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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

NATIONAL SURVEY OF AMBULATORY SURGERY

MEDICAL ABSTRACT

A. PATIENT INFORMATION

1. Facility number

2. NSAS number and list used

3. Date of surgery
Month Day Year 2 0 0

4. Residence ZIP Code –

B. PATIENT CHARACTERISTICS

5. Date of birth
Month Day Year

6. Age *(Complete only if date of birth not given)*
Units { 1 ☐ Years 2 ☐ Months 3 ☐ Days

7. Sex *(Mark (X) one)*
1 ☐ Male
2 ☐ Female
3 ☐ Not stated

8. Ethnicity *(Mark (X) one)*
1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino
3 ☐ Not Stated

9. Race *(Mark (X) all that apply)*
1 ☐ White
2 ☐ Black or African American
3 ☐ American Indian or Alaska Native
4 ☐ Asian
5 ☐ Native Hawaiian or Other Pacific Islander
6 ☐ Other →
7 ☐ Not Stated

10. Status/Disposition of Patient *(Mark (X) the appropriate 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 ☐ Surgery canceled or terminated
6 ☐ Other – *Specify* →
7 ☐ Status/Disposition not stated

C. PAYMENT INFORMATION

11. Expected source of payment

	Principal	Other sources
GOVERNMENT SOURCES		
Medicare	☐	☐
If available, also note whether –		
Fee-for-service	☐	
HMO	☐	
PPO	☐	
Medicaid	☐	☐
If available, also note whether –		
Fee-for-service	☐	
HMO	☐	
PPO	☐	
TRICARE	☐	☐
Worker's compensation	☐	☐
Other government	☐	☐
If so, please specify →		
PRIVATE INSURANCE		
Private or commercial	☐	☐
If available, also note whether –		
Fee-for-service	☐	
HMO	☐	
PPO	☐	
OTHER SOURCES		
Self pay	☐	☐
Not covered by insurance	☐	
Had no health insurance	☐	
Charity care/Write off	☐	☐
No charge	☐	☐
Other	☐	☐
Please specify →		
No source of payment indicated	☐	

12. Total charges $ .00 ☐ Not available

D. SURGICAL VISIT INFORMATION

13. Time

		Not available
a. Time in to operating room	a.m. p.m.	☐
b. Time surgery began	a.m. p.m.	☐
c. Time surgery ended	a.m. p.m.	☐
d. Time out of operating room	a.m. p.m.	☐
e. Time in to postoperative care	a.m. p.m.	☐
f. Time out of postoperative care	a.m. p.m.	☐

14. Type of anesthesia *(Mark (X) all that apply)*
a. Topical/local ☐
b. IV sedation ☐
c. MAC (Monitored Anesthesia Care) ☐
d. Regional
(1) Epidural ☐
(2) Spinal ☐
(3) Retrobulbar block ☐
(4) Peribulbar block ☐
(5) Block ☐
e. General ☐
f. Other – *Specify* → ☐
g. None specified ☐

15. Anesthesia administered by – *(Mark (X) all that apply)*
1 ☐ Anesthesiologist
2 ☐ CRNA (Certified Registered Nurse Anesthetist)
3 ☐ Surgeon/Other physician
4 ☐ Not stated/Not specified

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

F. FOLLOW-UP INFORMATION

	Yes	No	Unknown
19a. Did someone attempt to follow-up with the patient within 24 hours after the surgery?	1 ☐	2 ☐	3 ☐
b. Did they reach the patient? *If yes,*	1 ☐	2 ☐	3 ☐

(1) What was learned from this follow-up? *(Mark (X) all that apply)*

1 ☐ Patient had a question
2 ☐ Patient had no problems
3 ☐ Patient had problem(s) and –
- 1 ☐ Called his/her doctor
- 2 ☐ Went to the doctor
- 3 ☐ Called the ambulatory surgery center
- 4 ☐ Came back to the ambulatory surgery center
- 5 ☐ Called the emergency department
- 6 ☐ Went to an emergency department
- 7 ☐ Was admitted to the hospital
- 8 ☐ Other – *Please specify*

4 ☐ Nothing
5 ☐ 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