

**UCSF DEPARTMENT OF SURGERY  
QUALITY IMPROVEMENT CASE REVIEW REPORT**

Service Transplant

<b>Patient Name</b>	<b>MR#</b>	<b>DOB</b>
<b>Operation(s) Performed</b>		<b>Preoperative Diagnosis</b>
<b>Date(s) of Operation(s)</b>	<b>Attending Surgeons(s)</b>	<b>MD#(s)</b>
<b>Date(s) of Occurrence(s)</b>	<b>Housestaff Surgeon(s)</b>	<b>MD#(s)</b>
<b>Occurrence(s): select all that apply</b>		<b>Service specific occurrence(s): select all that apply</b>
<input type="checkbox"/> Death <input type="checkbox"/> Lasting organ failure <input type="checkbox"/> Unplanned return to OR <input type="checkbox"/> Unplanned readmission <input type="checkbox"/> Unplanned ICU care <input type="checkbox"/> Surgical site infection <input type="checkbox"/> Deep infection <input type="checkbox"/> Sepsis/ septic shock <input type="checkbox"/> Urinary tract infection		<input type="checkbox"/> Lymphocele <input type="checkbox"/> Renal/ pancreatic arterial thrombosis <input type="checkbox"/> Renal/ portal vein thrombosis <input type="checkbox"/> Ureteral leak/ obstruction <input type="checkbox"/> Pancreatic/ enteric leak <input type="checkbox"/> Biliary leak/ stricture <input type="checkbox"/> Hepatic artery thrombosis <input type="checkbox"/> Primary non-function <input type="checkbox"/> Graft loss <input type="checkbox"/> Other:
<b>Part I</b>		
<b>Narrative of Case:</b>		
_____ _____ _____ _____		
<b>Occurrence related to: select all that apply</b>		
<input type="checkbox"/> Diagnosis <input type="checkbox"/> Surgical technique <input type="checkbox"/> Other:		
<input type="checkbox"/> Underlying disease <input type="checkbox"/> Abnormal anatomy <input type="checkbox"/> Equipment malfunction		
<input type="checkbox"/> Systems problem <input type="checkbox"/> Management		
Form completed by:		date
Signature of attending		date

To be completed by housestaff/attending

Part I

To be completed by Section QI Chief

<b>Service Action Plan:</b> <input type="checkbox"/> No further action <input type="checkbox"/> Systems review <input type="checkbox"/> Root cause analysis <input type="checkbox"/> Other:		
<b>Narrative of Plan:</b>		
_____ _____ _____ _____		
<i>Date of review by Service QI Committee</i>		
<i>Signature of Service QI Chief</i>		date

Part II

To be completed by Dept QI

<b>QI COMMITTEE REVIEW</b>		<i>Date of review</i>
<b>Discussion:</b>		
Physician issue(s) <input type="checkbox"/> yes <input type="checkbox"/> no		Systems failure <input type="checkbox"/> yes <input type="checkbox"/> no
Complication management appropriate <input type="checkbox"/> yes <input type="checkbox"/> no		
<b>Narrative of Plan:</b>		
_____ _____ _____ _____		
<b>Action:</b> <input type="checkbox"/> No Action <input type="checkbox"/> Peer review <input type="checkbox"/> Refer to other service <input type="checkbox"/> RCA <input type="checkbox"/> Systems review <input type="checkbox"/> Other:		
<i>Signature of QI Chair/date</i>		

Part III