SURGERY

USER MANUAL

Version 3.0
July 1993

(Revised June 2007)

Department of Veterans Affairs
VistA Health Systems Design & 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
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)
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)

Date	Revised Pages	Patch Number	Description
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)
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)

Date	Revised Pages	Patch Number	Description
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.
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*.

(This page included for two-sided copying.)

The following example depicts Service Classification status change when the user updates a case.

The user can also edit diagnosis classification status individually using the *Surgeon's Verification of Diagnosis & Procedures* option or the *Update/Verify Procedure/Diagnosis Codes* option.

Example: Make an Operation Request with Service Classification Information

```
SURPATIENT,TEN  (000-12-3456)       ALLIED VETERAN

   * * * Eligibility Information and Service Connected Conditions * * *

     Primary Eligibility: SERVICE CONNECTED 50% to 100%
     Combat Vet: NO   A/O Exp.: YES    M/S Trauma: NO
     ION Rad.: YES    SWAC: YES        H/N Cancer: NO
     PROJ 112/SHAD: YES

         SC Percent: 100%
 Rated Disabilities: NONE STATED
-------------------------------------------------------------------------------

Please supply the following required information about this operation:

Treatment related to Service Connected condition (Y/N): N  NO
Treatment related to Agent Orange (Y/N): N  NO
Treatment related to Ionizing Radiation Exposure (Y/N): N  NO
Treatment related to SW Asia (Y/N): N  NO
Treatment related to PROJ 112/SHAD (Y/N): YES YES

Update all ‘OTHER POSTOP DIAGNOSIS' Eligibility and
Service Connected Conditions with these values?  Enter YES or NO. <NO>  Y

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 concurrent 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 concurrent 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 concurrent 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 concurrent cases (Example 5).
Change the Request Date	Alter the operation date of the request (Examples 3 and 6). For a set of concurrent cases to remain concurrent, the user must change the request date for both operations (Example 6).

Perioperative Occurrences Menu

[SRO COMPLICATIONS MENU]

Surgeons use options within the *Perioperative Occurrences Menu* option to enter or edit occurrences that occur before, during, and/or after a surgical procedure. It is also possible to enter occurrences for a patient who did not have a surgical procedure performed. The user can enter more than one occurrence per patient.

 This option is locked with the SROCOMP key.

Occurrences will be included on the Chief of Surgery's Morbidity & Mortality Reports.

Please review specific institution policy to determine what is considered an occurrence for any category.

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

Shortcut	Option Name
I	*Intraoperative Occurrences (Enter/Edit)*
P	*Postoperative Occurrences (Enter/Edit)*
N	*Non-Operative Occurrences (Enter/Edit)*
U	*Update Status of Returns Within 30 Days*
M	*Morbidity & Mortality Reports*

Key Vocabulary

The following terms are used in this section.

Term	Definition
Intraoperative Occurrence	Occurrence that occurs during the procedure.
Postoperative Occurrence	Occurrence that occurs after the procedure.
Non-Operative Occurrence	Occurrence that develops before a surgical procedure is performed.

Intraoperative Occurrences (Enter/Edit)
[SRO INTRAOP COMP]

The *Intraoperative Occurrences (Enter/Edit)* option is used to add information about an occurrence that occurs during the procedure. The user can also use this option to change the information. Occurrence information will be reflected in the Chief of Surgery's Morbidity & Mortality Report.

First, the user should select an operation. The software will then list any occurrences already entered for that operation. The user may edit a previously entered occurrence or can type the word **NEW** and press the **<Enter>** key to enter a new occurrence.

At the prompt "Enter a New Intraoperative Occurrence:" the user can enter two question marks **(??)** to get a list of categories. Be sure to enter a category for all occurrences to satisfy Surgery Central Office reporting needs.

Example: Entering Intraoperative Occurrences

```
Select Perioperative Occurrences Menu Option: I  Intraoperative Occurrences (Enter/Edit)

Select Patient: SURPATIENT,FIFTY         10-28-45     000459999

 SURPATIENT,FIFTY   000-45-9999

1. 06-30-06   CHOLECYSTECTOMY (COMPLETED)

2. 03-10-07   HEMORRHOIDECTOMY (COMPLETED)


Select Operation: 1
```

```
SURPATIENT,FIFTY (000-45-9999)        Case #213
JUN 30,2006   CHOLECYSTECTOMY
------------------------------------------------------------------------------


There are no Intraoperative Occurrences entered for this case.


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

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

Press RETURN to continue: <Enter>
```

```
SURPATIENT,FIFTY (000-45-9999)        Case #213
JUN 30,2006   CHOLECYSTECTOMY
------------------------------------------------------------------------------


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

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

Select Occurrence Information: 4:5
```

```
SURPATIENT,FIFTY  (000-45-9999)
------------------------------------------------------------------------------
Type of Treatment Instituted: CPR
Outcome to Date: ?
     CHOOSE FROM:
       U        UNRESOLVED
       I        IMPROVED
       D        DEATH
       W        WORSE
Outcome to Date: I  IMPROVED
```

```
SURPATIENT,FIFTY (000-45-9999)        Case #213
JUN 30,2006   CHOLECYSTECTOMY
------------------------------------------------------------------------------


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

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

Select Occurrence Information:
```

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

The *Postoperative Occurrences (Enter/Edit)* option is used to add information about an occurrence that occurs after the procedure. The user can also utilize this option to change the information. Occurrence information will be reflected in the Chief of Surgery's Morbidity & Mortality Report.

First, the user selects an operation. The software will then list any occurrences already entered for that operation. The user can choose to edit a previously entered occurrence or type the word **NEW** and press the **<Enter>** key to enter a new occurrence.

At the prompt "Enter a New Postoperative Complication:" the user can enter two question marks **(??)** to get a list of categories. Be sure to enter a category for all occurrences in order to satisfy Surgery Central Office reporting needs.

Example: Entering a Postoperative Occurrence

```
Select Perioperative Occurrences Menu Option: P  Postoperative Occurrence (Enter/Edit)

Select Patient: SURPATIENT,SEVENTEEN        09-13-28     000455119

 SURPATIENT,SEVENTEEN R.  000-45-5119

1. 04-18-07   CRANIOTOMY (COMPLETED)

2. 03-18-07   REPAIR INCARCERATED INGUINAL HERNIA (COMPLETED)



Select Operation: 2
```

```
SURPATIENT,SEVENTEEN  (000-45-5119)        Case #202
MAR 18,2007   REPAIR INCARCERATED INGUINAL HERNIA
------------------------------------------------------------------------------

There are no Postoperative Occurrences entered for this case.


Enter a New Postoperative Occurrence: ACUTE RENAL FAILURE
  NSQIP Definition (2007):
  In a patient who did not require dialysis preoperatively, worsening of
  renal dysfunction postoperatively requiring hemodialysis, peritoneal
  dialysis, hemofiltration, hemodiafiltration or ultrafiltration.

  TIP: If the patient refuses dialysis the answer is Yes to this
  variable, because he/she did require dialysis.

  CICSP Definition (2004):
  Indicate if the patient developed new renal failure requiring dialysis
  or experienced an exacerbation of preoperative renal failure requiring
  initiation of dialysis (not on dialysis preoperatively) within 30 days
  postoperatively.

Press RETURN to continue: <Enter>
```

```
SURPATIENT,SEVENTEEN  (000-45-5119)        Case #202
MAR 18,2007   REPAIR INCARCERATED INGUINAL HERNIA
-------------------------------------------------------------------------------


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

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

Select Occurrence Information: 4:6
```

```
SURPATIENT,SEVENTEEN  (000-45-5119)        Case #202
MAR 18,2007   REPAIR INCARCERATED INGUINAL HERNIA
-------------------------------------------------------------------------------


Treatment Instituted: ANTIBIOTICS
Outcome to Date: I  IMPROVED
Date/Time the Occurrence was Noted: 3/20  (MAR 20, 2007)
```

```
SURPATIENT,SEVENTEEN R. (000-45-5119)        Case #202
MAR 18,2007  REPAIR INCARCERATED INGUINAL HERNIA
-------------------------------------------------------------------------------


1. Occurrence:            ACUTE RENAL FAILURE
2. Occurrence Category:   ACUTE RENAL FAILURE
3. ICD Diagnosis Code:
4. Treatment Instituted:  DIALYSIS
5. Outcome to Date:       IMPROVED
6. Date Noted:            03/20/07
7. Occurrence Comments:

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

Select Occurrence Information:
```

Non-Operative Occurrence (Enter/Edit) [SROCOMP]

The *Non-Operative Occurrence (Enter/Edit)* option is used to enter or edit occurrences that are not related to surgical procedures. A non-operative occurrence is an occurrence that develops before a surgical procedure is performed.

At the "Occurrence Category:" prompt, the user can enter two question marks **(??)** to get a list of categories. Be sure to enter a category for each occurrence in order to satisfy Surgery Central Office reporting needs.

Example: Entering a Non-Operative Occurrence

```
Select Perioperative Occurrences Menu Option: N  Non-Operative Occurrences (Enter/Edit)

NOTE:  You are about to enter an occurrence for a patient that has not had an
operation during this admission. If this patient has a surgical procedure
during the current admission, use the option to enter or edit intraoperative
and postoperative occurrences.


Select PATIENT NAME: SURPATIENT,SEVENTEEN        09-13-28     000455119


   SURPATIENT,SEVENTEEN

1.           ENTER A NEW NON-OPERATIVE OCCURRENCE

Select Number:  1

Select the Date of Occurrence: 063007  (JUN 30, 2007)
Name of the Surgeon Treating the Complication: SURSURGEON,ONE
Name of the Attending Surgeon: SURSURGEON,TWO
Surgical Specialty: GENERAL(OR WHEN NOT DEFINED BELOW)
Select NON-OPERATIVE OCCURRENCES: SYSTEMIC SEPSIS
  Occurrence Category: SYSTEMIC SEPSIS
  NSQIP Definition (2007):
  Sepsis is a vast clinical entity that takes a variety of forms. The
  spectrum of disorders spans from relatively mild physiologic
  abnormalities to septic shock. Please report the most significant level
  using the criteria below:

  1. Sepsis: Sepsis is the systemic response to infection. Report this
  variable if the patient has clinical signs and symptoms of SIRS. SIRS
  is a widespread inflammatory response to a variety of severe clinical
  insults. This syndrome is clinically recognized by the presence of two
  or more of the following:
     - Temp >38 degrees C or <36 degrees C
     - HR >90 bpm
     - RR >20 breaths/min or PaCO2 <32 mmHg(<4.3 kPa)
     - WBC >12,000 cell/mm3, <4000 cells/mm3, or >10% immature (band)
       forms
     - Anion gap acidosis: this is defined by either:
        [Na + K] - [Cl + HCO3 (or serum CO2)]. If this number is
        greater than 16, then an anion gap acidosis is present.
       or
        Na - [Cl + HCO3 (or serum CO2)]. If this number is greater
        than 12, then an anion gap acidosis is present.

   and one of the following:
     - positive blood culture
     - clinical documentation of purulence or positive culture from any
       site thought to be causative
```

```
  2. Severe Sepsis/Septic Shock: Sepsis is considered severe when it is
  associated with organ and/or circulatory dysfunction. Report this
  variable if the patient has the clinical signs and symptoms of SIRS or
  sepsis AND documented organ and/or circulatory dysfunction. Examples of
  organ dysfunction include: oliguria, acute alteration in mental status,
  acute respiratory distress. Examples of circulatory dysfunction
  include: hypotension, requirement of inotropic or vasopressor agents.

  * For the patient that had sepsis preoperatively, worsening of any of
  the above signs postoperatively would be reported as a postoperative
  sepsis.

  Examples:

  A patient comes into the emergency room with signs of sepsis - WBC 31,
  Temperature 104. CT shows an abdominal abscess. He is given antibiotics
  and is then taken emergently to the OR to drain the abscess. He
  receives antibiotics intraoperatively. Postoperatively his WBC and
  Temperature are trending down.
    POD#1 WBC 24, Temp 102
    POD#2 WBC 14, Temp 100
    POD#3 WBC 10, Temp 99
  This patient does not have postoperative sepsis as his WBC and
  Temperature are improving each postoperative day.

  Patient comes into the ER with s/s of sepsis - WBC 31, Temp 104. CT
  shows an abdominal abscess. He is given antibiotics and is taken
  emergently to the OR to drain the abscess. He receives antibiotics
  intraoperatively. Postoperatively his WBC and Temp are as follows:
    POD#1 WBC 28, Temp 103
    POD#2 WBC 24, Temp 102.6
    POD#3 WBC 22, Temp 102
    POD#4 WBC 21, Temp 101.6
    POD#5 WBC 30, Temp 104
  This patient does have postoperative sepsis because on postoperative
  day #5, his WBC and Temperature increase. The patient is having
  worsening of the defined signs of sepsis.

  Treatment Instituted: ANTIBIOTICS
  Outcome to Date: U  UNRESOLVED
  Occurrence Comments:
  1>Cancel scheduled surgery for this week. Reschedule later.
  2><Enter>
EDIT Option: <Enter>

Press RETURN to continue
```

(This page included for two-sided copying.)

Example 3: Printing the Perioperative Occurrences Report – Sorted by Occurrence Category

```
Select Perioperative Occurrences Menu Option: M  Morbidity & Mortality Reports

The Morbidity and Mortality Reports include the Perioperative Occurrences
Report and the Mortality Report. Each report will provide information
from cases completed within the date range selected.

Do you want to generate both reports ?  YES//  N

1. Perioperative Occurrences Report
2. Mortality Report


Select Number:  (1-2): 1

Start with Date: 6/1  (JUN 01, 2007)
End with Date: 6/30  (JUN 30, 2007)

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

Print report by
 1. Surgical Specialty
 2. Attending Surgeon
 3. Occurrence Category

Select 1, 2 or 3:  (1-3): 1// 3

Do you want to print this report for all occurrence categories? YES// NO

Print the report for which Occurrence Category ? ACUTE RENAL FAILURE
  NSQIP Definition (2007):
  In a patient who did not require dialysis preoperatively, worsening of
  renal dysfunction postoperatively requiring hemodialysis, peritoneal
  dialysis, hemofiltration, hemodiafiltration or ultrafiltration.

  TIP: If the patient refuses dialysis the answer is Yes to this
  variable, because he/she did require dialysis.

  CICSP Definition (2004):
  Indicate if the patient developed new renal failure requiring dialysis
  or experienced an exacerbation of preoperative renal failure requiring
  initiation of dialysis (not on dialysis preoperatively) within 30 days
  postoperatively.

  CICSP Definition (2004):
  Indicate if the patient developed new renal failure requiring dialysis
  or experienced an exacerbation of preoperative renal failure requiring
  initiation of dialysis (not on dialysis preoperatively) within 30 days
  postoperatively.

Select an Additional Occurrence Category:  <Enter>

This report is designed to use a 132 column format.

Print the Report on which Device: [Select Print Device]
```

----------*report follows*----------

PATIENT ID# / OPERATION DATE	ATTENDING SURGEON / SURGICAL SPECIALTY / PRINCIPAL OPERATION	OCCURRENCE(S) - (DATE) / TREATMENT	OUTCOME
CATEGORY: ACUTE RENAL FAILURE			
SURPATIENT,SEVENTEEN 000-45-5119 JUN 18, 2007@07:15	SURGEON,TWO GENERAL REPAIR INCARCERATED INGUINAL HERNIA	ACUTE RENAL FAILURE DIALYSIS	I

OUTCOMES: U - UNRESOLVED, I - IMPROVED, W - WORSE, D - DEATH
'*' Represents Postoperative Occurrences

Update/Verify Procedure/Diagnosis Codes
[SRCODING EDIT]

The *Update/Verify Procedure/Diagnosis Codes* option allows the user to enter the final codes and associated information required for PCE upon completion of a Surgery case.

The procedure and diagnoses codes entered/edited through this option will be the coded information that is sent to the Patient Care Encounter (PCE) package. After the case is coded, the user will select to send the information to PCE.

When the user first edits a case through this option, the values will be pre-populated, using the values for planned codes entered by the nurse or surgeon. If there is no Planned Principal Procedure Code or no Principal Pre-op Diagnosis Code, then the Surgery software will prompt for the final CPT and ICD codes.

Because a case can have more than one procedure and/or diagnosis, the user can associate one or more diagnosis with each procedure. The Surgery software displays the diagnoses in the order in which the user entered them in the case. The user can then associate and reorder the relevant diagnoses to each procedure.

The user can also edit the service classifications for the Postoperative Diagnoses.

The following examples depict using the *Update/Verify Procedure/Diagnosis Codes* option to edit a Bronchoscopy, with no planned CPT or ICD-9 codes entered by a clinician.

Example: Entering Required Information

```
Select CPT/ICD9 Update/Verify Menu Option: UV  Update/Verify Procedure/Diagnosis
 Codes

SURPATIENT,TWELVE (000-41-8719)                                    Case #10062
JUN 08, 2005   BRONCHOSCOPY
------------------------------------------------------------------------------

Surgery Procedure PCE/Billing Information:

1. Principal Postop Diagnosis Code: NOT ENTERED
2. Other Postop Diagnosis Code:     NOT ENTERED
3. Principal CPT Code: NOT ENTERED
     Assoc. DX:
     NO Assoc. DX ENTERED
4. Other CPT Code:     NOT ENTERED
------------------------------------------------------------
 The following information is required before continuing.

Principal Postop Diagnosis Code (ICD9):934.0  934.0  FOREIGN BODY IN TRACHEA
         ...OK? Yes//   (Yes) <Enter>
```

Because the patient has a service-connected status, the Surgery software displays a service-connected prompt:

```
SURPATIENT,TWELVE (000-41-8719)       SC VETERAN

   * * * Eligibility Information and Service Connected Conditions * * *

     Primary Eligibility: SERVICE CONNECTED 50% TO 100%
     Combat Vet: NO   A/O Exp.: YES     M/S Trauma: NO
     ION Rad.: YES    SWAC: NO          H/N Cancer: NO
     PROJ 112/SHAD: NO

         SC Percent: 50%
 Rated Disabilities: NONE STATED
-------------------------------------------------------

Please supply the following required information about this operation:

Treatment related to Service Connected condition (Y/N): YES
Treatment related to Agent Orange Exposure (Y/N): YES
Treatment related to Ionizing Radiation Exposure (Y/N): YES
```

Note that when a Postop Diagnosis Code is entered, it is automatically associated to a Principal CPT code, even if a CPT code is not entered.

```
SURPATIENT,TWELVE (000-41-8719)                                    Case #10062
JUN 08, 2005   BRONCHOSCOPY
-------------------------------------------------------------------------------

Surgery Procedure PCE/Billing Information:

1. Principal Postop Diagnosis Code: 934.0  FOREIGN BODY IN TRACHEA
2. Other Postop Diagnosis Code:     NOT ENTERED
3. Principal CPT Code: NOT ENTERED
     Assoc. DX: 934.0 -FOREIGN BODY IN TRACHEA
4. Other CPT Code:     NOT ENTERED
-------------------------------------------------------------
The following information is required before continuing.

Principal Procedure Code (CPT): 31622  DX BRONCHOSCOPE/WASH
 BRONCHOSCOPY, RIGID OR FLEXIBLE, WITH OR WITHOUT FLUOROSCOPIC GUIDANCE;
 DIAGNOSTIC, WITH OR WITHOUT CELL WASHING (SEPARATE PROCEDURE)
 Modifier: <Enter>
```

```
SURPATIENT,TWELVE (000-41-8719)                                    Case #10062
JUN 08, 2005   BRONCHOSCOPY
-------------------------------------------------------------------------------

Surgery Procedure PCE/Billing Information:

1. Principal Postop Diagnosis Code: 934.0  FOREIGN BODY IN TRACHEA
2. Other Postop Diagnosis Code:     NOT ENTERED
3. Principal CPT Code: 31622  DX BRONCHOSCOPE/WASH
     Assoc. DX: 934.0  FOREIGN BODY IN TRACHEA
4. Other CPT Code:     NOT ENTERED
-------------------------------------------------------------

Enter number of item to edit (1-4):
```

Because all required information is now entered, the user can select to automatically send the information to PCE, or wait until other information is entered.

```
Is the coding of this case complete and ready to send to PCE? NO// <Enter>
```

```
SURPATIENT,TWELVE (000-41-8719)                                    Case #10062
JUN 08, 2005   BRONCHOSCOPY
-------------------------------------------------------------------------------
Surgery Procedure PCE/Billing Information:

1. Principal Postop Diagnosis Code: 934.0  FOREIGN BODY IN TRACHEA
2. Other Postop Diagnosis Code:     NOT ENTERED
3. Principal CPT Code: 31623  DX BRONCHOSCOPE/BRUSH
     Assoc. DX: 934.0-FOREIGN BODY IN TRACHE
4. Other CPT Code: 43200  ESOPHAGUS ENDOSCOPY
     Assoc. DX: 934.0-FOREIGN BODY IN TRACHE
-------------------------------------------------------------------------------
Enter number of item to edit (1-4):
```

Example: Editing Service Connected/Environmental Indicators (SC/EIs)

To edit service connected or environmental indicators, the user selects either the Principal Postop Diagnosis Code or the Other Postop Diagnosis Code.

```
SURPATIENT,TWELVE (000-41-8719)                                    Case #10062
JUN 08, 2005   BRONCHOSCOPY
-------------------------------------------------------------------------------
Surgery Procedure PCE/Billing Information:

1. Principal Postop Diagnosis Code: 934.0  FOREIGN BODY IN TRACHEA
2. Other Postop Diagnosis Code:     NOT ENTERED
3. Principal CPT Code: 31623  DX BRONCHOSCOPE/BRUSH
     Assoc. DX: 934.0-FOREIGN BODY IN TRACHE
4. Other CPT Code: 43200  ESOPHAGUS ENDOSCOPY
     Assoc. DX: 934.0-FOREIGN BODY IN TRACHE
-------------------------------------------------------------------------------
Enter number of item to edit (1-4): 1
```

The following shows an example of the Principal Postop Diagnosis Code being edited.

```
SURPATIENT,TWELVE (000-41-8719)                                    Case #10062
JUN 08, 2005   BRONCHOSCOPY
-------------------------------------------------------------------------------
Principal Postop Diagnosis:

     ICD9 Code: 934.0  FOREIGN BODY IN TRACHEA
             SC:Y    AO:Y    IR:Y

     Select one of the following:

          1         Update Principal Postop Diagnosis Code
          2         Update Service Connected/Environmental Indicators only

Enter selection (1 or 2): 1// 2  Update Service Connected/Environmental Indicato
rs only
```

The information displayed for this patient show Service Connected status of less than 50%, and the Agent Orange Exposure and Ionizing Radiation indicators associated with the diagnosis. The software gives the user the option to update all diagnoses with the same service-connected indicators simultaneously.

