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SURGERY

USER MANUAL

Version 3.0
July 1993

(Revised June 2017)

Department of Veterans Affairs
Product Development

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
6/17	124a, 124b, 481-487	SR*3*191	Updated risk assessment reports for cardiac and non-cardiac, and time out checklist (R. Neeld)
6/17	88	SR*3*191	Ask user to specify long form or short form in Schedule of Operations menu. (R. Neeld)
6/17	42, 46	SR*3*191	Added "Estimated Case Length" field to Schedule Operations menu. (R. Neeld)
6/17	120, 120a	SR*3*191	Updated "Post Operation" menu (R. Neeld)
6/17	121	SR*3*191	Updated "Enter PAC(U) Information" menu (R. Neeld)
6/17	461	SR*3*191	Added "(ICD10)" to "ICD Diagnosis Code" line of example. (R. Neeld)
6/17	477	SR*3*191	Added "(ICD10)" to "ICD Diagnosis Code" line of example. (R. Neeld)
6/17	449, 467, 452, 502	SR*3*191	Changed "History of severe COPD to "History of COPD" per ASU-10-010-19-RAM (R. Neeld)
6/17	38, 41, 44, 49, 51	SR*3*191	Modified page 3 of menu Request Operation > Delete or Update Operation Requests (R. Neeld)
5/17	99, 100, 117, 118	SR*3*191	Modified "Retained Surgical Item" fields per ASU-10-010-67 (R. Neeld)
5/17		SR*3*191	Updated Anesthesia Menu per ASU-10-010-68-OM (R. Neeld)
5/17	484, 486a	SR*3*191	Changed "Wound Disruption" to "Wound Dehiscence" per ASU-10-010-72-OM (R. Neeld)
5/17	449, 450, 467, 468	SR*3*191	Retire field "Sleep Apnea-Compliance" per ASU-10-010-RAM (R. Neeld, Tech Writer)
5/17	11, 32, 33, 38, 41, 43, 44, 48, 49, 51, 67, 68, 72, 101, 120a, 145, 145a, 152, 152a, 218, 411, 429	ASU-10-010-46	Changed all references of Sterile Processing Department (SPD) to Sterile Processing Service (SPS) (R. Neeld, Tech Writer)

2/17	1, 2, 36, 39, 40-41, 46, 47-48, 50, 55, 59, 61, 63, 69-72, 75-76, 78-79, 81-82, 89, 93, 164, 164a, 254, 502, 510, 512, 548, 550, 552, 553, 554	ASU-10-010-49	Changed all references of Concurrent Case to Multiple Team. Changed all references of 1-Liner to Abbreviated Case. (R. Neeld, Tech Writer)
11/15	i-viii, 9, 30, 32-33, 37, 38, 40-41, 42, 43, 44, 46, 47-48, 50-52, 65, 67-68, 72-73, 76-77, 79-80, 95, 98-99, 101-102a, 105, 108-110 111-113, 117, 118, 123, 124, 124a, 124b, 140-147, 150-152b, 212e, 219a, 219b, 432-433, 449-451, 458, 459, 465, 467-469, 470a-472, 473, 479-479a, 481-482a, 484, 486-486c, 489, 491, 493, 495-499, 501, 502a, 502c, 502e, 502g, 507, 510, 512, 527-556	SR*3*184	Updated definitions, added new data fields, made changes to data entry screens, reports, surgery risk management assessment transmissions. For more details, see the Annual Surgery Updates – VASQIP 2015, Release Notes.
09/14	i, ia, iii-vii, 6-9, 11, 13, 14, 28, 31-33, 37, 38, 40-44, 46-48, 50-52, 59, 64, 66-68, 72-73, 76, 77, 79-83, 99-105, 107-111, 114, 116, 117, 119-120a, 122-124a, 131, 140, 140a, 142-147, 149, 151-152a, 165, 180, 180a, 189-191, 218-219a, 285, 346, 349, 358, 360, 394a, 394b, 426-428, 449, 449a, 455-458, 467, 468, 473-474b, 482-484, 507, 510, 512, 519, 549, 549a, 551-556	SR*3*182	Updated definitions, added new data fields, made changes to data entry screens, reports, surgery risk management assessment transmissions. For more details, see the Annual Surgery Updates – VASQIP 2014, Release Notes. (Daniel Reed, PM; Starleigh Vetzel, Technical Writer)

Date	Revised Pages	Patch Number	Description
07/14	i-iib, 212a, 212d-212g, 238, 273, 405, 437, 480, 525, 526	SR*3*177	Updated examples to reflect ICD-10 Diagnosis Codes. Changed File Download Option 2 from "ICD9" to "ICD." Made ICD-9 references generic to ICD. Added ICD-10-CM Diagnosis Code Search. Updated Warning Message to Surgeon. Updated MailMan Messages for ICD-9 and ICD-10 codes. (K. Krause, VA
03/12	i-iid, v, vii, 6-11, 81-83, 120, 120a-120b, 140, 144-145, 145a-145b, 146, 151-152, 152a, 178, 207-209, 212c, 212f, 213, 215, 217-219, 219a-219b, 220, 222, 224, 226, 228, 230, 232, 234, 236, 239, 241, 243, 245, 247, 276, 327c, 394c, 395-396, 397a, 397c-397d, 411, 432, 449-450, 461, 464, 467-468, 474b, 482, 484, 486, 486a, 523, 525, 527, 549, 553-554	SR*3*176	Updated definitions, added new data fields, made changes to existing fields, data entry screens, reports, surgery risk assessment transmissions and transplant components of the VistA Surgery application. For more details, see the *Annual Surgery Updates – VASQIP 2011, Increment 2, Release Notes.* Chapter Seven: "CoreFLS/Surgery Interface" has been removed. (T. Leggett, PM; B. Thomas, Tech Writer)

09/11	i-iib, iii-iv, vi, 64, 66, 70, 98-101, 101a-101b, 109-112, 114-118, 122-124, 124a-124b, 142-152, 152a-152b, 176, 178, 180, 183-184, 184a-184f, 244, 246, 248, 325-326, 326a-326b, 327, 327a-327d, 368, 394a-394b, 394c-394d, 395-397, 397a-397d, 432-433, 441, 449-450, 458-459, 461, 464a, 471-474, 474a-474b, 475, 477, 480a, 482, 486-486a, 509,519, 521, 522a, 522c, 527, 534-535, 550, 552-556	SR*3*175	Updated definitions and made minor modifications to the non-cardiac, cardiac and transplant components of the VistA Surgery application. For more details, see the *Annual Surgery Updates – VASQIP 2011, Increment 1, Release Notes.* (T. Leggett, PM; B. Thomas, Tech Writer)

12/10	i-iib, 372, 376, 449-450, 458, 467-468, 468b, 471-474, 474a-474b, 479, 479a, 482, 486, 486a, 522c-522d	SR*3*174	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 *Annual Surgery Updates – VASQIP 2010 Release Notes.* (T. Leggett, PM; B. Thomas, Tech Writer)
11/08	vii-viii, 527-556	SR*3*167	New chapter added for transplant assessments. Changed Glossary to Chapter 10, and renumbered the Index. (M. Montali, PM; G. O'Connor, Tech Writer)
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.* (M. Montali, PM; G. O'Connor, Tech Writer)
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. (M. Montali, PM; S. Krakosky, Tech Writer)
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. (M. Montali, PM; S. Krakosky, Tech Writer)
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). (M. Montali, PM; S. Krakosky, Tech Writer)
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. (M. Montali, PM; S. Krakosky, Tech Writer)

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. (M. Montali, PM; S. Krakosky, Tech Writer)
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.* (M. Montali, PM; S. Krakosky, Tech Writer)
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. (M. Montali, PM; S. Krakosky, Tech Writer)
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. (M. Montali, PM; S. Krakosky, Tech Writer)
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. (M. Montali, PM; S. Krakosky, Tech Writer)

Date	Revised Pages	Patch Number	Description
04/06	6-8, 29, 31-32, 37-38, 40, 43-44, 46-48, 50, 52, 65-67, 71-73, 75-77, 79, 100, 102, 109-112, 117-120, 122-123, 125-127, 189-191, 195b, 209-212, 212a-h, 219a, 224-231, 238-242, 273-277, 311-313, 315-317, 369, 379- 392, 410, 449-464, 467-468, 468a-b, 469-470, 470a, 471-474, 474a-b, 475-479, 479a-b, 480, 483-484, 489-502, 507, 519	SR*3*142	Updated the data entry screens to reflect renaming of the Planned Principal CPT Code field and the Principal Pre-op ICD Diagnosis Code field. Updated the *Update/Verify Procedure/Diagnosis Coding* option to reflect new functionality. Updated Risk Assessment options to remove CPT codes from headers of cases displayed. Updated reports related to the coding option to reflect final CPT codes. For more specific information on changes, see the *Patient Financial Services System (PFSS) – Surgery Release Notes* for this patch. (M. Montali, PM; S. Krakosky, Tech Writer)
10/05	9, 109-110, 144, 151, 218	SR*3*147	Updated data entry screens to reflect renaming of the Preop Shave By field to Preop Hair Clipping By field. (M. Montali, PM; S. Krakosky, Tech Writer)
08/05	10, 14, 99-100, 114, 119-120, 124, 153-154, 162-164, 164a-b, 190, 192, 209-212f, 238-242	SR*3*119	Updated the Anesthesia Data Entry Menu section (and other data entry options) to reflect new functionality for entering multiple start and end times for anesthesia. Updated examples for Referring Physician updates (e.g., capability to automatically look up physician by name). Updated the PCE Filing Status Report section. (J. Podolec, PM; B. Manies, Tech Writer)
08/04	iv-vi, 187-189, 195, 195a-195b, 196, 207-208, 219a-b, 527-528	SR*3*132	Updated the Table of Contents and Index to reflect added options. Added the new *Non-OR Procedure Information* option and the *Tissue Examination Report* option (unrelated to this patch) to the Non-OR Procedures section.
08/04	31, 43, 46, 66, 71-72, 75-76, 311	SR*3*127	Updated screen captures to display new text for ICD-9 and CPT codes.

Date	Revised Pages	Patch Number	Description
08/04	vi, 441, 443, 445-456, 458-459, 461 463, 465, 467-468, 468a-b, 469-470, 470a-b, 471, 473-474, 474a-b, 474-479, 479a-b, 480-486, 486a-b, 519, 531-534	SR*3*125	Updated the Table of Contents and Index. Clarified the location of the national centers for NSQIP and CICSP. Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software and new options have been added. For an overview of the data entry changes, see the *Surgery NSQIP/CICSP Enhancements 2004 Release Notes.* Added the *Laboratory Test Result (Enter/Edit)* option and the *Outcome Information (Enter/Edit)* option to the *Cardiac Risk Assessment Information (Enter/Edit)* menu section. Changed the name of the *Cardiac Procedures Requiring CPB (Enter/Edit*) option to *Cardiac Procedures Operative Data (Enter/Edit)* option. Removed the *Update Operations as Unrelated/Related to Death* option from the *Surgery Risk Assessment Menu*.
08/04	6-10, 14, 103, 105-107, 109-112, 114-120, 122-124, 141-152, 218-219, 284-287, 324, 370-377	SR*3*129	Updated examples to include the new levels for the Attending Code (or Resident Supervision). Also updated examples to include the new fields for ensuring Correct Surgery. For specific options affected by each of these updates, please see the *Resident Supervision/Ensuring Correct Surgery Phase II Release Notes.*
04/04	All	SR*3*100	All pages were updated to reflect the most recent Clinical Ancillary Local Documentation Standards and the changes resulting from the Surgery Electronic Signature for Operative Reports project, SR*3*100. For more information about the specific changes, see the patch description or the *Surgery Electronic Signature for Operative Reports Release Notes*.

Because the PROSTHESIS INSTALLED field can contain multiple answers, a new screen immediately appeared as follows:

```
  ** OPERATION **   CASE #14  SURPATIENT,THREE            PAGE 1
         PROSTHESIS INSTALLED  (MANDIBULAR PLATES)

1    PROSTHESIS ITEM:         MANDIBULAR PLATES
2    IMPLANT STERILITY CHECKED:
3    STERILITY EXPIRATION DATE:
4    RN VERIFIER:
5    VENDOR:
6    MODEL:
7    LOT NUMBER:
8    SERIAL NUMBER:
9    STERILE RESP:
10   SIZE:
11   QUANTITY:
12   PROVIDER READ BACK PERFORMED:


Enter Screen Server Function:  2:11
Implant Sterility Checked (Y/N): Y  YES
Sterility Expiration Date: 01.30.07  (JAN 30, 2007)
RN Verifier: SURNURSE,ONE              OS
Manufacturer/Vendor: SYNTHES
Model: MAXILLOFACIAL
Lot Number: #20-15
Serial Number: 612A874
Who is Accountable for Sterilization: SPS
Size: 10 HOLE
Quantity: 20
```

The first response, 2:10, corresponds to data elements 2 through 10. We entered data for these elements one-by-one and the software processed the information and produced this update:

```
** OPERATION **   CASE #14  SURPATIENT,THREE            PAGE 1 OF 1
         PROSTHESIS INSTALLED  (MANDIBULAR PLATES)

1    PROSTHESIS ITEM:         MANDIBULAR PLATES
2    IMPLANT STERILITY CHECKED: YES
3    STERILITY EXPIRATION DATE: JAN 30, 2007
4    RN VERIFIER:             SURNURSE,ONE
5    VENDOR:                  SYNTHES
6    MODEL:                   MAXILLOFACIAL
7    LOT NUMBER:              20-15
8    SERIAL NUMBER:           612A874
9    STERILE RESP:            SPS
10   SIZE:                    10 HOLE
11   QUANTITY:                20
12   PROVIDER READ BACK PERFORMED:

Enter Screen Server Function:  <Enter>
```

Pressing **<Enter>** will now bring back the top-level screen and allow us to make another entry. As many as 15 prostheses can be added to this list. If we were to add more prostheses, the N and R shortcuts discussed on the next two pages would come in handy, but it is a good idea to practice the steps just covered before attempting the shortcuts.

```
                    OPERATION REQUEST: BLOOD INFORMATION

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


Request Blood Availability ? YES//   <Enter>
```

```
                    OPERATION REQUEST: OTHER INFORMATION

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

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

After entering the request information, the Screen Server redisplays all fields, providing an opportunity to the user to update the information.

```
          ** REQUESTS **   CASE #227  SURPATIENT,TWENTY         PAGE 1 OF 3

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

Enter Screen Server Function:  <Enter>
```

```
          ** REQUESTS **   CASE #227  SURPATIENT,TWENTY         PAGE 2 OF 3

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

Enter Screen Server Function: <Enter>
```

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

1    PHARMACY ITEMS:           (MULTIPLE)
2    REQ PHOTO:
3    PREOPERATIVE INFECTION:
4    REFERRING PHYSICIAN:       (MULTIPLE)
5    GENERAL COMMENTS:          (WORD PROCESSING)
6    INDICATIONS FOR OPERATIONS: (WORD PROCESSING)
7    BRIEF CLIN HISTORY:      (WORD PROCESSING)
8    SPS COMMENTS:            (WORD PROCESSING)
9    SPINE LEVEL:
10.  OR CIRC SUPPORT:         (MULTIPLE)
11.  OR SCRUB SUPPORT         (MULTIPLE)

Enter Screen Server Function: <Enter>
```

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

  Press RETURN to continue
```

Delete or Update Operation Requests
[SRSUPRQ]

The *Delete or Update Operation Requests* option is used to delete a request, to update information, or to change the date of a requested operation. When a user enters this option and selects a patient's name and case, he or she can choose one of the three functions. The three functions are explained below and the next few pages contain examples of how to use them.

The prompts differ for multiple team cases (operations performed by two different specialties at the same time on the same patient), as illustrated in Examples 4, 5, and 6. Whenever a user makes a change or updates information for one of the multiple team cases, the software wants to know if the other case is affected.

The three functions available in this option are also available in the *Request Operations* option when the user selects an outstanding request.

With this function:	The user can:
Delete	Permanently remove an operation request from the software files (Examples 1 and 4). Example 4 shows the deletion of one operation in a set of multiple team cases.
Update Request Information	Change the length of the operation and edit other data fields that were entered earlier (Example 2). The software can automatically update each case in a set of two multiple team cases (Example 5).
Change the Request Date	Alter the operation date of the request (Examples 3 and 6). For a set of multiple team cases to remain multiple team cases, the user must change the request date for both operations (Example 6).

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

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

Enter Screen Server Function:  <Enter>
```

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

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

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

1    PHARMACY ITEMS:          (MULTIPLE)
2    REQ PHOTO:
3    PREOPEARTIVE INFECTION:
4    REFERRING PHYSICIAN:     (MULTIPLE)
5    GENERAL COMMENTS:        (WORD PROCESSING)
6    INDICATIONS FOR OPERATIONS: (WORD PROCESSING)
7    BRIEF CLIN HISTORY:     (WORD PROCESSING)
8    SPS COMMENTS:           (WORD PROCESSING)
9    SPINE LEVEL
10   OR CIRC SUPPORT:        (MUILTIPLE)
11   OR SCRUB SPPORT:        (MULTIPLE)

Enter Screen Server Function:  <Enter>
```

Example 3: Change the Request Date

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

```
The following case is requested for SURPATIENT,TWENTY:
1. 12-01-01   CHOLECYSTECTOMY

1. Delete
2. Update Request Information
3. Change the Request Date
Select Number: 3
Change to which Date ? 11/30  (NOV 30, 2001)

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

Press RETURN to continue
```

Deleting or Updating Requests for Multiple Team Cases

Any changes made to one multiple team case can affect the other case. When one of the multiple team cases is deleted, a prompt will ask if the user wishes to delete the other case also. If the user responds with **NO**, the remaining operation will stay in the records as a single case. When the user changes the date of one operation of a multiple team case, the user must simultaneously change the date for the other operation, otherwise the operations will no longer be considered multiple team cases.

When updating a response to a prompt or group of related prompts, the software will ask if the user wants to store (meaning duplicate) the information in the other case. This saves time by storing the information into the other case so that it does not have to be entered again. If the user does not want the prompt response duplicated for the other case, enter **N** or **NO**.

Example 4: Delete a Request for Multiple Team Cases

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

The following cases are requested for SURPATIENT,FOUR:

1. 03-15-05       APPENDECTOMY
2. 08-15-05       CAROTID ARTERY ENDARTERECTOMY
3. 08-15-05       AORTO CORONARY BYPASS

Select Operation Request: 2

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

Select Number: 1

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

A multiple team case has been requested for this operation. Do you want
to delete the request for it also ?  YES// <Enter>

  Deleting Operation ...

  Deleting Concurrent Operation ...

Press <Enter> to continue <Enter>
```

Responding **YES** here will delete both operation requests. **NO** leaves the single remaining case, no longer concurrent.

Example 5: Update Request Information for a Multiple Team Case

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

The following cases are requested for SURPATIENT,TWELVE:

1. 03-16-05   CAROTID ARTERY ENDARTERECTOMY
2. 03-16-05   AORTO CORONARY BYPASS GRAFT

Select Operation Request: 1

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

Select Number: 2


How long is this procedure ? (HOURS:MINUTES)  1:30 // <Enter>
```

```
  ** UPDATE REQUEST **   CASE #178  SURPATIENT,TWELVE     PAGE 1 OF 3

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

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

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

```
          ** UPDATE REQUEST **   CASE #178  SURPATIENT,TWELVE     PAGE 1 OF 3

1    PRINCIPAL PROCEDURE: CAROTID ARTERY ENDARTERECTOMY
2    OTHER PROCEDURES:    (MULTIPLE)
3    PLANNED PRIN PROCEDURE CODE: 35301-59
4    LATERALITY OF PROCEDURE: (NA, LEFT, RIGHT, BILATERAL)
5    PRINCIPAL PRE-OP DIAGNOSIS: CAROTID ARTERY STENOSIS
6    PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9): 433.10
7    OTHER PREOP DIAGNOSIS: (MULTIPLE)
8    PALLIATION:
9    PLANNED ADMISSION STATUS: ADMITTED
10   PRE-ADMISSION TESTING: YES
11   CASE SCHEDULE TYPE: STANDBY
12   SURGERY SPECIALTY:  PERIPHERAL VASCULAR
13   PRIMARY SURGEON:            SURSURGEON,ONE
14   FIRST ASST:
15   SECOND ASST:

Enter Screen Server Function: <Enter>
```

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

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


Enter Screen Server Function: <Enter>
```

```
          ** UPDATE REQUEST **   CASE #229  SURPATIENT,TWELVE      PAGE 3 OF 3

1    PHARMACY ITEMS:           (MULTIPLE)
2    REQ PHOTO:
3    PREOPERATIVE INFECTION:
4    REFERRING PHYSICIAN:      (MULTIPLE)
5    GENERAL COMMENTS:         (WORD PROCESSING)
6    INDICATIONS FOR OPERATIONS: (WORD PROCESSING)
7    BRIEF CLIN HISTORY:       (WORD PROCESSING)
8    SPS COMMENTS:             (WORD PROCESSING)
9    SPINE LEVEL
10   OR CIRC SUPPORT:          (MUILTIPLE)
11   OR SCRUB SPPORT:          (MULTIPLE)

Enter Screen Server Function:
```

Example 6: Change the Request Date of Multiple Team Cases

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

```
The following cases are requested for SURPATIENT,FOUR:

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

Select Operation Request: 3

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

Select Number: 3

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

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

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

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

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

Press RETURN to continue
```

Make a Request from the Waiting List [SRSWREQ]

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

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

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

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

Example: Making A Request From the Waiting List

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

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

Procedures Entered on the Waiting List for SURPATIENT,FOURTEEN:

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

Is this the correct procedure ?  YES// <Enter>

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

```
                    OPERATION REQUEST: REQUIRED INFORMATION

SURPATIENT,FOURTEEN (000-45-7212)                                  DEC  1, 2005
================================================================================

Primary Surgeon: SURSURGEON,TWO
Attending Surgeon: SURSURGEON,TWO
Surgical Specialty: GENERAL(OR WHEN NOT DEFINED BELOW)
Principal Operative Procedure: REPAIR DIAPHRAGMATIC HERNIA
Principal Preoperative Diagnosis: ACUTE DIAPHRAGMATIC HERNIA


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


Press RETURN to continue  <Enter>

Laterality Of Procedure: NA
Planned Admission Status: 1  SAME DAY
Planned Principal Procedure Code: 39540     REPAIR OF DIAPHRAGM HERNIA
 REPAIR, DIAPHRAGMATIC HERNIA (OTHER THAN NEONATAL), TRAUMATIC; ACUTE
 Modifier:
 Estimated Case Length (HOURS:MINUTES): 1:30
Sending a Notification of Appointment Booking for case #229
```

```
                    OPERATION REQUEST: PROCEDURE INFORMATION

SURPATIENT,FOURTEEN (000-45-7212)                                DEC  1, 2005
================================================================================
Principal Procedure:      REPAIR DIAPHRAGMATIC HERNIA
Planned Principal Procedure Code (CPT): 39540       REPAIR OF DIAPHRAGM HERNIA
 REPAIR, DIAPHRAGMATIC HERNIA (OTHER THAN NEONATAL), TRAUMATIC; ACUTE  // <Enter>
Select OTHER PROCEDURE: <Enter>
Estimated Case Length (HOURS:MINUTES): 2:00
BRIEF CLIN HISTORY:
  1>Patient was reporting indigestion and a burning
  2>sensation in esophagus. Upper GI indicated hernia.
  3><Enter>
EDIT Option: <Enter>
```

```
                    OPERATION REQUEST: BLOOD INFORMATION

SURPATIENT,FOURTEEN (000-45-7212)                                DEC  1, 2005
================================================================================

Request Blood Availability (Y/N): NO// <Enter>
```

```
                    OPERATION REQUEST: OTHER INFORMATION

SURPATIENT,FOURTEEN (000-45-7212)                                DEC  1, 2005
================================================================================
Principal Preoperative Diagnosis: ACUTE DIAPHRAGMATIC HERNIA// <Enter>
Prin Pre-OP ICD Diagnosis Code (ICD9): 551.3

 One match found

      551.3     DIAPHRAGM HERNIA W GANGR (Major CC)

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

```
          ** REQUEST **   CASE #229  SURPATIENT,FOURTEEN          PAGE 1 OF 3

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

Enter Screen Server Function:   <Enter>
```

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

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


Enter Screen Server Function:   <Enter>
```

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

1    PHARMACY ITEMS:             (MULTIPLE)
2    REQ PHOTO:                  NO
3    PREOPERATIVE INFECTION:     CLEAN
4    REFERRING PHYSICIAN:        (MULTIPLE)
5    GENERAL COMMENTS:           (WORD PROCESSING)
6    INDICATIONS FOR OPERATIONS: (WORD PROCESSING)
7    BRIEF CLIN HISTORY:         (WORD PROCESSING)(DATA)
8    SPS COMMENTS:               (WORD PROCESSING)
9    SPINE LEVEL
10   OR CIRC SUPPORT:            (MUILTIPLE)
11   OR SCRUB SPPORT:            (MULTIPLE)
```

```
Enter Screen Server Function: <Enter>
```

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

Sending a Notification of Appointment Modification for case #229

  Press RETURN to continue:
```

Example 1: Make a Request for Multiple Team Cases

```
Select Request Operations Option: MT  Make a Request for Multiple Team Cases

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

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

                            FIRST MULTIPLE TEAM CASE
                     OPERATION REQUEST: REQUIRED INFORMATION

SURPATIENT,TWELVE (000-41-8719)                                    DEC  1, 2005
================================================================================

Primary Surgeon: SURSURGEON,ONE
Attending Surgeon: SURSURGEON,TWO
Surgical Specialty: 62          PERIPHERAL VASCULAR  PERIPHERAL VASCULAR
62
Principal Operative Procedure: CAROTID ARTERY ENDARTERECTOMY
Principal Preoperative Diagnosis: CAROTID ARTERY STENOSIS


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


Press RETURN to continue <Enter>

Laterality Of Procedure: NA
Planned Admission Status: SAME DAY
Planned Principal Procedure Code: 35526    REPAIR OF ANOMALOUS CORONARY ARTERY FROM PULMONARY
ARTERY ORIGIN; BY LIGATION
Modifier:
Estimated Case Length (HOURS:MINUTES): 1:30
Sending a Notification of Appointment Booking for case #230


                           SECOND MULTIPLE TEAM CASE
                     OPERATION REQUEST: REQUIRED INFORMATION

SURPATIENT,TWELVE (000-41-8719)                                    DEC  1, 2005
================================================================================

Primary Surgeon: SURSURGEON,TWO
Attending Surgeon: SURSURGEON,ONE
Surgical Specialty: 58          THORACIC SURGERY (INC. CARDIAC SURG.)  THORACIC
SURGERY (INC. CARDIAC SURG.)        58
Principal Operative Procedure: AORTO CORONARY BYPASS GRAFT
Principal Preoperative Diagnosis: CORONARY ARTERY DISEASE


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

Press RETURN to continue <Enter>

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

Modifier:
```

```
The following requests have been entered.

1. Case # 230                          DEC  1, 2005
    Surgeon: SURSURGEON,ONE                PERIPHERAL VASCULAR
    Procedure:  CAROTID ARTERY ENDARTERECTOMY

2. Case # 231                          DEC  1, 2005
    Surgeon: SURSURGEON,TWO                THORACIC SURGERY (INC. CARDIAC SURG.)

    Procedure:  AORTO CORONARY BYPASS GRAFT



1. Enter Request Information for Case #230
2. Enter Request Information for Case #231

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

```
Do you want to store this information in the multiple team case ?  YES//

Request Frozen Section Tests (Y/N): N  NO
Do you want to store this information in the multiple team       YES// <Enter>
case ? Requested Preoperative X-Rays: DOPPLER STUDIES
Do you want to store this information in the multiple team       YES//  N
case ? Intraoperative X-Rays (Y/N): N  NO
Do you want to store this information in the multiple team       YES// <Enter>
case ? Request Medical Media (Y/N): N  NO
Do you want to store this information in the multiple team       YES//  <Enter>
case ? Preoperative Infection: C  CLEAN
Select REFERRING PHYSICIAN: <Enter>
General Comments: <Enter>
  No existing text
  Edit? NO// <Enter>
SPS Comments: <Enter>
  No existing text
  Edit? NO// <Enter>

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

Sending a Notification of Appointment Modification for case #231
```

```
          ** REQUESTS **   CASE #231  SURPATIENT,TWELVE              PAGE 1 OF 3

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

Enter Screen Server Function:   <Enter>
```

```
          ** REQUESTS **   CASE #231  SURPATIENT,TWELVE              PAGE 2 OF 3

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

Enter Screen Server Function:  <Enter>
```

```
         ** REQUESTS **   CASE #231  SURPATIENT,TWELVE              PAGE 3 OF 3

1    PHARMACY ITEMS:             (MULTIPLE)
2    REQ PHOTO:                  NO
3    PREOPERATIVE INFECTION:     CLEAN
4    REFERRING PHYSICIAN:        (MULTIPLE)
5    GENERAL COMMENTS:           (WORD PROCESSING)
6    INDICATIONS FOR OPERATIONS: (WORD PROCESSING)
7    BRIEF CLIN HISTORY:         (WORD PROCESSING)
8    SPS COMMENTS:               (WORD PROCESSING)
9    SPINE LEVEL
10   OR CIRC SUPPORT:            (MUILTIPLE)
11   OR SCRUB SPPORT:            (MULTIPLE)
```

Enter Screen Server Function: **<Enter>**

```
The following requests have been entered.

1. Case # 230                          DEC  1, 2005
    Surgeon: SURSURGEON,ONE                PERIPHERAL VASCULAR
    Procedure:  CAROTID ARTERY ENDARTERECTOMY

2. Case # 231                          DEC  1, 2005
    Surgeon: SURSURGEON,TWO                THORACIC SURGERY (INC. CARDIAC SURG.)
    Procedure:  AORTO CORONARY BYPASS GRAFT



1. Enter Request Information for Case #230
2. Enter Request Information for Case #231

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

Example 2: Update Request Information for a Multiple Team Case

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


The following cases are requested for SURPATIENT,TWELVE:

1. 03-09-05   REMOVE FACIAL LESIONS
2. 12-01-05   CAROTID ARTERY ENDARTERECTOMY
3. 12-01-05   AORTO CORONARY BYPASS GRAFT

Select Operation Request: 2

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

Select Number: 2

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

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

1    PRINCIPAL PROCEDURE:     CAROTID ARTERY ENDARTERECTOMY
2    OTHER PROCEDURES:        (MULTIPLE)
3    PLANNED PRIN PROCEDURE CODE: 35301-59
4    LATERALITY OF PROCEDURE:
5    PRINCIPAL PRE-OP DIAGNOSIS: CAROTID ARTERY STENOSIS
6    PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9):
7    OTHER PREOP DIAGNOSIS:   (MULTIPLE)
8    PALLIATION:              NO
9    PLANNED ADMISSION STATUS: ADMITTED
10   PRE-ADMISSION TESTING:
11   CASE SCHEDULE TYPE:               STANDBY
12   SURGERY SPECIALTY:                PERIPHERAL VASCULAR
13   PRIMARY SURGEON:                  SURSURGEON,ONE
14   FIRST ASST:
15   SECOND ASST:
16   ATTENDING SURGEON:        SURSURGEON,TWO

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

 One match found

     433.1      CAROTID ARTERY OCCLUSION      COMPLICATION/COMORBIDITY

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

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

1    PRINCIPAL PROCEDURE:     CAROTID ARTERY ENDARTERECTOMY
2    OTHER PROCEDURES:        (MULTIPLE)
3    PLANNED PRIN PROCEDURE CODE: 35301-59
4    LATERALITY OF PROCEDURE:
5    PRINCIPAL PRE-OP DIAGNOSIS: CAROTID ARTERY STENOSIS
6    PRIN PRE-OP ICD DIAGNOSIS CODE (ICD): 433.1
7    OTHER PREOP DIAGNOSIS:   (MULTIPLE)
8    PALLIATION:
9    PLANNED ADMISSION STATUS: ADMITTED
10   PRE-ADMISSION TESTING:
11   CASE SCHEDULE TYPE:      STANDBY
12   SURGERY SPECIALTY:       PERIPHERAL VASCULAR
13   PRIMARY SURGEON:         SURSURGEON,ONE
14   FIRST ASST:
15   SECOND ASST:

Enter Screen Server Function:   <Enter>
```

```
          ** UPDATE REQUEST **   CASE #230  SURPATIENT,TWELVE        PAGE 2 OF 3

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

Enter Screen Server Function:  <Enter>
```

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

1    PHARMACY ITEMS:           (MULTIPLE)
2    REQ PHOTO:                NO
3    PREOPERATIVE INFECTION:
4    REFERRING PHYSICIAN:      (MULTIPLE)
5    GENERAL COMMENTS:         (WORD PROCESSING)
6    INDICATIONS FOR OPERATIONS: (WORD PROCESSING) (DATA)
7    BRIEF CLIN HISTORY:       (WORD PROCESSING)
8    SPS COMMENTS:             (WORD PROCESSING)
9    SPINE LEVEL
10   OR CIRC SUPPORT:          (MUILTIPLE)
11   OR SCRUB SPPORT:          (MULTIPLE)
```

```
Enter Screen Server Function:
```

Review Request Information
[SROREQV]

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

Example: Review Request Information

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

```
 SURPATIENT,ONE

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

Select Operation:  1
```

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

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

Enter Screen Server Function:  <Enter>
```

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

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

Enter Screen Server Function:
```

Requests by Ward
[SROWRQ]

Users can utilize the *Requests by Ward* option to print request information for patients in all wards or a specific ward. The first prompt asks if the user wants to print the requests for all wards. If not, accept the **NO** default and the next prompt will ask "Print schedule for which ward?". If the user enters a question mark **(?)**, the help screen will list the ward names from which to choose. Patients not assigned to a ward are listed under the category "Outpatient."

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

Example: Print Requests by Ward

```
Select Request Operations Option:  WR  Requests by Ward

Do you wish to print the requests for all wards ?  NO// Y
Print Requests on which Device: [Select Print Device]
```

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

```
                            Requests for Operations
================================================================================
                                  Ward: 1 SOUTH
================================================================================
 Patient: SURPATIENT,FOURTEEN (000-45-7212)                  Case Number: 180
 Date of Operation:    03/15/99         Case Order:
 Requested Anesthesia: GENERAL
 Operation(s): REPAIR DIAPHRAGMATIC HERNIA

 Comments:
--------------------------------------------------------------------------------

Press RETURN to continue or '^' to quit. <Enter>
```

```
                            Requests for Operations
================================================================================
                                  Ward: 2 WEST
================================================================================
 Patient: SURPATIENT,TWELVE (000-41-8719)                    Case Number: 178
 Date of Operation:    03/15/99         Case Order:  1
 Requested Anesthesia: GENERAL
 Operation(s): CAROTID ARTERY ENDARTERECTOMY

 Comments:

    Multiple Team Case Number: 179
    Procedure: AORTO CORONARY BYPASS GRAFT

Comments:
--------------------------------------------------------------------------------
 Patient: SURPATIENT,TWELVE (000-41-8719)                    Case Number: 179
 Date of Operation:    03/15/99         Case Order:  1
 Requested Anesthesia: GENERAL
 Operation(s): AORTO CORONARY BYPASS GRAFT

 Comments:

    Multiple Team Case Number: 178
    Procedure: CAROTID ARTERY ENDARTERECTOMY

Comments:
--------------------------------------------------------------------------------

Press RETURN to continue or '^' to quit. <Enter>
```

Schedule Operations
[SROSCHOP]

The options contained within the *Schedule Operations* menu are designed to be used by surgeons or the Scheduling Manager to book an operation when the date, time, and operating room are determined. The scheduling manager may schedule an already requested operation using the *Schedule Requested Operation* option. On the other hand, the scheduling manager may book an operation that has not been previously requested if the date, time and operating room are known. In this case, the *Request Operations* option can be skipped and the operation can be scheduled using the *Schedule Unrequested Operations* option.

 This option is locked with the SROSCH key.

Whether a user is booking a case from the Waiting List, *Request Menu*, *Scheduling Menu*, or as a new surgery, he or she will be asked to provide preoperative information about the case. It is advisable to enter as much information as possible. Later, the information can be updated.

The information gathered by the *Request Operations* options is collated by the software and used to produce reports. The person in charge of scheduling (scheduling manager) arranges the requests according to the hospital's Surgical Service protocols and schedules the operation by assigning the case an operating room and a time slot. The information gathered by the *Schedule Operations* menu is collated by the software and is used to produce reports for the scheduling manager.

Local restrictions can be applied to the scheduling of procedures. For example, a facility can require CPT codes be entered before a surgical case is scheduled. The *Surgery Site Parameters* (Enter/Edit) option is used to select required fields.

The options included in the *Schedule Operation* menu are listed below. To the left of the option name is the shortcut synonym that the user can enter to select the option.

Shortcut	Option Name
A	*Display Availability*
SR	*Schedule Requested Operations*
SU	*Schedule Unrequested Operations*
CON	*Schedule Unrequested Multiple Team Cases*
R	*Reschedule or Update Scheduled Operations*
C	*Cancel Scheduled Operation*
UC	*Update Cancellation Reason*
AN	*Schedule Anesthesia Personnel*
B	*Create Service Blockout*
DB	*Delete Service Blockout*
S	*Schedule of Operations*

Schedule Requested Operation
[SRSCHD1]

Users utilize the *Schedule Requested Operation* option to schedule a previously requested operation when enough information is available to assign an operating room and time slot. The user will also be prompted to provide anesthesia personnel information. The information entered here is reflected in the Schedule of Operations report. This option is designed for the scheduling manager to expeditiously schedule any or all requests on a specific date.

First, the user enters the patient to be scheduled. The software will automatically display all requests for that patient. The user then picks the request he or she wishes to schedule and assigns the operating room, beginning and end times, and anesthesia personnel for the case. The user can then choose another patient to schedule, or press the **<Enter>** key to leave the option.

The prompts that require a response before the user can continue with this option include the following.

"Schedule a Case for which Operating Room ?"
"Reserve from what time ? (24HR:NEAREST 15 MIN):"
"Reserve to what time ? (24HR:NEAREST 15 MIN):"

Scheduling a Multiple Team Case

A multiple team case occurs when a patient undergoes two operations by different surgical specialties simultaneously, or back-to-back in the same operating room. Example 2 demonstrates scheduling a requested multiple team case. When a user schedules a multiple team case, he or she must answer the prompt "There is a multiple team case associated with this operation. Do you want to schedule it for the same time? (Y/N) ". If the answer is **NO**, the two cases will no longer be considered multiple team cases. The user can enter anesthesia personnel information for each case.

The user should allow enough time for **both** surgeries when he or she answers the prompts, "Reserve from what time ? (24HR:NEAREST 15 MIN):" and "Reserve to what time ? (24HR:NEAREST 15 MIN):".

Example 2: Schedule Operation for a Multiple Team Case

```
Select Schedule Operations Option: SR  Schedule Requested Operations

Select Patient: SURPATIENT,EIGHTEEN          09-14-54     000223334

The following cases are requested for SURPATIENT,EIGHTEEN:

1. 07-06-99   CAROTID ARTERY ENDARTERECTOMY
2. 07-06-99   AORTO CORONARY BYPASS GRAFT

Select Operation Request: 1

Case Information:
CAROTID ARTERY ENDARTERECTOMY
By SURSURGEON,ONE                            On SURPATIENT,EIGHTEEN
Case # 262
STANDBY
  * Multiple Team Case # 263  AORTO CORONARY BYPASS
GRAFT
```

```
Display of Available Operating Room Time

1. Display Availability (12:00 AM - 12:00 PM)
2. Display Availability (06:00 AM - 08:00 PM)
3. Display Availability (12:00 PM - 12:00 AM)
4. Do Not Display Availability

Select Number: 2//  <Enter>
```

```
ROOM   6AM   7    8    9    10   11   12   13   14   15   16   17   18   19   20
OR1     |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
OR2     |____|card|card|card|card|card|card|card|card|card|   ____|____|____|____|
OR3     |____|orth|orth|orth|orth|orth|orth|____|____|____|____|____|____|____|
OR4     |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
OR5     |____|____|____|____|____|____|____|____|____|____|____|____|____|____|

Schedule a Case for which Operating Room ?  OR2

Reserve from what time ? (24HR:NEAREST 15 MIN):  7:15

Reserve to what time ? (24HR:NEAREST 15 MIN):  12:30


Principal Anesthetist: SURANESTHETIST,ONE
Anesthesiologist Supervisor: SURANESTHETIST,TWO

There is a multiple team case associated with this operation. Do you want
to schedule it for the same time ? (Y/N)  Y


Select Patient:
```

```
                    SCHEDULE UNREQUESTED OPERATION: BLOOD INFORMATION

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


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

Type and Crossmatch, Screen, or Autologous: TYPE & CROSSMATCH// <Enter> TYPE & CROSSMATCH
Select REQ BLOOD KIND: CPDA-1 WHOLE BLOOD// @
   SURE YOU WANT TO DELETE THE ENTIRE REQ BLOOD KIND? Y  (YES)
Select REQ BLOOD KIND: FA1  FRESH FROZEN PLASMA, CPDA-1       18201
  Units Required: 4
```

```
                    SCHEDULE UNREQUESTED OPERATION: OTHER INFORMATION

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

Prin Pre-OP ICD Diagnosis Code: 715.11  715.11          LOC PRIM OSTEOART-SHLDER
         ...OK? YES// <Enter>  (YES)
Hospital Admission Status:  2  ADMISSION
Case Schedule Type: S  STANDBY
First Assistant: TS  SURSURGEON,THREE
Second Assistant: SURSURGEON,FOUR
Requested Postoperative Care: W  WARD
Case Schedule Order: 1
Requested Anesthesia Technique: G  GENERAL
Request Frozen Section Tests (Y/N): N  NO
Requested Preoperative X-Rays: LEFT SHOULDER
Intraoperative X-Rays (Y/N/C): Y  YES
Request Medical Media (Y/N): N  NO
Preoperative Infection: C  CLEAN
GENERAL COMMENTS:
  1><Enter>
 SPS Comments:
  1><Enter>
```

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

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

Enter Screen Server Function:  <Enter>
```

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

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

Enter Screen Server Function:
```

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

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

Enter Screen Server Function:
```

Schedule Unrequested Multiple Team Cases
[SRSCHDC]

The *Schedule Unrequested Multiple Team Cases* option is used to schedule multiple team cases that have not been requested. A multiple team case is when a patient undergoes two operations by different surgical specialties simultaneously, or back to back in the same room. The user can schedule both cases with this one option. As usual, whenever the user enters a request, he or she is asked to provide preoperative information about the case. It is best to enter as much information as possible and update it later if necessary.

Required Prompts

After the patient name is entered, the user will be prompted to enter some required information about the first case. The mandatory prompts include the date, procedures, surgeon and attending surgeon, principal preoperative diagnosis, and time needed. If a mandatory prompt is not answered, the software will not book the operation and will return the cursor to the *Schedule Operations* menu. After answering the prompts for the first case, the user will be asked to answer the same prompts for the second case. The software will then provide a message stating that the two requests have been entered. The user can then select a case for entering detailed preoperative information. If the user does not want to enter details at this time, he or she should press the **<Enter>** key and the cursor will return to the *Schedule Operations* menu. In the example, detailed information for the first case has been entered.

Storing the Request Information

After every prompt or group of related prompts, the software will ask if the user wants to store (meaning duplicate) the answers in the multiple team case. This saves time by storing the information into the other case so that it does not have to be typed again. The software will then display the screen server summary and store any duplicated information into the other case. Finally, the software will inform the user that the two requests have been entered and prompt to select either case for entering detailed information. The user can select a case or press the **<Enter>** key to get back to the *Schedule Operations* menu.

Updating the Preoperative Information Later

Use the *Reschedule or Update a Scheduled Operation* option to change or update any of the information entered for either of the multiple team cases.

Example: Schedule Unrequested Multiple Team Cases

```
Select Schedule Operations Option: CON  Schedule Unrequested Multiple Team

Schedule Multiple Team Cases for which Patient ?                      06-04-35
  SURPATIENT,EIGHT

Schedule Concurrent Procedures for which Date ?  07 25 2005  (JUL 25, 2005)


Display of Available Operating Room Time

1. Display Availability (12:00 AM - 12:00 PM)
2. Display Availability (06:00 AM - 08:00 PM)
3. Display Availability (12:00 PM - 12:00 AM)
4. Do Not Display Availability

Select Number: 2//  4

Schedule a case for which operating Room ?  OR2

Reserve from what time ? (24HR:NEAREST 15 MIN):  11:15    (11:15)

Reserve to what time ? (24HR:NEAREST 15 MIN):  16:00    (16:00)
```

```
                          FIRST MULTIPLE TEAM CASE
              SCHEDULE UNREQUESTED OPERATION: REQUIRED INFORMATION

SURPATIENT,EIGHT (000-37-0555)                                    JUL 25, 2005
================================================================================

Desired Procedure Date: 07 25 2005  (JUL 25, 2005)
Primary Surgeon: SURSURGEON,ONE
Attending Surgeon: SURSURGEON,ONE
Surgical Specialty: 62          PERIPHERAL VASCULAR  PERIPHERAL VASCULAR        62

Principal Operative Procedure: CAROTID ARTERY ENDARTERECTOMY
Principal Preoperative Diagnosis: CAROTID ARTERY STENOSIS


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


Press RETURN to continue  <Enter>
```

```
                          SECOND MULTIPLE TEAM CASE
              SCHEDULE UNREQUESTED OPERATION: REQUIRED INFORMATION

SURPATIENT,EIGHT (000-37-0555)                                    JUL 25, 2005
================================================================================

Desired Procedure Date: 07 25 2005  (JUL 25, 2005)
Primary Surgeon: SURSURGEON,TWO
Attending Surgeon: SURSURGEON,ONE
Surgical Specialty: 58          THORACIC SURGERY (INC. CARDIAC SURG.)  THORACIC
SURGERY (INC. CARDIAC SURG.)        58
Principal Operative Procedure: AORTO CORONARY BYPASS GRAFT
Principal Preoperative Diagnosis: UNSTABLE ANGINA


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


Press RETURN to continue  <Enter>
```

```
 The following cases have been entered.

1. Case # 265                          JUL 25, 2005
    Surgeon: SURSURGEON,ONE                PERIPHERAL VASCULAR
    Procedure:  CAROTID ARTERY ENDARTERECTOMY

2. Case # 266                          JUL 25, 2005
    Surgeon: SURSURGEON,TWO                THORACIC SURGERY (INC. CARDIAC SURG.)
    Procedure:  AORTO CORONARY BYPASS GRAFT

1. Enter Information for Case #265
2. Enter Information for Case #266

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

```
                          FIRST MULTIPLE TEAM CASE
              SCHEDULE UNREQUESTED OPERATION: ANESTHESIA PERSONNEL

SURPATIENT,EIGHT (000-37-0555)                                 JUL 25, 2005
================================================================================
Principal Anesthetist: SURANESTHETIST,ONE
Anesthesiologist Supervisor: SURANESTHETIST,TWO
```

```
                          FIRST MULTIPLE TEAM CASE
              SCHEDULE UNREQUESTED OPERATION: PROCEDURE INFORMATION

SURPATIENT,EIGHT (000-37-0555)                                 JUL 25, 2005
================================================================================
Principal Procedure:      CAROTID ARTERY ENDARTERECTOMY
Planned Principal Procedure Code (CPT): RECHANNELING OF ARTERY
        THROMBOENDARTERECTOMY, WITH OR WITHOUT PATCH GRAFT; CAROTID, VERTEBRAL,
        SUBCLAVIAN, BY NECK INCISION
Modifier: <Enter>
Select OTHER PROCEDURE: <Enter>
Brief Clinical History:
  1>Patient with 3 episodes of amaurisis fugax in the last
  2>3 months. 6 mo history of increasing angina with little
  3>control from nitrates. Carotid arteriogram shows 95%
  4>occlusion on right, 80% on left. Angiogram shows 80%
  5>occlusion of left main artery.
  6><Enter>
EDIT Option: <Enter>
```

```
                          FIRST MULTIPLE TEAM CASE
                  SCHEDULE UNREQUESTED OPERATION: BLOOD INFORMATION

SURPATIENT,EIGHT (000-37-0555)                                 JUL 25, 2005
================================================================================


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

Type and Crossmatch, Screen, or Autologous: TYPE & CROSSMATCH// TYPE & CROSSMATCH
Select REQ BLOOD KIND: CPDA-1 WHOLE BLOOD// <Enter>
  Required Blood Product: CPDA-1 WHOLE BLOOD// <Enter>
  Units Required: 2
```

```
                          FIRST MULTIPLE TEAM CASE
                  SCHEDULE UNREQUESTED OPERATION: OTHER INFORMATION

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

Prin Pre-OP ICD Diagnosis Code: 433.11      OCCL&STEN/CAR ART W/CRB INF
 COMPLICATION/COMORBIDITY     ACTIVE
Hospital Admission Status:   2  ADMISSION

Do you want to store this information in the multiple team case ?  YES//  N

Case Schedule Type: S  STANDBY

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

First Assistant: SURSURGEON,FOUR
Second Assistant: TS  SURSURGEON,THREE
Requested Postoperative Care: SICU

Do you want to store this information in the multiple team case ?  YES//  N

Case Schedule Order: 2

Do you want to store this information in the multiple team case ?  YES//  N

Requested Anesthesia Technique: G  GENERAL

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

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

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

Requested Preoperative X-Rays: DOPPLER STUDIES

Do you want to store this information in the multiple team case ?  YES//  N

Intraoperative X-Rays (Y/N/C): N  NO

Do you want to store this information in the multiple team case ?  YES//  N

Request Medical Media (Y/N): N  NO

Do you want to store this information in the multiple team case ?  YES//  Y

Preoperative infection: C  CLEAN

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

GENERAL COMMENTS:
  1><Enter>
SPS Comments:
  1><Enter>
```

Example 1: How to Add a Multiple Team Case to a Scheduled Operation

```
Select Schedule Operations Option:  R  Reschedule or Update a Scheduled Operation

Select Patient: SURPATIENT,SIX          04-04-30     000098797
SURPATIENT,SIX (000-09-8797)

1. 09/16/05   CARPAL TUNNEL RELEASE (SCHEDULED)
2. 02/02/05   BUNIONECTOMY (SCHEDULED)

Select Number: 1

Do you want to add a multiple team case ?  NO//
```

```
                          SECOND MULTIPLE TEAM CASE
              SCHEDULE UNREQUESTED OPERATION: REQUIRED INFORMATION

SURPATIENT,SIX (000-09-8797)                                  SEP 16, 2005
================================================================================

Primary Surgeon: SURSURGEON,TWO
Attending Surgeon: SURSURGEON,TWO
Surgical Specialty: 54          ORTHOPEDICS         54
Principal Operative Procedure: ARTHROSCOPY, R SHOULDER
Principal Preoperative Diagnosis: DEGENERATIVE OSTEOARTHRITIS


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


Press RETURN to continue   <Enter>
```

```
                          SECOND MULTIPLE TEAM CASE
              SCHEDULE UNREQUESTED OPERATION: ANESTHESIA PERSONNEL

SURPATIENT,SIX (000-09-8797)                                  SEP 16, 2005
================================================================================
Principal Anesthetist: SURANESTHETIST,ONE
Anesthesiologist Supervisor: SURANESTHETIST,TWO
```

```
                          SECOND MULTIPLE TEAM CASE
              SCHEDULE UNREQUESTED OPERATION: PROCEDURE INFORMATION

SURPATIENT,SIX (000-09-8797)                                  SEP 16, 2005
================================================================================
Principal Procedure:      ARTHROSCOPY, R SHOULDER
Planned Principal Procedure Code (CPT): 23470       RECONSTRUCT SHOULDER JOINT
 ARTHROPLASTY, GLENOHUMERAL JOINT; HEMIARTHROPLASTY     ACTIVE
Modifier: <Enter>
Select OTHER PROCEDURE:  <Enter>
Brief Clinical History:
  1>CHRONIC DEBILITATING PAIN. X-RAY SHOWS SEVERE
  2>DEGENERATIVE OSTEOARTHRITIS.
  3><Enter>
EDIT Option:  <Enter>
```

```
                           SECOND MULTIPLE TEAM CASE
                  SCHEDULE UNREQUESTED OPERATION: BLOOD INFORMATION

SURPATIENT,SIX (000-09-8797)                                  SEP 16, 2005
================================================================================

Request Blood Availability ? YES//   <Enter>
Type and Crossmatch, Screen, or Autologous ? TYPE & CROSSMATCH//   <Enter> TYPE & CROSSMATCH
Select REQ BLOOD KIND: CPDA-1 WHOLE BLOOD// FA1  FRESH FROZEN PLASMA, CPDA-1
  18201
  Units Required: 2
```

```
                          SECOND MULTIPLE TEAM CASE
                  SCHEDULE UNREQUESTED OPERATION: OTHER INFORMATION

SURPATIENT,SIX (000-09-8797)                                    SEP 16, 2005
================================================================================

Prin Pre-OP ICD Diagnosis Code: 715.90 715.90     OSTEOARTHROS NOS-UNSPEC
      ACTIVE
         ...OK? Yes// <Enter>  (Yes)
(Hospital Admission Status: 2  ADMISSION

Do you want to store this information in the multiple team case ?  YES//  N

Case Schedule Type:  S  STANDBY

Do you want to store this information in the multiple team case ?  YES//  N

First Assistant: TS  SURSURGEON,THREE
Second Assistant:  <Enter>
Requested Postoperative Care: WARD

Do you want to store this information in the multiple team case ?  YES//  N

Case Schedule Order: 1

Do you want to store this information in the multiple team case ?  YES//  N

Requested Anesthesia Technique: GENERAL

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

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

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

Requested Preoperative X-Rays:  <Enter>
Intraoperative X-Rays (Y/N): Y  YES

Do you want to store this information in the multiple team case ?  YES//  N

Request Medical Media (Y/N): N  NO

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

Preoperative Infection: C  CLEAN

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

GENERAL COMMENTS:
  1>  <Enter>
```

Example 2: How to Reschedule an Operation, Change the Date, Time, or Operating Room

```
Select Schedule Operations Option: R  Reschedule or Update a Scheduled Operation

Select Patient: SURPATIENT,THREE          12-19-53     000212453
```

```
SURPATIENT,THREE (000-21-2453)


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

Select Number: 1

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

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

```
Operating Room Reservations:

Surgeon: SURSURGEON,ONE
Patient: SURPATIENT,THREE
Procedure(s): SHOULDER ARTHROPLASTY-PROTHESIS

Operating Room:  OR3
Scheduled Start: SEP 15, 2005 08:00
Scheduled End:   SEP 15, 2005 13:00


Reschedule this Procedure for which Date ?  <Enter>

Since no date has been entered, I must assume that you want to re-schedule
this case for the same date. If you have made a mistake and want to
leave this case scheduled for the same operating room at the same times,
enter RETURN when prompted to select an operating room.

Press RETURN to continue  <Enter>
```

```
Display of Available Operating Room Time

1. Display Availability (12:00 AM - 12:00 PM)
2. Display Availability (06:00 AM - 08:00 PM)
3. Display Availability (12:00 PM - 12:00 AM)
4. Do Not Display Availability

Select Number: 2//  4

Schedule this case for which Operating Room: OR3

Reserve from what time ? (24HR:NEAREST 15 MIN):  7:30

Reserve to what time ? (24HR:NEAREST 15 MIN):  13:00


Principal Anesthetist: SURANESTHETIST,ONE// <Enter>
Anesthesiologist Supervisor: SURANESTHETIST,TWO// <Enter>
```

Example 3: How to Update a Scheduled Operation

```
Select Schedule Operations Option: R  Reschedule or Update a Scheduled Operation

Select Patient: SURPATIENT,THREE          12-19-53     000212453
```

```
SURPATIENT,THREE (000-21-2453)


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

Select Number: 1

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

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

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

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

Enter Screen Server Function: <Enter>
```

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

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

Enter Screen Server Function:  8
```

Cancel Scheduled Operation
[SRSCAN]

When a scheduled operation is cancelled, the *Cancel Scheduled Operation* option will remove that case from the list of scheduled operations. A cancellation will remain in the system as a cancelled case and will be used in computing the facility's cancellation rate.

Enter the patient name and select the operation to be deleted from the choices listed. The "Primary Cancellation Reason:" prompt is a mandatory prompt. Enter a question mark for a list of primary cancellation reasons from which to select. If a mistake is made, or the user finds out later that the primary cancellation reason was not correct, the *Update Cancellation Reason* option allows the primary cancellation reason to be edited.

If there is a multiple team case associated with the operation being cancelled, the software will ask if the user wants to cancel it also.

Example 1: Cancel a Single Scheduled Operation

```
Select Schedule Operations Option: C  Cancel Scheduled Operation

Cancel a Scheduled Procedure for which Patient: SURPATIENT,NINETEEN            01-01-40
000287354 YES     SC VETERAN
```

```
SURPATIENT,NINETEEN (000-28-7354)

1. 09/12/11   FRONTAL CRANIOTOMY TO RULE OUT TUMOR (SCHEDULED)

Select Number: 1

Reservation for OR3
Scheduled Start Time: 09-12-11 11:00
Scheduled End Time:   09-12-11 13:00
Patient: SURPATIENT,NINETEEN
Physician: SURSURGEON,ONE
Procedure: FRONTAL CRANIOTOMY TO RULE OUT TUMOR

Is this the correct operation ?  YES// <Enter>

Cancellation Timeframe: 1 SURGERY CANCELLED <48 HRS BEFORE SCHEDULED SURGERY
Primary Cancellation Reason: 4    PATIENT HEALTH STATUS       4
Cancellation Avoidable: YES// N  NO
Do you want to create a new request for this cancelled case ??  YES// <Enter>

Make the new request for which Date ?  MAR 12, 2012// <Enter> (MAR 12, 2012)

Creating the new request...
```

Example 2: Cancel a Scheduled Multiple Team Case

```
Select Schedule Operations Option: C  Cancel Scheduled Operation

Cancel a Scheduled Procedure for which Patient:    SURPATIENT,SIX       04-04-30
  000098797
```

```
SURPATIENT,SIX (000-09-8797)


1. 09/16/11   ARTHROSCOPY, RIGHT SHOULDER (SCHEDULED)
2. 09/16/11   CARPAL TUNNEL RELEASE (SCHEDULED)
```

```
Select Number: 1

Reservation for OR2
Scheduled Start Time: 09-16-11 08:00
Scheduled End Time:   09-16-11 13:00
Patient:   SURPATIENT,SIX
Physician: SURSURGEON,TWO
Procedure: ARTHROSCOPY, RIGHT SHOULDER

Is this the correct operation ?  YES//  <Enter>

Cancellation Timeframe: 1  SURGERY CANCELLED <48 HRS BEFORE SCHEDULED SURGERY
Primary Cancellation Reason: 7   UNAVAILABLE BED       7
Cancellation Avoidable: YES// N  NO

Do you want to create a new request for this cancelled case ??  YES// <Enter>

Make the new request for which Date ?  MAR 29, 2012// <Enter> (MAR 29, 2012)

Creating the new request...

There is a multiple team case associated with this operation.  Do you want
to cancel it also ? YES// <Enter>

Do you want to create a new request for this cancelled case ??  YES// <Enter>

Make the new request for which Date ?  MAR 29, 2012// <Enter> (MAR 29, 2012)

Creating the new request...
```

Schedule of Operations
[SROSCH]

The *Schedule of Operations* option generates the Operating Room Schedule used by the OR nurses, surgeons, anesthetists and other hospital services. The report lists operations and patients scheduled for a particular date. It sorts by operating room and includes the procedure(s), blood products requested, and any preoperative x-rays requested. The schedule also provides anesthesia information and surgeon names.

This report has a 132-column format and is designed to be copied to a printer.

By setting up default printers in the SURGERY SITE PARAMETERS file, this report can be queued to print in various locations simultaneously. Please see "Chapter 5: Managing the Software Package" for more information.

Example: Print Schedule of Operations

```
Select Schedule Operations Option:  S  Schedule of Operations

Print Schedule of Operations for which date ?    9/8  (SEP 08, 1999)
```

```
Print the long form or the short form ?  SHORT //

This report is designed to use a 132 column format.

Print the report on which device: HOME //
```

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

SURGICAL SERVICE
SCHEDULE OF OPERATIONS SIGNATURE OF CHIEF: DR. ONE SURSURGEON
PRINTED: SEP 07, 1999 11:12 FOR: SEP 08, 1999

PATIENT ID# WARD	AGE	DISPOSITION START TIME END TIME	PREOPERATIVE DIAGNOSIS OPERATION(S)	REQ ANESTHESIA ANESTHESIOLOGIST PRIN. ANESTHETIST	SURGEON FIRST ASST. ATT SURGEON
OPERATING ROOM: OR1					
SURPATIENT,ONE		WARD	CARPAL TUNNEL SYNDROME	GENERAL	SURSURGEON, O
000-44-7629	46	07:30	REVISE MEDIAN NERVE	SURANESTHETIST, T	SURSURGEON, F
TO BE ADMITTED		09:30		SURANESTHETIST, O	SURSURGEON, O
Case # 143		PREOPERATIVE XRAYS: CARPAL TUNNEL, R WRIST			
OPERATING ROOM: OR2					
SURPATIENT,FOURTEEN		WARD	CHOLELITHIASIS	GENERAL	SURSURGEON, O
000-45-7212	48	06:30	CHOLECYSTECTOMY	SURANESTHETIST, T	SURSURGEON, T
HICU 212-B		08:00		SURANESTHETIST, O	SURSURGEON, O
Case # 141		REQUESTED BLOOD COMPONENTS: TYPE & CROSSMATCH CPDA-1 RED BLOOD CELLS - 2 UNITS			
SURPATIENT,TWELVE		WARD	ACUTE DIAPHRAGMATIC HERNIA	GENERAL	SURSURGEON, T
000-41-8719	71	08:00	REPAIR DIAPHRAGMATIC HERNIA	SURANESTHETIST, T	SURSURGEON, O
TO BE ADMITTED		09:30		SURANESTHETIST, O	SURSURGEON, T
Case # 142		REQUESTED BLOOD COMPONENTS: TYPE & CROSSMATCH CPDA-1 RED BLOOD CELLS - 2 UNITS PREOPERATIVE XRAYS: ABDOMEN			
SURPATIENT,THIRTY		WARD	CAROTID ARTERY STENOSIS	GENERAL	SURSURGEON, O
000-82-9472	48	11:15	CAROTID ARTERY ENDARTERECTOMY	SURANESTHETIST, T	SURSURGEON, F
TO BE ADMITTED		16:00		SURANESTHETIST, O	SURSURGEON, O
		** Multiple Team Case #157 AORTO CORONARY BYPASS GRAFT			
Case # 150		REQUESTED BLOOD COMPONENTS: TYPE & CROSSMATCH CPDA-1 RED BLOOD CELLS - UNITS NOT ENTERED CPDA-1 WHOLE BLOOD - 2 UNITS PREOPERATIVE XRAYS: DOPPLER STUDIES			
SURPATIENT,THIRTY		WARD	CORONARY ARTERY DISEASE	GENERAL	SURSURGEON, T
000-82-9472	48	11:15	AORTO CORONARY BYPASS GRAFT	SURANESTHETIST, T	SURSURGEON, F
TO BE ADMITTED		16:00		SURANESTHETIST, O	SURSURGEON, T
		** Multiple Team Case #150 CAROTID ARTERY ENDARTERECTOMY			
Case # 157					

TOTAL CASES SCHEDULED: 5

Chapter Two: Tracking Clinical Procedures

Introduction

The options described in this chapter provide on-line access to medical administration and laboratory information and provide tracking of operative procedures. They allow the following:

- Entry of information specific to an individual surgical case (for example, staff, times, diagnoses, complications, anesthesia).
- On-line entry of data inside the operating room during the actual operative procedure.
- Generation of patient records and reports.

Key Vocabulary

The following terms are used in this chapter.

Term	Definition
Multiple Team Case	The patient undergoes two operations, by two different specialties, at the same time in the same operating room.
Screen Server	After the data concerning the operation has been entered, the terminal display device will clear and then present a two-page Screen Server summary. The Screen Server summary organizes the information entered and gives the user another opportunity to enter or edit data.

Reviewing Information

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

Example: Review Information

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

