ANAESTHESIA RECORD

SURGISERVICES

Date (dd/mm/yy): ____________________
Anaesthetist: ____________________
Nurse: ____________________
Surgeon: ____________________
Dental Assistant: ____________________
Procedure: ____________________
Location: ____________________

Patient Information Gender: M F
Last Name:
First Name:
DOB (dd/mm/yy): Age:
Home Phone:
Companion's Name:
Companion's Phone: ☐ Armband

HxPI

PMHx ☐ Identity confirmed

PSHx

AnaeHx

FHx

Premeds
☐ Ibuprofen ________

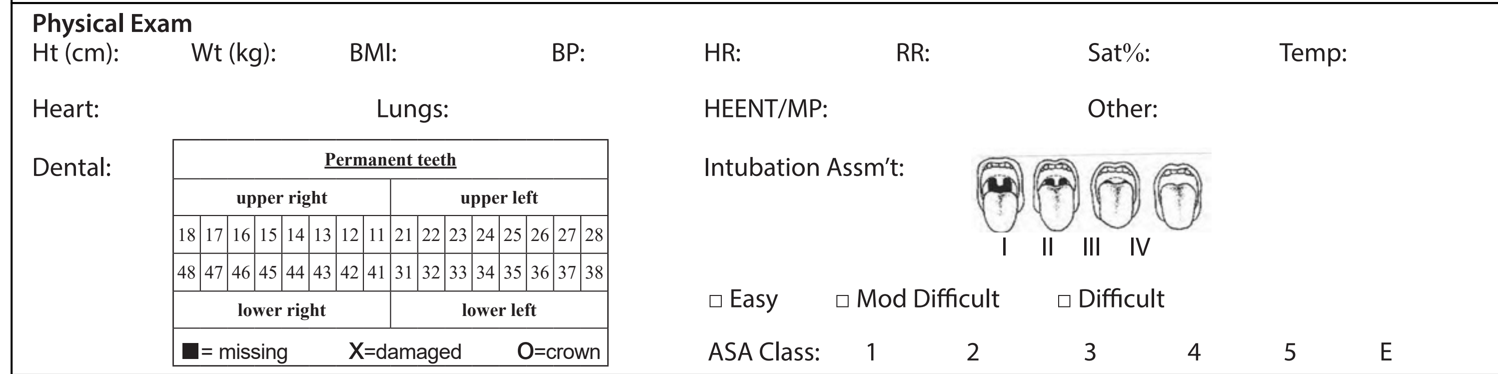
Current meds (√ = taken on schedule)

Allergies Symptoms

Sensitivities

ROS ☐ Normal ☐ Voided Number of hours since last intake of ___ clear fluids ___ light meal ___ full meal

Smoker: Y / N Pregnant: Y / N STOP-BANG Score*: N/V Score**: DVT Risk Factor***:



Physical Exam
Ht (cm): Wt (kg): BMI: BP: HR: RR: Sat%: Temp:

Heart: Lungs: HEENT/MP: Other:

Dental:

Permanent teeth															
upper right								upper left							
18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38
lower right								lower left							

■ = missing X=damaged O=crown

Intubation Assm't: I II III IV

☐ Easy ☐ Mod Difficult ☐ Difficult

ASA Class: 1 2 3 4 5 E

Investigations ☐ not indicated

Lab: EKG: Other:

Discussion ☐ ane/risks discussed ☐ dental risks disclosed ☐ questions answered ☐ informed consent obtained
Plan ☐ GA ☐ iv ind ☐ inh ind ☐ Sedation ☐ ETT ☐ LMA ☐ none
☐ parental presence at induction

☐ Healthy lifestyle counseling provided

Signature

STOP-BANG Score*
Snores loudly
Tired during daytime
Observed stopped breathing
Neck circumference > 40 cm
Male
Age > 50 yrs
BMI > 35
High BP

N/V Score**
Adult:
Female
Nonsmoking
Postop opioids
Hx PONV
motion sick
FHx PONV

Paediatric:
Procedure > 3 hrs
Age 3+
Strabismus
PONV in patient or 1st degree relative

DVT Risk Factors***
History of DVT
Age >60 years
Obesity >20% ideal weight
Hormone therapy
OR > 2 hours
Leg edema, ulcers, stasis
Hypercoagulable state
Inflamm. Bowel disease
Pregnancy
Postpartum <1 month
Malignancy

	Start	Stop
Anesthesia care		
Anesthesia		
Surgery		

Patient Name: Date: TOTAL:

PROPOFOL (mg)
PPF µg/kg/min
Sux / Roc (mg)
Decadron (mg)
Ketorolac (mg)
Ondansetron (mg)
Fentanyl (µg)
Remifentanyl (µg)
Remifentanyl (µg/kg/min)
Dexmedetomidine (µg)
LA: Bup Lido Arti Prilo Carbo % w/ Epi 1: 00K (mL)
LA: Bup Lido Arti Prilo Carbo % w/ Epi 1: 00K (mL)
N_2O / O_2 L/MIN

15 30 45 15 30 45 15 30 45

B.P. X	220
HR °	200
	180
	160
	140
Throat-pack in	120
	100
Throat-pack out ⓧ	80
	60
VAPOUR	40
	20

Sat %
$ETCO_2$
ECG
Airway Pressure
Tidal Volume / RR
Temperature (°C)
BIS or Ramsay
IV
EBL (cc)
Urine (cc)

OR:

Surgical Safety Check ☐ Briefing ☐ Timeout ☐ Debriefing **ABX** ☐ ordered ☐ not ordered **DVT** ☐ prophylaxis ☐ not ordered

Equipment/Machine ☐ checked **Monitors** ☐ EKG ☐ BP cuff ☐ Agent ☐ Pulse Ox ☐ CO_2 ☐ Temp ☐ SCVD ☐ BIS

IV site/size______________ **Technique** ☐ GA ☐ sedation ☐ minimal ☐ moderate ☐ deep **Eyes** ☐ taped ☐ checked

Induced ☐ iv ☐ inhal **Assistance** mom/dad/other_______ ☐ RN **Patient** ☐ cooperative ☐ cried ☐ combative

Arms right ☐ tucked ☐ arm boards less than 90 degrees **left** ☐ tucked ☐ arm boards less than 90 degrees

Position ☐ supine other_________________________ **Pressure points** ☐ checked ☐ padded Other______________

Mask Ventilation ☐ no PPV via mask ☐ with ease ☐ needed airway **Ventilation** ☐ spont ☐ assist ☐ controlled

Patient Name: Date:

Airway

□ Nasal Prongs □ Otrivin □ Lidocaine gel □ Oral □ Nasal □ R □ L

□ Laryngeal Mask size____

Endotracheal □ Oral □ Nasal □ R □ L □ Magills Blade size:______ □ Videolaryngoscope details: __________

ETT □ cuffed □ cuff inflated □ cuff deflated □ uncuffed

Tube type:_________ Tube Size:_________ □ cuff leak <20cm H_2O

□ throat pack

□ Cricoid Pressure

Larynx grade:

Intubation: □Easy □ Laryngospasm □ Other

Fluid Balance (mL's)

Fluid In: N/S: _______ Fluids Out: EBL: _____________

R/L: _______ Urine: _____________

Other: _______ Other: _____________

Total In: _______ Total Out: ___________ Fluid Balance:__________

Intraoperative Events □ uneventful case ETT or LMA removed in □ OR □ PACU □ awake □ deep

□ oral cavity inspected for foreign materials

To PACU via □ carried □ stretcher □ wheelchair □ walks □ recovery in OR

In PACU placed □ sitting □ supine □ laterally □ breathing well □ stable □ report to RN

PACU Admission

BP: P: RESP: □ $ETCO_2$ O_2 SAT%: Temp: Neuro: □ asleep □ arousable □ awake □ comfortable other: _________

PACU Orders

1) O_2 via FM 50% prn if Sat ≤92%
2) iv at ____ ml/hr , d/c iv when pt. awake and well
3) pain and PONV Rx per protocol
4) discharge pt. per protocol when criteria are met
5) give and explain post-anesthesia information sheet
6) d/c nasal cotton roll on R/L
7) reinforce healthy life style counseling
8) Vitals q5 min for the first 3 then q15 min until discharge (baseline vitals from preop or first anesthesia vitals if not available)

Signature: Date:

Patient Name: Date:

PACU

TIME																		
	220																	
BP V Λ	200																	
	180																	
PULSE •	160																	
	140																	
	120																	
PRE OP:	100																	
BP /	80																	
P	60																	
	40																	
ASA	20																	
	C.V.P.																	
SPON RESP/MIN																		
TEMPERATURE																		
O2 THERAPY (L/min)																		
O2 SATURATION (%)																		
PAIN SCORE 0-10																		
RN INITIAL																		
ETCO2																		

Aldrete Score	arrival	30 min
1. Activity -moves 4 extremities on command (2) -moves 2 extremities on command (1) -moves no extremities (0)		
2. Respiration -breathes deeply and coughs (2) -limited breathing (1) -apneic (0)		
3. Consciousness -fully awake (2) -arousable on calling (1) -not responsive (0)		
4. Circulation -BP within +/-20% of baseline (2) -BP within +/-30-50% of baseline (1) -BP within +/-50% of baseline (0)		
5. O_2 Sat - has sat >92% on room air (2) - needs O_2 to keep O_2 Sat >90% (1) - sat <90% even with O_2 (0)		
TOTAL		

DISCHARGE CRITERIA SCORE	**circle appropriate level**	
Vital signs	Within 20% of pre-op baseline	2
	20-40% of pre-op baseline	1
	40% of pre-op baseline	0
Activity	Steady, no dizziness, as pre-op	2
	Requires assistance	1
	Unable to ambulate	0
PONV	Minimal	2
	Moderate	1
	Severe	0
Pain	Minimal or no pain	2
	Moderate	1
	Severe	0
Bleeding	Minimal	2
	Moderate	1
	Severe	0
Total		________

PACU Notes

Medications given:

If pediatric (<18 y/o)	0	1	2	3	4
1. Eye contact?	Extremely	Very much	Quite a bit	A little	Not at all
2. Action purposeful?	Extremely	Very much	Quite a bit	A little	Not at all
3. Aware of surroundings?	Extremely	Very much	Quite a bit	A little	Not at all
4. Restless?	Not at all	A little	Quite a bit	Very much	Extremely
5. Inconsolable?	Not at all	A little	Quite a bit	Very much	Extremely
				TOTAL DELIRIUM SCORE	

□ Postsurgical care instructions explained and given

□ Discharge instructions explained and copy given

□ cotton roll from nose out □ iv out □ amnestic

□ satisfied □ QI data entered

Nausea? □ yes □ no

Vomiting? □ yes □ no

Discharge Time: **To the care of:** **Signature RN:** **Signature MD:**

F/U call date: time: Remarks: Signature: