RANDOM CASE REVIEW FORM

Period I – January 1 to June 30 **Period II** – July 1 to December 31

Period: Year:

Reviewing Physician: _____ Date: _____

Medical License Number: _____ Facility ID#: _____

FACILITY INFORMATION

Name: _____

Operating Surgeon: _____

Total Number of Cases for this Period: _____

PATIENT INFORMATION

Patient Initials: _____ Gender: _____ Height: _____

Age: _____ Weight: _____ Ethnicity: _____

SURGICAL CASE INFORMATION

Date: _____ Duration: _____hours _____minutes

Procedure: _____

NOTE: If there were additional procedures, please list them below

Procedure # 2: _____

Procedure # 3: _____

ANESTHESIA INFORMATION

Type of Anesthesia: _____

Anesthesia Provider (Anesthesiologist, CRNA, Operating Surgeon with Nurse): _____

Anesthesia Duration: _____hours _____minutes

CHART REVIEW

Pre-Op Plan for Treatment	⬭ YES	⬭ NO	⬭ N/A
Informed Consent	⬭ YES	⬭ NO	⬭ N/A
Medical History	⬭ YES	⬭ NO	⬭ N/A
Physical Examination	⬭ YES	⬭ NO	⬭ N/A
Laboratory Reports	⬭ YES	⬭ NO	⬭ N/A
Post-Op Recovery Record	⬭ YES	⬭ NO	⬭ N/A
Anesthesia Record	⬭ YES	⬭ NO	⬭ N/A
RX Given to Patient	⬭ YES	⬭ NO	⬭ N/A
Pathology Report	⬭ YES	⬭ NO	⬭ N/A
Discharge Instructions	⬭ YES	⬭ NO	⬭ N/A
Operative Report	⬭ YES	⬭ NO	⬭ N/A
Recorded in Log Book	⬭ YES	⬭ NO	⬭ N/A