SURGERY

USER MANUAL

Version 3.0
July 1993
(Revised April 2008)

__________________________________________
Department of Veterans Affairs
Veterans Health Information Technology
## Revision History

Each time this manual is updated, the Title Page lists the new revised date and this page describes the changes. If the Revised Pages column lists “All,” replace the existing manual with the reissued manual. If the Revised Pages column lists individual entries (e.g., 25, 32), either update the existing manual with the Change Pages Document or print the entire new manual.

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<td>04/08</td>
<td>iii-iv, vi, 160, 165, 168, 171-172, 296-298, 443, 447, 449-450, 459, 471-473, 479-479a, 482, 486-486a, 489, 491, 493-495, 497, 499, 501-502a, 502c, 502d-502h, 513-517, 522c-522d, 529, 534</td>
<td>SR<em>3</em>166</td>
<td>Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software. For more details, see the <em>Surgery NSQIP-CICSP Enhancements 2008 Release Notes</em>. (M. Montali, PM; G. O’Connor, Tech Writer)</td>
</tr>
<tr>
<td>11/07</td>
<td>479-479a, 486a</td>
<td>SR<em>3</em>164</td>
<td>Updated the <em>Resource Data Enter/Edit</em> and the <em>Print a Surgery Risk Assessment</em> options to reflect the new cardiac field for CT Surgery Consult Date. (M. Montali, PM; S. Krakosky, Tech Writer)</td>
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<tr>
<td>09/07</td>
<td>125, 371, 375, 382</td>
<td>SR<em>3</em>163</td>
<td>Updated the Service Classification section regarding environmental indicators, unrelated to this patch. Updated the Quarterly Report to reflect updates to the numbers and names of specific specialties in the NATIONAL SURGICAL SPECIALTY file. (M. Montali, PM; S. Krakosky, Tech Writer)</td>
</tr>
<tr>
<td>06/07</td>
<td>35, 210, 212b</td>
<td>SR<em>3</em>159</td>
<td>Updated screens to reflect change of the environmental indicator “Environmental Contaminant” to “SWAC” (e.g., SouthWest Asia). (M. Montali, PM; S. Krakosky, Tech Writer)</td>
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<td>176-180, 180a, 184c-d, 327c-d, 372, 375-376, 446, 449-450, 452-453, 455-456, 458, 461, 468, 470, 472, 479-479a, 482-484, 486a, 489, 491, 493, 495, 497, 499, 501, 502a-d, 504-506, 509-512, 519</td>
<td>SR<em>3</em>160</td>
<td>Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software. For more details, see the <em>Surgery NSQIP-CICSP Enhancements 2007 Release Notes</em>. Updated data entry screens to match software; changes are unrelated to this patch. (M. Montali, PM; S. Krakosky, Tech Writer)</td>
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<tr>
<td>11/06</td>
<td>10-12, 14, 21-22, 139-141, 145-150, 152, 219, 438</td>
<td>SR<em>3</em>157</td>
<td>Updated data entry options to display new fields for collecting sterility information for the Prosthesis Installed field; updated the Nurse Intraoperative Report section with these required new fields. For more details, see the <em>Surgery-Tracking Prosthesis Items Release Notes</em>. Updated data entry screens to match software; changes are unrelated to this patch. (M. Montali, PM; S. Krakosky, Tech Writer)</td>
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<td>6-9, 14, 109-112, 122-124, 141-149, 151-152, 176, 178-180, 180a-b, 181-184, 184a-d, 185-186, 218-219, 326-327, 327a-d, 328-329, 373, 377, 449-450, 452-456, 459, 461-462, 467-468, 468b, 469-470, 470a, 473-474, 474a-474b, 475, 477, 481-486, 486a-b, 489-502, 502a-b, 503-504, 509-512</td>
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<td>Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software. Updated data entry options to incorporate renamed/new Hair Removal documentation fields. Updated the Nurse Intraoperative Report and Quarterly Report to include these fields. For more details, see the <em>Surgery NSQIP/CICSP Enhancements 2006 Release Notes</em>. (M. Montali, PM; S. Krakosky, Tech Writer)</td>
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<tr>
<td>06/06</td>
<td>28-32, 40-50, 64-80, 101-102</td>
<td>SR<em>3</em>144</td>
<td>Updated options to reflect new required fields (Attending Surgeon and Principal Preoperative Diagnosis) for creating a surgery case. (M. Montali, PM; S. Krakosky, Tech Writer)</td>
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<td>06/06</td>
<td>vi, 34-35, 125, 210, 212b, 522a-b</td>
<td>SR<em>3</em>152</td>
<td>Updated Service Classification screen example to display new PROJ 112/SHAD prompt. This patch will prevent the PRIN PRE-OP ICD DIAGNOSIS CODE field of the Surgery file from being sent to the Patient Care Encounter (PCE) package. Added the new <em>Alert Coder Regarding Coding Issues</em> option to the Surgery Risk Assessment Menu option. (M. Montali, PM; S. Krakosky, Tech Writer)</td>
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<tr>
<td>04/06</td>
<td>445, 464a-b, 465, 480a-b</td>
<td>SR<em>3</em>146</td>
<td>Added the new <em>Alert Coder Regarding Coding Issues</em> option to the Assessing Surgical Risk chapter. (M. Montali, PM; S. Krakosky, Tech Writer)</td>
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Example: Option displayed with discrepancies

Select Operation Menu Option: **BLOOD PRODUCT VERIFICATION**

To use **BAR CODE READER**
   Pass reader wand over a **GROUP-TYPE (ABO/Rh)** label

Enter Blood Product Identifier: **KW10945**

1) **Unit ID: KW10945**
   Patient: SURPATIENT, FOURTEEN 000-45-7212
   CPDA-1 RED BLOOD CELLS
   Expiration Date: NOV 27, 1997

2) **Unit ID: KW10945**
   Patient: SURPATIENT, FOURTEEN 000-45-7212
   FRESH FROZEN PLASMA, ACD-A
   Expiration Date: MAY 19, 1998

3) **Unit ID: KW10945**
   Patient: SURPATIENT, FOURTEEN 000-45-7212
   PLATELETS, POOLED, IRRADIATED
   Expiration Date: MAR 24, 1998

Select the blood product matching the unit label: (1-3): **3**

**WARNING**

Blood Product Expiration Date is later than today's date.
Anesthesia Menu
[SROANES1]

The Anesthesia Menu is restricted to Anesthesia personnel and is locked with the SROANES key. It is designed for the convenient entry of data pertaining to the anesthesia agents and techniques used in a surgery.

The main options included in this menu are listed below. The Anesthesia Data Entry Menu contains sub-options. To the left of the option name is the shortcut synonym the user can enter to select the option.

<table>
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<td>S</td>
<td>Schedule Anesthesia Personnel</td>
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Prerequisites

To use the Anesthesia Data Entry Menu or the Anesthesia Report option, the user must first select a patient case. The user must select an operating room to use the Schedule Anesthesia Personnel option.
Anesthesia Technique (Enter/Edit)
[SROMEN-ANES TECH]

The Anesthesia Technique (Enter/Edit) option is used to enter information concerning the anesthesia technique. More than one anesthesia technique can be entered for a case. When the user is finished entering the first technique, he or she should select this option again to start entering another anesthesia technique.

The Surgery software recognizes the following different anesthesia techniques, each with different sets of prompts.

G  GENERAL
M  MONITORED ANESTHESIA CARE
S  SPINAL
E  EPIDURAL
O  OTHER
L  LOCAL
R  REGIONAL

Another choice for an anesthesia technique is NO ANESTHESIA. This selection does not include any additional prompts.

About the prompts

"Diagnostic/ Therapeutic (Y/N):" The user should answer Y or YES if the anesthesia procedure is itself a surgical procedure. The user will then have an opportunity to define the surgical (operative) procedure.

"Is this the Principal Technique (Y/N):" This prompt asks the user whether or not the technique being entered is the primary anesthesia technique for the case. For the technique being entered to appear on the Anesthesia AMIS Report, answer this prompt with a Y or YES.

"Select ANESTHESIA AGENTS:" The user can enter more than one anesthesia agent for a case by using the up-arrow (^) to jump to the "Select ANESTHESIA AGENTS:" prompt.
Example 1: General Technique

Select Anesthesia Data Entry Menu Option: T Anesthesia Technique (Enter/Edit)
Diagnostic/Therapeutic (Y/N): NO/ <Enter>
Select ANESTHESIA TECHNIQUE: G (GENERAL)
Diagnostic/Therapeutic (Y/N): NO/ <Enter>
Is this the Principal Technique (Y/N): YES/ <Enter> YES
Was the Patient Intubated? (Y/N): Y YES
Trauma Resulting from Intubation Process: NONE/ <Enter> NONE
Select ANESTHESIA AGENTS: ?

More than one anesthesia agent may be entered for each technique.

The ANESTHESIA AGENT field uses entries from the institution’s local DRUG file. Prior to using the Surgery package, drugs that will be used as anesthesia agents must be flagged (using the Chief of Surgery Menu) by the user's package coordinator. If the user experiences problems entering an agent, it is likely that the drug being chosen has not been flagged.

Select ANESTHESIA AGENTS: ENFLURANE
Dose (mg): <Enter>
Approach Technique: D DIRECT VISION LARYNGOSCOPY
Endotracheal Tube Route: O ORAL
Type of Laryngoscope: M MACINTOSH
Laryngoscope Size: 3
Was a Stylet Used? (Y/N): Y YES
Was Topical Lidocaine Used? (Y/N): N NO
Endotracheal Tube Size: PVC LOW PRESSURE
Location where the Endotracheal Tube was Removed: O ORAL
Who Removed the Endotracheal Tube?: SURANESTHETIST,SIX
Was Reintubation Required within 8 Hours? (Y/N): N NO
Was a Heat and Moisture Exchanger Used? (Y/N): N NO
Was a Bacterial Filter Used? (Y/N): N NO
Oral-Pharyngeal (OP) Score: CLASS 1
Mandibular Space (length in mm): 65
Airway Index: 1 INDEX LESS THAN OR EQUAL TO 0// No (No Editing)
GENERAL COMMENTS:
1> <Enter>

Example 2: Monitored Anesthesia Care Technique

Select Anesthesia Data Entry Menu Option: T Anesthesia Technique (Enter/Edit)
Diagnostic/Therapeutic (Y/N): NO/ <Enter>
Select ANESTHESIA TECHNIQUE: M (MONITORED ANESTHESIA CARE)
Diagnostic/Therapeutic (Y/N): NO/ <Enter>
Is this the Principal Technique (Y/N): YES/ <Enter> YES
Was the Patient Intubated? (Y/N): N NO
Select ANESTHESIA AGENTS: VALIUM
Dose (mg): 5
Oral-Pharyngeal (OP) Score: CLASS 1/<Enter>
Mandibular Space (length in mm): 65/<Enter>
Airway Index: 1 INDEX LESS THAN OR EQUAL TO 0// NO (No Editing)
GENERAL COMMENTS:
1> <Enter>
Example 3: Spinal Technique
Select Anesthesia Data Entry Menu Option: T Anesthesia Technique (Enter/Edit)
Diagnostic/Therapeutic (Y/N): NO/<Enter>
Select ANESTHESIA TECHNIQUE: S (SPINAL)
  Is this the Principal Technique (Y/N): YES/<Enter> YES
  Was the Patient Intubated? (Y/N): N NO
Select ANESTHESIA AGENTS: PONTOCAIN
  Dose (mg): 5
  Was the Catheter placed for Continuous Administration? (Y/N): NO/<Enter> NO
  Baricity: 1/<Enter> HYPERBARIC
Puncture Site: 2 L3-4
Needle Size: 25G 25G
Neurodermatone Anesthesia Sensory Level: T6 T6
Oral-Pharyngeal (OP) Score: CLASS 1/<Enter>
Mandibular Space (length in mm): 65/<Enter>
Airway Index: 1. INDEX LESS THAN OR EQUAL TO 0/<Enter> (No Editing)
GENERAL COMMENTS:
1><Enter>

