# Anesthesia Billing Record

## Anesthesia Solutions of Mobile
Providence Hospital

### Attention: Dotted areas created for VitalMed use.

**MDA Only**
- MDA 1 ___________  MDA 2 ___________  MDA 3 ___________
- Relief Given By ___________  Time in: ______  Time Out: ______ (relief must be noted in anes. recrd.)

**MDA/CRNA**
- CRNA 1 ___________  CRNA 2 ___________  CRNA 3 ___________
- Relief Given By ___________  Time in: ______  Time Out: ______ (relief must be noted in anes. recrd.)

### Date of Service:

### Admit Status (Circle One):
- Outpatient (<24 hr)
- Inpatient
- ASC
- Office

### Diagnosis(es):
1. __________________________  ICD-9
2. __________________________  ICD-9
3. __________________________  ICD-9
4. __________________________  ICD-9

### Surgical/Obstetrical Anesthesia (if post-op pain mgmt provided, fill in pain mgmt section below.)

#### Anesthesia Type (Circle One):
- General
- MAC
- Epidural
- Spinal
- Regional
- TIA
- Other ______

#### Start Time: _________  End Time: __________

### Physical Status:
- 1
- 2
- 3
- 4
- 5
- 6 (organ procurement

### Procedure(s): (Give Specifics)

### Ancillary Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>36555</td>
<td>Non–tunneled CV Line (&lt; 5 yrs)</td>
</tr>
<tr>
<td>36556</td>
<td>Non–tunneled CV LIne (5yrs or &gt;)</td>
</tr>
<tr>
<td>93503</td>
<td>Swan–Ganz</td>
</tr>
<tr>
<td>36620</td>
<td>Arterial Line</td>
</tr>
<tr>
<td>31500</td>
<td>Emergency Intubation</td>
</tr>
<tr>
<td>99116</td>
<td>Utilization of Total Body Hypothermia – complicating anes</td>
</tr>
<tr>
<td>99135</td>
<td>Utilization of Controlled Hypotension – complicating anes</td>
</tr>
<tr>
<td>99140</td>
<td>Emergency Complicating Anes.</td>
</tr>
<tr>
<td>93312</td>
<td>TEE probe placement:</td>
</tr>
<tr>
<td>93315</td>
<td>for cardiac anomaly</td>
</tr>
</tbody>
</table>

### Emergency Intubation
- Evaluation and Management Service (Documentation MUST be attached)

### Other Procedure(s) (Include Details)

### Post Operative Pain Management

#### Procedure: __________________________

#### Was this service for:
- Post op pain only
- Anes serv/ post op pain
- Other ______
- Daily Mgmt of continuous epi/spinal catheter (01996): Date(s):

---

ANES0002
Universal Protocol for Surgical/Invasive Procedures

<table>
<thead>
<tr>
<th>Location (Surgery/procedure area/unit):</th>
<th>Date:</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Procedure:</th>
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</table>

<table>
<thead>
<tr>
<th>Pre–operative Verification</th>
<th>Time Out Immediately Prior to Procedure</th>
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<tbody>
<tr>
<td></td>
<td>Initial</td>
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<tr>
<td>Correct Patient</td>
<td>Correct Patient</td>
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<tr>
<td>Correct Procedure</td>
<td>Correct Procedure</td>
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<tr>
<td>Correct Site:</td>
<td>Correct Side:</td>
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<td>Correct Site:</td>
<td>Correct Side:</td>
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<td>Left</td>
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</table>

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<tr>
<th>Site Marked by Physician</th>
<th>Correct Position</th>
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<table>
<thead>
<tr>
<th>Medical Records and Imaging Available and Verified</th>
<th>Prophylactic antibiotic received within one hour prior to surgical incision*</th>
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</thead>
<tbody>
<tr>
<td>Informed Consents</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>History and Physical</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>Anesthesia Evaluation</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>Lab</td>
<td>☐ Yes</td>
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<tr>
<td>X–rays</td>
<td>☐ Yes</td>
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<table>
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<tr>
<th>Participants:</th>
<th>Time: _________</th>
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<tbody>
<tr>
<td>Physician:</td>
<td></td>
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<tr>
<td>Anesthesia:</td>
<td>☐ NA</td>
</tr>
<tr>
<td>Nurse/Tech:</td>
<td></td>
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Initials/Signature ____________________________  Initials/Signature ____________________________

Initials/Signature ____________________________  Initials/Signature ____________________________

*Antibiotics are mandatory for the following procedure:

- Head and neck procedures (incisions through oral or pharyngeal mycosa)
- Elective Craniotomy
- Orthopedic with Implants
- Spine with implants
- Hysterectomy: Vaginal, Abdominal, or Radical
- Cardio–thoracic
- Hernia with mesh
- Abdominal (Gastroduodenal, Biliary)
- High Risk Genitourinary (ASA > 3)
- Vascular
- Appendectomy (Uncomplicated)
- Colorectal

Note: Use two methods of patient identification.
Place this form in the Consent Section of the chart.
PROVIDENCE HOSPITAL
6801 Airport Boulevard, Mobile AL 36608,
251/633−1000

BLOCK TREATMENT RECORD

Date: _________________  Pre−Op Start: _______________  End: _______________
OR Room #: _______________  OR Start: _______________  End: _______________
Surgeon: _______________  MD Start: _______________  End: _______________
Circulator: _______________  PACU Time: _______________
Scrub: _______________  Pre−Op Diagnosis: _______________
XRay: _______________  Surgical Procedure: _______________

