

Section Title	Effective Date:	Page: 1	Date Revised:
MEDICAL RECORDS			1-06
Subject:			
OPERATIVE REPORTS			

OPERATIVE REPORTS

Policy:

The findings and techniques of the operation are accurately and completely documented immediately after the procedure and authenticated by the health care practitioner that performed the procedure so that it is available for continuity of patient care. This post-op note and the operative report will become a permanent part of the medical record.

Procedure:

It is imperative that the medical record be completed as soon after surgery as possible. This includes both the written postop notation as well as the dictated operative report.

This will become a permanent part of the patient's medical record and should include the following information:

1. Patient's name.
2. Date
3. Operation / Procedure
4. Anesthesia - - including local anesthesia amounts & type
5. Procedure - include findings and postop diagnosis
6. Estimated Blood Loss
7. Condition
8. Complications
9. Plan recommendations to patient for postop and follow-up care

Template Documentation

Policy: To establish guidelines for the appropriate use of templates in medical documentation.

Procedure:

1. Physicians who wish to use templates to facilitate their surgical documentation should submit their templates to Lakeview management for submission to the transcription service.
2. Templates may be used for operative reports if they allow for the addition of patient specific pre and post operative diagnosis, plus any procedural findings and/or complications to be inserted into the body of the report. This specification is necessary to prevent the report from becoming a "cloned" report which is not allowed and to allow for accurate coding and billing.