```
SURPATIENT,TWELVE  (000-41-8719)       SC VETERAN

   * * * Eligibility Information and Service Connected Conditions * * *

     Primary Eligibility: SC LESS THAN 50%
     Combat Vet: NO   A/O Exp.: YES     M/S Trauma: NO
     ION Rad.: YES    SWAC: NO          H/N Cancer: NO
     PROJ 112/SHAD: NO

         SC Percent: %
 Rated Disabilities: NONE STATED
-------------------------------------------------------------------------------

Please supply the following required information about this operation:

Treatment related to Service Connected condition (Y/N): YES// <Enter>
Treatment related to Agent Orange Exposure (Y/N): NO
Treatment related to Ionizing Radiation Exposure (Y/N): YES

Update all 'OTHER POSTOP DIAGNOSIS' Eligibility and Service Connected
Conditions with these values (Y/N)? NO// <Enter>
```

```
SURPATIENT,TWELVE (000-41-8719)                                  Case #10062
JUN 08, 2005   BRONCHOSCOPY
-------------------------------------------------------------------------------
Surgery Procedure PCE/Billing Information:

1. Principal Postop Diagnosis Code: 934.0  FOREIGN BODY IN TRACHEA
2. Other Postop Diagnosis Code:     NOT ENTERED
3. Principal CPT Code: 31623  DX BRONCHOSCOPE/BRUSH
     Assoc. DX: 934.0-FOREIGN BODY IN TRACHE
4. Other CPT Code: 43200  ESOPHAGUS ENDOSCOPY
     Assoc. DX: 934.0-FOREIGN BODY IN TRACHE
-------------------------------------------------------------------------------
Enter number of item to edit (1-4):
```

REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: AUG 22,2006

PATIENT ID# / OPERATION DATE	PRINCIPAL OPERATION	OCCURRENCE(S) - (DATE) / TREATMENT	OUTCOME
ATTENDING: SURGEON,ONE			
SURPATIENT,TWELVE 000-41-8719 JUL 07, 2006@07:15	REPAIR DIAPHRAGMATIC HERNIA	MYOCARDIAL INFARCTION ASPIRIN THERAPY	I
		URINARY TRACT INFECTION * (07/09/06) IV ANTBIOTICS	I
SURPATIENT,THREE 000-21-2453 JUL 22, 2006@10:00	CARDIAC SURGERY CABG	REPEAT VENTILATOR SUPPORT W/IN 30 DAYS *	I
SURPATIENT,FOURTEEN 000-45-7212 JUL 31, 2006@09:00	CHOLECYSTECTOMY, APPENDECTOMY	SUPERFICIAL WOUND INFECTION * (08/02/06) ANTIBIOTICS	I

OUTCOMES: U - UNRESOLVED, I - IMPROVED, W - WORSE, D - DEATH
'*' Represents Postoperative Occurrences

Example 3: Printing the Perioperative Occurrences Report – Sorted by Occurrence Category

```
Select Perioperative Occurrences Menu Option: M  Morbidity & Mortality Reports

The Morbidity and Mortality Reports include the Perioperative Occurrences
Report and the Mortality Report. Each report will provide information
from cases completed within the date range selected.

Do you want to generate both reports ?  YES//  N

1. Perioperative Occurrences Report
2. Mortality Report


Select Number:  (1-2): 1

Start with Date: 6/1/07 (JUN 01, 2007)
End with Date: 6/30/07 (JUN 30, 2007)

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

Print report by
 1. Surgical Specialty
 2. Attending Surgeon
 3. Occurrence Category

Select 1, 2 or 3:  (1-3): 1// 3

Do you want to print this report for all occurrence categories? YES// NO

Print the report for which Occurrence Category ? ACUTE RENAL FAILURE
  NSQIP Definition (2007):
  In a patient who did not require dialysis preoperatively, worsening of
  renal dysfunction postoperatively requiring hemodialysis, peritoneal
  dialysis, hemofiltration, hemodiafiltration or ultrafiltration.

  TIP: If the patient refuses dialysis the answer is Yes to this
  variable, because he/she did require dialysis.

  CICSP Definition (2004):
  Indicate if the patient developed new renal failure requiring dialysis
  or experienced an exacerbation of preoperative renal failure requiring
  initiation of dialysis (not on dialysis preoperatively) within 30 days
  postoperatively.

Select an Additional Occurrence Category:  <Enter>

This report is designed to use a 132 column format.

Print the Report on which Device: [Select Print Device]
```

----------*report follows*----------

REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: AUG 22,2007

PATIENT ID# / OPERATION DATE	ATTENDING SURGEON / SURGICAL SPECIALTY / PRINCIPAL OPERATION	OCCURRENCE(S) - (DATE) / TREATMENT	OUTCOME
CATEGORY: ACUTE RENAL FAILURE			
SURPATIENT,SEVENTEEN 000-45-5119 JUN 18, 2007@07:15	SURGEON,TWO GENERAL REPAIR INCARCERATED INGUINAL HERNIA	ACUTE RENAL FAILURE DIALYSIS	I

OUTCOMES: U - UNRESOLVED, I - IMPROVED, W - WORSE, D - DEATH
'*' Represents Postoperative Occurrences

Example 4: Print the Mortality Report

```
Select Management Reports Option:  MM Morbidity & Mortality Reports

The Morbidity and Mortality Reports include the Perioperative Occurrences
Report and the Mortality Report. Each report will provide information
from cases completed within the date range selected.

Do you want to generate both reports ?  YES//  N

1. Perioperative Occurrences Report
2. Mortality Report


Select Number:  (1-2): 2

Start with Date: 1/1/02  (JAN 01, 2002)

End with Date: 12/31/02  (DEC 31, 2002)


This report is designed to use a 132 column format.

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

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

Hospital: MAYBERRY, NC
Station Number: 999
For Dates: JUN 01, 2004 to: JUN 30, 2004

	Total Cases	% of Total
Surgical Cases	315	100.0
Major Procedures	203	64.4
ASA Class (1)	10	4.9
ASA Class (2)	70	34.5
ASA Class (3)	120	59.1
ASA Class (4)	3	1.5
ASA Class (5)	0	0.0
ASA Class (6)	0	0.0
Postoperative Deaths	2	0.6
Ambulatory: 0		
Postoperative Occurrences	18	5.7
Ambulatory Procedures	201	63.8
Admitted Within 14 Days: 0		
Invasive Diagnostic: 1		
Inpatient Procedures	114	36.2
Emergency Procedures	14	4.4
Age>60 Years	141	44.8

SPECIALTY PROCEDURES

		PATIENTS	CASES	MAJOR	MINOR	---DEATHS--- TOTAL	%
50	GENERAL	63	64	54	10	1	1.6
51	GYNECOLOGY	7	7	7	0	0	0.0
52	NEUROSURGERY	12	14	13	1	0	0.0
53	OPHTHALMOLOGY	57	59	0	59	0	0.0
54	ORTHOPEDICS	53	56	46	10	0	0.0
55	OTORHINOLARYNGOLOGY	35	35	32	3	0	0.0
56	PLASTIC SURGERY	8	8	4	4	0	0.0
57	PROCTOLOGY	0	0	0	0	0	0.0
58	THORACIC SURGERY	3	3	3	0	0	0.0
59	UROLOGY	19	20	20	0	0	0.0
60	ORAL SURGERY	1	1	1	0	0	0.0
61	PODIATRY	25	25	3	22	0	0.0
62	PERIPHERAL VASCULAR	21	23	20	3	1	4.3
500	CARDIAC SURGERY	0	0	0	0	0	0.0
501	TRANSPLANTATION	0	0	0	0	0	0.0
502	ANESTHESIOLOGY	0	0	0	0	0	0.0

LEVEL OF RESIDENT SUPERVISION (%)

LEVEL OF RESIDENT SUPERVISION (%)

	MAJOR	MINOR
Level A	0.0	100.0
Level B	66.7	0.0
Level C	0.0	0.0
Level D	0.0	0.0
Level E	33.3	0.0
Level F	0.0	0.0
Level Not Entered	0.0	0.0

Hospital: MAYBERRY, NC
Station Number: 999
For Dates: JUN 01, 2004 to: JUN 30, 2004

INDEX PROCEDURES

	CASES	DEATHS	CASES WITH OCCURRENCES
Inguinal Hernia	13	0	0
Cholecystectomy	3	0	0
Coronary Artery Bypass	0	0	0
Colon Resection (L & R)	5	0	1
Fem-Pop Bypass	2	0	1
Pulmonary Lobectomy	0	0	0
Hip Replacement			
- Elective	7	0	2
- Acute Fracture	0	0	0
TURP	0	0	0
Laryngectomy	0	0	0
Craniotomy	0	0	0
Intraoccular Lens	44	0	0

PERIOPERATIVE OCCURRENCE CATEGORIES

Wound Occurrences	Total
A. Superficial Infection	6
B. Deep Wound Infection	0
C. Wound Disruption	0
D. Other	0

Urinary Occurrences	Total
A. Renal Insufficiency	2
B. Acute Renal Failure	0
C. Urinary Tract Infection	2
D. Other	0

Respiratory Occurrences	Total
A. Pneumonia	7
B. Unplanned Intubation	3
C. Pulmonary Embolism	0
D. On Ventilator >48 Hours	4
E. Tracheostomy	0
F. Repeat Vent w/in 30 Days	0
G. Other	0

CNS Occurrences	Total
A. CVA/Stroke	0
B. Coma >24 Hours	0
C. Peripheral Nerve Injury	1
D. Other	0

Cardiac Occurrences	Total
A. Cardiac Arrest Req. CPR	0
B. Myocardial Infarction	1
C. Endocarditis	0
D. Low Cardiac Output >6 Hrs.	0
E. Mediastinitis	0
F. Repeat Card Surg Proc	0
G. New Mech Circulatory Sup	1
H. Other	0

Other Occurrences	Total
A. Organ/Space SSI	0
B. Bleeding/Transfusions	1
C. Graft/Prosthesis/Flap Failure	0
D. DVT/Thrombophlebitis	0
E. Systemic Sepsis	2
F. Reoperation for Bleeding	0
G. C. difficile Colitis	2
H. Other	1

Clean Wound Infection Rate: 2.1

Hospital: MAYBERRY, NC Station Number: 999
For Dates: APR 01, 2004 to: JUN 30, 2004 Fiscal Year: 2004

	Total Cases	% of Total
Surgical Cases	1315	100.0
Major Procedures	973	74.0
ASA Class (1)	34	3.5
ASA Class (2)	305	31.3
ASA Class (3)	579	59.5
ASA Class (4)	54	5.5
ASA Class (5)	0	0.0
ASA Class (6)	0	0.0
ASA Class (Not Entered)	1	0.1
Postoperative Deaths	10	0.8
Ambulatory: 3		
Postoperative Occurrences	17	1.3
Ambulatory Procedures	794	60.4
Admitted Within 14 Days: 2		
Invasive Diagnostic: 146		
Inpatient Procedures	521	39.6
Emergency Procedures	45	3.4
Age>60 Years	729	55.4

SPECIALTY PROCEDURES

		PATIENTS	CASES	MAJOR	MINOR	---DEATHS--- TOTAL	%
50	GENERAL	140	147	147	0	4	2.7
51	GYNECOLOGY	9	9	9	0	0	0.0
52	NEUROSURGERY	53	56	56	0	1	1.8
53	OPHTHALMOLOGY	186	208	204	4	0	0.0
54	ORTHOPEDICS	156	162	159	3	1	0.6
55	OTORHINOLARYNGOLOGY	90	95	93	2	0	0.0
56	PLASTIC SURGERY	40	44	44	0	0	0.0
57	PROCTOLOGY	0	0	0	0	0	0.0
58	THORACIC SURGERY	19	22	22	0	0	0.0
59	UROLOGY	279	321	102	219	3	0.9
60	ORAL SURGERY	14	14	14	0	0	0.0
61	PODIATRY	36	42	42	0	0	0.0
62	PERIPHERAL VASCULAR	39	41	41	0	1	2.4
500	CARDIAC SURGERY	40	40	40	0	0	0.0
501	TRANSPLANTATION	0	0	0	0	0	0.0
502	ANESTHESIOLOGY	99	114	0	114	0	0.0

LEVEL OF RESIDENT SUPERVISION (%)

	MAJOR	MINOR
Level A	0.2	53.5
Level B	95.4	36.3
Level C	2.1	0.0
Level D	2.4	0.3
Level E	0.0	0.0
Level F	0.0	0.0
Level Not Entered	0.0	9.9

Hospital: MAYBERRY, NC Station Number: 999
For Dates: APR 01, 2004 to: JUN 30, 2004 Fiscal Year: 2004

INDEX PROCEDURES

	CASES	DEATHS	CASES WITH OCCURRENCES
Inguinal Hernia	31	0	1
Cholecystectomy	6	0	0
Coronary Artery Bypass	34	0	2
Colon Resection (L & R)	8	1	2
Fem-Pop Bypass	4	0	0
Pulmonary Lobectomy	3	0	0
Hip Replacement			
- Elective	14	0	0
- Acute Fracture	2	0	1
TURP	21	0	0
Laryngectomy	0	0	0
Craniotomy	4	0	0
Intraoccular Lens	135	0	0

PERIOPERATIVE OCCURRENCE CATEGORIES

Wound Occurrences	Total	Urinary Occurrences	Total
A. Superficial Infection	9	A. Renal Insufficiency	0
B. Deep Wound Infection	1	B. Acute Renal Failure	0
C. Wound Disruption	1	C. Urinary Tract Infection	2
D. Other	0	D. Other	0

Respiratory Occurrences	Total	CNS Occurrences	Total
A. Pneumonia	4	A. CVA/Stroke	0
B. Unplanned Intubation	2	B. Coma >24 Hours	0
C. Pulmonary Embolism	0	C. Peripheral Nerve Injury	0
D. On Ventilator >48 Hours	3	D. Other	0
E. Tracheostomy	0		
F. Repeat Vent w/in 30 Days	0		
G. Other	0		

Cardiac Occurrences	Total	Other Occurrences	Total
A. Cardiac Arrest Req. CPR	0	A. Organ/Space SSI	0
B. Myocardial Infarction	0	B. Bleeding/Transfusions	0
C. Endocarditis	0	C. Graft/Prosthesis/Flap Failure	0
D. Low Cardiac Output >6 Hrs.	0	D. DVT/Thrombophlebitis	0
E. Mediastinitis	0	E. Systemic Sepsis	1
F. Repeat Card Surg Proc	0	F. Reoperation for Bleeding	0
G. New Mech Circulatory Sup	0	G. C. difficile Colitis	1
H. Other	0	H. Other	0

Clean Wound Infection Rate: 1.0%

Non-Cardiac Risk Assessment Information (Enter/Edit)
[SROA ENTER/EDIT]

The nurse reviewer uses the *Non-Cardiac Risk Assessment Information (Enter/Edit)* option to enter a new risk assessment for a non-cardiac patient. This option is also used to make changes to an assessment that has already been entered. Cardiac cases are evaluated differently from non-cardiac cases and are entered into the software from different options. See the section, "Cardiac Risk Assessment Information (Enter/Edit)" for more information about risk assessments for cardiac cases.

