

Denominator for Procedure

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*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:	
Sex at Birth: F M Unknown	Gender Identity (Specify): Male Female Male-to-female transgender Female-to-male transgender Identifies as non-conforming Other Asked but unknown	
Ethnicity (Specify): Hispanic or Latino Not Hispanic or Latino Unknown Declined to respond	Race (Specify): American Indian or Alaska Native Asian Black or African American Middle Eastern or North African Native Hawaiian or Pacific Islander White Unknown Declined to respond	
Language: (Specify)	Interpreter Needed: Yes No Declined to Respond Unknown	
Event Type: PROC	*NHSN Procedure Code:	
*Date of Procedure:	ICD-10-PCS or CPT Procedure Code:	
Procedure Details		
*Outpatient: Yes No	*Duration: _____ Hours _____ Minutes	
*Wound Class: C CC CO D	*General Anesthesia: Yes No	
ASA Score: 1 2 3 4 5	*Emergency: Yes No	
*Trauma: Yes No	*Scope: Yes No	*Diabetes Mellitus: Yes No
*Height: _____ feet _____ inches	*Closure Technique: Primary Other than primary	
(choose one) _____ meters	Surgeon Code: _____	
*Weight: _____ lbs/kg (circle one)		
CSEC: *Duration of Labor: _____ hours		
Circle one: FUSN *Spinal Level (check one) <ul style="list-style-type: none"> <input type="checkbox"/> Atlas-axis <input type="checkbox"/> Atlas-axis/Cervical <input type="checkbox"/> Cervical <input type="checkbox"/> Cervical/Dorsal/Dorsolumbar <input type="checkbox"/> Dorsal/Dorsolumbar 	*Approach/Technique (check one) <ul style="list-style-type: none"> <input type="checkbox"/> Anterior <input type="checkbox"/> Posterior <input type="checkbox"/> Anterior and Posterior 	

<input type="checkbox"/> Lumbar/Lumbosacral	
Circle one: HPRO KPRO ICD-10-PCS Supplemental Procedure Code for HPRO/KPRO: _____ *Check one: <input type="checkbox"/> Total <input type="checkbox"/> Hemi <input type="checkbox"/> Resurfacing (HPRO only) If Total: <input type="checkbox"/> Total Primary <input type="checkbox"/> Total Revision If Hemi: <input type="checkbox"/> Partial Primary <input type="checkbox"/> Partial Revision If Resurfacing (HPRO only): <input type="checkbox"/> Total Primary <input type="checkbox"/> Partial Primary *If total or partial revision, was the revision associated with prior infection at index joint? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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)). CDC 57.121 Rev (NHSN 12.1 4/13/2024). Public reporting burden of this collection of information is estimated to average 14 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 H21-8, Atlanta, GA 30333, ATTN: PRA (0920-0666).	

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Custom Fields	
Label	Label
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Comments	

Custom Fields

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