Abstractor Name: _____ Date: _____

2020 SCOAP & Spine COAP Data Collection Form (Data version 5.0)

Effective for discharges starting January 1, 2021

Missing = Default for all variables. If left unchanged, the variable will be null and not captured in any report.

Not Applicable = Not Applicable
No = If something is not done or not mentioned at all
NA = Not Available
NA/Unknown = Not Available or Unknown

Demographics

Medical Record Number: _____

Site Patient ID: _____

Patient Last Name: _____

Patient First Name: _____

Patient Middle Name: _____

Date of Birth: mm/dd/yyyy

Sex: Male / Female

Race Documented: Yes, No, Patient declined to disclose

if yes, check all that apply:

☐ American Indian/ Alaskan Native
☐ Asian
☐ Black/ African American
☐ Native Hawaiian or Other Pacific Islander
☐ White/Caucasian
☐ Other or Multiple

Hispanic or Latino Ethnicity ☐ Yes ☐ No ☐ Not documented

Patient ID: *automatically generated*
Demographic Data Version: 5.0

Episode Summary

Choose Add New ⊕ Add New **to create new episode or the** ⊕ **button just to the right of the "SCOAP Episodes" box. Alternatively, you can double-click a Record to open an existing episode.**

*Each episode in Hybrid Outcomes should contain data for only *one* procedure.

Administrative

Data Version	**5.0**
Record ID	*automatically generated*
Abstractor's Name	*See Data Dictionary for instructions*

Procedure Type

Procedure Category:

Missing, Colorectal, Bariatric, Appendectomy (Pediatric appendectomy - auto-calculates based on patient age), Spine, Small Bowel Obstruction

Hospitalization

Date of Admission (and Time): mm/dd/yyyy 00:00

Encounter ID: _____

Abstractor Name: _____ Date: _____

Hospital Demographics: *select your site*

Patient Age: *automatically calculated*

Type of Admission: Inpatient, ASC (Ambulatory Surgery Center), Outpatient procedure with unplanned inpatient admission, Outpatient, Unable to Determine

If inpatient, admission source: Missing, ER, Clinic, Home, Transfer from other hospital, Unknow

If transferred from another hospital, indicate transfer locations: (Pediatric, SBO)
Missing, ER to ER, ER to Inpatient, Inpatient to Inpatient, Unknown

Transfer Reason: (Pediatric, SBO)
Higher Level of Care Needed, Patient Request, Provider Request

Admitted To: (Pediatric, SBO)
Medical Hospitalist Service, Medicine (private), Acute Care Surgery Service, Surgeon (private), Unknown

Treatment Type: (Pediatric, SBO)
Surgery, Medical Management

Height Collected: _____ (English/inches) *-OR-* _____ (Metric/centimeters) ○ NA
Calculated to cm: *automatically generated*

Weight Collected: _____ (English/pounds) *-OR-* _____ (Metric/kilograms) ○ NA
Calculated to kg: *automatically generated*

Body Mass Index: *automatically generated*

☐ **Payor - Private**

If private, specify primary:

Other Private
Regence
Premera
First Choice
Group Health
Aetna
Cigna
Uniform Medical
United Healthcare
Kaiser

☐ Medicare
☐ Medicaid
☐ Indian Health Services
☐ Uninsured
☐ Labor and Industry
☐ TriCare
☐ VA beneficiary
☐ Self
☐ Other Government program

Currently Working: (Spine) ☐ Yes ☐ No ☐ NA
if no, specify:
☐ On Disability Retired
☐ Unemployed
☐ Never Worked
☐ Not documented

Residence ZIP Code: _____ ☐ NA

Abstractor Name: _____ Date: _____

Risk Factors

History of Nicotine Use: ☐ Yes ☐ No ☐ Unknown

If yes, when did the patient stop using nicotine: Current user, Quit within past month, Quit between 1 month and 1 year, Quit greater than 1 year, Unknown

Indicate Method of Nicotine Use: Smoking, Vape, Chewing Tobacco, Nicotine Gum, Nicotine Patch, Missing

(colorectal, spine, bariatric)

Prior to hospitalization, was the patient counseled to stop nicotine use? Yes, No, NA

Prior to hospitalization (≤3 months), participation in nicotine/smoking cessation program? Yes, No, NA

Preoperative Lab Tests

Albumin:	_____ Gm/dl	☐ NA (within 6 weeks)
Creatinine:	_____ mg/dl	☐ NA
HGB:	_____ g/dl	☐ NA
WBC	_____*1000	☐ NA *(SBO and Peds Appy)*
HbA1C:	_____ %	☐ NA *(Diabetics only, within 3 months)*

The following labs should be noted for both SBO and Pediatric Appys:

C-Reactive Protein (CRP):	_____ mg/dl	☐ NA
Serum Lactate:	_____ mmol/L	☐ NA
Polys/Neutrophils:	_____ %	☐ NA
Count of Polys/Neutrophils:	_____ *1000	☐ NA
Bands:	_____ %	☐ NA
Count of Bands:	_____ *1000	☐ NA

Was a nutrition intervention performed within 30 days of hospitalization: Yes, No *(Colorectal, Bariatric)*

If yes,

IV Based	Yes, No
Oral Supplementation	Yes, No
Tube Feeding Supplementation	Yes, No
Arginine based	Yes, No, Unknown
Nutritionist or dietician involved	Yes, No

Current / Recent Medications Used

☐ Aspirin
☐ Statin
☐ Beta Blockers
☐ Therapeutic anticoagulation within 1 week of surgery
☐ Dabigatran (Pradaxa) within 1 week of surgery
☐ ACE Inhibitor or ARB
☐ PreOp Opioids
☐ Non-Steroidal Immunosuppressants (Pediatric)
☐ Steroids (SBO, Pediatric)

Comorbidities

Hypertension	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No

Diabetes Control, if yes, No meds, Single non-insulin, Multiple non-insulin, Insulin, Insulin plus other meds

Asthma	☐ Yes ☐ No
Sleep Apnea	☐ Yes ☐ No
Coronary Artery Disease	☐ Yes ☐ No
VTE	☐ Yes ☐ No
HIV / AIDS	☐ Yes ☐ No
Severe COPD	☐ Yes ☐ No
Dialysis	☐ Yes ☐ No

Abstractor Name: _____ Date: _____

Genetic Defect	☐ Yes	☐ No	☐ Suspected
Congenital Cardiac Defect	☐ Yes	☐ No	☐ Suspected
Developmental Delay	☐ Yes	☐ No	☐ Suspected
Premature <36 weeks gestation	☐ Yes	☐ No	

Comorbidity Index: *automatically generated*

Operative

Surgeon Information: *select, or search for, your facility's surgeon from the dropdown menu*

Anesthesiologist Information: *select, or search for, your facility's surgeon from the dropdown menu*

DO NOT DELETE PHYSICIAN NAMES/NPIs. Contact AskSCOAP@qualityhealth.org for assistance.

Intra Operative

Date & Time of Surgery: mm/dd/yyyy hh:mm ☐ NA

Incision Closure Date and Time: mm/dd/yyyy hh:mm ☐ NA

Surgical Approach:

Laparoscopic, Videoscopic
Lap converted to open
Lap, hand-assisted
Open
Lap, Robotic Assistance
Lap, Robotic Assistance Converted to Open
Lap, single site (*pediatric appendectomy only*)

Anesthesia: General: Yes, No
Anesthesia: Neuraxial (spinal/epidural): Yes, No
Anesthesia: Regional (tap block, brachial plexus, wound block)**:** Yes, No
Anesthesia: Conscious Sedation: Yes, No
Intraoperative Lidocaine: Yes, No
Intraoperative Ketamine: Yes, No
ASA Class: Class I, Class II, Class III, Class IV, Class V, NA
Emergent (E) (exclude spine)**:** Yes, No
Prophylaxis for Nausea / Vomiting (bariatrics and spine): Yes, No

Glucose Management

Highest perioperative blood glucose: _____mg ☐ NA
Insulin used in perioperative time period: Yes, No
Highest Blood Glucose within 48 hrs post-operatively: _____mg ☐ NA
Lowest Blood Glucose within 48 hrs post-operatively: _____mg ☐ NA
Insulin used in post-operative time period: Yes, No

Urine Output in Operating Room: _____mL ☐ NA

Normothermia

First temp on arrival to recovery collected: _____° Celsius -*OR* _____° Fahrenheit ☐ NA
(Not applicable if death in the OR)

Perioperative Interventions

Was the patient given a carbo-loading product preoperatively (at home or in hospital)? ☐ Yes ☐ No
(colorectal, spine, bariatric)

If yes, indicate type:

Gatorade Other, specify:_____
Gatorade Prime Diluted, PowerAde, Ensure Pre Surgery, Apple Juice, Breeze, ClearFast, NA

Preop Analgesia: ☐ Yes ☐ No ☐ Unknown

If yes, indicate type:

Gabapentin/Pregabalin:	☐ Yes ☐ No	☐ Contraindicated
Acetaminophen:	☐ Yes ☐ No	☐ Contraindicated
NSAID:	☐ Yes ☐ No	☐ Contraindicated
Cox2 Inhibitor:	☐ Yes ☐ No	☐ Contraindicated
Other:	☐ Yes ☐ No	☐ Contraindicated

Other, specify: _____

☐ Preop Analgesia Not Available

Anticoagulation

DVT Mechanical within 24 hours of Incision: ☐ Yes ☐ No ☐ Contraindicated

DVT Chemoprophylaxis within 24 hours of Incision: ☐ Yes ☐ No ☐ Contraindicated

If yes, when given: Preop, Post or Intra, Both

Anticoag ordered for in-hospital use after the first 24 hours post-op: ☐ Yes ☐ No ☐ Contraindicated

If yes, agent ordered most often in 7 days postop:

Heparin, Enoxaparin (Lovenox), Dalteparin (Fragmin), Tinzaparin (Innohep), Fondaparinux (Arixtra), Dextran, Coumadin, Asprin, Other

Perioperative Antibiotics

Antibiotics for the treatment of infection: ☐ Yes ☐ No *(exclude for Appy)*

Prophylactic antibiotics administered: ☐ Yes ☐ No

If yes, administered within 60 min of incision: ☐ Yes ☐ No

Prophylactic antibiotics stopped within 24 hours: ☐ Yes ☐ No

Postoperative Medications

Postop Analgesia: ☐ Yes ☐ No ☐ Unknown (colorectal, spine, bariatric only)

