### NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY
**1999-2000 OUTPATIENT DEPARTMENT RECORD**

**Patient's Name:**

<table>
<thead>
<tr>
<th>1. Patient's Zip Code</th>
<th>4. Sex</th>
<th>5. Ethnicity</th>
<th>7. Was Patient Referred by Another Physician or by a Health Plan for This Visit?</th>
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<tbody>
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<td>Yes</td>
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**Race:**
- Mark (X) one or more.
- White
- Black/African American
- Asian
- Hispanic or Latino
- Not Hispanic or Latino
- Native Hawaiian/Other Pacific Islander
- American Indian/Alaska Native

**Was Authorization Required for Care?**
- Yes
- No
- Unknown

**Primary Source of Payment for This Visit**
- Mark (X) one:
  - Private insurance
  - Medicare
  - Medicaid
  - Worker's Compensation
  - Self-pay
  - No charge
  - Other
  - Unknown

**Does Patient Belong to an HMO?**
- Yes
- No
- Unknown

**Is This a Capitated Visit?**
- Yes
- No
- Unknown

**Has Patient Been Seen in This Clinic Before?**
- Yes
- Established patient
- No, new patient

### Patient's Complaint(s), Symptoms, or Other Reasons for This Visit

**Use patient's own words**
- Most Important: [Fill in]
- Other: [Fill in]

### Major Reason for This Visit
- Mark (X) one:
  - Acute problem
  - Chronic problem, routine followup
  - Chronic problem, routine prevention, general exam, routine, prenatal
  - Pre- or post-surgery, injury followup
  - Non-illness care (e.g., routine, prenatal, general exam, well baby)

### Is This Visit Related to Injury or Poisoning?
- Yes
- No

**Place of occurrence**
- Mark (X) one:
  - Residence
  - Recreation/sports area
  - Street or highway
  - School
  - Other
  - Unknown

**Is this injury work-related?**
- Yes
- No

**Cause of Injury**
- Describe events that preceded injury (e.g., reaction to penicillin, wasp sting, driver in motor vehicle traffic accident involving collision with parked vehicle, shot with a handgun during a brawl, heroin overdose, etc.).

### Diagnostic/Screening Services
**Mark (X) all ordered or provided at this visit.**
- None

**Examinations**
- Blood pressure
- Cholesterol measure
- Hematocrit
- Hemoglobin
- PSA
- Other blood test

**Images**
- X-Ray
- CAT scan/MRI
- Mammography
- Ultrasound

### Counseling/Education:
- Tobacco use/education
- Growth development
- Stress management

### Other Therapy
- Psychotherapy
- Psycho-pharmacotherapy
- Physiotherapy
- Complementary or alternative medicine (CAM)

### Therapeutic and Preventive Services
**Mark (X) all ordered or provided at this visit. Exclude medications.**
- None

### Medications/Injections
**List names of up to 6 medications that were ordered, supplied, or administered during this visit, include Rx and OTC medications, immunizations, allergy shots, and anesthetics.**
- None

### Providers Seen This Visit
**Mark (X) all that apply.**
- R.N.
- P.N.
- Physician
- Medical/nursing assistant
- Other

### Visit Disposition
**Mark (X) all that apply.**
- Follow-up planned
- Returned to clinic
- Telephone follow-up planned
- Other

### Time Spent With Physician
- Minutes

**Form M03A0C-1000 (9-15-98)"