

1997 NAMCS PATIENT RECORD FORM - INSTRUCTIONS AND DEFINITIONS

ITEM 1 - DATE OF VISIT

The month, day and year should be recorded in figures, for example, 5/17/97 for May 17, 1997. Office staff may record the date on the forms 1) in advance, 2) at the end of the day, or 3) at the time of the visit.

ITEM 2 - DATE OF BIRTH

The month, day, and year of the patient's birth should be recorded here, in the same fashion as Date of Visit above. This information will almost always be available in the patient's file, although sometimes the assistant may be responsible for looking it up. In the rare event the date of birth is unknown, the year of birth should be estimated as closely as possible.

For patients born in the 19th century, record year as 18--.

ITEM 3 - SEX

Self-explanatory. If "male," the physician marks that box and goes on to Item 4. But *point out* that if he/she marks "*female*," he/she must also answer the *sub-question*: Is patient pregnant?

ITEM 4 - RACE

This information is to be recorded based on observation or the physician's knowledge of the patient. The physician and staff are not expected to ask the patient for this information. If the patient's race is not known and is not obvious, the physician or assistant should mark the box which in his/her judgment is most appropriate. The definitions of the categories are listed below.

Race	Definition
1 White	A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

2 Black	A person having origins in any of the black racial groups of Africa.
3 Asian/Pacific Islander	A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes, for example, China, India, Japan, Korea, the Philippine Islands, and Samoa.
4 American Indian/ Eskimo/Aleut	A person having origins in any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.

ITEM 5 - ETHNICITY

Ethnicity relates to belonging to an ethnic group - that is a person's national or cultural group. NAMCS has two categories for ethnicity, Hispanic or Not Hispanic.

If the patient's ethnicity is not known and is not obvious, the physician or assistant should mark the box which in his/her judgement is most appropriate.

Ethnicity	Definition
1 Hispanic Origin	A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race.
2 Not Hispanic	All other persons.

ITEM 6 - WAS PATIENT REFERRED BY ANOTHER PHYSICIAN OR BY A HEALTH PLAN?

This item provides an idea of the “flow” of ambulatory patients from one physician to another . Mark the “Yes,” “No,” or “Unknown” category, as appropriate.

Notice that this item concerns referrals to the sample physician by a *different* physician. The sample physician may or may not work in the same health care plan as the referring physician (or referring health plan). The interest is in referrals for *this* visit and not in referrals for any prior visit.

Referrals are any visits that are made because of the advice or direction of a physician (or health plan) other than the physician being visited.

ITEM 7 - WAS AUTHORIZATION REQUIRED FOR CARE?

Authorization is defined as permission sought or obtained from a third party payer prior to medical treatment. Instruct the physician to check “Yes” if authorization for care was required. Check “No” if authorization was not required and “Unknown” if it is not known.

ITEM 8 - ARE YOU THE PATIENT’S PRIMARY CARE PHYSICIAN?

The primary care physician plans and provides the comprehensive primary health care of the patient. Check “Yes” if the health care provided to the patient during this visit was from his/her primary care physician. If physician was substituting for the primary care physician, also check “Yes.” Check “No” if care was not from the primary care physician and “Unknown” if it is not known.

ITEM 9 - PRIMARY EXPECTED SOURCE OF PAYMENT FOR THIS VISIT

The physician or staff member is to check the primary expected source of payment that will pay for *this visit*. This information is usually in the patient's file. However, in large group practices, the business office may keep billing information on a computer.

The physician may **check only one** Primary Expected Source of Payment.

**Primary Expected Source
of Payment**

Definition

- | | |
|---------------------|--|
| 1 Private insurance | Charges paid in-part or in-full by a private insurer (e.g. Blue Cross or Blue Shield) either directly to the physician or reimbursed to the patient. Include charges covered under a private insurance sponsored prepaid plan. |
| 2 Medicare | Charges paid in-part or in-full by a Medicare plan. Includes payments directly to the physician as well as payments reimbursed to the patient. Include charges covered under a Medicare sponsored prepaid plan. |
| 3 Medicaid | Charges paid in-part or in-full by a Medicaid plan. Includes payments made directly to the physician as well as payments reimbursed to the patient. Include charges covered under a Medicaid sponsored prepaid plan. |

