DUNDY COUNTY HOSPITAL
SURGICAL INDICATIONS MONITORING

							January-04
Hospital No. Age - Sex	**Physician ID No.**	**X if Pt. Died**	**Pre-op Dx**	**Post-op Dx (If different than pre-op)**	**Procedure**	**Pathology Diagnosis**	**Comments* (reviewer sign & date)**

*Indicate whether surgery justified or not justified. May necessitate a chart review. if so, state findings.