SURGERY

USER MANUAL

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Department of Veterans Affairs
Veterans Health Information Technology

Revision History

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

Date	Revised Pages	Patch Number	Description
04/08	iii-iv, vi, 160, 165, 168, 171-172, 296-298, 443, 447, 449-450, 459, 471-473, 479-479a, 482, 486-486a, 489, 491, 493-495, 497, 499, 501-502a, 502c, 502d-502h, 513-517, 522c-522d, 529, 534	SR*3*166	Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software. For more details, see the *Surgery NSQIP-CICSP Enhancements 2008 Release Notes.* REDACTED
11/07	479-479a, 486a	SR*3*164	Updated the *Resource Data Enter/Edit* and the *Print a Surgery Risk Assessment* options to reflect the new cardiac field for CT Surgery Consult Date. REDACTED
09/07	125, 371, 375, 382	SR*3*163	Updated the Service Classification section regarding environmental indicators, unrelated to this patch. Updated the Quarterly Report to reflect updates to the numbers and names of specific specialties in the NATIONAL SURGICAL SPECIALTY file. REDACTED
06/07	35, 210, 212b	SR*3*159	Updated screens to reflect change of the environmental indicator “Environmental Contaminant” to “SWAC” (e.g., Southwest Asia). REDACTED
06/07	176-180, 180a, 184c-d, 327c-d, 372, 375-376, 446, 449-450, 452-453, 455-456, 458, 461, 468, 470, 472, 479-479a, 482-484, 486a, 489, 491, 493, 495, 497, 499, 501, 502a-d, 504-506, 509-512, 519	SR*3*160	Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software. For more details, see the *Surgery NSQIP-CICSP Enhancements 2007 Release Notes.* Updated data entry screens to match software; changes are unrelated to this patch. REDACTED

Date	Revised Pages	Patch Number	Description
11/06	10-12, 14, 21-22, 139-141, 145-150, 152, 219, 438	SR*3*157	Updated data entry options to display new fields for collecting sterility information for the Prosthesis Installed field; updated the Nurse Intraoperative Report section with these required new fields. For more details, see the *Surgery-Tracking Prosthesis Items Release Notes*. Updated data entry screens to match software; changes are unrelated to this patch. REDACTED
08/06	6-9, 14, 109-112, 122-124, 141-149, 151-152, 176, 178-180, 180a-b, 181-184, 184a-d, 185-186, 218-219, 326-327, 327a-d, 328-329, 373, 377, 449-450, 452-456, 459, 461-462, 467-468, 468b, 469-470, 470a, 473-474, 474a-474b, 475, 477, 481-486, 486a-b, 489-502, 502a-b, 503-504, 509-512	SR*3*153	Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software. Updated data entry options to incorporate renamed/new Hair Removal documentation fields. Updated the Nurse Intraoperative Report and Quarterly Report to include these fields. For more details, see the *Surgery NSQIP/CICSP Enhancements 2006 Release Notes.* REDACTED
06/06	28-32, 40-50, 64-80, 101-102	SR*3*144	Updated options to reflect new required fields (Attending Surgeon and Principal Preoperative Diagnosis) for creating a surgery case. REDACTED
06/06	vi, 34-35, 125, 210, 212b, 522a-b	SR*3*152	Updated Service Classification screen example to display new PROJ 112/SHAD prompt. This patch will prevent the PRIN PRE-OP ICD DIAGNOSIS CODE field of the Surgery file from being sent to the Patient Care Encounter (PCE) package. Added the new *Alert Coder Regarding Coding Issues* option to the Surgery Risk Assessment Menu option. REDACTED
04/06	445, 464a-b, 465, 480a-b	SR*3*146	Added the new *Alert Coder Regarding Coding Issues* option to the Assessing Surgical Risk chapter. REDACTED

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Example: Option displayed with discrepancies

```
Select Operation Menu Option: BLOOD PRODUCT VERIFICATION

To use BAR CODE READER
               Pass reader wand over a GROUP-TYPE ( ABO/Rh) label
                         =>
Enter Blood Product Identifier: KW10945

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

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

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

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

                       **WARNING**

 Blood Product Expiration Date is later than today's date.
```

Anesthesia Menu
[SROANES1]

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

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

Shortcut	Option Name
E	*Anesthesia Data Entry Menu*
R	*Anesthesia Report*
S	*Schedule Anesthesia Personnel*

Prerequisites

To use the *Anesthesia Data Entry Menu* or the *Anesthesia Report* option, the user must first select a patient case. The user must select an operating room to use the *Schedule Anesthesia Personnel* option.

Anesthesia Technique (Enter/Edit)
[SROMEN-ANES TECH]

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

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

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

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

About the prompts

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

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

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

Example 1: General Technique

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

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

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

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

Example 2: Monitored Anesthesia Care Technique

```
Select Anesthesia Data Entry Menu Option: T Anesthesia Technique (Enter/Edit)
Diagnostic/Therapeutic (Y/N): NO//  <Enter>
Select ANESTHESIA TECHNIQUE: M (MONITORED ANESTHESIA CARE)
  Is this the Principal Technique (Y/N): YES// <Enter> YES
  Was the Patient Intubated ? (Y/N): N  NO
  Select ANESTHESIA AGENTS: VALIUM
    Dose (mg):  5
Oral-Pharyngeal (OP) Score: CLASS 1// <Enter>
Mandibular Space (length in mm): 65// <Enter>
Airway Index: 1. INDEX LESS THAN OR EQUAL TO 0//NO   (No Editing)
GENERAL COMMENTS:
  1> <Enter>
```

Example 3: Spinal Technique

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

Example 4: Epidural Technique

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

Example 5: Other Technique

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

Example 6: Local Technique

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

Example 7: Regional Technique

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

Page 171 has been deleted. The *Anesthesia AMIS* option has been removed.

Page 172 has been deleted. The Anesthesia AMIS option has been removed.

```
                                                MAYBERRY, NC                                            PAGE: 1
                                              SURGICAL SERVICE                          REVIEWED BY:
                                     CIRCULATING NURSE STAFFING REPORT                  DATE REVIEWED:
                                     FROM: MAR 2,2001  TO: MAR 31,2001                  DATE PRINTED: APR 21,2001

DATE       PATIENT                          OPERATION(S)                         SCRUB NURSE         CIRC. NURSE     TIME IN
CASE #      ID#                                                                                                     TIME OUT
                                                                                                                ELAPSED (MINS)
==================================================================================================================================

                                                ** SURNURSE,SEVEN **

03/10/01 SURPATIENT,FIFTYONE       DRAINAGE OF OVARIAN CYST                      SURNURSE,THREE      SURNURSE,SEVEN     07:00
189      000-23-3221                                                                                                  08:54
                                                                                                                        114

                                                 ** SURNURSE,ONE **

03/09/01 SURPATIENT,NINE           CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM SURNURSE,THREE      SURNURSE,ONE       09:15
187      000-34-5555                                                                                                  12:40
                                                                                                                        205

03/10/01 SURPATIENT,FIFTY          HEMORRHOIDECTOMY                              SURNURSE,THREE      SURNURSE,ONE       14:00
200      000-45-9999                                                                                                  14:55
                                                                                                                         55

03/17/01 SURPATIENT,FOURTEEN       CHOLECYSTECTOMY                               SURNURSE,THREE      SURNURSE,ONE       12:55
203      000-45-7212                                                                                                  14:30
                                                                                                                         95

03/18/01 SURPATIENT,SEVENTEEN      REPAIR INCARCERATED INGUINAL HERNIA           SURNURSE,THREE      SURNURSE,ONE       07:30
202      000-45-5119                                                             SURNURSE,SEVEN                         09:03
                                                                                                                         93

                                                ** SURNURSE,TWO **

03/03/01 SURPATIENT,SIXTY          REMOVE CATARACTS, RETRO BULBAR BLOCK          SURNURSE,THREE      SURNURSE,TWO       09:00
205      000-56-7821                                                                                                  09:20
```

Anesthesia Reports
[SR ANESTH REPORTS]

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

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

Shortcut	Option Name
P	*List of Anesthetic Procedures*
D	*Anesthesia Provider Report*

Page 297 has been deleted. The *Anesthesia AMIS* option has been removed.

Page 298 has been deleted. The *Anesthesia AMIS* option has been removed.

Surgery Risk Assessment Menu
[SROA RISK ASSESSMENT]

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

This option is locked with the SR RISK ASSESSMENT key.

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

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

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

(This page included for two-sided copying.)

Editing an Incomplete Risk Assessment

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

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

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

```
Select Patient: #210
```

```
SURPATIENT,TEN  000-12-3456

03-22-02      HIP REPLACEMENT (INCOMPLETE)

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

Select Number: 1// <Enter>
```

```
Division: ALBANY  (500)

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


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

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

These options are described in the following sections.

Preoperative Information (Enter/Edit)
[SROA PREOP DATA]

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

About the "Select Preoperative Information to Edit:" Prompt

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

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

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

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

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

Example 1: Enter/Edit Preoperative Information

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

```
This patient had a previous non-cardiac operation on APR 28,1998@09:00

Case #63592  CHOLEDOCHOTOMY

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

```
SURPATIENT,SIXTY (000-56-7821)        Case #63592                 PAGE: 1 OF 2
JUN 23,1998   CHOLEDOCHOTOMY
--------------------------------------------------------------------------------
1. GENERAL:                               4. GASTROINTESTINAL:
  A. Height:                                A. Esophageal Varices:
  B. Weight:
  C. Diabetes Mellitus:                   5. CARDIAC:
  D. Current Smoker W/I 1 Year:             A. CHF Within 1 Month:
  E. ETOH > 2 Drinks/Day:                   B. MI Within 6 Months:
  F. Dyspnea:                               C. Previous PCI:
  G. DNR Status:                            D. Previous Cardiac Surgery:
  H. Preop Funct Status:                    E. Angina Within 1 Month:
                                            F. Hypertension Requiring Meds:
2. PULMONARY:
  A. Ventilator Dependent:                6. VASCULAR:
  B. History of Severe COPD:                A. Revascularization/Amputation:
  C. Current Pneumonia:                     B. Rest Pain/Gangrene:

3. HEPATOBILIARY:
  A. Ascites:
--------------------------------------------------------------------------------
Select Preoperative Information to Edit: 1:3
```

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



GENERAL: YES
```

```
Patient's Height 65 INCHES//: 62
Patient's Weight 140 POUNDS//: 175
Diabetes Mellitus Requiring Therapy With Oral Agents or Insulin: I INSULIN
Current Smoker: Y  YES
ETOH >2 Drinks Per Day in the Two Weeks Prior to Admission: N  NO
Dyspnea: N
     1   NO
     2   NO STUDY
Choose 1-2: 1  NO
DNR Status (Y/N): N  NO
Functional Health Status at Evaluation for Surgery: 1 INDEPENDENT

PULMONARY: NO

HEPATOBILIARY: NO
```

```
SURPATIENT,SIXTY (000-56-7821)        Case #63592                 PAGE: 1 OF 2
JUN 23,1998   CHOLEDOCHOTOMY
--------------------------------------------------------------------------------
1. GENERAL:                       YES      4. GASTROINTESTINAL:
  A. Height:                    62 INCHES    A. Esophageal Varices:
  B. Weight:                     175 LBS.
  C. Diabetes Mellitus:           INSULIN 5. CARDIAC:
  D. Current Smoker W/I 1 Year: YES        A. CHF Within 1 Month:
  E. ETOH > 2 Drinks/Day:         NO         B. MI Within 6 Months:
  F. Dyspnea:                     NO         C. Previous PCI:
  G. DNR Status:                  NO         D. Previous Cardiac Surgery:
  H. Preop Funct Status:   INDEPENDENT     E. Angina Within 1 Month:
                                             F. Hypertension Requiring Meds:
2. PULMONARY:                     NO
  A. Ventilator Dependent:        NO       6. VASCULAR:
  B. History of Severe COPD:      NO         A. Revascularization/Amputation:
  C. Current Pneumonia:           NO         B. Rest Pain/Gangrene:

3. HEPATOBILIARY:                 NO
  A. Ascites:                     NO
--------------------------------------------------------------------------------
Select Preoperative Information to Edit: <Enter>
```

```
SURPATIENT,SIXTY (000-56-7821)        Case #63592                 PAGE: 2 OF 2
JUN 23,1998   CHOLEDOCHOTOMY
--------------------------------------------------------------------------------

1. RENAL:                                 3. NUTRITIONAL/IMMUNE/OTHER:
  A. Acute Renal Failure:                   A. Disseminated Cancer:
  B. Currently on Dialysis:                 B. Open Wound:
                                            C. Steroid Use for Chronic Cond.:
2. CENTRAL NERVOUS SYSTEM:                  D. Weight Loss > 10%:
  A. Impaired Sensorium:                    E. Bleeding Disorders:
  B. Coma:                                  F. Transfusion > 4 RBC Units:
  C. Hemiplegia:                            G. Chemotherapy W/I 30 Days:
  D. History of TIAs:                       H. Radiotherapy W/I 90 Days:
  E. CVA/Stroke w. Neuro Deficit:           I. Preoperative Sepsis:
  F. CVA/Stroke w/o Neuro Deficit:          J. Pregnancy:          NOT APPLICABLE
  G. Tumor Involving CNS:
--------------------------------------------------------------------------------
Select Preoperative Information to Edit: 3E
```

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

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

```
SURPATIENT,SIXTY (000-56-7821)        Case #63592                 PAGE: 2 OF 2
JUN 23,1998   CHOLEDOCHOTOMY
--------------------------------------------------------------------------------

. RENAL:                                 3. NUTRITIONAL/IMMUNE/OTHER:
  A. Acute Renal Failure:                   A. Disseminated Cancer:
  B. Currently on Dialysis:                 B. Open Wound:
                                            C. Steroid Use for Chronic Cond.:
2. CENTRAL NERVOUS SYSTEM:                  D. Weight Loss > 10%:
  A. Impaired Sensorium:                    E. Bleeding Disorders:            YES
  B. Coma:                                  F. Transfusion > 4 RBC Units:
  C. Hemiplegia:                            G. Chemotherapy W/I 30 Days:
  D. History of TIAs:                       H. Radiotherapy W/I 90 Days:
  E. CVA/Stroke w. Neuro Deficit:           I. Preoperative Sepsis:
  F. CVA/Stroke w/o Neuro Deficit:          J. Pregnancy:          NOT APPLICABLE
  G. Tumor Involving CNS:
--------------------------------------------------------------------------------
Select Preoperative Information to Edit:
```

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

 1. Transfer Status:
 2. Observation Admission Date/Time:
 3. Observation Discharge Date/Time:
 4. Observation Treating Specialty:
 5. Hospital Admission Date/Time:
 6. Hospital Discharge Date/Time:
 7. Admit/Transfer to Surgical Svc.:
 8. Discharge/Transfer to Chronic Care:
 9. Length of Postop Hospital Stay:
10. In/Out-Patient Status:              INPATIENT
11. Patient's Ethnicity:                UNANSWERED
12. Patient's Race:                     UNANSWERED
13. Date of Death:
14. Date Surgery Consult Requested:
15. Surgery Consult Date:               JAN 12, 2005

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

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

Press RETURN to continue: <Enter>
```

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

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

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

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

Type of Treatment Instituted: CPR
Outcome to Date: I  IMPROVED
```

Operative Risk Summary Data (Enter/Edit) [SROA CARDIAC OPERATIVE RISK]

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

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

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

Example: Operative Risk Summary Data

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

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

 1. Physician's Preoperative Estimate of Operative Mortality: 78
    A. Date/Time Collected
 2. ASA Classification:        1-NO DISTURB.
 3. Surgical Priority:
 4. Date/Time Operation Began: JUN 18,2005 07:00
 5. Date/Time Operation Ended: JUN 18,2005 09:00
 6. Preoperative Risk Factors: NONE

 7. CPT Codes (view only):     33510   <---- This information cannot be edited.
-------------------------------------------------------------------------------

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

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



Physician's Preoperative Estimate of Operative Mortality: 32
Date/Time of Estimate of Operative Mortality: JUN 17,2005@18:15
         // <Enter>
ASA Class: 3 3-SEVERE DISTURB.
Cardiac Surgical Priority: ?
     Enter the surgical priority that most accurately reflects the acuity of
     patient's cardiovascular condition at the time of transport to the
     operating room.
     CHOOSE FROM:
       1        ELECTIVE
       2        URGENT
       3        EMERGENT (ONGOING ISCHEMIA)
       4        EMERGENT (HEMODYNAMIC COMPROMISE)
       5        EMERGENT (ARREST WITH CPR)
Cardiac Surgical Priority: 3 EMERGENT (ONGOING ISCHEMIA)
Date/Time of Cardiac Surgical Priority:  JUN 17,2005@13:29
         // <Enter>
```

```
SURPATIENT,NINETEEN (000-28-7354)   Case #60183                    PAGE: 1
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------
 1. Physician's Preoperative Estimate of Operative Mortality: 32%
    A. Date/Time Collected:    JUN 17,2005 18:15
 2. ASA Classification:        3-SEVERE DISTURB.
 3. Surgical Priority:         EMERGENT (ONGOING ISCHEMIA)
    A. Date/Time Collected:    JUN 17,2005 09:46
4.   Date/Time Operation Began: JUN 18,2005 08:45
5.   Date/Time Operation Ended: JUN 18,2005 14:25
 6. Preoperative Risk Factors: NONE

 7. CPT Codes (view only): 33510


*** NOTE: D/Time of Surgical Priority should be < the D/Time Patient in OR.***

*** NOTE: D/Time of Estimate of Mortality should be < the D/Time PT in OR. ***

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

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.

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

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

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

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

Example: Enter Cardiac Procedures Operative Data

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: CARD Cardiac Pr
ocedures Operative Data (Enter/Edit)
SURPATIENT,NINETEEN (000-28-7354)   Case #60183                     PAGE: 1 OF 2
JUN 18,2005   CORONARY ARTERY BYPASS
--------------------------------------------------------------------------------
Cardiac surgical procedures with or without cardiopulmonary bypass
CABG distal anastomoses:                11. Bridge to transplant/Device:
 1. Number with vein:                   12. TMR:
 2. Number with IMA:                    13. Maze procedure:
 3. Number with Radial Artery:          14. ASD repair:
 4. Number with Other Artery:           15. VSD repair:
 5. Number with Other Conduit:          16. Myectomy for IHSS:
                                        17. Myxoma resection:
 6. Aortic Valve Replacement:           18. Other tumor resection:
 7. Mitral Valve Replacement:           19. Cardiac transplant:
 8. Tricuspid Valve Replacement:        20. Great Vessel Repair:
 9. Valve Repair:                       21. Endovascular Repair:
10. LV Aneurysmectomy:                  22. Other cardiac procedures:

--------------------------------------------------------------------------------
Select Cardiac Procedures Operative Information to Edit: A
```

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

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

     Choose from:
       1        AORTIC
       2        MITRAL
       3        TRICUSPID
       4        OTHER/COMBINATION
       5        NONE
Valve Repair: 1  AORTIC
LV Aneurysmectomy (Y/N): N  NO
Device for bridge to cardiac transplant / Destination therapy:??
        CICSP Definition (2006):
        Indicate if patient received a mechanical support device
        (excluding IABP) as a bridge to cardiac transplant during the same
        admission as the transplant procedure; or patient received the device
        as destination therapy (does not intend to have a cardiac transplant),
        either with or without placing the patient on cardiopulmonary bypass.

