

Today's Date: ____/____/____
month day year

104.49

Hospital Discharge Form

HIP REPLACEMENT 13.4b

Patient ID _____

Physician ID _____

Clinic/Site ID _____

Hospital ID _____

Form filled out by (check one):

- Physician NP/PA
 Resident Other _____

0.0.0, 104.52, 104.53, 101.6

TO BE COMPLETED BY PHYSICIAN ON DAY OF DISCHARGE FROM HOSPITAL

1. Date of discharge from hospital: ____/____/____
month day year 104.195

2. Were antithrombotic methods used? (check all that apply) 104.196
 - a. None
 - b. Coumadin
 - c. Heparin
 - c. Low molecular weight Heparin
 - e. Other drug (specify) _____ ..
 - f. Other mechanical (specify) _____ ..

3. Were perioperative antibiotics used: 100.1492

| | | |
|----------------|------------------------------|-----------------------------|
| Pre-op | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Intra-op | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Post-op | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

4. Was heterotropic bone prophylaxis used? (check all that apply) 100.333
 - a. None
 - b. Radiation
 - c. Anti-inflammatory medications
 - d. Other (specify) _____

5. Were there any complications during or after the surgery? (check all that apply) 104.197
 - a. None
 - b. Wound infection
 - c. Cardiovascular (AMI, congestive heart failure)
 - d. Pneumonia
 - e. Pulmonary embolism
 - f. Dislocation or fracture of operative hip
 - g. Thrombophlebitis
 - h. Other (fever, drug reactions)
 - i. Death

6. Discharge destination: (check one) 104.198
 - a. Inpatient rehab unit (same facility)
 - b. Extended care facility
 - c. Home with home care
 - d. Home
 - e. Other _____