U.S. Department of Health and Human Services

Office of the National Coordinator for Health Information Technology

Clinical Encounter Note Details

Draft AHIC Extension/Gap

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1.0 Preface and Introduction

1.1 Background

In April and June of 2008, the American Health Information Community (AHIC) approved a recommendation to develop documents that address extensions/gaps from the use cases published between 2006 and 2008. One of the extensions/gaps prioritized for subsequent processing in the national health agenda activities in 2009 was Clinical Encounter Note Details. AHIC specifically requested that the Clinical Encounter Note Details Extension/ Gap address the development, completion, and exchange of interoperable clinical encounter notes and reports. A clinical encounter note or report can be structured and/or unstructured information exchanged between EHRs and other systems.

This extension/gap document is being developed by Office of the National Coordinator (ONC) to represent the AHIC priorities and provide context for the national health agenda activities, beginning with the selection of harmonized standards by the Health Information Technology Standards Panel (HITSP) for harmonized standards. Components that need to be considered during the standards identification and harmonization activities include standardized data sets, data elements, vocabularies, naming conventions, capabilities, and technical standards that support the information needs and processes of the consulting clinicians and clinicians consulting for or receiving patients from other care settings or organizations. During the development of the document there will be an opportunity for review and feedback by interested stakeholders within both the public and private sectors.

1.2 Progress to Date

To date, the national health agenda, including activities of AHIC and HITSP, has not fully addressed the interoperability requirements of exchanging clinical encounter notes between clinicians and across care settings.

Previously published AHIC use cases incorporate several concepts that have been evaluated by HITSP and could be leveraged during standards harmonization for this extension/gap.

- The 2008 Consultations and Transfers of Care Use Case describes the need for communicating information to request and fulfill a consultation and support transfers of care;
- The 2006 Biosurveillance Use Case describes the needs for communicating information about laboratory results, radiology results, and encounter summary messages to Public Health; and
- The 2008 Public Health Case Reporting Use Case describes the needs for communicating and reporting laboratory test results to public health when specific

reporting criteria are met. This use case also describes the communication of public health case reporting criteria for incorporation into EHR systems and utilization by clinicians.

2.0 Overview and Scope

2.1 Document/Request Overview

This extension/gap document is focused on information needs to facilitate the electronic exchange of Clinical Encounter Notes. The Clinical Encounter Note Details Extension/Gap document is divided into the following sections:

- Section 1.0, Preface and Introduction, describes the progress to date, the additional priorities identified by the AHIC, the resulting extensions/gaps, and their purpose;
- Section 2.0, Overview and Scope, describes the sections of an extension/gap document, the request being made to HITSP, and the scope of that request;
- Section 3.0, Functional Needs, describes the combination of end-user needs and system behaviors which support interoperability and information exchange;
- Section 4.0, Stakeholder Communities, describes individuals and organizations that participate in activities described in this extension/gap;
- Section 5.0, Issues and Obstacles, describes issues and obstacles which may need to be planned for, addressed, or resolved to achieve the capabilities described in the extension/gap;
- Section 6.0, References to Use Case Scenarios, describes various scenarios and information exchanges which assist in the communication of information. Scenarios may re-used from previously published 2006 – 2008 Use Cases and/or new scenarios may be described;
- Section 7.0, Information Exchange, describes information exchange capabilities which are needed to support the scenarios and the high-level role of information exchange;
- Section 8.0, Data Set Considerations, identifies specific information opportunities relevant to this extension/gap document that may support future identification, development, and harmonization of standards;
- Appendix A, Glossary, provides contextual descriptions of key concepts and terms introduced in this extension/gap document; and
- Appendix B, Analysis and Examples, identifies specific data types, data sets, data elements, vocabularies, naming conventions, capabilities, and technical standards which may support future industry efforts in the identification, development, and harmonization of standards.

2.2 Scope

Clinical Encounter Notes are the means by which clinicians document a patient encounter or visit. Clinicians treating patients as part of a consultation or in receipt of a transfer of care may access a patient's relevant clinical encounter documentation to gain a more comprehensive understanding of the patient's history.

Documents that are not authored and generated by a clinician (e.g. patient forms, consents, administrative documents) and do not constitute a clinician's documentation of a patient encounter are not in scope for this request. In addition, items which may accompany or support encounter notes or reports such as images and waveforms, are not in scope for this request. Therefore, requirements for Clinical Encounter Notes can be summarized as:

- The authoring clinician's ability to view, select, document, and communicate clinical encounter notes or reports; and
- The consulting clinician or receiving clinician's ability to access available encounter information and/or encounter note or report documents or sections thereof.

