

Postoperative Follow-up Call Sheet

Patient Name: _____ Date of Birth: ___/___/___

Procedure: _____ DOS: ___/___/___

Name of operating physician: _____

Patient called on ___/___/___ at _____ a.m. / p.m. (circle)

Post Surgical Condition:

- | | YES | NO |
|---------------------------------------|--------------------------|--------------------------|
| 1. Redness/Swelling of operative site | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Bleeding from operative site | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Drainage from operative site | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Pain in operative site | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Other: | YES | NO |
| a. Headache | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Nausea | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Vomiting | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Cough | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Other _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Comments on any YES response: (include advice given)

Activity:

- | | YES | NO |
|---------------|--------------------------|--------------------------|
| 1. Ambulating | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Resting | <input type="checkbox"/> | <input type="checkbox"/> |

Medications:

Name and direction for medication(s): _____

When was medication last taken? _____

Comments: _____

Signature and title of Phone Interviewer

___/___/___
Date