Denominator for Procedure

OMB No. 0920-0666
Exp. Date: xx-xx-20xx

*Facility ID # : _____ *Procedure # : _____

*Patient ID # : _____ Social Security # : ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Secondary ID # : _____

Patient Name, Last: _____ First: _____ Middle: _____

*Gender: ___ F ___ 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: ____Y ____ N *Duration: _____Hours _____ Minutes

*Wound Class: ___ C ___ CC ___ CO ___ D ___ U *General Anesthesia: ____Y ____ N

*ASA Class: ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 *Emergency: ____Y ____ N

*Trauma: ____Y ____ N *Endoscope: ___ Y ___ N *Multiple Procedures: ____Y ____ N

Surgeon Code: _____ *Implant: ___Y ___N If Y, specify type: _____

CSEC:

Height: _____ feet _____ inches Weight: _____ lbs / kg (circle one) Duration of Labor: _____ hours

(choose one) _____ meters Estimated Blood Loss: _____ ml

Circle one: FUSN RFUSN Diabetes Mellitus: ___ Y ___ N

Spinal Level: (check one)

_____ Atlas-axis
_____ Atlas-axis/Cervical
_____ Cervical
_____ Cervical/Dorsal/Dorsolumbar
_____ Dorsal/Dorsolumbar
_____ Lumbar/Lumbosacral
_____ Not specified

Approach/Technique: (check one)

_____ Anterior
_____ Posterior
_____ Anterior and Posterior
_____ Lateral transverse
_____ 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	
_____	____/____/____	_____	____/____/____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
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Comments