HARTFORD HOSPITAL
80 Seymour St. P.O. Box 5037
Hartford, CT 06102-5037

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	
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:*** _____