

SPINE SURGERY DATA SHEET

PATIENT NAME: _____ Surgery Date: _____

SURGEON: _____

PROCEDURE:

Patient is enrolled in a Clinical Trial

ESTIMATED LENGTH OF SURGERY: _____ DIAGNOSIS: _____

ASSISTING PERSONEL: _____

SPINAL CORD MONITORING: _____ YES _____ NO

CELL SAVER: _____ YES _____ NO

POSITIONING: _____ PRONE _____ RT. LATERAL _____ LEFT LATERAL _____ SUPINE

DEVICES: _____ HALL RELTON FRAME _____ MICROSCOPE

_____ JACKSON TABLE _____ WILSON FRAME

_____ BEANBAG _____ MAYFIELD CRANIAL PINS & HEADREST

RADIOLOGY: _____ X-RAY _____ PORTABLE _____ FLUORO

SPECIAL REQUESTS:

INSTRUMENTAION SALES REP: _____ NOTIFIED: _____ YES _____ NO

POST OP BED: _____ ICU _____ STEPDOWN _____ NURSING UNIT

Please contact Lori Mercer at 631-351-7982 or Lmercercer@hunthosp.org.

Please fax DATA SHEET to (631) 351-2696 Thank you.

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