SAMPLE
NATIONAL HOSPITAL CARE SURVEY – AMBULATORY COMPONENT

OUTPATIENT DEPARTMENT PATIENT RECORD

2014

OMB No. 0920-0212; Expiration date XX/XX/20XX

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| **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 INFORMATION** |
| **Patient’s name** | **PATIENT\_NAME** | **Patient’s SSSSNSSN** | **PATIENT\_SSN / ENTER\_SSN** | **Patient’s Control #** | **PTCTRLNUM /ENTER\_PTCTRLNUM EEEEENTER\_ENTER\_PTCTRLNUM** |
| **Patient’s address: RESIDENCE Street** | **PT\_STRET / PT\_STRET2** | **City** | **PT\_CITY** | **State** | **PT\_ST** | **Zip Code** | **PATZIP** |
| **Patient’s medical record #** | **PTMEDRECNUM / ENTER\_PTMEDRECNUM** | **Medicare Health Insurance Benefit/Claim #** | **MEDHLTHINSBEN /ENTER\_MEDHLTHINSBEN** |
| **NPI – Attending** | **NPI\_ATTEND / ENTER\_NPI\_ATTEND** | **NPI – Operating** | **NPI\_OPERATING / ENTER\_NPI\_OPERATING** |
| **Hospital location where visit occurred** | **HOSP\_LOC** |  |
| **Date of Visit**  | **Sex SEX**1 [ ]  Female – **Is patient pregnant?** **PREG** 1 [ ]  Yes – **Specify gestation**

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| **GESTWK** |

 **week**2 [ ]  No2 [ ]  Male**Ethnicity ETHNIC**1 [ ]  Hispanic or Latino2 [ ]  Not Hispanic or Latino | **Race –** *Mark (X) all that apply*. **MULTIRACE1-5** | **Expected source(s) of payment for this visit –** *Mark (X) all that apply*.**PAY\_SOURCE1-8**1 [ ]  Private insurance2 [ ]  Medicare3 [ ]  Medicaid or CHIP or other state-based program4 [ ]  Workers’ compensation5 [ ]  Self-pay6 [ ]  No charge/Charity7 [ ]  Other8 [ ]  Unknown | **Tobacco use****USETOBAC**1 [ ]  Not current  **EVERTOBAC** 1 [ ]  Never 2 [ ]  Former 3 [ ]  Unknownr 2 [ ]  Current 3 [ ]  Unknown |
| Month | Day | Year | 1 [ ]  White2 [ ]  Black or African American3 [ ]  Asian4 [ ]  Native Hawaiian or Other Pacific Islander5 [ ]  American Indian or Alaska Native |
|  | **VDATE** |  | **2** | **0** | **1** |  |
|  |
| **Date of Birth** |
| Month | Day | Year |
|  | **BDATE** |  |  |  |  |  |
| **Age AGE/AGET**

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| BIOMETRICS/VITAL SIGNS |
| **Height**

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| --- | --- | --- | --- |
| **HTFT** | ft | **HTINCG** | in |

**OR**

|  |  |  |
| --- | --- | --- |
|  | **HTCM** | cm |

 | **Weight**

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| --- | --- | --- | --- |
| **WTLBCG** | lb | **WTOZ** | oz |

**OR**

|  |  |  |  |
| --- | --- | --- | --- |
| **WTKG** | kg | **WTGM** | gm |

 | **Temperature**

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| **TEMP** |  |  |
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 | **Blood pressure**

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| --- | --- | --- |
| Systolic |  | Diastolic |
| **BPSYS** | / | **BPDIAS** |

Enter 998 for P, Palp, Dopp, or Doppler  |
| REASON FOR VISIT |
| **List the first 5 reasons for visit (i.e., complaint(s), symptom(s), problem(s), concern(s) of the patient in the order in which they appear. Start with the chief complaint and then move to the patient history for additional reasons.**  | **Major reason for this visit MAJOR**1 [ ]  New problem (<3 mos. onset)2 [ ]  Chronic problem, routine3 [ ]  Chronic problem, flare-up4 [ ]  Preventive care (e.g., routine, prenatal, well-baby, screening, insurance, general exams)5 [ ]  Pre-surgery/procedure6 [ ]  Post-surgery/procedure7 [ ]  Surgery/procedure |
| First: | 1. **VRFV1 / VRFV1\_LKUP** |  |
| Other: | 2. **VRFV2 / VRFV2\_LKUP** |  |
| Other: | 3. **VRFV3 / VRFV3\_LKUP** |  |
| Other: | 4. **VRFV4 / VRFV4\_LKUP** |  |
| Other: | 5. **VRFV5 / VRFV5\_LKUP** |  |
| INJURY/TRAUMA/OVERDOSE/POISONING/ADVERSE EFFECT |
| **Is this visit related to an injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment?**1 [ ]  Yes, injury/trauma **INJURY**2 [ ]  Yes,overdose/poisoning3 [ ]  Yes, adverse effect of medical/surgical  treatment or adverse effect of medicinal drug  *Skip ro Cause*4 [ ]  No5 [ ]  Unknown | **Did the injury/trauma or overdose/poisoning occur within 72 hours prior to the date and time of this visit?****INJURY72**1 [ ]  Yes2 [ ]  No3 [ ]  Unknown4 [ ]  Not applicable | **Is this injury/trauma or overdose/poisoning intentional?****INTENTO** 1 [ ]  Yes, intentional suicide attempt/ self-harm2 [ ]  Yes, intentional harm by another person (e.g., assault, poisoning)3 [ ]  No, unintentional (e.g., accidental)4 [ ]  Intent unclear |
|  |  |  |
| **Cause of injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment—** Describe the place and circumstances that preceded the injury/trauma, overdose/poisoning, or adverse effect.Examples:1. Injury/Trauma (e.g., patient fell while walking down stairs at home and sprained her ankle; patient was bitten by a spider)
2. Overdose/Poisoning (e.g., child was given adult cold/cough medicine and became lethargic; child swallowed large amount of liquid cleanser and began vomiting)
3. Adverse effect (e.g., patient developed a rash on his arm 2 days after taking penicillin for an ear infection)
 |
| (1) | **VCAUSE / VCAUSEDROPDOWN** |
| (2) | **VCAUSE2 / VCAUSEDROPDOWN2** |
| (3) | **VCAUSE3 / VCAUSEDROPDOWN3** |
| (4) | **VCAUSE4 / VCAUSEDROPDOWN4** |
| (5) | **VCAUSE5 / VCAUSEDROPDOWN5** |
| CONTINUITY OF CARE |
| **Is this clinic the patient’s primary care provider? PRIMCARE**1 [ ]  Yes 2 [ ]  No3 [ ]  Unknown **Was patient referred for this visit? REFER**1 [ ]  Yes2 [ ]  No3 [ ]  Unknown | **Has the patient been seen in this clinic before? SENBEFOR**1 [ ]  Yes, established patient  **How many past visits in the last 12 months?** **(**Exclude this visit.)

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| **PASTVIS** | Visits |

Enter F5 if unknown2 [ ]  No, new patient |
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| PROVIDER’S DIAGNOSIS FOR THIS VISIT |
| **As specifically as possible, list all diagnoses related to this visit, including chronic conditions. List primary diagnosis first.** | ICD-9-CM Code | ICD-10-CM Code |
| Primary: | **1.** | **VDIAG1 / VDIAG1\_LKUP** | **VDIAG1\_Code** |  |  |  |  |  | **VDIAG1\_Code10** |
| Other: | **2.** | **VDIAG2 / VDIAG2\_LKUP** | **VDIAG2\_Code** |  |  |  |  |  | **VDIAG2\_Code10** |
| Other: | **3.** | **VDIAG3 / VDIAG3\_LKUP** | **VDIAG3\_Code** |  |  |  |  |  | **VDIAG3\_Code10** |
| Other: | **4.** | **VDIAG4 / VDIAG4\_LKUP** | **VDIAG4\_Code** |  |  |  |  |  | **VDIAG4\_Code10** |
| Other: | **5.** | **VDIAG5 / VDIAG5\_LKUP** | **VDIAG5\_Code** |  |  |  |  |  | **VDIAG5\_Code10** |
|  |  |  |
| CONDITIONS |
| **Regardless of the diagnoses previously entered, does the patient now have –** *Mark (X) all that apply*. **PATIENT\_HAVE1-26** |
| 1 [ ]  Airway problem2 [ ]  Alcohol abuse, misuse, or dependence3 [ ]  Alzheimer’s disease/Dementia4 [ ]  Arthritis5 [ ]  Asthma |  6 [ ]  Cancer 7 [ ]  Cardiac surgery history 8 [ ]  Cerebrovascular disease/History of stroke (CVA) or transient ischemic attack (TIA) 9 [ ]  Chronic kidney disease (CKD) 10 [ ]  Chronic obstructive pulmonary disease (COPD) 11 [ ]  Congestive heart failure (CHF) 12 [ ]  Coronary artery disease (CAD), ischemic heart disease (IHD), or history of myocardial infarction (MI) 13 [ ]  Depression 14 [ ]  Diabetes mellitus (DM) – Type I15 [ ]  Diabetes mellitus (DM) – Type II | 16 [ ]  Diabetes mellitus (DM) – Type unspecified17 [ ]  End-stage renal disease (ESRD)18 [ ]  History of pulmonary embolism (PE), deep vein thrombosis (DVT), or venous thromboembolism (VTE)19 [ ]  HIV infection/AIDS20 [ ]  Hyperlipidemia21 [ ]  Hypertension22 [ ]  Obesity23 [ ]  Obstructive sleep apnea (OSA)24 [ ]  Osteoporosis25 [ ]  Substance abuse, misuse, or dependence26 [ ]  None of the above |
|  **Asthma severity:** **ASTH\_SEV** 1 [ ]  Intermittent2 [ ]  Mild persistent3 [ ]  Moderate persistent4 [ ]  Severe persistent5 [ ]  Other – Specify

