

## Attachment D2: 2016 Patient Record form (NAMCS-30), sample card

**SAMPLE**NATIONAL AMBULATORY MEDICAL CARE SURVEY  
PATIENT RECORD  
2016

OMB No. 0920-0234; Expiration date xx/xx/20xx

**NOTICE** – Public reporting burden of this collection of information is estimated to average 14 minute per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0234).

**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**

<b>Patient's medical record number</b>		<b>PTMEDRECNUM / ENTER_PTMEDRECNUM</b>		<b>Zip Code</b>				
<b>Date of Visit VDATE</b>			<b>Sex SEX</b>		<b>Race – Mark (X) all that apply.</b>		<b>Expected source(s) of payment for this visit – Mark (X) all that apply.</b>	
Month	Day	Year	1 <input type="checkbox"/> Female – Is patient pregnant?		1 <input type="checkbox"/> White		1 <input type="checkbox"/> Private insurance	
		2 0 1	PREG		2 <input type="checkbox"/> Black or African American		2 <input type="checkbox"/> Medicare	
<b>Date of Birth BDATE</b>			1 <input type="checkbox"/> Yes – Specify gestation		3 <input type="checkbox"/> Asian		3 <input type="checkbox"/> Medicaid or CHIP or other state-based program	
Month	Day		week →		4 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		4 <input type="checkbox"/> Workers' compensation	
GESTWK			2 <input type="checkbox"/> No		5 <input type="checkbox"/> American Indian or Alaska Native		5 <input type="checkbox"/> Self-pay	
<b>Age AGE/AGET</b>			2 <input type="checkbox"/> Male				6 <input type="checkbox"/> No charge/Charity	
			<b>Ethnicity ETHNIC</b>				7 <input type="checkbox"/> Other	
1 <input type="checkbox"/> Years			1 <input type="checkbox"/> Hispanic or Latino				8 <input type="checkbox"/> Unknown	
2 <input type="checkbox"/> Months			2 <input type="checkbox"/> Not Hispanic or Latino					
3 <input type="checkbox"/> Days								

**BIOMETRICS/VITAL SIGNS**

<b>Height</b>		<b>Weight</b>		<b>Temperature</b>	<b>Blood pressure</b>	
HTFT	ft	HTINCG	in	TEMP	Systolic	Diastolic
OR		OR			BPSYS	BPDIAS
HTCM		cm				
		WTLBCG	lb	WTOZ		
		OR				
		WTKG	kg	WTGM	gm	

**REASON FOR VISIT**

<b>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.</b>		<b>Major reason for this visit MAJOR</b>	
First:	1. VRFV1 / VRFV1_LKUP	1 <input type="checkbox"/> New problem (<3 mos. onset)	
Other:	2. VRFV2 / VRFV2_LKUP	2 <input type="checkbox"/> Chronic problem, routine	
Other:	3. VRFV3 / VRFV3_LKUP	3 <input type="checkbox"/> Chronic problem, flare-up	
Other:	4. VRFV4 / VRFV4_LKUP	4 <input type="checkbox"/> Pre-surgery	
Other:	5. VRFV5 / VRFV5_LKUP	5 <input type="checkbox"/> Post-surgery	
		6 <input type="checkbox"/> Preventive care (e.g., routine, prenatal, well-baby, screening, insurance, general exams)	

**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>		<b>Did the injury/trauma, overdose/poisoning, or adverse effect occur within 72 hours prior to the date and time of this visit?</b>		<b>Is this injury/trauma or overdose/poisoning intentional or unintentional?</b>	
1 <input type="checkbox"/> Yes, injury/trauma INJURY		INJURY72		INTENTO	
2 <input type="checkbox"/> Yes, overdose/poisoning		1 <input type="checkbox"/> Yes		1 <input type="checkbox"/> Intentional	
3 <input type="checkbox"/> Yes, adverse effect of medical or surgical treatment or adverse effect of medicinal drug		2 <input type="checkbox"/> No		2 <input type="checkbox"/> Unintentional (e.g., accidental)	
4 <input type="checkbox"/> No		3 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Intent unclear	
5 <input type="checkbox"/> Unknown					

**What was the intent of the injury/trauma or 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)

**VCAUSE**

**CONTINUITY OF CARE**

<p><b>Are you the patient's primary care provider? PRIMCARE</b></p> <p>1 <input type="checkbox"/> Yes          2 <input type="checkbox"/> No          3 <input type="checkbox"/> Unknown</p> <p><b>Was patient referred for this visit? REFER</b></p> <p>1 <input type="checkbox"/> Yes          2 <input type="checkbox"/> No          3 <input type="checkbox"/> Unknown</p>	<p><b>Has the patient been seen in this practice before? SENBEFOR</b></p> <p>1 <input type="checkbox"/> Yes, established patient  <b>How many past visits in the last 12 months?</b>          (Exclude this visit.)</p> <div style="border: 1px solid black; padding: 2px; display: inline-block; margin: 5px;"> <b>PASTVIS</b> </div> Visits <small>Enter F5 if unknown</small> 2 <input type="checkbox"/> No, new patient
--	---

**PROVIDER'S DIAGNOSIS FOR THIS VISIT**

**As specifically as possible, list all diagnoses related to this visit, including chronic conditions.**

Primary: 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. PAT\_HAV**

<p>1 <input type="checkbox"/> Alcohol misuse, abuse, or dependence</p> <p>2 <input type="checkbox"/> Alzheimer's disease/Dementia</p> <p>3 <input type="checkbox"/> Arthritis</p> <p>4 <input type="checkbox"/> Asthma</p> <p><b>Asthma severity: ASTH_SEV</b></p> <p>1 <input type="checkbox"/> Intermittent          2 <input type="checkbox"/> Mild persistent          3 <input type="checkbox"/> Moderate persistent          4 <input type="checkbox"/> Severe persistent          5 <input type="checkbox"/> Other – Specify</p> <div style="border: 1px solid black; padding: 2px; display: inline-block; margin: 5px;"> <b>ASTH_SEV_SP</b> </div> <p>6 <input type="checkbox"/> None recorded</p> <p>5 <input type="checkbox"/> Attention deficit disorder (ADD)/ Attention hyperactivity deficit disorder (ADHD/)</p>	<p>6 <input type="checkbox"/> Autism spectrum disorder</p> <p>7 <input type="checkbox"/> Cancer</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"/> Hepatitis B</p> <p>19 <input type="checkbox"/> Hepatitis C</p> <p>20 <input type="checkbox"/> History of pulmonary embolism (PE), deep vein thrombosis (DVT), or venous thromboembolism (VTE)</p> <p>21 <input type="checkbox"/> HIV infection/AIDS</p> <p>22 <input type="checkbox"/> Hyperlipidemia</p> <p>23 <input type="checkbox"/> Hypertension</p> <p>24 <input type="checkbox"/> Obesity</p> <p>25 <input type="checkbox"/> Obstructive sleep apnea (OSA)</p> <p>26 <input type="checkbox"/> Osteoporosis</p> <p>27 <input type="checkbox"/> Substance abuse or dependence</p> <p>28 <input type="checkbox"/> None of the above</p>
---	---	--

**Asthma control: ASTH\_CON91**

1  Well controlled  
 2  Not well controlled  
 3  Very poorly controlled  
 4  Other – Specify

**ASTH\_CON\_SP**

5  None recorded

**SERVICES**

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

<p>1 <input type="checkbox"/> NO SERVICES</p> <p><b>Examinations/Screenings</b></p> <p>2 <input type="checkbox"/> Alcohol misuse 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</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 testing/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 (UA) or urine dipstick</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"/> Other 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><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 misuse counseling</p> <p>71 <input type="checkbox"/> Asthma education</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> <div style="border: 1px solid black; padding: 2px; display: inline-block; margin: 5px;"> <b>OTHER_SP</b> </div> <p>Other service – Specify</p> <div style="border: 1px solid black; padding: 2px; display: inline-block; margin: 5px;"> <b>OTHER_SP2</b> </div> <p>Other service – Specify</p> <div style="border: 1px solid black; padding: 2px; display: inline-block; margin: 5px;"> <b>OTHER_SP3</b> </div> <p>Other service – Specify</p> <div style="border: 1px solid black; padding: 2px; display: inline-block; margin: 5px;"> <b>OTHER_SP4</b> </div> <p>Other service – Specify</p> <div style="border: 1px solid black; padding: 2px; display: inline-block; margin: 5px;"> <b>OTHER_SP5</b> </div>
--	---	--	--	--	--



## 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	Continued
(1)	<b>VMED1 / VMEDOTH1</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(2)	<b>VMED2 / VMEDOTH2</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(3)	<b>VMED3 / VMEDOTH3</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(4)	<b>VMED4 / VMEDOTH4</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(5)	<b>VMED5 / VMEDOTH5</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(6)	<b>VMED6 / VMEDOTH6</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(7)	<b>VMED7 / VMEDOTH7</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(8)	<b>VMED8 / VMEDOTH8</b>		
(9)	<b>VMED9 / VMEDOTH9</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(10-30)	<b>VMED10-30 / VMEDOTH10-30 (Up to 30 drugs can be listed.)</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>

## PROVIDERS

Mark (X) all providers seen at this visit **PROV\_SEEN1-7**

- |  |   |
|--|---|
| 1 <input type="checkbox"/> Physician                             | 5 <input type="checkbox"/> Mental health provider |
| 2 <input type="checkbox"/> Physician assistant (PA)              | 6 <input type="checkbox"/> Other                  |
| 3 <input type="checkbox"/> Nurse practitioner (NP)/Midwife (CNM) | 7 <input type="checkbox"/> NONE                   |
| 4 <input type="checkbox"/> RN/LPN                                |   |

## TIME SPENT WITH PROVIDER

Enter estimated time spent with **sampled** provider. Enter 0 if no provider seen. **DURATION**

## VISIT DISPOSITION

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

- |   |  |
|---|--|
| 1 <input type="checkbox"/> Return to referring physician/provider | 6 <input type="checkbox"/> Return at unspecified time    |
| 2 <input type="checkbox"/> Refer to other physician/provider      | 7 <input type="checkbox"/> Return as needed (p.r.n.)     |
| 3 <input type="checkbox"/> Return in less than 1 week             | 8 <input type="checkbox"/> Refer to ER/Admit to hospital |
| 4 <input type="checkbox"/> Return in 1 week to less than 2 months | 9 <input type="checkbox"/> Other                         |
| 5 <input type="checkbox"/> Return in 2 months or greater          |  |

## 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? <b>LAB_TEST</b>	Most recent result	Date of blood draw											
Total Cholesterol <b>CHOL</b> 1 <input type="checkbox"/> Yes <span style="font-size: 2em;">→</span> 2 <input type="checkbox"/> None found	<div style="border: 1px solid black; padding: 2px; display: inline-block;"><b>CHOLRES</b></div> mg/dL	<div style="border: 1px solid black; padding: 2px; display: inline-block;"><b>CHOLDATE</b></div> <table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; text-align: center;">20</td> <td style="border: 1px solid black; width: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; text-align: center;">1</td> <td style="border: 1px solid black; width: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: 8px;">mm</td> <td style="text-align: center; font-size: 8px;">dd</td> <td style="text-align: center; font-size: 8px;">yyyy</td> <td></td> </tr> </table>	20	0	1		mm	dd	yyyy				
20	0	1											
mm	dd	yyyy											
High density lipoprotein (HDL) <b>HDL</b> 1 <input type="checkbox"/> Yes <span style="font-size: 2em;">→</span> 2 <input type="checkbox"/> None found	<div style="border: 1px solid black; padding: 2px; display: inline-block;"><b>HDLRES</b></div> mg/dL	<div style="border: 1px solid black; padding: 2px; display: inline-block;"><b>HDLDATE</b></div> <table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; text-align: center;">20</td> <td style="border: 1px solid black; width: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; text-align: center;">1</td> <td style="border: 1px solid black; width: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: 8px;">mm</td> <td style="text-align: center; font-size: 8px;">dd</td> <td style="text-align: center; font-size: 8px;">yyyy</td> <td></td> </tr> </table>	20	0	1		mm	dd	yyyy				
20	0	1											
mm	dd	yyyy											
Low density lipoprotein (LDL) <b>LDL</b> 1 <input type="checkbox"/> Yes <span style="font-size: 2em;">→</span> 2 <input type="checkbox"/> None found	<div style="border: 1px solid black; padding: 2px; display: inline-block;"><b>LDLRES</b></div> mg/dL	<div style="border: 1px solid black; padding: 2px; display: inline-block;"><b>LDLDATE</b></div> <table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; text-align: center;">20</td> <td style="border: 1px solid black; width: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; text-align: center;">1</td> <td style="border: 1px solid black; width: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: 8px;">mm</td> <td style="text-align: center; font-size: 8px;">dd</td> <td style="text-align: center; font-size: 8px;">yyyy</td> <td></td> </tr> </table>	20	0	1		mm	dd	yyyy				
20	0	1											
mm	dd	yyyy											
Triglycerides <b>TGS</b> 1 <input type="checkbox"/> Yes <span style="font-size: 2em;">→</span> 2 <input type="checkbox"/> None found	<div style="border: 1px solid black; padding: 2px; display: inline-block;"><b>TGSRES</b></div> mg/dL	<div style="border: 1px solid black; padding: 2px; display: inline-block;"><b>TGSDATE</b></div> <table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; text-align: center;">20</td> <td style="border: 1px solid black; width: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; text-align: center;">1</td> <td style="border: 1px solid black; width: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: 8px;">mm</td> <td style="text-align: center; font-size: 8px;">dd</td> <td style="text-align: center; font-size: 8px;">yyyy</td> <td></td> </tr> </table>	20	0	1		mm	dd	yyyy				
20	0	1											
mm	dd	yyyy											
HbA1c (Glycohemoglobin) <b>A1C</b> 1 <input type="checkbox"/> Yes <span style="font-size: 2em;">→</span> 2 <input type="checkbox"/> None found	<div style="border: 1px solid black; padding: 2px; display: inline-block;"><b>A1CRES</b></div> %	<div style="border: 1px solid black; padding: 2px; display: inline-block;"><b>A1CDATE</b></div> <table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; text-align: center;">20</td> <td style="border: 1px solid black; width: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; text-align: center;">1</td> <td style="border: 1px solid black; width: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: 8px;">mm</td> <td style="text-align: center; font-size: 8px;">dd</td> <td style="text-align: center; font-size: 8px;">yyyy</td> <td></td> </tr> </table>	20	0	1		mm	dd	yyyy				
20	0	1											
mm	dd	yyyy											
Blood glucose (BG) <b>FBG</b> 1 <input type="checkbox"/> Yes <span style="font-size: 2em;">→</span> 2 <input type="checkbox"/> None found	<div style="border: 1px solid black; padding: 2px; display: inline-block;"><b>FBGRES</b></div> mg/dL	<div style="border: 1px solid black; padding: 2px; display: inline-block;"><b>FBGDATE</b></div> <table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; text-align: center;">20</td> <td style="border: 1px solid black; width: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; text-align: center;">1</td> <td style="border: 1px solid black; width: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: 8px;">mm</td> <td style="text-align: center; font-size: 8px;">dd</td> <td style="text-align: center; font-size: 8px;">yyyy</td> <td></td> </tr> </table>	20	0	1		mm	dd	yyyy				
20	0	1											
mm	dd	yyyy											
Serum creatinine <b>SERUM</b> 1 <input type="checkbox"/> Yes <span style="font-size: 2em;">→</span> 2 <input type="checkbox"/> None found	<div style="border: 1px solid black; padding: 2px; display: inline-block;"><b>SERUMRES</b></div> <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="font-size: 0.8em;">mg/dL</td> <td style="font-size: 1.5em;">↕</td> <td style="font-size: 0.8em;">μmol/L</td> </tr> </table>	mg/dL	↕	μmol/L	<div style="border: 1px solid black; padding: 2px; display: inline-block;"><b>SERUMDATE</b></div> <table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; text-align: center;">20</td> <td style="border: 1px solid black; width: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; text-align: center;">1</td> <td style="border: 1px solid black; width: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: 8px;">mm</td> <td style="text-align: center; font-size: 8px;">dd</td> <td style="text-align: center; font-size: 8px;">yyyy</td> <td></td> </tr> </table>	20	0	1		mm	dd	yyyy	
mg/dL	↕	μmol/L											
20	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.

<b>CPTCODE1</b>	<b>CPTCODE4</b>	<b>CPTCODE7</b>	<b>CPTCODE10</b>	<b>CPTCODE13</b>	<b>CPTCODE16</b>
<b>CPTCODE2</b>	<b>CPTCODE5</b>	<b>CPTCODE8</b>	<b>CPTCODE11</b>	<b>CPTCODE14</b>	<b>CPTCODE17</b>
<b>CPTCODE3</b>	<b>CPTCODE6</b>	<b>CPTCODE9</b>	<b>CPTCODE12</b>	<b>CPTCODE15</b>	<b>CPTCODE18</b>