The identification, development, and harmonization of standards to support the processes associated with the development, completion, and exchange of interoperable clinical encounter notes still requires additional work. As mentioned in Section 1.0, these needs have not yet been fully addressed by the national health agenda's standardization efforts. Examples of gaps in industry standards are outlined in the upcoming sections of this extension/gap document.

3.0 Functional Needs

This section describes a combination of end-user needs and interoperable system behaviors necessary to support the users during the exchange of clinical encounter notes and reports between EHRs. Rather than an all-inclusive list of functional interoperability requirements, key capabilities are outlined below with associated functionality... The descriptions in this section are not intended to prescribe policy nor propose architectures required to implement capabilities.

A. The ability to review a listing of available encounter documentation.

   i. When creating encounter documentation for a patient, an authoring clinician may need the ability to review a listing of common encounter documentation types. These listings may be acquired through libraries of commonly used encounter documentation types and may also include and specify clinical documentation requirements for specific encounter note or report types. These listings of encounter documentation may be grouped by encounter type. Examples of these encounter types may include: History and Physical, Progress/Office Note, Consult Note, Operative Note, Procedure Note, and Discharge Summary.

B. The ability to select an encounter document based upon service, role, clinical condition or diagnosis, specialty, and/or location.

   i. Using the list of available encounter documentation, an authoring clinician may select and complete encounter documentation within an EHR.

C. The ability to incorporate listings of available encounter documentation forms provided by external sources into an EHR.

   i. Listings of available commonly used encounter documentation forms may be available through libraries. These libraries may also include and specify clinical documentation requirements for specific encounter note or report types in forms that are human readable or can be processed electronically. These libraries may be made available by healthcare organizations, external knowledge suppliers, regulatory associations, and others.

D. The ability to provide required and optional encounter documentation details by using forms to facilitate development of an encounter note.

   i. When creating an encounter note for a patient, an authoring clinician may select forms that provide guidance for structuring and completing the relevant note type. The form may provide required and optional sections or fields to facilitate development of comprehensive and complete documentation that adheres to

industry, organizational, and/or coding guidelines for the selected type of documentation or type of patient encounter.

ii. The use of forms may enable the population of patient demographic or clinical information available or documented in other areas of the medical record during the current encounter, or during previous encounters. The use and implementation of this capability may vary based upon organizational and provider policies and preferences.

E. The ability to select from a listing of relevant options for a section within an encounter document to reduce the amount of free text information input for the section.

i. The use of forms may reduce the amount of free text information input by the clinician to complete a particular section of an encounter note. The form may provide guidance to enable consistency and completion of documentation that adheres to industry or recommended guidelines for the selected encounter note section.

F. The ability to communicate relevant encounter notes to the next provider of care to support a consultation or transfer of care.

i. In support of a request for consultation or patient transfer to another organization, an authorized care provider may provide access to relevant completed encounter notes and/or reports to the next provider of care. Available encounter notes and reports for a patient may be accessed from a list of clinical documents that may be sorted by parameters including but not limited to: document type, date range, reason for encounter/visit, problem/diagnosis, clinician name, clinical specialty, and organization type. The clinician may provide access to encounter documents for the current patient encounter or previous patient encounters.

G. The ability to communicate annotated notes to the next provider of care.

i. An authoring clinician may replace or amend a clinical encounter note that was previously communicated to the next provider of care in support of a request for consultation or patient transfer to another organization. The updated document is communicated to the next provider of care.

H. The ability for a consulting clinician or clinician at a receiving facility to view a list of clinical encounter notes completed for a patient.

i. Upon receipt of a consultation request or transfer information for a patient, the clinician may require access to additional patient information. The clinician may review a list of available clinical encounter notes for a patient.

ii. The clinician may wish to sort the list of available encounter notes by parameters including but not limited to: document type, date range, reason for encounter/visit, problem/diagnosis, clinician name, clinical specialty, and organization type.

I. The ability to view a clinical encounter note for a patient from another organization within the consulting clinician's or receiving facility's electronic health record.

i. The consulting clinician or receiving clinician is able to access and view prior clinical encounter notes for a patient. The requesting clinician or clinician at the transferring facility has previously granted access to these encounter notes or reports.

ii. The consulting clinician or receiving clinician may request access to encounter notes or reports residing in another EHR based upon knowledge or access to a patient's encounter history.