     Choose from:
       Y        YES
       N        NO
Device for bridge to cardiac transplant / Destination therapy: N NO
Transmyocardial Laser Revascularization: N  NO
Maze Procedure: N NO MAZE PERFORMED
ASD Repair (Y/N): N  NO
VSD Repair (Y/N): N NO
Myectomy for IHSS (Y/N): N NO
Myxoma Resection (Y/N): N  NO
Other Tumor Resection (Y/N): N NO
Cardiac Transplant (Y/N): N NO
Great Vessel Repair (Y/N): N  NO
Endovascular Repair of Descending Thoracic Aorta: N NO
Other Cardiac Procedures (Y/N): N  NO
```

Resource Data (Enter/Edit)
[SROA CARDIAC RESOURCE]

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

Example: Resource Data (Enter/Edit)

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

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

Enter/Edit Patient Resource Data

1. Capture Information from PIMS Records
2. Enter, Edit, or Review Information

Select Number: (1-2): 1

Are you sure you want to retrieve information from PIMS records ? YES// <Enter>

...HMMM, I'M WORKING AS FAST AS I CAN...
```

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

Enter/Edit Patient Resource Data

1. Capture Information from PIMS Records
2. Enter, Edit, or Review Information

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

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

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

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

Select number of item to edit: 11
```

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

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

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


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

Select number of item to edit:
```

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
ERAN

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)
================================================================================

Medical Center: ALBANY
Age:            81                     Operation Date:    JAN 09, 2006
Sex:            MALE                   Ethnicity: NOT HISPANIC OR LATINO
                                       Race:      AMERICAN INDIAN OR ALASKA
                                                  NATIVE, NATIVE HAWAIIAN OR
                                                  OTHER PACIFIC ISLANDER, WHITE
Transfer Status: NOT TRANSFERRED
Observation Admission Date:                   NA
Observation Discharge Date:                   NA
Observation Treating Specialty:               NA
Hospital Admission Date:                      JAN 7,2006   11:15
Hospital Discharge Date:                      JAN 12,2006  10:30
Admitted/Transferred  to  Surgical  Service:  JAN  7,2006  11:15
Discharged/Transferred  to  Chronic  Care:  JAN  12,2006  10:30
In/Out-Patient Status:                        INPATIENT
Date Surgery Consult Requested:               JAN 7,2006
Surgery Consult Date:                         JAN 8,2006
--------------------------------------------------------------------------------

                            PREOPERATIVE INFORMATION


GENERAL:                               GASTROINTESTINAL:
Height:               176 CENTIMETERS   Esophageal Varices:
Weight:                  89 KILOGRAMS
Diabetes Mellitus:                     CARDIAC:
Current Smoker W/I 1 Year:             CHF Within 1 Month:
ETOH > 2 Drinks/Day:                   MI Within 6 Months:
Dyspnea:                               Previous PCI:
DNR Status:                            Previous Cardiac Surgery:
Preop Funct Status:                    Angina Within 1 Month:
                                       Hypertension Requiring Meds:
PULMONARY:
Ventilator Dependent:                  VASCULAR:
History of Severe COPD:        NO      Revascularization/Amputation:
Current Pneumonia:                     Rest Pain/Gangrene:

HEPATOBILIARY:
Ascites:

RENAL:                         YES     NUTRITIONAL/IMMUNE/OTHER:       YES
 Acute Renal Failure:          NO       Disseminated Cancer:            NO
 Currently on Dialysis:        NO       Open Wound:                     NO
                                        Steroid Use for Chronic Cond.:  NO
 CENTRAL NERVOUS SYSTEM:       YES      Weight Loss > 10%:              NO
Impaired Sensorium:            NO      Bleeding Disorders:             NO
Coma:                          NO      Transfusion > 4 RBC Units:      NO
Hemiplegia:                    NO      Chemotherapy W/I 30 Days:       NO
History of TIAs:               NO      Radiotherapy W/I 90 Days:       NO
CVA/Stroke w. Neuro Deficit:   YES     Preoperative Sepsis:          NONE
CVA/Stroke w/o Neuro Deficit:  NO      Pregnancy:           NOT APPLICABLE
Tumor Involving CNS:           NO


