

MEDICAL RECORD -- SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is the Office of the Surgeon General.

REPORT TITLE

SAME DAY AMBULATORY SURGERY POST-OPERATIVE ASSESSMENT

OTSG APPROVED (Date)

1. Returned to unit via			2. Time		3. Procedure						
4a. IV: Was IV administered? <input type="checkbox"/> No <input type="checkbox"/> Yes (If "Yes," complete items b through g.)											
b. Fluid			c. Rate (cc/hr)	d. Method <input type="checkbox"/> IMED pump <input type="checkbox"/> DAF		e. Patent <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Positional		f. Location		g. Condition <input type="checkbox"/> No S/S infiltration <input type="checkbox"/> Red <input type="checkbox"/> Swollen	
5a. IV: Was a dressing administered? <input type="checkbox"/> No <input type="checkbox"/> Yes (If "Yes," complete items b through d.)											
b. Location			c. Condition <input type="checkbox"/> Dry and intact <input type="checkbox"/> Saturated _____ %			d. Packing drains			6. Fall Prone Protocol initiated <input type="checkbox"/> Yes <input type="checkbox"/> No		
7. LOC <input type="checkbox"/> Alert and oriented <input type="checkbox"/> Drowsy <input type="checkbox"/> Crying (pediatric)		8. Color <input type="checkbox"/> Pink <input type="checkbox"/> Pale or flushed <input type="checkbox"/> Natural		9. Respiratory <input type="checkbox"/> No distress <input type="checkbox"/> SOB		10. Pain and pressure <input type="checkbox"/> Yes <input type="checkbox"/> No Pain level (1-10):		11. Nausea/vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No		12. Extremity elevation and ice applied <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
13. Post-op vital signs						14. Signature, date and time					
15. Circulatory assessment (if applicable)						a. Location:					
Time b.	Blood pressure c.	Temp d.	Pulse e.	R/O2 saturation f.	Capillary refill g.	Skin temp h.	Extremities movement i.	Initials j.	k.		
16. Emesis											
First a	Amt (cc) a (1)	Time a (2)	Initials a (3)	Second b	Amt (cc) b (1)	Time b (2)	Initials b (3)	Third c	Amt (cc) c (1)	Time c (2)	Initials c (3)
17. Post-op medication											
Time a.	Indication b.	Medication c.		Amt/Dosage d.	Route/Site e.	Effectiveness Pos (+) Neg (-) f.		Signature g.			
18. Progress notes											

(Continue on reverse)

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE
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PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)

- HISTORY/PHYSICAL FLOW CHART
- OTHER EXAMINATION OR EVALUATION OTHER (Specify)
- DIAGNOSTIC STUDIES
- TREATMENT

19. Outcome criteria for discharge					
a. Vital signs: BP	T	P	R	O2	Pain level
b. Are vital signs +/- 20% of preanesthetic level? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:					
c. Is there an absence of respiratory distress? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:					
d. Are swallow, cough and gag reflexes present? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:					
e. Is patient fully awake and alert? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:					
f. Is nausea absent or minimal? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:					
g. Are PO fluids tolerated? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:					
h. Is patient able to move 4 extremities/neurovascular check WNL? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:					
i. Dressing and surgical wound checked with minimal drainage? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:					
j. Voiding: <input type="checkbox"/> Voided spontaneously <input type="checkbox"/> Unable to void but comfortable <input type="checkbox"/> Other:					
k. Was IV D/C'd? <input type="checkbox"/> Yes <input type="checkbox"/> No			l. Was a responsible adult present to escort the patient home? <input type="checkbox"/> Yes <input type="checkbox"/> No		
m.1. Was the patient and/or significant other given post-op instructions and were the instructions understood? <input type="checkbox"/> Yes <input type="checkbox"/> No					
m.2. The post-op instructions were: <input type="checkbox"/> Printed <input type="checkbox"/> Verbal <input type="checkbox"/> Demonstrated					
n. Comments:					
o.1. Discharged by			o.2. Via		o.3. Time
20. Follow up phone call data					
a. Home phone number	b. Work phone number	c. Data for 1st follow up call	d. Data for 2d follow up call	e. Data for 3d follow up call	
Date and time of call:					
General condition, as stated by patient or significant other:		<input type="checkbox"/> Excellent <input type="checkbox"/> Fair	<input type="checkbox"/> Excellent <input type="checkbox"/> Fair	<input type="checkbox"/> Excellent <input type="checkbox"/> Fair	
		<input type="checkbox"/> Good <input type="checkbox"/> Poor	<input type="checkbox"/> Good <input type="checkbox"/> Poor	<input type="checkbox"/> Good <input type="checkbox"/> Poor	
Pain tolerable:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pain level:		1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	
Pain location:					
Surgical wound and dressing problems:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes" to above question, state the problems:					
Tolerating PO intake well:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Voiding difficulty:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Activity problems:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes" to above question, state the problems:					
Neurovascular check WNL:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Discharge teaching reinforced:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Follow up appointment made or confirmed:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Comments:		See below	See below	See below	
c. Comments concerning the 1st follow up call					
Signature:			Date:		
d. Comments concerning the 2d follow up call					
Signature:			Date:		
e. Comments concerning the 3d follow up call					
Signature:			Date:		