

SCOAP Data Collection Form For Adults (effective for discharges starting January 1, 2010)

Note: Complete one form for each procedure: Appendectomy, Bariatric operation, or Colon surgery. A new record online should contain patient and procedure information for only one procedure.

B. Demographics

- B1) First 2 initials of Last Name/First Name:** ___ ___ / ___ ___ **B2) Hospital Code:** _____
- B3) Date of Birth:** ___ / ___ / ___ **B4) Medical record # (optional):** _____
- B5) Admit Date:** ___ / ___ / ___ Time: ___:___ **B6) Discharge Date:** ___ / ___ / ___ Time: ___:___
- B7) Gender:** Male Female **B8) Age at Admit** _____ (years)
- B9) Race:** American Indian/ Alaska Native Asian
 Black or African American Native Hawaiian or Other Pacific Islander
 White NA/Unknown
- B10) Ethnicity:** Hispanic or Latino Not Hispanic or Latino NA
- B11) Patient Height:** _____ (in) OR _____ (cm) **B12) Weight:** _____ (lbs) OR _____ (kg)
- B13) Insurance:** (Check all that apply)
- 13.1 Private: No Yes
13.2 If private, choose one: Regence Premera First Choice Group Health
 Aetna Cigna Uniform Medical
 United Healthcare Kaiser Other Private
- 13.3 Medicare: No Yes 13.4 Medicaid: No Yes
- 13.5 TriCare: No Yes 13.6 Indian Health Svcs: No Yes
- 13.7 VA benefic.: No Yes 13.8 Uninsured: No Yes
- 13.9 Self pay: No Yes 13.10 Labor and Industry No Yes
- B14) Admission is a transfer from another hospital:** No Yes
- B15) ZIP Code Collected:** No Yes 15a) Residence ZIP Code: _____

E. Operative

E1) Primary Surgeon: _____ (Optional, ID # only – NO names)

1a. Indicate surgeon specialty: General/colorectal surgeon OB/GYN

E2) Other Physician Identification: _____ (Optional, ID # only – NO names)

E3) Anesthesia provider: _____ (Optional, ID # only – NO names)

Indication for operation: *Check all that apply within each category*

E4) For appendectomy:	E5 For bariatric surgery:	E6 For colon:	
<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	
4.1 <input type="radio"/> Appendicitis	5.1 <input type="radio"/> Morbid obesity	6.1 <input type="radio"/> Cancer of colon	6.10 <input type="radio"/> GI bleeding
4.2 <input type="radio"/> Appendiceal mass or Cancer	5.2 <input type="radio"/> Other	6.2 <input type="radio"/> Diverticular disease	6.11 <input type="radio"/> Perforation
4.3 <input type="radio"/> Other	5.2a (specify): _____	6.3 <input type="radio"/> Trauma	6.12 <input type="radio"/> Cancer of rectum
4.3a (specify): _____		<i>If trauma,</i>	6.13 <input type="radio"/> Bowel obstruction
		6.3a <input type="radio"/> blunt	6.14 <input type="radio"/> Colostomy
		6.3b <input type="radio"/> penetrating	6.15 <input type="radio"/> Ulcerative colitis
		6.4 <input type="radio"/> Radiation colitis	6.16 <input type="radio"/> Crohn's disease
		6.5 <input type="radio"/> Volvulus	6.17 <input type="radio"/> Stricture
		6.6 <input type="radio"/> Arteriovenous malformation	6.18 <input type="radio"/> Gynecological malignancy
		6.7 <input type="radio"/> Ischemic colon	6.19 <input type="radio"/> Iatrogenic colectomy
		6.8 <input type="radio"/> Polyps	6.20 <input type="radio"/> Other:
		6.9 <input type="radio"/> Rectal prolapse	6.20a(specify): _____

F. Intra-Operative

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

F2) In-room Close Time Time: ____:____ (24-hr clock) NA

F3) Date of surgery: ____ / ____ / ____

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

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

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

F7) Highest perioperative blood glucose: _____mg NA

F8) Insulin used in perioperative time period: No Yes

F9) Highest Blood Glucose on Post Op Day 1: _____mg NA

F10) Highest Blood Glucose on Post Op Day 2: _____mg NA

F11) Lowest Blood Glucose within 48 hrs ending at the close of Post-op day 2: _____mg NA

