



Surgical Procedure Record (Page 1 of 2)

Name: _____

Date of Birth: _____

Addressograph Only

Date of H&P: _____ **Date of Procedure:** _____

Pre Operative Diagnosis: _____

Planned Procedure: _____

Options, indications, risks & benefits discussed with patient or parent/guardian and **Consent Obtained:** Yes

HISTORY

History of Present Illness: _____

Significant Medical and/or Surgical History: _____

Current Medications: _____

Allergies: _____ **Latex Allergy:** Yes

Type of Reaction: _____

Review of Systems: Relevant system review reveals no significant findings.

ROS findings: _____

PHYSICAL EXAMINATION *All six elements are required. Check or describe if variation.*

Head and Neck: (no masses or bruits) _____ **Abdomen:** (no mass, non-tender) _____

Heart: (sinus rhythm, no murmur) _____ **Neuro:** (alert & oriented x 3) _____

Chest: (clear) _____ **Extremities:** (no edema, pulses intact) _____

Additional Findings: _____

Print Name: _____ **Signature:** _____ MD

REQUIRED UPDATE *for H&P not done on day of procedure*

Check one line below as appropriate: To be completed on day of procedure only

H&P are greater than 30 days old; H&P have been re-performed. No changes noted.

H&P have been done within 30 days. No changes noted.

Changes: _____

Date: _____ **Signature:** _____ MD

Date of procedure



Addressograph Only

DOCTOR'S ORDERS

Key: # Administered/Performed

"In accordance with hospital policy, in effect since 1971, the physician agrees that drugs by their non-proprietary title may be dispensed for any trade name drug listed below. If a physician wishes to prescribe a specific non-formulary brand name product, he/she must complete and sign a non-formulary form."

Date	Time	ORDERS	Signature

WOUND CARE INSTRUCTIONS

		<input type="checkbox"/> Change dressing as necessary <input type="checkbox"/> Keep dressing clean and dry <input type="checkbox"/> Patient may shower/bathe in ___ days <input type="checkbox"/> Patient may remove dressing in ___ days	
		<input type="checkbox"/> Follow up appointment: _____ <input type="checkbox"/> Special instructions: _____ _____	

IMMEDIATE POST OPERATIVE NOTE

Date: _____ Time: _____

Pre Operative Diagnosis: _____

Post Operative Diagnosis: _____

Procedure Performed: _____

Primary Surgeon/MD (*print*): _____

Assistant MD (*print*): _____

Specimens Removed (*if applicable*): _____

Findings: _____

Complications: _____

Condition: _____

Print Name: _____ Signature: _____ MD