ACRIN NLST 6654
Outpatient Provider Visits

F1/F2 Interval: __________ - 20 ______ to __________ - 20 ______ (mm-dd-20yy)

Provider Code: ____________________

☐ Type of Visit

1 = Office Visit *(may include procedures)*
2 = Invasive Procedure *(no office visit)*
3 = Non-Invasive Procedure *(no office visit)*
4 = Other, specify: ____________________

<table>
<thead>
<tr>
<th>ICD-9-CM Reason for Visit</th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9-CM Pre-existing Condition</td>
<td></td>
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<tr>
<td>ICD-9-CM Final DX &amp; Complications</td>
<td></td>
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<tr>
<td>CPT Code</td>
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</tr>
</tbody>
</table>

☐ More Codes

☐ More Visits

☐ No More Visits

☐ This form was created in error and should be deleted and all information should be ignored

☑ = marked, □ = not marked

Reason for form deletion: *(choose only one)*

- ☐ 01 Query response
- ☐ 02 Data entry error correction
- ☐ 03 Audit QC Finding correction
- ☐ 04 Site revision

______________________________
Abstractor ID

______________________________
Abstractor Signature

_______ - ______ - 20 ______
Date Form Completed (mm-dd-20yy)

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