

*Facility ID # : _____		*Procedure # : _____	
*Patient ID # : _____		Social Security # : _____ - _____ - _____	
Secondary ID # : _____			
Patient Name, Last: _____		First: _____ Middle: _____	
*Gender: <input type="checkbox"/> F <input type="checkbox"/> M		*Date of Birth: ____ / ____ / ____	
Race (specify): _____		Ethnicity (specify): _____	
*Event Type: PROC		*Date of Procedure: ____ / ____ / ____	
*NHSN Procedure Code: _____		ICD-9-CM Procedure Code: _____	
Procedure Details			
*Outpatient: <input type="checkbox"/> Y <input type="checkbox"/> N		*Duration: _____ Hours <input type="checkbox"/> Minutes	
*Wound Class: <input type="checkbox"/> C <input type="checkbox"/> CC <input type="checkbox"/> CO <input type="checkbox"/> D <input type="checkbox"/> U		*General Anesthesia: <input type="checkbox"/> Y <input type="checkbox"/> N	
*ASA Class: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5		*Emergency: <input type="checkbox"/> Y <input type="checkbox"/> N	
*Trauma: <input type="checkbox"/> Y <input type="checkbox"/> N		*Endoscope: <input type="checkbox"/> Y <input type="checkbox"/> N	
*Multiple Procedures: <input type="checkbox"/> Y <input type="checkbox"/> N			
Surgeon Code: _____		*Implant: <input type="checkbox"/> Y <input type="checkbox"/> N If Y, specify type: _____	
CSEC:			
Height: _____ feet _____ inches		Weight: _____ lbs / kg (circle one)	
(choose one) _____ meters		Duration of Labor: _____ hours	
		Estimated Blood Loss: _____ ml	
Circle one: FUSN RFUSN		Diabetes Mellitus: <input type="checkbox"/> Y <input type="checkbox"/> N	
Spinal Level: (check one)		Approach/Technique: (check one)	
<input type="checkbox"/> Atlas-axis		<input type="checkbox"/> Anterior	
<input type="checkbox"/> Atlas-axis/Cervical		<input type="checkbox"/> Posterior	
<input type="checkbox"/> Cervical		<input type="checkbox"/> Anterior and Posterior	
<input type="checkbox"/> Cervical/Dorsal/Dorsolumbar		<input type="checkbox"/> Lateral transverse	
<input type="checkbox"/> Dorsal/Dorsolumbar		<input type="checkbox"/> Not specified	
<input type="checkbox"/> Lumbar/Lumbosacral			
<input type="checkbox"/> Not specified			
HPRO: (check one) _____ Total Primary _____ Partial Primary _____ Total Revision _____ Partial Revision			
KPRO: (check one) _____ Primary (Total) _____ Revision (Total or Partial)			
Custom Fields			
Label _____ / ____ / ____		Label _____ / ____ / ____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	
Comments			

Assurance of Confidentiality: The information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).

Public reporting burden of this collection of information is estimated to average 8 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Reports Clearance Officer, 1600 Clifton Rd., MS D-79, Atlanta, GA 30333, ATTN: PRA (0920-0666).

