

Entered: __/__/20__ Initials: _____ Verified: __/__/20__ Initials: _____

For office use only.

Discharge (DS) – Version 08/28/2006 FORMV

Patient ID _____ - _____ - _____ ID

Form Completion Date ___/___/20___
DSDAT mm dd yy

Surgeon certification number: _____ **CERT**

Date of Surgery ___/___/20___
SURGDAT mm dd yy

1. Were any post-operative anticoagulation therapies received prior to discharge? **DVTREC** 0. No 1. Yes
 If yes,

	Prophylactic (preventative) Use?		# of Days	Times per day	Therapeutic (as treatment) Use?		# of Days	Times per day
	No	Yes			No	Yes		
PSHEP	5000 units sub-cutaneous heparin		PSHEPPU	PSHEPPUD	PSHEPPUX	PSHEPTU	PSHEPTUD	PSHEPTUX
PAHEP	Other dose heparin (Dose AHEPD units)		PAHEPPU	PAHEPPUD	PAHEPPUX	PAHEPTU	PAHEPTUD	PAHEPTUX
PLHEP	Low molecular weight heparin If yes,		PLHEPPU	PLHEPPUD	PLHEPPUX	PLHEPTU	PLHEPTUD	PLHEPTUX
<input type="checkbox"/> PLHEPD Specify dose: <input type="checkbox"/> 20 mg <input type="checkbox"/> 40 mg <input type="checkbox"/> 60 mg <input type="checkbox"/> Other (Specify: PLHEPS _ mg)								
POTH	Other Anticoagulant If yes,		POTHPU	POTHPUUD	POTHPUX	POTHTU	POTHTUD	POTHTUX
<input type="checkbox"/> Specify name: POTHS Specify dose: POTHD <input type="checkbox"/> 1.mg <input type="checkbox"/> 2. units DOSETYPE								

2. Post-operative pain management (*check no or yes for each*):

- | | | | |
|---|--------------------------|---|--------------------------|
| No | Yes | No | Yes |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Thoracic epidural TEPIDU | | Intermittent IV narcotics IVNARC | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Abdominal epidural AEPIDU | | Tylenol TYLENOL | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Patient controlled anesthesia (PCA) pump PCA | | Ketorolac KETOROL | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Oral narcotics ORALNAR | | Other PAINS (Specify: PAINSO _____) | |

3. Patient disposition after surgery **PATDISP**: 1. ICU 2. Floor with 3. Floor without 4. Same day discharge
 If ICU, Telemetry Telemetry

3.1 Specify number of days of intubation after surgery: _____ (*day of surgery is defined as day zero*) **INTUBD**

3.2 Was the patient reintubated? **REINTUB** 0. No 1. Yes → If yes, # of times: **REINTUBD** _____

4. Was the patient discharged more than 30 days AFTER initial surgery? **GT30** 0. No 1. Yes

5. Date of hospital discharge (or date of death if patient died prior to discharge): ___/___/20___
 m m dd yy **DISCDAT**

6. Intended discharge location: **DISLOC**

- 1. Home
- 2. Rehabilitation facility
- 3. Skilled nursing facility

- 4. Other hospital
- 5. Was not discharged (patient died prior to discharge)

7. Did the patient have any in-hospital Post-Operative Complications prior to discharge? **POCOMP** 0. No 1. Yes
 If yes,

If patient was discharged more than 30 days AFTER initial surgery, check this box if complication occurred WITHIN 30 days of surgery																								
7.1. Re-operation REOP <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes If yes,		<input type="checkbox"/> within 30 days REOP30																						
<div style="border: 1px solid black; padding: 5px;"> 7.1.1 Specify reason for surgery (check all that apply): <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; text-align: center;">No</td> <td style="width: 50%; text-align: center;">Yes</td> </tr> <tr> <td><input type="checkbox"/> Intestinal obstruction REOPOBS</td> <td><input type="checkbox"/> Subsequent cholecystectomy REOPCHO</td> </tr> <tr> <td><input type="checkbox"/> Anastomotic leak REOPLEAK</td> <td><input type="checkbox"/> Other abdominal sepsis REOPSEPS</td> </tr> <tr> <td><input type="checkbox"/> Pulmonary embolism REOPEMBO</td> <td><input type="checkbox"/> Pneumonia REOPNEU</td> </tr> <tr> <td><input type="checkbox"/> Other respiratory failure REOPRESP</td> <td><input type="checkbox"/> Subsequent abdominoplasty REOPABDP</td> </tr> </table> </td> <td style="width: 50%; border: none;"> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; text-align: center;">No</td> <td style="width: 50%; text-align: center;">Yes</td> </tr> <tr> <td><input type="checkbox"/> Wound infection/evisceration REOPINF</td> <td><input type="checkbox"/> Fluid or electrolyte depletion REOPDEP</td> </tr> <tr> <td><input type="checkbox"/> Vomiting or poor intake REOPVOM</td> <td><input type="checkbox"/> Gastric distension REOPDIST</td> </tr> <tr> <td><input type="checkbox"/> Strictures REOPSTR</td> <td><input type="checkbox"/> Bleeding REOPBLED</td> </tr> <tr> <td><input type="checkbox"/> Infection/fever REOPFEVR</td> <td><input type="checkbox"/> Other REOPOTH</td> </tr> </table> (Specify: <u>REOPOS</u> _____) </td> </tr> </table> </div>			<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; text-align: center;">No</td> <td style="width: 50%; text-align: center;">Yes</td> </tr> <tr> <td><input type="checkbox"/> Intestinal obstruction REOPOBS</td> <td><input type="checkbox"/> Subsequent cholecystectomy REOPCHO</td> </tr> <tr> <td><input type="checkbox"/> Anastomotic leak REOPLEAK</td> <td><input type="checkbox"/> Other abdominal sepsis REOPSEPS</td> </tr> <tr> <td><input type="checkbox"/> Pulmonary embolism REOPEMBO</td> <td><input type="checkbox"/> Pneumonia REOPNEU</td> </tr> <tr> <td><input type="checkbox"/> Other respiratory failure REOPRESP</td> <td><input type="checkbox"/> Subsequent abdominoplasty REOPABDP</td> </tr> </table>	No	Yes	<input type="checkbox"/> Intestinal obstruction REOPOBS	<input type="checkbox"/> Subsequent cholecystectomy REOPCHO	<input type="checkbox"/> Anastomotic leak REOPLEAK	<input type="checkbox"/> Other abdominal sepsis REOPSEPS	<input type="checkbox"/> Pulmonary embolism REOPEMBO	<input type="checkbox"/> Pneumonia REOPNEU	<input type="checkbox"/> Other respiratory failure REOPRESP	<input type="checkbox"/> Subsequent abdominoplasty REOPABDP	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; text-align: center;">No</td> <td style="width: 50%; text-align: center;">Yes</td> </tr> <tr> <td><input type="checkbox"/> Wound infection/evisceration REOPINF</td> <td><input type="checkbox"/> Fluid or electrolyte depletion REOPDEP</td> </tr> <tr> <td><input type="checkbox"/> Vomiting or poor intake REOPVOM</td> <td><input type="checkbox"/> Gastric distension REOPDIST</td> </tr> <tr> <td><input type="checkbox"/> Strictures REOPSTR</td> <td><input type="checkbox"/> Bleeding REOPBLED</td> </tr> <tr> <td><input type="checkbox"/> Infection/fever REOPFEVR</td> <td><input type="checkbox"/> Other REOPOTH</td> </tr> </table> (Specify: <u>REOPOS</u> _____)	No	Yes	<input type="checkbox"/> Wound infection/evisceration REOPINF	<input type="checkbox"/> Fluid or electrolyte depletion REOPDEP	<input type="checkbox"/> Vomiting or poor intake REOPVOM	<input type="checkbox"/> Gastric distension REOPDIST	<input type="checkbox"/> Strictures REOPSTR	<input type="checkbox"/> Bleeding REOPBLED	<input type="checkbox"/> Infection/fever REOPFEVR	<input type="checkbox"/> Other REOPOTH
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7.2. Gastrojejunostomy leak GJLEAK <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes If yes,		<input type="checkbox"/> within 30 days GJLEAK30																						
<div style="border: 1px solid black; padding: 5px;"> 7.2.1 Specify grade: GJLEAKG <input type="checkbox"/> 1. Minimal – small contained leak, patient asymptomatic <input type="checkbox"/> 2. Moderate – moderate size forming collection, symptomatic, drain used. <input type="checkbox"/> 3. Large – not contained, symptomatic, requires re-operation. </div>																								
7.3. Jejuno-jejunostomy leak JJLEAK <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes If yes,		<input type="checkbox"/> within 30 days JJLEAK30																						
<div style="border: 1px solid black; padding: 5px;"> 7.3.1 Specify grade: JJLEAKG <input type="checkbox"/> 1. Minimal – small contained leak, patient asymptomatic <input type="checkbox"/> 2. Moderate – moderate size forming collection, symptomatic, drain used. <input type="checkbox"/> 3. Large – not contained, symptomatic, requires re-operation. </div>																								
7.4. Pancreatitis PANC <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes		<input type="checkbox"/> within 30 days PANC30																						
7.5. Post operative bleeding POBLE <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes If yes,		<input type="checkbox"/> within 30 days POBLE30																						
<div style="border: 1px solid black; padding: 5px;"> 7.5.1 Specify location: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; text-align: center;">No</td> <td style="width: 50%; text-align: center;">Yes</td> </tr> <tr> <td><input type="checkbox"/> Upper intestine POBLEUI</td> <td><input type="checkbox"/> Intra-peritoneal POBLEIP</td> </tr> <tr> <td><input type="checkbox"/> Lower intestine POBLELI</td> <td><input type="checkbox"/> Unknown POBLEUK</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Other: POBLEOTH</td> </tr> </table> (Specify: <u>POBLEOTS</u> _____) </div>			No	Yes	<input type="checkbox"/> Upper intestine POBLEUI	<input type="checkbox"/> Intra-peritoneal POBLEIP	<input type="checkbox"/> Lower intestine POBLELI	<input type="checkbox"/> Unknown POBLEUK	<input type="checkbox"/> Other: POBLEOTH															
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<input type="checkbox"/> Other: POBLEOTH																								
7.5.2 Specify # of units of blood required: <u>POBLEU</u>																								

