

NOTICE - All information which would permit identification of an individual or an establishment will be held confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to other persons or used for any other purpose. Public reporting burden for this collection of information is estimated to average 12 minutes per response. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to PHS Reports Clearance Officer: Atten: PRA: Hubert H. Humphrey Building, Room 721-B; 200 Independence Avenue, SW; Washington, DC 20201, and to the Office of Management and Budget; Paper Reduction Project (0920-0334), Washington, DC 20503.

FORM **NSAS-5**
(12-14-93)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR
DEPARTMENT OF HEALTH AND HUMAN SERVICES
U.S. PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL CENTER FOR HEALTH STATISTICS

NATIONAL SURVEY OF AMBULATORY SURGERY MEDICAL ABSTRACT

A. PATIENT IDENTIFICATION

| | | |
|---|---|--|
| 1. Facility number <input style="width: 100%; height: 20px;" type="text"/> | 2. NSAS number and list used <input style="width: 100%; height: 20px;" type="text"/> | 3. Medical record number <input style="width: 100%; height: 20px;" type="text"/> |
| 4. Date of surgery Month <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> Day <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> Year <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> | 5. Residence ZIP Code <input style="width: 100%; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/> | |

B. PATIENT CHARACTERISTICS

| | | |
|---|--|---|
| 6. Date of birth Month <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> Day <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> Year <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> | 7. Age (Complete only if date of birth not given) Units <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> { 1 <input type="checkbox"/> Years 2 <input type="checkbox"/> Months 3 <input type="checkbox"/> Days | |
| 8. Sex (Mark (X) one) 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female 3 <input type="checkbox"/> Not stated | 9. Race 1 <input type="checkbox"/> White 2 <input type="checkbox"/> Black 3 <input type="checkbox"/> American Indian/ Eskimo/Aleut 4 <input type="checkbox"/> Asian/Pacific Islander 5 <input type="checkbox"/> Other - Specify _____ 6 <input type="checkbox"/> Not stated | 10. Ethnicity (Mark (X) one) 1 <input type="checkbox"/> Hispanic origin 2 <input type="checkbox"/> Non-Hispanic 3 <input type="checkbox"/> Not stated |
| 11. Status/Disposition of patient (Mark (X) appropriate box) 1 <input type="checkbox"/> Routine discharge to customary residence 2 <input type="checkbox"/> Discharge to observation status 3 <input type="checkbox"/> Discharge to recovery care center 4 <input type="checkbox"/> Admitted to hospital as inpatient 5 <input type="checkbox"/> Surgery canceled or terminated 6 <input type="checkbox"/> Other - Specify <input checked="" type="checkbox"/> _____ 7 <input type="checkbox"/> Status/Disposition not stated | | |

C. PAYMENT DATA

| 12. Expected source(s) of payment | | Principal (Mark (X) one only) | Other additional sources (Mark (X) all that apply) |
|---|--|----------------------------------|---|
| Government sources | a. Worker's compensation | <input type="checkbox"/> | <input type="checkbox"/> |
| | b. Medicare | <input type="checkbox"/> | <input type="checkbox"/> |
| | c. Medicaid | <input type="checkbox"/> | <input type="checkbox"/> |
| | d. CHAMPUS | <input type="checkbox"/> | <input type="checkbox"/> |
| | e. Other government payments | <input type="checkbox"/> | <input type="checkbox"/> |
| Private sources | f. Blue Cross/Blue Shield | <input type="checkbox"/> | <input type="checkbox"/> |
| | g. HMO/PPO | <input type="checkbox"/> | <input type="checkbox"/> |
| | h. Other private or commercial insurance | <input type="checkbox"/> | <input type="checkbox"/> |
| Other sources | i. Self-pay | <input type="checkbox"/> | <input type="checkbox"/> |
| | j. No charge | <input type="checkbox"/> | <input type="checkbox"/> |
| | k. Other - Specify _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> No source of payment indicated | | | |

| | | |
|---|--|--|
| 13a. Billing number (If necessary) | 13b. Total charges: \$ _____ .00 | <input type="checkbox"/> Not available |
|---|--|--|

D. SURGICAL VISIT DATA

| | | | | |
|--|--------------|---|---|--|
| 14. Time | | Not available | 15. Type of anesthesia <i>(Mark (X) all that apply)</i> | |
| a. Time in to operating room | a.m. p.m. | <input type="checkbox"/> | a. Topical/local <input type="checkbox"/> b. IV sedation <input type="checkbox"/> c. MAC (Monitored Anesthesia Care) <input type="checkbox"/> d. Regional (1) Epidural <input type="checkbox"/> (2) Spinal <input type="checkbox"/> (3) Retrobulbar block <input type="checkbox"/> (4) Peribulbar block <input type="checkbox"/> (5) Block <input type="checkbox"/> e. General <input type="checkbox"/> f. Other – <i>Specify</i> <input checked="" type="checkbox"/> _____ _____ | |
| b. Time surgery began | a.m. p.m. | <input type="checkbox"/> | | |
| c. Time surgery ended | a.m. p.m. | <input type="checkbox"/> | | |
| d. Time out of operating room | a.m. p.m. | <input type="checkbox"/> | | |
| e. Time in to postoperative care | a.m. p.m. | <input type="checkbox"/> | | |
| f. Time out of postoperative care | a.m. p.m. | <input type="checkbox"/> | | |
| 16. Anesthesia administered by – (Mark (X) all that apply) | | | | |
| 1 <input type="checkbox"/> Anesthesiologist | | 3 <input type="checkbox"/> Surgeon/Other physician | | |
| 2 <input type="checkbox"/> CRNA (Certified Registered Nurse Anesthetist) | | 4 <input type="checkbox"/> Not stated/Not specified | | |

E. MEDICAL DATA

| | | | | | |
|--|----|-----------------------------|--|-----------------------------|--|
| 17. Final diagnoses (including E- code diagnoses) – Narrative description | | Optional – ICD-9-CM Nos. | | | |
| Principal | 1. | | | | |
| Other/ Additional | 2. | | | | |
| | 3. | | | | |
| | 4. | | | | |
| | 5. | | | | |
| | 6. | | | | |
| | 7. | | | | |
| 18. Surgical and diagnostic procedures – Narrative description | | Optional – CPT-4 Nos. | | Optional – ICD-9-CM Nos. | |
| Principal | 1. | | | | |
| Other/ Additional | 2. | | | | |
| | 3. | | | | |
| | 4. | | | | |
| | 5. | | | | |
| | 6. | | | | |
| <input type="checkbox"/> None | | | | | |

| | | | |
|--------------|------|--------------------------------|---------|
| Completed by | Date | OFFICE USE ONLY | FR code |
|--------------|------|--------------------------------|---------|