If procedure is appendectomy, skip questions 12 and 14

F12) Lowest intra-op temperature: _____°C NA

F13) Death in the OR: No Yes

F14) First temp on arrival to recovery: _____ °C NA (Not applicable if death in the OR)

G. Perioperative Interventions

Perioperative interventions: (Check all that apply. Skip all DVT prophylaxis questions if procedure is appendectomy)

DVT Prophylaxis: Heparin or low molecular weight heparin or synthetic factor Xa administered:
(Not applicable if apply)

G1) Within 24 hours of incision: No Yes Contraindicated

If yes; select all that apply:

- 1a. Heparin No Yes _____ units Frequency: x1 only **OR** q _____ hrs
- 1b. Enoxaparin (Lovenox) No Yes _____ mg Frequency: x1 only **OR** q _____ hrs
- 1c. Dalteparin (Fragmin) No Yes _____ IU Frequency: x1 only **OR** q _____ hrs
- 1d. Tinzaparin (Innohep) No Yes _____ Units Frequency: x1 only **OR** q _____ hrs
- 1e. Fondaparinux (Arixtra) No Yes _____ mg Frequency: x1 only **OR** q _____ hrs
- 1g. Other No Yes _____ mg Frequency: x1 only **OR** q _____ hrs
(e.g. Apixaban, Xarelto, Pradaxa) *If yes, specify type* _____

G2) Ordered post-op for in-hospital use after the first 24 hrs: No Yes Contraindicated
(Not applicable if death in O.R.)

If yes; select all that apply:

- 2a. Heparin No Yes _____ units Frequency: x1 only **OR** q _____ hrs × _____ days
- 2b. Enoxaparin (Lovenox) No Yes _____ mg Frequency: x1 only **OR** q _____ hrs × _____ days
- 2c. Dalteparin (Fragmin) No Yes _____ IU Frequency: x1 only **OR** q _____ hrs × _____ days
- 2d. Tinzaparin (Innohep) No Yes _____ Units Frequency: x1 only **OR** q _____ hrs × _____ days
- 2e. Fondaparinux (Arixtra) No Yes _____ mg Frequency: x1 only **OR** q _____ hrs × _____ days
- 2f. Coumadin No Yes _____ mg Frequency: x1 only **OR** q _____ hrs × _____ days
- 2g. Other No Yes _____ mg Frequency: x1 only **OR** q _____ hrs × _____ days
(e.g. Apixaban, Xarelto, Pradaxa) *If yes, specify type* _____

G3) Ordered on discharge:

No Yes Contraindicated

(Not applicable if discharge disposition is death)

If yes; check all that apply

3a. Heparin No Yes _____ units Frequency: xI only **OR** q _____ hrs × _____ days

3b. Enoxaparin (Lovenox) No Yes _____ mg Frequency: xI only **OR** q _____ hrs × _____ days

3c. Dalteparin (Fragmin) No Yes _____ IU Frequency: xI only **OR** q _____ hrs × _____ days

3d. Tinzaparin (Innohep) No Yes _____ Units Frequency: xI only **OR** q _____ hrs × _____ days

3e. Fondaparinux (Arixtra) No Yes _____ mg Frequency: xI only **OR** q _____ hrs × _____ days

3f. Coumadin No Yes _____ mg Frequency: xI only **OR** q _____ hrs × _____ days

3g. Other No Yes _____ mg Frequency: xI only **OR** q _____ hrs × _____ days
(e.g. Apixaban, Xarelto, Pradaxa) If yes, specify type _____

G4) Intermittent pneumatic compression in O.R.: *(not applicable if apply)* No Yes

Beta-blocker: *(Not applicable if apply)*

G5) Administered within 24hrs pre-op No Yes Contraindicated

G6) Administered intraoperatively (within the OR) No Yes Contraindicated

G7) Ordered within 24 hrs post-op: No Yes Contraindicated *(Not applicable if death in O.R.)*

