Surgery

User Manual

Version 3.0

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Department of Veterans Affairs

Office of Information and Technology (OIT)

Product Development

Revision History

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

Date	Revised Pages	Patch Number	Description
07/14	i-iib, 212a, 212d-212g, 238, 273, 405, 437, 480, 525, 526	SR*3*177	Updated examples to reflect ICD-10 Diagnosis Codes. Changed File Download Option 2 from "ICD9" to "ICD." Made ICD-9 references generic to ICD. Added ICD-10-CM Diagnosis Code Search. Updated Warning Message to Surgeon. Updated MailMan Messages for ICD-9 and ICD-10 codes. (K. Krause, VA PM; D. Getman, HP PM; E. Phelps, Tech Writer)
03/12	i-iid, v, vii, 6-11, 81-83, 120, 120a-120b, 140, 144-145, 145a-145b, 146, 151-152, 152a, 178, 207-209, 212c, 212f, 213, 215, 217-219, 219a-219b, 220, 222, 224, 226, 228, 230, 232, 234, 236, 239, 241, 243, 245, 247, 276, 327c, 394c, 395-396, 397a, 397c-397d, 411, 432, 449-450, 461, 464, 467-468, 474b, 482, 484, 486, 486a, 523, 525, 527, 549, 553-554	SR*3*176	Updated definitions, added new data fields, made changes to existing fields, data entry screens, reports, surgery risk assessment transmissions and transplant components of the VistA Surgery application. For more details, see the *Annual Surgery Updates – VASQIP 2011, Increment 2, Release Notes.* Chapter Seven: "CoreFLS/Surgery Interface" has been removed. (T. Leggett, PM; B. Thomas, Tech Writer)
09/11	i-iib, iii-iv, vi, 64, 66, 70, 98-101, 101a-101b, 109-112, 114-118, 122-124, 124a-124b, 142-152, 152a-152b, 176, 178, 180, 183-184, 184a-184f, 244, 246, 248, 325-326, 326a-326b, 327, 327a-327d, 368, 394a-394b, 394c-394d, 395-397, 397a-	SR*3*175	Updated definitions and made minor modifications to the non-cardiac, cardiac and transplant components of the VistA Surgery application. For more details, see the *Annual Surgery Updates – VASQIP 2011, Increment 1, Release Notes.* (T. Leggett, PM; B. Thomas, Tech Writer)

Date	Revised Pages	Patch Number	Description
	397d, 432-433, 441, 449-450, 458-459, 461, 464a, 471-474, 474a-474b, 475, 477, 480a, 482, 486-486a, 509,519, 521, 522a, 522c, 527, 534-535, 550, 552-556		
12/10	i-iib, 372, 376, 449-450, 458, 467-468, 468b, 471-474, 474a-474b, 479, 479a, 482, 486, 486a, 522c-522d	SR*3*174	Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software. For more details, see the *Annual Surgery Updates – VASQIP 2010 Release Notes.* (T. Leggett, PM; B. Thomas, Tech Writer)
11/08	vii-viii, 527-556	SR*3*167	New chapter added for transplant assessments. Changed Glossary to Chapter 10, and renumbered the Index. (M. Montali, PM; G. O'Connor, Tech Writer)
04/08	iii-iv, vi, 160, 165, 168, 171-172, 296-298, 443, 447, 449-450, 459, 471-473, 479-479a, 482, 486-486a, 489, 491, 493- 495, 497, 499, 501-502a, 502c, 502d-502h, 513-517, 522c-522d, 529, 534	SR*3*166	Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software. For more details, see the *Surgery NSQIP-CICSP Enhancements 2008 Release Notes.* (M. Montali, PM; G. O'Connor, Tech Writer)
11/07	479-479a, 486a	SR*3*164	Updated the *Resource Data Enter/Edit* and the *Print a Surgery Risk Assessment* options to reflect the new cardiac field for CT Surgery Consult Date. (M. Montali, PM; S. Krakosky, Tech Writer)
09/07	125, 371, 375, 382	SR*3*163	Updated the Service Classification section regarding environmental indicators, unrelated to this patch. Updated the Quarterly Report to reflect updates to the numbers and names of specific specialties in the NATIONAL SURGICAL SPECIALTY file. (M. Montali, PM; S. Krakosky, Tech Writer)

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)
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)

Date	Revised Pages	Patch Number	Description
			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)
08/04	iv-vi, 187-189, 195, 195a-195b, 196, 207-208, 219a-b, 527-528	SR*3*132	Updated the Table of Contents and Index to reflect added options. Added the new *Non-OR Procedure Information* option and the *Tissue Examination Report* option (unrelated to this patch) to the Non-OR Procedures section.
08/04	31, 43, 46, 66, 71-72, 75-76, 311	SR*3*127	Updated screen captures to display new text for ICD-9 and CPT codes.

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

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Table Of Contents

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Introduction

This section provides an overview of the Surgery package, and also provides documentation conventions used in this *Surgery V. 3.0 User Manual*. This section also discusses the use of the Screen Server in the Surgery package.

Overview

The Surgery package is designed to be used by Surgeons, Surgical Residents, Anesthetists, Operating Room Nurses and other surgical staff. The Surgery package is part of the patient information system that stores data on the Department of Veterans Affairs (VA) patients who have, or are about to undergo, surgical procedures. This package integrates booking, clinical, and patient data to provide a variety of administrative and clinical reports.

The *Surgery V. 3.0 User Manual* is designed to acquaint the user with the various Surgery options and to offer specific guidance on the use of the Surgery package. Documentation concerning the Surgery package, including any subsequent change pages affecting this documentation, can be found at the Veterans Health Information Systems and Technology Architecture (VistA) Documentation Library (VDL) on the Internet at http://www.va.gov/vdl/.

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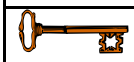
Documentation Conventions

This *Surgery V. 3.0 User Manual* includes documentation conventions, also known as notations, which are used consistently throughout this manual. Each convention is outlined below.

Convention	Example
Menu option text is italicized.	The *Print Surgery Waiting List* option generates the long form surgery Waiting List for the surgical service(s) selected.
Screen prompts are denoted with quotation marks around them.	The "Puncture Site:" prompt will display next.
Responses in bold face indicate user input.	Needle Size: **25G**
Text centered between bent parentheses represents a keyboard key that needs to be pressed for the system to capture a user response or move the cursor to another field. <**Enter**> indicates that the Enter key (or Return key on some keyboards) must be pressed. <**Tab**> indicates that the Tab key must be pressed.	Type **Y** for Yes or **N** for No and press <**Enter**>. Press <**Tab**> to move the cursor to the next field.
 Indicates especially important or helpful information.	 If the user attempts to reschedule a case after the schedule close time for the date of operation, only the time, and not the date, can be changed.
 Indicates that options are locked with a particular security key. The user must hold the particular security key to be able to perform the menu option.	 Without the SROAMIS key the *Anesthesia AMIS* option cannot be accessed.

Getting Help and Exiting

?, ??, ??? One, two or three question marks can be entered at any of the prompts for online help. One question mark elicits a brief statement of what information is appropriate for the prompt. Two question marks provide more help, plus the hidden actions, and three question marks will provide more detailed help, including a list of possible answers, if appropriate.

Typing an up arrow ^ (caret or a circumflex) and pressing <**Enter**> can be used to exit the current option.

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Using Screen Server

This section provides information about using the Screen Server utility with the Surgery software.

Introduction

Screen Server is a screen-based data entry utility. It allows the user to display and select data elements for entering, editing, and deleting information. The format is designed to display a number of data fields at one time on a menu. With Screen Server, a number of data elements are displayed at one time on a menu and the user is able to choose on which element to work.

This section contains a description of the Screen Server format and gives examples of how to respond to the unique Screen Server prompts. The screen facsimiles used in the examples are taken from the Surgery software; however, these screens may not display on the terminal monitor exactly as they display in this manual, because the Surgery package is subject to enhancements and local modifications. In this document, the different ways to respond to the Screen Server prompt, to perform a task, and to utilize shortcuts are explained. The shortcuts are listed below:

- Enter data
- Edit data
- Move between pages
- Enter/edit a range of data elements
- Multiples
- Multiple screen shortcuts
- Word processing

The user should be familiar with VistA conventions. In the examples, the user's response is presented in bold face text.

Navigating

The user can press the Return key to move through a prompt and go to the next page or item. To return directly to the *Surgery Menu* options, the user can enter an up-arrow (^), unless he or she is in a multiple field. To exit a multiple field, enter two up-arrows (^^).

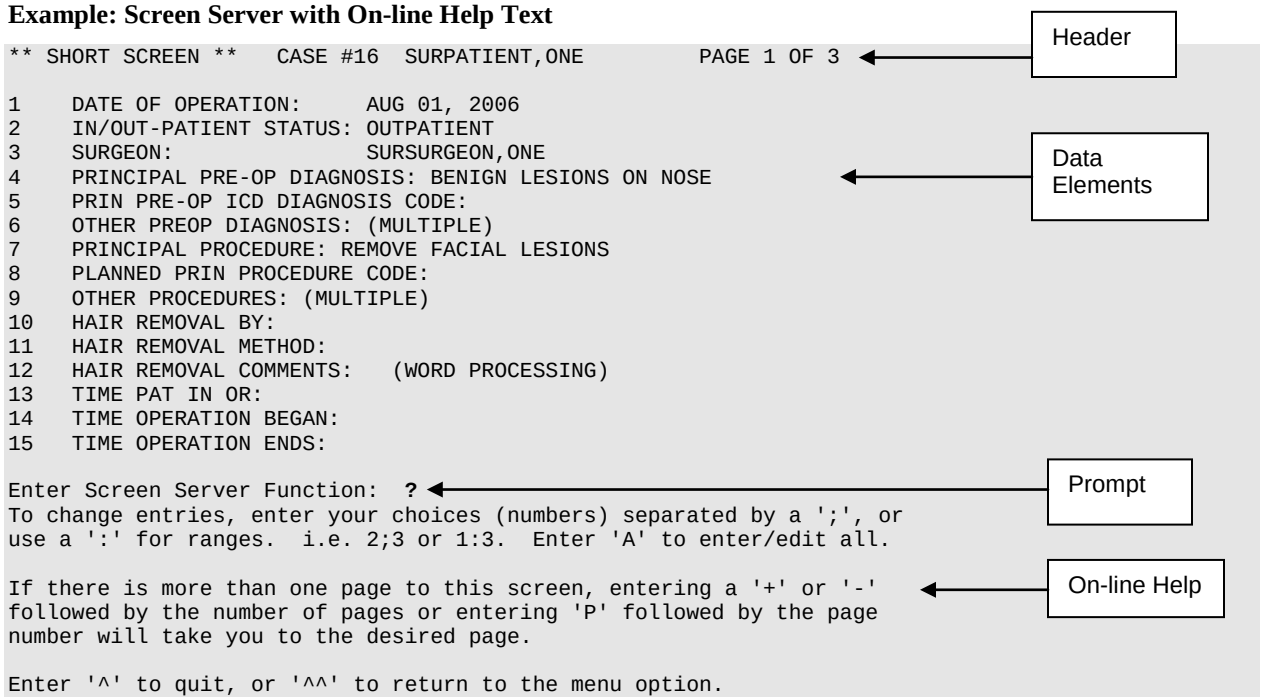
Basics of Screen Server

Each Screen Server arrangement consists of three basic parts: a header, data elements, and an action prompt. These items are defined in the following table.

Term	Definition
Header	The screen heading contains information specific to the record with which you are working. This can include the patient name or case number. The information in the heading is programmed and cannot be easily changed.
Data Elements	Each Screen Server display contains from 1 to 15 data elements (or fields). If information has been entered for any of the data elements defined, it will display to the right of the element. Some data elements are multiple fields, meaning they can contain more than one piece of information. These multiple fields are distinguished by the word "Multiple" next to the data element. If the multiple field contains information, the word "Data" will be next to the data element.
Prompt	The action prompt is at the bottom of each screen. From the prompt "Enter Screen Server Functions:" you can enter, edit, or delete information from the data elements. The possible responses to this prompt are explained in more detail on the following pages. Enter a question mark (?), for help text with possible prompt responses.

The following is an example of a Screen Server display with help text.

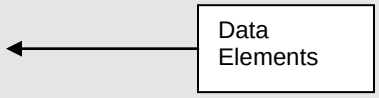
Example: Screen Server with On-line Help Text



Entering Data

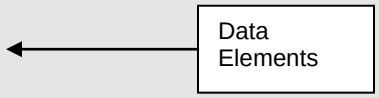
To enter or edit data, the user can type the item number corresponding with the data element for which he/she is entering information and press the **<Enter>** key. In the following example, we typed the number 10 at the prompt and pressed the **<Enter>** key. A new prompt appeared allowing us to enter the data. The software immediately processed this information and produced an updated menu screen and another action prompt.

```
 ** SHORT SCREEN **   CASE #16  SURPATIENT,ONE         PAGE 1 OF 3

1    DATE OF OPERATION:     AUG 01, 2006
2    IN/OUT-PATIENT STATUS: OUTPATIENT
3    SURGEON:               SURSURGEON,ONE
4    PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
5    PRIN PRE-OP ICD DIAGNOSIS CODE:
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    PRINCIPAL PROCEDURE: REMOVE FACIAL LESIONS
8    PLANNED PRIN PROCEDURE CODE:
9    OTHER PROCEDURES: (MULTIPLE)
10   HAIR REMOVAL BY:
11   HAIR REMOVAL METHOD:
12   HAIR REMOVAL COMMENTS:   (WORD PROCESSING)
13   TIME PAT IN OR:
14   TIME OPERATION BEGAN:
15   TIME OPERATION ENDS:

Enter Screen Server Function:  13
Time Patient In the O.R.:  13:00   AUG 1, 2006 AT 13:00
```



The software processes the information and produces an update.

```
 ** SHORT SCREEN **   CASE #16  SURPATIENT,ONE         PAGE 1 OF 3

1    DATE OF OPERATION:     AUG 01, 2006
2    IN/OUT-PATIENT STATUS: OUTPATIENT
3    SURGEON:               SURSURGEON,ONE
4    PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
5    PRIN PRE-OP ICD DIAGNOSIS CODE:
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    PRINCIPAL PROCEDURE: REMOVE FACIAL LESIONS
8    PLANNED PRIN PROCEDURE CODE:
9    OTHER PROCEDURES: (MULTIPLE)
10   HAIR REMOVAL BY:
11   HAIR REMOVAL METHOD:
12   HAIR REMOVAL COMMENTS:   (WORD PROCESSING)
13   TIME PAT IN OR:          AUG 1, 2006 AT 13:00
14   TIME OPERATION BEGAN:
15   TIME OPERATION ENDS:

Enter Screen Server Function:
```



Editing Data

Changing an existing entry is similar to entering. Once again, the user can type in the number for the data element he/she wants to change and press **<Enter>**. In the following example, the number 3 was entered to change the surgeon name. A new prompt appeared containing the existing value for the data element in a default format. We entered the new value, "SURSURGEON,TWO." The software immediately processed this information and produced an updated screen.

```
** SHORT SCREEN **   CASE #16  SURPATIENT,ONE         PAGE 1 OF 3

1    DATE OF OPERATION:     AUG 01, 2006
2    IN/OUT-PATIENT STATUS: OUTPATIENT
3    SURGEON:               SURSURGEON,ONE
4    PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
5    PRIN PRE-OP ICD DIAGNOSIS CODE:
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    PRINCIPAL PROCEDURE: REMOVE FACIAL LESIONS
8    PLANNED PRIN PROCEDURE CODE:
9    OTHER PROCEDURES: (MULTIPLE)
10   HAIR REMOVAL BY:
11   HAIR REMOVAL METHOD:
12   HAIR REMOVAL COMMENTS:   (WORD PROCESSING)
13   TIME PAT IN OR:          AUG 1, 2006 AT 13:00
14   TIME OPERATION BEGAN:
15   TIME OPERATION ENDS:

Enter Screen Server Function:  3
SURGEON:  SURSURGEON,ONE // SURSURGEON,TWO
```

Data Elements

The software processes the information and produces an update.

```
 ** SHORT SCREEN **   CASE #16  SURPATIENT,ONE         PAGE 1 OF 3

1    DATE OF OPERATION:     AUG 01, 2006
2    IN/OUT-PATIENT STATUS: OUTPATIENT
3    SURGEON:               SURSURGEON,TWO
4    PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
5    PRIN PRE-OP ICD DIAGNOSIS CODE:
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    PRINCIPAL PROCEDURE: REMOVE FACIAL LESIONS
8    PLANNED PRIN PROCEDURE CODE:
9    OTHER PROCEDURES: (MULTIPLE)
10   HAIR REMOVAL BY:
11   HAIR REMOVAL METHOD:
12   HAIR REMOVAL COMMENTS:   (WORD PROCESSING)
13   TIME PAT IN OR:          AUG 1, 2006 AT 13:00
14   TIME OPERATION BEGAN:
15   TIME OPERATION ENDS:

Enter Screen Server Function:
```

Data Elements

Turning Pages

No more than 15 data elements will fit on a single Screen Server formatted page, but there can be as many pages as needed. Because many screens contain more than one page of data elements, the screen server provides the ability to move between the pages. Pages are numbered in the heading. To go back one page, enter minus one (-1) at the action prompt. To go forward, enter plus one (+1) or press **<Enter>**. The user can move more than one page by combining the minus or plus sign with the number of pages needed to go backward or forward.

Entering or Editing a Range of Data Elements

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

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

Example 1: Colon

```
  ** STARTUP **   CASE #24  SURPATIENT,TWO            PAGE 2 OF 3

1    ASA CLASS:
2    PREOP MOOD:
3    PREOP CONSCIOUS:
4    PREOP SKIN INTEG:
5    TRANS TO OR BY:
6    HAIR REMOVAL BY:
7    HAIR REMOVAL METHOD:
8    HAIR REMOVAL COMMENTS:   (WORD PROCESSING)
9    SKIN PREPPED BY (1):
10   SKIN PREPPED BY (2):
11   SKIN PREP AGENTS:
12   SECOND SKIN PREP AGENT:
13   SURGERY POSITION:        (MULTIPLE)(DATA)
14   RESTR & POSITION AIDS:   (MULTIPLE)(DATA)
15   ELECTROGROUND POSITION:

Enter Screen Server Function:  1:6
ASA Class:  2    2-MILD DISTURB.
Preoperative Mood: RELAXED          R
Preoperative Consciousness: ALERT-ORIENTED          AO
Preoperative Skin Integrity: INTACT          I
Transported to O.R. By: STRETCHER
Preop Surgical Site Hair Removal by: SURNURSE,ONE          OS
```

Example 2: Semicolon

```
** STARTUP **   CASE #24  SURPATIENT,TWO            PAGE 1 OF 3

1    DATE OF OPERATION:     APR 19, 2006 AT 800
2    PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE
3    PRIN PRE-OP ICD DIAGNOSIS CODE:
4    OTHER PREOP DIAGNOSIS: (MULTIPLE)
5    OPERATING ROOM:        OR4
6    SURGERY SPECIALTY:     ORTHOPEDICS
7    MAJOR/MINOR:
8    REQ POSTOP CARE:       WARD
9    CASE SCHEDULE TYPE:    ELECTIVE
10   REQ ANESTHESIA TECHNIQUE: GENERAL
11   PATIENT EDUCATION/ASSESSMENT: YES
12   CANCEL DATE:
13   CANCEL REASON:
14   CANCELLATION AVOIDABLE:
15   DELAY CAUSE:          (MULTIPLE)

Enter Screen Server Function:  5;7;
Operating Room:  OR4// OR2
Major or Minor: MAJOR
```

Working with Multiples

The notation MULTIPLE indicates a data element that can have more than one answer. Some multiple fields have several layers of screens from which to respond. Navigating through the layers may seem tedious at first, but the user will soon develop speed. Remember, the user can press **<Enter>** at the prompt to go back to the main menu screen, or enter an up-arrow (^) to go back to the previous screen.

In the following examples, there are other screens after the initial (also called top-level) screen. With the multiple screens, a new menu list is built with each entry.

Example: Multiples

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

1    TIME PAT IN HOLD AREA: AUG 15, 2001 AT 740
2    TIME PAT IN OR:        AUG 15, 2001 AT 800
3    ANES CARE TIME BLOCK:    (MULTIPLE)(DATA)
4    TIME OPERATION BEGAN: AUG 15, 2001 AT 900
5    SPECIMENS:               (WORD PROCESSING)
6    CULTURES:                (WORD PROCESSING)
7    THERMAL UNIT:            (MULTIPLE)
8    ELECTROCAUTERY UNIT:
9    ESU COAG RANGE:
10   ESU CUTTING RANGE:
11   TIME TOURNIQUET APPLIED: (MULTIPLE)
12   PROSTHESIS INSTALLED:    (MULTIPLE)(DATA)
13   REPLACEMENT FLUID TYPE:  (MULTIPLE)
14   IRRIGATION:              (MULTIPLE)
15   MEDICATIONS:             (MULTIPLE)

Enter Screen Server Function:  12

   ** OPERATION **   CASE #14  SURPATIENT,THREE            PAGE 1
         PROSTHESIS INSTALLED

1    NEW ENTRY

Enter Screen Server Function:  1
Select PROSTHESIS INSTALLED PROSTHESIS ITEM: MANDIBULAR PLATES
   PROSTHESIS INSTALLED ITEM: MANDIBULAR PLATES//  <Enter>
```

Notice the three user responses entered above. The first response, 12, told the software that we want to enter data in the PROSTHESIS INSTALLED field. Then, at the next screen, we entered "1" because we wanted to make a new prosthesis entry for this case. The third response, MANDIBULAR PLATES, told the software the kind of prosthesis being installed. The software echoed back the full prosthesis name "MANDIBULAR PLATES" and we accepted it by pressing **<Enter>**.

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

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

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

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

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

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

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

Enter Screen Server Function:  <Enter>
```

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

Multiple Screen Shortcuts

The help text for a multiple field mentions the N and R functions. The user can enter a question mark (?) to view the help text at the prompt, as displayed in the following example.

```
  ** OPERATION **   CASE #14  SURPATIENT,THREE            PAGE 1 OF 1
        PROSTHESIS INSTALLED

1    PROSTHESIS ITEM:    MANDIBULAR PLATES
2    NEW ENTRY

Enter Screen Server Function:  ?
Enter 2N to enter only the top level of this multiple, or the number
of your choice followed by an 'R' to make a duplicate entry.

Press <RET> to continue
```

N Function

The N function allows the user to enter **new** entries without going beyond the top level screen, whereas the R function allows the user to **repeat** a previous top level response. In the following example we will build entries by entering the data element number and the letter N:

```
  ** OPERATION **   CASE #14  SURPATIENT,THREE            PAGE 1 OF 1
        PROSTHESIS INSTALLED

1    MANDIBULAR PLATES
2    NEW ENTRY

Enter Screen Server Function:  2N
Select PROSTHESIS INSTALLED PROSTHESIS ITEM: GLENOID COMPONENT
   PROSTHESIS INSTALLED ITEM: GLENOID COMPONENT// <Enter>
Select PROSTHESIS INSTALLED PROSTHESIS ITEM: HUMERAL COMPONENT
   PROSTHESIS INSTALLED ITEM: HUMERAL COMPONENT// <Enter>
Select PROSTHESIS INSTALLED PROSTHESIS ITEM: INTRAMEDULLARY PLUG
   PROSTHESIS INSTALLED ITEM: INTRAMEDULLARY PLUG// <Enter>
Select PROSTHESIS INSTALLED PROSTHESIS ITEM: <Enter>
```

The software processes the information and produces an update.

```
  ** OPERATION **   CASE #14  SURPATIENT,THREE            PAGE 1 OF 1
        PROSTHESIS INSTALLED

1    PROSTHESIS ITEM:    MANDIBULAR PLATES
2    PROSTHESIS ITEM:    GLENOID COMPONENT
3    PROSTHESIS ITEM:    HUMERAL COMPONENT
4    PROSTHESIS ITEM:    INTRAMEDULLARY PLUG
5    NEW ENTRY

Enter Screen Server Function: <Enter>
```

R Function

The R function saves the user from typing in the top-level information again. In this example, we have the same anesthesia technique but different anesthesia agents. By entering the element number we want to repeat, and the letter R, we avoid having to enter the top-level data again. This feature can also be useful in cases where the same medication is repeated at different times. After the user enters the item and the letter R, the software responds with a default prompt. The user can press **<Enter>** to accept the default.

```
  ** SHORT SCREEN **   CASE #10  SURPATIENT,FOUR   PAGE 1 OF 1
         ANESTHESIA TECHNIQUE

1    ANESTHESIA TECHNIQUE:  GENERAL
2    ANESTHESIA TECHNIQUE:  LOCAL
3    NEW ENTRY
Enter Screen Server Function:  1R
    ANESTHESIA TECHNIQUE: GENERAL// <Enter>
```

The software processes the information and produces an update.

```
  ** SHORT SCREEN **   CASE #10  SURPATIENT,FOUR   PAGE 1 OF 1
         ANESTHESIA TECHNIQUE  (0)

1    ANESTHESIA TECHNIQUE:  GENERAL
2    PRINCIPAL TECH:
3    ANESTHESIA AGENTS:     (MULTIPLE)

Enter Screen Server Function:  3
```

```
 ** SHORT SCREEN **   CASE #10  SURPATIENT,FOUR   PAGE 1 OF 1
         ANESTHESIA TECHNIQUE
0)
           ANESTHESIA AGENTS

1    NEW ENTRY

Enter Screen Server Function:  1
Select ANESTHESIA AGENTS: PROCAINE HYDROCHLORIDE
    ANESTHESIA AGENTS: PROCAINE HYDROCHLORIDE // <Enter>
```

```
  ** SHORT SCREEN **   CASE #10  SURPATIENT,FOUR   PAGE 1 OF 1
         ANESTHESIA TECHNIQUE  (0)
           ANESTHESIA AGENTS

1    ANESTHESIA AGENTS:     PROCAINE HYDROCHLORIDE
2    NEW ENTRY

Enter Screen Server Function: <Enter>
```

The software processes the information and produces an update.

```
  ** SHORT SCREEN **   CASE #10  SURPATIENT,FOUR   PAGE 1 OF 1
         ANESTHESIA TECHNIQUE  (0)

1    ANESTHESIA TECHNIQUE:  GENERAL
2    PRINCIPAL TECH:
3    ANESTHESIA AGENTS:     (MULTIPLE)(DATA)

Enter Screen Server Function:  <Enter>
```

The updating continues through to the top layer.

```
  ** SHORT SCREEN **   CASE #10  SURPATIENT,FOUR   PAGE 1 OF 1
         ANESTHESIA TECHNIQUE

1    ANESTHESIA TECHNIQUE:  INTRAVENOUS
2    ANESTHESIA TECHNIQUE:  LOCAL
3    ANESTHESIA TECHNIQUE:  INTRAVENOUS
4    NEW ENTRY

Enter Screen Server Function:
```

Word Processing

The phrase “Word Processing” in the menu means that the user can enter as much data as needed to complete the entry.

Following is an example of how we entered text on a Screen Server word processing field. Notice that we pressed **<Enter>** after each line of text as there is no automatic word-wrap:

```
** SHORT SCREEN **   CASE #25  SURPATIENT,FOUR       PAGE 3 OF 4

1    SPONGE, SHARPS, & INST COUNTER:
2    COUNT VERIFIER:
3    SURGERY SPECIALTY:       GENERAL
4    WOUND CLASSIFICATION:
5    ATTEND SURG:
6    ATTENDING CODE:       LEVEL D: ATTENDING IN O.R. SUITE, IMMEDIATELY AVAILABLE
7    SPECIMENS:            (WORD PROCESSING)
8    CULTURES:             (WORD PROCESSING)
9    NURSING CARE COMMENTS: (WORD PROCESSING)
10   ASA CLASS:
11   PRINC ANESTHETIST:
12   ANESTHESIA TECHNIQUE: (MULTIPLE)
13   ANES CARE TIME BLOCK:    (MULTIPLE)
14   DELAY CAUSE:             (MULTIPLE)
15   CANCEL DATE:

Enter Screen Server Function:  9
NURSING CARE COMMENTS:
  1>Patient arrived ambulatory from Ambulatory Surgery Unit.  <Enter>
  2>Discharged via wheelchair.  Lidocaine applied topically.       <Enter>
  3> <Enter>
EDIT Option: <Enter>
```

The software processes the information and produces an update.

```
** SHORT SCREEN **   CASE #25  SURPATIENT,FOUR       PAGE 3 OF 3

1    SPONGE, SHARPS, & INST COUNTER:
2    COUNT VERIFIER:
3    SURGERY SPECIALTY:       GENERAL
4    WOUND CLASSIFICATION:
5    ATTEND SURG:
6    ATTENDING CODE:       LEVEL D: ATTENDING IN O.R. SUITE, IMMEDIATELY AVAILABLE
7    SPECIMENS:            (WORD PROCESSING)
8    CULTURES:             (WORD PROCESSING)
9    NURSING CARE COMMENTS: (WORD PROCESSING)(DATA)
10   ASA CLASS:
11   PRINC ANESTHETIST:
12   ANESTHESIA TECHNIQUE: (MULTIPLE)
13   ANES CARE TIME BLOCK:    (MULTIPLE)
14   DELAY CAUSE:             (MULTIPLE)
15   CANCEL DATE:

Enter Screen Server Function:
```

Chapter One: Booking Operations

Introduction

The options described in this chapter facilitate the scheduling of surgical procedures. Automated scheduling provides better operating room use and greater ease in distributing the operating room schedule. These options help accomplish the following tasks.

- Track patients on a waiting list
- Track operation requests
- Chart operating room availability
- Designate operating rooms for a surgical service
- Schedule operations by assigning operating rooms and time slots
- Generate operating room schedules on any designated printer in the medical center
- Reschedule or cancel any operative procedures

Whether or not the user is booking a case from the Waiting List, *Request Operations* menu, or *Schedule Operations* menu, he/she will be asked to provide preoperative information about the case. Some of the preoperative information is mandatory and must be entered immediately to proceed with the option, while other information can be entered later. It is advisable to enter as much information as possible and update or correct it later. If a prompt cannot be answered, the user can press the **<Enter>** key to move to the next item.

Key Vocabulary

The following terms are used in this chapter.

Term	Definition
Concurrent Case	The patient undergoes two operations, by two different specialties, at the same time in the same operating room.
Cutoff Time	An institution might have a daily cutoff time for entering requests. After the cutoff time, the user is prohibited from booking a request for an operation to take place through midnight of the following day. The user may still book requests two or more days in advance.
Outstanding Requests	Requests that have been entered but not scheduled. When the patient name is entered, the software will list the outstanding requests for this patient.
Screen Server	After the data concerning the operation has been entered, the terminal display device will clear and then present a two-page Screen Server summary. The Screen Server summary organizes the information entered and gives the user another opportunity to enter or edit data.

Exiting an Option or the System

The user can type the up-arrow **(^)** at any prompt to stop the line of questioning and return to the previous level in the routine. To completely exit from the system, the user should continue entering up-arrows.

Option Overview

The main options included in this menu are listed below. Each of these options, except the *List Operation Requests* option and *List Scheduled Operations* option, contain submenus. To the left of the option name is the shortcut synonym that the user can enter to select the option.

Shortcut	Option Name
W	*Maintain Surgery Waiting List*
R	*Request Operations*
LR	*List Operation Requests*
S	*Schedule Operations*
LS	*List Scheduled Operations*

Maintain Surgery Waiting List
[SROWAIT]

The options within the *Maintain Surgery Waiting List* menu allow surgeons to develop waiting lists for selected surgery specialties. The patient can remain on the Waiting List until sufficient information is available to book the operation for a specific date (see *Make a Request from the Waiting List* option).

 This option is locked with the SROWAIT key.

The *Maintain Surgery Waiting List* menu contains the following options. To the left is the shortcut synonym the user can enter to select the option.

Shortcut	Option Name
W	*Print Surgery Waiting List*
E	*Enter a Patient on the Waiting List*
U	*Edit a Patient on the Waiting List*
D	*Delete a Patient from the Waiting List*

Print Surgery Waiting List
[SRSWL2]

Resident surgeons use the *Print Surgery Waiting List* option to print the waiting list for one or more surgical specialties. The Waiting List includes the names of patients waiting to have an operation and the type of operation. Cases entered on the Waiting List are not assigned an operating room or a date of operation.

The report can be sorted in several different ways. First, the user can sort the report by one or more surgical specialties. Then, the user can choose to sort the report either alphabetically by patient name, by the tentative date of the operation, or by the date the case was entered on the waiting list. A brief form can be requested, as in Example 1, or a long form report, as in Example 2. The long form report includes the procedure name, comments, referring physician, tentative admission date, patient address, and phone numbers.

This report has an 80-column format and can be viewed on a software terminal or copied to a printer. When the screen is full the user will be prompted to press the Return key to continue viewing the list.

Example 1: Print the Surgery Waiting List, Brief Form, Sort By T

```
Select Maintain Surgery Waiting List Option: W  Print Surgery Waiting List

                          Surgery Waiting List Reports

Print Report By:

         A    Alphabetical Order by Patient
         T    Tentative Date of Operation
         D    Date Entered on the Waiting List

Enter Selection (A,T, or D): T
```

```
Do you want to print the waiting list for all specialties ?  YES//  N

Select Surgical Specialty:  50          GENERAL(OR WHEN NOT DEFINED BELOW)  GENER
AL(OR WHEN NOT DEFINED BELOW)     50

Do you want to print the brief form ?  YES//  <Enter>

Print the Waiting List on which Device: [Select Print Device]
```

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

```
Surgery Waiting List for GENERAL (OR WHEN NOT DEFINED BELOW)
Printed JUN 28, 2001 at 14:10

Date Entered   Patient                  Operative Procedure
================================================================================
JAN 19, 2001   SURPATIENT,FIVE          Bunionectomy
Tentative Admission: JAN 23, 2001
Tentative Date of Operation: JAN 23, 2001
--------------------------------------------------------------------------------
JAN 21, 2001   SURPATIENT,SIX           REPAIR INGUINAL HERNIA
Tentative Admission: JAN 28, 2001
Tentative Date of Operation: JAN 29, 2001
--------------------------------------------------------------------------------
NOV 29, 1999   SURPATIENT,SEVEN         ARTHROSCOPY, RIGHT SHOULDER
Tentative Admission: DEC 29, 1999
Tentative Date of Operation: None Specified
--------------------------------------------------------------------------------
```

Example 2: Print the long form, Sort by D

```
Select Maintain Surgery Waiting List Option: W  Print Surgery Waiting List

                          Surgery Waiting List Reports

Print Report By:

         A    Alphabetical Order by Patient
         T    Tentative Date of Operation
         D    Date Entered on the Waiting List

Enter Selection (A,T, or D): D
```

```
Do you want to print the waiting list for all specialties ?  YES//  N

Select Surgical Specialty:  50          GENERAL(OR WHEN NOT DEFINED BELOW)  GENER
AL(OR WHEN NOT DEFINED BELOW)     50

Do you want to print the brief form ?  YES//  N

Print the Waiting List on which Device: [Select Print Device]
```

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

```
Surgery Waiting List for GENERAL (OR WHEN NOT DEFINED BELOW)
Printed JAN 20, 2001 at 14:11
================================================================================
Patient:      SURPATIENT,SEVEN (000-84-0987)
Date Entered: DEC 28, 2001 09:08
Procedure:    ARTHROSCOPY, RIGHT SHOULDER

Tentative Admission Date:    JAN 29, 2001

  Home Phone: (555) 555-5877             Work Phone: NOT ENTERED
  Address:

  Referring Physician/Institution:
     DR. SURSURGEON                           Phone: 555-555-0987
     122 1ST AVE.
     TUSCALOOSA, ALABAMA  35205
--------------------------------------------------------------------------------
Patient:      SURPATIENT,FIVE (000-58-7963)
Date Entered: JAN 19, 2001 15:17
Procedure:    Bunionectomy

Tentative Admission Date:    JAN 23, 2001
Tentative Date of Operation: JAN 23, 2001

  Home Phone: NOT ENTERED               Work Phone: NOT ENTERED
  Address:

  Referring Physician/Institution:
     Four Sursurgeon                     Phone:
     Sylacauga OPC
--------------------------------------------------------------------------------
Patient:      SURPATIENT,SIX (000-09-8797)
Date Entered: JAN 21, 2001 13:48
Procedure:    REPAIR INGUINAL HERNIA

Tentative Admission Date:    JAN 28, 2001
Tentative Date of Operation: JAN 29, 2001

Comments:
   Bland Diet

  Home Phone: 555-555-1233               Work Phone: NOT ENTERED
  Address:    117TH SO 40TH ST
              BIRMINGHAM, ALABAMA 35217

  Referring Physician/Institution:
     SURSURGEON                           Phone: 555-555-8900
     Jefferson OPC
--------------------------------------------------------------------------------
```

Enter a Patient on the Waiting List
[SROW-ENTER]

Resident surgeons use the *Enter a Patient on the Waiting List* option to enter a patient on the waiting list for a selected surgical specialty.

First, identify the surgical specialty to which the patient will be assigned. To add a new case to the waiting list, the user must enter the patient name and the procedure name. Comments, referring physician name and address, tentative admission date, and tentative operation date can also be added. This information will appear on the *Waiting List Report*. Patient names stay on the Waiting List until the data is used to make a request or until it is deleted.

Example: Enter a Patient on the Waiting List

```
Select Maintain Surgery Waiting List Option: E  Enter a Patient on the Waiting List

Select Surgical Specialty: 62     PERIPHERAL VASCULAR  PERIPHERAL VASCULAR 62
         ...OK? YES//  <Enter> (YES)
        PERIPHERAL VASCULAR

  Select Patient: SURPATIENT,EIGHT      06-04-35     000370555

  Select Operative Procedure: HAVEST SAPHENOUS VEIN

Select PATIENT: SURPATIENT,EIGHT// <Enter>

  General Comments/Special Instructions:
  1>Patient is an insulin dependent diabetic.
  2><Enter>
EDIT Option: <Enter>

  Tentative Admission Date: 08/25/01  (AUG 25, 2001)
  Tentative Date of Operation: 08/26/01  (AUG 26, 2001)

  Select REFERRING PHYSICIAN: DR. ONE SURSURGEON
    Street Address: VAMC HOUSTON
    City: HOUSTON
    State: TEXAS
    Zip Code: 77005
    Telephone Number: 555 555-5555


SURPATIENT,EIGHT has been entered on the waiting list for PERIPHERAL VASCULAR

Press RETURN to continue
```

Edit a Patient on the Waiting List
[SROW-EDIT]

The *Edit a Patient on the Waiting List* option is used to edit information collected for a patient who is already on the waiting list. The user enters the patient's name first. The user should be certain that the correct patient has been entered and that the right entry (there can be more than one) has been selected. Information can then be updated by simply typing in the new data at each prompt. If there is no change for a response, press the **<Enter>** key and the cursor will go to the next prompt.

This option allows changes to the procedure name, the referring physician information, comments, tentative admission date, and/or the tentative operation date. A patient's name cannot be edited. A patient's name will stay on the Waiting List until the data is used to make a request or until it is deleted.

Example: Edit Waiting List

```
Select Maintain Surgery Waiting List Option: U  Edit a Patient on the Waiting List

Edit which Patient ?  SURPATIENT,EIGHT        06-04-35     000370555

Procedures entered on the Waiting List for SURPATIENT,EIGHT


1. PERIPHERAL VASCULAR                  Date Entered on List:     AUG 11,2001
   HAVEST SAPHENOUS VEIN                Tentative Operation Date: AUG 26,2001

Principal Operative Procedure: HAVEST SAPHENOUS VEIN
           Replace HA <Enter> With HAR  <Enter> Replace <Enter>
   HARVEST SAPHENOUS VEIN
General Comments/Special Instructions:
  1>Patient is an insulin dependent diabetic.
EDIT Option: <Enter>
Tentative Admission Date: AUG 25,2001// 8/26  (AUG 26, 2001)
Tentative Date of Operation: AUG 26,2001// 8/27  (AUG 27, 2001)

Select REFERRING PHYSICIAN: DR. ONE SURSURGEON// <Enter>
  Referring Physician/Medical Center: DR. ONE SURSURGEON
           Replace  <Enter>
  Street Address: VAMC HOUSON// <Enter>
  City: HOUSTON// <Enter>
  State: TEXAS// <Enter>
  Zip Code: 77005// <Enter>
  Telephone Number: 555 555-5555// <Enter>

Press RETURN to continue
```

Delete a Patient from the Waiting List
[SROW-DELETE]

The *Delete a Patient from the Waiting List* option is used to delete a patient's procedure from the Surgery Waiting List. Enter the patient's name and select the procedure from the list of procedures and his or her entry will be deleted. The software will provide a message that the procedure has been deleted.

Example: Delete Patient From Waiting List

```
Select Maintain Surgery Waiting List Option: D  Delete a Patient from the Waiting List

Delete which Patient ? SURPATIENT,EIGHT      06-04-35     000370555

Procedures entered on the Waiting List for SURPATIENT,EIGHT


1. PERIPHERAL VASCULAR                  Date Entered on List:     AUG 11,2001
   HARVEST SAPHENOUS VEIN               Tentative Operation Date: AUG 26,2001


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

SURPATIENT,EIGHT has been removed from the Waiting List.

Press RETURN to continue
```

(This page included for two-sided copying.)

Request Operations Menu
[SROREQ]

The *Request Operations* menu contains several functions that the surgeons and resident surgeons use to book an operation. Options within the *Request Operations* menu are used to book an operation for a certain day. The surgeon can request, via the software, the operation(s) for a patient on a specific day and then enter additional information concerning the upcoming operation.

 This option is locked with the SROREQ key.

To request an operation, the user must have a patient name, an operative procedure to perform, and a date to book it. Also required are the Surgeon, Surgical Specialty, and the Indications for Operations. If the user does not know the anticipated date of surgery, the user can enter the patient on the Waiting List. If there is enough information to book the operation for a specific time and operating room, the user can use the *Schedule Unrequested Operations* option on the *Schedule Operation* menu to schedule the operation.

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

The options included in the *Request Operations* menu option are listed below. To the left of the option name is the shortcut character(s) the user can enter to select the option.

Shortcut	Option Name
A	*Display Availability*
R	*Make Operation Requests*
D	*Delete or Update Operation Requests*
W	*Make a Request from the Waiting List*
CC	*Make a Request for Concurrent Cases*
V	*Review Request Information*
OR	*Operation Requests for a Day*
WR	*Requests by Ward*

Display Availability
[SRODISP]

The *Display Availability* option is used to check on the availability of an operating room before booking an operation. This option allows the user to view the availability of operating rooms on a blockout graph. This screen is "read-only" with no editing capabilities.

Scheduled operations display on the graph as an equal sign (=) followed by the letter X. The equal sign before the X indicates the beginning of a scheduled operation. Surgical specialty blockouts are indicated by an abbreviation for the service (for more information on service blockouts, a function of the Scheduling menu, see the *Create Service Blockouts* option).

After entering this option, the user has a choice of viewing the room availability on the blockout graph in two ways. The user can either view all rooms for a particular date (as in Example 1) or view a particular operating room for a range of dates (Example 2). Notice, in the first example, that the user can also list requests, if any have been made.

Condensed Characters

If the display terminal can print condensed characters, a 24-hour graph will display on the screen. If not, the user will be prompted to select one of three graphs representing different chunks of that day.

Example 1: All O.R.S For One Day

```
Select Request Operations Option:  A Display Availability

Do you want to view all Operating Rooms on one day ?  YES //  <Enter>

Do you want to list requests also ?  NO// <Enter>

Display Operating Room Availability for which Date ?  T  (DEC 10, 2003)
```

```
Display of Available Operating Room Time

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

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

```
ROOM   6AM   7    8    9    10   11   12   13   14   15   16   17   18   19   20
OR1     |=XXX|XXXX|XXXX|gen.|gen.|gen.|____|____|____|____|____|____|____|____|
OR2     |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
OR3     |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
OR4     |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
OR5     |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
OR6     |____|____|____|____|____|____|____|____|____|____|____|____|____|____|

Press RETURN to continue
```

Example 2: One O.R. for a Date Range

```
Select Request Operations Option:  A Display Availability
```

```
Do you want to view all Operating Rooms on one day ?  YES //  N

Begin Display on which Date ?  T  (APR 14, 2003)

Select OPERATING ROOM NAME: OR1
```

```
Display of Available Operating Room Time

1. Display Availability (12:00 AM - 12:00 PM)
2. Display Availability (06:00 AM - 08:00 PM)
3. Display Availability (12:00 PM - 12:00 AM)

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

```
Operating Room: OR1           (6:00 AM - 8:00 PM)

DATE     6    7    8    9   10   11   12   13   14   15   16   17   18   19   20
04-14-03 |____|____|____|____|____|eye.|eye.|____|____|____|____|____|____|____|
04-15-03 |____|eye.|eye.|eye.|eye.|eye.|____|____|____|____|____|____|____|____|
04-16-03 |____|gen.|gen.|gen.|gen.|gen.|____|____|____|____|____|____|____|____|
04-17-03 |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
04-18-03 |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
04-19-03 |____|____|____|____|____|eye.|eye.|eye.|eye.|____|____|____|____|____|
04-20-03 |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
04-21-03 |____|____|____|____|____|eye.|eye.|____|____|____|____|____|____|____|
04-22-03 |____|eye.|eye.|eye.|eye.|eye.|____|____|____|____|____|____|____|____|
04-23-03 |=XXX|XXXX|XXXX|gen.|gen.|gen.|____|____|____|____|____|____|____|____|
04-24-03 |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
04-25-03 |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
04-26-03 |____|____|____|____|____|eye.|eye.|eye.|eye.|____|____|____|____|____|
04-27-03 |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
04-28-03 |____|____|____|____|____|eye.|eye.|____|____|____|____|____|____|____|

Press RETURN to continue
```

Make Operation Requests
[SROOPREQ]

The *Make Operation Requests* option allows the resident surgeon or scheduling manager to request an operation for a patient on a specific day. To request an operation the user must know the patient name, the operative procedure to be performed, and the date on which to book the procedure.

This option also asks for detailed information concerning the upcoming operation. First, the user will be prompted to enter required information, including the Date of Operation, Surgeon, Surgical Specialty, Principal Procedure, and indications for the operation. Facilities can set up additional required fields using the *Surgery Site Parameters (Enter/Edit)* option within the *Surgery Package Management* menu. Then, the user will be prompted to enter procedure information, such as the estimated case length, blood product information, and other information about the operation.

The user should enter as much information as possible when making the request. Later, more information can be added or corrections can be made by using the *Delete or Update Operation Requests* option.

About Outstanding Requests

When the patient name is entered, the software will list any requests that have been made but not scheduled. These requests are called outstanding requests. If the user discovers that the request being entered has already been made, he or she should respond **YES** to the prompt "Do you want to update the outstanding request ? ". Answering **YES** allows the user to view the information and make changes (see the following example).

If the user is entering a new, separate request for the same patient, he or she should respond **NO** to this prompt.

Example: Making an Operation Request

```
Select Request Operations Option:  R  Make Operation Requests
Select Patient:    SURPATIENT,NINE       12-09-51     000345555     NSC VETERAN

The following requests are outstanding for SURPATIENT,NINE:

1.  09-15-99
     Release of Hammer Toes
2.  11-20-99
     CHOLECYSTECTOMY

Do you want to update the outstanding request ?  YES// <Enter>

Select Operation Request: 1
```

Prompts that require a response before the user can continue with the option include the following.

"Make a Request for which Date ?"
"Surgeon:"
"Attending Surgeon:"
"Surgical Specialty:"
"Principal Operative Procedure:"
"Principal Preoperative Diagnosis:"

Entering Preoperative Information

At this prompt:	The user should do this:
Principal Preoperative Diagnosis	Type in the reason this procedure is being performed. The user must enter information into this field prompt before the option can be completed. The information entered in this field will automatically populate the Indications for Operations field, which can be edited through the Screen Server.
Planned Principal Procedure Code (CPT)	Type in the Current Procedural Terminology (CPT) identifying code for each procedure. If the code number is not known, the user can enter the type of operation (i.e., appendectomy) or a body organ and select from a list of codes.
Estimated Case Length (HOURS:MINUTES)	Either accept the default answer by pressing the **<Enter>** key, or enter a number for the length of time needed for this procedure. If a CPT Code is entered, the software will display the average length of time for the procedure based on the Surgical Specialty and CPT Code.
Brief Clinical History	This information will display on the Tissue Examination Report. It should contain any information relevant to the specimens being sent to the laboratory. This is a word-processing field.

----------*chart continues*----------

At this prompt:	The user should do this:
Select REQ BLOOD KIND	Enter the type of blood product that will be needed for the operation. The package coordinator can select a default response to this prompt when installing the package. If the default product is not what is wanted for a case, it can be deleted by entering the at-sign (@) at this prompt. The user can then select the preferred blood product (enter two question marks for a list of blood products). If no blood products are needed, do not enter **NO** or **NONE**. Instead, press the **<Enter>** key to bypass this prompt. To order more than one product for the same case, use the screen server summary that concludes the option and select item 9, REQ BLOOD KIND. This is a multiple field; as many blood products as needed may be entered.
Requested Preoperative X-Rays	Enter the types of preoperative x-ray films and reports required for delivery to the operating room before the operation. This field may be left blank if the user does not intend to order any x-ray products.
Request Clean or Contaminated	Enter the letter code **C** for clean or **D** for contaminated, or type in the first few letters of either word. This information allows the scheduling manager to determine how much time is needed between operations for sanitizing a room.

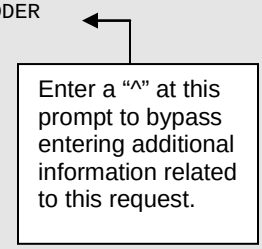
Example: Make Operation Requests

```
Select Request Operations Option: R  Make Operation Requests
```

```
Select Patient: SURPATIENT,TWENTY         03-27-40     000454886

The following request is outstanding for SURPATIENT,TWENTY:

1.      03-09-2002
        CARPAL TUNNEL RELEASE

Do you want to update the outstanding request ?  YES// N

Do you want to make a new request for SURPATIENT,TWENTY ? NO// Y

Make a Request for which Date ?  12/1  (DEC 01, 2004)
```

```
                    OPERATION REQUEST: REQUIRED INFORMATION

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

Surgeon: SURSURGEON,ONE
Attending Surgeon: SURSURGEON,ONE
Surgical Specialty: GENERAL(OR WHEN NOT DEFINED BELOW)       50
Principal Operative Procedure: CHOLECYSTECTOMY
Principal Preoperative Diagnosis: CHOLELITHIASIS

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


Press RETURN to continue  <Enter>
```

```
                    OPERATION REQUEST: PROCEDURE INFORMATION

SURPATIENT,TWENTY (000-45-4886)                                  DEC  1, 2004
================================================================================
Principal Procedure:      CHOLECYSTECTOMY
Planned Principal Procedure Code (CPT): 47480          INCISION OF GALLBLADDER
 CHOLECYSTOTOMY OR CHOLECYSTOSTOMY WITH EXPLORATION, DRAINAGE, OR REMOVAL
 OF CALCULUS (SEPARATE PROCEDURE)     ACTIVE

Modifier: 66          SURGICAL TEAM
 Modifier: <Enter>
Select OTHER PROCEDURE: <Enter>
Estimated Case Length (HOURS:MINUTES): 2:45
Brief Clinical History:
  1>SUBSCAPULAR PAIN FOR 3 DAYS. NAUSEA AND VOMITING. ACHOLIC
  2>STOOLS. CHOLANGIOGRAM SHOWS COMMON DUCT OBSTRUCTION.
  3><Enter>
EDIT Option: <Enter>
```



```
                    OPERATION REQUEST: BLOOD INFORMATION

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


Request Blood Availability ? YES//   <Enter>
Type and Crossmatch, Screen, or Autologous ? TYPE & CROSSMATCH// <Enter>  TYPE & CROSSMATCH
Select REQ BLOOD KIND: CPDA-1 WHOLE BLOOD// @
   SURE YOU WANT TO DELETE THE ENTIRE REQ BLOOD KIND? Y  (YES)
Select REQ BLOOD KIND: FA1  FRESH FROZEN PLASMA, CPDA-1      18201
  Units Required: 2
```

```
                    OPERATION REQUEST: OTHER INFORMATION

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

Principal Preoperative Diagnosis: CHOLELITHIASIS//  <Enter>
Prin Pre-OP ICD Diagnosis Code: 574.01   574.01   CHOLELITH/AC GB INF-OBST (w C/C
)
         ...OK? Yes//  <Enter> (YES)
Hospital Admission Status: I//  <Enter>  INPATIENT
Case Schedule Type: U  URGENT
First Assistant: SURSURGEON,TWO
Second Assistant: <Enter>
Requested Postoperative Care: WARD       W
Case Schedule Order: 1
Select SURGERY POSITION: SUPINE// <Enter>
  Surgery Position: SUPINE// <Enter>
Requested Anesthesia Technique: GENERAL <Enter>  GENERAL
Request Frozen Section Tests (Y/N/C): N  NO
Requested Preoperative X-Rays: ABDOMIN
Intraoperative X-Rays (Y/N): N
Request Medical Media (Y/N): N
Request Clean or Contaminated: CLEAN
Select REFERRING PHYSICIAN: <Enter>
General Comments: <Enter>
  No existing text
  Edit? NO// <Enter>
SPD Comments: <Enter>
  No existing text
  Edit? NO// <Enter>
```

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

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

1    PRINCIPAL PROCEDURE: CHOLECYSTECTOMY
2    OTHER PROCEDURES:   (MULTIPLE)
3    PLANNED PRIN PROCEDURE CODE: 47480-66
4    PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS
5    PRIN PRE-OP ICD DIAGNOSIS CODE: 574.01
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    IN/OUT-PATIENT STATUS: INPATIENT
8    PRE-ADMISSION TESTING:
9    CASE SCHEDULE TYPE: URGENT
10   SURGERY SPECIALTY:  GENERAL(OR WHEN NOT DEFINED BELOW)
11   SURGEON:            SURSURGEON,ONE
12   FIRST ASST:         SURSURGEON,TWO
13   SECOND ASST:
14   ATTEND SURG:        SURSURGEON,ONE
15   REQ POSTOP CARE:    WARD

Enter Screen Server Function:  <Enter>
```

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

1    CASE SCHEDULE ORDER: 1
2    SURGERY POSITION:   (MULTIPLE)(DATA)
3    REQ ANESTHESIA TECHNIQUE: GENERAL
4    REQ FROZ SECT:      NO
5    REQ PREOP X-RAY:    ABDOMIN
6    INTRAOPERATIVE X-RAYS: NO
7    REQUEST BLOOD AVAILABILITY: YES
8    CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH
9    REQ BLOOD KIND:     (MULTIPLE)(DATA)
10   REQ PHOTO:          NO
11   REQ CLEAN OR CONTAMINATED: CLEAN
12   REFERRING PHYSICIAN: (MULTIPLE)
13   GENERAL COMMENTS:   (WORD PROCESSING)
14   INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)
15   BRIEF CLIN HISTORY: (WORD PROCESSING)

Enter Screen Server Function: <Enter>
```

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

1    SPD COMMENTS:   (WORD PROCESSING)

Enter Screen Server Function: <Enter>
```

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

  Press RETURN to continue
```

Service Classifications

The Surgery software allows the user to associate a patient's Service Classification status when entering or editing a surgical case or Non-OR procedure. Service Classifications can be designated for a surgical case *only* if the veteran is first registered with these designations.

The Service Classifications that the user selects for the case also apply to the principal diagnosis.

These classifications default to each Other Postop Diagnosis as they are added to the case.

Updating an Operation Request with Service Classification Information

After the user selects the patient and enters the required data, a screen displays with questions about the Service Classifications.

If the patient is not enrolled, or his/her status is not populated in enrollment, the software displays the text "*SC/NSC status not found, **N** will be defaulted into all SC/EI categories*." The software defaults **N** into all Service Connected/Environmental Indicator fields related to the case.

If the user changes the SC/EI classifications at the case level, the software prompts the user with the message *"Update all 'OTHER POSTOP DIAGNOSIS' Eligibility and Service Connected Conditions with these values?"*

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).

Example 1: Delete a Request

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

The following cases are requested for SURPATIENT,NINE:

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

Select Operation Request: 2

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

Select Number: 1

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

Deleting Operation ...

Press RETURN to continue
```

Example 2: Update Request Information

```
Select Request Operations Option: D  Delete or Update Operation Requests

Select Patient: SURPATIENT,TWENTY         03-27-40     000454886


The following case is requested for SURPATIENT,TWENTY:

1. 12-01-01   CHOLECYSTECTOMY

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

Select Number: 2

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


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

1    PRINCIPAL PROCEDURE: CHOLECYSTECTOMY
2    OTHER PROCEDURES:   (MULTIPLE)
3    PLANNED PRIN PROCEDURE CODE: 47480-66
4    PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS
5    PRIN PRE-OP ICD DIAGNOSIS CODE 574.01
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    IN/OUT-PATIENT STATUS: INPATIENT
8    PRE-ADMISSION TESTING:
9    CASE SCHEDULE TYPE: URGENT
10   SURGERY SPECIALTY:  GENERAL(OR WHEN NOT DEFINED BELOW)
11   SURGEON:            SURSURGEON,ONE
12   FIRST ASST:         SURSURGEON,TWO
13   SECOND ASST:
14   ATTEND SURG:        SURSURGEON,ONE
15   REQ POSTOP CARE:    WARD

Enter Screen Server Function:  13
Second Assistant: SURSURGEON,THREE
```

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

1    PRINCIPAL PROCEDURE: CHOLECYSTECTOMY
2    OTHER PROCEDURES:   (MULTIPLE)
3    PLANNED PRIN PROCEDURE CODE: 47480-66
4    PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS
5    PRIN PRE-OP ICD DIAGNOSIS CODE: 574.01
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    IN/OUT-PATIENT STATUS: INPATIENT
8    PRE-ADMISSION TESTING:
9    CASE SCHEDULE TYPE: URGENT
10   SURGERY SPECIALTY:  GENERAL(OR WHEN NOT DEFINED BELOW)
11   SURGEON:            SURSURGEON,ONE
12   FIRST ASST:         SURSURGEON,TWO
13   SECOND ASST:        SURSURGEON,THREE
14   ATTEND SURG:        SURSURGEON,ONE
15   REQ POSTOP CARE:    WARD

Enter Screen Server Function:  <Enter>
```

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

1    CASE SCHEDULE ORDER: 1
2    SURGERY POSITION:   (MULTIPLE)(DATA)
3    REQ ANESTHESIA TECHNIQUE: GENERAL
4    REQ FROZ SECT:      NO
5    REQ PREOP X-RAY:    ABDOMIN
6    INTRAOPERATIVE X-RAYS: NO
7    REQUEST BLOOD AVAILABILITY: YES
8    CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH
9    REQ BLOOD KIND:     (MULTIPLE)(DATA)
10   REQ PHOTO:          NO
11   REQ CLEAN OR CONTAMINATED: CLEAN
12   REFERRING PHYSICIAN: (MULTIPLE)
13   GENERAL COMMENTS:   (WORD PROCESSING)
14   INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)
15   BRIEF CLIN HISTORY: (WORD PROCESSING)

Enter Screen Server Function:  <Enter>
```

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

1    SPD COMMENTS: (WORD PROCESSING)

Enter Screen Server Function:  <Enter>
```

Example 3: Change the Request Date

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

```
The following case is requested for SURPATIENT,TWENTY:

1. 12-01-01   CHOLECYSTECTOMY

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

Select Number: 3


Change to which Date ? 11/30  (NOV 30, 2001)

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

Press RETURN to continue
```

Deleting or Updating Requests for Concurrent Cases

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

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

Example 4: Delete a Request for Concurrent Cases

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

The following cases are requested for SURPATIENT,FOUR:

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

Select Operation Request: 2

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

Select Number: 1

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

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

  Deleting Operation ...

  Deleting Concurrent Operation ...

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

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

Example 5: Update Request Information for a Concurrent Case

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

The following cases are requested for SURPATIENT,TWELVE:

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

Select Operation Request: 1

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

Select Number: 2


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

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

1    PRINCIPAL PROCEDURE: CAROTID ARTERY ENDARTERECTOMY
2    OTHER PROCEDURES:   (MULTIPLE)
3    PLANNED PRIN PROCEDURE CODE: 35301-59
4    PRINCIPAL PRE-OP DIAGNOSIS:
5    PRIN PRE-OP ICD DIAGNOSIS CODE:
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    IN/OUT-PATIENT STATUS:
8    PRE-ADMISSION TESTING:
9    CASE SCHEDULE TYPE: STANDBY
10   SURGERY SPECIALTY:  PERIPHERAL VASCULAR
11   SURGEON:            SURSURGEON,ONE
12   FIRST ASST:
13   SECOND ASST:
14   ATTEND SURG:        SURSURGEON,ONE
15   REQ POSTOP CARE:    SICU

Enter Screen Server Function:  4;5;8
Principal Preoperative Diagnosis: CAROTID ARTERY STENOSIS
Prin Pre-OP ICD Diagnosis Code: 433.1        'C'       CAROTID ARTERY OCCLUSION
      COMPLICATION/COMORBIDITY
         ...OK? YES//  <Enter> (YES)

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

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

1    PRINCIPAL PROCEDURE: CAROTID ARTERY ENDARTERECTOMY
2    OTHER PROCEDURES:   (MULTIPLE)
3    PLANNED PRIN PROCEDURE CODE: 35301-59
4    PRINCIPAL PRE-OP DIAGNOSIS: CAROTID ARTERY STENOSIS
5    PRIN PRE-OP ICD DIAGNOSIS CODE: 433.10
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    IN/OUT-PATIENT STATUS: INPATIENT
8    PRE-ADMISSION TESTING: YES
9    CASE SCHEDULE TYPE: STANDBY
10   SURGERY SPECIALTY:  PERIPHERAL VASCULAR
11   SURGEON:            SURSURGEON,ONE
12   FIRST ASST:
13   SECOND ASST:
14   ATTEND SURG:        SURSURGEON,ONE
15   REQ POSTOP CARE:    SICU

Enter Screen Server Function: <Enter>
```

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

1    CASE SCHEDULE ORDER: 1
2    SURGERY POSITION:   (MULTIPLE)
3    REQ ANESTHESIA TECHNIQUE: GENERAL
4    REQ FROZ SECT:      NO
5    REQ PREOP X-RAY:    DOPPLER STUDIES
6    INTRAOPERATIVE X-RAYS: NO
7    REQUEST BLOOD AVAILABILITY:
8    CROSSMATCH, SCREEN, AUTOLOGOUS:
9    REQ BLOOD KIND:     (MULTIPLE)
10   REQ PHOTO:
11   REQ CLEAN OR CONTAMINATED: CLEAN
12   REFERRING PHYSICIAN: (MULTIPLE)
13   GENERAL COMMENTS:   (WORD PROCESSING)
14   INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)
15   BRIEF CLIN HISTORY: (WORD PROCESSING)

Enter Screen Server Function: <Enter>
```

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

1    SPD COMMENTS: (WORD PROCESSING)

Enter Screen Server Function:
```

Example 6: Change the Request Date of Concurrent Cases

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

The following cases are requested for SURPATIENT,FOUR:

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

Select Operation Request: 3

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

Select Number: 3

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

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

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

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

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

Press RETURN to continue
```

Make a Request from the Waiting List
[SRSWREQ]

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

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

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

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

Example: Making A Request From the Waiting List

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

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

Procedures Entered on the Waiting List for SURPATIENT,FOURTEEN:

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

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

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

```
                    OPERATION REQUEST: REQUIRED INFORMATION

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

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


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


Press RETURN to continue  <Enter>
Sending a Notification of Appointment Booking for case #229
```

```
                    OPERATION REQUEST: PROCEDURE INFORMATION

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

```
                    OPERATION REQUEST: BLOOD INFORMATION

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

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

```
                    OPERATION REQUEST: OTHER INFORMATION

SURPATIENT,FOURTEEN (000-45-7212)                                DEC  1, 2005
================================================================================
Principal Preoperative Diagnosis: ACUTE DIAPHRAGMATIC HERNIA
          Replace <Enter>
Prin Pre-OP ICD Diagnosis Code: 551.3 DIAPHRAGM HERNIA W GANGR (w C/C)
         ...OK? Yes//  <Enter> (YES)
Hospital Admission Status: I//  <Enter> INPATIENT
Case Schedule Type: S  STANDBY
First Assistant: SURSURGEON,ONE
Second Assistant: <Enter>
Requested Postoperative Care: WARD       W
Case Schedule Order: <Enter>
Select SURGERY POSITION: SUPINE// <Enter>
  Surgery Position: SUPINE// <Enter>
Requested Anesthesia Technique: GENERAL  GENERAL
Request Frozen Section Tests (Y/N): N  NO
Requested Preoperative X-Rays: ABDOMEN
Intraoperative X-Rays (Y/N): N  NO
Request Medical Media (Y/N): N  NO
Request Clean or Contaminated: C  CLEAN
Select REFERRING PHYSICIAN: <Enter>
General Comments: <Enter>
  No existing text
  Edit? NO// <Enter>
SPD Comments: <Enter>
  No existing text
  Edit? NO// <Enter>
```

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

1    PRINCIPAL PROCEDURE: REPAIR DIAPHRAGMATIC HERNIA
2    OTHER PROCEDURES:   (MULTIPLE)
3    PLANNED PRIN PROCEDURE CODE: 39540
4    PRINCIPAL PRE-OP DIAGNOSIS: ACUTE DIAPHRAGMATIC HERNIA
5    PRIN PRE-OP ICD DIAGNOSIS CODE: 551.3
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    IN/OUT-PATIENT STATUS: INPATIENT
8    PRE-ADMISSION TESTING:
9    CASE SCHEDULE TYPE: STANDBY
10   SURGERY SPECIALTY:  GENERAL(OR WHEN NOT DEFINED BELOW)
11   SURGEON:            SURSURGEON,TWO
12   FIRST ASST:         SURSURGEON,ONE
13   SECOND ASST:
14   ATTEND SURG:        SURSURGEON,TWO
15   REQ POSTOP CARE:    WARD

Enter Screen Server Function:   <Enter>
```

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

1    CASE SCHEDULE ORDER:
2    SURGERY POSITION:        (MULTIPLE)(DATA)
3    REQ ANESTHESIA TECHNIQUE: GENERAL
4    REQ FROZ SECT:            NO
5    REQ PREOP X-RAY:          ABDOMEN
6    INTRAOPERATIVE X-RAYS:    NO
7    REQUEST BLOOD AVAILABILITY: YES
8    CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH
9    REQ BLOOD KIND:          (MULTIPLE)(DATA)
10   REQ PHOTO:                NO
11   REQ CLEAN OR CONTAMINATED: CLEAN
12   REFERRING PHYSICIAN:      (MULTIPLE)
13   GENERAL COMMENTS:         (WORD PROCESSING)
14   INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)
15   BRIEF CLIN HISTORY:        (WORD PROCESSING)(DATA)

Enter Screen Server Function:   <Enter>
```

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

1    SPD COMMENTS: (WORD PROCESSING)
```

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

  Press RETURN to continue:
```

Make a Request for Concurrent Cases
[SRSREQCC]

The *Make a Request for Concurrent Cases* option is used to book concurrent operations. Concurrent cases are two operations performed on the same patient by different surgical specialties simultaneously, or back-to-back in the same room. A request may be made for each case at one time with this option. As usual, whenever a request is entered, the user is asked to provide preoperative information about the case. It is best to enter as much information as possible and update it later if necessary.

Mandatory Prompts

After the patient name has been entered, the user will be prompted to enter some required information about the first case (the mandatory prompts include the date of operation, procedure, surgeon and attending surgeon, principal preoperative diagnosis, and time needed). If a mandatory prompt is not answered, the software will not book the operation and will return the user to the *Request Operations* menu. After answering the prompts for the first case, the user is prompted to answer the same questions about the second case. Then, the software will provide a message that the two requests have been entered and simultaneously prompt the user to select one of the cases for entering detailed information. If the user does not want to enter detailed preoperative information at this time, pressing the **<Enter>** key will send the user to the *Request Operations* menu. In Example 1, detailed information is entered for the first case only.

Storing the Request Information

After most prompts, the software will ask if the user wants to store (meaning duplicate) this information in the concurrent, or other, case. This saves time by storing the information into the other case so that information does not have to be entered again. If the user does not want the prompt response duplicated for the other case, he or she should enter **N** or **NO**.

Finally, the software will display the Screen Server summary and store any duplicated information into the other case. At this point, the software will provide another message that the two requests have been entered and again prompt the user to select either case for entering detailed information. This whole process may be repeated with the other case by selecting the number for it, or pressing the **<Enter>** key to get back to the *Request Operations* menu.

Updating the Preoperative Information Later

Use the *Delete or Update Operation Requests* option to change or update any of the information entered for either or both concurrent cases (Example 2).

Example 1: Make a Request for Concurrent Cases

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


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

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


                           FIRST CONCURRENT CASE
                    OPERATION REQUEST: REQUIRED INFORMATION

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

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


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


Press RETURN to continue <Enter>


                           SECOND CONCURRENT CASE
                    OPERATION REQUEST: REQUIRED INFORMATION

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

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


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

Press RETURN to continue <Enter>


The following requests have been entered.

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

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



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

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

```
                          SECOND CONCURRENT CASE
                    OPERATION REQUEST: PROCEDURE INFORMATION

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

```
                          SECOND CONCURRENT CASE
                    OPERATION REQUEST: BLOOD INFORMATION

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


Request Blood Availability ? N// YES
Type and Crossmatch, Screen, or Autologous ? TYPE & CROSSMATCH//  <Enter> TYPE & CROSSMATCH
Select REQ BLOOD KIND: CPDA-1 WHOLE BLOOD// @
   SURE YOU WANT TO DELETE THE ENTIRE REQ BLOOD KIND? Y  (YES)
Select REQ BLOOD KIND: 04061  CPDA-1 RED BLOOD CELLS, DIVIDED UNIT      04061
  Units Required: 4
```

```
                          SECOND CONCURRENT CASE
                    OPERATION REQUEST: OTHER INFORMATION

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

Prin Pre-OP ICD Diagnosis Code: 996.03  996.03      'C'       MALFUNC CORON BYPASS GRF
COMPLICATION/COMORBIDITY
         ...OK? YES//  <Enter> (YES)
Hospital Admission Status: I//  <Enter> INPATIENT

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

Case Schedule Type: S  STANDBY

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

First Assistant: SURSURGEON,SIX
Second Assistant: <Enter>
Requested Postoperative Care: SICU

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

Case Schedule Order: 2

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

Select SURGERY POSITION: SUPINE// <Enter>
  Surgery Position: SUPINE// <Enter>
Requested Anesthesia Technique: GENERAL

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

Request Frozen Section Tests (Y/N): N  NO
Do you want to store this information in the concurrent case ?  YES// <Enter>
Requested Preoperative X-Rays: DOPPLER STUDIES
```

```
Do you want to store this information in the concurrent case ?  YES//  N
Intraoperative X-Rays (Y/N): N  NO
Do you want to store this information in the concurrent case ?  YES// <Enter>
Request Medical Media (Y/N): N  NO
Do you want to store this information in the concurrent case ?  YES//  <Enter>
Request Clean or Contaminated: C  CLEAN
Do you want to store this information in the concurrent case ?  YES// <Enter>
Select REFERRING PHYSICIAN: <Enter>
General Comments: <Enter>
  No existing text
  Edit? NO// <Enter>
SPD Comments: <Enter>
  No existing text
  Edit? NO// <Enter>

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

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

1    PRINCIPAL PROCEDURE: AORTO CORONARY BYPASS GRAFT
2    OTHER PROCEDURES:   (MULTIPLE)
3    PLANNED PRIN PROCEDURE CODE: 35526-66
4    PRINCIPAL PRE-OP DIAGNOSIS: CORONARY ARTERY DISEASE
5    PRIN PRE-OP ICD DIAGNOSIS CODE: 996.03
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    IN/OUT-PATIENT STATUS: INPATIENT
8    PRE-ADMISSION TESTING:
9    CASE SCHEDULE TYPE: STANDBY
10   SURGERY SPECIALTY:  THORACIC SURGERY (INC. CARDIAC SURG.)
11   SURGEON:            SURSURGEON,TWO
12   FIRST ASST:         SURSURGEON,SIX
13   SECOND ASST:
14   ATTEND SURG:        SURSURGEON,TWO
15   REQ POSTOP CARE:    SICU

Enter Screen Server Function:   <Enter>
```

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

1    CASE SCHEDULE ORDER: 2
2    SURGERY POSITION:   (MULTIPLE)(DATA)
3    REQ ANESTHESIA TECHNIQUE: GENERAL
4    REQ FROZ SECT:      NO
5    REQ PREOP X-RAY:    DOPPLER STUDIES
6    INTRAOPERATIVE X-RAYS: NO
7    REQUEST BLOOD AVAILABILITY: YES
8    CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH
9    REQ BLOOD KIND:     (MULTIPLE)(DATA)
10   REQ PHOTO:          NO
11   REQ CLEAN OR CONTAMINATED: CLEAN
12   REFERRING PHYSICIAN: (MULTIPLE)
13   GENERAL COMMENTS:   (WORD PROCESSING)
14   INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)
15   BRIEF CLIN HISTORY: (WORD PROCESSING)(DATA)

Enter Screen Server Function:  <Enter>
```

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

1    SPD COMMENTS: (WORD PROCESSING)

Enter Screen Server Function:   <Enter>
```

```
The following requests have been entered.

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

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



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

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

Example 2: Update Request Information for a Concurrent Case

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


The following cases are requested for SURPATIENT,TWELVE:

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

Select Operation Request: 2

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

Select Number: 2

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

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

1    PRINCIPAL PROCEDURE: CAROTID ARTERY ENDARTERECTOMY
2    OTHER PROCEDURES:   (MULTIPLE)
3    PLANNED PRIN PROCEDURE CODE: 35301-59
4    PRINCIPAL PRE-OP DIAGNOSIS: CAROTID ARTERY STENOSIS
5    PRIN PRE-OP ICD DIAGNOSIS CODE:
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    IN/OUT-PATIENT STATUS: INPATIENT
8    PRE-ADMISSION TESTING:
9    CASE SCHEDULE TYPE: STANDBY
10   SURGERY SPECIALTY:  PERIPHERAL VASCULAR
11   SURGEON:            SURSURGEON,ONE
12   FIRST ASST:
13   SECOND ASST:
14   ATTEND SURG:        SURSURGEON,TWO
15   REQ POSTOP CARE:    SICU

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

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

1    PRINCIPAL PROCEDURE: CAROTID ARTERY ENDARTERECTOMY
2    OTHER PROCEDURES:   (MULTIPLE)
3    PLANNED PRIN PROCEDURE CODE: 35301-59
4    PRINCIPAL PRE-OP DIAGNOSIS: CAROTID ARTERY STENOSIS
5    PRIN PRE-OP ICD DIAGNOSIS CODE: 433.10
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    IN/OUT-PATIENT STATUS: INPATIENT
8    PRE-ADMISSION TESTING:
9    CASE SCHEDULE TYPE: STANDBY
10   SURGERY SPECIALTY:  PERIPHERAL VASCULAR
11   SURGEON:            SURSURGEON,ONE
12   FIRST ASST:
13   SECOND ASST:
14   ATTEND SURG:        SURSURGEON,TWO
15   REQ POSTOP CARE:    SICU

Enter Screen Server Function:   <Enter>
```

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

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

Enter Screen Server Function:  <Enter>
```

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

1    SPD COMMENTS:            (WORD PROCESSING)

Enter Screen Server Function:
```

Review Request Information
[SROREQV]

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

Example: Review Request Information

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

```
 SURPATIENT,ONE

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

Select Operation:  1
```

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

1    PRINCIPAL PROCEDURE: REVISE MEDIAN NERVE
2    OTHER PROCEDURES:   (MULTIPLE)
3    PLANNED PRIN PROCEDURE CODE: 64721
4    PRINCIPAL PRE-OP DIAGNOSIS: CARPAL TUNNEL SYNDROME
5    PRIN PRE-OP ICD DIAGNOSIS CODE: 354.0
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    IN/OUT-PATIENT STATUS: INPATIENT
8    CASE SCHEDULE TYPE: ELECTIVE
9    SURGERY SPECIALTY:  ORTHOPEDICS
10   SURGEON:            SURSURGEON,ONE
11   FIRST ASST:         SURSURGEON,THREE
12   SECOND ASST:        SURSURGEON,TWO
13   ATTEND SURG:        SURSURGEON,ONE
14   REQ POSTOP CARE:    WARD
15   CASE SCHEDULE ORDER: 2ND

Enter Screen Server Function:  <Enter>
```

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

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

Enter Screen Server Function:
```

Operation Requests for a Day
[SROP REQ]

The *Operation Requests for a Day* option allows the scheduling manager to display or print a list of operation requests. The information from all surgical requests is collected by the software and made available by date. There are no editing capabilities for this feature. The user has a choice of printing a cursory short form or a long form encompassing all the request fields.

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

Example 1: Print Operation Requests for a Day, Short Form

```
Select Request Operations Option: OR  Operation Requests for a Day

Print Requests for which date ? 3/15  (MAR 15, 1999)

Would you like the long or short form ?  SHORT// <Enter>

Do you want the requests for all surgical specialties ?  YES//  N

Print Requests for which Surgical Specialty ?  GENERAL
 (OR WHEN NOT DEFINED BELOW)  GENERAL(OR WHEN NOT DEFINED BELOW)     50

Print the Requests on which Device: HOME// [Select Print Device]
```

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

```
OPERATION REQUESTS FOR GENERAL(OR WHEN NOT DEFINED BELOW)            03/15/99
------------------------------------------------------------------------------

1.  Case Number: 173                  Operation Date: 03/15/99
     Patient:   SURPATIENT,TWENTY          Ward:
     ID#:       000-45-4886             Surgeon: SURSURGEON,ONE
     Procedure: CHOLECYSTECTOMY (URGENT ADD TODAY)
     Estimated Case Length: 2:30
     Requested Anesthesia:  GENERAL

2.  Case Number: 180                  Operation Date: 03/15/99
     Patient:   SURPATIENT,FOURTEEN          Ward: 1 SOUTH
     ID#:       000-45-7212             Surgeon: SURSURGEON,TWO
     Procedure: REPAIR DIAPHRAGMATIC HERNIA (STANDBY)
     Estimated Case Length: 2:00
     Requested Anesthesia:  GENERAL


Press RETURN to continue  <Enter>
```

Example 2: Long Form

```
Select Request Operations Option:  OR Operation Requests for a Day

Print Requests for which date ? 3/15  (MAR 15, 1999)

Would you like the long or short form ?  SHORT// L

Do you want the requests for all surgical specialties ?  YES//  N

Print Requests for which Surgical Specialty ?  GENERAL
 (OR WHEN NOT DEFINED BELOW)  GENERAL(OR WHEN NOT DEFINED BELOW)     50

Print the Requests on which Device: HOME// [Select Print Device]
```

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

```
================================================================================
OPERATION REQUESTS FOR GENERAL(OR WHEN NOT DEFINED BELOW)
ON MAR 15, 1999
--------------------------------------------------------------------------------

Patient: SURPATIENT,TWENTY                  ID #: 000-45-4886
Age: 51                                     Ward: NOT ENTERED

Surgeon: SURSURGEON,ONE                     Attending: SURSURGEON,ONE
Preoperative Diagnosis: CHOLELITHIASIS

Principal Procedure:  CHOLECYSTECTOMY
Other Procedures:     INTRAOPERATIVE CHOLANGIOGRAM
Estimated Case Length: 2:30

Req. Anesthesia Technique: GENERAL
Blood Requested:      CPDA-1 WHOLE BLOOD   UNITS
                      FRESH FROZEN PLASMA, CPDA-1  2 UNITS
Restraints:           SAFETY STRAP
Requested by: SURNURSE,ONE on JAN  7, 1999 13:45


Press <Enter> to continue, or '^' to quit:  <Enter>

================================================================================
OPERATION REQUESTS FOR GENERAL(OR WHEN NOT DEFINED BELOW)
ON MAR 15, 1999
--------------------------------------------------------------------------------

Patient: SURPATIENT,FOURTEEN            ID #: 000-45-7212
Age: 48                                 Ward: 1 SOUTH

Surgeon: SURSURGEON,TWO                     Attending: SURSURGEON,TWO
Preoperative Diagnosis: ACUTE DIAPHRAGMATIC HERNIA

Principal Procedure:  REPAIR DIAPHRAGMATIC HERNIA
Estimated Case Length: 2:00

Req. Anesthesia Technique: GENERAL
Blood Requested:      CPDA-1 WHOLE BLOOD  2 UNITS
Restraints:           SAFETY STRAP
Requested by: SURNURSE,ONE on JAN 13, 1999 14:39


Press RETURN to continue  <Enter>
```

Requests by Ward
[SROWRQ]

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

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

Example: Print Requests by Ward

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

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

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

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

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

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

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

 Comments:

    Concurrent Case Number: 179
    Procedure: AORTO CORONARY BYPASS GRAFT

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

 Comments:

    Concurrent Case Number: 178
    Procedure: CAROTID ARTERY ENDARTERECTOMY

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

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

```
                            Requests for Operations
================================================================================
                                  Ward: OUTPATIENT
================================================================================
 Patient: SURPATIENT,FIFTEEN (000-98-1234)                    Case Number: 172
 Date of Operation:    03/25/99         Case Order:
 Requested Anesthesia:
 Operation(s): HEMMORHOIDECTOMY

 Comments:
--------------------------------------------------------------------------------
 Patient: SURPATIENT,TWENTY (000-45-4886)                     Case Number: 173
 Date of Operation:    03/15/99         Case Order:
 Requested Anesthesia: GENERAL
 Operation(s): CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM

 Comments:
--------------------------------------------------------------------------------
 Patient: SURPATIENT,SIXTEEN (000-11-1111)                    Case Number: 175
 Date of Operation:    03/14/99         Case Order:
 Requested Anesthesia: LOCAL
 Operation(s): REMOVE BUNION

 Comments:
--------------------------------------------------------------------------------
```

List Operation Requests
[SRSRBS]

Users can use the *List Operation Requests* option to produce a list of requested cases, including cases on the Waiting List. This report sorts by ward or surgical specialty.

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

Example 1: List Operation Requests, by Specialty

```
Select Surgery Menu Option:  LR  List Operation Requests

List requests by SPECIALTY or WARD ?  SPECIALTY// <Enter>

Do you want requests for all surgical specialties ? YES// N


List Request for which Specialty ? GENERAL  (OR WHEN NOT DEFINED BELOW)  GENERA
L(OR WHEN NOT DEFINED BELOW)     50

Print to Device: [Select Print Device]
```

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

```
     Operative Requests for GENERAL(OR WHEN NOT DEFINED BELOW)

Date          Patient                       Ward Location
Case Number   Operative Procedure
==========================================================================
APR  4, 1999  SURPATIENT,FOUR               1 SOUTH
180           000-45-7212
              REMOVE MOLE
--------------------------------------------------------------------------
JUN  1, 1999  SURPATIENT,SEVENTEEN          1 SOUTH
178           000-45-5119
              REPAIR DIAPHRAGMATIC HERNIA
--------------------------------------------------------------------------
AUG 15, 1999  SURPATIENT,NINE               1 NORTH
145           000-34-5555
              CHOLECYSTECTOMY
--------------------------------------------------------------------------
Press RETURN to continue
```

Example 2: List Operation Requests, by Ward

```
Select Surgery Menu Option:  LR List Operation Requests

List requests by SPECIALTY or WARD ?  SPECIALTY//  WARD

Do you want requests for all wards ? YES// N


Select Requests for which Ward ?  1 SOUTH
Print the Report on which Device: HOME//  [Select Print Device]
```

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

```
     Operative Requests for 1 SOUTH

Date          Patient                         Surgical Specialty
Case Number   Operative Procedure
================================================================================
APR  4, 1999  SURPATIENT,FOUR                 ORTHOPEDICS
179           000-45-7212
              ARTHROSCOPY, RIGHT KNEE
--------------------------------------------------------------------------------
APR  4, 1999  SURPATIENT,THREE                GENERAL
180           000-21-2453
              REMOVE MOLE
--------------------------------------------------------------------------------
JUN  1, 1999  SURPATIENT,SEVENTEEN            GENERAL
178           000-45-5119
              REPAIR DIAPHRAGMATIC HERNIA
--------------------------------------------------------------------------------
JUN  1, 1999  SURPATIENT,TWELVE               PERIPHERAL VASCULAR
181           000-41-8719
              CAROTID ARTERY ENDARTERECTOMY
--------------------------------------------------------------------------------
JUN  1, 1999  SURPATIENT,NINE                 THORACIC SURGERY
182           000-34-5555
              AORTO CORONARY BYPASS GRAFT
--------------------------------------------------------------------------------
Press RETURN to continue
```

Schedule Operations
[SROSCHOP]

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

 This option is locked with the SROSCH key.

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

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

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

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

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

Display Availability
[SRODISP]

A user can view the availability of operating rooms on a blockout graph before booking an operation with the *Display Availability* option. A user might also use this option to check a booking or service blockout. This feature is the same as the *Display Availability* option available on the *Request Operations* menu option.

Scheduled operations show up on the graph as an equal sign (=) followed by the letter X. The equal sign before the X indicates the beginning of a scheduled operation. Surgical specialty blockouts are indicated by an abbreviation for the service. For more information on service blockouts, a function of the scheduling menu, see the *Create Service Blockout* option.

If the facility has a display terminal that can print condensed characters, a 24-hour graph will display on the screen. If not, the user will be prompted to select one of three graphs representing different chunks of that day.

Example: Display all O.R.s for One Day

```
Select Schedule Operations Option: A  Display Availability

Do you want to view all Operating Rooms on one day ?  YES //  <Enter>

Do you want to list requests also ?  NO//  <Enter>

Display Operating Room Availability for which Date ?  T  (JUL 01, 1999)


Display of Available Operating Room Time

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

Select Number: 2//  <Enter>

ROOM   6AM   7    8    9    10   11   12   13   14   15   16   17   18   19   20
OR1     |____|uro.|uro.|uro.|uro.|uro.|uro.|uro.|uro.|____|____|____|____|____|
OR2     |____|card|card|card|card|card|card|card|card|card|____|____|____|____|
OR3     |____|thor|thor|thor|thor|thor|thor|thor|thor|____|____|____|____|____|
OR4     |____|gen.|gen.|gen.|gen.|gen.|gen.|gen.|gen.|____|____|____|____|____|
OR5     |____|=XXX|XXXX|=XXX|XXXX|____|____|____|____|____|____|____|____|____|

Press RETURN to continue
```

Schedule Requested Operation
[SRSCHD1]

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

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

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

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

Scheduling a Concurrent Case

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

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

Example 1: Schedule a Requested Operation

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

Select Patient: SURPATIENT,SIX         04-04-30     000098797

The following case is requested for SURPATIENT,SIX:

1. 04-24-99   CHOLECYSTECTOMY


Case Information:
CHOLECYSTECTOMY
By SURSURGEON,TWO                          On SURPATIENT,SIX
Case # 210                                For 1:00 Hours


Comments:

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

```
Display of Available Operating Room Time

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

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

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

Schedule a Case for which Operating Room ?  OR1

Reserve from what time ? (24HR:NEAREST 15 MIN):  7:00

Reserve to what time ? (24HR:NEAREST 15 MIN):  8:00


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

Select Patient:
```

Example 2: Schedule Operation for a Concurrent Case

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

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

The following cases are requested for SURPATIENT,EIGHTEEN:

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

Select Operation Request: 1

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

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

```
Display of Available Operating Room Time

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

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

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

Schedule a Case for which Operating Room ?  OR2

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

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


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

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


Select Patient:
```

Schedule Unrequested Operations
[SROSRES]

Users can use the *Schedule Unrequested Operations* option to schedule an operation that has not been requested. To schedule an operation, the user must determine the date, time, and operating room. The information entered in this option is reflected in the Schedule of Operations Report.

Whenever a new case is booked, the user is asked to provide preoperative information about the case. Enter as much information as possible. Later, the information can be updated or corrected.

Prompts that require a response before the user can continue with this option are listed below.

"Schedule Procedure for which Date ?"
"Select Patient:"
"Schedule a case for which operating Room ?"
"Reserve from what time ? (24HR:NEAREST 15 MIN):"
"Reserve to what time ? (24HR:NEAREST 15 MIN):"
“Desired Procedure Date:”
"Surgeon:"
"Attending Surgeon:"
"Surgical Specialty:"
"Principal Operative Procedure:"
"Principal Preoperative Diagnosis:"

Entering Preoperative Information

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

Example: Schedule an Unrequested Operation

```
Select Schedule Operations Option: SU  Schedule Unrequested Operations

Schedule a Procedure for which Date ?  7 18 05  (JUL 18, 2005)

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

Display of Available Operating Room Time

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

Select Number: 2//  <Enter>

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

Schedule a case for which operating Room ?  OR1

Reserve from what time ? (24HR:NEAREST 15 MIN):  8:00

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

              SCHEDULE UNREQUESTED OPERATION: REQUIRED INFORMATION

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

Desired Procedure Date: 7 18 05  (JUL 18, 2005)
Surgeon: SURSURGEON,ONE
Attending Surgeon: SURSURGEON,TWO
Surgical Specialty: 54          ORTHOPEDICS  ORTHOPEDICS        54
Principal Operative Procedure: SHOULDER ARTHROPLASTY-PROSTHESIS
Principal Preoperative Diagnosis: DEGENERATIVE JOINT DISEASE, L SHOULDER


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


Press RETURN to continue  <Enter>

              SCHEDULE UNREQUESTED OPERATION: ANESTHESIA PERSONNEL

SURPATIENT,THREE (000-21-2453)                                  JUL 18, 2005
================================================================================
Principal Anesthetist: SURANESTHETIST,ONE
Anesthesiologist Supervisor: SURANESTHETIST,TWO

              SCHEDULE UNREQUESTED OPERATION: PROCEDURE INFORMATION

SURPATIENT,THREE (000-21-2453)                                  JUL 18, 2005
================================================================================
Principal Procedure:      SHOULDER ARTHROPLASTY-PROSTHESIS
Planned Principal Procedure Code (CPT): 23470  ARTHROPLASTY, GLENOHUMERAL JOINT; HEMIART
Brief Clinical History:
  1>CHRONIC DEBILITATING PAIN. X-RAY SHOWS SEVERE
  2>DEGENERATIVE OSTEOARTHRITIS.
  3><Enter>
EDIT Option: <Enter>
```

```
                    SCHEDULE UNREQUESTED OPERATION: BLOOD INFORMATION

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


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

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

```
                    SCHEDULE UNREQUESTED OPERATION: OTHER INFORMATION

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

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

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

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

Enter Screen Server Function:  <Enter>
```

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

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

Enter Screen Server Function:
```

Schedule Unrequested Concurrent Cases
[SRSCHDC]

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

Required Prompts

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

Storing the Request Information

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

Updating the Preoperative Information Later

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

Example: Schedule Unrequested Concurrent Cases

```
Select Schedule Operations Option: CON  Schedule Unrequested Concurrent Cases

Schedule Concurrent Cases for which Patient ?  SURPATIENT,EIGHT        06-04-35
  000370555

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


Display of Available Operating Room Time

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

Select Number: 2//  4

Schedule a case for which operating Room ?  OR2

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

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

```
                            FIRST CONCURRENT CASE
              SCHEDULE UNREQUESTED OPERATION: REQUIRED INFORMATION

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

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

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


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


Press RETURN to continue  <Enter>
```

```
                            SECOND CONCURRENT CASE
              SCHEDULE UNREQUESTED OPERATION: REQUIRED INFORMATION

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

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


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


Press RETURN to continue  <Enter>
```

```
 The following cases have been entered.

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

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

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

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

```
                            FIRST CONCURRENT CASE
              SCHEDULE UNREQUESTED OPERATION: ANESTHESIA PERSONNEL

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

```
                            FIRST CONCURRENT CASE
              SCHEDULE UNREQUESTED OPERATION: PROCEDURE INFORMATION

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

```
                            FIRST CONCURRENT CASE
                     SCHEDULE UNREQUESTED OPERATION: BLOOD INFORMATION

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


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

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

```
                          FIRST CONCURRENT CASE
                  SCHEDULE UNREQUESTED OPERATION: OTHER INFORMATION

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

Prin Pre-OP ICD Diagnosis Code: 433.11     OCCL&STEN/CAR ART W/CRB INF
 COMPLICATION/COMORBIDITY     ACTIVE
Hospital Admission Status: I// <Enter> INPATIENT

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

Case Schedule Type: S  STANDBY

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

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

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

Case Schedule Order: 2

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

Requested Anesthesia Technique: G  GENERAL

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

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

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

Requested Preoperative X-Rays: DOPPLER STUDIES

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

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

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

Request Medical Media (Y/N): N  NO

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

Request Clean or Contaminated: C  CLEAN

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

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

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


Press RETURN to continue  <Enter>
```

```
  ** SCHEDULING **   CASE #265  SURPATIENT,EIGHT      PAGE 1 OF 3

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

Enter Screen Server Function:  <Enter>
```

```
  ** SCHEDULING **   CASE #265  SURPATIENT,EIGHT      PAGE 2 OF 3

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

Enter Screen Server Function:  <Enter>
```

```
  ** SCHEDULING **   CASE #265  SURPATIENT,EIGHT      PAGE 3 OF 3

1    SPD COMMENTS:            (WORD PROCESSING)

Enter Screen Server Function:
```

Reschedule or Update a Scheduled Operation
[SRSCHUP]

The *Reschedule or Update a Scheduled Operation* option has three uses: 1) to add a concurrent case, 2) to reschedule an operation for another date, time, and/or operating room, 3) to update the preoperative information that was entered earlier.

Adding a Concurrent Case (See Example 1)

After the case is selected, the software will ask whether the user wishes to add a concurrent case. If the response is **YES**, the software will prompt for information on the second case. To add the case, the user must enter a surgeon and attending surgeon, a surgical specialty, the principal operative procedure, and a principal preoperative diagnosis. The software will then inform the user that the case has been added. The user can then select another case or the same case for entering detailed preoperative information, or the user can press the **<Enter>** key to return to the *Schedule Operations* menu.

Changing the Date, Time, or Operating Room (See Example 2)

If a user does not wish to add a concurrent case, the software will prompt to change the date, time or operating room. If the user enters **YES**, the software will erase the old date, time, and operating room and prompt to re-enter this information. The user will be prompted to select a new date, but if the **<Enter>** key is pressed, the software will default to the original date and allow the user to change the room and time. The software supplies a blockout graph to help with rescheduling.

If the user attempts to reschedule a case after the schedule close time for the date of operation, only the time, and not the date, can be changed.

Updating the Preoperative Info (See Example 3)

To update the preoperative information that was entered earlier, the user should respond **NO** to the prompt asking if the user wishes to change the date, time or operating room. The terminal display screen will clear and present a two-page Screen Server summary. Any of the data fields may be changed, as in Example 2.

Example 3 also shows the user how to order more than one blood product for a case.

Example 1: How to Add a Concurrent Case to a Scheduled Operation

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

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

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

Select Number: 1

Do you want to add a concurrent case ?  NO// Y
```

```
                            SECOND CONCURRENT CASE
              SCHEDULE UNREQUESTED OPERATION: REQUIRED INFORMATION

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

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


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


Press RETURN to continue   <Enter>
```

```
                            SECOND CONCURRENT CASE
              SCHEDULE UNREQUESTED OPERATION: ANESTHESIA PERSONNEL

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

```
                            SECOND CONCURRENT CASE
              SCHEDULE UNREQUESTED OPERATION: PROCEDURE INFORMATION

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

```
                            SECOND CONCURRENT CASE
                     SCHEDULE UNREQUESTED OPERATION: BLOOD INFORMATION

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

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

```
                            SECOND CONCURRENT CASE
                    SCHEDULE UNREQUESTED OPERATION: OTHER INFORMATION

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

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

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

Case Schedule Type:  S  STANDBY

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

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

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

Case Schedule Order: 1

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

Requested Anesthesia Technique: GENERAL

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

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

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

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

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

Request Medical Media (Y/N): N  NO

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

Request Clean or Contaminated: C  CLEAN

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

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

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

```
  ** SCHEDULING **   CASE #245  SURPATIENT,SIX         PAGE 1 OF 3

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

Enter Screen Server Function:  <Enter>
```

```
  ** SCHEDULING **   CASE #245  SURPATIENT,SIX         PAGE 2 OF 3

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

Enter Screen Server Function:   <Enter>
```

```
  ** SCHEDULING **   CASE #245  SURPATIENT,SIX         PAGE 3 OF 3

1    SPD COMMENTS:            (WORD PROCESSING)

Enter Screen Server Function:   <Enter>
```

```
The following cases have been entered.

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

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



1. Enter Information for Case #224
2. Enter Information for Case #245

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

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

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

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

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


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

Select Number: 1

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

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

```
Operating Room Reservations:

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

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


Reschedule this Procedure for which Date ?  <Enter>

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

Press RETURN to continue  <Enter>
```

```
Display of Available Operating Room Time

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

Select Number: 2//  4

Schedule this case for which Operating Room: OR3

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

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


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

Example 3: How to Update a Scheduled Operation

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

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

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


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

Select Number: 1

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

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

```
 ** SCHEDULING **   CASE #218  SURPATIENT,THREE          PAGE 1 OF 3

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

Enter Screen Server Function: <Enter>
```

```
  ** SCHEDULING **   CASE #218  SURPATIENT,THREE          PAGE 2 OF 3

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

Enter Screen Server Function:  8
```

```
  ** SCHEDULING **   CASE #218  SURPATIENT,THREE          PAGE 1 OF 1
        REQ BLOOD KIND

1    REQ BLOOD KIND:        FRESH FROZEN PLASMA, CPDA-1
2    NEW ENTRY

Enter Screen Server Function:  2
Select REQ BLOOD KIND: CPDA-1 WHOLE BLOOD        00160
    REQ BLOOD KIND: CPDA-1 WHOLE BLOOD// <Enter>
```

```
 ** SCHEDULING **   CASE #218  SURPATIENT,THREE          PAGE 1 OF 1
        REQ BLOOD KIND  (CPDA-1 WHOLE BLOOD)

1    REQ BLOOD KIND:        CPDA-1 WHOLE BLOOD
2    UNITS REQ:

Enter Screen Server Function:  2
Units Required: 2
```

```
 ** SCHEDULING **   CASE #218  SURPATIENT,THREE          PAGE 1 OF 1
        REQ BLOOD KIND  (CPDA-1 WHOLE BLOOD)

1    REQ BLOOD KIND:        CPDA-1 WHOLE BLOOD
2    UNITS REQ:             2

Enter Screen Server Function:  <Enter>
```

```
  ** SCHEDULING **   CASE #218  SURPATIENT,THREE          PAGE 1 OF 1
        REQ BLOOD KIND

1    REQ BLOOD KIND:        FRESH FROZEN PLASMA, CPDA-1
2    REQ BLOOD KIND:        CPDA-1 WHOLE BLOOD
3    NEW ENTRY

Enter Screen Server Function:  <Enter>
```

```
  ** SCHEDULING **   CASE #218  SURPATIENT,THREE          PAGE 2 OF 3

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

Enter Screen Server Function:  <Enter>
```

```
  ** SCHEDULING **   CASE #218  SURPATIENT,THREE          PAGE 3 OF 3

1    SPD COMMENTS:            (WORD PROCESSING)

Enter Screen Server Function:
```

Cancel Scheduled Operation
[SRSCAN]

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

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

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

Example 1: Cancel a Single Scheduled Operation

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

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


SURPATIENT,NINETEEN (000-28-7354)

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

Select Number: 1

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

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

Cancellation Reason: CHANGE IN TREATMENT, PT HEALTH       2
Cancellation Avoidable: YES// N  NO

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

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

Creating the new request...
```

Example 2: Cancel a Scheduled Concurrent Case

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

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


SURPATIENT,SIX (000-09-8797)


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

Select Number: 1
```

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

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

Cancellation Reason: NO BED AVAILABLE       6
Cancellation Avoidable: YES// N  NO

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

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

Creating the new request...

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

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

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

Creating the new request...
```

Update Cancellation Reason
[SRSUPC]

The *Update Cancellation Reason* option is used to update the cancellation date and reason previously entered for a selected surgical case.

Example: Update Cancellation Reason

```
Select Schedule Operations Option:  UC Update Cancellation Reason

Update Cancellation Information for which Patient: SURPATIENT,NINETEEN         01-01-40
000287354     NSC VETERAN

1. 06-01-98   FRONTAL CRANIOTOMY TO RULE OUT TUMOR (CANCELLED)


Select Operation:  1

SURPATIENT,NINETEEN              000-28-7354       Case # 21199

06-01-98      FRONTAL CRANIOTOMY TO RULE OUT TUMOR (CANCELLED)


Cancellation Date: JUN 01,1998@10:53// <Enter>

Cancellation Reason: LAB TEST// EM  EMERGENCY CASE SUPERSEDES     EM
Cancellation Avoidable: NO// <Enter>

Press RETURN to continue  <Enter>
```

Schedule Anesthesia Personnel
[SRSCHDA]

The *Schedule Anesthesia Personnel* option allows anesthesia staff to assign, or change, anesthesia personnel for surgery cases. The scheduling manager may have already assigned some personnel to a case using other menu selections. For the user's convenience, the software will default to any previously entered data.

This option is locked with the SROANES key and will not appear on the menu if the user does not have this key.

This option is used to enter the names of the principal anesthetist, the supervisor, and anesthesia techniques for cases scheduled on a specific date. The user should first enter the date, and then select an operating room. The software will display all cases scheduled in that room. After scheduling personnel for any or all cases in one operating room, the user can do the same for other operating rooms without leaving this option.

This option also appears on the *Anesthesia* menu.

Example: Schedule Anesthesia Personnel

```
Select Schedule Operations Option: AN  Schedule Anesthesia Personnel

Schedule Anesthesia Personnel for which Date ?  8/16  (AUG 16, 1999)

Schedule Anesthesia Personnel for which Operating Room ?  OR2
```

```
Scheduled Operations for OR2
------------------------------------------------------------------------
Case # 5   Patient: SURPATIENT,TWENTY
From: 07:00  To: 09:00
HARVEST SAPHENOUS VEIN

Requested Anesthesia Technique: GENERAL//  <Enter>
Principal Anesthetist: SURANESTHETIST,ONE          OS      112G
Anesthesiologist Supervisor: SURANESTHETIST,TWO          TS

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

```
Scheduled Operations for OR2
------------------------------------------------------------------------
Case # 14   Patient: SURPATIENT,THREE
From: 13:00  To: 18:00
SHOULDER ARTHROPLASTY

Requested Anesthesia Technique: GENERAL//  <Enter>
Principal Anesthetist: SURANESTHETIST,ONE//     <Enter>      OS      112G
Anesthesiologist Supervisor: SURANESTHETIST,TWO       TS

Press RETURN to continue, or '^' to quit   <Enter>

Would you like to continue with another operating room ?  YES//  <Enter>

Schedule Anesthesia Personnel for which Operating Room ?  OR1

There are no cases scheduled for this operating room.

Press RETURN to continue   <Enter>

Would you like to continue with another operating room ?  YES// N
```

Create Service Blockout
[SRSBOUT]

At times, the surgical staff may need to set aside an operating room for a particular service on a recurring basis. The *Create Service Blockout* option is used by the scheduling manager to blockout the operating room(s) on a graph.

The resulting service blockout is automatically charted on a graph that can be viewed from the *Display Availability* option. This service blockout does not restrict the operating room to the service, but can assist the scheduling manager when assigning operating rooms.

The scheduling manager can create the service blockouts by following the example provided on the following page. The required data fields are listed in the following table.

At this prompt:	The user should do this:
For what service?	Enter a three or four letter abbreviation for the surgical service the room is being reserved (for example, card for cardiology, gen for general surgery). Do not use the letter X or an equal sign (=).
Select Operating Room	Enter the operating room name or code. The operating room must already exist in the HOSPITAL LOCATION file and the OPERATING ROOM file. The user should enter a question mark to get a list of operating rooms already included in these files. The supervisor or package coordinator can add an operating room to these files.
Select Starting Date	The user should enter the date for the blockout to begin.
Reserve from what time?	Enter the times for which this room will be blocked-out for a particular service. A room may be reserved at any time during the 24-hour cycle to the nearest 15 minutes.
Reserve to what time?	Enter the end time for the service blockout.

Example: Create a Service Blockout

```
Select Schedule Operations Option: B  Create Service Blockout

For what service ? (3-4 characters, do not use 'X' or '=')  CARD
Select Operating Room: OR2

Select Starting Date: T   (NOV 18, 1999)

Reserve from what time ? (24HR:NEAREST 15 MIN):  7  (07:00)

Reserve to what time ? (24HR:NEAREST 15 MIN):  12  (12:00)

1. Every week, same time
2. Every other week
3. Every month, same day of week & week of month

Select Number:  1

Updating Schedules...
```

After the service blockout has been created, it will appear on the operating room availability graph display, as shown below.

```
ROOM   6AM   7    8    9    10   11   12   13   14   15   16   17   18   19   20
OR1     |____|uro.|uro.|uro.|uro.|uro.|uro.|uro.|uro.|____|____|____|____|____|
OR2     |____|card|card|card|card|card|card|card|card|card|____|____|____|____|
OR3     |____|thor|thor|thor|thor|thor|thor|thor|thor|____|____|____|____|____|
OR4     |____|gen.|gen.|gen.|gen.|gen.|gen.|gen.|gen.|____|____|____|____|____|
OR5     |____|=XXX|XXXX|=XXX|XXXX|____|____|____|____|____|____|____|____|____|
```

Delete Service Blockout
[SRSBDEL]

The following example shows how to remove a service blockout from the blockout graph. A service blockout can be deleted for just one date or for all the reserved dates.

After starting this option, if the user decides not to delete a service blockout, he or she can enter an up-arrow (^) to exit.

Example: Delete Service Blockout

```
Select Schedule Operations Option: DB  Delete Service Blockout

Select service you wish to delete. (3-4 characters)  CARD


The service 'card' has the following time(s) scheduled:
  1. OR1 on Tuesday from 07.00 to 12.00


Which number would you like to delete ? 1

Delete the Blockout starting with which date ?  3/29  (MAR 29, 1999)

Do you want to delete the blockout for this service on this
date only ?  NO//  <Enter>

Updating Schedules...



Press RETURN to continue
```

Schedule of Operations
[SROSCH]

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

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

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

Example: Print Schedule of Operations

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

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

Do you want to print the schedule at all locations ?  NO// <Enter>

This report is designed to use a 132 column format.

DEVICE: [Select Print Device]
```

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

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

TOTAL CASES SCHEDULED: 5

(This page included for two-sided copying.)

List Scheduled Operations
[SRSCD]

The *List Scheduled Operations* option provides a short form listing of scheduled cases for a given date. It will sort by surgical specialty, operating room, or ward location.

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

Example: List Scheduled Operations

```
Select Surgery Menu Option:  LS  List Scheduled Operations
```

```
List of Scheduled Operations:

List Scheduled Operations for which date ?  3/12  (MAR 12, 1999)

Do you want to sort by OPERATING ROOM, SPECIALTY or WARD LOCATION ? SPE

Do you want a list of scheduled operations for a specific specialty ?  YES//  N

Print to Device:  [Select Print Device]
```

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

```
                    * Scheduled Operations for GENERAL *
                              MAR 12, 1999

Start Time   Patient                      Operating Room          Ward Location
             ID #
================================================================================
08:00        SURPATIENT,TWENTY                    OR2                  OUTPATIENT
             000-45-4886
             CHOLECYSTECTOMY
--------------------------------------------------------------------------------

Press RETURN to continue   <Enter>
```

```
                    * Scheduled Operations for ORTHOPEDICS *
                              MAR 12, 1999

Start Time   Patient                      Operating Room          Ward Location
             ID #
================================================================================
07:15        SURPATIENT,THREE                      OR4                  1 WEST
             000-21-2453
             SHOULDER ARTHROPLASTY-PROTHESIS
--------------------------------------------------------------------------------

Press RETURN to continue   <Enter>
```

```
                  * Scheduled Operations for PERIPHERAL VASCULAR *
                            MAR 12, 1999

Start Time   Patient                      Operating Room          Ward Location
             ID #
================================================================================
11:15        SURPATIENT,EIGHT                  OR2                  1 NORTH
             000-37-0555
             CAROTID ARTERY ENDARTERECTOMY
--------------------------------------------------------------------------------

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

```
                  * Scheduled Operations for THORACIC SURGERY  *
                            MAR 12, 1999

Start Time   Patient                     Operating Room          Ward Location
             ID #
================================================================================
11:15        SURPATIENT,EIGHT                  OR2                   1 NORTH
             000-37-0555
             AORTO CORONARY BYPASS GRAFT
--------------------------------------------------------------------------------

Press RETURN to continue
```

Chapter Two: Tracking Clinical Procedures

Introduction

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

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

Key Vocabulary

The following terms are used in this chapter.

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

Exiting an Option or the System

The user should enter an up-arrow (^) to stop what he or she is currently doing. The user can use the up-arrow at almost any prompt to terminate the line of questioning and return to the previous level in the routine. Continue entering up-arrows to completely exit the system.

Option Overview

The main options included in this chapter are listed in the following table. The *Operation Menu* option, *Anesthesia Menu* option, and the *Non-O.R.. Procedures* menu contain submenus. To the left of the option name is the shortcut synonym the user can enter to select the option.

Shortcut	Option Name
O	*Operation Menu*
A	*Anesthesia Menu*
PO	*Perioperative Occurrences Menu*
NON	*Non-O.R. Procedures*
C	*Comments*

Operation Menu
[SROPER]

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


This option is locked with the SROPER key.

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

Shortcut	Option Name
I	*Operation Information*
SS	*Surgical Staff*
OS	*Operation Startup*
O	*Operation*
PO	*Post Operation*
PAC	*Enter PAC(U) Information*
OSS	*Operation (Short Screen)*
V	*Surgeon's Verification of Diagnosis & Procedures*
A	*Anesthesia Menu*
OR	*Operation Report*
AR	*Anesthesia Report*
NR	*Nurse Intraoperative Report*
TR	*Tissue Examination Report*
R	*Enter Referring Physician Information*
RP	*Enter Irrigations and Restraints*
M	*Medications (Enter/Edit)*
B	*Blood Product Verification*

Using the Operation Menu Options

This section provides information on the following:

- accessing the *Operation Menu* option
- entering information
- reviewing information
- deleting a surgery case
- entering a new surgical case

Accessing the Operation Menu

To use one of the *Operation Menu* options, the user must first identify the patient and case on which he or she is currently working. When the *Operation Menu* option is selected, the user will be prompted to enter a patient name. The software will then list all the cases on record for the patient, including scheduled or requested cases and any operations that have been started or completed. Each case will have one of the following designations.

Designation	Definition
REQUESTED	The procedure is booked for a particular day but the time of surgery and the operating room are not yet confirmed.
SCHEDULED	The procedure is booked for both an operating room and a day, and the starting time of the surgery is scheduled.
NOT COMPLETE	The start time of the operation is recorded and the patient is still in the operating room.
COMPLETE	The operation is completed and the patient has left the operating room.
ABORTED	The patient entered the operating room, but the operation had to be cancelled.

Following is an example of how the software lists existing cases on record for a patient.

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

```
SURPATIENT,SIX 000-09-8797

1. 01-25-92   ARTHROSCOPY, RIGHT SHOULDER (SCHEDULED)

2. 01-05-92   CORONARY BYPASS (REQUESTED)

3. ENTER NEW SURGICAL CASE


Select Operation: <Enter>
```

The user can select from the case(s) listed or, as in an emergency situation, enter a new surgical case. When the existing case is selected, the software will ask whether the user wants to:

1) enter information for the case,
2) review the information already entered, or
3) delete the case.

```
SURPATIENT,SIX 000-09-8797

01-25-92       ARTHROSCOPY, RIGHT SHOULDER (SCHEDULED)

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

Select Number:  1//
```

Entering Information

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

Example: Enter Information

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

 SURPATIENT,THREE   000-21-2453

1. 03-12-92   SHOULDER ARTHROPLASTY-PROSTHESIS (SCHEDULED)

2. 08-15-88   SHOULDER ARTHROPLASTY (NOT COMPLETE)

3. ENTER NEW SURGICAL CASE


Select Operation: 2

 SURPATIENT,THREE  000-21-2453

 08-15-88     SHOULDER ARTHROPLASTY (NOT COMPLETE)


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

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

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

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


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

Select Operation Menu Option:
```

Now the user can select any of the *Operation Menu* options.

Reviewing Information

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

Example: Review Information

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

```
 SURPATIENT,THREE   000-21-2453

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

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

3. ENTER NEW SURGICAL CASE

Select Operation: 2
```

```
SURPATIENT,THREE  000-21-2453

 08-15-88     SHOULDER ARTHROPLASTY (NOT COMPLETE)


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

Select Number:  1//  2
```

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

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

Enter Screen Server Function:  <Enter>
```

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

1    SPONGE COUNT CORRECT (Y/N): YES
2    SHARPS COUNT CORRECT (Y/N): YES
3    INSTRUMENT COUNT CORRECT (Y/N):
4    SPONGE, SHARPS, & INST COUNTER: YES
5    COUNT VERIFIER:
6    SEQUENTIAL COMPRESSION DEVICE:
7    LASER UNIT:              (MULTIPLE)
8    CELL SAVER:              (MULTIPLE)
9    NURSING CARE COMMENTS:   (WORD PROCESSING) (DATA)
10   PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE L SHOULDER
11   PRIN PRE-OP ICD DIAGNOSIS CODE:
```

```
12   PRINCIPAL PROCEDURE:   SHOULDER ARTHROPLASTY
13   PLANNED PRIN PROCEDURE CODE :
14   OTHER PROCEDURES:        (MULTIPLE)
15   INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)

Enter Screen Server Function:  <Enter>
```

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

1    BRIEF CLIN HISTORY:      (WORD PROCESSING)

Enter Screen Server Function:
```

Deleting a Surgery Case

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

Example: How to Delete A Case

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

```
SURPATIENT,NINE   000-34-5555

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

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

3. ENTER NEW SURGICAL CASE

Select Operation: 2
```

```
 SURPATIENT,NINE  000-34-5555

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

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

Select Number:  1//  3

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

Entering a New Surgical Case

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

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

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

Prompts that require a response include:

"Select the Date of Operation:"
“Desired Procedure Date:”
"Enter the Principal Operative Procedure:"
"Principal Preoperative Diagnosis:"
"Select Surgeon:"
"Attending Surgeon:"
"Select Surgical Specialty:"

Example: Entering a New Surgical Case

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

 SURPATIENT,SIX   000-09-8797

1. ENTER NEW SURGICAL CASE

Select Operation: 1

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

Enter the Principal Operative Procedure: APPENDECTOMY
Principal Preoperative Diagnosis: APPENDICITIS

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

Press Return to continue <Enter>

Select Surgeon: SURSURGEON,ONE
Attending Surgeon: SURSURGEON,TWO
Select Surgical Specialty: 50          GENERAL(OR WHEN NOT DEFINED BELOW)

Brief Clinical History:
  1>PATIENT WITH 5-DAY HISTORY OF INCREASING ABDOMINAL
  2>PAIN, ONSET OF FEVER IN LAST 24 HOURS. REBOUND
  3>TENDERNESS IN RIGHT LOWER QUAD. NAUSEA AND
  4>VOMITING FOR 3 DAYS.
  5><Enter>
EDIT Option: <Enter>
Request Blood Availability (Y/N): N// YES

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

Select REQ BLOOD KIND: CPDA-1 RED BLOOD CELLS// <Enter>
```

```
Required Blood Product: CPDA-1 RED BLOOD CELLS// <Enter>
Units Required: 2
```

(This page included for two-sided copying.)

```
Principal Preoperative Diagnosis: APPENDICITIS// <Enter>
Prin Pre-OP ICD Diagnosis Code: 540.9  540.9     ACUTE APPENDICITIS NOS     COM
PLICATION/COMORBIDITY     ACTIVE
         ......OK? YES// <Enter>  (YES)

Hospital Admission Status: I//  <Enter> INPATIENT
Case Schedule Type: EM  EMERGENCY
First Assistant: SURSURGEON,ONE
Second Assistant: SURSURGEON,FOUR
Requested Postoperative Care: W  WARD
Case Schedule Order: <Enter>
Select SURGERY POSITION: SUPINE// <Enter>
  Surgery Position: SUPINE// <Enter>
Requested Anesthesia Technique: G  GENERAL
Request Frozen Section Tests (Y/N): N  NO
Requested Preoperative X-Rays: <Enter>
Intraoperative X-Rays (Y/N): N  NO
Request Medical Media: N  NO
Request Clean or Contaminated: C  CLEAN
Select REFERRING PHYSICIAN: <Enter>
General Comments:
  1> <Enter>
SPD Comments:
  No existing text
  Edit? NO// <Enter>
```

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

1    PRINCIPAL PROCEDURE: APPENDECTOMY
2    OTHER PROCEDURES:   (MULTIPLE)
3    PLANNED PRIN PROCEDURE CODE:
4    PRINCIPAL PRE-OP DIAGNOSIS: APPENDICITIS
5    PRIN PRE-OP ICD DIAGNOSIS CODE: 540.9
6    OTHER PREOP DIAGNOSIS: (MULTIPLE)
7    IN/OUT-PATIENT STATUS: INPATIENT
8    PRE-ADMISSION TESTING:
9    CASE SCHEDULE TYPE: EMERGENCY
10   SURGERY SPECIALTY:  GENERAL(OR WHEN NOT DEFINED BELOW)
11   SURGEON:            SURSURGEON,ONE
12   FIRST ASST:         SURSURGEON,ONE
13   SECOND ASST:        SURSURGEON,FOUR
14   ATTEND SURG:        SURSURGEON,TWO
15   REQ POSTOP CARE:    WARD

Enter Screen Server Function:  <Enter>
```

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

1    CASE SCHEDULE ORDER:
2    SURGERY POSITION:   (MULTIPLE)(DATA)
3    REQ ANESTHESIA TECHNIQUE: GENERAL
4    REQ FROZ SECT:      NO
5    REQ PREOP X-RAY:
6    INTRAOPERATIVE X-RAYS: NO
7    REQUEST BLOOD AVAILABILITY: YES
8    CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CROSSMATCH
9    REQ BLOOD KIND:     (MULTIPLE)(DATA)
10   REQ PHOTO:          NO
11   REQ CLEAN OR CONTAMINATED: CLEAN
12   REFERRING PHYSICIAN: (MULTIPLE)
13   GENERAL COMMENTS:   (WORD PROCESSING)
14   INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)
15   BRIEF CLIN HISTORY: (WORD PROCESSING)(DATA)

Enter Screen Server Function:   <Enter>
```

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

1    SPD COMMENTS
Enter Screen Server Function:
```

Operation Information
[SROMEN-OPINFO]

Surgeons and other members of the surgical staff use the *Operation Information* option for a quick reference on a case. It produces a report that touches on the more important areas of interest recorded for the case. The report can be viewed on screen but cannot be edited from this option.

An asterisk indicates the principal diagnosis for the case, since some cases have more than one diagnosis. Notice that the INTRAOP OCCURRENCES field and the POSTOP OCCURRENCES field indicate if there are occurrences; however, the occurrences will not be defined, as access to this information is restricted.

Example: Operation Information

```
Select Operation Menu Option:  I  Operation Information

--------------------------------------------------------------------------------
  Patient: SURPATIENT,SIX (000-09-8797)         Operation Date: MAR  9, 1999
  Surgeon: SURSURGEON,SIXTEEN                   Major/Minor:
  Attending Surgeon: SURSURGEON,FOUR            Operation Time: 45 Minutes
  Attending Code: LEVEL D: ATTENDING IN O.R. SUITE, IMMEDIATELY AVAILABLE
--------------------------------------------------------------------------------
  Operation(s):
  APPENDECTOMY
--------------------------------------------------------------------------------
  Postop Diagnosis:                           Intraop Occurrences: YES
  * APPENDICITIS                              Postop Occurrences:  YES
--------------------------------------------------------------------------------
  Anesthesia Technique:                       Anesthetist: SURANESTHETIST,THREE
    INHALATION
      ENFLURANE 125ML
--------------------------------------------------------------------------------
  Wound Classification:
  Intraoperative Blood Loss: 100 CC'S
--------------------------------------------------------------------------------


Press RETURN to continue
```

Surgical Staff
[SROMEN-STAFF]

The *Surgical Staff* option allows the operating room nurse or scheduling manager to enter or edit the names of the surgical team prior to the operation. Some data fields may be automatically filled in based on previous responses. The names entered will be reflected in the Nurse Intraoperative Report and other staffing reports.

At the "Enter Screen Server Function:" prompt, the user may choose the field(s) to be edited or press the **<Enter>** key to continue. Some of the data fields are "multiple" and may contain more than one value. When a field labeled "multiple" is selected, a new screen is generated so that the user can enter data related to that multiple. For example, the CIRC SUPPORT, SCRUB SUPPORT, and SCRUBBED ASSISTANT fields generate new screens that allow the user to add the TIME ON, TIME OFF, REASON FOR RELIEF, and STATUS. The TIME ON and TIME OFF fields also generate additional screens so that the user may enter more than one TIME ON/OFF for the same operation as some assistants must enter and exit more than once.

If entering times on a day other than the day of surgery, enter both the date and the time. Entering only a time will default the date to the current date.

Field Information

The following are fields that correspond to the Surgical Staff entries.

Field Name	Definition
ATTENDING CODE	This field corresponds to the highest level of supervision provided by the attending staff surgeon during the procedure. Enter a question mark **(?)** to retrieve the list of codes.
OTHER SCRUBBED ASSISTANTS	If there are more than two assistants scrubbed for this case, they can be entered here.
OTHER PERSONS IN O.R.	This fields includes any observers, such as equipment vendors, in the operating room.

Example: Entering Surgical Staff

```
Select Operation Menu Option: SS Surgical Staff

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

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

Enter Screen Server Function: 6;13;15
Attending Code: C  LEVEL C: ATTENDING IN O.R., NOT SCRUBBED  C
  The supervising practitioner is physically present in the operative or
  procedural room. The supervising practitioner observes and provides
  direction. The resident performs the procedure.
```

```
** SURGICAL STAFF **   CASE #193  SURPATIENT,THREE      PAGE 1
         OR SCRUB SUPPORT

1    NEW ENTRY

Enter Screen Server Function:  1
Select OR SCRUB SUPPORT: SURNURSE,ONE
    OR SCRUB SUPPORT: SURNURSE,ONE// <Enter>
```

```
** SURGICAL STAFF **   CASE #193  SURPATIENT,THREE      PAGE 1
         OR SCRUB SUPPORT  (SURNURSE,ONE)

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

Enter Screen Server Function: 2:3
Educational Status:  ?
     CHOOSE FROM:
       O        ORIENTEE
       F        FULLY TRAINED
Educational Status: F  FULLY TRAINED
```

```
** SURGICAL STAFF **   CASE #193  SURPATIENT,THREE      PAGE 1
         OR SCRUB SUPPORT  (SURNURSE,ONE)
           TIME ON

1    NEW ENTRY

Enter Screen Server Function:  1
Select TIME ON: 8:00  (JUN 06, 1999@08:00)
    TIME ON: JUN 06, 1999@08:00// <Enter>
```

```
** SURGICAL STAFF **   CASE #193  SURPATIENT,THREE      PAGE 1
         OR SCRUB SUPPORT  (SURNURSE,ONE)
           TIME ON  (2920606.08)

1    TIME ON:               JUN 06, 1999 AT 08:00
2    TIME OFF:
3    REASON FOR RELIEF:

Enter Screen Server Function: 2:3
Time Off: 13:00  (JUN 06, 1999@13:00)
Reason for Relief: ?
     Enter the code corresponding to the reason for relief.
     CHOOSE FROM:
       P        PERSONAL
       S        SHIFT CHANGE
       A        ADMINISTRATIVE
Reason for Relief: S  SHIFT CHANGE
```

```
** SURGICAL STAFF **   CASE #193  SURPATIENT,THREE      PAGE 1 OF 1
         OR SCRUB SUPPORT  (SURNURSE,ONE)
           TIME ON  (2920606.08)

1    TIME ON:               JUN 06, 1999 AT 08:00
2    TIME OFF:              JUN 06, 1999 AT 13:00
3    REASON FOR RELIEF:     SHIFT CHANGE

Enter Screen Server Function: <Enter>
```

```
** SURGICAL STAFF **   CASE #193  SURPATIENT,THREE      PAGE 1 OF 1
         OR SCRUB SUPPORT  (SURNURSE,ONE)
           TIME ON

1    TIME ON:               JUN 06, 1999 AT 08:00
2    NEW ENTRY

Enter Screen Server Function:  <Enter>
```

```
** SURGICAL STAFF **   CASE #193  SURPATIENT,THREE      PAGE 1 OF 1
         OR SCRUB SUPPORT  (SURNURSE,ONE)

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

Enter Screen Server Function:   <Enter>
```

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

1    OR SCRUB SUPPORT:      SURNURSE,ONE
2    NEW ENTRY

Enter Screen Server Function:  <Enter>
```

```
 ** SURGICAL STAFF **   CASE #193  SURPATIENT,THREE      PAGE 1 OF 1
         OTHER PERSONS IN OR

1    NEW ENTRY

Enter Screen Server Function:  1
Select OTHER PERSONS IN OR:  SURTECHNICIAN,ONE
    OTHER PERSONS IN OR: SURTECHNICIAN,ONE //  <Enter>
```

```
  ** SURGICAL STAFF **   CASE #193  SURPATIENT,THREE      PAGE 1 OF 1
         OTHER PERSONS IN OR  (0)

1    OTHER PERSONS IN OR:   ONE SURTECHNICIAN
2    TITLE/ORGANIZATION:

Enter Screen Server Function:  2
Title and Organization: TECHNICIAN, AMERICAN SURGICAL EQUIP
```

```
  ** SURGICAL STAFF **   CASE #193  SURPATIENT,THREE      PAGE 1 OF 1
         OTHER PERSONS IN OR  (0)

1    OTHER PERSONS IN OR:   ONE SURTECHNICIAN
2    TITLE/ORGANIZATION:    TECHNICIAN, AMERICAN SURGICAL EQUIP

Enter Screen Server Function:   <Enter>
```

```
 ** SURGICAL STAFF **   CASE #193  SURPATIENT,THREE      PAGE 1 OF 1
         OTHER PERSONS IN OR

1    OTHER PERSONS IN OR:   ONE SURTECHNICIAN
2    NEW ENTRY

Enter Screen Server Function:   <Enter>
```

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

1    SURGEON:               SURSURGEON,ONE
2    PGY OF PRIMARY SURGEON:
3    FIRST ASST:            SURSURGEON,TWELVE
4    SECOND ASST:           SURSURGEON,TWO
5    ATTEND SURG:           SURSURGEON,ONE
6    ATTENDING CODE:        LEVEL C: ATTENDING IN O.R., NOT SCRUBBED
7    PRINC ANESTHETIST:     SURANESTHETIST,FOUR
8    ASST ANESTHETIST:
9    ANESTHESIOLOGIST SUPVR: SURANESTHETIST,TWO
10   PERFUSIONIST:
11   ASST PERFUSIONIST:
12   OR CIRC SUPPORT:       (MULTIPLE)
13   OR SCRUB SUPPORT:      (MULTIPLE)(DATA)
14   OTHER SCRUBBED ASSISTANTS: (MULTIPLE)
15   OTHER PERSONS IN OR:   (MULTIPLE)(DATA)

Enter Screen Server Function:
```

Operation Startup
[SROMEN-START]

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

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

Field Information

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

Field Name	Definition
MAJOR/MINOR:	Major surgery is any operation performed under general, spinal, or epidural anesthesia plus all inguinal herniorrhaphies and carotid endarterectomies, regardless of anesthesia administered. Minor surgery is any operation not designated as Major.
CANCEL REASON:	The user must respond to this prompt if he or she has information in the CANCEL DATE field. Typing in a question mark **(?)** at the "Cancel Reason:" prompt allows the user to select from a list of cancellation reasons. The "Cancel Reason:" prompt should only be answered if the case has been aborted. Use the *Cancel Scheduled Case* option if the patient has not yet entered the operating room.
DELAY CAUSE:	If the actual start time of the surgery is significantly delayed (15 minutes or more, depending on the institution's policy) it is necessary to select a reason at the "Delay Cause:" prompt. Type in a question mark **(?)** at this prompt to select from a list of delay causes.
RESTR & POSITION AIDS:	A safety strap is automatically included as a restraint.

Example: Operation Startup

```
Select Operation Menu Option: OS  Operation Startup
```

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

1    DATE OF OPERATION:     DEC 06, 2004 AT 08:00
2    PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE, L SHOULDER
3    PRIN PRE-OP ICD DIAGNOSIS CODE:
4    OTHER PREOP DIAGNOSIS: (MULTIPLE)
5    OPERATING ROOM:        OR2
6    SURGERY SPECIALTY:     ORTHOPEDICS
7    MAJOR/MINOR:
8    REQ POSTOP CARE:       WARD
9    CASE SCHEDULE TYPE:    ELECTIVE
10   REQ ANESTHESIA TECHNIQUE: GENERAL
11   PATIENT EDUCATION/ASSESSMENT:
12   CANCEL DATE:
13   CANCEL REASON:
14   CANCELLATION AVOIDABLE:
15   DELAY CAUSE:           (MULTIPLE)

Enter Screen Server Function: 7;11
Major or Minor: J  MAJOR
Preoperative Patient Education: Y  YES
```

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

1    DATE OF OPERATION:     DEC 06, 2004 AT 08:00
2    PRINCIPAL PRE-OP DIAGNOSIS: DEGENERATIVE JOINT DISEASE, L SHOULDER
3    PRIN PRE-OP ICD DIAGNOSIS CODE:
4    OTHER PREOP DIAGNOSIS: (MULTIPLE)
5    OPERATING ROOM:        OR2
6    SURGERY SPECIALTY:     ORTHOPEDICS
7    MAJOR/MINOR:           MAJOR
8    REQ POSTOP CARE:       WARD
9    CASE SCHEDULE TYPE:    ELECTIVE
10   REQ ANESTHESIA TECHNIQUE: GENERAL
11   PATIENT EDUCATION/ASSESSMENT:  YES
12   CANCEL DATE:
13   CANCEL REASON:
14   CANCELLATION AVOIDABLE:
15   DELAY CAUSE:           (MULTIPLE)

Enter Screen Server Function: <Enter>
```

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

1    ASA CLASS:
2    PREOP MOOD:
3    PREOP CONSCIOUS:
4    PREOP SKIN INTEG:
5    TRANS TO OR BY:
6    HAIR REMOVAL BY:
7    HAIR REMOVAL METHOD:
8    HAIR REMOVAL COMMENTS:   (WORD PROCESSING)
9    SKIN PREPPED BY (1):
10   SKIN PREPPED BY (2):
11   SKIN PREP AGENTS:
12   SECOND SKIN PREP AGENT:
13   SURGERY POSITION:        (MULTIPLE)(DATA)
14   RESTR & POSITION AIDS:   (MULTIPLE)(DATA)
15   ELECTROGROUND POSITION:

Enter Screen Server Function:  A
```

```
ASA Class: 2  2     2-MILD DISTURB.
Preoperative Mood: ?
        Enter the code corresponding to the preoperative assessment of the
        patient's emotional status upon arrival to the operating room.
        Screen prevents selection of inactive entries.
    Answer with PATIENT MOOD  NAME, or CODE
   Choose from:
   AGITATED        AG
   ANGRY        ANG
   ANXIOUS        ANX
   APATHETIC        AP
   DEPRESSED        D
   RELAXED        R
   TESTY AND IRRATE, SLEEPY        BUF

Preoperative Mood: ANXIOUS       ANX
Preoperative Consciousness: AO  ALERT-ORIENTED     AO
Preoperative Skin Integrity: INTACT       I
Transported to O.R. By: PACU BED
Preop Surgical Site Hair Removal by: SURNURSE,TWO
Surgical Site Hair Removal Method: N  NO HAIR REMOVED
Hair Removal Comments:
  No existing text
  Edit? NO//  <Enter>
Skin Prepped By: <Enter>
Skin Prepped By (2): <Enter>
Skin Preparation Agent: HIBICLENS       HI
Second Skin Preparation Agent: <Enter>
Electroground Placement: RAT  RIGHT ANT THIGH
```

```
 ** STARTUP **   CASE #159  SURPATIENT,THREE             PAGE 1
        SURGERY POSITION

1    SURGERY POSITION:      SUPINE
2    NEW ENTRY

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

```
  ** STARTUP **   CASE #159  SURPATIENT,THREE             PAGE 1
        SURGERY POSITION  (SEMISUPINE)

1    SURGERY POSITION:      SEMISUPINE
2    TIME PLACED:

Enter Screen Server Function:  <Enter>
```

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

1    SURGERY POSITION:      SUPINE
2    SURGERY POSITION:      SEMISUPINE
3    NEW ENTRY

Enter Screen Server Function:  <Enter>
```

```
  ** STARTUP **   CASE #159  SURPATIENT,THREE             PAGE 1 OF 1
        RESTR & POSITION AIDS

1    RESTR & POSITION AIDS: SAFETY STRAP
2    NEW ENTRY

Enter Screen Server Function:  2
Select RESTR & POSITION AIDS: FOAM PADS
    RESTR & POSITION AIDS: FOAM PADS// <Enter>
```

```
  ** STARTUP **   CASE #159  SURPATIENT,THREE             PAGE 1 OF 1
        RESTR & POSITION AIDS  (FOAM PADS)

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

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

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

1    ASA CLASS:               2-MILD DISTURB.
2    PREOP MOOD:              ANXIOUS
3    PREOP CONSCIOUS:         ALERT-ORIENTED
4    PREOP SKIN INTEG:        INTACT
5    TRANS TO OR BY:          PACU BED
6    HAIR REMOVAL BY:         MONOSKY,ALAN
7    HAIR REMOVAL METHOD:     NO HAIR REMOVED
8    HAIR REMOVAL COMMENTS:   (WORD PROCESSING)
9    SKIN PREPPED BY (1):
10   SKIN PREPPED BY (2):
11   SKIN PREP AGENTS:        HIBICLENS
12   SECOND SKIN PREP AGENT:
13   SURGERY POSITION:        (MULTIPLE)(DATA)
14   RESTR & POSITION AIDS:   (MULTIPLE)(DATA)
15   ELECTROGROUND POSITION:  RIGHT ANT THIGH

Enter Screen Server Function: <Enter>
```

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

1    ELECTROGROUND POSITION (2):

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

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

1    ELECTROGROUND POSITION (2):

Enter Screen Server Function:
```

(This page included for two-sided copying.)

Operation
[SROMEN-OP]

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

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

Field Information

The following are fields that correspond to the Operation entries.

Field Name	Definition
TIME OPERATION BEGAN	The user should check his or her institution's policy concerning an operation's start time. In some institutions, this may be the time of first incision.

If entering times on a day other than the day of surgery, enter both the date and the time. Entering only a time will default the date to the current date.

Example: Operation Option: Entering Information

```
  ** OPERATION **   CASE #173  SURPATIENT,TWENTY        PAGE 1 OF 3

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

Enter Screen Server Function:  1;2;13:14
```

```
Time Patient Arrived in Holding Area: 8:50  (MAR 12, 1999@08:50)
Time Patient In the O.R.: 9:00  (MAR 12, 1999@09:00)
```

```
  ** OPERATION **   CASE #173  SURPATIENT,TWENTY        PAGE 1 OF 1
        REPLACEMENT FLUID TYPE

1    NEW ENTRY

Enter Screen Server Function:  1
Select REPLACEMENT FLUID TYPE: RINGERS LACTATED SOLUTION
    REPLACEMENT FLUID TYPE: RINGERS LACTATED SOLUTION// <Enter>
```

```
  ** OPERATION **   CASE #173  SURPATIENT,TWENTY        PAGE 1 OF 1
        REPLACEMENT FLUID TYPE  (RINGERS LACTATED SOLUTION)

1    REPLACEMENT FLUID TYPE: RINGERS LACTATED SOLUTION
2    QTY OF FLUID (ml):
3    SOURCE ID:
4    VA IDENT:
5    REPLACEMENT FLUID COMMENTS: (WORD PROCESSING)

Enter Screen Server Function:  2;3
Quantity of Fluid (ml): 1000
Source Identification Number: TRAVENOL
```

```
  ** OPERATION **   CASE #173  SURPATIENT,TWENTY        PAGE 1 OF 1
        REPLACEMENT FLUID TYPE  (RINGERS LACTATED SOLUTION)

1    REPLACEMENT FLUID TYPE: RINGERS LACTATED SOLUTION
2    QTY OF FLUID (ml):     1000
3    SOURCE ID:             TRAVENOL
4    VA IDENT:
5    REPLACEMENT FLUID COMMENTS: (WORD PROCESSING)

Enter Screen Server Function:  <Enter>
```

```
  ** OPERATION **   CASE #173  SURPATIENT,TWENTY        PAGE 1 OF 1
        REPLACEMENT FLUID TYPE

1    REPLACEMENT FLUID TYPE: RINGERS LACTATED SOLUTION
2    NEW ENTRY

Enter Screen Server Function:  <Enter>
```

```
    ** OPERATION **   CASE #173  SURPATIENT,TWENTY        PAGE 1 OF 1
         IRRIGATION

1    NEW ENTRY

Enter Screen Server Function:  1
Select IRRIGATION: NORMAL SALINE
    IRRIGATION: NORMAL SALINE//  <Enter>
```

```
  ** OPERATION **   CASE #173  SURPATIENT,TWENTY        PAGE 1 OF 1
         IRRIGATION  (NORMAL SALINE)

1    IRRIGATION:            NORMAL SALINE
2    TIME:                  (MULTIPLE)

Enter Screen Server Function:  2
```

```
  ** OPERATION **   CASE #173  SURPATIENT,TWENTY        PAGE 1
         IRRIGATION  (NORMAL SALINE)
           TIME

1    NEW ENTRY

Enter Screen Server Function:  1
Select TIME: 9:40   MAR 12, 1999@09:40
    TIME: MAR 12, 1999@09:40// <Enter>
```

```
  ** OPERATION **   CASE #173  SURPATIENT,TWENTY        PAGE 1
         IRRIGATION  (NORMAL SALINE)
           TIME  (2930601.094)

1    TIME:                  MAR 12, 1999 AT 09:40
2    AMOUNT USED:
3    PROVIDER:

Enter Screen Server Function:  2:3
Amount of Solution Used: 1000
Person Responsible: SURNURSE,THREE
```

```
  ** OPERATION **   CASE #173  SURPATIENT,TWENTY        PAGE 1 OF 1
         IRRIGATION  (NORMAL SALINE)
           TIME  (2930601.094)

1    TIME:                  MAR 12, 1999 AT 09:40
2    AMOUNT USED:           1000
3    PROVIDER:              SURNURSE,THREE

Enter Screen Server Function:  <Enter>
```

```
  ** OPERATION **   CASE #173  SURPATIENT,TWENTY        PAGE 1 OF 1
         IRRIGATION  (NORMAL SALINE)
           TIME

1    TIME:                  MAR 12, 1999 AT 09:40
2    NEW ENTRY

Enter Screen Server Function:  <Enter>
```

```
  ** OPERATION **   CASE #173  SURPATIENT,TWENTY        PAGE 1 OF 1
        IRRIGATION  (NORMAL SALINE)

1    IRRIGATION:            NORMAL SALINE
2    TIME:                  (MULTIPLE)(DATA)

Enter Screen Server Function:  <Enter>
```

```
  ** OPERATION **   CASE #173  SURPATIENT,TWENTY        PAGE 1 OF 1
        IRRIGATION

1    IRRIGATION:            NORMAL SALINE
2    NEW ENTRY

Enter Screen Server Function:  <Enter>
```

```
  ** OPERATION **   CASE #173  SURPATIENT,TWENTY        PAGE 1 OF 3

1    TIME PAT IN HOLD AREA:   MAR 12, 1999 AT 08:50
2    TIME PAT IN OR:          MAR 12, 1999 AT 09:00
3    ANES CARE TIME BLOCK:    (MULTIPLE)
4    TIME OPERATION BEGAN:
5    SPECIMENS:               (WORD PROCESSING)
6    CULTURES:                (WORD PROCESSING)
7    THERMAL UNIT:            (MULTIPLE)
8    ELECTROCAUTERY UNIT:
9    ESU COAG RANGE:
10   ESU CUTTING RANGE:
11   TIME TOURNIQUET APPLIED: (MULTIPLE)
12   PROSTHESIS INSTALLED:    (MULTIPLE)
13   REPLACEMENT FLUID TYPE:  (MULTIPLE)
14   IRRIGATION:              (MULTIPLE)
15   MEDICATIONS:             (MULTIPLE)

Enter Screen Server Function: <Enter>
```

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

1    SPONGE COUNT CORRECT (Y/N):
2    SHARPS COUNT CORRECT (Y/N):
3    INSTRUMENT COUNT CORRECT (Y/N):
4    SPONGE, SHARPS, & INST COUNTER:
5    COUNT VERIFIER:
6    SEQUENTIAL COMPRESSION DEVICE:
7    LASER UNIT:              (MULTIPLE)
8    CELL SAVER:              (MULTIPLE)
9    NURSING CARE COMMENTS:   (WORD PROCESSING)
10   PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS
11   PRIN PRE-OP ICD DIAGNOSIS CODE:
12   PRINCIPAL PROCEDURE:     CHOLECYSTECTOMY
13   PLANNED PRIN PROCEDURE CODE :
14   OTHER PROCEDURES:        (MULTIPLE)
15   INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)

Enter Screen Server Function: 1:4
```

```
Final Sponge Count Correct (Y/N): Y  YES
Final Sharps Count Correct (Y/N): Y  YES
Final Instrument Count Correct (Y/N): Y  YES
Person Responsible for Final Counts: SURNURSE,THREE
```

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

1    SPONGE COUNT CORRECT (Y/N): YES
2    SHARPS COUNT CORRECT (Y/N): YES
3    INSTRUMENT COUNT CORRECT (Y/N): YES
4    SPONGE, SHARPS, & INST COUNTER: SURNURSE,THREE
5    COUNT VERIFIER:
6    SEQUENTIAL COMPRESSION DEVICE:
7    LASER UNIT:              (MULTIPLE)
8    CELL SAVER:              (MULTIPLE)
9    NURSING CARE COMMENTS:   (WORD PROCESSING)
10   PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS
11   PRIN PRE-OP ICD DIAGNOSIS CODE:
12   PRINCIPAL PROCEDURE:     CHOLECYSTECTOMY
13   PLANNED PRIN PROCEDURE CODE :
14   OTHER PROCEDURES:        (MULTIPLE)
15   INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)

Enter Screen Server Function: 9
```

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

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

1    SPONGE COUNT CORRECT (Y/N): YES
2    SHARPS COUNT CORRECT (Y/N): YES
3    INSTRUMENT COUNT CORRECT (Y/N): YES
4    SPONGE, SHARPS, & INST COUNTER: SURNURSE,THREE
5    COUNT VERIFIER:
6    SEQUENTIAL COMPRESSION DEVICE:
7    LASER UNIT:              (MULTIPLE)
8    CELL SAVER:              (MULTIPLE)
9    NURSING CARE COMMENTS:   (WORD PROCESSING)(DATA)
10   PRINCIPAL PRE-OP DIAGNOSIS: CHOLELITHIASIS
11   PRIN PRE-OP ICD DIAGNOSIS CODE:
12   PRINCIPAL PROCEDURE:     CHOLECYSTECTOMY
13   PLANNED PRIN PROCEDURE CODE :
14   OTHER PROCEDURES:        (MULTIPLE)
15   INDICATIONS FOR OPERATIONS: (WORD PROCESSING)(DATA)

Enter Screen Server Function: <Enter>
```

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

1    BRIEF CLIN HISTORY:      (WORD PROCESSING)

Enter Screen Server Function:
```

Post Operation
[SROMEN-POST]

The *Post Operation* option concerns the close of the operation, discharge, and post anesthesia recovery. It is important to enter the operation and anesthesia end times, as well as the time the patient leaves the operation room, as these fields affect many reports.

Field Information

The following are fields that correspond to the *Post Operation* option entries.

Field Name	Definition
TIME PAT OUT OR	Entry of this field generates an alert notifying the circulating nurse that the Nurse Intraoperative Report is ready for signature.
ANES CARE TIME BLOCK	Entry of this multiple generates an alert notifying the anesthetist that the Anesthesia Report is ready for signature.

Example: Post Operation

```
Select Operation Menu Option: PO Post Operation

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

1    DRESSING:
2    PACKING:
3    TUBES AND DRAINS:
4    BLOOD LOSS (ML):
5    TOTAL URINE OUTPUT (ML):
6    GASTRIC OUTPUT:
7    WOUND CLASSIFICATION:
8    POSTOP MOOD:
9    POSTOP CONSCIOUS:
10   POSTOP SKIN INTEG:
11   TIME OPERATION ENDS:
12   ANES CARE TIME BLOCK:  (MULTIPLE)
13   TIME PAT OUT OR:
14   OP DISPOSITION:
15   DISCHARGED VIA:

Enter Screen Server Function:  A
Dressing(s): TELFA
Packing Type: <Enter>
Tubes and Drains: PENROSE
Intraoperative Blood Loss (ml): 200
Total Urine Output (ml): 600
Gastric Output (cc's): 150
Wound Classification: CC  CLEAN/CONTAMINATED
Postoperative Mood: RELAXED          R
Postoperative Consciousness: RESTING          R
Postoperative Skin Integrity: INTACT          I
Time the Operation Ends: 12:30  (APR 26, 2005@12:30)
Time Patient Out of the O.R.: 12:50  (APR 26, 2005@12:50)
Postoperative Disposition: PACU (RECOVERY ROOM)       R
Patient Discharged Via: PACU BED
```

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

1    NEW ENTRY

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

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

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

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

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

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

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

Enter Screen Server Function: <Enter>
```

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

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

Enter Screen Server Function: <Enter>
```

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

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

Enter Screen Server Function: <Enter>
```

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

1    PRINCIPAL POST-OP DIAG:  CHOLELITHIASIS
2    PRIN PRE-OP ICD DIAGNOSIS CODE:
3    OTHER POSTOP DIAGS:      (MULTIPLE)
4    PRINCIPAL PROCEDURE:     CHOLECYSTECTOMY
5    PLANNED PRIN PROCEDURE CODE:     47480
6    OTHER PROCEDURES:        (MULTIPLE)(DATA)
7    ATTENDING CODE:          LEVEL C: ATTENDING IN O.R., NOT SCRUBBED
8    FLASH-CONTAMINATION:     56
9    FLASH-SPD/OR MGT ISSUE:  0
10   FLASH-EMERGENCY CASE:    6
11   FLASH-NO BETTER OPTION:  4
```

```
12   FLASH-LOANER INSTRUMENT: 9
13   FLASH-DECONTAMINATION:   12

Enter Screen Server Function:
```

(This page included for two-sided copying.)

Enter PAC(U) Information
[SROMEN-PACU]

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

Example: Entering PAC(U) Information

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

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

1    ADMIT PAC(U) TIME:
2    PAC(U) ADMIT SCORE:
3    PAC(U) DISCH TIME:
4    PAC(U) DISCH SCORE:

Enter Screen Server Function: 1:4
PAC(U) Admission Time: 13:00  (APR 26, 1999@13:00)
PAC(U) Admission Score: 10
PAC(U) Discharge Date/Time: 14:00  (APR 26, 1999@14:00)
PAC(U) Discharge Score: 10

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

1    ADMIT PAC(U) TIME:     APR 26, 1999 AT 13:00
2    PAC(U) ADMIT SCORE:    10
3    PAC(U) DISCH TIME:     APR 26, 1999 AT 14:00
4    PAC(U) DISCH SCORE:    10

Enter Screen Server Function:
```

Operation (Short Screen)
[SROMEN-OUT]

The *Operation (Short Screen)* option provides a three-page screen of information concerning a surgical procedure performed on a patient. The *Operation (Short Screen)* option allows the nurse or surgeon to easily enter data relating to the operation during, and shortly after, the actual procedure. This time-saving option can replace the *Operation Startup* option, the *Operation* option, and the *Post Operation* option for minor surgeries.

When only one anesthesia technique is entered, the software will assume that it is the principal anesthesia technique for the case. Some data fields may be automatically pre-populated if the case was booked in advance.

Example: Operation Short Screen

```
Select Operation Menu Option: OSS  Operation (Short Screen)

  ** SHORT SCREEN **   CASE #186  SURPATIENT,TWELVE          PAGE 1 OF 3

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

Enter Screen Server Function: 13:15
Time Patient In the O.R.: 13:00  (MAR 09, 2005@13:00)
Time the Operation Began: 13:10  (MAR 09, 2005@13:10)
Time the Operation Ends: 13:36  (MAR 09, 2005@13:36)
```

```
  ** SHORT SCREEN **   CASE #186  SURPATIENT,TWELVE          PAGE 1 OF 3

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

Enter Screen Server Function:  <Enter>
```

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

1    TIME PAT OUT OR:
2    IV STARTED BY:
3    OR CIRC SUPPORT:         (MULTIPLE)
4    OR SCRUB SUPPORT:        (MULTIPLE)
5    OPERATING ROOM:
6    FIRST ASST:
7    SPONGE COUNT CORRECT (Y/N):
8    SHARPS COUNT CORRECT (Y/N):
9    INSTRUMENT COUNT CORRECT (Y/N):
10   SPONGE, SHARPS, & INST COUNTER:
11   COUNT VERIFIER:
12   SURGERY SPECIALTY:       GENERAL(OR WHEN NOT DEFINED BELOW)
13   WOUND CLASSIFICATION:
14   ATTEND SURG:             SURSURGEON,TWO
15   ATTENDING CODE:

Enter Screen Server Function:  1;5;15

Time Patient Out of the O.R.: 13:40  (MAR 09, 2005@13:40)
Operating Room: OR1
Attending Code: A    LEVEL A: ATTENDING DOING THE OPERATION  A
  The staff practitioner performs the case, but may be assisted by a
 resident.
```

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

1    TIME PAT OUT OR:         MAR 12, 2006 AT 13:40
2    IV STARTED BY:
3    OR CIRC SUPPORT:         (MULTIPLE)
4    OR SCRUB SUPPORT:        (MULTIPLE)
5    OPERATING ROOM:          OR1
6    FIRST ASST:
7    SPONGE COUNT CORRECT (Y/N):
8    SHARPS COUNT CORRECT (Y/N):
9    INSTRUMENT COUNT CORRECT (Y/N):
10   SPONGE, SHARPS, & INST COUNTER:
11   COUNT VERIFIER:
12   SURGERY SPECIALTY:       GENERAL(OR WHEN NOT DEFINED BELOW)
13   WOUND CLASSIFICATION:
14   ATTEND SURG:             SURSURGEON,TWO
15   ATTENDING CODE:          LEVEL A: ATTENDING DOING THE OPERATION

Enter Screen Server Function:  <Enter>
```

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

1    SPECIMENS:               (WORD PROCESSING)
2    CULTURES:                (WORD PROCESSING)
3    NURSING CARE COMMENTS:   (WORD PROCESSING) (DATA)
4    ASA CLASS:
5    PRINC ANESTHETIST:     SURANESTHETIST,FOUR
6    ANESTHESIA TECHNIQUE:    (MULTIPLE)
7    ANES CARE TIME BLOCK:    (MULTIPLE)
8    DELAY CAUSE:             (MULTIPLE)
9    CANCEL DATE:
10   CANCEL REASON:
11   CANCELLATION COMMENTS:

Enter Screen Server Function:  3:4

Nursing Care Comments:
  1>PATIENT ARRIVED AMBULATORY FROM AMBULATORY
  2>SURGERY UNIT. DISCHARGED VIA WHEELCHAIR, AWAKE,
  3>ALERT, ORIENTED.
  4><Enter>
EDIT Option:  <Enter>
ASA Class: 3  3     3-SEVERE DISTURB.
```

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

1    SPECIMENS:               (WORD PROCESSING)
2    CULTURES:                (WORD PROCESSING)
3    NURSING CARE COMMENTS:   (WORD PROCESSING) (DATA)
4    ASA CLASS:               3-SEVERE DISTURB.
5    PRINC ANESTHETIST:     SURANESTHETIST,FOUR
6    ANESTHESIA TECHNIQUE:    (MULTIPLE)
7    ANES CARE TIME BLOCK:    (MULTIPLE)
8    DELAY CAUSE:             (MULTIPLE)
9    CANCEL DATE:
10   CANCEL REASON:
11   CANCELLATION COMMENTS:

Enter Screen Server Function:  <Enter>
```

Time Out Verified Utilizing Checklist
[SROMEN-VERF]

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

Example: Time Out Verified Utilizing Checklist

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

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

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

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

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

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

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

1    CONFIRM PATIENT IDENTITY: YES
2    PROCEDURE TO BE PERFORMED: YES
3    SITE OF PROCEDURE:       YES
4    VALID CONSENT FORM:      YES
5    CONFIRM PATIENT POSITION: YES
6    MARKED SITE CONFIRMED:   YES
7    PREOPERATIVE IMAGES CONFIRMED: YES
8    CORRECT MEDICAL IMPLANTS: YES
9    AVAILABILITY OF SPECIAL EQUIP: YES
10   ANTIBIOTIC PROPHYLAXIS:  YES
11   APPROPRIATE DVT PROPHYLAXIS: YES
12   BLOOD AVAILABILITY:      YES
```

```
13   CHECKLIST COMMENT:       (WORD PROCESSING)
14   CHECKLIST CONFIRMED BY:  SURNURSE,FIVE

Enter Screen Server Function:
```

Surgeon's Verification of Diagnosis & Procedures
[SROVER]

Surgeons use this option to verify that the stated procedure(s), diagnosis, and occurrences are correct for a case. With this option, the surgeon can update the Operation Name, Planned CPT Code, Diagnosis, and Intraoperative Occurrences before verifying the case. If the case has already been verified, the user will be asked whether to re-verify it.

If the user responds **YES** to the prompt "Do you need to update the information above ?" the software will provide a summary for editing.

If there are no occurrences, the INTRAOP OCCURRENCES field should be left blank. Do **not** enter **NO** or **NONE**.

The procedure and diagnosis codes are the codes captured with clinical data, and are supplied as defaults to the Coder when entering the final codes that will be sent to PCE.

Service Classifications

Information relating to a patient's status of Service Connected (SC) and Environmental Indicators (EI) are captured during patient registration. The Surgery software receives this data from enrollment and displays it when the user creates a case.

In the Surgery software, the patient's Service Classification status is determined at the case level when the case is created. The user can further refine status designations, not only per case, but also per diagnosis.

The system defaults the case-level Service Classification indicators into each Other Postop Diagnosis field as the user adds the Other Postop Diagnoses. The system allows the user to edit these fields if the user determines that the defaulted value is incorrect.

Example: Surgeon's Verification of Diagnosis & Procedures

```
Select Operation Menu Option: V  Surgeon's Verification of Diagnosis & Procedures

SURPATIENT,ONE  (000-44-7629)
Operation Date: JUN  5, 2005
------------------------------------------------------------------------------
1. Indications for Operation:
   Swelling in the inguinal region.
2. Planned Principal CPT Code:  00830
   Assoc. DX: 1. 550.02  BILAT ING HERNIA W GANG
3. Principal Procedure: REMOVE HERNIA
4. Other Procedures:
5. Postoperative Diagnosis:   INGUINAL HERNIA
6. Intraoperative Occurrences: NO OCCURRENCES HAVE BEEN ENTERED
7. Principal Pre-OP Diagnosis: HERNIA
8. Principal Pre-OP Diagnosis Code: 550.02  BILAT ING HERNIA W GANG
------------------------------------------------------------------------------

Do you need to update the information above ?  NO//  Y

Select Information to Edit: 2:3
```

```
Planned Principal Procedure Code (CPT): 49521        REREPAIR ING HERNIA, BLOCKE
D
 REPAIR RECURRENT INGUINAL HERNIA, ANY AGE; INCARCERATED OR STRANGULATED
The Diagnosis to Procedure Associations may no longer be correct.
Delete Diagnosis Associations for this Procedure? N// NO


 Modifier: 59       DISTINCT PROCEDURAL SERVICE
 Modifier: <Enter>

 Principal Procedure: REMOVE HERNIA// REPAIR INGUINAL HERNIA
```

```
SURPATIENT,ONE  (000-44-7629)
Operation Date: JUN  5, 2005
------------------------------------------------------------------------------
1. Indications for Operation:
   Swelling in the inguinal region.

2. Planned Principal CPT Code:  49521
     REPAIR RECURRENT INGUINAL HERNIA, ANY AGE; INCARCERATED OR STRANGULATED


          Modifiers:  -59
3. Principal Procedure: REPAIR INGUINAL HERNIA
4. Other Procedures:
5. Postoperative Diagnosis:   INGUINAL HERNIA
6. Intraoperative Occurrences: NO OCCURRENCES HAVE BEEN ENTERED
7. Principal Pre-OP Diagnosis: HERNIA
8. Principal Pre-OP Diagnosis Code: 550.02  BILAT ING HERNIA W GANG
------------------------------------------------------------------------------

Do you need to update the information above ?  NO// <Enter>
Will you verify that the information on your screen is correct ? YES// <Enter>


Press RETURN to continue
```

Anesthesia for an Operation Menu
[SROANES]

The *Anesthesia for an Operation Menu* option is restricted to anesthesia personnel and is locked with the SROANES key.

This option is designed for convenient entry of data pertaining to the anesthesia agents, personnel and techniques. When the user selects this option from the *Operation Menu* option, he or she is given a submenu of five options.

The options included in this menu are listed below. To the left of the option name is the shortcut synonym that may be entered to select the option.

Shortcut	Option Name
I	*Anesthesia Information (Enter/Edit)*
T	*Anesthesia Technique (Enter/Edit)*
M	*Medications (Enter/Edit)*
R	*Anesthesia Report*
S	*Schedule Anesthesia Personnel*

Prerequisites

To use any of these options, other than the *Schedule Anesthesia Personnel* option, the user must first select a patient case. For the *Schedule Anesthesia Personnel* option, a date and then an operating room must first be selected.

These options can also be accessed from the main *Surgery Menu*.

Information related to these options is contained in "Chapter Two: Tracking Clinical Procedures," in the Anesthesia Menu section.

Operation Report
[SROSRPT]

The *Operation Report* option displays the dictated Operation Report for the patient case selected. This report contains the surgeon's dictation regarding the surgical procedure. The Operation Report is not electronically signed in the Surgery package. After the dictated Operation Report is uploaded into the Text Integration Utilities (TIU) package, it is then available for electronic signature through the Computerized Patient Record System (CPRS) Surgery tab.

When electronically signed, the Operation Report is also viewable through CPRS. The electronically signed Operation Report replaces VA Form 516. If the Operation Report has not been electronically signed, then CPRS will only display a stub for that document.

After the dictated Operation Report is transcribed and uploaded into TIU, the TIU software sends an alert to the surgeon responsible for electronically signing the report.

Until the Operation Report is signed, if the *Operation Report* option is selected, the following text displays:

"The Operation Report for this case is not yet available."

If the Operation Report has been signed, the *Operation Report* option will display the signed document. (See the example.)

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

Example: A signed Operation Report

```
                                                                        Page:  1
------------------------------------------------------------------------------
SURPATIENT,TEN  000-12-3456                                  OPERATION REPORT
------------------------------------------------------------------------------
NOTE DATED: 07/29/2003 15:15  OPERATION REPORT
VISIT: 07/29/2003 15:15 SURGERY OP REPORT NON-COUNT
SUBJECT: Case #: 73285


PREOPERATIVE DIAGNOSIS:  Visually significant cataract, right eye

POSTOPERATIVE DIAGNOSIS:  Visually significant cataract, right eye

PROCEDURE:  Phacoemulsification with intraocular lens placement, right eye

CLINICAL INDICATIONS:  This 64-year-old gentleman complains of decreased
vision in the right eye affecting his activities of daily living.  Best
corrected visual acuity is counting fingers at 6 feet, associated with a
2-3+ nuclear sclerotic and 4+ posterior subcapsular cataract in that eye.

ANESTHESIA:  Local monitoring with topical Tetracaine and 1% preservative
free Lidocaine.

DESCRIPTION OF THE PROCEDURE:  After the risks, benefits and alternatives
of the procedure were explained to the patient, informed consent was
obtained.  The patient's right eye was dilated with Phenylephrine,
Mydriacyl and Ocufen.  He was brought to the Operating Room and placed on
anesthetic monitors.  Topical Tetracaine was given.  He was prepped and
draped in the usual sterile fashion for eye surgery.  A Lieberman lid
speculum was placed.

A Supersharp was used to create a superior paracentesis port.  The anterior
chamber was irrigated with 1% preservative free Lidocaine.  The anterior
chamber was filled with Viscoelastic.  The diamond groove maker and diamond
keratome were used to create a clear corneal tunneled incision at the
temporal limbus.  The cystotome was used to initiate a continuous
capsulorrhexis, which was then completed using Utrata forceps.  Balanced
salt solution was used to hydrodissect and hydrodelineate the lens.

Phacoemulsification was used to remove the lens nucleus and epinucleus in a
non-stop horizontal chop fashion.  Cortex was removed using irrigation and
aspiration.  The capsular bag was filled with Viscoelastic.  The wound was
enlarged with a 69 blade. An Alcon model MA60BM posterior chamber
intraocular lens with a power of 24.0 diopters, serial #588502.064, was
folded and inserted with the leading haptic placed into the bag.  The
trailing haptic was dialed into the bag with the Lester hook.  The wound
was hydrated.  The anterior chamber was filled with balanced salt solution.
The wound was tested and found to be self-sealing.  Subconjunctival
antibiotics were given, and an eye shield was placed.  The patient was
taken in good condition to the Recovery Room.  There were no complications.

KJC/PSI
DATE DICTATED:  07/29/03
DATE TRANSCRIBED:  07/29/03
JOB:  629095

                  Signed by: /es/ FOURTEEN SURSURGEON, M.D.
                                 07/30/2003 10:31
```

Anesthesia Report
[SROARPT]

The Anesthesia Report details anesthesia information for the patient case selected. This option provides the capability to view/print the report, edit information contained in the report, and electronically sign the report. This option can also be accessed from the *Anesthesia Menu* option located on the *Operation Menu*, as well as on the main *Surgery Menu*.

Anesthesia Report (Unsigned)

Upon selecting this option, if the Anesthesia Report is not signed the report will begin displaying. The Anesthesia Report displays key fields on the first page. Several of these fields are required before the software will allow the user to electronically sign the report. If any of these fields are left blank, a warning will appear prompting the user to provide the missing information. The ANES CARE TIME field, ANESTHESIA TECHNIQUE field, ASA CLASS field, OP DISPOSITION field, and the PRINC ANESTHETIST field must all be completed before the Anesthesia Report can be electronically signed.

Entering the information into the ANES CARE END TIME field triggers an alert that is sent to the anesthetist responsible for signing the report. By responding to the alert, the user is taken to the *Anesthesia Report* option.

At the bottom of the first screen is the prompt, "Press <return> to continue, 'A' to access Anesthesia Report functions or '^' to exit:". The *Anesthesia Report* functions, accessed by entering **A** at the prompt, allow the user to edit the report, to view or print the report, or to electronically sign the report.

Example: First page of an Anesthesia Report

```
                          SURPATIENT,TEN (000-12-3456)
    MEDICAL RECORD        ANESTHESIA REPORT - CASE #267226             PAGE 1

Operating Room: WX OR3

Anesthetist: SURANESTHETIST,SEVEN               Relief Anesth:
Anesthesiologist: SURANESTHESIOLOGIST,ONE       Assist Anesth: SURANESTHETIST,FIVE
Attending Code: LEVEL 3. ATTENDING NOT PRESENT IN O.R. SUITE, IMMEDIATE
LY AVAILABLE.

Anes Begin:  FEB 12, 2004  08:00        Anes End: FEB 12, 2004  12:10

ASA Class: * NOT ENTERED *

Operation Disposition: * NOT ENTERED *

Anesthesia Technique(s):
GENERAL  (PRINCIPAL)
  Agent:     ISOFLURANE FOR INHALATION 100ML
  Intubated: YES
  Trauma: NONE

 Press <return> to continue, 'A' to access Anesthesia Report functions
 or '^' to exit: A
```

After entering an **A** at the prompt, the Anesthesia functions are displayed. The following examples demonstrate how these three functions are accessed and how they operate.

If the user enters a **1**, the Anesthesia Report data can be edited.

Example: Edit Report Information

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

 Anesthesia Report Functions:

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

Select number: 2// 1  Edit report information
```

```
** ANESTHESIA REPORT **   CASE #267226  SURPATIENT,TEN PAGE 1 OF 2

1    OPERATING ROOM:     WX OR3
2    PRINC ANESTHETIST:  SURANESTHETIST,SEVEN
3    RELIEF ANESTHETIST:
4    ANESTHESIOLOGIST SUPVR: SURANESTHESIOLOGIST,ONE
5    ANES SUPERVISE CODE: 3. STAFF ASSISTING C.R.N.A.
6    ASST ANESTHETIST:       SURANESTHETIST,FIVE
7    ANES CARE TIME BLOCK:   (MULTIPLE)(DATA)
8    ASA CLASS:
9    OP DISPOSITION:
10   ANESTHESIA TECHNIQUE:    (MULTIPLE) (DATA)
11   PRINCIPAL PROCEDURE:     MVR
12   OTHER PROCEDURES:        (MULTIPLE) (DATA)
13   MEDICATIONS:             (MULTIPLE)
14   MIN INTRAOP TEMPERATURE (C): 35
15   MONITORS:                (MULTIPLE)

Enter Screen Server Function:  9
Postoperative Disposition: SICU       S
```

```
** ANESTHESIA REPORT **   CASE #267226  SURPATIENT,TEN PAGE 1 OF 2

1    OPERATING ROOM:     WX OR3
2    PRINC ANESTHETIST:  SURANESTHETIST,SEVEN
3    RELIEF ANESTHETIST:
4    ANESTHESIOLOGIST SUPVR: SURANESTHESIOLOGIST,ONE
5    ANES SUPERVISE CODE: 3. STAFF ASSISTING C.R.N.A.
6    ASST ANESTHETIST:   SURANESTHETIST,FIVE
7    ANES CARE TIME BLOCK:   (MULTIPLE)(DATA)
8    ASA CLASS:
9    OP DISPOSITION:     SICU
10   ANESTHESIA TECHNIQUE: (MULTIPLE)(DATA)
11   PRINCIPAL PROCEDURE: MVR
12   OTHER PROCEDURES:   (MULTIPLE)(DATA)
13   MEDICATIONS:        (MULTIPLE)
14   MIN INTRAOP TEMPERATURE (C): 35
15   MONITORS:                (MULTIPLE)

Enter Screen Server Function: ^
```

If the user enters a **2,** the Anesthesia Report can be printed.

Example: Print the Anesthesia Report

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


 Anesthesia Report Functions:

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

Select number: 2// 2
```

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

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

SUBJECT: Case #: 267226

Operating Room: WX OR3

Anesthetist: SURANESTHETIST,SEVEN             Relief Anesth:
Anesthesiologist: SURANESTHESIOLOGIST,ONE       Assist Anesth: SURANESTHETIST,FIVE
Attending Code: LEVEL 3. ATTENDING NOT PRESENT IN O.R. SUITE, IMMEDIATE
LY AVAILABLE.

Anes Begin:  FEB 12, 2004  08:00        Anes End:  FEB 12, 2004  12:10

ASA Class: * NOT ENTERED *

Operation Disposition: SICU

Anesthesia Technique(s):
GENERAL  (PRINCIPAL)
  Agent:     ISOFLURANE FOR INHALATION 100ML
  Intubated: YES
  Trauma: NONE

Min Intraoperative Temp: 35

Intraoperative Blood Loss: 800 ml       Urine Output: 750 ml
Operation Disposition: SICU
PAC(U) Admit Score:                     PAC(U) Discharge Score:

Postop Anesthesia Note Date/Time:
```

To electronically sign the report, the user enters a **3**.

Example: Sign the Report Electronically

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


 Anesthesia Report Functions:

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

Select number: 2// 3
```

In this case, a key field, the ASA CLASS field, has been omitted. The system will prompt the user to supply the missing information before allowing the report to be electronically signed.

The Anesthesia Report cannot be signed if the ASA CLASS field, or any other key field information, is missing.

Responding **YES** to the, "Do you want to enter this information?" prompt allows the user to enter or correct fields on the Anesthesia Report.

Example: Entering or Correcting a Field on the Anesthesia Report prior to Signature

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

     ASA CLASS

Do you want to enter this information? YES// YES
```

```
** ANESTHESIA REPORT **   CASE #267226  SURPATIENT,TEN PAGE 1 OF 2

1    OPERATING ROOM:     WX OR3
2    PRINC ANESTHETIST:  SURANESTHETIST,SEVEN
3    RELIEF ANESTHETIST:
4    ANESTHESIOLOGIST SUPVR: SURANESTHESIOLOGIST,ONE
5    ANES SUPERVISE CODE: 3. STAFF ASSISTING C.R.N.A.
6    ASST ANESTHETIST:   SURANESTHETIST,FIVE
7    ANES CARE TIME BLOCK:   (MULTIPLE)(DATA)
8    ASA CLASS:
9    OP DISPOSITION:     SICU
10   ANESTHESIA TECHNIQUE: (MULTIPLE)(DATA)
11   PRINCIPAL PROCEDURE: MVR
12   OTHER PROCEDURES:   (MULTIPLE)(DATA)
13   MEDICATIONS:        (MULTIPLE)
14   MIN INTRAOP TEMPERATURE (C): 35
15   MONITORS:               (MULTIPLE)

Enter Screen Server Function:  8
ASA Class: 1  1     1-NO DISTURB.
```

```
** ANESTHESIA REPORT **   CASE #267226  SURPATIENT,TEN PAGE 1 OF 2

1    OPERATING ROOM:     WX OR3
2    PRINC ANESTHETIST:  SURANESTHETIST,SEVEN
3    RELIEF ANESTHETIST:
4    ANESTHESIOLOGIST SUPVR: SURANESTHESIOLOGIST,ONE
5    ANES SUPERVISE CODE: 3. STAFF ASSISTING C.R.N.A.
6    ASST ANESTHETIST:   SURANESTHETIST,FIVE
7    ANES CARE TIME BLOCK:   (MULTIPLE)(DATA)
8    ASA CLASS:          1-NO DISTURB.
9    OP DISPOSITION:     SICU
10   ANESTHESIA TECHNIQUE: (MULTIPLE)(DATA)
11   PRINCIPAL PROCEDURE: MVR
12   OTHER PROCEDURES:   (MULTIPLE)(DATA)
13   MEDICATIONS:        (MULTIPLE)
14   MIN INTRAOP TEMPERATURE (C): 35
15   MONITORS:               (MULTIPLE)

Enter Screen Server Function: ^
```

After any necessary edits have been made, the report can be electronically signed.

Example: Electronically signing the Anesthesia Report

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

 Anesthesia Report Functions:

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

Select number: 2// 3  Sign the report electronically

Enter your Current Signature Code: XXX  SIGNATURE VERIFIED

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

 * * The Anesthesia Report has been electronically signed. * *
```

When typing the electronic signature code, no characters will display on screen.

Once an Anesthesia Report has been signed, a warning informing the user that the Anesthesia Report has already been signed will display on screen and an addendum will be required for any future changes.

Anesthesia Report (Signed)

After an Anesthesia Report has been signed, any changes to the signed report will require a signed addendum.

Example: Editing the Signed Report

```
Select Operation Menu Option: AR  Anesthesia Report

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

 * * The Anesthesia Report has been electronically signed. * *

 Anesthesia Report Functions:

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

Select number: 2// 1  Edit report information
```

If the Anesthesia Report and/or the Nurse Intraoperative Report has already been signed, the following warning will be displayed. If any data on either signed report is edited, an addendum to the Anesthesia Report and/or to the Nurse Intraoperative Report will be required.

Example: Warning

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

                              >>>  WARNING  <<<

   Electronically signed reports are associated with this case. Editing
   of data that appear on electronically signed reports will require the
   creation of addenda to the signed reports.


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

The user can proceed to edit the report and sign the required addendum or simply exit.

Example: Editing the Signed Report

```
** ANESTHESIA REPORT **   CASE #267226  SURPATIENT,TEN PAGE 1 OF 2

1    OPERATING ROOM:     WX OR3
2    PRINC ANESTHETIST:  SURANESTHETIST,SEVEN
3    RELIEF ANESTHETIST:
4    ANESTHESIOLOGIST SUPVR: SURANESTHESIOLOGIST,ONE
5    ANES SUPERVISE CODE: 3. STAFF ASSISTING C.R.N.A.
6    ASST ANESTHETIST:   SURANESTHETIST,FIVE
7    ANES CARE TIME BLOCK:   (MULTIPLE)(DATA)
8    ASA CLASS:          1-NO DISTURB.
9    OP DISPOSITION:     SICU
10   ANESTHESIA TECHNIQUE: (MULTIPLE)(DATA)
11   PRINCIPAL PROCEDURE: MVR
12   OTHER PROCEDURES:   (MULTIPLE)(DATA)
13   MEDICATIONS:        (MULTIPLE)
14   MIN INTRAOP TEMPERATURE (C): 35
15   MONITORS:               (MULTIPLE)

Enter Screen Server Function:  1
Operating Room: WX OR3// BO OR1
```

```
** ANESTHESIA REPORT **   CASE #267226  SURPATIENT,TEN PAGE 1 OF 2

1    OPERATING ROOM:     BO OR1
2    PRINC ANESTHETIST:  SURANESTHETIST,SEVEN
3    RELIEF ANESTHETIST:
4    ANESTHESIOLOGIST SUPVR: SURANESTHESIOLOGIST,ONE
5    ANES SUPERVISE CODE: 3. STAFF ASSISTING C.R.N.A.
6    ASST ANESTHETIST:   SURANESTHETIST,FIVE
7    ANES CARE TIME BLOCK:   (MULTIPLE)(DATA)
8    ASA CLASS:          1-NO DISTURB.
9    OP DISPOSITION:     SICU
10   ANESTHESIA TECHNIQUE: (MULTIPLE)(DATA)
11   PRINCIPAL PROCEDURE: MVR
12   OTHER PROCEDURES:   (MULTIPLE)(DATA)
13   MEDICATIONS:        (MULTIPLE)
14   MIN INTRAOP TEMPERATURE (C): 35
15   MONITORS:               (MULTIPLE)

Enter Screen Server Function:  ^
```

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

An addendum to each of the following electronically signed document(s) is
required:

          Nurse Intraoperative Report - Case #267226
          Anesthesia Report - Case #267226

If you choose not to create an addendum, the original data will be restored
to the modified fields appearing on the signed reports.


Create addendum? YES// <Enter>
```

If the user elects to exit these options prior to signing the addendum, all fields on the report revert back to the values entered when electronically signed.

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

The Operating Room field was changed
  from WX OR3
    to BO OR1

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

```
Do you want to add a comment for this case? NO// YES


Comment: OPERATING ROOM NUMBER WAS CORRECTED.
```

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

The Operating Room field was changed
  from WX OR3
    to BO OR1

Addendum Comment: OPERATING ROOM NUMBER WAS CORRECTED.

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

Enter your Current Signature Code: XXX   SIGNATURE VERIFIED

Press RETURN to continue... <Enter>
```

When typing the electronic signature code, no characters will display on screen.

The *Print/View report from beginning* function can then be used to view or print the report with the addendum.

Example: Print/View Report With Addendum

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

 * * The Anesthesia Report has been electronically signed. * *

 Anesthesia Report Functions:

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

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

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

DEVICE: [Select Print Device]
```

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

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

SUBJECT: Case #: 267226

Operating Room: WX OR3

Anesthetist: SURANESTHETIST,SEVEN              Relief Anesth:
Anesthesiologist: SURANESTHESIOLOGIST,ONE       Assist Anesth: SURANESTHETIST,FIVE
Attending Code: 3. STAFF ASSISTING C.R.N.A.

Anes Begin:  FEB 12, 2004  08:00        Anes End:  FEB 12, 2004  12:10

ASA Class: 1-NO DISTURB.

Operation Disposition: SICU

Anesthesia Technique(s):
GENERAL  (PRINCIPAL)
  Agent:     ISOFLURANE FOR INHALATION 100ML
Enter RETURN to continue or '^' to exit:

  Intubated: YES
  Trauma: NONE

Procedure(s) Performed:
Principal: MVR

Min Intraoperative Temp: 35

Intraoperative Blood Loss: 800 ml       Urine Output: 750 ml
Operation Disposition: SICU
PAC(U) Admit Score:                     PAC(U) Discharge Score:

Postop Anesthesia Note Date/Time:


                  Signed by: /es/ SEVEN SURANESTHETIST
                                  03/04/2004 10:59



03/04/2004 11:04     ADDENDUM

The Operating Room field was changed
  from WX OR3
    to BO OR1

Addendum Comment: OPERATING ROOM NUMBER WAS CORRECTED.
                  Signed by: /es/ SEVEN SURANESTHETIST
                                  03/04/2004 11:04
```

Nurse Intraoperative Report
[SRONRPT]

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

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

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

Nurse Intraoperative Report - Before Electronic Signature

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

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

- TIME PAT IN OR
- HAIR REMOVAL METHOD
- CORRECT PATIENT IDENTITY
- SITE OF PROCEDURE
- CONFIRM PATIENT POSITION
- ANTIBIOTIC PROPHYLAXIS
- BLOOD AVAILABILITY
- CHECKLIST COMMENT
- TIME PAT OUT OR
- MARKED SITE CONFIRMED
- PREOPERATIVE IMAGING CONFIRMED
- PROCEDURE TO BE PERFORMED
- VALID CONSENT FORM
- CORRECT MEDICAL IMPLANTS
- APPROPRIATE DVT PROPHYLAXIS
- AVAILABILITY OF SPECIAL EQUIP

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

- SPONGE COUNT CORRECT (Y/N)
- INSTRUMENT COUNT CORRECT (Y/N)
- SHARPS COUNT CORRECT (Y/N)
- SPONGE, SHARPS, & INST COUNTER

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

- IMPLANT STERILITY CHECKED
- RN VERIFIER
- SERIAL NUMBER
- STERILITY EXPIRATION DATE
- LOT NUMBER

Entering the TIME PAT OUT OR field triggers an alert that is sent to the nurse responsible for signing the report. By acting on the alert, the nurse accesses the *Nurse Intraoperative Report* option to electronically sign the report.

At the bottom of the first screen is the prompt, "Press <return> to continue, 'A' to access Nurse Intraoperative Report functions, or '^' to exit:". The *Nurse Intraoperative Report* functions, accessed by entering **A** at the prompt, allow the user to edit the report, to view or print the report, or to electronically sign the report.

Example: First page of the Nurse Intraoperative Report

```
Select Operation Menu Option: NR  Nurse Intraoperative Report

                          SURPATIENT,TEN (000-12-3456)
   MEDICAL RECORD       NURSE INTRAOPERATIVE REPORT - CASE #267226       PAGE 1

Operating Room:  BO OR1                 Surgical Priority: ELECTIVE

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

Major Operations Performed:
Primary: MVR

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

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

 Press <return> to continue, 'A' to access Nurse Intraoperative Report
 functions, or '^' to exit: A
```

After the user enters an **A** at the prompt, the *Nurse Intraoperative Report* functions are displayed. The following examples demonstrate how these three functions are accessed and how they operate.
If the user enters a **1**, the Nurse Intraoperative Report data can be edited.

Example: Editing the Nurse Intraoperative Report

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

 Nurse Intraoperative Report Functions:

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

Select number: 2// 1
```

```
** NURSE INTRAOP **   CASE #267226  SURPATIENT,TEN PAGE 1 OF 6

1    CONFIRM PATIENT IDENTITY: YES
2    PROCEDURE TO BE PERFORMED: YES
3    SITE OF PROCEDURE:       YES
4    VALID CONSENT FORM:      YES
5    CONFIRM PATIENT POSITION: YES
6    MARKED SITE CONFIRMED:
7    PREOPERATIVE IMAGING CONFIRMED:
8    CORRECT MEDICAL IMPLANTS: YES
9    AVAILABILITY OF SPECIAL EQUIP: YES
10   ANTIBIOTIC PROPHYLAXIS:  YES
11   APPROPRIATE DVT PROPHYLAXIS: YES
12   BLOOD AVAILABILITY:      YES
13   CHECKLIST COMMENT:       (WORD PROCESSING)
14   CHECKLIST CONFIRMED BY:  SURNURSE,FIVE

Enter Screen Server Function: <Enter>
```

```
** NURSE INTRAOP **   CASE #267226  SURPATIENT,TEN PAGE 2 OF 6

1    SPONGE COUNT CORRECT (Y/N): YES
2    SHARPS COUNT CORRECT (Y/N): YES
3    INSTRUMENT COUNT CORRECT (Y/N): YES
4    SPONGE, SHARPS, & INST COUNTER: SURNURSE,FIVE
5    COUNT VERIFIER:
6    TIME PAT IN HOLD AREA:   JUL 12, 2004 AT 07:30
7    TIME PAT IN OR:          JUL 12, 2004 AT 08:00
8    TIME OPERATION BEGAN:    JUL 12, 2004 at 08:58
9    TIME OPERATION ENDS:     JUL 12, 2004 AT 12:30
10   SURG PRESENT TIME:
11   TIME PAT OUT OR:
12   PRINCIPAL PROCEDURE:     CHOLECYSTECTOMY
13   OTHER PROCEDURES:        (MULTIPLE)
14   WOUND CLASSIFICATION:    CLEAN
15   OP DISPOSITION:

Enter Screen Server Function:  14
Wound Classification: CLEAN// CONTAMINATED  CONTAMINATED
```

```
** NURSE INTRAOP **   CASE #267226  SURPATIENT,TEN PAGE 2 OF 6

1    SPONGE COUNT CORRECT (Y/N): YES
2    SHARPS COUNT CORRECT (Y/N): YES
3    INSTRUMENT COUNT CORRECT (Y/N): YES
4    SPONGE, SHARPS, & INST COUNTER: SURNURSE,FIVE
5    COUNT VERIFIER:
6    TIME PAT IN HOLD AREA:   JUL 12, 2004 AT 07:30
7    TIME PAT IN OR:          JUL 12, 2004 AT 08:00
8    TIME OPERATION BEGAN:    JUL 12, 2004 at 08:58
9    TIME OPERATION ENDS:     JUL 12, 2004 AT 12:30
10   SURG PRESENT TIME:
```

```
11   TIME PAT OUT OR:
12   PRINCIPAL PROCEDURE:     CHOLECYSTECTOMY
13   OTHER PROCEDURES:        (MULTIPLE)
14   WOUND CLASSIFICATION:    CONTAMINATED
15   OP DISPOSITION:

Enter Screen Server Function:  <Enter>
```

```
** NURSE INTRAOP **   CASE #267226  SURPATIENT,TEN PAGE 3 OF 6

1    MAJOR/MINOR:             MAJOR
2    OPERATING ROOM:          OR1
3    CASE SCHEDULE TYPE:      ELECTIVE
4    SURGEON:                 SURSURGEON,THREE
5    ATTEND SURG:             SURSURGEON,THREE
6    FIRST ASST:              SURSURGEON,FOUR
7    SECOND ASST:
8    PRINC ANESTHETIST:       SURANESTHETIST,SEVEN
9    ASST ANESTHETIST:
10   OTHER SCRUBBED ASSISTANTS: (MULTIPLE)
11   OR SCRUB SUPPORT:        (MULTIPLE)(DATA)
12   OR CIRC SUPPORT:         (MULTIPLE)(DATA)
13   OTHER PERSONS IN OR:     (MULTIPLE)
14   PREOP MOOD:              RELAXED
15   PREOP CONSCIOUS:         RESTING

Enter Screen Server Function:  <Enter>
```

```
** NURSE INTRAOP **   CASE #267226  SURPATIENT,TEN PAGE 4 OF 6

1    PREOP SKIN INTEG:        INTACT
2    PREOP CONVERSE:          NOT ANSWER QUESTIONS
3    HAIR REMOVAL BY:         SURNURSE,FIVE
4    HAIR REMOVAL METHOD:     OTHER
5    HAIR REMOVAL COMMENTS:   (WORD PROCESSING)(DATA)
6    SKIN PREPPED BY (1):     SURNURSE,FIVE
7    SKIN PREPPED BY (2):
8    SKIN PREP AGENTS:        BETADINE
9    SECOND SKIN PREP AGENT:  POVIDONE IODINE
10   SURGERY POSITION:        (MULTIPLE)(DATA)
11   RESTR & POSITION AIDS:   (MULTIPLE)(DATA)
12   ELECTROCAUTERY UNIT:
13   ESU COAG RANGE:
14   ESU CUTTING RANGE:
15   ELECTROGROUND POSITION:

Enter Screen Server Function:  ^
```

If SHAVING or OTHER is entered as the Hair Removal Method, then Hair Removal Comments must be entered before the report can be electronically signed.

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

Example: Printing the Nurse Intraoperative Report

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

 Nurse Intraoperative Report Functions:

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

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

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

```
------------------------------------------------------------------------------
SURPATIENT,TEN  000-12-3456                        NURSE INTRAOPERATIVE REPORT
------------------------------------------------------------------------------
NOTE DATED: 07/12/2004 08:00  NURSE INTRAOPERATIVE REPORT

SUBJECT: Case #: 267226

Operating Room:  BO OR1                Surgical Priority: ELECTIVE

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

Major Operations Performed:
Primary: MVR

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

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

Other Scrubbed Assistants: N/A

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

Other Persons in OR: N/A

Preop Mood:       ANXIOUS              Preop Consc:    ALERT-ORIENTED
Preop Skin Integ: INTACT               Preop Converse: N/A
Confirm Correct Patient Identity: YES
Confirm Procedure to be Performed: YES
Confirm Site of the Procedure, including laterality: YES
Confirm Valid Consent Form: YES
Confirm Patient Position: YES
Confirm Proc. Site has been Marked Appropriately and that the Site of the
 Mark is Visible After Prep and Draping: YES
Pertinent Medical Images have been Confirmed: YES
Correct Medical Implant(s) is available: YES
Availability of Special Equipment: YES
Appropriate Antibiotic Prophylaxis: YES
Appropriate Deep Vein Thrombosis Prophylaxis: YES
Blood Availability: YES
Checklist Comment: NO COMMENTS ENTERED

Checklist Confirmed By: SURNURSE,FIVE


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

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

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

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

Flash Sterilization Episodes:
   Contamination:                      0
```

```
   SPD Processing/OR Management Issues: 0
   Emergency Case:                      0
   No Better Option:                    0
   Loaner or Short Notice Instrument:   0
   Decontamination of Instruments Not for Use In Patient: 0

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


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

Anesthesia Technique(s):
 GENERAL  (PRINCIPAL)


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

Tourniquet: N/A

Thermal Unit: N/A

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


Medications: N/A

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

Blood Replacement Fluids: N/A

Sponge Count:
Sharps Count:       YES
Instrument Count:   NOT APPLICABLE
Counter:            SURNURSE,FOUR
Counts Verified By: SURNURSE,FIVE

Dressing: DSD, PAPER TAPE, MEPORE
Packing:  NONE

Blood Loss: 800 ml                    Urine Output: 750 ml

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

Laser Unit(s): N/A

Sequential Compression Device: NO
```

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

Devices: N/A

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

(This page included for two-sided copying.)

To electronically sign the report, the user enters a **3** at the *Nurse Intraoperative Report* functions prompt.

Example: Signing the Nurse Intraoperative Report

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

 Nurse Intraoperative Report Functions:

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

Select number: 2// 3
```

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

TIME PATIENT IN OR	TIME PATIENT OUT OF OR
MARKED SITE CONFIRMED	CORRECT PATIENT IDENTITY
PREOPERATIVE IMAGING CONFIRMED	HAIR REMOVAL METHOD
PROCEDURE TO BE PERFORMED	SITE OF THE PROCEDURE
VALID CONSENT FORM	PATIENT POSITION
CORRECT MEDICAL IMPLANTS	ANTIBIOTIC PROPHYLAXIS
APPROPRIATE DVT PROPHYLAXIS	BLOOD AVAILABILITY
AVAILABILITY OF SPECIAL EQUIP	CHECKLIST COMMENT

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

SPONGE COUNT CORRECT	SHARPS COUNT CORRECT (Y/N)
INSTRUMENT COUNT CORRECT (Y/N)	SPONGE, SHARPS, & INST COUNTER

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

IMPLANT STERILITY CHECKED (Y/N)	STERILITY EXPIRATION DATE
RN VERIFIER	LOT NUMBER
SERIAL NUMBER	

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

Example: Missing Field Warning

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

     ANTIBIOTIC PROPHYLAXIS
     CHECKLIST COMMENT

Do you want to enter this information? YES// YES
```

```
** NURSE INTRAOP **   CASE #267226  SURPATIENT,TEN PAGE 1 OF 6

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


Enter Screen Server Function:  10
Appropriate Antibiotic Prophylaxis: Y  YES
```

```
** NURSE INTRAOP **   CASE #267226  SURPATIENT,TEN PAGE 1 OF 6

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

Enter Screen Server Function: ^
```

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

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

 Nurse Intraoperative Report Functions:

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

Select number: 2// 3  Sign the report electronically

Enter your Current Signature Code: XXXXXX   SIGNATURE VERIFIED

Press RETURN to continue... <Enter>
```

When typing the electronic signature code, no characters will display on screen.

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

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

 Nurse Intraoperative Report Functions:

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

Select number: 2// ^
```

Nurse Intraoperative Report - After Electronic Signature

After the report has been signed, any changes to the report will require a signed addendum.

Example: Editing the Signed Nurse Intraoperative Report

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

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

 Nurse Intraoperative Report Functions:

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

Select number: 2// 1  Edit report information
```

If the Anesthesia Report and/or the Nurse Intraoperative Report is already signed, the following warning will be displayed. If any data on either signed report is edited, an addendum to the Anesthesia Report and/or to the Nurse Intraoperative Report will be required.

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


                              >>>  WARNING  <<<

   Electronically signed reports are associated with this case. Editing
   of data that appear on electronically signed reports will require the
   creation of addenda to the signed reports.



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

First, the user makes the edits to the desired field.

```
** NURSE INTRAOP **   CASE #267226  SURPATIENT,TEN PAGE 1 OF 6

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


Enter Screen Server Function:  14
Checklist Confirmed By: SURNURSE,FOUR // SURNURSE,FIVE
```

```
** NURSE INTRAOP **   CASE #267226  SURPATIENT,TEN PAGE 1 OF 6

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


Enter Screen Server Function: ^
```

An addendum is required before the edit can be made to the signed report.

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

An addendum to each of the following electronically signed document(s) is
required:

          Nurse Intraoperative Report - Case #267226

If you choose not to create an addendum, the original data will be restored
to the modified fields appearing on the signed reports.


Create addendum? YES//  <Enter>
```

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

The Checklist Confirmed By field was changed
  from SURNURSE,FOUR
    to SURNURSE,FIVE

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

Before the addendum is signed, comments may be added.

Example: Signing the Addendum

```
Comment: OPERATION END TIME WAS CORRECTED.

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

The Checklist Confirmed By field was changed
  from SURNURSE,FOUR
    to SURNURSE,FIVE

Addendum Comment: OPERATION END TIME WAS CORRECTED.

Enter RETURN to continue or '^' to exit:

Enter your Current Signature Code: XXXXXX   SIGNATURE VERIFIED..

Press RETURN to continue... <Enter>
```

When typing the electronic signature code, no characters will display on screen.

Example: Printing the Nurse Intraoperative Report

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

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

 Nurse Intraoperative Report Functions:

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

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

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

DEVICE: HOME//  [Select Print Device]
```

----------printout follows----------

```
------------------------------------------------------------------------------
SURPATIENT,TEN  000-12-3456                        NURSE INTRAOPERATIVE REPORT
------------------------------------------------------------------------------
NOTE DATED: 07/12/2004 08:00  NURSE INTRAOPERATIVE REPORT

SUBJECT: Case #: 267226

Operating Room:  BO OR1                 Surgical Priority: ELECTIVE

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

Major Operations Performed:
Primary: MVR

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

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

Other Scrubbed Assistants: N/A

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

Other Persons in OR: N/A

Preop Mood:       ANXIOUS               Preop Consc:    ALERT-ORIENTED
Preop Skin Integ: INTACT                Preop Converse: N/A
Confirm Correct Patient Identity: YES
Confirm Procedure to be Performed: YES
Confirm Site of the Procedure, including laterality: YES
Confirm Valid Consent Form: YES
Confirm Patient Position: YES
Confirm Proc. Site has been Marked Appropriately and that the Site of the
 Mark is Visible After Prep and Draping: YES
Pertinent Medical Images have been Confirmed: YES
Correct Medical Implant(s) Is Available: YES
Availability of Special Equipment: YES
Appropriate Antibiotic Prophylaxis: YES
Appropriate Deep Vein Thrombosis Prophylaxis: YES
Blood Availability: YES
Checklist Comment: NO COMMENTS ENTERED

Checklist Confirmed By: SURNURSE,FOUR


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

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

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

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

Flash Sterilization Episodes:
```

```
   Contamination:                       0
   SPD Processing/OR Management Issues: 0
   Emergency Case:                      0
   No Better Option:                    0
   Loaner or Short Notice Instrument:   0
   Decontamination of Instruments Not for Use In Patient: 0

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

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

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

Tourniquet: N/A

Thermal Unit: N/A

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

Medications: N/A

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

Blood Replacement Fluids: N/A

Sponge Count:       YES
Sharps Count:       YES
Instrument Count:   NOT APPLICABLE
Counter:            SURNURSE,FOUR
Counts Verified By: SURNURSE,FIVE

Dressing: DSD, PAPER TAPE, MEPORE
Packing:  NONE

Blood Loss: 800 ml                     Urine Output: 750 ml

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

Laser Unit(s): N/A

Sequential Compression Device: NO

Cell Saver(s): N/A

Devices: N/A

Nursing Care Comments:
```

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

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

The Checklist Confirmed By field was changed
  from SURNURSE,FOUR to SURNURSE,FIVE

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

(This page included for two-sided copying.)

Tissue Examination Report
[SROTRPT]

The *Tissue Examination Report* option is used to generate the Tissue Examination Report that contains information about cultures and specimens sent to the laboratory.

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

Example: Tissue Examination Report

```
Select Operation Menu Option: T Tissue Examination Report
DEVICE: [Select Print Device]
```

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

```
--------------------------------------------------------------------------------
     MEDICAL RECORD   |                    TISSUE EXAMINATION
--------------------------------------------------------------------------------
Specimen Submitted By:                           Obtained: MAR 09, 1999
   OR1,  SURGERY CASE # 187
--------------------------------------------------------------------------------
Specimen(s):
--------------------------------------------------------------------------------
Brief Clinical History:
  Subscapular pain for 3 days. Nausea and vomiting.
  Increased serum amylase.
--------------------------------------------------------------------------------
Operative Procedure(s):
   CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM
--------------------------------------------------------------------------------
Preoperative Diagnosis:
   CHOLECYSTITIS
--------------------------------------------------------------------------------
Operative Findings:
  THE GALLBLADDER HAD A FEW ADHESIONS EASILY REMOVED
  AND WAS FOUND TO BE FIRMLY DISTENDED WITH STONES.
--------------------------------------------------------------------------------
Postoperative Diagnosis:                         Signature and Title
   CHOLECYSTITIS                                 SURSURGEON,TWO
--------------------------------------------------------------------------------
Attending Surgeon: SURSURGEON,ONE
--------------------------------------------------------------------------------
                             PATHOLOGY REPORT
--------------------------------------------------------------------------------
Name of Laboratory                               Accession Number(s)

--------------------------------------------------------------------------------
Gross Description, Histologic Examination and Diagnosis



                             (Continue on reverse side)
--------------------------------------------------------------------------------
PATHOLOGIST'S SIGNATURE                                    DATE:
--------------------------------------------------------------------------------
SURPATIENT,NINE                    AGE: 48   SEX: MALE          ID # 000-34-5555
ETHNICITY: NOT HISPANIC                                    REGISTER NO.
RACE: WHITE, ASIAN
WARD:                        ROOM-BED:
--------------------------------------------------------------------------------
VAMC: MAYBERRY, NC                                         REPLACEMENT FORM 515
```

Enter Referring Physician Information
[SROMEN-REFER]

The *Enter Referring Physician Information* option allows the surgical staff to enter the name, address, and phone number of the individual or institution that referred the patient. The scheduling manager usually enters referring physician information when the operation is booked. This information shows up on many reports.

First, users identify the surgical specialty to which the patient will be assigned. To add a new case to the waiting list, the user must enter the patient's name and the procedure name. The user can also add comments, referring physician name and address, tentative admission date, and tentative operation date. This information will appear on the *Waiting List Report*. Patient names stay on the waiting list until the data is used to make a request or until the data is deleted.

After entering a Referring Physician name or partial name, the system prompts, "Is this a VA Physician from this facility? (Y/N): <Y>". If the user answers Y, a list of VA physician names displays that matches the data entered. The user selects from those listed. The physician's address and telephone number are also copied into the corresponding fields if the data is available. If no selection is made, the system accepts the information entered as free text.

If the referring physician is not from that VA facility, then the system uses the information already entered as the Referring Physician name, or the user can enter the appropriate name.

Example: Enter Referring Physician Information

```
Select Operation Menu Option: R  Enter Referring Physician Information

Select REFERRING PHYSICIAN: SURPHYSICIAN,ONE
Is this a VA physician from this facility?  (Y/N): Y
Lookup: NAME
    2  SURPHYSICIAN,O    OJ   112   SURGICAL STUDENT
    3  SURPHYSICIAN,S
    4  SURPHYSICIAN,S A
    5  SURPHYSICIAN,S T
    6  SURPHYSICIAN,T

Press <RETURN> to see more, '^' to exit this list, '^^' to exit all lists, OR
CHOOSE 1-5:
```

Enter Irrigations and Restraints
[SROMEN-REST]

The *Enter Irrigations and Restraints* option is designed to allow the nurse to quickly document the irrigation solutions or the restraint and positioning devices used in a case. The list of solutions or devices can be different at each facility.

At the "Select Number:" prompt, the user should choose the number corresponding to the solution or device. For more than one choice, numbers are separated with a comma. If an item has been selected before, a default prompt will appear. The user can enter an at-sign (@) to delete the selection, as in Example 3.

Example 1: Entering Irrigations

```
Select Operation Menu Option: RP  Enter Irrigations or Restraints

Enter/Edit Irrigations or Restraints and Positioning Aids:

1. Irrigations
2. Restraints and Positioning Aids
Select Number: 1

                        IRRIGATION SOLUTIONS
============================================================

       1.     AEROSP/PXYN           2.     BACITRACIN SOLUTION
       3.     BETADINE SOLUTION     4.     HEPARIN
       5.     HEPARINIZED SALINE    6.     ICED SALINE
       7.     KANTREX SOLUTION      8.     KEFLEX SOLUTION
       9.     NEOMYCIN              10.    NEOMYCIN SOLUTION
       11.    NORMAL SALINE         12.    POVODINE
       13.    SORBITAL              14.    STERILE WATER
       15.    VEIN GRAFT SOLUTION   16.    THROMBIN


Select the number(s) corresponding to your choice: 2,15

Entering BACITRACIN SOLUTION ...
Entering VEIN GRAFT SOLUTION ...

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

Example 2: Restraints and Positioning Aids

```
Select Operation Menu Option: RP  Enter Irrigations or Restraints

Enter/Edit Irrigations or Restraints and Positioning Aids:
1. Irrigations
2. Restraints and Positioning Aids

Select Number: 2
```

```
                    Restraints and Positioning Aids
==========================================================================
       1.     ARMSHEET              2.     SAFETY STRAP
       3.     ARMBOARD              4.     VAC PAC
       5.     FOAM PADS             6.     PILLOW
       7.     AXILLARY ROLL         8.     ADHESIVE TAPE
       9.     SURGERY ARMBOARD      10.    KIDNEY REST
       11.    SANDBAG               12.    OVERHEAD ARMREST
       13.    ROLLED SHEET          14.    LEG HOLDER
       15.    FOOT EXTENSION        16.    STIRRUPS
       17.    FRACTURE TABLE        18.    OTHER

Select the number(s) corresponding to your choice: 3,6,9
Entering ARMBOARD ...

Entering PILLOW ...

Entering SURGERY ARMBOARD ...

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

Example 3: Deleting Restraints and Positioning Aids

```
Select Operation Menu Option: RP  Enter Irrigations or Restraints
```

```
Enter/Edit Irrigations or Restraints and Positioning Aids:
1. Irrigations
2. Restraints and Positioning Aids

Select Number: 2
```

```
                    Restraints and Positioning Aids
==========================================================================
       1.     ARMSHEET              2.     SAFETY STRAP
       3.     ARMBOARD              4.     VAC PAC
       5.     FOAM PADS             6.     PILLOW
       7.     AXILLARY ROLL         8.     ADHESIVE TAPE
       9.     SURGERY ARMBOARD      10.    KIDNEY REST
       11.    SANDBAG               12.    OVERHEAD ARMREST
       13.    ROLLED SHEET          14.    LEG HOLDER
       15.    FOOT EXTENSION        16.    STIRRUPS
       17.    FRACTURE TABLE        18.    OTHER

Select the number(s) corresponding to your choice: 3
Entering ARMBOARD ...
  RESTR & POSITION AIDS: ARMBOARD// @
   SURE YOU WANT TO DELETE THE ENTIRE RESTR & POSITION AIDS? Y  (YES)

Press <Enter> to continue
```

Medications (Enter/Edit)
[SROANES MED]

The *Medications (Enter/Edit)* option allows the user to enter all the medications administered on a case. It is designed to aid in quickly entering many different medications for a case.

In one entry, the user can enter the medication, dosage, route, and time given with the use of slashes between these categories. After one medication has been entered, the software will return the cursor to the beginning prompt so that the user can enter another medication for the case. When the user is finished entering medications for the case, he or she should press the **<Enter>** key to return to the menu.

About the prompts

"ENTER MEDICATION/DOSE(MG)/ROUTE/TIME:" Respond to this prompt with the medication, dosage, route, and time given separated by slashes. If the software needs more specific information about the medication, the user will be prompted. In the example below, the software reads "Valium" and then asks the user to select from the Valiums on file. A question mark can be entered in place of one of the categories in order to get help or more information. In the example, a question mark was entered in place of the route. Then, in response to the question mark, the software offered a list of acceptable routes.

Example: Entering Medication

```
Select Operation Menu Option: Medications (Enter/Edit)

ENTER MEDICATION/DOSE(MG)/ROUTE/TIME: DIAZEPAM/5MG/?/8:00


     1   DIAZEPAM 10MG S.R. CAP                 N/F     ***NOT MANUFACTURED***
     2   DIAZEPAM 10MG S.T.                   NOTE RESTRICTIONS (ON OPTS ONLY)
     3   DIAZEPAM 15 MG S.R. CAP                N/F     NOTE RESTRICTIONS
     4   DIAZEPAM 2MG S.T.                 N/F
     5   DIAZEPAM 5MG S.T.                   NOTE RESTRICTIONS (ON OPTS ONLY)

Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 5

Route entered is not one of the available choices.
Please enter medication route again.

Choose from:
IV        INTRAVENOUS
T        TOPICAL
IR        IRRIGATION
IM        INTRAMUSCULAR
R        RECTAL
S        SUBLINGUAL
SC        SUBCUTANEOUS
IN        INFILTRATE
O        OTHER
P        PREPUMP
OR        ORAL

Enter ROUTE: IV  INTRAVENOUS

MEDICATION ENTERED ....

ENTER MEDICATION/DOSE(MG)/ROUTE/TIME:
```

Blood Product Verification
[SR BLOOD PRODUCT VERIFICATION]

The *Blood Product Verification* option is used for transfusion error risk management. This option is used in conjunction with a bar code reader to confirm that the blood product is assigned to the patient. The functionality provided by this option is meant as an additional check for proper patient identification and should never be relied upon as the primary check.

This option prompts the user to scan the blood product unit ID, after which the software checks the Blood Bank files for an association with the patient identified. If there are multiple entries with the unit ID scanned, these entries will be listed along with the Blood Component, Patient Associated, and Expiration Date. The user will then be prompted to select the one that matches the blood product about to be administered. If the selected product is not associated with the patient identified, a warning message will be displayed.

There are certain valid scenarios that are internal to the Blood Bank that may result in a blood component not being readable using the scanner and therefore may give an unexpected response. There will be some rare instances in which this option may not produce an expected result. After verifying proper patient identification, the option may be attempted again; however, it is recommended that the unit ID be typed in manually rather than be scanned in these cases.

Blood product manufacturers are required to label all units of blood in a consistent manner. The barcode that is to be scanned at the "Enter Blood Product Identifier:" prompt will always be the barcode in the upper-left portion of the blood product label. Since this label can be in close proximity to the ABO/Rh label, care should be taken not to read both labels during a scan. One way to accomplish this would be to use a finger or some other convenient object to cover the label that the user does not wish to have read during the scanning process. The light emitted from the scanner itself will cause no harm to skin, latex, or any other object with which it comes in contact.

Example: Option displayed with no discrepancies

```
Select Operation Menu Option: BLOOD PRODUCT VERIFICATION
To use BAR CODE READER
               Pass reader wand over a GROUP-TYPE ( ABO/Rh) label
                          =>
Enter Blood Product Identifier: KW10945


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

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

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

Select the blood product matching the unit label: (1-3): 2

No Discrepancies Found
```

Example: Option displayed with discrepancies

```
Select Operation Menu Option: BLOOD PRODUCT VERIFICATION

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

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

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

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

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

                       **WARNING**

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

Anesthesia Menu
[SROANES1]

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

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

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

Prerequisites

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

Anesthesia Data Entry Menu
[SROANES-D]

The *Anesthesia Data Entry Menu* allows the user to enter anesthesia data pertinent to a selected case. The information entered in these sub-options is reflected on the Anesthesia Report.

To use any option within the *Anesthesia Data Entry Menu*, the user must first enter a patient name and choose a patient case, as shown below.

Example: How to Select a Case for the Data Entry Menu

```
Select Surgery Menu Option:  A  Anesthesia Menu

   E      Anesthesia Data Entry Menu
   R      Anesthesia Report
   A      Anesthesia AMIS
   S      Schedule Anesthesia Personnel

Select Anesthesia Menu Option: E  Anesthesia Data Entry Menu
Select Patient: SURPATIENT,NINE         12-09-51     000345555     NSC VETERAN
```

```
 SURPATIENT,NINE   000-34-5555

1. 04-26-99   CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM (COMPLETED)

2. 11-20-98   Release of Hammer Toes (REQUESTED)

3. ENTER NEW SURGICAL CASE


Select Operation: 1
```

```
  SURPATIENT,NINE (000-34-5555)   Case #145 – APR 26,1999


   I      Anesthesia Information  (Enter/Edit)
   T      Anesthesia Technique (Enter/Edit)
   M      Medications (Enter/Edit)

Select Anesthesia Data Entry Menu Option:
```

Anesthesia Information (Enter/Edit)
[SROMEN-ANES]

Anesthesia staff uses this option to enter anesthesia related information for a given case. The first group of prompts affects the Anesthesia AMIS Report. Some of the data fields may be automatically filled in from previous responses.

At the "Enter Screen Server Function:" prompt, the user can choose the field(s) to be edited, or press the **<Enter>** key to continue. Some of the data fields are "multiple" and may contain more than one value. When a multiple field is selected, a new screen is generated so that the user can enter data related to that multiple. For instance, the MONITORS field generates a new screen for adding the device, time installed, and time removed. The TIME INSTALLED field and TIME REMOVED field generate additional screens so that the user may enter more than one time installed/removed for the same operation.

About the prompts

The prompts are described as follows:

- "Is this the Principal Technique (Y/N): " — Asks if the user has entered a technique that is the primary anesthesia technique for the case. The user should always establish the principal technique as this information affects many reports.
- "Would you like to enter additional anesthesia related information ? " — If the user wants to enter more detailed information concerning the case, he or she must answer **YES** to this prompt. Two Screen Server-formatted pages are then provided for entering more anesthesia information for the case.
- "Does this entry complete all start and end times for this case? "— The user should answer **YES** only if the block of time just completed is the final block of time for the case that he or she is documenting.

An Anesthesia Care Questionnaire will be added to allow a more complete capture of clinical data, which will support coding and billing efforts. The results of the questionnaire are crucial for a coder to use in order to select the proper modifier. Modifiers are required for reimbursement for all anesthesia services.

This information can be accessed through the Anesthesia menu, specifically through the Anesthesia Data Entry Menu. The user selects a patient and surgical case and completes the anesthesia information.

After completion, the user is prompted with the question, "Would you like to enter additional anesthesia related information? " The questions associated with the Anesthesia Care Questionnaire (shown as numbers 8-12 on the last screen display in this section) are located on page two of the anesthesia information sheet.

Example: Entering Anesthesia Information

```
Select Anesthesia Data Entry Menu Option: I  Anesthesia Information (Enter/Edit)

The following information is required for the Anesthesia AMIS.

Principal Anesthetist: SURANESTHETIST,THREE// <Enter>
Select ANESTHESIA TECHNIQUE: G  (G   GENERAL)
  Is this the Principal Technique (Y/N): YES// <Enter>
  Was the Patient Intubated ?  (Y/N): Y  YES
  Trauma Resulting from Intubation Process: NONE// <Enter>
  Select ANESTHESIA AGENTS: ENFLURANE                N/F
    Dose (mg): 125
Diagnostic/Therapeutic (Y/N): NO// <Enter>

ASA Class: 2  2-MILD DISTURB.

Mallampati Scale:
Mandibular Space (length in mm):

Would you like to enter additional anesthesia related information ? NO//Y
```

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

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

Enter Screen Server Function: 6
```

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

1    NEW ENTRY

Enter Screen Server Function:  1
Select ANES CARE TIME BLOCK ANES CARE MULTIPLE START TIME: 4/26@9:20
   ANES CARE TIME BLOCK ANES CARE MULTIPLE START TIME: APR 26, 1999@09:20
         //
```

```
  ** ANESTHESIA INFO **   CASE #145  SURPATIENT,NINE     PAGE 1 OF 1
        ANES CARE TIME BLOCK  (3030426.092)

1    ANES CARE MULTIPLE START TIME: APR 26, 1999 AT 09:20
2    ANES CARE MULTIPLE END TIME:

Enter Screen Server Function:  2
Anesthesia Care Multiple End Time: 4/26@12:45  (APR 26, 1999@12:45)

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

```
  ** ANESTHESIA INFO **   CASE #145  SURPATIENT,NINE     PAGE 1 OF 1
        ANES CARE TIME BLOCK  (3030426.092)

1    ANES CARE MULTIPLE START TIME: APR 26, 1999 AT 09:20
2    ANES CARE MULTIPLE END TIME: APR 26, 1999 AT 12:45

Enter Screen Server Function:  <Enter>
```

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

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

Enter Screen Server Function:  <Enter>
```

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

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

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

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

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

Enter Screen Server Function: <Enter>
```

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

Enter Screen Server Function:  4
```

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

1    NEW ENTRY

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

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

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

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

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


Enter Screen Server Function: 8:12

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

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

            ANES CONCURRENT CASES

1    NEW ENTRY

Enter Screen Server Function: <Enter>
```

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

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


Enter Screen Server Function: <Enter>
```

(This page included for two-sided copying.)

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

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

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

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

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

About the prompts

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

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

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

Example 1: General Technique

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

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

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

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

Example 2: Monitored Anesthesia Care Technique

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

Example 3: Spinal Technique

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

Example 4: Epidural Technique

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

Example 5: Other Technique

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

Example 6: Local Technique

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

Example 7: Regional Technique

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

Medications (Enter/Edit)
[SROANES MED]

Anesthesia staff members use the *Medications (Enter/Edit)* option to enter medications administered on a case. This is the last sub-option of the *Anesthesia Data Entry Menu*.

This option is designed to help the user quickly enter many different medications for a case. In one entry, the user can enter the medication, dosage, route, and time given with the use of slashes between these categories. (This is a different type of prompt response from what has been used elsewhere). After the user has finished entering one medication, the software will return the cursor to the beginning prompt so that he or she can enter another medication for the case. When the user finishes entering medications for the case, he or she should press the **<Enter>** key to return to the *Anesthesia Data Entry Menu*.

About the prompts

"ENTER MEDICATION/DOSE(MG)/ROUTE/TIME:" Respond to this prompt with the medication, dosage, route, and time given separated by slashes. If the software needs more specific information about the medication, the user will be prompted. In the example, the software reads "Valium" and then asks the user to select from the Valiums on file. A question mark can be entered in place of one of the categories in order to get help or more information. In the following example, a question mark was entered in place of the route. Then, in response to the question mark, the software offered a list of acceptable routes.

Example: Entering a Medication

```
Select Anesthesia Data Entry Menu Option: M  Medications (Enter/Edit)
```

```
ENTER MEDICATION/DOSE(MG)/ROUTE/TIME: VALIUM/5MG/?/7:50

     1   VALIUM 5MG          N/F
     2   VALIUM  DIAZEPAM 10MG S.T.       N/F      RESTRICTED TO
ENT/ANESTHESIA/PSYCHIATRY/PARAPLEGICS
     3   VALIUM  DIAZEPAM 2MG S.T.       N/F      RESTRICTED TO
ENT/ANESTHESIA/PSYCHIATRY/PARAPLEGICS
TYPE '^' TO STOP, OR
CHOOSE 1-3: 1    (JAN 13, 1999  07:50)

Route entered is not one of the available choices.
Please enter medication route again.

Choose from:
IV        INTRAVENOUS
T        TOPICAL
IR        IRRIGATION
IM        INTRAMUSCULAR
R        RECTAL
S        SUBLINGUAL
SC        SUBCUTANEOUS
IN        INFILTRATE
O        OTHER
P        PREPUMP
OR        ORAL

ENTER ROUTE: IV

MEDICATION ENTERED ....
```

```
ENTER MEDICATION/DOSE(MG)/ROUTE/TIME:
```

Anesthesia Report
[SROARPT]

Anesthesia staff uses the *Anesthesia Report* option to print all the anesthesia information entered for a case. When a hard copy of this report is made, space is provided for the Anesthetist's signature. This option is located on the *Anesthesia Menu* option. It can also be accessed from the *Operation Menu* option.

For more information, see the Anesthesia Report section in the Operation Menu section of this manual.

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

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

Schedule Anesthesia Personnel
[SRSCHDA]

Anesthesia staff uses the *Schedule Anesthesia Personnel* option to assign or change anesthesia personnel for surgery cases. The Scheduling Manager can also assign personnel to the selected case using other menu options.

This *Schedule Anesthesia Personnel* option is locked with the SROANES key and will not appear on the menu if the user does not have this key.

With this option, the user can enter an anesthesia technique and the names of the principal anesthetist and supervisor. When an operating room is selected, the software will present all cases scheduled for that room. After scheduling personnel for cases in one operating room, the user can do the same for other operating rooms without leaving this option. For convenience, the software will default to the anesthetist and anesthesiologist supervisor previously scheduled for that room.

Example: Scheduling Anesthesia Personnel

```
Select Anesthesia Menu Option: S  Schedule Anesthesia Personnel
Schedule Anesthesia Personnel for which Date ?  4/26  (APR 26,1999)

Schedule Anesthesia Personnel for which Operating Room ?  OR2
```

```
Scheduled Operations for OR2
------------------------------------------------------------------------------

Case # 145   Patient: SURPATIENT,NINE
From: 09:00  To: 12:00
CHOLECYSTECTOMY


Requested Anesthesia Technique: GENERAL// <Enter>
Principal Anesthetist: SURANESTHETIST,THREE    TS
Anesthesiologist Supervisor: SURANESTHESIOLOGIST,TWO// <Enter>

Press <Enter> to continue, or '^' to quit   <Enter>
```

```
Scheduled Operations for OR2
------------------------------------------------------------------------------

Case # 148   Patient: SURPATIENT,THREE
From: 13:00  To: 18:00
SHOULDER ARTHROPLASTY

Requested Anesthesia Technique: GENERAL//  <Enter>
Principal Anesthetist: SURANESTHETIST,THREE//  <Enter>      TS
Anesthesiologist Supervisor: SURSURGEON,TWO//  <Enter>      DA

Press <Enter> to continue, or '^' to quit  <Enter>

Would you like to continue with another operating room ?  YES//  <Enter>

Schedule Anesthesia Personnel for which Operating Room ?  OR3
```

```
Scheduled Operations for OR3
------------------------------------------------------------------------------

Case # 136   Patient: SURPATIENT,FORTY
From: 07:00  To: 10:30
CHOLECYSECTOMY

Requested Anesthesia Technique: GENERAL// <Enter>
Principal Anesthetist: SURSURGEON,ONE          OS
Anesthesiologist Supervisor: SURANESTHESIOLOGIST,TWO //   <Enter>

Press <Enter> to continue, or '^' to quit   <Enter>
```

```
Would you like to continue with another operating room ?  YES// Y

Schedule Anesthesia Personnel for which Operating Room ?  OR1

There are no cases scheduled for this operating room.

Press RETURN to continue  <Enter>
```

```
Would you like to continue with another operating room ?  YES// N
```

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

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

Press RETURN to continue: <Enter>
```

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

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


Press RETURN to continue: <Enter>
```

```
SURPATIENT,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
  Definition Revised (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.)

Update Status of Returns Within 30 Days
[SRO UPDATE RETURNS]

The *Update Status of Returns Within 30 Days* option will define a case as related or unrelated to another case. When a new surgical case is entered into the software, the user is asked whether it is related to any previous cases within the past 30 days. This option is designed to update that information.

The user should first enter the patient name and select a case. The software will list any cases that occurred within 30 days prior to the selected case and will indicate if the listed cases have been flagged as related or unrelated. At this point the user may update the status of the cases listed.

Example: Updating Status of Returns Within 30 days

```
Select Perioperative Occurrences Menu Option:  Update Status of Returns Within 3
0 Days

Select Patient: SURPATIENT,SIXTY           03-03-59     000567821     NO     NO
N-VETERAN (OTHER)
```

```
SURPATIENT,SIXTY   000-56-7821

1. 07-06-99   REPAIR INGUINAL HERNIA (COMPLETED)

2. 06-25-99   CHOLECYSTECTOMY, APPENDECTOMY (COMPLETED)

3. 06-23-99   CHOLEDOCHOTOMY (COMPLETED)

4. 04-10-98   CRANIOTOMY (COMPLETED)



Select Operation: 3
```

```
SURPATIENT,SIXTY (000-56-7821)        Case #62192           RETURNS TO SURGERY
JUN 23,1999   CHOLEDOCHOTOMY
------------------------------------------------------------------------------

1. 07/06/99    REPAIR INGUINAL HERNIA - UNRELATED

2. 06/25/99    CHOLECYSTECTOMY - UNRELATED

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


Select Number: 2
```

```
SURPATIENT,SIXTY (000-56-7821)        Case #62192           RETURNS TO SURGERY
JUN 23,1999   CHOLEDOCHOTOMY
------------------------------------------------------------------------------


2. 06/25/99    CHOLECYSTECTOMY - UNRELATED

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


This return to surgery is currently defined as UNRELATED to the case selected.
Do you want to change this status ? NO// Y
```

```
SURPATIENT,SIXTY (000-56-7821)        Case #62192           RETURNS TO SURGERY
JUN 23,1999   CHOLEDOCHOTOMY
------------------------------------------------------------------------------

1. 07/06/99    REPAIR INGUINAL HERNIA - UNRELATED

2. 06/25/99    CHOLECYSTECTOMY (- RELATED

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


Select Number:
```

Morbidity & Mortality Reports
[SROMM]

The *Morbidity & Mortality Reports* option generates two reports: the Perioperative Occurrences Report and the Mortality Report. The Perioperative Occurrences Report includes all cases that have occurrences, both intraoperatively and postoperatively, and can be sorted by specialty, attending surgeon, or occurrence category. The Mortality Report includes all cases performed within the selected date range that had a death within 30 days after surgery, and sort by specialty within a date range. Each surgical specialty will begin on a separate page.

After the user enters the date range, the software will ask whether to generate both reports. If the user answers **NO**, the software will ask the user to select from the Perioperative Occurrences Report or the Mortality Report.

These reports have a 132-column format and are designed to be copied to a printer.

Example 1: Printing the Perioperative Occurrences Report – Sorted by Specialty

```
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

Print Report for:

1. Intraoperative Occurrences
2. Postoperative Occurrences
3. Intraoperative and Postoperative Occurrences


Select Number:  (1-3): 3

Start with Date: 7/1  (JUL 01, 2006)
End with Date: 7/31  (JUL 31, 2006)

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// <Enter>
```

```
Do you want to print this report for all Surgical Specialties ?  YES// N


Print the report for which Specialty ?  GENERAL (OR WHEN NOT DEFINED BELOW)
Select an Additional Specialty  <Enter>

This report is designed to use a 132 column format.

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

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

SURGICAL SERVICE REVIEWED BY:
PERIOPERATIVE OCCURRENCES-INTRAOP/POSTOP DATE REVIEWED:
FROM: JUL 1,2006 TO: JUL 31,2006 DATE PRINTED: AUG 22,2006

PATIENT ID# / OPERATION DATE	ATTENDING SURGEON / PRINCIPAL OPERATION	OCCURRENCE(S) - (DATE) / TREATMENT	OUTCOME
GENERAL(OR WHEN NOT DEFINED BELOW)			
SURPATIENT,TWELVE 000-41-8719 JUL 07, 2006@07:15	SURSURGEON,THREE REPAIR DIAPHRAGMATIC HERNIA	MYOCARDIAL INFARCTION ASPIRIN THERAPY	I
		URINARY TRACT INFECTION * (07/09/06) IV ANTBIOTICS	I
SURPATIENT,FOURTEEN 000-45-7212 JUL 31, 2006@09:00	SURSURGEON,FIVE CHOLECYSTECTOMY, APPENDECTOMY	SUPERFICIAL WOUND INFECTION * (08/02/06) ANTIBIOTICS	I

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

Example 2: Printing the Perioperative Occurrences Report – Sorted by Attending Surgeon

```
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

Print Report for:

1. Intraoperative Occurrences
2. Postoperative Occurrences
3. Intraoperative and Postoperative Occurrences


Select Number:  (1-3): 3

Start with Date: 7/1  (JUL 01, 2006)
End with Date: 7/31  (JUL 31, 2006)

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// 2

Do you want to print this report for all Attending Surgeons ? YES//N

Print the report for which Attending Surgeon ? SURGEON,ONE

Select an Additional Attending Surgeon:  <Enter>

This report is designed to use a 132 column format.

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

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

SURGICAL SERVICE REVIEWED BY:
PERIOPERATIVE OCCURRENCES-INTRAOP/POSTOP DATE REVIEWED:
FROM: JUL 1,2006 TO: JUL 31,2006 DATE PRINTED: AUG 22,2006

PATIENT ID# / OPERATION DATE	SURGICAL SPECIALTY / PRINCIPAL OPERATION	OCCURRENCE(S) - (DATE) / TREATMENT	OUTCOME
ATTENDING: SURGEON,ONE			
SURPATIENT,TWELVE 000-41-8719 JUL 07, 2006@07:15	GENERAL(OR WHEN NOT DEFINED BELOW) 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	GENERAL(OR WHEN NOT DEFINED BELOW) 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

Print Report for:

1. Intraoperative Occurrences
2. Postoperative Occurrences
3. Intraoperative and Postoperative Occurrences


Select Number:  (1-3): 3

Start with Date: 7/1  (JUL 01, 2006)
End with Date: 7/31  (JUL 31, 2006)

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
  Definition Revised (2011): Indicate if the patient developed new
  renal failure requiring renal replacement therapy or experienced an
  exacerbation of preoperative renal failure requiring initiation of
  renal replacement therapy (not on renal replacement therapy
  preoperatively) within 30 days postoperatively.

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

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*----------

SURGICAL SERVICE REVIEWED BY:
PERIOPERATIVE OCCURRENCES-INTRAOP/POSTOP DATE REVIEWED:
FROM: JUN 1,2007 TO: JUN 30,2007 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

(This page included for two-sided copying.)

Example 4: Printing the *Mortality Report*

```
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): 2

Start with Date: 1/1/06  (JAN 01, 2006)
End with Date: 7/31/06  (JUL 31, 2006)

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

This report is designed to use a 132 column format.

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

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

MAYBERRY, NC PAGE 1
SURGICAL SERVICE REVIEWED BY:
MORTALITY REPORT DATE REVIEWED:
FROM: JAN 1,2006 TO: JUL 31,2006 DATE PRINTED: AUG 22,2006

OPERATION DATE	PATIENT ID#	PRINCIPAL OPERATIVE PROCEDURE	DATE OF DEATH AUTOPSY (Y/N)
		OTORHINOLARYNGOLOGY (ENT)	
JAN 22, 2006	SURPATIENT,SIXTEEN 000-11-1111	LARYNGOSCOPY, BRONCHOSCOPY, ESOPHAGOGASTROSCOPY	FEB 09, 2006 NO
JAN 27, 2006	SURPATIENT,TWO 000-45-1982	BRONCHOSCOPY	FEB 26, 2006 NOT AVAILABLE
JAN 29, 2006	SURPATIENT,SIXTEEN 000-11-1111	BILATERAL NECK DISECTION, LARYNGECTOMY	FEB 09, 2006 NO
FEB 08, 2006	SURPATIENT,SIXTEEN 000-11-1111	LIGATION LT INTERNAL JUGLAR , EXPLORATORY LAPARATOMY	FEB 09, 2006 NO
FEB 19, 2006	SURPATIENT,TEN 000-12-3456	TRACH	FEB 21, 2006 NO
JUL 20, 2006	SURPATIENT,FORTY 000-77-7777	LARYNGOSCOPY W/ BX, ESOPHAGOSCOPY	NOV 01, 2006 NOT AVAILABLE

Non-O.R. Procedures

[SRONOP]

The *Non-O.R. Procedures* option, located in the main *Surgery Menu* and locked with the SROPER key, is designed for documenting and reviewing Non-O.R. Procedures.

A Non-O.R. Procedure is any procedure not performed in an operating room, but which still involves surgical or anesthesia providers. Any procedures involving anesthesia providers will display on the Anesthesia AMIS Report.

The main options included in this menu are listed below. The first option, *Non-O.R.. Procedures (Enter Edit)*, contains options to enter or update cases. To the left of the option name is the shortcut synonym the user can enter to select the option.

Shortcut	Option Name
E	*Non-O.R.. Procedures (Enter/Edit)*
A	*Annual Report of Non-O.R.. Procedures*
R	*Report of Non-O.R.. Procedures*

Non-O.R. Procedures (Enter/Edit)
[SRONOP-ENTER]

The *Non-O.R. Procedures (Enter/Edit)* option allows the user to enter, edit, or delete information related to a Non-O.R. Procedure. The editing feature branches to another submenu that allows the user to enter or edit anesthesia information for a procedure. To use one of the *Non-O.R. Procedures (Enter/Edit)* options, the user must first identify the patient on which he or she is working.

Accessing the Non-O.R. Procedures Menu

When the *Non-O.R. Procedures (Enter/Edit)* option is selected, the user will be prompted to enter a patient name. The Surgery software will then list all non-O.R. procedures on record for the patient.

```
 SURPATIENT,FIFTEEN   000-98-1234

1. APR 22, 2002     BRONCHOSCOPY

2. NEW PROCEDURE

Select Procedure: 1
```

The user can select from the procedure(s) listed or enter a new procedure. When selecting an existing procedure, the software will ask whether the user wants to 1) edit information for the case, or 2) delete the procedure, as follows.

```
 SURPATIENT,FIFTEEN   000-98-1234

 APR 22, 2002       BRONCHOSCOPY


Do you want to edit or delete this procedure ?

1. Edit
2. Delete

Select Number:  1// 1
```

If the user enters **2** to delete, the software will permanently remove the procedure from the records. On the other hand, if the user accepts the default answer, **1**, to edit the existing procedure, the software will display the *Non-O.R. Procedures (Enter/Edit)* menu option. The user will see the following options.

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


   E      Edit Non-O.R. Procedure
   AI     Anesthesia Information  (Enter/Edit)
   AM     Medications (Enter/Edit)
   AT     Anesthesia Technique (Enter/Edit)
   PR     Procedure Report (Non-O.R.)
   TR     Tissue Examination Report
   I      Non-OR Procedure Information

Select Non-O.R. Procedures (Enter/Edit) Option:
```

Three of these sub-options, the *Anesthesia Information (Enter/Edit)* option, the *Medications (Enter/Edit)* option, and the *Anesthesia Technique (Enter/Edit)* option, are the same as the sub-options of the same name on the *Anesthesia Menu* option.

Edit Non-O.R. Procedure
[SRONOP-EDIT]

The *Edit Non-O.R. Procedure* option on the *Non-O.R. Procedures* menu allows the user to enter or edit data on the selected procedure.

The DICTATED SUMMARY EXPECTED field is used to determine whether a dictated summary will be required for this Non-O.R. Procedure case. If **NO** is entered into the DICTATED SUMMARY EXPECTED field, no alerts will be generated and no report information will be displayed. If **YES** is entered into the DICTATED SUMMARY EXPECTED field, an alert will be sent to the appropriate provider when the dictated summary is uploaded, informing him or her that the Procedure Summary is ready for signature.

The DICTATED SUMMARY EXPECTED field is used to determine whether a dictated summary will be required for a Non-O.R. Procedure case.

Example: Setting the DICTATED SUMMARY EXPECTED field to YES

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


   E      Edit Non-O.R. Procedure
   AI     Anesthesia Information  (Enter/Edit)
   AM     Medications (Enter/Edit)
   AT     Anesthesia Technique (Enter/Edit)
   PR     Procedure Report (Non-O.R.)
   TR     Tissue Examination Report
   I      Non-OR Procedure Information

Select Non-O.R. Procedures (Enter/Edit) Option: E  Edit Non-O.R. Procedure
```

```
** NON-O.R. PROCEDURE **   CASE #267260  SURPATIENT,FIFTEEN PAGE 1 OF 3

1    DATE OF PROCEDURE:  APR 22, 2002
2    PRINCIPAL PROCEDURE: BRONCHOSCOPY
3    PLANNED PRIN PROCEDURE CODE:
4    MEDICAL SPECIALTY:  GENERAL SURGERY
5    DICTATED SUMMARY EXPECTED:
6    IN/OUT-PATIENT STATUS:
7    TIME PROCEDURE BEGAN:
8    TIME PROCEDURE ENDED:
9    PROVIDER:           SURSURGEON,FIFTEEN
10   NON-OR LOCATION:
11   ASSOCIATED CLINIC:
12   PRINCIPAL DIAGNOSIS:
13   PLANNED PRIN DIAGNOSIS CODE:
14   INDICATIONS FOR OPERATIONS: (WORD PROCESSING)
15   BRIEF CLIN HISTORY: (WORD PROCESSING)

Enter Screen Server Function:  5
Dictated Summary Expected: YES  YES
```

```
** NON-O.R. PROCEDURE **   CASE #267260  SURPATIENT,FIFTEEN PAGE 1 OF 3

1    DATE OF PROCEDURE:  APRIL 22, 2002
2    PRINCIPAL PROCEDURE: BRONCHOSCOPY
3    PLANNED PRIN PROCEDURE CODE:
4    MEDICAL SPECIALTY:  GENERAL SURGERY
5    DICTATED SUMMARY EXPECTED: YES
6    IN/OUT-PATIENT STATUS:
7    TIME PROCEDURE BEGAN:
8    TIME PROCEDURE ENDED:
9    PROVIDER:           SURSURGEON, FIFTEEN
10   NON-OR LOCATION:
11   ASSOCIATED CLINIC:
12   PRINCIPAL DIAGNOSIS:
13   PLANNED PRIN DIAGNOSIS CODE:
14   INDICATIONS FOR OPERATIONS: (WORD PROCESSING)
15   BRIEF CLIN HISTORY: (WORD PROCESSING)

Enter Screen Server Function: <Enter>
```

```
** NON-O.R. PROCEDURE **   CASE #267260  SURPATIENT,FIFTEEN PAGE 2 OF 3

1    OPERATIVE FINDINGS: (WORD PROCESSING)
2    ATTEND PROVIDER:
3    ATTENDING CODE:
4    PRINC ANESTHETIST:
5    ANESTHESIOLOGIST SUPVR:
6    ANES CARE TIME BLOCK:    (MULTIPLE)
7    ANESTHESIA TECHNIQUE:    (MULTIPLE)
8    ANES SUPERVISE CODE:
9    DIAGNOSTIC/THERAPEUTIC (Y/N):
10   ASA CLASS:
11   OTHER PROCEDURES:        (MULTIPLE)
12   OTHER POSTOP DIAGS:      (MULTIPLE)
13   PROCEDURE OCCURRENCE:    (MULTIPLE)
14   SPECIMENS:               (WORD PROCESSING)
15   GENERAL COMMENTS:        (WORD PROCESSING)

Enter Screen Server Function: <Enter>
```

```
** NON-O.R. PROCEDURE **   CASE #267260  SURPATIENT,FIFTEEN PAGE 3 OF 3

1    CANCEL DATE:
2    CANCEL REASON:

Enter Screen Server Function:
```

If the user wishes to edit information in the Procedure Report (Non-O.R.), the *Edit Non-O.R.. Procedure* option on the *Non-O.R.. Procedures* menu can be used.

Example: Using the Edit Non-O.R. Procedure option

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

   E      Edit Non-O.R. Procedure
   AI     Anesthesia Information  (Enter/Edit)
   AM     Medications (Enter/Edit)
   AT     Anesthesia Technique (Enter/Edit)
   PR     Procedure Report (Non-O.R.)
   TR     Tissue Examination Report

Select Non-O.R. Procedures (Enter/Edit) Option: E  Edit Non-O.R. Procedure
```

```
** NON-O.R. PROCEDURE **   CASE #267260  SURPATIENT,FIFTEEN PAGE 1 OF 3

1    DATE OF PROCEDURE:  APR 22, 2002
2    PRINCIPAL PROCEDURE: BRONCHOSCOPY
3    PLANNED PRIN PROCEDURE CODE:
4    MEDICAL SPECIALTY:  GENERAL SURGERY
5    DICTATED SUMMARY EXPECTED: YES
6    IN/OUT-PATIENT STATUS:
7    TIME PROCEDURE BEGAN: APR 22, 2002 AT 08:50
8    TIME PROCEDURE ENDED: APR 22, 2002 AT 09:27
9    PROVIDER:           SURSURGEON,FIFTEEN
10   NON-OR LOCATION:
11   ASSOCIATED CLINIC:
12   PRINCIPAL DIAGNOSIS:
13   PLANNED PRIN DIAGNOSIS CODE:
14   INDICATIONS FOR OPERATIONS: (WORD PROCESSING)
15   BRIEF CLIN HISTORY: (WORD PROCESSING)

Enter Screen Server Function:  8
Time Procedure Ended: APR 22,2002@09:27// 917  (APR 22, 2002@09:17)
```

```
** NON-O.R. PROCEDURE **   CASE #267260  SURPATIENT,FIFTEEN PAGE 1 OF 3

1    DATE OF PROCEDURE:  APR 22, 2002
2    PRINCIPAL PROCEDURE: BRONCHOSCOPY
3    PLANNED PRIN PROCEDURE CODE:
4    MEDICAL SPECIALTY:  GENERAL SURGERY
5    DICTATED SUMMARY EXPECTED: YES
6    IN/OUT-PATIENT STATUS:
7    TIME PROCEDURE BEGAN: APR 22, 2002 AT 08:50
8    TIME PROCEDURE ENDED: APR 22, 2002 AT 09:17
9    PROVIDER:           SURSURGEON,FIFTEEN
10   NON-OR LOCATION:
11   ASSOCIATED CLINIC:
12   PRINCIPAL DIAGNOSIS:
13   PLANNED PRIN DIAGNOSIS CODE:
14   INDICATIONS FOR OPERATIONS: (WORD PROCESSING)
15   BRIEF CLIN HISTORY: (WORD PROCESSING)

Enter Screen Server Function:  <Enter>
```

```
** NON-O.R. PROCEDURE **   CASE #267260  SURPATIENT,FIFTEEN PAGE 2 OF 3

1    OPERATIVE FINDINGS: (WORD PROCESSING)
2    ATTEND PROVIDER:
3    ATTENDING CODE:
4    PRINC ANESTHETIST:
5    ANESTHESIOLOGIST SUPVR:
6    ANES CARE TIME BLOCK:    (MULTIPLE)
7    ANESTHESIA TECHNIQUE:    (MULTIPLE)
8    ANES SUPERVISE CODE:
9    DIAGNOSTIC/THERAPEUTIC (Y/N):
10   ASA CLASS:
11   OTHER PROCEDURES:        (MULTIPLE)
12   OTHER POSTOP DIAGS:      (MULTIPLE)
13   PROCEDURE OCCURRENCE:    (MULTIPLE)
14   SPECIMENS:               (WORD PROCESSING)
15   GENERAL COMMENTS:        (WORD PROCESSING)

Enter Screen Server Function:  <Enter>
```

```
** NON-O.R. PROCEDURE **   CASE #267260  SURPATIENT,FIFTEEN PAGE 3 OF 3

1    CANCEL DATE:
2    CANCEL REASON:

Enter Screen Server Function: ^
```

Procedure Report (Non-O.R.)
[SR NON-OR REPORT]

The *Procedure Report (Non-O.R..)* option details operation information for the patient case selected. This report includes the Procedure Summary section. The Procedure Summary is dictated by the provider after completing the Non-O.R. procedure and then is electronically signed.

Prior to Signature

The *Edit Non-O.R. Procedure* option on the *Non-O.R. Procedures* menu is used to enter the non-O.R. procedure data. The DICTATED SUMMARY EXPECTED field is used to determine whether a dictated summary will be required for this non-O.R. procedure. This field is a required entry when creating a new non-O.R. procedure and may be edited using the *Edit Non-O.R. Procedure* option. Entering YES in this field allows a Procedure Summary to be uploaded and signed in TIU, making a Procedure Report (Non-O.R.) available for this procedure.

The DICTATED SUMMARY EXPECTED field is used to determine whether a dictated summary will be required for a Non-O.R. Procedure case.

After the Procedure Summary has been electronically signed, the Procedure Report (Non-O.R..) is viewable through CPRS. If the Procedure Summary has not been electronically signed, the following displays:

"* * A Non-O.R. Procedure Summary is not available. * *"

After the Procedure Summary is transcribed and uploaded into TIU, the TIU software sends an alert to the provider responsible for electronically signing the report. The provider can then sign using CPRS options or the List Manager.

After Electronic Signature

After electronic signature, the report is available for viewing.

Example 1: Printing a Procedure (Non-O.R.) Report when the Procedure Summary has been signed

```
SURPATIENT,ONE (000-44-7629)  Case #267236 - FEB 13, 2002


Select Non-O.R. Procedures (Enter/Edit) Option: PR  Procedure Report (Non-O.R.)

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

DEVICE: HOME//   [Select Print Device]
```

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

```
------------------------------------------------------------------------------
SURPATIENT,ONE  000-44-7629                                  PROCEDURE REPORT
------------------------------------------------------------------------------
NOTE DATED: 02/13/2002 00:00  PROCEDURE REPORT

SUBJECT: Case #: 267236

PREOPERATIVE DIAGNOSIS:  RESPIRATORY FAILURE, PROLONGED TRACHEAL INTUBATION
                         AND FAILURE TO WEAN

POSTOPERATIVE DIAGNOSIS:  SAME

PROCEDURE PERFORMED:  OPEN TRACHEOSTOMY

PROVIDER:  DR. SURSURGEON

ASSISTANT PROVIDER:

ANESTHESIA:  GENERAL ENDOTRACHEAL ANESTHESIA

ESTIMATED BLOOD LOSS:  MINIMAL

COMPLICATIONS:  NONE

INDICATIONS FOR PROCEDURE:  The patient is a sixty-four-year-old gentleman
with a rather extensive past surgical history, mostly significant for status
post esophagogastrectomy and presented to the hospital approximately three
weeks ago with abdominal pain. Diagnostic evaluation consisted of an abdominal
CT scan, liver function tests and right upper quadrant ultrasound, all of
which were consistent with a diagnosis of acalculus cholecystitis. Because of
these findings, the patient was brought to the operating room approximately
three weeks ago where an open cholecystectomy was performed. The patient subsequent to that has
had a very rocky postoperative course, most significantly focusing around persistently spiking
fevers with sources significant for an E-coli sinusitis as well as a Staphylococcus E-coli
pneumonia with no evidence of bacteremia. As a result of all of this sepsis and persistent
spiking fevers, the patient has had a pneumonia, the patient has had a rather difficult time
weaning from the ventilator and because of the
almost three week period since his last operation with persistent endotracheal
tube in place, the patient was brought to the operating room for an open
tracheostomy procedure.

DESCRIPTION OF PROCEDURE:  After appropriate consent was obtained from the
patient's next of kin and the risks and benefits were explained to her, the
patient was then brought to the operating room where general endotracheal
anesthesia was induced. The area was prepped and draped in the usual fashion
with a towel roll under the patient's scapula and the neck extended.

A longitudinal incision of approximately 2 cm was made just below the cricoid
cartilage. The strap muscles were taken down using Bovee electrocautery. The
isthmus of the thyroid was clamped and tied off using 2-0 silk x two.
Hemostasis was assured. The thyroid cartilage was carefully dissected
directly onto it. The window in the third ring of the trachea was opened
after placement of retraction sutures of 0 silk, The hatch was cut open using
a hatch box shape. This opening was then dilated using the tracheal dilator.
The endotracheal tube was pulled back. A #7 Tracheostomy tube was placed with
ease. Breath sounds were assured. The patient was oxygenating well and the
stay sutures were placed. The patient tolerated the procedure well. The skin
was closed with 0 silk and trachea tip was applied. The patient tolerated the
procedure well. The endotracheal tube was finally removed. He was brought to
the Surgical Intensive Care Unit in stable, but critical condition.

Three Sursurgeon, M.D.

TS/jer:jw J#:  514 DD:  02-13-02 DT:  02-13-02

                  Signed by: /es/ THREE SURSURGEON
                                     02/13/2002 16:40
Enter RETURN to continue or '^' to exit: ^
```

Tissue Examination Report
[SROTRPT]

The *Tissue Examination Report* option is used to generate the Tissue Examination Report that contains information about cultures and specimens sent to the laboratory for a non-OR procedure.

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

Example: Tissue Examination Report

```
Select Non-O.R. Procedures (Enter/Edit) Option: TR  Tissue Examination Report
DEVICE: [Select Print Device]

-----------------------------------printout follows---------------------------------

--------------------------------------------------------------------------------
     MEDICAL RECORD   |                    TISSUE EXAMINATION
--------------------------------------------------------------------------------
Specimen Submitted By:                            Obtained: AUG 13, 2004
   OR1,  SURGERY CASE # 267260
--------------------------------------------------------------------------------
Specimen(s): BIOPSY OF STOMACH LINING
--------------------------------------------------------------------------------
Brief Clinical History:
The patient has had a pneumonia, and had a rather difficult time weaning
from the ventilator and because of the almost three week period since
his last operation with persistent endotracheal tube in place, the
patient was brought to the operating room for an open tracheostomy procedure.
--------------------------------------------------------------------------------
Operative Procedure(s):
   OPEN TRACHEOSTOMY
--------------------------------------------------------------------------------
Preoperative Diagnosis:
   RESPIRATORY FAILURE, PROLONGED TRACHEAL INTUBATION
   AND FAILURE TO WEAN
--------------------------------------------------------------------------------
Operative Findings:

--------------------------------------------------------------------------------
Postoperative Diagnosis:                          Signature and Title
   FOREIGN BODY IN TRACHEA                                  SURSURGEON,TWO
--------------------------------------------------------------------------------
Attending Surgeon: SURSURGEON,ONE
--------------------------------------------------------------------------------
                              PATHOLOGY REPORT
--------------------------------------------------------------------------------
Name of Laboratory                                Accession Number(s)

--------------------------------------------------------------------------------
Gross Description, Histologic Examination and Diagnosis



                              (Continue on reverse side)
--------------------------------------------------------------------------------
PATHOLOGIST'S SIGNATURE                                  DATE:
--------------------------------------------------------------------------------
SURPATIENT,FIFTEEN (000-98-1234)  Age: 64   SEX: MALE         ID # 000-98-1234
ETHNICITY: NOT HISPANIC                                  REGISTER NO.
RACE: WHITE, ASIAN
WARD:                         ROOM-BED:
--------------------------------------------------------------------------------
VAMC: MAYBERRY, NC                                       REPLACEMENT FORM 515

Press RETURN to continue
```

Non-OR Procedure Information
[SR NON-OR INFO]

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

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

Example: Non-OR Procedure Information Report

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

Select Non-O.R. Procedures (Enter/Edit) Option: I  Non-O.R. Procedure Information

DEVICE: HOME// [Select Print Device]


-----------------------------------printout follows---------------------------------

SURPATIENT,FIFTEEN (000-98-1234)  Age: 64                                   PAGE 1
NON-O.R. PROCEDURE - CASE #267260                 Printed: AUG 13, 2004@14:40
------------------------------------------------------------------------------

Med. Specialty: PULMONARY, NON-TB           Location: NON OR

Principal Diagnosis:
  FAILURE TO WEAN

Provider: SURSURGEON,TWO                          Patient Status: INPATIENT
Attending: SURSURGEON,FIFTEEN
Attending Code: LEVEL F: NON-OR PROCEDURE DONE IN THE OR, ATTENDING IDENTIFIED

Attend Anesth: N/A
Anesthesia Supervisor Code: N/A
Anesthetist: N/A

Anesthesia Technique(s): N/A

Proc Begin:  AUG 13, 2004  09:00        Proc End:  AUG 13, 2004  10:00

Procedure(s) Performed:
  Principal: OPEN TRACHEOSTOMY

Indications for Procedure:
  FOREIGN BODY IN TRACHEA.

Brief Clinical History:
  The patient is a sixty-four-year-old gentleman with a rather extensive past
surgical history, mostly significant for status post esophagogastrectomy and
presented to the hospital approximately three weeks ago with abdominal pain.
Diagnostic evaluation consisted of an abdominal CT scan, liver function
tests and right upper quadrant ultrasound, all of which were consistent
with a diagnosis of acalculus cholecystitis. Because of these findings,
the patient was brought to the operating room approximately three weeks ago
where an open cholecystectomy was performed.


Specimens: BIOPSY OF STOMACH LINING.

Dictated Summary Expected: YES

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

Annual Report of Non-O.R. Procedures
[SRONOP-ANNUAL]

The *Annual Report of Non-O.R.. Procedures* option generates the Annual Report of Non-O.R. Procedures. It displays the total number of non-O.R. procedures within the selected date range based on CPT code.

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

Example: Annual Report of Non-O.R. Procedures

```
Select Non-O.R. Procedures Option:  A  Annual Report of Non-O.R. Procedures

Annual Report of Non-O.R. Procedures


Starting with Date: 3/2  (MAR 02, 1999)
Ending with Date: 3/30  (MAR 30, 1999)

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

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

```
                    ANNUAL REPORT OF NON-O.R. PROCEDURES
                     FROM: MAR 2,1999  TO: MAR 30,1999

CPT - PROCEDURE               SPECIALTY                          TOTAL
================================================================================

                                  CARDIOLOGY

92960   HEART ELECTROCONVERSION                                    2

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

```
                    ANNUAL REPORT OF NON-O.R. PROCEDURES
                     FROM: MAR 2,1999  TO: MAR 30,1999

CPT - PROCEDURE               SPECIALTY                          TOTAL
================================================================================

                                GENERAL SURGERY

11404   REMOVAL OF SKIN LESION                                     1

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

```
                    ANNUAL REPORT OF NON-O.R. PROCEDURES
                     FROM: MAR 2,1999  TO: MAR 30,1999

CPT - PROCEDURE               SPECIALTY                          TOTAL
================================================================================

                           GENERAL(ACUTE MEDICINE)

11423   REMOVAL OF SKIN LESION                                     1
64510   INJECTION FOR NERVE BLOCK                                  1

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

```
                    ANNUAL REPORT OF NON-O.R. PROCEDURES
                     FROM: MAR 2,1999  TO: MAR 30,1999

CPT - PROCEDURE               SPECIALTY                          TOTAL
================================================================================

                                  PSYCHIATRY

90870   ELECTROCONVULSIVE THERAPY                                  3

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

```
                  ANNUAL REPORT OF NON-O.R. PROCEDURES
                        SUMMARY OF ALL SPECIALTIES
                     FROM: MAR 2,1999  TO: MAR 30,1999
================================================================================
CARDIOLOGY                          TOTAL NON-O.R. PROCEDURES: 2
GENERAL SURGERY                     TOTAL NON-O.R. PROCEDURES: 1
GENERAL(ACUTE MEDICINE)             TOTAL NON-O.R. PROCEDURES: 2
PSYCHIATRY                          TOTAL NON-O.R. PROCEDURES: 3

         TOTAL NON-O.R. PROCEDURES FOR THIS MEDICAL CENTER: 8


Press RETURN to continue
```

Report of Non-O.R. Procedures
[SRONOR]

This report chronologically lists non-O.R. procedures, and can be sorted by specialty, provider, or location.

This report prints in a 132-column format and must be copied to a printer.

Example 1: Report of Non-O.R. Procedures by Specialty

```
Select Non-O.R. Procedures Option:  Report of Non-O.R. Procedures

Report of Non-OR Procedures


Start with Date: 3/1  (MAR 01, 1999)
End with Date: 3/31  (MAR 31, 1999)

How do you want the report sorted ?

1. By Specialty
2. By Provider
3. By Location

Select Number:  1// <Enter>

Do you want to print the report for all Specialties ?  YES// N


Print the Report for which Specialty ?  Cardiology


This report is designed to use a 132 column format.

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

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

MAYBERRY, NC
SURGICAL SERVICE
REPORT OF NON-O.R. PROCEDURES
FROM: MAR 1,1999 TO: MAR 31,1999

REVIEWED BY:
DATE REVIEWED:

DATE CASE #	PATIENT (ID#) LOCATION (IN/OUT-PAT STATUS)	PROVIDER PROCEDURE(S)	START TIME FINISH TIME
	*** SPECIALTY: CARDIOLOGY ***		
03/02/92	SURPATIENT,TWELVE (000-41-8719)	SURSURGEON,TWO	03/02/92 13:05
501	AMBULATORY SURGERY (OUTPATIENT)	CARDIOVERSION	03/02/92 14:10
03/13/92	SURPATIENT,SIXTY (000-56-7821)	SURSURGEON,TWO	03/13/92 14:00
500	ICU (INPATIENT)	CARDIOVERSION	03/13/92 14:25

Example 2: Report of Non-O.R. Procedures by Provider

```
Select Non-O.R. Procedures Option:  Report of Non-O.R. Procedures


Report of Non-OR Procedures


Start with Date: 3/1  (MAR 01, 1999)
End with Date: 3/31  (MAR 31, 1999)


How do you want the report sorted ?

1. By Specialty
2. By Provider
3. By Location

Select Number:  2// <Enter>


Do you want to print the report for all Providers ?  YES// N


Print the Report for which Provider ?  SURSURGEON,SIXTEEN       SS


This report is designed to use a 132 column format.

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

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

MAYBERRY, NC
SURGICAL SERVICE — REVIEWED BY:
REPORT OF NON-O.R. PROCEDURES — DATE REVIEWED:
FROM: MAR 1,1999 TO: MAR 31,1999

DATE / CASE #	PATIENT (ID#) / LOCATION (IN/OUT-PAT STATUS)	SPECIALTY / PROCEDURE(S)	START TIME / FINISH TIME
	*** PROVIDER SURSURGEON,SIXTEEN ***		
03/12/92	SURPATIENT,TWO (000-45-1982)	PSYCHIATRY	03/12/92 08:00
195	PAC(U) - ANESTHESIA (INPATIENT)	ELECTROCONVULSIVE THERAPY	03/12/92 09:00
03/23/92	SURPATIENT,NINE (000-34-5555)	PSYCHIATRY	03/23/92 08:10
240	PAC(U) - ANESTHESIA (INPATIENT)	ELECTROCONVULSIVE THERAPY	03/23/92 08:40
03/25/92	SURPATIENT,FOURTEEN (000-45-7212)	PSYCHIATRY	03/12/92 09:30
266	PAC(U) - ANESTHESIA (INPATIENT)	ELECTROCONVULSIVE THERAPY	03/12/92 10:15

Example 3: Report of Non-O.R. Procedures by Location

```
Select Non-O.R. Procedures Option:  Report of Non-O.R. Procedures


Report of Non-OR Procedures


Start with Date: 3/1  (MAR 01, 1999)
End with Date: 3/31  (MAR 31, 1999)


How do you want the report sorted ?

1. By Specialty
2. By Provider
3. By Location

Select Number:  2// <Enter>


Do you want to print the report for all Locations ?  YES// N


Print the Report for which location ?  AMBULATORY SURGERY


This report is designed to use a 132 column format.

