SURGERY

Document type

History & Physical

Moderate Sedation

Operative &Procedure Reports

Post OP Progress Note

DOCUMENTATION REQUIREMENTS

Required elements

Medical history
Chief complaint
History of the current illness, including, when appropriate, assessment of emotional, behavioral and social status
Relevant past medical, family and/or social history appropriate to the patient's age.
Review of body systems.
A list of current medications and dosages.
Any known allergies including past medication reactions and biological allergies
Existing co-morbid conditions
Physical examination: current physical assessment
Provisional diagnosis: statement of the conclusions or impressions drawn from the medical history and physical examination
Initial plan: Statement of the course of action planned for the patient while in the Medical Center.
For other outpatient (ambulatory) surgical patients, as necessary for treatment

i. Indications/symptoms for the procedure.
ii. A list of current medications and dosages.
iii. Any known allergies including past medication reactions
iv. Existing co-morbid conditions
v. Assessment of mental status
vi. Exam specific to the procedure performed.

All elements above plus the following:

IV moderate sedation - For patients receiving IV moderate sedation, all of the above elements in H&P section, plus the following:

i. Examination of the heart and lungs by auscultation.
ii. American Society of Anesthesia (ASA) status
iii. Documentation that patient is appropriate candidate for IV moderate sedation.

An operative or other high-risk procedure report is documented upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care. If dictated an immediate post op note is acceptable and must include the same elements. (See below)
The name(s) of the licensed independent practitioner(s) who performed the procedure and his or her assistant(s)
The name of the procedure performed

A description of the procedure
Findings of the procedure
Any estimated blood loss
Any specimen(s) removed
The postoperative diagnosis

When a full operative or other high-risk procedure report cannot be documented immediately into the patient's medical record after the operation or procedure, a progress note is documented in the medical record before the patient is transferred to the next level of care. This progress note includes the name(s) of the primary surgeon(s) and assistant(s), procedures performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis.

Name(s) of the primary surgeon(s) and assistant(s)
Name(s) of the assistant(s)
procedures performed