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, as a minimum:

- patient name or initials;
- date of surgery and facility location;
- name of the primary surgeon and assistants;
- anesthesia used;
- diagnosis, preoperative and postoperative;
- indications for procedure;
- procedures, identified by CPT nomenclature and codes;
- details of procedure
- and such other elements as are necessary to assure and indicate a high standard of patient care, such as findings, drains, specimens, disposition of patient.

When the procedure involves flaps, the defect size and location and the size of the flap must be noted. Excisions and repairs should include size, margins, layers repaired, plus any specific undermining and length of the repaired wound. If a laser is used, its setting and the number of passes must be noted. Chemical peel reports should include indications for procedure and type of solution used.

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.