Table 2
Los Angeles County High Desert Health System

Post Operative Wound Infection Report

Surgery performed: ________________________________ Date of Surgery: ________________

Where performed? ____ HDHS ASC ____ Other: ________________________________

Provider evaluating wound: ________________________________ Date: ________________
Please Print

Infection Signs & Symptoms noted:

____ Pain	____ Purulent Drainage/Discharge at site	____ Cellulitis
____ Necrosis	____ Dehiscence/Wound Opening	____ Fever
____ Abscess	____ Erythema/Redness	____ Edema/Swelling
____ Tiredness	____ Warmth at Site	Other ____________

Culture & Sensitivity done/ordered? ____ Yes ____ No If no, why? ________________

I&D/Other Treatments?____ Yes ____ No

Antibiotics Prescribed? ____ Yes ____ No

Contributing factors: ____

Comment: ____

____

Person submitting report: ________________________________ Date: ________________

DO NOT **place this form in the Medical Record**
SEND **this report to the** ***QUALITY MANAGEMENT OFFICE*** **ONLY**
Phone: 661-471-4239 Fax: 661-524-2984

Patient Identification

NAME:

DOB:

MRUN #: