UNANTICIPATED SEQUELA FORM

Period I – January 1 to June 30 **Period II** – July 1 to December 31

Period: _____ Year: _____

Reviewing Physician's Name: _____ Facility ID#: _____

Medical License Number: _____ Review Date: _____

FACILITY INFORMATION

Name: _____

Operating Physician: _____

PATIENT INFORMATION

Patient Initials: _____ Gender: _____ Height: _____ Weight: _____

Age: _____ Ethnicity: _____

SURGERY INFORMATION

Original Surgery Date: _____ Duration: _____ Hours _____Minute

SEQUELA INFORMATION

Sequela Type: _____

NOTE: Any death occurring in an accredited facility, or any death occurring within thirty days of a surgical procedure performed in an accredited facility must be reported to the AAAASF office within five business days after the facility is notified, or otherwise becomes aware of that death.

Location of Event (physical location, Example: recovery room, home, etc.): _____

_____

Procedure (original procedure for which complication evolved):_____

Analysis of Reason for Problem: _____

NOTE: If there were additional procedures, please list them below

Procedure # 2: _____ Procedure #4: _____

Procedure # 3: _____Procedure #5:_____

ANESTHESIA INFORMATION

Anesthesia Type: _____

Anesthesia Provider (Anesthesiologist, CRNA Operating Surgeon with Nurse): _____

Anesthesia Duration: _____hours _____minutes

Sequela Outcome: _____

_____

REQUIRED FOR ALL DEATHS:

Days Elapsed Since Sequela(The number of days from the date of the sequel to the date of death): _____

Cause of Death: _____

Date of Death: _____

If any of the procedures reported for this unanticipated sequel included liposuction, infection of resulted in hospitalization, please fill out the Unanticipated Sequela Addendum sheet.

UNANTICIPATED SEQUELA ADDENDUM SHEET

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LIPOSUCTION

Total Volume Removed: _____cc Intravenous Fluid Type: _____

Total Intravenous Fluid Replaced: _____cc

Infusion Fluid Type: _____ Infusion Fluid Amounts: _____cc

Epinephrine Amount: _____per 1000 cc Infusion Fluid

Lodicaine Used: _____% Amount: _____ per 1000 Infusion Fluid

Marcaine Used: _____% Amount: _____ per 1000 Infusion Fluid

HOSPITAL INFORMATION

Hospital Name: _____

Date of Admission: _____ Date of Discharge: _____

Reason of Admission: _____

Explanation if Hospital Course (leave blank if not applicable): _____

_____

INFECTION INFORMATION

Anatomic Location: _____

Culture Result: _____

Wound Management: _____

Other Therapy: _____