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

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

MAYBERRY, NC
SURGICAL SERVICE
REPORT OF NON-O.R. PROCEDURES
FROM: MAR 1,1999 TO: MAR 31,1999

REVIEWED BY:
DATE REVIEWED:

DATE CASE #	PATIENT (ID#) SPECIALTY (IN/OUT-PAT STATUS)	PROVIDER PROCEDURE(S)	START TIME FINISH TIME
	*** LOCATION: AMBULATORY SURGERY ***		
03/02/92 201	SURPATIENT,TWELVE (000-41-8719) CARDIOLOGY (OUTPATIENT)	SURSURGEON,TWO CARDIOVERSION	03/02/92 13:05 03/02/92 14:10
03/06/92 198	SURPATIENT,TWENTY (000-45-4886) GENERAL(ACUTE MEDICINE) (OUTPATIENT)	SURSURGEON,FOUR EXCISION OF SKIN LESION	03/07/92 16:30 03/07/92 17:08
03/09/92 193	SURPATIENT,FIFTY (000-45-9999) GENERAL(ACUTE MEDICINE) (OUTPATIENT)	SURANESTHETIST,ONE STELLATE NERVE BLOCK	03/09/92 09:45 03/09/92 10:21
03/13/92 200	SURPATIENT,SIXTY (000-56-7821) CARDIOLOGY (INPATIENT)	SURSURGEON,TWO CARDIOVERSION	03/13/92 14:00 03/13/92 14:25
03/17/92 191	SURPATIENT,EIGHTEEN (000-22-3334) GENERAL SURGERY (OUTPATIENT)	SURSURGEON,FOUR EXCISION OF SKIN LESION	03/17/92 13:30 03/17/92 14:42

(This page included for two-sided copying.)

Comments Option
[SROMEN-COM]

Surgeons use the *Comments* option to respond to the GENERAL COMMENTS field for a surgical case or non-O.R. procedure. This option is designed to give surgeons an opportunity to directly add general comments after a case has been booked. The GENERAL COMMENTS field may already contain information added by the person booking the operation.

After selecting the patient case, the surgeon can add the general comments using the VA FileMan word-processing device, demonstrated below. The surgeon must press the **<Enter>** key at the end of each line with this type of word processing. The surgeon would press the **<Enter>** key again when he or she is through with the comments.

Example: Enter General Comments

```
Select Surgery Menu Option:  C  Comments

Select Patient: SURPATIENT,THREE        08-15-42      000212453

1. 11/20/99   CAROTID ARTERY ENDARTERECTOMY  (COMPLETED)
2. 11/20/99   AORTO CORONARY BYPASS GRAFT  (CANCELLED)

Select Number: 1

General Comments:
  1>Patient at high risk due to severe hypertension. Pre-operative
  2>evaluation recommended treatment by other than surgical means.
  3>This treatment, however, was unsuccessful necessitating
  4>surgery. Patient should be monitored closely & anesthesia time
  5>kept to a minimum.
  6> <Enter>
EDIT Option: <Enter>

Select Surgery Menu Option:
```

(This page included for two-sided copying.)

CPT/ICD Coding Menu

[SRCODING MENU]

The Surgery *CPT/ICD Coding Menu* option was developed to help assure access to the most accurate source documentation and to provide a means for efficient coding entry and validation. It provides coders with special, limited access to the VistA Surgery package.

From the menu, coders have ready access to the Operation Report, which is dictated by the surgeon postoperatively and contains the most comprehensive and accurate description of the procedure(s) actually performed. Coders can also view the Nurse Intraoperative Report, which is often an important supplementary source of data.

Using the same menu, coders can add and edit procedures, CPT codes, diagnoses, and International Classification of Diseases (ICD) codes, without having to rely on a paper-based system. Options are available to assist surgery staff and others who perform coding validation, as are several commonly used reports.

The *Surgery CPT/ICD Coding Menu* contains the following options. To the left is the shortcut synonym the user can enter to select the option:

Shortcut	Option Name
EDIT CPT/ICD	*Update/Verify Menu ...*
C	*Cumulative Report of CPT Codes*
A	*Report of CPT Coding Accuracy*
M	*List Completed Cases Missing CPT Codes*
L	*List of Operations*
LS	*List of Operations (by Surgical Specialty)*
U	*List of Undictated Operations*
D	*Report of Daily Operating Room Activity*
PS	*PCE Filing Status Report*
R	*Report of Non-O.R. Procedures*

CPT/ICD Update/Verify Menu
[SRCODING UPDATE/VERIFY MENU]

The *CPT/ICD Update/Verify Menu* is locked with the SR CODER security key.

This option provides coding personnel with access to review and edit procedure and diagnosis information. It also provides access to the Operation Report and Nurse Intraoperative Report for operations and to the Procedure Report (Non-O.R.) for non-O.R. procedures.

The *CPT/ICD Update/Verify Menu* contains the following options. To the left is the shortcut synonym the user can enter to select the option.

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

To access the *CPT/ICD Update/Verify Menu*, the user must first identify the patient and case. When the user selects **EDIT** for the *CPT/ICD Update/Verify Menu* from the *CPT/ICD Coding Menu*, the user will be prompted to enter a patient name. The software will then list all the cases on record for the patient, including any operations that are completed or are in progress and any non-O.R. procedures.

```
Select CPT/ICD Coding Menu Option: EDIT  CPT/ICD Update/Verify Menu

Select Patient: SURPATIENT,TWELVE             02-12-28     000418719     YES     S
C VETERAN

 SURPATIENT,TWELVE     000-41-8719

1. 08-07-99   REPAIR DIAPHRAGMATIC HERNIA (COMPLETED)

2. 02-24-99   CYSTOSCOPY (NON-OR PROCEDURE)

3. 02-18-03   TRACHEOSTOMY (COMPLETED)

4. 09-04-97   CHOLECYSTECTOMY (COMPLETED)

5. 09-28-95   INGUINAL HERNIA (COMPLETED)

6. 08-31-95   HIP REPLACEMENT (COMPLETED)


Select Case: 3

 SURPATIENT,TWELVE (000-41-8719)   Case #124 - FEB 18,2003


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

Select CPT/ICD Update/Verify Menu Option:
```

From this point, the user can select any of the *CPT/ICD Update/Verify Menu* options.

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 codes entered by a clinician.

Example: Entering Required Information

```
Select CPT/ICD 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 (ICD):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>
```

Example: Editing the Principal CPT 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: 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): 3
```

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

   CPT Code: 31622  DX BRONCHOSCOPE/WASH
   Modifiers: NOT ENTERED
     Assoc. DX: 934.0-FOREIGN BODY IN TRACHE

     Select one of the following:

          1         Update Principal Procedure CPT Code
          2         Update Associated Diagnoses

Enter selection (1 or 2): 1// 1  Update Principal Procedure CPT Code

Principal Procedure Code (CPT): 31622// 31623      DX BRONCHOSCOPE/BRUSH
 BRONCHOSCOPY (RIGID OR FLEXIBLE); WITH BRUSHING OR PROTECTED BRUSHINGS
 Modifier:
The Diagnosis to Procedure Associations may no longer be correct.
Delete all Principal Associated Diagnoses? N// <Enter>  NO
```

Editing or deleting any diagnosis or procedures may cause any associated diagnoses to be incorrect; the software prompts the user to check any diagnosis to procedure associations. The user can select to delete all associated diagnoses, or keep all associations.

```
SURPATIENT,TWELVE (000-41-8719)                                          Case #10062
JUN 08, 2005   BRONCHOSCOPY
------------------------------------------------------------------------------
   CPT Code: 31623  DX BRONCHOSCOPE/BRUSH
   Modifiers: NOT ENTERED
     Assoc. DX: 934.0-FOREIGN BODY IN TRACHE

Only the following ICD Diagnosis Codes can be associated:

1. 934.0-FOREIGN BODY IN TRACHEA

   Select the number(s) of the Diagnosis Code to associate to
   the procedure selected:  1// <Enter>
```

Example: Entering a New Other Procedure CPT 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 TRACHEA
4. Other CPT Code:     NOT ENTERED
------------------------------------------------------------

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

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

Other Procedures:

1. Enter NEW Other Procedure

Enter selection:  (1-1): 1


Enter new OTHER PROCEDURE CPT code: 43200       ESOPHAGUS ENDOSCOPY
 ESOPHAGOSCOPY, RIGID OR FLEXIBLE; DIAGNOSTIC, WITH OR WITHOUT COLLECTION
 OF SPECIMEN(S) BY BRUSHING OR WASHING (SEPARATE PROCEDURE)
 Modifier: <Enter>
```

All procedures must be associated with a diagnosis; the Surgery software allows the user to associate any or all available diagnoses to a single procedure. If more than one diagnosis if available, then the user enters the associations sequentially for the association.

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

1. CPT Code: 43200  ESOPHAGUS ENDOSCOPY
     Modifiers: NOT ENTERED
     Assoc. DX: NOT ENTERED

------------------------------------------------------------------------------
Only the following ICD Diagnosis Codes can be associated:

1. 934.0-FOREIGN BODY IN TRACHEA

   Select the number(s) of the Diagnosis Code to associate to
   the procedure selected:  1// <Enter>
```

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

1. CPT Code: 43200  ESOPHAGUS ENDOSCOPY
     Assoc. DX: 934.0-FOREIGN BODY IN TRACHE
2. Enter NEW Other Procedure Code

Enter selection:  (1-2): <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. The Principal Postop Diagnosis Code and Other Postop Diagnosis Code fields indicate ICD-9 or ICD-10 codes.

```
PTFPATIENT,TEST MALE  (000-00-1234)        Case #33
OCT 04, 2013   REMOVE FOOT
------------------------------------------------------------------------------
Surgery Procedure PCE/Billing Information:

1. Principal Postop Diagnosis Code (ICD10): R44.0  Auditory hallucinations
2. Other Postop Diagnosis Code (ICD10): G20.  Parkinson's disease
3. Principal CPT Code: 20838  REPLANTATION FOOT COMPLETE
     Assoc. DX(ICD10): R44.0-Auditory hallucination
4. Other CPT Code:     NOT ENTERED
------------------------------------------------------------------------------
Enter number of item to edit (1-4): 1

PTFPATIENT,TEST MALE  (000-00-1234)        Case #33
OCT 04, 2013   REMOVE FOOT
------------------------------------------------------------------------------
Principal Postop Diagnosis:

     ICD10 Code: R44.0  Auditory hallucinations
             SC:N

     Select one of the following:

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

Enter selection (1 or 2): 1// 1  Update Principal Postop Diagnosis Code

Principal Postop Diagnosis Code (ICD10): R44.0// TRACHAE
```

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):
```

The following examples depict using the *Update/Verify Procedure/Diagnosis Codes* option to edit a cardiac procedure (CABG), with clinician-entered Planned CPT and ICD codes.

Example: Editing Final Codes and Sending the Case to PCE

```
Select CPT/ICD Coding Menu Option: EDIT  CPT/ICD Update/Verify Menu

Select Patient:    SURPATIENT,SEVENTEEN        3-29-20    000455119     YES
SC VETERAN
```

```
 SURPATIENT,SEVENTEEN   000-45-5119

1. 07-15-05   CABG (COMPLETED)

2. 06-09-05   NASAL ENDOSCOPY (COMPLETED)


Select Case: 1
```

```
                            Division: ALBANY  (500)

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


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

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

Because the nurse or surgeon entered a Planned Principal CPT Code and a Preoperative Diagnosis Code, the corresponding fields pre-fill with those clinician-entered values when the user accesses the case through the *Update/Verify Procedure/Diagnosis Codes* option.

The user can either accept the codes that have been pre-operatively entered, or the user can edit the codes as necessary. In this example, the codes will be adjusted to accurately reflect the procedures by adding Other Postop Diagnosis Codes and Other CPT Codes.

```
SURPATIENT,SEVENTEEN  (000-45-5119)        Case #314
JUL 15, 2005   CABG
------------------------------------------------------------------------------
Surgery Procedure PCE/Billing Information:

1. Principal Postop Diagnosis Code: 402.01  HYP HEART DIS MALIGN WITH FAIL
2. Other Postop Diagnosis Code:     NOT ENTERED
3. Principal CPT Code: 33510  CABG, VEIN, SINGLE
     Assoc. DX: 402.01-HYP HEART DIS MALIGN
4. Other CPT Code:     NOT ENTERED
------------------------------------------------------------------------------
Enter number of item to edit (1-4): 2
```

```
SURPATIENT,SEVENTEEN  (000-45-5119)        Case #314
JUL 15, 2005   CABG
-------------------------------------------------------------------------------
Other Postop Diagnosis:

1. Enter NEW Other Postop Diagnosis Code

Enter selection:  (1-1): 1

Enter new OTHER POSTOP DIAGNOSIS Code: 599.0   599.0   URIN TRACT INFECTION NOS
(w C/C)
         ...OK? Yes//  <Enter> (Yes)

Please review and update procedure associations for this diagnosis.

Press Enter/Return key to continue <Enter>
```

The ICD Code fields below indicate ICD-9 or ICD-10 codes.

Example: ICD-9 Code

```
SRPATIENTA,ONE  (000-12-3456)        Case #35706
JAN 01, 2012   RIGHT ARM PAIN
-------------------------------------------------------------------------------
Other Postop Diagnosis:

1. ICD9 Code: 003.1  SALMONELLA SEPTICEMIA

2. ICD9 Code: 367.0  HYPERMETROPIA

3. Enter NEW Other Postop Diagnosis Code

Enter selection:  (1-3): 1
```

Now the Other CPT Code will be entered.

```
SURPATIENT,SEVENTEEN  (000-45-5119)        Case #314
JUL 15, 2005   CABG
-------------------------------------------------------------------------------
Surgery Procedure PCE/Billing Information:

1. Principal Postop Diagnosis Code: 402.01  HYP HEART DIS MALIGN WITH FAIL
2. Other Postop Diagnosis Code:     599.0  URIN TRACT INFECTION NOS
3. Principal CPT Code: 33510  CABG, VEIN, SINGLE
     Assoc. DX: 402.01-HYP HEART DIS MALIGN
4. Other CPT Code:     NOT ENTERED
-------------------------------------------------------------------------------
Enter number of item to edit (1-4): 4
```

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

1. Enter NEW Other Procedure Code


Enter selection:  (1-1): 1

Enter new OTHER PROCEDURE CPT code: 33510      CABG, VEIN, SINGLE
 CORONARY ARTERY BYPASS, VEIN ONLY; SINGLE CORONARY VENOUS GRAFT
 Modifier: <Enter>
```

Example: ICD-10 Code

```
SRPATIENTA,ONE  (000-12-3456)        Case #45731
FEB 27, 2014   HEART TRANSPLANT
------------------------------------------------------------------------------
Other Postop Diagnosis:

1. ICD10 Code: E83.41  Hypermagnesemia

2. ICD10 Code: V72.1XXD  Passenger on bus injured in clsn w 2/3-whl mv nontraf,
subs

3. Enter NEW Other Postop Diagnosis Code

Enter selection:  (1-3): 1

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

1. ICD10 Code: E83.41  Hypermagnesemia

     Select one of the following:

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

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

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

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

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

------------------------------------------------------------------------------
Only the following ICD Diagnosis Codes can be associated:

1. 402.01-HYP HEART DIS MALIGN WITH FAIL
2. 599.0-URIN TRACT INFECTION NOS

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

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

1. CPT Code: 33510  CABG, VEIN, SINGLE
     Assoc. DX: 402.01-HYP HEART DIS MALIGN     599.0-URIN TRACT INFECTION N
2. Enter NEW Other Procedure Code

Enter selection:  (1-2): <Enter>
```

The Surgery case displays the updated values.

```
SURPATIENT,SEVENTEEN  (000-45-5119)        Case #314
JUL 15, 2005   CABG
------------------------------------------------------------------------------
Surgery Procedure PCE/Billing Information:

1. Principal Postop Diagnosis Code: 402.01  HYP HEART DIS MALIGN WITH FAIL
2. Other Postop Diagnosis Code:     599.0  URIN TRACT INFECTION NOS
3. Principal CPT Code: 33510  CABG, VEIN, SINGLE
     Assoc. DX: 402.01-HYP HEART DIS MALIGN
4. Other CPT Code: 33510  CABG, VEIN, SINGLE
Assoc. DX: 402.01-HYP HEART DIS MALIGN     599.0-URIN TRACT INFECTION N
------------------------------------------------------------------------------
Enter number of item to edit (1-4): <Enter>
```

Because the coding for the case is completed, the user can select to stop editing the case and send the case to PCE.

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

Coding completed and sent to PCE.

Press Enter/Return key to continue
```

Prior to sending the case to PCE, the Surgery software checks to see if a specific code, 065.0 CRIMEAN HEMORRHAGIC FEV, is entered as a diagnosis code. If it is entered, the software prompts the user to make sure that the code is correct for the specified case. This check is added to prevent the inadvertent assignment of code 065.0 when "CHF" is entered for the Principal or Other ICD Diagnosis codes.

After the case has been sent to PCE, any changes made to the case through the Update/Verify Procedure/Diagnosis Codes option will be automatically sent to PCE.

Example: Editing a Case After Sending to PCE

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

```
SURPATIENT,SEVENTEEN  (000-45-5119)        Case #314
JUL 15, 2005   CABG
------------------------------------------------------------------------------
Coding for this case has been completed and sent to PCE.

Are you sure you want to edit this case? NO// YES
```

```
SURPATIENT,SEVENTEEN  (000-45-5119)        Case #314
JUL 15, 2005   CABG
------------------------------------------------------------------------------
Surgery Procedure PCE/Billing Information:

1. Principal Postop Diagnosis Code: 402.01  HYP HEART DIS MALIGN WITH FAIL
2. Other Postop Diagnosis Code:     599.0  URIN TRACT INFECTION NOS
3. Principal CPT Code: 33510  CABG, VEIN, SINGLE
     Assoc. DX: 402.01-HYP HEART DIS MALIGN
4. Other CPT Code: 33510  CABG, VEIN, SINGLE
     Assoc. DX: 402.01-HYP HEART DIS MALIGN     599.0-URIN TRACT INFECTION N
------------------------------------------------------------------------------
Enter number of item to edit (1-4): 4
```

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

1. CPT Code: 33510  CABG, VEIN, SINGLE
     Assoc. DX: 402.01-HYP HEART DIS MALIGN     599.0-URIN TRACT INFECTION N
2. Enter NEW Other Procedure Code

Enter selection:  (1-2): 1
```

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

1. CPT Code: 33510  CABG, VEIN, SINGLE
     Modifiers: NOT ENTERED
     Assoc. DX: 402.01-HYP HEART DIS MALIGN
                599.0-URIN TRACT INFECTION N

     Select one of the following:

          1         Update Other Procedure CPT Code
          2         Update Associated Diagnoses

Enter selection (1 or 2): 1//  <Enter> Update Other Procedure CPT Code

Other Procedure CPT Code: 33510// 33517      CABG, ARTERY-VEIN, SINGLE
 CORONARY ARTERY BYPASS, USING VENOUS GRAFT(S) AND ARTERIAL GRAFT(S);
 SINGLE VEIN GRAFT (LIST SEPARATELY IN ADDITION TO CODE FOR ARTERIAL
 GRAFT)
 Modifier: <Enter>

The Diagnosis to Procedure Associations may no longer be correct.
Delete all Other Associated Diagnoses? N// Y  YES
```

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

1. CPT Code: 33517  CABG, ARTERY-VEIN, SINGLE
     Modifiers: NOT ENTERED
     Assoc. DX: NOT ENTERED

-------------------------------------------------------------------------------
Only the following ICD Diagnosis Codes can be associated:

1. 402.01-HYP HEART DIS MALIGN WITH FAIL
2. 599.0-URIN TRACT INFECTION NOS

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

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

1. CPT Code: 33517  CABG, ARTERY-VEIN, SINGLE
     Assoc. DX: 402.01-HYP HEART DIS MALIGN     599.0-URIN TRACT INFECTION N
2. Enter NEW Other Procedure Code

Enter selection:  (1-2): <Enter>
```

```
SURPATIENT,SEVENTEEN  (000-45-5119)        Case #314
JUL 15, 2005   CABG
-------------------------------------------------------------------------------
Surgery Procedure PCE/Billing Information:

1. Principal Postop Diagnosis Code: 402.01  HYP HEART DIS MALIGN WITH FAIL
2. Other Postop Diagnosis Code:     599.0  URIN TRACT INFECTION NOS
3. Principal CPT Code: 33510  CABG, VEIN, SINGLE
     Assoc. DX: 402.01-HYP HEART DIS MALIGN
4. Other CPT Code: 33517  CABG, ARTERY-VEIN, SINGLE
     Assoc. DX: 402.01-HYP HEART DIS MALIGN     599.0-URIN TRACT INFECTION N
-------------------------------------------------------------------------------
Enter number of item to edit (1-4): <Enter>

Coding completed and sent to PCE.

Press Enter/Return key to continue
```

Operation/Procedure Report
[SRCODING OP REPORT]

The *Operation/Procedure Report* option is used by the coders to print the Operation Report for an operation or the Procedure Report (Non-O.R.) for a non-O.R. procedure.

Any user may print this report, which prints in an 80-column format and can be viewed on the screen or copied to a printer.

Example 1: Operation Report

```
Select CPT/ICD Update/Verify Menu Option: OR  Operation/Procedure Report
DEVICE: [Select Print Device]
```

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

SURPATIENT,TEN 000-12-3456 OPERATION REPORT

NOTE DATED: 07/29/2003 15:15 OPERATION REPORT
VISIT: 07/29/2003 15:15 SURGERY OP REPORT NON-COUNT
SUBJECT: Case #: 73285

PREOPERATIVE DIAGNOSIS: Visually significant cataract, right eye

POSTOPERATIVE DIAGNOSIS: Visually significant cataract, right eye

PROCEDURE: Phacoemulsification with intraocular lens placement, right eye

CLINICAL INDICATIONS: This 64-year-old gentleman complains of decreased vision in the right eye affecting his activities of daily living. Best corrected visual acuity is counting fingers at 6 feet, associated with a 2-3+ nuclear sclerotic and 4+ posterior subcapsular cataract in that eye.

ANESTHESIA: Local monitoring with topical Tetracaine and 1% preservative free Lidocaine.

DESCRIPTION OF THE PROCEDURE: After the risks, benefits and alternatives of the procedure were explained to the patient, informed consent was obtained. The patient's right eye was dilated with Phenylephrine, Mydriacyl and Ocufen. He was brought to the Operating Room and placed on anesthetic monitors. Topical Tetracaine was given. He was prepped and draped in the usual sterile fashion for eye surgery. A Lieberman lid speculum was placed.

A Supersharp was used to create a superior paracentesis port. The anterior chamber was irrigated with 1% preservative free Lidocaine. The anterior chamber was filled with Viscoelastic. The diamond groove maker and diamond keratome were used to create a clear corneal tunneled incision at the temporal limbus. The cystotome was used to initiate a continuous capsulorrhexis, which was then completed using Utrata forceps. Balanced salt solution was used to hydrodissect and hydrodelineate the lens.

Phacoemulsification was used to remove the lens nucleus and epinucleus in a non-stop horizontal chop fashion. Cortex was removed using irrigation and aspiration. The capsular bag was filled with Viscoelastic. The wound was enlarged with a 69 blade. An Alcon model MA60BM posterior chamber intraocular lens with a power of 24.0 diopters, serial #588502.064, was folded and inserted with the leading haptic placed into the bag. The trailing haptic was dialed into the bag with the Lester hook. The wound was hydrated. The anterior chamber was filled with balanced salt solution. The wound was tested and found to be self-sealing. Subconjunctival antibiotics were given, and an eye shield was placed. The patient was taken in good condition to the Recovery Room. There were no complications.

KJC/PSI
DATE DICTATED: 07/29/03
DATE TRANSCRIBED: 07/29/03
JOB: 629095

Signed by: /es/ FOURTEEN SURSURGEON, M.D.
07/30/2003 10:31

Example 2: Procedure Report (Non-OR)

```
Select CPT/ICD Update/Verify Menu Option: OR  Operation/Procedure Report
DEVICE: [Select Print Device]
```

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

```
---------------------------------------------------------------------------
SURPATIENT,ONE  000-44-7629                                PROCEDURE REPORT
---------------------------------------------------------------------------
NOTE DATED: 02/13/2002 00:00  PROCEDURE REPORT

SUBJECT: Case #: 267236

PREOPERATIVE DIAGNOSIS:  RESPIRATORY FAILURE, PROLONGED TRACHEAL INTUBATION
                         AND FAILURE TO WEAN

POSTOPERATIVE DIAGNOSIS:  SAME

PROCEDURE PERFORMED:  OPEN TRACHEOSTOMY

SURGEON:  DR. SURSURGEON

ASSISTANT SURGEON:

ANESTHESIA:  GENERAL ENDOTRACHEAL ANESTHESIA

ESTIMATED BLOOD LOSS:  MINIMAL

COMPLICATIONS:  NONE

INDICATIONS FOR PROCEDURE:  The patient is a forty-nine-year-old gentleman
with a rather extensive past surgical history, mostly significant for status
post esophagogastrectomy and presented to the hospital approximately three
weeks ago with abdominal pain. Diagnostic evaluation consisted of an abdominal
CT scan, liver function tests and right upper quadrant ultrasound, all of
which were consistent with a diagnosis of acalculus cholecystitis. Because of
these findings, the patient was brought to the operating room approximately
three weeks ago where an open cholecystectomy was performed. The patient subsequent to that has
had a very rocky postoperative course, most significantly focusing around persistently spiking
fevers with sources significant for an E-coli sinusitis as well as a Staphylococcus E-coli
pneumonia with no evidence of bacteremia. As a result of all of this sepsis and persistent
spiking fevers, the patient has had a pneumonia, the patient has had a rather difficult time
weaning from the ventilator and because of the
almost three week period since his last operation with persistent endotracheal
tube in place, the patient was brought to the operating room for an open
tracheostomy procedure.

DESCRIPTION OF PROCEDURE:  After appropriate consent was obtained from the
patient's next of kin and the risks and benefits were explained to her, the
patient was then brought to the operating room where general endotracheal
anesthesia was induced. The area was prepped and draped in the usual fashion
with a towel roll under the patient's scapula and the neck extended.

A longitudinal incision of approximately 2 cm was made just below the cricoid
cartilage. The strap muscles were taken down using Bovee electrocautery. The
isthmus of the thyroid was clamped and tied off using 2-0 silk x two.
Hemostasis was assured. The thyroid cartilage was carefully dissected
directly onto it. The window in the third ring of the trachea was opened
after placement of retraction sutures of 0 silk, The hatch was cut open using
a hatch box shape. This opening was then dilated using the tracheal dilator.
The endotracheal tube was pulled back. A #7 Tracheostomy tube was placed with
ease. Breath sounds were assured. The patient was oxygenating well and the
stay sutures were placed. The patient tolerated the procedure well. The skin
was closed with 0 silk and trachea tip was applied. The patient tolerated the
procedure well. The endotracheal tube was finally removed. He was brought to
the Surgical Intensive Care Unit in stable, but critical condition.

Three Sursurgeon, M.D.

TS/jer:jw J#:  514 DD:  02-13-02 DT:  02-13-02

                  Signed by: /es/ THREE SURSURGEON
                                     02/13/2002 16:40
Enter RETURN to continue or '^' to exit: ^
```

Nurse Intraoperative Report
[SRCODING NURSE REPORT]

The *Nurse Intraoperative Report* option is used by the coders to print the Nurse Intraoperative Report for an operation. This report is not available for non-O.R. procedures.

This report prints in an 80-column format and can be viewed on the screen or copied to a printer.

Example: Nurse Intraoperative Report

```
Select CPT/ICD Update/Verify Menu Option: NR  Nurse Intraoperative Report
DEVICE: [Select Print Device]
```

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

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

SUBJECT: Case #: 267226

Operating Room:  BO OR1                 Surgical Priority: ELECTIVE

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

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

Wound Classification: CONTAMINATED

Operation Disposition: SICU
Discharged Via: ICU BED

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

Other Scrubbed Assistants: N/A

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

Other Persons in OR: N/A

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

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

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

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

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

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

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

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

Flash Sterilization Episodes:
   Contamination:                       0
   SPD Processing/OR Management Issues: 0
   Emergency Case:                      0
```

```
   No Better Option:                    0
   Loaner or Short Notice Instrument:   0
   Decontamination of Instruments Not for Use In Patient: 0

Electrocautery Unit:       8845,5512
ESU Coagulation Range:     50-35


ESU Cutting Range:         35-35
Electroground Position(s): RIGHT BUTTOCK
                           LEFT BUTTOCK

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

Anesthesia Technique(s):
 GENERAL  (PRINCIPAL)


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

Tourniquet: N/A

Thermal Unit: N/A

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

Medications: N/A

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

Blood Replacement Fluids: N/A

Sponge Count:       YES
Sharps Count:       YES
Instrument Count:   NOT APPLICABLE
Counter:            SURNURSE,FOUR
Counts Verified By: SURNURSE,FIVE

Dressing: DSD, PAPER TAPE, MEPORE
Packing:  NONE

Blood Loss: 800 ml                     Urine Output: 750 ml

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

Laser Unit(s): N/A

Sequential Compression Device: NO

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

```
Devices: N/A

                  Signed by: /es/ FIVE SURNURSE
                                  03/04/2004 10:41
```

Non-OR Procedure Information
[SR NON-OR INFO]

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

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

Example: Non-OR Procedure Information

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


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

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

DEVICE: HOME// [Select Print Device]

-----------------------------------printout follows---------------------------------

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

Med. Specialty: GENERAL                     Location: NON OR

Principal Diagnosis: LARYNGEAL/TRACHEAL BURN

Provider: SURSURGEON,FIFTEEN                     Patient Status: NOT ENTERED
Attending:
Attending Code:

Attend Anesth: N/A
Anesthesia Supervisor Code: N/A
Anesthetist: N/A

Anesthesia Technique(s): N/A

Proc Begin:  JAN 14, 2004  08:00        Proc End:  JAN 14, 2004  09:00

Procedure(s) Performed:
  Principal: BRONCHOSCOPY


Dictated Summary Expected: YES

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

Cumulative Report of CPT Codes
[SROACCT]

The *Cumulative Report of CPT Codes* option counts and reports the number of times a procedure was performed (based on CPT codes) during a specified date range. There is also a column showing how many times it was in the Other Operative Procedure category.

After the user enters the date range, the software will ask if the user wants the Cumulative Report of CPT Codes to include only operating room surgical procedures, non-O.R. procedures, or both.

These reports have a 132-column format and are designed to be copied to a printer.

Example 1: Print the Cumulative Report of CPT Codes for only OR Surgical Procedures

```
Select CPT/ICD Coding Menu Option: C  Cumulative Report of CPT Codes

Cumulative Report of CPT Codes

Start with Date: 3/28  (MAR 28, 1999)
End with Date: 4/3  (APR 03, 1999)

Include which cases on the Cumulative Report of CPT Codes ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures.

Select Number:  1// <Enter>

This report is designed to use a 132 column format.


Select Device: [Select Print Device]
```

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

MAYBERRY, NC
SURGICAL SERVICE
CUMULATIVE REPORT OF CPT CODES
FROM: MAR 28,1999 TO: APR 3,1999

REVIEWED BY
DATE REVIEWED:

O.R. SURGICAL PROCEDURES

CPT CODE - SHORT DESCRIPTION	TOTAL PROCEDURES	TOTAL PRINCIPAL PROCEDURES	TOTAL OTHER PROCEDURES
10060 DRAINAGE OF SKIN ABSCESS	1	1	0
11440 REMOVAL OF SKIN LESION	1	1	0
11441 REMOVAL OF SKIN LESION	4	4	0
11641 REMOVAL OF SKIN LESION	4	2	2
24075 REMOVE ARM/ELBOW LESION	1	1	0
26989 HAND/FINGER SURGERY	1	1	0
30520 REPAIR OF NASAL SEPTUM	1	1	0
31231 NASAL ENDOSCOPY, DX	1	0	1
45315 PROCTOSIGMOIDOSCOPY	1	0	1
45330 SIGMOIDOSCOPY, DIAGNOSTIC	7	7	0
45333 SIGMOIDOSCOPY & POLYPECTOMY	1	1	0
45378 DIAGNOSTIC COLONOSCOPY	2	2	0
45385 COLONOSCOPY, LESION REMOVAL	3	3	0
47600 REMOVAL OF GALLBLADDER	1	0	1
49000 EXPLORATION OF ABDOMEN	1	1	0
49505 REPAIR INGUINAL HERNIA	2	1	1
66984 REMOVE CATARACT, INSERT LENS	4	3	1
68801 DILATE TEAR DUCT OPENING	1	1	0

Example 2: Print the Cumulative Report of CPT Codes for only Non-OR Procedures

```
Select CPT/ICD Coding Menu Option: C  Cumulative Report of CPT Codes

Cumulative Report of CPT Codes

Start with Date: 7 1 99  (JUL 01, 1999)
End with Date: 12 31 99  (DEC 31, 1999)

Include which cases on the Cumulative Report of CPT Codes ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures.

Select Number:  1// 2

This report is designed to use a 132 column format.


Select Device: [Select Print Device]
```

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

MAYBERRY, NC
SURGICAL SERVICE
CUMULATIVE REPORT OF CPT CODES
FROM: JUL 1,1999 TO: DEC 31,1999

REVIEWED BY
DATE REVIEWED:

NON-O.R. PROCEDURES

CPT CODE - SHORT DESCRIPTION	TOTAL PROCEDURES	TOTAL PRINCIPAL PROCEDURES	TOTAL OTHER PROCEDURES
10060 DRAINAGE OF SKIN ABSCESS	2	2	0
10061 DRAINAGE OF SKIN ABSCESS	1	1	0
11040 DEBRIDE SKIN PARTIAL	8	8	0
11042 DEBRIDE SKIN/TISSUE	1	1	0
11100 BIOPSY OF SKIN LESION	11	11	0
11402 REMOVAL OF SKIN LESION	1	1	0
11420 REMOVAL OF SKIN LESION	1	1	0
11620 REMOVAL OF SKIN LESION	1	1	0
11640 REMOVAL OF SKIN LESION	1	1	0
11730 REMOVAL OF NAIL PLATE	1	1	0
11750 REMOVAL OF NAIL BED	1	1	0
12001 REPAIR SUPERFICIAL WOUND(S)	3	3	0
12011 REPAIR SUPERFICIAL WOUND(S)	2	2	0
14060 SKIN TISSUE REARRANGEMENT	1	1	0
15782 ABRASION TREATMENT OF SKIN	1	1	0
17340 CRYOTHERAPY OF SKIN	1	1	0
20550 INJ TENDON/LIGAMENT/CYST	23	23	0
29799 CASTING/STRAPPING PROCEDURE	1	1	0
46083 INCISE EXTERNAL HEMORRHOID	2	2	0

Report of CPT Coding Accuracy

The Report of CPT Coding Accuracy lists cases sorted by the CPT code used in the PRINCIPAL PROCEDURES field and OTHER OPERATIVE PROCEDURES field entered by the coder. This option is designed to help check the accuracy of the coding procedures.

About the prompts

"Do you want to print the Report of CPT Coding Accuracy for all CPT Codes ?" The user should reply **NO** to this prompt to produce the report for only one CPT code. The user will then be prompted to enter the CPT code or category.

"Do you want to sort the Report of CPT Coding Accuracy by Surgical Specialty ?" The user should press the **<Enter>** key if he or she wants to sort the report by specialty. Enter **NO** to sort the report by date only.

"Do you want to print the Report to Check Coding Accuracy for all Surgical Specialties ?" The user can enter the code or name of the surgical service he or she wants the report to be based on. Or, the user can press the **<Enter>** key to print the report for all surgical specialties.

Example 1: Print the Report of CPT Coding Accuracy for OR Surgical Procedures, sorted by Surgical Specialty

```
Select CPT/ICD Coding Menu Option: A  Report of CPT Coding Accuracy

Report to Check CPT Coding Accuracy

Start with Date: 10 8 04  (OCT 08, 2004)
End with Date: 10 8 04  (OCT 08, 2004

Print the Report of CPT Coding Accuracy for which cases ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures (All Specialties).

Select Number:  1// <Enter>

Do you want to print the Report of CPT Coding Accuracy for all
CPT Codes ?  YES//  <Enter>

Do you want to sort the Report of CPT Coding Accuracy by
Surgical Specialty ?  YES//  <Enter>

Do you want to print the Report to Check Coding Accuracy for all
Surgical Specialties ?  YES//  NO

Print the Coding Accuracy Report for which Surgical Specialty ?  50       GENERA
L(OR WHEN NOT DEFINED BELOW)  GENERAL(OR WHEN NOT DEFINED BELOW)     50

This report is designed to use a 132 column format.

Select Device: [Select Print Device]
```

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

O.R. SURGICAL PROCEDURES

PROCEDURE DATE / CASE #	PATIENT ID#	PROCEDURES	SURGEON/PROVIDER / ATTEND SURG/PROV
		47600 REMOVAL OF GALLBLADDER PRINCIPAL PROCEDURES DESCRIPTION: CHOLECYSTECTOMY;	
10/08/04 07:00 63072	SURPATIENT,EIGHTEEN 000-22-3334	CHOLECYSTECTOMY CPT Codes: 47600-22	SURSURGEON,TWO SURSURGEON,FOUR
		47605 REMOVAL OF GALLBLADDER OTHER PROCEDURES DESCRIPTION: CHOLECYSTECTOMY; WITH CHOLANGIOGRAPHY	
10/08/04 10:00 63077	SURPATIENT,TWELVE 000-41-8719	INGUINAL HERNIA , OTHER OPERATIONS: CHOLECYSTECTOMY CPT Codes: 49521, 47605-22	SURSURGEON,FOUR SURSURGEON,FOUR
		49505 REPAIR INGUINAL HERNIA PRINCIPAL PROCEDURES DESCRIPTION: REPAIR INITIAL INGUINAL HERNIA, AGE 5 YEARS OR OVER; REDUCIBLE	
10/08/04 06:00 63071	SURPATIENT,FOUR 000-45-7212	INGUINAL HERNIA CPT Codes: 49505	SURSURGEON,FOUR SURSURGEON,SIXTEEN

Example 2: Print the Report of CPT Coding Accuracy for OR Surgical Procedures, sorted by Date

```
Select CPT/ICD Coding Menu Option: A  Report of CPT Coding Accuracy

Report to Check CPT Coding Accuracy

Start with Date: 10 1 04  (OCT 01, 2004)
End with Date: 10 7 04  (OCT 07, 2004)

Print the Report of CPT Coding Accuracy for which cases ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures (All Specialties).

Select Number:  1// <Enter>

Do you want to print the Report of CPT Coding Accuracy for all
CPT Codes ?  YES//  <Enter>

Do you want to sort the Report of CPT Coding Accuracy by
Surgical Specialty ?  YES//  N

This report is designed to use a 132 column format.


Select Device: [Select Print Device]
```

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

O.R. SURGICAL PROCEDURES

PROCEDURE DATE / CASE #	PATIENT / ID# / SPECIALTY	PROCEDURES	SURGEON/PROVIDER / ATTEND SURG/PROV
		31365 REMOVAL OF LARYNX PRINCIPAL PROCEDURES DESCRIPTION: LARYNGECTOMY; TOTAL, WITH RADICAL NECK DISSECTION	
10/03/04 07:00 63059	SURPATIENT,NINETEEN 000-28-7354 THORACIC SURGERY (INC. CARDIAC SURG.)	PULMONARY LOBECTOMY CPT Codes: 31365	SURSURGEON,SEVENTEEN SURSURGEON,FOUR
		32440 REMOVAL OF LUNG PRINCIPAL PROCEDURES DESCRIPTION: REMOVAL OF LUNG, TOTAL PNEUMONECTOMY;	
10/03/04 10:00 63060	SURPATIENT,TWENTY 000-45-4886 THORACIC SURGERY (INC. CARDIAC SURG.)	PULMONARY LOBECTOMY CPT Codes: 32440	SURSURGEON,FOUR SURSURGEON,FOUR
10/04/04 06:00 63069	SURPATIENT,TEN 000-12-3456 THORACIC SURGERY (INC. CARDIAC SURG.)	PULMONARY LOBECTOMY CPT Codes: 32440	SURSURGEON,TWO SURSURGEON,TWO

Example 3: Print the Report of CPT Coding Accuracy for Non-OR Procedures, sorted by CPT Code and Medical Specialty

```
Select CPT/ICD Coding Menu Option: A  Report of CPT Coding Accuracy

Report to Check CPT Coding Accuracy

Start with Date: 1 1 05  (JAN 01, 2005)
End with Date: 8 31 05  (AUG 31, 2005)

Print the Report of CPT Coding Accuracy for which cases ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures (All Specialties).

Select Number:  1// 2

Do you want to print the Report of CPT Coding Accuracy for all
CPT Codes ?  YES//  N


Print the Coding Accuracy Report for which CPT Code ?  92960
HEART ELECTROCONVERSION
        CARDIOVERSION, ELECTIVE, ELECTRICAL CONVERSION OF
        ARRHYTHMIA, EXTERNAL

Do you want to sort the Report of CPT Coding Accuracy by
Medical Specialty ?  YES//  <Enter>


Do you want to print the Report to Check Coding Accuracy for all
Medical Specialties ?  YES//  N


Print the Coding Accuracy Report for which Medical Specialty ?   MEDICINE

This report is designed to use a 132 column format.


Select Device: [Select Print Device]
```

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

NON-O.R. PROCEDURES

PROCEDURE DATE / CASE #	PATIENT ID#	PROCEDURES	SURGEON/PROVIDER / ATTEND SURG/PROV
92960 HEART ELECTROCONVERSION			
PRINCIPAL PROCEDURES			
DESCRIPTION: CARDIOVERSION, ELECTIVE, ELECTRICAL CONVERSION OF ARRHYTHMIA, EXTERNAL			
01/24/05	SURPATIENT,SEVENTEEN	CARDIOVERSION	SURSURGEON,TWO
15499	000-45-5119		SURSURGEON,TWO
		CPT Codes: 92690	
02/09/05	SURPATIENT,NINE	CARDIOVERSION	SURSURGEON,ONE
15701	000-34-5555		SURSURGEON,TWO
		CPT Codes: 92960	
03/29/05	SURPATIENT,FIFTEEN	CARDIOVERSION	SURSURGEON,THREE
15912	000-98-1234		
		CPT Codes: 92960	
08/04/05	SURPATIENT,SIX	CARDIOVERSION	SURSURGEON,TWO
16669	000-09-8797		SURSURGEON,FOUR
		CPT Codes: 92960	
08/25/05	SURPATIENT,TWO	CARDIOVERSION	SURSURGEON,TWO
16828	000-45-1982		SURSURGEON,TWO
		CPT Codes: 92960	

List Completed Cases Missing CPT Codes
[SRSCPT

The *List Completed Cases Missing CPT Codes* option generates a report of completed cases that are missing the Principal CPT code for a specified date range. Only procedures that have CPT codes will be counted on the Annual Report of Surgical Procedures.

After the user enters the date range, the software will ask whether the user wants the Cumulative Report of CPT Codes to include: 1) only operating room surgical procedures, 2) non-O.R. procedures, or 3) both.

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

Example: List Completed Cases Missing CPT Codes

```
Select CPT/ICD Coding Menu Option: M  List Completed Cases Missing CPT Codes

Print list of Completed Cases Missing CPT Codes for

1. OR Surgical Procedures.
2. Non-OR Procedures.
3. Both OR Surgical Procedures and Non-OR Procedures (All Specialties).

Select Number:  1// 1

Do you want the list for all Surgical Specialties ?  YES//  <Enter>

Start with Date: 2/1  (FEB 01, 2005)
End with Date: 4/30  (APR 30, 2005)

Print the List of Cases Missing CPT codes to which Printer ?  [Select Print Device]
```

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

MAYBERRY, NC
Completed Cases Missing CPT Codes
O.R. Surgical Procedures
From: FEB 1,2005 To: APR 30,2005
Specialty: GENERAL(OR WHEN NOT DEFINED BELOW)

Operation Date	Patient (ID#)	Surgeon/Provider	Case #
FEB 01, 2005	SURPATIENT,TWO (000-45-1982)	SURSURGEON,TWO	53708
	* EXC LEFT PREAURICULAR LESION		
FEB 08, 2005	SURPATIENT,FIVE (000-58-7963)	SURSURGEON,ONE	53747
	* EXCISION LESIONS SCALP		
	* N/A (CPT: MISSING)		
MAR 12, 2005	SURPATIENT,SEVEN (000-84-0987)	SURSURGEON,TWO	53973
	* COLONOSCOPY		
MAR 23, 2005	SURPATIENT,FORTYONE (000-43-2109)	SURSURGEON,ONE	54030
	* COLONOSCOPY/ATTEMPTED		
APR 27, 2005	SURPATIENT,THIRTY (000-82-9472)	SURSURGEON,SEVENTEEN	54325
	* EXCISION RT FOREARM LESIONS		
	* EXC LESION, RT EAR		
	* EXC LESION, RT FOREHEAD		
	* EXC LESION RT SCALP		
	* RXC LESION, NOSE		
	* EXC LESION, LEFT EAR		
	* EXC LESION, LEFT FOREARM		
	* EXC LESION, TOP OF HEAD		
	* EXC LESION, LEFT NECK		

List of Operations
[SROPLIST]

The List of Operations report contains general information for completed cases within a specified date range. It sorts the cases by date and includes the procedure(s), surgical service, length of actual operation, surgeons, and anesthesia technique. This report also includes aborted cases.

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

Example: List of Operations

```
Select CPT/ICD Coding Menu Option: L  List of Operations

List of Operations

Start with Date:  10/8  (OCT 08, 1999)
End with Date:  10/8  (OCT 08, 1999)

This report is designed to use a 132 column format.

Print to device: [Select Print Device]
```

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

SURGICAL SERVICE
LIST OF OPERATIONS
FROM: OCT 8,1999 TO: OCT 8,1999

REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: OCT 20,1999

DATE / CASE # / PRIORITY	PATIENT ID#	SERVICE / OPERATION(S)	SURGEON / 1ST ASSISTANT / 2ND ASSISTANT	ANESTHESIA TECH
10/08/99 63071 ELECTIVE	SURPATIENT,FOUR 000-45-7212	GENERAL(OR WHEN NOT DEFINED BELOW) INGUINAL HERNIA	SURSURGEON,FOUR SURSURGEON,ONE SURSURGEON,TWO	GENERAL OP TIME: 50 MIN.
10/08/99 63072 ELECTIVE	SURPATIENT,EIGHTEEN 000-22-3334	GENERAL(OR WHEN NOT DEFINED BELOW) CHOLECYSTECTOMY	SURSURGEON,TWO SURSURGEON,FOUR	GENERAL OP TIME: 50 MIN.
10/08/99 63073 URGENT, ADD TODAY	SURPATIENT,FIFTYONE 000-23-3221	OPHTHALMOLOGY INTRAOCCULAR LENS, CHOLECYSTECTOMY	SURSURGEON,FOUR SURSURGEON,THREE SURSURGEON,FOUR	SPINAL OP TIME: 50 MIN.
10/08/99 63074 ELECTIVE	SURPATIENT,FIVE 000-58-7963	GENERAL(OR WHEN NOT DEFINED BELOW) HIP REPLACEMENT	SURSURGEON,FOUR SURSURGEON,FOUR SURSURGEON,FIVE	NOT ENTERED OP TIME: 50 MIN.
10/08/99 63075 ELECTIVE	SURPATIENT,SIX 000-09-8797	GENERAL(OR WHEN NOT DEFINED BELOW) PULMONARY LOBECTOMY	SURSURGEON,TWO SURSURGEON,THREE SURSURGEON,TWO	NOT ENTERED OP TIME: 45 MIN.
10/08/99 63077 ELECTIVE	SURPATIENT,TWELVE 000-41-8719	GENERAL(OR WHEN NOT DEFINED BELOW) INGUINAL HERNIA, CHOLECYSTECTOMY	SURSURGEON,FOUR SURSURGEON,THREE SURSURGEON,THREE	GENERAL OP TIME: 63 MIN.
10/08/99 63076 ELECTIVE	SURPATIENT,FOURTEEN 000-45-7212	UROLOGY TURP	SURSURGEON,TWO SURSURGEON,FOUR SURSURGEON,TWO	GENERAL OP TIME: 45 MIN.

TOTAL CASES: 7

List of Operations (by Surgical Specialty) [SROPLIST1]

The List of Operations (by Surgical Specialty) report contains general information for completed cases within a selected date range. It sorts the cases by surgical specialty and case number.

This report includes information on case type, length of actual operation, surgeon names, and anesthesia technique. The user can request a list for all specialties or a selected specialty.

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

Example: List of Operations by Surgical Specialty

```
Select CPT/ICD Coding Menu Option: LS  List of Operations (by Surgical Specialty)

List of Operations sorted by Surgical Specialty

Start with Date:  10/4  (OCT 04, 1999)
End with Date:  10/8  (OCT 08, 1999)

Do you want to print the report for all Specialties ?  YES//  N

Print the report for which Surgical Specialty ?  GENERAL (OR WHEN NOT DEFINED BELOW)

This report is designed to use a 132 column format.

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

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

DATE REVIEWED:
REVIEWED BY:
DATE PRINTED: SEP 20,1999

DATE / CASE #	PATIENT / ID# / PRIORITY	OPERATION(S)	SURGEON / FIRST ASSISTANT / SECOND ASSISTANT	ANESTHESIA / TECHNIQUE
GENERAL(OR WHEN NOT DEFINED BELOW)				
10/04/99 63066	SURPATIENT,THREE 000-21-2453 STANDBY	INGUINAL HERNIA	SURSURGEON,THREE SURSURGEON,TWO SURSURGEON,ONE	GENERAL OP TIME: 40 MIN.
10/04/99 63067	SURPATIENT,EIGHT 000-37-0555 ELECTIVE	INGUINAL HERNIA	SURSURGEON,FOUR SURSURGEON,ONE SURSURGEON,TWO	GENERAL OP TIME: 50 MIN.
10/04/99 63068	SURPATIENT,ONE 000-44-7629 ELECTIVE	INGUINAL HERNIA	SURSURGEON,THREE SURSURGEON,ONE SURSURGEON,TWO	GENERAL OP TIME: 45 MIN.
10/07/99 63070	SURPATIENT,SIXTY 000-56-7821 ELECTIVE	INGUINAL HERNIA	SURSURGEON,TWO SURSURGEON,FOUR	GENERAL OP TIME: 45 MIN.
10/08/99 63071	SURPATIENT,FOUR 000-17-0555 ELECTIVE	INGUINAL HERNIA	SURSURGEON,FOUR SURSURGEON,ONE SURSURGEON,TWO	GENERAL OP TIME: 50 MIN.
10/08/99 63072	SURPATIENT,EIGHTEEN 000-22-3334 ELECTIVE	CHOLECYSTECTOMY	SURSURGEON,TWO SURSURGEON,FOUR	GENERAL OP TIME: 50 MIN.
10/08/99 63077	SURPATIENT,TWELVE 000-41-8719 ELECTIVE	INGUINAL HERNIA, CHOLECYSTECTOMY	SURSURGEON,FOUR SURSURGEON,THREE SURSURGEON,THREE	GENERAL OP TIME: 63 MIN.

TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 7

Report of Daily Operating Room Activity
[SROPACT]

The *Report of Daily Operating Room Activity* option generates a report listing cases started between 6:00 AM on the date selected and 5:59 AM of the following day for all operating rooms.

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

Example: Print the Report of Daily Operating Room Activity

```
Select CPT/ICD Coding Menu Option: D  Report of Daily Operating Room Activity

Print the Report of Daily Activity for which Date ?  3/9  (MAR 09, 1999)

This report will include all cases started between MAR  9, 1999 at 6:00 AM
and MAR 10, 1999 at 5:59 AM.

It is designed to use a 132 column format.

Print the Report to which Device ? [Select Print Device]
```

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

MAYBERRY, NC
SURGICAL SERVICE
DAILY REPORT OF OPERATING ROOM ACTIVITY
FOR: MAR 09, 1999

PATIENT ID # WARD	AGE	TIME IN OR TIME OUT OR CASE NUMBER	POSTOPERATIVE DIAGNOSIS PROCEDURE(S)	ANESTHESIOLOGIST PRIN. ANESTHETIST	SURGEON FIRST ASST. ATT SURGEON
OPERATING ROOM: OR1					
SURPATIENT,TWELVE		03/09 08:00	INGUINAL HERNIA	SURANESTHESIOLOGIST,O	SURSURGEON,E
000-41-8719	61	03/09 09:10	INGUINAL HERNIA	SURANESTHETIST,F	SURSURGEON,O
1 NORTH 161-1		194			SURSURGEON,T
OPERATING ROOM: OR3					
SURPATIENT,NINE		03/09 09:15	CHOLECYSTITIS	SURANESTHESIOLOGIST,T	SURSURGEON,T
000-34-5555	48	03/09 12:40	CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM	SURANESTHETIST,O	SURSURGEON,F
OUTPATIENT		187			SURSURGEON,T
OPERATING ROOM: OR5					
SURPATIENT,SIX		03/09 19:56	APPENDICITIS	SURANESTHESIOLOGIST,T	SURSURGEON,S
000-09-8797	50	03/09 21:05	APPENDECTOMY, COLONOSCOPY, CHOLECYSTECTOMY, CRAIN	SURANESTHETIST,F	SURSURGEON,F
1 WEST 101-1		188			SURSURGEON,F

PCE Filing Status Report
[SRO PCE STATUS]

The *PCE Filing Status Report* option provides a report of the Patient Care Encounter (PCE) filing status of completed cases performed during the selected date range in accordance with the site parameter controlling PCE updates. If this site parameter is turned off, the report will show no cases. The report may be printed for O.R. surgical cases, non-O.R. procedures or both. The report may also be printed for all specialties or for a single specialty only.

This report is intended to be used as a tool in the review of Surgery case information that is passed to PCE. The report uses 2 status categories:

(1) FILED - This status indicates that case information has already been filed with PCE.

(2) NOT FILED - This status indicates that the case information has not been filed with PCE. The case may or may not be missing information needed to file with PCE.

Two forms of the report are available: the short and the long forms. The short form uses an 80-column format and does not include surgeon/provider, attending, principal post-op diagnosis, and CPT and ICD code information. The totals printed at the end will show only the total cases for each status.

The long form uses a 132-column format and prints case information including the surgeon/provider, the attending, the specialty, the principal post-op diagnosis, and the principal procedure. If the PCE filing status is FILED, the CPT codes and ICD diagnosis codes will be printed. If the filing status is NOT FILED, information fields needed for PCE filing that do not contain data will be printed. At the end of the report, the number of cases in each PCE filing status will be printed, plus the number of CPT and ICD codes for cases with a status of FILED.

The PCE Filing Status report will display missing clinical indicator data information, per encounter. This indicates to the user what information is missing. The report displays CPT codes that do not have an associated diagnostic code, and textual diagnoses that do not have a corresponding ICD diagnosis code.

Example 1: PCE Filing Status Report (Short Form)

```
Select CPT/ICD Coding Menu Option: PS  PCE Filing Status Report

                          Report of PCE Filing Status

This report displays the filing status of completed cases performed during the
selected date range.


Print PCE filing status of completed cases for

1. O.R. Surgical Procedures
2. Non-O.R. Procedures
3. Both O.R. Surgical Procedures and Non-O.R. Procedures (All Specialties)

Select Number (1, 2 or 3): 1// <Enter>

Do you want the report for all Surgical Specialties ? YES// NO

Select Surgical Specialty: 50       GENERAL(OR WHEN NOT DEFINED BELOW)  GENERAL(
OR WHEN NOT DEFINED BELOW)     50

Start with Date: 6 8  (JUN 08, 2005)
End with Date: 6 10  (JUN 10, 2005)

Print the long form or the short form ? SHORT// <Enter>


Print the PCE Filing Status Report to which Printer ? [Select Print Device]
```

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

```
                                   ALBANY
                            PCE FILING STATUS REPORT                    PAGE 1
                         For Completed O.R. Surgical Procedures
                           From: JUN 8,2005  To: JUN 10,2005
                           Report Printed: JUL 19,2005@10:40

DATE OF OPERATION     PATIENT NAME          PATIENT ID  (AGE)     FILING STATUS
CASE #                SPECIALTY                                   SCHED STATUS
                      PRINCIPAL PROCEDURE
================================================================================
JUN 8,2005@07:00      SURPATIENT,TWELVE     045-14-6822  (80)     NOT FILED
277                   GENERAL(OR WHEN NOT                       <NONE>
                      TURP

                 Missing Information:
                   1. CLASSIFICATION INFORMATION
                   2. PRINCIPAL PROCEDURE CODE
                   3. PRIN PROCEDURE CODE MISSING ASSOCIATED DIAGNOSIS CODE
--------------------------------------------------------------------------------
JUN 10,2005@07:00     SURPATIENT,NINETYONE  604-06-1451P  (53)    FILED
292                   GENERAL(OR WHEN NOT                       <NONE>
                      APPENDECTOMY
--------------------------------------------------------------------------------
JUN 10,2005@10:00     SURPATIENT,FORTYONE   104-04-0550P  (55)    FILED
295                   GENERAL(OR WHEN NOT                       <NONE>
                      REMOVE THYROID CYST
--------------------------------------------------------------------------------

              FILED:     2
          NOT FILED:     1
                        -----
        TOTAL CASES:     3
```

Example 2: PCE Filing Status Report (Long Form)

```
Select CPT/ICD Coding Menu Option: PS  PCE Filing Status Report

                          Report of PCE Filing Status

This report displays the filing status of completed cases performed during the
selected date range.


Print PCE filing status of completed cases for

1. O.R. Surgical Procedures
2. Non-O.R. Procedures
3. Both O.R. Surgical Procedures and Non-O.R. Procedures (All Specialties)

Select Number (1, 2 or 3): 1// <Enter>

Do you want the report for all Surgical Specialties ? YES// NO

Select Surgical Specialty: 50       GENERAL(OR WHEN NOT DEFINED BELOW)  GENERAL(
OR WHEN NOT DEFINED BELOW)     50

Start with Date: 6 8   (JUN 08, 2005)
End with Date: 6 10  (JUN 10, 2005)

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

Print the PCE Filing Status Report to which Printer ? [Select Print Device]
```

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

```
                                                ALBANY
                                        PCE FILING STATUS REPORT                                                    PAGE 1
                                    For Completed O.R. Surgical Procedures
                                      From: JUN 8,2005  To: JUN 10,2005
                                      Report Printed: JUL 19,2005@08:19

DATE OF OPERATION     PATIENT NAME              SURGEON              SPECIALTY                                  PCE FILING STATUS
CASE #                PATIENT ID  (AGE)         ATTENDING            PRINCIPAL POST-OP DIAGNOSIS                SCHED STATUS
                      PRINCIPAL PROCEDURE
================================================================================================================================
JUN 8,2005@07:00      SURPATIENT,TWELVE         SURSURGEON,ONE       GENERAL(OR WHEN NOT DEFINED BELOW)         NOT FILED
277                   000-41-8719  (80)         SURSURGEON,ONE       TURPY                                      <NONE>
                      TURP

               Missing Information:
                 1. CLASSIFICATION INFORMATION
                 2. PRINCIPAL PROCEDURE CODE
                 3. PRIN PROCEDURE CODE MISSING ASSOCIATED DIAGNOSIS CODE
--------------------------------------------------------------------------------------------------------------------------------
JUN 9,2005@15:00      SURPATIENT,FIFTEEN        SURSURGEON,THREE     GENERAL(OR WHEN NOT DEFINED BELOW)         NOT FILED
280                   000-98-1234  (60)         SURSURGEON,ONE       HERNIA, INGUINAL                           <NONE>
                      HERNIA REPAIR

               Missing Information:
                 1. PRIN PROCEDURE CODE MISSING ASSOCIATED DIAGNOSIS CODE
                 2. OTHER PROCEDURE CPT MISSING ASSOCIATED DIAGNOSIS ICD CODE
--------------------------------------------------------------------------------------------------------------------------------
JUN 10,2005@07:00     SURPATIENT,NINETYONE      SURSURGEON,ONE       GENERAL(OR WHEN NOT DEFINED BELOW)         FILED
292                   000-06-1451   (53)        SURSURGEON,ONE       NOT ENTERED                                <NONE>
                      APPENDECTOMY

 CPT Code: 44950  APPENDECTOMY                                       ICD Diagnosis Code: 540.1  ABSCESS OF APPENDIX
                                                                     ICD Diagnosis Code: 560.31  GALLSTONE ILEUS
--------------------------------------------------------------------------------------------------------------------------------
JUN 10,2005@10:00     SURPATIENT,FORTYONE       SURSURGEON,THREE     GENERAL(OR WHEN NOT DEFINED BELOW)         FILED
295                   000-04-0550   (55)        SURSURGEON,THREE     THYROID CYST                               <NONE>
                      REMOVE THYROID CYST

 CPT Code: 60200  REMOVE THYROID LESION                              ICD Diagnosis Code: 246.2  CYST OF THYROID
--------------------------------------------------------------------------------------------------------------------------------
                            CPT     ICD
                  CASES  CODES   CODES
          FILED:     2      2       2
      NOT FILED:     2
                  -----  -----   -----
          TOTAL:     3      2       2
```

Report of Non-O.R. Procedures
[SRONOR]

The *Report of Non-O.R. Procedures* option chronologically lists non-O.R. procedures sorted by surgical specialty or surgeon. This report can be sorted by specialty, provider, or location.

This report prints in a 132-column format and must be copied to a printer.

Example 1: Report of Non-O.R. Procedures by Specialty

```
Select CPT/ICD Coding Menu Option: R  Report of Non-O.R. Procedures

Report of Non-OR Procedures


Start with Date: 3/1  (MAR 01, 1999)
End with Date: 3/31  (MAR 31, 1999)


How do you want the report sorted ?

1. By Specialty
2. By Provider
3. By Location

Select Number:  1// <Enter>

Do you want to print the report for all Specialties ?  YES// N

Print the Report for which Specialty ?  CARDIOLOGY


This report is designed to use a 132 column format.

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

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

MAYBERRY, NC
SURGICAL SERVICE
REPORT OF NON-O.R. PROCEDURES
FROM: MAR 1,1999 TO: MAR 31,1999

REVIEWED BY:
DATE REVIEWED:

DATE CASE #	PATIENT (ID#) LOCATION (IN/OUT-PAT STATUS)	PROVIDER PRINCIPAL ANESTHETIST ANESTHESIOLOGIST SUPERVISOR PROCEDURE(S)	START TIME FINISH TIME
*** SPECIALTY: CARDIOLOGY ***			
03/02/99 501	SURPATIENT,TWELVE (000-41-8719) AMBULATORY SURGERY (OUTPATIENT)	SURSURGEON,TWO **SURANESTHETIST,TWO** **SURANESTHETIST,ONE** CARDIOVERSION	03/02/99 13:05 03/02/99 14:10
03/13/99 500	SURPATIENT,SIXTY (000-56-7821) ICU (INPATIENT)	SURSURGEON,TWO **SURANESTHETIST,FOUR** **SURANESTHETIST,ONE** CARDIOVERSION	03/13/99 14:00 03/13/99 14:25

Example 2: Report of Non-O.R. Procedures by Provider

```
Select CPT/ICD Coding Menu Option: R  Report of Non-O.R. Procedures

Report of Non-OR Procedures


Start with Date: 3/1  (MAR 01, 1999)
End with Date: 3/31  (MAR 31, 1999)

How do you want the report sorted ?

1. By Specialty
2. By Provider
3. By Location

Select Number:  1// 2

Do you want to print the report for all Providers ?  YES// N

Print the Report for which Provider ?  SURSURGEON,SIXTEEN

This report is designed to use a 132 column format.

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

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

MAYBERRY, NC
SURGICAL SERVICE
REPORT OF NON-O.R. PROCEDURES
FROM: MAR 1,1999 TO: MAR 31,1999

REVIEWED BY:
DATE REVIEWED:

DATE CASE #	PATIENT (ID#) LOCATION (IN/OUT-PAT STATUS)	SPECIALTY PRINCIPAL ANESTHETIST ANESTHESIOLOGIST SUPERVISOR PROCEDURE(S)	START TIME FINISH TIME
*** PROVIDER SURSURGEON,SIXTEEN ***			
03/12/99 195	SURPATIENT,TWO (000-45-1982) PAC(U) - ANESTHESIA (INPATIENT)	PSYCHIATRY SURANESTHETIST,TWO SURANESTHETIST,ONE ELECTROCONVULSIVE THERAPY	03/12/99 08:00 03/12/99 09:00
03/23/99 240	SURPATIENT,NINE (000-34-5555) PAC(U) - ANESTHESIA (INPATIENT)	PSYCHIATRY SURANESTHETIST,SIX SURANESTHETIST,ONE ELECTROCONVULSIVE THERAPY	03/23/99 08:10 03/23/99 08:40
03/25/99 266	SURPATIENT,FOURTEEN (000-45-7212) PAC(U) - ANESTHESIA (INPATIENT)	PSYCHIATRY SURANESTHETIST,TWO SURANESTHETIST,ONE ELECTROCONVULSIVE THERAPY	03/12/99 09:30 03/12/99 10:15

Example 3: Report of Non-O.R. Procedures by Location

```
Select CPT/ICD Coding Menu Option: R  Report of Non-O.R. Procedures

Report of Non-OR Procedures


Start with Date: 3/1  (MAR 01, 1999)
End with Date: 3/31  (MAR 31, 1999)

How do you want the report sorted ?

1. By Specialty
2. By Provider
3. By Location

Select Number:  1// 3

Do you want to print the report for all Locations ?  YES// N

Print the Report for which Location ?  AMBULATORY SURGERY

This report is designed to use a 132 column format.

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

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

MAYBERRY, NC
SURGICAL SERVICE
REPORT OF NON-O.R. PROCEDURES
FROM: MAR 1,1999 TO: MAR 31,1999

REVIEWED BY:
DATE REVIEWED:

DATE CASE #	PATIENT (ID#) SPECIALTY (IN/OUT-PAT STATUS)	PROVIDER PRINCIPAL ANESTHETIST ANESTHESIOLOGIST SUPERVISOR PROCEDURE(S)	START TIME FINISH TIME
	*** LOCATION: AMBULATORY SURGERY ***		
03/02/99 201	SURPATIENT,TWELVE (000-41-8719) CARDIOLOGY (OUTPATIENT)	SURSURGEON,TWO SURANESTHETIST,FOUR SURANESTHETIST,ONE CARDIOVERSION	03/02/99 13:05 03/02/99 14:10
03/06/99 198	SURPATIENT,TWENTY (000-45-4886) GENERAL(ACUTE MEDICINE) (OUTPATIENT)	SURSURGEON,FOUR SURANESTHETIST,FIVE SURANESTHETIST,ONE EXCISION OF SKIN LESION	03/07/99 16:30 03/07/99 17:08
03/09/99 193	SURPATIENT,FIFTY (000-45-9999) GENERAL (ACUTE MEDICINE) (OUTPATIENT)	SURANESTHETIST,ONE SURANESTHETIST,FIVE SURANESTHETIST,SEVEN STELLATE NERVE BLOCK	03/09/99 09:45 03/09/99 10:21
03/13/99 200	SURPATIENT,SIXTY (000-56-7821) CARDIOLOGY (INPATIENT)	SURSURGEON,TWO SURANESTHETIST,TWO SURANESTHETIST,ONE CARDIOVERSION	03/13/99 14:00 03/13/99 14:25
03/17/99 194	SURPATIENT,EIGHTEEN (000-22-3334) GENERAL SURGERY (OUTPATIENT)	SURSURGEON,FOUR SURANESTHETIST,SIX SURANESTHETIST,SEVEN EXCISION OF SKIN LESION	03/17/99 13:30 03/17/99 14:42

Chapter Three: Generating Surgical Reports

Introduction

The Surgery package integrates clinical and patient data to provide a variety of reports for Surgery Service management. This chapter describes reports that are generated for Surgical Service staff. Among the reports generated are the Annual Report of Surgical Procedures, Anesthesia AMIS, Attending Surgeons Report, and Nurse Staffing Report.

Exiting an Option or the System

The user can enter an up-arrow (^) to stop what he or she is doing. The up-arrow can be used at almost any prompt to stop the line of questioning and return to the previous level in the option. The user should continue entering up-arrows to completely exit the system.

Option Overview

The main options included in this chapter are listed below. The *Surgery Reports* menu contains submenus. To the left of the option name is the shortcut synonym the user can enter to select the option. A restricted option (such as the *Surgery Reports* menu) will not display if the user does not have security clearance for that option.

Shortcut	Option Name
SR	*Surgery Reports*
L	*Laboratory Interim Report*

(This page included for two-sided copying.)

Surgery Reports
[SRORPTS]

The Chief of Surgery and staff members use the *Surgery Reports* menu to select various reports for the Surgical Service. Among the reports generated are the Annual Report of Surgical Procedures, Anesthesia AMIS, Attending Surgeons Report, and Nurse Staffing Report.

 This menu is locked with the SROREP key.

All of the menu items below contain sub-options. To the left of the menu name is the shortcut synonym the user can enter to select the option.

Shortcut	Option Name
M	*Management Reports*
S	*Surgery Staffing Reports*
A	*Anesthesia Reports*
CPT	*CPT Code Reports*

Management Reports
[SR MANAGE REPORTS]

The *Management Reports* menu provides access to several *Management Reports* options. These options generate reports on completed cases, meaning cases that have an entry for the TIME PAT OUT OR field.

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
S	*Schedule of Operations*
A	*Annual Report of Surgical Procedures*
L	*List of Operations*
LD	*List of Operations (by Postoperative Disposition)*
LS	*List of Operations (by Surgical Specialty)*
LP	*List of Operations (by Surgical Priority)*
P	*Report of Surgical Priorities*
U	*List of Undictated Operations*
D	*Report of Daily Operating Room Activity*
PS	*PCE Filing Status Report*
NOX	*Outpatient Encounters Not Transmitted to NPCD*

Schedule of Operations

[SROSCH]

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

This report can be printed on multiple printers simultaneously. Use the options included within the *Surgery Package Management Menu* option to enter the name of all printers on which the schedule will print.

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

Example: Print Schedule of Operations

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

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

This report is designed to use a 132 column format.

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

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

SURGICAL SERVICE
SCHEDULE OF OPERATIONS SIGNATURE OF CHIEF: DR. MOE HOWARD
PRINTED: SEP 07, 1999 11:12 FOR: SEP 08, 1999 _____

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

TOTAL CASES SCHEDULED: 5

Annual Report of Surgical Procedures

[SROARSP]

The *Annual Report of Surgical Procedures* option is used to generate the Annual Report of Surgical Procedures required by VA Central Office. This report counts the number of times a procedure was performed, based on the CPT code entry, within a surgical specialty.

The report includes only cases that have not been cancelled and that have an entry for the TIME PAT OUT OR field. Procedures without CPT codes are not included in this report.

This report can be generated for any date range, not only annually.

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

Example: Annual Report of Surgical Procedures

```
Select Management Reports Option:  A  Annual Report of Surgical Procedures

Annual Report of Surgical Procedures

Start with Date:  9/1  (SEP 01, 2001)
End with Date:  9/30  (SEP 30, 2001)

Do you want to print the Annual Report of Surgical Procedures for all Surgical Specialties?
YES// <Enter>

This report is designed to use a 132 column format, and must be run on a printer.

Select Printer:  [Select Print Device]
```

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

SURGICAL SERVICE
ANNUAL REPORT OF SURGICAL PROCEDURES
FROM: SEP 1,2001 TO: SEP 30,2001

REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: OCT 20,2001

CPT CODE - OPERATION	TOTAL	MAJOR STAFF	MAJOR RESIDENT	MAJOR TOTAL	MINOR STAFF	MINOR RESIDENT	MINOR TOTAL
NEUROSURGERY							
61304 OPEN SKULL FOR EXPLORATION	1	1	0	1	0	0	0
61680 INTRACRANIAL VESSEL SURGERY	1	0	0	0	1	0	1
TOTALS FOR NEUROSURGERY:	2	1	0	1	1	0	1
ORTHOPEDICS							
27130 TOTAL HIP REPLACEMENT	2	0	0	0	1	1	2
27236 REPAIR OF THIGH FRACTURE	1	0	0	0	0	1	1
TOTALS FOR ORTHOPEDICS:	3	0	0	0	1	2	3
OTORHINOLARYNGOLOGY (ENT)							
31365 REMOVAL OF LARYNX	2	0	0	0	2	0	2
TOTALS FOR OTORHINOLARYNGOLOGY (ENT):	2	0	0	0	2	0	2
THORACIC SURGERY (INC. CARDIAC SURG.)							
32480 PARTIAL REMOVAL OF LUNG	2	0	0	0	1	1	2
32500 PARTIAL REMOVAL OF LUNG	1	0	0	0	1	0	1
33510 CABG, VEIN, SINGLE	1	0	0	0	0	1	1
TOTALS FOR THORACIC SURGERY (INC. CARDIAC SURG.):	4	0	0	0	2	2	4
TOTAL OPERATIONS:	11	1	0	1	6	4	10

List of Operations

[SROPLIST]

The *List of Operations* option contains general information for completed cases within a specified date range. It sorts the cases by date and includes the procedure(s), surgical service, length of actual operation, surgeons, and anesthesia technique. This report also includes aborted cases.

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

Example: List of Operations

```
Select Management Reports Option:  L  List of Operations

List of Operations

Start with Date:  10/8  (OCT 08, 2001)
End with Date:  10/8  (OCT 08, 2001)

This report is designed to use a 132 column format.

Print to device:   [Select Print Device]
```

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

SURGICAL SERVICE
LIST OF OPERATIONS
FROM: OCT 8,2001 TO: OCT 8,2001

REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: SEP 20,2001

DATE / CASE #	PATIENT / ID# / PRIORITY	SERVICE / OPERATION(S)	SURGEON / 1ST ASSISTANT / 2ND ASSISTANT	ANESTHESIA TECH
10/08/01 63071	SURPATIENT,FOUR 000-17-0555 ELECTIVE	GENERAL(OR WHEN NOT DEFINED BELOW) INGUINAL HERNIA	SURSURGEON,FOUR SURSURGEON,ONE SURSURGEON,TWO	GENERAL OP TIME: 50 MIN.
10/08/01 63072	SURPATIENT,EIGHTEEN 000-22-3334 ELECTIVE	GENERAL(OR WHEN NOT DEFINED BELOW) CHOLECYSTECTOMY	SURSURGEON,TWO SURSURGEON,FOUR	GENERAL OP TIME: 50 MIN.
10/08/01 63073	SURPATIENT,FIFTYONE 000-23-3221 URGENT, ADD TODAY	OPHTHALMOLOGY INTRAOCCULAR LENS, CHOLECYSTECTOMY	SURSURGEON,FOUR SURSURGEON,THREE SURSURGEON,FOUR	SPINAL OP TIME: 50 MIN.
10/08/01 63074	SURPATIENT,FIVE 000-58-7963 ELECTIVE	GENERAL(OR WHEN NOT DEFINED BELOW) HIP REPLACEMENT	SURSURGEON,FOUR SURSURGEON,FOUR SURSURGEON,FIVE	NOT ENTERED OP TIME: 50 MIN.
10/08/01 63075	SURPATIENT,SIX 000-09-8797 ELECTIVE	GENERAL(OR WHEN NOT DEFINED BELOW) PULMONARY LOBECTOMY	SURSURGEON,TWO SURSURGEON,THREE SURSURGEON,TWO	NOT ENTERED OP TIME: 45 MIN.
10/08/01 63077	SURPATIENT,TWELVE 000-41-8719 ELECTIVE	GENERAL(OR WHEN NOT DEFINED BELOW) INGUINAL HERNIA, CHOLECYSTECTOMY	SURSURGEON,FOUR SURSURGEON,THREE SURSURGEON,THREE	GENERAL OP TIME: 63 MIN.
10/08/01 63076	SURPATIENT,FOURTEEN 000-45-7212 ELECTIVE	UROLOGY TURP	SURSURGEON,TWO SURSURGEON,FOUR SURSURGEON,TWO	GENERAL OP TIME: 45 MIN.

TOTAL CASES: 7

List of Operations (by Postoperative Disposition)

The *List of Operations (by Postoperative Disposition)* option contains general information for completed cases within a selected date range. It sorts the cases by postoperative disposition and by case number. Reports may also be sorted by specialty.

This report includes information on case type, length of actual operation, surgeon names, and anesthesia technique.

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

Example 1: List of Operations by Postoperative Disposition (All Dispositions)

```
Select Management Reports Option: LD  List of Operations (by Postoperative Disposition)

List of Operations by Postoperative Disposition:



Start with Date: 10/8  (OCT 08, 2001)
End with Date: 10/8  (OCT 08, 2001)

Print the List of Operations for which of the following ?

          1. All Dispositions
          2. A Specific Disposition
          3. No Disposition Entered

Enter selection: 1// 1  All Dispositions

Do you want the report sorted by surgical specialty ?  Y// <Enter>

Print for all surgical specialties ?  Y// N

Print the report for which Specialty ?  GENERAL(OR WHEN NOT DEFINED BELOW)

Select An Additional Specialty: <Enter>

This report is designed to use a 132 column format.

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

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

MAYBERRY, NC
SURGICAL SERVICE
LIST OF OPERATIONS BY POSTOP DISPOSITION
FROM: OCT 8,2001 TO: OCT 8,2001
POSTOP DISPOSITION: WARD

DATE PRINTED: OCT 20,2001
REVIEWED BY:
DATE REVIEWED:

DATE / CASE #	PATIENT / ID#	OPERATION(S)	SURGEON / 1ST ASST / 2ND ASST	ANESTHESIA TECH / IN/OUT-PAT STATUS / OP TIME
>> GENERAL(OR WHEN NOT DEFINED BELOW) <<				
10/08/01 63072	SURPATIENT,EIGHTEEN 000-22-3334	CHOLECYSTECTOMY	SURSURGEON,TWO SURSURGEON,FOUR	GENERAL OUTPATIENT 50 MIN.
10/08/01 63077	SURPATIENT,TWELVE 000-41-8719	INGUINAL HERNIA, CHOLECYSTECTOMY	SURSURGEON,FOUR SURSURGEON,THREE SURSURGEON,THREE	GENERAL OUTPATIENT 63 MIN.
10/08/01 63071	SURPATIENT,FOUR 000-17-0555	INGUINAL HERNIA	SURSURGEON,FOUR SURSURGEON,ONE SURSURGEON,TWO	GENERAL OUTPATIENT 50 MIN.

TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 3

Example 2: List of Operations by Postoperative Disposition (A Specific Disposition)

```
Select Management Reports Option: LD  List of Operations (by Postoperative Disposition)

List of Operations by Postoperative Disposition:



Start with Date: 10/4  (OCT 04, 2001)
End with Date: 10/8  (OCT 08, 2001)

Print the List of Operations for which of the following ?

          1. All Dispositions
          2. A Specific Disposition
          3. No Disposition Entered

Enter selection: 1// 2  A Specific Disposition

Print the report for which Disposition ?  OUTPATIENT       O

Do you want the report sorted by surgical specialty ?  Y// N

This report is designed to use a 132 column format.

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

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

MAYBERRY, NC PAGE 1
SURGICAL SERVICE
LIST OF OPERATIONS BY POSTOP DISPOSITION DATE PRINTED: OCT 20,2001
FROM: OCT 4,2001 TO: OCT 8,2001 REVIEWED BY:
POSTOP DISPOSITION: OUTPATIENT DATE REVIEWED:

DATE / CASE #	PATIENT / ID#	OPERATION(S)	SURGEON / 1ST ASST / 2ND ASST	ANESTHESIA TECH / IN/OUT-PAT STATUS / OP TIME
10/04/01 63066	SURPATIENT,THREE 000-21-2453 (GENERAL)	INGUINAL HERNIA	SURSURGEON,THREE SURSURGEON,TWO SURSURGEON,ONE	GENERAL OUTPATIENT 40 MIN.
10/04/01 63067	SURPATIENT,EIGHT 000-37-0555 (GENERAL)	INGUINAL HERNIA	SURSURGEON,FOUR SURSURGEON,ONE SURSURGEON,TWO	GENERAL OUTPATIENT 50 MIN.
10/04/01 63068	SURPATIENT,NINE 000-17-0555 (GENERAL)	INGUINAL HERNIA	SURSURGEON,THREE SURSURGEON,ONE SURSURGEON,TWO	GENERAL OUTPATIENT 45 MIN.
10/07/01 63070	SURPATIENT,SIXTY 000-56-7821 (GENERAL)	INGUINAL HERNIA	SURSURGEON,TWO SURSURGEON,FOUR	GENERAL OUTPATIENT 45 MIN.
10/08/01 63071	SURPATIENT,FOUR 000-17-0555 (GENERAL)	INGUINAL HERNIA	SURSURGEON,FOUR SURSURGEON,ONE SURSURGEON,TWO	GENERAL OUTPATIENT 50 MIN.

TOTAL OUTPATIENT: 5

Example 3: List of Operations by Postoperative Disposition (No Disposition Entered)

```
Select Management Reports Option: LD  List of Operations (by Postoperative Disposition)

List of Operations by Postoperative Disposition:



Start with Date: 10/4  (OCT 04, 2001)
End with Date: 10/8  (OCT 08, 2001)

Print the List of Operations for which of the following ?

          1. All Dispositions
          2. A Specific Disposition
          3. No Disposition Entered

Enter selection: 1// 3  No Disposition Entered

Do you want the report sorted by surgical specialty ?  Y// N

This report is designed to use a 132 column format.
Print the Report on which Device: [Select Print Device]
```

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

SURGICAL SERVICE
LIST OF OPERATIONS BY POSTOP DISPOSITION
FROM: OCT 4,2001 TO: OCT 8,2001
POSTOP DISPOSITION: DISPOSITION NOT ENTERED

DATE PRINTED: SEP 20,2001
REVIEWED BY:
DATE REVIEWED:

DATE / CASE #	PATIENT / ID#	OPERATION(S)	SURGEON / 1ST ASST / 2ND ASST	ANESTHESIA TECH / IN/OUT-PAT STATUS / OP TIME
10/04/01 63069	SURPATIENT,TEN 000-12-3456 (THORACIC SURGERY)	PULMONARY LOBECTOMY	SURSURGEON,TWO SURSURGEON,FIVE SURSURGEON,ONE	GENERAL OUTPATIENT 60 MIN.
10/08/01 63073	SURPATIENT,FIFTYONE 000-23-3221 (OPHTHALMOLOGY)	INTRAOCCULAR LENS, CHOLECYSTECTOMY	SURSURGEON,FOUR SURSURGEON,THREE SURSURGEON,FOUR	SPINAL OUTPATIENT 50 MIN.
10/08/01 63076	SURPATIENT,FOURTEEN 000-45-7212 (UROLOGY)	TURP	SURSURGEON,TWO SURSURGEON,FOUR SURSURGEON,TWO	GENERAL OUTPATIENT 45 MIN.

TOTAL DISPOSITION NOT ENTERED: 3

List of Operations (by Surgical Specialty)

The *List of Operations (by Surgical Specialty)* option contains general information for completed cases within a selected date range. It sorts the cases by surgical specialty and case number.

This report includes information on case type, length of actual operation, surgeon names, and anesthesia technique. The user can request a list for all specialties or a selected specialty.

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

Example: List of Operations by Surgical Specialty

```
Select Management Reports Option: LS  List of Operations (by Surgical Specialty)

List of Operations sorted by Surgical Specialty


Start with Date:  10/4  (OCT 04, 2001)
End with Date:  10/8  (OCT 08, 2001)

Do you want to print the report for all Specialties ?  YES//  N

Print the report for which Surgical Specialty ?  GENERAL (OR WHEN NOT DEFINED BELOW)

This report is designed to use a 132 column format.

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

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

DATE / CASE #	PATIENT / ID# / PRIORITY	OPERATION(S)	SURGEON / FIRST ASSISTANT / SECOND ASSISTANT	ANESTHESIA / TECHNIQUE
	GENERAL(OR WHEN NOT DEFINED BELOW)			
10/04/01 63066	SURPATIENT,THREE 000-21-2453 STANDBY	INGUINAL HERNIA	SURSURGEON,THREE SURSURGEON,TWO SURSURGEON,ONE	GENERAL OP TIME: 40 MIN.
10/04/01 63067	SURPATIENT,EIGHT 000-37-0555 ELECTIVE	INGUINAL HERNIA	SURSURGEON,FOUR SURSURGEON,ONE SURSURGEON,TWO	GENERAL OP TIME: 50 MIN.
10/04/01 63068	SURPATIENT,TEN 000-12-3456 ELECTIVE	INGUINAL HERNIA	SURSURGEON,THREE SURSURGEON,ONE SURSURGEON,TWO	GENERAL OP TIME: 45 MIN.
10/07/01 63070	SURPATIENT,SIXTY 000-56-7821 ELECTIVE	INGUINAL HERNIA	SURSURGEON,TWO SURSURGEON,FOUR	GENERAL OP TIME: 45 MIN.
10/08/01 63071	SURPATIENT,FOUR 000-17-0555 ELECTIVE	INGUINAL HERNIA	SURSURGEON,FOUR SURSURGEON,ONE SURSURGEON,TWO	GENERAL OP TIME: 50 MIN.
10/08/01 63072	SURPATIENT,EIGHTEEN 000-22-3334 ELECTIVE	CHOLECYSTECTOMY	SURSURGEON,TWO SURSURGEON,FOUR	GENERAL OP TIME: 50 MIN.
10/08/01 63077	SURPATIENT,FIVE 000-58-7963 ELECTIVE	INGUINAL HERNIA, CHOLECYSTECTOMY	SURSURGEON,FOUR SURSURGEON,THREE SURSURGEON,TWO	GENERAL OP TIME: 63 MIN.

TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 7

List of Operations (by Surgical Priority)

The *List of Operations (by Surgical Priority)* option generates a report containing general information for completed cases within a selected date range. It sorts the cases by surgical priority and surgical specialty.

This report includes information on case type, length of actual operation, surgeon names, and anesthesia technique. The user can request a list for all priorities or a selected priority. One or more surgical specialties can also be specified.

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

Example: List of Operations by Surgical Priority

```
Select Management Reports Option:  LP  List of Operations (by Surgical Priority)

List of Operations by Surgical Priority:



Start with Date:  8/1  (AUG 01, 2001)
End with Date:  9/30  (SEP 30, 2001)

Print List of Operations for all priorities ? Y// N

Print report for which Priority ?

1. EMERGENCY
2. ELECTIVE
3. ADD ON TODAY (NONEMERGENT)
4. STANDBY
5. URGENT ADD TODAY
6. PRIORITY NOT ENTERED

Select Number:  1// 4

Do you want the report sorted by surgical specialty ? Y// <Enter>

Print for all surgical specialties ? Y// <Enter>

This report is designed to use a 132 column format.

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

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

ISC-BIRMINGHAM, AL PAGE: 1
SURGICAL SERVICE
LIST OF OPERATIONS BY SURGICAL PRIORITY DATE PRINTED: OCT 20,2001
FROM: AUG 1,2001 TO: SEP 30,2001 REVIEWED BY:
SURGICAL PRIORITY: STANDBY DATE REVIEWED:

DATE / CASE #	PATIENT / ID#	OPERATION(S)	SURGEON / 1ST ASST / 2ND ASST	ANESTHESIA TECH
>> THORACIC SURGERY (INC. CARDIAC SURG.) <<				
08/21/01 62901	SURPATIENT,THREE 000-21-2453	PULMONARY LOBECTOMY	SURSURGEON,FOUR SURSURGEON,TWO SURSURGEON,ONE	GENERAL OP TIME: 170 MIN.
09/02/01 63002	SURPATIENT,NINE 000-34-5555	PULMONARY LOBECTOMY	SURSURGEON,TWO SURSURGEON,TWO	GENERAL OP TIME: 95 MIN.
09/29/01 63042	SURPATIENT,FOURTEEN 000-45-7212	PULMONARY LOBECTOMY	SURSURGEON,TWO SURSURGEON,FOUR	GENERAL OP TIME: 90 MIN.

TOTAL THORACIC SURGERY (INC. CARDIAC SURG.): 3

Report of Surgical Priorities

The *Report of Surgical Priorities* option provides the total number of completed surgical cases for each surgical priority, such as elective, emergency, and urgent within a date range. The user can sort the report by all surgical specialties, one surgical specialty (Example 1), or by all operations within a date range (Example 2).

This report has an 80-column format and can be viewed on your terminal display screen.

Example 1: Print Report of Surgical Priorities for a specialty

```
Select Management Reports Option: P  Report of Surgical Priorities

Report of Surgical Priorities


Start with Date: 3/1  (MAR 01, 2001)
End with Date: T  (MAR 26, 2001)

Do you want to review this information sorted by Surgical Specialty ?  YES// <Enter>

Do you want to print this report for all Surgical Specialties ?  YES// N

Print the report for which Surgical Specialty ? 50          GENERAL(OR WHEN NOT DEFINED BELOW)
GENERAL(OR WHEN NOT DEFINED BELOW)        50

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

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

```
                          MAYBERRY, NC
                       SURGICAL SERVICE
                TOTAL OPERATIONS BY SURGICAL PRIORITY
                  FROM: MAR 1,2001  TO: MAR 26,2001
_____________________________________________________________________________

                  GENERAL(OR WHEN NOT DEFINED BELOW)

                   1. ELECTIVE                   1
                   2. URGENT                     1
                   3. EMERGENCY                  2
                   4. ADD ON (NON-EMERGENT)      0
                   5. STANDBY                    1


                   TOTAL SURGICAL CASES:         5
```

Example 2: Print Report of Surgical Priorities for all Operations

```
Select Management Reports Option: P  Report of Surgical Priorities

Report of Surgical Priorities


Start with Date: 3/1  (MAR 01, 2001)
End with Date: T  (MAR 26, 2001)

Do you want to review this information sorted by Surgical Specialty ?  YES// N

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

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

```
                         MAYBERRY, NC
                       SURGICAL SERVICE
                TOTAL OPERATIONS BY SURGICAL PRIORITY
                  FROM: MAR 1,2001  TO: MAR 26,2001
_____________________________________________________________________________


                    1. ELECTIVE                   3
                    2. URGENT                     2
                    3. EMERGENCY                  2
                    4. ADD ON (NON-EMERGENT)      0
                    5. STANDBY                    4
                    6. PRIORITY NOT ENTERED       4


                    TOTAL SURGICAL CASES:        15
```

Report of Daily Operating Room Activity

The *Report of Daily Operating Room Activity* option generates a report listing cases started between 6:00 AM on the date selected and 5:59 AM of the following day for all operating rooms.

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

Example: Print the Report of Daily Operating Room Activity

```
Select Management Reports Option: D  Report of Daily Operating Room Activity

Print the Report of Daily Activity for which Date ?  3/9  (MAR 09, 2001)

This report will include all cases started between MAR  9, 2001 at 6:00 AM
and MAR 10, 2001 at 5:59 AM.

It is designed to use a 132 column format.

Print the Report to which Device ?  [Select Print Device]
```

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

MAYBERRY, NC
SURGICAL SERVICE
DAILY REPORT OF OPERATING ROOM ACTIVITY
FOR: MAR 09, 2001

PATIENT ID # WARD	AGE	TIME IN OR TIME OUT OR CASE NUMBER	POSTOPERATIVE DIAGNOSIS PROCEDURE(S)	ANESTHESIOLOGIST PRIN. ANESTHETIST	SURGEON FIRST ASST. ATT SURGEON
OPERATING ROOM: OR1					
SURPATIENT,TWELVE 000-41-8719 1 NORTH 161-1	62	03/09 08:00 03/09 09:10 194	INGUINAL HERNIA INGUINAL HERNIA	SURANESTHESIOLOGIST,O SURANESTHETIST,F	SURSURGEON,E SURSURGEON,O SURSURGEON,T
OPERATING ROOM: OR3					
SURPATIENT,NINE 000-34-5555 OUTPATIENT	48	03/09 09:15 03/09 12:40 187	CHOLECYSTITIS CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM	SURANESTHESIOLOGIST,T SURANESTHETIST,O	SURSURGEON,T SURSURGEON,F SURSURGEON,T
OPERATING ROOM: OR5					
SURPATIENT,SIX 000-09-8797 1 WEST 101-1	50	03/09 19:56 03/09 21:05 188	APPENDICITIS APPENDECTOMY, COLONOSCOPY, CHOLECYSTECTOMY, CRAIN	SURANESTHESIOLOGIST,T SURANESTHETIST,F	SURSURGEON,S SURSURGEON,F SURSURGEON,F

PCE Filing Status Report

The *PCE Filing Status Report* option provides a report of the Patient Care Encounter (PCE) filing status of completed cases performed during the selected date range in accordance with the site parameter controlling PCE updates. If this site parameter is turned off, the report will show no cases. The report may be printed for O.R. surgical cases, non-O.R. procedures or both. The report may also be printed for all specialties or for a single specialty only.

This report is intended to be used as a tool in the review of Surgery case information that is passed to PCE. The report uses 2 status categories:

(1) FILED - This status indicates that case information has already been filed with PCE.

(2) NOT FILED - This status indicates that the case information has not been filed with PCE. The case may or may not be missing information needed to file with PCE.

Two forms of the report are available: the short and the long forms. The short form uses an 80-column format and does not include surgeon/provider, attending, principal post-op diagnosis, and CPT and ICD code information. The totals printed at the end will show only the total cases for each status.

The long form uses a 132-column format and prints case information including the surgeon/provider, the attending, the specialty, the principal post-op diagnosis, and the principal procedure. If the PCE filing status is FILED, the CPT codes and ICD diagnosis codes will be printed. If the filing status is NOT FILED, information fields needed for PCE filing that do not contain data will be printed. At the end of the report, the number of cases in each PCE filing status will be printed, plus the number of CPT and ICD codes for cases with a status of FILED.

The PCE Filing Status report will display missing clinical indicator data information, per encounter. This indicates to the user what information is missing. The report displays CPT codes that do not have an associated diagnostic code, and textual diagnoses that do not have a corresponding ICD diagnosis code.

Example 1: PCE Filing Status Report (Short Form)

```
Select Management Reports Option: PS  PCE Filing Status Report

                          Report of PCE Filing Status

This report displays the filing status of completed cases performed during the
selected date range.


Print PCE filing status of completed cases for

1. O.R. Surgical Procedures
2. Non-O.R. Procedures
3. Both O.R. Surgical Procedures and Non-O.R. Procedures (All Specialties)

Select Number (1, 2 or 3): 1// <Enter>

Do you want the report for all Surgical Specialties ? YES// NO

Select Surgical Specialty: 50       GENERAL(OR WHEN NOT DEFINED BELOW)  GENERAL(
OR WHEN NOT DEFINED BELOW)     50

Start with Date: 6 8  (JUN 08, 2005)
End with Date: 6 10  (JUN 10, 2005)

Print the long form or the short form ? SHORT// <Enter>

Print the PCE Filing Status Report to which Printer ? [Select Print Device]
```

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

```
                                   ALBANY
                            PCE FILING STATUS REPORT                    PAGE 1
                        For Completed O.R. Surgical Procedures
                          From: JUN 8,2005  To: JUN 10,2005
                          Report Printed: JUL 19,2005@10:40

DATE OF OPERATION     PATIENT NAME          PATIENT ID  (AGE)     FILING STATUS
CASE #                SPECIALTY                                   SCHED STATUS
                      PRINCIPAL PROCEDURE
================================================================================
JUN 8,2005@07:00      SURPATIENT,TWELVE     000-14-6822  (80)     NOT FILED
277                   GENERAL(OR WHEN NOT                       <NONE>
                      TURP

                 Missing Information:
                   1. CLASSIFICATION INFORMATION
                   2. PRINCIPAL PROCEDURE CODE
                   3. PRIN PROCEDURE CODE MISSING ASSOCIATED DIAGNOSIS CODE
--------------------------------------------------------------------------------
JUN 10,2005@07:00     SURPATIENT,NINETYONE  000-06-1451  (53)     FILED
292                   GENERAL(OR WHEN NOT                       <NONE>
                      APPENDECTOMY
--------------------------------------------------------------------------------
JUN 10,2005@10:00     SURPATIENT,FORTYONE   000-04-0550  (55)     FILED
295                   GENERAL(OR WHEN NOT                       <NONE>
                      REMOVE THYROID CYST
--------------------------------------------------------------------------------

              FILED:     2
          NOT FILED:     1
                        -----
        TOTAL CASES:     3
```

Example 2: PCE Filing Status Report (Long Form)

```
Select CPT/ICD Coding Menu Option: PS  PCE Filing Status Report

                          Report of PCE Filing Status

This report displays the filing status of completed cases performed during the
selected date range.


Print PCE filing status of completed cases for

1. O.R. Surgical Procedures
2. Non-O.R. Procedures
3. Both O.R. Surgical Procedures and Non-O.R. Procedures (All Specialties)

Select Number (1, 2 or 3): 1// <Enter>

Do you want the report for all Surgical Specialties ? YES// NO

Select Surgical Specialty: 50       GENERAL(OR WHEN NOT DEFINED BELOW)  GENERAL(
OR WHEN NOT DEFINED BELOW)     50

Start with Date: 6 8   (JUN 08, 2005)
End with Date: 6 10  (JUN 10, 2005)

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

Print the PCE Filing Status Report to which Printer ? [Select Print Device]
```

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

DATE OF OPERATION CASE #	PATIENT NAME PATIENT ID (AGE) PRINCIPAL PROCEDURE	SURGEON ATTENDING	SPECIALTY PRINCIPAL POST-OP DIAGNOSIS	PCE FILING STATUS SCHED STATUS
JUN 8,2005@07:00 277	SURPATIENT,TWELVE 000-41-8719 (80) TURP	SURSURGEON,ONE SURSURGEON,ONE	GENERAL(OR WHEN NOT DEFINED BELOW) TURPY	NOT FILED <NONE>

Missing Information:
1. CLASSIFICATION INFORMATION
2. PRINCIPAL PROCEDURE CODE
3. PRIN PROCEDURE CODE MISSING ASSOCIATED DIAGNOSIS CODE

JUN 9,2005@15:00 280	SURPATIENT,FIFTEEN 000-98-1234 (60) HERNIA REPAIR	SURSURGEON,THREE SURSURGEON,ONE	GENERAL(OR WHEN NOT DEFINED BELOW) HERNIA, INGUINAL	NOT FILED <NONE>

Missing Information:
1. PRIN PROCEDURE CODE MISSING ASSOCIATED DIAGNOSIS CODE
2. OTHER PROCEDURE CPT MISSING ASSOCIATED DIAGNOSIS ICD CODE

JUN 10,2005@07:00 292	SURPATIENT,NINETYONE 000-06-1451 (53) APPENDECTOMY	SURSURGEON,ONE SURSURGEON,ONE	GENERAL(OR WHEN NOT DEFINED BELOW) NOT ENTERED	FILED <NONE>
CPT Code: 44950 APPENDECTOMY			ICD Diagnosis Code: 540.1 ABSCESS OF APPENDIX ICD Diagnosis Code: 560.31 GALLSTONE ILEUS	
JUN 10,2005@10:00 295	SURPATIENT,FORTYONE 000-04-0550 (55) REMOVE THYROID CYST	SURSURGEON,THREE SURSURGEON,THREE	GENERAL(OR WHEN NOT DEFINED BELOW) THYROID CYST	FILED <NONE>
CPT Code: 60200 REMOVE THYROID LESION			ICD Diagnosis Code: 246.2 CYST OF THYROID	

	CASES	CPT CODES	ICD CODES
FILED:	2	2	2
NOT FILED:	2		
TOTAL:	3	2	2

Outpatient Encounters Not Transmitted to NPCD

Outpatient surgical and non-O.R. procedures that are filed as encounters in the PCE package without an active count clinic identified for each encounter are not transmitted to the National Patient Care Database (NPCD) as workload. The *Outpatient Encounters Not Transmitted to NPCD* option may be used as a tool for identifying these encounters that represent uncounted workload so that corrective actions may be taken in the Surgery package to insure these procedures are associated with an active count clinic. After corrections are made, these encounters may be re-filed with PCE to be transmitted to NPCD.

This option provides functionality:

- To count and/or list surgical cases and non-O.R. procedures that have entries in PCE but have no matching entries in the OUTPATIENT ENCOUNTER file or have matching entries that are non-count encounters or encounters requiring action.

- To re-file with PCE the cases identified as having no matching entries in the OUTPATIENT ENCOUNTER file or having matching entries that are non-count encounters or encounters requiring action.

Both the report and the re-filing process may be run for O.R. surgical cases, non-O.R. procedures or both. The report and the re-filing process may be run for a specific specialty or for all specialties and may be run for a selected date range.

Example 1: Print List of Cases

```
Select Management Reports Option: NOX  Outpatient Encounters Not Transmitted to
NPCD

             Outpatient Surgery Encounters Not Transmitted to NPCD

Surgical cases filed with PCE that have no Scheduling appointment status
or that have an appointment status of ACTION REQUIRED or NON-COUNT indicate
surgical encounters that have not transmitted to the National Patient
Care Database. This option is intended as a tool to identify these
encounters and, after taking appropriate corrective measures, to
reinitiate the encounter transmission process.


  1. Print list of cases.
  2. Print total number of cases only.
  3. Re-file cases in PCE.

Select Number: 1// <Enter>

Print the list for the following.

  1. O.R. Surgical Procedures
  2. Non-O.R. Procedures
  3. Both O.R. Surgical Procedures and Non-O.R. Procedures (All Specialties)

Select Number (1, 2 or 3): 1// <Enter>

Do you want the report for all Surgical Specialties ? YES// NO

Select Surgical Specialty: 50       GENERAL(OR WHEN NOT DEFINED BELOW)  GENERAL(
OR WHEN NOT DEFINED BELOW)     50

Start with Date: 5/1  (MAY 01, 2001)
End with Date: 5/15  (MAY 15, 2001)

Print report on which printer ? [Select Print Device]
```

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

MAYBERRY, NC
Outpatient Surgery Encounters Not Transmitted to NPCD Page 1
For Completed O.R. Surgical Procedures
From: MAY 1,2001 To: MAY 15,2001
Report Printed: MAY 20,2001@06:44

DATE OF OPERATION PATIENT NAME PATIENT ID (AGE)	CASE # PRINCIPAL PROCEDURE	SPECIALTY	SCHED STATUS
MAY 1,2001@09:00 SURPATIENT,FOURTEEN 000-45-7212 (50)	63028 CHOLECYSTECTOMY	GENERAL(OR WHEN NOT	<NONE>
MAY 3,2001@05:45 SURPATIENT,SIXTY 000-56-7821 (42)	63092 CHOLEDOCHOTOMY	GENERAL(OR WHEN NOT	<NONE>
MAY 7,2001@07:15 SURPATIENT,TWELVE 000-41-8719 (73)	63142 REPAIR DIAPHRAGMATIC HERNIA	GENERAL(OR WHEN NOT	<NONE>
MAY 12,2001@06:00 SURPATIENT,NINE 000-34-5555 (64)	63191 INGUINAL HERNIA	GENERAL(OR WHEN NOT	<NONE>
MAY 14,2001@06:00 SURPATIENT,TWELVE 000-41-8719 (73)	63208 CHOLECYSTECTOMY	GENERAL(OR WHEN NOT	ACTION REQUIRED
MAY 15,2001@06:01 SURPATIENT,SIXTY 000-56-7821 (42)	63180 CHOLECYSTECTOMY	GENERAL(OR WHEN NOT	<NONE>

SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)

Total with NO status:	5
Total with NON-COUNT:	0
Total with ACTION REQUIRED:	1
Total cases identified:	6

Example 2: Print Total Number of Cases Only

```
Select Management Reports Option: NOX  Outpatient Encounters Not Transmitted to
NPCD

             Outpatient Surgery Encounters Not Transmitted to NPCD


Surgical cases filed with PCE that have no Scheduling appointment status
or that have an appointment status of ACTION REQUIRED or NON-COUNT indicate
surgical encounters that have not transmitted to the National Patient
Care Database. This option is intended as a tool to identify these
encounters and, after taking appropriate corrective measures, to
reinitiate the encounter transmission process.


  1. Print list of cases.
  2. Print total number of cases only.
  3. Re-file cases in PCE.

Select Number: 1// 2

Print the list for the following.

  1. O.R. Surgical Procedures
  2. Non-O.R. Procedures
  3. Both O.R. Surgical Procedures and Non-O.R. Procedures (All Specialties)

Select Number (1, 2 or 3): 1// <Enter>

Do you want the report for all Surgical Specialties ? YES// NO

Select Surgical Specialty: 50       GENERAL(OR WHEN NOT DEFINED BELOW)  GENERAL(
OR WHEN NOT DEFINED BELOW)     50

Start with Date: 5/1  (MAY 01, 2001)
End with Date: 5/15  (MAY 15, 2001)

Print report on which printer ? [Select Print Device]
```

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

```
                              MAYBERRY, NC
            Outpatient Surgery Encounters Not Transmitted to NPCD       Page 1
                    For Completed O.R. Surgical Procedures
                      From: MAY 1,2001  To: MAY 15,2001
                      Report Printed: MAY 20,2001@07:25
================================================================================

SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)

      Total with NO status:     5
      Total with NON-COUNT:     0
Total with ACTION REQUIRED:     1
                               -----
    Total cases identified:     6
```

Example 3: Re-File Cases in PCE

```
Select Management Reports Option: NOX  Outpatient Encounters Not Transmitted to
NPCD
```

```
             Outpatient Surgery Encounters Not Transmitted to NPCD


Surgical cases filed with PCE that have no Scheduling appointment status
or that have an appointment status of ACTION REQUIRED or NON-COUNT indicate
surgical encounters that have not transmitted to the National Patient
Care Database. This option is intended as a tool to identify these
encounters and, after taking appropriate corrective measures, to
reinitiate the encounter transmission process.


  1. Print list of cases.
  2. Print total number of cases only.
  3. Re-file cases in PCE.

Select Number: 1// 3
```

```
Re-file the following.

  1. O.R. Surgical Procedures
  2. Non-O.R. Procedures
  3. Both O.R. Surgical Procedures and Non-O.R. Procedures (All Specialties)

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

Do you want re-filing for all Surgical Specialties ? YES// NO

Select Surgical Specialty: 50       GENERAL(OR WHEN NOT DEFINED BELOW)  GENERAL(
OR WHEN NOT DEFINED BELOW)     50

Start with Date: 5/1  (MAY 01, 2001)
End with Date: 5/15  (MAY 15, 2001)
Requested Start Time: NOW//  (MAY 20, 2001@07:37:32)
 (Task #652379)

Press RETURN to continue  <Enter>
```

Surgery Staffing Reports
[SR STAFFING REPORTS]

The *Surgery Staffing Reports* menu provides access to several staffing related report options.

The options included in this submenu 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
A	*Attending Surgeon Reports*
S	*Surgeon Staffing Report*
N	*Surgical Nurse Staffing Report*
NS	*Scrub Nurse Staffing Report*
NC	*Circulating Nurse Staffing Report*

Attending Surgeon Reports

[SROATT]

The *Attending Surgeon Reports* option generates the Attending Surgeon Report, which provides staffing information for completed cases (Example 1). The Attending Surgeon Cumulative Report is a table with cumulative totals for each attending code (Example 2). You can print these reports separately or you can print both reports at one time.

The Attending Surgeon Report can be sorted by surgical specialty. They can also be generated for an individual surgeon, or for all attending surgeons.

The Attending Surgeon Report has a 132-column format and is designed to be copied to a printer. The Attending Surgeon Cumulative Report has an 80-column format and can be viewed on the screen.

Example 1: Print the Attending Surgeon Report

```
Select Surgery Staffing Reports Option: A  Attending Surgeon Reports

Attending Surgeon Report


Starting with which Date ?  6/9  (JUN 09, 2004)
Ending with which Date ?  6/18  (JUN 18, 2004)

Do you want to print the report for all Attending Surgeons ?  YES// <Enter>

Attending Surgeon Reports

1. Attending Surgeon Report
2. Attending Surgeon Cumulative Report
3. Attending Surgeon Report and Attending Surgeon Cumulative Report


Select the number corresponding with the desired report(s):  1

Start report for each attending surgeon on a new page ? NO// <Enter>

Do you want the report for all Surgical Specialties ?  YES//  N

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

The Attending Surgeon Report was designed to use a 132 column format.

Print the report on which Device ? [Select Print Device]
```

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

DATE / CASE # / ATTENDING CODE	PATIENT / ID#	PRINCIPAL DIAGNOSIS / PRINCIPAL OPERATIVE PROCEDURE	SURGEON / 1ST ASST / 2ND ASST
GENERAL(OR WHEN NOT DEFINED BELOW)			
ATTENDING SURGEON: SURSURGEON,TWO			
06/17/04	SURPATIENT,FOURTEEN	CHOLELITHIASIS	SURSURGEON,ONE
203	000-45-7212	CHOLECYSTECTOMY	SURSURGEON,FOUR
LEVEL B: ATTENDING IN O.R., SCRUBBED			
06/18/04	SURPATIENT,SEVENTEEN	INCARCERATED INGUINAL HERNIA	SURSURGEON,ONE
202	000-45-5119	REPAIR INCARCERATED INGUINAL HERNIA	SURSURGEON,FOUR
LEVEL B: ATTENDING IN O.R., SCRUBBED			
03/09/04	SURPATIENT,TWELVE	INCARCERATED INGUINAL HERNIA	SURSURGEON,THREE
494	000-41-8719	INGUINAL HERNIA	SURSURGEON,FOUR
ATTENDING CODE NOT ENTERED			
ATTENDING SURGEON: SURSURGEON,ONE			
06/10/04	SURPATIENT,FIFTYONE	RUPTURED TUBOOVARIAN ABSCESS	SURSURGEON,FOUR
189	000-23-3221	DRAINAGE OF OVARIAN CYST	
LEVEL E: EMERGENCY CARE, ATTENDING CONTACTED ASAP			
06/09/04	SURPATIENT,NINE	CHOLECYSTITIS	SURSURGEON,TWO
187	000-34-5555	CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM	SURSURGEON,FOUR
LEVEL C: ATTENDING IN O.R., NOT SCRUBBED			SURSURGEON,THREE
ATTENDING SURGEON: SURSURGEON,FOUR			
06/09/04	SURPATIENT,SIX	APPENDICITIS	SURSURGEON,SIX
188	000-09-8797	APPENDECTOMY, COLONOSCOPY, CHOLECYSTECTOMY	SURSURGEON,FOUR
LEVEL D: ATTENDING IN O.R. SUITE, IMMEDIATELY AVAILABLE			

Example 2: Print the Attending Surgeon Cumulative Report

```
Select Surgery Staffing Reports Option: A  Attending Surgeon Reports

Attending Surgeon Report


Starting with which Date ?  6/9  (JUN 09, 2004)
Ending with which Date ?  6/18  (JUN 18, 2004)

Do you want to print the report for all Attending Surgeons ?  YES// <Enter>

Attending Surgeon Reports

1. Attending Surgeon Report
2. Attending Surgeon Cumulative Report
3. Attending Surgeon Report and Attending Surgeon Cumulative Report


Select the number corresponding with the desired report(s):  2

Do you want the report for all Surgical Specialties ?  YES//  N

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

The Attending Surgeon Cumulative Report was designed to use a 80 column format.

Print the report on which Device ? [Select Print Device]
```

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

MAYBERRY, NC
SURGICAL SERVICE
ATTENDING SURGEON CUMULATIVE REPORT
FROM: JUN 9,2004 TO: JUN 18,2004

GENERAL(OR WHEN NOT DEFINED BELOW)

ATTENDING CODE	TOTAL CASES
LEVEL B: ATTENDING IN O.R., SCRUBBED	2
LEVEL C: ATTENDING IN O.R., NOT SCRUBBED	1
LEVEL D: ATTENDING IN O.R. SUITE, IMMEDIATELY AVAILABLE	1
LEVEL E: EMERGENCY CARE, ATTENDING CONTACTED ASAP	1
* ATTENDING CODE NOT ENTERED	1
TOTAL CASES FROM 06/09/04 TO 06/18/04	6

Surgeon Staffing Report

[SROSUR]

The *Surgeon Staffing Report* option lists completed cases sorted by the surgeon and his or her role (i.e., attending, first assistant) for each case. The report provides the procedure, diagnosis and operation date/time.

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

Example: Print Surgeon Staffing Report

```
Select Surgery Staffing Reports Option: S  Surgeon Staffing Report

Surgeon Staffing Report


Start with Date: 3/2  (MAR 02, 2001)
End with Date: 3/31  (MAR 31, 2001)

Do you want to print this report for an individual surgeon ?  YES//  <Enter>
Select Surgeon: SURSURGEON,ONE

This report is designed to use a 132 column format.

Print the report on which Device ? [Select Print Device]
```

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

DATE/TIME CASE #	PATIENT ID #	OPERATION(S)	DIAGNOSIS
** SURSURGEON,ONE **			
ROLE: ATTENDING SURGEON			
MAR 09, 2001@09:15 187	SURPATIENT,NINE 000-34-5555	CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM	CHOLECYSTITIS
MAR 10, 2001@07:00 189	SURPATIENT,FIFTYONE 000-23-3221	DRAINAGE OF OVARIAN CYST	APPENDICITIS
MAR 10, 2001@14:00 200	SURPATIENT,FIFTY 000-45-9999	HEMORRHOIDECTOMY	EXTERNAL HEMORRHOIDS
ROLE: SURGEON			
MAR 10, 2001@08:00 199	SURPATIENT,TWO 000-45-1982	CHOLECYSTECTOMY WITH CHOLANGIOGRAM	CHOLELITHIASIS WITH BILIARY COLIC
MAR 17, 2001@12:55 203	SURPATIENT,FOURTEEN 000-45-7212	CHOLECYSTECTOMY	CHOLELITHIASIS
MAR 18, 2001@07:30 202	SURPATIENT,SEVENTEEN 000-45-5119	REPAIR INCARCERATED INGUINAL HERNIA	INCARCERATED INGUINAL HERNIA

Surgical Nurse Staffing Report

[SRONSR]

This option generates the Surgical Nurse Staffing Report that lists completed cases within a specified date range. It provides the names of the scrub nurse, the circulating nurse, and the operation times.

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

Example: Print Surgical Nurse Staffing Report

```
Select Surgery Staffing Reports Option: N  Surgical Nurse Staffing Report

Surgical Nurse Staffing Report

Do you want the report for all nurses ?  YES// <Enter>

Start with Date: 3/9  (MAR 09, 2001)
End with Date: 3/10  (MAR 10, 2001)

This report is designed to use a 132 column format.

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

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

MAYBERRY, NC
SURGICAL SERVICE
SURGICAL NURSE STAFFING REPORT
FROM: MAR 9,2001 TO: MAR 10,2001

REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: MAR 20,2001

DATE / CASE #	PATIENT / ID#	OPERATION(S)	SCRUB NURSE	CIRC. NURSE	TIME IN / TIME OUT / ELAPSED (MINS)
03/09/01 194	SURPATIENT,TWELVE 000-41-8719	INGUINAL HERNIA	SURNURSE,TWO	SURNURSE,FIVE	08:00 09:10 70
03/09/01 187	SURPATIENT,NINE 000-34-5555	CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM	SURNURSE,THREE	SURNURSE,ONE	09:15 12:40 205
03/09/01 188	SURPATIENT,SIX 000-09-8797	APPENDECTOMY, COLONOSCOPY, CHOLECYSTECTOMY	SURNURSE,THREE	SURNURSE,SIX	19:56 21:05 69
03/10/01 189	SURPATIENT,FIFTYONE 000-23-3221	DRAINAGE OF OVARIAN CYST	SURNURSE,THREE	SURNURSE,SEVEN	07:00 08:54 114
03/10/01 199	SURPATIENT,TWO 000-45-1982	CHOLECYSTECTOMY WITH CHOLANGIOGRAM	SURNURSE,TWO	SURNURSE,FIVE	08:00 10:08 128
03/10/01 200	SURPATIENT,FIFTY 000-45-9999	HEMORRHOIDECTOMY	SURNURSE,THREE	SURNURSE,ONE	14:00 14:55 55

Scrub Nurse Staffing Report

[SROSNR]

The *Scrub Nurse Staffing Report* option lists each operating room scrub nurse and the completed cases they are assigned to within a specified date range. It also provides the circulating nurses, other scrub nurses, and operation times.

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

Example: Print Scrub Nurse Staffing Report

```
Select Surgery Staffing Reports Option: NS  Scrub Nurse Staffing Report

Scrub Nurse Staffing Report

Do you want the report for all nurses ?  YES// <Enter>

Start with Date: 3/8  (MAR 08, 2001)
End with Date: 3/20  (MAR 20, 2001)

This report is designed to use a 132 column format.

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

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

REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: MAR 22,2001

DATE / CASE #	PATIENT / ID#	OPERATION(S)	SCRUB NURSE	CIRC. NURSE	TIME IN / TIME OUT / ELAPSED (MINS)
		** SURNURSE,SEVEN **			
03/18/01	SURPATIENT,SEVENTEEN	REPAIR INCARCERATED INGUINAL HERNIA	SURNURSE,THREE	SURNURSE,ONE	07:30
202	000-45-5119		SURNURSE,SEVEN		09:03
					93
		** SURNURSE,THREE **			
03/09/01	SURPATIENT,NINE	CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM	SURNURSE,THREE	SURNURSE,ONE	09:15
187	000-34-5555				12:40
					205
03/09/01	SURPATIENT,SIX	APPENDECTOMY, COLONOSCOPY, CHOLECYSTECTOMY,	SURNURSE,THREE		19:56
188	000-09-8797				21:05
					69
03/10/01	SURPATIENT,FIFTYONE	DRAINAGE OF OVARIAN CYST	SURNURSE,THREE	SURNURSE,SEVEN	07:00
189	000-23-3221				08:54
					114
03/10/01	SURPATIENT,FIFTY	HEMORRHOIDECTOMY	SURNURSE,THREE	SURNURSE,ONE	14:00
200	000-45-9999				14:55
					55
03/17/01	SURPATIENT,FOURTEEN	CHOLECYSTECTOMY	SURNURSE,THREE	SURNURSE,ONE	12:55
203	000-45-7212				14:30
					95
03/18/01	SURPATIENT,SEVENTEEN	REPAIR INCARCERATED INGUINAL HERNIA	SURNURSE,THREE	SURNURSE,ONE	07:30
202	000-45-5119		SURNURSE,SEVEN		09:03
					93

Circulating Nurse Staffing Report

[SROCNR]

The *Circulating Nurse Staffing Report* option provides nurse staffing information, sorted by the circulating nurse's name. It lists the circulating nurses and the completed cases they are assigned to within a specified date range. The report includes the scrub nurse, other circulating nurses, and operation times.

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

Example: Print Circulating Nurse Staffing Report

```
Select Surgery Staffing Reports Option: NC  Circulating Nurse Staffing Report

Circulating Nurse Staffing Report

Do you want the report for all nurses ?  YES// <Enter>

Start with Date: 3/2  (MAR 02, 2001)
End with Date: 3/31  (MAR 31, 2001)

This report is designed to use a 132 column format.

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

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

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

DATE / CASE #	PATIENT / ID#	OPERATION(S)	SCRUB NURSE	CIRC. NURSE	TIME IN / TIME OUT / ELAPSED (MINS)
		** SURNURSE,SEVEN **			
03/10/01	SURPATIENT,FIFTYONE	DRAINAGE OF OVARIAN CYST	SURNURSE,THREE	SURNURSE,SEVEN	07:00
189	000-23-3221				08:54
					114
		** SURNURSE,ONE **			
03/09/01	SURPATIENT,NINE	CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM	SURNURSE,THREE	SURNURSE,ONE	09:15
187	000-34-5555				12:40
					205
03/10/01	SURPATIENT,FIFTY	HEMORRHOIDECTOMY	SURNURSE,THREE	SURNURSE,ONE	14:00
200	000-45-9999				14:55
					55
03/17/01	SURPATIENT,FOURTEEN	CHOLECYSTECTOMY	SURNURSE,THREE	SURNURSE,ONE	12:55
203	000-45-7212				14:30
					95
03/18/01	SURPATIENT,SEVENTEEN	REPAIR INCARCERATED INGUINAL HERNIA	SURNURSE,THREE	SURNURSE,ONE	07:30
202	000-45-5119		SURNURSE,SEVEN		09:03
					93
		** SURNURSE,TWO **			
03/03/01	SURPATIENT,SIXTY	REMOVE CATARACTS, RETRO BULBAR BLOCK	SURNURSE,THREE	SURNURSE,TWO	09:00
205	000-56-7821				09:20

Anesthesia Reports
[SR ANESTH REPORTS]

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

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

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

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

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

List of Anesthetic Procedures

[SROANP]

The *List of Anesthetic Procedures* option generates a report listing each completed case within the date range selected. It sorts by date order and provides the anesthesia personnel. This report also provides the anesthesia start, end, and elapsed times for each case.

After the user enters the date range, the software will ask whether the user wants the List of Anesthetic Procedures to include 1) only operating room surgical procedures, 2) non-O.R. procedures, or 3) both.

These reports have a 132-column format and are designed to be copied to a printer.

Example 1: Print the List of Anesthetic Procedures for only O.R. Surgical Procedures

```
Select Anesthesia Reports Option: P  List of Anesthetic Procedures

List of Anesthetic Procedures

Start with Date: 8/8  (AUG 08, 2001)
End with Date: 8/25  (AUG 25, 2001)

Print List of Anesthetic Procedures for

1. O.R. Surgical Procedures.
2. Non-O.R. Procedures.
3. Both O.R. Surgical Procedures and Non-O.R. Procedures.

Select Number:  1// <Enter>

This report is designed to use a 132 column format.

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

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

DATE / CASE #	PATIENT / ID# / ASA CLASS	PRINCIPAL DIAGNOSIS / PROCEDURE(S)	PRIN ANESTHETIST / ANESTH TECHNIQUE / ANESTH AGENT	START TIME / END TIME / ELAPSED
08/08/01 08:00 63085	SURPATIENT,NINE 000-34-5555 MILD DISTURB.	ABDOMINAL WOUND DEHISCENSE CLOSURE ABDOMINAL DEHISCENSE	SURANESTHETIST,ONE GENERAL DESFLURANE 240ML BTL	08:00 10:30 90
08/12/01 08:30 63090	SURPATIENT,SIX 000-09-8797 SEVERE DISTURB.	CA OF LARYNX LARYNGECTOMY	SURANESTHETIST,FOUR GENERAL SUFENTANIL CITRATE 5	08:35 10:35 120
08/16/01 08:00 63094	SURPATIENT,FOURTEEN 000-45-7212 NO DISTURB.	LESION RT EAR LOBE EXC LESION LESIO RT EAR LOBE	SURANESTHETIST,ONE LOCAL LIDOCAINE 2% (20MG/M	08:05 08:30 25
08/21/01 06:00 63100	SURPATIENT,FORTYONE 000-43-2109 MILD DISTURB.	DIAGNOSTIC COLONOSCOPY COLONOSCOPY	SURANESTHETIST,TWO GENERAL PROPOFOL 20ML INJ	06:00 07:05 65
08/21/01 07:00 63104	SURPATIENT,THREE 000-21-2453 SEVERE DISTURB.	PARATHYROID ADENOMA PARATHYROID EXPLORATION AND EXCISION ADENOMA	SURANESTHETIST,FOUR GENERAL SUFENTANIL CITRATE 5	07:00 09:00 120
08/22/01 10:10 63106	SURPATIENT,FIFTYTWO 000-99-8888 MILD DISTURB.	HX OF POLYP COLONOSCOPY, POLYPECTOMY	SURANESTHETIST,ONE GENERAL PROPOFOL 20ML INJ	10:15 11:15 60
08/22/01 09:56 63110	SURPATIENT,SIXTY 000-56-7821 MILD DISTURB.	CHOLECYSTITIS LAP CHOLE	SURANESTHETIST,TWO GENERAL DESFLURANE 240ML BTL	10:00 11:55 115
08/24/01 14:55 63115	SURPATIENT,FOURTEEN 000-45-7212 MILD DISTURB.	INGUINAL HERNIA INGUINAL HERNIA REPAIR	SURANESTHETIST,FOUR GENERAL PROPOFOL 20ML INJ	14:55 16:05 70

Example 2: Print the List of Anesthetic Procedures for only Non-OR Procedures

```
Select Anesthesia Reports Option: P  List of Anesthetic Procedures

List of Anesthetic Procedures

Start with Date: 1/1  (JAN 01, 2001)
End with Date: 1/7  (JAN 07, 2001)

Print List of Anesthetic Procedures for

1. O.R. Surgical Procedures.
2. Non-O.R. Procedures.
3. Both O.R. Surgical Procedures and Non-O.R. Procedures.

Select Number:  1// 2

This report is designed to use a 132 column format.

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

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

DATE / CASE #	PATIENT ID# / ASA CLASS	PRINCIPAL DIAGNOSIS / PROCEDURE(S)	PRIN ANESTHETIST / ANESTH TECHNIQUE / ANESTH AGENT	START TIME / END TIME / ELAPSED
01/02/01	SURPATIENT,SIXTEEN	TB	SURANESTHETIST,ONE	09:43
51051	000-11-1111	BRONCHOSCOPY	GENERAL	10:25
	MILD DISTURB.		PHENOBARBITAL SODIUM	42
01/02/01	SURPATIENT,SIXTEEN	ILEITIS	SURANESTHETIST,TWO	10:00
51053	000-11-1111	COLONSCOPY	OTHER	11:10
	MILD DISTURB.		FENTANYL 250MCG/5ML	70
01/02/01	SURPATIENT,SEVEN	ESOPHAGEAL VARICES	SURANESTHETIST,FOUR	13:10
51057	000-84-0987	ESOPHAGOSCOPY	GENERAL	13:45
	NO DISTURB.		PROPOFOL 20ML INJ	35
01/04/01	SURPATIENT,SIXTY	HISTOPLASMOSIS	SURANESTHETIST,THREE	08:20
51169	000-56-7821	BRONCHOSCOPY	OTHER	09:15
	MILD DISTURB.		FENTANYL 250MCG/5ML	55
01/04/01	SURPATIENT,FORTY	CARDIAC ARRYTHMIA	SURANESTHETIST,TWO	18:50
88	000-77-7777	CARDIOVERSION	GENERAL	19:25
	NO DISTURB.		PHENOBARBITAL 30MG/7	35
01/07/01	SURPATIENT,TEN	HISTOPLASMOSIS	SURANESTHETIST,THREE	10:05
51181	000-12-3456	BRONCHOSCOPY	OTHER	11:05
	MILD DISTURB.		FENTANYL 250MCG/5ML	60
01/07/01	SURPATIENT,EIGHT	CHRONIC DEPRESSION	SURANESTHETIST,TWO	13:10
51185	000-37-0555	ELECTROCONVULSIVE THERAPY	OTHER	13:35
	MILD DISTURB.		MIDAZOLAM 1MG/1ML 2M	25

Anesthesia Provider Report

[SROADOC]

The *Anesthesia Provider Report* option provides information concerning the anesthesia staff and techniques for completed cases within a selected date range. This report can be generated for all anesthesia providers or the user can specify one. It sorts the cases by the principal anesthetist and includes information on anesthesia personnel, technique, agent, level of supervision, and elapsed anesthesia time.

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

Example: Print the Anesthesia Provider Report

```
Select Anesthesia Reports Option: D  Anesthesia Provider Report

Anesthesia Provider Report

Start with Date: 3/2  (MAR 02, 2001)
End with Date: 3/15  (MAR 15, 2001)

Do you want to print the report for all Anesthesia Providers ? YES// N

Print the report for which Anesthesia Provider ?  SURANESTHETIST,ONE

This report is designed to use a 132 column format.

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

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

MAYBERRY, NC PAGE: 1
SURGICAL SERVICE
ANESTHESIA PROVIDER REPORT REVIEWED BY:
FROM: MAR 23,2001 TO: MAR 24,2001 DATE REVIEWED:
DATE PRINTED: MAR 29,2001

DATE / CASE #	PATIENT / ID#	PROCEDURE(S)	SUPERVISOR / RELIEF ANESTH / ASST ANESTH	ASA CLASS / PRINCIPAL TECHNIQUE / ANESTHESIA AGENT	LEVEL OF SUPERVISION / ELAPSED ANES TIME
***** SURANESTHETIST,ONE *****					
03/23/01 54014	SURPATIENT, O 000-44-7629	ESS, SEPTO,WITH LEFT TURBINECTOMY SCAR REVISION	SURANESTHETIST,T SURANESTHETIST,F	MILD DISTURB. GENERAL DESFLURANE 240ML BTL	1 105 MINS.
03/23/01 54020	SURPATIENT, F 000-45-7212	COLONOSCOPY/ATTEMPTED	SURANESTHETIST,T SURANESTHETIST,S	MILD DISTURB. GENERAL DESFLURANE 240ML BTL	1 55 MINS.
03/23/01 54050	SURPATIENT, N 000-34-5555	CYSTO, RETROGRADE, STENT	SURANESTHETIST,T SURANESTHETIST,F	MILD DISTURB. GENERAL DESFLURANE 240ML BTL	1 45 MINS.
03/24/01 54023	SURPATIENT, F 000-58-7963	COLONOSCOPY/POLYPECTOMY	SURANESTHETIST,T SURANESTHETIST,S	SEVERE DISTURB. GENERAL PROPOFOL 20ML INJ	1 50 MINS.
03/24/01 54025	SURPATIENT, E 000-37-0555	COLONOSCOPY	SURANESTHETIST,T SURANESTHETIST,F	MILD DISTURB. GENERAL DESFLURANE 240ML BTL	1 65 MINS.
03/24/01 54024 NON-OR	SURPATIENT, S 000-56-7821	CARDIOVERSION	SURANESTHETIST,T SURANESTHETIST,S	SEVERE DISTURB. GENERAL MIDAZOLAM 1MG/1ML 2M	1 35 MINS.
03/24/01 54058	SURPATIENT, S 000-45-5119	HEMORRHOIDECTOMY	SURANESTHETIST,T SURANESTHETIST,F	SEVERE DISTURB. SPINAL BUPIVACAINE 0.25%	1 45 MINS.
03/24/01 54079	SURPATIENT, F 000-99-8888	EXPL LAP, LYSIS OF ADHESIONS	SURANESTHETIST,T SURANESTHETIST,F SURANESTHETIST,S	SEVERE DIST.-EMERG GENERAL DESFLURANE 240ML BTL	1 120 MINS.

CPT Code Reports
[SR CPT REPORTS]

The *CPT Code Reports* menu contains reports based on CPT codes.

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
C	*Cumulative Report of CPT Codes*
A	*Report of CPT Coding Accuracy*
M	*List Completed Cases Missing CPT Codes*

Cumulative Report of CPT Codes

[SROACCT]

The *Cumulative Report of CPT Codes* option counts and reports the number of times a procedure was performed (based on CPT codes) during a specified date range. There is also a column showing how many times the procedure was in the Principal Procedure category, and how many times it was in the Other Operative Procedure category.

After the date range is entered, the software will ask if the user wants the Cumulative Report of CPT Codes to include 1) only operating room surgical procedures, 2) non-O.R. procedures, or 3) both.

These reports have a 132-column format and are designed to be copied to a printer.

Example 1: Print the Cumulative Report of CPT Codes for only OR Surgical Procedures

```
Select CPT Code Reports Option: C  Cumulative Report of CPT Codes

Cumulative Report of CPT Codes

Start with Date: 3/28  (MAR 28, 2001)
End with Date: 4/3  (APR 03, 2001)

Include which cases on the Cumulative Report of CPT Codes ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures.

Select Number:  1// <Enter>

This report is designed to use a 132 column format.


Select Device: [Select Print Device]
```

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

MAYBERRY, NC
SURGICAL SERVICE
CUMULATIVE REPORT OF CPT CODES
FROM: MAR 28,2001 TO: APR 3,2001

REVIEWED BY
DATE REVIEWED:

O.R. SURGICAL PROCEDURES

CPT CODE - SHORT DESCRIPTION	TOTAL PROCEDURES	TOTAL PRINCIPAL PROCEDURES	TOTAL OTHER PROCEDURES
10060 DRAINAGE OF SKIN ABSCESS	1	1	0
11440 REMOVAL OF SKIN LESION	1	1	0
11441 REMOVAL OF SKIN LESION	4	4	0
11641 REMOVAL OF SKIN LESION	4	2	2
24075 REMOVE ARM/ELBOW LESION	1	1	0
26989 HAND/FINGER SURGERY	1	1	0
30520 REPAIR OF NASAL SEPTUM	1	1	0
31231 NASAL ENDOSCOPY, DX	1	0	1
45315 PROCTOSIGMOIDOSCOPY	1	0	1
45330 SIGMOIDOSCOPY, DIAGNOSTIC	7	7	0
45333 SIGMOIDOSCOPY & POLYPECTOMY	1	1	0
45378 DIAGNOSTIC COLONOSCOPY	2	2	0
45385 COLONOSCOPY, LESION REMOVAL	3	3	0
47600 REMOVAL OF GALLBLADDER	1	0	1
49000 EXPLORATION OF ABDOMEN	1	1	0
49505 REPAIR INGUINAL HERNIA	2	1	1
66984 REMOVE CATARACT, INSERT LENS	4	3	1
68801 DILATE TEAR DUCT OPENING	1	1	0

Example 2: Print the Cumulative Report of CPT Codes for only Non-O.R. Procedures

```
Select CPT Code Reports Option: C  Cumulative Report of CPT Codes

Cumulative Report of CPT Codes

Start with Date: 7 1 01  (JUL 01, 2001)
End with Date: 12 31 01  (DEC 31, 2001)

Include which cases on the Cumulative Report of CPT Codes ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures.

Select Number:  1// 2

This report is designed to use a 132 column format.


Select Device: [Select Print Device]
```

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

MAYBERRY, NC
SURGICAL SERVICE
CUMULATIVE REPORT OF CPT CODES
FROM: JUL 1,2001 TO: DEC 31,2001

REVIEWED BY
DATE REVIEWED:

NON-O.R. PROCEDURES

CPT CODE - SHORT DESCRIPTION	TOTAL PROCEDURES	TOTAL PRINCIPAL PROCEDURES	TOTAL OTHER PROCEDURES
10060 DRAINAGE OF SKIN ABSCESS	2	2	0
10061 DRAINAGE OF SKIN ABSCESS	1	1	0
11040 DEBRIDE SKIN PARTIAL	8	8	0
11042 DEBRIDE SKIN/TISSUE	1	1	0
11100 BIOPSY OF SKIN LESION	11	11	0
11402 REMOVAL OF SKIN LESION	1	1	0
11420 REMOVAL OF SKIN LESION	1	1	0
11620 REMOVAL OF SKIN LESION	1	1	0
11640 REMOVAL OF SKIN LESION	1	1	0
11730 REMOVAL OF NAIL PLATE	1	1	0
11750 REMOVAL OF NAIL BED	1	1	0
12001 REPAIR SUPERFICIAL WOUND(S)	3	3	0
12011 REPAIR SUPERFICIAL WOUND(S)	2	2	0
14060 SKIN TISSUE REARRANGEMENT	1	1	0
15782 ABRASION TREATMENT OF SKIN	1	1	0
17340 CRYOTHERAPY OF SKIN	1	1	0
20550 INJ TENDON/LIGAMENT/CYST	23	23	0
29799 CASTING/STRAPPING PROCEDURE	1	1	0
46083 INCISE EXTERNAL HEMORRHOID	2	2	0

Report of CPT Coding Accuracy

[SR CPT ACCURACY]

The *Report of CPT Coding Accuracy* option lists cases sorted by the CPT code used in the PRINCIPAL PROCEDURES field and OTHER OPERATIVE PROCEDURES field. This option is designed to help check the accuracy of the coding procedures.

About the prompts

"Do you want to print the Report of CPT Coding Accuracy for all CPT Codes ?" The user should reply **NO** to this prompt to produce the report for only one CPT code. The software will then prompt the user to enter the CPT code or category.

"Do you want to sort the Report of CPT Coding Accuracy by Surgical Specialty ?" The user should press the **<Enter>** key if he or she wants to sort the report by specialty. The user would enter **NO** to sort the report by date only.

"Do you want to print the Report to Check Coding Accuracy for all Surgical Specialties ?" The user can enter the code or name of the surgical service he or she wants the report to be based on or can press the **<Enter>** key to print the report for all surgical specialties.

Example 1: Print the Report of CPT Coding Accuracy for OR Surgical Procedures, sorted by Surgical Specialty

```
Select CPT Code Reports Option: A  Report of CPT Coding Accuracy

Report to Check CPT Coding Accuracy

Start with Date: 10 8 01  (OCT 08, 2001)
End with Date: 10 8 01  (OCT 08, 2001)

Print the Report of CPT Coding Accuracy for which cases ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures (All Specialties).

Select Number:  1// <Enter>

Do you want to print the Report of CPT Coding Accuracy for all
CPT Codes ?  YES//  <Enter>


Do you want to sort the Report of CPT Coding Accuracy by
Surgical Specialty ?  YES//  <Enter>


Do you want to print the Report to Check Coding Accuracy for all
Surgical Specialties ?  YES//  NO

Print the Coding Accuracy Report for which Surgical Specialty ?  50       GENERA
L(OR WHEN NOT DEFINED BELOW)  GENERAL(OR WHEN NOT DEFINED BELOW)     50

This report is designed to use a 132 column format.


Select Device: [Select Print Device]
```

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

REPORT OF CPT CODING ACCURACY REVIEWED BY:
FOR GENERAL(OR WHEN NOT DEFINED BELOW) DATE REVIEWED:
FROM: OCT 8,2001 TO: OCT 8,2001

O.R. SURGICAL PROCEDURES

PROCEDURE DATE / CASE #	PATIENT ID#	PROCEDURES	SURGEON/PROVIDER / ATTEND SURG/PROV
		47600 REMOVAL OF GALLBLADDER PRINCIPAL PROCEDURES DESCRIPTION: CHOLECYSTECTOMY;	
10/08/01 07:00 63072	SURPATIENT,EIGHTEEN 000-22-3334	CHOLECYSTECTOMY CPT Codes:47600-22	SURSURGEON,TWO SURSURGEON,FOUR
		47605 REMOVAL OF GALLBLADDER OTHER PROCEDURES DESCRIPTION: CHOLECYSTECTOMY; WITH CHOLANGIOGRAPHY	
10/08/01 10:00 63077	SURPATIENT,TWELVE 000-41-8719	INGUINAL HERNIA, OTHER OPERATIONS: CHOLECYSTECTOMY (CPT Codes: 49521, 47605-22	SURSURGEON,FOUR SURSURGEON,FOUR
		49505 REPAIR INGUINAL HERNIA PRINCIPAL PROCEDURES DESCRIPTION: REPAIR INITIAL INGUINAL HERNIA, AGE 5 YEARS OR OVER; REDUCIBLE	
10/08/01 06:00 63071	SURPATIENT,FOUR 000-45-7212	INGUINAL HERNIA CPT Codes: 49505	SURSURGEON,FOUR SURSURGEON,SIXTEEN

Example 2: Print the Report of CPT Coding Accuracy for OR Surgical Procedures, sorted by Date

```
Select CPT Code Reports Option: A  Report of CPT Coding Accuracy

Report to Check CPT Coding Accuracy

Start with Date: 10 1 01  (OCT 01, 2001)
End with Date: 10 7 01  (OCT 07, 2001)

Print the Report of CPT Coding Accuracy for which cases ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures (All Specialties).

Select Number:  1// <Enter>

Do you want to print the Report of CPT Coding Accuracy for all
CPT Codes ?  YES//  <Enter>

Do you want to sort the Report of CPT Coding Accuracy by
Surgical Specialty ?  YES//  N

This report is designed to use a 132 column format.


Select Device: [Select Print Device]
```

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

O.R. SURGICAL PROCEDURES

PROCEDURE DATE / CASE #	PATIENT ID# / SPECIALTY	PROCEDURES	SURGEON/PROVIDER / ATTEND SURG/PROV
31365 REMOVAL OF LARYNX			
PRINCIPAL PROCEDURES			
DESCRIPTION: LARYNGECTOMY; TOTAL, WITH RADICAL NECK DISSECTION			
10/03/01 07:00	SURPATIENT,NINETEEN	PULMONARY LOBECTOMY	SURSURGEON,SEVENTEEN
63059	000-28-7354	CPT Codes: 31365	SURSURGEON,FOUR
	THORACIC SURGERY (INC. CARDIAC SURG.)		
32440 REMOVAL OF LUNG			
PRINCIPAL PROCEDURES			
DESCRIPTION: REMOVAL OF LUNG, TOTAL PNEUMONECTOMY;			
10/03/01 10:00	SURPATIENT,TWENTY	PULMONARY LOBECTOMY	SURSURGEON,FOUR
63060	000-45-4886	CPT Codes: 32440	SURSURGEON,FOUR
	THORACIC SURGERY (INC. CARDIAC SURG.)		
10/04/01 06:00	SURPATIENT,TEN	PULMONARY LOBECTOMY	SURSURGEON,TWO
63069	000-12-3456	CPT Codes: 32440	SURSURGEON,TWO
	THORACIC SURGERY (INC. CARDIAC SURG.)		
32480 PARTIAL REMOVAL OF LUNG			
PRINCIPAL PROCEDURES			
DESCRIPTION: REMOVAL OF LUNG, OTHER THAN TOTAL PNEUMONECTOMY; SINGLE LOBE (LOBECTOMY)			
10/03/01 06:00	SURPATIENT,TWELVE	PULMONARY LOBECTOMY	SURSURGEON,TWO
63049	000-41-8719	CPT Codes: 32480	SURSURGEON,ONE
	THORACIC SURGERY (INC. CARDIAC SURG.)		
10/03/01 07:00	SURPATIENT,SEVENTEEN	PULMONARY LOBECTOMY	SURSURGEON,TWO
63050	000-45-5119	CPT Codes: 32480	SURSURGEON,TWO
	THORACIC SURGERY (INC. CARDIAC SURG.)		

Example 3: Print the Report of CPT Coding Accuracy for Non-O.R. Procedures, sorted by CPT Code and Medical Specialty

```
Select CPT Code Reports Option: A  Report of CPT Coding Accuracy

Report to Check CPT Coding Accuracy

Start with Date: 1 1 01  (JAN 01, 2001)
End with Date: 8 31 01  (AUG 31, 2001)

Print the Report of CPT Coding Accuracy for which cases ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures (All Specialties).

Select Number:  1// 2

Do you want to print the Report of CPT Coding Accuracy for all
CPT Codes ?  YES//  N


Print the Coding Accuracy Report for which CPT Code ?  92960
HEART ELECTROCONVERSION
        CARDIOVERSION, ELECTIVE, ELECTRICAL CONVERSION OF
        ARRHYTHMIA, EXTERNAL

Do you want to sort the Report of CPT Coding Accuracy by
Medical Specialty ?  YES// <Enter>


Do you want to print the Report to Check Coding Accuracy for all
Medical Specialties ?  YES//  N


Print the Coding Accuracy Report for which Medical Specialty ?   MEDICINE

This report is designed to use a 132 column format.


Select Device: [Select Print Device]
```

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

MAYBERRY, NC
SURGICAL SERVICE
REPORT OF CPT CODING ACCURACY
FOR MEDICINE
FROM: JAN 1,2001 TO: AUG 31,2001

REVIEWED BY:
DATE REVIEWED:

NON-O.R. PROCEDURES

PROCEDURE DATE / CASE #	PATIENT ID#	PROCEDURES	SURGEON/PROVIDER / ATTEND SURG/PROV
92960 HEART ELECTROCONVERSION			
PRINCIPAL PROCEDURES			
DESCRIPTION: CARDIOVERSION, ELECTIVE, ELECTRICAL CONVERSION OF ARRHYTHMIA, EXTERNAL			
01/24/95	SURPATIENT,SEVENTEEN	CARDIOVERSION	SURSURGEON,TWO
15499	000-45-5119	CPT Codes (92960)	SURSURGEON,TWO
02/09/95	SURPATIENT,NINE	CARDIOVERSION	SURSURGEON,ONE
15701	000-34-5555	CPT Codes (92960)	SURSURGEON,TWO
03/29/95	SURPATIENT,FIFTEEN	CARDIOVERSION	SURSURGEON,THREE
15912	000-98-1234	CPT Codes (92960)	
08/04/95	SURPATIENT,SIX	CARDIOVERSION (	SURSURGEON,TWO
16669	000-09-8797	CPT Codes (92960)	SURSURGEON,FOUR
08/25/95	SURPATIENT,TWO	CARDIOVERSION	SURSURGEON,TWO
16828	000-45-1982	CPT Codes (92960)	SURSURGEON,TWO

List Completed Cases Missing CPT Codes

[SRSCPT]

The *List Completed Cases Missing CPT Codes* option generates a report of completed cases that are missing the Principal CPT code for a specified date range. Only procedures that have CPT codes will be counted on the Annual Report of Surgical Procedures.

After the date range has been entered, the software will ask if the user wants the Cumulative Report of CPT Codes to include: 1) only operating room surgical procedures, 2) non-O.R. procedures, or 3) both.

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

Example: List Completed Cases Missing CPT Codes

```
Select CPT Code Reports Option: M  List Completed Cases Missing CPT Codes

Print list of Completed Cases Missing CPT Codes for

1. OR Surgical Procedures.
2. Non-OR Procedures.
3. Both OR Surgical Procedures and Non-OR Procedures (All Specialties).

Select Number:  1// 1

Do you want the list for all Surgical Specialties ?  YES//  <Enter>

Start with Date: 2/1  (FEB 01, 2005)
End with Date: 4/30  (APR 30, 2005)

Print the List of Cases Missing CPT codes to which Printer ?  [Select Print Device]
```

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

MAYBERRY, NC
Completed Cases Missing CPT Codes
O.R. Surgical Procedures
From: FEB 1,2005 To: APR 30,2005
Specialty: GENERAL(OR WHEN NOT DEFINED BELOW)

Operation Date	Patient (ID#)	Surgeon/Provider	Case #
FEB 01, 2005	SURPATIENT,TWO (000-45-1982)	SURSURGEON,TWO	53708
	* EXC LEFT PREAURICULAR LESION		
FEB 08, 2005	SURPATIENT,FIVE (000-58-7963)	SURSURGEON,ONE	53747
	* EXCISION LESIONS SCALP		
MAR 12, 2005	SURPATIENT,SEVEN (000-84-0987)	SURSURGEON,TWO	53973
	* COLONOSCOPY		
MAR 23, 2005	SURPATIENT,FORTYONE (000-43-2109)	SURSURGEON,ONE	54030
	* COLONOSCOPY/ATTEMPTED		
APR 27, 2005	SURPATIENT,THIRTY (000-82-9472)	SURSURGEON,SEVENTEEN	54325
	* EXCISION RT FOREARM LESIONS		
	* EXC LESION, RT EAR		
	* EXC LESION, RT FOREHEAD		
	* EXC LESION RT SCALP		
	* RXC LESION, NOSE		
	* EXC LESION, LEFT EAR		
	* EXC LESION, LEFT FOREARM		
	* EXC LESION, TOP OF HEAD		
	* EXC LESION, LEFT NECK		

(This page included for two-sided copying.)

Laboratory Interim Report

[SRO-LRRP]

The *Laboratory Interim Report* option accesses the Laboratory Package to show what lab tests the patient has had. This option will print or display interim reports for a selected patient, within a given time period. The printout will go in inverse date order. This report will output all tests for the time period specified. This option only prints verified results and does not output the microbiology reports.

Example: Print Laboratory Interim Report

```
Select Surgery Menu Option: L   Laboratory Interim Report

Select Patient Name: SURPATIENT,SIXTY         03-03-59     000567821     NO
    NON-VETERAN (OTHER)
Date to START with: TODAY//5 15 01  (MAY 15, 2001)
Date to END  with: T-7//5 1 01  (MAY 01, 2001)
DEVICE: [Select Print Device]
```

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

```
SURPATIENT,SIXTY                                  09/21/2001 1:21 pm
     SSN: 000-56-7821    SEX: F    AGE: 42    LOC: LRC

       Provider: SURSURGEON,FOUR
       Specimen: SERUM
Accession [UID]: CH 0513 1 [3471330001]

                              05/13/1997 07:00
     Test name                Result    units      Ref.  range
     GLUCOSE                     87     mg/dL        60 -  123
     UREA NITROGEN               22     mg/dL        11 -   24
     CREATININE                 1.8     mg/dl         1 -  2.1
     POTASSIUM                  4.4     meq/L       3.5 -  4.8
     SODIUM                     143     meq/L       135 -  145
     CHLORIDE                   103     meq/L        95 -  105
     CO2                       27.0     meq/L        20 -   32
     CALCIUM                    8.7     mg/dL       8.5 -   11
================================================================================
       KEY: "L"=Abnormal low, "H"=Abnormal high, "*"=Critical value


SURPATIENT,SIXTY          000-56-7821  09/21/2001 1:21 pm  PRESS '^' TO STOP
```

Chapter Four: Chief of Surgery Reports

Introduction

This chapter describes options and reports for the exclusive use of the Surgical Service Chief, or his or her designee. The Chief has access to lists of cancellations, the Morbidity and Mortality Report, and Patient Occurrences.

Exiting an Option or the System

The user should enter an up-arrow (^) to stop what he or she is doing. The up-arrow can be used at almost any prompt to terminate the line of questioning and return to the previous level in the routine. Continuing to enter up-arrows will cause the user to completely exit the system.

Option Overview

The main options included in this chapter are listed below. To the left of the option name is the shortcut synonym that the user can enter to select the option. The *Chief of Surgery Menu* option will not display if the user does not have proper security clearance.

Shortcut	Option Name
CH	*Chief of Surgery Menu*

(This page included for two-sided copying.)

Chief of Surgery Menu

[SROCHIEF]

The *Chief of Surgery Menu* is a restricted option (locked with the SROCHIEF key), allowing access to various management reports and functions. It is designed for the Chief of Surgery and his or her designees. The options available from this menu are shown in the following table.

Shortcut	Option or Menu Name
V	*View Patient Perioperative Occurrences*
M	*Management Reports*
U	*Unlock a Case for Editing*
RET	*Update Status of Returns Within 30 Days*
CAN	*Update Cancelled Case ...*
D	*Update Operations as Unrelated/Related to Death*
CODE	*Update/Verify Procedure/Diagnosis Codes*

View Patient Perioperative Occurrences
[SROMEN-M&M]

The *View Patient Perioperative Occurrences* option is designed to provide a quick view of any occurrences for a particular case. This report can be viewed on a screen.

Example: View Patient Perioperative Occurrences

```
Select Chief of Surgery Menu Option: V  View Patient Perioperative Occurrences

Select Patient: SURPATIENT,NINE         09-01-50     000345555
```

```
 SURPATIENT,NINE   000-34-5555

1. 09-15-04   BYPASS (REQUESTED)

2. 09-15-04   CAROTID ARTERY ENDARTERECTOMY (SCHEDULED)

3. 03-09-04   CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM (COMPLETED)



Select Operation: 3
```

```
SURPATIENT,NINE (000-34-5555)                          OCCURRENCES
------------------------------------------------------------------------------

Date of Operation:   JUN 09, 2004 09:15
Principal Operation: CHOLECYSTECTOMY (47480)

Surgeon:           SURSURGEON,TWO
Attending Surgeon: SURSURGEON,ONE
Attending Code:    LEVEL B: ATTENDING IN O.R., SCRUBBED

Principal Postop Diagnosis:   CHOLECYSTITIS (574.01)

Intraoperative Occurrences:   PUNCTURED MESENTERIC ARTERY
                              Outcome: IMPROVED

Postoperative Occurrences:    EDEMA (03/10/92)
                              Outcome: IMPROVED

Press RETURN to continue  <Enter>
```

Management Reports
[SRO-CHIEF REPORTS]

The *Management Reports* menu is designed to give the Chief of Surgery various management reports. The reports contained on this menu are listed below. To the left of the option/report name is the shortcut synonym that the user can enter to select the option.

Shortcut	Option Name
MM	*Morbidity & Mortality Reports*
MV	*M&M Verification Report*
CD	*Comparison of Preop and Postop Diagnosis*
D	*Delay and Cancellation Reports ...*
V	*List of Unverified Surgery Cases*
RET	*Report of Returns to Surgery*
A	*Report of Daily Operating Room Activity*
NS	*Report of Cases Without Specimens*
ICU	*Report of Unscheduled Admissions to ICU*
OR	*Operating Room Utilization Report*
WC	*Wound Classification Report*
BA	*Print Blood Product Verification Audit Log*
KEY	*Key Missing Surgical Package Data*
OC	*Admitted w/in 14 days of Out Surgery If Postop Occ*
DS	*Death Within 30 Days of Surgery*

Morbidity & Mortality Reports

[SROMM]

The *Morbidity & Mortality Reports* option generates two reports: the Perioperative Occurrences Report and the Mortality Report. The Perioperative Occurrences Report includes all cases that have occurrences, both intraoperatively and postoperatively, and can be sorted by specialty, attending surgeon, or occurrence category. The Mortality Report includes all cases performed within the selected date range that had a death within 30 days after surgery, and sort by specialty within a date range. Each surgical specialty will begin on a separate page.

After the user enters the date range, the software will ask whether to generate both reports. If the user answers **NO**, the software will ask the user to select from the Perioperative Occurrences Report or the Mortality Report.

These reports have a 132-column format and are designed to be copied to a printer.

Example 1: Printing the Perioperative Occurrences Report – Sorted by Specialty

```
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

Print Report for:

1. Intraoperative Occurrences
2. Postoperative Occurrences
3. Intraoperative and Postoperative Occurrences


Select Number:  (1-3): 3

Start with Date: 7/1  (JUL 01, 2006)
End with Date: 7/31  (JUL 31, 2006)

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// <Enter>
```

```
Do you want to print this report for all Surgical Specialties ?  YES// N


Print the report for which Specialty ?  GENERAL (OR WHEN NOT DEFINED BELOW)
Select an Additional Specialty  <Enter>

This report is designed to use a 132 column format.

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

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

(This page included for two-sided copying.)

SURGICAL SERVICE
PERIOPERATIVE OCCURRENCES-INTRAOP/POSTOP
FROM: JUL 1,2006 TO: JUL 31,2006

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

PATIENT ID# / OPERATION DATE	ATTENDING SURGEON / PRINCIPAL OPERATION	OCCURRENCE(S) - (DATE) / TREATMENT	OUTCOME
GENERAL(OR WHEN NOT DEFINED BELOW)			
SURPATIENT,TWELVE 000-41-8719 JUL 07, 2006@07:15	SURSURGEON,THREE REPAIR DIAPHRAGMATIC HERNIA	MYOCARDIAL INFARCTION ASPIRIN THERAPY	I
		URINARY TRACT INFECTION * (07/09/06) IV ANTBIOTICS	I
SURPATIENT,FOURTEEN 000-45-7212 JUL 31, 2006@09:00	SURSURGEON,FIVE CHOLECYSTECTOMY, APPENDECTOMY	SUPERFICIAL WOUND INFECTION * (08/02/06) ANTIBIOTICS	I

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

Example 2: Printing the Perioperative Occurrences Report – Sorted by Attending Surgeon

```
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

Print Report for:

1. Intraoperative Occurrences
2. Postoperative Occurrences
3. Intraoperative and Postoperative Occurrences


Select Number:  (1-3): 3

Start with Date: 7/1  (JUL 01, 2006)
End with Date: 7/31  (JUL 31, 2006)

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// 2

Do you want to print this report for all Attending Surgeons ? YES//N

Print the report for which Attending Surgeon ? SURGEON,ONE

Select an Additional Attending Surgeon:  <Enter>

This report is designed to use a 132 column format.

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

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

SURGICAL SERVICE REVIEWED BY:
PERIOPERATIVE OCCURRENCES-INTRAOP/POSTOP DATE REVIEWED:
FROM: JUL 1,2006 TO: JUL 31,2006 DATE PRINTED: AUG 22,2006

PATIENT ID# / OPERATION DATE	SURGICAL SPECIALTY / PRINCIPAL OPERATION	OCCURRENCE(S) - (DATE) / TREATMENT	OUTCOME
ATTENDING: SURGEON,ONE			
SURPATIENT,TWELVE 000-41-8719 JUL 07, 2006@07:15	GENERAL(OR WHEN NOT DEFINED BELOW) 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	GENERAL(OR WHEN NOT DEFINED BELOW) 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

Print Report for:

1. Intraoperative Occurrences
2. Postoperative Occurrences
3. Intraoperative and Postoperative Occurrences


Select Number:  (1-3): 3

Start with Date: 7/1  (JUL 01, 2006)
End with Date: 7/31  (JUL 31, 2006)

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

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

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

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*----------

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

OPERATION DATE	PATIENT ID#	PRINCIPAL OPERATIVE PROCEDURE	DATE OF DEATH AUTOPSY (Y/N)
		OTORHINOLARYNGOLOGY (ENT)	
JAN 22, 2006	SURPATIENT,SIXTEEN 000-11-1111	LARYNGOSCOPY, BRONCHOSCOPY, ESOPHAGOGASTROSCOPY	FEB 09, 2006 NO
JAN 27, 2006	SURPATIENT,TWO 000-45-1982	BRONCHOSCOPY	FEB 26, 2006 NOT AVAILABLE
JAN 29, 2006	SURPATIENT,SIXTEEN 000-11-1111	BILATERAL NECK DISECTION, LARYNGECTOMY	FEB 09, 2006 NO
FEB 08, 2006	SURPATIENT,SIXTEEN 000-11-1111	LIGATION LT INTERNAL JUGLAR , EXPLORATORY LAPARATOMY	FEB 09, 2006 NO
FEB 19, 2006	SURPATIENT,TEN 000-12-3456	TRACH	FEB 21, 2006 NO
JUL 20, 2006	SURPATIENT,FORTY 000-77-7777	LARYNGOSCOPY W/ BX, ESOPHAGOSCOPY	NOV 01, 2006 NOT AVAILABLE

M&M Verification Report

[SRO M&M VERIFICATION REPORT]

The *M&M Verification Report* option produces the M&M Verification Report that may be useful for (1) reviewing occurrences and their assignments to operations and (2) reviewing deaths unrelated/related assignments to operations

Two varieties of this report are available. The first variety provides a report of all patients who had operations within the selected date range and experienced intraoperative occurrences, postoperative occurrences, or death within 90 days of surgery. The second variety provides a similar report for all risk-assessed operations that are in a completed state but have not yet been transmitted to the national database.

Variety #1: Report information is printed patient-by-patient, listing all operations for the patient that occurred during the selected date range, as well as any operations that may have occurred within 30 days prior to any postoperative occurrences or within 90 days prior to death. Therefore, this report may include some operations that were performed prior to the selected date range, and, if printed by specialty, may include operations performed by other specialties. For every operation that is listed, the intraoperative and postoperative occurrences are also listed. The report also includes information about whether the operation was unrelated or related to death as well as the risk assessment type and status (if assessed). The report may be printed for a selected list of surgical specialties.

Variety #2: Report information is printed patient-by-patient in a format similar to Variety #1. This report lists all risk-assessed operations that are in a completed state but have not yet been transmitted to the national database and that have intraoperative occurrences, postoperative occurrences, or death within 90 days of surgery. The report includes any operations that may have occurred within 30 days prior to any postoperative occurrences or within 90 days prior to death. Therefore, this report may include some other operations that may or may not be risk assessed, and, if risk assessed, may have any risk assessment status (incomplete, complete, or transmitted). Every patient listed on this report will have at least one operation with a risk assessment status of "complete."

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

```
Select Management Reports Option: MV  M&M Verification Report

                            M&M Verification Report

The M&M Verification Report is a tool to assist in the review of occurrences
and their assignments to operations and in the review of death unrelated or
related assignments to operations. Two varieties of this report are available.
The first variety provides a report of all patients who had operations within
the selected date range who experienced intraoperative occurrences,
postoperative occurrences, or death within 90 days of surgery. The second
variety provides a similar report for all risk assessed operations that are in
a completed state but have not yet transmitted to the national database.


Print which variety of the report ?

1. Print full report for selected date range.
2. Print pre-transmission report for completed risk assessments.

Enter selection (1 or 2): 1// <Enter>

Start with Date: 12 31 01  (DEC 31, 2001)
End with Date: 1 31 02  (JAN 31, 2002)
```

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

This report is designed to use a 132 column format.

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

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

M&M Verification Report
From: DEC 31,2001 To: JAN 31,2002 Reviewed By:
Report Generated: FEB 21,2002 Date Reviewed:

Op Date	Specialty	Procedure(s)	Death Related	Occurrence(s) - (Date)	Assessment Type/Status
>>> SURPATIENT,THIRTY (000-82-9472) - DIED 02/27/02					
01/06/02	GENERAL	TOTAL LARYNGECTOMY	NO		NON-CARD/T
12/29/01	THORACIC	CABG, VEIN, SIX+	NO		CARDIAC/I
11/20/01	PERIPHERAL	LT CAROTID ENDOARTERECTOMY	N/A	OTHER OCCURRENCE (11/20/01) ICD: 998.4 FB LEFT DURING PROCEDURE URINARY TRACT INFECTION * (12/08/01) ICD: 599.0 URIN TRACT INFECTION NOS OTHER RESPIRATORY OCCURRENCE * (11/25/01) ICD: 478.25 EDEMA PHARYNX/NASOPHARYX OTHER OCCURRENCE * (NO DATE) ICD: 530.1 ESOPHAGITIS	NON-CARD/T
11/02/01	PERIPHERAL	EVACUATION OF HEMATOMA LT.THIGH	YES	DVT/THROMBOPHLEBITIS * (11/06/01) ICD: 453.8 VENOUS THROMBOSIS NEC BLEEDING/TRANSFUSIONS * (11/04/01) BLEEDING/TRANSFUSIONS * (11/06/01) BLEEDING/TRANSFUSIONS * (11/06/01)	NON-CARD/I

Occurrences(s): '*' Denotes Postop Occurrence Assessment Status - I:Incomplete, C:Complete, T:Transmitted

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

```
Select Management Reports Option: MV  M&M Verification Report

                            M&M Verification Report

The M&M Verification Report is a tool to assist in the review of occurrences
and their assignments to operations and in the review of death unrelated or
related assignments to operations. Two varieties of this report are available.
The first variety provides a report of all patients who had operations within
the selected date range who experienced intraoperative occurrences,
postoperative occurrences, or death within 90 days of surgery. The second
variety provides a similar report for all risk assessed operations that are in
a completed state but have not yet transmitted to the national database.

Print which variety of the report ?

1. Print full report for selected date range.
2. Print pre-transmission report for completed risk assessments.

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


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

This report is designed to use a 132 column format.

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

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

MAYBERRY, NC Page 1
M&M Verification Report
Pre-Transmission Report for Completed Assessments Reviewed By:
Report Generated: DEC 31,2002 Date Reviewed:

Op Date	Specialty	Procedure(s)	Death Related	Occurrence(s) - (Date)	Assessment Type/Status
>>> SURPATIENT,FOUR (000-17-0555) - DIED 12/30/02@07:16					
12/24/02	UROLOGY	CYSTOSCOPY	YES		EXCLUDED/C
>>> SURPATIENT,FIFTYTWO (000-99-8888) - DIED 03/02/02@13:20					
01/31/02	GENERAL	LEFT BKA STUMP DEBRIDEMENT & REVISION	?	URINARY TRACT INFECTION * (02/09/02) ICD: 599.0 URIN TRACT INFECTION NOS PNEUMONIA * (02/15/02) ICD: 485. BRONCOPNEUMONIA ORG NOS	EXCLUDED/C
>>> SURPATIENT,ONE (000-44-7629) - DIED 08/13/02@19:00					
08/05/02	PERIPHERAL	LEFT LEG ABOVE KNEE AMPUTATION, RIGHT LEG ABOVE KNEE AMPUTATION	NO		EXCLUDED/C
>>> SURPATIENT,SIXTEEN (000-11-1111) - DIED 10/01/02					
08/21/02	PERIPHERAL	OMEGAPORT PLACEMENT	?		EXCLUDED/C
>>> SURPATIENT,FIVE (000-58-7963) - DIED 04/08/02					
03/14/02	GENERAL	HICKMAN CATH PLACMENT	NO		EXCLUDED/C

Occurrences(s): '*' Denotes Postop Occurrence Assessment Status - I:Incomplete, C:Complete, T:Transmitted

Comparison of Preop and Postop Diagnosis

[SROPPC]

The *Comparison of Preop and Postop Diagnosis* option generates a list of completed cases in which the principal preoperative and principal postoperative diagnoses are different.

Example: Print Comparison of Preop and Postop Diagnosis Report

```
Select Management Reports Option: CD  Comparison of Preop and Postop Diagnosis

Comparison of Preop and Postop Diagnosis

Start with Date: 3/1  (MAR 01, 2002)
End with Date: 3/31  (MAR 31, 2002)

This report is designed to use a 132 column format.

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

----------*report follows*----------

MAYBERRY, NC
SURGICAL SERVICE
COMPARISON OF PREOP AND POSTOP DIAGNOSIS
FROM: MAR 1,2002 TO: MAR 31,2002

REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: APR 22,2002

DATE CASE #	PATIENT ID # SURGICAL SPECIALTY	PREOPERATIVE DIAGNOSIS	POSTOPERATIVE DIAGNOSIS	WOUND CLASS
03/03/02 63064	SURPATIENT,ONE 000-44-7629 GENERAL	APPENDICITIS	ACUTE APPENDICITIS	D
03/04/02 63066	SURPATIENT,THREE 000-21-2453 GENERAL	BILATERAL INGUINAL HERNIA	BILATERAL INGUINAL HERNIA, WITH GANGRENE	C
03/04/02 63068	SURPATIENT,TEN 000-12-3456 GENERAL	BILATERAL INGUINAL HERNIA	BILAT INGUINAL HERNIA	C
03/08/02 63072	SURPATIENT,EIGHTEEN 000-22-3334 GENERAL	CHOLECYSTITIS	CHOLECYSTITIS WITH OBSTRUCTION	C

WOUND CLASSIFICATION CODES:
C: CLEAN, CC: CLEAN/CONTAMINATED, D: CONTAMINATED, I: INFECTED

Delay and Cancellation Reports

[SRO DEL MENU]

The *Delay and Cancellation Reports* menu provides access to various reports used to track delays and cancellations. The reports on this menu are listed below. To the left of the option/report name is the shortcut synonym the user can enter to select the option.

Shortcut	Option Name
D	*Report of Delayed Operations*
R	*Report of Delay Reasons*
T	*Report of Delay Time*
C	*Report of Cancellations*
A	*Report of Cancellation Rates*

Report of Delayed Operations
[SRODELA]

The *Report of Delayed Operations* option will list all cases that have been delayed within a specified date range. The report sorts by surgical service and includes both the delay cause and delay time.

This report is in a 132-column format and should be copied to a printer with wide paper.

Example: Report of Delayed Operations

```
Select Delay and Cancellation Reports Option: D  Report of Delayed Operations

Report of Delayed Operations

Start with which Date ?  7/1  (JUL 01, 1999)
End with which Date ?  7/31  (JUL 31, 1999)


Do you want to print the Report of Delayed Operations for all Surgical
Specialties ?  YES//  <Enter>

This report is designed to use a 132 column format.

Print the Report on which device ? [Select Print Device]
```

----------*report follows*----------

MAYBERRY, NC PAGE: 1
SURGICAL SERVICE REVIEWED BY:
REPORT OF DELAYED OPERATIONS DATE REVIEWED:
NEUROSURGERY
FROM: JUL 1,1999 TO: JUL 31,1999 DATE PRINTED: AUG 13,1999

DATE DELAY TIME	PATIENT ID #	ATTENDING SURGEON OPERATION(S)	DELAY COMMENTS
		OPERATING SURGEON NOT PRESENT	
07/13/99 30 MINS.	SURPATIENT,SEVENTEEN 000-45-5119	SURSURGEON,THREE L3-4 LUMBAR LAMINECTOMY WITH PARTIAL FACETECTOMY AND LEFT NEUROFORAMINOTOMY, ADDITIONAL L4-5	
		STAFF SURGEON NOT PRESENT	
07/28/99 45 MINS.	SURPATIENT,SIXTY 000-56-7821	SURSURGEON,TWO RT. MEDIAN NERVE DECOMPRESSION AT WRIST	WEDNESDAY UNIVERSITY MEETING

Report of Delay Reasons
[SROREAS]

The *Report of Delay Reasons* option lists reasons for delays, and the number of occurrences for delayed operations, within a specified date range.

This report is in an 80-column format and can be viewed on your screen.

Example: Report of Delay Reasons

```
Select Delay and Cancellation Reports Option: R  Report of Delay Reasons

Report of Delayed Operations

Start with which Date ?  3/1  (MAR 01, 1999)
End with which Date ?  3/31  (MAR 31, 1999)


Do you want to print the Report of Delay Reasons for all Surgical
Specialties ?  YES// <Enter>

Do you want to display the totals for each Surgical Specialty ?  YES// ?

Enter RETURN to display the totals for delay reasons for each specialty. If
you want to display the totals for all delay reasons for the entire medical
center, enter 'NO'.

Do you want to display the totals for each Surgical Specialty ?  YES// <Enter>

Print the Report on which device: [Select Print Device]
```

----------*printout follows*----------

```
                          REPORT OF DELAY REASONS
                         FROM 03/01/99  TO 03/31/99

                      GENERAL(OR WHEN NOT DEFINED BELOW)
                      ----------------------------------

ANESTHETIST NOT PRESENT                                              1
SPECIAL EQUIPMENT NOT READY                                          1
OTHER                                                                1

   TOTAL DELAYS FOR GENERAL(OR WHEN NOT DEFINED BELOW)               3


                          OTORHINOLARYNGOLOGY (ENT)
                          -------------------------

OPERATING SURGEON NOT PRESENT                                        1

   TOTAL DELAYS FOR OTORHINOLARYNGOLOGY (ENT)                        1


Press RETURN to continue, or '^' to quit:  <Enter>


                          REPORT OF DELAY REASONS
                         FROM 03/01/99  TO 03/31/99

================================================================================


OPERATING SURGEON NOT PRESENT                                        1
ANESTHETIST NOT PRESENT                                              1
SPECIAL EQUIPMENT NOT READY                                          1
OTHER                                                                1

TOTAL DELAY REASONS                                                  4

Press RETURN to continue  <Enter>
```

Report of Delay Time
[SRO DELAY TIME]

The *Report of Delay Time* option provides the total amount of delay time for each delay reason for a specified date range. The report sorts by surgical specialty.

This report is in an 80-column format and can be viewed on a screen.

Example: Report of Delay Time

```
Select Delay and Cancellation Reports Option: T  Report of Delay Time

Report of Delay Time

Start with which Date ?  3/1  (MAR 01, 1999)

End with which Date ?  3/31  (MAR 31, 1999)


Do you want to print the Report of Delay Time for all delay reasons ?  YES// ?

Enter RETURN to print this report for all delay reasons, or 'NO' to select
a specific delay reason.


Do you want to print the Report of Delay Time for all delay reasons ?  YES// <Enter>


Do you want to print the Report of Delayed Operations for all Surgical
Specialties ?  YES//  <Enter>

Print the Report on which device: [Select Print Device]
```

----------*printout follows*----------

```
                                MAYBERRY, NC                            PAGE 1
                             Report of Delay Times
                           From 03/01/99  To 03/31/99

                                   # OF       MINUTES
SURGICAL SPECIALTY                DELAYS      DELAYED
================================================================================
                >> Delay Reason: OPERATING SURGEON NOT PRESENT <<

OTORHINOLARYNGOLOGY (ENT)              1           15

--------------------------------------------------------------------------------
                    >> Delay Reason: ANESTHETIST NOT PRESENT <<

GENERAL(OR WHEN NOT DEFINED BE         1           30

--------------------------------------------------------------------------------
                  >> Delay Reason: SPECIAL EQUIPMENT NOT READY <<

GENERAL(OR WHEN NOT DEFINED BE         1           10

Press RETURN to continue, or '^' to quit. <Enter>
```

```
                                MAYBERRY, NC                            PAGE 2
                             Report of Delay Times
                           From 03/01/99  To 03/31/99

                                   # OF       MINUTES
SURGICAL SPECIALTY                DELAYS      DELAYED
================================================================================
                           >> Delay Reason: OTHER <<

GENERAL(OR WHEN NOT DEFINED BE         1           15

Press RETURN to continue, or '^' to quit. <Enter>
```

```
                                MAYBERRY, NC                          PAGE 3
                            Report of Delay Times
                          From 03/01/99  To 03/31/99

                                  # OF       MINUTES
DELAY REASON                     DELAYS      DELAYED
================================================================================
OPERATING SURGEON NOT PRESENT        1           15
ANESTHETIST NOT PRESENT              1           30
SPECIAL EQUIPMENT NOT READY          1           10
OTHER                                1           15

                         TOTAL       4           70

Press RETURN to continue  <Enter>
```

Report of Cancellations
[SROCAN]

The *Report of Cancellations* option is designed to provide information for cases that have been scheduled and cancelled.

This report is in a 132-column format and must be copied to a printer.

Example: Print Report of Cancellations

```
Select Delay and Cancellation Reports Option: C  Report of Cancellations

Report of Cancellations

NOTE: This report contains all cancelled cases, including those that were
      cancelled after the patient had entered the operating room. Aborted
      cases are identified by an '*' next to the procedure name.


Start with Date: 3/1  (MAR 01, 1999)
End with Date: 3/3  (MAR 03, 1999)


Do you want to print the report for all Surgical Specialties ?  YES//  <Enter>

This report is designed to use a 132 column format.

Print the Report on which device: [Select Print Device]
```

----------*printout follows*----------

REPORT OF CANCELLATIONS REVIEWED BY:
PRINTED: MAR 23, 1999 FROM 03/01/99 TO 03/03/99 DATE REVIEWED:

DATE / CASE #	PATIENT / ID#	OPERATION(S)	CANCEL DATE / REASON
>> SURGICAL SPECIALTY: OPHTHALMOLOGY <<			
MAR 01, 1999 31725	SURPATIENT,FIVE 000-58-7963	* PHACEOMULSIFICATION, LENS IMPLANT OS	MAR 01, 1999 11:00 MEDICAL
>> SURGICAL SPECIALTY: ORTHOPEDICS <<			
MAR 01, 1999 32066	SURPATIENT,FIVE 000-58-7963	LT. TOTAL KNEE ARTHROPLASTY	MAR 01, 1999 08:01 MEDICAL
MAR 03, 1999 32143	SURPATIENT,THREE 000-21-2453	HARDWARE REMOVAL RT. ANKLE	MAR 03, 1999 12:49 ADMINISTRATIVE CANCELLATION
>> SURGICAL SPECIALTY: PLASTIC SURGERY (INCLUDES HEAD AND NECK) <<			
MAR 01, 1999 32089	SURPATIENT,TEN 000-12-3456	DEBRIDMENT OF BACK, NECK WOUNDS, GOLDWEIGHT TO RT. EYE, RT. LATERAL CANTHOPLASTY	MAR 01, 1999 07:36 SURGEON
MAR 03, 1999 32141	SURPATIENT,TEN 000-12-3456	PRIMARY CLOSURE LT. CHEEK, SKIN GRAFT VS SKIN FLAP	APR 02, 1999 08:21 PATIENT NOT NPO
>> SURGICAL SPECIALTY: THORACIC SURGERY (INC. CARDIAC SURG.) <<			
MAR 01, 1999 32013	SURPATIENT,FORTY 000-77-7777	LT. THORACOTOMY, LOBECTOMY, PNEUMONECTOMY	MAR 01, 1999 07:35 MEDICAL
>> SURGICAL SPECIALTY: UROLOGY <<			
MAR 03, 1999 32119	SURPATIENT,NINETEEN 000-28-7354	TRANSURETHRAL RESECTION OF BLADDER TUMOR	MAR 19, 1999 08:00 PATIENT/GUARDIAN REFUSES
>> SURGICAL SPECIALTY: PODIATRY <<			
MAR 02, 1999 31865	SURPATIENT,SEVENTEEN 000-45-5119	1ST METATARSL REMODELING RT. FOOT, REMOVAL OF SOFT TISSUE NODULE RT. FOOT	MAR 29, 1999 08:52 MEDICAL

Report of Cancellation Rates
[SROCRAT]

The *Report of Cancellation Rates* option generates a report on the calculations of cancellation rates. This report can be printed for one or a few surgical specialties (Example 1), or for all surgical specialties (Example 2). Emergency cases are not included in this report.

This report is in an 80-column format and can be viewed on your screen.

How the Cancellation Rates Are Calculated

Cancellation Rate for Scheduled Cases =
(Total Cancels / Total Scheduled) x 100

Avoidable Cancellation Rate for Scheduled Cases =
(Total Avoidable Cancels / Total Scheduled) x 100

Avoidable Cancellation rate for all Cancelled Cases =
(Total Avoidable Cancels / Total Cancels) x 100

Example 1: View for Individual Surgical Specialties

```
Select Delay and Cancellation Reports Option: A  Report of Cancellation Rates

Report of Cancellation Rates


Start with which Date ?  3/2  (MAR 02, 1999)
End with which Date ?  3/20  (MAR 20, 1999)


Do you want to print the report for all Surgical Specialties ?  YES//  N


Print the report for which Specialty ?  50          GENERAL(OR WHEN NOT DEFINED BELOW)
Select An Additional Specialty:  ORTHOPEDICS  54        ORTHOPEDICS
Select An Additional Specialty:  PLASTIC SURGERY (INCLUDES HEAD AND NECK)  PROCTOLOGY  56
PLASTIC SURGERY (INCLUDES HEAD AND NECK)
Select An Additional Specialty: <Enter>

Print the Report on which device: [Select Print Device]
```

----------*printout follows*----------

```
                    ** GENERAL(OR WHEN NOT DEFINED BELOW) **

TOTAL SCHEDULED SURGICAL CASES: 18
CANCELLATION RATE FOR SCHEDULED CASES: 17 %
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 0 %
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 0 %

CANCELLATION REASON                          TOTAL CANCELS    TOTAL AVOIDABLE
-------------------------------------------------------------------------------
PREV. CASE LENGTH                                3                0
                                               -----            -----
TOTAL CANCELLATIONS                              3                0


Press RETURN to continue, or '^' to quit:  <Enter>


                                ** ORTHOPEDICS **

TOTAL SCHEDULED SURGICAL CASES: 23
CANCELLATION RATE FOR SCHEDULED CASES: 26 %
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 9 %
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 33 %

CANCELLATION REASON                          TOTAL CANCELS    TOTAL AVOIDABLE
-------------------------------------------------------------------------------
ADMINISTRATIVE CANCELLATION                      1                1
MEDICAL                                          4                1
SCHEDULING ERROR                                 1                0
                                               -----            -----
TOTAL CANCELLATIONS                              6                2


Press RETURN to continue, or '^' to quit:  <Enter>


                ** PLASTIC SURGERY (INCLUDES HEAD AND NECK) **

TOTAL SCHEDULED SURGICAL CASES: 10
CANCELLATION RATE FOR SCHEDULED CASES: 30 %
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 20 %
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 67 %

CANCELLATION REASON                          TOTAL CANCELS    TOTAL AVOIDABLE
-------------------------------------------------------------------------------
PATIENT NOT NPO                                  1                1
PREV. CASE LENGTH                                1                0
SURGEON                                          1                1
                                               -----            -----
TOTAL CANCELLATIONS                              3                2


Press RETURN to continue, or '^' to quit:  <Enter>
```

Example 2: View for All Specialties

```
Select Delay and Cancellation Reports Option: A  Report of Cancellation Rates

Report of Cancellation Rates


Start with which Date ?  3/2  (MAR 02, 1999)
End with which Date ?  3/20  (MAR 20, 1999)


Do you want to print the report for all Surgical Specialties ?  YES//  <Enter>

Do you want to display the cancellation reasons for each Surgical
Specialty ?  YES// <Enter>

Print the Report on which device: [Select Print Device]
```

----------printout follows----------

```
                    ** GENERAL(OR WHEN NOT DEFINED BELOW) **

TOTAL SCHEDULED SURGICAL CASES: 18
CANCELLATION RATE FOR SCHEDULED CASES: 17 %
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 0 %
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 0 %

CANCELLATION REASON                          TOTAL CANCELS    TOTAL AVOIDABLE
-------------------------------------------------------------------------------
PREV. CASE LENGTH                                3                0
                                               -----            -----
TOTAL CANCELLATIONS                              3                0


Press RETURN to continue, or '^' to quit:  <Enter>

                               ** NEUROSURGERY **

TOTAL SCHEDULED SURGICAL CASES: 8
CANCELLATION RATE FOR SCHEDULED CASES: 25 %
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 13 %
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 50 %

CANCELLATION REASON                          TOTAL CANCELS    TOTAL AVOIDABLE
-------------------------------------------------------------------------------
OPERATING ROOM                                   1                0
PATIENT NO-SHOW                                  1                1
                                               -----            -----
TOTAL CANCELLATIONS                              2                1


Press RETURN to continue, or '^' to quit: <Enter>

                               ** ORTHOPEDICS **

TOTAL SCHEDULED SURGICAL CASES: 23
CANCELLATION RATE FOR SCHEDULED CASES: 26 %
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 9 %
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 33 %

CANCELLATION REASON                          TOTAL CANCELS    TOTAL AVOIDABLE
-------------------------------------------------------------------------------
ADMINISTRATIVE CANCELLATION                      1                1
MEDICAL                                          4                1
SCHEDULING ERROR                                 1                0
                                               -----            -----
TOTAL CANCELLATIONS                              6                2


Press RETURN to continue, or '^' to quit:  <Enter>
```

```
                                ** OTORHINOLARYNGOLOGY (ENT) **

TOTAL SCHEDULED SURGICAL CASES: 18
CANCELLATION RATE FOR SCHEDULED CASES: 6 %
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 6 %
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 100 %

CANCELLATION REASON                          TOTAL CANCELS    TOTAL AVOIDABLE
-------------------------------------------------------------------------------
SCHEDULING ERROR                                     1                1
                                                   -----            -----
TOTAL CANCELLATIONS                                  1                1


Press RETURN to continue, or '^' to quit:  <Enter>

                             ** PERIPHERAL VASCULAR **

TOTAL SCHEDULED SURGICAL CASES: 16
CANCELLATION RATE FOR SCHEDULED CASES: 25 %
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 6 %
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 25 %

CANCELLATION REASON                          TOTAL CANCELS    TOTAL AVOIDABLE
-------------------------------------------------------------------------------
MEDICAL                                              2                0
PREV. CASE LENGTH                                    1                0
SCHEDULING ERROR                                     1                1
                                                   -----            -----
TOTAL CANCELLATIONS                                  4                1


Press RETURN to continue, or '^' to quit:  <Enter>

                  ** PLASTIC SURGERY (INCLUDES HEAD AND NECK) **

TOTAL SCHEDULED SURGICAL CASES: 10
CANCELLATION RATE FOR SCHEDULED CASES: 30 %
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 20 %
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 67 %

CANCELLATION REASON                          TOTAL CANCELS    TOTAL AVOIDABLE
-------------------------------------------------------------------------------
PATIENT NOT NPO                                      1                1
PREV. CASE LENGTH                                    1                0
SURGEON                                              1                1
                                                   -----            -----
TOTAL CANCELLATIONS                                  3                2


Press RETURN to continue, or '^' to quit:  <Enter>

                                  ** PODIATRY **

TOTAL SCHEDULED SURGICAL CASES: 14
CANCELLATION RATE FOR SCHEDULED CASES: 7 %
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 0 %
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 0 %

CANCELLATION REASON                          TOTAL CANCELS    TOTAL AVOIDABLE
-------------------------------------------------------------------------------
MEDICAL                                              1                0
                                                   -----            -----
TOTAL CANCELLATIONS                                  1                0


Press RETURN to continue, or '^' to quit:  <Enter>
```

```
                                   ** UROLOGY **

TOTAL SCHEDULED SURGICAL CASES: 11
CANCELLATION RATE FOR SCHEDULED CASES: 18 %
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 0 %
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 0 %

CANCELLATION REASON                          TOTAL CANCELS    TOTAL AVOIDABLE
-------------------------------------------------------------------------------
MEDICAL                                              1                0
PATIENT/GUARDIAN REFUSES                             1                0
                                                   -----            -----
TOTAL CANCELLATIONS                                  2                0


Press RETURN to continue, or '^' to quit:  <Enter>


TOTAL SURGICAL CASES SCHEDULED FOR MAYBERRY, NC: 118
CANCELLATION RATE FOR SCHEDULED CASES: 19 %
AVOIDABLE CANCELLATION RATE FOR SCHEDULED CASES: 6 %
AVOIDABLE CANCELLATION RATE FOR CANCELLED CASES: 32 %

CANCELLATION REASON                          TOTAL CANCELS    TOTAL AVOIDABLE
-------------------------------------------------------------------------------
ADMINISTRATIVE CANCELLATION                          1                1
MEDICAL                                              8                1
OPERATING ROOM                                       1                0
PATIENT NO-SHOW                                      1                1
PATIENT NOT NPO                                      1                1
PATIENT/GUARDIAN REFUSES                             1                0
PREV. CASE LENGTH                                    5                0
SCHEDULING ERROR                                     3                2
SURGEON                                              1                1
                                                   -----            -----
TOTAL CANCELLATIONS                                 22                7

Press RETURN to continue, or '^' to quit:  <Enter>

                                        PERCENT AVOIDABLE CANCELLATIONS
                                       ---------------------------------
SURGICAL SPECIALTY                    SCHEDULED CASES     CANCELLED CASES
===============================================================================


GENERAL(OR WHEN NOT DEFINED BELOW)                0 %                0 %
NEUROSURGERY                                     13 %               50 %
ORTHOPEDICS                                       9 %               33 %
OTORHINOLARYNGOLOGY (ENT)                         6 %              100 %
PERIPHERAL VASCULAR                               6 %               25 %
PLASTIC SURGERY (INCLUDES HEAD AND NECK)         20 %               67 %
PODIATRY                                          0 %                0 %
UROLOGY                                           0 %                0 %

Press RETURN to continue  <Enter>
```

List of Unverified Surgery Cases

[SROUNV]

The *List of Unverified Surgery Cases* option will generate a list of all completed surgery cases that have not had the procedure, diagnosis, and complications verified. The user can verify a case using the *Surgeon's Verification of Diagnosis & Procedures* option in the *Operation Menu*. This list can be compiled for one or all surgical specialties.

This report is in an 80-column format and can be viewed on your screen.

Example: List of Unverified Surgery Cases

```
Select Management Reports Option: V  List of Unverified Surgery Cases

Do you want the list for all Surgical Specialties ?  YES//  N

Select Surgical Specialty: GENERAL(OR WHEN NOT DEFINED BELOW)        50

Start with Date: 3/9  (MAR 09, 1999)

End with Date: 3/20  (MAR 20, 1999)

Print the List of Unverified Cases to which Printer ? [Select Print Device]
```

----------*printout follows*----------

```
     List of Unverified Cases for GENERAL(OR WHEN NOT DEFINED BELOW)

Operation Date      Patient (Case #)                      Surgeon
                    Patient ID #                          Attending Surgeon
================================================================================
MAR  9, 1999        SURPATIENT,SIX (15188)                SURSURGEON,SIXTEEN
                    000-09-8797                           SURSURGEON,FOUR

                    APPENDECTOMY * CPT CODE MISSING *
--------------------------------------------------------------------------------
MAR 10, 1999        SURPATIENT,FIFTYONE (15189)           SURSURGEON,FOUR
                    000-23-3221                           SURSURGEON,ONE

                    DRAINAGE OF OVARIAN CYST * CPT CODE MISSING *
--------------------------------------------------------------------------------
MAR 10, 1999        SURPATIENT,TWO (15199)                SURSURGEON,ONE
                    000-45-1982                           NOT ENTERED

                    CHOLECYSTECTOMY WITH CHOLANGIOGRAM * CPT CODE MISSING *
--------------------------------------------------------------------------------
MAR 17, 1999        SURPATIENT,FOURTEEN (15203)           SURSURGEON,ONE
                    000-45-7212                           SURSURGEON,TWO

                    CHOLECYSTECTOMY * CPT CODE MISSING *
--------------------------------------------------------------------------------
MAR 18, 1999        SURPATIENT,SEVENTEEN (15202)          SURSURGEON,ONE
                    000-45-5119                           SURSURGEON,TWO

                    REPAIR INCARCERATED INGUINAL HERNIA * CPT CODE MISSING *
--------------------------------------------------------------------------------

Press RETURN to continue, or '^' to quit:. <Enter>
```

Report of Returns to Surgery

[SRORET]

The *Report of Returns to Surgery* option lists cases that have had related surgical procedures performed within 30 days of the date of the operation. The user must enter the date range by which the software will sort.

This report has a 132-column format and must be copied to a printer with wide paper.

Example: Print the Report of Returns to Surgery

```
Select Management Reports Option: RET  Report of Returns to Surgery

Report of Returns to Surgery


Start with Date: 7/1  (JUL 01, 1999)
End with Date: 7/14  (JUL 14, 1999)

This report will list cases completed during the date range entered that
have had return cases associated with them. It is designed to use a 132
column format.


Print the Report on which Device: [Select Print Device]
```

----------*printout follows*----------

MAYBERRY, NC
SURGICAL SERVICE
REPORT OF RETURNS TO SURGERY
FROM: JUL 1,1999 TO: JUL 14,1999

REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: AUG 27,1999

OPERATION DATE	PATIENT (ID#)	PRINCIPAL OPERATIVE PROCEDURE
JUL 03, 1999	SURPATIENT,SEVENTEEN (000-45-5119)	REPAIR GASTRIC PERFORATION
RETURNS TO SURGERY: JUL 07, 1999	EXPLORATORY LAPAROTOMY	
JUL 06, 1999	SURPATIENT,FIVE (000-21-2453)	ATTEMPTED REVISION OF LEFT ARM A-V FISTULA WITH GRAFT
RETURNS TO SURGERY: JUL 15, 1999	CREATION OF A-V FISTULA W/VASCULAR GRAFT, RT ARM	
JUL 06, 1999	SURPATIENT,TWO (000-45-1982)	EXCISION OF GRANULATION TISSUE RT. FOOT
RETURNS TO SURGERY: AUG 03, 1999	STSG FROM RT. THIGH TO RIGHT FOOT	
JUL 06, 1999	SURPATIENT,FORTY (000-77-7777)	IRRIGATION AND DEBRIDEMENT OF LT. FOOT
RETURNS TO SURGERY: JUL 14, 1999	IRRIGATION AND DEBRIDEMENT OF LT. FOOT	
JUL 07, 1999	SURPATIENT,FORTYONE (000-43-2109)	EXPLORATORY LAPAROTOMY
RETURNS TO SURGERY: AUG 05, 1999	TRACHEOSTOMY	
JUL 10, 1999	SURPATIENT,ONE (000-44-7629)	RIGHT LOWER QUADRANT EXPLORATION
RETURNS TO SURGERY: JUL 13, 1999	SIGMOID COLECTOMY	

Report of Daily Operating Room Activity

[SROPACT]

The *Report of Daily Operating Room Activity* option provides a list of completed cases started between 6:00 AM on the date selected and 5:59 AM of the following day for all operating rooms.

Example: Print the Report of Daily Operating Room Activity

```
Select Management Reports Option: A Report of Daily Operating Room Activity

Print the Report of Daily Activity for which Date ?  7/1  (JUL 01, 1999)

This report will include all cases started between MAR 12, 1992 at 6:00 AM
and MAR 13, 1992 at 5:59 AM.

It is designed to use a 132 column format.

Print the Report to which Device ?  [Select Print Device]
```

----------*printout follows*----------

MAYBERRY, NC
SURGICAL SERVICE
DAILY REPORT OF OPERATING ROOM ACTIVITY
FOR: JUL 01, 1999

PATIENT ID # WARD	AGE	TIME IN OR TIME OUT OR CASE NUMBER	POSTOPERATIVE DIAGNOSIS PROCEDURE(S)	ANESTHESIOLOGIST PRIN. ANESTHETIST	SURGEON FIRST ASST. ATT SURGEON
OPERATING ROOM: CYSTO1					
SURPATIENT,SIX		07/01 14:00	GROSS HEMATURIA	SURSANESTHESIOLOGIST,O	SURSURGEON,F
000-09-8797	69	07/01 16:05	CYSTOURETHROSCOPY WITH BLADDER BIOPSY,	SURANESTHETIST,F	
OUTPATIENT		33536	TRANSURETHRAL RESECTION OF BLADDER TUMOR		SURSURGEON,O
OPERATING ROOM: OR1					
SURPATIENT,NINETEEN		07/01 08:00	LEFT COLD FOOT	SURSANESTHESIOLOGIST,O	SURSURGEON,T
000-28-7354	59	07/01 16:30	LEFT FEMORO-TIB TO TIB PERONEAL TRUNK	SURANESTHETIST,F	SURSURGEON,F
OUTPATIENT		33512	SAPHENOUS,IN-SITU, TIBIAL-PERONEAL EMBOLECTOMY, EXCLUSION OF POPLITEAL ANEURYSM, COMPLETION ANGIOGRAPHY, COMPLETION DUPLEX		SURSURGEON,O
SURPATIENT,SEVENTEEN		07/01 09:10	RT. CAROTID STENOSIS	SURSANESTHESIOLOGIST,T	SURSURGEON,F
000-45-5119	73	07/01 13:00	RT. CAROTID ENDARTERECTOMY		
OUTPATIENT		33521			SURSURGEON,S
OPERATING ROOM: OR2					
SURPATIENT,TEN		07/01 06:00	APPENDICITIS	SURSANESTHESIOLOGIST,O	SURSURGEON,F
000-12-3456	60	07/01 07:35	APPENDECTOMY	SURSANESTHESIOLOGIST,O	
OUTPATIENT		33519			SURSURGEON,S
OPERATING ROOM: OR4					
SURPATIENT,FIVE		07/01 07:45	RT. EAR,RT. EYELID BASAL CELL CA	SURSANESTHESIOLOGIST,O	SURSURGEON,S
000-58-7963	75	07/01 12:00	EXCISION OF RT. UPPER EYELID BASAL CELL CA,	SURSANESTHESIOLOGIST,O	
OUTPATIENT		33409	EXCISION OF RT. EAR BASAL CELL CA		SURSURGEON,F
OPERATING ROOM: OR5					
SURPATIENT,SIXTEEN		07/01 07:50	SINUSITIS ,RHNOPHYMA,NASAL OBSTRUCTION	SURSANESTHESIOLOGIST,O	SURSURGEON,F
000-11-1111	96	07/01 10:27	SEPTOPLASTY, TURBINECTOMY, INTERNAL INTRA NASAL	SURSANESTHESIOLOGIST,O	
OUTPATIENT		33399	SYNOIDECTOMY, LASER RESURFACE OF NOSE, NASAL POLYECTOMY RT., NASAL POLYPECTOMY LT.		SURSURGEON,S

Report of Cases Without Specimens

[SROSPEC]

The *Report of Cases Without Specimens* option lists all completed cases in which there were no specimens taken from the operative site. The report can be printed for an individual surgical specialty, if it is needed.

This report is in a 132-column format and must be copied to a printer with wide paper.

Example: Print the Report of Cases without Specimens

```
Select Management Reports Option: NS  Report of Cases Without Specimens

Report of Cases Without Specimens


Starting with which Date ?  7/12  (JUL 12, 1999)
Ending with which Date ?  7/14  (JUL 14, 1999)

Do you want the report sorted by Surgical Specialty ?  NO// <Enter>

This report is designed to use a 132 column format.

Print the Report on which Device ? [Select Print Device]
```

----------*printout follows*----------

MAYBERRY, NC PAGE 1
SURGICAL SERVICE REVIEWED BY:
CASES WITHOUT SPECIMENS DATE REVIEWED:
FROM: JUL 12,1999 TO: JUL 14,1999 DATE PRINTED: JUL 27,1999

DATE CASE #	PATIENT PATIENT ID	SURGICAL SPECIALTY POSTOPERATIVE DIAGNOSIS OPERATIVE PROCEDURE	SURGEON ATTENDING SURGEON
07/12/99 33613	SURPATIENT,TEN 000-12-3456	PERIPHERAL VASCULAR RENAL FAILURE PLACEMENT OF LEFT FEMORAL DIALYSIS TESSIO-CATHETER	SURSURGEON,THREE SURSURGEON,ONE
07/12/99 33616	SURPATIENT,FOUR 000-17-0555	OTORHINOLARYNGOLOGY (ENT) NASAL OBSTRUCTION LEFT LATERAL RHINOTOMY WITH RECONSTRUCTION OF NASAL VESTIBULE	SURSURGEON,TWO SURSURGEON,ONE
07/12/99 33659	SURPATIENT,SIXTEEN 000-11-1111	UROLOGY SIGMOID CA CYSTOURETOROSCOPY, RETROGRADE PYELOGRAPHY, BILATERAL URETERAL STENT PLACEMENT	SURSURGEON,FOUR SURSURGEON,FOUR
07/12/99 33653	SURPATIENT,SEVENTEEN 000-45-5119	GENERAL(OR WHEN NOT DEFINED BELOW) PROLONGED ANTIBOTIC THERAPHY PLACEMENT OF HICKMAN CATHETER	SURSURGEON,TWO SURSURGEON,SEVEN
07/13/99 33554	SURPATIENT,FIFTY 000-45-9999	OPHTHALMOLOGY CATARACT OS PHACEOMULSIFICATION, LENS IMPLANT OS	SURSURGEON,ONE SURSURGEON,ONE
07/14/99 33598	SURPATIENT,TEN 000-12-3456	PLASTIC SURGERY (INCLUDES HEAD AND NECK) MOH'S DEFECT LT. UPPER LIP FLAP CLOSURE OF MOHS DEFECT LEFT UPPER LIP	SURSURGEON,ONE SURSURGEON,FOUR
07/14/99 33645	SURPATIENT,EIGHTEEN 000-22-3334	PLASTIC SURGERY (INCLUDES HEAD AND NECK) INFECTED DIABETIC FOOT DEBRIDEMENT RIGHT FOOT, SKIN GRAFT RT THIGH TO RT FOOT	SURSURGEON,SIX SURSURGEON,TWO

TOTAL CASES WITHOUT SPECIMENS: 7

Report of Unscheduled Admissions to ICU

[SROICU]

The *Report of Unscheduled Admissions to ICU* option lists all unscheduled admissions to the Intensive Care Unit (ICU) based on the requested (expected) postoperative care and actual postoperative disposition.

This report is in a 132-column format and must be copied to a printer with wide paper.

Example: Print Report of Unscheduled Admissions to ICU

```
Select Management Reports Option: ICU  Report of Unscheduled Admissions to ICU

Report of Unscheduled Admissions to the ICU


Starting with which Date ?  7/1  (JUL 01, 1999)
Ending with which Date ?  7/31  (JUL 32, 1999)

Do you want the report for a specific Surgical Specialty ?  NO//  <Enter>

This report is designed to use a 132 column format.

Print the Report on which Device ? [Select Print Device]
```

----------*printout follows*----------

MAYBERRY, NC
SURGICAL SERVICE
UNSCHEDULED ADMISSIONS TO ICU
FROM 07/01/99 TO 07/31/99

REVIEWED BY:
DATE REVIEWED:

DATE	PATIENT PATIENT ID REQ DISPOSITION/POSTOP DISPOSITION	SURGICAL SPECIALTY POSTOPERATIVE DIAGNOSIS OPERATIVE PROCEDURE(S)	SURGEON ATTENDING SURGEON
07/01/99	SURPATIENT,EIGHTEEN 000-22-3334 PACU (RECOVERY ROOM)/SICU	GENERAL(OR WHEN NOT DEFINED BELOW) APPENDICITIS APPENDECTOMY	SURSURGEON,ONE SURSURGEON,THREE
07/06/99	SURPATIENT,TEN 000-12-3456 WARD/SICU	GENERAL(OR WHEN NOT DEFINED BELOW) INABILITY TO TAKE ORAL OR USE NG TUBE PLACEMENT OF G-TUBE	SURSURGEON,ONE SURSURGEON,FOUR
07/08/99	SURPATIENT,TWELVE 000-41-8719 WARD/MICU	GENERAL(OR WHEN NOT DEFINED BELOW) GANGRENE LT. FOOT LT. BELOW KNEE AMPUTATION	SURSURGEON,ONE SURSURGEON,THREE
07/23/99	SURPATIENT,TEN 000-12-3456 WARD/SICU	PERIPHERAL VASCULAR IV ACCESS PLACEMENT OF HICKMAN CATHATER, INTRODUCTION OF DOBHOFF TUBE	SURSURGEON,ONE SURSURGEON,FOUR
07/27/99	SURPATIENT,FORTY 000-77-7777 WARD/MICU	GENERAL(OR WHEN NOT DEFINED BELOW) RT BUTTOCK ABCESS I AND D OF RIGHT BUTTOCK ABSCESS	SURSURGEON,ONE SURSURGEON,TWO
07/29/99	SURPATIENT,FOUR 000-17-0555 WARD/MICU	GENERAL(OR WHEN NOT DEFINED BELOW) INCARCERATED EPIGASTRIC HERNIA REPAIR OF INCARCERATED EPIGASTRIC HERNIA	SURSURGEON,ONE SURSURGEON,TWO

Operating Room Utilization Report

[SR OR UTL1]

The *Operating Room Utilization Report* option prints utilization information for a selected date range for all operating rooms or for a single operating room. The report displays the percent utilization, the number of cases, the total operation time and the time worked outside normal hours for each operating room individually and all operating rooms collectively.

How the Percent Utilization is Derived

The percent utilization is derived by dividing the total operation time for all operations (including total time patients were in OR, plus the cleanup time allowed for each case) by the total functioning time, as defined in the SURGERY UTILIZATION file. The quotient is then multiplied by 100.

This report must be copied to a printer with wide paper

Example: Print the Operating Room Utilization Report

```
Select Management Reports Option: OR  Operating Room Utilization Report

Operating Room Utilization Report


Print utilization information starting with which date ?  3/8  (MAR 08, 1999)

Print utilization information through which date ?  3/9  (MAR 09, 1999)

Do you want to print the Operating Room Utilization Report for all
operating rooms ?  YES//  <Enter>
Print the Operating Room Utilization Report on which Device ? [Select Print Device]
```

----------*printout follows*----------

MAYBERRY, NC PAGE 1
SURGICAL SERVICE
OPERATING ROOM UTILIZATION REPORT
FOR ALL OPERATING ROOMS FROM: MAR 8,1999 TO: MAR 9,1999
DATE PRINTED: MAR 17,1999

OPERATING ROOM	PERCENT UTILIZATION	NUMBER OF CASES	TOTAL OPERATION TIME (INCLUDING OR MAINTENANCE)	TIME WORKED OUTSIDE NORMAL HRS
OR1	70%	3	17 hrs and 35 mins	6 hrs and 20 mins
OR2	39%	1	7 hrs and 25 mins	1 hr and 10 mins
OR3	133%	8	23 hrs and 42 mins	2 hrs and 30 mins
OR4	29%	3	4 hrs and 41 mins	-
OR5	84%	7	18 hrs and 50 mins	5 hrs and 25 mins
OR6	0	0	-	-
OR7	0	0	-	-
TOTAL UTILIZATION FOR ALL ROOMS	63%	22	72 hrs and 13 mins	15 hrs and 25 mins

Wound Classification Report

[SROWC]

The *Wound Classification Report* option generates a report showing the total number of surgical cases in each of the various wound classifications for a specified date range. The report is sorted by surgical service.

After selecting a date range, the user has the choice of printing one of three reports.

- Wound Classification Report: The user enters the number 1 to print this summary of wound classifications entered for surgical cases performed during the date range.
- List of Operations by Wound Classification: The user enters the number 2 to print this list of operations sorted by wound classification and by surgical specialty performed during the date range.
- Clean Wound Infection Summary: The user enters the number 3 to print this summary of clean wound infections.

These reports are in an 80-column format and can be viewed on the screen.

Example 1: Wound Classification Report (Summary)

```
Select Management Reports Option: WC  Wound Classification Report

Wound Classification Report


Start with Date: 7/1  (JUL 01, 1999)
End with Date: 7/15  (JUL 15, 1999)

Print which of the following ?

1. Wound Classification Report (Summary)
2. List of Operations by Wound Classification
3. Clean Wound Infection Summary

Select Number:  1// <Enter>


Do you want to print the report for all Surgical Specialties ?  YES//  N


Print the report for which Specialty ?  GENERAL(OR WHEN NOT DEFINED BE  LOW)
    50
Select An Additional Specialty:  ORTHOPEDICS          54
Select An Additional Specialty:  <Enter>

Print on Device: [Select Print Device]
```

----------*printout follows*----------

```
                        WOUND CLASSIFICATION REPORT
                      FROM: JUL 1,1999  TO: JUL 15,1999
------------------------------------------------------------------------------

                                 CLEAN                                 NO CLASS
SURGICAL SERVICE      CLEAN   CONTAMINATED   CONTAMINATED   INFECTED    ENTERED

GENERAL                 9         10             4             3           0
ORTHOPEDICS             9          0             0             0           0

SUB TOTAL:             18         10             4             3           0

TOTAL:    35

CLEAN WOUND INFECTION RATE:   0.0%

Press RETURN to continue  <Enter>
```

Example 2: List of Operations by Wound Classification

```
Select Management Reports Option: WC  Wound Classification Report

Wound Classification Report


Start with Date: 7/8  (JUL 08, 1999)
End with Date: 7/8  (JUL 08, 1999)

Print which of the following ?

1. Wound Classification Report (Summary)
2. List of Operations by Wound Classification
3. Clean Wound Infection Summary

Select Number:  1// 2


Do you want to print the report for all Wound Classifications ? YES//  N

Print report for which Wound Classification ?

1. CLEAN
2. CLEAN/CONTAMINATED
3. CONTAMINATED
4. INFECTED
5. NO CLASS ENTERED

Select Number:  1


Do you want to print the report for all Surgical Specialties ?  YES//  N

Print the report for which Specialty ?  GENERAL(OR WHEN NOT DEFINED BELOW)  50
Select An Additional Specialty:  PERIPHERAL VASCULAR  62
Select An Additional Specialty:  <Enter>

Print on Device:      [Select Print Device]
```

----------*printout follows*----------

```
                List of Surgical Cases by Wound Classification          Page:
                       FROM: JUL 8,1999  TO: JUL 8,1999                   1
                         Wound Classification: CLEAN
DATE PRINTED: JUL 27,1999

Operation Date    Patient                        Surgeon/Provider
Case #            ID #
================================================================================
                    >> GENERAL(OR WHEN NOT DEFINED BELOW) <<

JUL 08, 1999      SURPATIENT,TEN                 SURSURGEON,ONE
33280             000-12-3456
                  * RT. INGUINAL HERNIA REPAIR
--------------------------------------------------------------------------------
JUL 08, 1999      SURPATIENT,FOUR                SURSURGEON,FOUR
33629             000-17-0555
                  * INCARCERATED UMBILICAL HERNIA REPAIR
--------------------------------------------------------------------------------

Press RETURN to continue, or '^' to quit: <Enter>


                List of Surgical Cases by Wound Classification          Page:
                       FROM: JUL 8,1999  TO: JUL 8,1999                   2
                         Wound Classification: CLEAN
DATE PRINTED: JUL 27,1999

Operation Date    Patient                        Surgeon/Provider
Case #            ID #
================================================================================
                           >> PERIPHERAL VASCULAR <<

JUL 08, 1999      SURPATIENT,FORTY               SURSURGEON,ONE
33478             000-77-7777
                  * LEFT CAROTID ENDARTERECTOMY
                  * REOPERATION LEFT CAROTID
--------------------------------------------------------------------------------
JUL 08, 1999      SURPATIENT,TWO                 SURSURGEON,TWO
33575             000-45-1982
                  * LT. A-V FISTULA WITH LOOP VEIN GRAFT
--------------------------------------------------------------------------------

Press RETURN to continue  <Enter>
```

Example 3: Clean Wound Infection Summary

```
Select Management Reports Option: WC  Wound Classification Report

Wound Classification Report


Start with Date: 6/1  (JUN 01, 1999)
End with Date: 6/30  (JUN 30, 1999)

Print which of the following ?

1. Wound Classification Report (Summary)
2. List of Operations by Wound Classification
3. Clean Wound Infection Summary

Select Number:  1// 3


Do you want to print the report for all Surgical Specialties ?  YES// <Enter>

Print on Device: [Select Print Device]
```

----------printout follows----------

```
                                MAYBERRY, NC
                              SURGICAL SERVICE
                        CLEAN WOUND INFECTION SUMMARY
                       FROM: JUN 1,1999  TO: JUN 30,1999
                          DATE PRINTED: JUL 18,1999
                   REVIEWED BY:              DATE REVIEWED:

SURGICAL SERVICE        CLEAN WOUNDS    INFECTIONS    INFECTION RATE
================================================================================
GENERAL                       21              1              4.8%
GYNECOLOGY                     0              0              0.0%
NEUROSURGERY                  11              0              0.0%
OPHTHALMOLOGY                 30              0              0.0%
ORTHOPEDICS                   20              1              5.0%
OTORHINOLARYNGOLOGY            6              0              0.0%
PLASTIC SURGERY                7              0              0.0%
PROCTOLOGY                     0              0              0.0%
THORACIC SURGERY               2              0              0.0%
UROLOGY                        2              0              0.0%
ORAL SURGERY                   0              0              0.0%
PODIATRY                      14              0              0.0%
PERIPHERAL VASCULAR           28              0              0.0%
CARDIAC SURGERY                0              0              0.0%
TRANSPLANTATION                0              0              0.0%
ANESTHESIOLOGY                 0              0              0.0%
RHEUMATOLOGY                   1              0              0.0%
PULMONARY                      0              0              0.0%
GASTROENTEROLOGY               0              0              0.0%
NO SPECIALTY ENTERED           0              0              0.0%

TOTAL                        142              2              1.4%
```

Pages 368-392 have been deleted. The Quarterly Report Menus have been removed.

Print Blood Product Verification Audit Log

[SR BLOOD PRODUCT VERIFY AUDIT]

The *Blood Product Verification Audit Log* option is used to print the KERNEL audit log for the *Blood Product Verification* option.

Prior to printing entries from the KERNEL audit log for the *Blood Product Verification* option (located on the *Operation Menu*), the audit function must be turned on either through the *System Manager Menu* option or by invoking the *Establish System Audit Parameters* option in KERNEL, as shown in the following example.

Example: Establish System Audit Parameters

```
Select Systems Manager Menu Option: SYStem Security

Select System Security Option: AUDIt Features

Select Audit Features Option: MAintain System Audit Options

Select Maintain System Audit Options Option: ESTablish System Audit Parameters

                        Kernel Site Parameter edit

  DOMAIN: [Enter your domain here.]

OPTION AUDIT: SPECIFIC OPTIONS AUDITED    FAILED ACCESS ATTEMPTS:
   INITIATE AUDIT: [Enter date here.]        TERMINATE AUDIT: [Enter date here.]

   Option to audit                        Namespace to audit
   SR BLOOD PRODUCT VERIFICATION



   User to audit                          Device to audit




_______________________________________________________________________________

COMMAND:                                      Press <PF1>H for help    Insert
```

Example: Print Blood Product Verification Audit Log

```
Select Management Reports Option: BA  Print Blood Product Verification Audit Log

         Enter a date range to print the Blood Verification Audit Log.

* Previous selection: DATE/TIME from Feb 21,1999
START WITH DATE/TIME: FIRST// <Enter>
DEVICE: [Select Print Device]
```

----------*printout follows*----------

```
MENU OPTION AUDIT LOG    APR 2,1999         3:04 PM             PAGE 1
--------------------------------------------------------------------------------
         *** OPTION:  SR BLOOD PRODUCT VERIFICATION
    USER:  SURSURGEON,TWO
DATE/TIME (ENTRY):  MAR  5,1999  09:24     (EXIT):  MAR  5,1999  09:24
CPU:  VAA               DEVICE:  _LTA8720:        JOB:  541070010

         *** OPTION:  SR BLOOD PRODUCT VERIFICATION
    USER:  SURSURGEON,SIX
DATE/TIME (ENTRY):  MAR  5,1999  09:24     (EXIT):  MAR  5,1999  09:24
CPU:  VAA               DEVICE:  _LTA8720:        JOB:  541070010

         *** OPTION:  SR BLOOD PRODUCT VERIFICATION
    USER:  SURSURGEON,ONE
DATE/TIME (ENTRY):  MAR  6,1999  13:06     (EXIT):  MAR  6,1999  13:07
CPU:  VAA               DEVICE:  _LTA1411:        JOB:  541072157

         *** OPTION:  SR BLOOD PRODUCT VERIFICATION
    USER:  SURSURGEON,ONE
DATE/TIME (ENTRY):  MAR  6,1999  13:10     (EXIT):  MAR  6,1999  13:11
CPU:  VAA               DEVICE:  _LTA1411:        JOB:  541072157

         *** OPTION:  SR BLOOD PRODUCT VERIFICATION
    USER:  SURSURGEON,ONE
DATE/TIME (ENTRY):  MAR  6,1999  13:20     (EXIT):  MAR  6,1999  13:20
CPU:  VAA               DEVICE:  _LTA1411:        JOB:  541072157
```

Key Missing Surgical Package Data

[SROQ MISSING DATA]

The *Key Missing Surgical Package Data* option generates a list of surgical cases performed within the selected date range that are missing key information. This report includes surgical cases with an entry in the TIME PAT IN OR field and does not include aborted cases.

This report has a 132-column format and is designed to be copied to a printer.

Example: Key Missing Surgical Package Data

```
Select Management Reports Option: KEY  Key Missing Surgical Package Data

                  Report of Key Missing Surgical Package Data


For surgical cases with an entry in the TIME PAT IN OR field and that are not
aborted, this option generates a report of cases missing any of the following
pieces of information:

          In/Out-Patient Status
          Major/Minor
          Case Schedule Type
          Attending Code
          Time Pat Out OR
          Wound Classification
          ASA Class
          CPT Code (Principal)


Start with Date: Start with Date: 4 1  (APR 01, 2005)
End with Date: 4 30  (APR 30, 2005)

Do you want the report for all Surgical Specialties ? YES// <Enter>

This report is designed to use a 132 column format.

Print the report to which Printer ?  [Select Print Device]
```

----------*printout follows*----------

MAYBERRY, NC
Report of Key Missing Surgical Package Data PAGE 1
From: APR 1,2005 To: APR 30,2005
Report Printed: MAY 11,2005@15:09

DATE OF OPERATION CASE #	PATIENT NAME PATIENT ID (AGE)	SURGICAL SPECIALTY PRINCIPAL PROCEDURE	MISSING ITEMS
APR 6,2005@07:40 32474	SURPATIENT,ONE 000-44-7629 (46)	OPHTHALMOLOGY PHACHOEMULSIFICATION, LENS IMPLANT OD	D
APR 12,2005@12:00 32508	SURPATIENT,FORTYONE 000-43-2109 (78)	OPHTHALMOLOGY PHACOEMULSIFICATION, LENS IMPLANT OS	D
APR 12,2005@13:50 32534	SURPATIENT,ONE 000-44-7629 (46)	PLASTIC SURGERY (INCLUDES HEAD AND NECK) EXCISION OF RT. WRIST MASS	D
APR 12,2005@14:00 32544	SURPATIENT,THIRTY 000-82-9472 (48)	OPHTHALMOLOGY PHACOEMULSIFICATION OD	D
APR 13,2005@09:20 32513	SURPATIENT,FIFTYTWO 000-99-8888 (79)	OPHTHALMOLOGY PHACOEMULSIFICATION, LENS IMPLANT OD	D
APR 15,2005@13:05 32351	SURPATIENT,FIFTY 000-45-9999 (44)	GENERAL(OR WHEN NOT DEFINED BELOW) EXCISIONAL BIOPSY MASS RT. BREAST	D
APR 19,2005@13:00 32580	SURPATIENT,SEVENTEEN 000-45-5119 (71)	OPHTHALMOLOGY PHACOEMULSIFICATION LENS IMPLANT OD	D
APR 27,2005@13:15 32684	SURPATIENT,SIXTY 000-56-7821 (40)	OPHTHALMOLOGY TRABECULECTOMY OD	F

TOTAL CASES MISSING DATA: 8

MISSING ITEMS CODES: A-IN/OUT-PATIENT STATUS, B-MAJOR/MINOR, C-CASE SCHEDULE TYPE, D-ATTENDING CODE,
E-TIME PAT OUT OR, F-WOUND CLASSIFICATION, G-ASA CLASS, H-CPT CODE (PRINCIPAL)

Admitted w/in 14 days of Out Surgery If Postop Occ

[SROQADM]

The *Admitted w/in 14 days of Out Surgery If Postop Occ* option displays a list of patients with completed outpatient surgical cases that resulted in at least one postoperative occurrence and a hospital admission within 14 days of the surgery.

This report has a 132-column format and is designed to be copied to a printer with wide paper.

Example: Report of Admitted w/in 14 days of Out Surgery If Postop Occ

```
Select Management Reports Option: OC  Admitted w/in 14 days of Out Surgery If Po
stop Occ
                  Outpatient Cases with Postop Occurrences
                        and Admissions Within 14 Days


This report displays the completed outpatient surgical cases which resulted in
at least one postoperative occurrence and a hospital admission within 14 days.


Start with Date: 9 1 04  (SEP 01, 2004)
End with Date: 12 31 04 (DEC 31, 2004)

Do you want the report for all Surgical Specialties ? YES// <Enter>

This report is designed to use a 132 column format.

Print the report to which Printer ? [Select Print Device]
```

----------*printout follows*----------

MAYBERRY, NC
OUTPATIENT CASES WITH POSTOP OCCURRENCES AND ADMISSIONS WITHIN 14 DAYS PAGE 1
From: SEP 1,2004 To: DEC 31,2004
Report Printed: FEB 12,2005@13:44

DATE OF OPERATION CASE # *OCCURRENCE - (DATE)	PATIENT NAME PATIENT ID (AGE)	SURGICAL SPECIALTY PROCEDURE(S) PERFORMED	ANESTHESIA TECHNIQUE	DATE OF ADMISSION
SEP 24,2004@12:30 30395 *OTHER OCCURRENCE - (10/03/04)	SURPATIENT,FORTY 000-77-7777 (72)	THORACIC SURGERY (INC. CARDIAC MEDIASTINOSCOPY WITH NODE BIOPSY	GENERAL	OCT 3,2004@14:11
SEP 25,2004@14:30 30544 *OTHER OCCURRENCE - (09/28/04)	SURPATIENT,EIGHTEEN 000-22-3334 (71)	GENERAL(OR WHEN NOT DEFINED BE LEFT INGUINAL HERNIORRAPHY HYDROCELECTOMY	GENERAL	SEP 28, 2004@10:06
NOV 18,2004@09:45 31034 *SUPERFICIAL WOUND INFECTION - (11/28/04)	SURPATIENT,FIFTEEN 000-98-1234 (55)	PLASTIC SURGERY (INCLUDES HEAD GANGLION CYST LT. WRIST INCLUSION OF CYST INDEX FINGER LT. EXCISION OF LIPOMA OF LT. FOOT APPLICATION SHORT ARM SPLINT	GENERAL	NOV 28, 2004@12:51
DEC 9,2004@13:35 31242 *SUPERFICIAL WOUND INFECTION - (12/29/04)	SURPATIENT,EIGHT 000-37-0555 (64)	ORTHOPEDICS ORIF RT ULNA REPAIR RT. DISTALRADIOULNAR FX (	GENERAL	DEC 9, 2004@17:55
DEC 31,2004@07:30 31277 *OTHER CNS OCCURRENCE - (01/05/03)	SURPATIENT,FIFTYONE 000-23-3221 (31)	OTORHINOLARYNGOLOGY (ENT) NASAL SINUS SURGERY WITH BIL SPENOETHMOID POLYPECTOMY (CPT Code: 31205) BILATERAL ANTROSTOMY BILATERAL TURBINECTOMY	GENERAL	DEC 31, 2004@18:02

TOTAL CASES: 5

Deaths Within 30 Days of Surgery [SROQD]

The *Deaths Within 30 Days of Surgery* option lists patients who had surgery within the selected date range, died within 30 days of surgery. Two separate reports are available through this option.

1. **Total Cases Summary**: This report may be printed in one of three ways.

   A. All Cases

   The report will list all patients who had surgery within the selected date range and who died within 30 days of surgery, along with all of the patients' operations that were performed during the selected date range.

   B. Outpatient Cases Only

   The report will list only the surgical cases that are associated with deaths that are counted as outpatient (ambulatory) deaths.

   C. Inpatient Cases Only

   The report will list only the surgical cases that are associated with deaths that are counted as inpatient deaths.

2. **Specialty Procedures**: This report will list the surgical cases that are associated with deaths that are counted for the national surgical specialty linked to the local surgical specialty. Cases are listed by national surgical specialty.

These reports have a 132-column format and are designed to be copied to a printer.

Example 1: Deaths Within 30 Days of Surgery - Total Cases Summary

```
Select Management Reports Option: DS  Deaths Within 30 Days of Surgery

                         Deaths Within 30 Days of Surgery

This report lists patients who had surgery within the selected date range
and who died within 30 days of surgery.


Start with Date: 4/1  (APR 01, 2005)
End with Date: 4/30  (APR 30, 2005)

Print which report?

 1. Total Cases Summary
 2. National Specialty Procedures

Select number: 1// 1  Total Cases Summary

Print Deaths within 30 Days of Surgery for

  A - All cases
  O - Outpatient cases only
  I - Inpatient cases only

Select Letter (I, O or A): A// All Cases

This report is designed to use a 132 column format.

Print the report to which Printer ?  [Select Print Device]
```

----------*printout follows*----------

MAYBERRY, NC

DEATHS WITHIN 30 DAYS OF SURGERY PAGE 1
FOR SURGERY PERFORMED FROM: APR 1,2005 TO: APR 30,2005
Report Printed: MAY 18,2005@12:09

OP DATE	CASE #	IN/OUT	SURGICAL SPECIALTY	PROCEDURE(S)	DEATH RELATED
>>> SURPATIENT,FORTY (000-77-7777) - DIED 05/12/05 AGE: 70					
04/13/05	32571	INPAT	GENERAL(OR WHEN NOT DEFINED BELOW)	EXPLORATORY LAPAROTOMY RIGHT HEMICOLECTOMY ILEOSTOMY MUCOUS FISTULA OF COLON	UNRELATED
04/24/05	32693	INPAT	GENERAL(OR WHEN NOT DEFINED BELOW)	CLOSURE OF ABDOMINAL WALL FASCIA	UNRELATED
>>> SURPATIENT,TEN (000-12-3456) - DIED 05/12/05 AGE: 68					
04/26/05	32702	INPAT	THORACIC SURGERY (INC. CARDIAC SURG	RIGHT THORACOTOMY WITH LUNG BIOPSY DIAPHRAGM BIOPSY	UNRELATED
>>> SURPATIENT,SIXTY (000-56-7821) - DIED 04/30/05 AGE: 40					
04/21/05	32567	INPAT	THORACIC SURGERY (INC. CARDIAC SURG	ESOPHAGECTOMY ESOPHAGOSCOPY BRONCHOSCOPY FEEDING TUBE JEJUNOSTOMY	RELATED

TOTAL DEATHS: 3

Example 2: Deaths Within 30 Days of Surgery - Specialty Procedures

```
Select Management Reports Option: DS  Deaths Within 30 Days of Surgery
                        Deaths Within 30 Days of Surgery

This report lists patients who had surgery within the selected date range
and who died within 30 days of surgery.


Start with Date: 4/1  (APR 01, 2005)
End with Date: 4/30  (APR 30, 2005)

Print which report?

 1. Total Cases Summary
 2. National Specialty Procedures

Select number: 1// 2  Specialty Procedures

Do you want the report for all National Surgical Specialties ? YES// <Enter>

This report is designed to use a 132 column format.

Print the report to which Printer ? [Select Print Device]
```

----------*printout follows*----------

MAYBERRY, NC
DEATHS WITHIN 30 DAYS OF SURGERY LISTED FOR SPECIALTY PROCEDURES PAGE 1
FOR SURGERY PERFORMED FROM: APR 1,2005 TO: APR 30,2005
Report Printed: MAY 18,2005@12:38

OP DATE / CASE #	PATIENT NAME / PATIENT ID# (AGE)	DATE OF DEATH / PROCEDURE(S)	LOCAL SPECIALTY	IN/OUT	DEATH RELATED
>>> GENERAL SURGERY <<<					
04/24/05 32693	SURPATIENT,FORTY 000-77-7777 (70)	05/12/05 CLOSURE OF ABDOMINAL WALL FASCIA	GENERAL(OR WHEN NOT DEFINED BELOW)	INPAT	UNRELATED
TOTAL DEATHS FOR GENERAL SURGERY: 1					
>>> THORACIC SURGERY <<<					
04/26/05 32702	SURPATIENT,TEN 000-12-3456 (68)	05/12/05 RIGHT THORACOTOMY WITH LUNG BIOPSY DIAPHRAGM BIOPSY	THORACIC SURGERY (INC. CARDIAC SURG.)	INPAT	UNRELATED
04/21/05 32567	SURPATIENT,SIXTY 000-56-7821 (40)	04/30/05 ESOPHAGECTOMY ESOPHAGOSCOPY BRONCHOSCOPY FEEDING TUBE JEJUNOSTOMY	THORACIC SURGERY (INC. CARDIAC SURG.)	INPAT	RELATED
TOTAL DEATHS FOR THORACIC SURGERY: 2					
TOTAL FOR ALL SPECIALTIES: 3					

Pages 397c and 397d have been deleted.

(This page included for two-sided copying.)

Unlock a Case for Editing
[SRO-UNLOCK]

The Chief of Surgery, or a designee, uses the *Unlock a Case for Editing* option to unlock a case so that it can be edited. A case that has been completed will automatically lock within a specified time after the date of operation. When a case is locked, the data cannot be edited.

With this option, the selected case will be unlocked so that the user can use another option (such as in the *Operation Menu* option or *Anesthesia Menu* option) to make changes. The case will automatically re-lock in the evening. The package coordinator has the ability to set the automatic lock times.

Although the case may be unlocked to allow editing, any field that is included in an electronically signed report, for example in the Nurse Intraoperative Report, will require the creation of an addendum to the report before the edit can be completed.

Example: Unlock a Case for Editing

```
Select Chief of Surgery Menu Option:  Unlock a Case for Editing

Select PATIENT NAME:  SURPATIENT,THREE  08-15-91  000212453

       1. 05-15-91    CAROTID ARTERY ENDARTERECTOMY
       2. 05-15-91    AORTO CORONARY BYPASS GRAFT

Select Number:  1

Press <Enter> to continue. <Enter>

Case #115 is now unlocked

Select Chief of Surgery Menu Option:
```

Update Status of Returns Within 30 Days
[SRO UPDATE RETURNS]

The *Update Status of Returns Within 30 Days* option is used to update the status of Returns to Surgery within 30 days of a surgical case.

Example: Update Status of Returns

```
Select Chief of Surgery Menu Option: RET  Update Status of Returns Within 30 Days

Select Patient: SURPATIENT,FIFTY         10-28-45     000459999

 SURPATIENT,FIFTY   000-45-9999

1. 07-13-92   SPLENECTOMY (NOT COMPLETE)

2. 06-30-92   CHOLECYSTECTOMY (COMPLETED)

3. 03-10-92   HEMORRHOIDECTOMY (COMPLETED)



Select Operation: 2

SURPATIENT,FIFTY (000-45-9999)        Case #213               RETURNS TO SURGERY
JUN 30,1992   CHOLECYSTECTOMY (CPT MISSING)
------------------------------------------------------------------------------

1. 07/13/92    SPLENECTOMY (CPT MISSING) - RELATED


This return to surgery is currently defined as RELATED to the case selected.
Do you want to change this status ? NO// Y

Press RETURN to continue
```

Update Cancelled Cases
[SRO UPDATE CANCELLED CASE]

This option is locked with the SROCHIEF key and will not appear on the menu if the user does not have this key.

Normally, a cancelled case cannot be accessed for editing. However, the restricted *Update Cancelled Cases* option allows the Chief of Surgery to edit a cancelled case.

When the user enters this option, the software will allow access to the *Operations Menu* option.

Example: Update a Cancelled Case

```
Select Chief of Surgery Menu Option: CAN  Update Cancelled Case

Update Cancelled Case


Select Patient: SURPATIENT,FOURTEEN         08-16-51     000457212

 SURPATIENT,FOURTEEN   000-45-7212

1. 09-16-99   CHOLECYSTECTOMY (CANCELLED)

2. 09-15-99   CHOLECYSTECTOMY (CANCELLED)


Select Operation: 2

SURPATIENT,FOURTEEN (000-45-7212)   Case #15644 - SEP 15,1992


   I      Operation Information
   SS     Surgical Staff
   OS     Operation Startup
   O      Operation
   PO     Post Operation
   PAC    Enter PAC(U) Information
   OSS    Operation (Short Screen)
   V      Surgeon's Verification of Diagnosis & Procedures
   A      Anesthesia for an Operation Menu ...
   OR     Operation Report
   AR     Anesthesia Report
   NR     Nurse Intraoperative Report
   TR     Tissue Examination Report
   R      Enter Referring Physician Information
   RP     Enter Irrigations and Restraints

Select Update Cancelled Case Option:
```

Update Operations as Unrelated/Related to Death
[SRO DEATH RELATED]

The *Update Operations as Unrelated/Related to Death* option is used to update the status of operations performed within 90 days prior to death. The status is either UNRELATED or RELATED TO DEATH. With this option the user can add comments to further document the review of death.

Example: Updating an Operation as Related to Death

```
Select Surgery Risk Assessment Menu Option: D  Update Operations as Unrelated/Related to Death

               Update Operations as Unrelated or Related to Death

Select Patient: SURPATIENT,THIRTY       01-12-32     000829472     NO     NON-VETERAN (OTHER)

               Update Operations as Unrelated or Related to Death

SURPATIENT,THIRTY   000-82-9472        * DIED 02/27/00 *

Operations in 90 Days Prior to Death:

1. 01/29/00    CABG, VEIN, SIX+ (33516) - UNRELATED
                >>> Died 29 days postop. <<<

2. 01/06/00    TOTAL LARYNGECTOMY (CPT MISSING) - UNRELATED
                >>> Died 52 days postop. <<<

3. 12/02/99    EVACUATION OF HEMATOMA LT.THIGH (27301) - UNRELATED
                >>> Died 87 days postop. <<<

Select Number of Operation to be Updated:  (1-3): 1

               Update Operations as Unrelated or Related to Death

SURPATIENT,THIRTY   000-82-9472        * DIED 02/27/00 *

1. 01/29/00    CABG, VEIN, SIX+ (33516) - UNRELATED
                >>> Died 29 days postop. <<<

Was the Death Unrelated or Related to the Surgery?: UNRELATED
         // R  RELATED
Review of Death Comments:
  No existing text
  Edit? NO// <Enter>

               Update Operations as Unrelated or Related to Death

SURPATIENT,THIRTY   000-82-9472        * DIED 02/27/00 *

Operations in 90 Days Prior to Death:

1. 01/29/00    CABG, VEIN, SIX+ (33516) - RELATED
                >>> Died 29 days postop. <<<

2. 01/06/00    TOTAL LARYNGECTOMY (CPT MISSING) - UNRELATED
                >>> Died 52 days postop. <<<

3. 12/02/99    EVACUATION OF HEMATOMA LT.THIGH (27301) - UNRELATED
                >>> Died 87 days postop. <<<

Select Number of Operation to be Updated:  (1-3): <Enter>

               Update Operations as Unrelated or Related to Death

Select Patient:
```

Update/Verify Procedure/Diagnosis Codes
[SRCODING EDIT]

The *Update/Verify Procedure/Diagnosis Codes* option is used to edit and/or verify the CPT and ICD codes for an operation or non-O.R. procedure.

```
Select Chief of Surgery Menu Option: CODE  Update/Verify Procedure/Diagnosis Codes

Select Patient: D8719  SURPATIENT,TWELVE        02-12-28     000418719
 YES     SC VETERAN
```

```
SURPATIENT,TWELVE (000-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
-------------------------------------------------------------------------------
1. Principal Procedure: TRACHEOSTOMY
2. Principal CPT Code:  NOT ENTERED

3. Other Procedures: ** INFORMATION ENTERED **

4. Postoperative Diagnosis: FOREIGN BODY IN TRACHEA
5. Principal Diagnosis Code: NOT ENTERED

6. Other Postop Diagnosis: ** INFORMATION ENTERED **
-------------------------------------------------------------------------------

Select Information to Edit: ?

Enter the number corresponding to the information you want to update. You may
enter 'ALL' to update all the information displayed on this screen, or a
range of numbers separated by a ':' to update more than one item.

Select Information to Edit: 2
```

```
SURPATIENT,TWELVE (000-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
-------------------------------------------------------------------------------

Principal Procedure Code (CPT): 31600       INCISION OF WINDPIPE
        TRACHEOSTOMY, PLANNED (SEPARATE PROCEDURE);
 Modifier: 59       DISTINCT PROCEDURAL SERVICE
 Modifier:  <Enter>

SURPATIENT,TWELVE (000-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
-------------------------------------------------------------------------------
1. Principal Procedure: TRACHEOSTOMY
2. Principal CPT Code:  31600  INCISION OF WINDPIPE
      TRACHEOSTOMY, PLANNED (SEPARATE PROCEDURE);
          Modifiers:  -59

3. Other Procedures: ** INFORMATION ENTERED **

4. Postoperative Diagnosis: FOREIGN BODY IN TRACHEA
5. Principal Diagnosis Code: NOT ENTERED

6. Other Postop Diagnosis: ** INFORMATION ENTERED **
-------------------------------------------------------------------------------

Select Information to Edit: 3
```

```
SURPATIENT,TWELVE (000-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
------------------------------------------------------------------------------
Other Procedures:

1. BRONCHOSCOPY
      CPT Code: NOT ENTERED
2. Enter NEW Other Procedure

Enter selection:  (1-2): 1

   BRONCHOSCOPY
      CPT Code: NOT ENTERED

OTHER PROCEDURE: BRONCHOSCOPY// <Enter>
OTHER PROCEDURE CPT CODE: 31622       DX BRONCHOSCOPE/WASH
        BRONCHOSCOPY; DIAGNOSTIC, (FLEXIBLE OR RIGID), WITH OR WITHOUT CELL
        WASHING
 Modifier: <Enter>

Press RETURN to continue  <Enter>
```

```
SURPATIENT,TWELVE (000-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
------------------------------------------------------------------------------
Other Procedures:

1. BRONCHOSCOPY
      CPT Code: 31622  DX BRONCHOSCOPE/WASH
2. Enter NEW Other Procedure

Enter selection:  (1-2): 2


Enter new OTHER PROCEDURE: ESOPHAGOSCOPY
OTHER PROCEDURE CPT CODE: 43200       ESOPHAGUS ENDOSCOPY
        ESOPHAGOSCOPY, RIGID OR FLEXIBLE;
        DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF SPECIMEN(S) BY BRUSHING OR
        WASHING (SEPARATE PROCEDURE)

 Modifier: <Enter>

Press RETURN to continue  <Enter>
```

```
SURPATIENT,TWELVE (000-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
------------------------------------------------------------------------------
Other Procedures:

1. BRONCHOSCOPY
      CPT Code: 31622  DX BRONCHOSCOPE/WASH
2. ESOPHAGOSCOPY
      CPT Code: 43200  ESOPHAGUS ENDOSCOPY
3. Enter NEW Other Procedure

Enter selection:  (1-3): <Enter>
```

```
SURPATIENT,TWELVE (000-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
------------------------------------------------------------------------------
1. Principal Procedure: TRACHEOSTOMY
2. Principal CPT Code:  31600  INCISION OF WINDPIPE
      TRACHEOSTOMY, PLANNED (SEPARATE PROCEDURE);
          Modifiers:  -59

3. Other Procedures: ** INFORMATION ENTERED **

4. Postoperative Diagnosis: FOREIGN BODY IN TRACHEA
5. Principal Diagnosis Code: NOT ENTERED

6. Other Postop Diagnosis: ** INFORMATION ENTERED **
------------------------------------------------------------------------------

Select Information to Edit: 5
```

```
SURPATIENT,TWELVE (000-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
------------------------------------------------------------------------------

Prin Pre-OP ICD Diagnosis Code: 934.0   934.0     FOREIGN BODY IN TRACHEA
         ...OK? Yes// <Enter>
```

```
SURPATIENT,TWELVE (000-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
------------------------------------------------------------------------------
1. Principal Procedure: TRACHEOSTOMY
2. Principal CPT Code:  31600  INCISION OF WINDPIPE
      TRACHEOSTOMY, PLANNED (SEPARATE PROCEDURE);
          Modifiers:  -59

3. Other Procedures: ** INFORMATION ENTERED **

4. Postoperative Diagnosis: FOREIGN BODY IN TRACHEA
5. Principal Diagnosis Code: 934.0  FOREIGN BODY IN TRACHEA

6. Other Postop Diagnosis: ** INFORMATION ENTERED **
------------------------------------------------------------------------------

Select Information to Edit: 6
```

```
SURPATIENT,TWELVE (000-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
------------------------------------------------------------------------------
Other Postop Diagnosis:

1. Enter NEW Other Postop Diagnosis

Enter selection:  (1-1): 1
```

```
 SURPATIENT,TWELVE (000-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
------------------------------------------------------------------------------
Other Postop Diagnosis:

1. Enter NEW Other Postop Diagnosis

Enter selection:  (1-1): 1


Enter new OTHER POSTOP DIAGNOSIS: LARYNGEAL/TRACHEAL BURN
ICD DIAGNOSIS CODE: 947.1  947.1     BURN LARYNX/TRACHEA/LUNG
         ...OK? Yes// <Enter>
```

The ICD Code field below indicates ICD-9 or ICD-10 codes.

Example: ICD-9 Code

```
SRPATIENTA,ONE  (000-12-3456)        Case #35706
MAR 01, 2012   RIGHT ARM PAIN
------------------------------------------------------------------------------
Other Postop Diagnosis:

1. ICD9 Code: 003.1  SALMONELLA SEPTICEMIA

2. Enter NEW Other Postop Diagnosis Code

Enter selection:  (1-2):
```

```
SURPATIENT,TWELVE (000-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
------------------------------------------------------------------------------
1. Principal Procedure: TRACHEOSTOMY
2. Principal CPT Code:  31600  INCISION OF WINDPIPE
      TRACHEOSTOMY, PLANNED (SEPARATE PROCEDURE);
          Modifiers:  -59

3. Other Procedures: ** INFORMATION ENTERED **

4. Postoperative Diagnosis: FOREIGN BODY IN TRACHEA
5. Principal Diagnosis Code: 934.0  FOREIGN BODY IN TRACHEA

6. Other Postop Diagnosis: ** INFORMATION ENTERED **
------------------------------------------------------------------------------

Select Information to Edit:
```

Example: ICD-10 Code

```
SRPATIENTA,ONE  (000-12-3456)        Case #45670
MAY 01, 2014   REPAIR OF KIDNEY
------------------------------------------------------------------------------
Other Postop Diagnosis:

1. ICD10 Code: W32.0XXS  Accidental handgun discharge, sequela

2. Enter NEW Other Postop Diagnosis Code

Enter selection:  (1-2):
```

(This page included for two-sided copying.)

Chapter Five: Managing the Software Package

Introduction

This chapter describes options designed for the exclusive use of the Surgery package coordinator. The package coordinator can configure certain Surgery package fields to conform to a facility's needs.

Exiting an Option or the System

The user should enter an up-arrow (^) to stop what he or she is doing. The up-arrow can be used at almost any prompt to terminate the line of questioning and return to the previous level in the routine. The user would continue entering up-arrows to completely exit the system.

Option Overview

The main option included in this menu is listed below. To the left of the option name is the shortcut synonym that the user can enter to select the option. This is a restricted option and only users with the SRCOORD security key have access.

Shortcut	Option Name
M	*Surgery Package Management Menu*

(This page included for two-sided copying.)

Surgery Package Management Menu
[SRO PACKAGE MANAGEMENT]

The *Surgery Package Management Menu* provides access to options that are used to manage the Surgery software. Each option is discussed in the rest of this chapter.

The options included in this menu are listed below. To the left of the option name is the shortcut synonym that the user can enter to select the option.

Shortcut	Option Name
S	*Surgery Site Parameters (Enter/Edit)*
OR	*Operating Room Information (Enter/Edit)*
SU	*Surgery Utilization Menu ...*
KEY	*Person Field Restrictions Menu ...*
SD	*Update O.R. Schedule Devices*
U	*Update Staff Surgeon Information*
D	*Flag Drugs for Use as Anesthesia Agents*
F	*Update Site Configurable Files*
SI	*Surgery Interface Management Menu ...*
V	*Make Reports Viewable in CPRS*

Surgery Site Parameters (Enter/Edit) [SROPARAM]

Surgical Service managers use this option to create or update local site parameters for the Surgery package.

A question mark or two can be entered to access the help text at any prompt.

Example: Enter Surgery Site Parameters

```
Select Surgery Package Management Menu Option: S  Surgery Site Parameters (Enter/Edit)

Edit Parameters for which Surgery Site:  MAYBERRY, NC

 MAYBERRY, NC  (999)                            PAGE 1 OF 2

1    MAIL CODE FOR ANESTHESIA: 112G
2    CANCEL IVS:           CANCEL
3    DEFAULT BLOOD COMPONENT: CPDA-1 RED BLOOD CELLS
4    CHIEF'S NAME:         DR. THREE SURSURGEON
5    LOCK AFTER HOW MANY DAYS:
6    REQUEST DEADLINE:     15:00
7    SCHEDULE CLOSE TIME:  14:00
8    NURSE INTRAOP REPORT: PRINT TITLES WITH INFO ONLY
9    CARDIAC ASSESSMENT IN USE (Y/N): YES
10   ASK FOR RISK PREOP INFO: NO
11   PCE UPDATE ACTIVATION DATE: OCT 01, 1999
12   SURGICAL RESIDENTS (Y/N): NO

Enter Screen Server Function:  5
Lock Completed Cases after How Many Days ?: 14

 MAYBERRY, NC  (999)                            PAGE 1 OF 2

1    MAIL CODE FOR ANESTHESIA: 112G
2    CANCEL IVS:           CANCEL
3    DEFAULT BLOOD COMPONENT: CPDA-1 RED BLOOD CELLS
4    CHIEF'S NAME:         DR. THREE SURSURGEON
5    LOCK AFTER HOW MANY DAYS: 14
6    REQUEST DEADLINE:     15:00
7    SCHEDULE CLOSE TIME:  14:00
8    NURSE INTRAOP REPORT: PRINT TITLES WITH INFO ONLY
9    CARDIAC ASSESSMENT IN USE (Y/N): YES
10   ASK FOR RISK PREOP INFO: NO
11   PCE UPDATE ACTIVATION DATE: OCT 01, 1999
12   SURGICAL RESIDENTS (Y/N): NO

Enter Screen Server Function:  <Enter>
```

```
 MAYBERRY, NC  (999)                          PAGE 2 OF 2

1    REQUIRED FIELDS FOR SCHEDULING: (MULTIPLE)(DATA)
2    REQUEST CUTOFF FOR SUNDAY: SATURDAY
3    REQUEST CUTOFF FOR MONDAY: FRIDAY
4    REQUEST CUTOFF FOR TUESDAY: MONDAY
5    REQUEST CUTOFF FOR WEDNESDAY: TUESDAY
6    REQUEST CUTOFF FOR THURSDAY: WEDNESDAY
7    REQUEST CUTOFF FOR FRIDAY: THURSDAY
8    REQUEST CUTOFF FOR SATURDAY: FRIDAY
9    HOLIDAY SCHEDULING ALLOWED: (MULTIPLE)(DATA)
10   INACTIVE?:
11   AUTOMATED CASE CART ORDERING: YES
12   ANESTHESIA REPORT IN USE: YES
13   DEFAULT CLINIC FOR DOCUMENTS:

Enter Screen Server Function:  1
```

```
 MAYBERRY, NC  (999)                          PAGE 1 OF 1
         REQUIRED FIELDS FOR SCHEDULING

1    NEW ENTRY

Enter Screen Server Function:  1
Select REQUIRED FIELDS FOR SCHEDULING: 27  PRINCIPAL PROCEDURE CODE
   ARE YOU ADDING 'PRINCIPAL PROCEDURE CODE' AS
       A NEW REQUIRED FIELDS FOR SCHEDULING (THE 1ST FOR THIS SURGERY SITE PARAMETERS)? Y  (YES)
    REQUIRED FIELDS FOR SCHEDULING: PRINCIPAL PROCEDURE CODE
         // <Enter>
```

```
 MAYBERRY, NC  (999)                          PAGE 1 OF 1
         REQUIRED FIELDS FOR SCHEDULING  (PRINCIPAL PROCEDURE CODE)

1    REQUIRED FIELDS FOR SCHEDULING: PRINCIPAL PROCEDURE CODE
2    COMMENTS:              (WORD PROCESSING)

Enter Screen Server Function:  2
Comments:
  1>This field is required for SPD.
  2><Enter>
EDIT Option: <Enter>
```

```
 MAYBERRY, NC  (999)                          PAGE 1 OF 1
         REQUIRED FIELDS FOR SCHEDULING  (PRINCIPAL PROCEDURE CODE)

1    REQUIRED FIELDS FOR SCHEDULING: PRINCIPAL PROCEDURE CODE
2    COMMENTS:              (WORD PROCESSING)(DATA)

Enter Screen Server Function:  <Enter>
```

```
 MAYBERRY, NC  (999)                          PAGE 1 OF 1
         REQUIRED FIELDS FOR SCHEDULING

1    REQUIRED FIELDS FOR SCHEDULING: PRINCIPAL PROCEDURE CODE
2    NEW ENTRY

Enter Screen Server Function:  <Enter>
```

```
 MAYBERRY, NC  (999)                          PAGE 2 OF 2

1    REQUIRED FIELDS FOR SCHEDULING: (MULTIPLE)(DATA)
2    REQUEST CUTOFF FOR SUNDAY: SATURDAY
3    REQUEST CUTOFF FOR MONDAY: FRIDAY
4    REQUEST CUTOFF FOR TUESDAY: MONDAY
5    REQUEST CUTOFF FOR WEDNESDAY: TUESDAY
6    REQUEST CUTOFF FOR THURSDAY: WEDNESDAY
7    REQUEST CUTOFF FOR FRIDAY: THURSDAY
8    REQUEST CUTOFF FOR SATURDAY: FRIDAY
9    HOLIDAY SCHEDULING ALLOWED: (MULTIPLE)(DATA)
10   INACTIVE?:
11   AUTOMATED CASE CART ORDERING: YES
12   ANESTHESIA REPORT IN USE: YES
13   DEFAULT CLINIC FOR DOCUMENTS:

Enter Screen Server Function:
```

Operating Room Information (Enter/Edit)
[SRO-ROOM]

The *Operating Room Information (Enter/Edit)* option is used to enter or edit information pertinent to a selected operating room, including start and end times, and cleaning time.

At the TYPE field, the user can enter two question marks **(??)** to get a list of operating room types from which to select. If an operating room is not in service, the user can enter "YES" at the INACTIVE field to make the operating room inactive and prevent its use by other people using the Surgery software.

Example: Entering Operating Room Information

```
Select Surgery Package Management Menu Option: OR  Operating Room Information (Enter/Edit)

Enter/Edit Information for which Operating Room ?  OR1

OR1   ** Update O.R. **                        PAGE 1 OF 1

1    LOCATION:              1 WEST
2    PERSON RESP.:          SURSURGEON,ONE
3    TELEPHONE:             534-1231
4    TYPE:                  GENERAL PURPOSE OPERATING ROOM
5    CLEANING TIME:         15
6    REMARKS:
7    INACTIVE?:

Enter Screen Server Function:  2
Person Responsible for this Operating Room: SURSURGEON,ONE// SURSURGEON,THIRTY

OR1   ** Update O.R. **                        PAGE 1 OF 1

1    LOCATION:              1 WEST
2    PERSON RESP.:          SURSURGEON,THIRTY
3    TELEPHONE:             555-555-1234
4    TYPE:                  GENERAL PURPOSE OPERATING ROOM
5    CLEANING TIME:         15
6    REMARKS:
7    INACTIVE?:

Enter Screen Server Function:
```

Surgery Utilization Menu
[SR OR UTIL]

The *Surgery Utilization Menu* contains options designed to help determine operating room use. With this menu, Surgery Service managers can schedule the normal operating hours for an operating room, as well as the actual hours an operating room was in use. Operating rooms can also be inactivated. A report can be generated to see what percentage of available hours an operating room was in use and to see if an O.R. was used outside normal hours.

Shortcut	Option Name
E	*Operating Room Utilization (Enter/Edit)*
N	*Normal Daily Hours (Enter/Edit)*
R	*Operating Room Utilization Report*
H	*Report of Normal Operating Room Hours*
P	*Purge Utilization Information*

Operating Room Utilization (Enter/Edit)

[SR UTIL EDIT ROOM]

The *Operating Room Utilization (Enter/Edit)* option is used to update the actual start and end times for operating rooms on a selected date, one operating room at a time. This information is used when generating the operating room utilization reports.

The user first enters the date, then the name of the operating room. The software will default to the start and end times and allow the times to be edited. There is also a prompt for inactivating a room. If the user does not want to edit an entry, pressing the **<Enter>** key will display the next prompt.

When the user is finished entering or editing times for an operating room, he or she will be prompted for the name of the next operating room. If the user does not wish to edit times for any more operating rooms on this date, he or she should press the **<Enter>** key. The software will then prompt for a new date and the cycle begins again. When the user is finished editing times, he or she can press the **<Enter>** key or enter an up-arrow (^) to exit this option.

Example: Enter and Edit Operating Room Times

```
Select Surgery Utilization Menu Option: E  Operating Room Utilization (Enter/Edit)

Update Start and End Times for Operating Rooms

Update Times for which Date ?  T  (NOV 03, 2003)

Operating Room Utilization on NOV  3, 2003
------------------------------------------------------------------------------

Update Start and End Times for which Operating Room ?  OR1

Time this Operating Room Begins Functioning: 07:00
         // <Enter>
Time this Operating Room Stops Functioning: 17:00
         // 13:50  (NOV 03, 2003@13:50)
Has this Room been Inactivated on this Date ?  (Y/N): N  NO

Operating Room Utilization on NOV  3, 2003
------------------------------------------------------------------------------

Update Start and End Times for which Operating Room ?  OR2

Time this Operating Room Begins Functioning: 07:00
         // <Enter>
Time this Operating Room Stops Functioning: 17:00
         // 13:30  (NOV 03, 2003@13:30)
Has this Room been Inactivated on this Date ?  (Y/N): N  NO
```

```
 Operating Room Utilization on NOV  3, 2003
------------------------------------------------------------------------------

Update Start and End Times for which Operating Room ?  OR3

Time this Operating Room Begins Functioning: 07:00
         // <Enter>
Time this Operating Room Stops Functioning: 17:00
         // <Enter>
Has this Room been Inactivated on this Date ?  (Y/N): Y  YES
```

```
Operating Room Utilization on NOV  3, 2003
------------------------------------------------------------------------------

Update Start and End Times for which Operating Room ?  <Enter>
```

```
Update Start and End Times for Operating Rooms and Surgical Specialties

Update Times for which Date ?
```

Normal Daily Hours (Enter/Edit)

[SR NORMAL HOURS]

The *Normal Daily Hours (Enter/Edit)* option is used to schedule the normal start and end times of an operating room for each day of the week, one operating room at a time. The information is used to help determine operating room use on a weekly basis.

First, the user enters the name of the operating room. Beginning with Sunday, the software will provide an editing schedule for each day of the week and prompt for normal start and end times for each day. There is also a prompt for inactivating a room. When the schedules for the week have been completed, the user will be prompted for the name of the next operating room for which to enter times. When the use finishes editing times, he or she can press the **<Enter>** key or enter an up-arrow **(^)** to exit this option.

At the "Select information to edit:" prompt, the user can 1) enter the letter **A** to update all the information on the schedule, 2) enter a number to update information in the corresponding field, 3) enter a range of numbers separated by a colon (:), or 4) press the **<Enter>** key to move to the next day's schedule. To edit the schedule for a particular day, the user enters an up-arrow followed by a day of the week. For example, to edit Friday's schedule, **^Friday** would be entered. This is demonstrated in the following example.

The start and end times must be in military time. Also, use a leading zero when the hour is a single digit (e.g., 7 AM is 07:00).

Example: Enter Normal Start and End Times for an Operating Room

```
Select Surgery Utilization Menu Option: N  Normal Daily Hours (Enter/Edit)

================================================================================
               Normal Daily Schedules for Operating Rooms
================================================================================

Enter the name of the operating room: OR1

          Editing the SUNDAY Schedule for the OR1 Operating Room
================================================================================

1. Normal Start Time:   07:00
2. Normal End Time:     15:30
3. Inactive (Y/N):

================================================================================


Select information to edit: <Enter>
```

```
          Editing the MONDAY Schedule for the OR1 Operating Room
================================================================================

1. Normal Start Time:
2. Normal End Time:
3. Inactive (Y/N):

================================================================================


Select information to edit: 1:2


Normal Starting Time: 07:00
Normal Ending Time: 15:30
```

```
          Editing the MONDAY Schedule for the OR1 Operating Room
================================================================================

1. Normal Start Time:   07:00
2. Normal End Time:     15:30
3. Inactive (Y/N):

================================================================================


Select information to edit: ^FRIDAY
```

```
          Editing the FRIDAY Schedule for the OR1 Operating Room
================================================================================

1. Normal Start Time:
2. Normal End Time:
3. Inactive (Y/N):

================================================================================


Select information to edit: 1:2


Normal Starting Time: 07:00
Normal Ending Time: 15:30
```

```
          Editing the FRIDAY Schedule for the OR1 Operating Room
================================================================================

1. Normal Start Time:   07:00
2. Normal End Time:     15:30
3. Inactive (Y/N):

================================================================================


Select information to edit: ^
```

```
================================================================================
               Normal Daily Schedules for Operating Rooms
================================================================================

Enter the name of the operating room: ^
```

Operating Room Utilization Report

[SR OR UTL1]

The *Operating Room Utilization Report* option prints utilization information, within a selected date range, for all operating rooms or for a single operating room. The report displays the percent utilization, the number of cases, the total operation time and the time worked outside normal hours for each operating room individually and all operating rooms collectively.

How the Percent Utilization is Derived

The percent utilization is derived by dividing the total operation time for all operations (including total time patients were in O.R., plus the cleanup time allowed for each case) by the total functioning time as defined in the SURGERY UTILIZATION file. The quotient is then multiplied by 100.

This report has a 132-column format and is designed to be copied to a printer.

Example: Print the Operating Room Utilization Report

```
Select Management Reports Option: OR  Operating Room Utilization Report

Operating Room Utilization Report


Print utilization information starting with which date ?  3/8  (MAR 08, 2003)

Print utilization information through which date ?  3/9  (MAR 09, 2003)

Do you want to print the Operating Room Utilization Report for all
operating rooms ?  YES//  <Enter>
Print the Operating Room Utilization Report on which Device ? [Select Print Device]
```

----------*printout follows*----------

MAYBERRY, NC PAGE 1
SURGICAL SERVICE
OPERATING ROOM UTILIZATION REPORT
FOR ALL OPERATING ROOMS FROM: MAR 8,2003 TO: MAR 9, 2003
DATE PRINTED: MAR 17,2003

OPERATING ROOM	PERCENT UTILIZATION	NUMBER OF CASES	TOTAL OPERATION TIME (INCLUDING OR MAINTENANCE)	TIME WORKED OUTSIDE NORMAL HRS
OR1	70%	3	17 hrs and 35 mins	6 hrs and 20 mins
OR2	39%	1	7 hrs and 25 mins	1 hr and 10 mins
OR3	133%	8	23 hrs and 42 mins	2 hrs and 30 mins
OR4	29%	3	4 hrs and 41 mins	-
OR5	84%	7	18 hrs and 50 mins	5 hrs and 25 mins
OR6	0	0	-	-
OR7	0	0	-	-
TOTAL UTILIZATION FOR ALL ROOMS	63%	22	72 hrs and 13 mins	15 hrs and 25 mins

Report of Normal Operating Room Hours

[SR OR HOURS]

The *Report of Normal Operating Room Hours* option provides the start time and the end time of the normal working hours for all operating rooms or for the selected operating room for each date within the specified date range. The total time of the normal working day is displayed for each operating room for each date.

Example: Print Operating Room Normal Working Hours Report

```
Select Surgery Utilization Menu Option: H  Report of Normal Operating Room Hours

Operating Room Normal Working Hours Report


Print normal working hours starting with which date ?  3/1  (MAR 01, 1999)

Print normal working hours through which date ?  3/12  (MAR 12, 1999)

Do you want to print the Operating Room Normal Working Hours Report for all
operating rooms ?  YES//  <Enter>

Print the report on which Device: [Select Print Device]
```

----------*printout follows*----------

OPERATING ROOM NORMAL WORKING HOURS
FROM 03/01/99 TO 03/12/99

OPERATING ROOM	START TIME	END TIME	TOTAL TIME
	** MAR 1, 1999 **		
OR1	07:00	15:30	8 hrs and 30 mins
OR2	07:00	15:30	8 hrs and 30 mins
OR3		** INACTIVE **	
OR4		** INACTIVE **	
OR5	07:00	17:00	10 hrs
	** MAR 2, 1999 **		
OR1	07:00	15:30	8 hrs and 30 mins
OR2	07:00	15:30	8 hrs and 30 mins
OR3	07:00	15:30	8 hrs and 30 mins
OR4		** INACTIVE **	
OR5	07:00	17:00	10 hrs
	** MAR 3, 1999 **		
OR1	07:00	15:30	8 hrs and 30 mins
OR2	07:00	15:30	8 hrs and 30 mins
OR3	07:00	15:30	8 hrs and 30 mins
OR4	07:00	13:30	6 hrs and 30 mins
OR5	07:00	17:00	10 hrs
	** MAR 4, 1999 **		
OR1	07:00	15:30	8 hrs and 30 mins
OR2	07:00	15:30	8 hrs and 30 mins
OR3	07:00	15:30	8 hrs and 30 mins
OR4	07:00	13:30	6 hrs and 30 mins
OR5	07:00	17:00	10 hrs
	** MAR 5, 1999 **		
OR1	07:00	15:30	8 hrs and 30 mins
OR2	07:00	15:30	8 hrs and 30 mins
OR3	07:00	15:30	8 hrs and 30 mins
OR4	07:00	13:30	6 hrs and 30 mins
OR5	07:00	17:00	10 hrs
	** MAR 6, 1999 **		
OR1	07:00	15:30	8 hrs and 30 mins
OR2	07:00	15:30	8 hrs and 30 mins
OR3	07:00	15:30	8 hrs and 30 mins
OR4	07:00	13:30	6 hrs and 30 mins
OR5	07:00	17:00	10 hrs
	** MAR 7, 1999 **		
OR1	07:00	15:30	8 hrs and 30 mins
OR2	07:00	15:30	8 hrs and 30 mins

OPERATING ROOM NORMAL WORKING HOURS
FROM 03/01/99 TO 03/12/99

OPERATING ROOM	START TIME	END TIME	TOTAL TIME
	** MAR 7, 1999 **		
OR3	** INACTIVE **		
OR4	** INACTIVE **		
OR5	07:00	17:00	10 hrs
	** MAR 8, 1999 **		
OR1	07:00	15:30	8 hrs and 30 mins
OR2	07:00	15:30	8 hrs and 30 mins
OR3	** INACTIVE **		
OR4	** INACTIVE **		
OR5	07:00	17:00	10 hrs
	** MAR 9, 1999 **		
OR1	07:00	15:30	8 hrs and 30 mins
OR2	07:00	15:30	8 hrs and 30 mins
OR3	07:00	15:30	8 hrs and 30 mins
OR4	** INACTIVE **		
OR5	07:00	17:00	10 hrs
	** MAR 10, 1999 **		
OR1	07:00	15:30	8 hrs and 30 mins
OR2	07:00	15:30	8 hrs and 30 mins
OR3	07:00	15:30	8 hrs and 30 mins
OR4	07:00	13:30	6 hrs and 30 mins
OR5	07:00	17:00	10 hrs
	** MAR 11, 1999 **		
OR1	07:00	15:30	8 hrs and 30 mins
OR2	07:00	15:30	8 hrs and 30 mins
OR3	07:00	15:30	8 hrs and 30 mins
OR4	07:00	13:30	6 hrs and 30 mins
OR5	07:00	17:00	10 hrs
	** MAR 12, 1999 **		
OR1	07:00	15:30	8 hrs and 30 mins
OR2	07:00	15:30	8 hrs and 30 mins
OR3	07:00	15:30	8 hrs and 30 mins
OR4	07:00	13:30	6 hrs and 30 mins
OR5	07:00	17:00	10 hrs

Purge Utilization Information

[SR PURGE UTILIZATION]

The *Purge Utilization Information* option is used to purge utilization information for a selected date range. After selecting a starting date, the user can purge all utilization information for dates prior to, and including, that specified starting date.

Example: Purge Utilization Information

```
Select Surgery Utilization Menu Option: P  Purge Utilization Information

Purge Utilization Information


Starting with Date: 2/1  (FEB 28, 1999)

This option will purge all utilization information for the dates prior to (and
including) FEB 28, 1999.