Example 4: Epidural Technique
Select Anesthesia Data Entry Menu Option: T Anesthesia Technique (Enter/Edit)
Diagnostic/Therapeutic (Y/N): NO/<Enter>
Select ANESTHESIA TECHNIQUE: E (EPIDURAL)
  Is this the Principal Technique (Y/N): YES/<Enter> YES
  Was the Patient Intubated? (Y/N): N NO
Select ANESTHESIA AGENTS: LIDOCAINE
  Dose (mg): 5
  Was the Catheter placed for Continuous Administration? (Y/N): YES/<Enter> YES
Puncture Site: 2 L3-4
Dural Puncture? (Y/N): NO/<Enter> Y YES
  Who Removed the Catheter?: 213 SURANESTHETIST,SIX
  Date/Time that the Catheter was Removed: 5/4@2:30 (MAY 04, 1999@14:30)
Oral-Pharyngeal (OP) Score: CLASS 1/<Enter>
Mandibular Space (length in mm): 65/<Enter>
Airway Index: 1. INDEX LESS THAN OR EQUAL TO 0/<Enter> (No Editing)
GENERAL COMMENTS:
1>Loss of Resistance Technique
2><Enter>
EDIT Option: <Enter>

Example 5: Other Technique
Select Anesthesia Data Entry Menu Option: T Anesthesia Technique (Enter/Edit)
Diagnostic/Therapeutic (Y/N): NO/<Enter>
Select ANESTHESIA TECHNIQUE: O (OTHER)
  Is this the Principal Technique (Y/N): YES/<Enter> YES
  Was the Patient Intubated? (Y/N): N NO
Select ANESTHESIA AGENTS: LIDOCAINE
  Dose (mg): 5
Select BLOCK SITE: ABDOMINAL WALL Y4300
  ARE YOU ADDING 'ABDOMINAL WALL' AS A NEW BLOCK SITE (THE 1ST FOR THIS ANESTHESIA TECHNIQUE)? Y (YES)
  Length of Needle (cm): 3
  Gauge Size of the Needle: 22
Oral-Pharyngeal (OP) Score: CLASS 1/<Enter>
Mandibular Space (length in mm): 65/<Enter>
Airway Index: 1. INDEX LESS THAN OR EQUAL TO 0/<Enter> (No Editing)
GENERAL COMMENTS:
1> <Enter>
### Example 6: Local Technique

Select Anesthesia Data Entry Menu Option: **T** Anesthesia Technique (Enter/Edit)
Diagnostic/Therapeutic (Y/N): NO/ <Enter>
Select ANESTHESIA TECHNIQUE: **L** (LOCAL)
- Is this the Principal Technique (Y/N): YES/ <Enter> YES
- Was the Patient Intubated? (Y/N): **N** NO
Select ANESTHESIA AGENTS: LIDOCAINE
- Dose (mg): **5**
Select BLOCK SITE: OROPHARYNX 60200
- ARE YOU ADDING 'OROPHARYNX' AS A NEW BLOCK SITE (THE 1ST FOR THIS ANESTHESIA TECHNIQUE)? **Y** (YES)
- Length of Needle (cm): <Enter>
- Oral-Pharyngeal (OP) Score: CLASS 1/ <Enter>
- Mandibular Space (length in mm): 65/ <Enter>
- Airway Index: 1. INDEX LESS THAN OR EQUAL TO 0// (No Editing)
GENERAL COMMENTS:
- 1>

### Example 7: Regional Technique

Select Anesthesia Data Entry Menu Option: **T** Anesthesia Technique (Enter/Edit)
Diagnostic/Therapeutic (Y/N): NO/ <Enter>
Select ANESTHESIA TECHNIQUE: LOCAL/ **R** (REGIONAL)
- Is this the Principal Technique (Y/N): YES/ <Enter> YES
- Was the Patient Intubated? (Y/N): **N** NO
Select ANESTHESIA AGENTS: LIDOCAINE
- Dose (mg): 5
Select BLOCK SITE: OROPHARYNX 60200
- ARE YOU ADDING 'OROPHARYNX' AS A NEW BLOCK SITE (THE 1ST FOR THIS ANESTHESIA TECHNIQUE)? **Y** (YES)
- Length of Needle (cm): <Enter>
- Oral-Pharyngeal (OP) Score: CLASS 1/ <Enter>
- Mandibular Space (length in mm): 65/ <Enter>
- Airway Index: 1. INDEX LESS THAN OR EQUAL TO 0// (No Editing)
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Page 171 has been deleted. The *Anesthesia AMIS* option has been removed.
Page 172 has been deleted. The Anesthesia AMIS option has been removed.
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<th>SCRUB NURSE</th>
<th>CIRC. NURSE</th>
<th>TIME IN CASE #</th>
<th>ELAPSED (MINS)</th>
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<td>DRAINAGE OF OVARIAN CYST</td>
<td>SURNURSE,THREE</td>
<td>SURNURSE,SEVEN</td>
<td>07:00</td>
<td>07:54</td>
</tr>
<tr>
<td>03/09/01</td>
<td>SURPATIENT, NINE</td>
<td>CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM</td>
<td>SURNURSE,THREE</td>
<td>SURNURSE,ONE</td>
<td>09:15</td>
<td>12:40</td>
</tr>
<tr>
<td>03/10/01</td>
<td>SURPATIENT, FIFTY</td>
<td>HEMORRHOIDECTOMY</td>
<td>SURNURSE,THREE</td>
<td>SURNURSE,ONE</td>
<td>14:00</td>
<td>14:55</td>
</tr>
<tr>
<td>03/17/01</td>
<td>SURPATIENT, FOURTEEN</td>
<td>CHOLECYSTECTOMY</td>
<td>SURNURSE,THREE</td>
<td>SURNURSE,ONE</td>
<td>12:55</td>
<td>14:30</td>
</tr>
<tr>
<td>03/18/01</td>
<td>SURPATIENT, SEVENTEEN</td>
<td>REPAIR INCARCERATED INGUINAL HERNIA</td>
<td>SURNURSE,THREE</td>
<td>SURNURSE,SEVEN</td>
<td>07:30</td>
<td>09:03</td>
</tr>
<tr>
<td>03/03/01</td>
<td>SURPATIENT, SIXTY</td>
<td>REMOVE CATARACTS, RETRO BULBAR BLOCK</td>
<td>SURNURSE,THREE</td>
<td>SURNURSE,ONE</td>
<td>09:00</td>
<td>09:20</td>
</tr>
</tbody>
</table>
Anesthesia Reports
[SR ANESTH REPORTS]

The Anesthesia Reports menu provides options for printing various anesthesia reports.

The options included in this menu are listed below. To the left of the option name is the shortcut synonym the user can enter to select the option:

<table>
<thead>
<tr>
<th>Shortcut</th>
<th>Option Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>List of Anesthetic Procedures</td>
</tr>
<tr>
<td>D</td>
<td>Anesthesia Provider Report</td>
</tr>
</tbody>
</table>
Page 297 has been deleted. The Anesthesia AMIS option has been removed.
Page 298 has been deleted. The *Anesthesia AMIS* option has been removed.
Surgery Risk Assessment Menu  
[SROA RISK ASSESSMENT]

The Surgery Risk Assessment Menu option provides the designated Surgical Clinical Nurse Reviewer with on-line access to medical information. The menu options provide the opportunity to edit, list, print, and update an existing assessment for a patient or to enter information concerning a new risk assessment.

This option is locked with the SR RISK ASSESSMENT key.

This chapter follows the main menu of the Risk Assessment module and contains descriptions of the options and sub-options needed to maintain a Risk Assessment, transmit data, and create reports. The options are organized to follow a logical workflow sequence. Each option description is divided into two main parts: an overview and a detailed example.

The top-level options included in this menu are listed in the following table. To the left is the shortcut synonym that the user can enter to select the option.

<table>
<thead>
<tr>
<th>Shortcut</th>
<th>Option Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>Non-Cardiac Assessment Information (Enter/Edit) ...</td>
</tr>
<tr>
<td>C</td>
<td>Cardiac Risk Assessment Information (Enter/Edit) ...</td>
</tr>
<tr>
<td>P</td>
<td>Print a Surgery Risk Assessment</td>
</tr>
<tr>
<td>U</td>
<td>Update Assessment Completed/Transmitted in Error</td>
</tr>
<tr>
<td>L</td>
<td>List of Surgery Risk Assessments</td>
</tr>
<tr>
<td>F</td>
<td>Print 30 Day Follow-up Letters</td>
</tr>
<tr>
<td>R</td>
<td>Exclusion Criteria (Enter/Edit)</td>
</tr>
<tr>
<td>M</td>
<td>Monthly Surgical Case Workload Report</td>
</tr>
<tr>
<td>V</td>
<td>M&amp;M Verification Report</td>
</tr>
<tr>
<td>O</td>
<td>Update 1-Liner Case</td>
</tr>
<tr>
<td>T</td>
<td>Queue Assessment Transmissions</td>
</tr>
<tr>
<td>CODE</td>
<td>Alert Coder Regarding Coding Issues</td>
</tr>
<tr>
<td>ERM</td>
<td>Risk Model Lab Test (Enter/Edit)</td>
</tr>
</tbody>
</table>
Editing an Incomplete Risk Assessment

To edit an incomplete risk assessment, the user can either select the assessment by patient or by surgery case number.

Example: Using the Select by Case Number Function to Edit an Incomplete Assessment

Select Surgery Risk Assessment Menu Option: N  Non-Cardiac Assessment Information (Enter/Edit)

Select Patient: #210

SURPATIENT,TEN  000-12-3456
03-22-02      HIP REPLACEMENT (INCOMPLETE)

1. Enter Risk Assessment Information
2. Delete Risk Assessment Entry
3. Update Assessment Status to 'COMPLETE'

Select Number: 1// <Enter>

Division: ALBANY  (500)

SURPATIENT,TEN  000-12-3456   Case #210 - MAR 22,2002

  PRE  Preoperative Information (Enter/Edit)
  LAB  Laboratory Test Results (Enter/Edit)
  O    Operation Information (Enter/Edit)
  D    Patient Demographics (Enter/Edit)
  IO   Intraoperative Occurrences (Enter/Edit)
  PO   Postoperative Occurrences (Enter/Edit)
  RET  Update Status of Returns Within 30 Days
  U    Update Assessment Status to 'COMPLETE'
  CODE Alert Coder Regarding Coding Issues

Select Non-Cardiac Assessment Information (Enter/Edit) Option: PRE

These options are described in the following sections.
Preoperative Information (Enter/Edit)  
[SROA PREOP DATA]

The Preoperative Information (Enter/Edit) option is used to enter or edit preoperative assessment information. The software will present two pages. At the bottom of each page is a prompt to select one or more preoperative items to edit. If the user does not want to edit any items on the page, pressing the <Enter> key will advance to the next page or, if the user is already on page two, will exit the option.

About the "Select Preoperative Information to Edit:" Prompt
At this prompt the user enters the item number he or she wishes to edit. Entering A for ALL allows the user to respond to every item on the page, or a range of numbers separated by a colon (:) can be entered to respond to a range of items. Number-letter combinations can also be used, such as 2C, to update a field within a group, such as CURRENT PNEUMONIA.

Each prompt at the category level allows for an entry of YES or NO. If NO is entered, each item under that category will automatically be answered NO. On the other hand, responding YES at the category level allows the user to respond individually to each item under the main category.

For instance, if number 2 is chosen, and the "PULMONARY:" prompt is answered YES, the user will be asked if the patient is ventilator dependent, has a history of COPD, and has pneumonia. If the "PULMONARY:" prompt is answered NO, the software will place a NO response in all the fields of the Pulmonary group. The majority of the prompts in this option are designed to accept the letters Y, N, or NS for YES, NO, and NO STUDY.

After the information has been entered or edited, the terminal display screen will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data.

This functionality allows the nurse reviewer to duplicate preoperative information from an earlier operation within 60 days of the date of operation on the same patient.

Example 1: Enter/Edit Preoperative Information

Select Non-Cardiac Assessment Information (Enter/Edit) Option: PRE Preoperative Information (Enter/Edit)

This patient had a previous non-cardiac operation on APR 28,1998@09:00
Case #63592  CHOLEDOCHOTOMY

Do you want to duplicate the preoperative information from the earlier assessment in this assessment?  YES// NO
### General Information

**Height:** 65 INCHES

**Weight:** 140 POUNDS

- **Diabetes Mellitus:** Yes
- **Current Smoker:** Yes
- **ETOH >2 Drinks Per Day:** No
- **Dyspnea:** No
- **DNR Status:** No
- **Functional Health Status at Evaluation for Surgery:** Independent

### Pulmonary Information

- **Ventilator Dependent:** No
- **History of Severe COPD:** No
- **Current Pneumonia:** No

### Hepatobiliary Information

- **Ascites:** No

### Gastrointestinal Information

- **Esophageal Varices:** No

### Cardiac Information

- **CHF Within 1 Month:** No
- **MI Within 6 Months:** No
- **Previous PCI:** No
- **Previous Cardiac Surgery:** No
- **Angina Within 1 Month:** No
- **Hypertension Requiring Meds:** No

### Vascular Information

- **Revascularization/Amputation:** No
- **Rest Pain/Gangrene:** No
1. GENERAL:  YES  4. GASTROINTESTINAL:
   A. Height:  62 INCHES  A. Esophageal Varices:
   B. Weight:  175 LBS.
   C. Diabetes Mellitus: INSULIN
   D. Current Smoker W/I 1 Year: YES
   E. ETOH > 2 Drinks/Day: NO
   F. Dyspnea: NO
   G. DNR Status: NO
   H. Preop Funct Status: INDEPENDENT
   F. Hypertension Requiring Meds:

2. PULMONARY:  NO
   A. Ventilator Dependent: NO
   B. History of Severe COPD: NO
   C. Current Pneumonia: NO

3. HEPATOBILIARY: NO
   A. Ascites: NO

4. GASTROINTESTINAL:
   A. Esophageal Varices:
   B. MI Within 6 Months:
   C. Previous PCI:
   D. Previous Cardiac Surgery:
   E. Angina Within 1 Month:
   F. Hypertension Requiring Meds:

5. CARDIAC:
   A. CHF Within 1 Month:
   B. MI Within 6 Months:
   C. Previous PCI:
   D. Previous Cardiac Surgery:
   E. Angina Within 1 Month:

6. VASCULAR:
   A. Revascularization/Amputation:
   B. Rest Pain/Gangrene:

Select Preoperative Information to Edit: 3E

History of Bleeding Disorders (Y/N): Y  YES

Select Preoperative Information to Edit:
<table>
<thead>
<tr>
<th>Item</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Transfer Status:</td>
<td></td>
</tr>
<tr>
<td>2. Observation Admission Date/Time:</td>
<td></td>
</tr>
<tr>
<td>3. Observation Discharge Date/Time:</td>
<td></td>
</tr>
<tr>
<td>4. Observation Treating Specialty:</td>
<td></td>
</tr>
<tr>
<td>5. Hospital Admission Date/Time:</td>
<td></td>
</tr>
<tr>
<td>6. Hospital Discharge Date/Time:</td>
<td></td>
</tr>
<tr>
<td>7. Admit/Transfer to Surgical Svc.:</td>
<td></td>
</tr>
<tr>
<td>8. Discharge/Transfer to Chronic Care:</td>
<td></td>
</tr>
<tr>
<td>9. Length of Postop Hospital Stay:</td>
<td></td>
</tr>
<tr>
<td>10. In/Out-Patient Status:</td>
<td>INPATIENT</td>
</tr>
<tr>
<td>11. Patient's Ethnicity:</td>
<td>UNANSWERED</td>
</tr>
<tr>
<td>12. Patient's Race:</td>
<td>UNANSWERED</td>
</tr>
<tr>
<td>13. Date of Death:</td>
<td></td>
</tr>
<tr>
<td>14. Date Surgery Consult Requested:</td>
<td>JAN 12, 2005</td>
</tr>
<tr>
<td>15. Surgery Consult Date:</td>
<td></td>
</tr>
</tbody>
</table>
Intraoperative Occurrences (Enter/Edit)  
[SRO INTRAOP COMP]

The nurse reviewer uses the Intraoperative Occurrences (Enter/Edit) option to enter or change information related to intraoperative occurrences (called complications in earlier versions). Every occurrence entered must have a corresponding occurrence category. For a list of occurrence categories, enter a question mark (?) at the "Enter a New Intraoperative Occurrence:" prompt.

After an occurrence category has been entered or edited, the screen will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data.

Example: Enter an Intraoperative Occurrence

Select Non-Cardiac Assessment Information (Enter/Edit) Option: IO Intraoperative Occurrences (Enter/Edit)

SURPATIENT,EIGHT (000-37-0555)        Case #264
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
------------------------------------------------------------------------

There are no Intraoperative Occurrences entered for this case.

Enter a New Intraoperative Occurrence: CARDIAC ARREST REQUIRING CPR
NSQIP Definition (2006):
The absence of cardiac rhythm or presence of chaotic cardiac rhythm that results in loss of consciousness requiring the initiation of any component of basic and/or advanced cardiac life support. Patients with AICDs that fire but the patient does not lose consciousness should be excluded.

CICSP Definition (2004):
Indicate if there was any cardiac arrest requiring external or open cardiopulmonary resuscitation (CPR) occurring in the operating room, ICU, ward, or out-of-hospital after the chest has been completely closed and within 30 days of surgery.

Press RETURN to continue: <Enter>

SURPATIENT,EIGHT (000-37-0555)        Case #264
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
------------------------------------------------------------------------

1. Occurrence: CARDIAC ARREST REQUIRING CPR
2. Occurrence Category: CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:
4. Treatment Instituted:
5. Outcome to Date:
6. Occurrence Comments:

------------------------------------------------------------------------

Select Occurrence Information: 4:5
SURPATIENT,EIGHT (000-37-0555)        Case #264
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
------------------------------------------------------------------------

Type of Treatment Instituted: CPR
Outcome to Date: I IMPROVED
Operative Risk Summary Data (Enter/Edit)
[SROA CARDIAC OPERATIVE RISK]

The Operative Risk Summary Data option is used to enter or edit operative risk summary data for the cardiac surgery risk assessments. The software will present one page. At the bottom of the page is a prompt to select one or more items to edit. If the user does not want to edit any items on the page, pressing the <Enter> key will advance the user to another option.

About the "Select Operative Risk Summary Information to Edit:" prompt

At this prompt the user enters the item number to edit. Entering A for ALL allows the user to respond to every item on the page, or a range of numbers separated by a colon (:) can be entered to respond to a range of items.

Example: Operative Risk Summary Data

Select Cardiac Risk Assessment Information (Enter/Edit) Option: OP Operative Risk Summary Data (Enter/Edit)

SURPATIENT,NINETEEN (000-28-7354) Case #60183 PAGE: 1
JUN 18,2005 CORONARY ARTERY BYPASS
------------------------------------------------------------------
1. Physician's Preoperative Estimate of Operative Mortality: 78
   A. Date/Time Collected
2. ASA Classification: 1-NO DISTURB.
3. Surgical Priority:
4. Date/Time Operation Began: JUN 18,2005 07:00
5. Date/Time Operation Ended: JUN 18,2005 09:00
6. Preoperative Risk Factors: NONE
7. CPT Codes (view only): 33510

------------------------------------------------------------------
Select Operative Risk Summary Information to Edit: 1:3

SURPATIENT,NINETEEN (000-28-7354) Case #60183 PAGE: 1
JUN 18,2005 CORONARY ARTERY BYPASS
------------------------------------------------------------------
Physician's Preoperative Estimate of Operative Mortality: 32
Date/Time of Estimate of Operative Mortality: JUN 17,2005@18:15
   // <Enter>
ASA Class: 3 3-SEVERE DISTURB.
Cardiac Surgical Priority: ?
   Enter the surgical priority that most accurately reflects the acuity of patient’s cardiovascular condition at the time of transport to the operating room.
   CHOOSE FROM:
1   ELECTIVE
2   URGENT
3   EMERGENT (ONGOING ISCHEMIA)
4   EMERGENT (HEMODYNAMIC COMPROMISE)
5   EMERGENT (ARREST WITH CPR)
Cardiac Surgical Priority: 3 EMERGENT (ONGOING ISCHEMIA)
Date/Time of Cardiac Surgical Priority: JUN 17,2005@13:29
   // <Enter>
The Surgery software performs data checks on the following fields:

The Date/Time Collected field for Physician's Preoperative Estimate of Operative Mortality should be earlier than the Time Pat In OR field. This field is no longer auto-populated.

The Date/Time Collected field for Surgical Priority should be earlier than the Time Pat In OR field. This field is no longer auto-populated.

If the date entered does not conform to the specifications, then the Surgery software displays a warning at the bottom of the screen.
Cardiac Procedures Operative Data (Enter/Edit)  
[SROA CARDIAC PROCEDURES]

The Cardiac Procedures Operative Data (Enter/Edit) option is used to enter or edit information related to cardiac procedures requiring cardiopulmonary bypass (CPB). The software will present two pages. At the bottom of the page is a prompt to select one or more items to edit. If the user does not want to edit any items on the page, pressing the <Enter> key will advance the user to another option.

About the "Select Operative Information to Edit:" prompt
At this prompt, the user enters the item number to edit. Entering A for ALL allows the user to respond to every item on the page, or a range of numbers separated by a colon (:) can be entered to respond to a range of items. You can also use number-letter combinations, such as 11B, to update a field within a group, such as VSD Repair.

Each prompt at the category level allows for an entry of YES or NO. If NO is entered, each item under that category will automatically be answered NO. On the other hand, responding YES at the category level allows the user to respond individually to each item under the main category.

The user can also enter of N shall allow the user to Set All to No for the 22 Cardiac Procedures fields. A verification prompt will follow to ensure that user understands the entry.

Fields that do not have YES/NO responses will be updated as follows.

- Items #1-#5 are numeric and their values will be set to 0.
- #9 Valve Repair will be set to NONE
- #13 Maze Procedure will be set to NO MAZE PERFORMED

After the information has been entered or edited, the terminal display screen will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data.

Example: Enter Cardiac Procedures Operative Data

Select Cardiac Risk Assessment Information (Enter/Edit) Option: CARD Cardiac Procedures Operative Data (Enter/Edit)  
SURPATIENT,NINETEEN (000-28-7354)  Case #60183  PAGE: 1 OF 2  
JUN 18,2005  CORONARY ARTERY BYPASS  

Cardiac surgical procedures with or without cardiopulmonary bypass  
CABG distal anastomoses:  11. Bridge to transplant/Device:  
1. Number with vein:  12. TMR:  
2. Number with IMA:  13. Maze procedure:  
3. Number with Radial Artery:  14. ASD repair:  
4. Number with Other Artery:  15. VSD repair:  
5. Number with Other Conduit:  16. Myectomy for IHSS:  
6. Aortic Valve Replacement:  17. Myxoma resection:  
7. Mitral Valve Replacement:  18. Other tumor resection:  
8. Tricuspid Valve Replacement:  19. Cardiac transplant:  
9. Valve Repair:  20. Great Vessel Repair:  
10. LV Aneurysmectomy:  21. Endovascular Repair:  
22. Other cardiac procedures:

Select Cardiac Procedures Operative Information to Edit: A

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CABG Distal Anastomoses with Vein: 1
CABG Distal Anastomoses with IMA: 1
Number with Radial Artery: 0
Number with Other Artery: 1
CABG Distal Anastomoses with Other Conduit: 1
Aortic Valve Replacement (Y/N): Y YES
Mitral Valve Replacement (Y/N): N NO
Tricuspid Valve Replacement (Y/N): N NO
Valve Repair: ??
CICSP Definition (2006):
Indicate if the patient has had any reparative procedure to a native valve, either with or without placing the patient on cardiopulmonary bypass. Valve repair is defined as a procedure performed on the native valve to relieve stenosis and/or correct regurgitation (annuloplasty, commissurotomy, etc.); the native valve remains in place. Indicate the one appropriate response.

Choose from:
1 AORTIC
2 MITRAL
3 TRICUSPID
4 OTHER/COMBINATION
5 NONE

Valve Repair: 1 AORTIC
LV Aneurysmectomy (Y/N): N NO
Device for bridge to cardiac transplant / Destination therapy: ??
CICSP Definition (2006):
Indicate if patient received a mechanical support device (excluding IABP) as a bridge to cardiac transplant during the same admission as the transplant procedure; or patient received the device as destination therapy (does not intend to have a cardiac transplant), either with or without placing the patient on cardiopulmonary bypass.

Choose from:
Y YES
N NO

Device for bridge to cardiac transplant / Destination therapy: N NO
Transmyocardial Laser Revascularization: N NO
Maze Procedure: N NO MAZE PERFORMED
ASD Repair (Y/N): N NO
VSD Repair (Y/N): N NO
Myxoma Resection for IHSS (Y/N): N NO
Other Tumor Resection (Y/N): N NO
Cardiac Transplant (Y/N): N NO
Great Vessel Repair (Y/N): N NO
Endovascular Repair of Descending Thoracic Aorta: N NO
Other Cardiac Procedures (Y/N): N NO
Resource Data (Enter/Edit)
[SROA CARDIAC RESOURCE]

The nurse reviewer uses the Resource Data (Enter/Edit) option to enter, edit, or review risk assessment and cardiac patient demographic information such as hospital admission, discharge dates, and other information related to the surgical episode.

Example: Resource Data (Enter/Edit)

Select Cardiac Risk Assessment Information (Enter/Edit) Option: R  Resource Data

SURPATIENT, TEN (000-12-3456)        Case #49413
OCT 18, 2007   CABG X3 USING LSVG TO OMB, LV EXT. OF RCA, LIMA TO LAD
--------------------------------------------------------------------------------
Enter/Edit Patient Resource Data
1. Capture Information from PIMS Records
2. Enter, Edit, or Review Information
Select Number: (1-2): 1
Are you sure you want to retrieve information from PIMS records? YES//<Enter>
...HMMM, I'M WORKING AS FAST AS I CAN...

SURPATIENT, TEN (000-12-3456)        Case #49413
OCT 18, 2007   CABG X3 USING LSVG TO OMB, LV EXT. OF RCA, LIMA TO LAD
--------------------------------------------------------------------------------
Enter/Edit Patient Resource Data
1. Capture Information from PIMS Records
2. Enter, Edit, or Review Information
Select Number: (1-2): 2

SURPATIENT, TEN (000-12-3456)        Case #49413
OCT 18, 2007   CABG X3 USING LSVG TO OMB, LV EXT. OF RCA, LIMA TO LAD
--------------------------------------------------------------------------------
1. Hospital Admission Date:           FEB 11, 2007@15:39
2. Hospital Discharge Date:           FEB 16, 2007@13:44
3. Cardiac Catheterization Date:
4. Time Patient In OR:                FEB 12, 2007@06:30
5. Time Patient Out OR:               FEB 12, 2007@08:40
6. Date/Time Patient Extubated:
7. Date/Time Discharged from ICU:     FEB 16, 2007@13:44
8. Homeless:                          NO
9. Surg Performed at Non-VA Facility: NO
10. Resource Data Comments:
11. Employment Status Preoperatively:  EMPLOYED PART TIME
12. CT Surgery Consult Date:
13. Cause for Delay for Surgery:
--------------------------------------------------------------------------------
Select number of item to edit: 11
Employment Status Preoperatively: EMPLOYED FULL TIME

Enter the patient's employment status preoperatively.
Choose from:
1. EMPLOYED FULL TIME
2. EMPLOYED PART TIME
3. NOT EMPLOYED
4. SELF EMPLOYED
5. RETIRED
6. ACTIVE MILITARY DUTY
9. UNKNOWN

Employment Status Preoperatively: 3 NOT EMPLOYED

SURPATIENT, TEN (000-12-3456) Case #49413
OCT 18, 2007 CABG X3 USING LSVG TO OMB, LV EXT. OF RCA, LIMA TO LAD

1. Hospital Admission Date: FEB 11, 2007@15:39
2. Hospital Discharge Date: FEB 16, 2007@13:44
3. Cardiac Catheterization Date:
4. Time Patient In OR: FEB 12, 2007@06:30
5. Time Patient Out OR: FEB 12, 2007@08:40
6. Date/Time Patient Extubated: FEB 16, 2007@13:44
7. Date/Time Discharged from ICU: FEB 16, 2007@13:44
8. Homeless: NO
9. Surg Performed at Non-VA Facility: NO
10. Resource Data Comments:
11. Employment Status Preoperatively: EMPLOYED PART TIME
12. CT Surgery Consult Date:
13. Cause for Delay for Surgery:

The Surgery software performs data checks on the following fields:

The Date/Time Patient Extubated field should be later than the Time Patient Out OR field, and earlier than the Date/Time Discharged from ICU field.

The Date/Time Discharged from ICU field should be later than the Date/Time Patient Extubated field, and equal to or earlier than the Hospital Discharge Date field.

If the date entered does not conform to the specifications, then the Surgery software displays a warning at the bottom of the screen.
The *Print a Surgery Risk Assessment* option prints an entire Surgery Risk Assessment Report for an individual patient. This report can be displayed temporarily on a screen. As the report fills the screen, the user will be prompted to press the `<Enter>` key to go to the next page. A permanent record can be made by copying the report to a printer. When using a printer, the report is formatted slightly differently from the way it displays on the terminal.

**Example 1: Print Surgery Risk Assessment for a Non-Cardiac Case**

Select Surgery Risk Assessment Menu Option: **P** Print a Surgery Risk Assessment

Do you want to batch print assessments for a specific date range? **NO**/<Enter>

Select Patient: **SURPATIENT,FORTY**

<table>
<thead>
<tr>
<th>ERAN</th>
<th>05-07-23</th>
<th>000777777</th>
<th>NO</th>
<th>NSC VET</th>
</tr>
</thead>
</table>

**SURPATIENT,FORTY 000-77-7777**

1. 02-10-04 * CABG (INCOMPLETE)
2. 01-09-06 APPENDECTOMY (COMPLETED)

Select Surgical Case: **2**

Print the Completed Assessment on which Device: [Select Print Device]

---------------------------------------------printout follows---------------------------------------------
Medical Center: ALBANY  
Age: 81  
Sex: MALE  
Race: AMERICAN INDIAN OR ALASKA NATIVE, NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER, WHITE  
Transfer Status: NOT TRANSFERRED  
Hospital Admission Date: JAN 7, 2006  11:15  
Hospital Discharge Date: JAN 12, 2006  10:30  
In/Out-Patient Status: INPATIENT  
Date Surgery Consult Requested: JAN 7, 2006  
Surgery Consult Date: JAN 8, 2006  

---

### PREOPERATIVE INFORMATION

**GENERAL:**
- Height: 176 CENTIMETERS  
- Weight: 89 KILOGRAMS  
- Diabetes Mellitus:  
- Current Smoker W/I 1 Year:  
- ETOH > 2 Drinks/Day:  
- Dyspnea:  
- DNR Status:  
- Preop Funct Status:  
- Hypertension Requiring Meds:  

**GASTROINTESTINAL:**
- Esophageal Varices:

**CARDIAC:**
- CHF Within 1 Month:  
- MI Within 6 Months:  
- Previous PCI:  
- Previous Cardiac Surgery:  
- Angina Within 1 Month:  
- Hypertension Requiring Meds:

**PULMONARY:**
- Ventilator Dependent:  
- History of Severe COPD: NO  
- Current Pneumonia:  
- Rest Pain/Gangrene:

**HEPATOBILIARY:**
- Ascites:  
- Tumor Involving CNS:  

**RENAL:**
- Acute Renal Failure: NO  
- Currently on Dialysis: NO  
- Steroid Use for Chronic Cond.: NO  
- Weight Loss > 10%: NO  
- Bleeding Disorders: NO  
- Transfusion > 4 RBC Units: NO  
- Chemotherapy W/I 30 Days: NO  
- Radiotherapy W/I 90 Days: NO  
- Pregnancy: NOT APPLICABLE

**NUTRITIONAL/IMMUNE/OTHER:**
- Disseminated Cancer: NO  
- Open Wound: NO  
- Preoperative Sepsis: NONE

**CENTRAL NERVOUS SYSTEM:**
- Impaired Sensorium: NO  
- Coma: NO  
- Transfusion > 4 RBC Units: NO  
- Chemotherapy W/I 30 Days: NO  
- Radiotherapy W/I 90 Days: NO  
- Pregnancy: NOT APPLICABLE

