## POST OP DOCUMENTATION REQUIREMENTS

Full Operative Report Timeframe and Requirements  An operative report describing techniques, findings, and tissues removed or altered must be written or dictated immediately following surgery and signed by the surgeon.  The operative report shall be dictated or documented and authenticated in its entirety before the patient is transferred to the next level of care (e.g., before the patient leaves the post anesthesia care unit)  All surgeries or invasive procedures require an operative report, or a post operative/post procedure note if the operative report is not immediately available.  In the event that an operative report cannot be dictated before transfer to the next level of care in an inpatient setting, an immediate post operative / post procedure note is required to be documented.  Full Operative Report Element Requirements  The operative report includes at least:  Name and hospital identification number of the patient  Date and times of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision)  Pre-operative and post-operative diagnosis  Name of the specific surgical procedure(s) performed  Type of anesthesia administered  Complications, if any  A description of techniques, findings, and tissues removed or altered  Surgeons or practitioners name(s) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues); and	l (b)(6)	YES SS.8 SR.1 SS.8 SR.3 SS.8 SR.2	YES Article 7.B
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Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any.			
Immediate Note Elements and Requirements			
In the event that an operative report cannot be dictated before transfer to the next level of care in an inpatient		YES	YES
setting, an immediate post operative / post procedure note is required to be documented. The note shall include		SS.8 SR.4	Article 7.C
identification or description of:			
The surgeon and assistants     Estimated Blood Loss; (specify N/A if no blood loss)			
Pre-operative and post-operative diagnosis     Complications (if any encountered)			
Procedures performed     Type of anesthesia administered			
Specimens removed     Grafts or implants (may indicate where in chart for details) if any			