The following options are available from this option, and let the user add in-depth data for a case. To the left is the shortcut synonym that the user can enter to select the option.

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

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

Creating a New Risk Assessment

1. The user is prompted to select either a patient name or a case. Selecting by case lets the user enter a specific surgery case number. Selecting by patient will display any previously entered assessments for a patient. An asterisk (*) indicates cardiac cases. The user can then choose to create a new assessment or edit one of the previously entered assessments.

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

3. Preoperative, operative, postoperative, and lab information is entered and edited using the sub-option(s).

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

Example: Creating a New Risk Assessment (Non-Cardiac)

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

Select Patient: ?

     To lookup by patient, enter patient name or patient ID.  To lookup by
     surgical case/assessment number, enter the number preceded by "#",
     e.g., for case 12345 enter "#12345" (no spaces).

Select Patient:    SURPATIENT,THREE  01-01-45  000212453     NSC VETERAN
```

```
 SURPATIENT,THREE  000-21-2453

1. 02-01-95   INTRAOCCULAR LENS (INCOMPLETE)

2. 02-01-95   HIP REPLACEMENT (INCOMPLETE)

3. 09-18-91   FEMORAL POPLITEAL BYPASS GRAFT (INCOMPLETE)

4.  ----     CREATE NEW ASSESSMENT


Select Surgical Case: 4
```

```
 SURPATIENT,THREE  000-21-2453

1. 10-03-91   ABDOMINAL AORTIC ANEURYSM RESECTION (NOT COMPLETE)



Select Operation: 1
```

When selecting a case to be assessed, if coding is completed for the case, and only excluded CPT codes are assigned, the software warns the Nurse Reviewer with the message:
"Based on the CPT Codes assigned for this case, this case should be excluded."
This is only a warning. The Nurse Reviewer may still create the assessment.

When selecting a case to be assessed, if no CPT codes have been assigned to the case, the software warns the Nurse Reviewer with the message:
"No CPT Codes have been assigned for this case."
This is only a warning. The Nurse Reviewer may still create the assessment.

```
Are you sure that you want to create a Risk Assessment for this surgical
case ?  YES// <Enter>
```

To enter information for the risk assessment, use the sub-options from this menu option. These options are described in the following sections. For example, to enter operation information, select the *Operation Information Enter/Edit* option.

```
SURPATIENT,SIXTY (000-56-7821)        Case #63592                PAGE: 1 OF 2
JUN 23,1998   CHOLEDOCHOTOMY
--------------------------------------------------------------------------------
1. GENERAL:                                3. HEPATOBILIARY:
  A. Height:                  65 INCHES      A. Ascites:
  B. Weight:                   140 LBS.
  C. Diabetes Mellitus:                    4. GASTROINTESTINAL:
  D. Current Smoker W/I 1 Year:              A. Esophageal Varices:
  E. Pack/Years:
  F. ETOH > 2 Drinks/Day:                  5. CARDIAC:
  G. Dyspnea:                                A. CHF Within 1 Month:
  H. DNR Status:                             B. MI Within 6 Months:
  I. Pre-illness Funct                       C. Previous PCI:
                Status:                      D. Previous Cardiac Surgery:
  J. Preop Funct Status:                     E. Angina Within 1 Month:
                                             F. Hypertension Requiring Meds:
2. PULMONARY:
  A. Ventilator Dependent:                 6. VASCULAR:
  B. History of Severe COPD:                 A. Revascularization/Amputation:
  C. Current Pneumonia:                      B. Rest Pain/Gangrene:
--------------------------------------------------------------------------------
Select Preoperative Information to Edit: 1:3
```

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


GENERAL: YES
```

```
Patient's Height 65 INCHES//: 62
Patient's Weight 140 POUNDS//: 175
Diabetes Mellitus Requiring Therapy With Oral Agents or Insulin: I  INSULIN
Current Smoker: Y  YES
Pack/Year Cigarette History: ??
        NSQIP Definition (2004):
        If the patient has ever been a smoker, enter the total number of
        pack/years of smoking for this patient. Pack-years are defined as the
        number of packs of cigarettes smoked per day times the number of years
        the patient has smoked. If the patient has never been a smoker, enter
        "0". If pack-years are >200, just enter 200. If smoking history cannot
        be determined, enter "NS". The possible range for number of pack-years
        is 0 to 200. If the chart documents differing values for pack year
        cigarette history, or ranges for either packs/day or number of years
        patient has smoked, select the highest value documented, unless you are
        confident in a particular documenter's assessment (e.g., preoperative
        anesthesia evaluation often includes a more accurate assessment of this
        value because of the impact it may have on the patient's response to
        anesthesia).


Pack/Year Cigarette History: 25
ETOH >2 Drinks Per Day in the Two Weeks Prior to Admission: N  NO
Dyspnea: N
     1   NO
     2   NO STUDY
Choose 1-2: 1  NO
DNR Status (Y/N): N  NO
Functional Health Status Prior to Current Illness: 1  INDEPENDENT
Functional Health Status at Evaluation for Surgery: 1  INDEPENDENT

PULMONARY: NO

HEPATOBILIARY: NO
```

```
SURPATIENT,SIXTY (000-56-7821)        Case #63592                PAGE: 1 OF 2
JUN 23,1998   CHOLEDOCHOTOMY
-------------------------------------------------------------------------------
1. GENERAL:                      YES      3. HEPATOBILIARY:                  NO
  A. Height:                  62 INCHES     A. Ascites:                       NO
  B. Weight:                   175 LBS.
  C. Diabetes Mellitus:         INSULIN   4. GASTROINTESTINAL:
  D. Current Smoker W/I 1 Year: YES         A. Esophageal Varices:
  E. Pack/Years:                25
  F. ETOH > 2 Drinks/Day:       NO        5. CARDIAC:
  G. Dyspnea:                   NO          A. CHF Within 1 Month:
  H. DNR Status:                NO          B. MI Within 6 Months:
  I. Pre-illness Funct                      C. Previous PCI:
                Status:   INDEPENDENT       D. Previous Cardiac Surgery:
  J. Preop Funct Status:   INDEPENDENT      E. Angina Within 1 Month:
                                            F. Hypertension Requiring Meds:

2. PULMONARY:                    NO
  A. Ventilator Dependent:      NO        6. VASCULAR:
  B. History of Severe COPD:    NO          A. Revascularization/Amputation:
  C. Current Pneumonia:         NO          B. Rest Pain/Gangrene:
-------------------------------------------------------------------------------

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

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

1. RENAL:                               3. NUTRITIONAL/IMMUNE/OTHER:
  A. Acute Renal Failure:                 A. Disseminated Cancer:
  B. Currently on Dialysis:               B. Open Wound:
                                          C. Steroid Use for Chronic Cond.:
2. CENTRAL NERVOUS SYSTEM:                D. Weight Loss > 10%:
  A. Impaired Sensorium:                  E. Bleeding Disorders:
  B. Coma:                                F. Transfusion > 4 RBC Units:
  C. Hemiplegia:                          G. Chemotherapy W/I 30 Days:
  D. History of TIAs:                     H. Radiotherapy W/I 90 Days:
  E. CVA/Stroke w. Neuro Deficit:         I. Preoperative Sepsis:
  F. CVA/Stroke w/o Neuro Deficit:        J. Pregnancy:
  G. Tumor Involving CNS:
  H. Paraplegia:
  I. Quadriplegia:
-------------------------------------------------------------------------------
Select Preoperative Information to Edit: 3E
```

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

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

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

1. RENAL:                               3. NUTRITIONAL/IMMUNE/OTHER:
  A. Acute Renal Failure:                 A. Disseminated Cancer:
  B. Currently on Dialysis:               B. Open Wound:
                                          C. Steroid Use for Chronic Cond.:
2. CENTRAL NERVOUS SYSTEM:                D. Weight Loss > 10%:
  A. Impaired Sensorium:                  E. Bleeding Disorders:          YES
  B. Coma:                                F. Transfusion > 4 RBC Units:
  C. Hemiplegia:                          G. Chemotherapy W/I 30 Days:
  D. History of TIAs:                     H. Radiotherapy W/I 90 Days:
  E. CVA/Stroke w. Neuro Deficit:         I. Preoperative Sepsis:
  F. CVA/Stroke w/o Neuro Deficit:        J. Pregnancy:
  G. Tumor Involving CNS:
  H. Paraplegia:
  I. Quadriplegia:
-------------------------------------------------------------------------------
Select Preoperative Information to Edit:
```

Laboratory Test Results (Enter/Edit)
[SROA LAB]

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

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

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

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

Example 1: Capture Preoperative Laboratory Information

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

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

Enter/Edit Laboratory Test Results

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

Select Number: 1

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

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

The 'Time Operation Began' must be entered before continuing.

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

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

..Searching lab record for latest preoperative test data….

..Moving preoperative lab test data to Surgery Risk Assessment file….

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

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
```

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

Preoperative Platelet Count (X 1000/mm3): 289
Date Preoperative Platelet Count was Performed: 9/18/03  (SEP 18, 2003)
Preoperative PTT (seconds): 33.7
Date Preoperative PTT was Performed: 9/18/03  (SEP 18, 2003)
Preoperative PT (seconds): 11.8
Date Preoperative PT was Performed: 9/18/03  (SEP 18, 2003)
```

```
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:                289   (SEP 18,2003)
12. PTT:                           33.7  (SEP 18,2003)
13. PT:                            11.8  (SEP 18,2003)
14. INR:                           NS
15. Hemoglobin A1c (1000 days):    NS
--------------------------------------------------------------------------------

