

**Updated NOF Instructions (QxQs)**

This table summarizes changes to the NOF QxQ as of 02/10/2015

*Changes in the NOF QxQ are highlighted in yellow*

<b>Section in NOF QxQ</b>	<b>Description of Changes in NOF QxQ</b>
General Instructions, pg. 1	<ul style="list-style-type: none"><li>• Clarification added on when to complete a NOF form.</li></ul>

**INSTRUCTIONS FOR COMPLETING  
NO FORM  
NOF, VERSION A, 02/10/2015**

**I. GENERAL INSTRUCTIONS**

The No Form (NOF) should be completed for an identified event on the Hospital Index List or on the 'abstraction' list under certain circumstances. Complete this form if the 'abstraction' list indicates an abstraction is needed for Coronary Heart Disease (CHD) and/or Heart Failure (HF) but the abstraction(s) will not be done because of ineligibility. Community surveillance abstractions may be ineligible due to age, catchment or length of stay. Beginning February 2015, the NOF is completed for cohorts in only one circumstance, and that is when a possible cohort match on the H-List is found, upon investigation, to not be a real cohort. Otherwise, a CEL is completed for any cohort on the H-List. The abstractor must be certified and should be familiar with the document titled "General Instructions for Completing Paper Forms" prior to completing this form. Event ID Number should be assigned for all CHD and HF events.

**II. DETAILED INSTRUCTIONS FOR VARIOUS QUESTIONS**

0.a. Hospital Code Number. Using the hospital selection drop down list, enter the two digit code assigned to this hospital.

0.b. Medical Record Number. Enter the record number from the hospital chart. This number will be found stamped or typed on almost every page of the hospital record. The easiest place to find it is both on the medical record folder and in the upper right/left hand corner of the face sheet. List the number from left to right. Enter only digits and letters; omit dashes and spaces. Do not add zeroes to the right of the number. If the number changes with each admission, use the appropriate number for the one (admission) being abstracted.

0.c. Date of discharge. Date of Discharge (for nonfatal case) or Death. This information will generally be found on the face sheet. Enter the date as mm/dd/yyyy. If the patient died, then record the date of death. If transferred from acute care to rehabilitation or chronic care in the same hospital, count the date of transfer as the discharge date.

1. Type of requested abstraction deemed ineligible: If the abstractor deems the requested abstraction ineligible, indicate if the abstraction is requested and ineligible for either 'C' (CHD) or 'H' (HF), or 'B' (Both CHD and HF). If 'C' is selected, skip question 3. If 'H' is selected, skip question 2.
2. Reason for ineligibility for CHD: Indicate the reason for CHD ineligibility. If the patient's age is <35 or >84, select 'A'. If it is determined that the patient lives in an out of catchment area, select 'B'. If the patient stayed in hospital less than 24 hours, select 'C'. If the patient is a suggested cohort match but it is discovered that the patient is not a real cohort and the event is not eligible for community abstraction, select 'D'. Select 'E' if there is/are other reason/s for ineligibility and specify reason/s in a notelog.
3. Reason for ineligibility for HF: Indicate the reason for HF ineligibility. If the patient's age is <55, select 'A'. If it is determined that the patient lives in an out of catchment area, select 'B'. If the patient stayed in hospital less than 24 hours, select 'C'. If the patient is a suggested cohort match but it is discovered that the patient is not a real cohort and the event is not eligible for community abstraction, select 'D'. Select 'E' if there is/are other reason/s for ineligibility and specify reason/s in a note log.