**VASCULAR:**
- Rest Pain/Gangrene:

**OPERATION DATE/TIMES INFORMATION**
- Patient in Room (PIR): JAN 9, 2006  07:25  
- Procedure/Surgery Start Time (PST): JAN 9, 2006  07:25  
- Procedure/Surgery Finish (PPF): JAN 9, 2006  08:00  
- Patient Out of Room (POR): JAN 9, 2006  08:18  
- Anesthesia Start (AS): JAN 9, 2006  07:15  
- Anesthesia Finish (AF): JAN 9, 2006  08:10  
- Discharge from PACU (DPACU): JAN 9, 2006  09:15
**Example 2: Print Surgery Risk Assessment for a Cardiac Case**

Select Surgery Risk Assessment Menu Option: **P** Print a Surgery Risk Assessment

Do you want to batch print assessments for a specific date range? **NO**/ <Enter>

Select Patient: **R9922** SURPATIENT,NINE 12-19-51 000345555 NO SC VETERAN

<table>
<thead>
<tr>
<th>Date</th>
<th>手术名称及操作</th>
<th>传输状态</th>
</tr>
</thead>
<tbody>
<tr>
<td>07-01-06</td>
<td>CABG X3 (1A,2V), ARTERIAL GRAFTING</td>
<td>(TRANSMITTED)</td>
</tr>
<tr>
<td>03-27-05</td>
<td>INGUINAL HERNIA</td>
<td>(TRANSMITTED)</td>
</tr>
<tr>
<td>07-03-04</td>
<td>PULMONARY LOBECTOMY</td>
<td>(TRANSMITTED)</td>
</tr>
</tbody>
</table>

Select Surgical Case: Select Surgical Case: **1**

Print the Completed Assessment on which Device: [Select Print Device]

---------------------------------------------------------printout follows--------------------------------------------------
VA CONTINUOUS IMPROVEMENT IN CARDIAC SURGERY PROGRAM (CICSP/CICSP-X)

I. IDENTIFYING DATA
Patient: SURPATIENT,NINE  000-34-5555  Case #: 238  Fac./Div. #: 500
Surgery Date: 07/01/06  Address: Anyplace Way
Phone: NS/Unknown  Zip Code: 33445-1234  Date of Birth: 12/19/51

II. CLINICAL DATA
Gender: MALE  PCI: >72 hrs - 7 days
Age: 55  Prior MI: > 7 DAYS OF SURG
Height: 72 in  # of prior heart surgeries: NONE
Weight: 120 kg  Prior heart surgeries:
Diabetes: DIET  Peripheral Vascular Disease: NO
COPD: NO  Cerebral Vascular Disease: NO
FEV1: NS  Angina (use CCS Class): I
Cardiomegaly (X-ray): YES  CHF (use NYHA Class): I
Pulmonary Rales: NO  Current Diuretic Use: NO
Current Smoker: >3 MONTHS PRIOR TO SUR  Current Digoxin Use: NO
Active Endocarditis: NO  IV NTG 48 Hours Preceding Surgery: NO
Resting ST Depression: YES  Preop circulatory Device: VAD
Functional Status: PARTIAL DEPENDENT  Hypertension: NO

III. DETAILED LABORATORY INFO - PREOPERATIVE VALUES
Creatinine: 1.1 mg/dl 06/28/06  T. Bilirubin: .9 mg/dl 06/28/06
Hemoglobin: 15.6 mg/dl 06/28/06  T. Cholesterol: 230 mg/dl 06/28/06
Albumin: 4.4 g/dl 06/28/06  HDL: 90 mg/dl 06/28/06
Triglyceride: 77 mg/dl 06/28/06  LDL: 125 mg/dl 06/28/06
Potassium: 4.6 mg/dL 06/28/06  Hemoglobin A1c: 205 mg/dl 06/28/06

IV. CARDIAC CATHETERIZATION AND ANGIOGRAPHIC DATA
Cardiac Catheterization Date: 06/28/06
Procedure: NS  Native Coronaries:
LVEDP: NS  Left Main Stenosis: NS
Aortic Systolic Pressure: NS  LAD Stenosis: NS
For patients having right heart cath: Circumflex Stenosis: NS
PA Systolic Pressure: NS  Right Coronary Stenosis: NS
PAW Mean Pressure: NS  If a Re-do, indicate stenosis
If a Re-do, indicate stenosis
in graft to:
LAD: NS
Right coronary (include PDA): NS
Circumflex: NS

LV Contraction Grade (from contrast or radionuclide angiogram or 2D Echo):
Grade Ejection Fraction Range Definition
NO LV STUDY

Mitral Regurgitation: NS
Aortic stenosis: NS

V. OPERATIVE RISK SUMMARY DATA  (Operation Began: 07/01/06 10:10)
Physician's Preoperative  (Operation Ended: 07/01/06 12:20)
Estimate of Operative Mortality: NS  07/28/06 15:30
ASA Classification: 3-SEVERE DISTURB.
Surgical Priority: ELECTIVE  07/28/06 15:31
Principal CPT Code: 33517
Other Procedures CPT Codes: 33510
Preoperative Risk Factors:
VI. OPERATIVE DATA
Cardiac surgical procedures with or without cardiopulmonary bypass
CABG distal anastomoses: Bridge to transplant/Device: NO
Number with Vein: 2 TMR: NO
Number with IMA: 2 Maze procedure: NO MAZE PERFORMED
Number with Radial Artery: 0 ASD repair: NO
Number with Other Artery: 0 VSD repair: NO
Number with Other Conduit: 0 Myectomy for IHSS: NO
Aortic Valve Replacement: NO Myxoma resection: NO
Mitral Valve Replacement: NO Other tumor resection: NO
Tricuspid Valve Replacement: NO Cardiac transplant: NO
Valve Repair: NONE Great Vessel Repair: NO
LV Aneurysmectomy: NO Endovascular Repair: NO
Other Cardiac procedure(s): YES
* Other Cardiac procedures (Specify): OTHER CT PROCEDURE #1, OTHER CT PROCEDURE #2, OTHER CT PROC
Indicate other cardiac procedures only if done with cardiopulmonary bypass
Foreign body removal: YES
Pericardectomy: YES
Other Operative Data details
Total CPB Time: 85 min Total Ischemic Time: 60 min
Incision Type: FULL STERNOTOMY
Conversion Off Pump to CPB: N/A (began on-pump/ stayed on-pump)
VII. OUTCOMES
Operative Death: NO Date of Death:
Perioperative (30 day) Occurrences:
Perioperative MI: NO Repeat cardiac Surg procedure: YES
Endocarditis: NO Tracheostomy: YES
Renal Failure Requiring Dialysis: NO Ventilator supp within 30 days: YES
Mediastinitis: YES Stroke/CVA: NO
Cardiac Arrest Requiring CPR: YES Coma > or = 24 Hours: NO
Reoperation for Bleeding: NO New Mech Circulatory Support: YES
On ventilator > or = 48 hr: NO
VIII. RESOURCE DATA
Hospital Admission Date: 06/30/06 06:05
Hospital Discharge Date: 07/10/06 08:50
Time Patient In OR: 07/10/06 10:00
Time Patient Out OR: 07/10/06 12:30
Date and Time Patient Exubated: 07/10/06 13:13
Postop Intubation Hrs: +1.9
Date and Time Patient Discharged from ICU: 07/10/06 08:00
Patient is Homeless: NS
Cardiac Surg Performed at Non-VA Facility: UNKNOWN
CT Surgery Consult Date: 06/29/06
Cause for Delay for Surgery: NONE
Resource Data Comments:
IX. SOCIOECONOMIC, ETHNICITY, AND RACE
Employment Status Preoperatively: SELF EMPLOYED
Ethnicity: NOT HISPANIC OR LATINO
Race Category(ies): AMERICAN INDIAN OR ALASKA NATIVE,
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER, WHITE
X. DETAILED DISCHARGE INFORMATION
Discharge ICD-9 Codes: 414.01 V70.7 433.10 285.1 412. 307.9 427.31
Type of Disposition: TRANSFER
Place of Disposition: HOME-BASED PRIMARY CARE (HBPC)
Primary care or referral VAMC identification code: 526
Follow-up VAMC identification code: 526
*** End of report for SURPATIENT,NINE 000-34-5555 assessment #238 ***
List of Surgery Risk Assessments
[SROA ASSESSMENT LIST]

The List of Surgery Risk Assessments option is used to print lists of assessments within a date range. Lists of assessments in different phases of completion (for example, incomplete, completed, or transmitted) or a list of all surgical cases entered in the Surgery Risk Assessment software can be printed. The user can also request that the list be sorted by surgical service. The software will prompt for a beginning date and an ending date. The examples in this section illustrate printing assessments in the following formats.

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

Example 1: List of Incomplete Assessments

Select Surgery Risk Assessment Menu Option: L List of Surgery Risk Assessments

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

Select the Number of the Report Desired: (1-11): 1

Start with Date: 1 1 06 (JAN 01, 2006)
End with Date: 6 30 06 (JUN 30, 2006)

Print by Surgical Specialty ? YES/<Enter>

Print report for ALL specialties ? YES/<Enter>

Do you want to print all divisions? YES/NO

1. MAYBERRY, NC

Select Number: (1-2): 1

This report is designed to print to your screen or a printer. When using a printer, a 132 column format is used.

Print the List of Assessments to which Device: [Select Print Device]

--------------------------------------------------------------------printout follows--------------------------------------------------------------------
<table>
<thead>
<tr>
<th>ASSESSMENT #</th>
<th>PATIENT</th>
<th>OPERATIVE PROCEDURE(S)</th>
<th>ANESTHESIA TECHNIQUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>** SURGICAL SPECIALTY: CARDIAC SURGERY **</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28519</td>
<td>SURPATIENT,NINE 000-34-5555</td>
<td>* CABG X3 (2V,1A)</td>
<td>GENERAL</td>
</tr>
<tr>
<td>JAN 05, 2006</td>
<td>SUSRINERGEONE</td>
<td></td>
<td>CPT Codes: 33736</td>
</tr>
<tr>
<td>** SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW) **</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>63063</td>
<td>SURPATIENT,ONE 000-44-7629</td>
<td>INGUINAL HERNIA</td>
<td>SPINAL</td>
</tr>
<tr>
<td>JUN 09, 2006</td>
<td>SUSRINERGEONTWO</td>
<td></td>
<td>CPT Codes: 49521</td>
</tr>
<tr>
<td>** SURGICAL SPECIALTY: NEUROSURGERY **</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>63154</td>
<td>SURPATIENT,EIGHT 000-37-0555</td>
<td>CRANIOTOMY</td>
<td>NOT ENTERED</td>
</tr>
<tr>
<td>JUN 24, 2006</td>
<td>SUSRINERGEONFOUR</td>
<td></td>
<td>CPT Codes: NOT ENTERED</td>
</tr>
</tbody>
</table>
Example 2: List of Completed Assessments

Select Surgery Risk Assessment Menu Option: L List of Surgery Risk Assessments

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

Select the Number of the Report Desired: (1-11): 2

Start with Date: 1 1 06 (JAN 01, 2006)
End with Date: 6 30 06 (JUN 30, 2006)

Print by Surgical Specialty? YES/<Enter>

Print report for ALL specialties? YES/<Enter>

Do you want to print all divisions? YES//NO

1. MAYBERRY, NC
2. PHILADELPHIA, PA

Select Number: (1-2): 1

This report is designed to print to your screen or a printer. When using a printer, a 132 column format is used.

Print the List of Assessments to which Device: [Select Print Device]

---printout follows---
<table>
<thead>
<tr>
<th>ASSESSMENT #</th>
<th>PATIENT</th>
<th>OPERATION DATE</th>
<th>OPERATIVE PROCEDURE</th>
<th>DATE COMPLETED</th>
<th>ANESTHESIA TECHNIQUE</th>
</tr>
</thead>
</table>
| **SURGICAL SPECIALTY: GENERAL (OR WHEN NOT DEFINED BELOW)** **

92   SURPATIENT, SIXTY 000-56-7821   FEB 23, 2006   CHOLODOCHOTOMY   CPT Code: 47420   FEB 28, 2006   GENERAL

63045   SURPATIENT, FORTYONE 000-43-2109   MAR 01, 2006   INGUINAL HERNIA   CPT Code: 49521   MAR 29, 2006   GENERAL

**SURGICAL SPECIALTY: OPHTHALMOLOGY** **

1898   SURPATIENT, FORTYONE 000-43-2109   APR 28, 2006   INTRAOCULAR LENS   CPT Codes: NOT ENTERED   MAY 28, 2006   GENERAL
Example 3: List of Transmitted Assessments

Select Surgery Risk Assessment Menu Option: L List of Surgery Risk Assessments

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

Select the Number of the Report Desired: (1-11): 3

Print by Date of Operation or by Date of Transmission?

1. Date of Operation
2. Date of Transmission

Select Number: (1-2): 1

Start with Date: 11 06 (JAN 01, 2006)
End with Date: 630 06 (JUN 30, 2006)

Print which Transmitted Cases?

1. Assessed Cases Only
2. Excluded Cases Only
3. Both Assessed and Excluded

Select Number: (1-3): 1

Print by Surgical Specialty? YES

Print report for ALL specialties? YES

Print the Report for which Surgical Specialty: GENERAL SURGERY

1. 50 GENERAL SURGERY
2. 50 GASTROENTEROLOGY
3. 50 TWO GENERAL

CHOOSE 1-3: GENERAL SURGERY

Do you want to print all divisions? YES

1. MAYBERRY, NC
2. PHILADELPHIA, PA

Select Number: (1-2): 1

This report is designed to print to your screen or a printer. When using a printer, a 132 column format is used.

Print the List of Assessments to which Device: [Select Print Device]
<table>
<thead>
<tr>
<th>ASSESSMENT #</th>
<th>PATIENT</th>
<th>OPERATION DATE</th>
<th>TRANSMISSION DATE</th>
<th>PRINCIPAL OPERATIVE PROCEDURE</th>
<th>ANESTHESIA TECHNIQUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>63076</td>
<td>SURPATIENT, FOURTEEN 000-45-7212</td>
<td>JAN 08, 2006</td>
<td>FEB 12, 2006</td>
<td>INGUINAL HERNIA</td>
<td>GENERAL</td>
</tr>
<tr>
<td></td>
<td>CPT Codes: 49521</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>63077</td>
<td>SURPATIENT, FIVE 000-58-7963</td>
<td>FEB 08, 2006</td>
<td>FEB 30, 2006</td>
<td>INGUINAL HERNIA, OTHER PROC1</td>
<td>GENERAL</td>
</tr>
<tr>
<td></td>
<td>CPT Codes: NOT ENTERED</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>63103</td>
<td>SURPATIENT, NINE 000-34-5555</td>
<td>MAR 27, 2006</td>
<td>APR 09, 2006</td>
<td>INGUINAL HERNIA</td>
<td>GENERAL</td>
</tr>
<tr>
<td></td>
<td>CPT Codes: 49521</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>63171</td>
<td>SURPATIENT, FIFTY-TWO 000-99-8888</td>
<td>MAY 17, 2006</td>
<td>JUN 05, 2006</td>
<td>CHOLECYSTECTOMY</td>
<td>GENERAL</td>
</tr>
<tr>
<td></td>
<td>CPT Codes: 47600</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Example 4: List of Non-Assessed Major Surgical Cases

Select Surgery Risk Assessment Menu Option: L List of Surgery Risk Assessments

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

Select the Number of the Report Desired: (1-11): 4

Start with Date: 1 1 06 (JAN 01, 2006)
End with Date: 6 30 06 (JUN 30, 2006)

Print by Surgical Specialty ? YES// <Enter>

Print report for ALL specialties ? YES// N

Print the Report for which Surgical Specialty: GENERAL (OR WHEN NOT DEFINED BELOW) GENERAL (OR WHEN NOT DEFINED BELOW) 50

Do you want to print all divisions? YES// NO

1. MAYBERRY, NC
2. PHILADELPHIA, PA

Select Number: (1-2): 1

This report is designed to print to your screen or a printer. When using a printer, a 132 column format is used.

Print the List of Assessments to which Device: [Select Print Device]

---------------------------------------------------------------------------------------------------------printout follows---------------------------------------------------------------------------------------------------------
## NON-ASSESSED MAJOR SURGICAL CASES BY SURGICAL SPECIALTY

**MAYBERRY, NC**  
**SURGERY SERVICE**

**DATE REVIEWED:**
**FROM:** JAN 1, 2006  **TO:** JUN 30, 2006  
**REVIEWED BY:**

<table>
<thead>
<tr>
<th>CASE #</th>
<th>PATIENT</th>
<th>OPERATIVE PROCEDURE(S)</th>
<th>ANESTHESIA TECHNIQUE</th>
<th>SURGEON</th>
</tr>
</thead>
<tbody>
<tr>
<td>63071</td>
<td>SURPATIENT, FOUR 000-17-0555</td>
<td>INGUINAL HERNIA</td>
<td>GENERAL</td>
<td>SURSURGEON, TWO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CPT Codes: 49505</td>
<td></td>
<td></td>
</tr>
<tr>
<td>63136</td>
<td>SURPATIENT, EIGHT 000-34-5555</td>
<td>CHOLECYSTECTOMY</td>
<td>GENERAL</td>
<td>SURSURGEON, TWO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CPT Codes: 47605</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL GENERAL(OR WHEN NOT DEFINED BELOW):** 2
**Example 5: List of All Major Surgical Cases**

Select Surgery Risk Assessment Menu Option: List of Surgery Risk Assessments

<table>
<thead>
<tr>
<th>List of Surgery Risk Assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. List of Incomplete Assessments</td>
</tr>
<tr>
<td>2. List of Completed Assessments</td>
</tr>
<tr>
<td>3. List of Transmitted Assessments</td>
</tr>
<tr>
<td>4. List of Non-Assessed Major Surgical Cases</td>
</tr>
<tr>
<td>5. List of All Major Surgical Cases</td>
</tr>
<tr>
<td>6. List of All Surgical Cases</td>
</tr>
<tr>
<td>7. List of Completed/Transmitted Assessments Missing Information</td>
</tr>
<tr>
<td>8. List of 1-Liner Cases Missing Information</td>
</tr>
<tr>
<td>9. List of Eligible Cases</td>
</tr>
<tr>
<td>10. List of Cases With No CPT Codes</td>
</tr>
<tr>
<td>11. Summary List of Assessed Cases</td>
</tr>
</tbody>
</table>

Select the Number of the Report Desired: (1-11): 5

Start with Date: 1 1 06 (JAN 01, 2006)
End with Date: 6 30 06 (JUN 30, 2006)

Print by Surgical Specialty? YES/ <Enter>
Print report for ALL specialties? YES/ N

Print the Report for which Surgical Specialty: GENERAL (OR WHEN NOT DEFINED BELOW) GENERAL (OR WHEN NOT DEFINED BELOW)

Do you want to print all divisions? YES/ NO

1. MAYBERRY, NC
2. PHILADELPHIA, PA

Select Number: (1-2): 1

This report is designed to print to your screen or a printer. When using a printer, a 132 column format is used.

Print the List of Assessments to which Device: [Select Print Device]
## All Major Surgical Cases by Surgical Specialty

**Mayberry, NC**  
**Surgery Service**  
**Date Reviewed:**

**From:** Jan 1, 2006  
**To:** Jun 30, 2006  
**Reviewed By:**

<table>
<thead>
<tr>
<th>Case #</th>
<th>Patient</th>
<th>Assessment Status</th>
<th>Exclusion Criteria</th>
<th>Anesthesia Technique</th>
<th>Surgeon</th>
</tr>
</thead>
<tbody>
<tr>
<td>63110</td>
<td>SURPATIENT, SIXTY 000-56-7821</td>
<td>COMPLETED</td>
<td>SCNR WAS ON A/L</td>
<td>GENERAL</td>
<td>SURSURGEON, TWO</td>
</tr>
<tr>
<td>Jan 23, 2006</td>
<td>CHOLEDOCHOTOMY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CPT Codes: 47420</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>63131</td>
<td>SURPATIENT, FIFTYTWO 000-99-8888</td>
<td>NO ASSESSMENT</td>
<td></td>
<td>GENERAL</td>
<td>SURSURGEON, NINE</td>
</tr>
<tr>
<td>Apr 21, 2006</td>
<td>PERINEAL WOUND EXPLORATION</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CPT Codes: NOT ENTERED</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>63136</td>
<td>SURPATIENT, EIGHT 000-34-5555</td>
<td>NO ASSESSMENT</td>
<td></td>
<td>GENERAL</td>
<td>SURSURGEON, ONE</td>
</tr>
<tr>
<td>Jun 07, 2006</td>
<td>CHOLECYSTECTOMY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CPT Codes: 47600</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total General (or when not defined below):** 3

---

**CPT Codes:**
- 47420
- 47600
Example 6: List of All Surgical Cases

Select Surgery Risk Assessment Menu Option: **L** List of Surgery Risk Assessments

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

Select the Number of the Report Desired: (1-11): **6**

Start with Date: **1 1 06** (JAN 01, 2006)
End with Date: **6 30 06** (JUN 30, 2006)

Print by Surgical Specialty? YES// <Enter>

Print report for ALL specialties? YES// **N**

Print the Report for which Surgical Specialty: **50** GENERAL(OR WHEN NOT DEFINED BELOW)

Do you want to print all divisions? YES// **NO**

1. MAYBERRY, NC
2. PHILADELPHIA, PA

Select Number: (1-2): **1**

This report is designed to print to your screen or a printer. When using a printer, a 132 column format is used.

