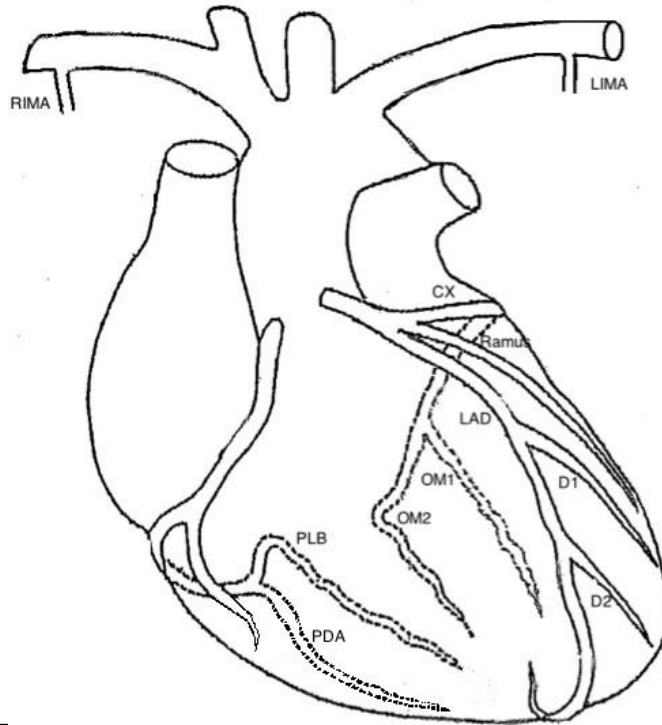


CARIOVASCULAR SURGERY POST-OPERATIVE DIAGRAM AND NOTE

NOTATIONS

All Bold Elements REQUIRED by CMS & Joint Commission. Please Fully Complete



Date of Procedure: ___/___/ 20__

Surgeon: _____ Assistant(s): _____

Pre-Operative Diagnosis: _____

Post-Operative Diagnosis: _____

- Procedure(s) Performed: 1) _____
 2) _____
 3) _____
 4) _____

Findings/Complications: _____

No Blood Loss unless noted: _____

No Specimens unless noted: _____

Drains: Pericardial x__	<input type="checkbox"/> L Pleural	<input type="checkbox"/> R Pleural	<input type="checkbox"/> R/ <input type="checkbox"/> L Pleura opened
Pacing Wires: Atrial x__	Ventricular x__	<input type="checkbox"/> Atrial to cut	<input type="checkbox"/> Ventricular to cut
Blood Products: PRBC's x__U	FFPx__U	Platelets x__U	Cell Saver: __cc

Physician's Signature _____ Date/Time: _____
(Full Report to follow)



PT.
MR. #/P.M.
DR.