```
 SURPATIENT,THREE   000-21-2453

1. 08-15-99   SHOULDER ARTHROPLASTY (NOT COMPLETE)

2. 03-12-92   SHOULDER ARTHROPLASTY-PROSTHESIS (SCHEDULED)

3. ENTER NEW SURGICAL CASE

Select Operation: 2
```

```
SURPATIENT,THREE  000-21-2453

 08-15-88     SHOULDER ARTHROPLASTY (NOT COMPLETE)


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

Select Number:  1//  2
```

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

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

Enter Screen Server Function:  <Enter>
```

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

1    POSSIBLE ITEM RETENTION:
2    SOFT GOODS FINAL COUNT CORRECT:
3    SHARPS FINAL COUNT CORRECT:
4    INSTRUMENT FINAL COUNT CORRECT:
5    WOUND SWEEP: NO
6    WOUND SWEEP COMMENTS:    (WORD PROCESSING)
7    WOUND DEHISCENCE         No
8    INTRA-OPERATIVE X-RAY: No
9    INTRA-OPERATIVE X-RAY COMMENTS:  (WORD PROCESSING)
10   SOFT GOOD, SHARP, & INST COUNTER:
11   COUNT VERIFIER:
12   SEQUENTIAL COMPRESSION DEVICE:    (MULTIPLE)
13   LASER PERFORMED:                  (MULTIPLE)
```

```
14   CELL SAVER: (MULTIPLE)
15   NURSING CARE COMMENTS: (WORD PROCESSING)


Enter Screen Server Function:  <Enter>
```

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

1    PRINCIPAL PRE-OP DIAGNOSIS:
2    PRIN PRE-OP ICD DIAGNOSIS CODE (ICD10):
3    PRINCIPAL PROCEDURE:     APPENDECTOMY TEST
4    PLANNED PRIN PROCEDURE CODE: 10040
5    OTHER PROCEDURES:        (MULTIPLE)
6    INDICATIONS FOR OPERATIONS: (WORD PROCESSING)DATA)
7    BRIEF CLIN HISTORY:      (WORD PROCESSING)

Enter Screen Server Function:
```

Deleting a Surgery Case

The user enters the number **3** to access this feature. The *Delete Surgery Case* feature will permanently remove all information on the operative procedure from the records; however, only cases that are not completed can be deleted.

Example: How to Delete A Case

```
Select Surgery Menu Option:  Operation Menu
Select Patient: SURPATIENT,NINE          12-09-51     000345555     NSC VETERAN
```

```
SURPATIENT,NINE   000-34-5555

1. 04-26-05   CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM (COMPLETED)

2. 12-20-05   REMOVE FACIAL LESIONS (NOT COMPLETE)

3. ENTER NEW SURGICAL CASE

Select Operation: 2
```

```
 SURPATIENT,NINE  000-34-5555

 12-20-05     REMOVE FACIAL LESIONS (NOT COMPLETE)

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

Select Number:  1//  3

Are you sure that you want to delete this case ?  NO//  Y
  Deleting Operation...
```

Abort/Cancel Operation
[SROABRT]

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

Example: Abort Operation

```
Select Schedule Operations Option:  AB Abort/Cancel Operation

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

Case Aborted?: N// Y
     1   YES-PRE ANESTHESIA
     2   YES-POST ANESTHESIA
Choose 1-2: 1  YES-PRE ANESTHESIA
Time Patient In the O.R.: JUN 22,2015@0730  (JUN 22, 2015@07:30)
Time Patient Out of the O.R.: JUN 22,2015@0800  (JUN 22, 2015@08:00)
Primary Cancellation Reason: 1  PATIENT RELATED ISSUE    1
Cancellation Date/Time: JUN 22,2015@0810  (JUN 22, 2015@08:10)
Cancellation Avoidable: N  NO

Aborting Surgery case #21814

Enter RETURN to continue or '^' to exit: <Enter>
```

Time Patient In the O.R. and Time Patient Out of the O.R. will only be asked if they weren't previously

Example: Cancel Operation

```
Select Schedule Operations Option:  AB Abort/Cancel Operation

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

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

Cancelling Surgery case #21815

Enter RETURN to continue or '^' to exit: <Enter>
```

Entering a New Surgical Case

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

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

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

Prompts that require a response include:

"Select the Date of Operation:"

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

1    POSSIBLE ITEM RETENTION:
2    SOFT GOODS FINAL COUNT CORRECT:
3    SHARPS FINAL COUNT CORRECT:
4    INSTRUMENT FINAL COUNT CORRECT:
5    WOUND SWEEP:
6    WOUND SWEEP COMMENTS:    (WORD PROCESSING)
7    WOULD DEHISCENCE: NO
8    INTRA-OPERATIVE X-RAY: NO
9    INTRA-OPERATIVE X-RAY COMMENTS: (WORD PROCESSING)
10   SOFT GOOD, SHARP, & INST COUNTER:
11   COUNT VERIFIER:
12   SEQUENTIAL COMPRESSION DEVICE:
13   LASER PERFORMED:          (MULTIPLE)
14   CELL SAVER:               (MULTIPLE)
15   NURSING CARE COMMENTS:    (WORD PROCESSING)

Enter Screen Server Function: 1:4
```

```
Possible Item Retention: Y
Soft Goods Final Count Correct: Y
Sharps Final Count Correct: Y
Instrument Final Count Correct: Y
```

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

1    POSSIBLE ITEM RETENTION:  YES
2    SOFT GOODS FINAL COUNT CORRECT: YES
3    SHARPS FINAL COUNT CORRECT: YES
4    INSTRUMENT FINAL COUNT CORRECT: YES
5    WOUND SWEEP:
6    WOUND SWEEP COMMENTS:    (WORD PROCESSING)
7    WOUND DESHISCENCE:        NO
8    INTRA-OPERATIVE X-RAY:    NO
9    INTRA-OPERATIVE X-RAY COMMENTS: (WORD PROCESSING)
10   SOFT GOOD, SHARP, & INST COUNTER:
11   COUNT VERIFIER:
12   SEQUENTIAL COMPRESSION DEVICE:
13   LASER PERFORMED:          (MULTIPLE)
14   CELL SAVER:               (MULTIPLE)
15   NURSING CARE COMMENTS:    (WORD PROCESSING)

Enter Screen Server Function: 14
```

```
NURSING CARE COMMENTS:
  1>Admitted with prosthesis in place, left eye is artificial eye.
  2>Foam pads applied to elbows and knees. Pillow placed
  3>under knees.
  4><Enter>
EDIT Option: <Enter>
```

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

1    POSSIBLE ITEM RETENTION:  YES
2    SOFT GOODS FINAL COUNT CORRECT: YES
3    SHARPS FINAL COUNT CORRECT: YES
4    INSTRUMENT FINAL COUNT CORRECT: YES
5    WOUND SWEEP:
6    WOUND SWEEP COMMENTS:    (WORD PROCESSING)
7    WOUND DESHISCENCE:        NO
8    INTRA-OPERATIVE X-RAY:    NO
9    INTRA-OPERATIVE X-RAY COMMENTS: (WORD PROCESSING)
10   SOFT GOOD, SHARP, & INST COUNTER:
11   COUNT VERIFIER:
12   SEQUENTIAL COMPRESSION DEVICE:
13   LASER PERFORMED:          (MULTIPLE)
14   CELL SAVER:               (MULTIPLE)
15   NURSING CARE COMMENTS:  (WORD PROCESSING)

Enter Screen Server Function: <Enter>
```

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

1    PRINCIPAL PRE-OP DIAGNOSIS: SDSFD DSFFDS
2    PRIN PRE-OP ICD DIAGNOSIS CODE (ICD9):
3    PRINCIPAL PROCEDURE:
4    PLANNED PRIN PROCEDURE CODE:
5    OTHER PROCEDURES:         (MULTIPLE)
6    INDICATIONS FOR OPERATIONS: (WORD PROCESSING)
7    BRIEF CLIN HISTORY:       (WORD PROCESSING)

Enter Screen Server Function:
```

```
            ** POST OPERATION **   CASE #145  SURPATIENT,NINE     PAGE 1 OF 1
           ANES CARE TIME BLOCK

1    NEW ENTRY

Enter Screen Server Function:  1
Select ANES CARE TIME BLOCK ANES CARE MULTIPLE START TIME: 10:30    APR 26, 2005@
10:30
   ANES CARE TIME BLOCK ANES CARE MULTIPLE START TIME: APR 26, 2005@10:30
         // <Enter>
```

```
          ** POST OPERATION **   CASE #145  SURPATIENT,NINE     PAGE 1 OF 1
            ANES CARE TIME BLOCK  (3050608.153)

1    ANES CARE MULTIPLE START TIME: APR 26, 2005@10:30
2    ANES CARE MULTIPLE END TIME:

Enter Screen Server Function:  2
Anesthesia Care Multiple End Time: 12:40  (APR 26, 2005@12:40)

Does this entry complete all start and end times for this case?  (Y/N)//  Y
```

```
          ** POST OPERATION **   CASE #145  SURPATIENT,NINE     PAGE 1 OF 1
            ANES CARE TIME BLOCK  (3050608.153)

1    ANES CARE MULTIPLE START TIME: APR 26, 2005 AT 10:30
2    ANES CARE MULTIPLE END TIME: APR 26, 2005 AT 12:40

Enter Screen Server Function: <Enter>
```

```
          ** POST OPERATION **   CASE #145  SURPATIENT,NINE     PAGE 1 OF 1
            ANES CARE TIME BLOCK

1    ANES CARE MULTIPLE START TIME: APR 26, 2005 AT 10:30
2    NEW ENTRY

Enter Screen Server Function: <Enter>
```

```
          ** POST OPERATION **   CASE #145  SURPATIENT,NINE      PAGE 1 OF 2

1    DRESSING:                TELFA
2    PACKING:
3    TUBES AND DRAINS:        PENROSE
4    BLOOD LOSS (ML):         200
5    TOTAL URINE OUTPUT (ML): 600
6    GASTRIC OUTPUT:          150
7    POSTOP MOOD:             RELAXED
8    POSTOP CONSCIOUS:        RESTING
9    POSTOP SKIN INTEG:       INTACT
10   TIME OPERATION ENDS:     APR 26, 2005 AT 12:30
11   ANES CARE TIME BLOCK:    (MULTIPLE) (DATA)
12   TIME PAT OUT OR:         APR 26, 2005 AT 12:50
13   OP DISPOSITION:          PACU (RECOVERY ROOM)
14   DISCHARGED VIA:          PACU BED
15   REPORT GIVEN TO:

Enter Screen Server Function: <Enter>
```

x

```
          ** POST OPERATION **   CASE #145  SURPATIENT,NINE      PAGE 2 OF 2

1    PRINCIPAL POST-OP DIAG:     TEST
2    PRIN PER-OP ICD DIAGNOSIS CODE (ICD10):
3    OTHER POSTOP DIAGS:         (MULTIPLE)
4    PRINCIPAL PROCEDURE:        TEST
5    PLANNED PRIN PROCEDURE CODE: 600
6    OTHER PROCEDURES:           (MULTIPLE)
7    WOUND CLASSIFICATION:
8    INTRAOP CPT CODE:
9    ATTENDING/RES SUP CODE:
10   IMMED USE-CONTAMINATION: 0
11   IMMED USE-SPS/OR MGT ISSUE: 0
12   IMMED USE-EMERGENCY CASE:0
13   IMMED USE-NO BETTER OPTION: 0
14   IMMED USE-LOANER INSTRUMENT: 0
15   IMMED USE-DECONTAMINATION: 0

Enter Screen Server Function: <Enter>
```

Enter PAC(U) Information
[SROMEN-PACU]

Personnel in the Post Anesthesia Care Unit (PACU) use the *Enter PAC(U) Information* option to enter the admission and discharge times and scores.

Example: Entering PAC(U) Information

```
Select Operation Menu Option: PAC  Enter PAC(U) Information
```

```
          ** PACU **           CASE #145  SURPATIENT,NINE            PAGE 1 OF 2

1    ADMIT PAC(U) TIME:     MAR 09, 2005
2    PAC(U)ADMIT SCORE:     10
3    OXYGENATION PH1 PAC(U):
4    RESPIRATORY STATUS PH1 PAC(U):
5    CIRCULATORY STATUS PH1 PAC(U):
6    LEVEL CONSCIOUSNESS PH1 PAC(U):
7    PAIN PH1 PAC(U):
8    NAUSEA/VOMITING PH1 PAC(U): 17000
9    LEVEL OF ACTIVITY PH1 PAC(U)
10   PAIN PH2 PAC(U):
11   NAUSEA/VOMITING PH2 PAC(U:
12   CIRCULATORY STATUS PH1 PAC(U):
13   ACTIVITY AND MENTAL STATUS PH2:
14   SURG SITE/DRESSING PH2 PAC(U):
15   INTAKE AND OUTPUT PH2 PAC(U):

Enter Screen Server Function:  <Enter>
```

```
          ** PACU **   CASE #145  SURPATIENT,NINE               PAGE 2 OF 2

1    PAC(U) DISCH TIME:     APR 26, 1999 AT 13:00
2    PAC(U) DISCH SCORE:    10
3    VA-PAS PH1 SCORE:
4    VA-PAS PH1 SCORE:

Enter Screen Server Function:
```

Time Out Verified Utilizing Checklist
[SROMEN-VERF]

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

Example: Time Out Verified Utilizing Checklist

```
Select Operation Menu Option: Time Out Verified Utilizing Checklist
```

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

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

Enter Screen Server Function:  A
Confirm Correct Patient Identity: Y  YES
Confirm Procedure To Be Performed: Y  YES
Confirm Site of Procedure, Including Laterality: Y  YES
Confirm Valid Consent: 1  YES, i-MED
Confirm Patient Position: N   NO
Confirm Proc. Site has been Marked Appropriately and the Site of the Mark is Vis
ible After Prep: Y  YES
Pertinent Medical Images Have Been Confirmed: Y  YES
Correct Medical Implant(s) is Available: Y  YES
Availability of Special Equipment: Y  YES
Appropriate Antibiotic Prophylaxis: Y  YES
Appropriate Deep Vein Thrombosis Prophylaxis: Y  YES
Blood Availability: Y  YES
Checklist Comment:
  No existing text
  Edit? NO// <Enter>
TIME-OUT DOCUMENT COMPLETED BY: SURNURSE,FIVE
TIME-OUT COMPLETED:

Checklist Comments should be entered when a "NO" response is entered for any of
 the Time Out Verified Utilizing Checklist fields.
Do you want to enter Checklist Comment ?  YES//

Checklist Comment:
  No existing text
  Edit? NO//
```

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

1    CONFIRM PATIENT IDENTITY: YES
2    PROCEDURE TO BE PERFORMED: YES
3    SITE OF PROCEDURE: YES
4    CONFIRM VALID CONSENT: YES, i-MED
5    CONFIRM PATIENT POSITION: YES
6    MARKED SITE CONFIRMED: YES
7    PREOPERATIVE IMAGES CONFIRMED: YES
8    CORRECT MEDICAL IMPLANTS: YES
9    AVAILABILITY OF SPECIAL EQUIP: YES
10   ANTIBIOTIC PROPHYLAXIS:  YES
```

```
11   APPROPRIATE DVT PROPHYLAXIS: YES
12   BLOOD AVAILABILITY: YES
13   CHECKLIST COMMENT:       (WORD PROCESSING)
14   TIME-OUT DOCUMENT COMPLETED BY: SURNURSE, FIVE
15   TIME-OUT COMPLETED:
Enter Screen Server Function:
```

If the PLANNED PRIN PROCEDURE CODE field for the case is one of the following CPT codes Time Out Checklist-2 will be displayed: 32851, 32852,3 2853, 32854, 33935, 33945, 44135, 44136, 47135, 47136, 48160, 48554, 50360, 50365.