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

```
SURPATIENT,FORTY (000-77-7777)        Case #68112                  PAGE: 2 OF 2
POSTOP LAB RESULTS WITHIN 30 DAYS AFTER SURGERY
SEP 19,2003   CHOLEDOCHOTOMY
--------------------------------------------------------------------------------

 1. Highest Anion Gap:             12        (SEP 20,2003)
 2. Highest Serum Sodium:          139       (SEP 20,2003)
 3. Lowest Serum Sodium:           135       (SEP 20,2003)
 4. Highest Potassium:             4.4       (SEP 20,2003)
 5. Lowest Potassium:              3.4       (SEP 20,2003)
 6. Highest Serum Creatinine:      1.2       (SEP 20,2003)
 7. Highest CPK:                   NS
 8. Highest CPK-MB Band:           NS
 9. Highest Total Bilirubin:       NS
10. Highest WBC:                   11.8      (SEP 20,2003)
11. Lowest Hematocrit:             40.3      (SEP 20,2003)
12. Highest Troponin I:            10.18     (SEP 24,2003)
13. Highest Troponin T:            12.13     (SEP 24,2003)
--------------------------------------------------------------------------------

Select Postoperative Laboratory Information to Edit: 2
```

```
SURPATIENT,FORTY (000-77-7777)        Case #68112
SEP 19,1998   CHOLEDOCHOTOMY
-------------------------------------------------------------------------------

Highest Postoperative Serum Sodium: 139// 144
Date Highest Serum Sodium was Recorded: 9/21/03  (SEP 21, 2003)
```

```
SURPATIENT,FORTY (000-77-7777)        Case #68112                     PAGE: 2 OF 2
POSTOP LAB RESULTS WITHIN 30 DAYS AFTER SURGERY
SEP 19,2003   CHOLEDOCHOTOMY
-------------------------------------------------------------------------------

 1. Highest Anion Gap:             12        (SEP 20,2003)
 2. Highest Serum Sodium:          144       (SEP 21,2003)
 3. Lowest Serum Sodium:           135       (SEP 20,2003)
 4. Highest Potassium:             4.4       (SEP 20,2003)
 5. Lowest Potassium:              3.4       (SEP 20,2003)
 6. Highest Serum Creatinine:      1.2       (SEP 20,2003)
 7. Highest CPK:                   NS
 8. Highest CPK-MB Band:           NS
 9. Highest Total Bilirubin:       NS
10. Highest WBC:                   11.8      (SEP 20,2003)
11. Lowest Hematocrit:             40.3      (SEP 20,2003)
12. Highest Troponin I:            10.18     (SEP 24,2003)
13. Highest Troponin T:            12.13     (SEP 24,2003)
-------------------------------------------------------------------------------

Select Postoperative Laboratory Information to Edit:
```

Operation Information (Enter/Edit)
[SROA OPERATION DATA]

The *Operation Information (Enter/Edit)* option is used to enter or edit information related to the operation. At the bottom of each page is a prompt to select one or more operative items to edit. If the user does not want to edit any items on the page, pressing the **<Enter>** key will exit the option. If they are not already there, it is important that the operation's beginning and ending times be entered so that the user can later enter postoperative information.

About the "Select Operative Information to Edit:" Prompt

The user should first enter the item number to edit at the "Select Operative Information to Edit:" prompt. To respond to every item on the page, the user should enter **A** for **ALL** or enter a range of numbers separated by a colon (:) to respond to a range of items.

After the information has been entered or edited, the display will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data. If information has been entered for the OTHER PROCEDURES field or the CONCURRENT PROCEDURES field, the summary will display ***INFORMATION ENTERED*** to the right of the items.

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

Example: Enter/Edit Operation Information

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

```
SURPATIENT,EIGHT (000-37-0555)        Case #264                  PAGE: 1 OF 2
Surgeon: SURSURGEON,ONE                                  >> Coding Complete <<
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
------------------------------------------------------------------------------
Postop Diagnosis Code (ICD9): NOT ENTERED

 1. Surgical Specialty:          ORTHOPEDICS
 2. Principal Operation:         ARTHROSCOPY, LEFT KNEE
 3. CPT Codes (view only):       29873-LT
 4. Other Procedures:
 5. Concurrent Procedure:
 6. PGY of Primary Surgeon:
 7. Surgical Priority:           ELECTIVE
 8. Wound Classification:        CLEAN
 9. ASA Classification:          1-NO DISTURB.
10. Princ. Anesthesia Technique: GENERAL
11. RBC Units Transfused:
12. Intraop Disseminated Cancer: NO
13. Intraoperative Ascites       NO
------------------------------------------------------------------------------

Select Operative Information to Edit: 8:9
```

This information cannot be edited.

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

Wound Classification: CLEAN// CL
     1   CLEAN
     2   CLEAN/CONTAMINATED
Choose 1-2: 2  CLEAN/CONTAMINATED
```

```
ASA Class: 1-NO DISTURB.// 2    2     2-MILD DISTURB.
```

```
SURPATIENT,EIGHT (000-37-0555)        Case #264                  PAGE: 1 OF 2
Surgeon: SURSURGEON,ONE                                  >> Coding Complete <<
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
------------------------------------------------------------------------------
Postop Diagnosis Code (ICD9): NOT ENTERED

 1. Surgical Specialty:          ORTHOPEDICS
 2. Principal Operation:         ARTHROSCOPY, LEFT KNEE
 3. CPT Codes (view only):       29873-LT
 4. Other Procedures:
 5. Concurrent Procedure:
 6. PGY of Primary Surgeon:
 7. Surgical Priority:           ELECTIVE
 8. Wound Classification:        CLEAN/CONTAMINATED
 9. ASA Classification:          2-MILD DISTURB.
10. Princ. Anesthesia Technique: GENERAL
11. RBC Units Transfused:
12. Intraop Disseminated Cancer: NO
13. Intraoperative Ascites       NO
------------------------------------------------------------------------------

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

```
SURPATIENT,EIGHT (000-37-0555)        Case #264                  PAGE: 2 OF 2
Surgeon: SURSURGEON,ONE
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
------------------------------------------------------------------------------

1. Patient in Room (PIR):              JUN 07, 2005  07:00
2. Procedure/Surgery Start Time (PST): JUN 07, 2005  07:10
3. Procedure/Surgery Finish (PF):      JUN 07, 2005  08:15
4. Patient Out of Room (POR):          JUN 07, 2005  08:40
5. Anesthesia Start (AS):              JUN 07, 2005  06:30
6. Anesthesia Finish (AF):             JUN 07, 2005  09:00
7. Discharge from PACU (DPACU):

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

Select Operative Information to Edit:
```

Patient Demographics (Enter/Edit)
[SROA DEMOGRAPHICS]

The surgical clinical nurse reviewer uses the *Patient Demographics (Enter/Edit)* option to capture patient demographic information from the Patient Information Management System (PIMS) record. The nurse reviewer can also enter, edit, and review this information. The demographic fields captured from PIMS are Race, Ethnicity, Hospital Admission Date, Hospital Discharge Date, Admission/Transfer Date, Discharge/Transfer Date, Observation Admission Date, Observation Discharge Date, and Observation Treating Specialty. With this option, the nurse reviewer can also edit the length of postoperative hospital stay, in/out-patient status, and transfer status.

The Race and Ethnicity information is displayed, but cannot be updated within this or any other Surgery package option.

Example: Entering Patient Demographics

```
Select Non-Cardiac Assessment Information (Enter/Edit) Option: D  Patient Demogr
aphics (Enter/Edit)

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

Enter/Edit Patient Demographic Information

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

Select Number:  (1-2): 1

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

...EXCUSE ME, JUST A MOMENT PLEASE...

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

Enter/Edit Patient Demographic Information

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

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

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

 1. Transfer Status:                    NOT TRANSFERRED
 2. Observation Admission Date/Time:    NA
 3. Observation Discharge Date/Time:    NA
 4. Observation Treating Specialty:     NA
 5. Hospital Admission Date/Time:       JUN 2, 2005@10:15
 6. Hospital Discharge Date/Time:       JUN 4, 2005@15:10
 7. Admit/Transfer to Surgical Svc.:    JUN 3, 2005@14:20
 8. Discharge/Transfer to Chronic Care:
 9. Length of Postop Hospital Stay:     1 Day
10. In/Out-Patient Status:              INPATIENT
11. Patient's Ethnicity                 NOT HISPANIC
12. Patient's Race:                     WHITE,ASIAN
13. Date/Time of Death:                 NA

------------------------------------------------------------------------------
Select number of item 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 (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
  NSQIP Definition (2007):
  In a patient who did not require dialysis preoperatively, worsening of
  renal dysfunction postoperatively requiring hemodialysis, peritoneal
  dialysis, hemofiltration, hemodiafiltration or ultrafiltration.

  TIP: If the patient refuses dialysis the answer is Yes to this
  variable, because he/she did require dialysis.

  CICSP Definition (2004):
  Indicate if the patient developed new renal failure requiring dialysis
  or experienced an exacerbation of preoperative renal failure requiring
  initiation of dialysis (not on dialysis preoperatively) within 30 days
  postoperatively.


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:
4. Treatment Instituted:
5. Outcome to Date:
6. Date Noted:
7. Occurrence Comments:

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

Select Occurrence Information: 4
```

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


Treatment Instituted: DIALYSIS
```

```
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:
4. Treatment Instituted:  DIALYSIS
5. Outcome to Date:
6. Date Noted:
7. Occurrence Comments:

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

Select Occurrence Information: <Enter>
```

```
SURPATIENT,EIGHT (000-37-0555)        Case #264
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
------------------------------------------------------------------------------
Enter/Edit Postoperative Occurrences

1.  ACUTE RENAL FAILURE
     Category: ACUTE RENAL FAILURE

Select a number (1), or type 'NEW' to enter another occurrence:
```

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

The *Clinical Information (Enter/Edit)* option is used to enter the clinical information required for a cardiac risk assessment. The software will present one page; at the bottom of the page is a prompt to select one or more items to edit. If the user does not want to edit any items on the page, pressing the **<Enter>** key will advance the user to another option.

About the "Select Clinical Information to Edit:" Prompt

At the "Select Clinical Information to Edit:" prompt, the user should enter the item number to edit. The user can then enter an **A** for **ALL** to respond to every item on the page, or enter a range of numbers separated by a colon (:) to respond to a range of items.

After the information has been entered or edited, the terminal display screen will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data. If assistance is needed while interacting with the software, the user can enter one or two question marks (**??**) to receive on-line help.

Example: Enter Clinical Information

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

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

 1. Height:                  63 in       13. Prior MI:                     NONE
 2. Weight:                  170 lb      14. Number prior heart surgeries:
 3. Diabetes:                            15. Prior heart surgeries:
 4. COPD:                                16. Peripheral Vascular Disease:
 5. FEV1:                                17. Cerebral Vascular Disease:
 6. Cardiomegaly (X-ray):                18. Angina (use CCS Class):
 7. Pulmonary Rales:                     19. CHF (use NYHA Class):
 8. Current Smoker:                      20. Current Diuretic Use:
 9. Active Endocarditis:                 21. Current Digoxin Use:
10. Resting ST Depression:               22. IV NTG within 48 Hours:
11. Functional Status:                   23. Preop circulatory Device:
12. PCI:                                 24. Hypertension (Y/N):

-------------------------------------------------------------------------------
Select Clinical Information to Edit: A
```

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

Patient's Height 63 INCHES//: 76
Patient's Weight170 LBS.//: 210
Diabetes: O  ORAL
History of Severe COPD (Y/N): Y  YES
FEV1 : NS
Cardiomegaly on Chest X-Ray (Y/N): Y  YES
Pulmonary Rales (Y/N): Y  YES
Current Smoker: 2  WITHIN 2 WEEKS OF SURGERY
Active Endocarditis (Y/N): N  NO
Resting ST Depression (Y/N): N  NO
Functional Status: I  INDEPENDENT
PCI: 0  NONE
Prior Myocardial Infarction: 1  LESS THAN OR EQUAL TO 7 DAYS PRIOR TO SURGERY
Number of Prior Heart Surgeries: 1  1
```

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

Prior heart surgeries:

0. None                      3. CABG/Valve
1. CABG-only                 4. Other
2. Valve-only                5. CABG/Other

Enter your choice(s) separated by commas  (0-5): // 2
                                          2 - Valve-only
Peripheral Vascular Disease (Y/N): Y  YES
Cerebral Vascular Disease (Y/N): N  NO
Angina (use CCS Functional Class): IV  CLASS IV
Congestive Heart Failure (use NYHA Functional Class): II  SLIGHT LIMITATION
Current Diuretic Use (Y/N): Y  YES
Current Digoxin Use (Y/N): N  NO
IV NTG within 48 Hours Preceding Surgery (Y/N): Y  YES
Preop use of circulatory Device: N  NONE
History of Hypertension (Y/N): Y  YES
```

