*Name: _____ *Visit/Procedure Date:____/___/_____Medical Record # _____
FIRST MIDDLE LAST MM DD YYYY

Demographics Tab

*Birthday____/___/_____
MM DD YYYY

*Gender ○ Male ○ Female

*Patient Race/Ethnicity *(Check all that*

☐ White Black or African-American ☐ Asian ☐ Hispanic or Latino
☐ American Indian or Alaskan Native ☐ Native Hawaiian or other Pacific Islander
☐ Other/Unknown _____

Payment Source (*Check all that apply*)

☐ Private Insurance ☐ Medicare /Medicaid
☐ Self- Pay ☐ Worker's Compensation
☐ Other_____

Clinical Tab

Tobacco Use
○ Current Tobacco User
○ Former Tobacco User
○ Non-tobacco User

Does the patient have diabetes?
○ Yes ○ No ○ Unknown

If yes, Diabetes Treatment
○ Insulin ○ Oral ○ Diet-controlled

Height _____in

Weight _____lb

BMI _____

Patient ASA Status
○ Normal
○ Mild systemic
○ Severe systemic
○ Constant life threat
○ Moribund

Hypertension requiring medication ○ Yes ○ No ○ N/A

History of MI (6-mo. prior to surgery) ○ Yes ○ No ○ N/A

Congestive Heart Failure (CHF) 30 days before surgery ○ Yes ○ No ○ N/A

Acute renal failure (pre-op) ○ Yes ○ No ○ N/A

History of severe COPD ○ Yes ○ No ○ N/A

Functional health status prior to surgery ○ Independent ○ Partially Dependent ○ Totally Dependent ○ Unknown

Procedures

Provider

Facility _____

CPT Code

*Anatomy *(Check all that apply)*

☐ Breast ☐ Genitalia ☐ Hand ☐ Head and Neck ☐ Lower Extremity ☐ Trunk ☐ Upper Extremity

*Classification *(Check all that apply)*

☐ Burn ☐ Bone & Joint ☐ Cancer (non-skin) ☐ Congenital ☐ Contracture and Joint Stiffness ☐ Cosmetic
☐ General/Reconstructive ☐ Micro-Vascular ☐ Nerve ☐ Non-Operative ☐ Skin (including skin cancer) ☐ Trauma Tendon/Muscle ☐ Other

*CPT Code_____ *Procedure Description_____ Modifier_____ # of Times _____

Is this a procedure revision within 1 (one) year of the initial procedure? ○ Yes ○ No

Is this a revision of my own work? ○ Yes ○ No

*Procedure Duration (skin-to-skin) _____:_____ ☐ Not Available
HH MM

*Anesthesia Provided By:

☐ Anesthesiologists ☐ CRNA (Supervised by Anesthesiologist) ☐ CRNA (Supervised by procedural Surgeon)
☐ Procedural Surgeon ☐ RN supervised by procedural Surgeon ☐ Other_____ ☐ None

*Mode of Anesthesia *(Check all that apply)*

☐ Conscious Sedation ☐ MAC ☐ Spinal/Epidural ☐ Tumescent ☐ General ☐ Peripheral Block ☐ Topical/Local
☐ Other_____ ☐ None

** = required field*

ICD-10 Code(s)

ICD-10 Code(s) _____

*Diagnosis Description _____

Optional Modules

Bariatric Module

Procedure is Related to Massive Weight Loss?

○ Yes ○ No ○ Unknown

Procedure is Related to Massive Weight Loss Due to Previous Bariatric Surgery Procedure?

○ Yes ○ No ○ Unknown

Lipoplasty

Estimated volume of subcutaneous fluids infused _____

Estimated IV intake _____

Estimated total volume aspirated _____

Breast Implants

	Right	Left
Implant Manufacturer	Allergan Mentor Sientra Other	Allergan Mentor Sientra Other
Shell Type	Smooth Textured	Smooth Textured
Implant Shape	Round Contour	Round Contour
Filler Type	Silicone Gel Saline Saline Postoperative Adjustable Saline and Silicone Gel	Silicone Gel Saline Saline Postoperative Adjustable Saline and Silicone Gel
Implant Position	Sub-glandular Sub-muscular Subcutaneous /Pre-Pectoral Dual plane (Pectoralis muscle separated from overlying breast tissue) Subfascial	Sub-glandular Sub-muscular Subcutaneous /Pre-Pectoral Dual plane (Pectoralis muscle separated from overlying breast tissue) Subfascial
Implant Size (CC)	_____	_____
Actual Filler Volume	_____._____	_____._____
Incision	Inframammary Crease Periareolar Axillary Umbillical Mastectomy Other	Inframammary Crease Periareolar Axillary Umbillical Mastectomy Other
Adjuncts	☐ None ☐ Pocket antibiotic irrigation ☐ Pocket betadine irrigation ☐ Keller Funnel or other insertion device	☐ None ☐ Pocket antibiotic irrigation ☐ Pocket betadine irrigation ☐ Keller Funnel or other insertion device

Right		Left	
Biologic or Prosthetic Products	None Biologic Synthetic	Biologic or Prosthetic Products	None Biologic Synthetic
Biologic Products	Alloderm Allomax DermaMatrix Flex HD Neoform Permacol Strattice Veritas (bovine pericardium) Other	Biologic Products	Alloderm Allomax DermaMatrix Flex HD Neoform Permacol Strattice Veritas (bovine pericardium) Other
Synthetic Products	Silk Vicryl Other	Synthetic Products	Silk Vicryl Other
Drains	○ No ○ Yes		○ No ○ Yes
Implant Serial Number	_____		_____

Name: _____ *Procedure Date:____/___/_____ Medical Record # _____

_First MIDDLE LAST MM DD YYYY

Outcome 30 days Post op ☐ No Adverse Events ☐ Adverse Events ☐ Outcome Unknown

I. Unanticipated Resource Utilization

☐ Unplanned Emergency Room Visit ☐ Unplanned Hospital Admission ☐ Unplanned Return to Operating Room

II. Procedure Specific Occurrences

	Related CPT code(s)
☐ Seroma Requiring Drainage	_____
☐ Hematoma Requiring Drainage	_____
☐ Wound Disruption Superficial	_____
☐ Wound Disruption Deep/Fascia	_____
☐ Superficial Incisional Surgery Site Infection	_____
☐ Deep Incisional Surgery Site Infection	_____
☐ Organ/Space Surgery Site	_____
☐ IV Antibiotics	_____
☐ PO Antibiotics	_____
☐ Total Flap Loss (>90%)	_____
☐ Partial Flap Loss (10%-90%)	_____
☐ Total Graft Loss (>90%)	_____
☐ Partial Graft Loss (10%-90%)	_____
☐ Implant/Prosthesis Loss	_____
☐ <= 4 U RBC Postoperative Bleeding Req Transfusion	_____
☐ > 4 U RBC Postoperative Bleeding Req Transfusion	_____

III. Thromboembolic Occurrences

☐ DVT ☐ Pulmonary Embolism

V. Other Occurrences

☐ Adverse Drug Event ☐ Mortality within 30 days

☐ Puncture or laceration to other body organ/structure

Related CPT Code(s) _____
Which organ or structure _____

Related CPT Code(s)

☐ Retained sponge/instrument _____

☐ Wrong Site Surgery _____

☐ Other _____

IV. Systemic Occurrences

Cardiac System

☐ Cardiac Arrest Req CPR ☐ Myocardial Infarction
☐ Other Cardiac Occurrence

Nervous System

☐ Coma > 24 hours ☐ Peripheral Nerve Injury
☐ Stroke/CVA ☐ Other Nerve Occurrence

Respiratory

☐ On Ventilator > 48 hrs ☐ Pneumonia
☐ Unplanned intubation ☐ Other Respiratory Occurrence

System Sepsis

☐ Sepsis ☐ Septic Shock
☐ Systemic Inflammatory Response Syndrome

Urinary System

☐ Acute Renal Insufficiency ☐ Progressive Renal Insufficiency
☐ Urinary Tract Infection ☐ Other Urinary Tract Occurrence

VI. Comments

_____

_____

_____

_____