Example: Time Out Verified Utilizing Checklist-2

```
          ** TIME OUT CHECKLIST **    CASE #145  SURPATIENT,NINE       PAGE 2 of 3

1    UNET VERIF BY SURGEON (Y/N):
2    ORGAN VER PRE-ANESTHESIA:
3    SURGEON VER ORGAN PRE-ANES:
4    SURGEON VER DONOR ORG PRE-ANES:
5    DONOR ORG VER PRE-ANES:
6    ORGAN VER PRE-TRANSPLANT:
7    SURGEON VER ORG PRE-TRANSPLANT:
8    DONOR VESSEL UNOS ID:    (MULTIPLE)
9    DONOR VESSEL USAGE:
10   DONOR VESSEL DISPOSITION:
11   NEW ORGAN CHECK-IN COMPLETE:
12   STAFF PERFORMING CHECK-IN:
13   D/T ORGAN ARRIVAL TO OR SUITE:
14   D/T SURGEON ORGAN PRE-TRNSPLNT:
15   UNOS TIMEOUT PERFORMED:
Enter Screen Server Function:

          ** TIME OUT CHECKLIST **    CASE #145  SURPATIENT,NINE       PAGE 3 of 3

1    D/T UNOS TIMEOUT:
2    D/T UNOS TIMEOUT #2:
3    D/T ORGAN ON FIELD:
4    ORGAN REPERFUSION TIME:
5    D/T ORGAN LEFT DONOR OR SUITE:
6    PEROPERATIVE IMAGES CONFIRMED:
7    CORRECT MEDICAL IMPLANTS:
8    ANTIBIOTIC PROPHYLAXIS:
9    APPROPRIATE DVT PROPHYLAXIS:
10   AVAILABILITY OF SPECIAL EQUIP:
Enter Screen Server Function:
```

```
Postoperative Skin Color:     N/A

Laser Performed: N/A

Sequential Compression Device: NO

Cell Saver(s): N/A

Devices: N/A

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

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

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

This section will only appear for Transplant cases that have a PLANNED PRIN PROCEDURE CODE that is one of the following: 32851,32852,32853,32854,33935,33945,44135,44136,47135,47136,48160,48554,50360,50365

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

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

Material Sent to Laboratory for Analysis:
Specimens:
 1. MITRAL VALVE
Cultures:  N/A
Anesthesia Technique(s):
 GENERAL  (PRINCIPAL)

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

Tourniquet: N/A

Thermal Unit: N/A

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

Medications: N/A

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

Blood Replacement Fluids: N/A
Possible Item Retention:    YES
Soft Goods Count:   YES
Sharps Count:       YES
Instrument Count:   NOT APPLICABLE
Wound Sweep:                * NOT ENTERED *
Wound Sweep Comment: NO COMMENTS ENTERED
Intra-Operative X-Ray:      * NOT ENTERED *
Intra-Operative X-Ray Comment: NO COMMENTS ENTERED
Counter:            SURNURSE,FOUR
Counts Verified By: SURNURSE,FIVE

Dressing: DSD, PAPER TAPE, MEPORE
Packing:  NONE

Blood Loss: 800 ml                      Urine Output: 750 ml

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

Laser Performed: (Multiple)

Sequential Compression Device: NO
```

```
Cell Saver(s): N/A

Devices: N/A

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

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

Nursing Care Comments:

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

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

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

Addendum Comment: OPERATION END TIME WAS CORRECTED.
                  Signed by: /es/ FIVE SURNURSE
                                  07/17/2004 16:42
```

This section will only appear for Transplant cases that have a PLANNED PRIN PROCEDURE CODE that is one of the following: 32851,32852,32853,32854,33935,33945,44135,44136,47135,47136,48160,48554,50360,50365

```
  ** ANESTHESIA INFO **   CASE #145  SURPATIENT,NINE    PAGE 1 OF 1
        ANES CARE TIME BLOCK

1    ANES CARE MULTIPLE START TIME: APR 26, 2003 AT 09:20
2    NEW ENTRY

Enter Screen Server Function:  <Enter>
```

```
** ANESTHESIA INFO **   CASE #145  SURPATIENT,NINE PAGE 1 OF 2

1    ANESTHESIOLOGIST SUPVR:
2    ANES SUPERVISE CODE:
3    PRINC ANESTHETIST:     SURANESTHETIST, THREE
4    RELIEF ANESTHETIST:
5    ASST ANESTHETIST:
6    ANES CARE TIME BLOCK: (MULTIPLE) (DATA)
7    INDUCTION COMPLETE:
8    ASA CLASS:             2-MILD DISTURB.
9    BLOOD LOSS (ML):       200
10   MIN INTRAOP TEMPERATURE (C):
11   FINAL ANESTHESIA TEMP (C):
12   TOTAL URINE OUTPUT (ML): 1
13   OP DISPOSITION:        PACU (RECOVERY ROOM)
14   POSTOP ANES NOTE:
15   ORAL-PHARYNGEAL SCORE: CLASS 2

Enter Screen Server Function: 9:12
Intraoperative Blood Loss (ml): 200// 500
Lowest Intraoperative Temperature (C): 28
Final Anesthesia Temperature (C): 37
Total Urine Output (ml): 1// 1800
```

```
  ** ANESTHESIA INFO **   CASE #145  SURPATIENT,NINE     PAGE 1 OF 2

1    ANESTHESIOLOGIST SUPVR:
2    ANES SUPERVISE CODE:
3    PRINC ANESTHETIST:    SURANESTHETIST, THREE
4    RELIEF ANESTHETIST:
5    ASST ANESTHETIST:
6    ANES CARE TIME BLOCK: (MULTIPLE)(DATA)
7    INDUCTION COMPLETE:
8    ASA CLASS:            2-MILD DISTURB.
9    BLOOD LOSS (ML):      500
10   MIN INTRAOP TEMPERATURE (C): 28
11   FINAL ANESTHESIA TEMP (C): 37
12   TOTAL URINE OUTPUT (ML): 1800
13   OP DISPOSITION:       PACU (RECOVERY ROOM)
14   POSTOP ANES NOTE:
15   ORAL-PHARYNGEAL SCORE: CLASS 2

Enter Screen Server Function: <Enter>
```

```
  ** ANESTHESIA INFO **   CASE #145  SURPATIENT,NINE     PAGE 2 OF 2
1    MANDIBULAR SPACE:     80
2    REPLACEMENT FLUID TYPE: (MULTIPLE)(DATA)
3    MEDICATIONS:          (MULTIPLE)(DATA)
4    MONITORS:             (MULTIPLE)
5    GENERAL COMMENTS:     (WORD PROCESSING)
6    THERMAL UNIT:         (MULTIPLE)(DATA)
7    ANESTHESIA TECHNIQUE: (MULTIPLE)(DATA)
8    ANES PERSONALLY PERFORMED:
9    NUM OF CONCURRENT ANES CASES:
10   ANES MULTIPLE TEAM CASES:
11   (MULTIPLE) ANES MEDICALLY
12   DIRECTED:

Enter Screen Server Function:  4
```

```
   ** ANESTHESIA INFO **   CASE #145  SURPATIENT,NINE     PAGE 1
         MONITORS

1    NEW ENTRY

Enter Screen Server Function:  1
Select MONITORS: ECG
    MONITORS: ECG// <Enter>
```

```
  ** ANESTHESIA INFO **   CASE #145  SURPATIENT,NINE     PAGE 1
        MONITORS  (ECG)
1    MONITORS:              ECG
2    TIME INSTALLED:
3    TIME REMOVED:
4    APPLIED BY:

Enter Screen Server Function:  2:4
Time Applied: 4/26@9:20  (APR 26, 1999@09:20)
Time Removed: 4/26@12:45  (APR 26, 1999@12:45)
Person Applying the Monitor: SURNURSE,ONE
```

```
  ** ANESTHESIA INFO **   CASE #145  SURPATIENT,NINE    PAGE 2 OF 2

1    MANDIBULAR SPACE:     80
2    REPLACEMENT FLUID TYPE: (MULTIPLE)(DATA)
3    MEDICATIONS:           (MULTIPLE)(DATA)
4    MONITORS:              (MULTIPLE)(DATA)
5    GENERAL COMMENTS:      (WORD PROCESSING)
6    THERMAL UNIT:          (MULTIPLE)(DATA)
7    ANESTHESIA TECHNIQUE: (MULTIPLE)(DATA)
8    ANES PERSONALLY PERFORMED:
9    NUM OF CONCURRENT ANES CASES:
10   ANES MULTIPLE TEAM CASES: (MULTIPLE)
11   ANES MEDICALLY DIRECTED:
12   ANES PHYSICIAN AVAILABLE:


Enter Screen Server Function: 8:12

Anesthesiologist Personally Performed: NO
Number Of Concurrent Anesthesiology Cases: <Enter>
Anesthesiologist Medically Directed: Y  YES
Teaching Physician Present: Y  YES
```

```
  ** ANESTHESIA INFO **   CASE #145  SURPATIENT,NINE    PAGE 1

            ANES MULTIPLE TEAM CASES

1    NEW ENTRY

Enter Screen Server Function: <Enter>
```

```
  ** ANESTHESIA INFO **   CASE #145  SURPATIENT,NINE    PAGE 2 OF 2

1    MANDIBULAR SPACE:     80
2    REPLACEMENT FLUID TYPE: (MULTIPLE)(DATA)
3    MEDICATIONS:           (MULTIPLE)(DATA)
4    MONITORS:              (MULTIPLE)(DATA)
5    GENERAL COMMENTS:      (WORD PROCESSING)
6    THERMAL UNIT:          (MULTIPLE)(DATA)
7    ANESTHESIA TECHNIQUE: (MULTIPLE)(DATA)
8    ANES PERSONALLY PERFORMED: NO
9    NUM OF CONCURRENT ANES CASES:
10   ANES MULTIPLE TEAM CASES: (MULTIPLE)
11   ANES MEDICALLY DIRECTED: NO
12   ANES PHYSICIAN AVAILABLE: YES


Enter Screen Server Function: <Enter>
```

```
------------------------------------------------------------------------------
SURPATIENT,TEN  000-12-3456                        NURSE INTRAOPERATIVE REPORT
------------------------------------------------------------------------------
NOTE DATED: 02/12/2004 08:00  NURSE INTRAOPERATIVE REPORT

SUBJECT: Case #: 267226

Operating Room:  BO OR1                 Surgical Priority: ELECTIVE

Patient in Hold: JUL 12, 2004  07:30    Patient in OR:  JUL 12, 2004  08:00
Operation Begin: JUL 12, 2004  08:58    Operation End:  JUL 12, 2004  12:10
Surgeon in OR:   JUL 12, 2004  07:55    Patient Out OR: JUL 12, 2004  12:15

Major Operations Performed:
Primary: MVR
Other:   ATRIAL SEPTAL DEFECT REPAIR
Other:   TEE

Wound Classification: CONTAMINATED

Operation Disposition: SICU
Discharged Via: ICU BED

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

Other Scrubbed Assistants: N/A

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

Other Persons in OR: N/A

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

Valid Consent/ID Band Confirmed By: SURSURGEON,FOUR
Mark on Surgical Site Confirmed: YES
  Marked Site Comments: NO COMMENTS ENTERED

Preoperative Imaging Confirmed: YES
  Imaging Confirmed Comments: NO COMMENTS ENTERED

Time Out Verification Completed: YES
  Time Out Verified Comments: NO COMMENTS ENTERED

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

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

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

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

Immediate Use Steam Sterilization Episodes:
   Contamination:                       0
   SPS Processing/OR Management Issues: 0
   Emergency Case:                      0
```

MAYBERRY, NC
SURGICAL SERVICE
SCHEDULE OF OPERATIONS
FOR: SEP 08, 1999

PRINTED: SEP 07, 1999 11:12

SIGNATURE OF CHIEF: DR. MOE HOWARD
_____

PATIENT ID# WARD	AGE	DISPOSITION START TIME END TIME	PREOPERATIVE DIAGNOSIS OPERATION(S)	REQ ANESTHESIA ANESTHESIOLOGIST PRIN. ANESTHETIST	PRIMARY SURGEON FIRST ASST. ATT SURGEON
OPERATING ROOM: OR1					
SURPATIENT,ONE 000-44-7629 TO BE ADMITTED Case # 143	46	WARD 07:30 09:30	CARPAL TUNNEL SYNDROME REVISE MEDIAN NERVE PREOPERATIVE XRAYS: CARPAL TUNNEL, R WRIST	GENERAL SURANESTHESIOLOGIST,O SURANESTHETIST, T	SURSURGEON, O SURSURGEON, F SURSURGEON, O
OPERATING ROOM: OR2					
SURPATIENT,FOURTEEN 000-45-7212 HICU 212-B Case # 141	48	WARD 06:30 08:00	CHOLELITHIASIS CHOLECYSTECTOMY REQUESTED BLOOD COMPONENTS: TYPE & CROSSMATCH CPDA-1 RED BLOOD CELLS - 2 UNITS PREOPERATIVE XRAYS: ABDOMIN	GENERAL SURANESTHESIOLOGIST,F SURANESTHETIST, O	SURSURGEON, O SURSURGEON, T SURSURGEON, O
SURPATIENT,TWELVE 000-41-8719 TO BE ADMITTED Case # 142	60	WARD 08:00 09:30	ACUTE DIAPHRAGMATIC HERNIA REPAIR DIAPHRAGMATIC HERNIA REQUESTED BLOOD COMPONENTS: TYPE & CROSSMATCH CPDA-1 RED BLOOD CELLS - 2 UNITS PREOPERATIVE XRAYS: ABDOMEN	GENERAL SURANESTHESIOLOGIST,T SURANESTHETIST, O	SURSURGEON, T SURSURGEON, O SURSURGEON, T
SURPATIENT,THIRTY 000-82-9472 TO BE ADMITTED Case # 150	48	WARD 11:15 16:00	CAROTID ARTERY STENOSIS CAROTID ARTERY ENDARTERECTOMY ** Multiple Team Case #157 AORTO CORONARY BYPASS GRAFT REQUESTED BLOOD COMPONENTS: TYPE & CROSSMATCH CPDA-1 RED BLOOD CELLS - UNITS NOT ENTERED CPDA-1 WHOLE BLOOD - 2 UNITS PREOPERATIVE XRAYS: DOPPLER STUDIES	GENERAL SURANESTHESIOLOGIST,T SURANESTHETIST, F	SURSURGEON, O SURSURGEON, F SURSURGEON, O
SURPATIENT,THIRTY 000-82-9472 TO BE ADMITTED Case # 157	48	WARD 11:15 16:00	CORONARY ARTERY DISEASE AORTO CORONARY BYPASS GRAFT ** Multiple Team Case #150 CAROTID ARTERY ENDARTERECTOMY	GENERAL SURANESTHESIOLOGIST,O SURANESTHETIST, O	SURSURGEON, T SURSURGEON, F SURSURGEON, T

TOTAL CASES SCHEDULED: 5

(This page included for two-sided copying.)