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

 1. Height:                  76 in       13. Prior MI:            < OR = 7 DAYS
 2. Weight:                  210 lb      14. Number prior heart surgeries: 1
 3. Diabetes:                ORAL        15. Prior heart surgeries:  VALVE-ONLY
 4. COPD:                     YES        16. Peripheral Vascular Disease:  YES
 5. FEV1:                     NS         17. Cerebral Vascular Disease:    NO
 6. Cardiomegaly (X-ray):     YES        18. Angina (use CCS Class):       IV
 7. Pulmonary Rales:          YES        19. CHF (use NYHA Class):         II
 8. Current Smoker: WITHIN 2 WEEKS OF S  20. Current Diuretic Use:         YES
 9. Active Endocarditis:      NO         21. Current Digoxin Use:          NO
10. Resting ST Depression:    NO         22. IV NTG within 48 Hours:       YES
11. Functional Status:       INDEPENDENT 23. Preop circulatory Device:     NONE
12. PCI:                          NONE   24. Hypertension (Y/N):          YES

------------------------------------------------------------------------------
Select Clinical Information to Edit:
```

Enter Cardiac Catheterization & Angiographic Data
[SROA CATHETERIZATION]

The *Enter Cardiac Catheterization & Angiographic Data* option is used to enter or edit cardiac catheterization and angiographic information for a cardiac risk assessment. The software will present one page. At the bottom of the page is a prompt to select one or more items to edit. If the user does not want to edit any items on the page, pressing the **<Enter>** key will advance the user to another option.

About the "Select Cardiac Catheterization and Angiographic Information to Edit:" Prompt

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

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

Example: Enter Cardiac Catheterization & Angiographic Data

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

SURPATIENT,NINETEEN (000-28-7354)        Case #60183                   PAGE: 1 OF 2
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------
1. Procedure:
2. LVEDP:
3. Aortic Systolic Pressure:

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

6. LV Contraction Grade  (from contrast
    or radionuclide angiogram or 2D echo):

7. Mitral Regurgitation:
8. Aortic Stenosis:

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

Select Cardiac Catheterization and Angiographic Information to Edit: A

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

Procedure Type: NS  NO STUDY/UNKNOWN
Do you want to automatically enter 'NS' for NO STUDY for all other fields within
  this option ? YES// <Enter>
```

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

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

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

6. LV Contraction Grade  (from contrast
    or radionuclide angiogram or 2D echo): NO LV STUDY

7. Mitral Regurgitation:      NS
8. Aortic Stenosis:           NS

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

Select Cardiac Catheterization and Angiographic Information to Edit: A
```

```
Procedure Type: NO STUDY/UNKNOWN// CATH CATH
You have changed the answer from "NS".
Do you want to clear 'NS' from all other fields within this option ? NO// N  NO

Left Ventricular End-Diastolic Pressure: NS// 56
Aortic Systolic Pressure: NS// 120
PA Systolic Pressure: NS//30
PAW Mean Pressure: NS//15
LV Contraction Grade: NS//?
Enter the grade that best describes left ventricular function.
     Screen prevents selection of code III.
     Choose from:
       I        > EQUAL 0.55 NORMAL
       II       0.45-0.54 MILD DYSFUNC.
       IIIa     0.40-0.44 MOD. DYSFUNC. A
       IIIb     0.35-0.39 MOD. DYSFUNC. B
       IV       0.25-0.34 SEVERE DYSFUNC.
       V        <0.25 VERY SEVERE DYSFUNC.
       NS       NO STUDY
LV Contraction Grade: NO STUDY//IIIa  0.40-0.44 MOD. DYSFUNC. A
Mitral Regurgitation: NO STUDY//?
     Enter the code describing presence/severity of mitral regurgitation.
     Choose from:
       0        NONE
       1        MILD
       2        MODERATE
       3        SEVERE
       NS       NO STUDY
Mitral Regurgitation: NO STUDY//2  MODERATE
Aortic Stenosis: NO STUDY//1  MILD
```

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

The *Operative Risk Summary Data (Enter/Edit)* option is used to enter or edit operative risk summary data for a cardiac risk assessment. This option records the physician's subjective estimate of operative mortality. To avoid bias, this should be completed preoperatively. The software will present one page. At the bottom of the page is a prompt to select one or more items to edit. If the user does not want to edit any of the items, the **<Enter>**key can be pressed to proceed to another option.

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

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

Example: Operative Risk Summary Data

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

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

 1. Physician's Preoperative Estimate of Operative Mortality: 78
 2. ASA Classification:        1-NO DISTURB.
 3. Surgical Priority:
 4. Date/Time Operation Began: JUN 18,2005 07:00
 5. Date/Time Operation Ended: JUN 18,2005 09:00
 6. Preoperative Risk Factors: NONE
 7. CPT Codes (view only):     33510

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

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

This information cannot be edited.

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


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

```
SURPATIENT,NINETEEN (000-28-7354)   Case #60183                        PAGE: 1
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------
Principal CPT Code: 33510
Other CPT Codes:    NOT ENTERED

 1. Physician's Preoperative Estimate of Operative Mortality: 32%
    A. Date/Time Collected:    JUN 17,2005 18:15
 2. ASA Classification:        3-SEVERE DISTURB.
 3. Surgical Priority:         EMERGENT (ONGOING ISCHEMIA)
    A. Date/Time Collected:    JUN 17,2005 09:46
 4. Date/Time Operation Began: JUN 18,2005 08:45
 5. Date/Time Operation Ended: JUN 18,2005 14:25
 6. Preoperative Risk Factors:

 7. CPT Codes (view only):     33510


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

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

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

Select Operative Risk Summary Information to Edit:
```

The Surgery software performs data checks on the following fields:

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

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

If the date entered does not conform to the specifications, then the Surgery software displays a warning at the bottom of the screen.

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

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

Example: Resource Data (Enter/Edit)

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

SURPATIENT,TEN (000-12-3456)        Case #49413
JUN 18,2005   CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD
------------------------------------------------------------------------------

Enter/Edit Patient Resource Data

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

Select Number:  (1-2): 1

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

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

SURPATIENT,TEN (000-12-3456)        Case #49413
JUN 18,2005   CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD
------------------------------------------------------------------------------

Enter/Edit Patient Resource Data

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

Select Number:  (1-2): 2

SURPATIENT,TEN (000-12-3456)        Case #49413
JUN 18,2005   CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD
------------------------------------------------------------------------------

 1. Hospital Admission Date:            JUN 16, 2005@08:00
 2. Hospital Discharge Date:            JUN 30, 2005@08:00
 3. Cardiac Catheterization Date:       JUN 21, 2005
 4. Time Patient In OR:                 JUN 18, 2005@07:30
 5. Time Patient Out OR:                JUN 18, 2005@14:30
 6. Date/Time Patient Extubated:        JUN 18, 2005@08:05
 7. Date/Time Discharged from ICU:
 8. Homeless:                           NO
 9. Surg Performed at Non-VA Facility:  NO
10. Resource Data Comments:
11. Employment Status Preoperatively:   SELF EMPLOYED



------------------------------------------------------------------------------
Select number of item to edit: 11
```

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

```
SURPATIENT,TEN (000-12-3456)        Case #49413
JUN 18,2005   CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD
------------------------------------------------------------------------------

1.  Hospital Admission Date:            JUN 16, 2005@08:00
2.  Hospital Discharge Date:            JUN 30, 2005@08:00
3.  Cardiac Catheterization Date:       JUN 21, 2005
4.  Time Patient In OR:                 JUN 18, 2005@07:30
5.  Time Patient Out OR:                JUN 18, 2005@14:30
6.  Date/Time Patient Extubated:        JUN 18, 2005@08:05
7.  Date/Time Discharged from ICU:
8.  Homeless:                           NO
9.  Surg Performed at Non-VA Facility:  NO
10. Resource Data Comments:
11. Employment Status Preoperatively:   NOT EMPLOYED

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

Select number of item to edit:
```

The Surgery software performs data checks on the following fields:

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

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

If the date entered does not conform to the specifications, then the Surgery software displays a warning at the bottom of the screen.

Print a Surgery Risk Assessment
[SROA PRINT ASSESSMENT]

The *Print a Surgery Risk Assessment* option prints an entire Surgery Risk Assessment Report for an individual patient. This report can be displayed temporarily on a screen. As the report fills the screen, the user will be prompted to press the **<Enter>** key to go to the next page. A permanent record can be made by copying the report to a printer. When using a printer, the report is formatted slightly differently from the way it displays on the terminal.

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

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

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


Select Patient: SURPATIENT,FORTY         05-07-23     000777777     NO     NSC VET
ERAN

SURPATIENT,FORTY  000-77-7777

1. 02-10-04   * CABG (INCOMPLETE)

2. 01-09-06   APPENDECTOMY (COMPLETED)


Select Surgical Case: 2

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

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

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

Medical Center: ALBANY
Age:            81                    Operation Date:    JAN 09, 2004
Sex:            MALE                  Ethnicity: NOT HISPANIC OR LATINO
                                      Race:      AMERICAN INDIAN OR ALASKA
                                                 NATIVE, NATIVE HAWAIIAN OR
                                                 OTHER PACIFIC ISLANDER, WHITE
Transfer Status: NOT TRANSFERRED
Observation Admission Date:                  NA
Observation Discharge Date:                  NA
Observation Treating Specialty:              NA
Hospital Admission Date:                     JAN 7,2006   11:15
Hospital Discharge Date:                     JAN 12,2006  10:30
Admitted/Transferred to Surgical Service:    JAN 7,2006   11:15
Discharged/Transferred to Chronic Care:      JAN 12,2006  10:30
In/Out-Patient Status:                       INPATIENT

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

                          PREOPERATIVE INFORMATION

GENERAL:                      YES     HEPATOBILIARY:                YES
Height:              176 CENTIMETERS  Ascites:                      YES
Weight:                 89 KILOGRAMS
Diabetes Mellitus:            INSULIN GASTROINTESTINAL:             YES
Current Smoker W/I 1 Year:    YES     Esophageal Varices:           YES
Pack/Years:                   0
ETOH > 2 Drinks/Day:          NO      CARDIAC:                      NO
Dyspnea:                      NO      CHF Within 1 Month:           NO
DNR Status:                   NO      MI Within 6 Months:           NO
Pre-illness Funct                     Previous PCI:
           Status:       INDEPENDENT  Previous Cardiac Surgery:
Preop Funct Status:      INDEPENDENT  Angina Within 1 Month:
                                      Hypertension Requiring Meds:
PULMONARY:
Ventilator Dependent:         NS      VASCULAR:                     YES
History of Severe COPD:       NO      Revascularization/Amputation: NO
Current Pneumonia:            NO      Rest Pain/Gangrene:           YES


