OPERATIVE RECORD FORM

**Spokane Oral &
Maxillofacial Surgery**
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Patient Name _____
MR # _____
Date _____

Surgeon_____ Surgical Assts _____

Asst. Surgeon _____ _____

Anesthesiologist_____ Anesthesia Type _____

Pre-Op Diagnosis

_____Code _____

_____Code _____

_____Code _____

Post-Op Diagnosis

_____Code _____

_____Code _____

_____Code _____

Procedures

_____Code _____

_____Code _____

_____Code _____

Surgical Wound Classification:

1	2	3	4
Clean	Clean Contaminated	Contaminated	Dirty/Infected

Specimens: Yes _____   No _____

_____

_____

_____

Cath/Drains:_____

Prosthesis/Grafts:_____

Serial #:_____

EBL_____FLDS_____UOP_____

Surgical Supplies

Plates: _____

_____

Screws: _____

Suture: _____

Other: _____

_____

X Surgeon's Signature

Dictated:_____

Counts
Sponges: _____
Needles: _____
Sharps: _____

Start
OR Entry: _____
Incision: _____
End
Dressings:_____
OR Depart:_____

SOMFS Form #808