

Surgical PR/UR Monitoring Form

Physician Name: _____

Monitor: _____
(Print Name)

Date: _____ Patient Name/Number: _____

Diagnosis: _____

Procedure: _____

CASE EVALUATION

	<u>Acceptable</u>	<u>Unacceptable</u>
Pre-Operative Evaluation including: Known allergies, current medications Lab, X-ray, EKG reviewed Informed consent Mental status Risk factors	()	()
Surgical Indication	()	()
Appropriateness of Procedure	()	()
Surgical Technique	()	()
Post-Operative Management including: Discharge instructions Discharge assessment/order	()	()
Medical Knowledge	()	()

NOTE: A statement is required for each case to ensure a meaningful and objective evaluation will be accomplished. Without this statement, the report **WILL NOT** be accepted by the medical director and will be returned to the monitor for completion.

Statement: _____

Physician Monitor's Signature: _____