McLaren FLINT

Pre- Admission Testing Summary Sheet

	NO LABS NEEDED		**Patient needs to stop in lab, notified**		**Patient Arrival Time**		**Registered**

Allergies: _____

_____

_____

_____

_____

STAT ON ADMISSION and Other Notes:

Pharmacy:

Primary Care:

Cardiologist:

	YES	NO	N/A
DIABETIC	☐	☐	
DIALYSIS	☐	☐	
HISTORY AND PHYSICAL	☐	☐	
CONSENT ON CHART	☐	☐	
- *SIGNED*	☐	☐	
ALLERGY BAND	☐	☐	☐
CA STAGING FORM ON CHART	☐	☐	☐

PREGNANCY TEST ☐ LMP: _____ Hyster: ☐

EKG ☐ ECHO_____CATH _____STRESS_____

DOCUMENTS RECEIVED FROM OFC

Labs Ordered	External Source	Anes Reviewed	Test	Labs Ordered	External Source	Anes Reviewed	TEST	Labs Ordered	External Source	Anes Reviewed	TEST
			BMP				PTINR				CAROTID DOPPLER
			BUN				APTT				PFT
			HEMDF				TROP				CT SCAN CHEST
			CMP				UA				ECHO
			CREA				CURINE				ABI
			GLU				T&S				VEIN MAPPING
			HGBAICD				T&C_____UNITS				Other:
			LYTES				12 LEAD EKG				Other:
			MRSASC				2V CHEST				Other:

DATE		ON CHART	FAXED	ANES
DATE	EKG FROM OUTSIDE SOURCE CONTACT/ NUMBER: FROM:	ON CHART	FAXED	ANES
DATE	CHEST X-RAY FROM OUTSIDE SOURCE CONTACT/ NUMBER: FROM:	ON CHART	FAXED	ANES
DATE	LABS FROM OUTSIDE SOURCE CONTACT/ NUMBER: FROM:	ON CHART	FAXED	ANES
DATE	CARDIAC CATH/ STRESS TEST/ ECHO REPORT CONTACT/ NUMBER: FROM:	ON CHART	FAXED	ANES
DATE	Medical Evaluation CONTACT/ NUMBER: FROM:	ON CHART	FAXED	ANES
DATE	Medical Evaluation CONTACT/ NUMBER: FROM:	ON CHART	FAXED	ANES

RN: _____**Checked Chart:**_____

CHART ASSEMBLED BY: _____**UC**

Pre-Admission Testing Summary Sheet

17857 (6/13) Intranet

680b

PT.

MR.#/P.M.

DR.

McLaren
FLINT

SURGICAL SITE INFECTION

Frequently asked questions about Surgical Site Infections

What is a Surgical Site Infection (SSI)?

A surgical site infection is an infection that occurs after surgery in the part of the body where the surgery took place. Most patients who have surgery do not develop an infection. However, infections develop in about 1 to 3 out of every 100 patient who have surgery. Some of the common symptoms of a surgical site infection are:

- Redness and pain around the area where you had surgery
- Drainage of cloudy fluid from your surgical wound
- Fever

Can SSI be treated?

Yes. Most surgical site infections can be treated with antibiotics. The antibiotic given to you depends on the bacteria (germs) causing the infection. Sometimes patients with SSIs also need another surgery to treat the infection.

What are some of the things that hospitals are doing to prevent SSIs?

To prevent SSIs, doctors, nurses, and other healthcare providers

- Clean their hands and arms to their elbows with an antiseptic agent just before surgery.
- Clean their hands with soap and water or an alcohol- based hand rub and after caring for each patient
- May remove some of your hair immediately before your surgery using electric clippers if the hair is in the same areas where the procedure will occur. They should not shave you with a razor.
- Wear special hair covers, masks, gowns, and gloves during surgery to keep the surgery area clean.
- Give you antibiotics before your surgery starts. In most cases, you should get antibiotics within 60 minutes before the surgery starts and the antibiotics should be stopped within 24 hours after surgery.
- Clean the skin at the site of your surgery with a special soap that kills germs.

What can I do to help prevent SSIs?

Before surgery:

- Tell your doctor about other medical problems you may have. Health problems such as allergies, diabetes, and obesity could affect your surgery and your treatment.
- Quit smoking. Patients who smoke get more infection. Talk to your doctors about how you can quit before your surgery.
- Do not shave near where you will have surgery. Shaving with a razor can irritate your skin and make it easier to develop and infection.

