

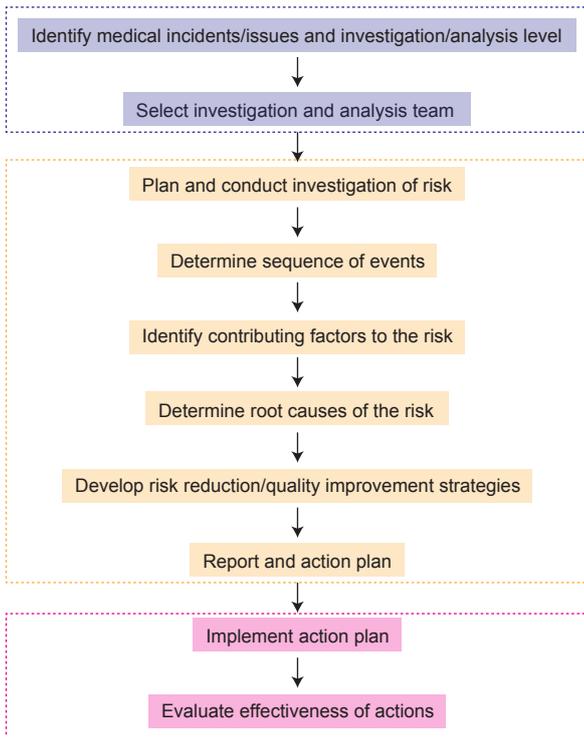
The notification of selective operation in hospital

Name_____	Gender_____	Age_____	
Ward_____	Bed No.____	Admission No._____	Time of surgery plan_____
Diagnosis_____			
Surgery name_____			
Anaesthesia_____			
Operative doctor_____		Assistant doctor_____	
Blood: blood type: <input type="checkbox"/> Rh(+) <input type="checkbox"/> Rh(-) <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> AB		Volume []	
Risk evaluation			
The cardiovascular system:	Coronary heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hyperpiesia <input type="checkbox"/> Yes___/___ <input type="checkbox"/> No
	Cardiac insufficiency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arrhythmia <input type="checkbox"/> Yes <input type="checkbox"/> No
	The others	<input type="checkbox"/> _____	
The nervous system:	Cerbral infraction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cerebral hemorrhage <input type="checkbox"/> Yes <input type="checkbox"/> No
	Neuromuscular disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nerve injury <input type="checkbox"/> Yes <input type="checkbox"/> No
	The others	<input type="checkbox"/> _____	
The respiratory system:	Chronic smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No
	Bronchiectasis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No
	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypopnoea <input type="checkbox"/> Yes <input type="checkbox"/> No
	The others	<input type="checkbox"/> _____	
The alimentary system:	Dystrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatic cirrhosis <input type="checkbox"/> Yes <input type="checkbox"/> No
	Hepatic inadequacy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer <input type="checkbox"/> Yes <input type="checkbox"/> No
	Cholecystitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	The others	<input type="checkbox"/> _____	
The metabolism system:	Diabetes mellitus	<input type="checkbox"/> Yes_____mmol/L <input type="checkbox"/> No	
	The others	<input type="checkbox"/> _____	
The endocrine system:	Hyperthyreosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypothyroidism <input type="checkbox"/> Yes <input type="checkbox"/> No
	The others	<input type="checkbox"/> _____	
The urinary system:	Renal inadequacy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Renal failure <input type="checkbox"/> Yes <input type="checkbox"/> No
	Nephritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Urethra infection <input type="checkbox"/> Yes <input type="checkbox"/> No
	The others	<input type="checkbox"/> _____	
The hematological system:	Thrombus history	<input type="checkbox"/> Yes <input type="checkbox"/> No	Laboratory test <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
	The others	<input type="checkbox"/> _____	
The immune system:	HAV <input type="checkbox"/> + <input type="checkbox"/> --	HBV <input type="checkbox"/> + <input type="checkbox"/> --	HCV <input type="checkbox"/> + <input type="checkbox"/> -- HEV <input type="checkbox"/> + <input type="checkbox"/> --
	AIDS <input type="checkbox"/> + <input type="checkbox"/> --	Syphilis <input type="checkbox"/> + <input type="checkbox"/> --	Tuberculosis <input type="checkbox"/> + <input type="checkbox"/> --
	The others	<input type="checkbox"/> _____	
The mental disorder:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
The history of great operation:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
The new medical technology:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Signed by the director of ward:			
Proposal from the center of preoperative evaluation:			

Risk evaluation

A

Root Cause Analysis (RCA) in PEC



B

