

# ANAESTHESIA RECORD

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

**Patient Information**  
 Last Name: \_\_\_\_\_  
 First Name: \_\_\_\_\_  
 DOB (dd/mm/yy): \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Companion's Name: \_\_\_\_\_  
 Companion's Phone: \_\_\_\_\_

Gender: M F  
 Age: \_\_\_\_\_  
 Armband

<b>HxPI</b>	<b>PMHx</b> <input type="checkbox"/> Identity confirmed
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<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\*\*\*: \_\_\_\_\_

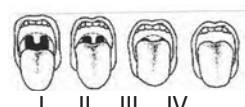
**Physical Exam**

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							
<input type="checkbox"/> = missing <input checked="" type="checkbox"/> = damaged <input type="checkbox"/> = crown															

Intubation Assm't: 

Easy     Mod Difficult     Difficult

ASA Class:    1    2    3    4    5    E

**Investigations**  not indicated

Lab: \_\_\_\_\_    EKG: \_\_\_\_\_    Other: \_\_\_\_\_

**Discussion Plan**

ane/risks discussed     dental risks disclosed     questions answered     informed consent obtained

GA     iv ind     inh ind     Sedation     ETT     LMA     none

parental presence at induction

Healthy lifestyle counseling provided

Signature \_\_\_\_\_

<b>STOP-BANG Score*</b> Snores 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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Patient Name:

Date:

**Airway**

Nasal Prongs       Otrivin       Lidocaine gel       Oral       Nasal       R       L

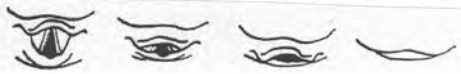
Laryngeal Mask size\_\_\_\_\_

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:

