ICPSR | INTER-UNIVERSITY CONSORTIUM FOR POLITICAL AND SOCIAL RESEARCH

ICPSR 28442

National Hospital Ambulatory Medical Care Survey, 2007

United States Department of Health and Human Services. Centers for Disease Control and Prevention. National Center for Health Statistics

Ambulatory Unit Induction Interview Questionnaire

Inter-university Consortium for Political and Social Research
P.O. Box 1248
Ann Arbor, Michigan 48106
www.icpsr.umich.edu

Terms of Use

The terms of use for this study can be found at:
http://www.icpsr.umich.edu/cocoon/ICPSR/TERMS/28442.xml

Information about Copyrighted Content

Some instruments administered as part of this study may contain in whole or substantially in part contents from copyrighted instruments. Reproductions of the instruments are provided as documentation for the analysis of the data associated with this collection. Restrictions on "fair use" apply to all copyrighted content. More information about the reproduction of copyrighted works by educators and librarians is available from the United States Copyright Office.

NOTICE
WARNING CONCERNING COPYRIGHT RESTRICTIONS

The copyright law of the United States (Title 17, United States Code) governs the making of photocopies or other reproductions of copyrighted material. Under certain conditions specified in the law, libraries and archives are authorized to furnish a photocopy or other reproduction. One of these specified conditions is that the photocopy or reproduction is not to be "used for any purpose other than private study, scholarship, or research." If a user makes a request for, or later uses, a photocopy or reproduction for purposes in excess of "fair use," that user may be liable for copyright infringement.

Form Approval OMB No. 0920-0278 Exp. Date 08/31/2009 CDC 64.150

FORM **NHAMCS-101(U)**
(9-27-2006)

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

AMBULATORY UNIT RECORD
National Hospital Ambulatory Medical Care Survey
2007 Panel

NOTICE – Public reporting burden of this collection of information is estimated to average 60 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 any 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 (0920-0278).

Assurance of confidentiality – All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used by persons engaged in and for the purpose of the survey and will not be disclosed or released to other persons or used for any other purpose without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m).

COMPLETE THIS RECORD FOR EACH AMBULATORY UNIT SELECTED

Section A – AMBULATORY UNIT INFORMATION

a. Is this ambulatory unit part of an emergency or outpatient department?

1 ☐ ED – *Mark (X) type* →
1 ☐ General
2 ☐ Adult
3 ☐ PED
4 ☐ Urgi-/Fast track
5 ☐ PSYC
6 ☐ Trauma
7 ☐ Other

2 ☐ OPD – *Mark (X) specialty* →
1 ☐ GM
2 ☐ SURG
3 ☐ PED
4 ☐ OBG
5 ☐ Substance Abuse
6 ☐ Other

b. AU No. _____ of _____
Total AU's sampled within the ED or OPD

c. Hospital number →

d. Hospital name

1. Enter the name of the (emergency service area/clinic). *(If no name, identify it by location, service type, or some other unique identifier.)*

Name

2. Where is the (emergency service area/clinic) located?

1 ☐ Onsite at hospital
2 ☐ Elsewhere – *Specify* →

Address *(Number and street)*

City/State

ZIP Code

3. What is the name, title, and telephone number of the director of the (emergency service area/clinic)?

Name

Title

Telephone *(Area code and number)*

Section B – SAMPLE INFORMATION

1. Take every number

2. Random start number

3. Estimated number of visits in this AU during reporting period

4. Total estimated number of visits during reporting period for **ENTIRE** department

5. REPORTING PERIOD *(Month/Day/Year)*
From: / /
To: / /

From the Sampling Plan: *If a sampling plan is not required, item 6 is the AU No. from Section A, item b. Items 7 and 8 are each 1.*

6. SU number

7. Numerator

8. Denominator

9. What was the total number of patient visits to this AU from *(dates specified in B5)*?(Refer to patient logs, etc. Ask if necessary.DO NOT LEAVE TOTAL BLANK. BE AS COMPLETE AND ACCURATE AS POSSIBLE.)