Antibiotics: *(Not applicable if apply)*

G8) On antibiotics for the treatment of infection: No Yes

- If yes:* a. At this hospital/upon admission No Yes
- b. At transferring hospital: No Yes

G9) Were prophylactic antibiotics indicated: No Yes

- If yes:* a. Administered within 60 min of incision: No Yes
- b. Discontinued within 24 hrs after closure: No Yes *(Not applicable if death in O.R.)*

Pain management: *(Not applicable if apply or death in the O.R.)*

G10) Epidural ordered within 24 hrs post-op: No Yes Contraindicated

a. If epidural, was the epidural a PCEA (Patient Controlled Epidural Analgesia) No Yes

G11) PCA ordered within 24 hrs post-op: No Yes Contraindicated

G12) NSAID ordered within 24 hrs post-op: No Yes Contraindicated

G13) Narcotic drip: No Yes Contraindicated

G14) Other: No Yes

a. *If yes, specify modality:* _____

Additional Perioperative Medications

G15) Was Entereg (generic is alvimopan) administered: No Yes

Patient Initials: _____

Date of Birth: _____

Admit Date: _____

(Applicable only to non-lap band bariatric and colorectal surgeries.)

G16) Was Aloxi (generic is palonosetron hydrochloride) administered: No Yes
(Applicable to all surgeries.)

G17) Was a statin ordered post-op for in-hospital use: No Yes (Not applicable if death in the O.R.)

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

G18) Left O.R. with NG tube in place: No Yes

G19) Left O.R. with G tube to drainage in place: No Yes

Red blood cell transfusion: (Not applicable if apply)

G20) Estimated blood loss during surgery: < 50cc 50-250cc >250cc NA

G21) Transfusion in O.R. or within 24 hrs post-op: No Yes

a. If yes, how many units? _____ units NA

b. If yes, lowest hemoglobin (Hgb) in the 12 hours prior to the transfusion order: _____ g/dl NA

G22) Transfusion after 24 hrs post-op: No Yes (Evaluate only the first 30 days of the hospitalization)

a. If yes, how many units? _____ units NA

b. If yes, lowest Hgb in the 12 hours prior to the transfusion order: _____ g/dl NA

G23) Last Hgb prior to discharge: _____ g/dl NA

G24) Mechanical ventilation: (Not applicable-chronic ventilator) No Yes

a. If yes, total hours? _____ hrs NA

G25) Highest creatinine level during this hospitalization: _____ mg/dL NA

(Evaluate only the first 30 days of the hospitalization)

Post-operative events: If the patient had any of these events **during the first 30 post-op days of this hospitalization**, check all that apply: (not applicable if death in the OR)

G26) Post-operative events: No Yes

If yes: 26.1 Myocardial infarction No Yes

26.2 CVA/stroke No Yes

26.3 Unplanned ICU stay/readmit to ICU No Yes

26.4 Fall with injury requiring surgery No Yes

26.5 c-Difficile infection No Yes

G27) Discharge disposition: Home Other acute care hospital

Rehab facility Death: a. If death, specify:

SNF

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, select all that apply and note the date first performed after surgery. Include only events that were unplanned; occurred after the index abdominal procedure & during this hospitalization. In the cases of prolonged hospital stay, evaluate the first 30 post-op days only. (Not applicable if death in the O.R.)

- H1) Reintervention:** No Yes
- H2) Abdominal re-operation:** No Yes
 If yes, specify procedure:
 - 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 No Yes Date: ____/____/____
 - 2.5 Gastrostomy revision No Yes Date: ____/____/____
 - 2.6 Anastomotic revision No Yes Date: ____/____/____
 - 2.7 Band replacement No Yes Date: ____/____/____
 - 2.8 Band/port revision No Yes Date: ____/____/____
 - 2.9 Wound revision No Yes Date: ____/____/____
 - 2.10 Negative re-exploration No Yes Date: ____/____/____
 - 2.11 Reoperation for bleeding No Yes Date: ____/____/____
 - 2.12 Other No Yes Date: ____/____/____
 a. Specify: _____
- 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) Anticoagulation therapy for presumed/confirmed DVT:** No Yes
- H8) Anticoagulation therapy for presumed/confirmed PE:** No Yes
- H9) Antibiotic for presumed/confirmed infection:** No Yes
 Indicate infection type: (excludes c-Difficile)
 - 9.1 Wound and/or skin No Yes
 - 9.2 Pneumonia No Yes
 - 9.3 UTI No Yes
 - 9.4 Other infection No Yes
- H10) Wound reopened:** No Yes
- H11) Radiologically demonstrated anastomotic leak:** No Yes
- H12) Radiologically demonstrated enterocutaneous fistula:** No Yes
- H13) Other:** No Yes
 13a Specify: _____

