OMB No. 0920-0334: Approval Expires 12/31/96

FORM **NSAS-5**
(12-14-93)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR
DEPARTMENT OF HEALTH AND HUMAN SERVICES
U.S. PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL CENTER FOR HEALTH STATISTICS

NATIONAL SURVEY OF AMBULATORY SURGERY
MEDICAL ABSTRACT

A. PATIENT IDENTIFICATION

1. Facility number ☐☐☐☐

2. NSAS number and list used ☐☐☐☐ ☐

3. Medical record number

4. Date of surgery
Month ☐☐ Day ☐☐ Year ☐☐

5. Residence ZIP Code ☐☐☐☐☐ - ☐☐☐☐

B. PATIENT CHARACTERISTICS

6. Date of birth
Month ☐☐ Day ☐☐ Year ☐☐☐☐

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

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

9. Race
1 ☐ White
2 ☐ Black
3 ☐ American Indian/ Eskimo/Aleut
4 ☐ Asian/Pacific Islander
5 ☐ Other – *Specify* _____
6 ☐ Not stated

10. Ethnicity *(Mark (X) one)*
1 ☐ Hispanic origin
2 ☐ Non-Hispanic
3 ☐ Not stated

11. Status/Disposition of patient *(Mark (X) appropriate box)*
1 ☐ Routine discharge to customary residence
2 ☐ Discharge to observation status
3 ☐ Discharge to recovery care center
4 ☐ Admitted to hospital as inpatient
5 ☐ Surgery canceled or terminated
6 ☐ Other – *Specify* _____
7 ☐ Status/Disposition not stated

C. PAYMENT DATA

12. Expected source(s) of payment

		Principal *(Mark (X) one only)*	Other additional sources *(Mark (X) all that apply)*
Government sources	**a.** Worker's compensation	☐	☐
	b. Medicare	☐	☐
	c. Medicaid	☐	☐
	d. CHAMPUS	☐	☐
	e. Other government payments	☐	☐
Private sources	**f.** Blue Cross/Blue Shield	☐	☐
	g. HMO/PPO	☐	☐
	h. Other private or commercial insurance	☐	☐
Other sources	**i.** Self-pay	☐	☐
	j. No charge	☐	☐
	k. Other – *Specify* _____	☐	☐

☐ No source of payment indicated

13a. Billing number *(If necessary)*

13b. Total charges:
$ _____ . 00 ☐ Not available

(OVER)

D. SURGICAL VISIT DATA

14. 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.	☐

15. 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 ☐

16. 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

E. MEDICAL DATA

17. Final diagnoses (including E- code diagnoses) – Narrative description

		Optional – ICD-9-CM Nos.
Principal	1.	
Other/ Additional	2.	
	3.	
	4.	
	5.	
	6.	
	7.	

18. Surgical and diagnostic procedures – Narrative description

		Optional – CPT-4 Nos.	Optional – ICD-9-CM Nos.
Principal	1.		
Other/ Additional	2.		
	3.		
	4.		
	5.		
	6.		

☐ None

Completed by	Date	OFFICE USE ONLY	FR code

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