- 4 Worker's Compensation Includes programs designed to enable employees injured on the job to receive financial compensation regardless of fault.
- 5 Self-pay Charges, to be paid by the patient or patient's family, which will not be reimbursed by a third party: Self-pay is perhaps a poor choice of wording since we really have no interest in whether the patient actually pays the bill. This category is intended to include visits for which the patient is expected to be ultimately responsible for the most of the bill. This should be mentioned when reviewing the PRF items with the physician and staff. DO NOT check this box for a copayment or deductibles.
- 6 No Charge Visits for which no fee is charged (e.g. charity, special research or teaching). Do not include visits paid for as part of a total package, e.g., prepaid plan visits, post-operative visits included in a surgical fee, and pregnancy visits included in a flat fee charged for the entire pregnancy. Mark the box, or boxes, that indicate how the services were originally paid.
- 7 Other Any other sources of payment not covered by the above categories, such as CHAMPUS, state and local governments, private charitable organizations, and other liability insurance (e.g. automobile collision policy coverage).

If the primary source of payment is not known, check the "Unknown" box.

ITEM 10 - DOES PATIENT BELONG TO AN HMO?

HMO is defined as a health care delivery system that offers comprehensive health services provided by an established panel or network of providers to a voluntarily enrolled population for a prepaid fixed fee and whose members are required to utilize services within the panel of contracted providers. Mark "Yes" if the patient belongs to an HMO. Mark "No" if the patient does not belong to an HMO and "Unknown" if it is not known.

ITEM 11 - IS THIS A CAPITATED VISIT?

Capitation is a method of payment for health services in which an individual or institutional provider is paid a fixed amount for each person served, without regard to the actual number or nature of services provided to each person in a set period of time. Capitation is the characteristic payment method in certain health maintenance organizations (HMOs). Mark "Yes" if the payment for this visit is capitated. Mark "No" if the payment method is not capitated and "Unknown" if it is not known.

**ITEM 12 - HAVE YOU OR ANYONE IN YOUR PRACTICE/
DEPARTMENT SEEN PATIENT BEFORE?**

"Seen" means "provided care for" at any time in the past. In group practices, check "Yes, established patient" if the patient was seen before by another physician or staff member in the group.

Check "No, new patient" if the physician or department never saw the patient before.

**ITEM 13 - PATIENT'S COMPLAINT(S), SYMPTOM(S) OR OTHER REASON(S) FOR
THIS VISIT**

(In patient's own words)

1. Most important
 2. Other
 3. Other
-

This is one of the most important items on the Patient Record Form. No similar data for visits to office-based physicians are available anywhere and there is tremendous interest in the findings. Take the time to be sure the doctor understands what is wanted--emphasizing the following three points:

- We want the patient's principal complaints, symptoms or other reason *as stated by the patient*. The physician may recognize right away, or may find out after examination, that the real problem is something entirely different, but in item 13 we are interested in how the patient defines his/her trouble.

- The item (like almost all other items on the Patient Record Form) refers to ***this visit***. Conceivably, the patient may be undergoing a course of treatment for a serious illness, but if his principal problem on this visit is a cut finger or a twisted ankle, that is the information we want.
- The complaint or symptom should be described in the ***patient's own words***. We will obtain the physician's diagnosis in item 16. Here we want the patient's description of the problem: "pain in chest," "cramps after eating."

Space has been allotted for both the "most important" and two "other" complaints, symptoms, and reasons mentioned by the patient. The most important should be entered in (1), the other or others in (2) and (3). By "most important" we mean that problem or symptom which in the physician's judgment was most responsible for the patient making this visit. Since we are interested only in the patient's ***principal complaints/ symptoms/ reasons***, it will seldom be necessary to record more than three.

There will be visits by patients for reasons other than some complaint or symptom. Examples might be:

- annual checkup,
- routine prenatal or
- postnatal care.

In such cases, the physician should simply enter the ***reason for the visit***.

NOTE: Remember that if the reason for patient's visit was only to pay a bill or ask the physician to complete an insurance form or drop off a specimen, the patient is not recorded on the Log and no Patient Record Form should be completed.

ITEM 14 - MAJOR REASON FOR THIS VISIT

The physician should check the major reason for the patient's present visit.

Instruct the physician to ***check only one*** of the following "Major Reasons:"

Major Reason

1 Acute Problem

Definition

Condition, illness, or injury having a relatively sudden or recent onset (within three months of this visit). For injury, only include the initial visit for treatment of the injury.

2 Chronic Problem, Routine	A visit primarily to receive care or examination for a pre-existing chronic condition, illness, or injury (onset of condition was three months or more before this visit).
3 Chronic Problem, Flare-up	A visit primarily due to sudden exacerbation of a pre-existing chronic condition.
4 Pre- or Post- Surgery/Injury Follow up	A visit scheduled primarily for follow up of a previous visit to any health care provider for treatment of an injury or for care required prior to or following surgery (e.g. pre-surgery tests, removing sutures or cast). If the injury occurred within the last three months and this is the initial visit for the injury, include it under "acute problem." If this visit is for follow up of an injury, not an initial visit for an injury, include it here.
5 Non-Illness Care	General health maintenance examinations and routine periodic examinations of presumably healthy persons, both children and adults. Includes prenatal and postnatal care, annual physicals, well-child exams and insurance examinations.

ITEM 15 - IS THIS VISIT RELATED TO INJURY OR POISONING?

The physician must mark the “Yes” or “No” box to indicate whether the patient's visit was due to any type of injury, poisoning, or other external factors. The injury/poisoning does not need to be recent. It can include those visits for follow up of previously treated injuries and visits for flare-ups of problems due to old injuries. This not only includes injuries or poisoning but also medical misadventures and adverse drug experiences.

If this visit is injury/poison related, instruct the physician to:

- a) Indicate where the injury/poisoning occurred.

Place of occurrence

Definition

1 Residence

apartment, boarding house, farm house, house (residential), home, including private driveway, garage, garden, walk, yard, swimming pool, noninstitutional place of residence.

Exclude home under construction but not yet occupied and institutional place of residence.

2 Recreation/sports	<p>all sports arenas including -- baseball field, basketball court, cricket ground, fives court, football field, golf course, gymnasium, hockey field, school gymnasium or sports field, race course, riding school, rifle range, sports ground, sports palace, stadium, tennis court, swimming pool (public), amusement park, beach resort, lake resort, mountain resort, resort, seashore, vacation resort, holiday camp, playground, public park, ice palace, skating rink.</p> <p>Exclude those areas that are in a private house or garden.</p>
3 Street or highway	freeway, motor way, pavement, road, sidewalk.
4 School	<p>include all private, public or state schools, university, kindergarten.</p> <p>Exclude places for recreation and sports located on school premises.</p>
5 Other public building	<p>building (including adjacent grounds) used by the general public. Includes -- airport, garage building (for car storage), station (bus or railway), bank, cafe, restaurant, casino church, cinema, theater, opera house, dance hall, music hall, movie house, broadcasting station, nightclub, public hall, clubhouse market (grocery or other commodity), shop (commercial), store, courthouse, post office, hotel, office, office building.</p> <p>Exclude home garage and industrial buildings.</p>
6 Industrial Places	building under construction, dockyard, dry dock, factory building or premises, industrial yard, loading platform, industrial plant, railway yard, warehouse.
7 Other	<p>mine and quarry, including, gravel pit, sand pit, and tunnel under construction.</p> <p>residential institutions: children's home, hospital, jail, senior citizen's home, orphanage, prison,</p>

reform school.

farm (buildings, land under cultivation, ranch).

farmhouse and home premises of farm should be included under "Residence."

If the place of injury is not known, check the "Unknown" box.

b) Indicate whether the injury was intentional (self-inflicted or assault), unintentional, or of unknown intent.

c) Indicate whether the injury is work related or not. Consider available information with regard to location and activity at time of injury (i.e. if location is farm, suspect work related and evaluate per criteria).

Criteria for work-related injuries:

1) On employer premises

- Engaged in work activity, apprentice, vocational training
- On break, in hallways, rest room, cafeteria, storage area
- In employer parking lot while working, arriving, or leaving

2) Off employer premises

- Working for pay or compensation, including at home
- Working as a volunteer EMS, firefighter, or law enforcement officer
- Working in family business, including family farm. Activity should be clearly related to a profit-oriented business
- Traveling on business, including to and from customer/business contacts
- Engaged in work activity where vehicle is considered the work environment (e.g., taxi driver, truck driver, etc.)

Criteria for non work-related injuries:

1) On employer premises

- Engaged in recreational activities on employer controlled facilities (games, etc) for personal enjoyment
- As a visitor for non-work purposes, not on official business

2) Off employer premises

- Homemaker working at homemaking activities
- Working for self-non profit, i.e., mowing lawn, repairing own roof, hobby, or recreation activities
- Student engaged in school activities
- Operating vehicle (personal or commercial) for non-work purposes
- Commuting to or from work site

d) Describe in detail the circumstances that caused the injury (e.g. fell off monkey bars, motor vehicle involving collision with another car). Include information on the role of the patient associated with the injury (e.g. bicyclist, pedestrian, unrestrained driver or passenger in a motor vehicle, horseback rider), the specific place of occurrence (e.g. lake), and the activity in which the patient was engaged at the time of the injury (e.g. swimming, boating).

