**REVSTAT**
REVIEW STATUS (not abstracted)
0. Abstraction has not begun
1. Abstraction in progress
2. Abstraction completed w/o errors
3. TVG failure (exclusion)
4. Record contains missing required answers (error record)
5. Administrative exclusion from all measures

**CATNUM**
Sample category
53. Surgical Care
55. Type 10 Surgery Cases

**SIADMDT** (SCIP)
Date of admission to inpatient care:

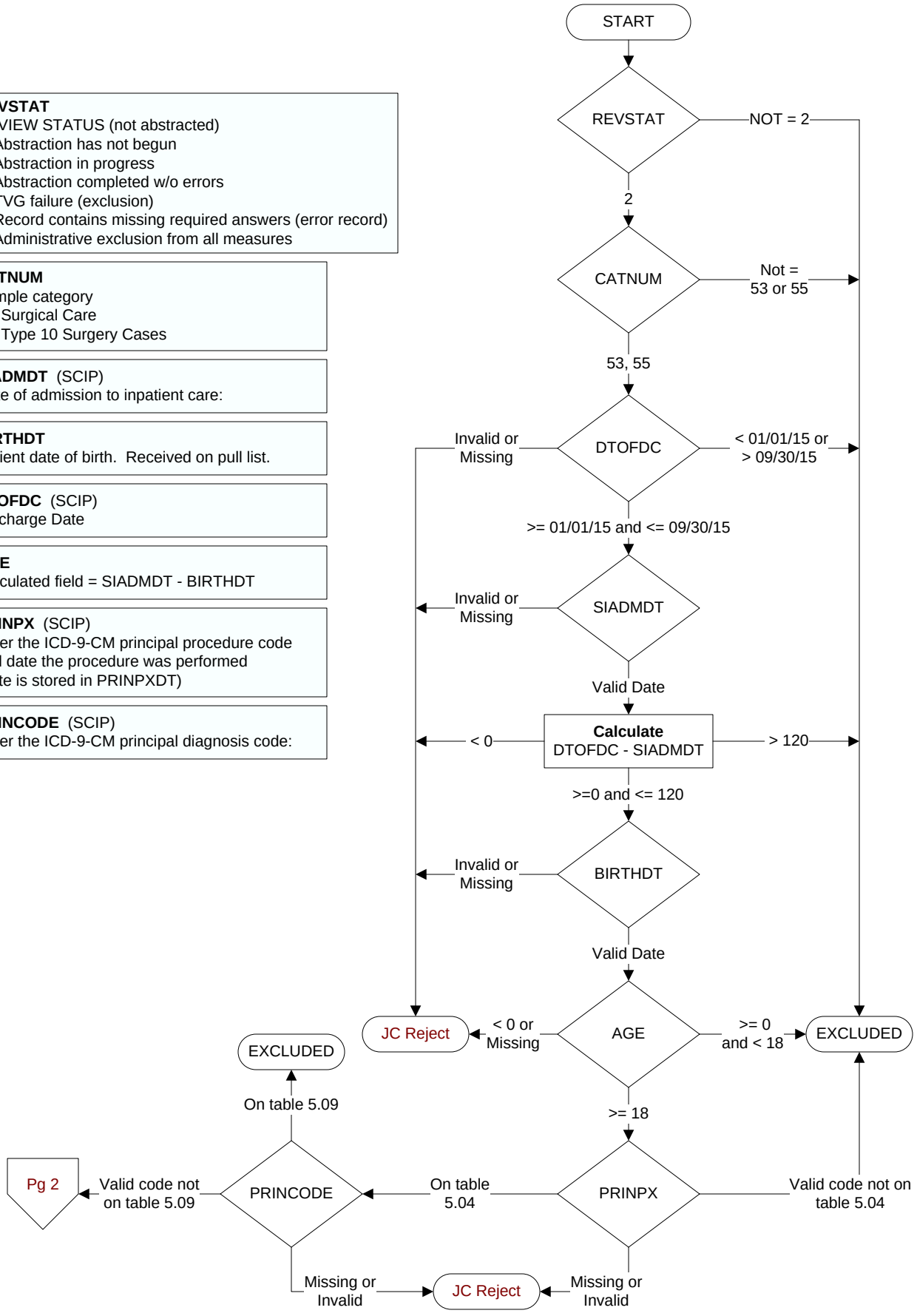
**BIRTHDT**
Patient date of birth. Received on pull list.

**DTOFDC** (SCIP)
Discharge Date

**AGE**
Calculated field = SIADMDT - BIRTHDT

**PRINPX** (SCIP)
Enter the ICD-9-CM principal procedure code and date the procedure was performed (date is stored in PRINPXDT)

**PRINCODE** (SCIP)
Enter the ICD-9-CM principal diagnosis code:



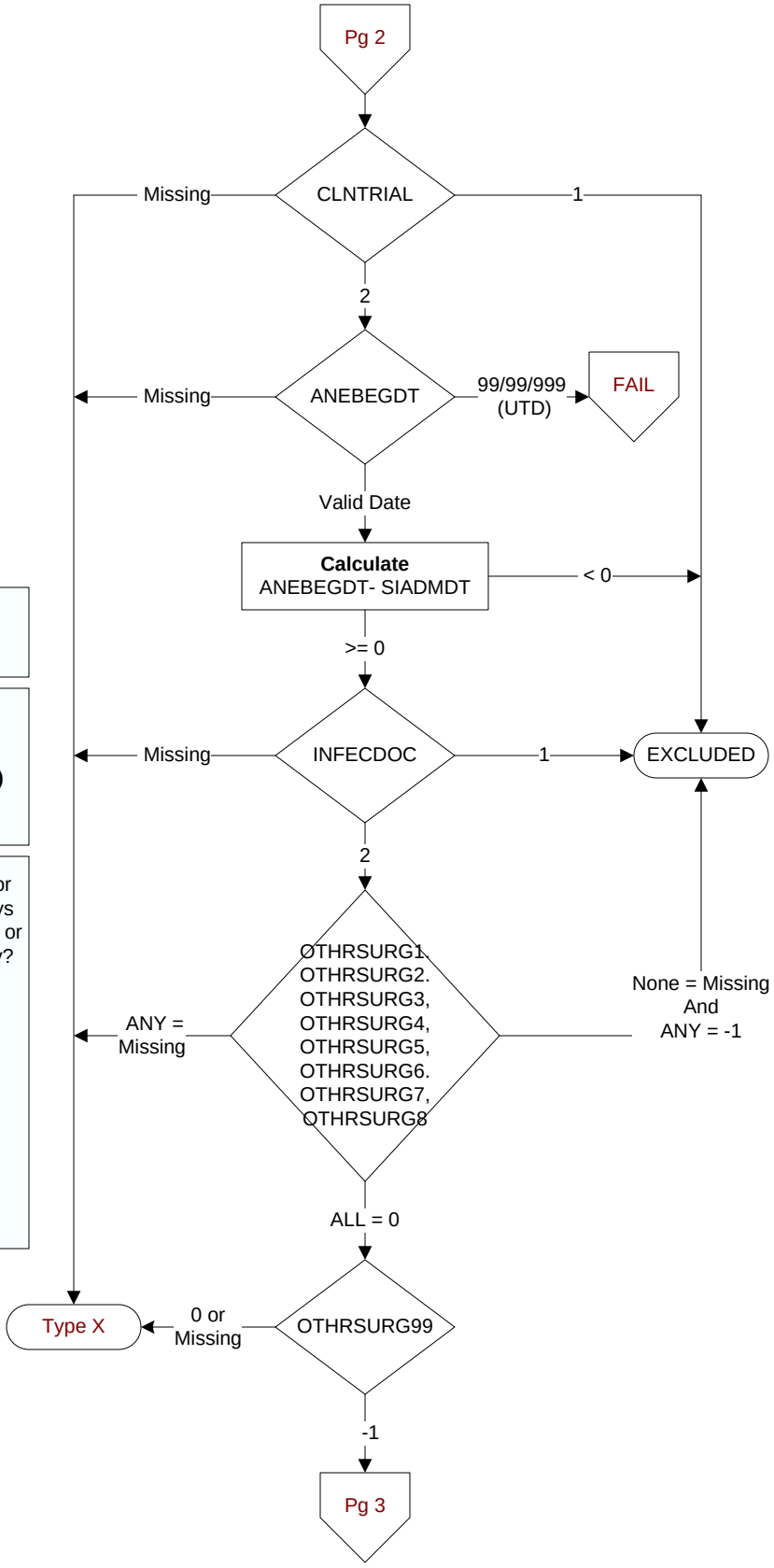
**LAPSCOPE** (SCIP)
Was the principal procedure performed entirely by laparoscope or other fiber optic scope?
1. Yes
2. No
99. Unable to determine

**CLNTRIAL** (SCIP)
During this hospital stay, was the patient enrolled in a clinical trial in which patients undergoing surgery were being studied?
1. Yes
2. No

**ANEBEGDT** (SCIP)
Enter the date the anesthesia was started for the principal procedure.

**INFECDOC** (SCIP)
Did the patient have an infection during this hospitalization prior to the principal procedure?
**(Requires Physician, APN, or PA documentation)**
1 = Yes
2 = No

Were there any other procedures requiring general or spinal/epidural anesthesia that occurred within 3 days (4 days for CABG or Other Cardiac Surgery) prior to or after the principal procedure during this hospital stay?
**Indicate all that apply:** (SCIP)
**OTHRSURG1**. CABG
**OTHRSURG2**. Other Cardiac surgery (not CABG)
**OTHRSURG3**. Hip arthroplasty
**OTHRSURG4**. Knee arthroplasty
**OTHRSURG5**. Colon surgery
**OTHRSURG6**. Hysterectomy
**OTHRSURG7**. Vascular surgery
**OTHRSURG8**. Other
**OTHRSURG99**. No other procedure performed within this timeframe



**PERIEXPR** (SCIP)
Is there documentation that the patient expired during the timeframe from surgical incision through discharge from the post anesthesia care/ recovery area?
1. Yes
2. No
95. Not applicable

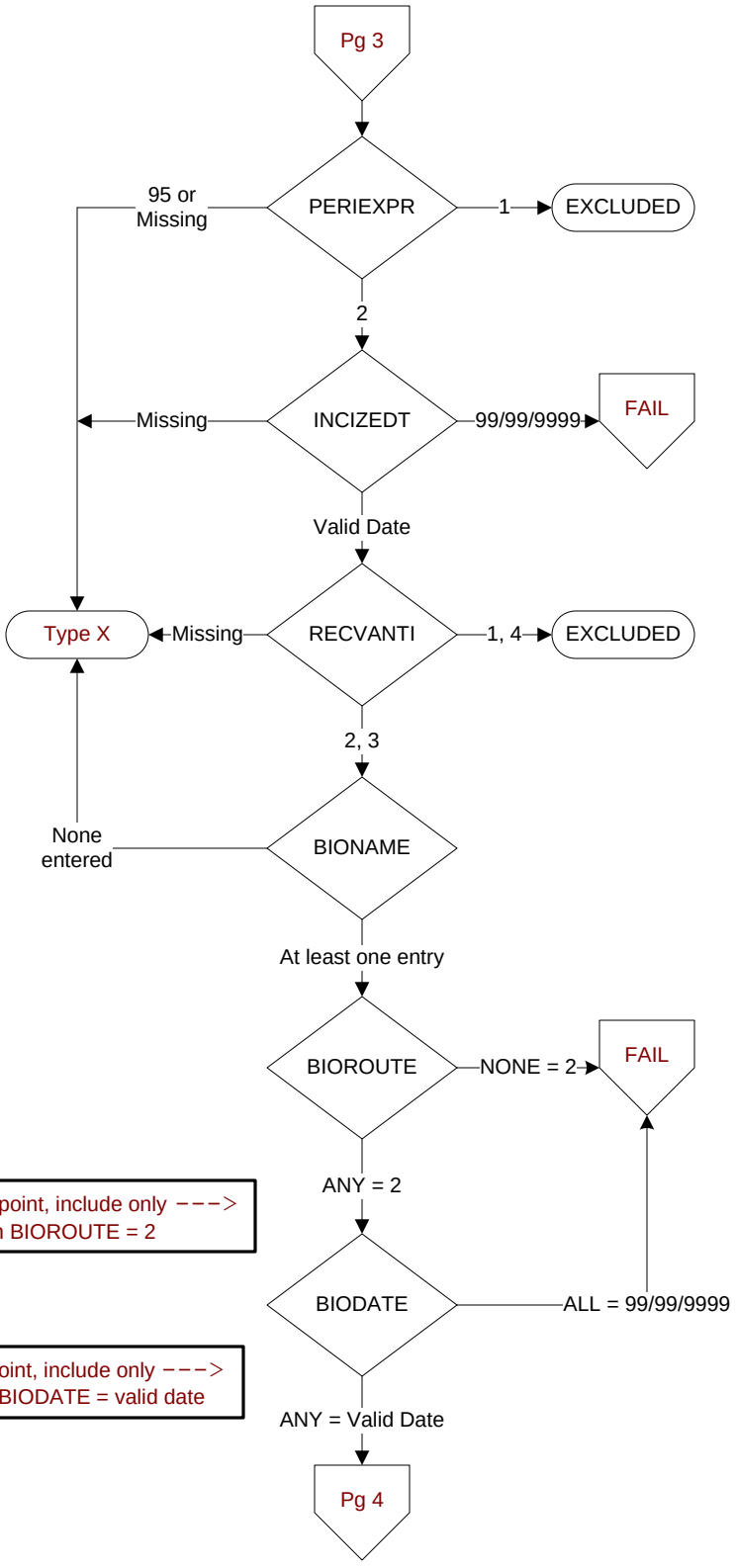
**INCIZEDT** (SCIP)
Enter the date the incision was made for the principal procedure.

**RECVANTI** (SCIP)
Did the patient receive an antibiotic via an appropriate route? (PO, NG, PEG, IV, or perfusion)
1. Antibiotic received only within 24 hours prior to arrival or the day prior to arrival and not during hospital stay
2. Antibiotic received within 24 hours prior to arrival or the day prior to arrival and during hospital stay.
3. Antibiotic received only during hospital stay (not prior to arrival)
4. Antibiotic not received or unable to determine from medical record documentation

**BIONAME** (SCIP)
Document the name of each antibiotic dose(s) administered from arrival through the first 48 hours after Anesthesia End Time (72 hours postop for CABG or Other Cardiac Surgery).

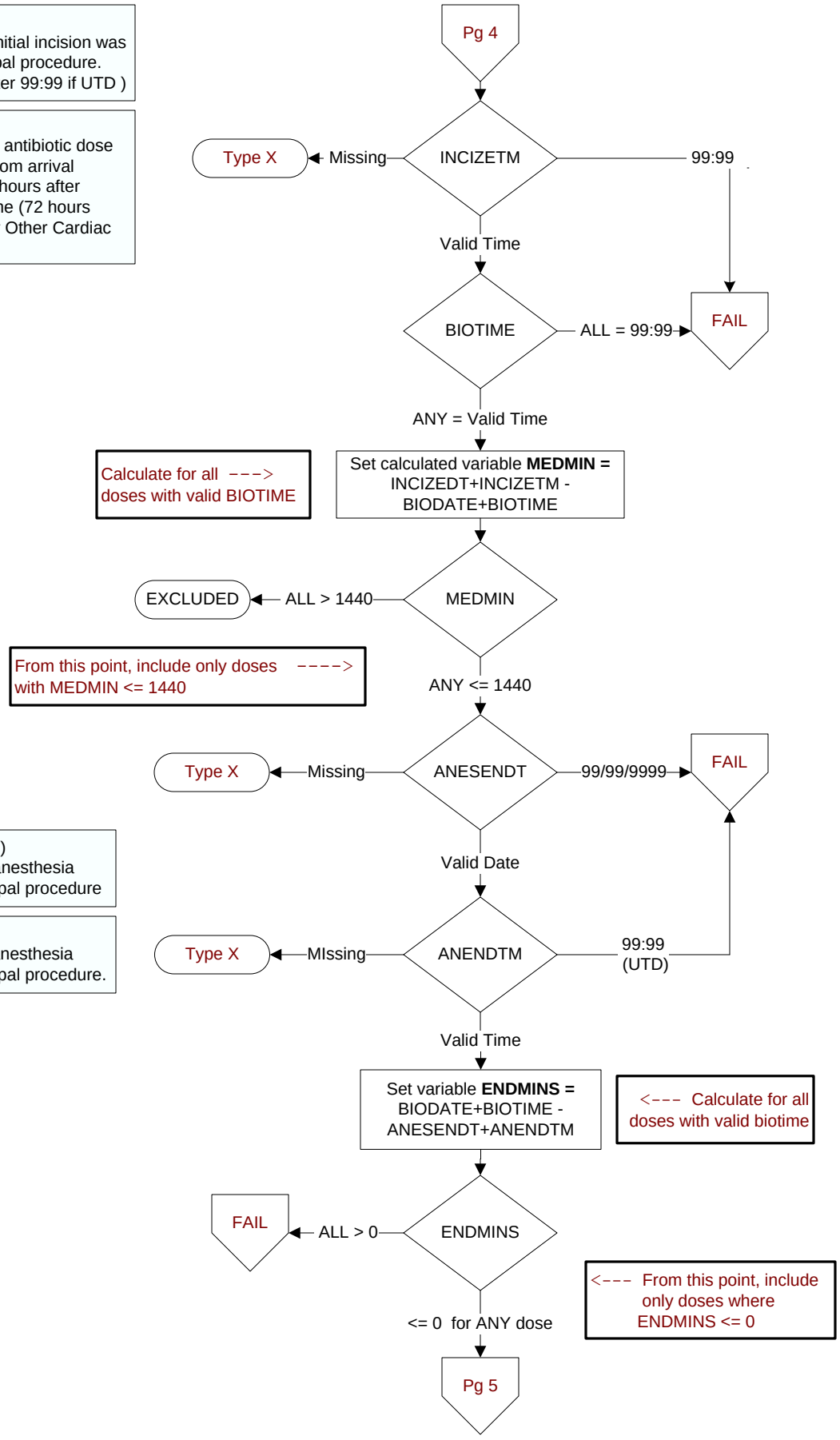
**BIOROUTE** (SCIP)
Enter the route of administration of each antibiotic dose that was administered from arrival through the first 48 hours after Anesthesia End Time (72 hours postop for **CABG or Other Cardiac Surgery**).
1. PO, NG, PEG tube (Oral)
2. IV (Intravenous, perfusion)
3. IM (Intramuscular)
99. UTD (Unable to determine route)

**BIODATE** (SCIP)
Enter the date each antibiotic was administered from arrival through the first 48 hours after Anesthesia End Time (72 hours postop for CABG or Other Cardiac Surgery). (Abstractor can enter 99/99/9999 if date cannot be determined )



**INCIZETM** (SCIP)
Enter the time the initial incision was made for the principal procedure. (Abstractor may enter 99:99 if UTD )

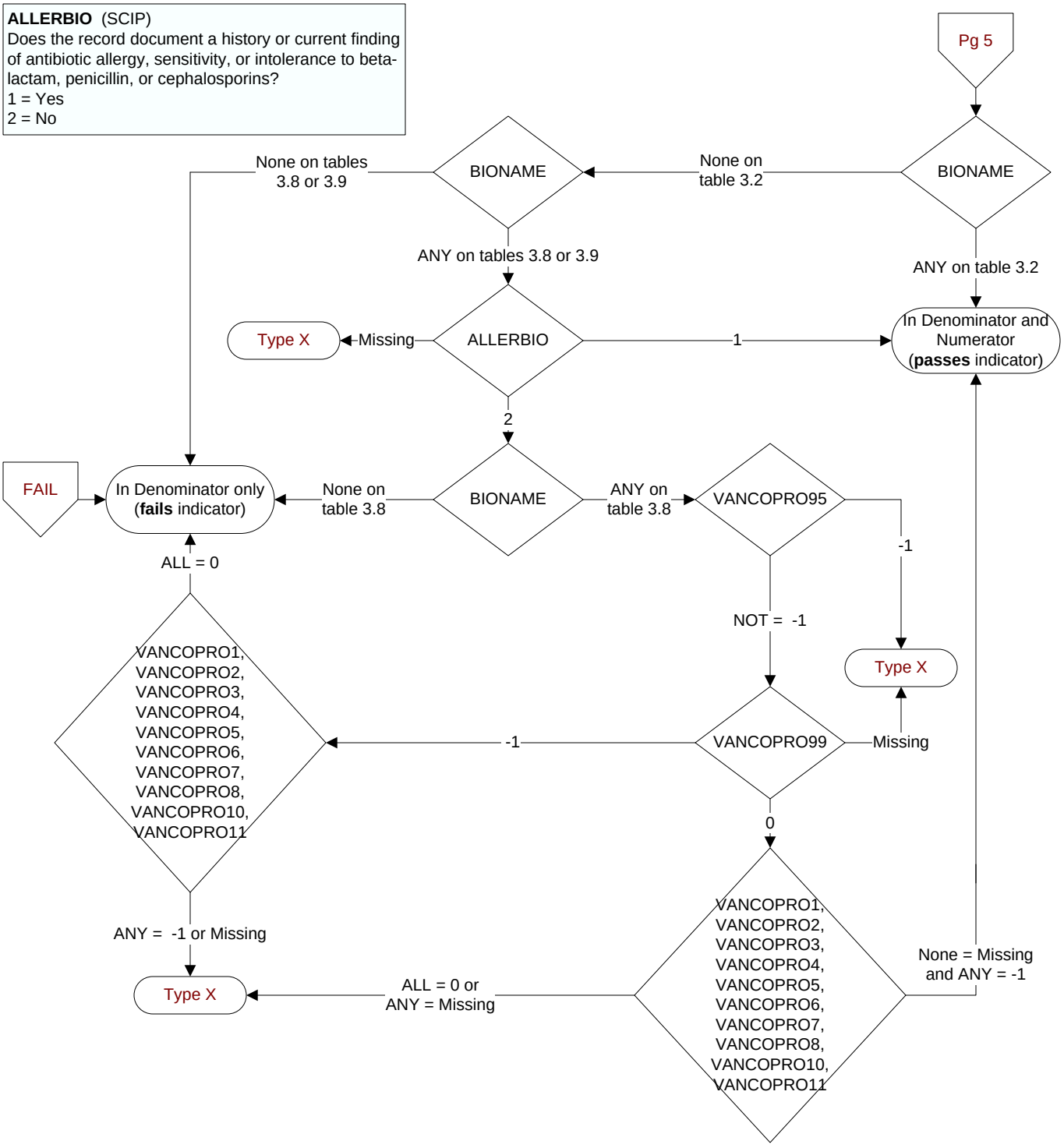
**BIOTIME** (SCIP)
Enter the time each antibiotic dose was administered from arrival through the first 48 hours after Anesthesia End Time (72 hours postop for CABG or Other Cardiac Surgery)




**ANESENDT** (SCIP)
Enter the date the anesthesia ended for the principal procedure

**ANENDTM** (SCIP)
Enter the time the anesthesia ended for the principal procedure.

**ALLERBIO** (SCIP)
Does the record document a history or current finding of antibiotic allergy, sensitivity, or intolerance to beta-lactam, penicillin, or cephalosporins?
1 = Yes
2 = No




What reason for using vancomycin was documented? (SCIP)
Select all that apply:
**VANCOPRO1**. Documentation of beta lactam (penicillin or cephalosporin) allergy
**VANCOPRO2**. Documentation of colonization with MRSA, positive MRSA screen, an MRSA infection, or a history of MRSA
**VANCOPRO3**. Documentation of patient being high-risk due to acute inpatient hospitalization within the last year
**VANCOPRO4**. Documentation of patient being high-risk due to nursing home or extended care facility settng within the last year, prior to admission
**VANCOPRO5**. Physician/APN/PA or pharmacist documentation of increased MRSA rate, either facility-wide or procedure-specific
**VANCOPRO6**. Physician/APN/PA or pharmacist documentation of chronic wound care or dialysis
**VANCOPRO7**. Documentation of continuous inpatient stay more than 24 hours prior to the principal procedure
**VANCOPRO8**. Other physician/APN/PA or pharmacist documented reason
**VANCOPRO10**. Physician/APN/PA or pharmacist documentation of patient undergoing valve surgery
**VANCOPRO11**. Documentation of patient being transferred from another inpatient hospitalization after a 3-day stay
**VANCOPRO95**. Not applicable
**VANCOPRO99**. No documented reason