Attachment G: Outpatient Department Patient Record

SAMPLE

NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY
2016 OUTPATIENT DEPARTMENT PATIENT RECORD

OMB No. 0920-0278; Expiration date 02/28/2018

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PATIENT INFORMATION

Patient's medical record number PATIENT_NUMBER

Zip Code PATZIP

Date of Visit

Month | Day | Year

VDATE | | | 2 | 0 | 1 |

Date of Birth

Month | Day | Year

BDATE | | | | | | |

Age AGE/AGET

1 ☐ Years
2 ☐ Months
3 ☐ Days

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.*

1 ☐ White
2 ☐ Black or African American
3 ☐ Asian
4 ☐ Native Hawaiian or Other Pacific Islander
5 ☐ American Indian or Alaska Native

MULTIRACE

Expected source(s) of payment for this visit – *Mark (X) all that apply.* PAY_SOURCE

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
2 ☐ Current
3 ☐ Unknown

EVERTOBAC
1 ☐ Never
2 ☐ Former
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

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 or history of present illness (HPI) 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 ☐ Pre-surgery
5 ☐ Post-surgery
6 ☐ Preventive care (e.g., routine, prenatal, well-baby, screening, insurance, general exams)

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 or surgical treatment or adverse effect of medicinal drug
4 ☐ No
5 ☐ Unknown

Did the injury/trauma, overdose/poisoning, or adverse effect occur within 72 hours prior to the date and time of this visit?

INJURY72
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

Is this injury/trauma or overdose/poisoning intentional or unintentional?

INTENTO
1 ☐ Intentional
2 ☐ Unintentional (e.g., accidental)
3 ☐ Intent unclear

What was the intent of the injury/trauma ot overdose/poisoning?

INTENTYP
1 ☐ Suicide attempt with intent to die
2 ☐ Intentional self-harm without intent to die
3 ☐ Unclear if suicide attempt or intentional self-harm without intent to die
4 ☐ Intentional harm inflicted by another person (e.g., assault, poisoning)
5 ☐ 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

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

☐ 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.

Primar v: **1** **VDIAG1 / VDIAG1_LKUP**
Other: **2** **VDIAG2 / VDIAG2_LKUP**
Other: **3** **VDIAG3 / VDIAG3_LKUP**
Other: **4** **VDIAG4 / VDIAG4_LKUP**
Other: **5** **VDIAG5 / VDIAG5_LKUP**

CONDITIONS

Regardless of the diagnoses previously entered, does the patient now have – *Mark (X) all that apply*. **PATIENT_HAVE**

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

Asthma severity:
ASTH_SEV
☐ Intermittent
☐ Mild persistent
☐ Moderate persistent

Asthma control:
ASTH_CON
☐ Well controlled
☐ Not well controlled
☐ Very poorly controlled
☐ Other – Specify

6 ☐ Autism spectrum disorder
7 ☐ Cancer
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)
16 ☐ Diabetes mellitus (DM), Type unspecified
17 ☐ End-stage renal disease (ESRD)
18 ☐ Hepatits B
19 ☐ Hepatits C
20 ☐ History of pulmonary embolism (PE), deep vein thrombosis (DVT), or venous thromboembolism (VTE)
21 ☐ HIV infection/AIDS
22 ☐ Hyperlipidemia

☐ Severe persistent
☐ Other – Specify
ASTH_CON_SP
ASTH_SEV_SP
☐ None recorded

☐ None recorded

5 ☐ Attention deficit disorder (ADD)/ Attention deficit hyperactivity disorder (ADHD)

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

23 ☐ Hypertension
24 ☐ Obesity
25 ☐ Obstructive sleep apnea (OSA)
26 ☐ Osteoporosis
27 ☐ Substance abuse or dependence
25 ☐ None of the above

8SERVICES

Enter all examinations/screenings, laboratory tests, imaging, procedures,treatment,health education/counseling,and other services not listed ORDERED OR PROVIDED. DIAG_SERVICE

1 ☐ NO SERVICES

Examinations/ Screenings

2 ☐ Alcohol misuse 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
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 testing/ 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 (UA) or urine dipstick
36 ☐ Vitamin D test

Imaging

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

Procedures

44 ☐ Audiometry
45 ☐ Biopsy
☐Yes
☐No
46 ☐ Cardiac stress test
47 ☐ Colonoscopy
☐Yes
☐No
48 ☐ Cryosurgery (cryotherapy)/ Destruction of tissue
49 ☐ EKG/ECG
50 ☐ Electroencephalogram (EEG)
51 ☐ Electromyogram (EMG)

Procedures (cont.)