Are you sure that you want to purge for this date range ?  NO// Y

The option to purge utilization data has been queued.

Press RETURN to continue
```

Person Field Restrictions Menu
[SROKEY MENU]

The *Person Field Restrictions Menu* contains options used by the package coordinator to maintain restrictions applied to person-type fields (meaning a field that points to the NEW PERSON field) in files.

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. None of these options will display if the user does not have proper security clearance.

Shortcut	Option Name
E	*Enter Restrictions for 'Person' Fields*
R	*Remove Restrictions on 'Person' Fields*

Enter Restrictions for 'Person' Fields

[SROKEY ENTER]

The *Enter Restrictions for 'Person' Fields* option allows IRM personnel to assign a key to a specific person-type field (meaning any field that points to the NEW PERSON field) in a file or sub-file.

A key limits the acceptable responses to a field. The Surgery software can be tailored to limit acceptable responses in the field to only those people assigned one of the keys used to restrict the field. For example, a prompt asking for the name of the attending surgeon can be modified to accept only the names of surgeons. Additionally, a field can have more than one key assigned to it; thus, the ATTENDING SURGEON field can be modified to accept the names of surgeons and other surgical staff.

Example 1 below shows how to enter the surgeon key for the SURGEON field in the SURGERY file. Example 2 shows how to enter the surgeon, nurse, and anesthetist keys for a sub-field in the SURGERY file.

Keys can be removed using the *Remove Restrictions on 'Person' Fields* option.

The user can enter one or two question marks to access the on-line help if assistance is needed while interacting with the software. A question mark can also be entered at the "Select Additional Key:" prompt for a list of keys from which to select.

Example 1: Enter Restrictions

```
Select Person Field Restrictions Menu Option: E  Enter Restrictions for 'Person' Fields

Add 'PERSON' Field Restrictions:

Select File: SURGERY
     1   SURGERY
     2   SURGERY CANCELLATION REASON
     3   SURGERY DISPOSITION
     4   SURGERY EXTRACT
     5   SURGERY INTERFACE PARAMETER
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 1  SURGERY
Select FIELD: SURGEON
     1   SURGEON
     2   SURGEON'S DICTATION      (word-processing)
CHOOSE 1-2: 1  SURGEON

There are no keys restricting entries in this field.

Do you want to add a key ?  YES// <Enter>

Select Additional Key: SR SURGEON
Select Additional Key: <Enter>

Entering Keys...
```

Example 2: Enter Restrictions

```
Select Person Field Restrictions Menu Option: E  Enter Restrictions for 'Person' Fields

Add 'PERSON' Field Restrictions:

Select File: SURGERY
     1   SURGERY
     2   SURGERY CANCELLATION REASON
     3   SURGERY DISPOSITION
     4   SURGERY EXTRACT
     5   SURGERY INTERFACE PARAMETER
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 1  SURGERY
Select FIELD: RESTR & POSITION AIDS      (multiple)
Select RESTR & POSITION AIDS SUB-FIELD: APPLIED BY

There are no keys restricting entries in this field.

Do you want to add a key ?  YES// <Enter>

Select Additional Key: SR NURSE
Select Additional Key: SR SURGEON
Select Additional Key: SR ANESTHETIST
Select Additional Key: <Enter>

Entering Keys...
```

Remove Restrictions on 'Person' Fields

[SROKEY REMOVE]

The *Remove Restrictions on 'Person' Fields* option allows IRM personnel to remove a key to a specific person-type field in a specific file. A key limits the acceptable responses to a field; removing a key removes a restriction on the acceptable responses.

In the example below, the key that permits the name of an anesthetist is removed from the RESTRAINTS & POSITION AIDS field, leaving the nurse and surgeon keys intact. All of the keys can be removed at one time by entering **ALL** at the "Select Number or 'ALL':" prompt.

Example: Remove Restrictions

```
Select Person Field Restrictions Menu Option: R  Remove Restrictions on 'Person' Fields

Remove 'PERSON' field restrictions:

Select File: SURGERY
     1   SURGERY
     2   SURGERY CANCELLATION REASON
     3   SURGERY DISPOSITION
     4   SURGERY EXTRACT
     5   SURGERY INTERFACE PARAMETER
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 1  SURGERY
Select FIELD: RESTR & POSITION AIDS      (multiple)
Select RESTR & POSITION AIDS SUB-FIELD: APPLIED BY

Current Restrictions for this Field:

  1. SR NURSE
  2. SR SURGEON
  3. SR ANESTHETIST

Do you want to remove one of these keys ?  YES// <Enter>

Select Number or "ALL": 3

Select Person Field Restrictions Option:
```

Update O.R. Schedule Devices
[SR UPDATE SCHEDULE DEVICE]

The *Update O.R. Schedule Devices* option is used to update the list of devices that will print the Schedule of Operations when printing to all pre-defined printers.

Example: Add a New Schedule Device

```
Select Surgery Package Management Menu Option: SD  Update O.R. Schedule Devices

Update O.R. Schedule Devices
----------------------------


Select OR SCHEDULE DEVICES: SPD PTR
   ARE YOU ADDING 'SPD PTR ' AS A NEW OR SCHEDULE DEVICES (THE 1ST FOR THIS SURGERY
SITE PARAMETERS)? Y  (YES)
Select OR SCHEDULE DEVICES:
```

Update Staff Surgeon Information
[SROSTAFF]

The *Update Staff Surgeon Information* option allows the designation of a user as a staff surgeon by assigning a security key called SR STAFF SURGEON. The Annual Report of Surgical Procedures will count cases performed by holders of this security key as having been performed by "staff." All other cases will be counted as performed by "resident."

Example 1: Designate a Staff Surgeon

```
Select Surgery Package Management Menu Option: U  Update Staff Surgeon Information

Update Information for which Surgeon: SURSURGEON,ONE

Do you want to designate this person as a 'Staff Surgeon' ? YES// <Enter>

SURSURGEON,ONE is now designated as a staff surgeon.

Press RETURN to continue
```

Example 2: Remove Staff Surgeon Designation

```
Select Surgery Package Management Menu Option: U  Update Staff Surgeon Information

Update Information for which Surgeon: SURSURGEON,ONE

This person is already designated as a staff surgeon. Do you want to remove
that designation ?  NO//  Y

Removing key designating SURSURGEON,ONE as a staff surgeon...

Press RETURN to continue
```

Flag Drugs for Use as Anesthesia Agents
[SROCODE]

Surgery Service managers use the *Flag Drugs for Use as Anesthesia Agents* option to mark drugs for use as anesthesia agents. If the drug is not flagged, the user will not be able to select it as an entry for the ANESTHESIA AGENT data field.

To flag a drug, it must already be listed in the Pharmacy DRUG file. To add a drug to this file, the user should contact the facility's Pharmacy Package Coordinator.

Example: Flag Drugs Used as Anesthesia Agents

```
Select Surgery Package Management Menu Option:  D  Flag Drugs for use as Anesthesia Agents

Enter the name of the drug you wish to flag:  HALOTHANE


Do you want to flag this drug for SURGERY (Y/N)? YES

Enter the name of the drug you wish to flag:
```

Update Site Configurable Files
[SR UPDATE FILES]

The *Update Site Configurable Files* option is designed for the package coordinator to add, edit, or inactivate file entries for the site-configurable files.

The software provides a numbered list of site-configurable files. The user should enter the number corresponding to the file that he or she wishes to update. The software will default to any previously entered information on the entry and provide a chance to edit it. The last prompt asks whether the user wants to inactivate the entry; answering **Yes** or **1** will inactivate the entry.

Example 1: Add a New Entry to a Site-Configurable File

```
Select Surgery Package Management Menu Option:  F  Update Site Configurable Files

============================================================================
                    Update Site Configurable Surgery Files
============================================================================
1.  Surgery Transportation Devices
2.  Prosthesis
3.  Surgery Positions
4.  Restraints and Positional Aids
5.  Surgical Delay
6.  Monitors
7.  Irrigations
8.  Surgery Replacement Fluids
9.  Skin Prep Agents
10. Skin Integrity
11. Patient Mood
12. Patient Consciousness
13. Local Surgical Specialty
14. Electroground Positions
15. Surgery Dispositions
============================================================================

Update Information for which File ?  2
```

```
Update Information in the Prosthesis file.
============================================================================


Select PROSTHESIS NAME: HUMERAL
   ARE YOU ADDING 'HUMERAL' AS A NEW PROSTHESIS (THE 112TH)?  Y (YES)
NAME: HUMERAL // HUMERAL COMPONENT
VENDOR: AMERICAN
MODEL: NEER II
STERILE RESP: MANUFACTURER
SIZE: STEM 150 MM, HEAD 22 MM
QUANTITY: <Enter>
LOT NUMBER: F19705-1087
SERIAL NUMBER: <Enter>
INACTIVE?: <Enter>


Select PROSTHESIS NAME:
```

Example 2: Re-Activate an Entry

```
Select Surgery Package Management Menu Option:  F  Update Site Configurable Files

================================================================================
                    Update Site Configurable Surgery Files
================================================================================
1.  Surgery Transportation Devices
2.  Prosthesis
3.  Surgery Positions
4.  Restraints and Positional Aids
5.  Surgical Delay
6.  Monitors
7.  Irrigations
8.  Surgery Replacement Fluids
9.  Skin Prep Agents
10. Skin Integrity
11. Patient Mood
12. Patient Consciousness
13. Local Surgical Specialty
14. Electroground Positions
15. Surgery Dispositions
================================================================================

Update Information for which File ?  6
```

```
Update Information in the Monitors file.
================================================================================


Select MONITORS NAME: ECG             ** INACTIVE **
NAME: ECG// <Enter>
INACTIVE?: YES// @
   SURE YOU WANT TO DELETE? Y  (YES)


Select MONITORS NAME:
```

Surgery Interface Management Menu
[SRHL INTERFACE]

The *Surgery Interface Management Menu* contains options that allow the user to set up certain interface parameters that control the processing of Health Level 7 (HL7) messages. The interface adheres to the HL7 protocol and forms the basis for the exchange of health care information between the VistA Surgery package and any ancillary system.

Currently, there are four options on the *Surgery Interface Management Menu*.

Shortcut	Option Name
I	*Flag Interface Fields*
F	*File Download*
T	*Table Download*
P	*Update Interface Parameter Field*

Flag Interface Fields

[SRHL INTERFACE FLDS]

The *Flag Interface Fields* option allows the package coordinator to set the INTERFACE field in the SURGERY INTERFACE file. The categories listed on the first screen correspond to entries in SURGERY INTERFACE file. These categories are listed in the Surgery HL7 Interface Specifications document as being the OBR (Observation Request) text identifiers. Each identifier corresponds to several fields in the VistA Surgery package. This allows the user to control the flow of data between the VistA Surgery package and the ancillary system on a field-by-field basis.

The option lists each identifier and its current setting. To receive the data coming from the ancillary system for a category, the flag the flag should be set to **R** for receive. To ignore the data, the flag should be set to **N** for not receive. To see a second underlying layer of OBX (Observation/Result) text identifiers (the SURGERY file fields) and their settings, the OBR (Observation Request) text identifier should be set to **R** for receive. The option will allow the user to toggle the settings for a range of items or for individual items.

Example: Flagging Operation Information to be Received

```
Select Surgery Interface Management Menu Option: I  Flag Interface Fields
```

```
                        Surgery Interface Setup Menu

To change the setting in one of the following categories, enter the
corresponding number.
 (R - Receive)
 (S - Send)
 (S/R - Send and Receive)
 (I - Ignore)


  1. OPERATION (S/R)
  2. TOURNIQUET (I)
  3. MONITOR (I)
  4. MEDICATION (R)
  5. ANESTHESIA (R)
  6. PROCEDURE (I)
  7. PROCEDURE OCCURRENCE (I)
  8. INTRAOPERATIVE OCCURRENCE (I)
  9. POSTOPERATIVE OCCURRENCE (I)
 10. NONOPERATIVE OCCURRENCE (I)

Enter a number: ?

The categories above refer to VistA Surgery data fields. Below are examples:
OPERATION -> File 130 fields.
TOURNIQUET -> TIME TOURNIQUET APPLIED (#.48) and File 130.02 fields.
MONITOR -> MONITORS (#.293) and File 130.41 fields.
MEDICATION -> MEDICATIONS (#.375) and File 130.33 fields.
ANESTHESIA -> ANESTHESIA TECHNIQUE (#.37) and File 130.06 fields.
Enter the corresponding number of the category you wish to edit. To edit
underlying fields, set the category to R for receive or S to send.

Enter a number: 1

Do you wish to change the current setting of OPERATION: IGNORE// RECEIVE



OPERATION DATA

Toggle the current setting to (R)eceive, (S)end, or (I)gnore.
```

```
 1. TIME OPERATION BEGAN (S)            17. OR SETUP TIME (I)
 2. TIME OPERATION ENDS (S)             18. ANESTHESIA TEMP (I)
 3. NURSE PRESENT TIME (I)              19. HR (I)
 4. TIME PATIENT IN HOLDING AREA (I)    20. RR (I)
 5. ANESTHESIA AVAILABLE TIME (I)       21. BP (I)
 6. TIME PATIENT IN OR (S)              22. ASA CLASS (I)
 7. SURGEON PRESENT TIME (I)            23. CASE SCHEDULE TYPE (I)
 8. ANESTHESIA CARE START TIME (I)      24. ATTENDING CODE (I)
 9. ANESTHESIA CARE END TIME (I)        25. REPLACEMENT FLUID (R)
10. TIME PATIENT OUT OR (I)             26. INDUCTION COMPLETE (I)
11. PRIN. ANES. (I)                     27. ANES. SUPERVISE CODE (I)
12. RELIEF ANESTHETIST (I)              28. SURGEON PGY (I)
13. ASSISTANT ANESTHETIST (I)           29. OR LOCATION (I)
14. ANES. SUPER. (I)                    30. PAC(U) ADMIT TIME (I)
15. BLOOD LOSS (I)                      31. PAC(U) DISCHARGE TIME (I)
16. TOTAL URINE OUTPUT (I)
Enter a number: ?

The items above refer to VistA Surgery package fields. Below are examples:
  HR -> End Pulse (#.84)
  BP -> End BP    (#.85)
  RR -> End Resp  (#.86)
To toggle the current setting of an item, enter its corresponding number.
```

File Download

[SRHL DOWNLOAD INTERFACE FILES]

The *File Download* option is used to download Surgery interface files to the Automated Anesthesia Information System (AAIS). The process is currently being done by a screen capture to a file. In the future, this will be changed to a background task that can be queued to send HL7 master file updates.

Example: Downloading Interface Files

```
Select Surgery Interface Management Menu Option: F File Download

              Surgery Interface File Download Option


1. CPT4
2. ICD
3. MEDICATION
4. MONITOR
5. PERSONNEL
6. REPLACEMENT FLUID
7. ANES SUPERVISE CODE
8. LOCATION

Enter file to Capture:  (1-8): 4
Update the MONITOR file? YES// <Enter>
Queuing message
```

Table Download

[SRHL DOWNLOAD SET OF CODES]

The *Table Download* option downloads the SURGERY file set of codes to the AAIS. This process is currently being done by a screen capture to a file. In the future, this will be changed to a background task that can be queued to send HL7 master file updates.

Example: Downloading Surgery Set of Codes

```
Select Surgery Interface Management Menu Option: T Table Download

                Surgery Interface Table Setup Menu

This option allows the users to populate table files on the Automated
Anesthesia Information System.


 1. CASE SCHEDULE TYPE                  10. TUBE TYPE
 2. ATTENDING CODE                      11. EXTUBATED IN
 3. SITE TOURNIQUET APPLIED             12. BARICITY
 4. MEDICATION ROUTE                    13. EPIDURAL METHOD
 5. PRINCIPAL ANES TECHNIQUE (Y/N)      14. ADMINISTRATION METHOD
 6. PATIENT STATUS                      15. PROCEDURE OCCURRENCE OUTCOME
 7. ANESTHESIA ROUTE                    16. INTRAOP OCCURRENCE OUTCOME
 8. ANESTHESIA APPROACH                 17. POSTOP OCCURRENCE OUTCOME
 9. LARYNGOSCOPE TYPE                   18. NONOP OCCURRENCE OUTCOME

Enter a list or range of numbers (1-18): 2
Update the ATTENDING CODE table? YES// <Enter>
MAD Sending HL7 Master File addition message.....
```

Update Interface Parameter Field

[SRHL DOWNLOAD SET OF CODES]

The *Update Interface Parameter Field* option may be used to edit the parameter that determines which Surgery HL7 interface will be used, the interface compatible with HL7 V. 1.6 or the older one compatible with HL7 V. 1.5.

If applications communicating with the Surgery HL7 interface must use the interface designed for use with HL7 V. 1.5, **YES** should be entered. Otherwise, **NO** should be entered or this field should be left blank.

Example: Updating Interface Parameter Field

```
Select Surgery Interface Management Menu Option: P  Update Interface Parameter Field

This option may be used to edit the parameter that determines which Surgery
HL7 interface will be used, the interface compatible with HL7 v1.6 or the
older one compatible with HL7 v1.5.

If applications communicating with the Surgery HL7 interface must use the
interface designed for HL7 v1.5, enter YES. Otherwise, enter NO or
or leave this field blank.

Use Surgery Interface Compatible with VistA HL7 v1.5 (Y/N): NO
```

Make Reports Viewable in CPRS
[SR VIEW HISTORICAL REPORTS]

This option allows Operation Reports, Nurse Intraoperative Reports, Anesthesia Reports, and Procedure Reports (Non-O.R.) for historical cases to be moved into TIU as “electronically unsigned” to make them viewable on the CPRS Surgery tab. This option lets the user move reports by division, if necessary.

```
Select Surgery Package Management Menu Option: V  Make Reports Viewable in CPRS

Make Reports Viewable in CPRS

     This option allows Operation Reports, Nurse Intraoperative Reports,
     Anesthesia Reports and Procedure Reports (Non-O.R.) for historical
     cases to be moved into TIU as "electronically unsigned" to make
     them viewable within the CPRS Surgery tab. Historical cases are
     cases performed before the Surgery Electronic Signature for
     Operative Reports feature was implemented.

     These "electronically unsigned" reports will contain a disclaimer
     stating: "This information is provided from historical files and
     cannot be verified that the author has authenticated/approved this
     information. The authenticated source document in the patient's
     medical record should be reviewed to ensure that all information
     concerning this event has been reviewed or noted."

     CAUTION!! This is a system intensive process that creates new
     documents in TIU. Please ensure adequate disk space availability
     before running this process.

Enter starting date for reports to be moved:  T-180  (MAR 19, 2003)

Move reports for all divisions? YES// NO

1. ALBANY
2. PHILADELPHIA, PA
3. SAN JUAN, PR

Select Number:  (1-3): 1

Do you want to move the Operation Reports (Y/N)? NO// YES

Do you want to move the Nurse Intraoperative Reports (Y/N)? NO// YES

Do you want to move the Anesthesia Reports (if used) (Y/N)? NO// YES

Do you want to move the Procedure Reports (Non-O.R.) (Y/N)? NO// YES

The following reports for cases performed MAR 19, 2003 to the present
for ALBANY will be moved.
   Operation Report
   Nurse Intraoperative Report
   Anesthesia Report
   Procedure Report (Non-O.R.)

Is this correct (Y/N)? NO// YES

Requested Start Time: NOW//  <Enter>  (SEP 15, 2003@13:13:21)

Queued as task #158943


Press RETURN to continue.
```

Chapter Six: Assessing Surgical Risk

Introduction

Unadjusted surgical mortality and morbidity rates can vary dramatically from hospital to hospital in the VA hospital system, as well as in the private sector. This can be the result of differences in patient mix, as well as differences in quality of care. Studies are being conducted to develop surgical risk assessment models for many of the major surgical procedures done in the VA system. It is hoped that these models will correct differences in patient mix between the hospitals so that remaining differences in adjusted mortality and morbidity might be an indicator of differences in quality of care. The objective of this module is to facilitate data entry and transmission to the national centers in Denver, Colorado, where the data is analyzed. The Veterans Affairs Surgery Quality Improvement Program (VASQIP) Executive Committee oversees the overall direction of the Surgery Risk Assessment program.

This Risk Assessment part of the Surgery software provides medical centers a mechanism to track information related to surgical risk and operative mortality. It gives surgeons an on-line method of evaluating and tracking patient probability of operative mortality. For example, a patient with a history of chronic illness may be more “at risk” than a patient with no prior illness.

Exiting an Option or the System

To get out of an option, the user should enter an up-arrow (^). The up-arrow can be entered at almost any prompt to terminate the line of questioning and return to the previous level in the routine. To completely exit the system, the user continues entering up-arrows.

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Surgery Risk Assessment Menu
[SROA RISK ASSESSMENT]

The *Surgery Risk Assessment Menu* option provides the designated Surgical Clinical Nurse Reviewer with on-line access to medical information. The menu options provide the opportunity to edit, list, print, and update an existing assessment for a patient or to enter information concerning a new risk assessment.

 This option is locked with the SR RISK ASSESSMENT key.

This chapter follows the main menu of the Risk Assessment module and contains descriptions of the options and sub-options needed to maintain a Risk Assessment, transmit data, and create reports. The options are organized to follow a logical workflow sequence. Each option description is divided into two main parts: an overview and a detailed example.

The top-level options included in this menu are listed in the following table. To the left is the shortcut synonym that the user can enter to select the option.

Shortcut	Option Name
N	*Non-Cardiac Assessment Information (Enter/Edit) ...*
C	*Cardiac Risk Assessment Information (Enter/Edit) ...*
P	*Print a Surgery Risk Assessment*
U	*Update Assessment Completed/Transmitted in Error*
L	*List of Surgery Risk Assessments*
F	*Print 30 Day Follow-up Letters*
R	*Exclusion Criteria (Enter/Edit)*
M	*Monthly Surgical Case Workload Report*
V	*M&M Verification Report*
O	*Update 1-Liner Case*
T	*Queue Assessment Transmissions*
CODE	*Alert Coder Regarding Coding Issues*
ERM	*Risk Model Lab Test (Enter/Edit)*

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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.

Editing an Incomplete Risk Assessment

To edit an incomplete risk assessment, the user can either select the assessment by patient or by surgery case number.

Example: Using the Select by Case Number Function to Edit an Incomplete Assessment

```
Select Surgery Risk Assessment Menu Option: N  Non-Cardiac Assessment Information (Enter/Edit)

Select Patient: #210

SURPATIENT,TEN  000-12-3456

03-22-02      HIP REPLACEMENT (INCOMPLETE)

1. Enter Risk Assessment Information
2. Delete Risk Assessment Entry
3. Update Assessment Status to 'COMPLETE'

Select Number:  1// <Enter>

Division: ALBANY  (500)

SURPATIENT,TEN  000-12-3456   Case #210 - MAR 22,2002


   PRE    Preoperative Information (Enter/Edit)
   LAB    Laboratory Test Results (Enter/Edit)
   O      Operation Information (Enter/Edit)
   D      Patient Demographics (Enter/Edit)
   IO     Intraoperative Occurrences (Enter/Edit)
   PO     Postoperative Occurrences (Enter/Edit)
   RET    Update Status of Returns Within 30 Days
   U      Update Assessment Status to 'COMPLETE'
   CODE   Alert Coder Regarding Coding Issues

Select Non-Cardiac Assessment Information (Enter/Edit) Option:
```

These options are described in the following sections.

Preoperative Information (Enter/Edit)
[SROA PREOP DATA]

The *Preoperative Information (Enter/Edit)* option is used to enter or edit preoperative assessment information. The software will present two pages. At the bottom of each page is a prompt to select one or more preoperative items to edit. If the user does not want to edit any items on the page, pressing the **<Enter>** key will advance to the next page or, if the user is already on page two, will exit the option.

About the "Select Preoperative Information to Edit:" Prompt

At this prompt the user enters the item number he or she wishes to edit. Entering **A** for **ALL** allows the user to respond to every item on the page, or a range of numbers separated by a colon (:) can be entered to respond to a range of items. Number-letter combinations can also be used, such as **2C**, to update a field within a group, such as CURRENT PNEUMONIA.

Each prompt at the category level allows for an entry of **YES** or **NO**. If **NO** is entered, each item under that category will automatically be answered **NO**. On the other hand, responding **YES** at the category level allows the user to respond individually to each item under the main category.

For instance, if number **2** is chosen, and the "PULMONARY:" prompt is answered **YES**, the user will be asked if the patient is ventilator dependent, has a history of COPD, and has pneumonia. If the "PULMONARY:" prompt is answered **NO**, the software will place a **NO** response in all the fields of the Pulmonary group. The majority of the prompts in this option are designed to accept the letters **Y**, **N**, or **NS** for **YES**, **NO**, and **NO STUDY**.

After the information has been entered or edited, the terminal display screen will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data.

This functionality allows the nurse reviewer to duplicate preoperative information from an earlier operation within 60 days of the date of operation on the same patient.

Example 1: Enter/Edit Preoperative Information

```
Select Non-Cardiac Assessment Information (Enter/Edit) Option: PRE  Preoperative Information
(Enter/Edit)

This patient had a previous non-cardiac operation on APR 28,1998@09:00

Case #63592  CHOLEDOCHOTOMY

Do you want to duplicate the preoperative information from the earlier assessment in this
assessment?  YES// NO
```

```
SURPATIENT,SIXTY (000-56-7821)        Case #63592                PAGE: 1 OF 2
JUN 23,1998   CHOLEDOCHOTOMY
-------------------------------------------------------------------------------
1. GENERAL:                              3. HEPATOBILIARY:
  A. Height:                               A. Ascites:
  B. Weight:
  C. Diabetes - Long Term:               4. GASTROINTESTINAL:
  D. Diabetes - 2 Wks Preop:               A. Esophageal Varices:
  E. Tobacco Use:
  F. Tobacco Use Timeframe: NOT APPLICABLE
  G. ETOH > 2 Drinks/Day:                5. CARDIAC:
  H. Positive Drug Screening:              A. CHF Within 1 Month:
  I. Dyspnea:                              B. MI Within 6 Months:
  J. Preop Sleep Apnea:                    C. Previous PCI:
  K. DNR Status:                           D. Previous Cardiac Surgery:
  L. 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: Chronic, Long-Term Management: I  INSULIN
Diabetes Mellitus: Management Prior to Surgery: I  INSULIN
Tobacco Use: 2  NO USE IN LAST 12 MOS
Tobacco Use Timeframe: NOT APPLICABLE// <enter>
ETOH >2 Drinks Per Day in the Two Weeks Prior to Admission: N  NO
Positive Drug Screening: N  NO
Dyspnea: N
     1   NO
     2   NO STUDY
Choose 1-2: 1  NO
Preoperative Sleep Apnea: NONE  NONE - LEVEL 1
DNR Status (Y/N): N  NO
Functional Health Status at Evaluation for Surgery: 1  INDEPENDENT

PULMONARY: NO

HEPATOBILIARY: NO
```

```
SURPATIENT,SIXTY (000-56-7821)        Case #63592                PAGE: 1 OF 2
JUN 23,1998   CHOLEDOCHOTOMY
-------------------------------------------------------------------------------
1. GENERAL:                      NO       3. HEPATOBILIARY:                  NO
  A. Height:                  62 INCHES     A. Ascites:                       NO
  B. Weight:                   175 LBS.
  C. Diabetes - Long Term:      INSULIN  4. GASTROINTESTINAL:
  D. Diabetes - 2 Wks Preop:    INSULIN    A. Esophageal Varices:
  E. Tobacco Use:  NO USE IN LAST 12 MOS
  F. Tobacco Use Timeframe: NOT APPLICABLE
  G. ETOH > 2 Drinks/Day:                5. CARDIAC:
  H. Positive Drug Screening:   NO         A. CHF Within 1 Month:
  I. Dyspnea:                   NO         B. MI Within 6 Months:
  J. Preop Sleep Apnea:        LEVEL 1     C. Previous PCI:
  K. DNR Status:                NO         D. Previous Cardiac Surgery:
  L. 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. CVD Repair/Obstruct:                H. Radiotherapy W/I 90 Days:
  E. History of CVD:                     I. Preoperative Sepsis:
  F. Tumor Involving CNS:                J. Pregnancy:          NOT APPLICABLE


-------------------------------------------------------------------------------

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. CVD Repair/Obstruct:                H. Radiotherapy W/I 90 Days:
  E. History of CVD:                     I. Preoperative Sepsis:
  F. Tumor Involving CNS:                J. Pregnancy:          NOT APPLICABLE
-------------------------------------------------------------------------------

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: 0  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 06, 2005@14:15
 6. Hospital Discharge Date/Time:       JUN 21, 2005@11:32
 7. Admit/Transfer to Surgical Svc.:    JUN 06, 2005@08:30
 8. Discharge/Transfer to Chronic Care: JUN 21, 2005@11:32
 9. Length of Postop Hospital Stay:     15 Days
10. In/Out-Patient Status:              INPATIENT
11. Patient's Ethnicity:                NOT HISPANIC OR LATINO
12. Patient's Race:                     AMERICAN INDIAN OR ALASKA NATIVE, ASIAN
13. Date of Death:                      NA
14. 30-Day Death:                       NO

-------------------------------------------------------------------------------
Select number of item to edit:
```

Intraoperative Occurrences (Enter/Edit)
[SRO INTRAOP COMP]

The nurse reviewer uses the *Intraoperative Occurrences (Enter/Edit)* option to enter or change information related to intraoperative occurrences (called complications in earlier versions). Every occurrence entered must have a corresponding occurrence category. For a list of occurrence categories, enter a question mark (**?**) at the "Enter a New Intraoperative Occurrence:" prompt.

After an occurrence category has been entered or edited, the screen will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data.

Example: Enter an Intraoperative Occurrence

```
Select Non-Cardiac Assessment Information (Enter/Edit) Option: IO  Intraoperative Occurrences
(Enter/Edit)

SURPATIENT,EIGHT (000-37-0555)        Case #264
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
------------------------------------------------------------------------------


There are no Intraoperative Occurrences entered for this case.


Enter a New Intraoperative Occurrence: CARDIAC ARREST REQUIRING CPR
   Definition Revised (2011): Indicate if there was any cardiac arrest
  requiring external or open cardiopulmonary resuscitation (CPR)
  occurring in the operating room, ICU, ward, or out-of-hospital after
  the chest had been completely closed and within 30 days of surgery.
  Patients with AICDs that fire but the patient does not lose
  consciousness should be excluded.

  If patient had cardiac arrest requiring CPR, indicate whether the
  arrest occurred intraoperatively or postoperatively. Indicate the
  one appropriate response:
  - intraoperatively: occurring while patient was in the operating room
  - postoperatively:  occurring after patient left the operating room.


Press RETURN to continue: <Enter>

SURPATIENT,EIGHT (000-37-0555)        Case #264
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
------------------------------------------------------------------------------

1. Occurrence:            CARDIAC ARREST REQUIRING CPR
2. Occurrence Category:   CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:
4. Treatment Instituted:
5. Outcome to Date:
6. Occurrence Comments:

------------------------------------------------------------------------------

Select Occurrence Information: 4:5

SURPATIENT,EIGHT (000-37-0555)        Case #264
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
------------------------------------------------------------------------------

Type of Treatment Instituted: CPR
Outcome to Date: I  IMPROVED
```

```
SURPATIENT,EIGHT (000-37-0555)        Case #264
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
------------------------------------------------------------------------------

1. Occurrence:            CARDIAC ARREST REQUIRING CPR
2. Occurrence Category:   CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:
4. Treatment Instituted:  CPR
5. Outcome to Date:       IMPROVED
6. Occurrence Comments:

------------------------------------------------------------------------------

Select Occurrence Information: <Enter>
```

```
SURPATIENT,EIGHT (000-37-0555)        Case #264
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
------------------------------------------------------------------------------
Enter/Edit Intraoperative Occurrences

1.  CARDIAC ARREST REQUIRING CPR
     Category: CARDIAC ARREST REQUIRING CPR

Select a number (1), or type 'NEW' to enter another occurrence:
```

Postoperative Occurrences (Enter/Edit)
[SRO POSTOP COMP]

The nurse reviewer uses the *Postoperative Occurrences (Enter/Edit)* option to enter or change information related to postoperative occurrences (called complications in earlier versions). Every occurrence entered must have a corresponding occurrence category. For a list of occurrence categories, the user should enter a question mark (**?**) at the "Enter a New Postoperative Occurrence:" prompt.

After an occurrence category has been entered or edited, the screen will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data.

Example: Enter a Postoperative Occurrence

```
Select Non-Cardiac Assessment Information (Enter/Edit) Option: PO  Postoperative Occurrences
(Enter/Edit)
```

```
SURPATIENT,EIGHT (000-37-0555)        Case #264
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
------------------------------------------------------------------------------

There are no Postoperative Occurrences entered for this case.


Enter a New Postoperative Occurrence: ACUTE RENAL FAILURE
  VASQIP Definition (2011):
  Indicate if the patient developed new renal failure requiring renal
  replacement therapy or experienced an exacerbation of preoperative
  renal failure requiring initiation of renal replacement therapy (not on
  renal replacement therapy preoperatively) within 30 days
  postoperatively.  Renal replacement therapy is defined as venous to
  venous hemodialysis [CVVHD], continuous venous to arterial hemodialysis
  [CVAHD], peritoneal dialysis, hemofiltration, hemodiafiltration or
  ultrafiltration.

  TIP: If the patient refuses dialysis report as an occurrence because
  he/she did require dialysis.


Press RETURN to continue: <Enter>
```

```
SURPATIENT,EIGHT (000-37-0555)        Case #264
JUN 7,2005   ARTHROSCOPY, LEFT KNEE
------------------------------------------------------------------------------

1. Occurrence:            ACUTE RENAL FAILURE
2. Occurrence Category:   ACUTE RENAL FAILURE
3. ICD Diagnosis Code:
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:
```

Update Status of Returns Within 30 Days
[SRO UPDATE RETURNS]

The *Update Status of Returns Within 30 Days* option is used to update the status of Returns to Surgery within 30 days of a surgical case.

Example: Update Status of Returns

```
Select Non-Cardiac Assessment Information (Enter/Edit) Option: RET  Update Statu
s of Returns Within 30 Days

SURPATIENT,SIXTY   000-56-7821

1. 07-06-05   REPAIR INGUINAL HERNIA (COMPLETED)

2. 06-25-05   CHOLECYSTECTOMY, APPENDECTOMY (COMPLETED)

3. 06-23-05   CHOLEDOCHOTOMY (COMPLETED)

4. 04-10-04   CRANIOTOMY (COMPLETED)


Select Operation: 3

SURPATIENT,SIXTY (000-56-7821)        Case #62192           RETURNS TO SURGERY
JUN 23,2005   CHOLEDOCHOTOMY
------------------------------------------------------------------------------

1. 07/06/05    REPAIR INGUINAL HERNIA - UNRELATED

2. 06/25/05    CHOLECYSTECTOMY - UNRELATED

------------------------------------------------------------------------------


Select Number: 2

SURPATIENT,SIXTY (000-56-7821)        Case #62192           RETURNS TO SURGERY
JUN 23,2005   CHOLEDOCHOTOMY
------------------------------------------------------------------------------


2. 06/25/05    CHOLECYSTECTOMY - UNRELATED

------------------------------------------------------------------------------


This return to surgery is currently defined as UNRELATED to the case selected.
Do you want to change this status ? NO// Y

SURPATIENT,SIXTY (000-56-7821)        Case #62192           RETURNS TO SURGERY
JUN 23,2005   CHOLEDOCHOTOMY
------------------------------------------------------------------------------

1. 07/06/05    REPAIR INGUINAL HERNIA - UNRELATED

2. 06/25/05    CHOLECYSTECTOMY - RELATED

------------------------------------------------------------------------------


Select Number:
```

Update Assessment Status to ‘Complete’
[SROA COMPLETE ASSESSMENT]

Use the *Update Assessment Status to ‘Complete’* option to upgrade the status of an assessment to Complete. A complete assessment has enough information for it to be transmitted to the centers where data are analyzed. Only complete assessments are transmitted. After updating the status, the patient’s entire Surgery Risk Assessment Report can be printed. This report can be copied to a screen or to a printer.

Example : Update Assessment Status to COMPLETE

```
Select Non-Cardiac Assessment Information (Enter/Edit) Option: U  Update Assessm
ent Status to 'COMPLETE'

This assessment is missing the following items:


      1. Rest Pain/Gangrene (Y/N)

Do you want to enter the missing items at this time? NO// YES
FOREIGN BODY REMOVAL (Y/N): N  NO

Are you sure you want to complete this assessment ? NO// YES

Updating the current status to 'COMPLETE'...

Do you want to print the completed assessment ?  YES//  NO
```

Alert Coder Regarding Coding Issues
[SROA CODE ISSUE]

This option allows the nurse reviewer to send an alert to the coder when there may be an issue with the CPT codes or the Postoperative Diagnosis codes for a Surgery case. When this option is selected, the nurse reviewer can enter a free-text message that will be sent to the coder on record, as well as to a pre-defined mail group identified in the Surgery Site Parameter titled CODE ISSUE MAIL GROUP. The message will not be sent if there is no coder, or if the mail group is not defined.

Example : Alert Coder Regarding Coding Issues

```
Select Non-Cardiac Assessment Information (Enter/Edit) Option: CODE  Alert Coder
 Regarding Coding Issues
```

```
Select Patient: SURPATIENT,TWO        4-3-23    000451982       YES
  SC VETERAN
```

```
 SURPATIENT,THREE   000-45-1982

1. 05-10-05   CHOLECYSTECOMY (COMPLETED)

2. 01-27-06   BRONCHOSCOPY (COMPLETED)

Select Operation: 1
```

```
SURPATIENT,TWO (000-45-1982)        Case #10102
MAY 10,2005   CHOLECYSTECTOMY
------------------------------------------------------------------------

The following "final" codes have been entered for the case.

Principal CPT Code: 47563 LAPARO CHOLECYSTECTOMY/GRAPH
Other CPT Codes:    NOT ENTERED
Postop Diagnosis Code (ICD9): 540.9   ACUTE APPENDICITIS NOS


If you believe that the information coded is not correct and would like to
alert the coders of the potential issue, enter a brief description of your
concern below.

Do you want to alert the coders (Y/N)? YES// <Enter>
```

```
==[ WRAP ]==[ INSERT ]=====< Coding Discrepancy Comments >===[ <PF1>H=Help ]====
I have reviewed this case for VASQIP. The final Principal CPT Code entered
is 47563. I would like to talk to you regarding the code. I think the code
should be 47562. Please call me at X2545.
<=======T=======T=======T=======T=======T=======T=======T=======T=======T>======
```

```
1. Transmit Message
2. Edit Text

Select Number:  1//  <Enter>

Transmitting message...
```

(This page included for two-sided copying.)

Cardiac Risk Assessment Information (Enter/Edit)

[SROA CARDIAC ENTER/EDIT]

The Surgical Clinical Nurse Reviewer uses the options within the *Cardiac Risk Assessment Information (Enter/Edit)* menu to create a new risk assessment for a cardiac patient. Cardiac cases are evaluated differently from non-cardiac cases, and the prompts are different. This option is also used to make changes to an assessment that has already been entered.

The example below demonstrates how to create a new risk assessment for cardiac patients and get to the sub-option menu as follows.

Shortcut	Option Name
CLIN	*Clinical Information (Enter/Edit)*
LAB	*Laboratory Test Results (Enter/Edit)*
CATH	*Enter Cardiac Catheterization & Angiographic Data*
OP	*Operative Risk Summary Data (Enter/Edit)*
CARD	*Cardiac Procedures Operative Data (Enter/Edit)*
OUT	*Outcome Information (Enter/Edit)*
IO	*Intraoperative Occurrences (Enter/Edit)*
PO	*Postoperative Occurrences (Enter/Edit)*
R	*Resource Data*
U	*Update Assessment Status to 'COMPLETE'*
CODE	*Alert Coder Regarding Coding Issues*

These sub-options are used for entering more in-depth data for a case, and are described in this chapter.

Creating a New Risk Assessment

1. Enter either the patient's name/patient ID (for example, SURPATIENT,NINETEEN) or the surgical case assessment number preceded by # (for example, #47063). If the patient has any previous assessments, they will be displayed. An asterisk (*) indicates a cardiac case. The user can now choose to create a new assessment or edit one of the previously entered assessments.

2. After choosing an operation on which to report, the user should respond **YES** to the prompt "Are you sure that you want to create a Risk Assessment for this surgical case ?" The user must answer **YES** (or press the **<Enter>** key to accept the **YES** default) to get to any of the sub-options. If the answer given is **NO**, the case created in step 1 will not be considered an assessment, although it can appear on some lists, and the software will return the user to the "Select Patient:" prompt.

3. The screen will clear and present the sub-options menu. The user can select a sub-option now to enter more in-depth information for the case, or press the **<Enter>** key to return to the main menu.

Example: Creating A New Risk Assessment (Cardiac)

```
Select Surgery Risk Assessment Menu Option: C Cardiac Risk Assessment Information (Enter/Edit)

Select Patient: SURPATIENT,FORTY          03-03-45     000777777       NSC VETERAN


 SURPATIENT,FORTY  000-77-7777

1.  ----     CREATE NEW ASSESSMENT


Select Surgical Case: 1
```

```
 SURPATIENT,FORTY   000-77-7777

1. 01-18-95   CORONARY ARTERY BYPASS (COMPLETED)

2. 06-18-93   INGUINAL HERNIA (COMPLETED)



Select Operation: 1
```

```
Are you sure that you want to create a Risk Assessment for this surgical
case ?  YES// <Enter>
```

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        16. Prior MI:
 2. Weight:                  170 lb       17. Num Prior Heart Surgeries:
 3. Diabetes - Long Term:                 18. Prior Heart Surgeries:
 4. Diabetes - 2 Wks Preop:               19. Peripheral Vascular Disease:
 5. COPD:                                 20. CVD Repair/Obstruct:
 6. FEV1:                                 21. History of CVD:
 7. Cardiomegaly (X-ray):                 22. Angina (use CCS Class):
 8. Pulmonary Rales:                      23. CHF (use NYHA Class):
 9. Tobacco Use:                          24. Current Diuretic Use:
10. Tobacco Use Timeframe: NOT APPLICABLE 25. Current Digoxin Use:
11. Positive Drug Screening:              26. IV NTG within 48 Hours:
12. Active Endocarditis:                  27. Preop Circulatory Device:
13. Resting ST Depression:                28. Hypertension (Y/N):
14. Functional Status:                    29. Preop Atrial Fibrillation:
15. PCI:
------------------------------------------------------------------------------
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 Weight: 170 LBS// 210
Diabetes Mellitus: Chronic, Long-Term Management: I  INSULIN
Diabetes Mellitus: Management Prior to Surgery: I  INSULIN
History of Severe COPD (Y/N): Y  YES
FEV1 : NS
Cardiomegaly on Chest X-Ray (Y/N): Y  YES
Pulmonary Rales (Y/N): Y  YES
Tobacco Use: 3  CIGARETTES ONLY
Tobacco Use Timeframe: 1  WITHIN 2 WEEKS
Positive Drug Screening: N  NO
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
Prior Surgical Repair/Carotid Artery Obstruction: 0  NO CVD
History of CVD Events: 0  NO CVD
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
Preoperative Atrial Fibrillation: N  NO
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183                      PAGE: 1
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------

 1. Height:                  76 in        16. Prior MI:           < OR = 7 DAYS
 2. Weight:                  210 lb       17. Num Prior Heart Surgeries:   1
 3. Diabetes - Long Term:     INSULIN     18. Prior Heart Surgeries: VALVE-ONLY
 4. Diabetes - 2 Wks Preop:   INSULIN     19. Peripheral Vascular Disease: YES
 5. COPD:                     YES         20. CVD Repair/Obstruct:       NO CVD
 6. FEV1:                     NS          21. History of CVD:            NO CVD
 7. Cardiomegaly (X-ray):     YES         22. Angina (use CCS Class):      IV
 8. Pulmonary Rales:          YES         23. CHF (use NYHA Class):        II
 9. Tobacco Use:         CIGARETTES ONLY  24. Current Diuretic Use:        YES
10. Tobacco Use Timeframe: WITHIN 2 WEEKS 25. Current Digoxin Use:         NO
11. Positive Drug Screening:  NO          26. IV NTG within 48 Hours:      YES
12. Active Endocarditis:      NO          27. Preop Circulatory Device:    NONE
13. Resting ST Depression:    NO          28. Hypertension (Y/N):          YES
14. Functional Status:       INDEPENDENT  29. Preop Atrial Fibrillation:   NO
15. PCI:                     NONE
------------------------------------------------------------------------------
Select Clinical Information to Edit:
```

Laboratory Test Results (Enter/Edit)
[SROA LAB-CARDIAC]

The *Laboratory Test Results (Edit/Edit)* option is used to enter or edit preoperative laboratory test results for an individual cardiac risk assessment. The option is divided into the two features listed below. The first feature allows the user to merge (also called "capture" or "load") lab information into the risk assessment from the VistA software. The second feature provides a two-page summary of the lab profile and allows direct editing of the information.

1. Capture Laboratory Information
2. Enter, Edit, or Review Laboratory Test Results

To "capture" preoperative lab data, the user must provide both the date and time the operation began. If this information has already been entered, the system will not prompt for it again.

If assistance is needed while interacting with the software, entering one or two question marks (**??**) allows the user to access the on-line help.

About the "Select Laboratory Information to Edit:" Prompt

At this prompt the user enters the item number to edit. Entering **A** for **ALL** allows the user to respond to every item on the page, or a range of numbers separated by a colon (:) can be entered to respond to a range of items.

After the information has been entered or edited, the terminal display screen will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data.

Example: Enter Laboratory Test Results

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: LAB  Laboratory
Test Results (Enter/Edit)


SURPATIENT,NINETEEN (000-28-7354)        Case #60183                      PAGE: 1
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------

Enter/Edit Laboratory Test Results

1. Capture Laboratory Information
2. Enter, Edit, or Review Laboratory Test Results

Select Number: 1

This selection loads the most recent cardiac lab data for tests performed
preoperatively.

Do you want to automatically load cardiac lab data ?  YES// <Enter>

..Searching lab record for latest test data....

Press <RET> to continue  <Enter>
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183                        PAGE: 1
JUN 18,2005   CORONARY ARTERY BYPASS
-------------------------------------------------------------------------------

Enter/Edit Laboratory Test Results

1. Capture Laboratory Information
2. Enter, Edit, or Review Laboratory Test Results

Select Number: 2
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183                        PAGE: 1
PREOPERATIVE LABORATORY RESULTS
JUN 18,2005   CORONARY ARTERY BYPASS
-------------------------------------------------------------------------------

 1. HDL:                     NS
 2. LDL:                    168    (JAN 2004)
 3. Total Cholesterol:      321    (JAN 2004)
 4. Serum Triglyceride:     >70    (JAN 2004)
 5. Serum Potassium:         NS
 6. Serum Bilirubin:         NS
 7. Serum Creatinine:        NS
 8. Serum Albumin:           NS
 9. Hemoglobin:              NS
10. Hemoglobin A1c:          NS
11. BNP:                     NS

-------------------------------------------------------------------------------

Select Laboratory Information to Edit: 1
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183                        PAGE: 1
PREOPERATIVE LABORATORY RESULTS
JUN 18,2005   CORONARY ARTERY BYPASS
-------------------------------------------------------------------------------

HDL (mg/dl): NS// 177
HDL, Date: JAN, 2005  (JAN 2005)
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183                        PAGE: 1
PREOPERATIVE LABORATORY RESULTS
JUN 18,2005   CORONARY ARTERY BYPASS
-------------------------------------------------------------------------------

 1. HDL:                    177    (JAN 2005)
 2. LDL:                    168    (JAN 2004)
 3. Total Cholesterol:      321    (JAN 2004)
 4. Serum Triglyceride:     >70    (JAN 2004)
 5. Serum Potassium:         NS
 6. Serum Bilirubin:         NS
 7. Serum Creatinine:        NS
 8. Serum Albumin:           NS
 9. Hemoglobin:              NS
10. Hemoglobin A1c:          NS
11. BNP:                     NS

-------------------------------------------------------------------------------

Select Laboratory Information to Edit:
```

Enter Cardiac Catheterization & Angiographic Data
[SROA CATHETERIZATION]

The *Enter Cardiac Catheterization & Angiographic Data* option is used to enter or edit cardiac catheterization and angiographic information for a cardiac risk assessment. The software will present one page. At the bottom of the page is a prompt to select one or more items to edit. If the user does not want to edit any items on the page, pressing the **<Enter>** key will advance the user to another option.

About the "Select Cardiac Catheterization and Angiographic Information to Edit:" Prompt

At this prompt the user enters the item number to edit. Entering **A** for **ALL** allows the user to respond to every item on the page, or a range of numbers separated by a colon (:) can be entered to respond to a range of items.

After the information has been entered or edited, the screen will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data.

Example: Enter Cardiac Catheterization & Angiographic Data

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: CATH  Enter Cardiac
Catheterization & Angiographic Data

SURPATIENT,NINETEEN (000-28-7354)        Case #60183                   PAGE: 1 OF 2
JUN 18,2005   CORONARY ARTERY BYPASS
-------------------------------------------------------------------------------
1. Procedure:
2. LVEDP:
3. Aortic Systolic Pressure:

For patients having right heart cath
4. PA Systolic Pressure:
5. PAW Mean Pressure:

6. LV Contraction Grade  (from contrast
    or radionuclide angiogram or 2D echo):

7. Mitral Regurgitation:
8. Aortic Stenosis:

-------------------------------------------------------------------------------

Select Cardiac Catheterization and Angiographic Information to Edit: A

SURPATIENT,NINETEEN (000-28-7354)        Case #60183                   PAGE: 1 OF 2
JUN 18,2005   CORONARY ARTERY BYPASS
-------------------------------------------------------------------------------

Procedure Type: NS  NO STUDY/UNKNOWN
Do you want to automatically enter 'NS' for NO STUDY for all other fields within
  this option ? YES// <Enter>
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183                    PAGE: 1 OF 2
JUN 18,2005   CORONARY ARTERY BYPASS
-------------------------------------------------------------------------------

1. Procedure:                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
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183                    PAGE: 1 OF 2
JUN 18,2005   CORONARY ARTERY BYPASS
-------------------------------------------------------------------------------
1. Procedure:                Cath
2. LVEDP:                     56 mm Hg
3. Aortic Systolic Pressure: 120 mm Hg

For patients having right heart cath
4. PA Systolic Pressure:      30 mm Hg
5. PAW Mean Pressure:         15 mm Hg

6. LV Contraction Grade  (from contrast
    or radionuclide angiogram or 2D echo): IIIa 0.40-0.44 MODERATE DYSFUNCTION A

7. Mitral Regurgitation:      MODERATE
8. Aortic Stenosis:           MILD

-------------------------------------------------------------------------------

Select Cardiac Catheterization and Angiographic Information to Edit: <Enter>
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183                        PAGE: 2 of 2
JUN 18,2005   CORONARY ARTERY BYPASS
-------------------------------------------------------------------------------

----- Native Coronaries -----
1. Left main stenosis:          NS
2. LAD Stenosis:                NS
3. Right coronary stenosis:     NS
4. Circumflex Stenosis:         NS

If a Re-do, indicate stenosis in graft to:
5. LAD:                         NS
6. Right coronary:              NS
7. Circumflex:                  NS

-------------------------------------------------------------------------------

Select Cardiac Catheterization and Angiographic Information to Edit: 3
Right Coronary Artery Stenosis: NS// ?
     Enter the percent (0-100) stenosis.
Right Coronary Artery Stenosis: NS// 30
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183                        PAGE: 2 of 2
JUN 18,2005   CORONARY ARTERY BYPASS
-------------------------------------------------------------------------------

----- Native Coronaries -----
1. Left main stenosis:          NS
2. LAD Stenosis:                NS
3. Right coronary stenosis:     30
4. Circumflex Stenosis:         NS

If a Re-do, indicate stenosis in graft to:
5. LAD:                         NS
6. Right coronary:              NS
7. Circumflex:                  NS

-------------------------------------------------------------------------------

Select Cardiac Catheterization and Angiographic Information to Edit:
```

(This page included for two-sided copying.)

Operative Risk Summary Data (Enter/Edit)
[SROA CARDIAC OPERATIVE RISK]

The *Operative Risk Summary Data (Enter/Edit)* option is used to enter or edit operative risk summary data for the cardiac surgery risk assessments. This option records the physician's subjective estimate of operative mortality. To avoid bias, this should be completed preoperatively. The software will present one page. At the bottom of the page is a prompt to select one or more items to edit. If the user does not want to edit any of the items, the **<Enter>** key can be pressed to proceed to another option.

About the "Select Operative Risk Summary Information to Edit:" prompt

At this prompt the user enters the item number to edit. Entering **A** for **ALL** allows the user to respond to every item on the page, or a range of numbers separated by a colon (:) can be entered to respond to a range of items.

Example: Operative Risk Summary Data

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: OP  Operative Risk Summary Data
(Enter/Edit)

SURPATIENT,NINETEEN (000-28-7354)   Case #60183                        PAGE: 1
JUN 18,2005   CORONARY ARTERY BYPASS
>> Coding Complete <<
------------------------------------------------------------------------------

 1. Physician's Preoperative Estimate of Operative Mortality: 78%
    A. Date/Time Collected: JUN 17,2005@18:15
 2. ASA Classification:        1-NO DISTURB.
 3. Surgical Priority:
 4. Preoperative Risk Factors: NONE

 5. CPT Codes (view only):     33510   <-- This information cannot be edited.
 6. Wound Classification:      CLEAN


------------------------------------------------------------------------------
Select Operative Risk Summary Information to Edit: 1:3
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------


Physician's Preoperative Estimate of Operative Mortality: 78
         // 32
Date/Time of Estimate of Operative Mortality: JUN 17, 2005@18:15
         // <Enter>
ASA Class: 1-NO DISTURB.// 3  3     3-SEVERE DISTURB.
Cardiac Surgical Priority: ?
     Enter the surgical priority that most accurately reflects the acuity of
     patient's cardiovascular condition at the time of transport to the
     operating room.
     Choose from:
       1        ELECTIVE
       2        URGENT
       3        EMERGENT (ONGOING ISCHEMIA)
       4        EMERGENT (HEMODYNAMIC COMPROMISE)
       5        EMERGENT (ARREST WITH CPR)
Cardiac Surgical Priority: 3  EMERGENT (ONGOING ISCHEMIA)
Date/Time of Cardiac Surgical Priority: JUN 18,2005@13:29  (JUN 18, 2005@13:29)
```

```
SURPATIENT,NINETEEN (000-28-7354)   Case #60183                        PAGE: 1
JUN 18,2005   CORONARY ARTERY BYPASS
>> Coding Complete <<
------------------------------------------------------------------------------

 1. Physician's Preoperative Estimate of Operative Mortality: 32%
    A. Date/Time Collected:    JUN 18,2005 18:15
 2. ASA Classification:        3-SEVERE DISTURB.
 3. Surgical Priority:         EMERGENT (ONGOING ISCHEMIA)
    A. Date/Time Collected:    JUN 18,2005 13:29
 4. Preoperative Risk Factors: NONE

 5. CPT Codes (view only):     33510
 6. Wound Classification:      CLEAN


*** NOTE: D/Time of Surgical Priority should be < the D/Time Patient in OR.***

------------------------------------------------------------------------------
Select Operative Risk Summary Information to Edit:
```

The Surgery software performs data checks on the following fields:

The Date/Time Collected field for Physician's Preoperative Estimate of Operative Mortality should be earlier than the Time Pat In OR field. This field is no longer auto-populated.

The Date/Time Collected field for Surgical Priority should be earlier than the Time Pat In OR field. This field is no longer auto-populated.

If the date entered does not conform to the specifications, then the Surgery software displays a warning at the bottom of the screen.

Cardiac Procedures Operative Data (Enter/Edit)
[SROA CARDIAC PROCEDURES]

The *Cardiac Procedures Operative Data (Enter/Edit)* option is used to enter or edit information related to cardiac procedures requiring cardiopulmonary bypass (CPB). The software will present two pages. At the bottom of the page is a prompt to select one or more items to edit. If the user does not want to edit any items on the page, pressing the **<Enter>** key will advance the user to another option.

About the "Select Operative Information to Edit:" prompt

At this prompt, the user enters the item number to edit. Entering **A** for **ALL** allows the user to respond to every item on the page, or a range of numbers separated by a colon (:) can be entered to respond to a range of items. You can also use number-letter combinations, such as **11B**, to update a field within a group, such as VSD Repair.

Each prompt at the category level allows for an entry of **YES** or **NO**. If **NO** is entered, each item under that category will automatically be answered **NO**. On the other hand, responding **YES** at the category level allows the user to respond individually to each item under the main category.

Entry of **N** shall allow the user to **Set All to No** for the Cardiac Procedures fields. A verification prompt will follow to ensure that user understands the entry.

Fields that do not have YES/NO responses will be updated as follows.

- Items #1-#5 are numeric and their values will be set to 0.
- Valve Procedures will be set to NONE
- #13 Maze Procedure will be set to NO MAZE PERFORMED

After the information has been entered or edited, the terminal display screen will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data.

Example: Enter Cardiac Procedures Operative Data

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: CARD  Cardiac Pr
ocedures Operative Data (Enter/Edit)

SURPATIENT,NINETEEN (000-28-7354)   Case #60183                    PAGE: 1 OF 2
JUN 18,2005   CORONARY ARTERY BYPASS
-------------------------------------------------------------------------------
Cardiac surgical procedures with or without cardiopulmonary bypass
CABG distal anastomoses:                13. Maze procedure:
 1. Number with vein:                   14. ASD repair:
 2. Number with IMA:                    15. VSD repair:
 3. Number with Radial Artery:          16. Myectomy:
 4. Number with Other Artery:           17. Myxoma resection:
 5. Number with Other Conduit:          18. Other tumor resection:
                                        19. Cardiac transplant:
 6. LV Aneurysmectomy:                  20. Great Vessel Repair:
 7. Bridge to transplant/Device:        21. Endovascular Repair:
 8. TMR:                                22. Other cardiac procedures:

 9. Aortic Valve Procedure:
10. Mitral Valve Procedure:
11. Tricuspid Valve Procedure:
12. Pulmonary Valve Procedure:
-------------------------------------------------------------------------------
Select Cardiac Procedures Operative Information to Edit: A
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------

CABG Distal Anastomoses with Vein: 1
CABG Distal Anastomoses with IMA: 1
Number with Radial Artery: 0
Number with Other Artery: 1
CABG Distal Anastomoses with Other Conduit: 1
LV Aneurysmectomy (Y/N): N  NO
Device for bridge to cardiac transplant / Destination therapy: ??
        Definition Revised (2006):
        Indicate if patient received a mechanical support device
        (excluding IABP) as a bridge to cardiac transplant during the same
        admission as the transplant procedure; or patient received the device
        as destination therapy (does not intend to have a cardiac transplant),
        either with or without placing the patient on cardiopulmonary bypass.

     Choose from:
       N        NONE
       B        BRIDGE TO
TRANSPLANT
        D       DESTINATION THERAPY
Device for bridge to cardiac transplant / Destination therapy: N  NONE
Transmyocardial Laser Revascularization: N  NO
Aortic Valve Procedure: ??
        VASQIP Definition (2010):
        Indicate if the patient had an aortic valve replacement (either the
        native or a prosthetic valve) or a repair (on the native valve to
        relieve stenosis and/or correct regurgitation -annuloplasty,
        commissurotomy, etc.); performed with or without additional
        procedure(s); either with or without placing the patient on
        cardiopulmonary bypass. (If a repair was attempted, but a replacement
        occurred, indicate the details of the replacement valve.) Indicate
        the one most appropriate procedure:
          * None
          * Mechanical Valve
          * Stented Bioprosthetic Valve
          * Stentless Bioprosthetic Valve
          * Homograft
          * Primary Valve Repair
          * Primary Valve Repair and Annuloplasty Device
          * Annuloplasty Device alone
          * Autograft Procedure (Ross Procedure)
          * Other

     Choose from:
       N        NONE
       M        MECHANICAL
       S        STENTED BIOPROSTHETIC
       B        STENTLESS BIOPROSTHETIC
       H        HOMOGRAFT
       PR       PRIMARY REPAIR
       PA       PRIMARY REPAIR & ANNULOPLASTY DEVICE
       AN       ANNULOPLASTY DEVICE ALONE
       AU       AUTOGRAFT (ROSS)
       O        OTHER
Aortic Valve Procedure: PR  PRIMARY REPAIR
Mitral Valve Procedure: N  NONE
Tricuspid Valve Procedure: N  NONE
Pulmonary Valve Procedure: N  NONE
Maze Procedure: N  NO MAZE PERFORMED
ASD Repair (Y/N): N  NO
VSD Repair (Y/N): N  NO
Myectomy (Y/N): N  NO
Myxoma Resection (Y/N): N  NO
Other Tumor Resection (Y/N): N  NO
Cardiac Transplant (Y/N): N  NO
Great Vessel Repair (Y/N): N  NO
Endovascular Repair of Aorta: N  NOther Cardiac Procedures (Y/N): N  NO
```

```
SURPATIENT,NINETEEN (000-28-7354)       Case #60183                PAGE: 1 of 2
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------
Cardiac surgical procedures with or without cardiopulmonary bypass
CABG distal anastomoses:                13. Maze procedure:  NO MAZE PERFORMED
 1. Number with vein:            1      14. ASD repair:               NO
 2. Number with IMA:             1      15. VSD repair:               NO
 3. Number with Radial Artery:   0      16. Myectomy:                 NO
 4. Number with Other Artery:    1      17. Myxoma resection:         NO
 5. Number with Other Conduit:   1      18. Other tumor resection:    NO
                                        19. Cardiac transplant:       NO
 6. LV Aneurysmectomy:           NO     20. Great Vessel Repair:      NO
 7. Bridge to transplant/Device: NONE   21. Endovascular Repair:      NO
 8. TMR:                         NO     22. Other cardiac procedures: NO

 9. Aortic Valve Procedure:      PRIMARY REPAIR
10. Mitral Valve Procedure:      NONE
11. Tricuspid Valve Procedure:   NONE
12. Pulmonary Valve Procedure:   NONE
------------------------------------------------------------------------------
Select Operative Information to Edit: <Enter>
```

```
SURPATIENT,NINETEEN (000-28-7354)      Case #60183                PAGE: 2 of 2
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------
Indicate other cardiac procedures only if done with cardiopulmonary bypass
------------------------------------------------------------------------------

 1. Foreign Body Removal:
 2. Pericardiectomy:

Other Operative Data details:
-----------------------------
 3. Total CPB Time:
 4. Total Ischemic Time:
 5. Incision Type:
 6. Convert Off Pump to CPB:  N/A (began on-pump/ stayed on-pump)
------------------------------------------------------------------------------

Select Operative Information to Edit:
```

Outcome Information (Enter/Edit)
[SROA CARDIAC-OUTCOMES]

This option is used to enter or edit outcome information for cardiac procedures.

Example: Enter Outcome Information

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: OUT  Outcome Inf
ormation (Enter/Edit)

SURPATIENT,TWENTY (000-45-4886)     Case #238                          PAGE: 1
OUTCOMES INFORMATION
FEB 10,2004   CABG
------------------------------------------------------------------------------

0. Operative Death:               NO

Perioperative (30 day) Occurrences:
----------------------------------
1. Perioperative MI:              NO    9. Tracheostomy:                  YES
2. Endocarditis:                  NO   10. Repeat ventilator w/in 30 days: YES
3. Superficial Incisional SSI:    NO   11. Stroke/CVA:                     NO
4. Mediastinitis:                 YES  12. Coma >= 24 hr:                NO
5. Cardiac arrest requiring CPR:  YES  13. New Mech Circ Support:         YES
6. Reoperation for bleeding:      NO   14. Postop Atrial Fibrillation:    NO
7. On ventilator >= 48 hr:        NO   15. Wound Disruption:              YES
8. Repeat cardiac surg procedure: NO   16. Renal failure require dialysis: NO

------------------------------------------------------------------------------

Select Outcomes Information to Edit: 8
Repeat Cardiac Surgical Procedure (Y/N): NO// Y  YES
Cardiopulmonary Bypass Status: ?

Enter NONE, ON BYPASS, or OFF BYPASS.
0       None
1       On-bypass
2       Off-bypass


Cardiopulmonary Bypass Status: 1  On-bypass
```

```
SURPATIENT,TWENTY (000-45-4886)     Case #238                          PAGE: 1
OUTCOMES INFORMATION
FEB 10,2004   CABG
------------------------------------------------------------------------------

0. Operative Death:               NO

Perioperative (30 day) Occurrences:
----------------------------------
1. Perioperative MI:              NO    9. Tracheostomy:                  YES
2. Endocarditis:                  NO   10. Repeat ventilator w/in 30 days: YES
3. Superficial Incisional SSI:    NO   11. Stroke/CVA:                     NO
4. Mediastinitis:                 YES  12. Coma >= 24 hr:                NO
5. Cardiac arrest requiring CPR:  YES  13. New Mech Circ Support:         YES
6. Reoperation for bleeding:      NO   14. Postop Atrial Fibrillation:    NO
7. On ventilator >= 48 hr:        NO   15. Wound Disruption:              YES
8. Repeat cardiac surg procedure: YES  16. Renal failure require dialysis: NO

------------------------------------------------------------------------------

Select Outcomes Information to Edit:
```

Intraoperative Occurrences (Enter/Edit)
[SRO INTRAOP COMP]

The nurse reviewer uses the *Intraoperative Occurrences (Enter/Edit)* option to enter or change information related to intraoperative occurrences. Every occurrence entered must have a corresponding occurrence category. For a list of occurrence categories, the user can enter a question mark (**?**) at the "Enter a New Intraoperative Occurrence:" prompt.

After an occurrence category has been entered or edited, the screen will clear and present a summary. The summary organizes the information entered and provides another opportunity to enter or edit data.

Example: Enter an Intraoperative Occurrence

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: IO  Intraoperative Occurrences
(Enter/Edit)

SURPATIENT,NINETEEN (000-28-7354)        Case #60183
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------

There are no Intraoperative Occurrences entered for this case.


Enter a New Intraoperative Occurrence: CARDIAC ARREST REQUIRING CPR
   Definition Revised (2011): Indicate if there was any cardiac arrest
  requiring external or open cardiopulmonary resuscitation (CPR)
  occurring in the operating room, ICU, ward, or out-of-hospital after
  the chest had been completely closed and within 30 days of surgery.
  Patients with AICDs that fire but the patient does not lose
  consciousness should be excluded.

  If patient had cardiac arrest requiring CPR, indicate whether the
  arrest occurred intraoperatively or postoperatively. Indicate the
  one appropriate response:
  - intraoperatively: occurring while patient was in the operating room
  - postoperatively:  occurring after patient left the operating room

Press RETURN to continue: <Enter>

SURPATIENT,NINETEEN (000-28-7354)        Case #60183
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------

1. Occurrence:          CARDIAC ARREST REQUIRING CPR
2. Occurrence Category: CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:
4. Treatment Instituted:
5. Outcome to Date:
6. Occurrence Comments:

------------------------------------------------------------------------------

Select Occurrence Information: 2:5
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------

Occurrence Category: CARDIAC ARREST REQUIRING CPR
         // <Enter>
ICD Diagnosis Code: 102.8  102.8        LATENT YAWS
         ...OK? YES// <Enter>   (YES)
Type of Treatment Instituted: CPR
Outcome to Date: I  IMPROVED
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------

1. Occurrence:            CARDIAC ARREST REQUIRING CPR
2. Occurrence Category:   CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:    102.8
4. Treatment Instituted:  CPR
5. Outcome to Date:       IMPROVED
6. Occurrence Comments:

------------------------------------------------------------------------------

Select Occurrence Information: <Enter>
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------
Enter/Edit Intraoperative Occurrences

1.   CARDIAC ARREST REQUIRING CPR
     Category: CARDIAC ARREST REQUIRING CPR

Select a number (1), or type 'NEW' to enter another occurrence:
```

Postoperative Occurrences (Enter/Edit)
[SRO POSTOP COMP]

The nurse reviewer uses the *Postoperative Occurrences (Enter/Edit)* option to enter or change information related to postoperative occurrences. Every occurrence entered must have a corresponding occurrence category. For a list of occurrence categories, the user can enter a question mark (**?**) at the "Enter a New Postoperative Occurrence:" prompt.

After an occurrence category has been entered or edited, the screen will clear and present a summary. The summary organizes the information entered and provides another opportunity to enter or edit data.

Example: Enter a Postoperative Occurrence

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: PO  Postoperative Occurrences
(Enter/Edit)

SURPATIENT,NINETEEN (000-28-7354)        Case #60183
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------

There are no Postoperative Occurrences entered for this case.


Enter a New Postoperative Occurrence: CARDIAC ARREST REQUIRING CPR
    Definition Revised (2011): Indicate if there was any cardiac arrest
  requiring external or open cardiopulmonary resuscitation (CPR)
  occurring in the operating room, ICU, ward, or out-of-hospital after
  the chest had been completely closed and within 30 days of surgery.
  Patients with AICDs that fire but the patient does not lose
  consciousness should be excluded.

  If patient had cardiac arrest requiring CPR, indicate whether the
  arrest occurred intraoperatively or postoperatively. Indicate the
  one appropriate response:
  - intraoperatively: occurring while patient was in the operating room
  - postoperatively:  occurring after patient left the operating room


Press RETURN to continue: <Enter>
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------


1. Occurrence:            CARDIAC ARREST REQUIRING CPR
2. Occurrence Category:   CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:
4. Treatment Instituted:
5. Outcome to Date:
6. Date Noted:
7. Occurrence Comments:

------------------------------------------------------------------------------

Select Occurrence Information: 4:6
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------

Treatment Instituted: CPR
Outcome to Date: I  IMPROVED
Date/Time the Occurrence was Noted: 6/19/05  (JUN 19, 2005)
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------

1. Occurrence:            CARDIAC ARREST REQUIRING CPR
2. Occurrence Category:   CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:
4. Treatment Instituted:  CPR
5. Outcome to Date:       IMPROVED
6. Date Noted:            06/19/05
7. Occurrence Comments:

------------------------------------------------------------------------------

Select Occurrence Information: <Enter>
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------------
Enter/Edit Intraoperative Occurrences

1.   CARDIAC ARREST REQUIRING CPR
     Category: CARDIAC ARREST REQUIRING CPR

Select a number (1), or type 'NEW' to enter another occurrence:
```

Resource Data (Enter/Edit)
[SROA CARDIAC RESOURCE]

The nurse reviewer uses the *Resource Data (Enter/Edit)* option to enter, edit, or review risk assessment and cardiac patient demographic information such as hospital admission, discharge dates, and other information related to the surgical episode.

Example: Resource Data (Enter/Edit)

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: R  Resource Data

SURPATIENT,TEN (000-12-3456)        Case #49413
OCT 18,2007   CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD
-------------------------------------------------------------------------------

Enter/Edit Patient Resource Data

1. Capture Information from PIMS Records
2. Enter, Edit, or Review Information

Select Number:  (1-2): 1

Are you sure you want to retrieve information from PIMS records ? YES// <Enter>

...HMMM, I'M WORKING AS FAST AS I CAN...

SURPATIENT,TEN (000-12-3456)        Case #49413
OCT 18,2007   CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD
-------------------------------------------------------------------------------

Enter/Edit Patient Resource Data

1. Capture Information from PIMS Records
2. Enter, Edit, or Review Information

Select Number:  (1-2): 2

SURPATIENT,TEN (000-12-3456)        Case #49413
OCT 18,2007   CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD
-------------------------------------------------------------------------------

 1. Hospital Admission Date:           FEB 11, 2007@15:39
 2. Hospital Discharge Date:           FEB 16, 2007@13:44
 3. Cardiac Catheterization Date:
 4. Time Patient In OR:                FEB 12, 2007@06:30
 5. Date/Time Operation Began:         FEB 12, 2007@06:40
 6. Date/Time Operation Ended:         FEB 12, 2007@08:30
 7. Time Patient Out OR:               FEB 12, 2007@08:40
 8. Date/Time Patient Extubated:
 9. Date/Time Discharged from ICU:     FEB 16, 2007@13:44
10. Homeless:                          NO
11. Surg Performed at Non-VA Facility: NO
12. Resource Data Comments:
13. Employment Status Preoperatively:  EMPLOYED PART TIME

---

Select Resource Information to Edit: Employment Status Preoperatively: EMPLOYED FULL TIME// ?
     Enter the patient's employment status preoperatively.
     Choose from:
       1        EMPLOYED FULL TIME
       2        EMPLOYED PART TIME
       3        NOT EMPLOYED
       4        SELF EMPLOYED
       5        RETIRED
       6        ACTIVE MILITARY DUTY
       9        UNKNOWN
```

```
Employment Status Preoperatively: 3  NOT EMPLOYED
```

```
SURPATIENT,TEN (000-12-3456)        Case #49413
OCT 18,2007   CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD
------------------------------------------------------------------------------

 1. Hospital Admission Date:           FEB 11, 2007@15:39
 2. Hospital Discharge Date:           FEB 16, 2007@13:44
 3. Cardiac Catheterization Date:
 4. Time Patient In OR:                FEB 12, 2007@06:30
 5. Date/Time Operation Began:         FEB 12, 2007@06:40
 6. Date/Time Operation Ended:         FEB 12, 2007@08:30
 7. Time Patient Out OR:               FEB 12, 2007@08:40
 8. Date/Time Patient Extubated:
 9. Date/Time Discharged from ICU:     FEB 16, 2007@13:44
10. Homeless:                          NO
11. Surg Performed at Non-VA Facility: NO
12. Resource Data Comments:
13. Employment Status Preoperatively:  NOT EMPLOYED

------------------------------------------------------------------------------

Select Resource Information 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.

(This page included for two-sided copying.)

Update Assessment Status to ‘COMPLETE’
[SROA COMPLETE ASSESSMENT]

The *Update Assessment Status to ‘COMPLETE’* option is used to upgrade the status of an assessment to “Complete.” A complete assessment has enough information for it to be transmitted to the centers where data are analyzed. Only complete assessments are transmitted. This option also notifies the user if procedure (CPT) and diagnosis (ICD) coding has not been completed.

After updating the status, the user can print the patient’s entire Surgery Risk Assessment Report. This report can be copied to a screen or to a printer.

Example: Update Assessment Status to COMPLETE

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: U  Update Assess
ment Status to 'COMPLETE'

This assessment is missing the following items:


      1. Foreign Body Removal (Y/N)

Do you want to enter the missing items at this time? NO// YES
FOREIGN BODY REMOVAL (Y/N): N  NO

Are you sure you want to complete this assessment ? NO// YES

Updating the current status to 'COMPLETE'...

Do you want to print the completed assessment ?  YES//  NO
```

Alert Coder Regarding Coding Issues
[SROA CODE ISSUE]

This option allows the nurse reviewer to send an alert to the coder when there may be an issue with the CPT codes or the Postoperative Diagnosis codes for a Surgery case. When this option is selected, the nurse reviewer can enter a free-text message that will be sent to the coder on record, as well as to a pre-defined mail group identified in the Surgery Site Parameter titled CODE ISSUE MAIL GROUP. The message will not be sent if there is no coder, or if the mail group is not defined.

Example : Alert Coder Regarding Coding Issues

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: CODE  Alert Coder
 Regarding Coding Issues
```

```
Select Patient: SURPATIENT,NINETEEN            000287354       YES
  SC VETERAN
```

```
 SURPATIENT,NINETEEN   000-28-7354

1. 05-10-05   CHOLECYSTECOMY (COMPLETED)

2. 06-18-05   * CORONARY ARTERY BYPASS (COMPLETED)

Select Operation: 2
```

```
SURPATIENT,NINETEEN (000-28-7354)        Case #60183
JUN 18,2005   CORONARY ARTERY BYPASS
------------------------------------------------------------------------

The following "final" codes have been entered for the case.

Principal CPT Code: 33510
Other CPT Codes:    NOT ENTERED
Postop Diagnosis Code (ICD9): 402.10   HYP HEART DIS BENING W/0 FAIL

If you believe that the information coded is not correct and would like to
alert the coders of the potential issue, enter a brief description of your
concern below.

