MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*	ISSUANCE DATE

LOCAL FORM TITLE ***(Optional)***

PROCEDURE DESCRIPTION:

_____

_____

BENEFITS DISCUSSED:

- ☐ OBTAINING A DIAGNOSIS IN THE LEAST INVASIVE MANNER
- ☐ USING ULTRASOUND/CT GUIDANCE TO OBTAIN CELLS/TISSUE FOR PATHOLOGY

RISKS DISCUSSED:

- ☐ BLEEDING
- ☐ INFECTION
- ☐ DAMAGE TO SURROUNDING STRUCTURES
- ☐ RESULTS MAY BE INCONCLUSIVE

ALTERNATIVES:

- ☐ OPEN BIOPSY (SURGERY)
- ☐ DECLINE THE PROCEDURE (DO NOTHING)

ALLERGIES: LATEX _____ **MEDICATION** _____

ANESTHESIA/ANALGESIA: _____ **LIDOCAINE 1%** _____

TIME OUT VERIFICATION

CORRECT PATIENT: ☐ YES ☐ NO **POSITION OF PATIENT:** _____

CORRECT PROCEDURE SITE: ☐ YES ☐ NO **CORRECT PROCEDURE:** ☐ YES ☐ NO

ALL TEAM MEMBERS INVOLVED IN TIME-OUT: ☐ YES ☐ NO

POST PROCEDURE:

STANDARD PROCEDURE: _____

IMMEDIATE COMPLICATION: ☐ NO ☐ YES _____

POST PROCEDURE INSTRUCTIONS GIVEN: ☐ YES ☐ NO

PATIENT SENT TO: ☐ APU ☐ WARD ☐ HOME ☐ OTHER _____

_____ _____

PHYSICIAN'S SIGNATURE **DATE**

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	