Hand Help, Inc.

Screening/Diagnosis/Surgery Form

Date Screened: _____ Patient to return for surgery on: _____

Patient Name:

DOB:_____ Age:_____ Contact phone:_____

Parent/Guardian Name:

Screening Surgeon:

History:

Physical Exam:

Diagnosis:

Treatment Plan:

Date of surgery: Surgeon: Assistant:
Op Note (draw picture on reverse):

Cost of Surgery:
Surgeon: _____
Anesthesia: _____

Time out:
Patient verified:
Site verified with patient: