



Outpatient Procedure Component Event

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*required for saving

Facility ID:		Event #:	
*Patient ID:		Social Security #:	
Secondary ID #:		Medicare #:	
Patient Name, Last:		First:	Middle:
*Gender: F M Other		*Date of Birth:	
Ethnicity (Specify):		Race (Specify):	
*Date admitted to facility where procedure occurred (MM/DD/YYYY):			
Four Same Day Outcome Measures			
*Specify event: (check all that apply)			
<input type="checkbox"/> Patient burn	<input type="checkbox"/> Patient fall	<input type="checkbox"/> Hospital transfer/admission	
<input type="checkbox"/> Wrong site	<input type="checkbox"/> Wrong side	<input type="checkbox"/> Wrong patient	<input type="checkbox"/> Wrong procedure <input type="checkbox"/> Wrong implant
Prophylactic IV Antibiotic Timing			
<input type="checkbox"/> Had an order for a prophylactic IV antibiotic that was NOT administered on time			
Surgical Site Infection (SSI)			
*Date of SSI: ___/___/___		*Primary CPT Code: _____	NHSN Procedure Code: _____
*Specific event (type of SSI): <input type="checkbox"/> Superficial incisional <input type="checkbox"/> Deep incisional <input type="checkbox"/> Organ/space			
*How infection was first reported: (Check all that apply):			
<input type="checkbox"/> Surgeon	<input type="checkbox"/> Attending physician other than surgeon		
<input type="checkbox"/> Admitting inpatient facility	<input type="checkbox"/> Routine follow-up at outpatient facility	<input type="checkbox"/> Patient or family member	
*Specify SSI criteria used (check all that apply):			
<u>Signs & Symptoms</u>		<u>Laboratory</u>	
<input type="checkbox"/> Purulent drainage	<input type="checkbox"/> Redness	<input type="checkbox"/> Positive culture	
<input type="checkbox"/> Incision deliberately opened/drained	<input type="checkbox"/> Heat	<input type="checkbox"/> Not cultured	
<input type="checkbox"/> Pain or tenderness	<input type="checkbox"/> Abscess	<input type="checkbox"/> Imaging test evidence of infection	
<input type="checkbox"/> Localized swelling	<input type="checkbox"/> Fever (>38°C)	<input type="checkbox"/> Histopathologic evidence of infection	
<input type="checkbox"/> Wound spontaneously dehisces			
<u>Other</u>			
<input type="checkbox"/> Diagnosis of superficial SSI by surgeon or attending physician			
<input type="checkbox"/> Other evidence of infection on direct exam or during invasive procedure			
*Pathogens identified: <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, indicate up to 3 pathogens: _____			
Custom Fields			
Label _____		Label _____	
Comments			
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