

# SAMPLE

## NATIONAL HOSPITAL CARE SURVEY – AMBULATORY COMPONENT OUTPATIENT DEPARTMENT PATIENT RECORD 2016

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                             | <b>PATIENT_NAME</b>                    | Patient's                                 | <b>PATIENT_SSN / ENTER_SSN</b>             | Patient's Control # | <b>PTCTRLNUM</b> |
| Patient's address: <b>RESIDENCE</b> Street | <b>PT_STRET / PT_STRET2</b>            | City                                      | <b>PT_CITY</b>                             | State               |                  |
| Patient's medical record #                 | <b>PTMEDRECNUM / ENTER_PTMEDRECNUM</b> | Medicare Health Insurance Benefit/Claim # | <b>MEDHLTHINSBEN / ENTER_MEDHLTHINSBEN</b> |                     |                  |
| NPI – Attending                            | <b>NPI_ATTEND / ENTER_NPI_ATTEND</b>   | NPI – Operating                           | <b>NPI_OPERATING / ENTER_NPI_OPERATING</b> |                     |                  |
| Hospital location where visit occurred     | <b>HOSP_LOC</b>                        |   |  |                     |                  |

|   |  |  |  |  |
|---|--|--|--|--|
| <b>Date of Visit</b><br>Month   Day   Year<br>VDATE   2   0   1<br>GESTWK | <b>Sex SEX</b><br>1 <input type="checkbox"/> Female – Is patient pregnant?<br><b>PREG</b><br>1 <input type="checkbox"/> Yes – Specify gestation week →<br>2 <input type="checkbox"/> No<br>2 <input type="checkbox"/> Male | <b>Race – Mark (X) all that apply. MULTIRACE1-5</b><br>1 <input type="checkbox"/> White<br>2 <input type="checkbox"/> Black or African American<br>3 <input type="checkbox"/> Asian<br>4 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander<br>5 <input type="checkbox"/> American Indian or Alaska Native | <b>Expected source(s) of payment for this visit – Mark (X) all that apply. PAY_SOURCE1-8</b><br>1 <input type="checkbox"/> Private insurance<br>2 <input type="checkbox"/> Medicare<br>3 <input type="checkbox"/> Medicaid or CHIP or other state-based program<br>4 <input type="checkbox"/> Workers' compensation<br>5 <input type="checkbox"/> Self-pay<br>6 <input type="checkbox"/> No charge/Charity<br>7 <input type="checkbox"/> Other<br>8 <input type="checkbox"/> Unknown | <b>Tobacco use USETOBAC</b><br>1 <input type="checkbox"/> Not current<br><b>EVERTOBAC</b><br>1 <input type="checkbox"/> Never<br>2 <input type="checkbox"/> Former<br>3 <input type="checkbox"/> Unknown<br>2 <input type="checkbox"/> Current<br>3 <input type="checkbox"/> Unknown |
| <b>Date of Birth</b><br>Month   Day   Year<br>BDATE                       | <b>Ethnicity ETHNIC</b><br>1 <input type="checkbox"/> Hispanic or Latino<br>2 <input type="checkbox"/> Not Hispanic or Latino  |  |  |  |
| <b>Age AGE/AGET</b><br>_____  |  |  |  |  |

### BIOMETRICS/VITAL SIGNS

|   |   |                            |  |
|---|---|----------------------------|--|
| <b>Height</b><br>HTFT ft   HTINCG in<br>OR<br>HTCM cm | <b>Weight</b><br>WTLBCG lb   WTOZ oz<br>OR<br>WTKG kg   WTGM gm | <b>Temperature</b><br>TEMP | <b>Blood pressure</b><br>Systolic   Diastolic<br>BPSYS / BPDIAS<br>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.<br>First: 1. <b>VRFV1 / VRFV1_LKUP</b><br>Other: 2. <b>VRFV2 / VRFV2_LKUP</b><br>Other: 3. <b>VRFV3 / VRFV3_LKUP</b><br>Other: 4. <b>VRFV4 / VRFV4_LKUP</b><br>Other: 5. <b>VRFV5 / VRFV5_LKUP</b> | <b>Major reason for this visit MAJOR</b><br>1 <input type="checkbox"/> New problem (<3 mos. onset)<br>2 <input type="checkbox"/> Chronic problem, routine<br>3 <input type="checkbox"/> Chronic problem, flare-up<br>4 <input type="checkbox"/> Preventive care (e.g., routine, prenatal, well-baby, screening, insurance, general exams)<br>5 <input type="checkbox"/> Pre-surgery/procedure<br>6 <input type="checkbox"/> Post-surgery/procedure<br>7 <input type="checkbox"/> Surgery/procedure |
|---|--|

### INJURY/TRAUMA/OVERDOSE/POISONING/ADVERSE EFFECT

|  |   |  |
|--|---|--|
| <b>Is this visit related to an injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment?</b><br>1 <input type="checkbox"/> Yes, injury/trauma <b>INJURY</b><br>2 <input type="checkbox"/> Yes, overdose/poisoning<br>3 <input type="checkbox"/> Yes, adverse effect of medical/surgical treatment or adverse effect of medicinal drug<br><i>Skip to Cause</i><br>4 <input type="checkbox"/> No<br>5 <input type="checkbox"/> Unknown | <b>Did the injury/trauma or overdose/poisoning occur within 72 hours prior to the date and time of this visit?</b><br><b>INJURY72</b><br>1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No<br>3 <input type="checkbox"/> Unknown<br>4 <input type="checkbox"/> Not applicable | <b>Is this injury/trauma or overdose/poisoning intentional?</b><br><b>INTENTO</b><br>1 <input type="checkbox"/> Yes, intentional suicide attempt/ self-harm<br>2 <input type="checkbox"/> Yes, intentional harm by another person (e.g., assault, poisoning)<br>3 <input type="checkbox"/> No, unintentional (e.g., accidental)<br>4 <input type="checkbox"/> 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) | <b>VCAUSE / VCAUSEDROPDOWN</b>   |
| (2) | <b>VCAUSE2 / VCAUSEDROPDOWN2</b> |
| (3) | <b>VCAUSE3 / VCAUSEDROPDOWN3</b> |
| (4) | <b>VCAUSE4 / VCAUSEDROPDOWN4</b> |

(5) **VCAUSE5 / VCAUSEDROPDOWN5**

### CONTINUITY OF CARE

|   |   |
|---|---|
| <p><b>Is this clinic PRIMCARE</b> the patient's primary care provider?</p> <p>1 <input type="checkbox"/> Yes<br/>                 2 <input type="checkbox"/> No<br/>                 3 <input type="checkbox"/> Unknown</p> <p><b>Was patient referred for this visit? REFER</b></p> <p>1 <input type="checkbox"/> Yes<br/>                 2 <input type="checkbox"/> No<br/>                 3 <input type="checkbox"/> Unknown</p> | <p><b>Has the patient been seen in this clinic before? SENBEFOR</b></p> <p>1 <input type="checkbox"/> Yes, established patient<br/> <b>How many past visits in the last 12 months?</b><br/>                 (Exclude this visit.)</p> <p style="text-align: center;"><b>PASTVIS</b> Visits<br/>                 Enter F5 if unknown</p> <p>2 <input type="checkbox"/> No, new patient</p> |
|---|---|

### 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. <b>VDIAG1 / VDIAG1_LKUP</b>  | <b>VDIAG1_Code</b> | <b>VDIAG1_Code10</b> |
| Other: 2. <b>VDIAG2 / VDIAG2_LKUP</b>  | <b>VDIAG2_Code</b> | <b>VDIAG2_Code10</b> |
| Other: 3. <b>VDIAG3 / VDIAG3_LKUP</b>  | <b>VDIAG3_Code</b> | <b>VDIAG3_Code10</b> |
| Other: 4. <b>VDIAG4 / VDIAG4_LKUP</b>  | <b>VDIAG4_Code</b> | <b>VDIAG4_Code10</b> |
| Other: 5. <b>VDIAG5 / VDIAG5_LKUP</b>  | <b>VDIAG5_Code</b> | <b>VDIAG5_Code10</b> |

