

FORM **NSAS-5**
(2-1-2006)

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

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 of this collection of information is estimated to average 12 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or an other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0334).

NATIONAL SURVEY OF AMBULATORY SURGERY MEDICAL ABSTRACT

A. PATIENT INFORMATION

1. Facility number <input style="width: 100%;" type="text"/>	2. NSAS number and list used <input style="width: 100%;" type="text"/>	3. Date of surgery Month <input style="width: 20px;" type="text"/> Day <input style="width: 20px;" type="text"/> Year <input style="width: 20px;" type="text"/> 2 <input style="width: 20px;" type="text"/> 0 <input style="width: 20px;" type="text"/> 0	4. Residence ZIP Code <input style="width: 100%;" type="text"/>
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B. PATIENT CHARACTERISTICS

5. Date of birth Month <input style="width: 20px;" type="text"/> Day <input style="width: 20px;" type="text"/> Year <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	6. Age (Complete only if date of birth not given) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> Units { 1 <input type="checkbox"/> Years 2 <input type="checkbox"/> Months 3 <input type="checkbox"/> Days	7. Sex (Mark (X) one) 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female 3 <input type="checkbox"/> Not stated
8. Ethnicity (Mark (X) one) 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino 3 <input type="checkbox"/> Not Stated	9. Race (Mark (X) all that apply) 1 <input type="checkbox"/> White 2 <input type="checkbox"/> Black or African American 3 <input type="checkbox"/> American Indian or Alaska Native 4 <input type="checkbox"/> Asian 5 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 6 <input type="checkbox"/> Other → <input style="width: 100%;" type="text"/> 7 <input type="checkbox"/> Not Stated	
10. Status/Disposition of Patient (Mark (X) the 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 post-surgical/recovery care facility 4 <input type="checkbox"/> Admitted to hospital as inpatient 5 <input type="checkbox"/> Surgery canceled or terminated 6 <input type="checkbox"/> Other – Specify → <input style="width: 100%;" type="text"/> 7 <input type="checkbox"/> Status/Disposition not stated		

C. PAYMENT INFORMATION

11. Expected source of payment																																																																																																							
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D. SURGICAL VISIT INFORMATION

13. Time	14. Type of anesthesia (Mark (X) all that apply)																																																																
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15. Anesthesia administered by – (Mark (X) all that apply)				
<table style="width: 100%;"> <tr> <td>1 <input type="checkbox"/> Anesthesiologist</td> <td>3 <input type="checkbox"/> Surgeon/Other physician</td> </tr> <tr> <td>2 <input type="checkbox"/> CRNA (Certified Registered Nurse Anesthetist)</td> <td>4 <input type="checkbox"/> Not stated/Not specified</td> </tr> </table>	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
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Please continue on the reverse side

E. MEDICAL INFORMATION

16. FINAL DIAGNOSES (including E-code diagnoses) – Narrative description		Optional – ICD-9-CM Codes				
Principal	1.					
Other/ Additional	2.					
	3.					
	4.					
	5.					
	6.					
	7.					

17. Surgical and diagnostic procedures – Narrative description		Optional – CPT-4 Codes					Optional – ICD-9-CM Codes				
Principal	1.										
Other/ Additional	2.										
	3.										
	4.										
	5.										
	6.										

None

18. Symptoms present during or after surgery. (Mark (X) all that apply)

1 <input type="checkbox"/> Accidental laceration, puncture or perforation	12 <input type="checkbox"/> High blood pressure/hypertension	22 <input type="checkbox"/> None Indicated
2 <input type="checkbox"/> Airway obstruction	13 <input type="checkbox"/> Hypoxia	
3 <input type="checkbox"/> Apnea	14 <input type="checkbox"/> Incontinence	
4 <input type="checkbox"/> Bleeding/hemorrhage	15 <input type="checkbox"/> Low blood pressure/hypotension	
5 <input type="checkbox"/> Blood transfusion needed	16 <input type="checkbox"/> Malignant hyperthermia	
6 <input type="checkbox"/> Cardiac arrest	17 <input type="checkbox"/> Nausea	
7 <input type="checkbox"/> Difficulty waking up	18 <input type="checkbox"/> Peripheral site burn	
8 <input type="checkbox"/> Dysrhythmia/arrhythmia	19 <input type="checkbox"/> Shock	
9 <input type="checkbox"/> Embolism	20 <input type="checkbox"/> Vomiting	
10 <input type="checkbox"/> Fainting/vasovagal syncope	21 <input type="checkbox"/> Other – Please specify →	
11 <input type="checkbox"/> Fistula		

F. FOLLOW-UP INFORMATION

19a. Did someone attempt to follow-up with the patient within 24 hours after the surgery?

	Yes	No	Unknown
	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

b. Did they reach the patient? *If yes, →*

	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
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(1) What was learned from this follow-up? (Mark (X) all that apply)

1 <input type="checkbox"/> Patient had a question	6 <input type="checkbox"/> Went to an emergency department
2 <input type="checkbox"/> Patient had no problems	7 <input type="checkbox"/> Was admitted to the hospital
3 <input type="checkbox"/> Patient had problem(s) and –	8 <input type="checkbox"/> Other – Please specify →
1 <input type="checkbox"/> Called his/her doctor	
2 <input type="checkbox"/> Went to the doctor	
3 <input type="checkbox"/> Called the ambulatory surgery center	
4 <input type="checkbox"/> Came back to the ambulatory surgery center	
5 <input type="checkbox"/> Called the emergency department	
4 <input type="checkbox"/> Nothing	
5 <input type="checkbox"/> Unknown	

(2) What problem(s) did the patient mention (e.g., site drainage, temperature, pain, nausea) ?

20. Completed by	21. Date	OFFICE USE ONLY	FR code
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