HEALTHCARE

DIAGNOSTIC IMAGING
POST PROCEDURE NOTE

THIS FORM IS TO BE COMPLETED ON ALL INTERVENTIONAL PROCEDURES

Date of Procedure: **In-patient Out-patient**

Pre-procedure diagnoses:

Physician:

Assistant(s):

Procedure Performed:

Findings:

IV Fluids: **Total Contrast:**

Anesthesia Type: **By DR:**

Blood Loss:

Specimens:

Devices/Drains/Catheters left in place:

Complications:

.M.D.

(Physician Signature) **(Print Name)** **(Pager)**

PILOT

01/2004