                        OPERATION DATE/TIMES INFORMATION

                Patient in Room (PIR): JAN 9,2006  07:25
   Procedure/Surgery Start Time (PST): JAN 9,2006  07:25
        Procedure/Surgery Finish (PF): JAN 9,2006  08:00
            Patient Out of Room (POR): JAN 9,2006  08:10
                Anesthesia Start (AS): JAN 9,2006  07:15
               Anesthesia Finish (AF): JAN 9,2006  08:08
          Discharge from PACU (DPACU): JAN 9,2006  09:15
```

Example 2: Print Surgery Risk Assessment for a Cardiac Case

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

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


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

SURPATIENT,NINE  000-34-5555

1. 07-01-06   * CABG X3 (1A,2V), ARTERIAL GRAFTING (TRANSMITTED)

2. 03-27-05   INGUINAL HERNIA (TRANSMITTED)

3. 07-03-04   PULMONARY LOBECTOMY (TRANSMITTED)


Select Surgical Case: Select Surgical Case: 1

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

---*printout follows*---

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

================================================================================
I. IDENTIFYING DATA
Patient: SURPATIENT,NINE  000-34-5555      Case #: 238         Fac./Div. #: 500
Surgery Date: 07/01/06   Address: Anyplace Way
Phone: NS/Unknown        Zip Code: 33445-1234        Date of Birth: 12/19/51
================================================================================
II. CLINICAL DATA
Gender:                   MALE          PCI:                >72 hrs - 7 days
Age:                      55            Prior MI:            > 7 DAYS OF SURG
Height:                   72 in         # of prior heart surgeries:        NONE
Weight:                   120 kg        Prior heart surgeries:
Diabetes:                 DIET          Peripheral Vascular Disease:       NO
COPD:                     NO            Cerebral Vascular Disease:         NO
FEV1:                     NS            Angina (use CCS Class):            III
Cardiomegaly (X-ray):     YES           CHF (use NYHA Class):              I
Pulmonary Rales:          NO            Current Diuretic Use:              NO
Current Smoker: >3 MONTHS PRIOR TO SUR  Current Digoxin Use:               NO
Active Endocarditis:      NO            IV NTG 48 Hours Preceding Surgery: NO
Resting ST Depression:    YES           Preop   circulatory   Device:   VAD
Functional Status:  PARTIAL DEPENDENT   Hypertension:                      NO

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

IV. CARDIAC CATHETERIZATION AND ANGIOGRAPHIC DATA
Cardiac Catheterization Date: 06/28/06
Procedure:                 NS           Native Coronaries:
LVEDP:                     NS           Left Main Stenosis:            NS
Aortic Systolic Pressure:  NS           LAD Stenosis:                  NS
                                        Right  Coronary  Stenosis:      NS
For patients having right heart cath:   Circumflex Stenosis:           NS
PA Systolic Pressure:  NS
PAW Mean Pressure:         NS           If a Re-do, indicate stenosis
                                            in graft to:
                                        LAD:                           NS
                                        Right coronary (include PDA): NS
                                        Circumflex:                    NS
--------------------------------------------------------------------------------
LV Contraction Grade (from contrast or radionuclide angiogram or 2D Echo):
       Grade     Ejection Fraction Range           Definition
        NO LV STUDY
--------------------------------------------------------------------------------
Mitral Regurgitation:     NS
Aortic stenosis:          NS

 V. OPERATIVE RISK SUMMARY DATA          (Operation Began: 07/01/06 10:10)
      Physician's Preoperative           (Operation Ended: 07/01/06 12:20)
                     Estimate of Operative Mortality: NS07/28/06 15:30)
     ASA Classification:           3-SEVERE DISTURB.
     Surgical Priority:            ELECTIVE              07/28/06 15:31)
     Principal CPT Code:           33517
     Other Procedures CPT Codes:   33510
     Preoperative Risk Factors:
```

```
SURPATIENT,NINE  000-34-5555
================================================================================
 VI. OPERATIVE DATA
Cardiac surgical procedures with or without cardiopulmonary bypass
CABG distal anastomoses:                Bridge   to   transplant/Device:   NO
  Number with Vein:             2      TMR:                                NO
  Number with IMA:              2    Maze  procedure:    NO  MAZE  PERFORMED
  Number with Radial Artery:    0      ASD repair:                         NO
  Number with Other Artery:     0      VSD repair:                         NO
  Number with Other Conduit:    0      Myectomy for IHSS:                  NO
Aortic Valve Replacement:       NO     Myxoma resection:                   NO
Mitral Valve Replacement:       NO     Other tumor resection:              NO
Tricuspid Valve Replacement:    NO     Cardiac transplant:                 NO
Valve Repair:                   NONE   Great Vessel Repair:                NO
LV Aneurysmectomy:              NO     Endovascular Repair:                NO
                                       Other Cardiac procedure(s):        YES
* Other Cardiac procedures (Specify): OTHER CT PROCEDURE #1, OTHER CT PROCEDURE #2,
OTHER CT PROC

Indicate other cardiac procedures only if done with cardiopulmonary bypass
Foreign body removal:           YES
Pericardiectomy:                YES

Other Operative Data details
Total CPB Time:     85 min               Total Ischemic Time: 60 min
Incision Type:          FULL STERNOTOMY
Conversion Off Pump to CPB: N/A (began on-pump/ stayed on-pump)

VII. OUTCOMES
Operative Death:  NO                      Date of Death:

Perioperative (30 day) Occurrences:
  Perioperative MI:                NO    Repeat cardiac Surg procedure:  YES
  Endocarditis:                    NO    Tracheostomy:                   YES
  Renal Failure Requiring Dialysis: NO   Ventilator supp within 30 days: YES
  Mediastinitis:                   YES   Stroke/CVA:                     NO
  Cardiac Arrest Requiring CPR:    YES   Coma > or = 24 Hours:           NO
  Reoperation for Bleeding:        NO    New Mech Circulatory Support:   YES
  On ventilator > or = 48 hr:      NO

VIII. RESOURCE DATA
Hospital Admission Date:                       06/30/06 06:05
Hospital Discharge Date:                       07/10/06 08:50
Time Patient In  OR:                           07/10/06 10:00
Time Patient Out OR:                           07/10/06 12:30
Date and Time Patient Extubated:               07/10/06 13:13
     Postop Intubation Hrs: +1.9
Date and Time Patient Discharged from ICU:     07/10/06 08:00
Patient is Homeless:                           NS
Cardiac Surg Performed at Non-VA Facility:     UNKNOWN
CT Surgery Consult Date:                       06/29/06
Cause for Delay for Surgery:                   NONE
Resource Data Comments:
================================================================================
IX. SOCIOECONOMIC, ETHNICITY, AND RACE
 Employment Status Preoperatively:      SELF EMPLOYED
 Ethnicity:                             NOT HISPANIC OR LATINO
 Race Category(ies):                    AMERICAN INDIAN OR ALASKA NATIVE,
                                        NATIVE HAWAIIAN OR OTHER PACIFIC
                                        ISLANDER, WHITE

X. DETAILED DISCHARGE INFORMATION
   Discharge ICD-9 Codes: 414.01 V70.7 433.10 285.1 412. 307.9  427.31

Type of Disposition: TRANSFER
Place of Disposition: HOME-BASED PRIMARY CARE (HBPC)
Primary care or referral VAMC identification code: 526
Follow-up VAMC identification code: 526

 *** End of report for SURPATIENT,NINE 000-34-5555 assessment #238 ***
```

(This page included for two-sided copying.)

List of Surgery Risk Assessments

[SROA ASSESSMENT LIST]

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

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

Example 1: List of Incomplete Assessments

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

```
List of Surgery Risk Assessments

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

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

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

Print by Surgical Specialty ?  YES// <Enter>

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

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

1. MAYBERRY, NC

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

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

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

--*printout follows*---

```
                                     INCOMPLETE RISK ASSESSMENTS                                    PAGE 1
                                          MAYBERRY, NC
                                         SURGERY SERVICE                          DATE REVIEWED:
                                FROM: JAN 1,2006  TO: JUN 30,2006                 REVIEWED BY:

ASSESSMENT #        PATIENT                                  OPERATIVE PROCEDURE(S)                 ANESTHESIA TECHNIQUE
OPERATION DATE                          SURGEON
==================================================================================================================================

** SURGICAL SPECIALTY: CARDIAC SURGERY **

28519               SURPATIENT,NINE 000-34-5555              * CABG X3 (2V,1A)                     GENERAL
JAN 05, 2006                            SURSURGEON,ONE
                                                             CPT Codes: 33736

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

** SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW) **

63063               SURPATIENT,ONE    000-44-7629            INGUINAL HERNIA                        SPINAL
JUN 09, 2006                            SURSURGEON,TWO
                                                             CPT Codes: 49521


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

** SURGICAL SPECIALTY: NEUROSURGERY **

63154               SURPATIENT,EIGHT 000-37-0555             CRANIOTOMY                             NOT ENTERED
JUN 24, 2006                            SURSURGEON,FOUR
                                                             CPT Codes: NOT ENTERED

----------------------------------------------------------------------------------------------------------------------------------
```

Example 2: List of Completed Assessments

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

```
List of Surgery Risk Assessments

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

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

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

Print by Surgical Specialty ?  YES// <Enter>

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

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

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

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

---*printout follows*---

```
                                       COMPLETED RISK ASSESSMENTS                                  PAGE 1
                                              MAYBERRY, NC
                                            SURGERY SERVICE                              DATE REVIEWED:
                                  FROM: JAN 1,2006  TO: JUN 30,2006                      REVIEWED BY:

ASSESSMENT #        PATIENT                                       DATE COMPLETED                          ANESTHESIA TECHNIQUE
OPERATION DATE      OPERATIVE PROCEDURE
=====================================================================================================================================

** SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW) **

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

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

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

** SURGICAL SPECIALTY: OPHTHALMOLOGY **

1898                SURPATIENT,FORTYONE 000-43-2109               MAY 28, 2006                            GENERAL
APR 28, 2006        INTRAOCCULAR LENS
                                                                  CPT Codes: NOT ENTERED

-------------------------------------------------------------------------------------------------------------------------------------
```

Example 3: List of Transmitted Assessments

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

```
List of Surgery Risk Assessments

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

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

```
Print by Date of Operation or by Date of Transmission ?

