Preoperative Neurosurgical Documentation

- Mapping the Clinical Pathway for Patients Undergoing Vestibular Schwannoma Resection
- Early evaluation of a natural language processing tool to improve access to educational resources for surgical patients
- Analysis of bihemispheric language function in pediatric neurosurgical patients using repetitive navigated transcranial magnetic stimulation
- Process analysis of the patient pathway for automated data collection: an exemplar using pituitary surgery
- The Enhanced Recovery After Surgery protocol for the perioperative management of pituitary neuroendocrine tumors/pituitary adenomas
- A Contemporary Clinico-Anatomical Guide to Craniovertebral Junction Surgery
- Routine ICU admission after brain tumor surgery: retrospective validation and critical appraisal of two prediction scores
- Patient Characteristics Associated With Occurrence of Preoperative Goals-of-Care Conversations

This includes documenting the patient's medical history, physical examination findings, diagnostic test results (such as imaging studies), and the indication for surgery. It may also involve documenting the patient's consent for the procedure, discussion of potential risks and benefits, and any alternative treatment options.

Preoperative documentation refers to the process of gathering and recording information about a patient prior to a neurosurgical procedure. It involves documenting the patient's medical history, physical examination findings, diagnostic test results, and other relevant information necessary for the surgical planning and preparation. Here are some key elements of preoperative documentation:

Medical History: This includes obtaining a comprehensive medical history of the patient, including previous surgeries, medical conditions, allergies, medications, and family history of diseases. It helps to identify any underlying medical conditions that may impact the surgery or anesthesia.

Physical Examination: A thorough physical examination is conducted to assess the patient's overall health status, identify any abnormalities, and evaluate their fitness for surgery. It typically involves assessing vital signs, auscultation of the heart and lungs, examination of the abdomen, assessment of the nervous system, and evaluation of the surgical site.

Diagnostic Test Results: Preoperative documentation includes recording the results of any diagnostic tests that have been performed, such as blood tests, imaging studies (e.g., X-rays, CT scans, MRIs), electrocardiograms (ECGs), or other specialized tests. These results help in assessing the patient's baseline health and identifying any preexisting conditions or abnormalities.

Anesthesia Evaluation: If the patient will receive anesthesia during the surgery, preoperative documentation includes an evaluation by an anesthesiologist or anesthesia provider. This evaluation assesses the patient's anesthesia-related risks, airway assessment, medication allergies, and any specific anesthesia requirements or concerns.

Surgical Consent: Preoperative documentation involves obtaining the patient's informed consent for the surgical procedure. This includes explaining the nature of the surgery, its risks and benefits, and any alternative treatment options. Documentation of the patient's understanding and agreement to

proceed with the surgery is essential.

Preoperative Instructions: It is important to provide the patient with preoperative instructions, including fasting guidelines, medication instructions (such as stopping certain medications before surgery), and any specific preparations required before the procedure (e.g., bowel preparation).

Communication and Collaboration: Preoperative documentation serves as a means of communication and collaboration among healthcare providers involved in the patient's care. It ensures that the surgical team has access to all relevant information and can make informed decisions and plans for the surgery.

Accurate and thorough preoperative documentation is essential for patient safety, continuity of care, and effective communication among healthcare providers. It provides a baseline assessment of the patient's health, facilitates surgical planning, and serves as a reference point for comparison during postoperative care.