Operative Report Standards Utilized by the ABFPRS Credentials Committee During the Review of Applicants' Operative Experience

Eligible case reports must follow the standards set by the Joint Commission for the Accreditation of Healthcare Organizations or the Accreditation Association for Ambulatory Health Care. These standards require, in general, that operative reports contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the postoperative course and results, and promote continuity of care.

Specifically, operative reports should include:

- the date and location of surgery;
- the name of the primary surgeon and assistants;
- findings;
- procedures used (preferably, identified by CPT nomenclature and codes);
- specimens removed;
- postoperative diagnosis and course, including postoperative complications and their management;
- discharge condition;
- instruction for follow-up care;
- and such other elements as are necessary to assure a high standard of patient care.

When the procedure involves flaps, their size and location must be noted; likewise, if a laser it used, its setting and the number of passes must be noted.

You may view several samples of operative reports that the ABFPRS Credentials Committee has determined to be Acceptable and Unacceptable. These documents are included for informational purposes only and any resemblance contained in these operative reports to persons living or deceased is purely coincidental.