

41. NPA	a) <input type="checkbox"/> Yes - Recovery Only <input type="checkbox"/> Yes - Overnight <input type="checkbox"/> No b) <input type="checkbox"/> Planned <input type="checkbox"/> Unplanned
42. Recovery - Uneventful	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please specify: <input type="text"/>
43. Surgical Complications	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify: <input type="text"/>
44. Transfusions	a) <input type="checkbox"/> Yes <input type="checkbox"/> No b) If yes, please specify volume in mls: <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>

45. Anaesthesia	a) Type: <input type="text"/> Hours Mins b) Length: <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> c) Complications: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>
46. Analgesia	a) Pre op: <input type="checkbox"/> Yes <input type="checkbox"/> No ai) If yes, please specify: <input type="checkbox"/> paracetamol <input type="checkbox"/> morphine iv <input type="checkbox"/> fentanyl <input type="checkbox"/> morphine NCA b) Intra op: <input type="checkbox"/> Yes <input type="checkbox"/> No bi) If yes, please specify: <input type="checkbox"/> paracetamol <input type="checkbox"/> morphine iv <input type="checkbox"/> fentanyl <input type="checkbox"/> morphine NCA c) Post op: <input type="checkbox"/> Yes <input type="checkbox"/> No ci) If yes, please specify: <input type="checkbox"/> paracetamol <input type="checkbox"/> morphine iv <input type="checkbox"/> fentanyl <input type="checkbox"/> morphine NCA
47. Tranexamic Acid	<input type="checkbox"/> Yes <input type="checkbox"/> No
48. Steroids	<input type="checkbox"/> Yes <input type="checkbox"/> No
49. Other	<input type="text"/>

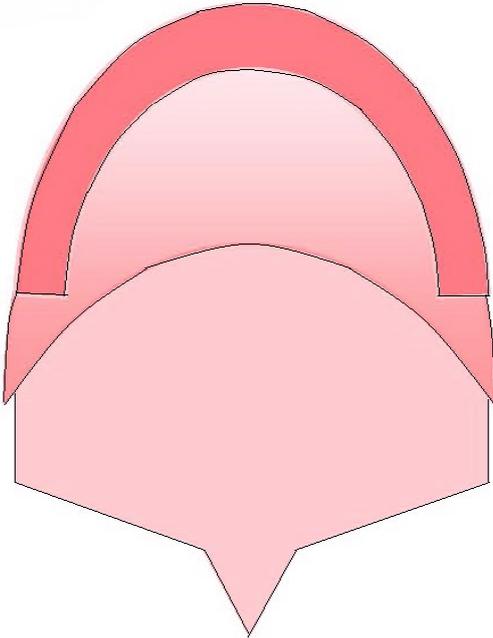
POST OP INSTRUCTIONS	
50. Antibiotics Regimen	<input type="checkbox"/> Nil <input type="checkbox"/> 24 hours post op <input type="checkbox"/> Other <input type="checkbox"/> On induction <input type="checkbox"/> 5-7 days post op (Please specify) <input type="text"/>
51. Antibiotic Drug	<input type="checkbox"/> Coamoxiclav <input type="checkbox"/> Metronidazole <input type="checkbox"/> Amoxicillin <input type="checkbox"/> Other (Please specify) <input type="text"/>
52. Arms	<input type="checkbox"/> Splints <input type="checkbox"/> Mittens <input type="checkbox"/> Nil
53. Review Arrangements	<input type="text"/>

Please turn over to complete diagrams



54. Nasal layer and muscle

a)

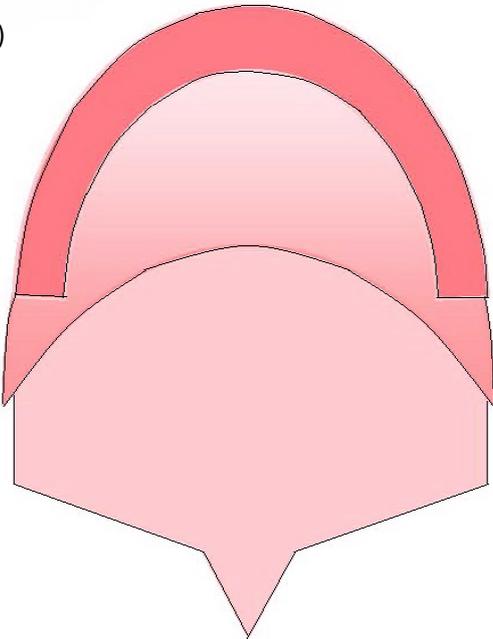


Notes

b)

55. Oral layer

a)



Notes

b)

Signature:

Date

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Name:

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