

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

### BIOMETRICS/VITAL SIGNS

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

### 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.		Major reason for this visit <b>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

<p><b>Is this visit related to an injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment?</b></p> <p>1 <input type="checkbox"/> Yes, injury/trauma <b>INJURY</b></p> <p>2 <input type="checkbox"/> Yes, overdose/poisoning</p> <p>3 <input type="checkbox"/> Yes, adverse effect of medical or surgical treatment or adverse effect of medicinal drug</p> <p>4 <input type="checkbox"/> No</p> <p>5 <input type="checkbox"/> Unknown</p>	<p><b>Did the injury/trauma, overdose/poisoning, or adverse effect occur within 72 hours prior to the date and time of this visit?</b></p> <p><b>INJURY72</b></p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Unknown</p>	<p><b>Is this injury/trauma or overdose/poisoning intentional or unintentional?</b></p> <p><b>INTENTO</b></p> <p>1 <input type="checkbox"/> Intentional</p> <p>2 <input type="checkbox"/> Unintentional (e.g., accidental)</p> <p>3 <input type="checkbox"/> Intent unclear</p>
<p><b>What was the intent of the injury/trauma or overdose/poisoning?</b></p> <p><b>INTENTYP</b></p> <p>1 <input type="checkbox"/> Suicide attempt with intent to die</p> <p>2 <input type="checkbox"/> Intentional self-harm without intent to die</p> <p>3 <input type="checkbox"/> Unclear if suicide attempt or intentional self-harm without intent to die</p> <p>4 <input type="checkbox"/> Intentional harm inflicted by another person (e.g., assault, poisoning)</p> <p>5 <input type="checkbox"/> Intent unclear</p>		
<p><b>Cause of injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment—</b> Describe the place and circumstances that preceded the injury/trauma, overdose/poisoning, or adverse effect.</p> <p>Examples:</p> <ol style="list-style-type: none"> <li>Injury/Trauma (e.g., patient fell while walking down stairs at home and sprained her ankle; patient was bitten by a spider)</li> <li>Overdose/Poisoning (e.g., child was given adult cold/cough medicine and became lethargic; child swallowed large amount of liquid cleanser and began vomiting)</li> <li>Adverse effect (e.g., patient developed a rash on his arm 2 days after taking penicillin for an ear infection)</li> </ol>		
<p>(1) <b>VCAUSE</b></p>		

<b>CONTINUITY OF CARE</b>	
<p><b>Is this clinic the patient's primary care provider? PRIMCARE</b></p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Unknown</p> <p><b>Was patient referred for this visit? REFER</b></p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Unknown</p>	<p><b>Has the patient been seen in this clinic before? SENBEFOR</b></p> <p><input type="checkbox"/> Yes, established patient</p> <p><b>How many past visits in the last 12 months?</b> (Exclude this visit.)</p> <p style="text-align: center;"><b>PASTVIS</b> Visits</p> <p style="text-align: center;"><small>Enter F5 if unknown</small></p> <p>2 <input type="checkbox"/> No, new patient</p>
<b>PROVIDER'S DIAGNOSIS FOR THIS VISIT</b>	
<p><b>As specifically as possible, list all diagnoses related to this visit, including chronic conditions.</b></p>	
<p>Primary:</p>	<p>1 <b>VDIAG1 / VDIAG1_LKUP</b></p>
<p>Other:</p>	<p>2 <b>VDIAG2 / VDIAG2_LKUP</b></p>
<p>Other:</p>	<p>3 <b>VDIAG3 / VDIAG3_LKUP</b></p>
<p>Other:</p>	<p>4 <b>VDIAG4 / VDIAG4_LKUP</b></p>
<p>Other:</p>	<p>5 <b>VDIAG5 / VDIAG5_LKUP</b></p>
<b>CONDITIONS</b>	
<p><b>Regardless of the diagnoses previously entered, does the patient now have – Mark (X) all that apply. PATIENT_HAVE</b></p>	
<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><input type="checkbox"/> Intermittent</p> <p><input type="checkbox"/> Mild persistent</p> <p><input type="checkbox"/> Moderate persistent</p> <p><b>Asthma control: ASTH_CON</b></p> <p><input type="checkbox"/> Well controlled</p> <p><input type="checkbox"/> Not well controlled</p> <p><input type="checkbox"/> Very poorly controlled</p> <p><input type="checkbox"/> Other – Specify</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>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>

<input type="checkbox"/> Severe persistent	<input type="checkbox"/> Other – Specify	<b>ASTH_CON_SP</b>	12 <input type="checkbox"/> Coronary artery disease (CAD), ischemic heart disease (IHD), or history of myocardial infarction (MI)	23 <input type="checkbox"/> Hypertension
<input type="checkbox"/> None recorded	<input type="checkbox"/> None recorded		13 <input type="checkbox"/> Depression	24 <input type="checkbox"/> Obesity
<b>ASTH_SEV_SP</b>			14 <input type="checkbox"/> Diabetes mellitus (DM), Type I	25 <input type="checkbox"/> Obstructive sleep apnea (OSA)
<input type="checkbox"/> None recorded			15 <input type="checkbox"/> Diabetes mellitus (DM), Type II	26 <input type="checkbox"/> Osteoporosis
5 <input type="checkbox"/> Attention deficit disorder (ADD)/ Attention deficit hyperactivity disorder (ADHD)				27 <input type="checkbox"/> Substance abuse or dependence
				25 <input type="checkbox"/> 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 <input type="checkbox"/> NO SERVICES <b>Examinations/Screenings</b> 2 <input type="checkbox"/> Alcohol misuse screening (includes AUDIT, MAST, CAGE, T-ACE) 3 <input type="checkbox"/> Breast 4 <input type="checkbox"/> Depression screening 5 <input type="checkbox"/> Domestic violence screening 6 <input type="checkbox"/> Foot 7 <input type="checkbox"/> Neurologic 8 <input type="checkbox"/> Pelvic 9 <input type="checkbox"/> Rectal 10 <input type="checkbox"/> Retinal/Eye 11 <input type="checkbox"/> Skin 12 <input type="checkbox"/> Substance abuse screening (includes NIDA/NM ASSIST, CAGE-AID, DAST-10) <b>Laboratory Tests</b> 13 <input type="checkbox"/> BMP (Basic metabolic panel) 14 <input type="checkbox"/> CBC 15 <input type="checkbox"/> Chlamydia test	<b>Laboratory Tests (cont.)</b> 16 <input type="checkbox"/> CMP (Comprehensive metabolic panel) 17 <input type="checkbox"/> Creatinine/Renal function panel 18 <input type="checkbox"/> Culture, blood 19 <input type="checkbox"/> Culture, throat 20 <input type="checkbox"/> Culture, urine 21 <input type="checkbox"/> Culture, other 22 <input type="checkbox"/> Glucose, serum 23 <input type="checkbox"/> Gonorrhea test 24 <input type="checkbox"/> HbA1C (Glycohemoglobin) 25 <input type="checkbox"/> Hepatitis testing/panel 26 <input type="checkbox"/> HIV test 27 <input type="checkbox"/> HPV DNA test 28 <input type="checkbox"/> Lipid profile/panel 29 <input type="checkbox"/> Liver enzymes/ Hepatic function panel 30 <input type="checkbox"/> PAP test 31 <input type="checkbox"/> Pregnancy/HCG test 32 <input type="checkbox"/> PSA (prostate specific antigen) 33 <input type="checkbox"/> Rapid strep test	<b>Laboratory Tests (cont.)</b> 34 <input type="checkbox"/> TSH/Thyroid panel 35 <input type="checkbox"/> Urinalysis (UA) or urine dipstick 36 <input type="checkbox"/> Vitamin D test <b>Imaging</b> 37 <input type="checkbox"/> Bone mineral density 38 <input type="checkbox"/> CT scan 39 <input type="checkbox"/> Echocardiogram 40 <input type="checkbox"/> Other ultrasound 41 <input type="checkbox"/> Mammography 42 <input type="checkbox"/> MRI 43 <input type="checkbox"/> X-ray <b>Procedures</b> 44 <input type="checkbox"/> Audiometry 45 <input type="checkbox"/> Biopsy <input type="checkbox"/> Yes <input type="checkbox"/> No 46 <input type="checkbox"/> Cardiac stress test 47 <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No 48 <input type="checkbox"/> Cryosurgery (cryotherapy)/ Destruction of tissue 49 <input type="checkbox"/> EKG/ECG 50 <input type="checkbox"/> Electroencephalogram (EEG) 51 <input type="checkbox"/> Electromyogram (EMG)	<b>Procedures (cont.)</b> 52 <input type="checkbox"/> Excision of tissue <input type="checkbox"/> Yes <input type="checkbox"/> No 53 <input type="checkbox"/> Fetal monitoring 54 <input type="checkbox"/> Peak flow 55 <input type="checkbox"/> Sigmoidoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No 56 <input type="checkbox"/> Spirometry 57 <input type="checkbox"/> Tonometry 58 <input type="checkbox"/> Tuberculosis skin testing/ PPD 59 <input type="checkbox"/> Upper gastrointestinal endoscopy (EGD) <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Treatments</b> 60 <input type="checkbox"/> Cast/splint/wrap 61 <input type="checkbox"/> Complementary and alternative medicine (CAM) 62 <input type="checkbox"/> Durable medical equipment 63 <input type="checkbox"/> Home health care 64 <input type="checkbox"/> Mental health counseling, excluding psychotherapy 65 <input type="checkbox"/> Occupational therapy 66 <input type="checkbox"/> Physical therapy 67 <input type="checkbox"/> Psychotherapy	<b>Treatments (cont.)</b> 68 <input type="checkbox"/> Radiation therapy 69 <input type="checkbox"/> Wound care <b>Health Education/ Counseling</b> 70 <input type="checkbox"/> Alcohol abuse counseling 71 <input type="checkbox"/> Asthma education 72 <input type="checkbox"/> Asthma action plan given to patient 73 <input type="checkbox"/> Diabetes education 74 <input type="checkbox"/> Diet/Nutrition 75 <input type="checkbox"/> Exercise 76 <input type="checkbox"/> Family planning/ Contraception 77 <input type="checkbox"/> Genetic counseling 78 <input type="checkbox"/> Growth/ Development 79 <input type="checkbox"/> Injury prevention 80 <input type="checkbox"/> STD prevention 81 <input type="checkbox"/> Stress management 82 <input type="checkbox"/> Substance abuse counseling 83 <input type="checkbox"/> Tobacco use/ Exposure 84 <input type="checkbox"/> Weight reduction	<b>Other services not listed</b> 85 <input type="checkbox"/> Other service – Specify <div style="border: 1px solid black; padding: 2px; text-align: center; margin-top: 5px;"><b>OTHER_SP</b></div> Other service – Specify <input type="text"/> <div style="border: 1px solid black; padding: 2px; text-align: center; margin-top: 5px;"><b>OTHER_SP2</b></div> Other service – Specify <input type="text"/> <div style="border: 1px solid black; padding: 2px; text-align: center; margin-top: 5px;"><b>OTHER_SP3</b></div> Other service – Specify <input type="text"/> <div style="border: 1px solid black; padding: 2px; text-align: center; margin-top: 5px;"><b>OTHER_SP4</b></div> Other service – Specify <input type="text"/> <div style="border: 1px solid black; padding: 2px; text-align: center; margin-top: 5px;"><b>OTHER_SP5</b></div>
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### 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.

		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"/>
(5)	<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>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(9)	<b>VMED9 / VMEDOTH9</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(10- ~)	<b>VMED10-30 / VMEDOTH10-30</b> (Up to 30 drugs can be listed.)	1 <input type="checkbox"/>	2 <input type="checkbox"/>

### PROVIDERS

Mark (X) all providers seen at this visit **PROV\_SEEN**

- |  |   |
|--|---|
| 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                                |   |

### 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

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

### 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>