   1. Date of Operation
   2. Date of Transmission

Select Number: (1-2): 1// <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     GENERAL
 SURGERY
     1   50  GENERAL SURGERY     50
     2   50  GASTROENTEROLOGY     50     GASTR
     3   50  TWO GENERAL     50     TG
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]
```

---*printout follows*---

```
                                        TRANSMITTED RISK ASSESSMENTS                                      PAGE 1
                                               MAYBERRY, NC
                                              SURGERY SERVICE                               DATE REVIEWED:
                             OPERATION DATES FROM: JAN 1,2006  TO: JUN 30,2006         REVIEWED BY:

ASSESSMENT #        PATIENT                                        TRANSMISSION DATE                        ANESTHESIA TECHNIQUE
OPERATION DATE      PRINCIPAL OPERATIVE PROCEDURE
=====================================================================================================================================

** SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW) **

63076               SURPATIENT,FOURTEEN 000-45-7212                FEB 12, 2006                             GENERAL
JAN 08, 2006        INGUINAL HERNIA
                    CPT Codes: 49521

63077               SURPATIENT,FIVE 000-58-7963                    FEB 30, 2006                             GENERAL
FEB 08, 2006        INGUINAL HERNIA, OTHER PROC1
                    CPT Codes: NOT ENTERED

63103               SURPATIENT,NINE 000-34-5555                    APR 09, 2006                             GENERAL
MAR 27, 2006        INGUINAL HERNIA
                    CPT Codes: 49521

63171               SURPATIENT,FIFTYTWO 000-99-8888                JUN 05, 2006                             GENERAL
MAY 17, 2006        CHOLECYSTECTOMY
                    CPT Codes: 47600
-------------------------------------------------------------------------------------------------------------------------------------
```

Example 4: List of Non-Assessed Major Surgical Cases

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

```
List of Surgery Risk Assessments

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

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

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

Print by Surgical Specialty ? YES// <Enter>

Print report for ALL specialties ? YES// N

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

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

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

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

printout follows

```
                                      NON-ASSESSED MAJOR SURGICAL CASES BY SURGICAL SPECIALTY                       PAGE 1
                                                          MAYBERRY, NC
                                                        SURGERY SERVICE                          DATE REVIEWED:
                                                FROM: JAN 1,2006  TO: JUN 30,2006                REVIEWED BY:

CASE #              PATIENT                                                                             ANESTHESIA TECHNIQUE
OPERATION DATE      OPERATIVE PROCEDURE(S)                                                              SURGEON
==============================================================================================================================

SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)

63071               SURPATIENT,FOUR  000-17-0555                                                        GENERAL
FEB 08, 2006        INGUINAL HERNIA                                                                     SURSURGEON,TWO
                    CPT Codes: 49505

63136               SURPATIENT,EIGHT  000-34-5555                                                       GENERAL
MAR 07, 2006        CHOLECYSTECTOMY                                                                     SURSURGEON,TWO
                    CPT Codes: 47605

TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 2
------------------------------------------------------------------------------------------------------------------------------
```

Example 5: List of All Major Surgical Cases

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

```
List of Surgery Risk Assessments

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

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

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

Print by Surgical Specialty ? YES// <Enter>

Print report for ALL specialties ? YES// N

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

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

```

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

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

--*printout follows*--

```
                                   ALL MAJOR SURGICAL CASES BY SURGICAL SPECIALTY                                    PAGE 1
                                                    MAYBERRY, NC
                                                  SURGERY SERVICE                                   DATE REVIEWED:
                                        FROM: JAN 1,2006  TO: JUN 30,2006                           REVIEWED BY:

CASE #              PATIENT                                      ASSESSMENT STATUS                      ANESTHESIA TECHNIQUE
OPERATION DATE      OPERATIVE PROCEDURE(S)                       EXCLUSION CRITERIA                     SURGEON
==================================================================================================================================

SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)

63110               SURPATIENT,SIXTY 000-56-7821                 COMPLETED                              GENERAL
JAN 23, 2006        CHOLEDOCHOTOMY                               SCNR WAS ON A/L                        SURSURGEON,TWO
                    CPT Codes: 47420

63131               SURPATIENT,FIFTYTWO 000-99-8888              NO ASSESSMENT                          GENERAL
APR 21, 2006        PERINEAL WOUND EXPLORATION                                                          SURSURGEON,NINE
                    CPT Codes: NOT ENTERED

63136               SURPATIENT,EIGHT 000-34-5555                 NO ASSESSMENT                          GENERAL
JUN 07, 2006        CHOLECYSTECTOMY                                                                     SURSURGEON,ONE
                    CPT Codes: 47600

TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 3
----------------------------------------------------------------------------------------------------------------------------------
```

Example 6: List of All Surgical Cases

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

```
List of Surgery Risk Assessments

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

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

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

Print by Surgical Specialty ? YES// <Enter>


Print report for ALL specialties ? YES// N

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

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

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

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

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

```
                                    ALL SURGICAL CASES BY SURGICAL SPECIALTY                              PAGE 1
                                                MAYBERRY, NC
                                               SURGERY SERVICE                        DATE REVIEWED:
                                      FROM: JAN 1,2006  TO: JUN 30,2006               REVIEWED BY:

CASE #              PATIENT                                        ASSESSMENT STATUS                      ANESTHESIA TECHNIQUE
OPERATION DATE      PRINCIPAL OPERATIVE PROCEDURE                  EXCLUSION CRITERIA                     SURGEON
==================================================================================================================================

SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)

63110               SURPATIENT,SIXTY 000-56-7821                    COMPLETED                              GENERAL
JAN 23, 2006        CHOLEDOCHOTOMY                                  SCNR WAS ON A/L                        SURSURGEON,TWO
                    CPT Code: 47420

63079               SURPATIENT,FIFTYTWO 000-99-8888                 INCOMPLETE                             GENERAL
APR 02, 2006        INGUINAL HERNIA                                                                        SURSURGEON,ONE
                    CPT Codes: NOT ENTERED

