

# ANAESTHESIA RECORD



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

<b>Patient Information</b>	Gender: M F
Last Name: _____	
First Name: _____	
DOB (dd/mm/yy): _____	Age: _____
Home Phone: _____	
Companion's Name: _____	
Companion's Phone: _____	<input type="checkbox"/> Armband

<b>HxPI</b>	<b>PMHx</b> <input type="checkbox"/> Identity confirmed
Requested modality <input type="checkbox"/> Sedation <input type="checkbox"/> General Anesthesia	
Reason: <input type="checkbox"/> Anxiety <input type="checkbox"/> Dental phobia <input type="checkbox"/> Unable to cooperate <input type="checkbox"/> Case Complexity	

<b>PSHx</b>	<b>AnaeHx</b>	<b>FHx</b>
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<b>Premeds</b> <input type="checkbox"/> Ibuprofen _____	<b>Current meds</b> (√ = taken on schedule)	<b>Allergies</b>	<b>Symptoms</b>
		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: 

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

<b>STOP-BANG Score*</b> Snore loudly Tired during daytime Observed stopped breathing Neck circumference > 40 cm	Male Age > 50 yrs BMI > 35 High BP	<b>N/V Score**</b> <b>Adult:</b> Female Nonsmoking Postop opioids Hx PONV motion sick FHx PONV	<b>Paediatric:</b> Procedure > 3 hrs Age 3+ Strabismus PONV in patient or 1 <sup>st</sup> degree relative	<b>DVT Risk Factors***</b> 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
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	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 <sub>2</sub> O / O <sub>2</sub> 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 %										
FiO <sub>2</sub>										
ETCO <sub>2</sub>										
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 / FiO<sub>2</sub>  Pulse Ox  CO<sub>2</sub>  
 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  
ETT  cuffed     cuff inflated     cuff deflated  
Tube type:\_\_\_\_\_ Tube Size:\_\_\_\_\_

Magills Blade size:\_\_\_\_\_       Videolaryngoscope details: \_\_\_\_\_  
 uncuffed  
 cuff leak <20cm H<sub>2</sub>O  
 throat pack

Cricoid Pressure

Larynx grade:



Intubation:     Easy                       Laryngospasm                       Other

**Fluid Balance (mL's)**

Fluid In: N/S: \_\_\_\_\_  
R/L: \_\_\_\_\_  
Other: \_\_\_\_\_

Fluids Out: EBL: \_\_\_\_\_  
Urine: \_\_\_\_\_  
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<sub>2</sub>                      O<sub>2</sub> SAT%:                      Temp:                      Neuro:  asleep  
 arousable  
 awake  
 comfortable  
other: \_\_\_\_\_

- PACU Orders**
- 1) O<sub>2</sub> 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:

