

**Section H - TRAINING**

*Enter dates and times of training sessions, the name of the instructor, and the names of the hospital staff members trained.*

Line No. (a)	Date (b)	Time (c)	Instructor (d)	Trainee(s) (e)		
				1	2	3
1		a.m. p.m.		1	2	3
				4	5	6
2		a.m. p.m.		1	2	3
				4	5	6
3		a.m. p.m.		1	2	3
				4	5	6
4		a.m. p.m.		1	2	3
				4	5	6

**Section I - QC VISITS**

*Record dates and times of QC visits and the names of contact(s) at the visit.*

Line No. (a)	Date (b)	Time (c)	Contact(s) (d)	
			1	2
1		a.m. p.m.	1	2
			3	4
2		a.m. p.m.	1	2
			3	4
3		a.m. p.m.	1	2
			3	4
4		a.m. p.m.	1	2
			3	4
5		a.m. p.m.	1	2
			3	4
6		a.m. p.m.	1	2
			3	4

NOTES

**Section J - UPDATED CONTACT OR APPROVAL INFORMATION**

1	Contact name	Shift
	Title	Area Code Number Extension
1	Telephone	
	Comments	

2	Contact name	Shift
	Title	Area Code Number Extension
2	Telephone	
	Comments	

**Section K - FINAL DISPOSITION**

1. FINAL DISPOSITION	Ambulatory unit
	<ul style="list-style-type: none"> <li>1 <input type="checkbox"/> Participated                             <ul style="list-style-type: none"> <li>a <input type="checkbox"/> Patients seen</li> <li>b <input type="checkbox"/> No patients seen</li> </ul> </li> <li>2 <input type="checkbox"/> Refused</li> <li>3 <input type="checkbox"/> Closed                             <ul style="list-style-type: none"> <li>a <input type="checkbox"/> Temporary</li> <li>b <input type="checkbox"/> Permanent</li> </ul> </li> <li>4 <input type="checkbox"/> Ineligible <i>z</i> <ul style="list-style-type: none"> <li>a <input type="checkbox"/> AU not under auspices of hospital</li> <li>b <input type="checkbox"/> Only ancillary services provided</li> <li>c <input type="checkbox"/> Care not provided by or under the direct supervision of a physician</li> <li>d <input type="checkbox"/> Clinic classified as out-of-scope</li> <li>e <input type="checkbox"/> Other - <i>Specify z</i></li> </ul> </li> </ul>
2. Who completed the patient record forms? <i>Mark (X) all that apply</i>	
	<ul style="list-style-type: none"> <li>1 <input type="checkbox"/> Hospital staff</li> <li>2 <input type="checkbox"/> FR - abstraction DURING reporting period</li> <li>3 <input type="checkbox"/> FR - abstraction AFTER reporting period</li> <li>4 <input type="checkbox"/> Other - <i>Specify z</i></li> </ul>

NOTES

NOTES

FORM **NHAMCS-101(U)**  
(7-12-2004)

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

**AMBULATORY UNIT RECORD**  
**National Hospital Ambulatory Medical Care Survey**  
**2005 Panel**

**NOTICE** - Public reporting burden of this collection of information is estimated to average 60 minutes 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 Reports Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0278).

**Assurance of confidentiality** - All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used by persons engaged in and for the purpose of the survey and will not be disclosed or released to other persons or used for any other purpose without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m).

**COMPLETE THIS RECORD FOR EACH AMBULATORY UNIT SELECTED**

**Section A - AMBULATORY UNIT INFORMATION**

**a.** Is this ambulatory unit part of an emergency or outpatient department?  
 1  ED - Mark (X) type → 1  General 3  PED 5  PSYC 7  Other  
 2  Adult 4  Urgi-/Fast track 6  Trauma  
 2  OPD - Mark (X) specialty → 1  GM 3  PED 5  Substance Abuse  
 2  SURG 4  OBG 6  Other

**b.** AU No. \_\_\_\_\_ of \_\_\_\_\_  
Total AU's sampled within the ED or OPD

**c.** Hospital number → \_\_\_\_\_

**d.** Hospital name \_\_\_\_\_

**1.** Enter the name of the (emergency service area/clinic). (If no name, identify it by location, service type, or some other unique identifier.) Name \_\_\_\_\_

**2. Where is the (emergency service area/clinic) located?** 1  Onsite at hospital 2  Elsewhere - Specify    
Address (Number and street) \_\_\_\_\_  
City/State \_\_\_\_\_ ZIP Code \_\_\_\_\_

**3. What is the name, title, and telephone number of the director of the (emergency service area/clinic)?** Name \_\_\_\_\_  
Title \_\_\_\_\_  
Telephone (Area code and number) \_\_\_\_\_

**Section B - SAMPLE INFORMATION**

**1.** Take every number \_\_\_\_\_ **4.** Total estimated number of visits during reporting period for **ENTIRE** department \_\_\_\_\_

**2.** Random start number \_\_\_\_\_ **5.** REPORTING PERIOD (Month/Day/Year) From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

**3.** Estimated number of visits in this AU during reporting period \_\_\_\_\_ **6.** SU number \_\_\_\_\_ **7.** Numerator \_\_\_\_\_ **8.** Denominator \_\_\_\_\_

**From the Sampling Plan:** If a sampling plan is not required, item 6 is the AU No. from Section A, item b. Items 7 and 8 are each 1.

9. What was the total number of patient visits to this AU (ESA or Clinic) from (dates specified in B5)? (Refer to patient logs, registration lists, etc. Ask if necessary. DO NOT LEAVE TOTAL BLANK. BE AS COMPLETE AND ACCURATE AS POSSIBLE.)	NUMBER OF VISITS				
	Week 1	Week 2	Week 3	Week 4	TOTAL
	____/____/____	____/____/____	____/____/____	____/____/____	

10. How many patient record forms were filled out for this AU (emergency service area/clinic)?	NUMBER OF FORMS				
	Week 1	Week 2	Week 3	Week 4	TOTAL

**Section C - EMERGENCY SERVICES/OUTPATIENT CLINIC INFORMATION AND LOGS**

**1. What are the usual operating hours of this unit?**

Day(s) (a)	FROM	Time (b)	Mark (X) ONLY one		
			Open 24 hours (c)	Not open (d)	Hours vary (e)
Monday		a.m. TO p.m.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Tuesday		a.m. TO p.m.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Wednesday		a.m. TO p.m.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Thursday		a.m. TO p.m.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Friday		a.m. TO p.m.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Saturday		a.m. TO p.m.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Sunday		a.m. TO p.m.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

**2. How many separate shifts are there in this unit?** Number of separate shifts \_\_\_\_\_

**3. How many separate patient registration logs are maintained in this unit?** Number of logs \_\_\_\_\_

**Section D - VERIFICATION OF ESTIMATED VISITS**

Verify with ED/Clinic director BEFORE data collection begins (and records have been pulled).

**1. According to our information, about (Number from B-3) patient visits are expected during the reporting period. Do you agree with this estimate?** 1  Yes - SKIP to section F, page 3  
2  No

**2. About how many visits do you expect during the reporting period, \_\_\_\_\_ to \_\_\_\_\_?** Revised estimate \_\_\_\_\_

Determine if new Take Every and Random Start numbers must be calculated for this clinic.

**3a.** Divide the revised estimate by the original estimate from B-3. Revised estimate =  $\frac{\text{Revised estimate}}{\text{Original estimate}}$  = \_\_\_\_\_ (Result)

**b. Is the result of (a) between 0.7 and 1.3?** 1  Yes - SKIP to section F, page 3  
2  No

**Section E - CALCULATE NEW TAKE EVERY AND RANDOM START NUMBERS FOR THIS ESA/CLINIC**

**1.** Calculate new sampling Take Every, using the appropriate table (page 2 or 4) of the NHAMCS-124. (Use the revised estimate of visits from D-2 and the original total visits from B-4). New Take Every \_\_\_\_\_

**2.** Calculate new Random Start, using the next available row on the label affixed to the back of the NHAMCS-101. New Random Start \_\_\_\_\_

**Section F - DATA COORDINATOR AND HOSPITAL STAFF**

Enter the name, title, shift, and telephone number of the data coordinator and hospital staff involved in the data collection.

Line No. (a)	Name (b)	Title (c)	Shift (d)	Telephone number (e)		
				Area code	Number	Ext.
1						
2						
3						
4						
5						
6						
7						
8						

**Section G - PATIENT RECORD FORM INFORMATION**

**1. Enter the range of Patient Record Forms that were ACTUALLY used by the unit.**

FIRST FOLIO FROM: \_\_\_\_\_ TO: \_\_\_\_\_

SECOND FOLIO FROM: \_\_\_\_\_ TO: \_\_\_\_\_

THIRD FOLIO FROM: \_\_\_\_\_ TO: \_\_\_\_\_

**CHECK ITEM A** This NHAMCS-101(U) is being completed for:  
 OPD - SKIP to Section H  
 ED - Continue with item 2.

**2. Of the completed PRF's in this ESA, how many had a visit disposition (item 11) of "Admit to hospital?"** Number of PRF's with visit disposition of "Admit to hospital" \_\_\_\_\_

If the number of PRF's given above is 0, then return to the ED for an explanation and write it in the "NOTES" section below. If an error was found in sampling or recording the disposition, then make the correction and note it below.

**NOTE** - On average, about 12 percent of ED visits result in hospital admission; therefore, it would be unusual to have no PRF's with this disposition during the 4-week reporting period.

NOTES