

SUR Module

2026 eCQM HH-PRF (Hospital Harm Postoperative Respiratory Failure)



Currently, identification of Cath Lab patients who receive anesthesia and subsequently experience postoperative respiratory failure during the same hospitalization relies on non-standardized procedural data sources from third-party applications. These complications, including unplanned intubation or delayed extubation occurring outside of the procedural or surgical setting, are difficult to consistently capture without a clear indication of when the patient was in a procedural area.

This update will establish a standardized, EHR-based approach within Meditech to capture procedural timing and related anesthesia events at the point of care. By clearly identifying when a patient is in a procedural setting, Quality teams can more reliably identify, track, and analyze postoperative respiratory failure events, supporting improved clinical oversight, quality monitoring, and eCQM reporting.

Procedural and PACU staff play a critical role in this process by documenting the required intervention in Meditech. Accurate and timely documentation ensures the procedural context is clearly defined, enabling reliable eCQM measurement and reporting.

The new intervention, **Cath Lab Procedure +**, will replace the **PCI Procedure** intervention.

Is this a PCI procedure has a 'Yes' or 'No' response.

Note: The yellow information box stating, "This is a quality measure data point," is available on most fields in this intervention.

Cath Lab Procedure J00021639878 LCOE,TEST

Procedure start time:

7	8	9	Del
4	5	6	
1	2	3	
	0	Now	

Enter all details related to the procedure below.

These are quality measure data points.

Is this a PCI procedure: ☐ Yes

Procedure start time:

Procedure start date:

Procedure end time:

Procedure end date:

Anesthesia type:

The following fields are time and date related responses for:

- Procedure start time
- Procedure start date
- Procedure end time
- Procedure end date

Cath Lab Procedure J00021639878 LCOE,TEST

Anesthesia type:

1	2	3	4	5	6	7	8	9	0	Del
Q	W	E	R	T	Y	U	I	O	P	\
A	S	D	F	G	H	J	K	L		
Z	X	C	V	B	N	M	,	.		

Lookup

Use F9 key to pull up Anesthesia type options. Select the type used with this procedure.

These are quality measure data points.

Anesthesia type:

Anesthesia provider start time:

Anesthesia provider start date:

Anesthesia provider end time:

Anesthesia provider end date:

Anesthetic Type Lookup

Select

Mnemonic	Description
1	EPI Epidural Anesthetic
2	GEN General Anesthesia
3	GENEPI Combined General/Epi
4	GENREG Combined General/Reg
5	GENSPI Combined General/Spi
6	LOCAL Local Anesthesia
7	MAC Monitored Anes Care
8	MOD Moderate Sedation
9	NONE None
10	PER Peribulbar
11	REG Regional Anesthesia
12	SPI Spinal Anesthetic
13	SPIEPI Combined Spinal/Epi
14	SPIREG Combined Spinal/Reg

<End of list>

Anesthesia type will look up into the facility specific Anesthesia Types available. Below is an example of responses:

- Epidural Anesthetic
- General Anesthesia
- Combined General/Epi
- Combined General/Reg
- Combined General/Spi
- Local Anesthesia
- Monitored Anes Care
- Moderate Sedation
- None
- Peribulbar
- Regional Anesthesia
- Spinal Anesthesia
- Combined Spinal/Epi
- Combined Spinal/Reg

Cath Lab Procedure J00021639878 LCOE,TEST

Anesthesia provider start time:

7	8	9	Del
4	5	6	
1	2	3	
	0	Now	

Enter all details related to the procedure below.

These are quality measure data points.

Anesthesia type: GEN General Anesthesia

Anesthesia provider start time:

Anesthesia provider start date:

Anesthesia provider end time:

Anesthesia provider end date:

(End)

The following fields are time and date related responses for:

- Anesthesia provider start time
- Anesthesia provider start date
- Anesthesia provider end time
- Anesthesia provider end date

Nursing	SURG
Cath Lab Procedures +	SURG: Cath Lab Procedure Intra-op+ & PACU

Pressure Support and Airway Tube Size Update



Current documentation workflows for Respiratory Therapists do not include structured fields for documenting pressure support in BiPAP/CPAP interventions or a response option for airway tube sizes greater than 10.5mm for Intubation interventions. This update adds a *Pressure support* field to all **BiPAP/CPAP** interventions and expands the *Airway tube size* responses to include 11mm, 12mm, and free text option for all **Intubation** interventions.

RT BiPAP/CPAP Pressure support (cmH2O): 7 8 9 Del 4 5 6 1 2 3 - 0 . Calc Set tidal volume (mL):> O2 Liters per minute: > O2 mL per minute: > FiO2%: > Set IPAP (cmH2O): > Set EPAP/CPAP (cmH2O): > Pressure support (cmH2O): > Set rate (bpm): > P max (cmH2O): >	The <i>Pressure support</i> (cmH2O) has been added to all RT: BiPAP/CPAP interventions.																																
<table border="1"> <thead> <tr> <th colspan="2">Nursing</th> <th>Emergency Department</th> </tr> </thead> <tbody> <tr> <td>RT: BiPAP/CPAP Initial</td> <td>RT PED: BiPAP/CPAP Initial</td> <td>RT: BiPAP/CPAP</td> </tr> <tr> <td>RT: BiPAP/CPAP Subsequent</td> <td>RT PED: BiPAP/CPAP Subsequent</td> <td></td> </tr> <tr> <td>RT: BiPAP/CPAP</td> <td></td> <td></td> </tr> </tbody> </table>	Nursing		Emergency Department	RT: BiPAP/CPAP Initial	RT PED: BiPAP/CPAP Initial	RT: BiPAP/CPAP	RT: BiPAP/CPAP Subsequent	RT PED: BiPAP/CPAP Subsequent		RT: BiPAP/CPAP																							
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Rapid Response Update



The current **Rapid Response/Code Record** combines Rapid Response and Code Blue documentation into a single intervention, leading to confusion, inconsistent documentation, and incomplete data capture. The updated workflow separates these processes by renaming the intervention to **Rapid Response Event Outcome** and removing Code Blue documentation. This change improves documentation consistency, increases visibility into rapid response events, and supports quality improvement initiatives.

Rapid Response Record

Rapid response activated date:

Calendar Del
Yesterday
Today
Tomorrow

Rapid response activated date:

Rapid response activated time:

Rapid response team arrival time:

Rapid response activated time:

7 8 9 Del
4 5 6
1 2 3
0 Now

The time the event was recognized.

Rapid response activated date:

Rapid response activated time:

Rapid response team arrival time:

Rapid response team reason for call: *

Enter reason for call if OTHER selected:

(Next Page)

The following fields represent when the event was identified, not when the response team arrived.

- Rapid Response Activated Date
- Rapid Response Activated Time

Note: The highlighted box for *Rapid response activated time* instructing to enter 'The time the event was recognized.'

Rapid Response Record

Rapid response team arrival time:

7 8 9 Del
4 5 6
1 2 3
0 Now

The time that the response team entered the room.

Rapid response activated date:

Rapid response activated time:

Rapid response team arrival time:

Rapid response team reason for call: *

Enter reason for call if OTHER selected:

(Next Page)

Document the time the response team entered the room in *Rapid response team arrival time* field.

Note: The highlighted information box stating to enter 'The time that the response team entered the room.'

Rapid Response Record

OK Rapid response team reason for call:

- 1 Change in LOC
- 2 Change in vital signs
- 3 Staff/family concern
- 4 Other

Rapid response activated date: >

Rapid response activated time: >

Rapid response team arrival time: >

Rapid response team reason for call:

Enter reason for call if OTHER selected:

(Next Page)

Rapid response team reason for call is required and has the following responses:

- Change in LOC
- Change in vital signs
- Staff/family concern
- Other

Rapid Response Record

OK Enter reason for call if OTHER selected:

Enter free text.

Rapid response activated date: >

Rapid response activated time: >

Rapid response team arrival time: >

Rapid response team reason for call: Other

Enter reason for call if OTHER selected:

(Next Page)

When 'Other' is selected for *Rapid response team reason for call*, *Enter reason for call* field becomes required.

The field allows for free text entry.

Rapid Response Record

Rapid response event comments:

Enter free text.
Word wrap allowed.

Rapid response event comments:

Outcome of rapid response:

Rapid response end date:

Rapid response end time:

(Prev Page) (End)

Use the field **Rapid Response Event Comments** to document additional clinical details that are not captured elsewhere.

Rapid Response Record

Outcome of rapid response:

- 1 Code blue initiated
- 2 Patient stayed in room
- 3 Level of care escalated

Rapid response event comments:

Outcome of rapid response:*

Rapid response end date:

Rapid response end time:

(Prev Page)

(End)

Outcome of rapid response is a required field and has the following responses:

- Code blue initiated
- Patient stayed in room
- Level of care escalated

Rapid Response Record

Rapid response end date:

Calendar Del

Yesterday

Today

Tomorrow

Rapid response event comments:

Outcome of rapid response:*

Rapid response end date:

Rapid response end time:

The *Rapid response end date* and *Rapid response end time* fields allow for documentation of the end date and time of the rapid response.

Rapid Response Record

Rapid response end time:

7 8 9 Del

4 5 6

1 2 3

0 Now

Rapid response event comments:

Outcome of rapid response:*

Rapid response end date:

Rapid response end time:

(Prev Page)

(End)

Nursing	Surgery
Rapid Response Event Outcome	SURG: Rapid Response Event Outcome Pre+
	SURG: Rapid Response Event Outcome Int+
	SURG: Rapid Response Event Outcome PAC+

Restraint 2026 Phase 2 Strategic Agenda



As part of the ongoing Corporate Responsible Restraint Program, the 2026 initiative focuses on refining policies and clarifying clinical practice expectations to ensure alignment with The Joint Commission (TJC) and CMS requirements. Restraint documentation workflows have been streamlined to remove duplicative, outdated, and non-required elements. These updates reduce documentation burden, improve regulatory compliance, and enhance efficiency in both bedside care and EHR documentation. The revised workflow standardizes restraint documentation to reflect current regulatory requirements while maintaining existing system programming across all restraint episodes.

In **Start** workflow, *Alternatives utilized* has been updated to *Alternatives attempted* and the response options have been streamlined to better align with policy.

The documentation fields on pages 2 and 3 of the **Start** and **Monitor** workflow have been removed to eliminate duplicative documentation.

Restraint Documentation

☒ Restraints are clinically justified:

1 Yes
2 No

- Second tier review -
Click below to default system normal values
DFT Norms
DFT Norms (Go to File)

--- The following must be reviewed with the RN. ---

Restraints clinically justified: ☐ *

Reasons reviewed: ☐ *

Least restrictive type planned: ☐ *

Alternatives attempted, ineffective documented: ☐ *

Cause of patient reviewed: ☐ *

Consideration for vulnerability: ☐ *

Justified for restraint type/device: ☐ *

Assessed restraints were safely and appropriately applied: ☐ *

Patients rights, dignity, and safety have been upheld: ☐ *

(Prev Page) ☐ (Next Page) ☐

The **Second tier review** documentation has been removed in alignment with recent policy updates.

Note: Second tier review has also been removed from the Restraints Report.

Restraint Documentation

☒ Safety/Rights/Dignity maintained verified:

1 Done now
2 Three times every hour
3 Every 15 minutes per hour

Done now - use to document each observation in real time, three times every hour.

For patients under continuous or frequent in-person observation or continuous audio/video monitoring, or if a paper checklist is used and scanned into the EHR/HPF medical record, the following may be used:
Three times every hour
Every 15 minutes per hour

Safety/Rights/Dignity maintained verified:

(Prev Page) ☐ (Next Page) ☐

Safety/Rights/Dignity documentation is now only available for violent restraint episodes.

Restraint Documentation

☒ Reviewed/attempted ways to help the patient regain control:

1 Yes
2 No

Reviewed/attempted ways to help the patient regain control: ☐ *

Evaluated the patients immediate situation: ☐ *

Evaluated the patients reaction to the intervention: ☐ *

Evaluated the patients medical and behavioral condition: ☐ *

Evaluated the need to continue or terminate restraint/seclusion: *

(Prev Page) ☐ (Next Page) ☐

For Violent level of restraints, the one-time **Face to face** documentation has been reduced.

Restraint Documentation

Response to restraint:

1 Tolerant
2 Combative

- Monitor/RN assess -
Click below to
default system normal values
DFT Norms
DFT Norms (Go to File)

Response to restraint: *

Vital signs taken per unit policy or doctors orders: *

Free from injury or pain associated with restraint: *

Free from respiratory/airway compromise associated with restraint: *

Skin under/around restraint verified (when applicable): *

Range of motion done: *

Response to restraint has been added to the **Monitor/RN assess** documentation. Responses continue to allow for selection of 'DFT Norms' and 'DFT Norms (Go to File)'.

Note: *Monitor/RN assess* may be documented as often as necessary/per policy.

Restraint Documentation

Date restraint discontinued:

Calendar Del
Yesterday
Today
Tomorrow

Date restraint discontinued: *

Time restraint discontinued: *

(Prev Page) ☐ (End) ☐

The **Restraint Discontinue** workflow has been updated to require documentation of only the date and time the restraint was discontinued for both Violent and Non-violent workflows.

Restraint Debriefing

Circumstances leading to restraint/seclusion incident:

1 ☐ NV-Attempts remove device 7 ☐ V-Physical aggression
2 ☐ NV-Handle wound/dressings
3 ☐ NV-OOB extreme inj risk
4 ☐ V-Attempts self-harm
5 ☒ V-Combative
6 ☐ V-Destructive

Circumstances leading to restraint/seclusion incident:→

Recommendations for future actions:→

Post counseling provided to: *

Debriefing Comment:→

(End) ☐

The **Restraint Debriefing** documentation has been removed from the Violent level of restraint discontinue workflow documentation.

Telemetry Documentation for SUR



The SUR module currently lacks an assessment for documenting the application or discontinuation of telemetry for patients with an active order. This update will add the **Tele App/DC ORD REQ** assessment to all phases of the Surgical Profile to support required documentation. Note that telemetry is when a patient is being remotely monitored by a central monitoring unit via a portable telemetry box. Continuous cardiac monitoring that is watched, monitored, and acted upon by the nurse does not constitute telemetry.

The image shows three overlapping 'Select Assessment' dialog boxes. Each box has a table with two columns: 'Assessment' and 'Last Documented'. The first box shows 'SURG: Tele App/DC ORD REQ Pre' selected. The second box shows 'SURG: Tele App/DC ORD REQ Int' selected. The third box shows 'SURG: Tele App/DC ORD REQ PACU' selected. Other options visible include 'SURG: Transport Pre', 'SURG: Transport Int', 'SURG: Transport PAC', and 'SURG: Universal Timeout PACU'.

After the provider enters a Telemetry order and the order is acknowledged, documentation of telemetry is completed using the **Tele App/DC ORD REQ** assessment in each phase of care in the Surgical Profile.

Select the appropriate Phase of Care. From Page 1, select Assessments then Enter Forms. Select **SURG: Tele App/DC ORD REQ**.

Note: A provider order is required before documentation of the telemetry application.

The image shows the 'Telemetry Application/Discontinuation' form. At the top, there is a checkbox labeled 'Telemetry unavailable and patient maintained on continuous monitor:'. Below this, there is a yellow highlighted box with the text: 'If a telemetry box is unavailable, place the patient on a continuous monitor and validate that the patient is being monitored.' An arrow points from this box to the checkbox. Below the checkbox, there are fields for 'Telemetry application date:', 'Telemetry application time:', 'Telemetry box number:', 'Telemetry discontinued date:', and 'Telemetry discontinued time:'. At the bottom right, there is an '(End)' checkbox.

If telemetry is unavailable and patient is maintained on a continuous monitor, 'Yes' is documented in the field.

The remainder of the fields on the screen will be bypassed.

Note: The highlighted information box states, 'If a telemetry box is unavailable, place the patient on a continuous monitor and validate that the patient is being monitored.'

Telemetry Application/Discontinuation

Telemetry application date:

Calendar Del
Yesterday
Today
Tomorrow

Telemetry unavailable and patient maintained on continuous monitor:→

Telemetry application date: *

Telemetry application time: *

Telemetry Application/Discontinuation

Telemetry application time:

7 8 9 Del
4 5 6
1 2 3
0 Now

Telemetry unavailable and patient maintained on continuous monitor:→

Telemetry application date: *

Telemetry application time: *

Telemetry box number:→

The *Telemetry application date* is a required field utilizing the calendar function.

The highlighted information box states:

Confirm telemetry order is in place prior to starting telemetry monitoring and documentation.

The *Telemetry application time* is also a required field using the keypad numeric function.

Note: The date and time will auto-populate on subsequent entries to the intervention until a discontinuation is entered.

Telemetry box number allows for free text entry of alpha-numeric characters. The field can be edited in subsequent entries as needed.

Note: The *Telemetry discontinuation date* and *Telemetry discontinued time* should be skipped upon telemetry application documentation.

For discontinuation, once the Telemetry Discontinuation order has been entered and acknowledged, document in the *Telemetry discontinuation date* and *Telemetry application time* fields.

Telemetry Application/Discontinuation

Telemetry box number:

Enter free text.

Telemetry unavailable and patient maintained on continuous monitor:→

Telemetry application date:→ *

Telemetry application time: *

Telemetry box number:

Telemetry discontinued date:→

Telemetry discontinued time:→

(End) ☐

Telemetry Application/Discontinuation

Telemetry discontinued date:

Calendar Del
Yesterday
Today
Tomorrow

Telemetry unavailable and patient maintained on continuous monitor:→

Telemetry application date:→ *

Telemetry application time:→ *

Telemetry box number:→

Telemetry discontinued date:→

Telemetry discontinued time:→

(End) ☐

The Tele unavailable; on continuous monitor is documented in SUR will display on the Perioperative Patient Handoff Report.

The Tele application date and time documented in SUR will display on the Perioperative Patient Handoff Report.

Telemetry unavailable and patient maintained on continuous monitor:

✓ 1 Yes

If a telemetry box is unavailable, place the patient on a continuous monitor and validate that the patient is being monitored.

Telemetry unavailable and patient maintained on continuous monitor: **Yes**

Telemetry application date:

Telemetry applic

RUN DATE: 06/24/26		QAIA FACILITY (QAA) **ADMISSIONS**		PAGE 1
RUN TIME: 1414		Perioperative Patient Handoff Report		
RUN USER: 1PDPQL3124				
Patient: TEST, ADULT 1		J000210179 / J0000912946		Admit/Service Date: 07/15/21
DOB: 08/12/80	Age: 45	Sex: M	Room/Bed: J.TEST-K	
Code status:				
Admitting MD:		Weight (kg):		
Attending MD:		Height (cm):		
Reason for Visit/Chief Complaint: TESTING..../Respiratory				
Brief History:				
Consulting MD: TELEHEALTH, GENERIC MD				
.ER, GENERIC PHYSICIAN O				
.ER, GENERIC PHYSICIAN P				
sTelehealth Maternal Fetal Med				
sTelehealth Nephrology Consult				
Surgeon:				
Anesthesiologist:				
Anesthesia type: LOCAL				
Procedure scheduled:				
Actual procedure performed: ESWL				
Tele unavailable; on continuous monitor: Yes (06/19/26 1430)				
Suicide risk: None Documented		Pain control goal: None Documented		
Hold status: None Documented		Pain scale utilized:		

Telemetry application time:

7	8	9	Del
4	5	6	
1	2	3	
0			Now

Telemetry unavailable and patient maintained on continuous monitor:

Telemetry application date: **06/24/26**

Telemetry application time: **1419**

RUN DATE: 06/24/26		QAIA FACILITY (QAA) **ADMISSIONS**		PAGE 1
RUN TIME: 1420		Perioperative Patient Handoff Report		
RUN USER: 1PDPQL3124				
Patient: TEST, ADULT 1		J000210179 / J0000912946		Admit/Service Date: 07/15/21
DOB: 08/12/80	Age: 45	Sex: M	Room/Bed: J.TEST-K	
Code status:				
Admitting MD:		Weight (kg):		
Attending MD:		Height (cm):		
Reason for Visit/Chief Complaint: TESTING..../Respiratory				
Brief History:				
Consulting MD: TELEHEALTH, GENERIC MD				
.ER, GENERIC PHYSICIAN O				
.ER, GENERIC PHYSICIAN P				
sTelehealth Maternal Fetal Med				
sTelehealth Nephrology Consult				
Surgeon:				
Anesthesiologist:				
Anesthesia type: LOCAL				
Procedure scheduled:				
Actual procedure performed: ESWL				
Tele application date: 06/24/26				
Tele application time: 1419				
Suicide risk: None Documented		Pain control goal: None Documented		
Hold status: None Documented		Pain scale utilized:		

Surgery

SURG: Telemetry Application/DC Pre

SURG: Telemetry Application/DC Int

SURG: Telemetry Application/DC PACU