DATE: ***Surgery Date*** **IMD**
PATIENT: ***Last Name, First Name***
PATIENT ID #: ***6789***
DATE OF BIRTH: ***00-00-0000***
ACCOUNT #: ***12345***
SURGEON: ***Surgeon Name***
FACILITY: ***Facility Name***

PROCEDURE NOTE

SURGEON: *Surgeon Name*

ANESTHESIA: General.

PREOPERATIVE DIAGNOSIS: Biliary colic.

POSTOPERATIVE DIAGNOSIS: Biliary colic.

PROCEDURE:
1. Laparoscopic cholecystectomy with intraoperative cholangiogram (47563).
2. Interpretation of intraoperative cholangiogram (74300).

ESTIMATED BLOOD LOSS: Less than 5 cc.

COMPLICATIONS: None.

COUNTS: Correct.

BRIEF HISTORY: This is a 54-year-old while female who is referred by Dr. Glenn Hunt with biliary colic.

INFORMED CONSENT: I have discussed risks, benefits, side effects, and reasonable alternatives, including possible results of not receiving treatment, potential problems related to recuperation and the likelihood of achieving goals with the patient/caregivers. Informed consent was obtained.

PROCEDURE IN DETAIL: The patient was taken to the operating room with IV access in place. Once an adequate level of general endotracheal anesthesia was obtained and appropriate monitoring modalities attached, an orogastric tube was inserted into the stomach, PlexiPulse devices were placed on both feet and the abdomen prepped and draped. I injected the area with 0.25% Marcaine and epinephrine in the right rectus sheath at the level of the umbilicus.

A transverse incision was made and intraabdominal access gained with a 5 mm Optiview trocar. The abdomen was insufflated to the appropriate CO2 pneumoperitoneum. I injected the subxiphoid and two right subcostal positions placing a 10 and two 5 mm trocars. The gallbladder was grasped at the fundus and retracted cephalad. It was grasped at the infundibulum and retracted laterally. The cystic duct and cystic artery were circumferentially dissected. A Kumar clamp was placed across the infundibulum and a Preview cholangiogram catheter inserted.

A cholangiogram was performed, showing normal filling of the intra- and extra-hepatic bile ducts with no filling defects and normal flow of contrast into the duodenum. She did have somewhat of an anomalous anatomy with a short cystic duct and the common hepatic artery bifurcating directly over the top of the common hepatic duct.

After exposing the cystic duct and cystic artery, these structures were clipped and divided with endoscopic shears. The gallbladder was removed from its hepatic attachments with cautery and placed in an endoscopic retrieval bag. The bag was removed from the abdomen at the subxiphoid trocar site. I reinstilled the pneumoperitoneum copiously irrigating the right upper quadrant confirming hemostasis. The pneumoperitoneum was released. I closed all skin incisions with 4-0 Monocryl. The wounds were cleaned and dried and Mastisol and Steri-Strips applied as well as sterile dressing.

The patient was then taken to the recovery room in stable condition having tolerated the procedure well.

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Surgeon Name

sn/ab: Doc# 00001254/Job# 63201264
DD: 12/27/2011
DT: 12/28/2011