- continued

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SURGICAL SITE INFECTION

Frequently asked questions about Surgical Site Infections– *continued*

What can I do to help prevent SSIs?

Before surgery:

- Tell your doctor about other medical problems you may have. Health problems such as allergies, diabetes, and obesity could affect your surgery and your treatment.
- Quit smoking. Patients who smoke get more infection. Talk to your doctors about how you can quit before your surgery.
- Do not shave near where you will have surgery. Shaving with a razor can irritate your skin and make it easier to develop and infection.

At the time of surgery:

- At McLaren- Flint a healthcare professional may need to carefully prep your surgical site area with a clipper (a clipper is not a RAZOR). This is an acceptable way to remove hair.
- Ask if you will get antibiotics before surgery.

After your surgery:

- Make sure that your healthcare providers clean their hands before examining you, either with soap and water or an alcohol based hand rub.

If you do not see your healthcare providers clean their hands, please ask them to do so.

- Family and friends who visit you should not touch your surgical wound or dressings.
- Family and friends who clean their hands with soap and water or an alcohol- based hand rub before and after visiting you. If you do not see them clean their hands, ask them to clean their hands.

What do I need to do when I go home from the hospital?

- Before you go home, your doctor or nurse should explain everything you need to know about taking care of your wound. Make sure you understand how to care for your wound before you leave the hospital.
- Always clean your hands before and after caring for your wound. Before you go home, make sure you know who to contact if you have questions or problems after your get home.
- If you have any symptoms of an infection, such as redness and pain at the surgery site, drainage, or fever, call your doctor immediately.

If you have additional questions, please ask your doctor or nurse.

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NURSES NOTES

Date	Time	Nurses Notes	Signature

NURSES NOTES

700

PT.

MR.#/RM.

DR.

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FLINT, MICHIGAN 48532

NURSES NOTES

Date	Time	Nurses Notes	Signature

PT.

MR.#/RM.

DR.

McLaren Flint

FLINT, MICHIGAN

CONSENT TO OPERATION OR OTHER PROCEDURE

1. I have been told by my physician, _____, that my present condition or conditions may effectively be treated by the following procedure(s):_____

_____

I hereby authorize my physician and the associates and assistants selected by him to perform the described procedure(s).

2. I understand that unforeseen circumstances may arise during an operation or procedure, and may require performance of operations or procedures different from or in addition to those originally planned, in order to safeguard and promote the well being of the patient. I consent to such other or additional surgery, procedures, or therapies as may be considered necessary or advisable by my doctors under such circumstances. I authorize and request that my Physician, his assistants or his designees, perform such additional procedures as are necessary. If at an outpatient facility, I consent to transfer to McLaren Flint main campus in the event that my condition warrants such a transfer.
3. I am aware that McLaren Flint is a resident teaching facility and that physician residents and/or medical students may be involved with my care under the supervision of my physician. I consent to their involvement and participation in my treatment planning and care.
4. I understand that such procedure(s) may involve transfusion of blood or blood cell products. I have been made aware that, despite routine screening procedures, use of blood and blood cell products always carries some risk of transmissible disease, including hepatitis virus, or other blood-borne agents. I give authorization to administer to me during the procedure(s):
   ( ) regular blood or blood products from the Blood Bank;
   ( ) autologous blood only (blood I have given); In the absence of the sufficient quantity of blood I have given, I understand regular blood or blood products from the Blood Bank will be used.
   ( ) designated (directed) donations only;
   ( ) no blood products.
5. I agree to the use of anesthesia and/ or sedation as deemed appropriate by the anesthesiologist or his/her designee. It has been explained to me that all forms of anesthesia involve some risks and although rare, unexpected severe complications may occur including but not limited to mouth or throat pain, injury to mouth or teeth, infection, injury to blood vessels, headache, backache and others. It has been explained to me that sometimes an anesthesia technique which involves the use of local anesthetics with or without sedation, may not succeed completely and therefore another technique may have to be used including general anesthesia. I consent to the anesthesia service discussed with the anesthesia provider. I also consent to an alternative type of anesthesia if necessary as deemed appropriate by my anesthesia provider.
6. I acknowledge that full discussion has taken place between my physician and me prior to the procedure(s) herein authorized, that the advantages and disadvantages of such procedure(s) including the risk of infection, have been explained to me, and that alternative methods of treatment have been discussed with me. I have been made aware of certain risk(s) and consequences that are associatedwith the procedure(s) described in Paragraph 1 and understand that submitting to the procedure(s) may endanger my life or future health.I am aware that the practice of medicine and of surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedure(s).

Signature of Patient: _____ Date & Time _____

If patient is unable to sign or is a minor, complete the following:
Signature of Next of Kin
or Legal Guardian: _____ Date & Time _____

Signature Witnessed by: _____ Date & Time _____

I, Dr. _____, hereby attest to providing information regarding the patient's risk, including risk of infection, benefits, as well as alternative methods of treatment available to aid the patient and family in the decision process regarding this procedure(s).

Signature of Physician: _____ Date & Time _____

Anesthesia Provider Signature: _____ Date & Time _____

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CONSENT TO OPERATION OR OTHER PROCEDURE

820b

McLaren Flint

ANESTHESIA ASSESSMENT

Pre-op Vital Sign: B/P _____ **P** _____ **Resp** _____ **Temp** _____ **SpO2**_____ **NPO Since:** _____ **Wt.** _____		
ASA Rating 1 2 3 4 5	**Anesthesia Plan:** MAC GA Block SP EP	☐ Chart Reviewed
Mallampati I II III IV	**Anesthesia Plan, risks, and benefits discussed with:** ☐ Patient ☐ Parent ☐ Guardian	

Systemic Review	Unremarkable	Abnormal Findings	Allergies
Cardiovascular	☐		
Respiratory	☐		
GI/ GU/ Endocrine	☐		
Mental Status/ Nervous System	☐		
Musculoskeletal/ Other	☐		

Physical Exam	Unremarkable	Abnormal Findings
HEENT/ Dental/ Airway	☐	
Heart	☐	
Lungs	☐	
Abdomen	☐	
Other / General Condition	☐	

Diagnostic Testing

Test	Ordered	Result
CBC	☐	**Preg Test + -**
Lytes	☐	
PT/ PTT/ INR	☐	
CXR	☐	
Cath/ Echo/ Stress	☐	
EKG	☐	

CRNA_____ Date:_____/_____/_____ Time:_____

Anesthesiologist_____ Date:_____/_____/_____ Time:_____

PACU Discharge Note:

Date _____ Time _____

Patient Complaint: _____

☐ Patient met discharge criteria from PACU

☐ Patient met discharge bypass criteria to phase II

Comments: _____

_____

Anesthesiologist/CRNA Signature: _____

Inpatient Post- Anesthesia Note:

Date _____ Time _____

Comments: _____

_____

☐ Patient unable to participate in post anesthesia visit.
Care transferred to attending physician.

Anesthesiologist/CRNA Signature: _____

☐ **Outpatient Discharge Evaluation**

☐ **Inpatient Post Anesthesia Visit Evaluation**

Yes	No	
☐	☐	Vital Signs within 20% of pre-op value
☐	☐	O_2 Sat > 92% ☐ N/A
☐	☐	Respiratory function stable; airway patient
☐	☐	Adequate Hydration
☐	☐	Mental Status alert, oriented and able to participate in evaluation
☐	☐	Pain Control Satisfactory
☐	☐	Normothermic
☐	☐	Nausea and vomiting control satisfactory

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DR.

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Date

month day year

O.R. #:

ASA: 1 2 3 E 4 5 6

☐ Hand Hygiene Performance
☐ Time out
☐ Identified
☐ Chart Reviewed
☐ Permit Signed

PATIENT SAFETY

Anes. Machine # ☐ Checked
☐ Safety belt on ☐ Axillary roll
☐ Armboard restraints ☐ Arms tucked
☐ Presure pts. checked & padded

Eye Care: ☐ Ointment
☐ Taped ☐ Pads
☐ Saline ☐ Goggles

Warming measures:
☐ N/A: time <60
☐ Intentional hypothermia (eg cardiac)
☐ N-W: temp >36 or warming measures
☐ Fluid ☐ Blankets
☐ Forced air ☐ Head cover

Transesophageal Echocardiography:
☐ TEE Placement only ☐ TEE Interpretation only
☐ TEE Placement w/Interp Diagnostic Purpose:

PREOP MEDICATIONS

☐ BETA BLOCKER PROTOCOL

LINES	Location:	Start:	Stop:
IV ☐		Start:	Stop:
A-line ☐		Start:	Stop:
CVC ☐		Start:	Stop:
Swan ☐		Start:	Stop:

CVC sterile technique: ☐ Cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics)

☐ Not followed Medical reason(s): _____
☐ Time Out/Site Verified
☐ Provider # _____

Patient Label

Anesthesia Type: ☐General ☐Regional ☐MAC

Anes Start	Induction	Anes Stop

Surgery Start	Surgery Stop

SURGEONS

DIAGNOSES

PROCEDURES

INDUCTION

☐ Preoxygenation
☐ IV Induction
☐ Rapid seq
☐ Cricoid press
☐ Inhal induct

AIRWAY MGMT

☐ Oxygen: nasal / mask
☐ Airway: oral / nasal

Circuit:
☐ HME
☐ SCCA Adult
☐ SCCA Pediatric
☐ Mapleson

Other:
☐ Mask GA
☐ LMA # _____
☐ Intubation

Blade: _____
Tube Size: _____
Attempts: _____
Laryngoscopy Grade: 1 2 3 4
Secured @_____cm
☐ Oral ☐ Nasal
☐ Direct ☐ Blind
☐ RAE ☐ Fiberoptic
☐ Uncuffed ☐ Cuffed
☐ Leak @ _____cmH_2O
☐ Cuff to Seal
☐ BS Equal bilateral
☐ EtCO2 present
☐ Difficult airway
☐ see REMARKS

REGIONAL

☐ Spiral
☐ Epidural
☐ Branch plexus block
☐ IV regional
☐ Other _____
☐ Continuous block
☐ For post-op pain only
☐ at Surgeon's request
☐ Ultrasound guided
Start: _____
Stop: _____
Position: _____
☐ Sterile prep & technique
Site: _____
Needle: _____
Attempts: _____
Drug/Dose: _____
Level: _____

See Block Record: _____

☐ Catheter
☐ Parasthesias Yes No
☐ CSF clear Free flow

MEDICATIONS

Oxygen														(l/m)
☐ N2O ☐ AIR														(l/m)
☐ SEVO ☐ ISO ☐ DES														E(%)
☐ Propofol ☐ Etomidate														(mg)
Succinylcholine														(mg)
Rocuronium/Cisatracurium														(mg)
Lidocaine														(mg)
Midazolam														(mg)
Fentanyl														(mcg)

TOTALS

Time:

VITALS

Preinduction Vitals:
B/P: _____
HR: _____
RR: _____
SpO2%: _____

Position:
☐ Supine
☐ Prone
☐ R/L Lateral
☐ Beach Chair
☐ Lithotomy

180 160 140 120 100 80 70 60 40 30 20

☐ Left Uterine Displacement
☐ NIBP
☐ A-Line

MONITORS

☐ ECG Rhythm														
☐ O_2mon FIO_2														
☐ Pulse ox SpO_2														
☐ Capno $EICO_2$														
☐ Steth Resp														
☐ Spirom Vt														
☐ PIP														
☐ Temp °C														
☐ NMB														
CVP mmHg														
PAP mmHg														
CO/SVO2 (L/min)/(%)														

FLUID

NS (cc)														
LR (cc)														
Blood products														
EBL (cc)														

REMARKS

IV ANTIBIOTIC(S)

Drug/Dose: _____
Time: _____
Drug/Dose: _____
Time: _____
Redose: _____
☐ Not Indicated
☐ Correct Abx Confirmed
☐ Not Given:
☐ 1P (on abx)
☐ 8P (ordered after incision)

TOTAL FLUIDS

Crystalloid _____ cc
Colloid _____ cc
Blood _____ cc
EBL _____ cc
Urine _____ cc

Post OP

Time In: _____ Date: _____
Loc: ☐ PACU ☐ ICU
☐ _____
☐ Report to RN
BP: _____
P: _____ EKG: _____
RR: _____
SpO_2: _____ Temp: _____
Oxygen delivery:
☐Nasal ☐Mask
☐T-Piece
☐Vent: Mode: _____
Vt: _____ FiO2: _____
Rate: _____
Airway:
☐ Nasal ☐ Oral
☐ ETT ☐ LMA
☐ BBS equal/exchanging well
Mental Status:
☐ Consc. ☐ Unconsc.
☐ Responds to commands
☐ Vocalizing ☐ Sleepy
☐ Reflexive

Cancelled Case:
☐ Before induction
☐ After induction

Qualifying Circumstances:
☐ Extreme Age
☐ Hypothermia
☐ Hypotension
☐ One Lung Vent.

