

Patient Initials: _____

Date of Birth: _____

Admit Date: _____

B21) Admission is a transfer from another hospital: No Yes

21.1 If yes, on oxygen:

No Yes

21.2 If yes, on mechanical ventilation:

No Yes

B22) Number of days patient had symptoms prior to this admission for the index surgery: NA _____(days)

B23) Resident Zip Code: _____

C. Risk Factors

▲ C1) Maternal Risk Factors:

- 1.1 Perinatal Complications NA No Yes (specify) _____
- 1.2 Gestational Complications NA No Yes (specify) _____
- 1.3 Group B Strep NA No Yes
- 1.4 HIV NA No Yes
- 1.5 Alcohol/Illicit Drug Exposure NA No Yes (specify) _____
- 1.6 Tobacco Smoking NA No Yes
- 1.7 Rubella NA No Yes
- 1.8 Other NA No Yes (specify) _____

C2) Most recent laboratory values within 30 days of or upon admission:

- 2.1 Albumin: NA _____ g/dl
- 2.2 Hct: NA _____ %
- 2.3 Creatinine: NA _____ mg/dl
- 2.4 HGB: NA _____ g/dl
- 2.5 WBC: NA _____ K/mm³
- 2.6 Total Bilirubin NA _____ mg/dl
- 2.7 Conj Bilirubin: NA _____ mg/dL
- 2.8 Unconj Bilirubin: NA _____ mg/dL
- 2.9 PLT: NA _____ K/mm³

C3) Current / recent (within 30 days) medications used pre-operatively:

- 3.1 Non-steroidal Immunosuppressant No Yes
- 3.2 Steroids No Yes
- 3.3 Asthma medications No Yes
- 3.4 Anti-seizure meds No Yes
- 3.5 Anti-reflux meds No Yes
- 3.6 Chemotherapy for Cancer No Yes
- 3.7 Antibiotics No Yes
- 3.8 Diuretics No Yes
- 3.9 Narcotics No Yes

C4) Home O₂ use: No Yes NA

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D. Comorbidities

Comorbidities:

If yes, check the best response

D1) Developmental delay: No Yes Suspected

D2) Congenital cardiac defect: No Yes Suspected

AV canal VSD Tetralogy
 Other (specify): _____

D3) Chronic lung disease: No Yes Suspected

No meds O2 Diuretics
 Other (specify): _____

D4) Asthma: No Yes Suspected

No Yes No meds
 No Yes Steroid use
 No Yes Inhalers
 No Yes Other Tx

D5) History of sleep apnea: No Yes Suspected

No treatment CPAP (or similar tx)
 Tonsillectomy w/in 30 days

D6) Genetic defect: No Yes Suspected

Trisomy 21 Trisomy 18
 Other (specify): _____

D7) GERD: No Yes Suspected

D8) Multiple birth: No Yes

Twin birth Triplet birth Greater # _____

D9) Other Comorbidity: No Yes

Specify: _____

E. Operative

E1) Primary Surgeon: _____ (Optional; use physician ID # only – NO names)

Indication for operation: Check all that apply within the chosen (yes) procedure category; indicate no for the other procedure categories

E2) Appendectomy:

No Yes

2.1 Appendicitis

2.2 Other

(specify): _____

E3) Gastric:

No Yes

3.1 Emesis

3.2 Failure to thrive

3.3 GERD

3.4 Hypertrophic Pyloric
Stenosis

3.5 Pulmonary
complication:

(specify) _____

3.6 Other (specify): _____

E4) Colon:

No Yes

4.1 NEC

4.2 Stricture

4.3 Volvulus

4.4 Ischemic colon

4.5 Anorectal
malformation

4.6 Ca of Colon

4.7 Ulcerative colitis

4.8 Crohn's disease

4.9 Perforation

4.10 Hirschsprung's

4.11 Polyp disease
(eg FAP)

4.12 Rectal prolapse

4.13 Other (specify): _____

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F. Intra-Operative

F1) Time of first Incision: NA ____:____ (24-hr clock)

F2) In-room close time: NA ____:____ (24-hr clock)

F3) Date of surgery: ____ / ____ / ____

F4) In-room close date: ____ / ____ / ____

F5) Surgical Approach: Laparoscopic Lap converted to open
 Lap, hand-assisted Open (no lap ports)

F6) ASA Class: NA I II III IV V Already intubated

F7) Highest perioperative blood glucose: Not performed ____mg

F8) Insulin used in perioperative time period: No Yes

F9) Lowest intra-op temperature: NA ____°C

F10) Death in the OR: No Yes

F11) First temperature on arrival to recovery room / ICU: NA ____°C Not applicable if death in the OR

G. Perioperative Interventions

Antibiotics:

G1) On antibiotics prior to arrival in the OR: No Yes

If yes: 1.1 At this hospital No Yes

If yes: a. For treatment of the surgical indication No Yes

b. For treatment of a different indication No Yes

If yes: 1.2 At transferring hospital: No Yes (Not applicable if not transferred)

If yes: a. For treatment of the surgical indication No Yes

b. For treatment of a different indication No Yes

G2) Were prophylactic antibiotics indicated: No Yes

If yes: 2.1 Administered within 60 min of incision: No Yes

2.2 Discontinued within 24 hrs after closure: No Yes (Not applicable if death in O.R.)

Pain management:

G3) Regional anesthesia used intra-op: No Yes Contraindicated

(Remaining pain management items not applicable if death in the O.R.)

G4) Epidural ordered within 24 hrs post-op: No Yes Contraindicated

G5) PCA ordered within 24 hrs post-op: No Yes Contraindicated

G6) NSAID ordered in OR or within 24 hrs post-op: No Yes Contraindicated

G7) Narcotic drip: No Yes Contraindicated

G8) Other: No Yes

8a If yes, specify modality: _____

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Nasogastric tube: (Not applicable if death in the O.R.)

G9) Left O.R. with NG tube in place: No Yes

G10) Left O.R. with G tube to drainage in place: No Yes

Transfusion: (Not applicable if apply)

G11) RBC tranfusion in O.R. or within 24 hrs post-op: No Yes 11a If yes, NA _____ units or _____ ml

G12) PLT transfusion in O.R. or within 24 hrs post-op: No Yes 12a If yes, NA _____ units or _____ ml

Mechanical Ventilation: (Not applicable if Death in O.R.)

G13) Beyond recovery room: No Yes Not applicable – chronic ventilator patient
13a If yes, total hours: NA _____ hrs

Post-operative events: If the patient had the event **during this hospitalization** and following the procedure **within 30 days**, (not applicable if death in the OR)

G14) Unplanned ICU stay or readmission to ICU No Yes

G15) Discharge disposition:

- Home Foster Care
- SNF Rehab facility
- Other acute care hospital Other location If other, specify: _____

- Death: 15a If death, specify: Death in the O.R.
- Death within 24hrs post-op
- Death after 24 hrs post-op

H. Reintervention

If the patient had any of the surgical operations or therapies listed below **during this hospitalization** and following the abdominal procedure, select all that apply and note the date first performed after surgery. (Not applicable if death in the O.R.)

H1) Any Reintervention: No Yes

H2) Abdominal re-operation: No Yes

If yes, indicate abdominal procedure (2.1 thru 2.9); if no, skip to H3

- 2.1 Colostomy or ileostomy No Yes Date: ____/____/____ (mm/dd/yyyy)
- 2.2 Abscess drainage No Yes Date: ____/____/____
- 2.3 Operative drain placement No Yes Date: ____/____/____
- 2.4 Gastrostomy revision No Yes Date: ____/____/____
- 2.5 Re-exploration/washout No Yes Date: ____/____/____
- 2.6 Anastomotic revision No Yes Date: ____/____/____
- 2.7 Wound revision / evisceration No Yes Date: ____/____/____
- 2.8 Negative re-exploration No Yes Date: ____/____/____

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2.9 Other
2.9a (Specify: _____)

No Yes

Date: ____/____/____

H3) Tracheal reintubation:

No Yes

Date: ____/____/____

H4) NG tube replacement (non-routine):

No Yes

Date: ____/____/____

H5) Tracheostomy:

No Yes

Date: ____/____/____

H6) Placement of percutaneous drain:

No Yes

Date: ____/____/____

H7) Antibiotic for presumed/confirmed infection:

No Yes

H8) Wound reopened:

No Yes

H9) Radiologically demonstrated anastomotic leak:

No Yes

H10) Radiologically demonstrated enterocutaneous fistula: No Yes

H11) Other:

No Yes

11a. If yes, specify: _____

I. Gastric Procedures

I1) Prior foregut surgery:

No Yes

I2) Procedure of record:

2.1 Pyloromyotomy

No Yes

2.2 Antireflux Operation

No Yes

If Antireflux Op:

2.2 a. specify type of fundoplication: _____

2.2 b. was a concurrent gastrostomy performed? No Yes

2.2 c. was a gastrostomy tube already in place? No Yes

I3) Procedure type:

Primary

Re-Operative

I4) Preoperative evaluation:

No Yes

NA

If yes, indicate all that apply:

4.1 UGI

No Yes

4.2 Manometry

No Yes

4.3 UGI with SBFT

No Yes

4.4 Esophagoscopy

No Yes

4.5 US

No Yes

4.6 Gastric emptying study

No Yes

4.7 pH probe

No Yes

4.8 Impedance

No Yes

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J. Non-elective Appendectomy

J1) Concurrent abdominal/pelvic procedure performed (e.g. colectomy, hernia repair): No Yes

1a If yes, specify: _____

J2) Pre-op imaging within 72 hrs

2.1 First imaging study obtained: No Yes

2.1a If yes, initial study performed at outside hospital: No Yes

2.1b If yes, imaging type: CT scan Ultrasound

2.1c If yes, results were: Consistent with appendicitis
 Not consistent with appendicitis
 Indeterminate

2.2 Second imaging study obtained: No Yes
(Not applicable if no initial imaging done)

2.2a If yes, study performed at outside hospital: No Yes

2.2b If yes, imaging type: CT scan Ultrasound

2.2c If yes, results were: Consistent with appendicitis
 Not consistent with appendicitis
 Indeterminate

2.3 Third imaging study obtained: No Yes
(Not applicable if no previous imaging done)

2.3a If yes, study performed at outside hospital: No Yes

2.3b If yes, imaging type: CT scan Ultrasound

2.3c If yes, results were: Consistent with appendicitis
 Not consistent with appendicitis
 Indeterminate

J3) ER/urgent care visit within one week prior to operation: No Yes

3.1 If yes, imaging study done during visit: No Yes

3.2 If yes, imaging type: CT scan Ultrasound

J4) Pathology results: appendiceal pathology No Yes

J5) Perforated appendix: 5.1 Per surgeon: No Yes

5.2 Per pathology: No Yes

5.2a If yes, Microperforation: No Yes

K. Colon Procedures

K1) Prior colon or pelvic surgery: No Yes

K2) Prior colon resection within 30 days: No Yes

2.1 If yes, indicate at which hospital performed _____

K3) Procedure priority: Elective Non-elective

K4) Operation Characteristics

If Indication Anorectal Malformation:

4.1 Operation Type:

a. PSARP No Yes

b. Laparoscopic pull-through No Yes

c. Other No Yes

(specify: _____)

4.2 Protective ostomy: No Yes

4.2a If yes, ostomy location: Ileostomy Colostomy

4.2b If colostomy, specify: Right Transverse Left

Sigmoid Unknown

4.3 Fistula: No Yes

4.3a If yes, location (Check one only)

Bladder Perineal Prostatic urethra

Urethra Vaginal Vestibular

K5) Operation Characteristics

If Indication Hirschsprung's Disease:

5.1 Operation Type:

a. Diverting ostomy (e.g. for Megacolon) No Yes

b. Pull-through procedure No Yes

If Diverting ostomy

5.2 Location of ostomy: Ileostomy Colostomy

5.2a If colostomy, specify: Right Transverse Left

Sigmoid Unknown

5.2b If colostomy, levelling: No Yes

If Pull-through

5.3 Primary pull-through: No Yes

5.3a If Primary, pull-through Type: Soave Swenson Duhamel

Other (specify: _____)

5.3b If Primary, was pull-through laparoscopic: No Yes

5.3c If Primary, Protective ostomy: No Yes

1. Location of ostomy: Ileostomy Colostomy

2. If colostomy, specify: Right Transverse Left

Sigmoid Unknown

5.3d If NOT primary:

1. Level of prior ostomy: Ileostomy Colostomy

2. If colostomy, specify: Right Transverse Left

Sigmoid Unknown

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K6) Operation Characteristics

If Indication Ulcerative Colitis:

6.1 Operation Type:

- a. Total abdominal colectomy with ileostomy No Yes
- b. Total abdominal proctocolectomy with ileoanal pull-through No Yes
- c. Proctocolectomy with ileoanal pull-through No Yes

6.2 If ileoanal pull-through,

- a. Protective ileostomy: No Yes
- b. Pouch created: No Yes
- If yes, pouch type: J pouch S pouch Other
(specify: _____)

K7) Operation Characteristics

If Other Indications: (all other colon indications not previously described above)

7.1 Operation Type:

- a. Ileocecectomy (often Crohn's) No Yes
- b. Colectomy No Yes
- If colectomy, indicate location/type (check all that apply)
 - Right No Yes
 - Transverse No Yes
 - Left No Yes
 - Sigmoid No Yes
 - Rectum No Yes

- c. Other operation type No Yes
Please, specify: _____

7.2 Protective ostomy: No Yes

- a. Location of ostomy: Ileostomy Colostomy
- b. If colostomy, specify: Right Transverse Left
 Sigmoid Unknown

7.3 Anastomosis: No Yes

- a. If anastomosis, specify type:
 - Colocolon (colon to colon) Ileocolon (ileum to colon)
 - Ileoanal (ileum to anal) Coloanal (colon to anal)
 - Cannot be determined

- b. If ileoanal or coloanal anastomosis, pouch created: No Yes
- If yes, pouch type: J pouch S pouch Other
(specify: _____)

7.4 Anastomosis tested: No Yes (Not applicable if no anastomosis)

- a. If yes, specify:
 - Scope (flexible endoscopy or sigmoidoscope) No Yes
 - Methylene blue No Yes
 - Air/saline injected via tube or syringe No Yes
 - Palpation/inspection No Yes
 - Other No Yes
(specify: _____)

K8) Did the patient have a VCUG: No Yes

K9) Pathology results confirm diagnosis: No Yes