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§482.51(b)(6) - An operative report describing techniques, findings, and tissues removed or altered must be written or dictated immediately following surgery and signed by the surgeon.

Interpretive Guidelines §482.51(b)(6)

The operative report includes at least:

- Name and hospital identification number of the patient;

- Date and times of the surgery;
- Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision);
- Pre-operative and post-operative diagnosis;
- Name of the specific surgical procedure(s) performed;
- Type of anesthesia administered;
- Complications, if any;
- A description of techniques, findings, and tissues removed or altered;
- Surgeons or practitioners name(s) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues); and
- Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any.

Survey Procedures §482.51(b)(6)

Review a minimum of six random medical records of patients who had a surgical encounter. Verify that they contain a surgical report that is dated and signed by the responsible surgeon and includes the information specified in the interpretive guidelines.