



Republic of the Philippines  
Department of Health  
Central Luzon Center for Health Development  
**DR. PAULINO J. GARCIA MEMORIAL RESEARCH  
AND MEDICAL CENTER**  
Cabanatuan City  
 ISO QMS Certified



## GENERAL SURGERY OPERATIVE RECORD

**OPERATION DATE:**

☐ ER ☐ OR ☐ OPD ☐ WARD

**HOSPITAL NUMBER:**

**SEX:** ☐ M ☐ F

**DATE OF BIRTH:** MM/DD/YYYY

**PATIENT NAME:** SURNAME, FIRST NAME MI

**CONSULTANT:**

**SURGEON:**

**ASSISTANTS:**

**ANESTHESIOLOGIST:**

**TYPE OF ANESTHESIA:**

<b>CLASSIFICATION:</b>	<input type="checkbox"/> ELECTIVE	<input type="checkbox"/> EMERGENCY
<b>SPECIALTIES:</b>		
<input type="checkbox"/> GS	<input type="checkbox"/> TRAUMA	<input type="checkbox"/> HEAD & NECK
<input type="checkbox"/> BREAST	<input type="checkbox"/> HBT	<input type="checkbox"/> COLORECTAL
<input type="checkbox"/> MIS	<input type="checkbox"/> UROLOGY	<input type="checkbox"/> NEURO
<input type="checkbox"/> PLASTICS	<input type="checkbox"/> PEDIA	<input type="checkbox"/> TCVS

**PRE OPERATIVE DIAGNOSIS:**

**POST OPERATIVE DIAGNOSIS:**

**OPERATION PERFORMED:**

**RVS CODE:**

**TIME STARTED:**

**TIME ENDED:**

**UNPLANNED RETURN TO OR:** ☐ YES ☐ NO

**OPERATIVE FINDINGS:**


**TECHNIQUE:**

<b>PATHOLOGY:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>DRAIN:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>SURGICAL COUNT COMPLETE:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>BLOOD TRANSFUSED:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO

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Printed Name and Signature of Surgeon



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REMARKS:

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Printed Name and Signature of Surgeon