### CONDITIONS

Regardless of the diagnoses previously entered, does the patient now have – Mark (X) all that apply. **PATIENT\_HAVE1-26**

|  |   |  |
|--|---|--|
| <p>1 <input type="checkbox"/> Airway problem</p> <p>2 <input type="checkbox"/> Alcohol abuse, misuse, or dependence</p> <p>3 <input type="checkbox"/> Alzheimer's disease/Dementia</p> <p>4 <input type="checkbox"/> Arthritis</p> <p>5 <input type="checkbox"/> Asthma</p> <p><b>Asthma severity: ASTH_SEV</b></p> <p>1 <input type="checkbox"/> Intermittent<br/>                 2 <input type="checkbox"/> Mild persistent<br/>                 3 <input type="checkbox"/> Moderate persistent<br/>                 4 <input type="checkbox"/> Severe persistent<br/>                 5 <input type="checkbox"/> Other – Specify</p> <p style="text-align: center;"><b>ASTH_SEV_SP</b></p> <p>6 <input type="checkbox"/> None recorded</p> | <p><b>Asthma control: ASTH_CON</b></p> <p>1 <input type="checkbox"/> Well controlled<br/>                 2 <input type="checkbox"/> Not well controlled<br/>                 3 <input type="checkbox"/> Very poorly controlled<br/>                 4 <input type="checkbox"/> Other – Specify</p> <p style="text-align: center;"><b>ASTH_CON_SP</b></p> <p>5 <input type="checkbox"/> None recorded</p> | <p>6 <input type="checkbox"/> Cancer</p> <p>7 <input type="checkbox"/> Cardiac surgery history</p> <p>8 <input type="checkbox"/> Cerebrovascular disease/History of stroke (CVA) or transient ischemic attack (TIA)</p> <p>9 <input type="checkbox"/> Chronic kidney disease (CKD)</p> <p>10 <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD)</p> <p>11 <input type="checkbox"/> Congestive heart failure (CHF)</p> <p>12 <input type="checkbox"/> Coronary artery disease (CAD), ischemic heart disease (IHD), or history of myocardial infarction (MI)</p> <p>13 <input type="checkbox"/> Depression</p> <p>14 <input type="checkbox"/> Diabetes mellitus (DM) – Type I</p> <p>15 <input type="checkbox"/> Diabetes mellitus (DM) – Type II</p> |
|--|---|--|

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

### SERVICES

Enter all examinations/screenings, laboratory tests, imaging, procedures, treatment, health education/counseling, and other services not listed ORDERED OR PROVIDED. **DIAG\_SERVICE1-85**

|  |   |   |   |   |   |
|--|---|---|---|---|---|
| <p>1 <input type="checkbox"/> NO SERVICES</p> <p><b>Examinations/Screenings</b></p> <p>2 <input type="checkbox"/> Alcohol abuse screening (includes AUDIT, MAST, CAGE, T-ACE)</p> <p>3 <input type="checkbox"/> Breast</p> <p>4 <input type="checkbox"/> Depression screening</p> <p>5 <input type="checkbox"/> Domestic violence screening</p> <p>6 <input type="checkbox"/> Foot</p> <p>7 <input type="checkbox"/> Neurologic</p> <p>8 <input type="checkbox"/> Pelvic</p> <p>9 <input type="checkbox"/> Rectal</p> <p>10 <input type="checkbox"/> Retinal/Eye Exam</p> <p>11 <input type="checkbox"/> Skin</p> <p>12 <input type="checkbox"/> Substance abuse screening (includes NIDA/NM ASSIST, CAGE-AID, DAST-10)</p> <p><b>Laboratory Tests</b></p> <p>13 <input type="checkbox"/> BMP (Basic metabolic panel)</p> <p>14 <input type="checkbox"/> CBC</p> <p>15 <input type="checkbox"/> Chlamydia test</p> | <p><b>Laboratory Tests (cont.)</b></p> <p>16 <input type="checkbox"/> CMP (Comprehensive metabolic panel)</p> <p>17 <input type="checkbox"/> Creatinine/Renal function panel</p> <p>18 <input type="checkbox"/> Culture, blood</p> <p>19 <input type="checkbox"/> Culture, throat</p> <p>20 <input type="checkbox"/> Culture, urine</p> <p>21 <input type="checkbox"/> Culture, other</p> <p>22 <input type="checkbox"/> Glucose, serum</p> <p>23 <input type="checkbox"/> Gonorrhea test</p> <p>24 <input type="checkbox"/> HbA1C (Glycohemoglobin)</p> <p>25 <input type="checkbox"/> Hepatitis panel</p> <p>26 <input type="checkbox"/> HIV test</p> <p>27 <input type="checkbox"/> HPV DNA test</p> <p>28 <input type="checkbox"/> Lipid profile/panel</p> <p>29 <input type="checkbox"/> Liver enzymes/Hepatic function panel</p> <p>30 <input type="checkbox"/> PAP test</p> <p>31 <input type="checkbox"/> Pregnancy/HCG test</p> <p>32 <input type="checkbox"/> PSA (prostate specific antigen)</p> <p>33 <input type="checkbox"/> Rapid strep test</p> | <p><b>Laboratory Tests (cont.)</b></p> <p>34 <input type="checkbox"/> TSH/Thyroid panel</p> <p>35 <input type="checkbox"/> Urinalysis</p> <p>36 <input type="checkbox"/> Vitamin D test</p> <p><b>Imaging</b></p> <p>37 <input type="checkbox"/> Bone mineral density</p> <p>38 <input type="checkbox"/> CT scan</p> <p>39 <input type="checkbox"/> Echocardiogram</p> <p>40 <input type="checkbox"/> Ultrasound</p> <p>41 <input type="checkbox"/> Mammography</p> <p>42 <input type="checkbox"/> MRI</p> <p>43 <input type="checkbox"/> X-ray</p> <p><b>Procedures</b></p> <p>44 <input type="checkbox"/> Audiometry</p> <p>45 <input type="checkbox"/> Biopsy</p> <p>46 <input type="checkbox"/> Cardiac stress test</p> <p>47 <input type="checkbox"/> Colonoscopy</p> <p>48 <input type="checkbox"/> Cryosurgery (cryotherapy)/ Destruction of tissue</p> <p>49 <input type="checkbox"/> EKG/ECG</p> <p>50 <input type="checkbox"/> Electroencephalogram (EEG)</p> <p>51 <input type="checkbox"/> Electromyogram (EMG)</p> <p>52 <input type="checkbox"/> Excision of tissue</p> <p>53 <input type="checkbox"/> Fetal monitoring</p> | <p><b>Procedures (cont.)</b></p> <p>54 <input type="checkbox"/> Peak flow</p> <p>55 <input type="checkbox"/> Sigmoidoscopy</p> <p>56 <input type="checkbox"/> Spirometry</p> <p>57 <input type="checkbox"/> Tonometry</p> <p>58 <input type="checkbox"/> Tuberculosis skin testing/ PPD</p> <p>59 <input type="checkbox"/> Upper gastrointestinal endoscopy (EGD)</p> <p><b>Treatments</b></p> <p>60 <input type="checkbox"/> Cast/splint/wrap</p> <p>61 <input type="checkbox"/> Complementary and alternative medicine (CAM)</p> <p>62 <input type="checkbox"/> Durable medical equipment</p> <p>63 <input type="checkbox"/> Home health care</p> <p>64 <input type="checkbox"/> Mental health counseling, excluding psychotherapy</p> <p>65 <input type="checkbox"/> Occupational therapy</p> <p>66 <input type="checkbox"/> Physical therapy</p> <p>67 <input type="checkbox"/> Psychotherapy</p> | <p><b>Treatments (cont.)</b></p> <p>68 <input type="checkbox"/> Radiation therapy</p> <p>69 <input type="checkbox"/> Wound care</p> <p><b>Health Education/ Counseling</b></p> <p>70 <input type="checkbox"/> Alcohol abuse counseling</p> <p>71 <input type="checkbox"/> Asthma</p> <p>72 <input type="checkbox"/> Asthma action plan given to patient</p> <p>73 <input type="checkbox"/> Diabetes education</p> <p>74 <input type="checkbox"/> Diet/Nutrition</p> <p>75 <input type="checkbox"/> Exercise</p> <p>76 <input type="checkbox"/> Family planning/ Contraception</p> <p>77 <input type="checkbox"/> Genetic counseling</p> <p>78 <input type="checkbox"/> Growth/ Development</p> <p>79 <input type="checkbox"/> Injury prevention</p> <p>80 <input type="checkbox"/> STD prevention</p> <p>81 <input type="checkbox"/> Stress management</p> <p>82 <input type="checkbox"/> Substance abuse counseling</p> <p>83 <input type="checkbox"/> Tobacco use/ Exposure</p> <p>84 <input type="checkbox"/> Weight reduction</p> | <p><b>Other services not listed</b></p> <p>85 <input type="checkbox"/> Other service Specify</p> <p style="text-align: center;"><b>OTHER_SP</b></p> <p>Other service – Specify</p> <p style="text-align: center;"><b>OTHER_SP2</b></p> <p>Other service – Specify</p> <p style="text-align: center;"><b>OTHER_SP3</b></p> <p>Other service – Specify</p> <p style="text-align: center;"><b>OTHER_SP4</b></p> <p>Other service – Specify</p> <p style="text-align: center;"><b>OTHER_SP5</b></p> |
|--|---|---|---|---|---|



| ANESTHESIA  | PROVIDER(S) OF ANESTHESIA   |
|---|---|
| <p><b>Type(s) of anesthesia administered – Mark (X) all that apply. ANESTH1-12</b></p> <p>1 <input type="checkbox"/> NONE</p> <p>2 <input type="checkbox"/> General</p> <p>3 <input type="checkbox"/> Conscious/IV sedation/MAC (Monitored Anesthesia Care)</p> <p>4 <input type="checkbox"/> Local/Topical</p> <p>5 <input type="checkbox"/> Regional epidural</p> <p>6 <input type="checkbox"/> Regional peribulbar block</p> <p>7 <input type="checkbox"/> Regional peripheral nerve</p> <p>8 <input type="checkbox"/> Regional retrobulbar block</p> <p>9 <input type="checkbox"/> Regional spinal (subarachnoid)</p> <p>10 <input type="checkbox"/> Other regional block</p> <p>11 <input type="checkbox"/> Other</p> <p>12 <input type="checkbox"/> Not applicable – no procedure performed</p> | <p><b>Anesthesia administered by – Mark (X) all that apply. ANESTH_BY1-6</b></p> <p>1 <input type="checkbox"/> Anesthesiologist</p> <p>2 <input type="checkbox"/> CRNA (Certified Registered Nurse Anesthetist)</p> <p>3 <input type="checkbox"/> Surgeon/Other physician</p> <p>4 <input type="checkbox"/> Resident</p> <p>5 <input type="checkbox"/> Other provider</p> <p>6 <input type="checkbox"/> Unknown</p> |

