

HYST

Exp. Date: xx-xx-xxxx

OMB No. 0920-0666 **Denominator for Procedure** Page 1 of 2 * required for saving Procedure #: Facility ID: Social Security #: *Patient ID: Secondary ID: Middle: Patient Name, Last: First: *Gender: F M *Date of Birth: Ethnicity (specify): Race (specify): **Event Type: PROC** *NHSN Procedure Code: *Date of Procedure: ICD-9-CM Procedure Code: **Risk Factors** Surgeon Code: *Outpatient: Yes *Duration: ____hours ____minutes *ASA Score: 1 2 5 *Wound Class: C CC CO D *Diabetes Mellitus: Yes No *Height: ____ feet ____inches *Weight: ____ lbs / kgs (circle one) or ____ meters (choose one) When NHSN Proc Code is **Additional Risk Factors** one of those listed below, circle_the code and factor(s) AAA CHOL HER NEPH *Endoscope: Yes No *Implant: Yes No REC VHYS APPY *Emergency: Yes No *Endoscope: Yes No BILI OVRY PRST SB *Endoscope: Yes THOR XLAP BRST CEA PVBY VSHN *Implant: Yes No CARD LTP *Emergency: Yes No *Endoscope (for CBGB donor site only): Yes No **CBGB** COLO LAM *Endoscope: Yes No *Implant: Yes No *General Anesthesia: Yes **CRAN** *Trauma: Yes No *Implant: Yes No **CSEC** *Emergency: Yes No *General Anesthesia: Yes *Duration of Labor: hours **GAST** *Emergency: Yes No *Endoscope: Yes No *Implant: Yes No HPRO KPRO *General Anesthesia: Yes No *Trauma: Yes No *Check one: ____Total ____Hemi ____ Resurfacing (HPRO only) If Total: ____Primary ____Total Revision ____Partial Revision If Hemi: ____Primary ____Total Revision ____Partial Revision

____Revision Total

Revision Partial

Assurance of Confidentiality: The voluntarily provided 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)).

*Endoscope: Yes No

If Resurfacing (HPRO only): ____Primary Total

Primary Partial

*General Anesthesia: Yes

Public reporting burden of this collection of information is estimated to average 10 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-74, Atlanta, GA 30333, ATTN: PRA (0920-0666).



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When NHSN Proc Code is one of those listed below, circle the code and complete additional risk factor(s)	Additional Risk Factors		
FUSN RFUSN	*Spinal Level: (check one) Atlas-axis Atlas-axis/Cervica Cervical Cervical/Dorsal/D Dorsal/Dorsoluml Lumbar/Lumbosa *Implant: Yes No	orsolumbar oar	*Approach/Technique: (check one)
Custom Fields			
Label		Label 	
Comments			
CDC 57.121 (Back) Rev. 4, v6.4			