



Service: Plastics Pediatric

Care Venue: HSC Childrens

Case Details <small>*all fields are mandatory in Novari ATC</small>	Patient Name*:		DOB: MM/DD/YYYY			
	PHIN*:					
Diagnosis Category*						
<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> [C] Known Cancer <input type="checkbox"/> [C] Suspected Cancer <input type="checkbox"/> ABDOMINAL RECONSTRUCTION <input type="checkbox"/> BENIGN TUMOURS <input type="checkbox"/> BREAST PATHOLOGY (GYNECOMASTIA, HYPERMASTIA, ASYMMETRY) <input type="checkbox"/> BREAST RECONSTRUCTION, POST ONCOLOGIC RESECTION (DELAYED) <input type="checkbox"/> BREAST RECONSTRUCTION, POST ONCOLOGIC RESECTION (IMMEDIATE) <input type="checkbox"/> BURNS, FROSTBITE, NECROTIZING INFECTION" <input type="checkbox"/> CONGENITAL ABNORMALITIES <input type="checkbox"/> COSMETIC PROCEDURES </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> DISORDERS OF BONES (CRANIOFACIAL, HAND, WRIST) <input type="checkbox"/> DISORDERS OF HEAD AND NECK BONES, CARTILAGE <input type="checkbox"/> DISORDERS OF JOINTS <input type="checkbox"/> DISORDERS OF TENDONS/LIGAMENTS OF HANDS, WRIST, FEET <input type="checkbox"/> DISORDERS OF THE BRACHIAL PLEXUS, PERIPHERAL NERVES AND MUSCLES <input type="checkbox"/> INFECTIONS OF SKIN SOFT TISSUES AND HANDS <input type="checkbox"/> OTHER PLASTICS DIAGNOSES <input type="checkbox"/> RECONSTRUCTION AFTER BURNS, FROSTBITE, NECROTIZING INFECTION <input type="checkbox"/> SCARS, ULCERS AND OTHER NON-TUMOROUS LESIONS OF THE SKIN AND SUBCUT TISSUES <input type="checkbox"/> TRAUMA </td> </tr> </table>					<input type="checkbox"/> [C] Known Cancer <input type="checkbox"/> [C] Suspected Cancer <input type="checkbox"/> ABDOMINAL RECONSTRUCTION <input type="checkbox"/> BENIGN TUMOURS <input type="checkbox"/> BREAST PATHOLOGY (GYNECOMASTIA, HYPERMASTIA, ASYMMETRY) <input type="checkbox"/> BREAST RECONSTRUCTION, POST ONCOLOGIC RESECTION (DELAYED) <input type="checkbox"/> BREAST RECONSTRUCTION, POST ONCOLOGIC RESECTION (IMMEDIATE) <input type="checkbox"/> BURNS, FROSTBITE, NECROTIZING INFECTION" <input type="checkbox"/> CONGENITAL ABNORMALITIES <input type="checkbox"/> COSMETIC PROCEDURES	<input type="checkbox"/> DISORDERS OF BONES (CRANIOFACIAL, HAND, WRIST) <input type="checkbox"/> DISORDERS OF HEAD AND NECK BONES, CARTILAGE <input type="checkbox"/> DISORDERS OF JOINTS <input type="checkbox"/> DISORDERS OF TENDONS/LIGAMENTS OF HANDS, WRIST, FEET <input type="checkbox"/> DISORDERS OF THE BRACHIAL PLEXUS, PERIPHERAL NERVES AND MUSCLES <input type="checkbox"/> INFECTIONS OF SKIN SOFT TISSUES AND HANDS <input type="checkbox"/> OTHER PLASTICS DIAGNOSES <input type="checkbox"/> RECONSTRUCTION AFTER BURNS, FROSTBITE, NECROTIZING INFECTION <input type="checkbox"/> SCARS, ULCERS AND OTHER NON-TUMOROUS LESIONS OF THE SKIN AND SUBCUT TISSUES <input type="checkbox"/> TRAUMA
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If Cancer*: <input type="checkbox"/> Diagnostic <input type="checkbox"/> Treatment <input type="checkbox"/> Reconstruction <input type="checkbox"/> Prophylactic <input type="checkbox"/> Staging <input type="checkbox"/> Surveillance <input type="checkbox"/> Palliative						
Please refer to the Case Priority Criteria to complete this section						
Wait 2 Priority*: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5		Diagnosis Description:				
Consented Procedure*:				Est. Procedure Time*: <small>Default value provided by system when available</small> ____ mins		
Procedure Notes:						
DTT*: MM/DD/YYYY	Laterality*: <small>(if applicable)</small> <input type="checkbox"/> Left <input type="checkbox"/> Right	Attend Short*: <small>Patient is available on short notice as a last-minute case replacement.</small> <input type="checkbox"/> Yes <input type="checkbox"/> No	Admission Type*: <input type="checkbox"/> Day Surgery <input type="checkbox"/> Inpatient <input type="checkbox"/> Same Day Admit <input type="checkbox"/> Short Stay	Post Procedural Destination*: <small>Day Surgery</small> <input type="checkbox"/> ICU <input type="checkbox"/> Unit LOS: ____ days		
Special Instructions:						

Case Priority Criteria

Priority / Target Days	Diagnosis Description
1 (21 days)	P-CATS IIb Criteria <input type="checkbox"/> NERVE INJURIES: CLOSED
2 (42 days)	P-CATS III Criteria <input type="checkbox"/> BENIGN SOLID TUMOR
3 (64 days)	P-CATS IV Criteria <input type="checkbox"/> MICROSURGICAL RECONSTRUCTION: NON-ACUTE
4 (128 days)	P-CATS V Criteria <input type="checkbox"/> BENIGN LESIONS <input type="checkbox"/> MALE & FEMALE BREAST DEFORMITY <input type="checkbox"/> RHINOPLASTY <input type="checkbox"/> SCAR REVISION - PSYCHOLOGICAL <input type="checkbox"/> VASCULAR ANOMALIES WITHOUT FUNCTIONAL ISSUES
5 (364 days)	P-CATS VI Criteria <input type="checkbox"/> OTHER PLASTIC SURGERY
Oncology	
1 (14 days)	P-CATS IIA CANCER Criteria: <input type="checkbox"/> MALIGNANT SOLID TUMOURS <input type="checkbox"/> MALIGNANT LESIONS OF SOFT TISSUE OR SKIN <input type="checkbox"/> SOLID TUMOURS (SUSPECTED MALIGNANT) <input type="checkbox"/> LESIONS OF SOFT TISSUE OR SKIN (SUSPECTED MALIGNANT) <input type="checkbox"/> Pediatric Diagnostic Surgical Oncology Cases
2 (21 days)	P-CATS III CANCER Criteria: N/A <input type="checkbox"/> (no specific diagnosis examples or criteria) <input type="checkbox"/> Pediatric patients diagnosed with highly aggressive malignancies
3 (28 days)	P-CATS IV CANCER Criteria: N/A <input type="checkbox"/> (no specific diagnosis examples or criteria) <input type="checkbox"/> Cancer is not highly aggressive or indolent <input type="checkbox"/> Pediatric patients with suspected highly invasive Cancer
4 (42 days)	P-CATS V CANCER Criteria: N/A <input type="checkbox"/> (no specific diagnosis examples or criteria) <input type="checkbox"/> Pediatric patients diagnosed or suspected to have indolent malignancies