J. The ability to compare or view a patient's progress over time for a specific type of encounter note or specific section within encounter notes.

i. A clinician may view a patient's progress or history over time for a specific type of patient encounter and access desired sections of a note to review progress.

4.0 Stakeholder Communities

Examples of stakeholders who may be directly or indirectly involved in the exchange of clinical encounter notes have been listed below. Specific descriptions of each type of stakeholder can be found in the previous 2006 – 2008 AHIC Use Cases.

Stakeholders that may be directly involved in the exchange of general clinical encounter notes may include: Authoring Clinicians, Consulting Clinicians, and Receiving Clinicians.

Stakeholders that may assist in clinical encounter note communication may include: EHR System Suppliers.

Stakeholders that may be sources or recipients of clinical encounter note or report information may include: Clinicians, Patients, Consumers, Knowledge Suppliers, Public Health, Government Agencies, and Healthcare Payors.

5.0 Issues and Obstacles

A number of issues in today's health information technology environment are obstacles to achieving the full potential of electronic health information exchange (HIE). Some general issues were described within the 2006 – 2008 AHIC Use Cases. Examples of specific issues and obstacles related to Clinical Encounter Notes are outlined below.

A. Clinical Encounter Note and Report Types:

i. In order for clinicians to effectively develop and exchange clinical encounter notes and reports, standard terminology and naming conventions for document type, document name, type of service, problem/diagnosis, and clinical specialty, and roles may be needed.

   a. Without the ability to map current standards and/or select a specific interoperable standard to ensure communication (e.g., LOINC, SNOMED CT, CPT) it may be difficult to efficiently select and communicate clinical encounter notes and reports.

   b. Without the identification and adoption of standard naming or coding conventions, it may be difficult to effectively select and communicate clinical encounter notes and reports.

B. Clinical Encounter Note Sections and Details:

ii. In order for clinicians to effectively develop and exchange clinical encounter notes and reports, standard clinical encounter note and report types, sections and/or details may be needed.

   a. In many cases, organizations and systems may use clinical encounter types to assist in determining the required encounter details. Without the identification and adoption of standard encounter types it may be difficult to determine standard required encounter sections and details.

   b. There are types of encounter notes that require similar sections, such as patient information, provider information, reason for encounter, medications, and allergies.

   c. There are also types of reports, such as operative reports, procedure notes, and specialty progress notes where the encounter note sections or details may be substantially different. An example may be a section such as estimated blood loss, which would be relevant to an operative report.

d. Without the development of standard clinical encounter note sections and details, clinicians may use free text descriptions for common encounter sections, which may create challenges in reviewing patient progress and documentation over a period of time.

C. Encounter Document Source and Identification:

i. In order for clinicians to effectively exchange clinical encounter notes, systems may need to be capable of generating a method to uniquely identify a clinical encounter note, its author, and additional document source and identification details.

a. If systems do not have capabilities to uniquely identify clinical encounter notes, it may be difficult for providers to distinguish between multiple types of clinical documentation that may have been developed for a patient during a single patient encounter except when viewing the encounter document. Structured and/or coded information associated with encounter notes may assist providers in distinguishing between different encounter notes for a patient.

D. Patient Data Access and Communication:

i. Clinical encounter notes may be exchanged to coordinate or support a consultation or transfer of care. If a care setting determines that it is not able to accept a patient for consultation or from a transfer of care, the patient data may still be accessed by this setting. There is a need to consider the duration for which patient information is accessible by recipients of this information.

a. Without processes that define the duration that patient data is accessible, patient information may be sent or accessible to a setting that did not accept the patient or for a patient that is longer its responsibility.

ii. Clinical encounter notes developed within a setting may be updated (e.g. amended, replaced) after an initial information transfer of core data to the next provider of care has taken place. The updated information may need to be communicated to providers and other stakeholders. There is a need to consider the scope, mechanism, and timeframe within which updated information is communicated to recipients.

b. Without processes that define the method and duration to send or receive updated patient information, information exchanged between care settings may be incomplete, or of questionable integrity. Providers may also receive updates for patients who are no longer their responsibility.

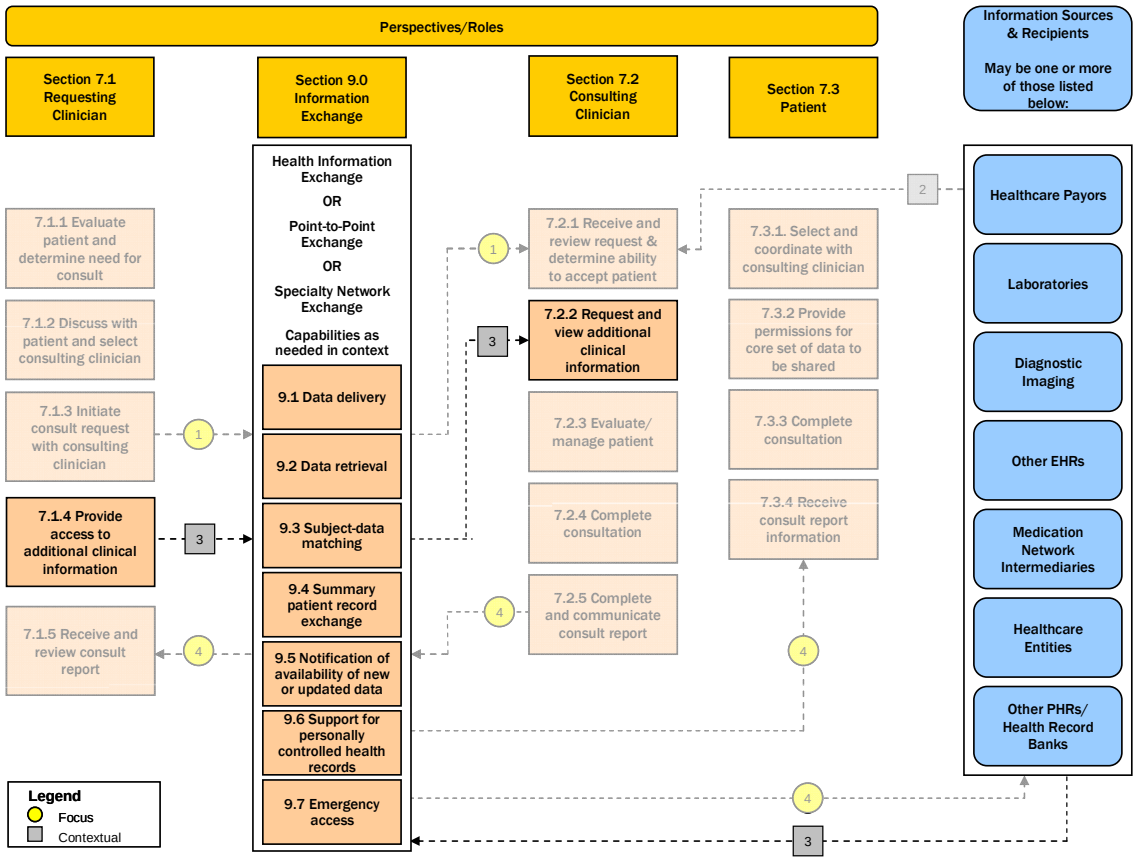
6.0 References to Prior Use Case Scenarios

The Clinical Encounter Note Extension/Gap Draft Document focuses on the exchange of clinical encounter notes and reports between EHRs and PHRs. Specific events and information exchanges have been selected from previous use cases for contextual purposes.

The 2008 Consultations and Transfers of Care Use Case contains a scenario which describes the communication of information required for a consultation request, completion of a consultation, and coordination of a transfer of care. The 2008 Public Health Case Reporting Use Case contains a scenario which describes the communication of requirements by various sources and the incorporation of these requirements into EHRs. The events and information flows which are pertinent to the Clinical Encounter Notes Extension/Gap are shown in bold. All other events and information flows have been faded out.

