

**OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT  
AMBULATORY SURGERY DATA RECORD  
MANUAL ABSTRACT REPORTING FORM**

~~For use with encounters on or after January 1, 2006~~

**Effective with encounters occurring on or after January 1, 2009**

Instructions: For a description of the data elements, refer to the appropriate section of the Patient Data Reporting Requirements  
(Title 22, Sections 97251 through 97265, and 97267)

<b>A. FACILITY ID NUMBER</b>  <div style="border: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div>	<b>B. ABSTRACT RECORD NUMBER (Optional)</b>  <div style="border: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div> <div style="border: 1px solid black; width: 100%; height: 15px; margin-bottom: 5px;"></div>																																
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Month		Day		Year (4-digit)																													
M	M	D	D	C	C	Y	Y																										
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Month		Day		Year (4-digit)																													
M	M	D	D	C	C	Y	Y																										

**PRINCIPAL LANGUAGE SPOKEN**

Enter only one 3-digit value in the space provided.

Or, if patient's Principal Language Spoken is not included in the list, then enter language spoken, up to 24 alpha characters.

- |                          |                                 |
|--------------------------|---------------------------------|
| <u>ENG</u> English       | <u>LAO</u> Laotian              |
| <u>ARA</u> Arabic        | <u>HMN</u> Miao, Hmong          |
| <u>ARM</u> Armenian      | <u>KHM</u> Mon-Khmer, Cambodian |
| <u>CHI</u> Chinese       | <u>NAV</u> Navajo               |
| <u>FRE</u> French        | <u>PER</u> Persian              |
| <u>CPF</u> French Creole | <u>POL</u> Polish               |
| <u>GER</u> German        | <u>POR</u> Portuguese           |
| <u>GRE</u> Greek         | <u>RUS</u> Russian              |
| <u>GUJ</u> Guarathi      | <u>SCR</u> Serbo-Croatian       |
| <u>HEB</u> Hebrew        | <u>SPA</u> Spanish              |
| <u>HIN</u> Hindi         | <u>TGL</u> Tagalog              |
| <u>HUN</u> Hungarian     | <u>THA</u> Thai                 |
| <u>ITA</u> Italian       | <u>URD</u> Urdu                 |
| <u>JPN</u> Japanese      | <u>VIE</u> Vietnamese           |
| <u>KOR</u> Korean        | <u>YID</u> Yiddish              |
|                          | <u>999</u> Unknown              |

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		<b>7. SERVICE DATE (MMDDCCYY)</b> <input type="text"/>

**15. EXPECTED SOURCE OF PAYMENT**

<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

<input type="text"/>	<input type="text"/>
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- 09 Self Pay
- 11 Other Non-federal programs
- 12 Preferred Provider Organization (PPO)
- 13 Point of Service (POS)
- 14 Exclusive Provider Organization (EPO)
- 16 Health Maintenance Organization (HMO) Medicare Risk
- AM Automobile Medical
- BL Blue Cross/Blue Shield
- CH CHAMPUS (TRICARE)
- CI Commercial Insurance Company
- ~~DS Disability~~
- ~~HM Health Maintenance Organization~~
- ~~MA Medicare Part A~~
- ~~MB Medicare Part B~~
- ~~MC Medicaid (Medi-Cal)~~
- ~~OF Other federal program~~
- ~~TV Title V~~
- ~~VA Veterans Affairs Plan~~
- ~~WC Workers' Compensation Health Claim~~
- ~~00 Other~~

- DS Disability
- HM Health Maintenance Organization
- MA Medicare Part A
- MB Medicare Part B
- MC Medicaid (Medi-Cal)
- OF Other federal program
- TV Title V
- VA Veterans Affairs Plan
- WC Workers' Compensation Health Claim
- 00 Other

**14. DISPOSITION OF PATIENT**

<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

<input type="text"/>	<input type="text"/>
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- 01 Discharged to home or self care (routine discharge)
- 02 Discharged/transferred to a short term general hospital for inpatient care
- 03 Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care
- 04 Discharged/transferred to an intermediate care facility (ICF)
- 05 Discharged/transferred to another type of institution not defined elsewhere in this code list
- 06 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
- 07 Left against medical advice or discontinued care
- 20 Expired
- 43 Discharged/transferred to a federal health care facility
- 50 Discharged home with hospice care
- 51 Discharged to a medical facility with hospice care
- 61 Discharged/transferred to a hospital-based Medicare approved swing bed
- 62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part unit of a hospital
- 63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)
- 64 Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare
- 65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
- 66 Discharged/transferred to a Critical Access Hospital (CAH)
- 00 Other

**8. PRINCIPAL DIAGNOSIS**

ICD-9-CM CODE

<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

**9. OTHER DIAGNOSIS**

ICD-9-CM CODE

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**A. FACILITY ID NUMBER**

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**B. ABSTRACT RECORD NUMBER (Optional)**

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**1. DATE OF BIRTH (MMDDCCYY)**

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**7. SERVICE DATE (MMDDCCYY)**

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**10. PRINCIPAL EXTERNAL CAUSE OF INJURY E-CODE**

ICD-9-CM CODE

E					
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**11. OTHER EXTERNAL CAUSE OF INJURY E-CODES**

ICD-9-CM CODE

a. 

E					
---	--	--	--	--	--

b. 

E					
---	--	--	--	--	--

c. 

E					
---	--	--	--	--	--

d. 

E					
---	--	--	--	--	--

**12. PRINCIPAL PROCEDURE**

CPT-4 CODE

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**13. OTHER PROCEDURES**

CPT-4 CODE

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