

Basic form: operation

Patient's Personal Identity No. (12 digits)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Operated hand:

Left Right Both

Operation date (yyyy-mm-dd):

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Operation is (mark only one alternative):

- Primary operation in a single-step procedure
- First operation in treatment programme / procedure involving several steps
(e.g. reconstruction of tendon, reconstruction after trauma, repeated dressing/revision due to infection etc.)
- Re-operation within 12 months (applies also to patients who underwent surgery in another clinic)

If **re-operation**, answer the questions below:

1. Did the primary operation take place at another clinic? No Yes

2. Indicate **reason** for reoperation:

- Part of treatment programme / procedure involving several steps
(e.g. reconstruction of tendon, reconstruction after trauma, repeated dressing/revision due to infection etc.)

Is it the last operation planned in the treatment: No Yes

- Removal of osteosynthesis material to prevent complication

- Re-operation due to postoperative **complication**

Mark **type** of complication (check the correct alternative in each row)

Osteosynthesis-related complication	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Infection	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Skin necrosis /wound healing problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Hematoma / bleeding	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Nerve compression / compartment syndrome	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Tendon rupture	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Nerve damage	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Adherence formation / contracture	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Pseudarthrosis / incorrectly healed fracture or arthrodesis	<input type="checkbox"/> No	<input type="checkbox"/> Yes
After arthroplasty (loosening, dislocation etc)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Other postoperative complication:	<input type="checkbox"/> No	<input type="checkbox"/> Yes

If yes, indicate type and cause: _____

- Other reason for reoperation

Specify reason:

Preoperative antibiotic prophylaxis:

No Yes

Surgeon's initials:

Diagnosis codes (ICD10; max 5 codes)

Operation codes (KKÅ97; max 5 codes)

Primary diagnosis code:

Primary operation code:

Diagnosis code 2:

Operation code 2:

Diagnosis code 3:

Operation code 3:

Diagnosis code 4:

Operation code 4:

Diagnosis code 5:

Operation code 5: