SAMPLE

NATIONAL HOSPITAL CARE SURVEY – AMBULATORY COMPONENT
OUTPATIENT DEPARTMENT PATIENT RECORD
2014

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

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**	PATIENT_SSN / ENTER_SSN	**Patient's Control #**	PTCTRLNUM
Patient's address: RESIDENCE **Street**	PT_STRET / PT_STRET2	**City**	PT_CITY	**State**	
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
Month | Day | Year
VDATE: 2 0 1

Date of Birth
Month | Day | Year
BDATE

Age AGE/AGET

Sex SEX
1 ☐ Female – **Is patient pregnant?** PREG
1 ☐ Yes – **Specify gestation week** → GESTWK
2 ☐ No
2 ☐ Male

Ethnicity ETHNIC
1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino

Race – *Mark (X) all that apply*. MULTIRACE1-5
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 – *Mark (X) all that apply*. PAY_SOURCE1-8
1 ☐ Private insurance
2 ☐ Medicare
3 ☐ Medicaid or CHIP or other state-based program
4 ☐ Workers' compensation
5 ☐ Self-pay
6 ☐ No charge/Charity
7 ☐ Other
8 ☐ Unknown

Tobacco use
USETOBAC
1 ☐ Not current
EVERTOBAC
1 ☐ Never
2 ☐ Former
3 ☐ Unknownr
2 ☐ Current
3 ☐ Unknown

BIOMETRICS/VITAL SIGNS

Height
HTFT ft HTINCG in
OR
HTCM cm

Weight
WTLBCG lb WTOZ oz
OR
WTKG kg WTGM gm

Temperature
TEMP

Blood pressure
Systolic BPSYS / Diastolic 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.

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

Major reason for this visit MAJOR
1 ☐ New problem (<3 mos. onset)
2 ☐ Chronic problem, routine
3 ☐ Chronic problem, flare-up
4 ☐ Preventive care (e.g., routine, prenatal, well-baby, screening, insurance, general exams)
5 ☐ Pre-surgery/procedure
6 ☐ Post-surgery/procedure
7 ☐ Surgery/procedure

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/poisoning
3 ☐ Yes, adverse effect of medical/surgical treatment or adverse effect of medicinal drug
Skip ro Cause
4 ☐ No
5 ☐ Unknown

Did the injury/trauma or overdose/poisoning occur within 72 hours prior to the date and time of this visit?
INJURY72
1 ☐ Yes
2 ☐ No
3 ☐ Unknown
4 ☐ Not applicable

Is this injury/trauma or overdose/poisoning intentional?
INTENTO
1 ☐ Yes, intentional suicide attempt/ self-harm
2 ☐ 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 ☐ No
3 ☐ Unknown

Was patient referred for this visit? REFER

1 ☐ Yes
2 ☐ No
3 ☐ 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.)

PASTVIS Visits
Enter F5 if unknown

2 ☐ No, new patient

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 problem
2 ☐ Alcohol abuse, misuse, or dependence
3 ☐ Alzheimer's disease/Dementia
4 ☐ Arthritis
5 ☐ Asthma

Asthma severity: ASTH_SEV
1 ☐ Intermittent
2 ☐ Mild persistent
3 ☐ Moderate persistent
4 ☐ Severe persistent
5 ☐ Other – Specify
ASTH_SEV_SP
6 ☐ None recorded

Asthma control: ASTH_CON
1 ☐ Well controlled
2 ☐ Not well controlled
3 ☐ Very poorly controlled
4 ☐ Other – Specify
ASTH_CON_SP
5 ☐ None recorded

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 I
15 ☐ Diabetes mellitus (DM) – Type II
16 ☐ Diabetes mellitus (DM) – Type unspecified
17 ☐ End-stage renal disease (ESRD)
18 ☐ History of pulmonary embolism (PE), deep vein thrombosis (DVT), or venous thromboembolism (VTE)
19 ☐ HIV infection/AIDS
20 ☐ Hyperlipidemia
21 ☐ Hypertension
22 ☐ Obesity
23 ☐ Obstructive sleep apnea (OSA)
24 ☐ Osteoporosis
25 ☐ Substance abuse, misuse, or dependence
26 ☐ None of the above

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 ☐ Skin
12 ☐ Substance abuse screening (includes NIDA/NM ASSIST, CAGE-AID, DAST-10)

Laboratory Tests
13 ☐ BMP (Basic metabolic panel)
14 ☐ CBC
15 ☐ Chlamydia test

Laboratory Tests (cont.)
16 ☐ CMP (Comprehensive metabolic panel)
17 ☐ Creatinine/Renal function panel
18 ☐ Culture, blood
19 ☐ Culture, throat
20 ☐ Culture, urine
21 ☐ Culture, other
22 ☐ Glucose, serum
23 ☐ Gonorrhea test
24 ☐ HbA1C (Glycohemoglobin)
25 ☐ Hepatitis panel
26 ☐ HIV test
27 ☐ HPV DNA test
28 ☐ Lipid profile/panel
29 ☐ Liver enzymes/ Hepatic function panel
30 ☐ PAP test
31 ☐ Pregnancy/HCG test
32 ☐ PSA (prostate specific antigen)
33 ☐ Rapid strep test

Laboratory Tests (cont.)
34 ☐ TSH/Thyroid panel
35 ☐ Urinalysis
36 ☐ Vitamin D test

