| MEDICAL RECORD | INTRAOPERATIVE DOCUMENT<br>For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General. |
|---|---|
| 1. PATIENT TRANSPORTED TO OPERATING ROOM<br>VIA BY | 2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE<br>VERIFIED BY |
| 3. DATE TIME PATIENT ARRIVED IN SUITE | 4. PATIENT IN ROOM<br>TIME NUMBER |

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:

6. NURSING PERSONNEL

| | | | |
|---|---|---|---|
| ASSIGNED SCRUB | | RELIEF SCRUB | |
| ASSIGNED CIRCULATOR | | RELIEF CIRCULATOR | |

7. POSITION AND POSITIONAL AIDS *(Specify)*

☐ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS:

8. SKIN PREPARATION

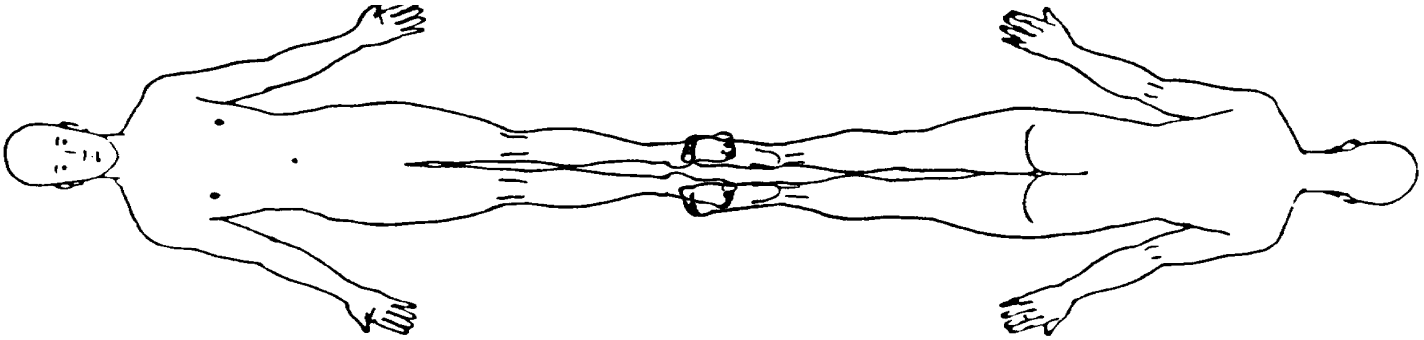
HAIR REMOVAL ☐ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)*
SITE: BY WHOM:
SITE: BY WHOM:

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap = = = Tourniquet

C = Correct I = Incorrect

| 10. COUNTS | Other** | First Closing Count | Final Closing Count | SCRUB | CIRCULATOR |
|---|---|---|---|---|---|
| Sponge ☐ Yes ☐ No | | | | | |
| Needle Sharp ☐ Yes ☐ No | | | | | |
| Instrument ☐ Yes ☐ No | | | | | |
| Other ☐ Yes ☐ No | | | | | |

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

12. ELECTROSURGERY DEVICE(S) (ESU) ☐ YES ☐ NO

☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____
☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____
☐ BIPOLAR NO: _____

13. PROSTHESIS, IMPLANTS ☐ YES ☐ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☐

| MEDICATIONS/SOLUTION | DOSAGE | TIME | METHOD | PREPARED BY | GIVEN BY |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

WOUND IRRIGATION ☐ YES ☐ NO, TYPE(S):

| OTHER ORDERS | TIME | CARRIED OUT BY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☐ NO ☐ IF YES, SITE

16. LABORATORY SPECIMENS

| | | |
|---|---|---|
| SPECIMEN (S) YES ☐ NO ☐ | NAME | NAME |
| FROZEN SECTION (FS) YES ☐ NO ☐ | NAME | NAME |
| CULTURE (C) YES ☐ NO ☐ | NAME | NAME |
| NAME | NAME | NAME |
| NAME | NAME | 18. DRESSING/IMMOBILIZATION *(Specify)* |

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

| | | | |
|---|---|---|---|
| TYPE/SIZE | 1. | 2. | 3. |
| SITE | 1. | 2. | 3. |

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED

| 21. PATIENT TRANSFERRED TO | TIME | METHOD |
|---|---|---|
| | | |

22. REGISTERED NURSE SIGNATURE