6.1 Reference to Prior Use Case: 2008 Consultations and Transfers of Care (Scenario 1)

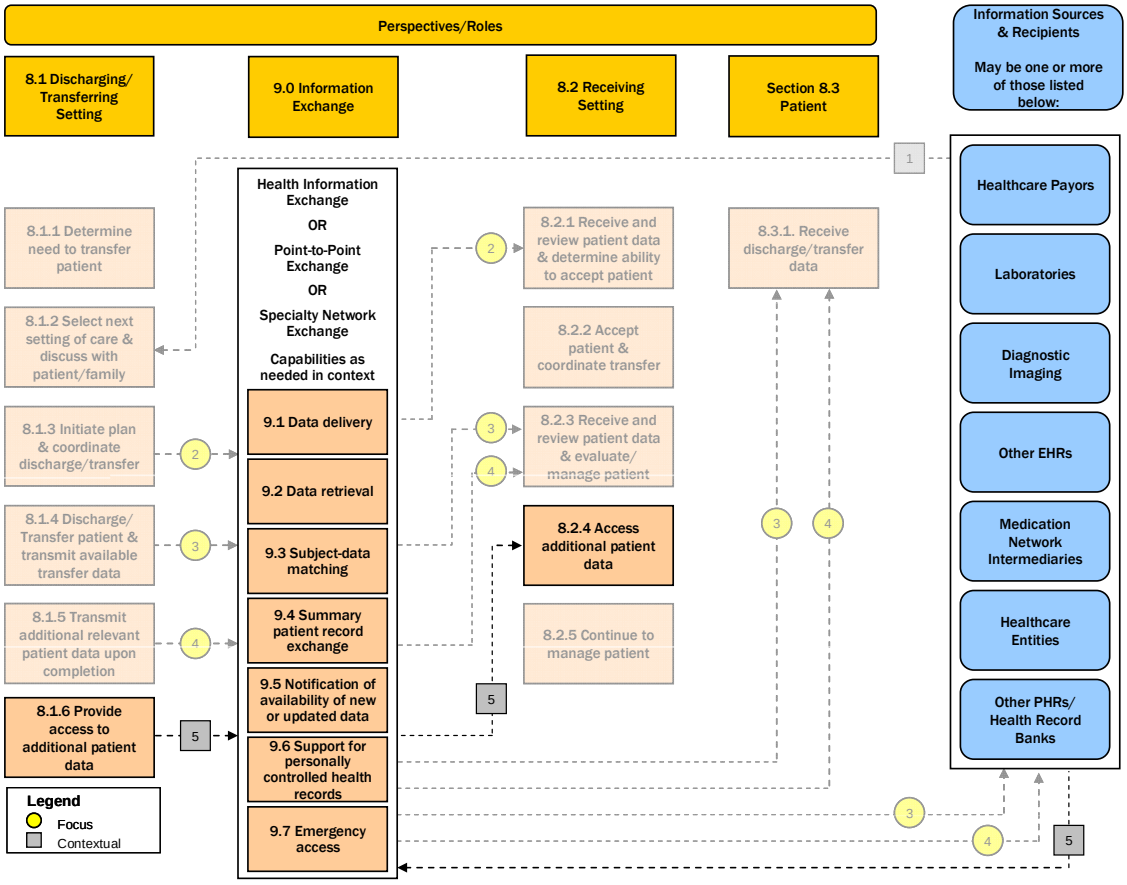
Figure 6-1.
Consultations



As expressed in the 2008 Consultations and Transfers of Care events 7.1.4, 7.2.2 and information flow 3; clinical encounter notes may be communicated via health information exchange activities and incorporated into EHRs and/or PHRs. Therefore, information flow 3 should be referenced and considered to be a focus information flow when addressing Clinical Encounter Notes.