If yes, indicate type:

Gabapentin/Pregabalin	☐ Yes ☐ No	☐ Contraindicated
Benzodiazepines	☐ Yes ☐ No	☐ Contraindicated
Acetaminophen	☐ Yes ☐ No	☐ Contraindicated
NSAID	☐ Yes ☐ No	☐ Contraindicated
Cox2 Inhibitor	☐ Yes ☐ No	☐ Contraindicated
Opioids	☐ Yes ☐ No	☐ Contraindicated
Ketamine	☐ Yes ☐ No	☐ Contraindicated
Lidocaine	☐ Yes ☐ No	☐ Contraindicated
Postop Analgesia Other	☐ Yes ☐ No	

Postop Analgesia Specify _____

☐ Post Op Analgesia Not Available

Entereg administered after surgery: ☐ Yes ☐ No

Beta Blocker ordered within 24 hours postop: ☐ Yes ☐ No

(Applicable if patient on beta blocker, Not applicable if death in the O.R.)

Statin ordered within 24 hours postop: ☐ Yes ☐ No

(Applicable if patient on statin, not applicable if death in the O.R.)

Other Interventions

Left OR with NG tube in place: ☐ Yes ☐ No

Diet Advanced Beyond Clear Liquids: ☐ Yes ☐ No

Post Op Day Diet Successfully Advanced: *indicate number*

☐ **NA – Post Op Day Diet Successfully Advanced**

Estimated blood loss during surgery:

< 50 ml 50-250 ml 251-500 ml 501 - 1000 ml >1000 ml NA

RBC Transfusion in the O.R.: ☐ Yes ☐ No

If yes, how many units? 1 unit 2 units 3 units 4 or more units NA

RBC Transfusion within 24 hours after leaving O.R.: ☐ Yes ☐ No

If yes, how many units? 1 unit 2 units 3 units 4 or more units NA

Crystalloid in Operating Room: _____ (total mL)
Albumin in Operating Room: _____ (total mL)

RBC transfusion after 24 hours postop: ☐ Yes ☐ No

If yes, how many units? 1 unit 2 units 3 units 4 or more units NA

Crystalloid within 24 hours postop: _____ (total mL)
Albumin within 24 hours postop: _____ (total mL)

Mechanical ventilation: ☐ Yes ☐ No ☐ Not applicable if chronic-vent patient

If yes, total vent hours: less than 12hrs, 12 to less than 24hrs, 24 to less than 48hrs, 48 to less than 96hrs, more than 96hrs

Bariatric/Gastric

Indications

Morbid Obesity: ☐ Yes ☐ No
Bariatric Revision or Reversal: ☐ Yes ☐ No
Prior foregut surgery: ☐ Yes ☐ No

Procedure Type *(Select all that apply)*

Gastric Bypass (proximal): ☐ Yes ☐ No
Gastric Bypass (distal): ☐ Yes ☐ No
Gastric Bypass (other): ☐ Yes ☐ No
Sleeve Gastrectomy: ☐ Yes ☐ No
Takedown of vertical band: ☐ Yes ☐ No
Revision of gastric bypass: ☐ Yes ☐ No
Other bariatric procedure: ☐ Yes ☐ No

If yes: specify _____

Total Gastrectomy: ☐ Yes ☐ No
Partial/Subtotal Gastrectomy: ☐ Yes ☐ No

Does the procedure include removal of previously placed band ☐ Yes ☐ No

Anastomosis

Anastomosis (either distal or proximal) Stapled: ☐ Yes ☐ No ☐ Unknown

If stapled, was a sealing device used (e.g. Gore Seam Guard): ☐ Yes ☐ No

Anastomosis/ staple line tested: ☐ Yes ☐ No

If yes, indicate how tested:

☐ Scope ☐ Air/saline injected
☐ Methylene blue ☐ Palpation/inspection
☐ Other, if other, indicate method:_____

Appendectomy

Procedure Detail

Appendicitis: ☐ Yes ☐ No
Appendiceal mass or cancer: ☐ Yes ☐ No
Appendectomy Other: ☐ Yes ☐ No **If other**, specify _____

Was the patient pregnant? ☐ Yes ☐ No
If yes, number of weeks pregnant: _____ ☐ NA

ER or Urgent Care visit within one week and more than 12 hours prior to operation: ☐ Yes ☐ No
If yes, where: ☐ This facility ☐ Other facility

Patient admitted through this hospital through ER: ☐ Yes ☐ No
If yes, date and time: mm/dd/yyyy hh:mm

Concurrent abdominal or pelvic procedure: ☐ Yes ☐ No (*e.g. colectomy, ovarian cystectomy*)
If yes, indicate type: Gynecologic, Colon, Gall bladder, Other
If other, specify:_____

PEDIATRIC PROCEDURES ONLY:

Indicate any of the following as documented in the patient's chart:

Nausea/Vomiting: ☐ Yes ☐ No ☐ NA
Fever>=38C: ☐ Yes ☐ No ☐ NA
Migration of Pain: ☐ Yes ☐ No ☐ NA
Anorexia: ☐ Yes ☐ No ☐ NA
Pain with Movement: ☐ Yes ☐ No ☐ NA
Right Lower Quadrant (RLQ) Pain: ☐ Yes ☐ No ☐ NA
PAS score if documented in chart (0-10): _____

Was the patient ever hospitalized for appendicitis in the past? ☐ Yes ☐ No
If yes, type of treatment**:** Antibiotics Only, Antibiotics and Drainage, NA
Antibiotics for Primary Treatment: ☐ Yes ☐ No
Percutaneous Drain for Primary Treatment: ☐ Yes ☐ No

For surgery patients, indicate urgency of appendectomy:

☐ Non-elective appendectomy ☐ Interval appendectomy

Preop imaging within 24 hours (adult) or 72 hours (pediatric): ☐ Yes ☐ No
If yes, select all that apply: ☐ CT scan ☐ Ultrasound ☐ MRI

CT:

More than one CT scan performed: ☐ Yes ☐ No
Date and Time of MOST RECENT scan: mm/dd/yyyy hh:m
Use of contrast: ☐ Yes ☐ No ☐ NA
If yes, choose all that apply: IV Oral Rectal
Dose Length Product (DLP): _____ ☐ NA
CT Scan imaging results: Consistent with appendicitis, Not consistent with appendicitis, Indeterminate
CT Scan performed at: This Facility, Other Facility

Ultrasound:

US Date and Time: mm/dd/yyyy hh:mm
US results: Consistent with appendicitis, Not consistent with appendicitis, Indeterminate
US performed at: This facility, Other facility

MRI:

MRI Date and Time: mm/dd/yyyy hh:mm

MRI results: Consistent with appendicitis, Not consistent with appendicitis, Indeterminate

MRI performed at: This facility, Other facility

Appendiceal pathology: ☐ Yes ☐ No

Perforated appendix: ☐ Yes ☐ No

Colorectal Operation

Indications for Surgery (Diagnosis):

☐ **Colon Cancer**
☐ **Rectal Cancer**
☐ **Diverticular Disease**
☐ **GI Bleeding**
☐ **Colon mass**
☐ **Perforation**
☐ **Bowel obstruction**
☐ **Volvulus**
☐ **Colostomy**
☐ **Inflammatory Bowel Disease**
☐ **Crohn's Disease**
☐ **Ulcerative Colitis**
☐ **Ischemic Colon**
☐ **Stricture**
☐ **Polyps**
☐ **Gynecological Malignancy**
☐ **Rectal Prolapse**
☐ **Other**

If other, specify:_____

Medical Treatment for *IBD, Crohn's Disease* and *Ulcerative Colitis*:

Steroid Treatment: ☐ Yes ☐ No

If yes, stopped before surgery: Missing, Not Stopped, Within 30 days, Within 3 months

Biologics Treatment: ☐ Yes ☐ No

If yes, stopped before surgery: Missing, Not Stopped, Within 30 days, Within 3 months

Indicate Type of Biologics: Missing, Infliximab (Remicade), Adalimumab (Humira), Certolizumab Pegol (Cimzia), Golimumab (Simponi), Vedolizumab (Entyvio), Natalizumab (Tysabri)

Prior colon or pelvic surgery: ☐ Yes ☐ No

Procedure

Procedure Priority: ☐ Elective ☐ Non-elective

Operation type: (*Select all that apply*)

☐ Right/Transverse Hemicolectomy
☐ Left Hemicolectomy
☐ Low Anterior Resection (LAR)
☐ Sigmoid Colectomy
☐ Abdominal Perineal Resection (APR)
☐ Stoma Takedown
☐ Total Abdominal Colectomy (TAC)
☐ Proctocolectomy
☐ Ileal Pouch-Anal Anastomosis (IPAA)
☐ Colon Abdominal Proctectomy
☐ Perineal Proctectomy
☐ Additional (or staged) Procedure (planned return to OR during current admission)
☐ Proctopexy
☐ Ileocecectomy:
☐ Small Bowel Resection: (Crohn's Disease only)
☐ Stricturoplasty: (Crohn's Disease only)
If yes, indicate number of strictures:_____

Ostomy: No ostomy, Colostomy, Ileostomy, Protective stoma

Colon Anastomosis: ☐ Yes ☐ No

If yes, indicate type:

Colon to Colon (colocolon)
Ileum to Colon (ileocolon)
Ileum to Anus (ileoanal)
Colon to Anus (coloanal)
Cannot be determined
Colon to Rectum (colorectal)
Ileum to Rectum (ileorectal)

Pouch Created: ☐ Yes ☐ No

Anastomosis Stapled: ☐ Yes ☐ No ☐ Unknown

If yes, was a sealing device (e.g. Seam Guard) Used: ☐ Yes ☐ No

Anastomosis Tested: ☐ Yes ☐ No (*Applicable only if anastomosis; excludes Right hemicolectomy*)

If yes, specify: ☐ Scope ☐ Air/Saline Injected ☐ Other
☐ Methylene blue ☐ Palpation/Inspection If Other, *specify*: _____

Bowel Prep Used: ☐ Yes ☐ No ☐ NA

If yes, *select all that apply:* ☐ Mechanical ☐ Antibiotics

Only applicable if pre- or post-operative diagnosis for Colorectal Surgery is Cancer:

Cancer Processes

Postop Cancer Diagnosis: ☐ Yes ☐ No

Preoperative Neoadjuvant Treatment Given? ☐ Yes ☐ No

If yes, indicate therapy type: Chemotherapy: ☐ Yes ☐ No
Radiation Therapy: ☐ Yes ☐ No

If radiation, number of WEEKS between end of Preoperative Radiation and Surgery? _____ ☐ NA

Rectal Cancer only:

Procedure Done for Palliation: ☐ Yes ☐ No

Tumor to anal verge distance defined: ☐ Yes ☐ No

***If yes**, specify method(s):* (Check all that apply)

☐ Rigid Scope ☐ Digital Exam
☐ Flexible Scope ☐ Unknown

Distance (centimeters) from the anal verge in cm: _____ ☐ NA

Distance determined after neoadjuvant therapy: ☐ Yes ☐ No ☐ NA

Tumor fixed to Underlying Structures: ☐ Yes ☐ No

If yes, was it fixed after neoadjuvant therapy: ☐ Yes ☐ No ☐ NA

Total mesorectal excision (TME) done: ☐ Yes ☐ No

TME Capsule Intact: ☐ Yes ☐ No

Distance to radial margin (cm): <1 cm, 1-2 cm, >2 cm, NA

EUS, TRUS or MRI used to define the stage: ☐ Yes ☐ No ☐ NA

If yes, specify:

☐ Endoscopic Ultrasound (EUS) ☐ Transrectal Ultrasound (TRUS) ☐ MRI

For all Cancer, please complete Cancer Staging Section.

Diverticulitis Processes

(Select all that apply):

Acute Diverticulitis: ☐ Yes ☐ No
Current Gastrointestinal Bleeding: ☐ Yes ☐ No
Diverticulitis Stricture: ☐ Yes ☐ No
Colovesical Fistula: ☐ Yes ☐ No
Other Colon Fistulas: ☐ Yes ☐ No
Abscess ☐ Yes ☐ No

Prior Episodes of Diverticular Disease: ☐ Yes ☐ No ☐ NA

If yes, indicate number of prior treated episodes of diverticulitis: 1, 2, 3 – 10, >10, NA

Was patient treated as an *inpatient* for a prior episode? ☐ Yes ☐ No ☐ NA

Abstractor Name: _____ Date: _____

Small Bowel Obstruction

Prior hospitalizations for small bowel obstruction: ☐ Yes ☐ No ☐ Unknown
if yes, how many: 1, 2, 3-10, >10 , NA

Prior Abdominal Procedures: ☐ Yes ☐ No
if yes, **prior surgery approach:** Open, Laparoscopic, Both, Unknown

☐ Urologic/Gynecologic surgery
☐ Appendectomy
☐ GI Surgery
☐ Incisional Hernia Repair
☐ Mesh used
☐ Bariatric surgery
☐ Vascular procedure
☐ Radiation Therapy
☐ Other
if other, specify _____

Non-surgical Management

CT Scan Performed: ☐ Yes ☐ No ☐ Unknown

Date and Time of CT scan: Date: mm/dd/yyyy hh:mm ☐ NA

CT Scan Findings:

☐ Free Fluid
☐ Fecalization
☐ Pneumatosis
☐ Swirl Sign
☐ Other
if other, specify _____
☐ Ischemic (dead) Bowel
☐ Obstruction
☐ If obstructed, characterize:
Partial, Complete/Closed Loop, NA

Gastrografin Challenge ☐ Yes ☐ No
If yes, was contrast seen in the colon within 24 hrs? ☐ Yes ☐ No

Was a nasogastric tube inserted? ☐ Yes ☐ No
Date and Time of NG tube Insertion: mm/dd/yyyy hh:mm ☐ NA
Date and Time of Removal: mm/dd/yyyy hh:mm ☐ NA

Was there a documented surgery consult during hospitalization? ☐ Yes ☐ No
Date and time of surgery consult: mm/dd/yyyy hh:mm ☐ NA

Surgical Procedures

Procedure Type:

☐ Lysis of adhesions
☐ Bypass
☐ Resection with anastomosis
☐ Resection with stoma
☐ Anti-adhesion barrier placed
☐ Other
If Other, specify: _____

Surgery Findings

☐ Multiple adhesions
☐ Single band adhesion
☐ Negative exploration
☐ Inadvertent Enterotomy
☐ Ischemic (dead) bowel
☐ Obstruction
☐ Other
If Other, specify _____

Abstractor Name: _____ Date: _____

Spine

Indications for Surgery

Diagnosis: (Select all that apply)

☐ Degenerative Disc Disease
☐ Disc Herniation
☐ Stenosis
☐ Instability
☐ Dural Tear
☐ Neck/Back Pain
☐ Rheumatoid Arthritis
☐ Spondylolisthesis
☐ Spondylosis
☐ Pseudarthrosis
☐ Post Laminectomy/Failed Back Syndrome
☐ Other If other, specify_____

Spine Procedure Type: Cervical, Lumbar

Documented Conservative Treatment: Yes, No

Radiculopathy: Yes, No, Not Documented

If radiculopathy, ☐ Extremity Pain ☐ Diminished Reflex
☐ Motor Weakness ☐ Neurogenic Claudication

Myelopathy: Yes, No, Not Documented

Pre-op Baseline Function

NRS: Back/Neck Pain _____ ☐ NA
Extremity Pain _____ ☐ NA
Cervical: NDI Score _____ ☐ NA
Lumbar: ODI Score _____ ☐ NA

Spine Process of Care

Indications for Surgery: (Check all that apply):

Anterior Cervical ☐ Yes ☐ No
Posterior Cervical ☐ Yes ☐ No
Anterior Lumbar ☐ Yes ☐ No
Lateral Lumbar ☐ Yes ☐ No
Posterior Lumbar ☐ Yes ☐ No

Is this procedure a revision of a prior spine surgery: Yes, No

***If yes,* same level:** Yes, No

L6 vertebral involvement (*Lumbar procedures only*): ☐ Yes ☐ No

Spine Approach: Open, Minimally Invasive

Procedures: (Indicate levels; select all that apply)		**Proximal**	**Distal**
Discectomy	Yes, No	_____	_____
Fusion	Yes, No	_____	_____
Artificial Disc Replacement	Yes, No	_____	_____
Microdiscectomy	Yes, No	_____	_____
Laminotomy and/or Foraminotomy	Yes, No	_____	_____
Laminectomy	Yes, No	_____	_____
Laminoplasty (cervical only)	Yes, No	_____	_____
Corpectomy	Yes, No	_____	_____
Dural Repair	Yes, No	_____	_____
Other	Yes, No	_____	_____

if other, specify_____

Fusion Technique Used: ☐ Yes ☐ No

If yes, select all that apply

☐ Autologous (iliac/local) ☐ Allograft/Demineralized Bone Matrix Extender
☐ BMP ☐ Other, *if other*, specify:_____
☐ Unable to determine type of fusion technique

X-Ray Verification of Level: Yes, No
Neurologic Monitoring: Yes, No
Local antibiotics placed in wound prior to closure: Yes, No
Dural tear occurred and was repaired during the index surgery: Yes, No

Spine Instrumentation

Instrumentation Used *(If yes, select all that apply):* Yes, No

Anterior Instrumentation: Yes, No		**Proximal**	**Distal**
Plate	Yes, No	_____	_____
Cage	Yes, No	_____	_____
Disc Replacement	Yes, No	_____	_____
Anterior Other	Yes, No		
Other Anterior Specify: _____		_____	_____
Unknown	Yes, No	_____	_____

Posterior Cervical Instrumentation Used: Yes, No		**Proximal**	**Distal**
Lateral mass/Laminar Screws/Rod	Yes, No	_____	_____
Posterior Cervical Other	Yes, No		
Other Specify: _____		_____	_____
Unknown	Yes, No	_____	_____

Posterior Lumbar Instrumentation Used: Yes, No		**Proximal**	**Distal**
Pedicle screw/rod	Yes, No	_____	_____
Posterior Lumbar Interbody Fusion Implant	Yes, No	_____	_____
Posterior Lumbar Other	Yes, No		
Specify: _____		_____	_____
Unknown	Yes, No	_____	_____

Lateral Lumbar Instrumentation*:* Yes, No		**Proximal**	**Distal**
Cage	Yes, No	_____	_____
Screw/Rod	Yes, No	_____	_____
Lateral Lumbar Other	Yes, No		
Specify: _____		_____	_____
Unknown	Yes, No	_____	_____

Cancer Staging

Reference Data Dictionary for definitions

Preoperative T Stage: Tx, T0, T1a, T1, T1b ,T1c, T2, T2a, T2b, T2c, T3, T3a, T3b, T3c, T4 , T4a, T4b, Tis, pT0, pTx, pyT0, NA

T Stage on Pathology: Tx, T0, T1, T1a, T1b ,T1c, T2, T2a, T2b, T2c, T3, T3a, T3b, T3c, T4 , T4a, T4b, Tis, pT0, pTx, pyT0, NA

N Stage on Pathology: N0, NA, N1, N2, N3, NA

M Stage on Pathology: MX, M0, M1a, M1b, M1c, NA

Number of lymph nodes removed and studied: _____ ☐ NA

Number of lymph nodes positive for cancer: _____ ☐ NA

Abstractor Name: _____ Date: _____

Margins free of cancer: Yes, No

If yes, *specify:* **Distal Margin (cm):** <1 cm, 1-2 cm, >2 cm, NA
Proximal Margin (cm): <1 cm, 1-2 cm, >2 cm, NA

In Hospital Events

*Indicate if the patient experienced any of the listed events during the **first 30 post-operative days**.*
Include only events that were unplanned and occurred after the index procedure.

Post Operative Occurrences		☐ Yes ☐ No ☐ NA
If yes,	Myocardial infarction	☐ Yes ☐ No
	New Onset Cardiac Rhythm Abnormality Requiring Treatment	☐ Yes ☐ No
	CVA or Stroke	☐ Yes ☐ No
	Unplanned admit to ICU	☐ Yes ☐ No
	Acute Kidney Injury (AKI)	☐ Yes ☐ No
	Renal Failure	☐ Yes ☐ No
	Urinary Retention	☐ Yes ☐ No
Spine	New Neurologic Deficit	☐ Yes ☐ No
Gen	Enterocutaneous Fistula	☐ Yes ☐ No
Gen	Anastomotic Leak	☐ Yes ☐ No
Peds Appy	Bowel Obstruction	☐ Yes ☐ No
	Post-Op Infection	☐ Yes ☐ No
	c-Difficile Infection	☐ Yes ☐ No
	Surgical Site Infection	☐ Yes ☐ No
	Superficial	☐ Yes ☐ No
	Deep Tissue	☐ Yes ☐ No
	Organ Space	☐ Yes ☐ No
	Pneumonia:	☐ Yes ☐ No
	If yes, on vent	☐ Yes ☐ No
	UTI	☐ Yes ☐ No
	Other Infection	☐ Yes ☐ No
	Other (postop occurrence)	☐ Yes ☐ No
	If yes, specify _____	