NUMBER OF VISITS				
Week 1	Week 2	Week 3	Week 4	TOTAL
/ – /	/ – /	/ – /	/ – /	

10. How many patient record forms were filled out for this AU *(emergency service area/clinic)?*

NUMBER OF FORMS				
Week 1	Week 2	Week 3	Week 4	TOTAL

Section C – EMERGENCY SERVICES/OUTPATIENT CLINIC INFORMATION AND LOGS

1. What are the usual operating hours of this unit?

Day(s) (a)	Time (b)		Mark (X) ONLY one: Open 24 hours (c)	Not open (d)	Hours vary (e)
Monday	FROM a.m. p.m.	TO a.m. p.m.	1 ☐	2 ☐	3 ☐
Tuesday	FROM a.m. p.m.	TO a.m. p.m.	1 ☐	2 ☐	3 ☐
Wednesday	FROM a.m. p.m.	TO a.m. p.m.	1 ☐	2 ☐	3 ☐
Thursday	FROM a.m. p.m.	TO a.m. p.m.	1 ☐	2 ☐	3 ☐
Friday	FROM a.m. p.m.	TO a.m. p.m.	1 ☐	2 ☐	3 ☐
Saturday	FROM a.m. p.m.	TO a.m. p.m.	1 ☐	2 ☐	3 ☐
Sunday	FROM a.m. p.m.	TO a.m. p.m.	1 ☐	2 ☐	3 ☐

2. How many separate shifts are there in this unit? — Number of separate shifts

3. How many separate patient registration logs are maintained in this unit? — Number of logs

Section D – VERIFICATION OF ESTIMATED VISITS

Verify with ED/Clinic director BEFORE data collection begins (and records have been pulled).

1. According to our information, about (Number from B-3) patient visits are expected during the reporting period. Do you agree with this estimate?

1 ☐ Yes – *SKIP to section F, page 3*
2 ☐ No

2. About how many visits do you expect during the reporting period, _____ to _____? — Revised estimate

Determine if new Take Every and Random Start numbers must be calculated for this clinic.

3a. Divide the revised estimate by the original estimate from B-3.

$$\frac{\text{Revised estimate}}{\text{Original estimate}} = \frac{\square}{\square} = \square \text{ (Result)}$$

b. Is the result of (a) between 0.7 and 1.3?

1 ☐ Yes – *SKIP to section F, page 3*
2 ☐ No

Section E – CALCULATE NEW TAKE EVERY AND RANDOM START NUMBERS FOR THIS ESA/CLINIC

1. Calculate new sampling Take Every, using the appropriate table (page 2 or 4) of the NHAMCS-124. *(Use the revised estimate of visits from D-2 and the original total visits from B-4).* — New Take Every ☐☐☐

2. Calculate new Random Start, using the next available row on the label affixed to the back of the NHAMCS-101. — New Random Start ☐☐☐

Section F – DATA COORDINATOR AND HOSPITAL STAFF

Enter the name, title, shift, and telephone number of the data coordinator and hospital staff involved in the data collection.

Line No. (a)	Name (b)	Title (c)	Shift (d)	Telephone number (e)		
				Area code	Number	Ext.
1						
2						
3						
4						
5						
6						
7						
8						

Section G – PATIENT RECORD FORM INFORMATION

1. *Enter the range of Patient Record Forms that were* ***ACTUALLY*** *used by the unit.*

FIRST FOLIO FROM: ☐☐☐☐☐☐☐ TO: ☐☐☐☐☐☐☐

SECOND FOLIO FROM: ☐☐☐☐☐☐☐ TO: ☐☐☐☐☐☐☐

THIRD FOLIO FROM: ☐☐☐☐☐☐☐ TO: ☐☐☐☐☐☐☐

CHECK ITEM A

This NHAMCS-101(U) is being completed for:

☐ OPD – *SKIP to Section H*

☐ ED – *Continue with item 2.*

2. Of the completed PRF's in this ESA, how many had a visit disposition (item 11) of "Admit to hospital?"

Number of PRFs with visit disposition of "Admit to hospital" ☐

If the number of PRFs given above is 0, then return to the ED for an explanation and write it in the "NOTES" section below. If an error was found in sampling or recording the disposition, then make the correction and note it below.

3. Did you complete a NHAMCS-105, Hospital Admission Log for any PRFs where the patient was admitted to the hospital?

1 ☐ Yes

2 ☐ No

NOTE – On average, about 12 percent of ED visits result in hospital admission; therefore, it would be unusual to have no PRFs with this disposition during the 4-week reporting period.

NOTES

Section H – FINAL DISPOSITION

1. FINAL DISPOSITION

Ambulatory unit

1 ☐ Participated
- a ☐ Patients seen
- b ☐ No patients seen

2 ☐ Refused

3 ☐ Closed
- a ☐ Temporary
- b ☐ Permanent

4 ☐ Ineligible
- a ☐ AU not under auspices of hospital
- b ☐ Only ancillary services provided
- c ☐ Care not provided by or under the direct supervision of a physician
- d ☐ Clinic classified as out-of-scope
- e ☐ Other – *Specify*

_____

2. Who completed the patient record forms?

Mark (X) all that apply

1 ☐ Hospital staff
2 ☐ FR – abstraction DURING reporting period
3 ☐ FR – abstraction AFTER reporting period
4 ☐ Other – *Specify*

_____

NOTES