Update O.R. Schedule Devices
[SR UPDATE SCHEDULE DEVICE]

The *Update O.R. Schedule Devices* option is used to update the list of devices that will print the Schedule of Operations when printing to all pre-defined printers.

Example: Add a New Schedule Device

```
Select Surgery Package Management Menu Option: SD  Update O.R. Schedule Devices
```

```
Update O.R. Schedule Devices
----------------------------


Select OR SCHEDULE DEVICES: SPS PTR
   ARE YOU ADDING 'SPS PTR ' AS A NEW OR SCHEDULE DEVICES (THE 1ST FOR THIS SURGERY
SITE PARAMETERS)? Y  (YES)
Select OR SCHEDULE DEVICES:
```

```
SURPATIENT,SIXTY (000-56-7821)      Case #63592                   PAGE: 1 OF 4
JUN 23,1998   CHOLEDOCHOTOMY
-------------------------------------------------------------------------------
1. GENERAL:
  A. Height:                        58 INCHES
  B. Weight:                        150 LBS
  C. Diabetes - Long Term:          NO
  D. Diabetes - 2 Wks Preop:        NO
  E. Tobacco Use:                   NO USE IN LAST 12 MOS
  F. Tobacco Use Timeframe:         NOT APPLICABLE
  G. ETOH > 2 Drinks/Day:           NO
  H. Positive Drug Screening:       NEG RESULT
  I. Dyspnea:                       DYSPNEA UPON MODERATE EXERTION
  J. Preop Sleep Apnea:             NO
  K. DNR Status:                    NO
  L. Functional Health Status:      INDEPENDENT
  M. Current Residence:             HOME
  N. Ambulationj Device:            AMBULATES W/OUT ASSISTIVE DEVICE
  O. Homelessness:                  NO
  P. Employment Status Preop:
-------------------------------------------------------------------------------
Select Preoperative Information to Edit:
```

```
SURPATIENT,SIXTY (000-56-7821)       Case #63592                PAGE: 2 OF 4
JUN 23,1998   CHOLEDOCHOTOMY
-------------------------------------------------------------------------------
2. PULMONARY:
  A. Ventilator Dependent:          NO
  B. History of COPD:               NO
  C. Current Pneumonia:             NO
3. HEPATOBILIARY:
  A. Ascites:
4. GASTROINTESTINAL:
  A. Esophageal Varices:
5. CARDIAC:
  A. Congestive Heart Failure:      N CARD DX/CHF, SX UNKNOWN
  B. Prior MI:                      NO PRIOR MI
  C. PCI:                           NONE
  D. Prior Heart Surgery:           VALVE ONLY
  E. Angina Severity                NONE
  F. Angina Timeframe:              NO ANGINA
  G. Hypertension:                  NO
  H. Prio Surg in Same OP Field:    NO PREVIOUS SURGERIES
  I. Hx Rad Rx Planned Surg Field:  NO
  J. CVD Repair/Obstruction:        NO CVD
  K. Donor Serology HIV:
-------------------------------------------------------------------------------

Select Preoperative Information to Edit: <Enter>
```

```
SURPATIENT,SIXTY (000-56-7821)      Case #63592                    PAGE: 3 OF 4
JUN 23,1998   CHOLEDOCHOTOMY
-------------------------------------------------------------------------------
6. VASCULAR:
  A. PAD:                           NO
  B. Rest Pain/Gangrene::           NO
7. RENAL:
  A. Acute Renal Failure Preop:     NO
  B. Currently on Dialysis:         NO
8. CENTRAL NERVOUS SYSTEM:
  A. Impaired Sensorium:            NO
  B. Coma:                          NO
  C. Hemiplegia/Hemiparesis:        NO
  D. CVD Repair/Obstruct:           NO CVD
  E. History of CVD:                NO CVD
  F. Tumor Involving CNS:           NO
  G. Impaired Cognitive Function:   NO DOCUMENTATION
-------------------------------------------------------------------------------
Select Preoperative Information to Edit:
```

```
-------------------------------------------------------------------------------
 SURPATIENT,SIXTY (000-56-7821)       Case #63592                PAGE: 4 OF 4
JUN 23,1998   CHOLEDOCHOTOMY
-------------------------------------------------------------------------------
9. NUTRITIONAL/IMMUNE/OTHER:
  A. Disseminated Cancer:           NO
  B. Open Wound:                    NO
  C. Steroid Use Preop:             NO, specific criteria not met.
  D. Weight Loss > 10%:             NO
  E. Bleeding Disorders:            NO
  F. Bleed Due to Med:              NO BLEEDING RISK
  G. Transfusion > 4 RBC Units:     NO
  H. Chemo for Malig Last 90 Days   NO CHEMO
  I. Radiotherapy W/I 90 Days:      NO
  J. Preoperative Sepsis:           NONE
  K. Pregnancy:                     NOT APPLICABLE
  L. History of Radiation Therapy:  NO
  M. Preop Funct. Health Status:    INDEPENDENT
-------------------------------------------------------------------------------

Select Preoperative Information to Edit: <Enter>
```

Example 2: Capture Postoperative Laboratory Information

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

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


Select Number: 2

This selection loads highest or lowest lab data for tests performed within 30 days after the
operation.

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

'Time the Operation Ends' must be entered before continuing.

Do you want to enter the time that the operation was completed at
this time ?  YES//   <Enter>

Time the Operation Ends: 12:00  (SEP 25, 2003@12:00)

..Searching lab record for postoperative lab test data….

..Moving postoperative lab data to Surgery Risk Assessment file….

Press <RET> to continue
```

Example 3: Enter, Edit, or Review Laboratory Test Results

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

Enter/Edit Laboratory Test Results

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

Select Number: 3

SURPATIENT,FORTY (000-77-7777)        Case #68112                  PAGE: 1 OF 2
LATEST PREOP LAB RESULTS IN 90 DAYS PRIOR TO SURGERY  UNLESS OTHERWISE SPECIFIED
SEP 19,2003   CHOLEDOCHOTOMY
------------------------------------------------------------------------------

 1. Anion Gap (in 48 hrs.):        12    (SEP 18,2003)
 2. Serum Sodium:                  139   (SEP 18,2003)
 3. BUN:                           13    (SEP 18,2003)
 4. Serum Creatinine:              1     (SEP 18,2003)
 5. Serum Albumin:                 4     (SEP 18,2003)
 6. Total Bilirubin:               .8    (SEP 18,2003)
 7. SGOT:                          29    (SEP 18,2003)
 8. Alkaline Phosphatase:          120   (SEP 18,2003)
 9. WBC:                           12.8  (SEP 18,2003)
10. Hematocrit:                    45.7  (SEP 18,2003)
11. Platelet Count:                NS
12. PTT:                           NS
13. PT:                            NS
14. INR:                           NS
15. Hemoglobin A1c (1000 days):    NS
------------------------------------------------------------------------------

Select Preoperative Laboratory Information to Edit: 11:13
```

Postoperative Occurrences (Enter/Edit)
[SRO POSTOP COMP]

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

```
Select Non-Cardiac Assessment Information (Enter/Edit) Option: PO  Postoperative Occurrences
(Enter/Edit)
```

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

There are no Postoperative Occurrences entered for this case.


Enter a New Postoperative Occurrence: ACUTE RENAL FAILURE
  VASQIP Definition (2011):
  Indicate if the patient developed new renal failure requiring renal
  replacement therapy or experienced an exacerbation of preoperative
  renal failure requiring initiation of renal replacement therapy (not on
  renal replacement therapy preoperatively) within 30 days
  postoperatively.  Renal replacement therapy is defined as venous to
  venous hemodialysis [CVVHD], continuous venous to arterial hemodialysis
  [CVAHD], peritoneal dialysis, hemofiltration, hemodiafiltration or
  ultrafiltration.

  TIP: If the patient refuses dialysis report as an occurrence because
  he/she did require dialysis.


Press RETURN to continue: <Enter>
```

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

1. Occurrence:            ACUTE RENAL FAILURE
2. Occurrence Category:   ACUTE RENAL FAILURE
3. ICD Diagnosis Code (ICD10):
4. Treatment Instituted:
5. Outcome to Date:
6. Date Noted:
7. Occurrence Comments:

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

Select Occurrence Information: 4
```

Clinical Information (Enter/Edit)
[SROA CLINICAL INFORMATION]

The *Clinical Information (Enter/Edit)* option is used to enter the clinical information required for a cardiac risk assessment. The software will present page one; 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 the next page.

About the "Select Clinical Information to Edit:" Prompt

At the "Select Clinical Information to Edit:" prompt, the user should enter the item number, number/letter combination, or range of numbers to edit. The user can then enter an **A** for **ALL** to respond to every item on the page, or enter a range of numbers separated by a colon (:) to respond to a range of items. The user can enter **N** to set all fields on the page to **NO.** If assistance is needed while interacting with the software, the user can enter one or two question marks (**??**) to receive on-line help.

Example: Enter Clinical Information

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

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183                      PAGE: 1 OF 4
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------
 1. Height:                          70 in
 2. Weight:                          185 lb
 3. Diabetes - Long Term:            NO
 4. Diabetes - 2 Wks Preop:          NO
 5. History of COPD:                 NO
 6. FEV1:                            9.3 liters
 7. Cardiomegaly (X-ray):            YES
 8. Tobacco Use:                     NEVER USED TOBACCO
 9. Tobacco Use Timeframe:           NOT APPLICABLE
10. Positive Drug Screening:         NOT DONE
11. Active Endocarditis:             NO
12. Functional Status:               INDEPENDENT
13. PCI:                             NONE
14. Prior MI:                        UNKNOWN
15. Prior Surg in Same OP field:     NONE
16. Num Prior Heart Surgeries:       NONE
17. Prior Heart Surgery:             NONE
18. PAD:
------------------------------------------------------------------------------
Select Clinical Information to Edit:
```

```
SURPATIENT,NINETEEN (000-28-7354)         Case #60183                     PAGE: 2 OF 4
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------
19. CVD Repair/Obstruct:             NO CVD
20. History of CVD:                  NO CVD
21. Angina Severity:                 NONE
22. Angina Timeframe:                W/N 14 DAY OF SU
23. Congestive Heart Failure:        0
24. Current Diuretic Use:            NO
25. IV NTG within 48 Hours:          NO
26. Preop Circulatory Device:        NONE
27. Hypertension:                    NO
28. Preop Atrial Fibrillation:       NO
29. Preop Sleep Apnea:               Level 1
30. Impaired Cognitive Func:
31. Residence 30 Days Preop:         HOME
32. Ambulation Device Preop:         AMBULATES W/OUT ASSISTIVE DEVICE
33. Hx Rad Rx Planned Surg Field:
35. Myocardial Infarction:           NO
36. Tracheostomy:                    NO
------------------------------------------------------------------------------
Select Clinical Information to Edit:
```

Postoperative Occurrences (Enter/Edit)
[SRO POSTOP COMP]

The nurse reviewer uses the *Postoperative Occurrences (Enter/Edit)* option to enter or change information related to postoperative occurrences. Every occurrence entered must have a corresponding occurrence category. For a list of occurrence categories, the user can enter a question mark (**?**) at the "Enter a New Postoperative 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 opportunity to enter or edit data.

Example: Enter a Postoperative Occurrence

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: PO  Postoperative Occurrences
(Enter/Edit)
```

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

There are no Postoperative Occurrences entered for this case.


Enter a New Postoperative Occurrence: CARDIAC ARREST REQUIRING CPR
    Definition Revised (2011): Indicate if there was any cardiac arrest
  requiring external or open cardiopulmonary resuscitation (CPR)
  occurring in the operating room, ICU, ward, or out-of-hospital after
  the chest had been completely closed and within 30 days of surgery.
  Patients with AICDs that fire but the patient does not lose
  consciousness should be excluded.

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


Press RETURN to continue: <Enter>
```

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


1. Occurrence:            CARDIAC ARREST REQUIRING CPR
2. Occurrence Category:   CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code (ICD10):
4. Treatment Instituted:
5. Outcome to Date:
6. Date Noted:
7. Occurrence Comments:

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

Select Occurrence Information: 4:6
```

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 <TEST ACCOUNT> Option: P  Print a Surgery Rt

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

Select Patient: BILLEN,BRADY SCOTT,BRADY SCOTT  BILLEN,BRADY SCOTT        10-15D
 Enrollment Priority: GROUP 3    Category: ENROLLED      End Date:

 BILLEN,BRADY SCOTT  NNN

1. 06-08-17   * Cardiac Case (COMPLETE)

2. 04-13-17   Test (COMPLETED)

Select Operation, or enter <RET> to continue listing Procedures: 2

Print the Completed Assessment on which Device: HOME//   HOME  (CRT)
```

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

```
VA NON-CARDIAC RISK ASSESSMENT             Assessment: 53261         PAGE 1
FOR BILLEN,BRADY SCOTT  NNN (COMPLETED)
================================================================================

Medical Center: CHEYENNE VAMC
Age:            40                      Operation Date:    APR 13, 2017
Sex:            MALE                    Ethnicity:         NOT HISPANIC OR LATIO
                                        Race:              WHITE
Transfer Status:                            NON-VAMC ACUTE CARE HOSPITAL
Observation Admission Date:                 MAY 1,2017  10:36
Observation Discharge Date:                 MAY 1,2017  10:36
Observation Treating Specialty:             NEUROLOGY OBSERVATION
Hospital Admission Date:                    MAY 1,2017  10:36
Hospital Discharge Date:                    MAY 12,2017  10:15
Admitted/Transferred to Surgical Service:   MAY 1,2017  10:36
Discharged/Transferred to Chronic Care:     MAY 1,2017  10:36
DC/REL Destination:                         ACUTE CARE FACIL VA/NON-VA
Hospital Admission Status:                  SAME DAY
Assessment Completed by:                    SURGEON,ONE

VA NON-CARDIAC RISK ASSESSMENT             Assessment: 53261         PAGE 2
FOR BILLEN,BRADY SCOTT  NNN (COMPLETED)
================================================================================

                            PREOPERATIVE INFORMATION
GENERAL:
  Height:                                   59 INCHES
  Weight:                                   150 LBS.
  Diabetes - Long Term:                     NO
  Diabetes - 2 Wks Preop:                   NO
  Tobacco Use:                              NO USE IN LAST 12 MOS
  Tobacco Use Timeframe:                    NOT APPLICABLE
  ETOH > 2 Drinks/Day:                      NO
  Positive Drug Screening:                  NEG RESU
  Dyspnea:                                  DYSPNEA UPON M
  Preop Sleep Apnea:                        LEVEL 1
  DNR Status:                               NO
```

```
  Functional Status:                    PARTIAL DEPEND
  Current Residence:                    NO HOME (HOMELESS)
  Ambulation Device:                    AMB W/O ASSISTIVE DEVICE
PULMONARY:
  Ventilator Dependent:  NO
  History of COPD:       NO
  Current Pneumonia:     NO


VA NON-CARDIAC RISK ASSESSMENT            Assessment: 53261         PAGE 3
FOR BILLEN,BRADY SCOTT  NNN (COMPLETED)
================================================================================

                            PREOPERATIVE INFORMATION

HEPATOBILIARY:
  Ascites:                              NO
GASTROINTESTINAL:
  Esophageal Varices:                   NO
CARDIAC:
  Congestive Heart Failure:             N CARD DX/CHF, SX UNKNOWN
  Prior MI:                             NO
  PCI:                                  NONE
  Prior Heart Surgery:                  Valve-only
  Angina Severity:                      NONE
  Angina Timeframe:                     NO ANGINA
  Hypertension:                         NO
  Prio Surg in Same OP Field:           NO PREVIOUS SURGERIES
  Hx Rad Rx Planned Surg Field:         NO
  CVD Repair/Obstruction:               NO CVD
  Organ/Space Incisional SSI:
  Donor Serology HIV:
VASCULAR:
  PAD:                                  NO
  Rest Pain/Gangrene:                   NO


VA NON-CARDIAC RISK ASSESSMENT            Assessment: 53261         PAGE 4
FOR BILLEN,BRADY SCOTT  NNN (COMPLETED)
================================================================================

                            PREOPERATIVE INFORMATION

RENAL:
  Acute Renal Failure Preop:            NO
  Currently on Dialysis:                NO

CENTRAL NERVOUS SYSTEM:
  Impaired Sensorium:                   NO
  Coma:                                 NO
  Hemiplegia/Hemiparesis:               NO
  CVD Repair/Obstruct:                  NO CVD
  History of CVD:                       NO CVD
  Tumor Involving CNS:                  NO
  Impaired Cognitive Function:          NO DOCUMENTATION


VA NON-CARDIAC RISK ASSESSMENT            Assessment: 53261         PAGE 5
FOR BILLEN,BRADY SCOTT  NNN (COMPLETED)
================================================================================

                            PREOPERATIVE INFORMATION

NUTRITIONAL/IMMUNE/OTHER:
  Disseminated Cancer:                  NO
  Open Wound:                           NO
  Steroid Use Preop:                    No, specific criteria not met.
  Weight Loss > 10%:                    NO
  Bleeding Disorders:                   NO
  Bleeding Due To Med:                  NO BLEEDING RISK FROM MED
  Transfusion > 4 RBC Units:                                        NO
```

```
  Chemo for Malig Last 90 Days:         NO CHEMO
  Radiotherapy W/I 90 Days:             NO
  Preoperative Sepsis:                  NONE
  Pregnancy:                            NOT APPLICABLE
  History of Radiation Therapy:         NO
  Prior Surg in Same Operative:         0
  Homelessness:                         N
  Employment Status Preop:
```



```
                        OPERATION DATE/TIMES INFORMATION

               Patient in Room (PIR): APR 13,2017  09:00
   Procedure/Surgery Start Time (PST): MAY 1,2017  10:34
        Procedure/Surgery Finish (PF): MAY 1,2017  10:34
            Patient Out of Room (POR): APR 13,2017  09:05
                Anesthesia Start (AS):
              Anesthesia Finish (AF):
         Discharge from PACU (DPACU):
```



```
                             OPERATIVE INFORMATION

                  Surgical Specialty: GENERAL(OR WHEN NOT DEFINED BELOW)

                 Principal Operation: Test

                 Procedure CPT Codes:

                Multi-Team Procedure: N/A
                            CPT Code: N/A
```



```
                             OPERATIVE INFORMATION

              PGY of Primary Surgeon: 0
                Emergency Case (Y/N): NO
                Wound Classification: NO INCISION
                  ASA Classification: N-None Assigned
      Principal Anesthesia Technique: GENERAL
                RBC Units Transfused: 2
         Intraop Disseminated Cancer: NO
              Intraoperative Ascites: NO
```



```
                    PREOPERATIVE LABORATORY TEST RESULTS
             Anion Gap (in 48 hrs.): 2        (MAY 1,2017)
                       Serum Sodium: 1        (MAY 1,2017)
                  Serum Creatinine: 0        (MAY 1,2017)
                               BUN: 0        (MAY 1,2017)
                     Serum Albumin: 0        (MAY 1,2017)
                   Total Bilirubin: 0        (MAY 1,2017)
                              SGOT: 0        (MAY 1,2017)
```

```
                Alkaline Phosphatase: 0        (MAY 1,2017)
                   White Blood Count: 0        (MAY 1,2017)
                           Hematocrit: 0       (MAY 1,2017)
                      Platelet Count: 0        (MAY 1,2017)
                                 PTT: 0        (MAY 1,2017)
                                  PT: 0        (MAY 1,2017)
                                 INR: 2        (MAY 1,2017)
                      Hemoglobin A1c: n        (MAY 1,2017)


VA NON-CARDIAC RISK ASSESSMENT             Assessment: 53261         PAGE 10
FOR BILLEN,BRADY SCOTT  NNN (COMPLETED)
================================================================================

                      POSTOPERATIVE LABORATORY RESULTS

                              * Highest Value
                             ** Lowest Value

                          * Anion Gap: 22       (MAY 1,2017)
                       * Serum Sodium: 1        (MAY 1,2017)
                      ** Serum Sodium: 2        (MAY 1,2017)
                          * Potassium: 1        (MAY 1,2017)
                         ** Potassium: 2        (MAY 1,2017)
                    * Serum Creatinine: 2        (MAY 1,2017)
                                * CPK: 3        (MAY 1,2017)
                           * CPK-MB Band: 4        (MAY 1,2017)
                     * Total Bilirubin: 5        (MAY 1,2017)
                    * White Blood Count: 6        (MAY 1,2017)
                         ** Hematocrit: 5        (MAY 1,2017)
                          * Troponin I: 2        (MAY 1,2017)
                          * Troponin T: 2        (MAY 1,2017)


VA NON-CARDIAC RISK ASSESSMENT             Assessment: 53261         PAGE 11
FOR BILLEN,BRADY SCOTT  NNN (COMPLETED)
================================================================================

                            OUTCOME INFORMATION

 Postoperative Diagnosis Code (ICD10):
Length of Postoperative Hospital Stay: 0 DAYS
                       Date of Death: MAY 01, 2017@10:36
VA NON-CARDIAC RISK ASSESSMENT             Assessment: 53261         PAGE 12
FOR BILLEN,BRADY SCOTT  NNN (COMPLETED)
================================================================================

                      PERIOPERATIVE OCCURRENCE INFORMATION

WOUND OCCURRENCES:              NO          CNS OCCURRENCES:               NO
Superficial Incisional SSI:     NO          Stroke/CVA:                    NO
Deep Incisional SSI:            NO          Coma > 24 Hours:               NO
Wound Dehiscence:               NO          Peripheral Nerve Injury:       NO

URINARY TRACT OCCURRENCES:      NO          CARDIAC OCCURRENCES:           NO
Renal Insufficiency Postop:     NO          Arrest Requiring CPR:          NO
Acute Renal Failure Postop:     NO          Myocardial Infarction:         NO
Symptomatic UTI:                NO
                                            OTHER OCCURRENCES:             YES
RESPIRATORY OCCURRENCES:        NO          Bleeding/Transfusions:         NO
Pneumonia:                      NO          Graft/Prosthesis/Flap Failure:NO
Out Of OR Unplanned Intub:      NO          DVT/Thrombophlebitis:          NO
Pulmonary Embolism:             NO          Systemic Sepsis:               NO
On Ventilator > 48 Hours:       NO          Organ/Space SSI:               YES
                                            C. difficile Colitis:          NO
```

Page 483a removed.

Example 2: Print Surgery Risk Assessment for a Cardiac Case

```
Select Surgery Risk Assessment Menu <TEST ACCOUNT> Option: p  Print a Surgery Rt

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

Select Patient: BILLEN,BRADY SCOTT,BRADY SCOTT  BILLEN,BRADY SCOTT        10-15D
 Enrollment Priority: GROUP 3    Category: ENROLLED      End Date:

 BILLEN,BRADY SCOTT  CCC

1. 06-08-17   * Cardiac Case (INCOMPLETE)

2. 05-23-17   * Test (INCOMPLETE)


Select Operation, or enter <RET> to continue listing Procedures: 1

  Print the Completed Assessment on which Device: HOME//   HOME  (CRT)
 ----------------------------------------------------------printout follows-----------------------------------------------
```

```
VA SURGICAL QUALITY IMPROVEMENT PROGRAM - CARDIAC SPECIALTY

================================================================================
I. IDENTIFYING DATA                                        Case #: 53290
Patient: BILLEN,BRADY SCOTT  CCC                    Fac./Div. #: 442
Surgery Date: 06/08/17   Address: 4945 MARK DABLING BLVD LOT 2
Phone: (666) 666-6666    Zip Code: 80918             Date of Birth: 10/15/76
================================================================================
II. CLINICAL DATA
Gender:                    MALE
Age:                       40
Height:
Prior MI:                  YES, DATE OF MOST RECENT MI UNKNOWN
Weight:
Number of prior heart surgeries:
Diabetes - Long Term:
Prior heart surgery:
Diabetes - 2 Wks Preop:
PAD:
COPD:
CVD Repair/Obstruct:       YES - PRIOR SURGICAL REPAIR
FEV1:
History of CVD:            CVA/STROKE W/ NEURO DEFICIT
Cardiomegaly (X-ray):
Angina Severity:
Angina Timeframe:          UNKNOWN
Tobacco Use:
Tobacco Use Timeframe: NOT APPLICABLE
Congestive Heart Failure: -Y CARD DX/CHF, SX UNKNOWN
Positive Drug Screening:
Current Diuretic Use:
Active Endocarditis:
IV NTG 48 Hours Preceding Surgery:
Functional Status:             UNKNOWN
Preop Circulatory Device: VAD (includes BIVAD)
PCI:                       UNKNOWN
Hypertension:
Preop Sleep Apnea:
Preoperative Atrial Fibrillation:
Sleep Apnea-Compliance:
Impaired Cognitive Function:


BILLEN,BRADY SCOTT  CCC
================================================================================

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

T. Bilirubin: mg/dl (NS)

BILLEN,BRADY SCOTT CCC
==

IV. CARDIAC CATHETERIZATION AND ANGIOGRAPHIC DATA
Cardiac Catheterization Date:
Procedure:
LVEDP: mm Hg
Aortic Systolic Pressure: mm Hg

For patients having right heart cath:
PA Systolic Pressure: mm Hg
PAW Mean Pressure: mm Hg

Native Coronaries:
Left Main Stenosis:
LAD Stenosis:
Right Coronary Stenosis:
Circumflex Stenosis:

If a Re-do, indicate stenosis in graft to:
LAD:
Right coronary (include PDA):
Circumflex:

LV Contraction Grade (from contrast or radionuclide angiogram or 2D Echo):

Grade	Ejection Fraction Range	Definition

Mitral Regurgitation:
Aortic stenosis:

BILLEN,BRADY SCOTT CCC
==

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

BILLEN,BRADY SCOTT CCC
==

VI. OPERATIVE DATA

Bridge to Transplant:

Operative Data details:
Total CPB Time: min
Total Ischemic Time: min
Incision Type:
Conversion Off Pump to CPB:

VII. OUTCOMES

Perioperative (30 day) Occurrences:

Myocardial Infarction:	NO	Tracheostomy:	NO
Endocarditis:	NO	Out Of OR Unplanned Intubation:	NO
Superficial Incisional SSI:	NO	Stroke/CVA:	NO SYMPTOMS
Mediastinitis:	NO	Coma > or = 24 Hours:	NO
Cardiac Arrest Requiring CPR:	NO	New Mech Circulatory Support:	NO
Reoperation for Bleeding:	NO	Postop Atrial Fibrillation:	NO
On ventilator > or = 48 hr:	NO	Wound Dehiscence:	NO
Repeat cardiac Surg procedure:	NO	Renal Failure Requiring Dialysis:	NO
Clostridium Difficile Colitis:		Deep Incisional SSI:	
DVT/Thrombophlebitis:		Organ/Space SSI:	
Nerve Injury:		Pneumonia:	
Renal Insufficiency:		Pulmonary Embolism:	
Symptomatic UTI:		Systemic Sepsis:	

Transfusion > 4 RBC Units Within 72 Hrs Prior to Surgery:

BILLEN,BRADY SCOTT CCC

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 # / OPERATION DATE	PATIENT / OPERATION(S)	TYPE	STATUS
63172 MAY 17, 2006	SURPATIENT,FIFTYTWO 000-99-8888 REPAIR ARTERIAL BLEEDING CPT Code: 33120	NON-CARDIAC	TRANSMITTED

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

ASSESSMENT # / OPERATION DATE	PATIENT / OPERATION(S)	TYPE	STATUS
63185 APR 17, 2006	SURPATIENT,SIXTEEN 000-11-1111 INGUINAL HERNIA, CHOLECYSTECTOMY	NON-CARDIAC	TRANSMITTED

Missing information:
1. The final coding for Procedure and Diagnosis is not complete.
2. Multiple Team 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)

ASSESSMENT # / OPERATION DATE	PATIENT / OPERATION(S)	TYPE	STATUS
63080 JAN 03, 2006	SURPATIENT,THIRTY 000-82-9472 TURP	EXCLUDED	COMPLETE

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

MAYBERRY, NC
REPORT OF MONTHLY SURGICAL CASE WORKLOAD
FOR MAY 2007

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

NUMBER OF INCOMPLETE ASSESSMENTS REMAINING FOR PAST YEAR

	CARDIAC	NON-CARDIAC	TOTAL
MAY 2006	0	0	0
JUN 2006	0	0	0
JUL 2006	0	0	0
AUG 2006	0	0	0
SEP 2006	0	0	0
OCT 2006	0	0	0
NOV 2006	0	0	0
DEC 2006	0	0	0
JAN 2007	0	0	0
FEB 2007	0	0	0
MAR 2007	0	0	0
APR 2007	0	0	0
MAY 2007	15	82	97
	15	82	97

ALBANY - ALL DIVISIONS
REPORT OF SURGICAL CASE WORKLOAD
FOR OCT 2005 THROUGH MAY 2006

TOTAL CASES PERFORMED	=	30
TOTAL ELIGIBLE CASES	=	5
CASES MEETING EXCLUSION CRITERIA	=	1
NON-SURGEON CASE	=	0
ANESTHESIA TYPE	=	0
EXCEEDS MAX. ASSESSMENTS	=	0
EXCEEDS MAXIMUM TURPS	=	0
INCLUSION CRTA NOT MET	=	0
10% RULE	=	1
MULTIPLE TEAM CASE	=	0
EXCEEDS MAXIMUM HERNIAS	=	0
ABORTED	=	0
ASSESSED CASES	=	20
NOT LOGGED ELIGIBLE CASES	=	0
CARDIAC CASES	=	4
NON-CARDIAC CASES	=	16

Chapter Nine: Glossary

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

Term	Definition
Aborted	Case status indicating the case was cancelled after the patient entered the operating room. The Cases shall be considered "ABORTED" if the TIME PAT OUT OR field (#.205) and/or TIME PAT IN OR field (#.232) and CANCEL DATE field (#17), and the CASE ABORTED field entered with "YES".
ASA Class	This is the American Society of Anesthesiologists classification relating to the patient's physiologic status. Numbers followed by an 'E' indicate an emergency.
Attending Code	Code that corresponds to the highest level of supervision provided by the attending staff surgeon during the procedure.
Blockout Graph	Graph showing the availability of operating rooms.
Cancelled Case	Case status indicating that an entry has been made in the CANCEL DATE field, CANCELLATION TIMEFRAME and/or the PRIMARY CANCEL REASON field without the patient entering the operating room.
CCSHS	VA Center for Cooperative Studies in Health Services located at Hines, Illinois.
CICSP	Continuous Improvement in Cardiac Surgery Program.
Completed Case	Case status indicating that an entry has been made in the TIME PAT OUT OR field.
Multiple Team Case	A patient undergoing two operations by different surgical specialties at the same time, or back to back, in the same operating room.
CPT Code	Also called Operation Code. CPT stands for Current Procedural Terminology.
CRT	Cathode ray tube display. A display device that uses a cathode ray tube.
Intraoperative Occurrence	Perioperative occurrence during the procedure.
Major	Any operation performed under general, spinal, or epidural anesthesia plus all inguinal herniorrhaphies and carotid endarterectomies regardless of anesthesia administered.
Minor	All operations not designated as Major.
New Surgical Case	A surgical case that has not been previously requested or scheduled such as an emergency case. A surgical case entered in the records without being booked through scheduling will not appear on the Schedule of Operations or as an operative request.
Non-Operative Occurrence	Occurrence that develops before a surgical procedure is performed.
Not Complete	Case status indicating one of the following two situations with no entry in the TIME PAT OUT OR field (#.232). 1) Case has entry in TIME PAT IN OR field (#.205). 2) Case has not been requested or scheduled.
NSQIP	National Surgical Quality Improvement Program.

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