Non-Operative Interventions		☐ Yes ☐ No ☐ NA
If yes,	Tracheal Reintubation/Tracheostomy	☐ Yes ☐ No
	NG Tube Replacement (non-routine)	☐ Yes ☐ No
	Anticoagulation therapy for DVT/PE	☐ Yes ☐ No
Peds Appy	PICC or Central Line Inserted	☐ Yes ☐ No
Peds Appy	Total Parenteral Nutrition (TPN) Administered	☐ Yes ☐ No
Peds Appy	Repeat Imaging	☐ Yes ☐ No
	Endoscopy: bleeding or dilation	☐ Yes ☐ No
	Non-operative Wound Intervention	☐ Yes ☐ No
	Other Non Operative Intervention	☐ Yes ☐ No
	If other, specify _____	

Abstractor Name: _____ Date: _____

Operative Intervention		☐ Yes ☐ No ☐ NA
If yes,	Colostomy or Ileostomy	☐ Yes ☐ No
	Operative Wound Intervention	☐ Yes ☐ No
	Gastrostomy/gastrostomy revision	☐ Yes ☐ No
	Anastomotic Revision	☐ Yes ☐ No
	Drainage for Bleeding/Hematoma/Seroma/Abscess	☐ Yes ☐ No
Spine	Return to OR for Dural Repair	☐ Yes ☐ No
Spine	Implant revision/removal	☐ Yes ☐ No
	Negative Re-exploration	☐ Yes ☐ No
	Other Reoperative Intervention	☐ Yes ☐ No
	If Other Reoperative Intervention text _____	
	Highest Postop Creatinine during Hospital Stay	mL, NA
	☐ Highest Creatinine - NA	

Discharge

Date and Time of Discharge: mm/dd/yyyy hh:mm

Discharge Disposition: Missing, Home, SNF, Other acute care hospital or inpatient facility, Death

Death Type: Death in the O.R., Death post-op in hospital

LOS-Admit-Discharge: *automatically calculated*
LOS-Admit-Surgery: *automatically calculated*
LOS-Surgery-Discharge: *automatically calculated*

Discharge Medications

Aspirin ☐ Yes ☐ No ☐ Contraindicated
Statin ☐ Yes ☐ No ☐ Contraindicated
Beta Blocker ☐ Yes ☐ No ☐ Contraindicated
Dabigatran ☐ Yes ☐ No ☐ Contraindicated
Anticoagulant ☐ Yes ☐ No ☐ Contraindicated if yes, how many days: _____ ☐ NA
ACE Inhibitor or ARB ☐ Yes ☐ No ☐ Contraindicated

Discharge Analgesia: ☐ Yes ☐ No ☐ Contraindicated (colorectal, spine, bariatric only)

If yes, indicate type:

Gabapentin/Pregabalin ☐ Yes ☐ No ☐ Contraindicated
Benzodiazepnes ☐ Yes ☐ No ☐ Contraindicated
Acetaminophen ☐ Yes ☐ No ☐ Contraindicated
NSAID ☐ Yes ☐ No ☐ Contraindicated
Cox2 Inhibitor ☐ Yes ☐ No ☐ Contraindicated
Opioids ☐ Yes ☐ No ☐ Contraindicated
Postop Analgesia Other ☐ Yes ☐ No
Post op Analgesia Specify _____
☐ Post Op Analgesia Not Available

Pediatric Appendectomy Only

Discharge Antibiotics: ☐ Yes ☐ No ☐ Contraindicated
If yes, how many days:_____ ☐ NA

Abstractor Name: _____ Date: _____

Choose up to 3 antibiotic medications:

1st Route: _____ *(Oral, IV, NA, Missing)*
Type: _____ *(Ampicillin, Augmentin, Cipro, Ertapenum, Flagyl, Gentamicin, Metropenum, Omnicef, Zosyn, Other, Missing)*

2nd Route: _____ (select from dropdown)
Type: _____ (select from dropdown)

3rd Route: _____ (select from dropdown)
Type: _____ (select from dropdown)

Other Types:_____

Post-discharge Events

Unplanned Readmission within 30 days of discharge: Yes, No

How many days from discharge to readmission? _____

For medically managed appendicitis, did the patient have a non-elective appendectomy within 30 days: Yes, No, NA

Was the patient readmitted for treatment of SBO within 30 days? Yes, No, NA
If yes, did the patient have surgery for SBO? Yes, No