I. Bariatric Procedures

Complete this section for the appropriate operation.

I1) Prior foregut surgery: No Yes

I2) Procedure of record:

- Gastric bypass (proximal)
- Gastric bypass (distal)
- Other gastric bypass:
 - 2a. If other, specify Roux length: _____ cm NA
- Sleeve gastrectomy
 - 2b. If sleeve, small bowel resection No Yes
- Biliopancreatic bypass
- Biliopancreatic bypass with duodenal switch
- Adjustable Lap Band
 - 2c. Specify size: 9.5 cm AP Large
 - 10 cm Other _____ cm NA
 - 11 cm NA
 - AP Standard

I3) Stomach divided: No Yes (Not applicable for lap band operations)

I4) Urinary catheter removed before discharge: No Yes Not applicable -- no urinary catheter or pt has permanent indwelling urinary catheter

a. If yes, Postop day urinary catheter removed: _____ NA

Questions 5 & 6 are optional

I5) Distal reapproximation of tissues (anastomosis) technique described: No Yes
(Not applicable for lap band operations or sleeve gastrectomy without small bowel resection)

5.1 If yes, Stapled No Yes

a. If stapled: circular (EEA) linear

- 1. If linear, number of fires of stapler: _____ fires NA
- 2. If linear, sealing device (e.g. Seam Guard) used: No Yes
- If yes, number of devices used: _____ NA

5.2 If yes, Handsewn No Yes

I6) Proximal reapproximation of tissues (anastomosis) technique described: No Yes
(Not applicable for lap band operations)

6.1 If yes, Stapled No Yes

a. If stapled: circular (EEA) linear

- 1. If linear, number of fires of stapler: _____ fires NA
- 2. If linear, sealing device (e.g. Seam Guard) used: No Yes
- If yes, number of devices used: _____ NA

6.2 If yes, Handsewn No Yes

I7) Anastomosis tested: No Yes (Not applicable for lap band operations)

Note: Cannot infer that if a scope was used for some purpose during the surgery, that it was used for testing anastomosis; Op note must specifically state that was used for anastomosis testing.

If yes, indicate how tested:

7.1 Scope No Yes

7.2 Methylene blue No Yes

7.3 Air/saline injected No Yes

7.4 Palpation/inspection No Yes

7.5 Other No Yes a. Specify: _____

J. Non-elective Appendectomy

Complete this section for the appropriate operation.

J1) Was the patient pregnant? No Yes (Applicable if female)

a. If yes, number of weeks pregnant: _____ NA

J2) ER/urgent care visit within one week and more than 12 hrs prior to operation: No Yes

If yes:

5.1 Where: this facility other facility

a. If other, facility name: _____

J3) Was patient admitted to this hospital through this hospital's ER: No Yes

if yes, indicate date and time of arrival at ER:

a. Date ____/____/____ NA b. Time ____:____ NA

J4) Concurrent abdominal or pelvic procedure performed: No Yes

(e.g. colectomy, ovarian cystectomy)

a. If yes, specify: Gynecologic Colon Gall bladder Other

J5) Pre-op imaging within 24 hrs: No Yes

If yes, specify type: (choose all that apply)

a. CT scan No Yes

b. Ultrasound No Yes

c. MRI No Yes

For CT scan:

5.1.1 Date and time of CT scan: Date: ____/____/____ NA Time: ____:____ NA

5.1.2 Use of contrast No Yes

If yes, route: (choose all that apply)

a. IV No Yes

b. Oral No Yes

c. Rectal No Yes

5.1.3 Imaging results: Consistent with appendicitis Not consistent with appendicitis
 Indeterminate

5.1.4 Imaging performed at: this facility other facility

For Ultrasound:

5.2.1 Date and time of Ultrasound: Date: ____/____/____ NA Time: ____:____ NA

5.2.2 Imaging results: Consistent with appendicitis Not consistent with appendicitis
 Indeterminate

5.2.3 Imaging performed at: this facility other facility

For MRI:

5.3.1 Date and time of MRI: Date: ____/____/____ NA Time: ____:____ NA

5.3.2 Imaging results: Consistent with appendicitis Not consistent with appendicitis
 Indeterminate

5.3.3 Imaging performed at: this facility other facility

J6) Pathology results: appendiceal pathology No Yes

J7) Perforated appendix: No Yes

K. Colon Procedures

Complete this section for the appropriate operation.

K1) Prior colon or pelvic surgery: No Yes

K2) Is this colon surgery the primary or secondary surgery Primary Secondary

2a If secondary, indicate category of the primary surgery:

Gyn Gall bladder Vascular Other

K3) Prior colon resection within 30 days? No Yes

3a If yes, indicate at which hospital performed _____

K4) Procedure priority: Elective Non-elective

4a. If non-elective, staged procedure: No Yes

K5) Operation type: (Select all that apply)

5.1 Right hemicolectomy No Yes

5.2 Left hemicolectomy No Yes

5.3 Low anterior resection (LAR) No Yes

5.4 Abdominal Perineal Resection (APR) No Yes

5.5 Total abdominal colectomy No Yes

5.6 Stoma takedown No Yes

5.7 Perineal proctectomy No Yes

5.8 Abdominal proctectomy No Yes

5.9 Additional procedure to establish intestinal continuity (Staged procedure) No Yes

K6) Ostomy: No ostomy Colostomy Ileostomy Protective stoma

K7) Anastomosis: No Yes

If yes,

7a. specify type: Colocolon (colon to colon) Coloanal (colon to anal)
 Ileocolon (ileum to colon) Ileoanal (ileum to anal)
 Cannot be determined

7b. Was pouch created: No Yes

Question 8 is optional

K8) Anastomosis technique described: No Yes

(Applicable only if anastomosis)

8.1 Stapled No Yes

a. If stapled, device type: circular linear

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

If yes, number of sealing devices used: _____ NA

8.2 Handsewn No Yes

K9) Anastomosis tested: No Yes (Applicable only if anastomosis)

Note: Cannot infer that if a scope was used for some purpose during the surgery, that it was used for testing anastomosis; Op note must specifically state that was used for anastomosis testing.

If yes, specify:

- 9.1 Scope No Yes
- 9.2 Methylene blue No Yes
- 9.3 Air/saline injected No Yes
- 9.4 Palpation/inspection No Yes
- 9.5 Other No Yes (Specify: _____)

K10) Urinary catheter removed before discharge: No Yes Not applicable -- no urinary catheter or pt has permanent indwelling urinary catheter

10a. If yes, Postop day urinary catheter removed: _____ NA

K11) Bowel prep used: No Yes
If yes, (select all that apply) a. Mechanical No Yes
b. Antibiotics No Yes

K12) Diet advanced beyond clear liquids/ice chips: No Yes
a. Post op day diet successfully advanced: _____ NA

Complete questions 13-26 only if the pre or postoperative diagnosis for colorectal surgery is cancer. If the preoperative diagnosis is for something other than cancer, but cancer is found during the surgery, complete this set of data elements.

K13) Post-op cancer diagnosis: No Yes

K14) Number of lymph nodes removed and studied: _____ NA

K15) Number of lymph nodes positive for cancer: _____ NA

K16) Metastatic disease beyond lymph nodes: No Yes (e.g. liver, diaphragm, peritoneum)

K17) Margins free of cancer: No Yes
If yes, specify: a. cm to distal margin: <1 cm 1-2 cm >2 cm NA
b. cm to proximal margin: <1 cm 1-2 cm >2 cm NA

K18) T stage (based on pathology): Tis T₁ T₂ T₃ T₄ NA
 pTO pTx pyTO

Questions 19 – 24 for rectal cancer only

K19) Procedure done for palliation: No Yes

K20) Was preoperative neoadjuvant treatment given? No Yes

If yes, type of therapy:

- a. chemotherapy therapy: No Yes
 b. radiation therapy: No Yes

if radiation therapy,

- c. time interval between the end of preoperative radiation and surgery?
 _____(number of weeks) NA

K21) Was the distance of the tumor from the anal verge defined? No Yes

If yes,

21.1 distance determined by: (Check all that apply)

- a. rigid scope No Yes
 b. flexible scope No Yes
 c. digital exam No Yes
 d. NA/Unknown No Yes

21.2. Distance from the anal verge? _____(cm) NA

21.3. Was the distance determined after neoadjuvant therapy? No Yes NA

K22) Was the tumor fixed to underlying structures? No Yes

a. If yes, was it fixed after neoadjuvant therapy? No Yes NA

K23) Total mesorectal excision (TME) done No Yes

- a. Distance to radial margin: <1 cm 1-2 cm >2 cm NA
 b. TME capsule intact: No Yes NA

K24) Was EUS, TRUS or MRI used to define the stage: No Yes

if yes, specify:

- a. Endoscopic ultrasound (EUS) No Yes
 b. Transrectal ultrasound (TRUS) No Yes
 c. MRI No Yes

Questions 25 – 26 for diverticular disease only

K25) Characterize the diverticular disease:

indicate type, check all that apply:

- a. acute diverticulitis: No Yes
 b. current gastrointestinal bleeding: No Yes
 c. colovesical fistula: No Yes
 d. stricture: No Yes

K26) Prior episodes of diverticular disease No Yes NA

If yes,

- a. How many prior episodes of treated diverticulitis? _____ NA
 b. Was patient treated as an inpatient for any of the episodes? No Yes NA

L. Post-discharge

Complete this section only if there is access to events that occur within the first 30 days AFTER discharge from the index hospitalization.

L) 30-day follow-up completed: No Yes

L1) Wound occurrences No Yes

- If yes, 1.1 Superficial incisional surgical site infection No Yes
 1.2 Deep incisional surgical site infection No Yes
 1.3 Organ/space surgical site infection No Yes
 1.4 Other No Yes a. specify _____

L2) Respiratory Occurrences No Yes

- If yes, 2.1 Pneumonia No Yes
 2.2 Unplanned intubation No Yes
 2.3 Pulmonary embolism No Yes
 2.4 On ventilation > 48 hrs No Yes
 2.5 Other No Yes a. specify _____

L3) Urinary tract occurrences No Yes

- If yes, 3.1 Progressive renal insufficiency No Yes
 3.2 Acute renal failure No Yes
 3.3 Urinary tract infection No Yes
 3.4 Other No Yes a. specify _____

L4) CNS Occurrences No Yes

- If yes, 4.1 Stroke/CVA No Yes
 4.2 Coma > 24 hrs No Yes
 4.3 Peripheral nerve injury No Yes
 4.4 Other No Yes a. specify _____

L5) Cardiac occurrences No Yes

- If yes, 5.1 Cardiac arrest requiring CPR No Yes
 5.2 Myocardial infarction No Yes
 5.3 Other No Yes a. specify _____

L6) Other occurrences No Yes

- If yes, 6.1 Bleeding > 4 units RBCs in first 72 hrs No Yes
 6.2 DVT requiring therapy No Yes
 6.3 Systemic sepsis No Yes
 6.4 Severe sepsis/septic shock No Yes
 6.5 Other No Yes a. specify _____

L7) Readmitted to acute care hospital: No Yes

- If yes, 7.1 Admission date ____/____/____ NA
 7.2 ICD9 diagnosis code: _____ NA
 7.3 Return to Operating room: No Yes
 If yes, type of operation: a. ICD9 procedure code: _____ NA
 b. CPT code: _____ NA

L8) Death No Yes If yes, a. Date of death ____/____/____ NA