Form Approved: OMB No. 0920-0278; Expiration date 09/30/2010

FORM **NHAMCS-100(ASC)**
(9-24-2008)

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

NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY
2009 AMBULATORY SURGERY CENTER PATIENT RECORD

PATIENT RECORD NO.:

PATIENT'S NAME:

Assurance of confidentiality – All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used 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

a. Date of visit

Month	Day	Year
		0

b. ZIP Code

c. Date of birth

Month	Day	Year

d. Sex
1 ☐ Female 2 ☐ Male

e. Ethnicity
1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino

f. Race – *Mark (X) all that apply.*
1 ☐ White
2 ☐ Black or African American
3 ☐ Asian
4 ☐ Native Hawaiian or Other Pacific Islander
5 ☐ American Indian or Alaska Native

g. Expected source(s) of payment for this visit – *Mark (X) all that apply.*
1 ☐ Private insurance
2 ☐ Medicare
3 ☐ Medicaid/SCHIP
4 ☐ Worker's compensation
5 ☐ Self-pay
6 ☐ No charge/Charity
7 ☐ Other
8 ☐ Unknown

h. Time

(1) Time in to operating room . . . . . ☐ ☐ : ☐ ☐ ☐ a.m. ☐ p.m. ☐ Military

(2) Time surgery began . . . . . ☐ ☐ : ☐ ☐ ☐ a.m. ☐ p.m. ☐ Military

(3) Time surgery ended . . . . . ☐ ☐ : ☐ ☐ ☐ a.m. ☐ p.m. ☐ Military

(4) Time out of operating room . . . . ☐ ☐ : ☐ ☐ ☐ a.m. ☐ p.m. ☐ Military

(5) Time in to postoperative care . . . ☐ ☐ : ☐ ☐ ☐ a.m. ☐ p.m. ☐ Military

(6) Time out of postoperative care . . ☐ ☐ : ☐ ☐ ☐ a.m. ☐ p.m. ☐ Military

2. FINAL DIAGNOSIS

As specifically as possible, list all diagnoses related to this visit.

Optional – ICD-9-CM Code

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

3. EXTERNAL CAUSE OF INJURY

As specifically as possible, describe the injury that preceded the visit or adverse effect that occurred during the visit.

☐ NONE

Optional – E-Code

4. PROCEDURE(S)

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

☐ NONE

Optional – CPT-4 Codes

Optional – ICD-9-CM-Codes

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

PLEASE CONTINUE ON THE REVERSE SIDE

5. MEDICATION(S) & ANESTHESIA

a. Include Rx and OTC drugs, anesthetics, and oxygen that were ordered, supplied, or administered during this visit or at discharge.

☐ NONE

		During this visit	At discharge
(1)		1 ☐	2 ☐
(2)		1 ☐	2 ☐
(3)		1 ☐	2 ☐
(4)		1 ☐	2 ☐
(5)		1 ☐	2 ☐
(6)		1 ☐	2 ☐
(7)		1 ☐	2 ☐
(8)		1 ☐	2 ☐

b. Type(s) of anesthesia – *Mark (X) all that apply.*

1 ☐ NONE
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