



# DEPARTMENT OF THE NAVY

NAVAL MEDICAL CENTER PORTSMOUTH  
DIRECTOR, SURGICAL SERVICES

You recently had an operation at Naval Medical Center Portsmouth. We are interested in how you have been feeling and whether you have experienced any health problems since your operation. Please take a few minutes to respond to the questions below. Return this letter using the enclosed self-addressed stamped envelope. Your health is important to us and if necessary, we will call for further information.

Have you been seen in a clinic or doctor's office since your surgery?  Yes  No

If "Yes" please tell us the name of the physician, the clinic name, location and date.

Were you re-admitted to a hospital within 30 days after your surgery?  Yes  No

If "Yes" please describe where and why you were readmitted.

Have you experienced any of the following complications following your surgery? Check all that apply:

<input type="checkbox"/> Wound Infection	<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Fever > 100.5	<input type="checkbox"/> Excessive Bleeding
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Sepsis (Life threatening blood infection)
<input type="checkbox"/> Blood Clot in the Lungs	<input type="checkbox"/> Additional Surgical Procedure
<input type="checkbox"/> Urinary Tract Infection	<input type="checkbox"/> Other Describe
<input type="checkbox"/> Stroke	
<input type="checkbox"/> Nerve Injury	
<input type="checkbox"/> Coma	

Is there anything else you would like us to know about your care before, during or after your recent surgery? (Use the space below and the back of this form if necessary).

Sincerely,

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