Print the List of Assessments to which Device: [Select Print Device]

------------------------------------------------------------------------------------------printout follows------------------------------------------------------------------------------------------
<table>
<thead>
<tr>
<th>CASE #</th>
<th>PATIENT</th>
<th>SURGERY DATE</th>
<th>PRINCIPAL OPERATIVE PROCEDURE</th>
<th>ASSESSMENT STATUS</th>
<th>EXCLUSION CRITERIA</th>
<th>ANESTHESIA TECHNIQUE</th>
<th>SURGEON</th>
</tr>
</thead>
<tbody>
<tr>
<td>63110</td>
<td>SURPATIENT,SIXTY 000-56-7821</td>
<td>JAN 23, 2006</td>
<td>CHOLEDOCHOTOMY</td>
<td>COMPLETED</td>
<td>SCNR WAS ON A/L</td>
<td>GENERAL</td>
<td>SURSURGEON, TWO</td>
</tr>
<tr>
<td>63079</td>
<td>SURPATIENT,FIFTY-TWO 000-99-8888</td>
<td>APR 02, 2006</td>
<td>INGUINAL HERNIA</td>
<td>INCOMPLETE</td>
<td>NOT ENTERED</td>
<td>GENERAL</td>
<td>SURSURGEON, ONE</td>
</tr>
<tr>
<td>63131</td>
<td>SURPATIENT,FIFTY-TWO 000-99-8888</td>
<td>APR 21, 2006</td>
<td>PERINEAL WOUND EXPLORATION</td>
<td>NO ASSESSMENT</td>
<td>NOT ENTERED</td>
<td>GENERAL</td>
<td>SURSURGEON, NINE</td>
</tr>
<tr>
<td>63180</td>
<td>SURPATIENT,SIXTY 000-56-7821</td>
<td>JUN 23, 2006</td>
<td>CHOLECYSTECTOMY</td>
<td>NO ASSESSMENT</td>
<td>NOT ENTERED</td>
<td>NOT ENTERED</td>
<td>SURSURGEON, ONE</td>
</tr>
</tbody>
</table>

TOTAL GENERAL (OR WHEN NOT DEFINED BELOW): 4
Example 7: List of Completed/Transmitted Assessments Missing Information

Select Surgery Risk Assessment Menu Option: 1 List of Surgery Risk Assessments

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

Select the Number of the Report Desired: (1-11): 7

Start with Date: 1 1 06 (JAN 01, 2006)
End with Date: 6 30 06 (JUN 30, 2006)

Print by Surgical Specialty? YES// <Enter>

Print report for ALL specialties? YES// <Enter>

Do you want to print all divisions? YES// NO

1. MAYBERRY, NC
2. PHILADELPHIA, PA

Select Number: (1-2): 1
Print the List of Assessments to which Device: [Select Print Device]

----------------------------------printout follows----------------------------------
** GENERAL (OR WHEN NOT DEFINED BELOW)**

<table>
<thead>
<tr>
<th>ASSESSMENT #</th>
<th>PATIENT</th>
<th>TYPE</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PATIENT,FIFTY</td>
<td>NON-CARDIAC</td>
<td>TRANSMITTED</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>REPAIR ARTERIAL</td>
<td>BLEEDING</td>
</tr>
<tr>
<td></td>
<td>000-99-8888</td>
<td>CPT Code: 33120</td>
<td></td>
</tr>
</tbody>
</table>

Missing information:
1. The final coding for Procedure and Diagnosis is not complete.
2. Anesthesia Technique

<table>
<thead>
<tr>
<th>ASSESSMENT #</th>
<th>PATIENT</th>
<th>TYPE</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PATIENT,SIXTEEN</td>
<td>NON-CARDIAC</td>
<td>TRANSMITTED</td>
</tr>
<tr>
<td></td>
<td>000-11-1111</td>
<td>INGUINAL HERNIA,</td>
<td>CHOLECYSTECTOMY</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CPT Code:</td>
<td></td>
</tr>
</tbody>
</table>

Missing information:
1. The final coding for Procedure and Diagnosis is not complete.
2. Concurrent Case
3. History of COPD (Y/N)
4. Ventilator Dependent Greater than 48 Hrs (Y/N)
5. Weight Loss > 10% of Usual Body Weight (Y/N)
6. Transfusion Greater than 4 RBC Units this Admission (Y/N)

<table>
<thead>
<tr>
<th>ASSESSMENT #</th>
<th>PATIENT</th>
<th>TYPE</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PATIENT,THIRTY</td>
<td>EXCLUDED</td>
<td>COMPLETE</td>
</tr>
<tr>
<td></td>
<td>000-82-9472</td>
<td>TURP</td>
<td></td>
</tr>
</tbody>
</table>

Missing information:
1. The final coding for Procedure and Diagnosis is not complete.

TOTAL FOR GENERAL (OR WHEN NOT DEFINED BELOW): 3

TOTAL FOR ALL SPECIALTIES: 3
Example 8: List of 1-Liner Cases Missing Information

Select Surgery Risk Assessment Menu Option: L List of Surgery Risk Assessments

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

Select the Number of the Report Desired: (1-11): 8

Start with Date: 2 27 06 (FEB 27, 2006)
End with Date: 6 30 06 (JUN 30, 2006)

Print by Surgical Specialty? YES// <Enter>
Print report for ALL specialties? YES// <Enter>
Do you want to print all divisions? YES// NO

1. MAYBERRY, NC
2. PHILADELPHIA, PA

Select Number: (1-2): 1
Print the List of Assessments to which Device: [Select Print Device]

--------------------------------------------------------------------------------------------------------------------------printout follows----------------------------------------------------------
** UROLOGY

<table>
<thead>
<tr>
<th>CASE #</th>
<th>PATIENT</th>
<th>TYPE</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>317</td>
<td>SURPATIENT,FOURTEEN 000-45-7212</td>
<td>CARDIAC</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>APR 10, 2006</td>
<td>Vasectomy</td>
<td>CPT Codes: NOT ENTERED</td>
<td></td>
</tr>
</tbody>
</table>

** Missing information:**
1. The final coding for Procedure and Diagnosis is not complete.
2. Attending Code
3. Wound Classification
4. ASA Class

TOTAL FOR UROLOGY: 1
### Example 9: List of Eligible Cases

Select Surgery Risk Assessment Menu Option: **L** List of Surgery Risk Assessments

<table>
<thead>
<tr>
<th>List of Surgery Risk Assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. List of Incomplete Assessments</td>
</tr>
<tr>
<td>2. List of Completed Assessments</td>
</tr>
<tr>
<td>3. List of Transmitted Assessments</td>
</tr>
<tr>
<td>4. List of Non-Assessed Major Surgical Cases</td>
</tr>
<tr>
<td>5. List of All Major Surgical Cases</td>
</tr>
<tr>
<td>6. List of All Surgical Cases</td>
</tr>
<tr>
<td>7. List of Completed/Transmitted Assessments Missing Information</td>
</tr>
<tr>
<td>8. List of 1-Liner Cases Missing Information</td>
</tr>
<tr>
<td>9. List of Eligible Cases</td>
</tr>
<tr>
<td>10. List of Cases With No CPT Codes</td>
</tr>
<tr>
<td>11. Summary List of Assessed Cases</td>
</tr>
</tbody>
</table>

Select the Number of the Report Desired: (1-11): **9**

- **Start with Date:** 6 1 06 (JUN 01, 2006)
- **End with Date:** 6 30 07 (JUN 30, 2007)

Print which Eligible Cases?

1. Assessed Cases Only
2. Excluded Cases Only
3. Non-Assessed Cases only
4. All Cases

Select Number: (1-4): **1**

Print by Surgical Specialty? YES// <Enter>

Print report for ALL specialties? YES// NO NO

Print the Report for which Surgical Specialty: **GENERAL SURGERY 50**  GENERAL SURGERY

Do you want to print all divisions? YES// NO

1. MAYBERRY, NC
2. PHILADELPHIA, PA

Select Number: (1-2): **1**

Print the List of Assessments to which Device: **[Select Print Device]**

```
---printout follows---------------------
```
<table>
<thead>
<tr>
<th>CASE #</th>
<th>PATIENT</th>
<th>TYPE</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>10095</td>
<td>SURPATIENT, SEVENTY 000-00-0125</td>
<td>CARDIAC</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>JUN 04, 2006</td>
<td>CABG, REGRAFT</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

>>> Final CPT Coding is not complete.
CPT Codes: *33510, *33511

<table>
<thead>
<tr>
<th>CASE #</th>
<th>PATIENT</th>
<th>TYPE</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>10084</td>
<td>SURPATIENT, NINE 000-34-5555</td>
<td>CARDIAC</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>JUL 08, 2006</td>
<td>CABG</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CPT Codes: *33502, 11402

<table>
<thead>
<tr>
<th>CASE #</th>
<th>PATIENT</th>
<th>TYPE</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>10380</td>
<td>SURPATIENT, THREE 000-21-2453</td>
<td>NOT LOGGED</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>FEB 06, 2007</td>
<td>CORONARY ARTERY BYPASS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CPT Codes: NOT ENTERED

<table>
<thead>
<tr>
<th>CASE #</th>
<th>PATIENT</th>
<th>TYPE</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>10383</td>
<td>SURPATIENT, ONE 000-44-7629</td>
<td>NON-CARDIAC</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>FEB 08, 2007</td>
<td>STENT</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CPT Codes: NOT ENTERED

TOTAL FOR CARDIAC SURGERY: 4

<table>
<thead>
<tr>
<th>CASE #</th>
<th>PATIENT</th>
<th>TYPE</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>10061</td>
<td>SURPATIENT, FIFTEEN 666-98-1288</td>
<td>NON-CARDIAC</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>FEB 11, 2007</td>
<td>APPENDECTOMY, SPLENECTOMY</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

>>> Final CPT Coding is not complete.
CPT Codes: *44955, *38100

<table>
<thead>
<tr>
<th>CASE #</th>
<th>PATIENT</th>
<th>TYPE</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>10079</td>
<td>SURPATIENT, SEVENTY 000-00-0125</td>
<td>EXCLUDED</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>MAR 31, 2007</td>
<td>HERNIA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

>>> Final CPT Coding is not complete.
CPT Codes: *49521, *49521

TOTAL FOR GENERAL SURGERY: 2
Example 10: List of Cases With No CPT Codes

Select Surgery Risk Assessment Menu Option: L List of Surgery Risk Assessments

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

Select the Number of the Report Desired: (1-11): 10

Start with Date: 1 1 07 (JAN 01, 2007)
End with Date: T (JAN 23, 2008)

Print by Surgical Specialty ? YES// <Enter>
Print report for ALL specialties ? YES// <Enter>
Do you want to print all divisions? YES// <Enter>
Print the List of Assessments to which Device: HOME// [Select Print Device]

-------------------------------------------------------------------printout follows-------------------------------------------------------------------
<table>
<thead>
<tr>
<th>CASE #</th>
<th>PATIENT</th>
<th>TYPE</th>
<th>STATUS</th>
<th>OP DATE</th>
<th>OPERATION(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10429</td>
<td>SURPATIENT, TEN 666-12-3456</td>
<td>CARDIAC</td>
<td>COMPLETE</td>
<td>FEB 12, 2007</td>
<td>CABG</td>
</tr>
<tr>
<td>10420</td>
<td>SURPATIENT, F. 666-00-0804</td>
<td>CARDIAC</td>
<td>TRANSMITTED</td>
<td>FEB 12, 2007</td>
<td>CABG</td>
</tr>
<tr>
<td>10423</td>
<td>SURPATIENT, TWO 666-45-1982</td>
<td>CARDIAC</td>
<td>INCOMPLETE</td>
<td>MAR 12, 2007</td>
<td>cabg</td>
</tr>
<tr>
<td>10430</td>
<td>SURPATIENT, EIGHT 666-37-0555</td>
<td>CARDIAC</td>
<td>INCOMPLETE</td>
<td>MAR 18, 2007</td>
<td>CABG X3</td>
</tr>
<tr>
<td>10374</td>
<td>SURPATIENT, NINE 666-34-5555</td>
<td>NOT LOGGED</td>
<td>NO ASSESSMENT</td>
<td>MAY 10, 2007</td>
<td>CABG X 3</td>
</tr>
</tbody>
</table>

