's MRN: NAMCS Medications & Immunization

♦ Were any prescription or non-prescription drugs ORDERED or PROVIDED (by any route of administration) at this visit? Include allergy shots and other biologicals. Also, include drugs prescribed at a previous visit if the patient was instructed at THIS VISIT to continue with the medication.

1. Yes 2. No

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♦ 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

Drugs 1	<input type="radio"/> 1. New	<input type="radio"/> 2. Continued
1 Other		
Drugs 2	<input type="radio"/> 1. New	<input type="radio"/> 2. Continued
2 Other		
Drugs 3	<input type="radio"/> 1. New	<input type="radio"/> 2. Continued
3 Other		
Drugs 4	<input type="radio"/> 1. New	<input type="radio"/> 2. Continued
4 Other		
Drugs 5	<input type="radio"/> 1. New	<input type="radio"/> 2. Continued
5 Other		
Drugs 6	<input type="radio"/> 1. New	<input type="radio"/> 2. Continued
6 Other		
Drugs 7	<input type="radio"/> 1. New	<input type="radio"/> 2. Continued
7 Other		
Drugs 8	<input type="radio"/> 1. New	<input type="radio"/> 2. Continued
8 Other		
Drugs 9	<input type="radio"/> 1. New	<input type="radio"/> 2. Continued
9 Other		
Drugs 10	<input type="radio"/> 1. New	<input type="radio"/> 2. Continued
10 Other		

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1 of 1 PRF's MRN: NAMCS Providers

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

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

Enter 0 if no provider seen

♦ 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

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1 of 1 PRF's MRN: NAMCS Providers

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
<input type="checkbox"/> Total cholesterol? (1 = yes 2 = none found)	<input type="text"/> Total cholesterol mg/dl	<input type="text"/>
<input type="checkbox"/> High density lipoprotein (HDL)? (1 = yes 2 = none found)	<input type="text"/> HDL mg/dl	<input type="text"/>
<input type="checkbox"/> Low density lipoprotein (LDL)? (1 = yes 2 = none found)	<input type="text"/> LDL mg/dl	<input type="text"/>
<input type="checkbox"/> Triglycerides (TGS) ? (1 = yes 2 = none found)	<input type="text"/> TGS mg/dl	<input type="text"/>
<input type="checkbox"/> HbA1c Glycohemoglobin ? (1 = yes 2 = none found)	<input type="text"/> A1C %	<input type="text"/>
<input type="checkbox"/> Fasting blood glucose (FBG) ? (1 = yes 2 = none found)	<input type="text"/> FBG mg/dl	<input type="text"/>

Please indicate all CPT codes associated with the current visit:

1.
2.
3.
4.
5.

6.
7.
8.
9.
10.

11.
12.
13.
14.
15.

No CPT codes associated with the current visit.