Post Discharge Occurrences		☐ Yes ☐ No
If yes,	Myocardial Infarction	☐ Yes ☐ No
	New Onset Cardiac Rhythm Abnormality Requiring Treatment	☐ Yes ☐ No
	CVA or Stroke	☐ Yes ☐ No
	Acute Kidney Injury (AKI)	☐ Yes ☐ No
	Renal Failure	☐ Yes ☐ No
	Anastomotic Leak (SBO)	☐ Yes ☐ No
	Enterocutaneous Fistula (SBO)	☐ Yes ☐ No
	Dehydration/Volume Depletion	☐ Yes ☐ No
Spine	New Neurological Deficit	☐ Yes ☐ No
	Post-Discharge Infection	☐ Yes ☐ No
	c-Difficile Infection	☐ Yes ☐ No
	Surgical Site Infection	☐ Yes ☐ No
	Superficial	☐ Yes ☐ No
	Deep Tissue	☐ Yes ☐ No
	Organ Space	☐ Yes ☐ No
	Pneumonia:	☐ Yes ☐ No
	If yes, on vent	☐ Yes ☐ No
	Urinary Tract Infection (UTI)	☐ Yes ☐ No
	Other Post Discharge Occurrence	☐ Yes ☐ No
	If yes, specify _____	

Abstractor Name: _____ Date: _____

Non Operative Intervention		☐ Yes ☐ No ☐ NA
If yes,	Tracheal Reintubation/Tracheostomy	☐ Yes ☐ No
	NG Tube Replacement (non-routine)	☐ Yes ☐ No
	Endoscopy for bleeding/dilation	☐ Yes ☐ No
	Anticoagulant for DVT/PE	☐ Yes ☐ No
	Non-Operative Wound Intervention	☐ Yes ☐ No
	Other Non Operative Intervention	☐ Yes ☐ No
	If yes, specify _____	

ReOperative Intervention:		☐ Yes ☐ No ☐ NA
If yes,	Colostomy or Ileostomy	☐ Yes ☐ No
	Operative Wound Intervention	☐ Yes ☐ No
	Anastomotic Revision	☐ Yes ☐ No
	Gastrostomy/Gastrostomy Revision	☐ Yes ☐ No
	Negative re-exploration	☐ Yes ☐ No
	Post Discharge Drainage for Bleeding/Hematoma/Seroma/Abscess	☐ Yes ☐ No
Spine	Implant Revision	☐ Yes ☐ No
	Other Reoperative Intervention	☐ Yes ☐ No ☐ NA
Spine	NRS neck/back	number
Spine	☐ NA – Spine: NRS neck/back	NA
Spine	NRS extremity	number
Spine	☐ NA – Spine: NRS extremity	NA
Spine	Return to work	☐ Yes ☐ No ☐ NA

Hospital Comments

Optional Hospital-specific Comment Fields: (*Fields intended for notes regarding case)*

Hospital Comment 1:_____

Hospital Comment 2: _____

Hospital Comment 3: _____

POC Custom Other 1 _____

POC Custom Other 2 _____

POC Custom Other 3 _____

POC Custom Other 4 _____

Abstractor Name: _____ Date: _____

Follow Up

Post-discharge Death: ☐ Yes ☐ No
Post-discharge Death Date: mm/dd/yyyy ☐ NA

6 Month Follow-up

☐ Follow up at 6 Months

Date of 6 mo Followup: mm/dd/yyyy hh:mm

Any Readmit between 30 days and 6 months:
☐ Yes ☐ No

Reoperation related to index procedure:
☐ Yes ☐ No

Implant revision or removal:
☐ Yes ☐ No

Other reinterventions:
☐ Yes ☐ No

If yes, specify: _____

Return to work: ☐ Yes ☐ No

NRS neck/back: _____ ☐ NA
NRS extremity: _____ ☐ NA

If cervical: NDI: _____ ☐ NA
If lumbar: ODI: _____ ☐ NA

18 Month Follow-up

☐ Follow up at 18 Month

Date of 18 Mo Followup: mm/dd/yyyy hh:mm

Any readmit between 1 year and 18 months:
☐ Yes ☐ No

Reoperation related to index procedure:
☐ Yes ☐ No

Implant revision or removal:
☐ Yes ☐ No

Other reinterventions:
☐ Yes ☐ No

If yes, specify: _____

Return to work: ☐ Yes ☐ No

NRS neck/back: _____ ☐ NA
NRS extremity: _____ ☐ NA

If cervical: NDI: _____ ☐ NA
If lumbar: ODI: _____ ☐ NA

1 Year Follow-up

☐ Follow up at 1 Year

Date of 1 Yr Followup: mm/dd/yyyy hh:mm

Any Readmit between 6 months and 1 Year:
☐ Yes ☐ No

Reoperation related to index procedure:
☐ Yes ☐ No

Implant revision or removal:
☐ Yes ☐ No

Other reinterventions:
☐ Yes ☐ No

If yes, specify: _____

Return to work: ☐ Yes ☐ No

NRS neck/back: _____ ☐ NA
NRS extremity: _____ ☐ NA

If cervical: NDI: _____ ☐ NA
If lumbar: ODI: _____ ☐ NA

2 Year Follow-up

☐ Follow up at 2 Years

Date of 2 Yr Followup: mm/dd/yyyy hh:mm

Any Readmit between 18 months and 2 Years:
☐ Yes ☐ No

Reoperation related to index procedure:
☐ Yes ☐ No

Implant revision or removal:
☐ Yes ☐ No

Other reinterventions:
☐ Yes ☐ No

If yes, specify: _____

Return to work: ☐ Yes ☐ No

NRS neck/back: _____ ☐ NA
NRS extremity: _____ ☐ NA

If cervical: NDI: _____ ☐ NA
If lumbar: ODI: _____ ☐ NA