

|                                                                                                                                                                                                                                                                                                                                                                                                                                                            |    |    |     |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                        |                                                                                                                                                                                                                                                                                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|----|-----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Age                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Ht | Wt | BMI | <b>CARDIAC</b> <input type="checkbox"/> NRML<br><input type="checkbox"/> Pacemaker <input type="checkbox"/> AICD <input type="checkbox"/> A Fib<br><input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> CHF <input type="checkbox"/> Stents<br><input type="checkbox"/> MI <input type="checkbox"/> CAD <input type="checkbox"/> Stress test<br><input type="checkbox"/> HTN <input type="checkbox"/> Murmurs |                                                                                                                        |                                                                                                                                                                                                                                                                                                              |
| <b>Diagnosis</b><br>Free Text Entry                                                                                                                                                                                                                                                                                                                                                                                                                        |    |    |     | <b>PULMONARY</b> <input type="checkbox"/> NRML<br><input type="checkbox"/> Asthma <input type="checkbox"/> SOB <input type="checkbox"/> Tobacco use<br><input type="checkbox"/> COPD <input type="checkbox"/> CPAP <input type="checkbox"/> Sleep apnea                                                                                                                                                                   |                                                                                                                        |                                                                                                                                                                                                                                                                                                              |
| <b>Procedure</b><br>Free Text Entry                                                                                                                                                                                                                                                                                                                                                                                                                        |    |    |     | <b>GI / HEPATIC</b> <input type="checkbox"/> NRML<br><input type="checkbox"/> PONV risk <input type="checkbox"/> Recreational drug use<br><input type="checkbox"/> GERD <input type="checkbox"/> Hepatitis <input type="checkbox"/> EtOH                                                                                                                                                                                  |                                                                                                                        |                                                                                                                                                                                                                                                                                                              |
| <b>Medications</b> <input type="checkbox"/> See MAR for list and doses                                                                                                                                                                                                                                                                                                                                                                                     |    |    |     | <b>NEURO</b> <input type="checkbox"/> NRML<br><input type="checkbox"/> Seizures <input type="checkbox"/> Migraines <input type="checkbox"/> Chronic pain<br><input type="checkbox"/> CVA/TIA <input type="checkbox"/> Neuropathy <input type="checkbox"/> MS <input type="checkbox"/> MG <input type="checkbox"/> ALS                                                                                                     |                                                                                                                        |                                                                                                                                                                                                                                                                                                              |
| <b>Allergies</b> <input type="checkbox"/> None <input type="checkbox"/> Latex <input type="checkbox"/> PCN <input type="checkbox"/> Sulfa                                                                                                                                                                                                                                                                                                                  |    |    |     | <b>RENAL/GU</b> <input type="checkbox"/> NRML<br><input type="checkbox"/> ARF <input type="checkbox"/> Peritoneal dialysis<br><input type="checkbox"/> CKD <input type="checkbox"/> Hemodialysis                                                                                                                                                                                                                          | <b>ENDOCRINE</b> <input type="checkbox"/> NRML<br><input type="checkbox"/> DM <input type="checkbox"/> Thyroid disease |                                                                                                                                                                                                                                                                                                              |
| <b>Surgical History</b> <input type="checkbox"/> None Prior anes comp: <input type="radio"/> Yes <input type="radio"/> No<br>FHx of anes comp: <input type="radio"/> Yes <input type="radio"/> No                                                                                                                                                                                                                                                          |    |    |     | <b>HEME/ONCOLOGY</b> <input type="checkbox"/> NRML<br><input type="checkbox"/> Anemia <input type="checkbox"/> Sickle cell<br><input type="checkbox"/> Bleeding disorder <input type="checkbox"/> Cancer                                                                                                                                                                                                                  |                                                                                                                        |                                                                                                                                                                                                                                                                                                              |
| <b>Labs</b> <input type="checkbox"/> Labs checked<br><div><div>WBC</div><div>Hgb</div><div>Hct</div><div>Plt</div><div>Na</div><div>Cl</div><div>BUN</div><div>Gr</div><div>K</div><div>CO2</div><div>Gluc</div><div>INR</div><div>PT</div><div>PTT</div></div> <div>GFR: _____<br/>Alb: _____<br/>Mg: _____<br/>CXR: _____<br/>EKG: _____<br/>Echo: _____<br/>Cath: _____</div> <div>HcG: <input type="checkbox"/> Pos <input type="checkbox"/> Neg</div> |    |    |     | <b>MUSCULOSKELETAL</b> <input type="checkbox"/> NRML<br><input type="checkbox"/> RA <input type="checkbox"/> Arthritis<br><input type="checkbox"/> Hypotonia <input type="checkbox"/> Fibromyalgia                                                                                                                                                                                                                        |                                                                                                                        | <b>PSYCHOSOCIAL</b> <input type="checkbox"/> NRML<br><input type="checkbox"/> Bipolar <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> PTSD<br><input type="checkbox"/> Panic Disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> ADD/ADHD |
| <b>PEDS</b> <input type="checkbox"/> NRML<br><input type="checkbox"/> Prematurity <input type="checkbox"/> Apnea                                                                                                                                                                                                                                                                                                                                           |    |    |     | <b>COMORBIDITY CODES</b> <input type="checkbox"/> Case cancelled prior to day of surgery                                                                                                                                                                                                                                                                                                                                  |                                                                                                                        |                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                            |    |    |     | <b>Pre-Eval by:</b> ID #1 SIGNATURE DATE / TIME                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                        |                                                                                                                                                                                                                                                                                                              |
| <b>WEEKS GESTATION</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |    |    |     |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                        |                                                                                                                                                                                                                                                                                                              |