6.2 Reference to Prior Use Case: 2008 Consultations and Transfers of Care (Scenario 2)

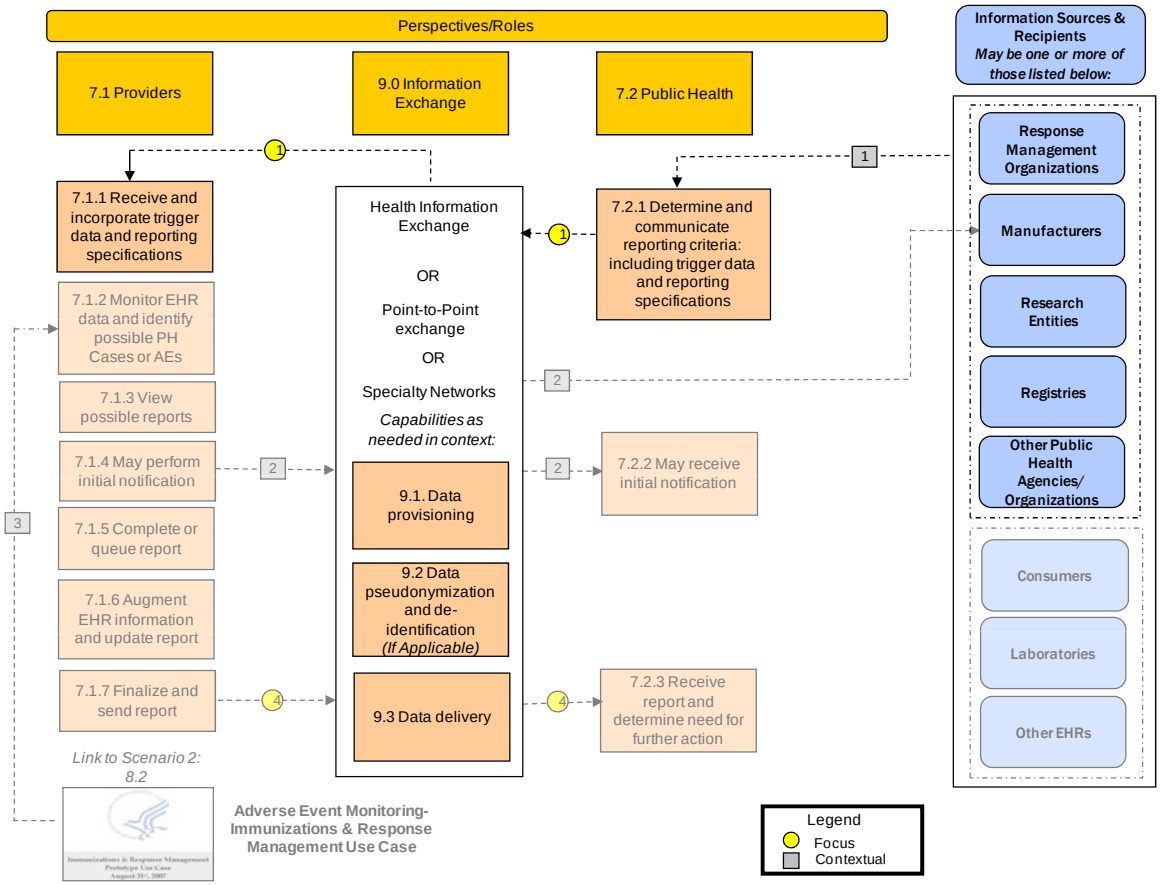
Figure 6-2. Transfers of Care



As expressed in the 2008 Consultations and Transfers of Care events 8.1.6, 8.2.4 and information flow 5; clinical encounter notes may be communicated via health information exchange activities and incorporated into EHRs and/or PHRs. Therefore, information flow 5 should be referenced and considered a focus information flow when addressing Clinical Encounter Notes.

6.3 Reference to Prior Use Case: 2008 Public Health Case Reporting (Scenario 1)

Figure 6-3. Reporting from EHRS



As expressed in the 2008 Public Health Case Reporting Use Case events 7.1.1, 7.2.1 and information flow 1; reporting criteria, including trigger data and reporting specifics may be communicated via health information exchange activities and incorporated into provider systems, e.g. EHRs and/or public health systems.

In the case of Clinical Encounter Notes, Knowledge Suppliers/Sources may communicate clinical encounter documentation requirements via health information exchange activities. Clinical encounter note requirements may also be incorporated from clinical documentation systems, such as EHRs. Therefore, Information Flow 1 should be referenced when addressing Clinical Encounter Notes.

7.0 Information Exchange

The information exchange requirements for the effective selection and communication of clinical encounter notes may comprise:

- The ability to communicate an encounter note or report form based upon function, clinical condition, specialty, and/or care setting.
- The ability to utilize a form to facilitate development of an encounter note or report details.
- The ability to communicate relevant encounter notes or reports to the next provider of care to support a consultation or transfer of care.
- The ability to communicate annotated notes or reports to the next provider of care.
- The ability for a consulting clinician or clinician at a receiving facility to view a list of clinical encounter notes and reports available for a patient.
- The ability to view a clinical encounter note or report for a patient from another organization within the consulting clinician's or receiving facility's EHR.
- The ability to compare or view a patient's progress over time using a specific type of encounter note or report and/or specific section within encounter notes or reports.

Examples of information exchange capabilities described above and in Section 3.0 may include: Data Delivery, Routing, Data Retrieval, Subject Data Matching, Notification of New or Updated Data, and Emergency Access. Descriptions of each of these are in the previous 2006 – 2008 AHIC Use Cases.

The functional capabilities may be fully or partially provided by a variety of organizations including: free-standing or geographic health information exchanges (e.g., Regional Health Information Organizations), integrated care delivery networks, provider organizations, health record banks, specialty networks, and others.

While not described in this section, Health Information Exchange (HIE), Point-to-Point, or Specialty Network exchanges may assist in the completion of the processes described in this extension/gap. Examples of these exchanges can be found in the previous 2006 – 2008 AHIC Use Cases.

8.0 Clinical Encounter Note Dataset Considerations

The following non-exhaustive information categories and limited examples illustrate some of the information needs from this extension/gap document. An analysis of the dataset and examples of common encounter note types and sections are included in Appendix B.

Encounter Document Identification – Specific information which assists in the communication and tracking of an encounter note may be considered. This information may include patient, clinician, and other encounter identification details.

Encounter Condition/Diagnosis – Specific information which assists in the communication of reason for the encounter may be considered. The use of available code sets for condition, diagnosis, procedures, and chief complaint such as those addressed by LOINC, SNOMED CT, ICD, CPT, and other standards, may be valuable.

Encounter Service Type – Specific information which assists in the description of the type of service provided during the patient encounter.

Encounter Provider Role – Specific information which provides a description of the service provider role during the encounter.

Encounter Service Location – Specific information which assists in the description of the encounter location or place of service may be considered.

Encounter Document Type - Determining and standardizing all encounter document types and names may not be practical. Focusing on commonly used encounter notes, such as those addressed by LOINC, SNOMED, HL7, and other standards may be valuable. Specific information that further describes the document should also be considered.

Encounter Note Section Type – Determining and standardizing sections for all encounter document types may not be practical and should be prioritized for commonly used encounter notes, such as History and Physical, Diagnostic Reports, Discharge Summary, Procedure Reports, Operative Reports, and Progress/Office Visit Notes. Specific information that further describes the document and identifies required or optional sections may be considered.

Appendix A: Glossary

The 2006 – 2008 AHIC Use Cases contained general terms and their contextual descriptions. Listed below are the new terms that are specific to this extension/gap.

Authoring Clinician: A clinician that completes an encounter note, during or following completion of a patient visit, to document the care provided and/or outcomes during the encounter.

Encounter Note Libraries: The listings of all possible encounter notes or reports that may be selected by a clinician for documentation or access. Encounter note libraries also include section detail for relevant encounter notes.

Encounter Note Section: Common information types which may be included within a particular encounter note type. One or more information types may be used within an encounter note and/or report form.

Encounter Note Type: Clinical documentation category that distinguishes the purpose of a clinical document from other clinical documents.

Appendix B: Analysis and Examples

Multiple industry efforts have been initiated in the past or are currently in progress to identify the dataset for clinical encounter notes and reports. An analysis of the dataset and examples of common encounter note and report types are included in Appendix B. The information, dataset, and examples provided in Appendix B are intended to serve as examples and do not constitute a comprehensive set of clinical encounter note or report information. This example and analysis is included for discussion purposes and may or may not be included in the final document.

Encounter note standardization efforts have been initiated by many public sector healthcare organizations such as the Department of Defense (AHLTA) and Veterans Administration (VistA) and private, academic, and research healthcare institutions using both internally-developed and vendor EHRs. Clinical documentation standards such as HL7 Clinical Document Architecture (CDA), ASTM Continuity of Care Record (CCR), and PDF for Healthcare, and standards initiatives such as HL7's Structured Documents Work Group, CDA4CDT, Integrating the Healthcare Enterprise's (IHE) Patient Care Coordination Technical Committee have reviewed, researched, and/or developed document formats and dataset recommendations for various clinical encounter note types. The Healthcare Information Technology Standards Panel (HITSP) has initiated or completed activities for clinical documentation associated with 2006-2008 AHIC Use Cases. The Joint Commission (TJC) also has specific requirements for information that must be available during transitions in care and policies surrounding clinical care that may impact documentation needs.

A coordinated effort that facilitates collaboration and participation from the public and private sector, including healthcare organizations, clinical stakeholders, and standards development organizations (SDOs) is needed to select standards, identify gaps, and drive standards development and selection for gap areas.

The following non-exhaustive information categories and limited examples are provided as background information for future standards efforts to provide direction on information needs for clinical encounter notes and reports:

Encounter Document Identification – Specific information which assists in the communication and tracking of an encounter note may be considered. This information may include:

- Patient Identification Information
- Authoring Clinician Identification Information
- Date of Encounter/Time Intervals
- Data Enterer Identification

Encounter Condition / Diagnosis – Specific information which assists in the communication of reason for the encounter may be considered. The use of available code sets for condition, diagnosis, procedures, and chief complaint such as those addressed by LOINC, SNOMED CT, ICD, CPT, and other standards, may be valuable.

Encounter Service Type – Specific information which assists in the identification of the type of service provided during a patient encounter. This information may include:

- Correspondence
    - Email
    - Telephone
    - Laboratory Follow-up
    - Test Follow-up
    - Medication Refill
- Diagnostic Procedure or Test
    - Demographics
        - Gender
        - Cardiac Catheterization
        - Echocardiogram
        - Electrocardiogram
        - Electrophysiology Study
        - Tilt Table Test
    - Radiology
        - Imaging
- Evaluation and Management
    - Hospital Admission/Initial Evaluation
    - Consultation
    - Pre-Operative

    - Subsequent Evaluation
    - Discharge
- Interventional Procedure
    - Radiology Procedure
        - Angiography
        - Angioplasty
        - Biopsy
        - Embolization
        - Epidural
        - Nerve Block
        - RF Ablation
        - Vascular
    - Surgical/Operative Procedure
- Screening

Encounter Provider Role – Specific information which assists in the identification of the service provider role. This information may include:

- Role, Training, or Professional Level
    - Case Manager
    - Clinical Pharmacist
    - Medical Student
    - Student Nurse
    - Registered Nurse
    - Advanced Practice Nurse
    - Occupational Therapist

- Physical Therapist
- Physician
  - Attending Physician
  - Specialty Physician
- Resident
- Respiratory Therapist
- Social Worker
- Speech Therapist

Encounter Service Location – Specific information which assists in the identification of the encounter location or type of service may be considered. This information may include:

- Outpatient Facility/Clinic
  - Primary Care Clinic
  - Specialty Clinic (e.g., Cardiology, Gastroenterology, Neurology,
  - School-based Clinic
- Inpatient Facility
  - Acute Care Hospital
  - Emergency Room
  - Rehabilitation Hospital

Encounter Document Type - Determining and standardizing all encounter document types and names is not practical. Focusing on commonly used encounter notes, such as those addressed by LOINC, SNOMED, HL7, and other standards may be valuable. Specific information that further describes the document should also be considered. This information may include:

- Ambulatory Encounter or Clinic Visit
  - Primary Care
  - Specialty (e.g., Cardiology, Gastroenterology, Neurology)

- Cardiology Report
    - Catheterization Lab Report
    - Echocardiogram Report
- Case Manager / Social Worker Report or Progress Note
- Dietary Note
- Discharge Summary
- Emergency Department Report
- History and Physical
    - Admission History and Physical
    - Medical Student History and Physical
    - Psychiatric History and Physical
- Mental/Behavioral Health Report
- Nursing Notes
    - Assessment
    - Flowsheet
    - Re-Assessment
- Operative Report
    - Anesthesia Pre-operative Report
    - Pre-operative Report
    - Operative Report
- Pathology Report
- Procedure Report
- Progress Report
- Radiology Report

- Therapy Progress Note or Report
    - Occupational Therapy
    - Physical Therapy
    - Speech Therapy
    - Residential Treatment Facility
    - Nursing Facility

Encounter Note Section Type – Determining and standardizing sections for all encounter document types is not practical and should be prioritized for commonly used encounter notes, such as: History and Physical, Diagnostic Reports, Discharge Summary, Procedure Reports, Operative Reports, and Progress/Office Visit Notes. Specific information that further describes the document and identifies required or optional sections should also be considered. Common encounter note document section types are provided below for History and Physical and Operative Notes as examples:

- History and Physical
    - Patient Demographic and Administrative Information
        - Sex
        - Age
        - Date of Birth
        - Ethnicity
        - Marital Status
    - Chief Complaint/Reason for Encounter
    - Consultation Report
    - History of Present Illness
        - Condition with Pertinent Positives and Pertinent Negatives
        - Duration
        - Onset

- Review of Systems
  - Pertinent Negatives
  - Pertinent Positives
- Past Medical History
- Allergies
- Medications
- Diagnosis or Preliminary Diagnosis
- Problem List
- Social History
- Family History
- History of Present Illness
- Vital Signs
  - Temperature
  - Blood Pressure
  - Heart Rate
  - Pain Scale
- Physical Examination
- Assessment and Plan
- Immunizations

- Operative Report
  - Surgeon and Staff Identification
  - Preoperative Diagnosis
  - Postoperative Diagnosis
  - Surgery Date, Details and Description

- Operative Note Findings
- Anesthesia Information
- Estimated Blood Loss
- Specimens Removed
- Procedure(s)
- Indications
- Intra-operative Complications
- Disposition
- Plan
- Operative Note Fluids
- Surgical Drains