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


                      OPERATION DATE/TIMES INFORMATION

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

```
VA NON-CARDIAC RISK ASSESSMENT            Assessment: 236          PAGE 2
FOR SURPATIENT,FORTY  000-77-7777 (COMPLETED)
================================================================================
                            OPERATIVE INFORMATION

                  Surgical Specialty: GENERAL(OR WHEN NOT DEFINED BELOW)

                 Principal Operation: APPENDECTOMY

                 Procedure CPT Codes: 44950


                Concurrent Procedure:
                            CPT Code:
              PGY of Primary Surgeon: 0
                Emergency Case (Y/N): NO
                Wound Classification: CONTAMINATED
                  ASA Classification: 3-SEVERE DISTURB.
      Principal Anesthesia Technique: GENERAL
                RBC Units Transfused: 0
         Intraop Disseminated Cancer: NO
              Intraoperative Ascites: NO

                   PREOPERATIVE LABORATORY TEST RESULTS

                           Anion Gap: 12         (JAN 7,2006)
                        Serum Sodium: 144.6      (JAN 7,2006)
                     Serum Creatinine: .9        (JAN 7,2006)
                                 BUN: 18         (JAN 7,2006)
                        Serum Albumin: 3.5       (JAN 7,2006)
                      Total Bilirubin: .9        (JAN 7,2006)
                                SGOT: 46         (JAN 7,2006)
                   Alkaline Phosphatase: 34      (JAN 7,2006)
                      White Blood Count: 15.9    (JAN 7,2006)
                             Hematocrit: 43.4    (JAN 7,2006)
                         Platelet Count: 356     (JAN 7,2006)
                                    PTT: 25.9    (JAN 7,2006)
                                     PT: 12.1    (JAN 7,2006)
                                    INR: 1.54    (JAN 7,2006)
                         Hemoglobin A1c: NS

                     POSTOPERATIVE LABORATORY RESULTS

                              * Highest Value
                             ** Lowest Value

                           * Anion Gap: 11        (JAN 7,2006)
                         * Serum Sodium: 148      (JAN 12,2006)
                        ** Serum Sodium: 144.2    (FEB 2,2006)
                            * Potassium: 4.5      (JAN 12,2006)
                           ** Potassium: 4.5      (JAN 12,2006)
                   * Serum Creatinine: 1.4        (FEB 2,2006)
                                * CPK: 88         (JAN 12,2006)
                            * CPK-MB Band: <1     (JAN 12,2006)
                    * Total Bilirubin: 1.3        (JAN 12,2006)
                  * White Blood Count: 12.2       (JAN 12,2006)
                       ** Hematocrit: 42.9        (JAN 12,2006)
                        * Troponin I: 1.42       (JAN 12,2006)
                        * Troponin T: NS
```

```
VA NON-CARDIAC RISK ASSESSMENT            Assessment: 236          PAGE 3
FOR SURPATIENT,FORTY  000-77-7777 (COMPLETED)
================================================================================

                           OUTCOME INFORMATION

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


                     PERIOPERATIVE OCCURRENCE INFORMATION

WOUND OCCURRENCES:               YES     CNS OCCURRENCES:                YES
Superficial Incisional SSI:      NO      Stroke/CVA:                     NO
Deep Incisional SSI:             NO      Coma > 24 Hours:                NO
Wound Disruption:             01/10/06   Peripheral Nerve Injury:     01/10/06
* 427.31 ATRIAL FIBRILLATI    01/10/06

URINARY TRACT OCCURRENCES:       YES     CARDIAC OCCURRENCES:            YES
Renal Insufficiency:             NO      Arrest Requiring CPR:           NO
Acute Renal Failure:             NO      Myocardial Infarction:       01/09/06
Urinary Tract Infection:      01/11/06

RESPIRATORY OCCURRENCES:         YES     OTHER OCCURRENCES:              YES
Pneumonia:                       NO      Bleeding/Transfusions:          NO
Unplanned Intubation:            NO      Graft/Prosthesis/Flap Failure:  NO
Pulmonary Embolism:              NO      DVT/Thrombophlebitis:           NO
On Ventilator > 48 Hours:        NO      Systemic Sepsis: SEPTIC SHOCK 01/11/06
                                         Organ/Space SSI:             01/11/06
                                         C. difficile Colitis:           NO

* 477.0 RHINITIS DUE TO P     01/12/06
* indicates Other (ICD9)
```

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

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

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

VII. OUTCOMES
Operative Death:  NO                      Date of Death:

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

VIII. RESOURCE DATA
Hospital Admission Date:                      06/30/06 06:05
Hospital Discharge Date:                      07/10/06 08:50
Time Patient In  OR:                          07/10/06 10:00
Time Patient Out OR:                          07/10/06 12:30
Date and Time Patient Extubated:              07/10/06 13:13
Date and Time Patient Discharged from ICU:    07/10/06 08:00
Patient is Homeless:                          NS
Cardiac Surg Performed at Non-VA Facility:    UNKNOWN
Resource Data Comments: Indicate other cardiac procedures only if done
     with cardiopulmonary bypass
================================================================================
IX. SOCIOECONOMIC, ETHNICITY, AND RACE
 Employment Status Preoperatively:     SELF EMPLOYED
 Ethnicity:                            NOT HISPANIC OR LATINO
 Race Category(ies):                   AMERICAN INDIAN OR ALASKA NATIVE,
                                       NATIVE HAWAIIAN OR OTHER PACIFIC
                                       ISLANDER, WHITE

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

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

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

(This page included for two-sided copying.)

List of Surgery Risk Assessments
[SROA ASSESSMENT LIST]

The *List of Surgery Risk Assessments* option is used to print lists of assessments within a date range. Lists of assessments in different phases of completion (for example, incomplete, completed, or transmitted) or a list of all surgical cases entered in the Surgery Risk Assessment software can be printed. The user can also request that the list be sorted by surgical service. The software will prompt for a beginning date and an ending date. Examples 1-9 illustrate printing assessments in each of the following formats.

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases

Example 1: List of Incomplete Assessments

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

List of Surgery Risk Assessments

  1. List of Incomplete Assessments
  2. List of Completed Assessments
  3. List of Transmitted Assessments
  4. List of Non-Assessed Major Surgical Cases
  5. List of All Major Surgical Cases
  6. List of All Surgical Cases
  7. List of Completed/Transmitted Assessments Missing Information
  8. List of 1-Liner Cases Missing Information
  9. List of Eligible Cases

Select the Number of the Report Desired: 1

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

Print by Surgical Specialty ?  YES// <Enter>

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

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

Select Number:  (1-2): 1

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

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

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

MAYBERRY, NC
SURGERY SERVICE DATE REVIEWED:
FROM: JAN 1,2006 TO: JUN 30,2006 REVIEWED BY:

ASSESSMENT # / OPERATION DATE	PATIENT / SURGEON	OPERATIVE PROCEDURE(S)	ANESTHESIA TECHNIQUE
** SURGICAL SPECIALTY: CARDIAC SURGERY **			
28519 JAN 05, 2006	SURPATIENT,NINE 000-34-5555 SURSURGEON,ONE	* CABG X3 (2V,1A) CPT Codes: 33736	GENERAL
** SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW) **			
63063 JUN 09, 2006	SURPATIENT,ONE 000-44-7629 SURSURGEON,TWO	INGUINAL HERNIA CPT Codes: 49521	SPINAL
** SURGICAL SPECIALTY: NEUROSURGERY **			
63154 JUN 24, 2006	SURPATIENT,EIGHT 000-37-0555 SURSURGEON,FOUR	CRANIOTOMY CPT Codes: NOT ENTERED	NOT ENTERED

Example 2: List of Completed Assessments

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

List of Surgery Risk Assessments

  1. List of Incomplete Assessments
  2. List of Completed Assessments
  3. List of Transmitted Assessments
  4. List of Non-Assessed Major Surgical Cases
  5. List of All Major Surgical Cases
  6. List of All Surgical Cases
  7. List of Completed/Transmitted Assessments Missing Information
  8. List of 1-Liner Cases Missing Information
  9. List of Eligible Cases

Select the Number of the Report Desired: 2

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

Print by Surgical Specialty ?  YES// <Enter>

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

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

Select Number:  (1-2): 1

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

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

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

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

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

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

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

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

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

** SURGICAL SPECIALTY: OPHTHALMOLOGY **

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

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

Example 3: List of Transmitted Assessments

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

List of Surgery Risk Assessments

  1. List of Incomplete Assessments
  2. List of Completed Assessments
  3. List of Transmitted Assessments
  4. List of Non-Assessed Major Surgical Cases
  5. List of All Major Surgical Cases
  6. List of All Surgical Cases
  7. List of Completed/Transmitted Assessments Missing Information
  8. List of 1-Liner Cases Missing Information
  9. List of Eligible Cases

Select the Number of the Report Desired: 3

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

Print by Surgical Specialty ?  YES// <Enter>

Print report for ALL specialties ?  YES// N

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

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

Select Number:  (1-2): 1


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

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

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

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

ASSESSMENT # / OPERATION DATE	PATIENT / PRINCIPAL OPERATIVE PROCEDURE	TRANSMISSION DATE	ANESTHESIA TECHNIQUE
** SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW) **			
63076 JAN 08, 2006	SURPATIENT,FOURTEEN 000-45-7212 INGUINAL HERNIA CPT Codes: 49521	FEB 12, 2006	GENERAL
63077 FEB 08, 2006	SURPATIENT,FIVE 000-58-7963 INGUINAL HERNIA, OTHER PROC1 CPT Codes: NOT ENTERED	FEB 30, 2006	GENERAL
63103 MAR 27, 2006	SURPATIENT,NINE 000-34-5555 INGUINAL HERNIA CPT Codes: 49521	APR 09, 2006	GENERAL
63171 MAY 17, 2006	SURPATIENT,FIFTYTWO 000-99-8888 CHOLECYSTECTOMY CPT Codes: 47600	JUN 05, 2006	GENERAL

Example 4: List of Non-Assessed Major Surgical Cases

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

List of Surgery Risk Assessments

  1. List of Incomplete Assessments
  2. List of Completed Assessments
  3. List of Transmitted Assessments
  4. List of Non-Assessed Major Surgical Cases
  5. List of All Major Surgical Cases
  6. List of All Surgical Cases
  7. List of Completed/Transmitted Assessments Missing Information
  8. List of 1-Liner Cases Missing Information
  9. List of Eligible Cases

Select the Number of the Report Desired: 4

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

Print by Surgical Specialty ?  YES// <Enter>

Print report for ALL specialties ?  YES// N

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

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

Select Number:  (1-2): 1

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

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

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

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

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

SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)

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

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


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

Example 5: List of All Major Surgical Cases

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

List of Surgery Risk Assessments

  1. List of Incomplete Assessments
  2. List of Completed Assessments
  3. List of Transmitted Assessments
  4. List of Non-Assessed Major Surgical Cases
  5. List of All Major Surgical Cases
  6. List of All Surgical Cases
  7. List of Completed/Transmitted Assessments Missing Information
  8. List of 1-Liner Cases Missing Information
  9. List of Eligible Cases

Select the Number of the Report Desired: 5

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

Print by Surgical Specialty ?  YES// <Enter>

Print report for ALL specialties ?  YES// N

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

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

Select Number:  (1-2): 1


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

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

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

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

CASE # / OPERATION DATE	PATIENT / OPERATIVE PROCEDURE(S)	ASSESSMENT STATUS / EXCLUSION CRITERIA	ANESTHESIA TECHNIQUE / SURGEON
SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)			
63110	SURPATIENT,SIXTY 000-56-7821	COMPLETED	GENERAL
JAN 23, 2006	CHOLEDOCHOTOMY	SCNR WAS ON A/L	SURSURGEON,TWO
	CPT Codes: 47420		
63131	SURPATIENT,FIFTYTWO 000-99-8888	NO ASSESSMENT	GENERAL
APR 21, 2006	PERINEAL WOUND EXPLORATION		SURSURGEON,NINE
	CPT Codes: NOT ENTERED		
63136	SURPATIENT,EIGHT 000-34-5555	NO ASSESSMENT	GENERAL
JUN 07, 2006	CHOLECYSTECTOMY		SURSURGEON,ONE
	CPT Codes: 47600		
TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 3			

Example 6: List of All Surgical Cases

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

List of Surgery Risk Assessments

  1. List of Incomplete Assessments
  2. List of Completed Assessments
  3. List of Transmitted Assessments
  4. List of Non-Assessed Major Surgical Cases
  5. List of All Major Surgical Cases
  6. List of All Surgical Cases
  7. List of Completed/Transmitted Assessments Missing Information
  8. List of 1-Liner Cases Missing Information
  9. List of Eligible Cases

Select the Number of the Report Desired: 6

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

Print by Surgical Specialty ?  YES// <Enter>


Print report for ALL specialties ?  YES// N

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

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

Select Number:  (1-2): 1


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

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

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

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

CASE # / OPERATION DATE	PATIENT / PRINCIPAL OPERATIVE PROCEDURE	ASSESSMENT STATUS / EXCLUSION CRITERIA	ANESTHESIA TECHNIQUE / SURGEON
SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)			
63110 JAN 23, 2006	SURPATIENT,SIXTY 000-56-7821 CHOLEDOCHOTOMY CPT Code: 47420	COMPLETED SCNR WAS ON A/L	GENERAL SURSURGEON,TWO
63079 APR 02, 2006	SURPATIENT,FIFTYTWO 000-99-8888 INGUINAL HERNIA CPT Codes: NOT ENTERED	INCOMPLETE	GENERAL SURSURGEON,ONE
63131 APR 21, 2006	SURPATIENT,FIFTYTWO 000-99-8888 PERINEAL WOUND EXPLORATION CPT Codes: NOT ENTERED	NO ASSESSMENT	GENERAL SURSURGEON,NINE
63180 JUN 23, 2006	SURPATIENT,SIXTY 000-56-7821 CHOLECYSTECTOMY CPT Codes: 47600	NO ASSESSMENT	NOT ENTERED SURSURGEON,ONE
TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 4			

