Hartford Hospital
A Hartford HealthCare Partner

510

AMBULATORY RECORD

NOTE TO PHYSICIAN: When entering your name you also certify the patient meets the Medical necessity requirements of the Medicare Act when applicable.

DATE / TIME	DOCTOR	ORDERS	NOTED BY WHOM	TIME GIVEN OR DONE BY WHOM

BRIEF OPERATIVE NOTE

Date	
Pre-op Diagnosis	
Post-op Diagnosis	
Operation	
Surgeon(s)	
Drains	
Anesthesia	
Estimated Blood Loss	□ Minimal □ < 50 cc □ < 100 cc □ _____
Complications (if any)	
Findings	
Specimens	
	SIGNATURE: ***DATE*** ***TIME***

SUMMARY OF PATIENT VISIT

It is not necessary to complete this portion if there is a typed operative note or a completed handwritten procedure note form.

DIAGNOSIS(ES): **(no abbreviations)** _____

OPERATIONS / PROCEDURES:_____

_____

SIGNATURE:_____ ***DATE:***_____***TIME***_____ ***FOLLOW UP:***_____