

FORM **NHAMCS-100(ASC)**  
(10-14-2009)

U.S. DEPARTMENT OF COMMERCE  
Economics and Statistics Administration  
U.S. CENSUS BUREAU  
ACTING AS DATA COLLECTION AGENT FOR THE  
U.S. Department of Health and Human Services  
Centers for Disease Control and Prevention  
National Center for Health Statistics

**PATIENT RECORD NO.:**

**PATIENT'S NAME:**

**NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY  
2010 AMBULATORY SURGERY CENTER PATIENT RECORD**

**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).

(Provider: Detach and keep upper portion)

Please keep (X) marks inside of boxes →  Correct  Incorrect

**1. PATIENT INFORMATION**

<b>a. Date of visit</b>			<b>f. Race – Mark (X) all that apply.</b>			<b>h. Time</b>		
Month	Day	Year	1 <input type="checkbox"/> White	<b>h. Time</b>				<input type="checkbox"/> a.m.
			2 <input type="checkbox"/> Black or African American	(1) Time into operating room . . . . .				<input type="checkbox"/> p.m.
<b>b. ZIP Code</b>			3 <input type="checkbox"/> Asian					<input type="checkbox"/> Military
			4 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander	(2) Time surgery began . . . . .				<input type="checkbox"/> a.m.
			5 <input type="checkbox"/> American Indian or Alaska Native					<input type="checkbox"/> p.m.
<b>c. Date of birth</b>			<b>g. Expected source(s) of payment for this visit – Mark (X) all that apply.</b>					
Month	Day	Year	1 <input type="checkbox"/> Private insurance	(3) Time surgery ended . . . . .				<input type="checkbox"/> a.m.
			2 <input type="checkbox"/> Medicare					<input type="checkbox"/> p.m.
			3 <input type="checkbox"/> Medicaid or CHIP/SCHIP	(4) Time out of operating room . . . . .				<input type="checkbox"/> Military
			4 <input type="checkbox"/> Worker's compensation					<input type="checkbox"/> a.m.
<b>d. Sex</b>			5 <input type="checkbox"/> Self-pay	(5) Time into postoperative care . . . . .				<input type="checkbox"/> p.m.
1 <input type="checkbox"/> Female 2 <input type="checkbox"/> Male			6 <input type="checkbox"/> No charge/Charity					<input type="checkbox"/> Military
<b>e. Ethnicity</b>			7 <input type="checkbox"/> Other	(6) Time out of postoperative care . . . . .				<input type="checkbox"/> a.m.
1 <input type="checkbox"/> Hispanic or Latino			8 <input type="checkbox"/> Unknown					<input type="checkbox"/> p.m.
2 <input type="checkbox"/> Not Hispanic or Latino								<input type="checkbox"/> Military

**2. FINAL DIAGNOSIS**

<b>As specifically as possible, list all diagnoses related to this visit.</b>				Optional – ICD-9-CM Code			
Primary: 1.							
Other: 2.							
Other: 3.							
Other: 4.							
Other: 5.							

**3. EXTERNAL CAUSE OF INJURY**

<b>As specifically as possible, describe the injury that preceded the visit or adverse effect that occurred during the visit.</b>				Optional – E-Code			
<input type="checkbox"/> NONE							

**4. PROCEDURE(S)**

<b>As specifically as possible, list all diagnostic and surgical procedures performed during this visit.</b>				Optional – CPT-4 Codes				Optional – ICD-9-CM-Code			
<input type="checkbox"/> NONE											
Primary: 1.											
Other: 2.											
Other: 3.											
Other: 4.											
Other: 5.											
Other: 6.											
Other: 7.											

**PLEASE CONTINUE ON THE REVERSE SIDE**

**5. MEDICATION(S) & ANESTHESIA**

**a. Was oxygen administered during this visit?**

Mark (X) one box.

- 1  Yes
- 2  No
- 3  Unknown

**b. List up to 12 Rx and OTC drugs and anesthetics that were ordered, supplied, or administered during this visit or at discharge, excluding oxygen.**

NONE – SKIP to item 7.

	During this visit	At discharge
(1)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(2)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(3)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(4)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(5)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(6)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(7)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(8)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(9)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(10)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(11)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(12)	1 <input type="checkbox"/>	2 <input type="checkbox"/>

**c. Type(s) of anesthesia listed in 5b – Mark (X) all that apply.**

1  NONE – SKIP to item 7.

- 2  General
- 3  IV sedation
- 4  MAC (Monitored Anesthesia Care)
- 5  Topical/Local

Regional

- 6  Epidural
- 7  Spinal
- 8  Retrobulbar block
- 9  Peribulbar block
- 10  Other block
- 11  Other

**6. PROVIDER(S) OF ANESTHESIA**

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

- 1  Anesthesiologist
- 2  CRNA (Certified Registered Nurse Anesthetist)
- 3  Surgeon/Other physician
- 4  Unknown

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

Mark (X) all that apply.

- 1  NONE
- 2  Apnea
- 3  Bleeding/Hemorrhage
- 4  Difficulty waking up
- 5  Dysrhythmia/Arrhythmia
- 6  Hypertension/High blood pressure
- 7  Hypotension/Low blood pressure
- 8  Hypoxia
- 9  Incontinence
- 10  Nausea
- 11  Vomiting
- 12  Other

**8. DISPOSITION**

Mark (X) one box.

- 1  Routine discharge to customary residence
- 2  Discharge to observation status
- 3  Discharge to post-surgical/recovery care facility
- 4  Admitted to hospital as inpatient
- 5  Referred to ED
- 6  Surgery terminated
- 7  Other
- 8  Unknown

**9. FOLLOW-UP INFORMATION**

**a. Did someone attempt to follow-up with the patient within 24 hours after the surgery?**

Mark (X) one box.

- 1  Yes – Continue with Item 9b.
  - 2  No
  - 3  Unknown
- } END – Patient Record complete.

**b. What was learned from this follow-up?**

Mark (X) all that apply.

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