MEDICAL DIRECTION
☐ Conducted preanesthesia evaluation & plan & post anesthesia care
☐ Present for all key portions
☐ Induction _____ Provider #:
☐ Emergence Provider #:
☐ Frequent monitoring Provider #:
☐ Present & available for emergencies

ANESTHESIOLOGIST/PROVIDER:

RESIDENT

CRNA/PROVIDER:

SRNA

RELIEF: (in/out times)

RELIEF: (in/out times)

ANESTHESIA RECORD/ ASSESSMENT

ANESTHESIA ROUTINE ORDERS

PATIENT IDENTIFICATION

1. Pre Procedure Testing Per Protocol

- ☐ BMP
- ☐ CMP
- ☐ CBC/ Plt
- ☐ Drug Level
- ☐ HCG
- ☐ PT/PTT/ INR
- ☐ UA/ C&S
- ☐ Type & Cross _____ Units
- ☐ Type & Screen
- ☐ EKG
- ☐ CXR
- ☐ MRSA Nasal Swab
- ☐ Other: _____
- ☐ Other: _____

RN Signature | Date (required) | Time (required)

1. Pre-op Holding Routine Orders for all Patients

- Oxygen PRN for saturations <93% after sedation or <93% on room air
- IV start (subcutaneous 1% Lidocaine may be used per patient request)
- LR 1000 mL start at _____mL/hr and titrate for desired effects
- NS 500ml at_____mL/hr rate for Dialysis Patients
- Pediatric: use LR 500 ml 30 mL/hr with micro drip tubing

2. Diabetic Patients

- No insulin in AM
- Hold all oral hypoglycemic in AM of procedure
- Perform glucometer / FBS, report FBS ≤ 70 ≥ 250

3. General Anesthesia Patients

- Pepcid 20 mg with sip of H_2O on admission for patients ≥ than 18 years old with BMI ≥25, DM, GERD or reflux; hold if reflux meds taken that day
- Hold Metoclopramide (REGLAN) if ≥ 70 years old

4. Pre Operative Medications- ONE TIME ONLY MEDICATIONS

- ☐ Famotidine (PEPCID) 20 mg PO/ IVP
- ☐ Metoclopramide (REGLAN) 10 mg PO/ IVP
- ☐ Diphenhydramine (BENEDRYL) 25 mg PO/ IVP
- ☐ Ondansetron (ZOFRAN)_____mg IVP
- ☐ Dexamethasone (DECADRON)_____mg IVP N/V
- ☐ Hydrocortisone (SOLU CORTEF)_____mg IVP
- ☐ Labetalol (NORMODYNE,TRANDATE)_____mg IVP
- ☐ Pregabalin (LYRICA) 50 mg PO
- ☐ Pregabalin (LYRICA) 100 mg PO
- ☐ Ibuprofen (MOTRIN) 600 mg PO
- ☐ Celecoxib (CELEBREX) 200 mg PO
- ☐ Acetaminophen (TYLENOL) 1000 mg PO
- ☐ Bicitra 30 mL PO
- ☐ Midazolam (VERSED)_____mg IVP anxiety
- ☐ Midazolam (VERSED) Syrup _____ mg PO anxiety
- ☐ Fentanyl_____mcg IVP
- ☐ Glycopyrrolate (ROBINUL) _____mg IVP
- ☐ Hydromorphone (DILAUDID) _____mg IVP
- ☐ Scopalamine Patch
- ☐ Other:_____

RN Signature | Date (required) | Time (required)

Physician Signature | Date (required) | Time (required)

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MEDICATION ADMINISTRATION RECORD

THE SIGNATURE OF A PHYSICIAN MUST ACCOMPANY EACH ORDER	
Date:	Time

M.A.R. VERIFIED BY:_____

HT:_____Wgt:_____ BSA:_____

Est:_____

ALLERGIES:

ADMINISTRATION PERIOD:

MEDICATION				START	STOP	Suggested Admin Timse	DAY SHIFT 0700-1459	EVENING SHIFT 1500-2259	NIGHT SHIFT 2300-0659
DOSE	ROUTE	FREQ	RX NUMBER						

