

Patient ID	_____
Physician ID	_____
Clinic/Site ID	_____
Form filled out by (check one):	
<input type="checkbox"/> Physician _____	<input type="checkbox"/> NP/PA _____
<input type="checkbox"/> Resident _____	<input type="checkbox"/> Other _____

0.0.0, 104.52, 104.53, 101.6

# Hospital Discharge

## TOTAL KNEE REPLACEMENT FORM 16.5

TO BE COMPLETED BY **PHYSICIAN** AT TIME OF DISCHARGE FROM SURGICAL HOSPITALIZATION

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100.907

5. CULTURES OF OPERATIVE JOINT: (check one per row)

	Not Obtained	Positive	Negative
5a. Pre-operative cultures:			
a. right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5b. Intra-operative cultures:			
a. right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. COMPLICATIONS DURING POST-OPERATIVE HOSPITAL STAY (check all that apply): 100.724

a. None	<input type="checkbox"/>
b. Wound Infection	<input type="checkbox"/>
c. Delayed wound healing (including flat necrosis, persistent drainage)	<input type="checkbox"/>
d. Cardiovascular (AMI, congestive heart failure)	<input type="checkbox"/>
e. Pneumonia	<input type="checkbox"/>
f. Pulmonary embolism	<input type="checkbox"/>
g. Genitourinary (obstructive uropathy, UTI)	<input type="checkbox"/>
h. Dislocation of operative joint	<input type="checkbox"/>
i. Fracture/perforation of operative joint	<input type="checkbox"/>
j. Thrombophlebitis	<input type="checkbox"/>
k. Nerve Palsy	<input type="checkbox"/>
l. Prolonged bleeding/Hematoma	<input type="checkbox"/>
m. Death	<input type="checkbox"/>
n. Other (fever $\geq 39$ , drug reactions): _____	<input type="checkbox"/>

7. Weight bearing at discharge? (check one)

100.909

a. Full	<input type="checkbox"/>
b. Partial	<input type="checkbox"/>
c. Toe touch	<input type="checkbox"/>
d. None	<input type="checkbox"/>

8. What is the patient's discharge destination? (check one)

100.335

a. Inpatient rehab unit (same facility)	<input type="checkbox"/>
b. Extended care facility	<input type="checkbox"/>
c. Home with home care	<input type="checkbox"/>
d. Home	<input type="checkbox"/>
e. Other	<input type="checkbox"/>

9. Date patient discharged from hospital:

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
month      day      year

104.230