

SAMPLE

NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY 2016 AMBULATORY SURGERY PATIENT RECORD

Form Approved: OMB No. 0920-0278; Expiration date 02/28/2018

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PATIENT INFORMATION

Patient medical record number	Age 1 <input type="checkbox"/> Years 2 <input type="checkbox"/> Months 3 <input type="checkbox"/> Days	Date/Time of surgery															
Date of visit	Sex 1 <input type="checkbox"/> Female 2 <input type="checkbox"/> Male	(1) Date/Time surgery began															
Month Day Year 201	Ethnicity 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>Month</td><td>Day</td><td>Year</td><td>Time</td><td>a.m.</td><td>p.m.</td><td>Military</td> </tr> <tr> <td></td><td></td><td>201</td><td></td><td></td><td></td><td></td> </tr> </table>		Month	Day	Year	Time	a.m.	p.m.	Military			201				
Month	Day	Year	Time	a.m.	p.m.	Military											
		201															
ZIP Code – Enter "1" if homeless.	Race – Mark (X) all that apply.	(2) Date/Time surgery ended															
Month Day Year	1 <input type="checkbox"/> White 2 <input type="checkbox"/> Black or African American 3 <input type="checkbox"/> Asian 4 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 5 <input type="checkbox"/> American Indian or Alaska Native	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>Month</td><td>Day</td><td>Year</td><td>Time</td><td>a.m.</td><td>p.m.</td><td>Military</td> </tr> <tr> <td></td><td></td><td>201</td><td></td><td></td><td></td><td></td> </tr> </table>		Month	Day	Year	Time	a.m.	p.m.	Military			201				
Month	Day	Year	Time	a.m.	p.m.	Military											
		201															
Date of birth	Expected source(s) of payment for THIS VISIT – Mark (X) all that apply.																
Month Day Year	1 <input type="checkbox"/> Private insurance 2 <input type="checkbox"/> Medicare 3 <input type="checkbox"/> Medicaid or CHIP or other state-based program 4 <input type="checkbox"/> Workers' compensation 5 <input type="checkbox"/> Self-pay 6 <input type="checkbox"/> No charge/Charity 7 <input type="checkbox"/> Other 8 <input type="checkbox"/> Unknown																

DIAGNOSIS

As specifically as possible, list all diagnoses related to this surgery or procedure. List PRIMARY diagnosis first.

Primary: **1.**
Other: **2.**
Other: **3.**
Other: **4.**
Other: **5.**

CONDITIONS

Does patient have any of the following conditions? (Note: These conditions could impact this surgery or procedure) – Mark (X) all that apply.

- | | |
|---|--|
| 1 <input type="checkbox"/> Airway problem
2 <input type="checkbox"/> Asthma
3 <input type="checkbox"/> Cardiac surgery history
4 <input type="checkbox"/> Cerebrovascular disease/History of stroke (CVA) or transient ischemic attack (TIA)
5 <input type="checkbox"/> Chronic kidney disease (CKD)
6 <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD)
7 <input type="checkbox"/> Congestive heart failure (CHF)
8 <input type="checkbox"/> Coronary artery disease (CAD), ischemic heart disease (IHD) or history of myocardial infarction (MI) | 9 <input type="checkbox"/> Diabetes mellitus (DM), Type 1
10 <input type="checkbox"/> Diabetes mellitus (DM), Type 2
11 <input type="checkbox"/> Diabetes mellitus (DM), Type unspecified
12 <input type="checkbox"/> End-stage renal disease (ESRD)
13 <input type="checkbox"/> Hypertension
14 <input type="checkbox"/> Obesity
15 <input type="checkbox"/> Obstructive sleep apnea (OSA)
16 <input type="checkbox"/> None of the above |
|---|--|

PROCEDURE(S)

As specifically as possible, list all diagnostic or surgical procedures performed during this visit.

NONE

CPT Code
(Optional)

ICD10-CM Procedure Code
(Optional)

Primary: **1.**
Other: **2.**
Other: **3.**
Other: **4.**
Other: **5.**
Other: **6.**
Other: **7.**

MEDICATION(S)

List up to 30 drugs and anesthetics that were administered and whether they were administered preoperatively, intraoperatively, and/or postoperatively. Mark (X) all that apply.

	Preoperatively	Intraoperatively	Postoperatively
1 <input type="checkbox"/> NONE/No more			
2 <input type="checkbox"/> Fentanyl	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
3 <input type="checkbox"/> Lidocaine	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
4 <input type="checkbox"/> Nitrous oxide	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
5 <input type="checkbox"/> Oxygen	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
6 <input type="checkbox"/> Pentothal	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
7 <input type="checkbox"/> Propofol	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
8 <input type="checkbox"/> Versed (Midazolam)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
9 <input type="checkbox"/> Zofran (Ondansetron)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
10 <input type="checkbox"/> Other – Specify ↴ _____	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
11 <input type="checkbox"/> Other – Specify ↴ _____	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
12 <input type="checkbox"/> Other – Specify ↴ _____	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
↓			
30 <input type="checkbox"/> Other – Specify ↴ _____	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

ANESTHESIA

Type(s) of anesthesia listed in the drug description fields – Mark (X) all that apply.

- 1 NONE
- 2 General
- 3 Conscious/IV sedation/
MAC (Monitored Anesthesia Care)
- 4 Local/topical
- 5 Regional epidural
- 6 Regional peribulbar block
- 7 Regional peripheral nerve block
- 8 Regional retrobulbar block
- 9 Regional spinal (Subarachnoid)
- 10 Other regional block
- 11 Other

Anesthesia administered by –

Mark (X) all that apply.

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

DISPOSITION

Symptoms present during or after procedure – Mark (X) all that apply.

- 1 NONE
- 2 Airway problem or aspiration
- 3 Arrhythmia – significant
- 4 Bleeding (post-operative) – moderate to severe
- 5 Hypertension/High blood pressure – >20% change from baseline
- 6 Hypotension/Low blood pressure – >20% change from baseline
- 7 Hypoxia
- 8 Nausea – moderate to severe
- 9 Pain – moderate to severe
- 10 Sedation – excessive
- 11 Surgical complications – unanticipated
- 12 Urinary retention
- 13 Vomiting – moderate to severe
- 14 Other

Enter disposition – Mark (X) all that apply.

- 1 Routine discharge to customary residence
- 2 Discharge to observation status
- 3 Admitted to hospital as inpatient
- 4 Referred to ED
- 5 Surgery terminated
Reason for surgery termination
1 Allergic reaction
2 Unable to intubate
3 Other
4 Unknown
- 6 Procedure canceled on arrival to clinic or ambulatory surgery unit/location
Reason for cancellation
1 Patient not n.p.o./fasting
2 Incomplete or inadequate medical evaluation
3 Surgical issue
4 Other
5 Unknown
- 7 Other
- 8 Unknown

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

Mark (X) one box.

- 1 Yes
- 2 No
- 3 Unknown

What was learned from this follow-up?

Mark (X) all that apply.

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