52 ☐ Excision of tissue
☐Yes
☐No
53 ☐ Fetal monitoring
54 ☐ Peak flow
55 ☐ Sigmoidoscopy
☐Yes
☐No
56 ☐ Spirometry
57 ☐ Tonometry
58 ☐ Tuberculosis skin testing/ PPD
59 ☐ Upper gastrointestinal endoscopy (EGD)
☐Yes
☐No

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 education
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

MEDICATION(S) & IMMUNIZATIONS

NOMED **Were any prescription or non-prescription drugs ORDERED or PROVIDED (by any route of administration) at this visit?** 1 ☐ Yes 2 ☐ No **Include Rx and OTC drugs, 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.**

		NCMED New	NCMED Continued
(1)	VMED1 / VMEDOTH1	1 ☐	2 ☐
(2)	VMED2 / VMEDOTH2	1 ☐	2 ☐
(3)	VMED3 / VMEDOTH3	1 ☐	2 ☐

(4)	VMED4 / VMEDOTH4	1 ☐	2 ☐
(5)	VMED5 / VMEDOTH5	1 ☐	2 ☐
(5)	VMED6 / VMEDOTH6	1 ☐	2 ☐
(7)	VMED7 / VMEDOTH7	1 ☐	2 ☐
(8)	VMED8 / VMEDOTH8	1 ☐	2 ☐
(9)	VMED9 / VMEDOTH9	1 ☐	2 ☐
(10-30)	VMED10-30 / VMEDOTH10-30 **(Up to 30 drugs can be listed.)**	1 ☐	2 ☐

PROVIDERS

Mark (X) all providers seen at this visit PROV_SEEN

1 ☐ Physician
2 ☐ Physician assistant (PA)
3 ☐ Nurse practitioner (NP)/Midwife (CNM)
4 ☐ RN/LPN
5 ☐ Mental health provider
6 ☐ Other
7 ☐ NONE

VISIT DISPOSITION

Mark (X) all that apply. VISIT_DISP

1 ☐ Return to referring physician/provider
2 ☐ Refer to other physician/provider
3 ☐ Return in less than 1 week
4 ☐ Return in 1 week to less than 2 months
5 ☐ Return in 2 months or greater
6 ☐ Return at unspecified time
7 ☐ Return as needed (p.r.n.)
8 ☐ Refer to ER/Admit to hospital
9 ☐ Other

TESTS

	Most recent result	Date of blood draw
Total Cholesterol CHOL 1 ☐ Yes → 2 ☐ None found	CHOLRES mg/dL	CHOLDATE 2 0 1 _ (mm dd yyyy)
High density lipoprotein (HDL) HDL 1 ☐ Yes → 2 ☐ None found	HDLRES mg/dL	HDLDATE 2 0 1 _ (mm dd yyyy)
Low density lipoprotein (LDL) LDL 1 ☐ Yes → 2 ☐ None found	LDLRES mg/dL	LDLDATE 2 0 1 _ (mm dd yyyy)
Triglycerides TGS 1 ☐ Yes → 2 ☐ None found	TGSRES mg/dL	TGSDATE 2 0 1 _ (mm dd yyyy)
HbA1c (Glycohemoglobin) A1C 1 ☐ Yes → 2 ☐ None found	A1CRES %	A1CDATE 2 0 1 _ (mm dd yyyy)
Blood glucose (BG) FBG 1 ☐ Yes → 2 ☐ None found	FBGRES mg/dL	FBGDATE 2 0 1 _ (mm dd yyyy)
Serum creatinine SERUM 1 ☐ Yes → 2 ☐ None found	SERUMRES mg/dL	SERUMDATE 2 0 1 _ (mm dd yyyy)

CPT CODES

Enter Current Procedure Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code. Up to 18 CPT codes can be listed.

CPTCODE1	CPTCODE4	CPTCODE7	CPTCODE1	CPTCODE13	CPTCODE16
CPTCODE2	CPTCODE5	CPTCODE8	CPTCODE1	CPTCODE14	CPTCODE17
CPTCODE3	CPTCODE6	CPTCODE9	CPTCODE1	CPTCODE15	CPTCODE18