# 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.

<table>
<thead>
<tr>
<th>Date</th>
<th>Revised Pages</th>
<th>Patch Number</th>
<th>Description</th>
</tr>
</thead>
</table>

(Daniel Reed, PM; Starleigh Vetzel, Technical Writer)
<table>
<thead>
<tr>
<th>Date</th>
<th>Revised Pages</th>
<th>Patch Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/14</td>
<td>549, 549a, 551-556</td>
<td>SR<em>3</em>177</td>
<td>Updated examples to reflect ICD-10 Diagnosis Codes. Changed File Download Option 2 from “ICD9” to “ICD.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Made ICD-9 references generic to ICD.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Added ICD-10-CM Diagnosis Code Search.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Updated Warning Message to Surgeon.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Updated MailMan Messages for ICD-9 and ICD-10 codes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(K. Krause, VA)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Chapter Seven: “CoreFLS/Surgery Interface” has been removed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(T. Leggett, PM; B. Thomas, Tech Writer)</td>
</tr>
</tbody>
</table>
Chapter Two: Tracking Clinical Procedures

Introduction ........................................................................................................... 93
  Key Vocabulary .................................................................................................. 93
  Exiting an Option or the System ....................................................................... 94
  Option Overview ................................................................................................ 94

Operation Menu .................................................................................................... 95
  Using the Operation Menu Options .................................................................. 96
  Operation Information ....................................................................................... 103
  Surgical Staff [SROMEN-STAFF] ..................................................................... 104
  Operation Startup .............................................................................................. 108
  Operation ........................................................................................................... 113
  Post Operation ................................................................................................... 119
  Enter PAC(U) Information ................................................................................ 121
  Operation (Short Screen) .................................................................................. 122
  Time Out Verified Utilizing Checklist .............................................................. 125
  Surgeon’s Verification of Diagnosis & Procedures ............................................. 125
  Anesthesia for an Operation Menu .................................................................... 128
  Operation Report ............................................................................................... 129
  Anesthesia Report ............................................................................................. 131
  Nurse Intraoperative Report ............................................................................. 140
  Tissue Examination Report .............................................................................. 153
  Enter Referring Physician Information ............................................................ 154
  Enter Irrigations and Restraints ........................................................................ 155
  Medications (Enter/Edit) ................................................................................... 157
  Blood Product Verification ................................................................................ 158

Anesthesia Menu .................................................................................................... 160
  Prerequisites ....................................................................................................... 160
  Anesthesia Data Entry Menu ............................................................................ 161
  Anesthesia Information (Enter/Edit) ................................................................. 162
  Anesthesia Technique (Enter/Edit) ................................................................... 165
  Medications (Enter/Edit) .................................................................................. 169
  Anesthesia Report .............................................................................................. 170
  Schedule Anesthesia Personnel ....................................................................... 173

Perioperative Occurrences Menu .......................................................................... 175
  Key Vocabulary ................................................................................................ 175
  Intraoperative Occurrences (Enter/Edit) ............................................................ 176
  Postoperative Occurrences (Enter/Edit) ............................................................. 178
  Non-Operative Occurrence (Enter/Edit) ............................................................ 180
  Update Status of Returns Within 30 Days ......................................................... 181
  Morbidity & Mortality Reports .......................................................................... 183

Non-O.R. Procedures ............................................................................................. 187
  Non-O.R. Procedures (Enter/Edit) .................................................................... 188
  Edit Non-O.R. Procedure .................................................................................. 189
  Procedure Report (Non-O.R.) ........................................................................... 193
  Tissue Examination Report .............................................................................. 196
  Non-OR Procedure Information ........................................................................ 197
Chapter Six: Assessing Surgical Risk ................................................................. 441

- Introduction ........................................................................................................ 441
- Exiting an Option or the System ........................................................................ 441

Surgery Risk Assessment Menu ........................................................................... 443

Non-Cardiac Risk Assessment Information (Enter/Edit) ..................................... 445
- Creating a New Risk Assessment ....................................................................... 445
- Editing an Incomplete Risk Assessment .............................................................. 447
- Preoperative Information (Enter/Edit) ................................................................. 448
- Laboratory Test Results (Enter/Edit) ................................................................. 451
- Operation Information (Enter/Edit) ..................................................................... 455
- Patient Demographics (Enter/Edit) .................................................................. 457
- Intraoperative Occurrences (Enter/Edit) ............................................................. 459
- Postoperative Occurrences (Enter/Edit) ............................................................. 461
- Update Status of Returns Within 30 Days .......................................................... 463
- Update Assessment Status to ‘Complete’ ............................................................ 464
- Alert Coder Regarding Coding Issues ............................................................... 464

Cardiac Risk Assessment Information (Enter/Edit) ............................................ 465
- Creating a New Risk Assessment ....................................................................... 465
- Clinical Information (Enter/Edit) ...................................................................... 467
- Laboratory Test Results (Enter/Edit) ................................................................. 469
- Enter Cardiac Catheterization & Angiographic Data .......................................... 469
- Operative Risk Summary Data (Enter/Edit) ....................................................... 471
- Cardiac Procedures Operative Data (Enter/Edit) .............................................. 473
- Intraoperative Occurrences (Enter/Edit) ............................................................. 475
- Postoperative Occurrences (Enter/Edit) ............................................................. 477
- Resource Data (Enter/Edit) .............................................................................. 479
- Update Assessment Status to ‘COMPLETE’ ...................................................... 481
- Alert Coder Regarding Coding Issues ............................................................... 481

Print a Surgery Risk Assessment ......................................................................... 481

Update Assessment Completed/Transmitted in Error ........................................... 487

List of Surgery Risk Assessments ......................................................................... 489

Print 30 Day Follow-up Letters ............................................................................ 503

Exclusion Criteria (Enter/Edit) ............................................................................ 507

Monthly Surgical Case Workload Report .............................................................. 509

M&M Verification Report .................................................................................... 513

Update 1-Liner Case ............................................................................................. 519

Queue Assessment Transmissions ....................................................................... 521

Alert Coder Regarding Coding Issues ............................................................... 522

Risk Model Lab Test ............................................................................................. 522

Chapter Seven: Code Set Versioning ................................................................. 525
**Entering or Editing a Range of Data Elements**

Colons and semicolons are used as delineators for ranges of item numbers. This allows the user to respond to two or more data elements on the same page of a screen at one time. Typing a colon and/or semicolon between the item numbers at the prompt tells the software what elements to display for editing.

Colons are used when the user wants to respond to all numbers within a sequence (for example, 2:5 means items 2, 3, 4, and 5). Semicolons are used to separate the item numbers for non-sequential items (e.g., 2; 5; 9; 11 means items 2, 5, 9 and 11). To respond to all the data elements on the page, enter “A” for all.

**Example 1: Colon**

<table>
<thead>
<tr>
<th><strong>STARTUP</strong></th>
<th>CASE #24 SURPATIENT,TWO</th>
<th>PAGE 2 OF 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>PREOP CONSCIOUS:</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>PREOP SKIN INTEG:</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>TRANS TO OR BY:</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>HAIR REMOVAL BY:</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>HAIR REMOVAL METHOD:</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>HAIR REMOVAL COMMENTS:</td>
<td>(WORD PROCESSING)</td>
</tr>
<tr>
<td>7</td>
<td>FOLEY CATHETER INSERTED BY:</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>SKIN PREPARED BY (1):</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>SKIN PREPARED BY (2):</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>SKIN PREP AGENTS:</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>SECOND SKIN PREP AGENT:</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>SURGERY POSITION:</td>
<td>(MULTIPLE)</td>
</tr>
<tr>
<td>13</td>
<td>LATERALITY OF PROCEDURE:</td>
<td>LEFT</td>
</tr>
<tr>
<td>14</td>
<td>RESTR &amp; POSITION AIDS:</td>
<td>(MULTIPLE)</td>
</tr>
<tr>
<td>15</td>
<td>ELECTROGROUND POSITION:</td>
<td></td>
</tr>
</tbody>
</table>

Enter Screen Server Function: 1:4
Preoperative Consciousness: ALERT-ORIENTED AO
Preoperative Skin Integrity: INTACT I
Transported to O.R. By: STRETCHER
Preop Surgical Site Hair Removal by: SURNURSE, ONE OS

**Example 2: Semicolon**

<table>
<thead>
<tr>
<th><strong>STARTUP</strong></th>
<th>CASE #24 SURPATIENT,TWO</th>
<th>PAGE 1 OF 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>HEIGHT:</td>
<td>58 INCHES</td>
</tr>
<tr>
<td>2</td>
<td>WEIGHT:</td>
<td>264 LBS.</td>
</tr>
<tr>
<td>3</td>
<td>DATE OF OPERATION:</td>
<td>APR 19, 2006 AT 800</td>
</tr>
<tr>
<td>4</td>
<td>PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>PRINCIPAL PRE-OP ICD DIAGNOSIS CODE (ICD9):</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>OTHER PREOP DIAGNOSIS:</td>
<td>(MULTIPLE)</td>
</tr>
<tr>
<td>7</td>
<td>OP ROOM PROCEDURE PERFORMED: OR4</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>SURGERY SPECIALTY:</td>
<td>ORTHOPEDICS</td>
</tr>
<tr>
<td>9</td>
<td>PLANNED POSTOP CARE:</td>
<td>WARD</td>
</tr>
<tr>
<td>10</td>
<td>CASE SCHEDULE TYPE:</td>
<td>ELECTIVE</td>
</tr>
<tr>
<td>11</td>
<td>REQ ANESTHESIA TECHNIQUE:</td>
<td>GENERAL</td>
</tr>
<tr>
<td>12</td>
<td>PATIENT EDUCATION/ASSESSMENT: YES</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>DELAY CAUSE:</td>
<td>(MULTIPLE)</td>
</tr>
<tr>
<td>14</td>
<td>ASA CLASS:</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>PREOP MOOD:</td>
<td></td>
</tr>
</tbody>
</table>

Enter Screen Server Function: 7;9:
Operating Room Procedure Performed: OR4// OR2
Planned Postop Care: WARD//OUTPATIENT/DISCHARGE
At this prompt: | The user should do this:
---|---
Select REQ BLOOD KIND | Enter the type of blood product that will be needed for the operation.

The package coordinator can select a default response to this prompt when installing the package. If the default product is not what is wanted for a case, it can be deleted by entering the at-sign (@) at this prompt. The user can then select the preferred blood product (enter two question marks for a list of blood products).

If no blood products are needed, do not enter NO or NONE. Instead, press the <Enter> key to bypass this prompt.

To order more than one product for the same case, use the screen server summary that concludes the option and select item 9, REQ BLOOD KIND. This is a multiple field; as many blood products as needed may be entered.

Requested Preoperative X-Rays | Enter the types of preoperative x-ray films and reports required for delivery to the operating room before the operation. This field may be left blank if the user does not intend to order any x-ray products.

Preoperative Infection | Enter the letter code “C” for clean or “D” for contaminated or “S” for ‘SPECIAL CONSIDERATIONS’ or type in the first few letters of either word. This information allows the scheduling manager to determine how much time is needed between operations for sanitizing a room.
OPERATION REQUEST: BLOOD INFORMATION

SURPATIENT,TWENTY (000-45-4886)                                      DEC 1, 2004

Request Blood Availability ? YES// <Enter>

OPERATION REQUEST: OTHER INFORMATION

SURPATIENT,TWENTY (000-45-4886)                                      DEC 1, 2004

Principal Preoperative Diagnosis: CHOLELITHIASIS// <Enter>
Print Pre-OP ICD Diagnosis Code (ICD9): 574.01 574.01 CHOLELITH/AC GB INF-OBST (w C/C)
...OK? Yes// <Enter> (YES)
Palliation:
Pre-admission Testing Complete (Y/N):
Case Schedule Type: U URGENT
First Assistant: SURSURGEON,TWO
Second Assistant: <Enter>
Attending Surgeon:
Planned Postop Care: WARD W
Case Schedule Order: 1
Select SURGERY POSITION: SUPINE// <Enter>
Surgery Position: SUPINE// <Enter>
Requested Anesthesia Technique: GENERAL <Enter> GENERAL
Request Frozen Section Tests (Y/N): N NO
Requested Preoperative X-Rays: ABDOMIN
Intraoperative X-Rays (Y/N/C): N
Request Medical Media (Y/N): N
Preoperative Infection: CLEAN
Select REFERRING PHYSICIAN: <Enter>
General Comments: <Enter>
No existing text
Edit? NO// <Enter>
SPD Comments: <Enter>
No existing text
Edit? NO// <Enter>

After entering the request information, the Screen Server redisplay all fields, providing an opportunity to the user to update the information.
** REQUESTS **   CASE #227  SURPATIENT,TWENTY         PAGE 2 OF 3

1 ATTENDING SURGEON:  SURSURGEON,ONE  
2 PLANNED POSTOP CARE:  
3 CASE SCHEDULE ORDER:  1  
4 SURGERY POSITION:  (MULTIPLE)(DATA)  
5 REQ ANESTHESIA TECHNIQUE:  GENERAL  
6 REQ FROZ SECT:  NO  
7 REQ PREOP X-RAY:  ABDOMIN  
8 INTRAOPERATIVE X-RAYS:  NO  
9 REQUEST BLOOD AVAILABILITY:  YES  
10 CROSSMATCH, SCREEN, AUTOLOGOUS:  TYPE & CROSSMATCH  
11 REQ BLOOD KIND:  (MULTIPLE)(DATA)  
12 SPECIAL EQUIPMENT:  (MULTIPLE)  
13 PLANNED IMPLANT:  (MULTIPLE)  
14 SPECIAL SUPPLIES:  (MULTIPLE)  
15 SPECIAL INSTRUMENTS:  (MULTIPLE)  

Enter Screen Server Function:  <Enter>

** REQUESTS **   CASE #227  SURPATIENT,TWENTY         PAGE 3 OF 3

1 PHARMACY ITEMS:  (MULTIPLE)  
2 REQ PHOTO:  
3 PREOPERATIVE INFECTION:  
4 REFERRING PHYSICIAN:  (MULTIPLE)  
5 GENERAL COMMENTS:  (WORD PROCESSING)  
6 INDICATIONS FOR OPERATIONS:  (WORD PROCESSING)  
7 BRIEF CLIN HISTORY:  (WORD PROCESSING)  
8 SPD COMMENTS:  (WORD PROCESSING)  

Enter Screen Server Function:  <Enter>

A request has been made for SURPATIENT,TWENTY on 12-01-01.

Press RETURN to continue
Example 1: Delete a Request

Select Request Operations Option: D  Delete or Update Operation Requests
Select Patient:  SURPATIENT,NINE  12-09-51  000345555  NSC VETERAN

The following cases are requested for SURPATIENT,NINE:

1. 08-15-01  CHOLECYSTECTOMY
2. 09-15-01  Release of Hammer Toes

Select Operation Request: 2

1. Delete
2. Update Request Information
3. Change the Request Date

Select Number: 1

Are you sure that you want to delete this request?  YES//<Enter>

Deleting Operation ...

Press RETURN to continue

Example 2: Update Request Information

Select Request Operations Option: D  Delete or Update Operation Requests
Select Patient:  SURPATIENT,TWENTY  03-27-40  000454886

The following case is requested for SURPATIENT,TWENTY:

1. 12-01-01  CHOLECYSTECTOMY

1. Delete
2. Update Request Information
3. Change the Request Date

Select Number: 2

How long is this procedure?  (HOURS:MINUTES)  2:45 // 2:30

** UPDATE REQUEST **  CASE #227  SURPATIENT,TWENTY  PAGE 1 OF 3

1  PRINCIPAL PROCEDURE: CHOLECYSTECTOMY
2  OTHER PROCEDURES: (MULTIPLE)
3  PLANNED PRIN PROCEDURE CODE: 47480-66
4  LATERALITY OF PROCEDURE: (NA/ LEFT, RIGHT, BILATERAL)
5  PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS
6  PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9): 574.01
7  OTHER PREOP DIAGNOSIS: (MULTIPLE)
8  PALLIATION:
9  PLANNED ADMISSION STATUS: ADMISSION
10  PRE-ADMISSION TESTING:
11  CASE SCHEDULE TYPE: URGENT
12  SURGERY SPECIALTY:  GENERAL(OR WHEN NOT DEFINED BELOW)
13  PRIMARY SURGEON:  SURSURGEON,ONE
14  FIRST ASST:  SURSURGEON,TWO
15  SECOND ASST:  SURLSURGEON,THREE

Enter Screen Server Function: 15

Second Assistant:  SURSURGEON,THREE
** UPDATE REQUEST **   CASE #227  SURPATIENT,TWENTY   PAGE 1 OF 3

1  PRINCIPAL PROCEDURE: CHOLECYSTECTOMY
2  OTHER PROCEDURES: (MULTIPLE)
3  PLANNED PRIN PROCEDURE CODE: 47480-66
4  LATERALITY OF PROCEDURE: (NA/ LEFT, RIGHT, BILATERAL)
5  PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS
6  PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9): 574.01
7  OTHER PREOP DIAGNOSIS: (MULTIPLE)
8  PALLIATION:
9  PLANNED ADMISSION STATUS: ADMITTED
10  PRE-ADMISSION TESTING:
11  CASE SCHEDULE TYPE: URGENT
12  SURGERY SPECIALTY: GENERAL (OR WHEN NOT DEFINED BELOW)
13  PRIMARY SURGEON: SURSURGEON,ONE
14  FIRST ASST: SURSURGEON,TWO
15  SECOND ASST:

Enter Screen Server Function:  <Enter>

** UPDATE REQUEST **   CASE #227  SURPATIENT,TWENTY   PAGE 2 OF 3

1  ATTENDING SURGEON: SURSURGEON,ONE
2  PLANNED POSTOP CARE: WARD
3  CASE SCHEDULE ORDER: 1
4  SURGERY POSITION: (MULTIPLE) (DATA)
5  REQ ANESTHESIA TECHNIQUE: GENERAL
6  REQ FROZ SECT: NO
7  REQ PREOP X-RAY: ABDOMIN
8  INTRAOPERATIVE X-RAYS: NO
9  REQUEST BLOOD AVAILABILITY: YES
10  CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH
11  REQ BLOOD KIND: (MULTIPLE) (DATA)
12  SPECIAL EQUIPMENT: (MULTIPLE)
13  PLANNED IMPLANT: (MULTIPLE)
14  SPECIAL SUPPLIES: (MULTIPLE)
15  SPECIAL INSTRUMENTS: (MULTIPLE)

Enter Screen Server Function:  <Enter>

** UPDATE REQUEST **   CASE #227  SURPATIENT,TWENTY   PAGE 3 OF 3

1  PHARMACY ITEMS: (MULTIPLE)
2  REQ PHOTO:
3  PREOPERATIVE INFECTION:
4  REFERRING PHYSICIAN: (MULTIPLE)
5  GENERAL COMMENTS: (WORD PROCESSING)
6  INDICATIONS FOR OPERATIONS: (WORD PROCESSING)
7  BRIEF CLIN HISTORY: (WORD PROCESSING)
8  SPD COMMENTS: (WORD PROCESSING)

Enter Screen Server Function:  <Enter>

Example 3: Change the Request Date

Select Request Operations Option: D  Delete or Update Operation Requests
Select Patient:  SURPATIENT,TWENTY  03-27-40  000454886

The following case is requested for SURPATIENT,TWENTY:

1. 12-01-01  CHOLECYSTECTOMY

1. Delete
2. Update Request Information
3. Change the Request Date

Select Number: 3
Change to which Date? 11/30 (NOV 30, 2001)

The request for SURPATIENT,TWENTY has been changed to NOV 30, 2001.

Press RETURN to continue
** UPDATE REQUEST **   CASE #178  SURPATIENT,TWELVE     PAGE 1 OF 3

1 PRINCIPAL PROCEDURE: CAROTID ARTERY ENDARTERECTOMY
2 OTHER PROCEDURES:  (MULTIPLE)
3 PLANNED PRIN PROCEDURE CODE: 35301-59
4 LATERALITY OF PROCEDURE: (NA, LEFT, RIGHT, BILATERAL)
5 PRINCIPAL PRE-OP DIAGNOSIS:
6 PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9):
7 OTHER PREOP DIAGNOSIS:  (MULTIPLE)
8 PALLIATION:
9 PLANNED ADMISSION STATUS:
10 PRE-ADMISSION TESTING:
11 CASE SCHEDULE TYPE: STANDBY
12 SURGERY SPECIALTY:  PERIPHERAL VASCULAR
13 PRIMARY SURGEON:            SURSURGEON,ONE
14 FIRST ASST:
15 SECOND ASST:

Enter Screen Server Function:  5;6;10
Principal Preoperative Diagnosis:  CAROTID ARTERY STENOSIS
Prin Pre-OP ICD Diagnosis Code: 433.1 'C' CAROTID ARTERY OCCLUSION
COMPILATION/COMORBIDITY
...OK? YES// <Enter> (YES)

Pre-admission Testing Complete (Y/N):  YES  YES
Do you want to store this information in the concurrent case ?  YES// N

** UPDATE REQUEST **   CASE #178  SURPATIENT,TWELVE     PAGE 2 OF 3

1 ATTENDING SURGEON:        SURSURGEON,ONE
2 PLANNED POSTOP CARE: SICU
3 CASE SCHEDULE ORDER:  1
4 SURGERY POSITION:  (MULTIPLE)
5 REQ ANESTHESIA TECHNIQUE: GENERAL
6 REQ FROZ SECT: NO
7 REQ PREOP X-RAY:  DOPPLER STUDIES
8 INTRAOPERATIVE X-RAYS: NO
9 REQUEST BLOOD AVAILABILITY:
10 CROSSMATCH, SCREEN, AUTOLOGOUS:
11 REQ BLOOD KIND:  (MULTIPLE)
12 SPECIAL EQUIPMENT:  (MULTIPLE)
13 PLANNED IMPLANT:  (MULTIPLE)
14 SPECIAL SUPPLIES:  (MULTIPLE)
15 SPECIAL INSTRUMENTS:  (MULTIPLE)

Enter Screen Server Function: <Enter>
** UPDATE REQUEST ** CASE #229 SURPATIENT,TWELVE PAGE 3 OF 3

1. PHARMACY ITEMS: (MULTIPLE)
2. REQ PHOTO:
3. PREOPERATIVE INFECTION:
4. REFERRING PHYSICIAN: (MULTIPLE)
5. GENERAL COMMENTS: (WORD PROCESSING)
6. INDICATIONS FOR OPERATIONS: (WORD PROCESSING)
7. BRIEF CLIN HISTORY: (WORD PROCESSING)
8. SPD COMMENTS: (WORD PROCESSING)

Enter Screen Server Function:

**Example 6: Change the Request Date of Concurrent Cases**

Select Request Operations Option: D Delete or Update Operation Requests
Select Patient: SURPATIENT,FOUR 01-16-35 000170555 NSC VETERAN

The following cases are requested for SURPATIENT,FOUR:

1. 04-04-05 ARTHROSCOPY, RIGHT KNEE
2. 04-04-05 REMOVE MOLE
3. 06-01-05 CAROTID ARTERY ENDOARTERECTOMY
4. 06-01-05 AORTO CORONARY BYPASS GRAFT

Select Operation Request: 3

1. Delete
2. Update Request Information
3. Change the Request Date

Select Number: 3

Change to which Date? 6/2 (JUN 02, 2005)

There is a concurrent case associated with this operation. Do you want to change the date of it also? YES/?

Enter <Enter> if these cases will remain concurrent, or 'NO' if they will no longer be associated together.

There is a concurrent case associated with this operation. Do you want to change the date of it also? YES/ <Enter>

The request for SURPATIENT,FOUR has been changed to JUN 2, 2005.

Press RETURN to continue
Make a Request from the Waiting List

[SRSWREQ]

The Make a Request from the Waiting List option uses data from the Waiting List to make an operation request. It can save time by moving data from the Waiting List to the request (simultaneously removing it from the waiting list). As with any request, a date for the surgery is required.

After the user enters the patient name, the software will list any operations on the Waiting List for that patient. The user then selects the operative procedure wanted. The software will advise if the patient selected has any outstanding requests.

Each institution might have a daily cutoff time for entering requests. After the cutoff time for a particular day, the users are prohibited from booking a request for an operation to take place through midnight of that day.

When a request is made, the user is asked to provide preoperative information about the case. It is best to enter as much information as available.

Example: Making A Request From the Waiting List

Select Request Operations Option: W Make a Request from the Waiting List

Make a request from the waiting list for which patient? SURPATIENT, FOURTEEN 08-16-51 000457212

Procedures Entered on the Waiting List for SURPATIENT, FOURTEEN:

1. GENERAL (OR WHEN NOT DEFINED BELOW) Date Entered on List: NOV 17, 2005
   REPAIR DIAPHRAGMATIC HERNIA

Is this the correct procedure? YES/<Enter>

Make a request for which Date? 12/1 (DEC 01, 2005)

OPERATION REQUEST: REQUIRED INFORMATION

SURPATIENT, FOURTEEN (000-45-7212) DEC 1, 2005
======================================================================
Primary Surgeon: SURSURGEON, TWO
Attending Surgeon: SURSURGEON, TWO
Surgical Specialty: GENERAL (OR WHEN NOT DEFINED BELOW)
Principal Operative Procedure: REPAIR DIAPHRAGMATIC HERNIA
Principal Preoperative Diagnosis: ACUTE DIAPHRAGMATIC HERNIA

The information entered into the Principal Preoperative Diagnosis field has been transferred into the Indications for Operation field.
The Indications for Operation field can be updated later if necessary.