63131               SURPATIENT,FIFTYTWO 000-99-8888                 NO ASSESSMENT                          GENERAL
APR 21, 2006        PERINEAL WOUND EXPLORATION                                                             SURSURGEON,NINE
                    CPT Codes: NOT ENTERED

63180               SURPATIENT,SIXTY 000-56-7821                    NO ASSESSMENT                          NOT ENTERED
JUN 23, 2006        CHOLECYSTECTOMY                                                                        SURSURGEON,ONE
                    CPT Codes: 47600

TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 4
----------------------------------------------------------------------------------------------------------------------------------
```

Example 7: List of Completed/Transmitted Assessments Missing Information

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

```
List of Surgery Risk Assessments

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

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

```
             COMPLETED/TRANSMITTED ASSESSMENTS MISSING INFORMATION       PAGE 1
                                MAYBERRY, NC
                      FROM: JAN 1,2006 TO: JUN 30,2006
                         DATE PRINTED: JUL 13,2006

** GENERAL(OR WHEN NOT DEFINED BELOW)

ASSESSMENT #      PATIENT                            TYPE          STATUS
OPERATION DATE    OPERATION(S)
============================================================================
63172             SURPATIENT,FIFTYTWO  000-99-8888   NON-CARDIAC   TRANSMITTED
MAY 17, 2006      REPAIR ARTERIAL BLEEDING
                  CPT Code: 33120
     Missing information:
     1. The final coding for Procedure and Diagnosis is not complete.
     2. Anesthesia Technique
------------------------------------------------------------------------------
63185             SURPATIENT,SIXTEEN 000-11-1111      NON-CARDIAC   TRANSMITTED
APR 17, 2006      INGUINAL HERNIA, CHOLECYSTECTOMY
     Missing information:
     1. The final coding for Procedure and Diagnosis is not complete.
     2. Concurrent Case
     3. History of COPD (Y/N)
     4. Ventilator Dependent Greater than 48 Hrs (Y/N)
     5. Weight Loss > 10% of Usual Body Weight (Y/N)
     6. Transfusion Greater than 4 RBC Units this Admission (Y/N)
------------------------------------------------------------------------------
63080             SURPATIENT,THIRTY  000-82-9472      EXCLUDED      COMPLETE
JAN 03, 2006      TURP
     Missing information:
     1. The final coding for Procedure and Diagnosis is not complete.


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

TOTAL FOR ALL SPECIALTIES: 3
```

Example 8: List of 1-Liner Cases Missing Information

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

```
List of Surgery Risk Assessments

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

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

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

Print by Surgical Specialty ?  YES// <Enter>

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

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

---*printout follows*--

```
                       1-LINER CASES MISSING INFORMATION                 PAGE 1
                                    MABERRY, NC
                       FROM: FEB 27,2006 TO: JUN 30,2006
                            DATE PRINTED: JUN 30,2006

** UROLOGY

CASE #            PATIENT                            TYPE          STATUS
OP DATE           OPERATION(S)
================================================================================

317               SURPATIENT,FOURTEEN 000-45-7212     CARDIAC       COMPLETE
APR 10, 2006      Vasectomy
                  CPT Codes: NOT ENTERED
     Missing information:
     1. The final coding for Procedure and Diagnosis is not complete.
     2. Attending Code
     3. Wound Classification
     4. ASA Class
--------------------------------------------------------------------------------

TOTAL FOR UROLOGY: 1
```

Example 9: List of Eligible Cases

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

```
List of Surgery Risk Assessments

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

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

```
                     CASES ELIGIBLE FOR ASSESSMENT                  PAGE 1
                                MAYBERRY, NC
                   FROM: JUN 1,2006 TO: JUN 30,2007
                       DATE PRINTED: JUN 30,2007

                                                '*' Denotes Eligible CPT Code
>>> CARDIAC SURGERY

CASE #            PATIENT                                TYPE          STATUS
OP DATE           OPERATION(S)
================================================================================
10095             SURPATIENT,SEVENTY 000-00-0125         CARDIAC       COMPLETE
JUN 04, 2006      CABG, REGRAFT

>>> Final CPT Coding is not complete.
CPT Codes: *33510, *33511
--------------------------------------------------------------------------------
10084             SURPATIENT,NINE 000-34-5555            CARDIAC       COMPLETE
JUL 08, 2006      CABG

CPT Codes: *33502, 11402
--------------------------------------------------------------------------------
10380             SURPATIENT,THREE 000-21-2453           NOT LOGGED    COMPLETE
FEB 06, 2007      CORONARY ARTERY BYPASS

CPT Codes: NOT ENTERED
--------------------------------------------------------------------------------
10383             SURPATIENT,ONE 000-44-7629             NON-CARDIAC   COMPLETE
FEB 08, 2007      STENT

CPT Codes: NOT ENTERED
--------------------------------------------------------------------------------

TOTAL FOR CARDIAC SURGERY: 4

>>> GENERAL SURGERY

CASE #            PATIENT                                TYPE          STATUS
OP DATE           OPERATION(S)
================================================================================
10061             SURPATIENT,FIFTEEN 666-98-1288         NON-CARDIAC   COMPLETE
FEB 11, 2007      APPENDECTOMY, SPLENECTOMY

>>> Final CPT Coding is not complete.
CPT Codes: *44955, *38100
--------------------------------------------------------------------------------
10079             SURPATIENT,SEVENTY 000-00-0125         EXCLUDED      COMPLETE
MAR 31, 2007      HERNIA

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

TOTAL FOR GENERAL SURGERY: 2
```

Example 10: List of Cases With No CPT Codes

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

```
List of Surgery Risk Assessments

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

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

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

Print by Surgical Specialty ?  YES// <Enter>

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

Do you want to print all divisions? YES// <Enter>
Print the List of Assessments to which Device: HOME// [Select Print Device]
```

printout follows

```
                                 CASES WITHOUT CPT CODES                     PAGE 1
                                 ALBANY - ALL DIVISIONS
                            FROM: JAN 1,2007  TO: JAN 23,2008
                                DATE PRINTED: JAN 23,2008
>>> CARDIAC SURGERY

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

TOTAL FOR CARDIAC SURGERY: 5


TOTAL FOR ALL SPECIALTIES: 5
```

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

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

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

Print by Surgical Specialty ? YES// <Enter>

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

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

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

```
                        SUMMARY LIST OF ASSESSED CASES                  PAGE 1
                                   ALBANY
                      FROM: JAN 1,2008  TO: JAN 30,2008
                          DATE PRINTED: JAN 30,2008

SURGICAL SPECIALTY              INCOMPLETE | COMPLETE | TRANSMITTED | EXCLUDED
================================================================================
CARDIAC SURGERY                          8          1             1          0
GENERAL SURGERY                         17          1             1          6
NEUROSURGERY                             1          0             1          0
OPHTHALMOLOGY                            2          0             0          0
ORTHOPEDICS                              2          0             0          0
OTORHINOLARYNGOLOGY (ENT)                1          0             0          0
PLASTIC SURGERY (INCLUDES HEAD           2          0             0          0
TWO GENERAL                              1          0             0          0
UROLOGY                                  0          0             0          1

TOTAL FOR ALL SPECIALTIES:              34          2             3          7
```

M&M Verification Report
[SRO M&M VERIFICATION REPORT]

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

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

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

Full Report:

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

Pre-Transmission Report:

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

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

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

```
                            M&M Verification Report

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

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

```
Print which report ?