TOTAL FOR CARDIAC SURGERY: 5

TOTAL FOR ALL SPECIALTIES: 5
Example 11: Summary List of Assessed Cases

Select Surgery Risk Assessment Menu Option: List of Surgery Risk Assessments

List of Surgery Risk Assessments

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

Select the Number of the Report Desired: (1-11): 11

Start with Date: 01 01 08 (JAN 01, 2008)
End with Date: 01 30 08 (JAN 30, 2008)

Print by Surgical Specialty ? YES/<Enter>
Print report for ALL specialties ? YES/<Enter>

Do you want to print all divisions? YES// NO
1. ALBANY
2. PHILADELPHIA, PA

Select Number: (1-2): 1
Print the List of Assessments to which Device: HOME// [Select Print Device]
<table>
<thead>
<tr>
<th>SURGICAL SPECIALTY</th>
<th>INCOMPLETE</th>
<th>COMPLETE</th>
<th>TRANSMITTED</th>
<th>EXCLUDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARDIAC SURGERY</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>GENERAL SURGERY</td>
<td>17</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>NEUROSURGERY</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>OPHTHALMOLOGY</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ORTHOPEDICS</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>OTORHINOLARYNGOLOGY (ENT)</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PLASTIC SURGERY (INCLUDES HEAD TWO GENERAL)</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>UROLOGY</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL FOR ALL SPECIALTIES:</strong></td>
<td><strong>34</strong></td>
<td><strong>2</strong></td>
<td><strong>3</strong></td>
<td><strong>7</strong></td>
</tr>
</tbody>
</table>
M&M Verification Report
[SRO M&M VERIFICATION REPORT]

The M&M Verification Report option produces the M&M Verification Report, which may be useful for:

- reviewing occurrences and their assignment to operations
- reviewing death unrelated/related assignments to operations

The full report includes all patients who had operations within the selected date range who experienced intraoperative occurrences, postoperative occurrences or death within 90 days of surgery. The pre-transmission report is similar but includes operations with completed risk assessments that have not yet transmitted to the national database.

Full Report:

Information is printed by patient, listing all operations for the patient that occurred during the selected date range, plus any operations that may have occurred within 30 days prior to any postoperative occurrences or within 90 days prior to death. Therefore, this report may include some operations that were performed prior to the selected date range and, if printed by specialty, may include operations performed by other specialties. For every operation listed, the intraoperative and postoperative occurrences are listed. The report indicates if the operation was flagged as unrelated or related to death and the risk assessment type and status. The report may be printed for a selected list of surgical specialties.

Pre-Transmission Report:

Information is printed in a format similar to the full report. This report lists all completed risk assessed operations that have not yet transmitted to the national database and that have intraoperative occurrences, postoperative occurrences, or death within 90 days of surgery. The report includes any operations that may have occurred within 30 days prior to any postoperative occurrences or within 90 days prior to death. Therefore, this report may include some operations that may or may not be risk assessed, and, if risk assessed, may have a status other than 'complete'. However, every patient listed on this report will have at least one operation with a risk assessment status of 'complete'.

Example 1: Generate an M&M Verification Report (Full Report)

Select Surgery Risk Assessment Menu Option: V M&M Verification Report

The M&M Verification Report is a tool to assist in the review of occurrences and their assignment to operations and in the review of death unrelated or related assignments to operations.

The full report includes all patients who had operations within the selected date range who experienced intraoperative occurrences, postoperative occurrences or death within 90 days of surgery. The pre-transmission report is similar but includes only operations with completed risk assessments that have not yet transmitted to the national database.
Print which report?

1. Full report for selected date range.
2. Pre-transmission report for completed risk assessments.

Enter selection (1 or 2): 1/<Enter>

Start with Date: 03 01 07 (MAR 01, 2007)
End with Date: 03 30 07 (MAR 30, 2007)

Do you want to print all divisions? YES/<Enter>

Do you want to print this report for all Surgical Specialties? YES/<Enter>

This report is designed to use a 132 column format.

Print report on which Device: [Select Print Device]

---------------------------------------------------------printout follows--------------------------------------------------
### M&M Verification Report

**From:** MAR 1, 2007  **To:** MAR 30, 2007

**Report Generated:** APR 23, 2007

<table>
<thead>
<tr>
<th>OP DATE</th>
<th>CASE #</th>
<th>SURGICAL SPECIALTY</th>
<th>ASSESSMENT TYPE</th>
<th>STATUS</th>
<th>DEATH RELATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/01/07</td>
<td>10401</td>
<td>GENERAL SURGERY</td>
<td>NON-CARDIAC</td>
<td>TRANSMITTED</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>APPENDECTOMY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CPT Codes: 44970</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Occurrences: ACUTE RENAL FAILURE ** POSTOP ** (03/02/07)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>03/07/07</td>
<td>10421</td>
<td>GENERAL SURGERY</td>
<td>NON-CARDIAC</td>
<td>TRANSMITTED</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>APPENDECTOMY, CHolecystectomy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CPT Codes: 44950, 47610</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Occurrences: URINARY TRACT INFECTION ** POSTOP ** (03/09/07)</td>
<td>ACUTE RENAL FAILURE ** POSTOP ** (03/10/07)</td>
<td>OTHER RESPIRATORY OCCURRENCE ** POSTOP ** (03/10/07)</td>
<td>ICD: 478.25 EDema Pharynx/Nasopharyx</td>
</tr>
<tr>
<td>03/07/07</td>
<td>10422</td>
<td>NEUROSURGERY</td>
<td>NON-CARDIAC</td>
<td>TRANSMITTED</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>LAMENCTOMY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CPT Codes: 22630</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Occurrences: OTHER OCCURRENCE (03/07/07)</td>
<td>ICD: 415.19 OTH PULM EMB &amp; INFARC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>03/10/07</td>
<td>10100</td>
<td>GENERAL SURGERY</td>
<td>NON-CARDIAC</td>
<td>INCOMPLETE</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>REMOVAL OF GALLIBLADDER</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CPT Codes: 47600</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Occurrences: PULMONARY EMBOLISM ** POSTOP ** (03/10/07)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**

Patient complained of chest pain and shortness of breath. Heparin was administered immediately by IV.

**Date of Death:** 03/10/07@14:50

Review of Death Comments: Patient expired from large pulmonary embolus before anticoagulant treatment could take effect. Patient's obesity and prolonged immobilization were likely contributing factors.
Example 2: Generate an M&M Verification Report (Pre-Transmission Report)

Select Surgery Risk Assessment Menu Option: V  M&M Verification Report

The M&M Verification Report is a tool to assist in the review of occurrences and their assignment to operations and in the review of death unrelated or related assignments to operations.

The full report includes all patients who had operations within the selected date range who experienced intraoperative occurrences, postoperative occurrences or death within 90 days of surgery. The pre-transmission report is similar but includes only operations with completed risk assessments that have not yet transmitted to the national database.

Print which report?
1. Full report for selected date range.
2. Pre-transmission report for completed risk assessments.

Enter selection (1 or 2): 1// 2

Do you want to print all divisions? YES// <Enter>

Do you want to print this report for all Surgical Specialties? YES// <Enter>

This report is designed to use a 132 column format.

Print report on which Device: [Select Print Device]

---------------------------------------------------------printout follows--------------------------------------------------
<table>
<thead>
<tr>
<th>OP DATE</th>
<th>CASE #</th>
<th>SURGICAL SPECIALTY</th>
<th>ASSESSMENT TYPE</th>
<th>STATUS</th>
<th>DEATH RELATED</th>
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</thead>
<tbody>
<tr>
<td>09/21/07</td>
<td>45466</td>
<td>PLASTIC SURGERY</td>
<td>NON-CARDIAC</td>
<td>COMPLETE</td>
<td>N/A</td>
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<tr>
<td></td>
<td></td>
<td>RHINOPLASTY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CPT Codes: 30410</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Occurrences: DEEP INCISIONAL SSI ** POSTOP ** (09/23/07)</td>
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<tr>
<td>09/16/07</td>
<td>45475</td>
<td>EAR, NOSE, THROAT (ENT)</td>
<td>NON-CARDIAC</td>
<td>COMPLETE</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>LARYNGECTOMY (TOTAL)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
<td>CPT Codes: 31360</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Occurrences: BLEEDING/TRANSFUSIONS ** POSTOP ** (09/17/07)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt;&gt;&gt; Comments:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Esophageal varices were the source of bleeding.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>09/19/07</td>
<td>45499</td>
<td>GENERAL SURGERY</td>
<td>NON-CARDIAC</td>
<td>COMPLETE</td>
<td>N/A</td>
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<tr>
<td></td>
<td></td>
<td>INGUINAL HERNIA</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td>CPT Codes: 49505</td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Occurrences: URINARY TRACT INFECTION ** POSTOP ** (09/21/07)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(This page included for two-sided copying.)
Risk Model Lab Test
[SROA LAB TEST EDIT]

In order to assist the nurse reviewer, in the Surgery Risk Assessment Menu is the Risk Model Lab Test (Enter/Edit) option, which allows the nurse to map NSQIP-CICSP data in the RISK MODEL LAB TEST file (#139.2). The option synonym is ERM.

Risk Model Lab Test (Enter/Edit)

Select item to edit from list below:

1. ALBUMIN                     14. LDL
2. ALKALINE PHOSPHATASE        15. PLATELET COUNT
3. ANION GAP                   16. POTASSIUM
4. BUN                        17. PT
5. CHOLESTEROL                18. PTT
6. CPK                        19. SGOT
7. CPK-MB                     20. SODIUM
8. CREATININE                 21. TOTAL BILIRUBIN
9. HDL                        22. TRIGLYCERIDE
10. HEMATOCRIT                23. TROPONIN I
11. HEMOGLOBIN                24. TROPONIN T
12. HEMOGLOBIN A1C             25. WHITE BLOOD COUNT
13. INR

Enter number (1-25): 5

Risk Model Lab Test (Enter/Edit)

Test Name: CHOLESTEROL

Laboratory Data Name(s): NONE ENTERED

Specimen: SERUM

Do you want to edit this test? NO// YES

Select LABORATORY DATA NAME: CHOLESTEROL
  1  CHOLESTEROL
  2  CHOLESTEROL CRYSTALS

CHOOSE 1-2: 1  CHOLESTEROL

Select LABORATORY DATA NAME: <Enter>

Specimen: SERUM// <Enter>
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<td>3</td>
<td>ANION GAP</td>
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<td>4</td>
<td>BUN</td>
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<tr>
<td>5</td>
<td>CHOLESTEROL</td>
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<tr>
<td>6</td>
<td>CPK</td>
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<td>CPK-MB</td>
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<td>PT</td>
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<td>18</td>
<td>PTT</td>
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<tr>
<td>19</td>
<td>SGOT</td>
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<tr>
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<tr>
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<td>TOTAL BILIRUBIN</td>
</tr>
<tr>
<td>22</td>
<td>TRIGLYCERIDE</td>
</tr>
<tr>
<td>23</td>
<td>TROPONIN I</td>
</tr>
<tr>
<td>24</td>
<td>TROPONIN T</td>
</tr>
<tr>
<td>25</td>
<td>WHITE BLOOD COUNT</td>
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</table>

Enter number (1-25):
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