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| **ASTH\_SEV\_SP** |

6 [ ]  None recorded | **Asthma control:****ASTH\_CON**1 [ ]  Well controlled2 [ ]  Not well controlled3 [ ]  Very poorly controlled4 [ ]  Other – Specify

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| **ASTH\_CON\_SP** |

5 [ ]  None recorded |
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| SERVICES |
| *Enter all examinations/screenings, laboratory tests, imaging, procedures,treatment,health education/counseling,and other services not listed ORDERED OR PROVIDED*. **DIAG\_SERVICE1-85** |
|  1 [ ]  NO SERVICES**Examinations/****Screenings** 2 [ ]  Alcohol abuse screening (includes AUDIT, MAST, CAGE,  T-ACE) 3 [ ]  Breast 4 [ ]  Depression screening 5 [ ]  Domestic violence  screening 6 [ ]  Foot 7 [ ]  Neurologic 8 [ ]  Pelvic 9 [ ]  Rectal 10 [ ]  Retinal/Eye Exam 11 [ ]  Skin12 [ ]  Substance abuse screening  (includes  NIDA/NM ASSIST, CAGE-AID,  DAST-10)**Laboratory Tests**13 [ ]  BMP (Basic metabolic panel)14 [ ]  CBC15 [ ]  Chlamydia test | **Laboratory Tests (cont.)**16 [ ]  CMP (Comprehensive metabolic panel)17 [ ]  Creatinine/Renal function panel18 [ ]  Culture, blood19 [ ]  Culture, throat20 [ ]  Culture, urine21 [ ]  Culture, other22 [ ]  Glucose, serum23 [ ]  Gonorrhea test24 [ ]  HbA1C (Glycohemoglobin)25 [ ]  Hepatitis panel26 [ ]  HIV test27 [ ]  HPV DNA test28 [ ]  Lipid profile/panel29 [ ]  Liver enzymes/ Hepatic function panel30 [ ]  PAP test31 [ ]  Pregnancy/HCG test32 [ ]  PSA (prostate specific antigen)33 [ ]  Rapid strep test | **Laboratory Tests (cont.)**34 [ ]  TSH/Thyroid panel35 [ ]  Urinalysis36 [ ]  Vitamin D test**Imaging**37 [ ]  Bone mineral density38 [ ]  CT scan39 [ ]  Echocardiogram40 [ ]  Ultrasound41 [ ]  Mammography42 [ ]  MRI43 [ ]  X-ray**Procedures**44 [ ]  Audiometry45 [ ]  Biopsy46 [ ]  Cardiac stress test47 [ ]  Colonoscopy48 [ ]  Cryosurgery (cryotherapy)/ Destruction of tissue49 [ ]  EKG/ECG50 [ ]  Electroencephalogram (EEG)51 [ ]  Electromyogram (EMG)52 [ ]  Excision of tissue53 [ ]  Fetal monitoring | **Procedures (cont.)**54 [ ]  Peak flow55 [ ]  Sigmoidoscopy56 [ ]  Spirometry57 [ ]  Tonometry58 [ ]  Tuberculosis skin testing/ PPD59 [ ]  Upper gastrointestinal endoscopy (EGD)**Treatments**60 [ ]  Cast/splint/wrap61 [ ]  Complementary and alternative medicine (CAM)62 [ ]  Durable medical equipment63 [ ]  Home health care64 [ ]  Mental health counseling, excluding psychotherapy65 [ ]  Occupational therapy66 [ ]  Physical therapy67 [ ]  Psychotherapy | **Treatments (cont.)**68 [ ]  Radiation therapy 69 [ ]  Wound care**Health Education/ Counseling**70 [ ]  Alcohol abuse counseling71 [ ]  Asthma72 [ ]  Asthma action plan given to patient73 [ ]  Diabetes education74 [ ]  Diet/Nutrition75 [ ]  Exercise76 [ ]  Family planning/ Contraception77 [ ]  Genetic counseling78 [ ]  Growth/ Development79 [ ]  Injury prevention80 [ ]  STD prevention81 [ ]  Stress management82 [ ]  Substance abuse counseling83 [ ]  Tobacco use/ Exposure84 [ ]  Weight reduction | **Other services not listed**85 [ ]  Other service – Specify