Imaging
37 ☐ Bone mineral density
38 ☐ CT scan
39 ☐ Echocardiogram
40 ☐ Ultrasound
41 ☐ Mammography
42 ☐ MRI
43 ☐ X-ray

Procedures
44 ☐ Audiometry
45 ☐ Biopsy
46 ☐ Cardiac stress test
47 ☐ Colonoscopy
48 ☐ Cryosurgery (cryotherapy)/ Destruction of tissue
49 ☐ EKG/ECG
50 ☐ Electroencephalogram (EEG)
51 ☐ Electromyogram (EMG)
52 ☐ Excision of tissue
53 ☐ Fetal monitoring

Procedures (cont.)
54 ☐ Peak flow
55 ☐ Sigmoidoscopy
56 ☐ Spirometry
57 ☐ Tonometry
58 ☐ Tuberculosis skin testing/ PPD
59 ☐ Upper gastrointestinal endoscopy (EGD)

Treatments
60 ☐ Cast/splint/wrap
61 ☐ Complementary and alternative medicine (CAM)
62 ☐ Durable medical equipment
63 ☐ Home health care
64 ☐ Mental health counseling, excluding psychotherapy
65 ☐ Occupational therapy
66 ☐ Physical therapy
67 ☐ Psychotherapy

Treatments (cont.)
68 ☐ Radiation therapy
69 ☐ Wound care

Health Education/ Counseling
70 ☐ Alcohol abuse counseling
71 ☐ Asthma
72 ☐ Asthma action plan given to patient
73 ☐ Diabetes education
74 ☐ Diet/Nutrition
75 ☐ Exercise
76 ☐ Family planning/ Contraception
77 ☐ Genetic counseling
78 ☐ Growth/ Development
79 ☐ Injury prevention
80 ☐ STD prevention
81 ☐ Stress management
82 ☐ Substance abuse counseling
83 ☐ Tobacco use/ Exposure
84 ☐ Weight reduction

Other services not listed
85 ☐ Other service Specify
OTHER_SP
Other service – Specify
OTHER_SP2
Other service – Specify
OTHER_SP3
Other service – Specify
OTHER_SP4
Other service – Specify
OTHER_SP5

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	Most recent result	Date of blood draw
Total Cholesterol CHOL 1 ☐ Yes → 2 ☐ No test found	CHOLRES mg/dL	CHOLDATE mm dd 20 0 1 yyyy
High density lipoprotein (HDL) HDL 1 ☐ Yes → 2 ☐ No test found	HDLRES mg/dL	HDLDATE mm dd 20 0 1 yyyy
Low density lipoprotein (LDL) LDL 1 ☐ Yes → 2 ☐ No test found	LDLRES mg/dL	LDLDATE mm dd 20 0 1 yyyy
Triglycerides TGS 1 ☐ Yes → 2 ☐ No test found	TGSRES mg/dL	TGSDATE mm dd 20 0 1 yyyy
HbA1c (Glycohemoglobin) A1C 1 ☐ Yes → 2 ☐ No test found	A1CRES %	A1CDATE mm dd 20 0 1 yyyy
Blood glucose (BG) FBG 1 ☐ Yes → 2 ☐ No test found	FBGRES mg/dL	FBGDATE mm dd 20 0 1 yyyy
Serum creatinine SERUM 1 ☐ Yes → 2 ☐ No test found	SERUMRES mg/dL	SERUMDATE mm dd 20 0 1 yyyy

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
2 ☐ Physician
3 ☐ Physician assistant (PA)
4 ☐ Nurse practitioner (NP)/Midwife (CNM)
5 RN/LPN
6 Mental health provider
7 Other

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 ☐	☐	☐	☐
(2) Date and time surgery/procedure ended	SURE_DATE		1	☐☐:☐☐SURE_TIME ☐	☐	☐	☐

ANESTHESIA

Type(s) of anesthesia administered – *Mark (X) all that apply.* **ANESTH1-12**

1 ☐ NONE
2 ☐ General
3 ☐ Conscious/IV sedation/MAC (Monitored Anesthesia Care)
4 ☐ Local/Topical
5 ☐ Regional epidural
6 ☐ Regional peribulbar block
7 ☐ Regional peripheral nerve
8 ☐ Regional retrobulbar block
9 ☐ Regional spinal (subarachnoid)
10 ☐ Other regional block
11 ☐ Other
12 ☐ Not applicable – no procedure performed

PROVIDER(S) OF ANESTHESIA

Anesthesia administered by – *Mark (X) all that apply*.
ANESTH_BY1-6

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

SYMPTOM(S) PRESENT DURING OR AFTER PROCEDURE

Mark (X) all that apply. **SYMPTOMS1-15**

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
15 ☐ Not applicable – no procedure performed

FOLLOW-UP INFORMATION

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

1 ☐ Yes → **Skip to VISIT_DISP**
2 ☐ No
3 ☐ Unknown
4 ☐ Not applicable – No procedure performed

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

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

DISPOSITION

Mark (X) all that apply. **VISIT_DISP**

1 ☐ Admit to hospital
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./fasting
2 ☐ Incomplete or inadequate medical evaluation
3 ☐ Surgical issue
4 ☐ Other
5 ☐ Unknown

Specify: **CANCELED_OTHER**

6 ☐ Refer to ED
7 ☐ Refer to other physician/provider
8 ☐ Return to referring physician/provider
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 reaction
2 ☐ Unable to intubate
3 ☐ Other
4 ☐ Unknown

16 ☐ Other
17 ☐ Unknown