Patient Name:[name]
Account number: [account number]
MR #: [MR]
Date of Birth: [mm/dd/yyyy]
Date of Visit: [Date]

DATE OF PROCEDURE: [ ]

PREOPERATIVE DIAGNOSIS:

[ ]

POSTOPERATIVE DIAGNOSIS:

[ ]

PROCEDURE PERFORMED:

Open reduction internal fixation of tibial plateau fracture

COMPLICATIONS: None apparent.

SURGEON: Brian Gilmer, MD.

ASSISTANT: [Karly Dawson PAC]

ANESTHESIOLOGIST: [ ]

ANESTHESIA: General

COMPLEXITY: Normal

DEVICES AND IMPLANTS: [ ]

IMPLANT SHEET REVIEWED: Yes

ESTIMATED BLOOD LOSS: [250mL]

SPECIMEN REMOVED: None.

BLOOD ADMINISTERED: None.

TOURNIQUET TIME: [ ] minutes

INDICATIONS:

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Patient Name:[name]
Account number: [account number]
MR #: [MR]
Date of Birth: [mm/dd/yyyy]
Date of Visit: [Date]

The patient is a [ ] who sustained an injury to their knee. We had a thorough discussion regarding treatment options. We discussed increased healing rates and improved functional outcomes with operative versus nonoperative management for this fracture pattern. We discussed that these potential benefits came with increased risks of surgery. We reviewed these which include, but are not limited to, nonunion, malunion, bleeding, damage to neurovascular structures which may be temporary and/or permanent, infection, symptomatic hardware, need for hardware removal, failure of fixation and need for revision fixation, persistent pain, incomplete return of function, development of a new or exacerbation of an existing medical comorbidity. The rare possibility of death was discussed. The expected operative and postoperative course was explained as well as any restrictions on weightbearing and range of motion and I spent some time answering their questions. Understanding all this, they asked me to proceed.

DESCRIPTION OF PROCEDURE:

On the date of surgery the patient was identified in the preoperative holding area. Surgical site was agreed upon, confirmed, marked by the surgery team, nursing staff, and the patient. I marked the limb myself. They were taken to the operating room and a surgical time-out was performed. They were positioned supine with attention paid to padding all bony prominences. The upper extremity was prepped and draped in the usual sterile fashion. They received antibiotic prophylaxis within 30 minutes of incision and mechanical DVT prophylaxis to the nonoperative leg.

Attention was first turned to the skin.

[ ]

Plate options were then examined and the appropriately sized plate was selected. A nonlocking screw was placed on either side of the fracture to draw the plate to the bone. The reduction was again assessed and was not compromised.

Additional screws were then placed in serial fashion. Final fluoroscopic images were obtained. Reduction was excellent and well maintained throughout the procedure.

The wound was then copiously irrigated. The wound was closed in layers including 2-0 Vicryl in the fascia. A sterile dressing was placed. Local anesthetic was administered in

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the incision for postoperative pain control prior to placement of the dressing. The patient was awakened from anesthesia and taken to recovery room in good condition.

POSTOPERATIVE PLAN:

Nonweightbearing for 8-10 weeks then start partial progressive pending radiographic signs of healing. Start therapy as soon as possible. Admit to floor for pain control and mobility.

Electronically signed by Brian B. Gilmer, MD [date]. [time]