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| **OTHER\_SP** |

Other service – Specify

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| **OTHER\_SP2** |

Other service – Specify

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| **OTHER\_SP3** |

Other service – Specify

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| **OTHER\_SP4** |

Other service – Specify

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| **OTHER\_SP5** |

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| TESTS |
| Was blood for the following laboratory tests drawn on the day of the sampled visit or during the 12 months prior to the visit? **LAB\_TEST**1 [ ]  Yes2 [ ]  No test found | Most recent result | Date of blood draw |
| Total Cholesterol **CHOL**1 [ ]  Yes2 [ ]  No test found |

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| **CHOLRES** | mg/dL |

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| **CHOLDATE** | 201 | 0 | **1** |  |
| mm | dd | yyyy |

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| High density lipoprotein (HDL) **HDL**1 [ ]  Yes2 [ ]  No test found |

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| **HDLRES** | mg/dL |

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| **HDLDATE** | 201 | 0 | **1** |  |
| mm | dd | yyyy |

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| Low density lipoprotein (LDL) **LDL**1 [ ]  Yes2 [ ]  No test found |

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| --- | --- |
| **LDLRES** | mg/dL |

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| **LDLDATE** | 201 | 0 | **1** |  |
| mm | dd | yyyy |

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| Triglycerides **TGS**1 [ ]  Yes2 [ ]  No test found |

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| --- | --- |
| **TGSRES** | mg/dL |

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| **TGSDATE** | 201 | 0 | **1** |  |
| mm | dd | yyyy |

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| HbA1c (Glycohemoglobin) **A1C**1 [ ]  Yes2 [ ]  No test found |

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| --- | --- |
| **A1CRES** | % |

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| **A1CDATE** | 201 | 0 | **1** |  |
| mm | dd | yyyy |

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| Blood glucose (BG) **FBG**1 [ ]  Yes2 [ ]  No test found |

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| **FBGRES** | mg/dL |

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| **FBGDATE** | 201 | 0 | **1** |  |
| mm | dd | yyyy |

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| Serum creatinine **SERUM**1 [ ]  Yes2 [ ]  No test found |

|  |  |
| --- | --- |
| **SERUMRES** | mg/dL |

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|  |  |  |  |  |  |  |  |
| **SERUMDATE** | 201 | 0 | **1** |  |
| mm | dd | yyyy |

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| **MEDICATION(S)** |
| **NOMED=Were any prescription or non-prescription medications ORDERED or PROVIDED (by any route of administration) at this visit?** 1 [ ]  Yes 2 [ ]  No  **Include Rx and OTC medications, immunizations, allergy shots, oxygen, anesthetics, chemotherapy, and dietary supplements that were ordered, supplied, administered, or continued during this visit. Include medications prescribed at a previous visit if the patient was instructed at THIS VISIT to continue with the medication. Enter XXX if medication cannot be found. Enter 0 for No more.** | **New** | **NCMED** **Continued** | **Administered at this visit** |
| (1) | **VMED1 / VMEDOTH1**  |  | 1 [ ]  | 2 [ ]  | 3 [ ]  |
| (2) | **VMED2 / VMEDOTH2**  |  | 1 [ ]  | 2 [ ]  | 3 [ ]  |
| (3) | **VMED3 / VMEDOTH3**  |  | 1 [ ]  | 2 [ ]  | 3 [ ]  |
| (4) | **VMED4 / VMEDOTH4**  |  | 1 [ ]  | 2 [ ]  | 3 [ ]  |
| (5) | **VMED5 / VMEDOTH5**  |  | 1 [ ]  | 2 [ ]  | 3 [ ]  |
| (5) | **VMED6 / VMEDOTH6**  |  | 1 [ ]  | 2 [ ]  | 3 [ ]  |
| (7) | **VMED7 / VMEDOTH7**  |  | 1 [ ]  | 2 [ ]  | 3 [ ]  |
| (8) | **VMED8 / VMEDOTH8**  |  | 1 [ ]  | 2 [ ]  | 3 [ ]  |
| (9) | **VMED9 / VMEDOTH9**  |  | 1 [ ]  | 2 [ ]  | 3 [ ]  |
| (10-30) | **VMED10-30 / VMEDOTH10-30**  |  | 1 [ ]  | 2 [ ]  | 3 [ ]  |
|  |  |  |  |  |  |
| PROVIDERS |
| **Mark (X) all providers seen at this visit PROV\_SEEN1-7** |
| 1 [ ]  | NONE |  | 5 [ ]  | RN/LPN |
| 2 [ ]  | Physician |  | 6 [ ]  | Mental health provider |
| 3 [ ]  | Physician assistant (PA) |  | 7 [ ]  | Other |
| 4 [ ]  | Nurse practitioner (NP)/Midwife (CNM) |  |  |  |
|  |  |  |  |  |  |
| PROCEDURE(S) |
| **As specifically as possible, list all diagnostic and surgical procedures performed during this visit. Code each procedure using the lookup list. Once all procedures have been entered, enter 0.** | **CPT-4 Code** | **ICD-9-CM Code** | **ICD-10-CM Code** |
| Primary: | 1. **VPROC1 / VPROC1\_DD** |  | **CPTCODE1** |  | **ICD9CM1** |  |  |  | **ICD10CM1** |  |
| Other: | 2. **VPROC2 / VPROC2\_DD** |  | **CPTCODE2** |  | **ICD9CM2** |  |  |  | **ICD10CM2** |  |
| Other: | 3. **VPROC3 / VPROC3\_DD** |  | **CPTCODE3** |  | **ICD9CM3** |  |  |  | **ICD10CM3** |  |
| Other: | 4. **VPROC4 / VPROC4\_DD** |  | **CPTCODE4** |  | **ICD9CM4** |  |  |  | **ICD10CM4** |  |
| Other: | 5. **VPROC5 / VPROC5\_DD** |  | **CPTCODE5** |  | **ICD9CM5** |  |  |  | **ICD10CM5** |  |
| Other: | 6. **VPROC6 / VPROC6\_DD** |  | **CPTCODE6** |  | **ICD9CM6** |  |  |  | **ICD10CM6** |  |
| Other: | 7. **VPROC7 / VPROC7\_DD** |  | **CPTCODE7** |  | **ICD9CM7** |  |  |  | **ICD10CM7** |  |
|  |  |  |
|  | Month | Day | Year | Time | a.m. | p.m. | Mil. |
| (1) Date and time surgery/procedure began | **SURB\_DATE** |  |  | **1** |  |  [ ] [ ] :[ ] [ ] **SURB\_TIME** [ ]  | [ ]  | [ ]  |
|  |  |  |  |  |  |  |  |  |  |  |
|  | Month | Day | Year | Time | a.m. | p.m. | Mil. |
| (2) Date and time surgery/procedure ended | **SURE\_DATE** |  |  | **1** |  |   [ ] [ ] :[ ] [ ] **SURE\_TIME** [ ]  | [ ]  | [ ]  |
|  |  |  |  |  |  |  |  |  |  |  |

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| ANESTHESIA | PROVIDER(S) OF ANESTHESIA |
| **Type(s) of anesthesia administered – *Mark (X) all that apply.* ANESTH1-12** | **Anesthesia administered by – *Mark (X) all that apply*.****ANESTH\_BY1-6** |
| 1 | **[ ]**  | NONE | 7 | [ ]  Regional peripheral nerve | 1 | **[ ]** Anesthesiologist |
| 2 | **[ ]**  | General | 8 | [ ]  Regional retrobulbar block | 2 | **[ ]** CRNA (Certified Registered Nurse Anesthetist) |
| 3 | **[ ]**  | Conscious/IV sedation/MAC (Monitored Anesthesia Care) | 9 | [ ]  Regional spinal (subarachnoid) | 3 | [ ]  Surgeon/Other physician |
|  |  | 10 | [ ]  Other regional block | 4 | [ ]  Resident |
| 4 | **[ ]**  | Local/Topical | 11 | [ ]  Other | 5 | [ ]  Other provider |
| 5 | **[ ]**  | Regional epidural | 12 | [ ]  Not applicable – no procedure performed | 6 | [ ]  Unknown |
| 6 | **[ ]**  | Regional peribulbar block |  |  |  |
|  |  |  |  |  |  |  |
| SYMPTOM(S) PRESENT DURING OR AFTER PROCEDURE |
| ***Mark (X) all that apply.* SYMPTOMS1-15** |
| 1 | **[ ]**  | NONE | 9 | [ ]  Pain – moderate to severe |
| 2 | **[ ]**  | Airway problem or aspiration | 10 | [ ]  Sedation – excessive |
| 3 | **[ ]**  | Arrhythmia – significant | 11 | [ ]  Surgical complications – unanticipated |
| 4 | **[ ]**  | Bleeding (post-operative) – moderate to severe | 12 | [ ]  Urinary retention |
| 5 | **[ ]**  | Hypertension/High blood pressure - >20% change from baseline | 13 | [ ]  Vomiting – moderate to severe |
| 6 | **[ ]**  | Hypotension/Low blood pressure - >20% change from baseline | 14 | [ ]  Other |
| 7 | **[ ]**  | Hypoxia | 15 | [ ]  Not applicable – no procedure performed  |
| 8 | **[ ]**  | Nausea – moderate to severe |  |  |
|  |  |  |  |  |
| FOLLOW-UP INFORMATION |
| **Did someone attempt to follow-up with the patient within 24 hours after the surgery?** *Mark (X) one box*.**FUSURG** | **What was learned from this follow-up?** *Mark (X) all that apply.***LEARNED** |
| 1 [ ]  Unable to reach patient |
| 1 **[ ]**  |  Yes | 2 [ ]  Patient reported no medical or surgical problems |
| 2 **[ ]**  | No**Skip to** **VISIT\_DISP** | 3 [ ]  Patient reported problems and sought medical care |
| 3 **[ ]**  | Unknown | 4 [ ]  Patient reported problems and was advised by staff to seek medical care |
| 4 **[ ]**  | Not applicable –  | 5 [ ]  Patient reported problems, but no follow-up medical care was needed |
|  | No procedure performed | 6 [ ]  Other |
|  |  | 7 [ ]  Unknown |
| DISPOSITION |
| *Mark (X) all that apply.*  **VISIT\_DISP** |
| 1 | **[ ]**  | Admit to hospital |  9 [ ]  Return in less than 1 week 10 [ ]  Return in 1 week to less than 2 months 11 [ ]  Return in 2 months or greater 12 [ ]  Return at unspecified time 13 [ ]  Return as needed (p.r.n.) 14 [ ]  Routine discharge to customary residence 15 [ ]  Surgery terminated **Reason for termination: TERMINATE**1 [ ]  Allergic reaction2 [ ]  Unable to intubate3 [ ]  Other4 [ ]  Unknown 16 [ ]  Other 17 [ ]  Unknown |
| 2 | **[ ]**  | Discharge to observation status |
| 3 | **[ ]**  | Discharge to post-surgery/recovery care facility |
| 4 | **[ ]**  | Move to observation/post-surgical/recovery care area in the same hospital, i.e., not admitted as an inpatient |
| 5 | **[ ]**  | Procedure cancelled on arrival to clinic/ambulatory surgery location**Reason for cancellation: CANCELED**1 [ ]  Patient not n.p.o./fasting2 [ ]  Incomplete or inadequate medical evaluation3 [ ]  Surgical issue4 [ ]  Other5 [ ]  Unknown **Specify**: **CANCELED\_OTHER**  |
| 6 | **[ ]**  | Refer to ED |
| 7 | **[ ]**  | Refer to other physician/provider |
| 8 | **[ ]**  | Return to referring physician/provider |
|  |
|  |