RESPONSE	MEDS NOT GIVEN		INJECTION SITES	
Q. Relief in 30 min	A. NPO Diag	G. Off Unit	I. Right Deltoid Area	II. Left Deltoid Area
R. Relief in 60 min	B. NPO Surgery	H. Drug not available	III. Right Gluteal Area	IV. Left Gluteal Area
S. No Relief	C. NPO Studies	J. Patient Asleep	V. Right Abdomen	IV. Left Abdomen
	D. Patient Refused	K. See Nursing Notes	VII. Right Thigh	VIII. Left Thigh
	E. Nausea			
	F. Hold Dose			

INITIALS	PRINT NAME	SIGNATURE

MEDICATION ADMINISTRATION RECORD

912 Revised 10/21/11 (Intranet)

740b

PT.

MR.#/P.M.

DR.

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FLINT, MICHIGAN 48532

Date _____

HISTORY & PHYSICAL

Patient _____ Physician _____

Chief Complaint _____

HISTORY
Present Illness _____

_____

_____

_____

_____

Allergies _____

Current Medications _____

_____

Past Medical History (check √ if present) or ☐ None

- ☐ Hypertension
- ☐ Coronary Artery Disease
- ☐ Myocardial Infarction
- ☐ Irregular Heart Beat
- ☐ Congestive Heart Failure
- ☐ Peripheral Vascular Disease
- ☐ Murmur
- ☐ Pacemaker/ICD
- ☐ COPD
- ☐ Asthma
- ☐ Tuberculosis
- ☐ GERD
- ☐ Hepatitis
- ☐ Ulcers
- ☐ CVA
- ☐ Transient Ischemic Attack
- ☐ Seizures

Diabetes Mellitus
- ☐ Type I
- ☐ Type II

Thyroid
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

- ☐ Cancer
- ☐ Chronic Kidney Disease
- ☐ Bleeding Disorders

_____ Pregnancies

_____ Deliveries

☐ Other

_____

Past Surgical History _____

_____

Social History

- ☐ Occupation _____
- ☐ Smoking _____ ☐ Drugs _____
- ☐ Alcohol _____ ☐ Abuse (Psychosocial) _____

Family History

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Bleeding Disorders
- ☐ Cancer
- ☐ Malignant Hyperthermia

Review of Systems (check √ if present) or ☐ None

- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Sore Throat
- ☐ Fever/Chills
- ☐ Dizziness
- ☐ Nausea/Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Visual Disturbance
- ☐ Hearing Problems
- ☐ Light-headedness
- ☐ Altered Bowel Habits
- ☐ Altered Bladder Habits
- ☐ Dyspepsia/Dysphagia
- ☐ Anorexia/Weight Loss
- ☐ Fatigue/Weakness
- ☐ Weakness in Extremities

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PHYSICAL (Explain any abnormalities under "Other"):

Vital Signs: ☐ Reviewed ☐ Other _____

HEENT: ☐ Normal ☐ Other _____

Neck: ☐ Normal ☐ Other _____

Breast: ☐ Normal ☐ N/A ☐ Other _____

Thorax: ☐ Normal ☐ Other _____

Heart: ☐ Normal ☐ Other _____

Lungs: ☐ Normal ☐ Other _____

Abdomen: ☐ Normal ☐ Other _____

Genitalia: ☐ Normal ☐ N/A ☐ Other _____

Pelvic: ☐ Normal ☐ N/A ☐ Other _____

Rectal: ☐ Normal ☐ N/A ☐ Other _____

Extremities: ☐ Normal ☐ Other _____

Neuro: ☐ Normal ☐ Other _____

Pertinent Labs & X-Rays:

_____

_____

_____

Provisional Diagnosis / Plan of Treatment:

_____

_____

_____

_____

_____

Date: _____ Time: _____Physician Signature _____

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DR.

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Flint, Michigan

POST-OPERATIVE/PROCEDURE NOTE

NOTATIONS **All Bold Elements REQUIRED by CMS & Joint Commission. Please Fully Complete.**	
Pre - Operative Diagnosis:	
Post-Operative Diagnosis:	
Procedure(s) Performed:	
Physician/Surgeon(s):	**Assistant(s):**
No Specimens unless noted: _____	**No Blood loss unless noted: _____**
	Findings/Complications:
Anesthesia:	
❑ General	
❑ Local	
❑ Spinal	
❑ IV Sedation	
Teaching Physician Addendum:	
Physician's Signature _____ Date/Time: _____	

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