Press RETURN to continue <Enter>

Laterality Of Procedure: NA
Planned Admission Status: 1 SAME DAY
Planned Principal Procedure Code: 39540 REPAIR OF DIAPHRAGM HERNIA
REPAIR, DIAPHRAGMATIC HERNIA (OTHER THAN NEONATAL), TRAUMATIC; ACUTE
Modifier:
Sending a Notification of Appointment Booking for case #229

OPERATION REQUEST: PROCEDURE INFORMATION
Principal Procedure: REPAIR DIAPHRAGMATIC HERNIA
Planned Principal Procedure Code (CPT): 39540 REPAIR OF DIAPHRAGM HERNIA
REPAIR, DIAPHRAGMATIC HERNIA (OTHER THAN NEONATAL), TRAUMATIC; ACUTE
Estimated Case Length (HOURS:MINUTES): 2:00
BRIEF CLIN HISTORY:
1> Patient was reporting indigestion and a burning sensation in esophagus. Upper GI indicated hernia.
2> <Enter>
EDIT Option: <Enter>

OPERATION REQUEST: BLOOD INFORMATION
Request Blood Availability (Y/N): NO// <Enter>

OPERATION REQUEST: OTHER INFORMATION
Principal Preoperative Diagnosis: ACUTE DIAPHRAGMATIC HERNIA// <Enter>
Prin Pre-OP ICD Diagnosis Code (ICD9): 551.3
One match found

551.3     DIAPHRAGM HERNIA W GANGR (Major CC)

OK? Yes// <Enter> (YES) 551.3     DIAPHRAGM HERNIA W GANGR(Major CC) 551.3  ICD-9
DIAPHRAGM HERNIA W GANGR
Palliation: <Enter>
Pre-admission Testing Complete (Y/N): Y YES
Case Schedule Type: S STANDBY
First Assistant: SURSURGEON, ONE
Second Assistant: <Enter>
Planned Postop Care: WARD W
Case Schedule Order: <Enter>
Select SURGERY POSITION: SUPINE// <Enter>
Surgery Position: SUPINE// <Enter>
Requested Anesthesia Technique: G GENERAL
Requested Frozen Section Tests (Y/N): N NO
Requested Preoperative X-Rays: ABDOMEN
Intraoperative X-Rays (Y/N/C): N NO
Request Medical Media (Y/N): N NO
Preoperative Infection: C CLEAN
Select REFERRING PHYSICIAN: <Enter>
General Comments: <Enter>
No existing text
Edit? NO// <Enter>
SPD Comments: <Enter>
No existing text
Edit? NO// <Enter>
** REQUEST **   CASE #229  SURPATIENT,FOURTEEN          PAGE 1 OF 3

1. PRINCIPAL PROCEDURE: REPAIR DIAPHRAGMATIC HERNIA
2. OTHER PROCEDURES: (MULTIPLE)
3. PLANNED PRINCIPAL PROCEDURE CODE: 39540
4. LATERALITY OF PROCEDURE: (NA, RIGHT, LEFT, BILATERAL)
5. PRINCIPAL PRE-OP DIAGNOSIS: ACUTE DIAPHRAGMATIC HERNIA
6. PRINCIPAL PRE-OP ICD DIAGNOSIS CODE: 551.3
7. OTHER PREOP DIAGNOSIS: (MULTIPLE)
8. PALLIATION:
9. PLANNED ADMISSION STATUS: ADMITTED
10. PRE-ADMISSION TESTING: YES
11. CASE SCHEDULE TYPE: STANDBY
12. SURGERY SPECIALTY: GENERAL (OR WHEN NOT DEFINED BELOW)
13. PRIMARY SURGEON: SURSURGEON, TWO
14. FIRST ASST: SURSURGEON, ONE
15. SECOND ASST:

Enter Screen Server Function: <Enter>

** REQUEST **   CASE #229  SURPATIENT,FOURTEEN          PAGE 2 OF 3

1. ATTENDING SURGEON: SURSURGEON, TWO
2. PLANNED POSTOP CARE: WARD
3. CASE SCHEDULE ORDER:
4. SURGERY POSITION: (MULTIPLE) (DATA)
5. REQ ANESTHESIA TECHNIQUE: GENERAL
6. REQ FROZ SECT: NO
7. REQ PREOP X-RAY: ABDOMEN
8. INTRAOPERATIVE X-RAYS: NO
9. REQUEST BLOOD AVAILABILITY: NO
10. CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH
11. REQ BLOOD KIND: (MULTIPLE) (DATA)
12. SPECIAL EQUIPMENT: (MULTIPLE)
13. PLANNED IMPLANT: (MULTIPLE)
14. SPECIAL SUPPLIES: (MULTIPLE)
15. SPECIAL INSTRUMENTS: (MULTIPLE)

Enter Screen Server Function: <Enter>

** REQUEST **   CASE #229  SURPATIENT,FOURTEEN          PAGE 3 OF 3

1. PHARMACY ITEMS: (MULTIPLE)
2. REQ PHOTO: NO
3. PREOPERATIVE INFECTION: CLEAN
4. REFERRING PHYSICIAN: (MULTIPLE)
5. GENERAL COMMENTS: (WORD PROCESSING)
6. INDICATIONS FOR OPERATIONS: (WORD PROCESSING)
7. BRIEF CLIN HISTORY: (WORD PROCESSING) (DATA)
8. SPD COMMENTS: (WORD PROCESSING)

Enter Screen Server Function: <Enter>

A request has been made for SURPATIENT, FOURTEEN on 12/01/2005.

Press RETURN to continue
Example 1: Make a Request for Concurrent Cases

Select Request Operations Option: CC  Make a Request for Concurrent Cases

Request Concurrent Cases for which Patient?  SURPATIENT,TWELVE  02-12-28 000418719

Make a Request for Concurrent Cases on which Date?  12/1  (DEC 01, 1999)

FIRST CONCURRENT CASE
OPERATION REQUEST: REQUIRED INFORMATION

SURPATIENT,TWELVE (000-41-8719)                                     DEC 1, 2005
=================================================================
Primary Surgeon:  SURSURGEON,ONE
Attending Surgeon:  SURSURGEON,TWO
Surgical Specialty:  62  PERIPHERAL VASCULAR  PERIPHERAL VASCULAR  62
Principal Operative Procedure:  CAROTID ARTERY ENDARTERECTOMY
Principal Preoperative Diagnosis:  CAROTID ARTERY STENOSIS

The information entered into the Principal Preoperative Diagnosis field has been transferred into the Indications for Operation field. The Indications for Operation field can be updated later if necessary.

Press RETURN to continue <Enter>

Laterality Of Procedure:  NA
Planned Admission Status:  SAME DAY
Planned Principal Procedure Code:  35526  REPAIR OF ANOMALOUS CORONARY ARTERY FROM PULMONARY ARTERY ORIGIN; BY LIGATION
Modifier:  Sending a Notification of Appointment Booking for case #230

SECOND CONCURRENT CASE
OPERATION REQUEST: REQUIRED INFORMATION

SURPATIENT,TWELVE (000-41-8719)                                     DEC 1, 2005
=================================================================
Primary Surgeon:  SURSURGEON,TWO
Attending Surgeon:  SURSURGEON,ONE
Surgical Specialty:  58  THORACIC SURGERY (INC. CARDIAC SURG.)  THORACIC SURGERY (INC. CARDIAC SURG.)  58
Principal Operative Procedure:  AORTO CORONARY BYPASS GRAFT
Principal Preoperative Diagnosis:  CORONARY ARTERY DISEASE

The information entered into the Principal Preoperative Diagnosis field has been transferred into the Indications for Operation field. The Indications for Operation field can be updated later if necessary.

Press RETURN to continue <Enter>

Laterality Of Procedure:  NA
Planned Admission Status:  SAME DAY
Planned Principal Procedure Code:  35526  ARTERY BYPASS GRAFT  BYPASS GRAFT, WITH VIEN; AORTOSUBCLAVIAN, AORTOINNOMINATE, OR AORTOCAROTID
Modifier:  

46
Surgery V. 3.0 User Manual
November 2015
## SECOND CONCURRENT CASE
**OPERATION REQUEST: PROCEDURE INFORMATION**

<table>
<thead>
<tr>
<th>SURPATIENT, TWELVE (000-41-8719)</th>
<th>DEC 1, 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principal Procedure: AORTO CORONARY BYPASS GRAFT</td>
<td></td>
</tr>
<tr>
<td>Planned Principal Procedure Code (CPT): <strong>35526</strong> ARTERY BYPASS GRAFT</td>
<td></td>
</tr>
<tr>
<td>Modifier: -66 SURGICAL TEAM</td>
<td></td>
</tr>
<tr>
<td>Select OTHER PROCEDURE: &lt;Enter&gt;</td>
<td></td>
</tr>
<tr>
<td>Estimated Case Length (HOURS:MINUTES): 3:30</td>
<td></td>
</tr>
<tr>
<td><strong>BRIEF CLIN HISTORY:</strong></td>
<td></td>
</tr>
<tr>
<td>1&gt; CARDIAC CATH SHOWS 80% OCCLUSION OF THE LAD, 75% OCCLUSION OF</td>
<td></td>
</tr>
<tr>
<td>2&gt; RIGHT CORONARY. ALSO, ANTERIOR INFERIOR HYPOKINESIS WITH</td>
<td></td>
</tr>
<tr>
<td>3&gt; POOR LEFT VENTRICULAR FUNCTION, 27%.</td>
<td></td>
</tr>
<tr>
<td>4&gt; &lt;Enter&gt;</td>
<td></td>
</tr>
<tr>
<td><strong>EDIT Option:</strong> &lt;Enter&gt;</td>
<td></td>
</tr>
</tbody>
</table>

## SECOND CONCURRENT CASE
**OPERATION REQUEST: BLOOD INFORMATION**

<table>
<thead>
<tr>
<th>SURPATIENT, TWELVE (000-41-8719)</th>
<th>DEC 1, 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Request Blood Availability ? N// <strong>YES</strong></td>
<td></td>
</tr>
<tr>
<td>Type and Crossmatch, Screen, or Autologous ? TYPE &amp; CROSSMATCH// &lt;Enter&gt; TYPE &amp; CROSSMATCH</td>
<td></td>
</tr>
<tr>
<td>Select REQ BLOOD KIND: CPDA-1 WHOLE BLOOD// @</td>
<td></td>
</tr>
<tr>
<td>SURE YOU WANT TO DELETE THE ENTIRE REQ BLOOD KIND? Y (YES)</td>
<td></td>
</tr>
<tr>
<td>Select REQ BLOOD KIND: 04061 CPDA-1 RED BLOOD CELLS, DIVIDED UNIT 04061</td>
<td></td>
</tr>
<tr>
<td>Units Required: 4</td>
<td></td>
</tr>
</tbody>
</table>

## SECOND CONCURRENT CASE
**OPERATION REQUEST: OTHER INFORMATION**

<table>
<thead>
<tr>
<th>SURPATIENT, TWELVE (000-41-8719)</th>
<th>DEC 1, 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Principal Preoperative Diagnosis:</strong> CORONARY ARTERY DISEASE</td>
<td></td>
</tr>
<tr>
<td>Replace &lt;ENTER&gt;</td>
<td></td>
</tr>
<tr>
<td>Prin Pre-OP ICD Diagnosis Code (ICD9): <strong>996.03</strong></td>
<td></td>
</tr>
<tr>
<td>One match found</td>
<td></td>
</tr>
<tr>
<td>996.03 MALFUNC CORON BYPASS GRF(CC)</td>
<td></td>
</tr>
<tr>
<td>...OK? YES// &lt;Enter&gt; (YES) 996.03 MALFUNC CORON BYPASS GRF(CC) 996.03 ICD-9 MAL</td>
<td></td>
</tr>
<tr>
<td>FUNC CORON BYPASS GRF</td>
<td></td>
</tr>
<tr>
<td>Palliation: <strong>NO</strong></td>
<td></td>
</tr>
<tr>
<td>Pre-admission Testing Complete (Y/N): Y YES</td>
<td></td>
</tr>
<tr>
<td>Do you want to store this information in the concurrent case? <strong>YES</strong>// &lt;Enter&gt;</td>
<td></td>
</tr>
<tr>
<td>Case Schedule Type: <strong>S</strong> STANDBY</td>
<td></td>
</tr>
<tr>
<td>Do you want to store this information in the concurrent case? <strong>YES</strong>// &lt;Enter&gt;</td>
<td></td>
</tr>
<tr>
<td>First Assistant: <strong>SURGERON,SIX</strong></td>
<td></td>
</tr>
<tr>
<td>Second Assistant: &lt;Enter&gt;</td>
<td></td>
</tr>
<tr>
<td>Attending Surgeon: <strong>SURGERON,ONE</strong>// &lt;Enter&gt;</td>
<td></td>
</tr>
<tr>
<td>Planned Postop Care: ICU I</td>
<td></td>
</tr>
<tr>
<td>Case Schedule Order: <strong>2</strong></td>
<td></td>
</tr>
<tr>
<td>Do you want to store this information in the concurrent case? <strong>YES</strong>// <strong>N</strong></td>
<td></td>
</tr>
<tr>
<td>Select SURGERY POSITION: SUPINE// &lt;Enter&gt;</td>
<td></td>
</tr>
<tr>
<td>Surgery Position: SUPINE// &lt;Enter&gt;</td>
<td></td>
</tr>
</tbody>
</table>
Requested Anesthesia Technique: **GENERAL**

Do you want to store this information in the concurrent case?  YES// <Enter>

Request Frozen Section Tests (Y/N): N NO
Do you want to store this information in the concurrent case?  YES// <Enter>

Requested Preoperative X-Rays: **DOPPLER STUDIES**
Do you want to store this information in the concurrent case?  YES// N

Intraoperative X-Rays (Y/N): N NO
Do you want to store this information in the concurrent case?  YES// <Enter>

Request Medical Media (Y/N): N NO
Do you want to store this information in the concurrent case?  YES// <Enter>

Preoperative Infection: C CLEAN
Select REFERRING PHYSICIAN: <Enter>

General Comments: <Enter>
  No existing text
  Edit? NO// <Enter>

SPD Comments: <Enter>
  No existing text
  Edit? NO// <Enter>

The information to be duplicated in the concurrent case will now be entered....

Sending a Notification of Appointment Modification for case #231
Press RETURN to continue

** REQUESTS **  CASE #231  SURPATIENT,TWELVE  PAGE 1 OF 3
1  PRINCIPAL PROCEDURE:  AORTO CORONARY BYPASS GRAFT
2  OTHER PROCEDURES:  (MULTIPLE)
3  PLANNED PRINCIPAL PROCEDURE CODE: 35526-66
4  LATERALITY OF PROCEDURE:
5  PRINCIPAL PRE-OP DIAGNOSIS:  CORONARY ARTERY DISEASE
6  PRINCIPAL PRE-OP ICD DIAGNOSIS CODE (ICD9): 996.03
7  OTHER PREOP DIAGNOSIS:  (MULTIPLE)
8  PALLIATION:  NO
9  PLANNED ADMISSION STATUS:  ADMITTED
10  PRE-ADMISSION TESTING:
11  CASE SCHEDULE TYPE:  STANDBY
12  SURGERY SPECIALTY:  THORACIC SURGERY (INC. CARDIAC SURG.)
13  PRIMARY SURGEON:  SURSURGEON,TWO
14  FIRST ASST:  SURSURGEON,SIX
15  SECOND ASST:

Enter Screen Server Function:  <Enter>

** REQUESTS **  CASE #231  SURPATIENT,TWELVE  PAGE 2 OF 3
1  ATTENDING SURGEON:  SURSURGEON,TWO
2  PLANNED POSTOP CARE:  ICU
3  CASE SCHEDULE ORDER:  2
4  SURGERY POSITION:  (MULTIPLE)(DATA)
5  REQ ANESTHESIA TECHNIQUE:  GENERAL
6 REQ FROZ SECT: NO
7  REQ PREOP X-RAY:  DOPPLER STUDIES
8  INTRAOPERATIVE X-RAYS:  NO
9  REQUEST BLOOD AVAILABILITY: YES
10  CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH
11  REQ BLOOD KIND:  (MULTIPLE)(DATA)
12  SPECIAL EQUIPMENT:  (MULTIPLE)
13  PLANNED IMPLANT:  (MULTIPLE)
14  SPECIAL SUPPLIES:  (MULTIPLE)
15  SPECIAL INSTRUMENTS:  (MULTIPLE)

Enter Screen Server Function:  <Enter>
Example 2: Update Request Information for a Concurrent Case

Select Request Operations Option: D Delete or Update Operation Requests
Select Patient: SURPATIENT,TWELVE 02-12-28 000418719

The following cases are requested for SURPATIENT,TWELVE:
1. 03-09-05 REMOVE FACIAL LESIONS
2. 12-01-05 CAROTID ARTERY ENDARTERECTOMY
3. 12-01-05 AORTO CORONARY BYPASS GRAFT

Select Operation Request: 2
1. Delete
2. Update Request Information
3. Change the Request Date
Select Number: 2

How long is this procedure? (HOURS:MINUTES) // 1:30

** UPDATE REQUEST ** CASE #230 SURPATIENT,TWELVE PAGE 1 OF 3

** UPDATE REQUEST ** CASE #230 SURPATIENT,TWELVE PAGE 1 OF 3

Enter Screen Server Function: 6
Prin Pre-OP ICD Diagnosis Code (ICD9): 433.1

One match found
433.1 CAROTID ARTERY OCCLUSION COMPLICATION/COMORBIDITY

...OK? YES// <Enter> (YES)
** UPDATE REQUEST **   CASE #230  SURPATIENT,TWELVE        PAGE 2 OF 3

1  ATTENDING SURG:           SURSURGEON,TWO
2  PLANNED POSTOP CARE:
3  CASE SCHEDULE ORDER:
4  SURGERY POSITION:        (MULTIPLE)
5  REQ ANESTHESIA TECHNIQUE: GENERAL
6  REQ FROZ SECT:      NO
7  REQ PREOP X-RAY:
8  INTRAOPERATIVE X-RAYS: NO
9  REQUEST BLOOD AVAILABILITY:
10 CROSSMATCH, SCREEN, AUTOLOGOUS:
11 REQ BLOOD KIND:        (MULTIPLE)
12 SPECIAL EQUIPMENT:      (MULTIPLE)
13 PLANNED IMPLANT:        (MULTIPLE)
14 SPECIAL SUPPLIES:       (MULTIPLE)
15 SPECIAL INSTRUMENTS:    (MULTIPLE)

Enter Screen Server Function: <Enter>

** UPDATE REQUEST **   CASE #230  SURPATIENT,TWELVE        PAGE 3 OF 3

1  PHARMACY ITEMS:         (MULTIPLE)
2  REQ PHOTO:              NO
3  PREOPERATIVE INFECTION:
4  REFERRING PHYSICIAN:   (MULTIPLE)
5  GENERAL COMMENTS:       (WORD PROCESSING)
6  INDICATIONS FOR OPERATIONS: (WORD PROCESSING) (DATA)
7  BRIEF CLIN HISTORY:     (WORD PROCESSING)
8  SPD COMMENTS:          (WORD PROCESSING)

Enter Screen Server Function:
Review Request Information
[SROREQV]

Surgeons and nurses use the Review Request Information option to edit or review the preoperative information that was entered when the case was requested. This option can be accessed after the case has been scheduled.

Example: Review Request Information

Select Request Operations Option: V Review Request Information
Select Patient: SURPATIENT,ONE 02-23-53 000447629

SURPATIENT,ONE
1. 03-09-99 REVISE MEDIAN NERVE (REQUESTED)

Select Operation: 1

** REVIEW REQUEST **  CASE #35 SURPATIENT,ONE  PAGE 1 OF 2

1 PRINCIPAL PROCEDURE: REVISE MEDIAN NERVE
2 OTHER PROCEDURES: (MULTIPLE)
3 PLANNED PRINCIPAL PROCEDURE CODE: 64721
4 LATERALITY OF PROCEDURE: NA
5 PRINCIPAL PRE-OP DIAGNOSIS: CARPAL TUNNEL SYNDROME
6 PRINCIPAL PRE-OP ICD DIAGNOSIS CODE (ICD9): 354.0
7 OTHER PREOP DIAGNOSIS: (MULTIPLE)
8 PLANNED ADMISSION STATUS: ADMITTED
9 CASE SCHEDULE TYPE: ELECTIVE
10 SURGERY SPECIALTY: ORTHOPEDICS
11 PRIMARY SURGEON: SURsurgeon,ONE
12 FIRST ASST: Sursurgeon,THREE
13 SECOND ASST: Sursurgeon,TWO
14 ATTENDING SURGEON: Sursurgeon,ONE
15 PLANNED POSTOP CARE: ICU

Enter Screen Server Function: <Enter>

** REVIEW REQUEST **  CASE #35 SURPATIENT,ONE  PAGE 2 OF 2

1 CASE SCHEDULE ORDER:
2 SURGERY POSITION: (MULTIPLE)(DATA)
3 REQ ANESTHESIA TECHNIQUE: GENERAL
4 REQ FROZ SECT:
5 REQ PREOP X-RAY: CARPAL TUNNEL, R WRIST
6 INTRAOPERATIVE X-RAYS:
7 REQUEST BLOOD AVAILABILITY: NO
8 CROSSMATCH, SCREEN, AUTOLOGOUS:
9 REQ BLOOD KIND: (MULTIPLE)
10 REQ PHOTO:
11 PREOPERATIVE INFECTION: CLEAN
12 REFERRING PHYSICIAN: (MULTIPLE)
13 GENERAL COMMENTS: (WORD PROCESSING)
14 INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)

Enter Screen Server Function:
### Entering Preoperative Information

<table>
<thead>
<tr>
<th>At this prompt:</th>
<th>The user should do this:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Principal Procedure Code (CPT)</td>
<td>Enter the Current Procedural Terminology (CPT) identifying code for each procedure. If the code number is not known, the user can enter the type of operation (i.e., appendectomy) or a body organ and select from a list of codes.</td>
</tr>
<tr>
<td>Principal Preoperative Diagnosis</td>
<td>Type in the reason this procedure is being performed. The user must enter information into this field prompt before the option can be completed. The information entered in this field will automatically populate the Indications for Operations field, which can be edited through the Screen Server.</td>
</tr>
<tr>
<td>Brief Clinical History</td>
<td>Enter any information relevant to the specimens being sent to the laboratory. This is an open-text word-processing field. This information will display on the Tissue Examination Report.</td>
</tr>
<tr>
<td>Select REQ BLOOD KIND</td>
<td>Enter the type of blood product needed for the operation. If no blood products are needed, do not enter NO or NONE; instead, press the &lt;Enter&gt; key to bypass this prompt.</td>
</tr>
<tr>
<td></td>
<td>The package coordinator at each facility can select a default response to this prompt when installing the package. If the default product is not what is wanted for a case, it can be deleted by entering the at-sign (@) at this prompt. Then, the user can select the preferred blood product. (Enter two question marks for a list of blood products.)</td>
</tr>
<tr>
<td></td>
<td>To order more than one product for the same case, use the screen server summary that concludes the option. On page two of the summary, select item 7, REQ BLOOD KIND, to enter as many blood products as needed.</td>
</tr>
<tr>
<td>Requested Preoperative X-Rays</td>
<td>Enter the types of preoperative x-ray films and reports required for delivery to the operating room before the operation. If the user does not intend to order any x-ray products, this field should be left blank.</td>
</tr>
<tr>
<td>Preoperative Infection</td>
<td>Enter the letter code “C” for clean or “D” for contaminated or “S” for ‘SPECIAL CONSIDERATIONS’ or type in the first few letters of either word. This information allows the scheduling manager to determine how much time is needed between operations for sanitizing a room.</td>
</tr>
</tbody>
</table>
SCHEDULE UNREQUESTED OPERATION: BLOOD INFORMATION

SURPATIENT, THREE (000-21-2453)                  JUL 18, 2005

Request Blood Availability (Y/N): Y//<Enter> YES

Type and Crossmatch, Screen, or Autologous: TYPE & CROSSMATCH// <Enter> TYPE & CROSSMATCH

Select REQ BLOOD KIND: CPDA-1 WHOLE BLOOD//

SURE YOU WANT TO DELETE THE ENTIRE REQ BLOOD KIND? Y (YES)

Select REQ BLOOD KIND: FA1 FRESH FROZEN PLASMA, CPDA-1 18201

Units Required: 4

SCHEDULE UNREQUESTED OPERATION: OTHER INFORMATION

SURPATIENT, THREE (000-21-2453)                  JUL 18, 2005

Prin Pre-OP ICD Diagnosis Code: 715.11 715.11 LOC PRIM OSTEOART-SHLDER

...OK? YES//<Enter> (YES)

Hospital Admission Status: 2 ADMISSION

Case Schedule Type: S STANDBY

First Assistant: TS SURSURGEON, THREE

Second Assistant: SURSURGEON, FOUR

Requested Postoperative Care: W WARD

Case Schedule Order: 1

Requested Anesthesia Technique: G GENERAL

Request Frozen Section Tests (Y/N): N NO

Requested Preoperative X-Rays: LEFT SHOULDER

Intraoperative X-Rays (Y/N/C): Y YES

Request Medical Media (Y/N): N NO

Preoperative Infection: C CLEAN

GENERAL COMMENTS:

1><Enter>

SPD Comments:

1><Enter>

** SCHEDULING ** CASE #264 SURPATIENT, THREE PAGE 1 OF 2

1   PRINCIPAL PROCEDURE: SHOULDER ARTHROPLASTY-PROSTHESIS
2   PLANNED PRIN PROCEDURE CODE: 23470
3   OTHER PROCEDURES: (MULTIPLE)
4   PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE, L SHOULDER
5   PRIN PRE-OP ICD DIAGNOSIS CODE: 715.11
6   OTHER PREOP DIAGNOSIS: (MULTIPLE)
7   HOSPITAL ADMISSION STATUS: ADMISSION
8   PRE-ADMISSION TESTING:
9   CASE SCHEDULE TYPE: STANDBY
10  SURGERY SPECIALTY: ORTHOPEDICS
11  PRIMARY SURGEON: SURSURGEON, ONE
12  FIRST ASST: SURSURGEON, THREE
13  SECOND ASST: SURSURGEON, FOUR
14  ATTENDING SURGEON: SURSURGEON, TWO
15  PLANNED POSTOP CARE: WARD

Enter Screen Server Function: <Enter>
** SCHEDULING **   CASE #264  SURPATIENT,THREE

1    CASE SCHEDULE ORDER: 1
2    REQ ANESTHESIA TECHNIQUE: GENERAL
3    REQ FROZ SECT:      NO
4    REQ PREOP X-RAY:    LEFT SHOULDER
5    INTRAOPERATIVE X-RAYS: YES
6    REQUEST BLOOD AVAILABILITY: YES
7    CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH
8    REQ BLOOD KIND:      (MULTIPLE) (DATA)
9    SPECIAL EQUIPMENT:   (MULTIPLE)
10   PHARMACY ITEMS:       (MULTIPLE)
11   REQ PHOTO:            NO
12   PREOPERATIVE INFECTION: CLEAN
13   PRINC ANESTHETIST:   SURANESTHETIST, ONE
14   ANESTHESIOLOGIST SUPVR: SURSURGEON, TWO
15   BRIEF CLIN HISTORY:   (WORD PROCESSING) (DATA)
16   GENERAL COMMENTS:     (WORD PROCESSING)
1    SPD COMMENTS:         (WORD PROCESSING)

Enter Screen Server Function:
FIRST CONCURRENT CASE
SCHEDULE UNREQUESTED OPERATION: OTHER INFORMATION

SURPATIENT,EIGHT (000-37-0555) JUL 25, 1999

--------------------------------------------------------------------------------
Prin Pre-OP ICD Diagnosis Code: 433.11 OCCL&STEN/CAR ART W/CRB INF
COMPLICATION/COMORBIDITY ACTI
Hospital Admission Status: 2 ADMISSION
Do you want to store this information in the concurrent case? YES// N

Case Schedule Type: S STANDBY
Do you want to store this information in the concurrent case? YES// <Enter>

First Assistant: SURSURGEON,FOUR
Second Assistant: TS SURSURGEON,THREE
Requested Postoperative Care: SICU
Do you want to store this information in the concurrent case? YES// N

Case Schedule Order: 2
Do you want to store this information in the concurrent case? YES// N

Requested Anesthesia Technique: G GENERAL
Do you want to store this information in the concurrent case? YES// <Enter>

Request Frozen Section Tests (Y/N): N NO
Do you want to store this information in the concurrent case? YES// <Enter>

Requested Preoperative X-Rays: DOPPLER STUDIES
Do you want to store this information in the concurrent case? YES// N

Intraoperative X-Rays (Y/N/C): N NO
Do you want to store this information in the concurrent case? YES// N

Request Medical Media (Y/N): N NO
Do you want to store this information in the concurrent case? YES// Y

Preoperative infection: C CLEAN
Do you want to store this information in the concurrent case? YES// <Enter>

GENERAL COMMENTS:
1> <Enter>
SPD Comments:
1> <Enter>

The information to be duplicated in the concurrent case will now be entered....

Press RETURN to continue <Enter>
** SCHEDULING **   CASE #265  SURPATIENT,EIGHT      PAGE 1 OF 2

1 PRINCIPAL PROCEDURE: CAROTID ARTERY ENDARTERECTOMY
2 PLANNED PRIN PROCEDURE CODE: 35301
3 OTHER PROCEDURES:  (MULTIPLE)
4 PRINCIPAL PRE-OP DIAGNOSIS: CAROTID ARTERY STENOSIS
5 PRIN PRE-OP ICD DIAGNOSIS CODE: 433.1
6 OTHER PREOP DIAGNOSIS: (MULTIPLE)
7 HOSPITAL ADMISSION STATUS: ADMISSION
8 PRE-ADMISSION TESTING:
9 CASE SCHEDULE TYPE: STANDBY
10 SURGERY SPECIALTY: PERIPHERAL VASCULAR
11 PRIMARY SURGEON:  SURSURGEON,ONE
12 FIRST ASST:         SURSURGEON,FOUR
13 SECOND ASST:        SURSURGEON,THREE
14 ATTENDING SURG:      SURSURGEON,ONE
15 PLANNED POSTOP CARE: SICU

** SCHEDULING **   CASE #265  SURPATIENT,EIGHT      PAGE 2 OF 2

1 CASE SCHEDULE ORDER: 2
2 REQ ANESTHESIA TECHNIQUE: GENERAL
3 REQ FROZ SECT: NO
4 REQ PREOP X-RAY:  DOPPLER STUDIES
5 INTRAOPERATIVE X-RAYS: NO
6 REQUEST BLOOD AVAILABILITY: YES
7 CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH
8 REQ BLOOD KIND:  (MULTIPLE)(DATA)
9 PHARMACY ITEMS:  (MULTIPLE)
10 Req PHOTO: NO
11 PREOPERATIVE INFECTION: CLEAN
12 PRINC ANESTHETIST:  SURANESTHETIST,ONE
13 ANESTHESIOLOGIST SUPVR: SURANESTHETIST, TWO
14 BRIEF CLIN HISTORY:  (WORD PROCESSING)
15 GENERAL COMMENTS:  (WORD PROCESSING)

Enter Screen Server Function:  <Enter>
SECOND CONCURRENT CASE
SCHEDULE UNREQUESTED OPERATION: OTHER INFORMATION
SURPATIENT, SIX (000-09-8797) SEP 16, 2005

Prin Pre-OP ICD Diagnosis Code: 715.90 715.90 OSTEOARTROS NOS-UNSPEC
ACTIVE ...OK? Yes// <Enter> (Yes)
(Hospital Admission Status: 2 ADMISSION
Do you want to store this information in the concurrent case? YES// N
Case Schedule Type: S STANDBY
Do you want to store this information in the concurrent case? YES// N
First Assistant: TS SURGEON, THREE
Second Assistant: <Enter>
Requested Postoperative Care: WARD
Do you want to store this information in the concurrent case? YES// N
Case Schedule Order: 1
Do you want to store this information in the concurrent case? YES// N
Requested Anesthesia Technique: GENERAL
Do you want to store this information in the concurrent case? YES// <Enter>
Request Frozen Section Tests (Y/N): N NO
Do you want to store this information in the concurrent case? YES// <Enter>
Requested Preoperative X-Rays: <Enter>
Intraoperative X-Rays (Y/N): Y YES
Do you want to store this information in the concurrent case? YES// N
Request Medical Media (Y/N): N NO
Do you want to store this information in the concurrent case? YES// <Enter>
Preoperative Infection: C CLEAN
Do you want to store this information in the concurrent case? YES// <Enter>

GENERAL COMMENTS:
1> <Enter>
SPD Comments:
1> <Enter>

The information to be duplicated in the concurrent case will now be entered....
** SCHEDULING **   CASE #245  SURPATIENT,SIX   PAGE 1 OF 2

1 PRINCIPAL PROCEDURE: ARTHROSCOPY, R SHOULDER
2 PLANNED PRIN PROCEDURE CODE: 23470
3 OTHER PROCEDURES: (MULTIPLE)
4 PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE OSTEOARTHRITIS
5 PRIN PRE-OP ICD DIAGNOSIS CODE: 715.90
6 OTHER PREOP DIAGNOSIS: (MULTIPLE)
7 HOSPITAL ADMISSION STATUS: ADMISSION
8 PRE-ADMISSION TESTING:
9 CASE SCHEDULE TYPE: STANDBY
10 SURGERY SPECIALTY: ORTHOPEDICS
11 PRIMARY SURGEON: SURSURGEON,TWO
12 FIRST ASST: SURSURGEON,THREE
13 SECOND ASST:
14 ATTENDING SURGEON: SURSURGEON,TWO
15 PLANNED POSTOP CARE: WARD

Enter Screen Server Function: <Enter>

** SCHEDULING **   CASE #245  SURPATIENT,SIX   PAGE 2 OF 2

1 CASE SCHEDULE ORDER: 1
2 REQ ANESTHESIA TECHNIQUE: GENERAL
3 REQ FROZ SECT: NO
4 REQ PREOP X-RAY:
5 INTRAOPERATIVE X-RAYS: YES
6 REQUEST BLOOD AVAILABILITY: YES
7 CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH
8 REQ BLOOD KIND: (MULTIPLE) (DATA)
9 PHARMACY ITEMS: (MULTIPLE)
10 REQ PHOTO: NO
11 PREOPERATIVE INFECTION: CLEAN
12 PRINC ANESTHETIST: SURANESTHETIST,ONE
13 ANESTHESIOLOGIST SUPVR: SURANESTHETIST,TWO
14 BRIEF CLIN HISTORY: (WORD PROCESSING) (DATA)
15 GENERAL COMMENTS: (WORD PROCESSING)

Enter Screen Server Function: <Enter>

The following cases have been entered.

1. Case # 224 SEP 16, 2005
   Surgeon: SURSURGEON,ONE NEUROSURGERY
   Procedure: CARPAL TUNNEL RELEASE

2. Case # 245 SEP 16, 2005
   Surgeon: SURSURGEON,TWO ORTHOPEDICS
   Procedure: ARTHROSCOPY, R SHOULDER

1. Enter Information for Case #245
2. Enter Information for Case #245
Example 3: How to Update a Scheduled Operation

Select Schedule Operations Option: R  Reschedule or Update a Scheduled Operation
Select Patient: SURPATIENT,THREE  12-19-53  000212453

SURPATIENT,THREE (000-21-2453)

1. 09/15/05  SHOULDER ARTHROPLASTY-PROSTHESIS (SCHEDULED)

Select Number: 1

Do you want to add a concurrent case? NO/<Enter>

Do you want to change the date/time or operating room for which this case is scheduled? NO/<Enter>

** SCHEDULING **  CASE #218  SURPATIENT,THREE          PAGE 1 OF 2

1  PRINCIPAL PROCEDURE: SHOULDER ARTHROPLASTY-PROSTHESIS
2  PLANNED PRIN PROCEDURE CODE: 23470
3  OTHER PROCEDURES: (MULTIPLE)
4  PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE, L SHOULDER
5  PRIN PRE-OP ICD DIAGNOSIS CODE: 715.11
6  OTHER PREOP DIAGNOSIS: (MULTIPLE)
7  HOSPITAL ADMISSION STAUTS: ADMISSION
8  PRE-ADMISSION TESTING:
9  CASE SCHEDULE TYPE: STANDBY
10 SURGERY SPECIALTY: ORTHOPEDICS
11 PRIMARY SURGEON: SURSURGEON,ONE
12 FIRST ASST: SURSURGEON,TWO
13 SECOND ASST: SURSURGEON,FOUR
14 ATTENDING SURGEON: SURSURGEON,ONE
15 PLANNED POSTOP CARE: WARD

Enter Screen Server Function: <Enter>

** SCHEDULING **  CASE #218  SURPATIENT,THREE          PAGE 2 OF 2

1  CASE SCHEDULE ORDER: 1
2  REQ ANESTHESIA TECHNIQUE: GENERAL
3  REQ FROZ SECT: NO
4  REQ PREOP X-RAY: LEFT SHOULDER
5  INTRAOPERATIVE X-RAYS: YES
6  REQUEST BLOOD AVAILABILITY: YES
7  CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH
8  REQ BLOOD KIND: (MULTIPLE)
9  PHARMACY ITEMS: (MULTIPLE)
10  REQ PHOTO: NO
11  PREOPERATIVE INFECTION: CLEAN
12  PRINC ANESTHETIST: SURANESTHETIST,ONE
13  ANESTHESIOLOGIST SUPVR: SURANESTHETIST,TWO
14  BRIEF CLIN HISTORY: (WORD PROCESSING)
15  GENERAL COMMENTS: (WORD PROCESSING)

Enter Screen Server Function: 8
** SCHEDULING **   CASE #218  SURPATIENT,THREE          PAGE 1 OF 1
REQ BLOOD KIND
1  REQ BLOOD KIND:  FRESH FROZEN PLASMA, CPDA-1
2  NEW ENTRY
Enter Screen Server Function:  2
Select REQ BLOOD KIND:  CPDA-1 WHOLE BLOOD  00160
  REQ BLOOD KIND: CPDA-1 WHOLE BLOOD/<Enter>

** SCHEDULING **   CASE #218  SURPATIENT,THREE          PAGE 1 OF 1
REQ BLOOD KIND (CPDA-1 WHOLE BLOOD)
1  REQ BLOOD KIND:  CPDA-1 WHOLE BLOOD
2  UNITS REQ:
Enter Screen Server Function:  2
Units Required:  2

** SCHEDULING **   CASE #218  SURPATIENT,THREE          PAGE 1 OF 1
REQ BLOOD KIND (CPDA-1 WHOLE BLOOD)
1  REQ BLOOD KIND:  CPDA-1 WHOLE BLOOD
2  UNITS REQ:  2
Enter Screen Server Function:  <Enter>

** SCHEDULING **   CASE #218  SURPATIENT,THREE          PAGE 1 OF 1
REQ BLOOD KIND
1  REQ BLOOD KIND:  FRESH FROZEN PLASMA, CPDA-1
2  REQ BLOOD KIND:  CPDA-1 WHOLE BLOOD
3  NEW ENTRY
Enter Screen Server Function:  <Enter>

** SCHEDULING **   CASE #218  SURPATIENT,THREE          PAGE 2 OF 2
1  CASE SCHEDULE ORDER:  1
2  REQ ANESTHESIA TECHNIQUE: GENERAL
3  REQ FROZ SECT:  NO
4  REQ PREOP X-RAY:  LEFT SHOULDER
5  INTRAOPERATIVE X-RAYS:  YES
6  REQUEST BLOOD AVAILABILITY:  YES
7  CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH
8  REQ BLOOD KIND:  (MULTIPLE)(DATA)
9  SPECIAL EQUIPMENT:  (MULTIPLE)
19  PHARMACY ITEMS:  (MULTIPLE)
10  REQ PHOTO:  NO
11  PREOPERATIVE INFECTION:  CLEAN
12  PRINC ANESTHETIST:  SURANESTHETIST,ONE
13  ANESTHESIOLOGIST SUPVR:  SURANESTHETIST,TWO
14  BRIEF CLIN HISTORY:  (WORD PROCESSING)
15  GENERAL COMMENTS:  (WORD PROCESSING)
Enter Screen Server Function:  <Enter>
Operation Menu

[SROPER]

The *Operation Menu* provides operating room personnel with on-line access to medical administration and laboratory information and generates post-operative reports, including the Nurse Intraoperative Report and the Operation Report. The menu options provide the opportunity to delete, edit, or review a patient’s operation history or to enter information concerning a new surgery. The *Operation Menu* allows the user to select an area on which to concentrate data entry or review, such as post operation or anesthesia information. It is designed for operating room nurses, surgeons, and anesthetists to use before, during, and after surgery. The Screen Server utility is used extensively to provide quick access to relevant information.

This option is locked with the SROPER key.

The *Operation Menu* contains the following options. To the left is the keyboard shortcut the user can enter to select the option. A restricted option, such as the *Anesthesia Menu*, will not display if the user does not have security clearance for that option.

<table>
<thead>
<tr>
<th>Shortcut</th>
<th>Option Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td><em>Operation Information</em></td>
</tr>
<tr>
<td>SS</td>
<td><em>Surgical Staff</em></td>
</tr>
<tr>
<td>OS</td>
<td><em>Operation Startup</em></td>
</tr>
<tr>
<td>O</td>
<td><em>Operation</em></td>
</tr>
<tr>
<td>PO</td>
<td><em>Post Operation</em></td>
</tr>
<tr>
<td>PAC</td>
<td><em>Enter PAC(U) Information</em></td>
</tr>
<tr>
<td>OSS</td>
<td><em>Operation (Short Screen)</em></td>
</tr>
<tr>
<td>V</td>
<td><em>Surgeon’s Verification of Diagnosis &amp; Procedures</em></td>
</tr>
<tr>
<td>A</td>
<td><em>Anesthesia Menu</em></td>
</tr>
<tr>
<td>OR</td>
<td><em>Operation Report</em></td>
</tr>
<tr>
<td>AR</td>
<td><em>Anesthesia Report</em></td>
</tr>
<tr>
<td>NR</td>
<td><em>Nurse Intraoperative Report</em></td>
</tr>
<tr>
<td>TR</td>
<td><em>Tissue Examination Report</em></td>
</tr>
<tr>
<td>R</td>
<td><em>Enter Referring Physician Information</em></td>
</tr>
<tr>
<td>RP</td>
<td><em>Enter Irrigations and Restraints</em></td>
</tr>
<tr>
<td>M</td>
<td><em>Medications (Enter/Edit)</em></td>
</tr>
<tr>
<td>AB</td>
<td><em>Abort/Cancel Operation</em></td>
</tr>
<tr>
<td>B</td>
<td><em>Blood Product Verification</em></td>
</tr>
</tbody>
</table>
**Entering Information**

First, the user selects the patient name. The Surgery software will then list all the cases on record for the patient, including scheduled or requested cases and any operations that have been started or completed. Then, the user selects the appropriate case.

**Example: Enter Information**

Select Surgery Menu Option: O  Operation Menu
Select Patient: SURPATIENT,THREE  12-19-53  000212453

<table>
<thead>
<tr>
<th>SURPATIENT,THREE  000-21-2453</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 03-12-92  SHOULDER ARTHROPLASTY-PROSTHESIS (SCHEDULED)</td>
</tr>
<tr>
<td>2. 08-15-88  SHOULDER ARTHROPLASTY (NOT COMPLETE)</td>
</tr>
</tbody>
</table>

3. ENTER NEW SURGICAL CASE

Select Operation: 2

SURPATIENT,THREE  000-21-2453

08-15-88  SHOULDER ARTHROPLASTY (NOT COMPLETE)

1. Enter Information
2. Review Information
3. Delete Surgery Case

Select Number: 1/ <Enter>

After the case is displayed, the user will press the <Enter> key or enter the number 1 to enter information for the case.

SURPATIENT,THREE (000-21-2453)  Case #14 - MAR 12,1999

<table>
<thead>
<tr>
<th>I</th>
<th>Operation Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>SS</td>
<td>Surgical Staff</td>
</tr>
<tr>
<td>OS</td>
<td>Operation Startup</td>
</tr>
<tr>
<td>O</td>
<td>Operation</td>
</tr>
<tr>
<td>PO</td>
<td>Post Operation</td>
</tr>
<tr>
<td>PAC</td>
<td>Enter PAC(U) Information</td>
</tr>
<tr>
<td>OSS</td>
<td>Operation (Short Screen)</td>
</tr>
<tr>
<td>TO</td>
<td>Time Out Verified Utilizing Checklist</td>
</tr>
<tr>
<td>V</td>
<td>Surgeon's Verification of Diagnosis &amp; Procedures</td>
</tr>
<tr>
<td>A</td>
<td>Anesthesia for an Operation Menu ...</td>
</tr>
<tr>
<td>OR</td>
<td>Operation Report</td>
</tr>
<tr>
<td>AR</td>
<td>Anesthesia Report</td>
</tr>
<tr>
<td>NR</td>
<td>Nurse Intraoperative Report</td>
</tr>
<tr>
<td>TR</td>
<td>Tissue Examination Report</td>
</tr>
<tr>
<td>R</td>
<td>Enter Referring Physician Information</td>
</tr>
<tr>
<td>RP</td>
<td>Enter Irrigations and Restraints</td>
</tr>
<tr>
<td>M</td>
<td>Medications (Enter/Edit)</td>
</tr>
<tr>
<td>AB</td>
<td>Abort/Cancel Operation</td>
</tr>
<tr>
<td>B</td>
<td>Blood Product Verification</td>
</tr>
</tbody>
</table>

Select Operation Menu Option:

Now the user can select any of the Operation Menu options.
Reviewing Information

The user enters the number 2 to access this feature. This feature displays a two-page summary of the case. The user cannot edit from this feature. Press the <Enter> key at the "Enter Screen Server Function:" prompt to move to the next page, or enter +1 or -1 to move forward or backward one page.

Example: Review Information

Select Surgery Menu Option: Operation Menu
Select Patient: SURPATIENT,THREE 12-19-53 000212453

SURPATIENT,THREE 000-21-2453

1. 08-15-99 SHOULDER ARTHROPLASTY (NOT COMPLETE)
2. 03-12-92 SHOULDER ARTHROPLASTY-PROSTHESIS (SCHEDULED)
3. ENTER NEW SURGICAL CASE

Select Operation: 2

SURPATIENT,THREE 000-21-2453

08-15-88 SHOULDER ARTHROPLASTY (NOT COMPLETE)

1. Enter Information
2. Review Information
3. Delete Surgery Case

Select Number: 1// 2

** REVIEW ** CASE #14 SURPATIENT,THREE PAGE 1 OF 3

1 TIME PAT IN HOLD AREA: AUG 15, 1999 AT 07:40
2 TIME PAT IN OR: AUG 15, 1999 AT 08:00
3 ANES CARE TIME BLOCK: (MULTIPLE)
4 TIME OPERATION BEGAN: AUG 15, 1999 AT 09:00
5 SPECIMENS: (WORD PROCESSING)
6 CULTURES: (WORD PROCESSING)
7 THERMAL UNIT: (MULTIPLE)
8 ELECTROCAUTERY UNIT:
9 ESU COAG RANGE:
10 ESU CUTTING RANGE:
11 TIME Tourniquet Applied: (MULTIPLE)
12 PROSTHESIS INSTALLED: (MULTIPLE)
13 REPLACEMENT FLUID TYPE: (MULTIPLE)
14 IRRIGATION: (MULTIPLE)
15 MEDICATIONS: (MULTIPLE)

Enter Screen Server Function: <Enter>

** REVIEW ** CASE #14 SURPATIENT,THREE PAGE 2 OF 3

1 POSSIBLE ITEM RETENTION:
2 SPONGE FINAL COUNT CORRECT:
3 SHARPS FINAL COUNT CORRECT:
4 INSTRUMENT FINAL COUNT CORRECT:
5 WOUND SWEEP: No
6 WOUND SWEEP COMMENTS: (WORD PROCESSING)
7 INTRA-OPERATIVE X-RAYS: No
8 INTRA-OPERATIVE X-RAYS COMMENTS: (WORD PROCESSING)
9 SPONGE, SHARPS, & INST COUNTER:
10 COUNT VERIFIER:
11 SEQUENTIAL COMPRESSION DEVICE:
12 LASER PERFORMED: (MULTIPLE)
13 CELL SAVER: (MULTIPLE)
Abort/Cancel Operation
[SROABRT]

The Abort/Cancel Operation option is used to Abort or Cancel a previously entered surgical case. This menu option should only be used if the patient has been taken to the operating room and no incision has been made. If an incision is made, the case should be completed and the discontinued procedure indicated in the record. Cancellation of future surgical cases should not use this option.

Example: Abort Operation

Select Schedule Operations Option: AB Abort/Cancel Operation

SURPATIENT,ELEVEN (666-00-0785) Case #21814 - JUN 22, 2015

Case Aborted?: N//Y
1 YES-PRE ANESTHESIA
2 YES-POST ANESTHESIA
Choose 1-2: 1 YES-PRE ANESTHESIA

Time Patient In the O.R.: JUN 22,2015@0730 (JUN 22, 2015@07:30)
Time Patient Out of the O.R.: JUN 22,2015@0800 (JUN 22, 2015@08:00)

Primary Cancellation Reason: 1 PATIENT RELATED ISSUE
Cancellation Date/Time: JUN 22,2015@0810 (JUN 22, 2015@08:10)
Cancellation Avoidable: N NO

Aborting Surgery case #21814

Enter RETURN to continue or "'" to exit: <Enter>

Example: Cancel Operation

Select Schedule Operations Option: AB Abort/Cancel Operation

SURPATIENT,ELEVEN (666-00-0785) Case #21815 - JUN 22, 2015

Case Aborted?: N// <Enter> NO
Primary Cancellation Reason: 6 SCHED ISSUES NON EMERGENT CASE
Cancellation Date/Time: JUN 22,2015@0700 (JUN 22, 2015@07:00)
Cancellation Avoidable: N NO

Cancelling Surgery case #21815

Enter RETURN to continue or "'" to exit: <Enter>

Entering a New Surgical Case

A new surgical case is a case that has not been previously requested or scheduled. This option is designed primarily for entering emergency cases. Be aware that a surgical case entered in the records without being booked through scheduling will not appear on the operating room schedule or as an operative request.

At the "Select Operation:" prompt the user enters the number corresponding to the ENTER NEW SURGICAL CASE field. He or she will then be prompted to supply preoperative information concerning the case.

After the user has entered data concerning the operation, the screen will clear and present a two-page Screen Server summary and provide another opportunity to enter or edit data.

Prompts that require a response include:
"Select the Date of Operation:"
“Desired Procedure Date:"
"Enter the Principal Operative Procedure:"
"Principal Preoperative Diagnosis:"
"Select Primary Surgeon:"
"Attending Surgeon:"
"Select Surgical Specialty:"
“Planned Principal Procedure Code:"

Example: Entering a New Surgical Case

Select Surgery Menu Option: O Operation Menu
Select Patient: SURPATIENT,SIX 04-04-30 000098797

SURPATIENT,SIX 000-09-8797

1. ENTER NEW SURGICAL CASE

Select Operation: 1

Select the Date of Operation: T (JAN 14, 2006)
Desired Procedure Date: T (JAN 14, 2006)

Enter the Principal Operative Procedure: APPENDECTOMY

Principal Preoperative Diagnosis: APPENDICITIS

The information entered into the Principal Preoperative Diagnosis field has been transferred into the Indications for Operation field.

The Indications for Operation field can be updated later if necessary.

Select Primary Surgeon: SURSURGEON,ONE
Attending Surgeon: SURSURGEON,ONE
Select Surgical Specialty: GENERAL SURGERY GENERAL SURGERY 50  (OR WHEN NOT DEFINED BELOW)
Planned Principal Procedure Code: 44960 APPENDECTOMY
APPENDECTOMY; FOR RUPTURED APPENDIX WITH ABSCESS OR GENERALIZED PERITONITIS

Modifier:

Brief Clinical History:

1>PATIENT WITH 5-DAY HISTORY OF INCREASING ABDOMINAL
2>PAIN, ONSET OF FEVER IN LAST 24 HOURS, REBOUND
3>TENDERNESS IN RIGHT LOWER QUAD. NAUSEA AND
4>VOMITING FOR 3 DAYS.
5><Enter>

EDIT Option: <Enter>

Request Blood Availability (Y/N): N// YES

Type and Crossmatch, Screen, or Autologous: TYPE & CROSSMATCH// <Enter> TYPE & CROSSMATCH

Select REQ BLOOD KIND: AS-1 RED BLOOD CELLS// <Enter>
Required Blood Product: CPDA-1 RED BLOOD CELLS// <Enter>
Units Required: 2

Principal Preoperative Diagnosis: APPENDICITIS// <Enter>

Prin Pre-OP ICD Diagnosis Code (ICD9): 540.9

One match found

540.9 ACUTE APPENDICITIS NOS (CC)

OK? Yes// <Enter> YES 540.9 ACUTE APPENDICITIS NOS (CC) 540.9 ICD-9 ACUTE

Hospital Admission Status: 2 <Enter> ADMISSION
Case Schedule Type: EM EMERGENCY
First Assistant: SURSURGEON,ONE
Second Assistant: SURSURGEON,ONE
Attending Surgeon:
Planned Postop Care: W WARD
Case Schedule Order: <Enter>
Select SURGERY POSITION: SUPINE// <Enter>
Surgery Position: SUPINE// <Enter>
Requested Anesthesia Technique: G GENERAL
Request Frozen Section Tests (Y/N): N NO
Requested Preoperative X-Rays: <Enter>
Intraoperative X-Rays (Y/N/C): N NO
Request Medical Media (Y/N): N NO
Preoperative infection: C CLEAN
Select REFERRING PHYSICIAN: <Enter>

General Comments:
1> <Enter>

SPD Comments:
No existing text
Edit? NO// <Enter>

** NEW SURGERY ** CASE #185 SURPATIENT,SIX PAGE 1 OF 3

1 PRINCIPAL PROCEDURE: APPENDECTOMY
2 OTHER PROCEDURES: (MULTIPLE)
3 PLANNED PRIN PROCEDURE CODE:
4 LATERALITY OF PROCEDURE: LEFT
5 PRINCIPAL PRE-OP DIAGNOSIS: APPENDICITIS
6 PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9): 540.9
7 OTHER PREOP DIAGNOSIS: (MULTIPLE)
8 PALLIATION: NO
9 PLANNED ADMISSION STATUS: ADMITTED
10 PRE-ADMISSION TESTING:
11 CASE SCHEDULE TYPE: EMERGENCY
12 SURGERY SPECIALTY: GENERAL(CR WHEN NOT DEFINED BELOW)
13 PRIMARY SURGEON: SURSURGEON,ONE
14 FIRST ASST: SURSURGEON,ONE
15 SECOND ASST: SURSURGEON,FOUR
16 ATTENDING SURGEON: SURSURGEON,TWO

Enter Screen Server Function: <Enter>

** NEW SURGERY ** CASE #185 SURPATIENT,SIX PAGE 2 OF 3

1 ATTENDING SURGEON: SURSURGEON,TWO
2 PLANNED POSTOP CARE: WARD
3 CASE SCHEDULE ORDER:
4 SURGERY POSITION: (MULTIPLE) (DATA)
5 REQ ANESTHESIA TECHNIQUE: GENERAL
6 REQ FROZ SECT: NO
7 REQ PREOP X-RAY:
8 INTRAOPERATIVE X-RAYS: NO
9 REQUEST BLOOD AVAILABILITY: YES
10 CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH
11 REQ BLOOD KIND: (MULTIPLE) (DATA)
12 SPECIAL EQUIPMENT: (MULTIPLE)
13 PLANNED IMPLANT: (MULTIPLE)
14 SPECIAL SUPPLIES: (MULTIPLE)
15 SPECIAL INSTRUMENTS: (MULTIPLE)

Enter Screen Server Function: <Enter>

** NEW SURGERY ** CASE #185 SURPATIENT,SIX PAGE 3 OF 3

1 PHARMACY ITEMS: (MULTIPLE)
2 REQ PHOTO: NO
3 PREOPERATIVE INFECTION: CLEAN
4 REFERRING PHYSICIAN: (MULTIPLE)
5 GENERAL COMMENTS: (WORD PROCESSING)
6 INDICATIONS FOR OPERATIONS: (WORD PROCESSING)
7 BRIEF CLIN HISTORY: (WORD PROCESSING) (DATA)
8 SPD COMMENTS: (WORD PROCESSING)

Enter Screen Server Function:
Example: Entering Surgical Staff

Select Operation Menu Option: **SS Surgical Staff**

```
** SURGICAL STAFF **  CASE #193  SURPATIENT,THREE  PAGE 1 OF 1

1  PRIMARY SURGEON          SURSURGEON,ONE
2  PGY OF PRIMARY SURGEON:  
3  FIRST ASST:              SURSURGEON,TWELVE
4  SECOND ASST:            SURSURGEON,ONE
5  ATTENDING SURGEON:      SURSURGEON,ONE
6  ATTENDING/RES SUP CODE: 
7  PRINC ANESTHETIST:      SURANESTHETIST,TWO
8  ASST ANESTHETIST:       SURANESTHETIST,FIVE
9  ANESTHESIOLOGIST SUPVR: SURSURGEON,ONE
10  PERFUSIONIST:          SURPERFUSIONIST,ONE
11  ASST PERFUSIONIST:     SURPERFUSIONIST,ONE
12  OR CIRC SUPPORT:       (MULTIPLE)
13  OR SCRUB SUPPORT:      (MULTIPLE)
14  OTHER SCRUBBED ASSISTANTS: (MULTIPLE)
15  OTHER PERSONS IN OR:   (MULTIPLE)

Enter Screen Server Function: **6;13;15**
Attending/Res Sup Code: **C**  LEVEL C: ATTENDING IN O.R., NOT SCRUBBED  C

The supervising practitioner is physically present in the operative or procedural room. The supervising practitioner observes and provides direction. The resident performs the procedure.

** SURGICAL STAFF **  CASE #193  SURPATIENT,THREE  PAGE 1

1  NEW ENTRY

Enter Screen Server Function: **1**
Select OR SCRUB SUPPORT: **SURNURSE,ONE**

** SURGICAL STAFF **  CASE #193  SURPATIENT,THREE  PAGE 1

1  OR SCRUB SUPPORT:       SURNURSE,ONE
2  TIME ON:               (MULTIPLE)
3  STATUS:               

Enter Screen Server Function: **2;3**
Educational Status: **F**  FULLY TRAINED

```

** SURGICAL STAFF **  CASE #193  SURPATIENT,THREE  PAGE 1

1  NEW ENTRY

Enter Screen Server Function: **1**
Select TIME ON: **8:00**  (JUN 06, 1999@08:00)

TIME ON: JUN 06, 1999@08:00// <Enter>
Operation Startup
[SROMEN-START]

The nurse or other operating room staff uses the Operation Startup option to enter data concerning the patient’s preparation for the surgery (for example, diagnosis, delays, skin prep, and position aids). Some data fields may be automatically filled in based on previous responses.

Some of the data fields are "multiple fields" and can have more than one value. For example, a patient can have more than one diagnosis or restraint/position aid. When a multiple field is selected, a new screen is generated so that the user can enter data related to that multiple. At the "Enter Screen Server Function:" prompt, the user can choose the field(s) to be edited, or press the <Enter> key to go to the next item or page.

Field Information

The following are fields that correspond to the Operation Startup entries.

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>DELAY CAUSE:</td>
<td>If the actual start time of the surgery is significantly delayed (15 minutes or more, depending on the institution's policy) it is necessary to select a reason at the &quot;Delay Cause:&quot; prompt. Type in a question mark (?) at this prompt to select from a list of delay causes.</td>
</tr>
<tr>
<td>RESTR &amp; POSITION AIDS:</td>
<td>A safety strap is automatically included as a restraint.</td>
</tr>
</tbody>
</table>
** Example: Operation Startup **

Select Operation Menu Option: **OS**  Operation Startup

```
** STARTUP ** CASE #159 SURPATIENT,THREE PAGE 1 OF 3

1  HEIGHT:                  58 INCHES
2  WEIGHT:                  264 LBS.
3  DATE OF OPERATION:       DEC 06, 2004 AT 08:00
4  PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE, L SHOULDER
5  PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9):
6  OTHER PREOP DIAGNOSIS: (MULTIPLE)
7  OP ROOM PROCEDURE PERFORMED:   OR2
8  SURGERY SPECIALTY:  ORTHOPEDICS
9  PLANNED POSTOP CARE:       WARD
10  CASE SCHEDULE TYPE:   ELECTIVE
11  REQ ANESTHESIA TECHNIQUE: GENERAL
12  PATIENT EDUCATION/ASSESSMENT:
13  DELAY CAUSE:           (MULTIPLE)
14  ASA CLASS:
15  PREOP MOOD:

Enter Screen Server Function:  9:12
Planned Postop Care:   WARD  W
Preoperative Patient Education:  Y  YES
```

```
** STARTUP ** CASE #159 SURPATIENT,THREE PAGE 1 OF 3

1  HEIGHT:                  58 INCHES
2  WEIGHT:                  264 LBS.
3  DATE OF OPERATION:       DEC 06, 2004 AT 08:00
4  PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE, L SHOULDER
5  PRIN PRE-OP ICD DIAGNOSIS CODE:
6  OTHER PREOP DIAGNOSIS: (MULTIPLE)
7  OP ROOM PROCEDURE PERFORMED:   OR2
8  SURGERY SPECIALTY:  ORTHOPEDICS
9  PLANNED POSTOP CARE:       WARD
10  CASE SCHEDULE TYPE:   ELECTIVE
11  REQ ANESTHESIA TECHNIQUE: GENERAL
12  PATIENT EDUCATION/ASSESSMENT: YES
13  DELAY CAUSE:           (MULTIPLE)
14  ASA CLASS:
15  PREOP MOOD:

Enter Screen Server Function: <Enter>
```

```
** STARTUP ** CASE #159 SURPATIENT,THREE PAGE 2 OF 3

1  PREOP CONSCIOUS:
2  PREOP SKIN INTEG:
3  TRANS TO OR BY:
4  HAIR REMOVAL BY:
5  HAIR REMOVAL METHOD:
6  HAIR REMOVAL COMMENTS: (WORD PROCESSING)
7  FOLEY CATHETER INSERTED BY:
8  SKIN PREPBy (1):
9  SKIN PREP By (2):
10  SKIN PREP AGENTS:
11  SECOND SKIN PREP AGENT:
12  SURGERY POSITION: (MULTIPLE) (DATA)
13  LATERALITY OF PROCEDURE:
14  RESTR & POSITION AIDS: (MULTIPLE) (DATA)
15  ELECTROGROUND POSITION:

Enter Screen Server Function:  A
```
Preoperative Consciousness: **AO ALERT-ORIENTED**  
Preoperative Skin Integrity: **INTACT**  
Transported to O.R. By: **PACU BED**  
Preop Surgical Site Hair Removal by: **SURNURSE, TWO**  
Surgical Site Hair Removal Method: **N NO HAIR REMOVED**  
Hair Removal Comments:  
No existing text  
Edit? NO//<Enter>  
Foley Catheter Inserted By:  
Skin Prepped By: <Enter>  
Skin Prepped By (2):  
Skin Preparation Agent: **HIBICLENS HI**  
Second Skin Preparation Agent: <Enter>  
Laterality Of Procedure: **NA**  
Electroground Placement:

| **STARTUP** CASE #159 SURPATIENT,THREE  PAGE 1 |
|-----------|----------------|
| 1 SURGERY POSITION:  | SUPINE         |
| 2 NEW ENTRY       |                |

Enter Screen Server Function: 2
Select SURGERY POSITION: SEMISUPINE
SURGERY POSITION: SEMISUPINE//<Enter>

| **STARTUP** CASE #159 SURPATIENT,THREE  PAGE 1 |
|-----------|----------------|
| 1 SURGERY POSITION:  | SEMISUPINE     |
| 2 TIME PLACED:       |                |

Enter Screen Server Function: <Enter>

| **STARTUP** CASE #159 SURPATIENT,THREE  PAGE 1 OF 1 |
|-----------|----------------|
| 1 SURGERY POSITION:  | SUPINE         |
| 2 SURGERY POSITION:  | SEMISUPINE     |
| 3 NEW ENTRY         |                |

Enter Screen Server Function: <Enter>

| **STARTUP** CASE #159 SURPATIENT,THREE  PAGE 1 OF 1 |
|-----------|----------------|
| 1 RESTR & POSITION AIDS:  | SAFETY STRAP   |
| 2 NEW ENTRY               |                |

Enter Screen Server Function: 2
Select RESTR & POSITION AIDS: FOAM PADS
RESTR & POSITION AIDS: FOAM PADS//<Enter>
**STARTUP**  CASE #159  SURPATIENT,THREE  PAGE 1 OF 1

1  RESTR & POSITION AIDS: FOAM PADS
2  APPLIED BY:

Enter Screen Server Function:  2
Applied By:  SURNURSE, TWO

**STARTUP**  CASE #159  SURPATIENT,THREE  PAGE 2 OF 3

1  PREOP CONSCIOUS:
2  PREOP SKIN INTEG:
3  TRANS TO OR BY:
4  HAIR REMOVAL BY:
5  HAIR REMOVAL METHOD:
6  HAIR REMOVAL COMMENTS:  (WORD PROCESSING)
7  FOLEY CATHETER INSERTED BY:
80  SKIN PREPPED BY (1):
91  SKIN PREPPED BY (2):
10  SKIN PREP AGENTS:
11  SECOND SKIN PREP AGENT:
12  SURGERY POSITION:  (MULTIPLE) (DATA)
13  LATERALITY OF PROCEDURE:
14  RESTR & POSITION AIDS:  (MULTIPLE) (DATA)
15  ELECTROGROUND POSITION:

Enter Screen Server Function:  <Enter>

**STARTUP**  CASE #159  SURPATIENT,THREE  PAGE 3 OF 3

1  ELECTROGROUND POSITION (2):

Enter Screen Server Function:  1
Electroground Position (2):  LF  LEFT FLANK

**STARTUP**  CASE #159  SURPATIENT,THREE  PAGE 3 OF 3

1  ELECTROGROUND POSITION (2):

Enter Screen Server Function:
**Operation [SROMEN-OP]**

Surgeons and nurses use the Operation option to enter data relating to the operation during or immediately following the actual procedure. It is very important to record the time of the patient’s entrance into the hold area and operating room, the time anesthesia is administered, and the operation start time.

Many of the data fields are "multiple fields" and can have more than one value. For example, a patient can have more than one diagnosis or procedure done per operation. When a multiple field is selected, a new screen is generated so that the user can enter data related to that multiple. The up-arrow (^) can be used to exit from any multiple field. Enter a question mark (?) for software-assisted instruction.

**Field Information**

The following are fields that correspond to the Operation entries.

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIME OPERATION BEGAN</td>
<td>The user should check his or her institution’s policy concerning an operation’s start time. In some institutions, this may be the time of first incision.</td>
</tr>
</tbody>
</table>

If entering times on a day other than the day of surgery, enter both the date and the time. Entering only a time will default the date to the current date.
** OPERATION **   CASE #173  SURPATIENT,TWENTY        PAGE 2 OF 3

1    POSSIBLE ITEM RETENTION:  YES
2    SPONGE FINAL COUNT CORRECT:  YES
3    SHARPS FINAL COUNT CORRECT:  YES
4    INSTRUMENT FINAL COUNT CORRECT:  YES
5    WOUND SWEEP:
6    WOUND SWEEP COMMENT: (WORD PROCESSING)
7    INTRA-OPERATIVE X-RAYS: No
8    INTRA-OPERATIVE X-RAYS COMMENT: (WORD PROCESSING)
9    SPONGE, SHARPS, & INST COUNTER:
10   COUNT VERIFIER:
11   SEQUENTIAL COMPRESSION DEVICE:
12   LASER PERFORMED: (MULTIPLE)
13   CELL SAVER: (MULTIPLE)
14   NURSING CARE COMMENTS: (WORD PROCESSING)
15   PRINCIPAL PRE-OP DIAGNOSIS: SDSFD DSFFDS

Enter Screen Server Function: 1:4

Possible Item Retention:  Y  YES
Sponge Final Count Correct:  Y  YES
Sharps Final Count Correct:  Y  YES
Instrument Final Count Correct:  Y  Yes

** OPERATION **   CASE #173  SURPATIENT,TWENTY        PAGE 2 OF 3

1>Admitted with prosthesis in place, left eye is artificial eye.
2>Foam pads applied to elbows and knees. Pillow placed under knees.
3><Enter>

EDIT Option: <Enter>
** SHORT SCREEN **   CASE #186  SURPATIENT,TWELVE          PAGE 1 OF 3

1 DATE OF OPERATION:     MAR 09, 2005
2 HOSPITAL ADMISSION STATUS: SAME DAY
3 PRIMARY SURGEON:      SURSURGEON,FOUR
4 PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
5 PRIN PRE-OP ICD DIAGNOSIS CODE:
6 OTHER PREOP DIAGNOSIS:  (MULTIPLE)
7 PRINCIPAL PROCEDURE:   REMOVE FACIAL LESIONS
8 PLANNED PRIN PROCEDURE CODE: 17000
9 OTHER PROCEDURES:   (MULTIPLE)
10 HAIR REMOVAL BY:
11 HAIR REMOVAL METHOD:
12 HAIR REMOVAL COMMENTS:   (WORD PROCESSING)
13 TIME PAT IN OR:        MAR 09, 2005 AT 13:00
14 TIME OPERATION BEGAN:  MAR 09, 2005 at 13:10
15 TIME OPERATION ENDS:  MAR 09, 2005 AT 13:36

Enter Screen Server Function:  <Enter>

** SHORT SCREEN **   CASE #186  SURPATIENT,TWELVE          PAGE 2 OF 3

1 TIME PAT OUT OR:
2 IV STARTED BY:
3 OR CIRC SUPPORT:       (MULTIPLE)
4 OR SCRUB SUPPORT:      (MULTIPLE)
5 OP ROOM PROCEDURE PERFORMED: OR1
6 FIRST ASST:
7 POSSIBLE ITEM RETENTION:
8 SPONGE FINAL COUNT CORRECT:
9 SHARPS FINAL COUNT CORRECT:
10 INSTRUMENT FINAL COUNT CORRECT:
11 WOUND SWEEP: No
12 WOUND SWEEP COMMENT:
13 INTRA-OPERATIVE X-RAYS: No
14 INTRA-OPERATIVE X-RAYS COMMENT:
15 SPONGE, SHARPS, & INST COUNTER:

Enter Screen Server Function:  1;5

Time Patient Out of the O.R.: 13:40  (MAR 09, 2005@13:40)
Operating Room Procedure Performed: OR1

** SHORT SCREEN **   CASE #186  SURPATIENT,TWELVE          PAGE 2 OF 3

1 TIME PAT OUT OR:       MAR 12, 2006 AT 13:40
2 IV STARTED BY:
3 OR CIRC SUPPORT:       (MULTIPLE)
4 OR SCRUB SUPPORT:      (MULTIPLE)
5 OP ROOM PROCEDURE PERFORMED: OR1
6 FIRST ASST:
7 POSSIBLE ITEM RETENTION:
8 SPONGE FINAL COUNT CORRECT:
9 SHARPS FINAL COUNT CORRECT:
10 INSTRUMENT FINAL COUNT CORRECT:
11 WOUND SWEEP: No
12 WOUND SWEEP COMMENT:
13 INTRA-OPERATIVE X-RAYS: No
14 INTRA-OPERATIVE X-RAYS COMMENT:
15 SPONGE, SHARPS, & INST COUNTER:

Enter Screen Server Function:
** SHORT SCREEN **  CASE #186  SURPATIENT,TWELVE  PAGE 3 OF 3

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>COUNT VERIFIER:</td>
</tr>
<tr>
<td>2</td>
<td>SURGERY SPECIALTY:  GENERAL(OR WHEN NOT DEFINED BELOW)</td>
</tr>
<tr>
<td>3</td>
<td>WOUND CLASSIFICATION:</td>
</tr>
<tr>
<td>4</td>
<td>ATTENDING SURGEON:  MO,CHAUNCEY G</td>
</tr>
<tr>
<td>5</td>
<td>ATTENDING/RES SUP CODE:</td>
</tr>
<tr>
<td>6</td>
<td>SPECIMENS:  (WORD PROCESSING)</td>
</tr>
<tr>
<td>7</td>
<td>CULTURES:  (WORD PROCESSING)</td>
</tr>
<tr>
<td>8</td>
<td>NURSING CARE COMMENTS:  (WORD PROCESSING)</td>
</tr>
<tr>
<td>9</td>
<td>ASA CLASS:</td>
</tr>
<tr>
<td>10</td>
<td>PRINC ANESTHETIST:</td>
</tr>
<tr>
<td>11</td>
<td>ANESTHESIA TECHNIQUE:  (MANDATORY)</td>
</tr>
<tr>
<td>12</td>
<td>ANES CARE TIME BLOCK:  (MULTIPLE)</td>
</tr>
<tr>
<td>13</td>
<td>DELAY CAUSE:  (MULTIPLE)</td>
</tr>
</tbody>
</table>

Enter Screen Server Function:  <Enter>
Time Out Verified Utilizing Checklist
[SROMEN-VERF]

This option is used to enter information related to the Time Out Verified Utilizing Checklist.

Example: Time Out Verified Utilizing Checklist

Select Operation Menu Option: Time Out Verified Utilizing Checklist

** TIME OUT CHECKLIST **  CASE #145  SUR, NINE  PAGE 1 OF 1

- Confirm Correct Patient Identity: YES
- Confirm Procedure To Be Performed: YES
- Confirm Site of Procedure, Including Laterality: YES
- Confirm Valid Consent: YES, i-MED
- Confirm Patient Position: N
- Confirm Proc. Site has been Marked Appropriately and the Site of the Mark is Visible After Prep: YES
- Pertinent Medical Images Have Been Confirmed: YES
- Correct Medical Implant(s) is Available: YES
- Availability of Special Equipment: YES
- Appropriate Antibiotic Prophylaxis: YES
- Appropriate Deep Vein Thrombosis Prophylaxis: YES
- Blood Availability: YES
- Checklist Comment: No existing text
- Edit? NO

TIME-OUT DOCUMENT COMPLETED BY: SURNURSE, FIVE
TIME-OUT COMPLETED:

Checklist Comments should be entered when a "NO" response is entered for any of the Time Out Verified Utilizing Checklist fields.

Do you want to enter Checklist Comment? YES

Checklist Comment: No existing text

** TIME OUT CHECKLIST **  CASE #145  SURPATIENT, NINE  PAGE 1 OF 1

- Confirm Correct Patient Identity: YES
- Confirm Procedure To Be Performed: YES
- Confirm Site of Procedure: YES
- Confirm Valid Consent: YES, i-MED
- Confirm Patient Position: YES
- Confirm Proc. Site has been Marked Appropriately and the Site of the Mark is Visible After Prep: YES
- Pertinent Medical Images Have Been Confirmed: YES
- Correct Medical Implant(s) is Available: YES
- Availability of Special Equipment: YES
- Appropriate Antibiotic Prophylaxis: YES
If the PLANNED PRIN PROCEDURE CODE field for the case is one of the following CPT codes Time Out Checklist-2 will be displayed: 32851, 32852, 32853, 32854, 33935, 44135, 44136, 47135, 47136, 48160, 48554, 50360, 50365.

Example: Time Out Verified Utilizing Checklist-2

** TIME OUT CHECKLIST-2 ** CASE #811 SURPATIENT, FOUR PAGE 1 OF 2

1 ORGAN TO BE TRANSPLANTED: (MULTIPLE)
2 UNOS NUMBER:
3 DONOR SEROLOGY HCV:
4 DONOR SEROLOGY HBV:
5 DONOR SEROLOGY CMV:
6 DONOR SEROLOGY HIV:
7 DONOR ABO TYPE:
8 RECIPIENT ABO TYPE:
9 BLOOD BANK ABO VERIFICATION:
10 BLOOD BANK ABO VER COMMENTS:
11 D/T BLOOD BANK ABO VERIF:
12 OR ABO VERIFICATION (Y/N):
13 OR ABO VER COMMENTS:
14 D/T OR ABO VERIF:
15 SURGEON VERIFYING UNET:

Enter Screen Server Function:

** TIME OUT CHECKLIST-2 ** CASE #811 SURPATIENT, FOUR PAGE 2 OF 2

1 UNET VERIF BY SURGEON (Y/N):
2 ORGAN VER PRE-ANESTHESIA:
3 SURGEON VER ORGAN PRE-ANES:
4 SURGEON VER DONOR ORG PRE-ANES:
5 DONOR ORG VER PRE-ANES:
6 ORGAN VER PRE-TRANSPLANT:
7 SURGEON VER ORG PRE-TRANSPLANT:
8 ORGAN VER PRE-TRANSPLANT:
9 DONOR VESSEL UNOS ID: (MULTIPLE)
10 DONOR VESSEL USAGE:
11 DONOR VESSEL DISPOSITION:

Enter Screen Server Function:
Nurse Intraoperative Report

[SRONRPT]
The Nurse Intraoperative Report details case information relating to nursing care provided for the patient during the operative case selected. This option provides the capability to view and print the report, edit information contained in the report, and electronically sign the report.

With the Surgery Site Parameters option located on the Surgery Package Management Menu, the user can select one of two different formats for this report. One format includes all field names whether or not information has been entered. The other format only includes fields that have actual data.

Electronically signed reports may be viewed through CPRS for completed operations.

Nurse Intraoperative Report - Before Electronic Signature

Upon selecting the Nurse Intraoperative Report option, if the Nurse Intraoperative Report is not signed, the report will begin displaying on the screen. The Nurse Intraoperative Report displays key fields on the first page. Several of these fields are required before the software will allow the user to electronically sign the report. If any required fields are left blank, a warning will appear prompting the user to provide the missing information.

The following fields are required before electronic signature of the Nurse Intraoperative Report:

- TIME PAT IN OR
- HAIR REMOVAL METHOD
- CORRECT PATIENT IDENTITY
- SITE OF PROCEDURE
- CONFIRM PATIENT POSITION
- ANTIBIOTIC PROPHYLAXIS
- BLOOD AVAILABILITY
- CHECKLIST COMMENT
- TIME-OUT COMPLETED

The WOUND SWEEP and INTRAOPERATIVE-XRAY will be required to sign the NIR if any of the cout fields (SPONGE FINAL COUNT CORRECT, SHARPS FINAL COUNT CORRECT, and INSTRUMENT FINAL COUNT CORRECT) is answered with “NO”.

If the COUNT VERIFIER field has been entered, the following fields are required:

- SPONGE FINAL COUNT CORRECT
- INSTRUMENT FINAL COUNT CORRECT
- SHARPS FINAL COUNT CORRECT
- SPONGE, SHARPS, & INST COUNTER
- TIME-OUT COMPLETED
- POSSIBLE ITEM RETENTION

**NOTE:** The ANESTHESIA TECHNIQUE field is made mandatory in order for the NIR report to be signed.

If the PROSTHESIS INSTALLED field has an item (or items) entered, the following fields are required for each item:

- IMPLANT STERILITY CHECKED
- RN VERIFIER
- SERIAL NUMBER
- TIME PAT OUT OR
- MARKED SITE CONFIRMED
- PREOPERATIVE IMAGING CONFIRMED
- PROCEDURE TO BE PERFORMED
- CONFIRM VALID CONSENT
- CORRECT MEDICAL IMPLANTS
- APPROPRIATE DVT PROPHYLAXIS
- AVAILABILITY OF SPECIAL EQUIP
- PROSTHESIS INSTALLED

- STERILITY EXPIRATION DATE
- LOT NUMBER
- PROVIDER READ BACK PERFORMED
If the PLANNED PRIN PROCEDURE CODE field for the case is matches one of these CPT codes
32851, 32852, 32853, 32854, 33935, 33945, 44135, 44136, 47135, 47136, 48160, 48554, 50360, 50365;
the following fields are required:

- ORGAN TO BE TRANSPLANTED
- UNOS NUMBER
- DONOR SEROLOGY HCV
- DONOR SEROLOGY HBV
- DONOR SEROLOGY CMV
- DONOR SEROLOGY HIV
- DONOR ABO TYPE
- RECEIPIENT ABO TYPE
- BLOOD BANK ABO VERIFICATION
- BLOOD BANK ABO VER COMMENTS
- D/T BLOOD BANK ABO VERIF
- OR ABO VERIFICATION
- D/T OR ABO VERIF
- SURGEON VERIFYING UNET
- UNET VERIF BY SURGEON
- ORGAN VER PRE-ANESTHESIA
- SURGEON VER ORGAN PRE-ANES
- SURGEON VER DONOR ORG PRE-ANES
- DONOR ORG VER PRE-ANES
- ORGAN VER PRE-TRANSPLANT
- SURGEON VER ORG PRE-TRANSPLANT
- DONOR VESSEL UNOS ID
- DONOR VESSEL USAGE
- DONOR VESSEL DISPOSITION
NOTE: Entering the TIME PAT OUT OR field triggers an alert that is sent to the nurse responsible for signing the report. By acting on the alert, the nurse accesses the Nurse Intraoperative Report option to electronically sign the report.
At the bottom of the first screen is the prompt, "Press <return> to continue, 'A' to access Nurse Intraoperative Report functions, or '^' to exit:'. The Nurse Intraoperative Report functions, accessed by entering A at the prompt, allow the user to edit the report, to view or print the report, or to electronically sign the report.

Example: First page of the Nurse Intraoperative Report

Select Operation Menu Option: NR Nurse Intraoperative Report

<table>
<thead>
<tr>
<th>SURPATIENT; TEN (000-12-3456)</th>
<th>MEDICAL RECORD</th>
<th>NURSE INTRAOPERATIVE REPORT - CASE #267226</th>
<th>PAGE 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating Room: BO OR1</td>
<td>Surgical Priority: ELECTIVE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient in Hold: JUL 12, 2004 07:30</td>
<td>Patient in OR: JUL 12, 2004 08:00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operation Begin: JUL 12, 2004 08:58</td>
<td>Operation End: JUL 12, 2004 12:10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon in OR: JUL 12, 2004 07:55</td>
<td>Patient Out OR: JUL 12, 2004 12:45</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major Operations Performed:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary: MVR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wound Classification: CLEAN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operation Disposition: SICU</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharged Via: ICU BED</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Surgeon: SURSURGEON,THREE</td>
<td>First Assist: SURSURGEON,FOUR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attending Surgeon: SURSURGEON,THREE</td>
<td>Second Assist: N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anesthetist: SURANESTHETIST,SEVEN</td>
<td>Assistant Anesth: N/A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Press <return> to continue, 'A' to access Nurse Intraoperative Report functions, or '^' to exit: A
After the user enters an A at the prompt, the Nurse Intraoperative Report functions are displayed. The following examples demonstrate how these three functions are accessed and how they operate.

If the user enters a 1, the Nurse Intraoperative Report data can be edited.

**Example: Editing the Nurse Intraoperative Report**

<table>
<thead>
<tr>
<th>SURPATIENT,TEN (000-12-3456)</th>
<th>Case #267226 - JUL 12, 2004</th>
</tr>
</thead>
</table>

Nurse Intraoperative Report Functions:

1. Edit report information
2. Print/View report from beginning
3. Sign the report electronically

Select number: 2//1

** NURSE INTRAOP **  CASE #267226  SURPATIENT,TEN PAGE 1 OF 7

1    CONFIRM PATIENT IDENTITY: YES  
2    PROCEDURE TO BE PERFORMED: YES  
3    SITE OF PROCEDURE: YES  
4    CONFIRM VALID CONSENT: YES, i-MED  
5    CONFIRM PATIENT POSITION: YES  
6    MARKED SITE CONFIRMED: YES  
7    PREOPERATIVE IMAGES CONFIRMED: YES  
8    CORRECT MEDICAL IMPLANTS: YES  
9    AVAILABILITY OF SPECIAL EQUIP: YES  
10   ANTIBIOTIC PROPHYLAXIS: YES  
11   APPROPRIATE DVT PROPHYLAXIS: YES  
12   BLOOD AVAILABILITY: YES  
13   CHECKLIST COMMENT: (WORD PROCESSING)  
14   TIME-OUT DOCUMENT COMPLETED BY: SURNURSE, FIVE  
15   TIME-OUT COMPLETED: 07/12/2004@0800

Enter Screen Server Function: <Enter>

** NURSE INTRAOP **  CASE #267226  SURPATIENT,TEN PAGE 2 OF 7

1    POSSIBLE ITEM RENTENTION: YES  
2    SPONGE FINAL COUNT CORRECT: YES  
3    SHARPS FINAL COUNT CORRECT: YES  
4    INSTRUMENT FINAL COUNT CORRECT:  
5    WOUND SWEEP:  
6    WOUND SWEEP COMMENTS: (WORD PROCESSING)  
7    INTRA-OPERATIVE X-RAY:  
8    INTRA-OPERATIVE X-RAY COMMENTS: (WORD PROCESSING)  
9    SPONE, SHARPS, & INST COUNTER:  
10   COUNT VERIFIED:  
11   TIME PAT IN HOLD AREA: JUL 12, 2004 AT 07:30  
12   TIME PAT IN OR: JUL 12, 2004 AT 08:00  
13   TIME OPERATION BEGAN: JUL 12, 2004 AT 08:58  
14   TIME OPERATION ENDS: JUL 12, 2004 AT 12:30  
15   SURG PRESENT TIME:  

Enter Screen Server Function: <Enter>

** NURSE INTRAOP **  CASE #267226  SURPATIENT,TEN PAGE 3 OF 7

1    TIME PAT OUT OR:  
2    PRINCIPAL PROCEDURE:  
3    OTHER PROCEDURES:  
4    WOUND CLASSIFICATION:  
5    OP DISPOSITION:  
6    OP ROOM PROCEDURE PERFORMED: OR1  
7    CASE SCHEDULE TYPE: ELECTIVE  
8    PRIMARY SURGEON: SURSURGEON,THREE  
9    ATTENDING SURGEON: SURSURGEON,THREE  
10   FIRST ASST: SURSURGEON,FOUR  
11   SECOND ASST:  

At the Nurse Intraoperative Report functions, the report can be printed if the user enters a 2.

**Example: Printing the Nurse Intraoperative Report**

SURPATIENT,TEN (000-12-3456) Case #267226 - JUL 12, 2004

Nurse Intraoperative Report Functions:

1. Edit report information
2. Print/View report from beginning
3. Sign the report electronically

Select number: 2// <Enter>

--------------------printout follows-----------------------
NOTE DATED: 07/12/2004 08:00  NURSE INTRAOPERATIVE REPORT

SUBJECT: Case #: 267226

Operating Room: BO OR1  Surgical Priority: ELECTIVE

Patient in Hold: JUL 12, 2004 07:30  Patient in OR: JUL 12, 2004 08:00
Operation Begin: JUL 12, 2004 08:58  Operation End: JUL 12, 2004 12:10
Surgeon in OR: JUL 12, 2004 07:55  Patient Out OR: JUL 12, 2004 12:45

Major Operations Performed:
Primary: MVR

Wound Classification: CONTAMINATED
Operation Disposition: SICU
Discharged Via: ICU BED

Primary Surgeon: SURSURGEON,THREE  First Assist: SURSURGEON,FOUR
Attending Surgeon: SURSURGEON,THREE  Second Assist: N/A
Anesthetist: SURANESTHETIST,SEVEN  Assistant Anesth: N/A

Other Scrubbed Assistants: N/A

OR Support Personnel:
  Scrubbed  Circulating
  SURNURSE,ONE (FULLY TRAINED)  SURNURSE,FIVE (FULLY TRAINED)
  SURNURSE,FOUR (FULLY TRAINED)

Other Persons in OR: N/A

Preop Mood: ANXIOUS  Preop Consc: ALERT-ORIENTED
Preop Skin Integ: INTACT  Preop Converse: N/A

--- Time Out Checklist ---
Confirm Correct Patient Identity: YES
Confirm Procedure to be Performed: YES
Confirm Site of the Procedure, including laterality: YES
Confirm Valid Consent: YES, i-MED
Confirm Patient Position: YES
Confirm Proc. Site has been Marked Appropriately and that the Site of the Mark is Visible After Prep and Draping: YES
Pertinent Medical Images have been Confirmed: YES
Correct Medical Implant(s) is available: YES
Availability of Special Equipment: YES
Appropriate Antibiotic Prophylaxis: YES
Appropriate Deep Vein Thrombosis Prophylaxis: YES
Blood Availability: YES
Checklist Comment: NO COMMENTS ENTERED

Time-Out Document Completed By: SURNURSE,FIVE
Time-Out Completed: 07/12/2004@0800

Skin Prep By: SURNURSE,FOUR  Skin Prep Agent: BETADINE SCRUB
Skin Prep By (2): SURNURSE,FIVE  2nd Skin Prep Agent: Povidone Iodine

Preop Surgical Site Hair Removal by: SURNURSE,FIVE
Surgical Site Hair Removal Method: OTHER
  Hair Removal Comments: SHAVING AND DEPILATORY COMBINATION USED.

Surgery Position(s):
  SUPINE  Placed: N/A

Restrains and Position Aids:
  SAFETY STRAP  Applied By: N/A
  ARMBORD  Applied By: N/A
  FOAM PADS  Applied By: N/A
  KODEL PAD  Applied By: N/A
  STIRRUPS  Applied By: N/A
Immediate Use Steam Sterilization Episodes:
Contamination: 0
SPS Processing/OR Management Issues: 0
Emergency Case: 0
No Better Option: 0
Loaner or Short Notice Instrument: 0
Decontamination of Instruments Contaminated During the Case: 0

Electrocautery Unit: 8845,5512
ESU Coagulation Range: 50-35
ESU Cutting Range: 35-35
Electroground Position(s): RIGHT BUTTOCK
                                LEFT BUTTOCK

Material Sent to Laboratory for Analysis:
Specimens:
1. MITRAL VALVE
Cultures: N/A

Anesthesia Technique(s):
GENERAL (PRINCIPAL)

Tubes and Drains:
#16FOLEY, #18NGTUBE, #36 &2 #32RA CHEST TUBES

Tourniquet: N/A

Thermal Unit: N/A

Prosthesis Installed:
Item: MITRAL VALVE
  Implant Sterility Checked (Y/N): YES
  Sterility Expiration Date: DEC 15, 2004
  RN Verifier: SURNURSE,ONE
  Vendor: BAXTER EDWARDS
  Model: 6900
  Lot Number: T87-12321
  Serial Number: 945673WRU
  Sterile Resp: SPD
  Size: LG Quantity: 2

Medications: N/A

Irrigation Solution(s):
HEPARINIZED SALINE
NORMAL SALINE
COLD SALINE

Blood Replacement Fluids: N/A

Possible Item Retention: YES
Sponge Final Count Correct: YES
Sharps Final Count Correct: YES
Instrument Final Count Correct: NOT APPLICABLE
Wound Sweep: * NOT ENTERED *
Wound Sweep Comment: NO COMMENTS ENTERED
Intra-Operative X-Ray: * NOT ENTERED *
Intra-Operative X-Ray Comment: NO COMMENTS ENTERED
Counter: SURNURSE,FOUR
Counts Verified By: SURNURSE,FIVE

Dressing: DSD, PAPER TAPE, MEPORE
Packing: NONE

Blood Loss: 800 ml Urine Output: 750 ml

Postoperative Mood: RELAXED
Postoperative Consciousness: ANESTHETIZED
Postoperative Skin Integrity: SUTURED INCISION
Postoperative Skin Color: N/A
Laser Performed: N/A
Sequential Compression Device: NO
Cell Saver(s): N/A
Devices: N/A

Transplant Information:
   Organ to be Transplanted: * NOT ENTERED *
   UNOS Identification Number of Donor:
   Donor Serology Hepatitis C virus (HCV): * NOT ENTERED *
   Donor Serology Hepatitis B Virus (HBV): * NOT ENTERED *
   Donor Serology Cytomegalovirus (CMV): * NOT ENTERED *
   Donor Serology HIV: * NOT ENTERED *
   Donor ABO Type: * NOT ENTERED *
   Recipient ABO Type: * NOT ENTERED *
   Blood Bank ABO Type: * NOT ENTERED *
   Blood Bank ABO Verification Comments:
   Date/Time of Blood Bank ABO Verification: * NOT ENTERED *
   OR Verification of ABO Type: * NOT ENTERED *
   OR ABO Verification Comments:
   Surgeon Performing UNET Verification: * NOT ENTERED *
   UNET Verification by Surgeon: * NOT ENTERED *
   Organ Verification Prior to Anesthesia: * NOT ENTERED *
   Surgeon Verifying Organ Prior to Anesthesia: * NOT ENTERED *
   Donor Organ Verification Prior to Anesthesia: * NOT ENTERED *
   Organ Verification Prior to Transplant: * NOT ENTERED *
   Surgeon Verifying the Organ Prior to Transplant: * NOT ENTERED *
   Donor Vessel Usage: * NOT ENTERED *
   Donor Vessel Disposition if not used:
   Donor Vessel UNOS ID:

Immediate Use Steam Sterilization Episodes:
   Contamination: 0
   SPS Processing/OR Management Issues: 0
   Emergency Case: 0
   No Better Option: 0
   Loaner or Short Notice Instrument: 0
   Decontamination of Instruments Contaminated During the Case: 0

Nursing Care Comments:
   PATIENT STATES HE IS ALLERGIC TO PCN. ALL WRVAMC INTRAOPERATIVE NURSING
   STANDARDS WERE MONITORED THROUGHOUT THE PROCEDURE. VANCOMYCIN PASTE WAS
   APPLIED TO STERNUM.

This section will only appear for Transplant cases that have a
PLANNED PRIN PROCEDURE
CODE that is one of the following:
32851,32852,32853,32854,33935,33945,44135,44136,47135,47136,48160,48554,50360,50365
(This page included for two-sided copying.)
To electronically sign the report, the user enters a 3 at the Nurse Intraoperative Report functions prompt.

Example: Signing the Nurse Intraoperative Report

SURPATIENT,TEN (000-12-3456)   Case #267226 - JUL 12, 2004

Nurse Intraoperative Report Functions:

1. Edit report information
2. Print/View report from beginning
3. Sign the report electronically

Select number: 2//3

The Nurse Intraoperative Report may only be signed by a circulating nurse on the case. At the time of electronic signature, the software checks for data in key fields. The nurse will not be able to sign the report if the following fields are not entered:

- TIME PATIENT IN OR MARKED SITE CONFIRMED
- PREOPERATIVE IMAGING CONFIRMED
- PROCEDURE TO BE PERFORMED
- CONFIRM VALID CONSENT
- CORRECT MEDICAL IMPLANTS
- APPROPRIATE DVT PROPHYLAXIS
- AVAILABILITY OF SPECIAL EQUIP
- TIME-OUT COMPLETED

- TIME PATIENT OUT OF OR
- CORRECT PATIENT IDENTITY
- HAIR REMOVAL METHOD
- SITE OF THE PROCEDURE
- CONFIRM PATIENT POSITION
- ANTIBIOTIC PROPHYLAXIS
- BLOOD AVAILABILITY
- CHECKLIST AVAILABILITY

The WOUND SWEEP and INTRAOPERATIVE X-XRAY fields will be required to sign the NIR if any of the count fields (SPONGE FINAL COUNT CORRECT, SHARPS FINAL COUNT CORRECT, and INSTRUMENT FINAL COUNT CORRECT) is answered with “NO”

If the COUNT VERIFIER field is entered, the other counts related fields must be populated. These count fields include the following:

- SPONGE FINAL COUNT CORRECT
- INSTRUMENT FINAL COUNT CORRECT
- POSSIBLE ITEM RETENTION

- SHARPS FINAL COUNT CORRECT
- SPONGE, SHARPS, & INST COUNTER

The ANESTHESIA TECHNIQUE field is made mandatory in order for the NIR report to be signed.

If the PROSTHESIS INSTALLED field has an item (or items) entered, the following fields are required for each item:

- IMPLANT STERILITY CHECKED (Y/N)
- RN VERIFIER
- SERIAL NUMBER

- STERILITY EXPIRATION DATE
- LOT NUMBER
- PROVIDER READ BACK PERFORMED

If the PLANNED PRIN PROCEDURE CODE field is one of the following codes 32851,32852,32853,32854,33935,33945,44135,44136,47135,47136,48160,48554,50360,50365
the following fields are required:
<table>
<thead>
<tr>
<th>Field</th>
<th>Signature Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORGAN TO BE TRANSPLANTED</td>
<td>SURGEON VERIFYING UNET</td>
</tr>
<tr>
<td>UNOS NUMBER</td>
<td>UNET VERIF BY SURGEON</td>
</tr>
<tr>
<td>DONOR SEROLOGY HCV</td>
<td>ORGAN VER PRE-ANESTHESIA</td>
</tr>
<tr>
<td>DONOR SEROLOGY HBV</td>
<td>SURGEON VER ORGAN PRE-ANES</td>
</tr>
<tr>
<td>DONOR SEROLOGY CMV</td>
<td>SURGEON VER DONOR PRE-ANES</td>
</tr>
<tr>
<td>DONOR SEROLOGY HIV</td>
<td>DONOR ORG VER PRE-ANES</td>
</tr>
<tr>
<td>DONOR ABO TYPE</td>
<td>ORGAN VER PRE-TRANSPLANT</td>
</tr>
<tr>
<td>RECIPIENT ABO TYPE</td>
<td>SURGEON VER ORG PRE-TRANSPLANT</td>
</tr>
<tr>
<td>BLOOD BANK ABO VERIFICATION</td>
<td>DONOR VESSEL UNOS ID</td>
</tr>
<tr>
<td>BLOOD BANK ABO VER COMMENTS</td>
<td>DONOR VESSEL USAGE</td>
</tr>
<tr>
<td>D/T BLOOD BANK ABO VERIF</td>
<td>DONOR VESSEL DISPOSITION</td>
</tr>
<tr>
<td>OR ABO VERIFICATION</td>
<td>OR ABO VER COMMENTS</td>
</tr>
<tr>
<td>OR ABO VER COMMENTS</td>
<td>D/T OR ABO VERIF</td>
</tr>
</tbody>
</table>

If any of the key fields are missing, the software will require them to be entered prior to signature. In the following example, the final sponge count must be entered before the nurse is allowed to electronically sign the report.
Example: Missing Field Warning

The following information is required before this report may be signed:

<table>
<thead>
<tr>
<th>ANTIBIOTIC PROPHYLAXIS CHECKLIST COMMENT</th>
</tr>
</thead>
</table>

Do you want to enter this information? YES// YES
** NURSE INTRAOP ** CASE #267226 SURPATIENT,TEN PAGE 1 OF 7

1 CONFIRM PATIENT IDENTITY: YES
2 PROCEDURE TO BE PERFORMED: YES
3 SITE OF PROCEDURE: YES
4 CONFIRM VALID CONSENT: YES, i-MED
5 CONFIRM PATIENT POSITION: YES
6 MARKED SITE CONFIRMED: YES
7 PREOPERATIVE IMAGES CONFIRMED: YES
8 CORRECT MEDICAL IMPLANTS: YES
9 AVAILABILITY OF SPECIAL EQUIP: YES
10 ANTIBIOTIC PROPHYLAXIS: YES
11 APPROPRIATE DVT PROPHYLAXIS: YES
12 BLOOD AVAILABILITY: YES
13 CHECKLIST COMMENT: (WORD PROCESSING)
14 TIME-OUT DOCUMENT COMPLETED BY: SURNURSE, FIVE
15 TIME-OUT COMPLETED: 07/12/2004@0800

Enter Screen Server Function: ** NURSE INTRAOP ** CASE #267226 SURPATIENT,TEN PAGE 1 OF 7

1 CONFIRM PATIENT IDENTITY: YES
2 PROCEDURE TO BE PERFORMED: YES
3 SITE OF PROCEDURE: YES
4 CONFIRM VALID CONSENT: YES, i-MED
5 CONFIRM PATIENT POSITION: YES
6 MARKED SITE CONFIRMED: YES
7 PREOPERATIVE IMAGES CONFIRMED: YES
8 CORRECT MEDICAL IMPLANTS: YES
9 AVAILABILITY OF SPECIAL EQUIP: YES
10 ANTIBIOTIC PROPHYLAXIS: YES
11 APPROPRIATE DVT PROPHYLAXIS: YES
12 BLOOD AVAILABILITY: YES
13 CHECKLIST COMMENT: (WORD PROCESSING)
14 TIME-OUT DOCUMENT COMPLETED BY: SURNURSE, FIVE
15 TIME-OUT COMPLETED: 07/12/2004@0800

Enter Screen Server Function: ^

If any of the Time Out Verified Utilizing Checklist fields is answered with “NO”, then the user is prompted to enter information in the CHECKLIST COMMENT field. Entry in the CHECKLIST COMMENT field is required in such cases where “NO” has been entered before the user can electronically sign the Nurse Intraoperative Report.

SURPATIENT,TEN (000-12-3456) Case #267226 - JUL 12, 2004

Nurse Intraoperative Report Functions:

1. Edit report information
2. Print/View report from beginning
3. Sign the report electronically

Select number: 2/3 Sign the report electronically

Enter your Current Signature Code: XXXXXX SIGNATURE VERIFIED

Press RETURN to continue... <Enter>
Before the addendum is signed, comments may be added.

**Example: Signing the Addendum**

Comment: **OPERATION END TIME WAS CORRECTED.**

Addendum for Case #267226 - JUL 12, 2004
Patient: SURPATIENT, TEN (000-12-3456)

The Time-Out Document Completed By field was changed from SURNURSE, FOUR to SURNURSE, FIVE

Addendum Comment: **OPERATION END TIME WAS CORRECTED.**

Enter RETURN to continue or '^' to exit:

Enter your Current Signature Code: XXXXXX SIGNATURE VERIFIED.

Press RETURN to continue... <Enter>

**Example: Printing the Nurse Intraoperative Report**

SURPATIENT, TEN (000-12-3456) Case #267226 - JUL 12, 2004

* * The Nurse Intraoperative Report has been electronically signed. * *

Nurse Intraoperative Report Functions:

1. Edit report information
2. Print/View report from beginning

Select number: 2// 2 Print/View report from beginning

Do you want WORK copies or CHART copies? WORK// <Enter>

DEVICE: HOME// [Select Print Device]

---------------------------------------------------------------------printout follows---------------------------------------------------------------------
NOTE DATED: 07/12/2004 08:00  NURSE INTRAOPERATIVE REPORT

SUBJECT: Case #: 267226

Operating Room: BO OR1  Surgical Priority: ELECTIVE

Patient in Hold: JUL 12, 2004  07:30  Patient in OR: JUL 12, 2004  08:00
Operation Begin: JUL 12, 2004  08:58  Operation End: JUL 12, 2004  12:30
Surgeon in OR: JUL 12, 2004  07:55  Patient Out OR: JUL 12, 2004  12:45

Major Operations Performed:
Primary: MVR

Wound Classification: CONTAMINATED
Operation Disposition: SICU
Discharged Via: ICU BED

Primary Surgeon: SURSURGEON,THREE  First Assist: SURSURGEON,FOUR
Attending Surgeon: SURSURGEON,THREE  Second Assist: N/A
Anesthetist: SURANESTHETIST,SEVEN  Assistant Anesth: N/A

Other Scrubbed Assistants: N/A

OR Support Personnel:
Scrubbed  Circulating
SURNURSE,ONE (FULLY TRAINED)  SURNURSE,FIVE (FULLY TRAINED)
SURNURSE,FOUR (FULLY TRAINED)

Other Persons in OR: N/A

Preop Mood: ANXIOUS  Preop Consc: ALERT-ORIENTED
Preop Skin Integ: INTACT  Preop Converse: N/A

--- Time Out Checklist ---
Confirm Correct Patient Identity: YES
Confirm Procedure to be Performed: YES
Confirm Site of the Procedure, including laterality: YES
Confirm Valid Consent: YES, 1-MED
Confirm Patient Position: YES
Confirm Proc. Site has been Marked Appropriately and that the Site of the
Mark is Visible After Prep and Draping: YES
Correct Medical Implant(s) Is Available: YES
Availability of Special Equipment: YES
Appropriate Antibiotic Prophylaxis: YES
Appropriate Deep Vein Thrombosis Prophylaxis: YES
Blood Availability: YES
Checklist Comment: NO COMMENTS ENTERED

Time-Out Document Completed By: SURNURSE,FOUR
Time-Out Completed:07/12/20040800

Skin Prep By: SURNURSE,FOUR  Skin Prep Agent: BETADINE SCRUB
Skin Prep By (2): SURNURSE,FIVE  2nd Skin Prep Agent: POVIDONE IODINE

Preop Surgical Site Hair Removal by: SURNURSE,FIVE
Surgical Site Hair Removal Method: OTHER
Hair Removal Comments: SHAVING AND DEPILATORY COMBINATION USED.

Surgery Position(s):
SUPINE  Placed: N/A

Restrains and Position Aids:
SAFTY STRAP  Applied By: N/A
ARMBOARD  Applied By: N/A
FOAM PADS  Applied By: N/A
KODEL PAD  Applied By: N/A
STIRRUPS  Applied By: N/A

Immediate Use Steam Sterilization Episodes:
Contamination: 0
SPS Processing/OR Management Issues: 0
Emergency Case: 0
No Better Option: 0
Loaner or Short Notice Instrument: 0
Decontamination of Instruments Contaminated During the Case: 0

Electrocautery Unit: 8845, 5512
ESU Coagulation Range: 50-35
ESU Cutting Range: 35-35
Electroground Position(s): RIGHT BUTTOCK
LEFT BUTTOCK

Material Sent to Laboratory for Analysis:
Specimens:
1. MITRAL VALVE

Cultures: N/A

Anesthesia Technique(s):
GENERAL (PRINCIPAL)

Tubes and Drains:
#16FOLEY, #18NGTUBE, #36 & #32RA CHEST TUBES

Tourniquet: N/A

Thermal Unit: N/A

Prosthesis Installed:
Item: MITRAL VALVE
Implant Sterility Checked (Y/N): YES
Sterility Expiration Date: DEC 15, 2004
RN Verifier: SURNURSE, ONE
Vendor: BAXTER EDWARDS
Model: 6900
Lot Number: T87-12321
Serial Number: 945673WRU
Sterile Resp: SPD
Size: LG
Provider Read Back Performed: YES

Medications: N/A

Irrigation Solution(s):
HEPARINIZED SALINE
NORMAL SALINE
COLD SALINE

Blood Replacement Fluids: N/A
Possible Item Retention: YES
Sponge Count: YES
Sharps Count: YES
Instrument Count: NOT APPLICABLE

Wound Sweep: * NOT ENTERED *
Wound Sweep Comment: NO COMMENTS ENTERED
Intra-Operative X-Ray: * NOT ENTERED *
Intra-Operative X-Ray Comment: NO COMMENTS ENTERED
Counter: SURNURSE, FOUR
Counts Verified By: SURNURSE, FIVE

Dressing: DSD, PAPER TAPE, MEPORE
Packing: NONE

Blood Loss: 800 ml
Urine Output: 750 ml

Postoperative Mood: RELAXED
Postoperative Consciousness: ANESTHETIZED
Postoperative Skin Integrity: SUTURED INCISION
Postoperative Skin Color: N/A

Laser Performed: (Multiple)

Sequential Compression Device: NO
Cell Saver(s): N/A

Devices: N/A

Transplant Information:
- Organ to be Transplanted: * NOT ENTERED *
- UNOS Identification Number of Donor: * NOT ENTERED *
- Donor Serology Hepatitis C Virus (HCV): * NOT ENTERED *
- Donor Serology Hepatitis B Virus (HBV): * NOT ENTERED *
- Donor Serology Cytomegalovirus (CMV): * NOT ENTERED *
- Donor Serology HIV: * NOT ENTERED *
- Donor ABO Type: * NOT ENTERED *
- Recipient ABO Type: * NOT ENTERED *
- Blood Bank Verification of ABO Type: * NOT ENTERED *
- Date/Time of Blood Bank ABO Verification: * NOT ENTERED *
- OR Verification of ABO Type: * NOT ENTERED *
- Surgeon Performing UNET Verification: * NOT ENTERED *
- UNET Verification by Surgeon: * NOT ENTERED *
- Surgeon Verifying Organ Prior to Anesthesia: * NOT ENTERED *
- Organ Verification Prior to Anesthesia: * NOT ENTERED *
- Elevated Organ Prior to Donor Anesthesia: * NOT ENTERED *
- Surgeon Verifying the Organ Prior to Transplant: * NOT ENTERED *
- Donor Organ Verification Prior to Transplant: * NOT ENTERED *
- Donor Vessel Usage: * NOT ENTERED *
- Donor Vessel Disposition if not used: * NOT ENTERED *
- Donor Vessel UNOS ID: * NOT ENTERED *

Immediate Use Steam Sterilization Episodes:
- Contamination: 0
- SPS Processing/OR Management Issues: 0
- Emergency Case: 0
- No Better Option: 0
- Loaner or Short Notice Instrument: 0
- Decontamination of Instruments Contaminated During the Case: 0

Nursing Care Comments:

PATIENT STATES HE IS ALLERGIC TO PCN. ALL WRVAMC INTRAOPERATIVE NURSING STANDARDS WERE MONITORED THROUGHOUT THE PROCEDURE. VANCOMYCIN PASTE WAS APPLIED TO STERNUM.

Signed by: /es/ FIVE SURNURSE
07/13/2004 10:41
07/17/2004 16:42 ADDENDUM

The Time-Out Document Completed By field was changed from SURNURSE, FOUR to SURNURSE, FIVE

Addendum Comment: OPERATION END TIME WAS CORRECTED.
Signed by: /es/ FIVE SURNURSE
07/17/2004 16:42
(This page included for two-sided copying.)
Example: ICD-10 Code

SRPATIENTA, ONE (000-12-3456) Case #45731
FEB 27, 2014 HEART TRANSPLANT

Other Postop Diagnosis:
1. ICD10 Code: E83.41 Hypermagnesemia
2. ICD10 Code: V72.1XXD Passenger on bus injured in clsn w 2/3-whl mv momtraf, Subs
3. Enter NEW Other Postop Diagnosis Code
Enter selection: (1-3): 1

SRPATIENTA, ONE (xxx-xx-xxxx) Case #45731
FEB 27, 2014 HEART TRANSPLANT

Other Postop Diagnosis:
1. ICD10 Code: E83.41 Hypermagnesemia

Select on of the following
1. Update Other Postop Diagnosis Code
2. Update Service Connected/Environmental Indicators only
Enter selection (1 or 2): 1/

When additional diagnoses and procedure codes are entered, the user should review the procedure to diagnosis associations to ensure that the associations are correct. In this example, additional associations will be assigned.

SURPATIENT, SEVENTEEN (000-45-5119) Case #314
JUL 15, 2005 CABG

Other Procedures:
1. CPT Code: 33510 CABG, VEIN, SINGLE
Modifiers: NOT ENTERED
Assoc. DX: NOT ENTERED

Only the following ICD Diagnosis Codes can be associated:
1. 402.01-HYP HEART DIS MALIGN WITH FAIL
2. 599.0-URIN TRACT INFECTION NOS

Select the number(s) of the Diagnosis Code to associate to the procedure selected: 1///1,2

SURPATIENT, SEVENTEEN (000-45-5119) Case #314
JUL 15, 2005 CABG

Other Procedures:
1. CPT Code: 33510 CABG, VEIN, SINGLE
Assoc. DX: 402.01-HYP HEART DIS MALIGN 599.0-URIN TRACT INFECTION N
2. Enter NEW Other Procedure Code
Enter selection: (1-2): <Enter>
Laser Performed: (Multiple)
Sequential Compression Device: NO
Cell Saver(s): N/A
Devices: N/A

Signed by: /es/ FIVE SURNURSE
03/04/2004 10:41
Non-OR Procedure Information
[SR NON-OR INFO]

The Non-OR Procedure Information option displays information on the selected non-OR procedure, with the exception of the provider's dictated summary.

This report prints in an 80-column format and can be viewed on the screen.

Example: Non-OR Procedure Information

```
SURPATIENT,FIFTEEN (000-98-1234)   Case #267260 - APR 22,2002

UV Update/Verify Procedure/Diagnosis Codes
OR Operation/Procedure Report
NR Nurse Intraoperative Report
PI Non-OR Procedure Information

Select CPT/ICD Update/Verify Menu Option: I Non-O.R. Procedure Information

DEVICE: HOME// [Select Print Device]

---printout follows---

SURPATIENT,FIFTEEN (000-98-1234) Age: 60                                     PAGE 1
NON-O.R. PROCEDURE - CASE #267260 Printed: AUG 04, 2004@14:40

-------------------------------------------------------------------------------
Med. Specialty: GENERAL       Location: NON OR
Principal Diagnosis: LARYNGEAL/TRACHEAL BURN
Provider: SURSURGEON,FIFTEEN Patient Status: NOT ENTERED
Attending:                        Attending Code:
Attend Anesth: N/A
Anesthesia Supervisor Code: N/A
Anesthetist: N/A
Anesthesia Technique(s): N/A
Proc Begin: JAN 14, 2004 08:00 Proc End: JAN 14, 2004 09:00
Procedure(s) Performed:
       Principal: BRONCHOSCOPY

Dictated Summary Expected: YES
Enter RETURN to continue or '^' to exit:
```
Update Site Configurable Files
[SR UPDATE FILES]

The Update Site Configurable Files option is designed for the package coordinator to add, edit, or inactivate file entries for the site-configurable files.

The software provides a numbered list of site-configurable files. The user should enter the number corresponding to the file that he or she wishes to update. The software will default to any previously entered information on the entry and provide a chance to edit it. The last prompt asks whether the user wants to inactivate the entry; answering Yes or 1 will inactivate the entry.

Example 1: Add a New Entry to a Site-Configurable File

Select Surgery Package Management Menu Option:  F  Update Site Configurable Files

<table>
<thead>
<tr>
<th>Update Site Configurable Surgery Files</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Surgery Transportation Devices</td>
</tr>
<tr>
<td>2. Prosthesis</td>
</tr>
<tr>
<td>3. Surgery Positions</td>
</tr>
<tr>
<td>4. Restraints and Positional Aids</td>
</tr>
<tr>
<td>5. Surgical Delay</td>
</tr>
<tr>
<td>6. Monitors</td>
</tr>
<tr>
<td>7. Irrigations</td>
</tr>
<tr>
<td>8. Surgery Replacement Fluids</td>
</tr>
<tr>
<td>9. Skin Prep Agents</td>
</tr>
<tr>
<td>10. Skin Integrity</td>
</tr>
<tr>
<td>11. Patient Mood</td>
</tr>
<tr>
<td>12. Patient Consciousness</td>
</tr>
<tr>
<td>13. Local Surgical Specialty</td>
</tr>
<tr>
<td>14. Electroground Positions</td>
</tr>
<tr>
<td>15. Special Equipment</td>
</tr>
<tr>
<td>16. Planned Implant</td>
</tr>
<tr>
<td>17. Pharmacy Items</td>
</tr>
<tr>
<td>18. Special Instruments</td>
</tr>
<tr>
<td>19. Special Supplies</td>
</tr>
</tbody>
</table>

Update Information for which File?  2

Update Information in the Prosthesis file.

Select PROSTHESIS NAME:  HUMERAL
ARE YOU ADDING 'HUMERAL' AS A NEW PROSTHESIS (THE 112TH)?  Y (YES)
NAME:  HUMERAL / HUMERAL COMPONENT
VENDOR:  AMERICAN
MODEL:  NEER II
STERILE RESP:  MANUFACTURER
SIZE:  STEM 150 MM, HEAD 22 MM
QUANTITY:  <Enter>
LOT NUMBER:  F19705-1087
SERIAL NUMBER:  <Enter>
INACTIVE?:  <Enter>

Select PROSTHESIS NAME:
Example 2: Re-Activate an Entry

Select Surgery Package Management Menu Option: F Update Site Configurable Files

Update Site Configurable Surgery Files

1. Surgery Transportation Devices
2. Prosthesis
3. Surgery Positions
4. Restraints and Positional Aids
5. Surgical Delay
6. Monitors
7. Irrigations
8. Surgery Replacement Fluids
9. Skin Prep Agents
10. Skin Integrity
11. Patient Mood
12. Patient Consciousness
13. Local Surgical Specialty
14. Electroground Positions
15. Special Equipment
16. Planned Implant
17. Pharmacy Items
18. Special Instruments
19. Special Supplies

Update Information for which File? 6

Update Information in the Monitors file.

Select MONITORS NAME: ECG ** INACTIVE **
NAME: ECG/ <Enter>
INACTIVE?: YES/ @
SURE YOU WANT TO DELETE? Y (YES)

Select MONITORS NAME:
1. GENERAL:
   
   C. Current Pneumonia:
      A. Height: 58 INCHES
   B. Weight:
      A. Ascites:
   
   3. HEPATOBILIARY:
      A. Diabetes - Long Term:
      B. Diabetes - 2 Wks Preop:
   
   4. GASTROINTESTINAL:
      A. Esophageal Varices:
   
   5. CARDIAC:
      A. Congestive Heart Failure: 1
      B. Prior MI:
      C. PCI:
      D. Prior Heart Surgery:
      E. Angina Severity:
      F. Angina Timeframe:
      G. Hypertension:
      H. Positive Drug Screening:
   
   6. VASCULAR:
      A. Ventilator Dependent:
      B. History of Severe COPD:
      C. PAD:
      D. Rest Pain/Gangrene:

Select Preoperative Information to Edit: A

2. PULMONARY:

GENERAL:

Patient's Height 65 INCHES//: 62
Patient's Weight 140 POUNDS//: 175
Diabetes Mellitus: Chronic, Long-Term Management: I INSULIN
Diabetes Mellitus: Management Prior to Surgery: I INSULIN
Tobacco Use: 2 NO USE IN LAST 12 MOS
Tobacco Use Timeframe: NOT APPLICABLE// <enter>
ETOH >2 Drinks Per Day in the Two Weeks Prior to Admission: N NO
Positive Drug Screening:
Dyspnea: N
   1 NO
   2 NO STUDY
Choose 1-2: 1 NO
Preoperative Sleep Apnea: LEVEL 1// 3 SLEEP APNEA CONFIRMED - LEVEL 3
Sleep Apnea-Compliance: ?
   Enter the level of the patient's reported compliance with sleep apnea
   Treatment.
   Choose from:
   1     NIGHTLY
   2     > OR EQUAL 4 TIMES A WEEK
   3     < 4 TIMES A WEEK
   4     NOT DOCUMENTED
Sleep Apnea-Compliance: 4 NOT DOCUMENTED
DNR Status (Y/N): N NO
Functional Status at Evaluation for Surgery: 1 INDEPENDENT
Current Residence (w/in 30 days prior to surgery): LONG TERM CARE// <Enter>
Ambulation Device: AMBULATES W/OUT ASSISTIVE DEVICE// <Enter>

PULMONARY: NO

HEPATOBILIARY: NO

GASTROINTESTINAL: NO

CARDIAC: NO

VASCULAR: NO
SURPATIENT,SIXTY (000-56-7821)        Case #63592
JUN 23,1998   CHOLEDOCHOTOMY

1. GENERAL:
   A. Height: 58 INCHES
   B. Weight:
   C. Diabetes - Long Term:
   D. Diabetes - 2 Wks Preop:
   E. Tobacco Use:
   F. Tobacco Use Timeframe: NOT APPLICABLE
   G. ETOH > 2 Drinks/Day:
   H. Positive Drug Screening:
   I. Dyspnea:
   J. Preop Sleep Apnea: LEVEL 3
   K. Sleep Apnea-Compliance: > OR EQUAL
   L. DNR Status:
   M. Functional Status: PARTIAL INDEPENDENT
   N. Current Residence: LONG TERM CARE
   O. Ambulation Device:

2. PULMONARY:
   A. Ventilator Dependent:
   B. History of Severe COPD:

1. RENAL:
   A. Acute Renal Failure:
   B. Currently on Dialysis:
   C. Steroid Use for Chronic Cond.:

2. CENTRAL NERVOUS SYSTEM:
   A. Impaired Sensorium:
   B. Coma:
   C. Hemiplegia:
   D. CVD Repair/Obstruct:
   E. History of CVD:
   F. Tumor Involving CNS:
   G. Impaired Cognitive Function:

3. NUTRITIONAL/IMMUNE/OTHER:
   A. Disseminated Cancer:
   B. Open Wound:
   C. Steroid Use for Chronic Cond.:

2. CARDIAC:
   A. Congestive Heart Failure:
   B. Prior MI:
   C. PCI:
   D. Previous Heart Surgeries:
   E. Angina Severity:
   F. Angina Timeframe:

2. PULMONARY:
   A. Peripheral Arterial Disease:
   B. Rest Pain/Gangrene:

Select Preoperative Information to Edit: <Enter>

SURPATIENT,SIXTY (000-56-7821)        Case #63592
JUN 23,1998   CHOLEDOCHOTOMY

1. RENAL:
   A. Acute Renal Failure:
   B. Currently on Dialysis:

2. CENTRAL NERVOUS SYSTEM:
   A. Impaired Sensorium:

3. NUTRITIONAL/IMMUNE/OTHER:
   A. Disseminated Cancer:
   B. Open Wound:
   C. Steroid Use for Chronic Cond.:

Bleeding (Coagulation) Disorders (Y/N): Y YES
Laboratory Test Results (Enter/Edit)  
[SROA LAB]

Use the *Laboratory Test Results (Enter/Edit)* option to enter or edit preoperative and postoperative lab information for an individual risk assessment. The option is divided into the three features listed below. The first two features allow the user to merge (also called “capture” or “load”) lab information into the risk assessment from the VistA software. The third feature provides a two-page summary of the lab profile and allows direct editing of the information.

1. Capture Preoperative Laboratory Information  
2. Capture Postoperative Laboratory Information  
3. Enter, Edit, or Review Laboratory Test Results

To “capture” preoperative lab data, the user must provide both the date and time the operation began. Likewise, to capture postoperative lab data, the user must provide both the date and time the operation was completed. If this information has already been entered, the system will not prompt for it again.

If assistance is needed while interacting with the software, entering one or two question marks (??) will access the on-line help.

**Example 1: Capture Preoperative Laboratory Information**

Select Non-Cardiac Assessment Information (Enter/Edit) Option: **LAB** Laboratory Test Results (Enter/Edit)

SURPATIENT,FORTY (000-77-7777)  Case #68112  
SEP 19, 2003  CHOLEDOCHOTOMY

--------

Enter/Edit Laboratory Test Results

1. Capture Preoperative Laboratory Information  
2. Capture Postoperative Laboratory Information  
3. Enter, Edit, or Review Laboratory Test Results

Select Number: 1

This selection loads the most recent lab data for tests performed within 90 days before the operation.

Do you want to automatically load preoperative lab data?  YES// <Enter>

The ‘Time Operation Began’ must be entered before continuing.

Do you want to enter ‘Time Operation Began’ at this time?  YES// <Enter>

Time the Operation Began: 8:00  (SEP 25, 2003@08:00)

..Searching lab record for latest preoperative test data...
..Moving preoperative lab test data to Surgery Risk Assessment file...

Press <RET> to continue  <Enter>
<table>
<thead>
<tr>
<th>Item</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Transfer Status:</td>
<td>NOT TRANSFERRED</td>
</tr>
<tr>
<td>2. Observation Admission Date/Time:</td>
<td>NA</td>
</tr>
<tr>
<td>3. Observation Discharge Date/Time:</td>
<td>NA</td>
</tr>
<tr>
<td>4. Observation Treating Specialty:</td>
<td>NA</td>
</tr>
<tr>
<td>5. Hospital Admission Date/Time:</td>
<td>JUN 06, 2005@14:15</td>
</tr>
<tr>
<td>6. Admit/Transfer to Surgical Svc.:</td>
<td>JUN 06, 2005@08:30</td>
</tr>
<tr>
<td>7. Discharge/Transfer to Chronic Care:</td>
<td>JUN 21, 2005@11:32</td>
</tr>
<tr>
<td>8. DC/REL Destination:</td>
<td></td>
</tr>
<tr>
<td>9. Length of Postop Hospital Stay:</td>
<td>15 Days</td>
</tr>
<tr>
<td>10. Hospital Admission Status:</td>
<td>ADMISSION</td>
</tr>
<tr>
<td>11. Patient's Ethnicity:</td>
<td>NOT HISPANIC OR LATINO</td>
</tr>
<tr>
<td>12. Patient's Race:</td>
<td>AMERICAN INDIAN OR ALASKA NATIVE, ASIAN</td>
</tr>
<tr>
<td>13. Date of Death:</td>
<td>NA</td>
</tr>
<tr>
<td>14. 30-Day Death:</td>
<td>NO</td>
</tr>
</tbody>
</table>

Select number of item to edit:
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

Definition Revised (2011): 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 had been completely closed and within 30 days of surgery. Patients with AICDs that fire but the patient does not lose consciousness should be excluded.

If patient had cardiac arrest requiring CPR, indicate whether the arrest occurred intraoperatively or postoperatively. Indicate the one appropriate response:
- intraoperatively: occurring while patient was in the operating room
- postoperatively: occurring after patient left the operating room.

Press RETURN to continue:
```

```
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: IMPROVE
6. Occurrence Comments: 
--------------------------------------------------------------------------------
Select Occurrence Information: 4:5
--------------------------------------------------------------------------------
Type of Treatment Instituted: CPR
Outcome to Date: I IMPROVE
```
Cardiac Risk Assessment Information (Enter/Edit)
[SROA CARDIAC ENTER/EDIT]

The Surgical Clinical Nurse Reviewer uses the options within the Cardiac Risk Assessment Information (Enter/Edit) menu to create a new risk assessment for a cardiac patient. Cardiac cases are evaluated differently from non-cardiac cases, and the prompts are different. This option is also used to make changes to an assessment that has already been entered.

The example below demonstrates how to create a new risk assessment for cardiac patients and get to the sub-option menu as follows.

<table>
<thead>
<tr>
<th>Shortcut</th>
<th>Option Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLIN</td>
<td>Clinical Information (Enter/Edit)</td>
</tr>
<tr>
<td>LAB</td>
<td>Laboratory Test Results (Enter/Edit)</td>
</tr>
<tr>
<td>CATH</td>
<td>Enter Cardiac Catheterization &amp; Angiographic Data</td>
</tr>
<tr>
<td>OP</td>
<td>Operative Risk Summary Data (Enter/Edit)</td>
</tr>
<tr>
<td>CARD</td>
<td>Cardiac Procedures Operative Data (Enter/Edit)</td>
</tr>
<tr>
<td>IO</td>
<td>Intraoperative Occurrences (Enter/Edit)</td>
</tr>
<tr>
<td>PO</td>
<td>Postoperative Occurrences (Enter/Edit)</td>
</tr>
<tr>
<td>R</td>
<td>Resource Data</td>
</tr>
<tr>
<td>U</td>
<td>Update Assessment Status to 'COMPLETE'</td>
</tr>
<tr>
<td>CODE</td>
<td>Alert Coder Regarding Coding Issues</td>
</tr>
</tbody>
</table>

These sub-options are used for entering more in-depth data for a case, and are described in this chapter.

Creating a New Risk Assessment

1. Enter either the patient’s name/patient ID (for example, SURPATIENT,NINETEEN) or the surgical case assessment number preceded by # (for example, #47063). If the patient has any previous assessments, they will be displayed. An asterisk (*) indicates a cardiac case. The user can now choose to create a new assessment or edit one of the previously entered assessments.

2. After choosing an operation on which to report, the user should respond YES to the prompt "Are you sure that you want to create a Risk Assessment for this surgical case?" The user must answer YES (or press the <Enter> key to accept the YES default) to get to any of the sub-options. If the answer given is NO, the case created in step 1 will not be considered an assessment, although it can appear on some lists, and the software will return the user to the "Select Patient:" prompt.

3. The screen will clear and present the sub-options menu. The user can select a sub-option now to enter more in-depth information for the case, or press the <Enter> key to return to the main menu.
Clinical Information (Enter/Edit)
[SROA CLINICAL INFORMATION]

The Clinical Information (Enter/Edit) option is used to enter the clinical information required for a cardiac risk assessment. 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 Clinical Information to Edit:" Prompt
At the "Select Clinical Information to Edit:" prompt, the user should enter the item number to edit. The user can then enter an A for ALL to respond to every item on the page, or enter a range of numbers separated by a colon (:) to respond to a range of items.

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. If assistance is needed while interacting with the software, the user can enter one or two question marks (??) to receive on-line help.

Example: Enter Clinical Information

Select Cardiac Risk Assessment Information (Enter/Edit) Option: CLIN Clinical Information (Enter/Edit)

SURPATIENT,NINETEEN (000-28-7354) Case #60183 PAGE: 1
JUN 18,2005 CORONARY ARTERY BYPASS

--------------------------------------------------------------------------------
1. Height: 70 in 17. PAD: NO
2. Weight: 185 lb 18. CVD Repair/Obstruct: NO CVD
5. COPD: NO 21. Angina Timeframe: W/N 14 DAY OF SU
6. FEV1: 9.3 liters 22. Congestive Heart Failure: 0
8. Tobacco Use: NEVER USED TOBACCO 24. IV NTG within 48 Hours: NO
11. Active Endocarditis: NO 27. Preop Atrial Fibrillation: NO
13. PCI: NONE 29. Sleep Apnea-Compliance: 
15. Num Prior Heart Surgeries: NONE
16. Prior Heart Surgery: NONE

--------------------------------------------------------------------------------
Select Clinical Information to Edit: A
Patient's Height: 63 INCHES
Patient's Weight: 170 LBS
Diabetes Mellitus: Chronic, Long-Term Management: I INSULIN
Diabetes Mellitus: Management Prior to Surgery: I INSULIN
History of Severe COPD (Y/N): Y YES
FEV1: NS
Cardiomegaly on Chest X-Ray (Y/N): Y YES
Tobacco Use: 3 CIGARETTES ONLY
Tobacco Use Timeframe: 1 WITHIN 2 WEEKS
Positive Drug Screening:
Active Endocarditis (Y/N): N NO
Functional Status: I INDEPENDENT
PCI: NONE
Prior MI: 1 YES, < OR EQUAL TO 7 DAYS PRIOR TO SURG
Number of Prior Heart Surgeries: 1 1

Prior heart surgeries:
0. NONE
1. CABG-ONLY
2. VALVE-ONLY
3. CABG/VALVE
4. OTHER
Enter your choice(s) separated by commas (0-5): 2
2 = VALVE-ONLY
Peripheral Arterial Disease: 2 YES-W/O ANGI, REVASC, or AMPUT
Prior Surgical Repair/Carotid Artery Obstruction: 0 NO CVD
History of CVD Events: 0 NO CVD
Angina Severity: IV CLASS IV
Angina Timeframe: 1 NO ANGINA
Preop Congestive Heart Failure: N CARD DX, CHF, OR SX

Current Diuretic Use (Y/N): Y YES
IV NTG within 48 Hours Preceding Surgery (Y/N): Y YES
Preoperative use of circulatory Device: N NONE
Hypertension: 2 YES WITHOUT MED
Preoperative Atrial Fibrillation: N NO
Preoperative Sleep Apnea: 1 NONE - LEVEL 1
Sleep Apnea-Compliance: IMPaired Cognitive Function in the 90 Days Preop: YES-DOCUMENTED HISTORY

Select Clinical Information to Edit:
Laboratory Test Results (Enter/Edit)  
[SROA LAB-CARDIAC]

The Laboratory Test Results (Edit/Edit) option is used to enter or edit preoperative laboratory test results for an individual cardiac risk assessment. The option is divided into the two features listed below. The first feature allows the user to merge (also called “capture” or “load”) lab information into the risk assessment from the VistA software. The second feature provides a two-page summary of the lab profile and allows direct editing of the information.

1. Capture Laboratory Information  
2. Enter, Edit, or Review Laboratory Test Results

To “capture” preoperative lab data, the user must provide both the date and time the operation began. If this information has already been entered, the system will not prompt for it again.

If assistance is needed while interacting with the software, entering one or two question marks (??) allows the user to access the on-line help.

About the "Select Laboratory 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.

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 Laboratory Test Results

Enter/Edit Laboratory Test Results
1. Capture Laboratory Information  
2. Enter, Edit, or Review Laboratory Test Results

Select Number: 1
This selection loads the most recent cardiac lab data for tests performed preoperatively.

Do you want to automatically load cardiac lab data ? YES// <Enter>

Searching lab record for latest test data....

Press <RET> to continue <Enter>
Enter/Edit Laboratory Test Results

1. Capture Laboratory Information
2. Enter, Edit, or Review Laboratory Test Results

Select Number: 2

1. HDL:                   NS
2. LDL:                   168 (JAN 2004)
3. Total Cholesterol:     321 (JAN 2004)
4. Serum Triglyceride:    >70 (JAN 2004)
5. Serum Potassium:       NS
6. Serum Bilirubin:       NS
7. Serum Creatinine:      NS
8. Serum Albumin:         NS
9. Hemoglobin:            NS
10. Hemoglobin A1c:       NS
11. BNP:                  NS

Select Laboratory Information to Edit: 1

1. HDL:                   NS
2. LDL:                   168 (JAN 2004)
3. Total Cholesterol:     321 (JAN 2004)
4. Serum Triglyceride:    >70 (JAN 2004)
5. Serum Potassium:       NS
6. Serum Bilirubin:       NS
7. Serum Creatinine:      NS
8. Serum Albumin:         NS
9. Hemoglobin:            NS
10. Hemoglobin A1c:       NS
11. BNP:                  NS

Select Laboratory Information to Edit:
Enter Cardiac Catheterization & Angiographic Data
[SROA CATHETERIZATION]

The Enter Cardiac Catheterization & Angiographic Data option is used to enter or edit cardiac catheterization and angiographic information for a cardiac risk assessment. 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 Cardiac Catheterization and Angiographic 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.

After the information 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 Cardiac Catheterization & Angiographic Data

Select Cardiac Risk Assessment Information (Enter/Edit) Option: CATH Enter Cardiac Catheterization & Angiographic Data

SURPATIENT,NINETEEN (000-28-7354) Case #60183 PAGE: 1 OF 2
JUN 18,2005 CORONARY ARTERY BYPASS

1. Procedure:
2. LVEDP:
3. Aortic Systolic Pressure:

For patients having right heart cath
4. PA Systolic Pressure:
5. PAW Mean Pressure:

6. LV Contraction Grade (from contrast or radionuclide angiogram or 2D echo):
7. Mitral Regurgitation:
8. Aortic Stenosis:

Select Cardiac Catheterization and Angiographic Information to Edit: A

SURPATIENT,NINETEEN (000-28-7354) Case #60183 PAGE: 1 OF 2
JUN 18,2005 CORONARY ARTERY BYPASS

Procedure Type: NS NO STUDY/UNKNOWN
Do you want to automatically enter 'NS' for NO STUDY for all other fields within this option ? YES// <Enter>
SURPATIENT,NINETEEN (000-28-7354)        Case #60183                    PAGE: 1 OF 2
JUN 18,2005   CORONARY ARTERY BYPASS

1. Procedure:  Cath
2. LVEDP:  56 mm Hg
3. Aortic Systolic Pressure:  120 mm Hg

For patients having right heart cath
4. PA Systolic Pressure:  30 mm Hg
5. PAW Mean Pressure:  15 mm Hg
6. LV Contraction Grade (from contrast or radionuclide angiogram or 2D echo): IIIa 0.40-0.44 MODERATE DYSFUNCTION A
7. Mitral Regurgitation:  MODERATE
8. Aortic Stenosis:  MILD

Select Cardiac Catheterization and Angiographic Information to Edit: <Enter>

----- Native Coronaries -----
1. Left main stenosis:  NS
2. LAD Stenosis:  NS
3. Right coronary stenosis:  NS
4. Circumflex Stenosis:  NS

Select Cardiac Catheterization and Angiographic Information to Edit: Right Coronary Artery Stenosis: NS// 30

----- Native Coronaries -----
1. Left main stenosis:  NS
2. LAD Stenosis:  NS
3. Right coronary stenosis:  30
4. Circumflex Stenosis:  NS

Select Cardiac Catheterization and Angiographic Information to Edit:
(This page included for two-sided copying.)
Operative Risk Summary Data (Enter/Edit)  
[SROA CARDIAC OPERATIVE RISK]

The Operative Risk Summary Data (Enter/Edit) option is used to enter or edit operative risk summary data for the cardiac surgery risk assessments. This option records the physician’s subjective estimate of operative mortality. To avoid bias, this should be completed preoperatively. 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 of the items, the <Enter> key can be pressed to proceed 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
>> Coding Complete <<
------------------------------------------------------------------
1. ASA Classification: 1-NO DISTURB.
2. Surgical Priority: 
3. Preoperative Risk Factors: NONE 
4. CPT Codes (view only): 33510 
5. Wound Classification: CLEAN 
------------------------------------------------------------------
Select Operative Risk Summary Information to Edit: 1:3

SURPATIENT,NINETEEN (000-28-7354) Case #60183
JUN 18,2005 CORONARY ARTERY BYPASS

------------------------------------------------------------------
ASA Class: 1-NO DISTURB. // 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 18,2005@13:29 (JUN 18, 2005@13:29)
```
Select Operative Risk Summary Information to Edit:

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.

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
JUN 18,2005 CORONARY ARTERY BYPASS
Operative Data details:
---------------------------------
1. Bridge to Transplant: 
2. Total CPB Time: 
3. Total Ischemic Time: 
4. Incision Type: 
5. Convert Off Pump to CPB: N/A (began on-pump/ stayed on-pump)
---------------------------------
Select Operative Information to Edit:
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>

...HMM, 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 PAGE: 1 OF 2
OCT 18,2007 CABG X3 USING LSVG TO OMB, LV EXT. OF RCA, LIMA TO LAD

1. Transfer Status: NON-VAMC ACUTE CARE HOSPITAL
2. Hospital Admission Date: OCT 03, 2007@08:00
3. Hospital Discharge Date: OCT 03, 2007@12:30
4. DC/REL Destination: ACUTE CARE FACIL TRANSFER VA/NON-VA
5. Cardiac Catheterization Date: MAY 14, 2015@12:07
6. Time Patient In OR: OCT 03, 2007@08:00
7. Date/Time Operation Began: OCT 03, 2007@09:00
8. Date/Time Operation Ended: OCT 03, 2007@10:00
9. Time Patient Out OR: OCT 03, 2007@12:30
10. Date/Time Patient Exhusted: OCT 03, 2007@14:35
11. Postop Intubation Hrs: +2.1
12. Date/Time Discharged from ICU: OCT 03, 2007@14:35
13. Homeless: NO
14. Employment Status Preoperatively: NOT EMPLOYED
15. Date of Death: NA
16. 30-Day Death: NO

SURPATIENT,TEN (000-12-3456) Case #49413 PAGE: 2 OF 2
OCT 18,2007 CABG X3 USING LSVG TO OMB, LV EXT. OF RCA, LIMA TO LAD

1. Current Residence: ACUTE CARE FACILITY
2. Ambulation Device: AMBULATES W/OUT ASSISTIVE DEVICE
3. History of Cancer: NO
4. History of Radiation Therapy: YES

November 2015 Surgery V. 3.0 User Manual 479
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.
Print a Surgery Risk Assessment
[SROA PRINT ASSESSMENT]

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**
05-07-23  000777777  NO  NSC VET

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--------------------------------------------------------------------------------------------------------------------------
VA NON-CARDIAC RISK ASSESSMENT  Assessment: 236  PAGE 1
FOR SURPATIENT, FORTY 000-77-7777 (COMPLETED)

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Center:</td>
<td>ALBANY</td>
</tr>
<tr>
<td>Age</td>
<td>81</td>
</tr>
<tr>
<td>Sex</td>
<td>MALE</td>
</tr>
<tr>
<td>Operation Date:</td>
<td>JAN 09, 2006</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>NOT HISPANIC OR LATINO</td>
</tr>
<tr>
<td>Race</td>
<td>AMERICAN INDIAN OR ALASKA</td>
</tr>
<tr>
<td>Other Pacific Islander</td>
<td>WHITE</td>
</tr>
<tr>
<td>Observation Admission Date</td>
<td>NA</td>
</tr>
<tr>
<td>Observation Discharge Date</td>
<td>NA</td>
</tr>
<tr>
<td>Hospital Admission Date</td>
<td>NOV 27, 2007 13:11</td>
</tr>
<tr>
<td>Admitted/Transferred to Surgical Service:</td>
<td>NOT ENTERED</td>
</tr>
<tr>
<td>Discharged/Transferred to Chronic Care:</td>
<td>NOT ENTERED</td>
</tr>
<tr>
<td>Hospital Admission Status</td>
<td></td>
</tr>
<tr>
<td>Assessment Completed by</td>
<td>SURNURSE, SEVEN</td>
</tr>
</tbody>
</table>

**PREOPERATIVE INFORMATION**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>GENERAL:</td>
<td>YES</td>
</tr>
<tr>
<td>HEPATOBILIARY:</td>
<td>YES</td>
</tr>
<tr>
<td>Height:</td>
<td>Ascites:</td>
</tr>
<tr>
<td>Weight:</td>
<td>GASTROINTESTINAL:</td>
</tr>
<tr>
<td>Diabetes - Long Term:</td>
<td>NO</td>
</tr>
<tr>
<td>Diabetes - 2 Wks Preop:</td>
<td>Esophageal Varices:</td>
</tr>
<tr>
<td>Tobacco Use:</td>
<td>NO</td>
</tr>
<tr>
<td>Tobacco Use Timeframe:</td>
<td>NOT APPLICABLE</td>
</tr>
<tr>
<td>ETOH &gt; 2 Drinks/Day:</td>
<td>NO</td>
</tr>
<tr>
<td>Positive Drug Screening:</td>
<td>Congestive Heart Failure:</td>
</tr>
<tr>
<td>Dyspnea:</td>
<td>Prior MI:</td>
</tr>
<tr>
<td>Sleep Apnea:</td>
<td>PCI:</td>
</tr>
<tr>
<td>Sleep Apnea - Compliance:</td>
<td>&gt; OR EQUI</td>
</tr>
<tr>
<td>DNR Status:</td>
<td>Prior Heart Surgery:</td>
</tr>
<tr>
<td>Functional Status:</td>
<td>Angina Severity:</td>
</tr>
<tr>
<td>Current Residence:</td>
<td>ACUTE CARE FACILITY</td>
</tr>
<tr>
<td>Ambulation Device:</td>
<td>Angina Timeframe:</td>
</tr>
<tr>
<td>PULMONARY:</td>
<td>Hypertension:</td>
</tr>
<tr>
<td>Ventilator Dependent:</td>
<td>VASCULAR:</td>
</tr>
<tr>
<td>History of Severe COPD:</td>
<td>PAD:</td>
</tr>
<tr>
<td>Current Pneumonia:</td>
<td>Rest Pain/Gangrene:</td>
</tr>
</tbody>
</table>

**PREOPERATIVE INFORMATION**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>RENAL:</td>
<td>NUTRITIONAL/IMMUNE/OTHER:</td>
</tr>
<tr>
<td>Acute Renal Failure:</td>
<td>Disseminated Cancer:</td>
</tr>
<tr>
<td>Currently on Dialysis:</td>
<td>Open Wound:</td>
</tr>
<tr>
<td>CENTRAL NERVOUS SYSTEM:</td>
<td>Steroid Use for Chronic Cond.:</td>
</tr>
<tr>
<td>Impaired Sensorium:</td>
<td>Weight Loss &gt; 10%:</td>
</tr>
<tr>
<td>Coma:</td>
<td>Bleeding Disorders:</td>
</tr>
<tr>
<td>Hemiplegia:</td>
<td>Bleeding Due To Med:</td>
</tr>
<tr>
<td>CVD Repair/Obstruct:</td>
<td>Transfusion &gt; 4 RBC Units:</td>
</tr>
<tr>
<td>History of CVD:</td>
<td>Chemo for Malig Last 90 Days:</td>
</tr>
<tr>
<td>Tumor Involving CNS:</td>
<td>Radiotherapy W/I 90 Days:</td>
</tr>
<tr>
<td>Impaired Cognitive Function:</td>
<td>Preoperative Sepsis:</td>
</tr>
<tr>
<td>History of Cancer:</td>
<td>Pregnancy:</td>
</tr>
<tr>
<td>History of Radiation Therapy:</td>
<td>NOT APPLICABLE</td>
</tr>
<tr>
<td>Prior Surg in Same Operative:</td>
<td></td>
</tr>
</tbody>
</table>

**OPERATION DATE/TIMES INFORMATION**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient in Room (PIR):</td>
<td>JUL 20, 2007 07:00</td>
</tr>
<tr>
<td>Procedure/Surgery Start Time (PST):</td>
<td>JUL 20, 2007 07:30</td>
</tr>
<tr>
<td>Procedure/Surgery Finish (PF):</td>
<td>JUL 20, 2007 08:30</td>
</tr>
<tr>
<td>Patient Out of Room (POR):</td>
<td>JUL 20, 2007 08:40</td>
</tr>
<tr>
<td>Anesthesia Start (AS):</td>
<td></td>
</tr>
<tr>
<td>Anesthesia Finish (AF):</td>
<td></td>
</tr>
<tr>
<td>Discharge from PACU (DPACU):</td>
<td></td>
</tr>
</tbody>
</table>
OUTCOME INFORMATION

Postoperative Diagnosis Code (ICD9): 540.1  ABSCESS OF APPENDIX
Length of Postoperative Hospital Stay: 3 DAYS
Date of Death: NO
Return to OR Within 30 Days: NO

PERIOPERATIVE OCCURRENCE INFORMATION

<table>
<thead>
<tr>
<th>Occurrence</th>
<th>Yes/No</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postoperative Diagnosis Code</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Length of Postoperative Hospital Stay</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Date of Death</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Return to OR Within 30 Days</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>WOUND OCCURRENCES:</td>
<td>YES</td>
<td>CNS OCCURRENCES:</td>
</tr>
<tr>
<td>Superficial Incisional SSI</td>
<td>NO</td>
<td>Stroke/CVA:</td>
</tr>
<tr>
<td>Deep Incisional SSI</td>
<td>NO</td>
<td>Coma &gt; 24 Hours:</td>
</tr>
<tr>
<td>Wound Disruption</td>
<td>01/10/06</td>
<td>Peripheral Nerve Injury:</td>
</tr>
<tr>
<td>* 427.31 ATRIAL FIBRILLATION</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>URINARY TRACT OCCURRENCES:</td>
<td>YES</td>
<td>CARDIAC OCCURRENCES:</td>
</tr>
<tr>
<td>Renal Insufficiency</td>
<td>NO</td>
<td>Arrest Requiring CPR:</td>
</tr>
<tr>
<td>Acute Renal Failure</td>
<td>NO</td>
<td>Myocardial Infarction:</td>
</tr>
<tr>
<td>Urinary Tract Infection</td>
<td>01/11/06</td>
<td></td>
</tr>
<tr>
<td>RESPIRATORY OCCURRENCES:</td>
<td>YES</td>
<td>OTHER OCCURRENCES:</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>NO</td>
<td>Bleeding/Transfusions:</td>
</tr>
<tr>
<td>Unplanned Intubation</td>
<td>NO</td>
<td>Graft/Prosthesis/Flap Failure:</td>
</tr>
<tr>
<td>Pulmonary Embolism</td>
<td>NO</td>
<td>DVT/Thrombophlebitis:</td>
</tr>
<tr>
<td>On Ventilator &gt; 48 Hours</td>
<td>NO</td>
<td>Systemic Sepsis: SEPTIC SHOCK</td>
</tr>
<tr>
<td>* 477.0 RHINITIS DUE TO P</td>
<td>01/12/06</td>
<td>Organ/Space SSI:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>C. difficile Colitis:</td>
</tr>
</tbody>
</table>

* indicates Other (ICD)
I. IDENTIFYING DATA
Case #: 45730
Patient: SQWNW, BILL 000-00-1941
Fac./Div. #: 442
Surgery Date: 01/27/14  Address:
Phone: NS/Unknown   Zip Code: NS/Unknown   Date of Birth: 08/11/57

II. CLINICAL DATA
Gender: MALE   Age: 67
Height: 70 in    Prior MI: UNKNOWN
Weight: 185 lb   Number of prior heart surgeries: NONE
Diabetes - Long Term: NO   Prior heart surgery: NONE
Diabetes - 2 Wks Preop: NO   PAD: NO
COPD: NO   CVD Repair/Obstruct: NO CVD
FEV1: 9.3 liters    History of CVD: NO CVD
Cardiomegaly (X-ray): YES   Angina Severity: NONE
Tobacco Use: NEVER USED TOBACCO   Angina Timeframe: W/N 14 DAY OF SURG
Tobacco Use Timeframe: NOT APPLICABLE   Congestive Heart Failure: 0-N CARD DX
Positive Drug Screening: NOT DONE   Current Diuretic Use: NO
Active Endocarditis: NO   Preop Circulatory Device: NONE
Functional Status: INDEPENDENT   Preoperative Atrial Fibrillation: NO
PCI: NONE   Hypertension: NO
Preop Sleep Apnea: LEVEL 1   Preoperative Circulatory Device: NONE
Sleep Apnea-Compliance: Impaired Cognitive Function: YES-DOCUEN

III. DETAILED LABORATORY INFO - PREOPERATIVE VALUES
Creatinine: mg/dl (NS)   T. Cholesterol: mg/dl (NS)
Hemoglobin: mg/dl (NS)   HDL: mg/dl (NS)
Albumin: g/dl (NS)   LDL: mg/dl (NS)
Triglyceride: mg/dl (NS)   Hemoglobin A1c: % (NS)
Potassium: mg/L (NS)   BNP: mg/dl (NS)
T. Bilirubin: mg/dl (NS)

IV. CARDIAC CATHETERIZATION AND ANGIOGRAPHIC DATA
Cardiac Catheterization Date:
Procedure: Native Coronaries:
LVEDP: mm Hg   Left Main Stenosis:
Aortic Systolic Pressure: mm Hg   LAD Stenosis:
Right Coronary Stenosis:
For patients having right heart cath: Circumflex Stenosis:
PA Systolic Pressure: mm Hg
PAW Mean Pressure: mm Hg
If a Re-do, indicate stenosis in graft to:
LAD:
Right coronary (include PDA):
Circumflex:
LV Contraction Grade (from contrast or radionuclide angiogram or 2D Echo):
Grade Ejection Fraction Range  Definition

Mitral Regurgitation:
Aortic stenosis:

V. OPERATIVE RISK SUMMARY DATA
ASA Classification:
Surgical Priority:
Principal CPT Code: CPT Code Missing
Other Procedures CPT Codes:
Wound Classification:

VI. OPERATIVE DATA
Bridge to Transplant:
Operative Data details
Total CPB Time: min   Total Ischemic Time: min
Incision Type:
Conversion Off Pump to CPB:

VII. OUTCOMES

Perioperative (30 day) Occurrences:

<table>
<thead>
<tr>
<th>Event</th>
<th>Occurrence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myocardial Infarction</td>
<td>YES</td>
</tr>
<tr>
<td>Endocarditis</td>
<td>NO</td>
</tr>
<tr>
<td>Superficial Incisional SSI</td>
<td>NO</td>
</tr>
<tr>
<td>Mediastinitis</td>
<td>NO</td>
</tr>
<tr>
<td>Cardiac Arrest Requiring CPR</td>
<td>NO</td>
</tr>
<tr>
<td>Reoperation for Bleeding</td>
<td>NO</td>
</tr>
<tr>
<td>On ventilator &gt; or = 48 hr</td>
<td>NO</td>
</tr>
<tr>
<td>Repeat cardiac Surg procedure</td>
<td>NO</td>
</tr>
<tr>
<td>Tracheostomy</td>
<td>NO</td>
</tr>
<tr>
<td>Unplanned Intub W/In 30 Days</td>
<td>NO</td>
</tr>
<tr>
<td>Stroke/CVA</td>
<td>NO SYMPTOMS</td>
</tr>
<tr>
<td>Coma &gt; or = 24 Hours</td>
<td>NO</td>
</tr>
<tr>
<td>New Mech Circulatory Support</td>
<td>NO</td>
</tr>
<tr>
<td>Postop Atrial Fibrillation</td>
<td>NO</td>
</tr>
<tr>
<td>Wound Disruption</td>
<td>NO</td>
</tr>
<tr>
<td>Renal Failure Requiring Dialysis</td>
<td>NO</td>
</tr>
</tbody>
</table>
VIII. RESOURCE DATA
Transfer Status:
Hospital Admission Date:

DC/REL Destination:
Time Patient In OR: Operation Began:
Operation Ended: Time Patient Out OR:
Date and Time Patient Extubated:
Postop Intubation Hrs:
Date and Time Patient Discharged from ICU:
Patient is Homeless:
Date of Death:
30-Day Death:
Current Residence: Ambulation Device:
History of Cancer: History of Radiation Therapy:
Prior Surg in Same Operative:

IX. SOCIOECONOMIC, ETHNICITY, AND RACE
Employment Status Preoperatively:
Ethnicity: UNANSWERED
Race Category(ies): UNANSWERED

X. DETAILED DISCHARGE INFORMATION
Discharge ICD-9 Codes:

Type of Disposition:
Place of Disposition:
Preferred VAMC identification code:

Primary care or referral VAMC identification code:
Follow-up VAMC identification code:

*** End of report for SQWMNW,BILL 000-00-1941 assessment #45730 ***

Enter RETURN to continue or '^' to exit:
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 (Deactivated)
5. List of All Major Surgical Cases (Deactivated)
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 (Deactivated)
5. List of All Major Surgical Cases (Deactivated)
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---------------------------------------------------------
## Example 2: List of Completed Assessments

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 (Deactivated)</td>
</tr>
<tr>
<td>5. List of All Major Surgical Cases (Deactivated)</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): 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-----------------------------------------------------------------------------
Example 3: List of Transmitted Assessments

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 (Deactivated)
5. List of All Major Surgical Cases (Deactivated)
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 // <Enter>

Start with Date: 1 1 06 (JAN 01, 2006)
End with Date: 6 30 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 // <Enter>

Print by Surgical Specialty? YES // <Enter>

Print report for ALL specialties? YES // N

Print the Report for which Surgical Specialty: GENERAL SURGERY 50

CHOOSE 1-3: <Enter> SURGERY GENERAL SURGERY 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]
**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 (Deactivated)
- 5. List of All Major Surgical Cases (Deactivated)
- 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**

This display is no longer used. Please select a different list.

Press Enter to continue
Page 496 has been deleted. The *List of Non-Assessed Major Surgical Cases* has been removed with patch SR*3*184.
**Example 5: List of All Major Surgical Cases**

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

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

This display is no longer used. Please select a different list.

Press Enter to continue
Page 498 has been deleted. The *List of All Major Surgical Cases* has been removed with patch SR#3#184.
**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 (Deactivated)
5. List of All Major Surgical Cases (Deactivated)
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]
**Example 7: List of Completed/Transmitted Assessments Missing Information**

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 (Deactivated)
5. List of All Major Surgical Cases (Deactivated)
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---

------------------------------------------------------------------------------------------------------------------
Example 8: List of 1-Liner Cases Missing Information

Select Surgery Risk Assessment Menu Option: 8 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 (Deactivated)
5. List of All Major Surgical Cases (Deactivated)
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---------------------------------------------------------------
Example 9: List of Eligible 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 (Deactivated)
5. List of All Major Surgical Cases (Deactivated)
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): 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 // <Enter>

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-----------------------------------------------------------------------------------
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 (Deactivated)
5. List of All Major Surgical Cases (Deactivated)
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---------------------------------------------------------
**Example 11: Summary List of Assessed 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 (Deactivated)
5. List of All Major Surgical Cases (Deactivated)
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]
Exclusion Criteria (Enter/Edit)

[SR NO ASSESSMENT REASON]

The Exclusion Criteria (Enter/Edit) option is used to flag major cases that will not have a surgery risk assessment due to certain exclusion criteria. At the prompt "Reason an Assessment was not Created:" enter a question mark (?) to see a list of reasons.

Example: Enter Reason for No Assessment

Select Surgery Risk Assessment Menu Option: R Exclusion Criteria (Enter/Edit)
Select Patient: R9922 SURPATIENT,NINE 03-03-34 000345555 NO SC

SURPATIENT,NINE 000-34-5555
1. 11-01-04 TURP (COMPLETED)
2. 08-01-03 CABG X3 (1A,2V), ARTERIAL GRAFTING (COMPLETED)
3. 07-03-01 PULMONARY LOBECTOMY, TURP (COMPLETED)

Select Operation: 1
Reason an Assessment was not Created: 6 10% RULE

SURPATIENT,NINE (000-34-5555) Case #63159
Transmission Status: QUEUED TO TRANSMIT
NOV 1,2004 TURP (CPT Code: 52601-59)

1. Exclusion Criteria: 10% RULE
2. Surgical Priority: ELECTIVE
3. Surgical Specialty: UROLOGY
4. Principal Anesthesia Technique: GENERAL
5. Major or Minor: MAJOR

Select Excluded Case Information to Edit:
MAYBERRY, NC
REPORT OF MONTHLY SURGICAL CASE WORKLOAD
FOR MAY 2007

TOTAL CASES PERFORMED - 249
TOTAL ELIGIBLE CASES - 227
CASES MEETING EXCLUSION CRITERIA - 114
NON-SURGEON CASE - 55
EXCEEDS MAX. ASSESSMENTS - 0
EXCEEDS MAXIMUM TURPS - 0
INCLSN CRTA NOT MET - 59
10% RULE - 0
CONCURRENT CASE - 0
EXCEEDS MAXIMUM HERNIAS - 0
ABORTED - 0
ASSESSED CASES - 135
NOT LOGGED ELIGIBLE CASES - 0
CARDIAC CASES - 16
NON-CARDIAC CASES - 119
ASSESSED CASES PER DAY - 6.75

NUMBER OF INCOMPLETE ASSESSMENTS REMAINING FOR PAST YEAR

<table>
<thead>
<tr>
<th></th>
<th>CARDIAC</th>
<th>NON-CARDIAC</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAY 2006</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>JUN 2006</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>JUL 2006</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>AUG 2006</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>SEP 2006</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>OCT 2006</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NOV 2006</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>DEC 2006</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>JAN 2007</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>FEB 2007</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MAR 2007</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>APR 2007</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MAY 2007</td>
<td>15</td>
<td>82</td>
<td>97</td>
</tr>
</tbody>
</table>

15 82 97
**ALBANY - ALL DIVISIONS**

**REPORT OF SURGICAL CASE WORKLOAD**

FOR OCT 2005 THROUGH MAY 2006

```
<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL CASES PERFORMED</td>
<td>30</td>
</tr>
<tr>
<td>TOTAL ELIGIBLE CASES</td>
<td>5</td>
</tr>
<tr>
<td>CASES MEETING EXCLUSION CRITERIA</td>
<td>1</td>
</tr>
<tr>
<td>NON-SURGEON CASE</td>
<td>0</td>
</tr>
<tr>
<td>ANESTHESIA TYPE</td>
<td>0</td>
</tr>
<tr>
<td>EXCEEDS MAX. ASSESSMENTS</td>
<td>0</td>
</tr>
<tr>
<td>EXCEEDS MAXIMUM TURPS</td>
<td>0</td>
</tr>
<tr>
<td>INCLSN CRTA NOT MET</td>
<td>0</td>
</tr>
<tr>
<td>10% RULE</td>
<td>1</td>
</tr>
<tr>
<td>CONCURRENT CASE</td>
<td>0</td>
</tr>
<tr>
<td>EXCEEDS MAXIMUM HERNIAS</td>
<td>0</td>
</tr>
<tr>
<td>ABORTED</td>
<td>0</td>
</tr>
<tr>
<td>ASSESSED CASES</td>
<td>20</td>
</tr>
<tr>
<td>NOT LOGGED ELIGIBLE CASES</td>
<td>0</td>
</tr>
<tr>
<td>CARDIAC CASES</td>
<td>4</td>
</tr>
<tr>
<td>NON-CARDIAC CASES</td>
<td>16</td>
</tr>
</tbody>
</table>
```

---

Pages 527-547 have been deleted. The *Transplant Assessment Menu* has been removed with patch SR*3*184.
### Chapter Nine: Glossary

The following table contains terms that are used throughout the *Surgery V.3.0 User Manual*, and will aid the user in understanding the use of the Surgery package.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aborted</td>
<td>Case status indicating the case was cancelled after the patient entered the operating room. The Cases shall be considered “ABORTED” if the TIME PAT OUT OR field (#.205) and/or TIME PAT IN OR field (#.232) and CANCEL DATE field (#17), and the CASE ABORTED field entered with “YES”.</td>
</tr>
<tr>
<td>ASA Class</td>
<td>This is the American Society of Anesthesiologists classification relating to the patient’s physiologic status. Numbers followed by an 'E' indicate an emergency.</td>
</tr>
<tr>
<td>Attending Code</td>
<td>Code that corresponds to the highest level of supervision provided by the attending staff surgeon during the procedure.</td>
</tr>
<tr>
<td>Blockout Graph</td>
<td>Graph showing the availability of operating rooms.</td>
</tr>
<tr>
<td>Cancelled Case</td>
<td>Case status indicating that an entry has been made in the CANCEL DATE field, CANCELLATION TIMEFRAME and/or the PRIMARY CANCEL REASON field without the patient entering the operating room.</td>
</tr>
<tr>
<td>CCSHS</td>
<td>VA Center for Cooperative Studies in Health Services located at Hines, Illinois.</td>
</tr>
<tr>
<td>CICSP</td>
<td>Continuous Improvement in Cardiac Surgery Program.</td>
</tr>
<tr>
<td>Completed Case</td>
<td>Case status indicating that an entry has been made in the TIME PAT OUT OR field.</td>
</tr>
<tr>
<td>Concurrent Case</td>
<td>A patient undergoing two operations by different surgical specialties at the same time, or back to back, in the same operating room.</td>
</tr>
<tr>
<td>CRT</td>
<td>Cathode ray tube display. A display device that uses a cathode ray tube.</td>
</tr>
<tr>
<td>Intraoperative Occurrence</td>
<td>Perioperative occurrence during the procedure.</td>
</tr>
<tr>
<td>Major</td>
<td>Any operation performed under general, spinal, or epidural anesthesia plus all inguinal herniorrhaphies and carotid endarterectomies regardless of anesthesia administered.</td>
</tr>
<tr>
<td>Minor</td>
<td>All operations not designated as Major.</td>
</tr>
<tr>
<td>New Surgical Case</td>
<td>A surgical case that has not been previously requested or scheduled such as an emergency case. A surgical case entered in the records without being booked through scheduling will not appear on the Schedule of Operations or as an operative request.</td>
</tr>
<tr>
<td>Non-Operative Occurrence</td>
<td>Occurrence that develops before a surgical procedure is performed.</td>
</tr>
<tr>
<td>Not Complete</td>
<td>Case status indicating one of the following two situations with no entry in the TIME PAT OUT OR field (#.232).</td>
</tr>
<tr>
<td></td>
<td>1) Case has entry in TIME PAT IN OR field (#.205).</td>
</tr>
<tr>
<td></td>
<td>2) Case has not been requested or scheduled.</td>
</tr>
<tr>
<td>NSQIP</td>
<td>National Surgical Quality Improvement Program.</td>
</tr>
<tr>
<td>Term</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Operation Code</td>
<td>Identifying code for reporting medical services and procedures performed by physicians. See CPT Code.</td>
</tr>
<tr>
<td>PACU</td>
<td>Post Anesthesia Care Unit.</td>
</tr>
<tr>
<td>Postoperative Occurrence</td>
<td>Perioperative occurrence following the procedure.</td>
</tr>
<tr>
<td>Procedure Occurrence</td>
<td>Occurrence related to a non-O.R. procedure.</td>
</tr>
<tr>
<td>Requested</td>
<td>Operation has been slotted for a particular day but the time and operating room are not yet firm.</td>
</tr>
<tr>
<td>Risk Assessment</td>
<td>Part of the Surgery software that provides medical centers a mechanism to track information related to surgical risk and operative mortality. Completed assessments are transmitted to the VASQIP national database for statistical analysis.</td>
</tr>
<tr>
<td>Scheduled</td>
<td>Operation has both an operating room and a scheduled starting time, but the operation has not yet begun.</td>
</tr>
<tr>
<td>Screen Server</td>
<td>A format for displaying data on a cathode ray tube display. Screen Server is designed specifically for the Surgery Package.</td>
</tr>
<tr>
<td>Screen Server Function</td>
<td>The Screen Server prompt for data entry.</td>
</tr>
<tr>
<td>Service Blockouts</td>
<td>The reservation of an operating room for a particular service on a recurring basis. The reservation is charted on a blockout graph.</td>
</tr>
<tr>
<td>Transplant Assessments</td>
<td>Part of the Surgery software that provides medical centers a mechanism to track information related to transplant risk and operative mortality. Completed assessments are transmitted to the VASQIP national database for statistical analysis. The Transplant Assessment Menu has been removed with patch SR<em>3</em>184.</td>
</tr>
<tr>
<td>VASQIP</td>
<td>Veterans Affairs Surgery Quality Improvement Program.</td>
</tr>
</tbody>
</table>
Index

A
AAIS, 437, 438
anesthesia
agents, 128, 160
entering data, 161
printing information, 170
staff, 162
techniques, 160
anesthesia agents
flagging a drug, 431
anesthesia personnel, 61, 128
assigning, 173
scheduling, 84
anesthesia technique
entering information, 165, 173
assessment
changing existing, 465
changing status of, 487
creating new, 465
upgrading status of, 464
Automated Anesthesia Information System (AAIS), 437, 438
B
bar code reader, 158
blockout an operating room, 85
blockout graph, 60
Blood Bank, 158
blood product
label, 158
verification, 158
book an operation, 25
book concurrent operation, 45
C
cancellation rates
calculations, 347
case
cancelled, 345
cardiac, 465
delayed, 338
designation, 96
editing cancelled, 400
list of requested, 57
scheduling, 96, 345
updating the cancellation date, 83
updating the cancellation reason, 83
verifying, 352
Chief of Surgery, 178, 251, 398
Code Set Versioning, 525
coding
checking accuracy of procedures, 310
entry, 207
validation, 207
comments
adding, 205
completed cases, 355, 357
PCE filing status of, 238, 273
report of, 232, 234, 257, 265, 267
reports on, 252
staffing information for, 284
surgical priority, 269
complications, 93, 459
concurrent case, 93
adding, 74
defined, 15
scheduling, 61
scheduling unrequested operations, 69
condensed characters, 26
count clinic
active, 278
CPT codes, 59, 207, 220, 224, 255, 525
CPT modifiers, 525
cultures, 153, 196
cutoff time, 15, 42
D
deaths
reviewing, 330
within 30 days of surgery, 183, 326
within 90 days of surgery, 330
delays
reasons for, 340
devices, 155
updating list of, 429
diagnosis, 113, 208, 238, 273
dosage, 157, 169
downloading Surgery set of codes, 438
E
electronically signing a report
Anesthesia Report, 131, 134
Nurse Intraoperative Report, 2
F
flag a drug, 431
G
Glossary, 549
H
HL7, 434, 435, 439
master file updates, 437, 438
I
ICD-10 codes, 207, 525
interim reports, 319
intraoperative occurrence
entering, 459, 475
irrigation solutions, 155
K
KERNEL audit log, 393
L
laboratory information, 95
entering, 451
Laboratory Package, 319
list of requested cases, 57
M
medical administration, 95
medications, 157, 169
mortality and morbidity rates, 183, 326
multiple fields, 108
N
new surgical case, 101
non-count encounters, 278
non-O.R. procedure, 187
deleting data, 188
editing data, 188
entering data, 188
NSQIP, 509, 519, 550
NSQIP transmission process, 521
nurse staffing information, 294
nursing care, 140
O
occurrence, 180
adding information about a postoperative, 178
dergiving, 176
entering, 176
intraoperative, 330, 459, 475
adding information about an, 176
M&M Verification Report, 330
number of for delayed operations, 340
postoperative, 330, 461
reviewing, 330
viewing, 324
Operating Room
determining use of, 414
entering information, 413
percent utilization, 361
rescheduling, 74
reserving on a recurring basis, 85
utilization reports, 415
viewing availability of, 26
viewing availability of, 60
Operating Room Schedule, 88, 253
operation
book concurrent, 45
booking, 25, 59
canceling scheduled, 81
close of, 119
discharge, 119
outstanding requests, 28
patient preparation, 108
post anesthesia recovery, 119
requesting, 25
rescheduling, 74
scheduled, 26
scheduled by surgical specialty, 91
scheduling requested, 59
scheduling unrequested, 64
starting time, 113
operation information
entering or editing, 455
operation request
deleting, 36
printing a list, 53
Options
Admissions Within 14 Days of Outpatient Surgery, 0
Anesthesia Data Entry Menu, 161
Anesthesia for an Operation Menu, 128
Anesthesia Information (Enter/Edit), 162
Anesthesia Menu, 160
Anesthesia Provider Report, 303
Anesthesia Report, 131, 170
Anesthesia Reports, 296
Anesthesia Technique (Enter/Edit), 165
Annual Report of Surgical Procedures, 255
Attending Surgeon Reports, 284
Blood Product Verification, 158
Cancel Scheduled Operation, 81
Cardiac Procedures Requiring CPB (Enter/Edit), 473
Chief of Surgery, 323
Chief of Surgery Menu, 321
Circulating Nurse Staffing Report, 294
Clinical Information (Enter/Edit), 467
Comments Option, 205
Comparison of Preop and Postop Diagnosis, 335
CPT Code Reports, 305
CPT/ICD-10 Coding Menu, 207
CPT/ICD-10 Update/Verify Menu, 208
Create Service Blockout, 85
Cumulative Report of CPT Codes, 220, 306
Deaths Within 30 Days of Surgery, 395
Delay and Cancellation Reports, 337
Delete a Patient from the Waiting List, 23
Delete or Update Operation Requests, 36
Delete Service Blockout, 87
Display Availability, 26, 60
Edit a Patient on the Waiting List, 22
Edit Non-O.R. Procedure, 189
Enter a Patient on the Waiting List, 21
Enter Cardiac Catheterization & Angiographic Data, 469
Enter Irrigations and Restraints, 155
Enter PAC(U) Information, 121, 125
Enter Referring Physician Information, 154
Enter Restrictions for 'Person' Fields, 426
Exclusion Criteria (Enter/Edit), 507
File Download, 437
Flag Drugs for Use as Anesthesia Agents, 431
Flag Interface Fields, 435
Intraoperative Occurrences (Enter/Edit), 176, 459, 475
Laboratory Interim Report, 319
Laboratory Test Results (Enter/Edit), 451, 470
List Completed Cases Missing CPT Codes, 230, 316
List of Anesthetic Procedures, 299
List of Operations, 232, 257
List of Operations (by Postoperative Disposition), 259
List of Operations (by Surgical Priority), 267
List of Operations (by Surgical Specialty), 234, 265
List of Surgery Risk Assessments, 489
List of Unverified Surgery Cases, 352
List Operation Requests, 57
List Scheduled Operations, 91
M&M Verification Report, 330, 513
Maintain Surgery Waiting List menu, 17
Make a Request for Concurrent Cases, 45
Make a Request from the Waiting List, 42
Make Operation Requests, 28
Make Reports Viewable in CPRS, 440
Management Reports, 252, 325
Medications (Enter/Edit), 157, 169
Monthly Surgical Case Workload Report, 509
Morbidity & Mortality Reports, 183, 326
Non-Cardiac Risk Assessment Information (Enter/Edit), 445
Non-O.R. Procedures, 187
Non-O.R. Procedures (Enter/Edit), 188
Non-Operative Occurrence (Enter/Edit), 180
Normal Daily Hours (Enter/Edit), 417
Nurse Intraoperative Report, 140, 217
Operating Room Information (Enter/Edit), 413
Operating Room Utilization (Enter/Edit), 415
Operating Room Utilization Report, 361, 419
Operation, 113
Operation (Short Screen), 122
Operation Information, 103
Operation Information (Enter/Edit), 455
Operation Menu, 95
Operation Report, 129
Operation Requests for a Day, 53
Operation Startup, 108
Operation/Procedure Report, 213
Operative Risk Summary Data (Enter/Edit), 471
Outpatient Encounters Not Transmitted to NPCD, 278
Patient Demographics (Enter/Edit), 457
PCE Filing Status Report, 238, 273
Perioperative Occurrences Menu, 175
Person Field Restrictions Menu, 425
Post Operation, 119
Postoperative Occurrences (Enter/Edit), 178, 461, 477
Print 30 Day Follow-up Letters, 503
Print a Surgery Risk Assessment, 481
Print Blood Product Verification Audit Log, 393
Print Surgery Waiting List, 18
Procedure Report (Non-O.R.), 193
Purge Utilization Information, 424
Queue Assessment Transmissions, 521
Remove Restrictions on 'Person' Fields, 428
Report of Cancellation Rates, 347
Report of Cancellations, 345
Report of Cases Without Specimens, 357
Report of CPT Coding Accuracy, 224, 310
Report of Daily Operating Room Activity, 236, 271, 355
Report of Delay Reasons, 340
Report of Delay Time, 342
Report of Delayed Operations, 338
Report of Missing Quarterly Report Data, 0
Report of Normal Operating Room Hours, 421
Report of Returns to Surgery, 353
Report of Surgical Priorities, 269
Report of Unscheduled Admissions to ICU, 359
Request Operations menu, 25
Requests by Ward, 55
Reschedule or Update a Scheduled Operation, 74
Resource Data (Enter/Edit), 479
Review Request Information, 52
Risk Assessment, 465
Schedule Anesthesia Personnel, 84, 173
Schedule of Operations, 88, 253
Schedule Operations, 59
Schedule Requested Operation, 61
Schedule Unrequested Concurrent Cases, 69
Schedule Unrequested Operations, 64
Scrub Nurse Staffing Report, 292
Surgeon Staffing Report, 288
Surgeon’s Verification of Diagnosis & Procedures, 125
Surgery Interface Management Menu, 434
Surgery Package Management Menu, 409
Surgery Reports, 251
Surgery Site Parameters (Enter/Edit), 410
Surgery Staffing Reports, 283
Surgery Utilization Menu, 414
Surgical Nurse Staffing Report, 290
Surgical Staff, 104
Table Download, 438
Tissue Examination Report, 153
Unlock a Case for Editing, 398
Update I-Liner Case, 519
Update Assessment Completed/Transmitted in Error, 487
Update Assessment Status to ‘Complete’, 464, 0
Update Assessment Status to ‘COMPLETE’, 481
Update Cancellation Reason, 83
Update Cancelled Cases, 400
Update Interface Parameter Field, 439
Update O.R. Schedule Devices, 429
Update Operations as Unrelated/Related to Death, 401
Update Site Configurable Files, 432
Update Staff Surgeon Information, 430
Update Status of Returns Within 30 Days, 181, 399, 463
Update/Verify Procedure/Diagnosis Codes, 209, 402
View Patient Perioperative Occurrences, 324
Wound Classification Report, 363
Options:, 196, 197, 221
outstanding requests defined, 15
P
PACU, 121
PCE filing status, 238, 273
percent utilization, 361, 419
person-type field
assigning a key, 426
removing a key, 426, 428
Pharmacy Package Coordinator, 431
positioning devices, 155
Post Anesthesia Care Unit (PACU), 121
postoperative occurrence entering, 461, 474, 477
preoperative assessment entering information, 448
preoperative information, 15 editing, 52
entering, 29, 65
reviewing, 52
updating, 74
Preoperative Information (Enter/Edit), 448
principal diagnosis, 103
procedure deleting, 23
dictating a summary, 189
editing data for non-O.R., 189
entering data for non-O.R., 189
filed as encounters, 278
summary for non-O.R., 193
purging utilization information, 424
Q
quick reference on a case, 103
R
Referring physician information, 154
reporting
tracking cancellations, 337
tracking delays, 337
reports
Admissions Within 14 Days of Outpatient Surgery Report, 0
Anesthesia Provider Report, 303
Anesthesia Report, 131
Annual Report of Surgical Procedures, 255
Attending Surgeon Cumulative Report, 284, 286
Attending Surgeon Report, 284
Cases Without Specimens, 357
Circulating Nurse Staffing Report, 294
Clean Wound Infection Summary, 367
Comparison of Preop and Postop Diagnosis, 335
Completed Cases Missing CPT Codes, 230, 316
Cumulative Report of CPT Codes, 220, 222, 306, 308
Daily Operating Room Activity, 236
Daily Operating Room Activity, 271
Surgical Service Chief, 321
Surgical Service managers, 410
surgical specialty, 21, 57, 74, 234
Surgical staff, 104
T
time given, 157, 169
transfusion
error risk management, 158
U
utilization information, 361, 419
purging, 424
V
VA Central Office, 255

W
Waiting List
adding a new case, 21
deleting a procedure, 23
editing a patient on the, 22
entering a patient, 21
printing, 18
waiting lists, 17
workload
report, 509
uncounted, 278
wound classification, 363
(This page blank to preserve original page numbering)