OMB 0920-0666
Exp. Date xx-xx-xxxx
www.cdc.gov/nhsn

Outpatient Procedure Component Same Day Outcome Measures

This form is used for reporting data on each patient having experienced one or more of the same day outcome measures events.

*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 of Encounter (Admission) at the Outpatient Procedure Center (MM/DD/YYYY):			

Same Day Outcome Measures

*Specify event: *(check all that apply)*

☐ Patient burn ☐ Patient fall ☐ Hospital transfer/admission

Wrong Event *(any that apply)*	☐ Wrong side	☐ Wrong patient
	☐ Wrong implant	☐ Wrong site
	☐ Wrong procedure	

Custom Fields

Label		Label	
_____	___ / ___ / ___	_____	___ / ___ / ___
_____	___ / ___ / ___	_____	___ / ___ / ___
_____	___ / ___ / ___	_____	___ / ___ / ___
_____	___ / ___ / ___	_____	___ / ___ / ___
_____	___ / ___ / ___	_____	___ / ___ / ___
	___ / ___ / ___		___ / ___ / ___