

SEDATION CLINICAL RECORD

DATE:

GENERAL INFORMATION

PATIENT IDENTIFICATION

PROCEDURES:

Venipuncture Start
By:

Time:

Device:

Site:

Provider Information and Signature:

Staff Information and Signature:

Monitor/Assistant

SEDATION DATA

TIME

TOTALS

AGENTS

USED

DISCARDED

FLUIDS

l/min

% N₂O

l/min

% O₂

SaO₂ %

RESPONSIVENESS

ECG

LEGEND

BP v
 ^
PULSE ■
RESP o

Analg Equip Tested
_____ Procedure Start Time

_____ Procedure End Time
MONITORS (Check)

- BP Cuff
- Auto BP Cuff
- Precordial Stethoscope
- ECG
- Pulse Oximeter
- Visual
- Other

REMARKS:

DISCHARGE DATA

CONDITION ON RELEASE (Check one or more)

- Alert / Reactive
- Vital Signs Stable / Spontaneous Respirations
- Sedated But Arousable / Vital Signs Stable

DISPOSITION (Check One)

Discharge to care of:

Transfer to Recovery Room / APU / Observation Area

Other:

POST-OP INSTRUCTIONS TO:

Patient Escort
Followup Appt Date/Time Time of Release

ALDRETE SCORE (Circle)

Activity 0 1 2
Respiration 0 1 2
Circulation 0 1 2
Consciousness 0 1 2
Color 0 1 2

TOTAL SCORE

SaO₂ %

(Room Air)

PREANESTHETIC ASSESSMENT FOR CONSCIOUS SEDATION							
HISTORY		Age: _____	Height: _____	Weight: _____	Date: _____		
AF FORM 696, REVIEWED?	<input type="checkbox"/> YES <input type="checkbox"/> NO	ALLERGIES <input type="checkbox"/> NKDA		CURRENT MEDICATIONS: <input type="checkbox"/> NONE			
FAMILY HISTORY Major Illnesses: _____			Anesthetic Complications <input type="checkbox"/> Yes <input type="checkbox"/> No		PREVIOUS ANESTHESIA OR SURGERY <input type="checkbox"/> None		
HABITS		Tobacco: _____		Alcohol: _____		Drugs: _____	Other: _____
AIRWAY		RESPIRATORY		CARDIAC		OB-GYN	
Nasal Congestion: Snoring: Sleep Apnea: Neck Injury:		Asthma: Bronchitis: Pneumonia: Emphysema:		MI: HTN: Angina: CHF: Murmur:		Does the Patient Deny Possibility of Pregnancy Now? YES <input type="checkbox"/> NO <input type="checkbox"/> LMP: _____	
PHYSICAL EXAMINATION		Pulse	BP /	Resp	Temp	O2 SAT -- Rm Air	
AIRWAY			BREATHING		CIRCULATION		OTHER SYSTEM EXAM
Tongue <input type="checkbox"/> Normal <input type="checkbox"/> Enlarged Pharynx <input type="checkbox"/> Visible <input type="checkbox"/> Hidden Nasal Airway <input type="checkbox"/> Clear <input type="checkbox"/> Obstructed			Resp Sounds <input type="checkbox"/> Quiet <input type="checkbox"/> Noisy Resp Effort <input type="checkbox"/> Easy <input type="checkbox"/> Labored		Color <input type="checkbox"/> Normal <input type="checkbox"/> Pale <input type="checkbox"/> Dusky Pulse <input type="checkbox"/> Regular <input type="checkbox"/> Irregular		A B C D E
Other Airway Exam		Other Pulmonary Exam		Other Cardiac Exam		ASA Classification	
PREOP DIAGNOSIS		ANESTHESIA PLAN			REASON FOR CHOICE OF ANESTHESIA		
		<input type="checkbox"/> N2O/O2 <input type="checkbox"/> Conscious Sedation <input type="checkbox"/> Local Anes <input type="checkbox"/> Physician Consult			<input type="checkbox"/> Patient Choice <input type="checkbox"/> Pain Control <input type="checkbox"/> Anxiety Control		
INFORMED CONSENT HANDWRITTEN STATEMENT							
Premedication <input type="checkbox"/> NONE		----- ----- ----- ----- -----					
Provider Information				Provider Signature			Date
IMMEDIATE PREPROCEDURE ASSESSMENT		Date	Time	Pulse	Blood Pressure	Resp	Temp
				/			
Interval Changes Since Preanesthetic Assessment: <input type="checkbox"/> YES Explain: _____ <input type="checkbox"/> NO				Did Patient Take Required Premedication? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A			
Patient Has Been NPO Hours _____		Does the Patient Deny Possibility of Pregnancy Now? NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO			Are There Any Modifications to the Anesthetic or Surgical Plans? <input type="checkbox"/> YES <input type="checkbox"/> NO		
PATIENT IDENTIFICATION			Remarks:			Lab Data:	
						Test	Date
						Result	