|                                                                                                                                                                                                                                                                                                                                                           |      |                                                                                                                                                                                                                                                                                                                               |    |                                                                                                                                                                   |                                                                                      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| <b>PreProc Eval (Must be completed the day of surgery)</b>                                                                                                                                                                                                                                                                                                |      |                                                                                                                                                                                                                                                                                                                               |    |                                                                                                                                                                   |                                                                                      |
| BP                                                                                                                                                                                                                                                                                                                                                        | SpO2 | HR                                                                                                                                                                                                                                                                                                                            | RR | Temp                                                                                                                                                              | NPO: Solids 8 hrs<br>Clears 2 hrs <input type="radio"/> Yes <input type="radio"/> No |
| Mallampati: <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> Unable                                                                                                                                                                                                                  |      | Teeth: <input type="checkbox"/> Multiple missing <input type="checkbox"/> Loose <input type="checkbox"/> Chipped <input type="checkbox"/> Neck ROM: <input type="radio"/> Normal <input type="radio"/> Limited <input type="checkbox"/> Pulmonary: <input type="radio"/> Clear/Equal Bilat <input type="radio"/> Abnrm: _____ |    | Dent: <input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> Upper <input type="checkbox"/> Lower                                |                                                                                      |
|                                                                                                                                                                                                                                                                                                                                                           |      | Cardiac: <input type="radio"/> RRR, no murmurs <input type="radio"/> Abnrm: _____                                                                                                                                                                                                                                             |    | DoS changes: _____                                                                                                                                                |                                                                                      |
|                                                                                                                                                                                                                                                                                                                                                           |      |                                                                                                                                                                                                                                                                                                                               |    | <input type="checkbox"/> General <input type="checkbox"/> Regional <input type="checkbox"/> Epidural <input type="checkbox"/> MAC <input type="checkbox"/> Spinal |                                                                                      |
|                                                                                                                                                                                                                                                                                                                                                           |      |                                                                                                                                                                                                                                                                                                                               |    | ASA E <input type="checkbox"/>                                                                                                                                    |                                                                                      |
| I have explained the anesthetic plan, options, and pertinent complications including when appropriate: death, severe neurologic impairment and blindness. The patient and/or legal guardian has communicated to me an understanding of both the anesthetic plan and inherent risks. Patient history reviewed. <input type="checkbox"/> Translator present |      |                                                                                                                                                                                                                                                                                                                               |    |                                                                                                                                                                   |                                                                                      |
| ID#                                                                                                                                                                                                                                                                                                                                                       |      | SIGNATURE                                                                                                                                                                                                                                                                                                                     |    | DATE TIME                                                                                                                                                         |                                                                                      |

ANESTHESIA PRE-OP

## CONSENT FOR ANESTHESIA SERVICES

I acknowledge that my doctor has explained to me that I will have an operation, diagnostic or treatment procedure. My doctor has explained the risks of the procedure advised me of alternative treatments and told me about the expected outcome and what could happen if my condition remains untreated. I also understand that anesthesia services are needed so that my doctor can perform the operation or procedure.

It has been explained to me that all forms of anesthesia involve some risks and no guarantees or promises can be made concerning the results of my procedure or treatment. Although rare, unexpected severe complications with anesthesia can occur and include the remote possibility of infection, bleeding, drug reactions, blood clots,

loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack, or death. I understand that these risks apply to all forms of anesthesia and that additional or specific risks have been identified below as they may apply to a specific type of anesthesia. I understand that the type(s) of anesthesia service checked below will be used for my procedure and that the anesthetic technique to be used is determined by many factors including my physical condition, the type of procedure my doctor is to do, his or her preference, as well as my own desire. It has been explained to me that sometimes an anesthesia technique which involves the use of local anesthetics, with or without sedation, may not succeed completely and therefore another technique may have to be used including general anesthesia.

|                                                                                                                                                 |                                       |                                                                                                                                                                                                                                                                                                                                                                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> General Anesthesia                                                                                                     | Expected Result<br>Technique<br>Risks | Total unconscious state, possible placement of a tube into the windpipe<br>Drug injected into bloodstream, breathed into the lungs, or by other routes<br>Mouth or throat pain, hoarseness, injury to mouth or teeth, awareness under anesthesia, injury to blood vessels, aspiration, pneumonia.                                                                        |
| <input type="checkbox"/> Spinal or Epidural<br><input type="checkbox"/> With sedation<br><input type="checkbox"/> Without sedation              | Expected Result<br>Technique<br>Risks | Temporary decreased or loss of feeling and/or movement to lower part of the body<br>Drug injected through a needle/catheter placed either directly into the spinal canal or immediately outside the spinal canal<br>Headache, backache, buzzing in the ears, convulsions, infection, persistent weakness, numbness, residual pain, injury to blood vessels, total spinal |
| <input type="checkbox"/> Major/ Minor Nerve Block<br><input type="checkbox"/> With sedation<br><input type="checkbox"/> Without sedation        | Expected Result<br>Technique<br>Risks | Temporary loss of feeling and/or movement of a specific limb or area<br>Drug injected near nerves providing loss of sensation to the area of the operation<br>Infection, convulsions, weakness, persistent numbness, residual pain, injury to blood vessels                                                                                                              |
| <input type="checkbox"/> Intravenous Regional Anesthesia<br><input type="checkbox"/> With sedation<br><input type="checkbox"/> Without sedation | Expected Result<br>Technique<br>Risks | Temporary loss of feeling and/or movement of a limb<br>Drug injected into veins of arm or leg while using a tourniquet<br>Infection, convulsions, persistent numbness, residual pain, injury to blood vessels                                                                                                                                                            |
| <input type="checkbox"/> Monitored Anesthesia Care<br><input type="checkbox"/> With sedation                                                    | Expected Result<br>Technique<br>Risks | Reduced anxiety and pain, partial or total amnesia<br>Drug injected into the bloodstream, breathed into the lungs, or by other routes producing a semi-conscious state<br>An unconscious state, depressed breathing, injury to blood vessels, aspiration, pneumonia                                                                                                      |
| <input type="checkbox"/> Monitored Anesthesia Care<br><input type="checkbox"/> Without sedation                                                 | Expected Result<br>Technique<br>Risks | Measure of vital signs, availability of anesthesia provider for further intervention<br>None<br>Increased awareness, anxiety and/or discomfort                                                                                                                                                                                                                           |

I hereby consent to the anesthesia service checked above and authorize that it be administered by those who are privileged to provide anesthesia services at \_\_\_\_\_.

I consent to an alternative type of anesthesia, if necessary, as deemed appropriate by them. I also consent for additional trained personnel (i.e. RT, RN, EMS) to perform tasks deemed

appropriate (i.e. Intubation, IV start, etc.) under the direct supervision of the surgeon/anesthesia provider.

I certify and acknowledge that I have read this form or had it read to me, that I understand the risks, alternatives and expected result of the anesthesia service; and that I had ample time to ask questions and to consider my decision.

|                                              |      |      |
|----------------------------------------------|------|------|
| SIGNATURE (Patient / Patient Representative) | DATE | TIME |
| <div>Patient</div> _____                     |      |      |
| (PRINT)                                      |      |      |

☐ See Spanish consent

|    |                      |             |
|----|----------------------|-------------|
| ID | SIGNATURE (Provider) | DATE / TIME |
|    |                      |             |

|                     |      |      |
|---------------------|------|------|
| SIGNATURE (Witness) | DATE | TIME |
| _____               |      |      |
| (PRINT)             |      |      |



ANESTHESIA CONSENT

## CONSENTIMIENTO PARA SERVICIOS DE ANESTESIA

Yo reconozco que mi médico me ha explicado que tendré una operación, diagnóstico o procedimiento. Mi Médico me ha explicado los riesgos del pro- cedimiento, me ha explicado los tratamientos alternativos y me ha informado sobre los resultados que se esperan, así como lo que pudiera suceder si mi condición continúa sin tratamiento alguno. Yo entiendo también que se necesitan servicios de anestesia para que mi médico pueda efectuar la cirugía o el procedimiento.

Se me ha explicado que todos los tipos de anestesia involucran ciertos riesgos y que no se pueden otorgar garantías o promesas relacionadas a los resultados de mi procedimiento o tratamiento. Aunque raramente, pueden suceder complicaciones severas con la anestesia y existe la remota posibilidad de infección, sangrado, reacción a las

drogas, coágulo de sangre, pérdida de sensación, pérdida de función en las extremidades, parálisis, embolia, daño cerebral, ataque al corazón o muerte. Yo entiendo que todos estos riesgos se aplican a todos los tipos de anestesia y que riesgos específicos o adicionales han sido identificados a continuación, al poder ellos ser aplicables a ciertos tipos de anestesia. Yo entiendo que el tipo de servicio de anestesia indicado a continuación será utilizado en mi operación y que la técnica anestésica será deter- minada basada en varios factores, incluyendo mi condición física, el tipo de procedimiento que mi médico efectuará, su preferencia, así como mi propia elección. Se me ha explicado que a veces una técnica anestésica que involucra el uso de anestésicos locales, con o sin sedación, puede no ser completamente exitosa y por lo tanto otra técnica tendrá que ser usada, incluyendo la anes. general.

|                                                                                                                                           |                                            |                                                                                                                                                                                                                                                                                                                                                                                                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Anestesia General                                                                                                | Resultados Esperados<br>Técnica<br>Riesgos | Estado total inconsciente, posible colocación de un tubo dentro de la tráquea.<br>Droga inyectada dentro del flujo sanguíneo, inhalada a los pulmones, o por otras vías.<br>Dolor en la boca o garganta, ronquera, daño en la boca o dientes, conciencia durante la anestesia, daño a los vasos sanguíneos, aspiración, neumonía.                                                                                         |
| <input type="checkbox"/> Espinal o Epidural<br><input type="checkbox"/> Con sedación<br><input type="checkbox"/> Sin sedación             | Resultados Esperados<br>Técnica<br>Riesgos | Disminución temporaria o pérdida de sensación y/o movimiento de la parte inferior del cuerpo.<br>Drug injected through a needle/catheter placed either directly into the spinal canal or immediately outside the spinal canal<br>Dolor de cabeza, dolor de espalda, zumbido en los oídos, convulsiones, infección, debilidad per- sistente, adormecimiento, dolor residual, daño a los vasos sanguíneos, "total espinal". |
| <input type="checkbox"/> Mayor/Menor Bloqueo Nervioso<br><input type="checkbox"/> Con sedación<br><input type="checkbox"/> Sin sedación   | Resultados Esperados<br>Técnica<br>Riesgos | Pérdida temporal de sensación y/o movimiento de una extremidad específica o área.<br>Droga inyectada cerca de los nervios que causa pérdida de sensación en el área de la operación.<br>Infección, convulsiones, debilidad, persistente adormecimiento, dolor residual, daño a los vasos san- guíneos.                                                                                                                    |
| <input type="checkbox"/> Anestesia Regional Intravenosa<br><input type="checkbox"/> Con sedación<br><input type="checkbox"/> Sin sedación | Resultados Esperados<br>Técnica<br>Riesgos | Pérdida temporal de sensación y/o movimiento de una extremidad.<br>Droga inyectada en las venas del brazo o pierna mientras se usa un torniquete.<br>Infección, convulsiones, adormecimiento persistente, dolor residual, daño a los vasos                                                                                                                                                                                |
| <input type="checkbox"/> Cuidado de Anestesia Monitoreado<br><input type="checkbox"/> Con sedación                                        | Resultados Esperados<br>Técnica<br>Riesgos | Dolor y ansiedad reducida, amnesia parcial o total.<br>Droga inyectada dentro del fl ujo sanguíneo, inhalada a los pulmones, o por otras vías produciendo un estado semiconsciente.<br>Un estado inconsciente, falta de aire, daño a los vasos sanguíneos.                                                                                                                                                                |
| <input type="checkbox"/> Cuidado de Anestesia Monitoreado<br><input type="checkbox"/> Sin sedación                                        | Resultados Esperados<br>Técnica<br>Riesgos | Medición de signos vitales, disponibilidad de un proveedor de anestesia para inmediata intervención.<br>Ninguna.<br>Aumento del estado de conciencia, ansiedad y/o incomodidad.                                                                                                                                                                                                                                           |

Yo doy mi consentimiento para el servicio de anestesia seleccionado en este formulario y autorizo para que sea administrado por o su asociado, quienes tienen credenciales para proveer servicios de anestesia

RN, EMS) realice las tareas que se consideren apropiadas (es decir, la intubación, el inicio IV, etc.) bajo la supervisión directa del cirujano/proveedor de anestesia.

Yo también doy mi consentimiento para el uso de un tipo alternativo de anestesia, si fuera necesario, determinado por ellos. También doy mi consentimiento para que el personal entrenado adicional (es decir, RT,

Yo certifico y admito que he leído este formulario o que ha sido leído para mí, que entiendo los riesgos, alternativas y resultados espera- dos de los servicios de anestesia y que he tenido suficiente tiempo para efectuar preguntas y considerar mi decisión.

|                                                                                             |       |      |
|---------------------------------------------------------------------------------------------|-------|------|
| Firma (del Paciente o del Representante)                                                    | FECHA | HORA |
|  (PRINT) |       |      |

|                     |       |      |
|---------------------|-------|------|
| Firma (del Testigo) | FECHA | HORA |
| (PRINT)             |       |      |

☐ See English consent

|    |                      |            |
|----|----------------------|------------|
| ID | Firma (del Provider) | FECHA/HORA |
|    |                      |            |



ANESTHESIA CONSENT

GRAPHIC HEALTH

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BMI

AGE

HT

WT

ALLERGY

☐ NKDA

☐ Latex

☐ PCN

☐ Sulfa

Time

O2 (L/min)

N2O/AIR (L/min)

FIO2

IA: / E (%)

SpO2

EtCO2

ECG

Temp

TOF

BIS

Vt

Mode

PIP/PEEP

(#)

TOTAL

WST

COMMENTS

COMMENTS

|                                                                                                                                                                                                                                                                                                               |       |       |                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |      |                         |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|-------|--------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-------------------------|--|--|
| EXTRA LOCATIONS                                                                                                                                                                                                                                                                                               |       |       |                          |  | <b>ARTERIAL LINE</b> <span style="float: right;">Code:</span><br>Sterile tech used: <span style="margin-left: 20px;"><input type="radio"/> Left <input type="radio"/> Right</span> <span style="float: right;">Code:</span><br>Indication: <input type="checkbox"/> Hemodynamic instability anticipated <input type="checkbox"/> Sample Analysis<br><input type="checkbox"/> 20g Arrow Cath cannulated the artery, then secured with tegaderm and tape.                                                                                                                                                                                                                                                                                                                                                                                        |      |                         |  |  |
| #1                                                                                                                                                                                                                                                                                                            |       | Start | Time Out                 |  | <b>CENTRAL LINE</b> <span style="float: right;">Code:</span><br>Sterile tech used: <span style="margin-left: 20px;"><input type="radio"/> Left <input type="radio"/> Right</span> <span style="float: right;">Code:</span><br><input type="checkbox"/> Line placed in OR <input type="checkbox"/> Other: _____<br><input type="checkbox"/> Catheter 7F 15 cm <input type="checkbox"/> 9F 10cm MAC <input type="checkbox"/> _____<br><input type="checkbox"/> Time out performed. Trendelenburg position, and 18g needle cannulated vein. Venous cannulation confirmed, dark non-pulsatile blood flow. J wire threaded through the needle then removed. Skin nick, dilator over wire and removed. Catheter threaded over the wire. Wire removed. Ports aspirated and flushed. Sutured in at _____ cm. Covered with sterile tegaderm.            |      |                         |  |  |
| #2                                                                                                                                                                                                                                                                                                            |       |       | <input type="checkbox"/> |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |      |                         |  |  |
| EXTRA SURGEONS                                                                                                                                                                                                                                                                                                |       |       |                          |  | Start                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Stop | ID# SIGNATURE DATE TIME |  |  |
| #1                                                                                                                                                                                                                                                                                                            |       |       |                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |      |                         |  |  |
| #2                                                                                                                                                                                                                                                                                                            |       |       |                          |  | <b>NEURAXIAL</b> <span style="float: right;">Start: End: <input type="checkbox"/> Time Out</span><br><input type="radio"/> PostOp pain control per surgeon <input type="radio"/> Surgical/Labor analgesia<br>REQUESTED BY: <span style="float: right;">Surg #1 U/S Used <input type="radio"/> Yes <input type="radio"/> No</span><br>SPINAL BLOCK: POSITION: Sit / LLD / RLD<br>APPROACH: Central / Right / Left / Paramedian<br>INTERSPACE: T10 - T11 - T12 - L1 - L2 - L3 - L4 - L5 Other: _____<br>PREP: Beta / Alc / HIB / CHP Draped: Y / N<br>LOCAL WHEEL: Y / N 1% Lidocaine Vol: _____ mL<br>NEEDLE TYPE: Epidural: Tuohy Size: 17G / 18G<br>Spinal: Pencil Point / Cutting Size: 22G / 25G / 27G<br>Blood: Y / N Paresth: Y / N Resolved: Y / N CSF: Y / N<br>LOR: Air / NS at _____ cm Aspiration: Neg / Pos<br>Test dose: Neg / Pos |      |                         |  |  |
| ADDITIONAL PROCEDURES                                                                                                                                                                                                                                                                                         |       |       |                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |      |                         |  |  |
| #1                                                                                                                                                                                                                                                                                                            | Code: |       |                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |      |                         |  |  |
| #2                                                                                                                                                                                                                                                                                                            | Code: |       |                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |      |                         |  |  |
| #3                                                                                                                                                                                                                                                                                                            | Code: |       |                          |  | Medications Time Wst<br>Catheter secured at: _____ cm<br>Dressing: Tegaderm / Op-Site<br>Sensory level adequate: Y / N<br>Infusion Rate: _____<br>Block compl at: _____<br>Epidural D/C'd: Y / N<br>(See RN notes for removal time)<br>Tip intact: Y / N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |      |                         |  |  |
| ADDITIONAL ANESTHESIA PROVIDERS                                                                                                                                                                                                                                                                               |       |       |                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |      |                         |  |  |
| #4                                                                                                                                                                                                                                                                                                            |       |       |                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |      |                         |  |  |
| #5                                                                                                                                                                                                                                                                                                            |       |       |                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |      |                         |  |  |
| #6                                                                                                                                                                                                                                                                                                            |       |       |                          |  | ABORTED: <span style="float: right;">Free Text</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |      |                         |  |  |
| #7                                                                                                                                                                                                                                                                                                            |       |       |                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |      |                         |  |  |
| <input type="checkbox"/> Field Avoidance Indicator <span style="float: right;">Code:</span><br><input type="checkbox"/> Deliberate Hypotension per surgeon's request <span style="float: right;">Code:</span><br><input type="checkbox"/> Unusual Position Indicator <span style="float: right;">Code:</span> |       |       |                          |  | ID# SIGNATURE DATE TIME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |      |                         |  |  |
| COMMENTS                                                                                                                                                                                                                                                                                                      |       |       |                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |      |                         |  |  |

## ANESTHESIA RECORD -- EXTRA INFO

| REGIONAL                                                                                                                                                                                                                                                                                                                                                                                                                                        | Start:    | End: | <input type="checkbox"/> Time Out |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|------|-----------------------------------|
| <input type="radio"/> Block for Post op pain control / surgeon request<br><input type="radio"/> Block for surgical anesthesia<br>REQUESTED BY: _____<br>BLOCK: _____ U/S <input type="radio"/> Yes <input type="radio"/> No<br>LATERALITY: <input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Bilateral                                                                                                               |           |      |                                   |
| REGION MACRO POSITION: Sit / LLD / RLD / Sup / Prone Attempts: _____<br>PREP: Beta / Alc / HIB / CHP Draped: Y / N <input type="checkbox"/> Full monitors used<br>LOCAL WHEEL: Y / N Needle Size: _____G<br>NEEDLE MANUFACTURER: _____<br>Size: 17 G / 20 G / 21 G / 22 G / Other: _____<br>Length: 80mm / 100mm / Other: _____<br>N Stim to _____mA (if applicable)<br>Blood Asp: Y / N Easy Inject: Y / N Paresth: Y / N Inc Injection: Y / N |           |      |                                   |
| <input type="checkbox"/> Catheter tunneled at: _____ Dressing: Tegaderm / Op-Site / None<br>SUCCESS: _____ On/Q _____ Infusion Pump _____<br><input type="radio"/> Complete <input type="radio"/> Partial <input type="radio"/> Failed <input type="radio"/> Eval Pending                                                                                                                                                                       |           |      |                                   |
| Medications Time Wst Photo                                                                                                                                                                                                                                                                                                                                                                                                                      |           |      |                                   |
| COMMENTS ABORTED: _____<br>Prox #1                                                                                                                                                                                                                                                                                                                                                                                                              |           |      |                                   |
| ID#                                                                                                                                                                                                                                                                                                                                                                                                                                             | SIGNATURE | DATE | TIME                              |

| REGIONAL                                                                                                                                                                                                                                                                                                                                                                                                                                        | Start:    | End: | <input type="checkbox"/> Time Out |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|------|-----------------------------------|
| <input type="radio"/> Block for Post op pain control / surgeon request<br><input type="radio"/> Block for surgical anesthesia<br>REQUESTED BY: _____<br>BLOCK: _____ U/S <input type="radio"/> Yes <input type="radio"/> No<br>LATERALITY: <input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Bilateral                                                                                                               |           |      |                                   |
| REGION MACRO POSITION: Sit / LLD / RLD / Sup / Prone Attempts: _____<br>PREP: Beta / Alc / HIB / CHP Draped: Y / N <input type="checkbox"/> Full monitors used<br>LOCAL WHEEL: Y / N Needle Size: _____G<br>NEEDLE MANUFACTURER: _____<br>Size: 17 G / 20 G / 21 G / 22 G / Other: _____<br>Length: 80mm / 100mm / Other: _____<br>N Stim to _____mA (if applicable)<br>Blood Asp: Y / N Easy Inject: Y / N Paresth: Y / N Inc Injection: Y / N |           |      |                                   |
| <input type="checkbox"/> Catheter tunneled at: _____ Dressing: Tegaderm / Op-Site / None<br>SUCCESS: _____ On/Q _____ Infusion Pump _____<br><input type="radio"/> Complete <input type="radio"/> Partial <input type="radio"/> Failed <input type="radio"/> Eval Pending                                                                                                                                                                       |           |      |                                   |
| Medications Time Wst Photo                                                                                                                                                                                                                                                                                                                                                                                                                      |           |      |                                   |
| COMMENTS ABORTED: _____<br>Prox #1                                                                                                                                                                                                                                                                                                                                                                                                              |           |      |                                   |
| ID#                                                                                                                                                                                                                                                                                                                                                                                                                                             | SIGNATURE | DATE | TIME                              |

COMMENTS

COMMENTS

COMMENTS

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