7.6. Abdominal abscess ABSC	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days ABSC30															
If yes,																	
<table border="1"> <tr> <td>7.6.1 Specify location:</td> <td>No</td> <td>Yes</td> </tr> <tr> <td><input type="checkbox"/> Left upper quadrant ABSCLO</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Subhepatic ABSCSUB</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Lower abdomen ABSCLA</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Other (specify: ABSCSO/ABSCS _____)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>			7.6.1 Specify location:	No	Yes	<input type="checkbox"/> Left upper quadrant ABSCLO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Subhepatic ABSCSUB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Lower abdomen ABSCLA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other (specify: ABSCSO/ABSCS _____)	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/> Other (specify: ABSCSO/ABSCS _____)	<input type="checkbox"/>	<input type="checkbox"/>															
7.7. Esophageal injury ESOINJ	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days ESOINJ30															
7.8. Wound infection WINF	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days WINF30															
<i>(Cellulitis around incision site accompanied by fever)</i>																	
7.9. Fascial dehiscence DEHIS	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days DEHIS30															
7.10. Seroma of wound SERO	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days SERO30															
7.11. Small bowel obstruction SBOBS	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days SBOBS30															
If yes,																	
<table border="1"> <tr> <td>7.11.1 Specify obstruction: SBOBSS</td> <td colspan="2">7.11.2 Specify cause: SBOBSC</td> </tr> <tr> <td><input type="checkbox"/> 1. Partial obstruction</td> <td><input type="checkbox"/> 1. Internal hernia</td> <td><input type="checkbox"/> 4. Obstructed JJ Anastomosis</td> </tr> <tr> <td><input type="checkbox"/> 2. Complete obstruction</td> <td><input type="checkbox"/> 2. Adhesions</td> <td><input type="checkbox"/> 5. Unknown</td> </tr> <tr> <td></td> <td><input type="checkbox"/> 3. Anastomotic anatomy</td> <td><input type="checkbox"/> 6. Other (Specify: SBOBSCS)</td> </tr> </table>			7.11.1 Specify obstruction: SBOBSS	7.11.2 Specify cause: SBOBSC		<input type="checkbox"/> 1. Partial obstruction	<input type="checkbox"/> 1. Internal hernia	<input type="checkbox"/> 4. Obstructed JJ Anastomosis	<input type="checkbox"/> 2. Complete obstruction	<input type="checkbox"/> 2. Adhesions	<input type="checkbox"/> 5. Unknown		<input type="checkbox"/> 3. Anastomotic anatomy	<input type="checkbox"/> 6. Other (Specify: SBOBSCS)			
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	<input type="checkbox"/> 3. Anastomotic anatomy	<input type="checkbox"/> 6. Other (Specify: SBOBSCS)															
7.12. Stomal/gastric outlet obstruction STOBS	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days STOBS30															
7.13. Stomal stenosis STSTE	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days STSTE30															
7.14. GI ulcer(s) GIULC	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days GIULC30															
7.15. Ateletasis (significant) ATEL	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days ATEL30															
<i>(Diagnosis by chest X-ray accompanied by fever)</i>																	
7.16. Pneumothorax PNEUX	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days PNEUX30															
7.17. Pleural effusion EFFUS	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days EFFUS30															
7.18. Pulmonary embolism PE	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days PE30															
7.19. Deep vein thrombosis PODVT	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days PODVT30															
7.20. Pneumonia POPNEU	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days POPNEU30															
7.21. Respiratory failure requiring intubation RESPFI	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days RESPFI30															
If yes,																	
<table border="1"> <tr> <td>7.21.1 Specify cause: RESPFIS</td> <td><input type="checkbox"/> 1. ARDS</td> <td><input type="checkbox"/> 4. Other (Specify: RESPFISS)</td> </tr> <tr> <td><input type="checkbox"/> 2. Pneumonia</td> <td><input type="checkbox"/> -3. Unknown</td> <td></td> </tr> <tr> <td><input type="checkbox"/> 3. PE</td> <td></td> <td></td> </tr> </table>			7.21.1 Specify cause: RESPFIS	<input type="checkbox"/> 1. ARDS	<input type="checkbox"/> 4. Other (Specify: RESPFISS)	<input type="checkbox"/> 2. Pneumonia	<input type="checkbox"/> -3. Unknown		<input type="checkbox"/> 3. PE								
7.21.1 Specify cause: RESPFIS	<input type="checkbox"/> 1. ARDS	<input type="checkbox"/> 4. Other (Specify: RESPFISS)															
<input type="checkbox"/> 2. Pneumonia	<input type="checkbox"/> -3. Unknown																
<input type="checkbox"/> 3. PE																	
7.22. Renal/urinary tract infection UTI	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days UTI30															
7.23 Renal failure RENALF	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days RENALF30															
If yes,																	
<table border="1"> <tr> <td>7.23. Specify type of diagnosis (<i>check "no" or "yes" for each</i>):</td> <td>No</td> <td>Yes</td> </tr> <tr> <td>RENALFO</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Oliguric/anuric</td> </tr> <tr> <td>RENALFC</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Creatinine</td> </tr> </table>			7.23. Specify type of diagnosis (<i>check "no" or "yes" for each</i>):	No	Yes	RENALFO	<input type="checkbox"/>	<input type="checkbox"/> Oliguric/anuric	RENALFC	<input type="checkbox"/>	<input type="checkbox"/> Creatinine						
7.23. Specify type of diagnosis (<i>check "no" or "yes" for each</i>):	No	Yes															
RENALFO	<input type="checkbox"/>	<input type="checkbox"/> Oliguric/anuric															
RENALFC	<input type="checkbox"/>	<input type="checkbox"/> Creatinine															

7.24. TIA POTIA	<input type="checkbox"/> 0. No	<input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days POTIA30
7.25. Stroke STROKE If yes,	<input type="checkbox"/> 0. No	<input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days STROKE30
7.25.1 Specify type of diagnosis: <input type="checkbox"/> 1. Ischemic POSTROS <input type="checkbox"/> 2. Hemorrhagic			
7.26. Urinary retention URET	<input type="checkbox"/> 0. No	<input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days URET30
7.27. New decubitus ulcers (bed sores) BEDS	<input type="checkbox"/> 0. No	<input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days BEDS30
7.28. Rhabdomyolysis (defined as CPK's of 5000 or more) RHAB	<input type="checkbox"/> 0. No	<input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days RHAB30
7.29. Jaundice JAUND	<input type="checkbox"/> 0. No	<input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days JAUND30
7.30. Hepatitis HEPA	<input type="checkbox"/> 0. No	<input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days HEPA30
7.31. Liver failure LFAIL	<input type="checkbox"/> 0. No	<input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days LFAIL30
7.32. Acute cholecystitis/biliaric colic CHOL	<input type="checkbox"/> 0. No	<input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days CHOL30
7.33. Common bile duct stones/choolangitis STONE	<input type="checkbox"/> 0. No	<input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days STONE30
7.34. Arrhythmia ARRHY	<input type="checkbox"/> 0. No	<input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days ARRHY30
7.35. Persistent Tachycardia TACH	<input type="checkbox"/> 0. No	<input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days TACH30
7.36. Myocardial infarction MI	<input type="checkbox"/> 0. No	<input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days MI30
7.37. Cardiac arrest ARREST	<input type="checkbox"/> 0. No	<input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days ARREST30
7.38. Death PODIE	<input type="checkbox"/> 0. No	<input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days PODIE30
7.39. Other event that resulted in an unexpected course of action OTHEVT (Specify: __ OTHEVTS __)	<input type="checkbox"/> 0. No	<input type="checkbox"/> 1. Yes	<input type="checkbox"/> within 30 days OTHEVT30