**SYMPTOM(S) PRESENT DURING OR AFTER PROCEDURE**

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

|   |   |
|---|---|
| <p>1 <input type="checkbox"/> NONE</p> <p>2 <input type="checkbox"/> Airway problem or aspiration</p> <p>3 <input type="checkbox"/> Arrhythmia – significant</p> <p>4 <input type="checkbox"/> Bleeding (post-operative) – moderate to severe</p> <p>5 <input type="checkbox"/> Hypertension/High blood pressure - &gt;20% change from baseline</p> <p>6 <input type="checkbox"/> Hypotension/Low blood pressure - &gt;20% change from baseline</p> <p>7 <input type="checkbox"/> Hypoxia</p> <p>8 <input type="checkbox"/> Nausea – moderate to severe</p> | <p>9 <input type="checkbox"/> Pain – moderate to severe</p> <p>10 <input type="checkbox"/> Sedation – excessive</p> <p>11 <input type="checkbox"/> Surgical complications – unanticipated</p> <p>12 <input type="checkbox"/> Urinary retention</p> <p>13 <input type="checkbox"/> Vomiting – moderate to severe</p> <p>14 <input type="checkbox"/> Other</p> <p>15 <input type="checkbox"/> Not applicable – no procedure performed</p> |
|---|---|

**FOLLOW-UP INFORMATION**

|  |   |
|--|---|
| <p><b>Did someone attempt to follow-up with the patient within 24 hours after the surgery? Mark (X) one box.</b></p> <p><b>FUSURG</b></p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Unknown</p> <p>4 <input type="checkbox"/> Not applicable – No procedure performed</p> | <p><b>What was learned from this follow-up? Mark (X) all that apply.</b></p> <p><b>LEARNED</b></p> <p>1 <input type="checkbox"/> Unable to reach patient</p> <p>2 <input type="checkbox"/> Patient reported no medical or surgical problems</p> <p>3 <input type="checkbox"/> Patient reported problems and sought medical care</p> <p>4 <input type="checkbox"/> Patient reported problems and was advised by staff to seek medical care</p> <p>5 <input type="checkbox"/> Patient reported problems, but no follow-up medical care was needed</p> <p>6 <input type="checkbox"/> Other</p> <p>7 <input type="checkbox"/> Unknown</p> |
|--|---|

**DISPOSITION**

**Mark (X) all that apply. VISIT\_DISP**

|  |   |
|--|---|
| <p>1 <input type="checkbox"/> Admit to hospital</p> <p>2 <input type="checkbox"/> Discharge to observation status</p> <p>3 <input type="checkbox"/> Discharge to post-surgery/recovery care facility</p> <p>4 <input type="checkbox"/> Move to observation/post-surgical/recovery care area in the same hospital, i.e., not admitted as an inpatient</p> <p>5 <input type="checkbox"/> Procedure cancelled on arrival to clinic/ambulatory surgery location</p> <p><b>Reason for cancellation: CANCELED</b></p> <p>1 <input type="checkbox"/> Patient not n.p.o./fasting</p> <p>2 <input type="checkbox"/> Incomplete or inadequate medical evaluation</p> <p>3 <input type="checkbox"/> Surgical issue</p> <p>4 <input type="checkbox"/> Other</p> <p>5 <input type="checkbox"/> Unknown</p> <p><b>Specify: CANCELED OTHER</b></p> <p>6 <input type="checkbox"/> Refer to ED</p> <p>7 <input type="checkbox"/> Refer to other physician/provider</p> <p>8 <input type="checkbox"/> Return to referring physician/provider</p> | <p>9 <input type="checkbox"/> Return in less than 1 week</p> <p>10 <input type="checkbox"/> Return in 1 week to less than 2 months</p> <p>11 <input type="checkbox"/> Return in 2 months or greater</p> <p>12 <input type="checkbox"/> Return at unspecified time</p> <p>13 <input type="checkbox"/> Return as needed (p.r.n.)</p> <p>14 <input type="checkbox"/> Routine discharge to customary residence</p> <p>15 <input type="checkbox"/> Surgery terminated</p> <p><b>Reason for termination: TERMINATE</b></p> <p>1 <input type="checkbox"/> Allergic reaction</p> <p>2 <input type="checkbox"/> Unable to intubate</p> <p>3 <input type="checkbox"/> Other</p> <p>4 <input type="checkbox"/> Unknown</p> <p>16 <input type="checkbox"/> Other</p> <p>17 <input type="checkbox"/> Unknown</p> |
|--|---|