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

Enter selection (1 or 2): 1// <Enter>
Start with Date: 03 01 07 (MAR 01, 2007)
End with Date: 03 30 07 (MAR 30, 2007)

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

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

This report is designed to use a 132 column format.

Print report on which Device: [Select Print Device]
```

printout follows

```
                                                   ALBANY - ALL DIVISIONS                                               Page 1
                                                   M&M Verification Report
                                              From: MAR 1,2007  To: MAR 30,2007                      REVIEWED BY:
                                                Report Generated: APR 23,2007                        DATE REVIEWED:

OP DATE    CASE #        SURGICAL SPECIALTY                                    ASSESSMENT TYPE   STATUS            DEATH RELATED
           PRINCIPAL PROCEDURE
==================================================================================================================================
>>> SURPATIENT,FIVE (666-58-7963)

03/01/07   10401         GENERAL SURGERY                                       NON-CARDIAC       TRANSMITTED       N/A
           APPENDECTOMY
           CPT Codes: 44970
           Occurrences: ACUTE RENAL FAILURE ** POSTOP **  (03/02/07)

----------------------------------------------------------------------------------------------------------------------------------
>>> SURPATIENT,ONE (666-44-7629)

03/07/07   10421         GENERAL SURGERY                                       NON-CARDIAC       TRANSMITTED       N/A
           APPENDECTOMY, CHOLECYSTECTOMY
           CPT Codes: 44950, 47610
           Occurrences: URINARY TRACT INFECTION ** POSTOP ** (03/09/07)
                        ACUTE RENAL FAILURE ** POSTOP **  (03/10/07)
                        OTHER RESPIRATORY OCCURRENCE ** POSTOP ** (03/10/07)
                          ICD: 478.25 EDEMA PHARYNX/NASOPHARYX
----------------------------------------------------------------------------------------------------------------------------------
>>> SURPATIENT,TWO (666-45-1982)

03/07/07   10422         NEUROSURGERY                                          NON-CARDIAC       TRANSMITTED       N/A
           LAMINECTOMY
           CPT Codes: 22630
           Occurrences: OTHER OCCURRENCE  (03/07/07)
                          ICD: 415.19 OTH PULM EMB & INFARC

----------------------------------------------------------------------------------------------------------------------------------
>>> SURPATIENT,ELEVEN (666-00-0748) - DIED 03/10/07@14:50

03/10/07   10100         GENERAL SURGERY                                       NON-CARDIAC       INCOMPLETE         NO
           REMOVAL OF GALLBLADDER
           CPT Codes: 47600
           Occurrences: PULMONARY EMBOLISM ** POSTOP **  (03/10/07)
                          >>> Comments:
                              Patient complained of chest pain and shortness of breath. Heparin was administered immediately by IV.
           Date of Death: 03/10/07@14:50
           Review of Death Comments: Patient expired from large pulmonary embolus before anticoagulant treatment could take effect.
                                      Patient's obesity and prolonged immobilization were likely contributing factors.
----------------------------------------------------------------------------------------------------------------------------------
```

Example 2: Generate an M&M Verification Report (Pre-Transmission Report)

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

```
                            M&M Verification Report

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

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

```
Print which report ?

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

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

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

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

This report is designed to use a 132 column format.

Print report on which Device: [Select Print Device]
```

---*printout follows*---

```
                                                   ALBANY - ALL DIVISIONS                                        Page 1
                                                   M&M Verification Report
                                         PRE-TRANSMISSION REPORT FOR COMPLETED ASSESSMENTS          REVIEWED BY:
                                                 Report Generated: OCT 23,2007                      DATE REVIEWED:

OP DATE    CASE #        SURGICAL SPECIALTY                                     ASSESSMENT TYPE   STATUS           DEATH RELATED
           PRINCIPAL PROCEDURE
=====================================================================================================================================
>>> SURPATIENT,TWELVE (666-00-0762)

09/21/07   45466         PLASTIC SURGERY                                        NON-CARDIAC       COMPLETE         N/A
           RHINOPLASTY
           CPT Codes: 30410
           Occurrences: DEEP INCISIONAL SSI ** POSTOP **  (09/23/07)

-------------------------------------------------------------------------------------------------------------------------------------
>>> SURPATIENT,FIFTEEN (666-00-0194)

09/16/07   45475         EAR, NOSE, THROAT (ENT)                                NON-CARDIAC       COMPLETE         N/A
           LARYNGECTOMY (TOTAL)
           CPT Codes: 31360
           Occurrences: BLEEDING/TRANSFUSIONS ** POSTOP **  (09/17/07)
                          >>> Comments:
                              Esophageal varices were the source of bleeding.

-------------------------------------------------------------------------------------------------------------------------------------
>>> SURPATIENT,FORTY (666-00-4174)

09/19/07   45499         GENERAL SURGERY                                        NON-CARDIAC       COMPLETE         N/A
           INGUINAL HERNIA
           CPT Codes: 49505
           Occurrences: URINARY TRACT INFECTION ** POSTOP **  (09/21/07)

-------------------------------------------------------------------------------------------------------------------------------------
```

(This page included for two-sided copying.)

Risk Model Lab Test

[SROA LAB TEST EDIT]

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

```
Risk Model Lab Test (Enter/Edit)

 Select item to edit from list below:

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

Enter number (1-25): 5
```

```
          Risk Model Lab Test (Enter/Edit)


                Test Name: CHOLESTEROL

  Laboratory Data Name(s): NONE ENTERED

                 Specimen: SERUM


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

Select LABORATORY DATA NAME: CHOLESTEROL
     1   CHOLESTEROL
     2   CHOLESTEROL CRYSTALS
CHOOSE 1-2: 1  CHOLESTEROL
Select LABORATORY DATA NAME: <Enter>
Specimen: SERUM// <Enter>
```

```
           Risk Model Lab Test (Enter/Edit)

 Select item to edit from list below:

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

Enter number (1-25):



Select Surgery Risk Assessment Menu Option:
```

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