Also include what happened to the patient and identify the proximate cause of the injury or injuries for which the patient sought treatment. The proximate cause of injury is the mechanism of injury that is temporarily or immediately responsible for the injury. An example is a laceration caused by a broken piece of glass. Include, in addition, the underlying or precipitating cause of injury ...the event, mechanism, or external cause of injury that initiated and led to the proximate cause of injury. An example is a house fire that caused a person to jump out of the window. Both the precipitating or underlying cause (house fire) and the proximate cause (fall from roof) would be important to record. It's especially important to record as much detail about falls and motor vehicle accidents as possible. For each, indicate what the fall was from and where the patient landed. NCHS will use the information collected to classify the cause of the injury using the International Classification of Diseases, Supplementary Classification of External Causes of Injury and Poisoning codes (ICD-9-CM E-Codes).

ITEM 16 - PHYSICIAN'S DIAGNOSES

1. Primary diagnosis

2. Other

3. Other

This is one of the most important items on the Patient Record Form. Item 16-1 refers to the physician's primary diagnosis for this visit. While the diagnosis may be tentative, provisional, or definitive it should represent the physician's best judgment at this time, expressed in acceptable medical terminology including "problem" terms.

If a patient appears for *postoperative* care (follow up visit after surgery), the physician should record the postoperative diagnosis as well as any other. The postoperative diagnosis should be indicated with the letters (P.O.).

Space has been allotted for two "other" diagnoses. In Items 16-2 and 16-3 the physician should list *other conditions related to this visit or to the choice of treatment or medications ordered or provided for the patient at this time.* Include chronic conditions (e.g. hypertension, depression, etc.) if related to this visit.

ITEM 17 - DIAGNOSTIC/SCREENING SERVICES

The physician should mark all services that were ordered or provided during *this visit* for the purpose of screening (i.e. early detection of health problems in asymptomatic individuals) or diagnosis (i.e. identification of health problems causing individuals to be symptomatic). During a visit for a complete physical exam, several of the services may be ordered or provided. **EACH SERVICE SHOULD BE MARKED.**

If services were ordered or provided but not listed, mark the “All other” box and specify in the space(s) provided.

If no *Examinations, Tests and Measurements, or Imaging* were ordered or provided, instruct the physician to check the “None” box.

ITEM 18 - THERAPEUTIC AND PREVENTIVE SERVICES

Counseling/Education

Instruct the physician to check all appropriate boxes for any of the following types of counseling, advice, education, instructions, or recommendations to the patient that were ordered or provided during the visit:

Diet/nutrition-- any topic related to the foods and/or beverages consumed by the patient. Examples include general **dietary guidelines** of health promotion and disease prevention, **dietary restrictions** to treat or control a specific medical problem or condition, and **dietary instructions** related to medications. Includes referrals to other health professionals, for example, dietitians and nutritionists.

Exercise-- any topics related to the patient’s physical conditioning or fitness. Examples include information aimed at general health promotion and disease prevention and information given to treat or control a specific medical condition. Includes referrals to other health and fitness professionals. Does not include referrals for physiotherapy. Physiotherapy ordered or provided at this visit is listed as a separate check box under “Other Therapy.”

HIV/STD transmission-- information intended to help the patient understand how HIV (human immunodeficiency virus) or STDs (sexually transmitted diseases) are transmitted. Includes topics such as “safe sex,” IV drug use, and exchange of bodily fluids.

Family planning/contraception-- information given to the patient to assist in conception or intended to help the patient understand how to prevent conception.

Prenatal instructions-- information given to the mother during her entire pregnancy on the growth and development of her unborn child and its chances for survival and good health after birth. Includes information about the mother's dietary intake, her weight, other factors affecting the unborn child such as alcohol and certain drugs taken by the mother during pregnancy, and diseases that increase the risk of obstetrical complications such as diabetes, heart disease, hypertension, kidney disease, and anemia.

Breast self-exam-- information given to the patient instructing her when and how to perform a simple self-examination of the breasts.

Tobacco use/exposure-- information given to the patient on issues related to tobacco use in any form, including cigarettes, cigars, snuff, and chewing tobacco, and on the exposure to tobacco in the form of "secondhand smoke." Includes information on smoking cessation as well as prevention of tobacco use. Includes referrals to other health professionals for smoking cessation programs.

Growth/development-- any topics related to human growth and development.

Mental health-- general advice or counseling about mental health issues and education about mental disorders. Includes referrals to other mental health professionals for mental health counseling.

Stress management-- information intended to help patient reduce stress through exercise, biofeedback, yoga, etc. Includes referrals to other health professionals for the purpose of health stress coping mechanisms.

Skin cancer prevention-- information intended to help the patient understand strategies for reducing exposure to the sun and its effects. Includes information on sunbathing and the use of sunscreens.

Injury prevention-- any topic aimed at minimizing the chances of injury in one's daily life. May include issues as diverse as drinking and driving, child safety, avoidance of injury through proper techniques for various physical activities, etc.

Other Therapy Instruct the physician to check all appropriate boxes for therapeutic services (excluding medication) ordered or provided. Examples include:

Psychotherapy-- All *treatments* involving the intentional use of **verbal techniques** to explore or alter the patient's emotional life in order to effect symptom reduction or behavior change.

Psycho-pharmacotherapy-- All *treatments* involving the intentional use of **medicinal techniques** to explore or alter the patient's emotional life in order to effect symptom reduction or behavior change.

Physiotherapy-- Any form of physical therapy including treatments using heat, light, sound, or physical pressure or movement. For example: ultrasonic, ultraviolet, infrared, whirlpool, diathermy, cold and manipulative therapy.

All specific forms of medication are excluded because that information is collected in Item 20.

If services were ordered or provided, but not listed, mark the "All other" box and specify in the space(s) provided.

If no Counseling/Educational or Other Therapeutic services were ordered or provided, instruct the physician to check the "None" box.

ITEM 19 - AMBULATORY SURGICAL PROCEDURES

Instruct the physician to record the specific name of up to two ambulatory surgical procedures actually performed at this visit. Routine surgical procedures (e.g. wound care) as well as more complex procedures (e.g., cataract extraction, vasectomy, hernia repair, growth removal, etc.) should be reported. Any procedure designated in the ICD-9-CM Volume 3 (which physicians and their staffs will be familiar with) as a surgical procedure may be recorded. Diagnostic surgical procedures such as biopsy should also be recorded.

If no surgical procedures were performed, instruct the physician to check the "None" box.

ITEM 20 - MEDICATION/INJECTIONS

Explain to the physician that he/she should list **all** medications (drugs, vitamins, hormones, ointments, suppositories) injected, prescribed, administered, or supplied this visit, using either brand or generic names.

Medication, broadly defined, includes the specific name of any:

prescription **and** non-prescription medication;

injections;

vaccinations;

anesthetics;

immunization and allergy shots;

drugs and medications which the doctor ordered or provided *prior to this visit* and *instructs or expects* the patient to continue taking regardless of whether a “refill” is provided at the time of visit.

Be sure you give the following instructions to the doctor:

Record the same specific drug name (brand or generic) used on any prescription or office medical record.

Do not enter broad drug classes, such as “laxative,” “cough preparation,” “analgesic,” “antacids,” “birth control pill,” or “antibiotics.” The one exception is “allergy shot.”

Limit entries to **drug name only**. Additional information such as dosage strength or regimen is **not** required. For example, the medication might be in the form of pills, injections, slaves or ointments, drops, suppositories, powders, or skin patch, but this information should not be entered on the PRF.

Check the box to the *left* of drug name if it is from the patient’s insurance formulary list. If none of the medications prescribed or provided is from the patient’s insurance formulary list, check the appropriate box.

If no medication was prescribed or provided, the physician should indicate by marking the “None” box.

ITEM 21 - PROVIDERS SEEN THIS VISIT

Mark all providers seen during this visit. If care was provided, at least in part, by a person not represented in the seven categories, mark the “Other” box.

ITEM 22 - TIME SPENT WITH PHYSICIAN

Include here the length of time the sample *physician* spent with the patient. **DO NOT** include the time the patient spent waiting to see the doctor or receiving care from someone other than the doctor. For example, the nurse gave the patient an inoculation, or a technician administered an electrocardiogram. It is entirely possible that for visits such as these, the patient would not see the doctor at all. In that case, “0” minutes should be entered in Item 22.

DO NOT include time spent on the patient, but not with the patient, such as time spent reviewing the patient's medical records or test results before seeing the patient.

The intent of this item is to get the total time spent in face-to-face contact with the *physician*.

If more than one patient is seen by the doctor at the same time, apply the following rule:

If the doctor can easily separate the time spent with each (e.g., 3 minutes with one and 27 minutes with the other), he/she should record that on the Patient Record Forms. If the doctor cannot easily estimate how much time was spent with each, he/she should divide the total time equally among the patients seen together.