Example 7: List of Completed/Transmitted Assessments Missing Information

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

List of Surgery Risk Assessments

  1. List of Incomplete Assessments
  2. List of Completed Assessments
  3. List of Transmitted Assessments
  4. List of Non-Assessed Major Surgical Cases
  5. List of All Major Surgical Cases
  6. List of All Surgical Cases
  7. List of Completed/Transmitted Assessments Missing Information
  8. List of 1-Liner Cases Missing Information
  9. List of Eligible Cases

Select the Number of the Report Desired: 7

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

Print by Surgical Specialty ?  YES// <Enter>

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

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

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

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

** GENERAL(OR WHEN NOT DEFINED BELOW)

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


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

TOTAL FOR ALL SPECIALTIES: 3
```

Example 8: List of Completed/Transmitted Assessments Missing Information

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

List of Surgery Risk Assessments

  1. List of Incomplete Assessments
  2. List of Completed Assessments
  3. List of Transmitted Assessments
  4. List of Non-Assessed Major Surgical Cases
  5. List of All Major Surgical Cases
  6. List of All Surgical Cases
  7. List of Completed/Transmitted Assessments Missing Information
  8. List of 1-Liner Cases Missing Information
  9. List of Eligible Cases

Select the Number of the Report Desired: 8

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

Print by Surgical Specialty ?  YES// <Enter>

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

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

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

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

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

** UROLOGY

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

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


TOTAL FOR UROLOGY: 1
```

Example 9: List of Eligible Cases

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

List of Surgery Risk Assessments

  1. List of Incomplete Assessments
  2. List of Completed Assessments
  3. List of Transmitted Assessments
  4. List of Non-Assessed Major Surgical Cases
  5. List of All Major Surgical Cases
  6. List of All Surgical Cases
  7. List of Completed/Transmitted Assessments Missing Information
  8. List of 1-Liner Cases Missing Information
  9. List of Eligible Cases

Select the Number of the Report Desired: 9

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

Print by Surgical Specialty ?  YES// <Enter>

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

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

1. MAYBERRY, NC
2. PHILADELPHIA, PA

Select Number:  (1-2): 1

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

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

```
                    CASES ELIGIBLE FOR ASSESSMENT                  PAGE 1
                   FROM: JUN 1,2006  TO: JUN 30,2007

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

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

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

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

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

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

TOTAL FOR CARDIAC SURGERY: 4

>>> GENERAL SURGERY

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

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

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

TOTAL FOR GENERAL SURGERY: 2
```

Print 30 Day Follow-up Letters
[SROA REPRINT LETTERS]

The Surgical Clinical Nurse Reviewer uses the *Print 30 Day Follow-up Letters* option to automatically print a letter, or a batch of letters, addressed to a specific patient or patients.

About the "Do you want to print the letter for a specific assessment?" Prompt

The user responds **YES** to this prompt in order to print a follow-up letter for a single assessment. The software will ask the user to select the patient and case for which the letter will be printed. See Example 1 below.

The user responds **NO** to this prompt if he or she wants to print a batch of follow-up letters for surgical cases within a data range. The software will ask for the beginning and ending dates of the date range for which the letters will be printed. See Example 2 on the following pages.

If the patient has died, the software notifies the user of the death, and will not print the letter. Also, if a patient has not been discharged, the follow up letter will not print.

Example 1: Print a Single Follow-up Letter

```
Select Surgery Risk Assessment Menu Option: F  Print 30 Day Follow-up Letters

Do you want to edit the text of the letter? NO// <Enter>

Do you want to print the letter for a specific assessment ?  YES// <Enter>

Select Patient:      SURPATIENT,NINETEEN     03-03-30     000287354     SC VETERAN

SURPATIENT,NINETEEN 000-28-7354

1. 06-18-06   CORONARY ARTERY BYPASS (INCOMPLETE)

2. 01-25-06   PULMONARY LOBECTOMY (TRANSMITTED)



Select Surgical Case: 1

Print 30 Day Letters on which Device: [Select Print Device]
```

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

NINETEEN SURPATIENT JUL 18, 2006
Operation Date: 06/18/06
Specialty: GENERAL SURGERY

Dear Mr. Surpatient,

One month ago, you had an operation at the VA Medical Center. We are interested in how you feel. Have you had any health problems since your operation ? We would like to hear from you. Please take a few minutes to answer these questions and return this letter in the self-addressed stamped envelope.

Have you been to a hospital or seen a doctor for any reason since your operation ? ___ Yes ___ No

If you answered NO, you do not need to answer any more questions. Please return this sheet in the self-addressed stamped envelope.

If you have answered YES, please answer the following questions.

1) Have you been seen in an outpatient clinic or doctor's office ?
___ Yes ___ No

Why did you go to the clinic or doctor's office ? _____

Where ? (name and location) _____ Date ? _____

Who was your doctor ? _____

2) Were you admitted to a hospital ? ___ Yes ___ No

Why did you go to the hospital ? _____

Where ? (name and location) _____ Date ? _____

Who was your doctor ? _____

Please return this letter whether or not you have had any medical problems. Your health and opinion are important to us. Thank you.

Sincerely,

Surgical Clinical Nurse Reviewer

Example 2: Print Letters Within a Date Range

```
Select Surgery Risk Assessment Menu Option:  P Print 30 Day Follow-up Letters

Do you want to print the letter for a specific assessment ?  YES//  N

This option will allow you to reprint the 30 day follow up letters for the date that they were
originally printed. When printed automatically, the letters print 25 days after the date of
operation.

Print letters for BEGINNING date: TODAY// 6/1/07  (JUN 01, 2007)
Print letters for ENDING date: TODAY// <Enter> (JUN 02, 2007)

Print 30 Day Letters on which Device: [Select Print Device]
```

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

FORTYONE SURPATIENT JUN 02, 2007
87 NORTH STREET Operation Date: 05/08/07
PHILADELPHIA, PA 91776 Specialty: GENERAL SURGERY

Dear Mr. Surpatient,

One month ago, you had an operation at the VA Medical Center. We are interested in how you feel. Have you had any health problems since your operation ? We would like to hear from you. Please take a few minutes to answer these questions and return this letter in the self-addressed stamped envelope.

Have you been to a hospital or seen a doctor for any reason since your operation ? ___ Yes ___ No

If you answered NO, you do not need to answer any more questions. Please return this sheet in the self-addressed stamped envelope.

If you have answered YES, please answer the following questions.

1) Have you been seen in an outpatient clinic or doctor's office ?
___ Yes ___ No

Why did you go to the clinic or doctor's office ? _____

Where ? (name and location) _____ Date ? _____

Who was your doctor ? _____

2) Were you admitted to a hospital ? ___ Yes ___ No

Why did you go to the hospital ? _____

Where ? (name and location) _____ Date ? _____

Who was your doctor ? _____

Please return this letter whether or not you have had any medical problems. Your health and opinion are important to us. Thank You.

Sincerely,

Surgical Clinical Nurse Reviewer

Monthly Surgical Case Workload Report
[SROA MONTHLY WORKLOAD REPORT]

The *Monthly Surgical Case Workload Report* option generates the Monthly Surgical Case Workload Report that may be printed and/or transmitted to the NSQIP national database. The report can be printed for a specific month, or for a range of months.

Example: Monthly Surgical Case Workload Report – Single Month

```
Select Surgery Risk Assessment Menu Option: M  Monthly Surgical Case Workload Report

Report of Monthly Case Workload Totals

Print which report?

1. Report for Single Month
2. Report for Range of Months

Select Number (1 or 2): 1//  <Enter>

This option provides a report of the monthly risk assessment surgical case
workload totals which include the following categories:
     1. All cases performed
     2. Eligible cases
     3. Eligible cases meeting exclusion criteria
     4. Assessed cases
     5. Not logged eligible cases
     6. Cardiac cases
     7. Non-cardiac cases
     8. Assessed cases per day (based on 20 days/month)

The second part of this report provides the total number of incomplete
assessments remaining for the month selected and the prior 12 months.

Compile workload totals for which month and year? MAY 2007//  <Enter>

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

This report may be printed and/or transmitted to the national database.

Do you want this report to be transmitted to the central database? NO// <Enter>

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

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

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
STUDY CRITERIA	=	59
SCNR WAS ON A/L	=	0
CONCURRENT CASE	=	0
EXCEEDS MAXIMUM HERNIAS	=	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

Example: Monthly Surgical Case Workload Report – Range of Months

```
Select Surgery Risk Assessment Menu Option: M  Monthly Surgical Case Workload Report

Report of Monthly Case Workload Totals

Print which report?

1. Report for Single Month
2. Report for Range of Months

Select Number (1 or 2): 1//  2

Start with which month and year? OCT 2006//   (OCT 2006)  <Enter>

End with which month and year? MAY 2007//   (MAY 2007)  <Enter>

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

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

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

```
            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
         STUDY CRITERIA                =     0
         SCNR WAS ON A/L               =     1
         CONCURRENT CASE               =     0
         EXCEEDS MAXIMUM HERNIAS       =     0
     ASSESSED CASES                    =    20
     NOT LOGGED ELIGIBLE CASES         =     0
     CARDIAC CASES                     =     4
     NON-CARDIAC CASES                 =    16
-------------------------------------------------
```

Update 1-Liner Case

[SROA ONE-LINER UPDATE]

The *Update 1-Liner* option may be used to enter missing data for the 1-liner cases (major cases marked for exclusion from assessment, minor cases, and cardiac-assessed cases that transmit to the NSQIP database as a single line or two of data). Cases edited with this option will be queued for transmission to the NSQIP database at Chicago.

Example: Update 1-Liner Case

```
Select Surgery Risk Assessment Menu Option: O  Update 1-Liner Case

Select Patient: SURPATIENT,TWELVE                    02-12-28     000418719     YES
    SC VETERAN
```

```
 SURPATIENT,TWELVE            000-41-8719

1. 08-07-04   REPAIR DIAPHRAGMATIC HERNIA (COMPLETED)

2. 02-18-99   TRACHEOSTOMY, BRONCHOSCOPY, ESOPHAGOSCOPY (COMPLETED)

3. 09-04-97   CHOLECYSTECTOMY (COMPLETED)

Select Case: 1
```

```
SURPATIENT,TWELVE          (000-41-8719)        Case #142
Transmission Status: QUEUED TO TRANSMIT                  >> Coding Complete <<
AUG 7,2004   REPAIR DIAPHRAGMATIC HERNIA (CPT Code: 39540)
------------------------------------------------------------------------------
 1. In/Out-Patient Status:      OUTPATIENT
 2. Surgical Specialty:         GENERAL(OR WHEN NOT DEFINED BELOW)
 3. Surgical Priority:          STANDBY
 4. Attending Code:             LEVEL A. ATTENDING DOING THE OPERATION
 5. ASA Class:                  2-MILD DISTURB.
 6. Wound Classification:
 7. Anesthesia Technique:       GENERAL
 8. CPT Codes (view only):      39540
 9. Other Procedures:           ***NONE ENTERED***

------------------------------------------------------------------------------
Select number of item to edit: 6

Wound Classification: C  CLEAN
```

```
SURPATIENT,TWELVE          (000-41-8719)        Case #142
Transmission Status: QUEUED TO TRANSMIT                  >> Coding Complete <<
AUG 7,2004   REPAIR DIAPHRAGMATIC HERNIA (CPT Code: 39540)
------------------------------------------------------------------------------
 1. In/Out-Patient Status:      OUTPATIENT
 2. Surgical Specialty:         GENERAL(OR WHEN NOT DEFINED BELOW)
 3. Surgical Priority:          STANDBY
 4. Attending Code:             LEVEL A. ATTENDING DOING THE OPERATION
 5. ASA Class:                  2-MILD DISTURB.
 6. Wound Classification:       CLEAN
 7. Anesthesia Technique:       GENERAL
 8. CPT Codes (view only):      39540
 9. Other Procedures:           ***NONE ENTERED***
------------------------------------------------------------------------------

Select number of item to edit:
```

(This page included for two-sided copying.)