OMB No. 0920-0666
Exp. Date: xx/xx/20xx
www.cdc.gov/nhsn

Outpatient Procedure Component
Denominator for Procedure

*required for saving

Facility ID	Procedure #:
*Patient ID:	Social Security #:
Secondary ID:	Medicare #:
Patient Name, Last:	First: Middle:
*Gender: F M Other	*Date of Birth:
Ethnicity (Specify):	Race (Specify):
Event Type: PROC	*NHSN Procedure Code Category:
*Date of Procedure:	CPT Procedure Code:

Procedure Details

*Wound Class: C CC CO D

*ASA Score: 1 2 3 4 5

*Endoscope: Yes No

Surgeon Code: _____

*Duration: _____Hours _____Minutes

*General Anesthesia: Yes No

*Diabetes Mellitus: Yes No

*Height: (choose one)
_____feet _____inches
_____meters

*Weight: _____ lbs/kg (circle one)

Custom Fields

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

Comments