Do you want to alert the coders (Y/N)? YES// <Enter>
```

```
==[ WRAP ]==[ INSERT ]=====< Coding Discrepancy Comments >===[ <PF1>H=Help ]====
I have reviewed this case for VASQIP. The final Principal CPT Code entered
is 33510. I would like to talk to you regarding the code. I think the code
should be 33502. Please call me at X2545.
<=======T=======T=======T=======T=======T=======T=======T=======T=======T>======
```

```
1. Transmit Message
2. Edit Text

Select Number:  1//  <Enter>
```

(This page included for two-sided copying.)

Print a Surgery Risk Assessment

[SROA PRINT ASSESSMENT]

The *Print a Surgery Risk Assessment* option prints an entire Surgery Risk Assessment Report for an individual patient. This report can be displayed temporarily on a screen. As the report fills the screen, the user will be prompted to press the **<Enter>** key to go to the next page. A permanent record can be made by copying the report to a printer. When using a printer, the report is formatted slightly differently from the way it displays on the terminal.

Example 1: Print Surgery Risk Assessment for a Non-Cardiac Case

```
Select Surgery Risk Assessment Menu Option: P  Print a Surgery Risk Assessment

Do you want to batch print assessments for a specific date range ? NO//  <Enter>


Select Patient: SURPATIENT,FORTY         05-07-23     000777777     NO     NSC VET
ERAN

SURPATIENT,FORTY  000-77-7777

1. 02-10-04   * CABG (INCOMPLETE)

2. 01-09-06   APPENDECTOMY (COMPLETED)


Select Surgical Case: 2

Print the Completed Assessment on which Device: [Select Print Device]
```

----------*printout follows*----------

```
VA NON-CARDIAC RISK ASSESSMENT            Assessment: 236          PAGE 1
FOR SURPATIENT,FORTY  000-77-7777 (COMPLETED)
================================================================================

Medical Center: ALBANY
Age:            81                    Operation Date:    JAN 09, 2006
Sex:            MALE                  Ethnicity: NOT HISPANIC OR LATINO
                                      Race:      AMERICAN INDIAN OR ALASKA
                                                 NATIVE, NATIVE HAWAIIAN OR
                                                 OTHER PACIFIC ISLANDER, WHITE
Transfer Status: NOT TRANSFERRED
Observation Admission Date:                  NA
Observation Discharge Date:                  NA
Observation Treating Specialty:              NA
Hospital Admission Date:                     JAN 7,2006   11:15
Hospital Discharge Date:                     JAN 12,2006  10:30
Admitted/Transferred to Surgical Service:    JAN 7,2006   11:15
In/Out-Patient Status:                       INPATIENT
Assessment Completed by:                     SURNURSE,SEVEN
--------------------------------------------------------------------------------

                          PREOPERATIVE INFORMATION


GENERAL:                      NO       HEPATOBILIARY:                 NO
Height:                    70 INCHES   Ascites:                       NO
Weight:                     180 LBS.
Diabetes - Long Term:         NO       GASTROINTESTINAL:              NO
Diabetes - 2 Wks Preop:       NO       Esophageal Varices:            NO
Tobacco Use:       NEVER USED TOBACCO
Tobacco Use Timeframe: NOT APPLICABLE
ETOH > 2 Drinks/Day:          NO       CARDIAC:                       NO
Positive Drug Screening:      NO       CHF Within 1 Month:            NO
Dyspnea:                      NO       MI Within 6 Months:            NO
Preop Sleep Apnea:          LEVEL 1    Previous PCI:                  NO
DNR Status:                   NO       Previous Cardiac Surgery:      NO
Preop Funct Status:       INDEPENDENT  Angina Within 1 Month:         NO
                                       Hypertension Requiring Meds:   NO
PULMONARY:                    NO
Ventilator Dependent:         NO       VASCULAR:                      NO
History of Severe COPD:       NO       Revascularization/Amputation:  NO
Current Pneumonia:            NO       Rest Pain/Gangrene:            NO

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
CVD Repair/Obstruct:    YES/NO SURG    Radiotherapy W/I 90 Days:      NO
History of CVD:       HIST OF TIA'S    Preoperative Sepsis:          NONE
Tumor Involving CNS:          NO       Pregnancy:          NOT APPLICABLE


                       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
* 477.0 RHINITIS DUE TO P      01/12/06   Organ/Space SSI:              01/11/06
                                          C. difficile Colitis:            NO


* indicates Other (ICD)
```

Example 2: Print Surgery Risk Assessment for a Cardiac Case

```
Select Surgery Risk Assessment Menu Option: P  Print a Surgery Risk Assessment

Do you want to batch print assessments for a specific date range ? NO//  <Enter>


Select Patient: R9922  SURPATIENT,NINE         12-19-51     000345555     NO     SC
 VETERAN

SURPATIENT,NINE  000-34-5555

1. 07-01-06   * CABG X3 (1A,2V), ARTERIAL GRAFTING (TRANSMITTED)

2. 03-27-05   INGUINAL HERNIA (TRANSMITTED)

3. 07-03-04   PULMONARY LOBECTOMY (TRANSMITTED)


Select Surgical Case: Select Surgical Case: 1

Print the Completed Assessment on which Device: [Select Print Device]
```

----------*printout follows*----------

```
VA SURGICAL QUALITY IMPROVEMENT PROGRAM – CARDIAC SPECIALTY
================================================================================
I. IDENTIFYING DATA
Patient: SURPATIENT,NINE  000-34-5555      Case #: 238         Fac./Div. #: 500
Surgery Date: 07/01/06   Address: Anyplace Way
Phone: NS/Unknown        Zip Code: 33445-1234        Date of Birth: 12/19/51
================================================================================
II. CLINICAL DATA
Gender:                   MALE          Age:                                56
Height:                   72 in         Prior MI:                           NONE
Weight:                   177 lb        Number of prior heart surgeries:    NONE
Diabetes - Long Term:     NO            Prior heart surgeries:              None
Diabetes - 2 Wks Preop:   NO            Peripheral Vascular Disease:        NO
COPD:                     NO            CVD Repair/Obstruct:     YES/PRIOR SURG
FEV1:                     NS            History of CVD:       CVA W/O NEURO DEF
Cardiomegaly (X-ray):     NO            Angina (use CCS Class):             II
Pulmonary Rales:          NO            CHF (use NYHA Class):               II
Tobacco Use:       NEVER USED TOBACCO   Current Diuretic Use:               NO
Tobacco Use Timeframe: NOT APPLICABLE   Current Digoxin Use:                NO
Positive Drug Screening:  NO            IV NTG 48 Hours Preceding Surgery: NO
Active Endocarditis:      NO            Preop Circulatory Device:         NONE
Resting ST Depression:    NO            Hypertension:                       YES
Functional Status:        INDEPENDENT   Preoperative Atrial Fibrillation:  NO
PCI:                            None

III. DETAILED LABORATORY INFO - PREOPERATIVE VALUES
Creatinine:        mg/dl (NS)            T. Cholesterol:      mg/dl (NS)
Hemoglobin:        mg/dl (NS)            HDL:                 mg/dl (NS)
Albumin:           g/dl  (NS)            LDL:                 mg/dl (NS)
Triglyceride:      mg/dl (NS)            Hemoglobin A1c:      %     (NS)
Potassium:         mg/L  (NS)            BNP:                 mg/dl (NS)
T. Bilirubin:      mg/dl (NS)

IV. CARDIAC CATHETERIZATION AND ANGIOGRAPHIC DATA
Cardiac Catheterization Date: 06/28/06
Procedure:                 NS            Native Coronaries:
LVEDP:                     NS            Left Main Stenosis:           NS
Aortic Systolic Pressure:  NS            LAD Stenosis:                 NS
                                         Right Coronary Stenosis:      NS
For patients having right heart cath:    Circumflex Stenosis:          NS
PA Systolic Pressure:      NS
PAW Mean Pressure:         NS            If a Re-do, indicate stenosis
                                             in graft to:
                                         LAD:                          NS
                                         Right coronary (include PDA): NS
                                         Circumflex:                   NS
--------------------------------------------------------------------------------
LV Contraction Grade (from contrast or radionuclide angiogram or 2D Echo):
       Grade     Ejection Fraction Range          Definition
        NO LV STUDY
--------------------------------------------------------------------------------
Mitral Regurgitation:     NS
Aortic stenosis:          NS

V. OPERATIVE RISK SUMMARY DATA
     Physician's Preoperative
       Estimate of Operative Mortality: NS               07/28/06 15:30)
     ASA Classification:           3-SEVERE DISTURB.
     Surgical Priority:            ELECTIVE              07/28/06 15:31)
     Principal CPT Code:           33517
     Other Procedures CPT Codes:   33510
     Preoperative Risk Factors:
     Wound Classification:         CLEAN
```

```
SURPATIENT,NINE  00-34-5555
================================================================================
 VI. OPERATIVE DATA
Cardiac surgical procedures with or without cardiopulmonary bypass
CABG distal anastomoses:                Maze procedure:      NO MAZE PERFORMED
  Number with Vein:              1      ASD repair:                         NO
  Number with IMA:               1      VSD repair:                         NO
  Number with Radial Artery:     0      Myectomy:                           NO
  Number with Other Artery:      1      Myxoma resection:                   NO
  Number with Other Conduit:     1      Other tumor resection:              NO
LV Aneurysmectomy:               NO     Cardiac transplant:                 NO
Bridge to transplant/Device:     NONE   Great Vessel Repair:                NO
TMR:                             NO     Endovascular Repair:                NO
                                        Other Cardiac procedure(s):         NO
Aortic Valve Procedure:          PRIMARY REPAIR
Mitral Valve Procedure:          NONE
Tricuspid Valve Procedure:       NONE
Pulmonary Valve Procedure:       NONE
* Other Cardiac procedures (Specify):

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    Tracheostomy:                       NO
  Endocarditis:                    NO    Ventilator supp within 30 days:     NO
  Superficial Incisional SSI:      NO    Stroke/CVA:                 NO SYMPTOMS
  Mediastinitis:                   NO    Coma > or = 24 Hours:               NO
  Cardiac Arrest Requiring CPR:    NO    New Mech Circulatory Support:       NO
  Reoperation for Bleeding:        NO    Postop Atrial Fibrillation:         NO
  On ventilator > or = 48 hr:      NO    Wound Disruption:                   NO
  Repeat cardiac Surg procedure:   NO    Renal Failure Requiring Dialysis:   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      Operation Began: 07/01/06 10:10
Operation Ended:         07/10/06 12:30      Time Patient Out OR: 07/01/06 12:20
Date and Time Patient Extubated:               07/10/06 13:13
     Postop Intubation Hrs: +1.9
Date and Time Patient Discharged from ICU:     07/10/06 08:00
Patient is Homeless:                           NS
Cardiac Surg Performed at Non-VA Facility:     UNKNOWN
Resource Data Comments:
================================================================================
IX. SOCIOECONOMIC, ETHNICITY, AND RACE
 Employment Status Preoperatively:      SELF EMPLOYED
 Ethnicity:                             NOT HISPANIC OR LATINO
 Race Category(ies):                    AMERICAN INDIAN OR ALASKA NATIVE,
                                        NATIVE HAWAIIAN OR OTHER PACIFIC
                                        ISLANDER, WHITE

X. DETAILED DISCHARGE INFORMATION
   Discharge ICD 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.)

Update Assessment Completed/Transmitted in Error
[SROA TRANSMITTED IN ERROR]

The *Update Assessment Completed/Transmitted in Error* option is used to change the status of a completed or transmitted assessment that contains errors or has been entered in error. The status will change from Completed or Transmitted to Incomplete so that the user can edit the assessment. Transmitted assessments will be re-transmitted if they are re-completed within 14 days of the original transmission date.

Example: Update Assessment Completed/Transmitted in Error

```
Select Surgery Risk Assessment Menu Option: U  Update Assessment Completed/Transmitted in Error

Select Patient: SURPATIENT,NINETEEN       03-03-30     000287354     SC VETERAN

SURPATIENT,NINETEEN 000-28-7354

1. 02-08-95   CORONARY ARTERY BYPASS (INCOMPLETE)

2. 01-25-95   PULMONARY LOBECTOMY (TRANSMITTED)



Select Surgical Case: 2

Are you sure that you want to change the status of this assessment
from 'TRANSMITTED' to 'INCOMPLETE' ?  YES//  <Enter>

The Assessment Status has been changed to 'INCOMPLETE'.

Press <Enter> to continue
```

(This page included for two-sided copying.)

List of Surgery Risk Assessments

[SROA ASSESSMENT LIST]

The *List of Surgery Risk Assessments* option is used to print lists of assessments within a date range. Lists of assessments in different phases of completion (for example, incomplete, completed, or transmitted) or a list of all surgical cases entered in the Surgery Risk Assessment software can be printed. The user can also request that the list be sorted by surgical service. The software will prompt for a beginning date and an ending date. The examples in this section illustrate printing assessments in the following formats.

1. List of Incomplete Assessments
2. List of Completed Assessments
3. List of Transmitted Assessments
4. List of Non-Assessed Major Surgical Cases
5. List of All Major Surgical Cases
6. List of All Surgical Cases
7. List of Completed/Transmitted Assessments Missing Information
8. List of 1-Liner Cases Missing Information
9. List of Eligible Cases
10. List of Cases With No CPT Codes
11. Summary List of Assessed Cases

Example 1: List of Incomplete Assessments

```
Select Surgery Risk Assessment Menu Option: L List of Surgery Risk Assessments

List of Surgery Risk Assessments

  1. List of Incomplete Assessments
  2. List of Completed Assessments
  3. List of Transmitted Assessments
  4. List of Non-Assessed Major Surgical Cases
  5. List of All Major Surgical Cases
  6. List of All Surgical Cases
  7. List of Completed/Transmitted Assessments Missing Information
  8. List of 1-Liner Cases Missing Information
  9. List of Eligible Cases
 10. List of Cases With No CPT Codes
 11. Summary List of Assessed Cases

Select the Number of the Report Desired:  (1-11): 1

Start with Date: 1 1 06  (JAN 01, 2006)
End with Date: 6 30 06  (JUN 30, 2006)

Print by Surgical Specialty ?  YES// <Enter>

Print report for ALL specialties ?  YES// <Enter>

Do you want to print all divisions? YES// NO

1. MAYBERRY, NC

Select Number:  (1-2): 1

This report is designed to print to your screen or a printer. When
using a printer, a 132 column format is used.

Print the List of Assessments to which Device: [Select Print Device]
```

----------printout follows----------

```
                                        INCOMPLETE RISK ASSESSMENTS                                          PAGE 1
                                              MAYBERRY, NC
                                           SURGERY SERVICE                          DATE REVIEWED:
                                     FROM: JAN 1,2006  TO: JUN 30,2006              REVIEWED BY:

ASSESSMENT #        PATIENT                                   OPERATIVE PROCEDURE(S)              ANESTHESIA TECHNIQUE
OPERATION DATE                        SURGEON
================================================================================================================================

** SURGICAL SPECIALTY: CARDIAC SURGERY **

28519               SURPATIENT,NINE 000-34-5555               * CABG X3 (2V,1A)                   GENERAL
JAN 05, 2006                          SURSURGEON,ONE
                                                              CPT Codes: 33736

--------------------------------------------------------------------------------------------------------------------------------

** SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW) **

63063               SURPATIENT,ONE    000-44-7629             INGUINAL HERNIA                     SPINAL
JUN 09, 2006                          SURSURGEON,TWO
                                                              CPT Codes: 49521


--------------------------------------------------------------------------------------------------------------------------------

** SURGICAL SPECIALTY: NEUROSURGERY **

63154               SURPATIENT,EIGHT 000-37-0555              CRANIOTOMY                          NOT ENTERED
JUN 24, 2006                          SURSURGEON,FOUR
                                                              CPT Codes: NOT ENTERED

--------------------------------------------------------------------------------------------------------------------------------
```

Example 2: List of Completed Assessments

```
Select Surgery Risk Assessment Menu Option: L List of Surgery Risk Assessments

List of Surgery Risk Assessments

  1. List of Incomplete Assessments
  2. List of Completed Assessments
  3. List of Transmitted Assessments
  4. List of Non-Assessed Major Surgical Cases
  5. List of All Major Surgical Cases
  6. List of All Surgical Cases
  7. List of Completed/Transmitted Assessments Missing Information
  8. List of 1-Liner Cases Missing Information
  9. List of Eligible Cases
 10. List of Cases With No CPT Codes
 11. Summary List of Assessed Cases

Select the Number of the Report Desired:  (1-11): 2

Start with Date: 1 1 06  (JAN 01, 2006)
End with Date: 6 30 06  (JUN 30, 2006)

Print by Surgical Specialty ?  YES// <Enter>

Print report for ALL specialties ?  YES// <Enter>

Do you want to print all divisions? YES// NO

1. MAYBERRY, NC
2. PHILADELPHIA, PA

Select Number:  (1-2): 1

This report is designed to print to your screen or a printer. When
using a printer, a 132 column format is used.

Print the List of Assessments to which Device: [Select Print Device]
```

----------*printout follows*----------

COMPLETED RISK ASSESSMENTS PAGE 1
MAYBERRY, NC
SURGERY SERVICE DATE REVIEWED:
FROM: JAN 1,2006 TO: JUN 30,2006 REVIEWED BY:

ASSESSMENT # / OPERATION DATE	PATIENT / OPERATIVE PROCEDURE	DATE COMPLETED	ANESTHESIA TECHNIQUE
** SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW) **			
92 FEB 23, 2006	SURPATIENT,SIXTY 000-56-7821 CHOLEDOCHOTOMY CPT Code: 47420	FEB 28, 2006	GENERAL
63045 MAR 01, 2006	SURPATIENT,FORTYONE 000-43-2109 INGUINAL HERNIA CPT Code: 49521	MAR 29, 2006	GENERAL
** SURGICAL SPECIALTY: OPHTHALMOLOGY **			
1898 APR 28, 2006	SURPATIENT,FORTYONE 000-43-2109 INTRAOCCULAR LENS	MAY 28, 2006 CPT Codes: NOT ENTERED	GENERAL

Example 3: List of Transmitted Assessments

```
Select Surgery Risk Assessment Menu Option: L List of Surgery Risk Assessments

List of Surgery Risk Assessments

  1. List of Incomplete Assessments
  2. List of Completed Assessments
  3. List of Transmitted Assessments
  4. List of Non-Assessed Major Surgical Cases
  5. List of All Major Surgical Cases
  6. List of All Surgical Cases
  7. List of Completed/Transmitted Assessments Missing Information
  8. List of 1-Liner Cases Missing Information
  9. List of Eligible Cases
 10. List of Cases With No CPT Codes
 11. Summary List of Assessed Cases

Select the Number of the Report Desired:  (1-11): 3

Print by Date of Operation or by Date of Transmission ?

   1. Date of Operation
   2. Date of Transmission

Select Number:  (1-2): 1// <Enter>

Start with Date: 1 1 06  (JAN 01, 2006)
End with Date: 6 30 06  (JUN 30, 2006)


Print which Transmitted Cases ?

   1. Assessed Cases Only
   2. Excluded Cases Only
   3. Both Assessed and Excluded

Select Number:  (1-3): 1// <Enter>

Print by Surgical Specialty ?  YES// <Enter>

Print report for ALL specialties ?  YES// N

Print the Report for which Surgical Specialty: GENERAL SURGERY  50     GENERAL
 SURGERY
     1   50  GENERAL SURGERY     50
     2   50  GASTROENTEROLOGY     50     GASTR
     3   50  TWO GENERAL     50     TG
CHOOSE 1-3: <Enter> SURGERY  GENERAL SURGERY     50

Do you want to print all divisions? YES// NO

1. MAYBERRY, NC
2. PHILADELPHIA, PA

Select Number:  (1-2): 1


This report is designed to print to your screen or a printer. When
using a printer, a 132 column format is used.

Print the List of Assessments to which Device: [Select Print Device]
```

----------*printout follows*----------

TRANSMITTED RISK ASSESSMENTS PAGE 1
MAYBERRY, NC
SURGERY SERVICE DATE REVIEWED:
OPERATION DATES FROM: JAN 1,2006 TO: JUN 30,2006 REVIEWED BY:

ASSESSMENT # / 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
 10. List of Cases With No CPT Codes
 11. Summary List of Assessed Cases

Select the Number of the Report Desired:  (1-11): 4

Start with Date: 1 1 06  (JAN 01, 2006)
End with Date: 6 30 06  (JUN 30, 2006)

Print by Surgical Specialty ?  YES// <Enter>

Print report for ALL specialties ?  YES// N

Print the Report for which Surgical Specialty: GENERAL(OR WHEN NOT
DEFINED BELOW)  GENERAL(OR WHEN NOT DEFINED BELOW)        50

Do you want to print all divisions? YES// NO

1. MAYBERRY, NC
2. PHILADELPHIA, PA

Select Number:  (1-2): 1


This report is designed to print to your screen or a printer. When
using a printer, a 132 column format is used.

Print the List of Assessments to which Device: [Select Print Device]
```

----------*printout follows*----------

```
                    NON-ASSESSED MAJOR SURGICAL CASES BY SURGICAL SPECIALTY                    PAGE 1
                                                MAYBERRY, NC
                                              SURGERY SERVICE                        DATE REVIEWED:
                                     FROM: JAN 1,2006  TO: JUN 30,2006               REVIEWED BY:

CASE #              PATIENT                                                              ANESTHESIA TECHNIQUE
OPERATION DATE      OPERATIVE PROCEDURE(S)                                               SURGEON
=============================================================================================================================

SURGICAL SPECIALTY: GENERAL(OR WHEN NOT DEFINED BELOW)

63071               SURPATIENT,FOUR  000-17-0555                                         GENERAL
FEB 08, 2006        INGUINAL HERNIA                                                      SURSURGEON,TWO
                    CPT Codes: 49505

63136               SURPATIENT,EIGHT  000-34-5555                                        GENERAL
MAR 07, 2006        CHOLECYSTECTOMY                                                      SURSURGEON,TWO
                    CPT Codes: 47605


TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 2
-----------------------------------------------------------------------------------------------------------------------------
```

Example 5: List of All Major Surgical Cases

```
Select Surgery Risk Assessment Menu Option: L List of Surgery Risk Assessments

List of Surgery Risk Assessments

  1. List of Incomplete Assessments
  2. List of Completed Assessments
  3. List of Transmitted Assessments
  4. List of Non-Assessed Major Surgical Cases
  5. List of All Major Surgical Cases
  6. List of All Surgical Cases
  7. List of Completed/Transmitted Assessments Missing Information
  8. List of 1-Liner Cases Missing Information
  9. List of Eligible Cases
 10. List of Cases With No CPT Codes
 11. Summary List of Assessed Cases

Select the Number of the Report Desired:  (1-11): 5

Start with Date: 1 1 06  (JAN 01, 2006)
End with Date: 6 30 06  (JUN 30, 2006)

Print by Surgical Specialty ?  YES// <Enter>

Print report for ALL specialties ?  YES// N

Print the Report for which Surgical Specialty: GENERAL(OR WHEN NOT
DEFINED BELOW)  GENERAL(OR WHEN NOT DEFINED BELOW)        50

Do you want to print all divisions? YES// NO

1. MAYBERRY, NC
2. PHILADELPHIA, PA

Select Number:  (1-2): 1


This report is designed to print to your screen or a printer. When
using a printer, a 132 column format is used.

Print the List of Assessments to which Device: [Select Print Device]
```

----------*printout follows*----------

ALL MAJOR SURGICAL CASES BY SURGICAL SPECIALTY PAGE 1
MAYBERRY, NC
SURGERY SERVICE DATE REVIEWED:
FROM: JAN 1,2006 TO: JUN 30,2006 REVIEWED BY:

CASE # / OPERATION DATE	PATIENT / OPERATIVE PROCEDURE(S)	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 Codes: 47420	COMPLETED SCNR WAS ON A/L	GENERAL SURSURGEON,TWO
63131 APR 21, 2006	SURPATIENT,FIFTYTWO 000-99-8888 PERINEAL WOUND EXPLORATION CPT Codes: NOT ENTERED	NO ASSESSMENT	GENERAL SURSURGEON,NINE
63136 JUN 07, 2006	SURPATIENT,EIGHT 000-34-5555 CHOLECYSTECTOMY CPT Codes: 47600	NO ASSESSMENT	GENERAL SURSURGEON,ONE
TOTAL GENERAL(OR WHEN NOT DEFINED BELOW): 3			

Example 6: List of All Surgical Cases

```
Select Surgery Risk Assessment Menu Option: L List of Surgery Risk Assessments

List of Surgery Risk Assessments

  1. List of Incomplete Assessments
  2. List of Completed Assessments
  3. List of Transmitted Assessments
  4. List of Non-Assessed Major Surgical Cases
  5. List of All Major Surgical Cases
  6. List of All Surgical Cases
  7. List of Completed/Transmitted Assessments Missing Information
  8. List of 1-Liner Cases Missing Information
  9. List of Eligible Cases
 10. List of Cases With No CPT Codes
 11. Summary List of Assessed Cases

Select the Number of the Report Desired:  (1-11): 6

Start with Date: 1 1 06  (JAN 01, 2006)
End with Date: 6 30 06  (JUN 30, 2006)

Print by Surgical Specialty ?  YES// <Enter>


Print report for ALL specialties ?  YES// N

Print the Report for which Surgical Specialty: 50       GENERAL(OR WHEN NOT DEFINED BELOW)
GENERAL(OR WHEN NOT DEFINED BELOW)        50

Do you want to print all divisions? YES// NO

1. MAYBERRY, NC
2. PHILADELPHIA, PA

Select Number:  (1-2): 1


This report is designed to print to your screen or a printer. When
using a printer, a 132 column format is used.

Print the List of Assessments to which Device: [Select Print Device]
```

----------*printout follows*----------

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
 10. List of Cases With No CPT Codes
 11. Summary List of Assessed Cases

Select the Number of the Report Desired:  (1-11): 7

Start with Date: 1 1 06  (JAN 01, 2006)
End with Date: 6 30 06  (JUN 30, 2006)

Print by Surgical Specialty ?  YES// <Enter>

Print report for ALL specialties ?  YES// <Enter>

Do you want to print all divisions? YES// NO

1. MAYBERRY, NC
2. PHILADELPHIA, PA

Select Number:  (1-2): 1
Print the List of Assessments to which Device: [Select Print Device]
```

----------*printout follows*----------

```
            COMPLETED/TRANSMITTED ASSESSMENTS MISSING INFORMATION       PAGE 1
                              MAYBERRY, NC
                        FROM: JAN 1,2006  TO: JUN 30,2006
                            DATE PRINTED: JUL 13,2006

** GENERAL(OR WHEN NOT DEFINED BELOW)

ASSESSMENT #      PATIENT                              TYPE           STATUS
OPERATION DATE    OPERATION(S)
================================================================================
63172             SURPATIENT,FIFTYTWO  000-99-8888   NON-CARDIAC    TRANSMITTED
MAY 17, 2006      REPAIR ARTERIAL BLEEDING
                  CPT Code: 33120
     Missing information:
     1. The final coding for Procedure and Diagnosis is not complete.
     2. Anesthesia Technique
--------------------------------------------------------------------------------
63185             SURPATIENT,SIXTEEN 000-11-1111      NON-CARDIAC   TRANSMITTED
APR 17, 2006      INGUINAL HERNIA, CHOLECYSTECTOMY
     Missing information:
     1. The final coding for Procedure and Diagnosis is not complete.
     2. Concurrent Case
     3. History of COPD (Y/N)
     4. Ventilator Dependent Greater than 48 Hrs (Y/N)
     5. Weight Loss > 10% of Usual Body Weight (Y/N)
     6. Transfusion Greater than 4 RBC Units this Admission (Y/N)
--------------------------------------------------------------------------------
63080             SURPATIENT,THIRTY  000-82-9472      EXCLUDED      COMPLETE
JAN 03, 2006      TURP
     Missing information:
     1. The final coding for Procedure and Diagnosis is not complete.


TOTAL FOR GENERAL(OR WHEN NOT DEFINED BELOW): 3

TOTAL FOR ALL SPECIALTIES: 3
```

Example 8: List of 1-Liner Cases Missing Information

```
Select Surgery Risk Assessment Menu Option: L List of Surgery Risk Assessments

List of Surgery Risk Assessments

  1. List of Incomplete Assessments
  2. List of Completed Assessments
  3. List of Transmitted Assessments
  4. List of Non-Assessed Major Surgical Cases
  5. List of All Major Surgical Cases
  6. List of All Surgical Cases
  7. List of Completed/Transmitted Assessments Missing Information
  8. List of 1-Liner Cases Missing Information
  9. List of Eligible Cases
 10. List of Cases With No CPT Codes
 11. Summary List of Assessed Cases

Select the Number of the Report Desired:  (1-11): 8

Start with Date: 2 27 06  (FEB 27, 2006)
End with Date: 6 30 06  (JUN 30, 2006)

Print by Surgical Specialty ?  YES// <Enter>

Print report for ALL specialties ?  YES// <Enter>

Do you want to print all divisions? YES// NO

1. MAYBERRY, NC
2. PHILADELPHIA, PA

Select Number:  (1-2): 1

Print the List of Assessments to which Device: [Select Print Device]
```

----------printout follows----------

```
                    1-LINER CASES MISSING INFORMATION                PAGE 1
                                 MABERRY, NC
                    FROM: FEB 27,2006  TO: JUN 30,2006
                         DATE PRINTED: JUN 30,2006

** UROLOGY

CASE #            PATIENT                              TYPE           STATUS
OP DATE           OPERATION(S)
================================================================================

317               SURPATIENT,FOURTEEN 000-45-7212     CARDIAC        COMPLETE
APR 10, 2006      Vasectomy
                  CPT Codes: NOT ENTERED
     Missing information:
     1. The final coding for Procedure and Diagnosis is not complete.
     2. Attending Code
     3. Wound Classification
     4. ASA Class
--------------------------------------------------------------------------------


TOTAL FOR UROLOGY: 1
```

Example 9: List of Eligible Cases

```
Select Surgery Risk Assessment Menu Option: L List of Surgery Risk Assessments

List of Surgery Risk Assessments

  1. List of Incomplete Assessments
  2. List of Completed Assessments
  3. List of Transmitted Assessments
  4. List of Non-Assessed Major Surgical Cases
  5. List of All Major Surgical Cases
  6. List of All Surgical Cases
  7. List of Completed/Transmitted Assessments Missing Information
  8. List of 1-Liner Cases Missing Information
  9. List of Eligible Cases
 10. List of Cases With No CPT Codes
 11. Summary List of Assessed Cases

Select the Number of the Report Desired:  (1-11): 9

Start with Date: 6 1 06  (JUN 01, 2006)
End with Date: 6 30 07  (JUN 30, 2007)

Print which Eligible Cases ?

   1. Assessed Cases Only
   2. Excluded Cases Only
   3. Non-Assessed Cases only
   4. All Cases

Select Number:  (1-4): 1// <Enter>

Print by Surgical Specialty ?  YES// <Enter>
Print report for ALL specialties ?  YES// NO  NO

Print the Report for which Surgical Specialty: GENERAL SURGERY  50     GENERAL SURGERY

Do you want to print all divisions? YES// NO

1. MAYBERRY, NC
2. PHILADELPHIA, PA

Select Number:  (1-2): 1

Print the List of Assessments to which Device: [Select Print Device]
```

----------*printout follows*----------

```
                    CASES ELIGIBLE FOR ASSESSMENT                  PAGE 1
                              MAYBERRY, NC
                        FROM: JUN 1,2006  TO: JUN 30,2007
                            DATE PRINTED: JUN 30,2007

                                                  '*' Denotes Eligible CPT Code
>>> CARDIAC SURGERY

CASE #            PATIENT                            TYPE           STATUS
OP DATE           OPERATION(S)
================================================================================
10095             SURPATIENT,SEVENTY 000-00-0125     CARDIAC        COMPLETE
JUN 04, 2006      CABG, REGRAFT

>>> Final CPT Coding is not complete.
CPT Codes: *33510, *33511
--------------------------------------------------------------------------------
10084             SURPATIENT,NINE 000-34-5555        CARDIAC        COMPLETE
JUL 08, 2006      CABG

CPT Codes: *33502, 11402
--------------------------------------------------------------------------------
10380             SURPATIENT,THREE 000-21-2453       NOT LOGGED     COMPLETE
FEB 06, 2007      CORONARY ARTERY BYPASS

CPT Codes: NOT ENTERED
--------------------------------------------------------------------------------
10383             SURPATIENT,ONE 000-44-7629         NON-CARDIAC    COMPLETE
FEB 08, 2007      STENT

CPT Codes: NOT ENTERED
--------------------------------------------------------------------------------

TOTAL FOR CARDIAC SURGERY: 4

>>> GENERAL SURGERY

CASE #            PATIENT                            TYPE           STATUS
OP DATE           OPERATION(S)
================================================================================
10061             SURPATIENT,FIFTEEN 666-98-1288     NON-CARDIAC    COMPLETE
FEB 11, 2007      APPENDECTOMY, SPLENECTOMY

>>> Final CPT Coding is not complete.
CPT Codes: *44955, *38100
--------------------------------------------------------------------------------
10079             SURPATIENT,SEVENTY 000-00-0125     EXCLUDED       COMPLETE
MAR 31, 2007      HERNIA

>>> Final CPT Coding is not complete.
CPT Codes: *49521, *49521
--------------------------------------------------------------------------------

TOTAL FOR GENERAL SURGERY: 2
```

Example 10: List of Cases With No CPT Codes

```
Select Surgery Risk Assessment Menu Option: L List of Surgery Risk Assessments

List of Surgery Risk Assessments

  1. List of Incomplete Assessments
  2. List of Completed Assessments
  3. List of Transmitted Assessments
  4. List of Non-Assessed Major Surgical Cases
  5. List of All Major Surgical Cases
  6. List of All Surgical Cases
  7. List of Completed/Transmitted Assessments Missing Information
  8. List of 1-Liner Cases Missing Information
  9. List of Eligible Cases
 10. List of Cases With No CPT Codes
 11. Summary List of Assessed Cases

Select the Number of the Report Desired:  (1-11): 10

Start with Date: 1 1 07  (JAN 01, 2007)
End with Date: T  (JAN 23, 2008)

Print by Surgical Specialty ?  YES// <Enter>

Print report for ALL specialties ?  YES// <Enter>

Do you want to print all divisions? YES// <Enter>
Print the List of Assessments to which Device: HOME// [Select Print Device]
```

----------*printout follows*----------

CASES WITHOUT CPT CODES PAGE 1
ALBANY - ALL DIVISIONS
FROM: JAN 1,2007 TO: JAN 23,2008
DATE PRINTED: JAN 23,2008

>>> CARDIAC SURGERY

CASE # / OP DATE	PATIENT / OPERATION(S)	TYPE	STATUS
10429 FEB 12, 2007	SURPATIENT,TEN 666-12-3456 CABG	CARDIAC	COMPLETE
10420 FEB 12, 2007	SURPATIENT,F. 666-00-0804 CABG	CARDIAC	TRANSMITTED
10423 MAR 12, 2007	SURPATIENT,TWO 666-45-1982 cabg	CARDIAC	INCOMPLETE
10430 MAR 18, 2007	SURPATIENT,EIGHT 666-37-0555 CABG X3	CARDIAC	INCOMPLETE
10374 MAY 10, 2007	SURPATIENT,NINE 666-34-5555 CABG X 3	NOT LOGGED	NO ASSESSMENT

TOTAL FOR CARDIAC SURGERY: 5

TOTAL FOR ALL SPECIALTIES: 5

Example 11: Summary List of Assessed Cases

```
Select Surgery Risk Assessment Menu Option: L List of Surgery Risk Assessments

List of Surgery Risk Assessments

  1. List of Incomplete Assessments
  2. List of Completed Assessments
  3. List of Transmitted Assessments
  4. List of Non-Assessed Major Surgical Cases
  5. List of All Major Surgical Cases
  6. List of All Surgical Cases
  7. List of Completed/Transmitted Assessments Missing Information
  8. List of 1-Liner Cases Missing Information
  9. List of Eligible Cases
 10. List of Cases With No CPT Codes
 11. Summary List of Assessed Cases

Select the Number of the Report Desired:  (1-11): 11

Start with Date: 01 01 08  (JAN 01, 2008)
End with Date: 01 30 08  (JAN 30, 2008)

Print by Surgical Specialty ?  YES// <Enter>

Print report for ALL specialties ?  YES// <Enter>

Do you want to print all divisions? YES// NO

1. ALBANY
2. PHILADELPHIA, PA

Select Number:  (1-2): 1
Print the List of Assessments to which Device: HOME// [Select Print Device]
```

SUMMARY LIST OF ASSESSED CASES PAGE 1
ALBANY
FROM: JAN 1,2001 TO: JAN 23,2008
DATE PRINTED: JAN 23,2008

SURGICAL SPECIALTY	INCOMPLETE	COMPLETE	TRANSMITTED	EXCLUDED
CARDIAC SURGERY	8	1	1	0
GENERAL SURGERY	17	1	1	6
NEUROSURGERY	1	0	1	0
OPHTHALMOLOGY	2	0	0	0
ORTHOPEDICS	2	0	0	0
OTORHINOLARYNGOLOGY (ENT)	1	0	0	0
PLASTIC SURGERY (INCLUDES HEAD	2	0	0	0
TWO GENERAL	1	0	0	0
UROLOGY	0	0	0	1
TOTAL FOR ALL SPECIALTIES:	34	2	3	7

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

Exclusion Criteria (Enter/Edit)

[SR NO ASSESSMENT REASON]

The *Exclusion Criteria (Enter/Edit)* option is used to flag major cases that will not have a surgery risk assessment due to certain exclusion criteria. At the prompt "Reason an Assessment was not Created:" enter a question mark (**?**) to see a list of reasons.

Example: Enter Reason for No Assessment

```
Select Surgery Risk Assessment Menu Option: R Exclusion Criteria (Enter/Edit)

Select Patient: R9922  SURPATIENT,NINE         03-03-34     000345555     NO     SC
 VETERAN

SURPATIENT,NINE   000-34-5555

1. 11-01-04   TURP (COMPLETED)

2. 08-01-03   CABG X3 (1A,2V), ARTERIAL GRAFTING (COMPLETED)

3. 07-03-01   PULMONARY LOBECTOMY, TURP (COMPLETED)


Select Operation: 1

Reason an Assessment was not Created: 6  SCNR WAS ON ANNUAL LEAVE

SURPATIENT,NINE (000-34-5555)        Case #63159
Transmission Status: QUEUED TO TRANSMIT
NOV 1,2004   TURP (CPT Code: 52601-59)
------------------------------------------------------------------------------

1. Exclusion Criteria:             SCNR WAS ON A/L
2. Surgical Priority:              ELECTIVE
3. Surgical Specialty:             UROLOGY
4. Principal Anesthesia Technique: GENERAL
5. Major or Minor:                 MAJOR

------------------------------------------------------------------------------

Select Excluded Case Information to Edit:
```

(This page included for two-sided copying.)

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 VASQIP 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
-------------------------------------------------
```

M&M Verification Report

[SRO M&M VERIFICATION REPORT]

The *M&M Verification Report* option produces the M&M Verification Report, which may be useful for:

- reviewing occurrences and their assignment to operations
- reviewing death unrelated/related assignments to operations

The full report includes all patients who had operations within the selected date range who experienced intraoperative occurrences, postoperative occurrences or death within 90 days of surgery. The pre-transmission report is similar but includes operations with completed risk assessments that have not yet transmitted to the national database.

Full Report:

Information is printed by patient, listing all operations for the patient that occurred during the selected date range, plus any operations that may have occurred within 30 days prior to any postoperative occurrences or within 90 days prior to death. Therefore, this report may include some operations that were performed prior to the selected date range and, if printed by specialty, may include operations performed by other specialties. For every operation listed, the intraoperative and postoperative occurrences are listed. The report indicates if the operation was flagged as unrelated or related to death and the risk assessment type and status. The report may be printed for a selected list of surgical specialties.

Pre-Transmission Report:

Information is printed in a format similar to the full report. This report lists all completed risk assessed operations that have not yet transmitted to the national database and that have intraoperative occurrences, postoperative occurrences, or death within 90 days of surgery. The report includes any operations that may have occurred within 30 days prior to any postoperative occurrences or within 90 days prior to death. Therefore, this report may include some operations that may or may not be risk assessed, and, if risk assessed, may have a status other than 'complete'. However, every patient listed on this report will have at least one operation with a risk assessment status of 'complete'.

Example 1: Generate an M&M Verification Report (Full Report)

```
Select Surgery Risk Assessment Menu Option: V  M&M Verification Report

                              M&M Verification Report

The M&M Verification Report is a tool to assist in the review of occurrences
and their assignment to operations and in the review of death unrelated or
related assignments to operations.

The full report includes all patients who had operations within the selected
date range who experienced intraoperative occurrences, postoperative
occurrences or death within 90 days of surgery. The pre-transmission report
is similar but includes only operations with completed risk assessments that
have not yet transmitted to the national database.
```

```
Print which report ?

1. Full report for selected date range.
2. Pre-transmission report for completed risk assessments.

Enter selection (1 or 2): 1// <Enter>
Start with Date: 03 01 07  (MAR 01, 2007)
End with Date: 03 30 07  (MAR 30, 2007)

Do you want to print all divisions? YES// <Enter>

Do you want to print this report for all Surgical Specialties ? YES// <Enter>

This report is designed to use a 132 column format.

Print report on which Device: [Select Print Device]
```

----------*printout follows*----------

```
OP DATE    CASE #        SURGICAL SPECIALTY                                  ASSESSMENT TYPE   STATUS            DEATH RELATED
           PRINCIPAL PROCEDURE
================================================================================================================================
>>> SURPATIENT,FIVE (666-58-7963)

03/01/07   10401         GENERAL SURGERY                                     NON-CARDIAC       TRANSMITTED       N/A
           APPENDECTOMY
           CPT Codes: 44970
           Occurrences: ACUTE RENAL FAILURE  ** POSTOP **  (03/02/07)

--------------------------------------------------------------------------------------------------------------------------------
>>> SURPATIENT,ONE (666-44-7629)

03/07/07   10421         GENERAL SURGERY                                     NON-CARDIAC       TRANSMITTED       N/A
           APPENDECTOMY, CHOLECYSTECTOMY
           CPT Codes: 44950, 47610
           Occurrences: URINARY TRACT INFECTION  ** POSTOP **  (03/09/07)
                        ACUTE RENAL FAILURE  ** POSTOP **  (03/10/07)
                        OTHER RESPIRATORY OCCURRENCE  ** POSTOP **  (03/10/07)
                          ICD: 478.25  EDEMA PHARYNX/NASOPHARYX
--------------------------------------------------------------------------------------------------------------------------------
>>> SURPATIENT,TWO (666-45-1982)

03/07/07   10422         NEUROSURGERY                                        NON-CARDIAC       TRANSMITTED       N/A
           LAMINECTOMY
           CPT Codes: 22630
           Occurrences: OTHER OCCURRENCE  (03/07/07)
                         ICD: 415.19  OTH PULM EMB & INFARC

--------------------------------------------------------------------------------------------------------------------------------
>>> SURPATIENT,ELEVEN (666-00-0748) - DIED 03/10/07@14:50

03/10/07   10100         GENERAL SURGERY                                     NON-CARDIAC       INCOMPLETE         NO
           REMOVAL OF GALLBLADDER
           CPT Codes: 47600
           Occurrences: PULMONARY EMBOLISM  ** POSTOP **  (03/10/07)
                         >>> Comments:
                             Patient complained of chest pain and shortness of breath. Heparin was administered immediately by IV.
           Date of Death: 03/10/07@14:50
           Review of Death Comments:  Patient expired from large pulmonary embolus before anticoagulant treatment could take effect.
                                      Patient's obesity and prolonged immobilization were likely contributing factors.
--------------------------------------------------------------------------------------------------------------------------------
```

Example 2: Generate an M&M Verification Report (Pre-Transmission Report)

```
Select Surgery Risk Assessment Menu Option: V  M&M Verification Report

                              M&M Verification Report

The M&M Verification Report is a tool to assist in the review of occurrences
and their assignment to operations and in the review of death unrelated or
related assignments to operations.

The full report includes all patients who had operations within the selected
date range who experienced intraoperative occurrences, postoperative
occurrences or death within 90 days of surgery. The pre-transmission report
is similar but includes only operations with completed risk assessments that
have not yet transmitted to the national database.

Print which variety of the report ?

1. Print full report for selected date range.
2. Print pre-transmission report for completed risk assessments.

Enter selection (1 or 2): 1// 2

Do you want to print all divisions? YES// <Enter>

Do you want to print this report for all Surgical Specialties ? YES// <Enter>

This report is designed to use a 132 column format.

Print report on which Device: [Select Print Device]
```

----------*printout follows*----------

```
OP DATE    CASE #        SURGICAL SPECIALTY                                  ASSESSMENT TYPE   STATUS            DEATH RELATED
           PRINCIPAL PROCEDURE
================================================================================================================================
>>> SURPATIENT,TWELVE (666-00-0762)

09/21/07   45466         PLASTIC SURGERY                                     NON-CARDIAC       COMPLETE          N/A
           RHINOPLASTY
           CPT Codes: 30410
           Occurrences: DEEP INCISIONAL SSI  ** POSTOP **  (09/23/07)

--------------------------------------------------------------------------------------------------------------------------------
>>> SURPATIENT,FIFTEEN (666-00-0194)

09/16/07   45475         EAR, NOSE, THROAT (ENT)                             NON-CARDIAC       COMPLETE          N/A
           LARYNGECTOMY (TOTAL)
           CPT Codes: 31360
           Occurrences: BLEEDING/TRANSFUSIONS  ** POSTOP **  (09/17/07)
                         >>> Comments:
                             Esophageal varices were the source of bleeding.

--------------------------------------------------------------------------------------------------------------------------------
>>> SURPATIENT,FORTY (666-00-4174)

09/19/07   45499         GENERAL SURGERY                                     NON-CARDIAC       COMPLETE          N/A
           INGUINAL HERNIA
           CPT Codes: 49505
           Occurrences: URINARY TRACT INFECTION  ** POSTOP **  (09/21/07)

--------------------------------------------------------------------------------------------------------------------------------
```

(This page included for two-sided copying.)

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 VASQIP database as a single line or two of data). Cases edited with this option will be queued for transmission to the VASQIP 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.)

Queue Assessment Transmissions
[SROA TRANSMIT ASSESSMENTS]

The *Queue Assessment Transmissions* option may be used to manually queue the VASQIP transmission process to run at a selected time. The VASQIP transmission process is a part of the nightly maintenance and cleanup process.

Example: Queue Assessment Transmissions

```
Select Surgery Risk Assessment Menu Option: T  Queue Assessment Transmissions

Transmit Surgery Risk Assessments

Requested Start Time: NOW// <Enter>

Queued as task #2651700

Press RETURN to continue
```

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Alert Coder Regarding Coding Issues

[SROA CODE ISSUE]

This option allows the nurse reviewer to send an alert to the coder when there may be an issue with the CPT codes or the Postoperative Diagnosis codes for a Surgery case. When this option is selected, the nurse reviewer can enter a free-text message that will be sent to the coder on record, as well as to a pre-defined mail group identified in the Surgery Site Parameter titled CODE ISSUE MAIL GROUP. The message will not be sent if there is no coder, or if the mail group is not defined.

Example : Alert Coder Regarding Coding Issues

```
Select Surgery Risk Assessment Menu Option: CODE  Alert Coder Regarding Coding
Issues
```

```
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 Operation: 1
```

```
SURPATIENT,TWELVE (000-41-8719)        Case #142
AUG 7,2004   REPAIR DIAPHRAGMATIC HERNIA
------------------------------------------------------------------------

The following "final" codes have been entered for the case.

Principal CPT Code: 39540 REPAIR DIAPHRAGMATIC HERNIA
Other CPT Codes:    NOT ENTERED
Postop Diagnosis Code (ICD9): 551.3 DIAPHRAGM HERNIA W GANGR (w C/C)


If you believe that the information coded is not correct and would like to
alert the coders of the potential issue, enter a brief description of your
concern below.

Do you want to alert the coders (Y/N)? YES// <Enter>
```

```
==[ WRAP ]==[ INSERT ]=====< Coding Discrepancy Comments >===[ <PF1>H=Help ]====
I have reviewed this case for VASQIP. The final Principal CPT Code entered
is 39540. I would like to talk to you regarding the code. I think the code
should be 39541. Please call me at X2545.
<=======T=======T=======T=======T=======T=======T=======T=======T=======T>======
```

```
1. Transmit Message
2. Edit Text

Select Number:  1//  <Enter>

Transmitting message...
```

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Risk Model Lab Test

[SROA LAB TEST EDIT]

In order to assist the nurse reviewer, in the *Surgery Risk Assessment Menu* is the *Risk Model Lab Test (Enter/Edit)* option, which allows the nurse to map VASQIP data in the RISK MODEL LAB TEST file (#139.2). The option synonym is ERM.

```
Risk Model Lab Test (Enter/Edit)
Select Surgery Risk Assessment Menu Option:  Risk Model Lab Test (Enter/Edit)




           Risk Model Lab Test (Enter/Edit)

 Select item to edit from list below:

 1. ALBUMIN                      14. INR
 2. ALKALINE PHOSPHATASE         15. LDL
 3. ANION GAP                    16. PLATELET COUNT
 4. B-TYPE NATRIURETIC PEPTIDE   17. POTASSIUM
 5. BUN                          18. PT
 6. CHOLESTEROL                  19. PTT
 7. CPK                          20. SGOT
 8. CPK-MB                       21. SODIUM
 9. CREATININE                   22. TOTAL BILIRUBIN
10. HDL                          23. TRIGLYCERIDE
11. HEMATOCRIT                   24. TROPONIN I
12. HEMOGLOBIN                   25. TROPONIN T
13. HEMOGLOBIN A1C               26. WHITE BLOOD COUNT

Enter number (1-25): 6
```

```
           Risk Model Lab Test (Enter/Edit)


                Test Name: CHOLESTEROL

  Laboratory Data Name(s): NONE ENTERED

                 Specimen: SERUM


Do you want to edit this test ? NO// YES

Select LABORATORY DATA NAME: CHOLESTEROL
     1   CHOLESTEROL
     2   CHOLESTEROL CRYSTALS
CHOOSE 1-2: 1  CHOLESTEROL
Select LABORATORY DATA NAME: <Enter>
Specimen: SERUM// <Enter>
```

```
                      Risk Model Lab Test (Enter/Edit)

 Select item to edit from list below:

 1. ALBUMIN                      14. INR
 2. ALKALINE PHOSPHATASE         15. LDL
 3. ANION GAP                    16. PLATELET COUNT
 4. B-TYPE NATRIURETIC PEPTIDE   17. POTASSIUM
 5. BUN                          18. PT
 6. CHOLESTEROL                  19. PTT
 7. CPK                          20. SGOT
 8. CPK-MB                       21. SODIUM
 9. CREATININE                   22. TOTAL BILIRUBIN
10. HDL                          23. TRIGLYCERIDE
11. HEMATOCRIT                   24. TROPONIN I
12. HEMOGLOBIN                   25. TROPONIN T
13. HEMOGLOBIN A1C               26. WHITE BLOOD COUNT

Enter number (1-26):
```

Page 523 has been deleted. Chapter Seven: CoreFLS/Surgery Interface has been removed.

(This page included for two-sided copying.)

Chapter Seven: Code Set Versioning

The Code Set Versioning enhancement to the Surgery package ensures that only CPT codes, CPT modifiers, and ICD codes that are active for the operation or procedure date will be available for selection by the user, regardless of when the CPT entry or edit is made. Also, when a future operation or procedure date is entered, only active codes will be available.

It is possible that a new code set will be loaded between the time that an operation or procedure is scheduled and the time the operation or procedure occurs. Re-validation of the codes and modifiers occurs when the date and time that a patient enters the operating room is entered in the Surgery package. If the code (CPT or ICD) or CPT modifier is invalid — inactive for the date of operation or procedure — the inactive codes or modifiers will be deleted. Then, these two actions transpire:

1. A warning message displays on the screen, corresponding to the specific code or modifier that is inactive.
2. A MailMan message is sent to the surgeon (or provider), attending surgeon of record, and to the user who edited the record. The MailMan message contains the patient's name, date of operation, case number, free-text operation or procedure name, CPT or ICD codes, CPT modifiers deleted (if any), and the reason for deletion.

The first sample warning message shows an inactive CPT code, its modifiers, and ICD-10 codes, and the second warning message is for a Non-O.R. procedure.

Example: Warning Message to Surgeon

```
The following codes are no longer active and will be deleted for case # 45715.

       PRIN DIAGNOSIS CODE (ICD10):  H54.0

New active codes must be re-entered. A MailMan message will be sent to the surgeon and attending
surgeon of record and to the user who edited the record with case details for follow-up.
```

Example: Warning Message to Provider

```
The following codes are no longer active and will be deleted for case #:242

       PRINCIPAL CPT CODE:    00869
       CPT MODIFIER:          23  UNUSUAL ANESTHESIA

New active codes must be re-entered. A MailMan message will be sent to
the provider and attending provider of record and to the user who edited
the record with case details for follow-up.
```

The following sample MailMan message is sent to the surgeon, attending surgeon of record, and to the user who edited the record. The sample shows ICD codes, CPT codes, and CPT modifiers that are inactive.

Example: MailMan Message to Surgeon ICD-9 Code

```
Subj: ICD-9 OR CPT CODE DELETION  [#208145] 05/06/14@09:56  11 lines
From: SURGERY PACKAGE  In 'IN' basket.   Page 1  *New*
------------------------------------------------------------------------------
Patient: SRPATIENTA,ONE                 Case #: 45804
Operation Date: MAY 06, 2014@11:11      OBS
```

```
The following codes are no longer active and were deleted for this
case when the Time Patient in OR was entered.


        PRIN DIAGNOSIS CODE (ICD9):        600.01


New active codes must be re-entered.
```

Example: MailMan Message to Surgeon ICD-10 Code

```
Subj: ICD OR CPT CODE DELETION  [#207963] 04/18/14@16:21  11 lines
From: SURGERY PACKAGE  In 'IN' basket.   Page 1
---------------------------------------------------------------------------
Patient: SRPATIENTB,TWO                 Case #: 45715
Operation Date: JAN 01, 2012@13:33      KIDNEY PROBLEMS

The following codes are no longer active and were deleted for this
case when the Time Patient in OR was entered.


        PRIN DIAGNOSIS CODE (ICD10):        H54.0


New active codes must be re-entered.

Enter message action (in IN basket): Ignore//
```

For Non-O.R. procedures, the MailMan message is sent to the provider and attending provider.

Example: MailMan Message to Provider

```
Subj: ICD OR CPT CODE DELETION  [#88073] 06/26/03@12:32  12 lines
From: SURGERY PACKAGE  In 'IN' basket.   Page 1  *New*
---------------------------------------------------------------------------
Patient: SURPATIENT,ONE                    CASE #: 242
OPERATION DATE: JUN 26, 2003      STELLATE NERVE BLOCK

The following codes are no longer active and were deleted for this
case when the Time Procedure Began was entered.

        PRINCIPAL CPT CODE:         00869
         CPT MODIFIER:              23  UNUSUAL ANESTHESIA

New active codes must be re-entered.

Enter message action (in IN basket): Ignore//
```

The following options allow for re-validation of the ICD and CPT codes and modifiers when the TIME PAT IN OR field or TIME PROCEDURE BEGAN field is entered.

- *Operation*
- *Operation (Short Screen)*
- *Edit Non-O.R. Procedure*
- *Operation Information (Enter/Edit)*
- *Resource Data*

Chapter Eight: Assessing Transplants

Introduction

The Transplant Assessment module allows qualified personnel to create and manage transplant assessments. Menu options provide the ability to enter transplant assessment information for a patient and transmit the assessment to the Veterans Affairs Surgery Quality Improvement Program (VASQIP) national databases. Options are also provided to print and list transplant assessments.

(This page included for two-sided copying.)

Transplant Assessment Menu
[SR TRANSPLANT ASSESSMENT]

The *Transplant Assessment Menu* contains options that allow transplant coordinators to create and manage transplant assessments for the following transplant types.

- Kidney
- Liver
- Lung
- Heart

The menu options provide the opportunity to enter information concerning a new transplant assessment and to edit, list, print, and update an existing patient assessment.

 This menu is locked with the SR TRANSPLANT security key.

This chapter follows the main menu of the Transplant Assessment module and contains descriptions of the options and sub-options needed to maintain a transplant assessment, transmit data, and create reports. The options are organized to follow a logical workflow sequence. Each option description is divided into two main parts: an overview and a detailed example.

The top-level options included in this menu are listed in the following table. To the left is the shortcut synonym that the user can enter to select the option.

Shortcut	Option Name
E	*Enter/Edit Transplant Assessments*
P	*Print Transplant Assessment*
L	*List of Transplant Assessments*
S	*Transplant Assessment Parameters (Enter/Edit)*

(This page included for two-sided copying.)

Enter/Edit Transplant Assessments

[SR TRANSPLANT ENTER/EDIT]

Transplant coordinators use the *Enter/Edit Transplant Assessments* option to enter a new transplant assessment. This option is also used to make changes to an assessment that has already been entered. This option also allows the assessment to be completed and transmitted.

Creating a New Transplant Assessment

Perform the following steps to create a transplant assessment.

1. The user is prompted to select a patient name which will display any previously entered assessments for the patient selected. The user can then choose to create a new assessment.

2. After choosing to create a new assessment, the user will select one of the following transplant types.

   - Kidney
   - Liver
   - Lung
   - Heart

   Note: The ability to select a transplant type is based on how your transplant assessment parameters are set. Your facility may not perform every type of transplant.

3. After choosing a transplant type, the user responds to the prompt, "Is this a VA or a Non-VA Transplant (V or N):" with one of the following responses.

   - V for VA
   - N for non-VA

     Note: If the user identifies the transplant as non-VA, the user will be asked to enter the transplant date.

     Note: If the user identifies the transplant as VA, the user will be asked to associate the assessment with an existing Surgery case.

4. The user then supplies a VACO ID number and presses **<Enter>**. A series of data entry forms appear and must be filled in to complete the transplant assessment.

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 Transplant Assessment

In our example for creating a new transplant assessment, a VA Kidney Transplant will be created. The process for creating a lung, liver, and heart transplant assessments is similar. Because the option works the same for creating these other organ transplant assessments, a specific example for these other organs will not be displayed.

```
                                  Division: ALBANY  (500)


   E      Enter/Edit Transplant Assessments
   P      Print Transplant Assessment
   L      List of Transplant Assessments
   S      Transplant Assessment Parameters (Enter/Edit)

Select Transplant Assessment Menu Option: E Enter/Edit Transplant Assessments

Select Patient:    SURPATIENT,NINETYSIX  05-05-64  666000288     NSC VETERAN
```

```
SURPATIENT,NINETYSIX   666-00-0288


1.   ----     CREATE NEW TRANSPLANT ASSESSMENT


Select Assessment: 1

1. Kidney
2. Liver
3. Lung
4. Heart

Select Type of Transplant:  (1-4):1

Is this a VA or a Non-VA Transplant (V or N): V
```

```
SURPATIENT,NINETYSIX  666-00-0288


1. 09-03-98   APPENDECTOMY (COMPLETED)

2. 06-17-08   KIDNEY TRANSPLANT (COMPLETED)


Select Operation: 2

Sure you want to create a Transplant Assessment for this surgical case? YES// Y

VACO ID: 12121
```

```
SURPATIENT,NINETYSIX (0288)   VACO ID: 12121   CASE: 482          PAGE: 1 OF 5
JUN 17,2008   KIDNEY TRANSPLANT                          RECIPIENT INFORMATION
------------------------------------------------------------------------------
1.  VACO ID:                  12121
2.  Date Placed on Waiting:
3.  Date Started Dialysis:
4.  Recipient ABO Blood Type:
5.  Recipient CMV:

Diagnosis Information
=====================
6.  Calcineurin Inhibitor Toxicity:      13. Obstructive Uropathy from BPH:
7.  Glomerular Sclerosis/Nephritis:      14. Polycistic Disease:
8.  Graft Failure:                       15. Renal Cancer:
9.  IgA Nephropathy:                     16. Rejection:
10. Lithium Toxicity:
11. Membranous Nephropathy:

12. Transplant Comments:
------------------------------------------------------------------------------
Select Transplant Information to Edit: 2:5
```

```
SURPATIENT,NINETYSIX (0288)   VACO ID: 12121   CASE: 482
JUN 17,2008   KIDNEY TRANSPLANT
------------------------------------------------------------------------------



Date Placed on Waiting List: 05/04/2008  (MAY 04, 2008)
Date Started Dialysis: 1 21 08  (JAN 21, 2008)
Recipient ABO Blood Type: O  O
Recipient CMV: +  POSITIVE
```

```
SURPATIENT,NINETYSIX (0288)   VACO ID: 12121   CASE: 482          PAGE: 1 OF 5
JUN 17,2008   KIDNEY TRANSPLANT                          RECIPIENT INFORMATION
------------------------------------------------------------------------------
1.  VACO ID:                  12121
2.  Date Placed on Waiting:   MAY 04, 2008
3.  Date Started Dialysis:    JAN 21, 2008
4.  Recipient ABO Blood Type: O
5.  Recipient CMV:            POSITIVE

Diagnosis Information
=====================
6.  Calcineurin Inhibitor Toxicity:      13. Obstructive Uropathy from BPH:
7.  Glomerular Sclerosis/Nephritis:      14. Polycistic Disease:
8.  Graft Failure:                       15. Renal Cancer:
9.  lgA Nephropathy:                     16. Rejection:
10. Lithium Toxicity:
11. Membranous Nephropathy:
12. Transplant Comments:
------------------------------------------------------------------------------
Select Transplant Information to Edit: <Enter>
```

```
SURPATIENT,NINETYSIX (0288)   VACO ID: 12121   CASE: 482          PAGE: 2 OF 5
JUN 17,2008   KIDNEY TRANSPLANT                 KIDNEY TRANSPLANT INFORMATION
--------------------------------------------------------------------------------

1.  Warm Ischemia time:
2.  Cold Ischemia time:
3.  Total Ischemia time:
4.  Crossmatch D/R:
5.  PRA at Listing:
6.  PRA at Transplant:
7.  IVIG Recipient:
8.  Plasmapheresis:

HLA Typing (#,#,#,#)
====================
9.  Recipient HLA-A:
10. Recipient HLA-B:
11. Recipient HLA-C:
12. Recipient HLA-DR:
13. Recipient HLA-BW:
14. Recipient HLA-DQ:

--------------------------------------------------------------------------------
Select Transplant Information to Edit: <Enter>
```

```
SURPATIENT,NINETYSIX (0288)   VACO ID: 12121   CASE: 482          PAGE: 3 OF 5
JUN 17,2008   KIDNEY TRANSPLANT                              RISK ASSESSMENT
--------------------------------------------------------------------------------

1.  Diabetic Retinopathy:
2.  Diabetic Neuropathy:
3.  Cardiac Disease:
4.  Liver Disease:
5.  HIV + (positive):
6.  Lung Disease:
7.  Pre-Transplant Malignancy:
8.  Active Infection Immediately Pre-TX req. Antibiotics:
9.  Non-Compliance (Med and Diet):
10. Recipient Substance Abuse:
11. Post-TX Prophylaxis for CMV/Antiviral Treatment:
12. Post-TX Prophylaxis for PCP/Antibiotic Treatment:
13. Post-TX Prophylaxis for TB/Antimycobacterial Treatment:
14. Graft Failure Date:

--------------------------------------------------------------------------------

Select Transplant Information to Edit: <Enter>
```

```
SURPATIENT,NINETYSIX (0288)   VACO ID: 12121   CASE: 482          PAGE: 4 OF 5
JUN 17,2008   KIDNEY TRANSPLANT                              DONOR INFORMATION
-------------------------------------------------------------------------------

1.  Donor Race:
2.  Donor Gender:
3.  Donor Height:                          HLA Typing (#,#,#,#)
4.  Donor Weight:                          ====================
5.  Donor DOB:                             13. Donor HLA-A:
6.  Donor Age:                             14. Donor HLA-B:
7.  Donor ABO Blood Type:                  15. Donor HLA-C:
8.  Donor CMV:                             16. Donor HLA-DR:
9.  Donor Substance Abuse:                 17. Donor HLA-BW:
10. Deceased Donor:                        18. Donor HLA-DQ:
11. Living Donor:
12. Donor with Malignancy:

-------------------------------------------------------------------------------

Select Transplant Information to Edit: <Enter>
```

```
SURPATIENT,NINETYSIX (0288)   VACO ID: 12121   CASE: 482          PAGE: 5 OF 5
JUN 17,2008   KIDNEY TRANSPLANT                           PANCREAS INFORMATION
-------------------------------------------------------------------------------

1. Pancreas (SPK/PAK):             NO STUDY
2. Glucose at Time of Listing:     NO STUDY
3. C-peptide at Time of Listing:   NO STUDY
4. Pancreatic Duct Anastomosis:    NO STUDY
5. Glucose Post Transplant:        NO STUDY
6. Amylase Post Transplant:        NO STUDY
7. Lipase Post Transplant:         NO STUDY
8. Insulin Req Post transplant:    NO STUDY
9. Oral Hypoglycemics Req Post-TX: NO STUDY

-------------------------------------------------------------------------------

Select Transplant Information to Edit: <Enter>

Are you ready to complete and transmit this transplant assessment? NO// <Enter>
```

Edit a Transplant Assessment

When selecting an existing transplant assessment, the user has the following options.

- Enter Transplant Assessment Information
- Delete Transplant Assessment Entry
- Update Transplant Assessment Status to 'COMPLETE'
- Change VA/Non-VA Transplant Indicator

Enter Transplant Assessment Information

Example: Editing a Transplant Assessment

```
                                  Division: ALBANY  (500)


   E      Enter/Edit Transplant Assessments
   P      Print Transplant Assessment
   L      List of Transplant Assessments
   S      Transplant Assessment Parameters (Enter/Edit)

Select Transplant Assessment Menu Option: E Enter/Edit Transplant Assessments

Select Patient:    SURPATIENT,NINETYSIX  05-05-64  666000288     NSC VETERAN
```

```
SURPATIENT,NINETYSIX   666-00-0288


1. 06-17-08   KIDNEY TRANSPLANT (INCOMPLETE)

2.   ----     CREATE NEW TRANSPLANT ASSESSMENT


Select Assessment: 1
```

```
SURPATIENT,NINETYSIX

06-17-06      KIDNEY TRANSPLANT (INCOMPLETE)

1. Enter Transplant Assessment Information
2. Delete Transplant Assessment Entry
3. Update Transplant Assessment Status to 'COMPLETE'
4. Change VA/Non-VA Transplant Indicator

Select Number: 1// <Enter>
```

```
SURPATIENT,NINETYSIX (0288)   VACO ID: 12121   CASE: 482           PAGE: 1 OF 5
JUN 17,2008   KIDNEY TRANSPLANT                          RECIPIENT INFORMATION
------------------------------------------------------------------------------
1.  VACO ID:                  12121
2.  Date Placed on Waiting:   MAY 04, 2008
3.  Date Started Dialysis:    JAN 21, 2008
4.  Recipient ABO Blood Type: O
5.  Recipient CMV:            POSITIVE

Diagnosis Information
=====================
6.  Calcineurin Inhibitor Toxicity:      13. Obstructive Uropathy from BPH:
7.  Glomerular Sclerosis/Nephritis:      14. Polycistic Disease:
8.  Graft Failure:                       15. Renal Cancer:
9.  lgA Nephropathy:                     16. Rejection:
10. Lithium Toxicity:
11. Membranous Nephropathy:
12. Transplant Comments:
------------------------------------------------------------------------------
Select Transplant Information to Edit: 6
```

```
SURPATIENT,NINETYSIX (0288)   VACO ID: 12121   CASE: 482
JUN 17,2008   KIDNEY TRANSPLANT

------------------------------------------------------------------------------



Calcineurin Inhibitor Toxicity: Y    YES
```

```
SURPATIENT,NINETYSIX (0288)   VACO ID: 12121   CASE: 482          PAGE: 1 OF 5
JUN 17,2008   KIDNEY TRANSPLANT                          RECIPIENT INFORMATION
------------------------------------------------------------------------------
1.  VACO ID:                  12121
2.  Date Placed on Waiting:   MAY 04, 2008
3.  Date Started Dialysis:    JAN 21, 2008
4.  Recipient ABO Blood Type: O
5.  Recipient CMV:            POSITIVE

Diagnosis Information
=====================
6.  Calcineurin Inhibitor Toxicity: YES  13. Obstructive Uropathy from BPH:
7.  Glomerular Sclerosis/Nephritis:      14. Polycistic Disease:
8.  Graft Failure:                       15. Renal Cancer:
9.  lgA Nephropathy:                     16. Rejection:
10. Lithium Toxicity:
11. Membranous Nephropathy:
12. Transplant Comments:
------------------------------------------------------------------------------
Select Transplant Information to Edit: 7:10
```

```
SURPATIENT,NINETYSIX (0288)   VACO ID: 12121   CASE: 482
JUN 17,2008   KIDNEY TRANSPLANT
------------------------------------------------------------------------------



Glomerular Sclerosis/Nephritis: Y  YES
Graft Failure: N  NO
IgA Nephropathy: N  NO
Lithium Toxicity: Y  YES
```

```
SURPATIENT,NINETYSIX (0288)   VACO ID: 12121   CASE: 482          PAGE: 1 OF 5
JUN 17,2008   KIDNEY TRANSPLANT                          RECIPIENT INFORMATION
------------------------------------------------------------------------------
1.  VACO ID:                  12121
2.  Date Placed on Waiting:   MAY 04, 2008
3.  Date Started Dialysis:    JAN 21, 2008
4.  Recipient ABO Blood Type: O
5.  Recipient CMV:            POSITIVE

Diagnosis Information
=====================
6.  Calcineurin Inhibitor Toxicity: YES  13. Obstructive Uropathy from BPH:
7.  Glomerular Sclerosis/Nephritis: YES  14. Polycistic Disease:
8.  Graft Failure:                  NO   15. Renal Cancer:
9.  lgA Nephropathy:                NO   16. Rejection:
10. Lithium Toxicity:               YES
11. Membranous Nephropathy:
12. Transplant Comments:
------------------------------------------------------------------------------
Select Transplant Information to Edit: ^
```

Deleting a Transplant Assessment

Example: Deleting a Transplant Assessment

```
                                  Division: ALBANY  (500)


   E      Enter/Edit Transplant Assessments
   P      Print Transplant Assessment
   L      List of Transplant Assessments
   S      Transplant Assessment Parameters (Enter/Edit)

Select Transplant Assessment Menu Option: E Enter/Edit Transplant Assessments

Select Patient:    SURPATIENT,NINETYONE  05-05-64  666000288     NSC VETERAN
```

```
SURPATIENT,NINETYONE   666-00-0288


1. 07-25-08   HEART TRANSPLANT (INCOMPLETE)

2.   ----     CREATE NEW TRANSPLANT ASSESSMENT


Select Assessment: 1
```

```
SURPATIENT,NINETYONE  666-00-0288

07-25-08      HEART TRANSPLANT (INCOMPLETE)

1. Enter Transplant Assessment Information
2. Delete Transplant Assessment Entry
3. Update Transplant Assessment Status to 'COMPLETE'
4. Change VA/Non-VA Transplant Indicator

Select Number: 1// 2

Are you sure that you want to delete this assessment ? NO// Y

Deleting Transplant Assessment...

Press <RET> to continue <Enter>
```

Update a Transplant Assessment to Complete

Upon leaving the last data entry page, the following prompt appears.

```
Are you ready to complete and transmit this transplant assessment NO//
```

If the user presses **<Enter>**, the assessment remains incomplete and not transmitted. If the user enters **YES**, the assessment is completed and transmitted immediately.

Alternatively, the user can complete and transmit the assessment using the following screen below.

Example: Update a Transplant Assessment to Complete

```
                                  Division: ALBANY  (500)


   E      Enter/Edit Transplant Assessments
   P      Print Transplant Assessment
   L      List of Transplant Assessments
   S      Transplant Assessment Parameters (Enter/Edit)

Select Transplant Assessment Menu Option: E Enter/Edit Transplant Assessments

Select Patient:    SURPATIENT,NINETYTHREE  05-05-64  666000288     NSC VETERAN
```

```
SURPATIENT,NINETYTHREE  666-00-0288

08-08-08      LUNG TRANSPLANT (INCOMPLETE)

1. Enter Transplant Assessment Information
2. Delete Transplant Assessment Entry
3. Update Transplant Assessment Status to 'COMPLETE'
4. Change VA/Non-VA Transplant Indicator

Select Number: 1// 3

Are you ready to complete and transmit this transplant assessment NO// YES
```

Change VA/Non-VA Transplant Indicator

Example: Changing the Transplant Indicator

```
                                  Division: ALBANY  (500)


   E      Enter/Edit Transplant Assessments
   P      Print Transplant Assessment
   L      List of Transplant Assessments
   S      Transplant Assessment Parameters (Enter/Edit)

Select Transplant Assessment Menu Option: E Enter/Edit Transplant Assessments

Select Patient:    SURPATIENT,ONE  05-05-64  666000288     NSC VETERAN
```

```
SURPATIENT,ONE  666-00-0288

08-08-08      LUNG TRANSPLANT (INCOMPLETE)

1. Enter Transplant Assessment Information
2. Delete Transplant Assessment Entry
3. Update Transplant Assessment Status to 'COMPLETE'
4. Change VA/Non-VA Transplant Indicator

Select Number: 1// 4

This assessment has a current status of 'Incomplete'
The Transplant Assessment Indicator is a Non-VA type

Are you sure that you want to change the indicator to VA? NO// Y
```

```
SURPATIENT,ONE  666-00-0288


1. 08-08-08   LUNG TRANSPLANT (COMPLETE)



Select Operation: 1

Sure you want to assign this Surgical case to the Transplant Assessment? YES//<Enter>

Changing Assessment type...

Press <RET> to continue <Enter>
```

Print Transplant Assessment

[SRTP PRINT ASSESSMENT]

The *Print Transplant Assessment* option is used to print a single Surgery transplant assessment.

The following example demonstrates how to print a transplant assessment.

Printing a Transplant Assessment

1. The user is prompted to select a patient name which will display any previously entered assessments for that patient. The user can then choose an assessment.

2. After choosing the assessment, the user will select a printing device.

3. The assessment displays.

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: Printing a Transplant Assessment

```
                                  Division: ALBANY  (500)


   E      Enter/Edit Transplant Assessments
   P      Print Transplant Assessment
   L      List of Transplant Assessments
   S      Transplant Assessment Parameters (Enter/Edit)

Select Transplant Assessment Menu Option: P  Print Transplant Assessment

Select Patient:    SURPATIENT,NINETYFIVE  05-05-34  234516666     NSC VETERAN
```

```
 SURPATIENT,NINETYFIVE   234-51-6666


1. 07-28-08   KIDNEY TRANSPLANT (INCOMPLETE)


Select Assessment: 1

Print the Transplant Assessment on which Device: HOME// ENTER PRINTER NAME
```

----------*printout follows*----------

```
KIDNEY TRANSPLANT ASSESSMENT   VA SURGERY CASE #482                  PAGE 1
FOR SURPATIENT,NINETYSIX  666-00-0288 (INCOMPLETE)
Medical Center: ALBANY
================================================================================

                           RECIPIENT INFORMATION

Age:                  74               Transplant Date:   JULY 28, 2008
Gender:                                Ethnicity: UNANSWERED
VACO ID:              12121            Race:      UNANSWERED

Date Placed on Waiting:                Recipient CMV:
Date Started Dialysis:                 Recipient ABO Blood Type:
Calcineurin Inhibitor Toxicity:        Membranous Nephropathy:
Glomerular Sclerosis/Nephritis: YES    Obstructive Uropathy from BPH:
Graft Failure:                  NO     Polycistic Disease:
IgA Nephropathy:                NO     Renal Cancer:
Lithium Toxicity:               YES    Rejection:

Transplant Comments:

                           KIDNEY TRANSPLANT INFORMATION

Ischemia Time for Organ (minutes)
 - Warm Ischemia:                                Recipient HLA-A:
 - Cold Ischemia:                                Recipient HLA-B:
 - Total Ischemia:                               Recipient HLA-C:
Crossmatch D/R:                                  Recipient HLA-DR:
PRA at Listing:                                  Recipient HLA-BW:
PRA at Transplant:                               Recipient HLA-DQ:
IVIG Recipient:
Plasmapheresis:
```

RISK ASSESSMENT

Diabetic Retinopathy:
Diabetic Neuropathy:
Cardiac Disease:
Liver Disease:
HIV + (positive):
Lung Disease:
Pre-Transplant Malignancy:
Active Infection Immediately
 Pre-Trans Req. Antibiotics:
Non-Compliance (Med and Diet):
Recipient Substance Abuse:
Post Transplant Prophylaxis for
- CMV/Antiviral Treatment:
- PCP/Antibiotic Treatment:
- TB/Antimycobacterial Treatment:
Graft Failure Date:

DONOR INFORMATION

Donor Race:
Donor Gender:
Donor Height:
Donor Weight:
Donor DOB:
Donor Age:
ABO Blood Type:
Donor CMV:
Substance Abuse:
Deceased Donor:
Living Donor:
With Malignancy:
Donor HLA-A:
Donor HLA-B:
Donor HLA-C:
Donor HLA-DR:
Donor HLA-BW:
Donor HLA-DQ:

PANCREAS INFORMATION

Pancreas (SPK/PAK): NO STUDY
Glucose at Time of Listing: NO STUDY
C-peptide at Time of Listing: NO STUDY
Pancreatic Duct Anastomosis: NO STUDY
Glucose Post Transplant: NO STUDY
Amylase Post Transplant: NO STUDY
Lipase Post Transplant: NO STUDY
Insulin Req Post Transplant: NO STUDY
Oral Hypoglycemics Req. Post TX: NO STUDY

List of Transplant Assessments
[SRTP ASSESSMENT LIST]

The *List of Transplant Assessments* option is used to print a list of Surgery transplant assessments.

The following example demonstrates how to print a list of transplant assessments.

Printing a List of Transplant Assessments

1. The user is prompted to enter a start date and end date.

2. After choosing a date range, the user will select one of the following transplant assessment list types.

   - Incomplete Only
   - Transmitted/Complete
   - All

3. After choosing a transplant assessment list type, the user will select one of the following transplant types.

   - Kidney
   - Liver
   - Lung
   - Heart
   - All

4. If the facility is multi-divisional, after choosing a transplant type, the user responds to the prompt, "Do you want to print all divisions? YES//." The user should respond **YES** to print all divisions, or **NO** and then select a single division.

5. At the "Print the List of Transplant Assessments to which Device:" prompt, select a printer or print to the screen.

6. The list of transplant assessments prints.

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: List of Transplant Assessments

```
                                  Division: ALBANY  (500)


   E      Enter/Edit Transplant Assessments
   P      Print Transplant Assessment
   L      List of Transplant Assessments
   S      Transplant Assessment Parameters (Enter/Edit)

Select Transplant Assessment Menu Option: L  List of Transplant Assessments

Start with Date: 070708  (JUL 07, 2008)
End with Date: 083008  (AUG 30, 2008)

Print which Assessment Status ?

   1. Incomplete Only
   2. Complete/Transmitted
   3. ALL

Select Number:  (1-3): 3// 3

Select Type of Transplant ?

   1. Kidney
   2. Liver
   3. Lung
   4. Heart
   5. ALL

Select Number:  (1-5): 5// 5


Do you want to print all divisions? YES// <ENTER>
```

```
This report is designed to print to your terminal screen or a printer. When
using a printer, a 132 column format is used.

Print the List of Transplant Assessments to which Device: HOME// <ENTER>
```

```
                        LIST OF TRANSPLANT ASSESSMENTS
                      FROM: JUL 7,2008  TO: AUG 30,2008

VACO ID         PATIENT                            TRANSPLANT DATE  STATUS
SURGERY CASE #  ORGAN TYPE
================================================================================
22222           SURPATIENT,EIGHTY (666-00-0038)    JUL 09, 2008     INCOMPLETE
N/A             HEART
--------------------------------------------------------------------------------
179992          SURPATIENT,EIGHTY (666-00-0038)    JUL 21, 2008     INCOMPLETE
N/A             LIVER
--------------------------------------------------------------------------------
107992          SURPATIENT,EIGHTY (666-00-0038)    JUL 21, 2008     INCOMPLETE
N/A             LUNG
--------------------------------------------------------------------------------
62345           SURPATIENT,N. (666-00-0279)        JUL 25, 2008     INCOMPLETE
N/A             HEART
--------------------------------------------------------------------------------

Press <RET> to continue, or '^' to quit
```

Transplant Assessment Parameters (Enter/Edit)
[SR TRANSPLANT PARAMETERS]

The transplant coordinator uses the *Transplant Assessment Parameters (Enter/Edit)* option to change the list of organ transplants assessed at their VA facility. The values entered for these parameters will limit the choices displayed when entering a transplant assessment.

The following example demonstrates how to change transplant assessment parameters.

Changing Transplant Assessment Parameters

1. The user should enter a surgery site at the prompt, "Edit Parameters for which Surgery Site".

2. After entering a surgery site, the user should verify the chosen surgery site (which displays) and should choose **YES** at the prompt, "...OK? Yes//".

3. The user can change any of the following parameter options.

    - Kidney transplants assessed:
    - Liver transplants assessed:
    - Lung transplants assessed:
    - Heart transplants assessed:

Example: Changing Transplant Assessment Parameters

In this example, the facility does Kidney and Liver Transplant Assessments.

```
                                  Division: ALBANY  (500)


   E      Enter/Edit Transplant Assessments
   P      Print Transplant Assessment
   L      List of Transplant Assessments
   S      Transplant Assessment Parameters (Enter/Edit)

Select Transplant Assessment Menu Option: S  Transplant Assessment Parameters (Enter/Edit)

Edit Parameters for which Surgery Site:  ALBANY      NY  VAMC  500
         ...OK? Yes//<Enter>
```

```
           ALBANY  (500)                                                    PAGE 1 OF 1

1    KIDNEY TRANSPLANTS ASSESSED:
2    LIVER TRANSPLANTS ASSESSED:
3    LUNG TRANSPLANTS ASSESSED:
4    HEART TRANSPLANTS ASSESSED:

Enter Screen Server Function:  1:4
KIDNEY TRANSPLANTS ASSESSED: YES
LIVER TRANSPLANTS ASSESSED: YES
LUNG TRANSPLANTS ASSESSED: NO
HEART TRANSPLANTS ASSESSED: NO
```

```
           ALBANY  (500)                                                    PAGE 1 OF 1

1    KIDNEY TRANSPLANTS ASSESSED: YES
2    LIVER TRANSPLANTS ASSESSED: YES
3    LUNG TRANSPLANTS ASSESSED: NO
4    HEART TRANSPLANTS ASSESSED: NO

Enter Screen Server Function:
```

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Chapter Nine: Glossary

The following table contains terms that are used throughout the *Surgery V.3.0 User Manual*, and will aid the user in understanding the use of the Surgery package.

Term	Definition
Aborted	Case status indicating the case was cancelled after the patient entered the operating room. Cases with ABORTED status must contain entries in TIME PAT OUT OR field (#.205) and/or TIME PAT IN OR field (#.232), plus CANCEL DATE field (#17) and/or CANCEL REASON field (#18).
ASA Class	This is the American Society of Anesthesiologists classification relating to the patient's physiologic status. Numbers followed by an 'E' indicate an emergency.
Attending Code	Code that corresponds to the highest level of supervision provided by the attending staff surgeon during the procedure.
Blockout Graph	Graph showing the availability of operating rooms.
Cancelled Case	Case status indicating that an entry has been made in the CANCEL DATE field and/or the CANCEL REASON field without the patient entering the operating room.
CCSHS	VA Center for Cooperative Studies in Health Services located at Hines, Illinois.
CICSP	Continuous Improvement in Cardiac Surgery Program.
Completed Case	Case status indicating that an entry has been made in the TIME PAT OUT OR field.
Concurrent Case	A patient undergoing two operations by different surgical specialties at the same time, or back to back, in the same operating room.
CPT Code	Also called Operation Code. CPT stands for Current Procedural Terminology.
CRT	Cathode ray tube display. A display device that uses a cathode ray tube.
Intraoperative Occurrence	Perioperative occurrence during the procedure.
Major	Any operation performed under general, spinal, or epidural anesthesia plus all inguinal herniorrhaphies and carotid endarterectomies regardless of anesthesia administered.
Minor	All operations not designated as Major.
New Surgical Case	A surgical case that has not been previously requested or scheduled such as an emergency case. A surgical case entered in the records without being booked through scheduling will not appear on the Schedule of Operations or as an operative request.
Non-Operative Occurrence	Occurrence that develops before a surgical procedure is performed.
Not Complete	Case status indicating one of the following two situations with no entry in the TIME PAT OUT OR field (#.232). 1) Case has entry in TIME PAT IN OR field (#.205). 2) Case has not been requested or scheduled.
NSQIP	National Surgical Quality Improvement Program.
Operation Code	Identifying code for reporting medical services and procedures performed by physicians. See CPT Code.

PACU	Post Anesthesia Care Unit.
Postoperative Occurrence	Perioperative occurrence following the procedure.
Procedure Occurrence	Occurrence related to a non-O.R. procedure.
Requested	Operation has been slotted for a particular day but the time and operating room are not yet firm.
Risk Assessment	Part of the Surgery software that provides medical centers a mechanism to track information related to surgical risk and operative mortality. Completed assessments are transmitted to the VASQIP national database for statistical analysis.
Scheduled	Operation has both an operating room and a scheduled starting time, but the operation has not yet begun.
Screen Server	A format for displaying data on a cathode ray tube display. Screen Server is designed specifically for the Surgery Package.
Screen Server Function	The Screen Server prompt for data entry.
Service Blockouts	The reservation of an operating room for a particular service on a recurring basis. The reservation is charted on a blockout graph.
Transplant Assessments	Part of the Surgery software that provides medical centers a mechanism to track information related to transplant risk and operative mortality. Completed assessments are transmitted to the VASQIP national database for statistical analysis.
VASQIP	Veterans Affairs Surgery Quality Improvement Program.

Index

P

Q

R

S

T

U

V

W

(This page included for two-sided copying.)