Medication Injection Charges

35516689 – IV Piggy/back/hr: _______________  35516670 – IM or Sub Q Injection: _______________
35516662 – IV Push Injection: _______________  35516697 – Moderate Sedation: _______________

Outpatient Surgery Implant & Equipment Verification Checklist / Logging / QA

Time In: _______________  Time Out: _______________  Signature: _______________
Case Set Up: _______________  Finish: _______________  Room Clean Up: _______________  Finish: _______________

Surgeon Late: (LO2)
Case Scheduled for _______________
Case Bumped/Delayed until _______________
Case Moved to Main OR _______________
Surgery arrived at: _______________
Called Charge Nurse to Notify _______________
Case Cancelled _______________
Comments: _______________

Case Delay
Lab−L08 [ ] Anesthesia – L03 [ ] Pt. Late Arrival – L01 [ ] Pre−Op – L12 [ ] Transport – L13
Line Placement [ ] Previous Case Ran Late – L07 [ ] Unavailable Equipment – C15
X−Ray – C−Arm – L09 [ ] X−Ray – Portable – L09 [ ] Unavailable Instruments
Unavailable Staff [ ] Circulator – C19 [ ] Scrub – C18 [ ] Retractor – C17
Length of Delay: _______________
Comments: _______________

Difficult Intubation: (Q29)
Multiple Attempts [ ] Oral – Laryngeal Trauma [ ] Laryngospasm [ ] Case Cancelled
Flexible Intubation [ ] Light Wand [ ]
Comments: _______________

Equipment Malfunction: (C09)
Removed from Patient Care [ ] Reported to Bio−Med for Repairs
Report of Event Filed [ ] Name of Equipment: _______________
Describe Event: _______________

Case Cancelled
Due to:
Patient Condition – C03 [ ] Anesthesia – C02 [ ] Surgeon – C04 [ ] Patient Request
Case Transferred to Main OR – C24
Comments: _______________

Patient Return to OR: (C23)
Hemmorhage [ ] Airway Control [ ] Unstable Vital
Comments: _______________
Signs: _______________

IF CASE CANCELLED WHILE PATIENT ON O.R. TABLE OR IF PATIENT RETURNS TO O.R. IN SAME DAY, YOU MUST FILL OUT REPORT OF EVENT FORM

IMPLANT INFORMATION: APPLY STICKERS IF AVAILABLE

Manufacturer: _______________  Model #: _______________  Lot #: _______________
Size: _______________  Catalog #: _______________  Quantity: _______________
UCG: [ ] Yes [ ] No

Dev: 10/2001
rev 6/05 OPS00006
Anesthesia Solutions of Mobile, Inc.

Consent for Anesthesia

I hereby authorize and direct Anesthesia Solutions of Mobile, Inc. and the individual anesthesia provider to care for me, and to administer general, regional, or monitored anesthesia care (intravenous sedation) for surgery.

The nature, purpose, and risks of the anesthetic, the possibility of complications, as well as alternatives have been fully explained by Anesthesia Solutions of Mobile. I understand that although favorable results can be expected, they cannot be and are not guaranteed.

It is the understanding of the undersigned that an Anesthesiologist, or a Certified Registered Nurse Anesthetist (CRNA) under the direction of the Anesthesiologist, will administer the anesthesia, and that the administration and maintenance of anesthesia is an independent function from the surgery.

__________________________________________________________________________
Signature of patient or guardian

__________________________________________________________________________
Witness

__________________________________________________________________________
Date
OUTPATIENT
SURGERY CENTER
PRE–OPERATIVE NURSES’ NOTES

Pre–Op Call Made Patient Instructed Regarding:
NPO Location Time to Arrive
Valuables Contact Lenses Makeup

Date: ____________________________

Driver/Responsible Adult

Op site and procedure verified with schedule, consent, patient, family

Pre–Op Orientation/Instruction Given

Pt./Significant other verbalizes understanding

Patient Concerns: ____________________________

Physical Assessment of Systems (Check Box):

Behavior: ☐ Cooperative ☐ Talkative ☐ Anxious ☐ Withdrawn ☐ Combative ☐ Calm
☐ Crying ☐ Other: ____________________________

Vision: ☐ No Problems ☐ Glasses/Contacts ☐ Cataracts ☐ Blind ☐ R ☐ L

Hearing: ☐ No Problems ☐ Hard of Hearing ☐ R ☐ L ☐ Hearing Aid ☐ R ☐ L ☐ Deaf ☐ R ☐ L

Speech: ☐ No Problems ☐ Hoarse ☐ Slurred ☐ Aphasia ☐ Language Barrier

Respiratory: ☐ No Problems ☐ Cough (Productive/Nonproductive) ☐ Dyspnea ☐ Crackles/Wheezees
☐ Rales/Rhonchi ☐ Orthopnea ☐ Sleep Apnea ☐ Snoring ☐ Comments: ____________________________

Cardiovascular: ☐ No Problems ☐ Pacemaker ☐ Palpitations ☐ Chest Pain ☐ Edema
☐ Comments: ____________________________

Gastrointestinal: ☐ No Problems ☐ Constipation ☐ Diarrhea ☐ Hyperglycemia
☐ Recent Weight Gain/Loss ☐ Hyperglycemia ☐ Nausea ☐ Vomiting
☐ Special Diet Comments: ____________________________

Urinary: ☐ No Problems ☐ Frequency ☐ Urgency ☐ Catheter ☐ Comments
☐ Hesitancy ☐ Comments

Musculoskeletal: ☐ No Problems ☐ Swelling ☐ Pain ☐ Deformities ☐ Range of Motion
☐ Hesitancy Comments

NURSES NOTES:

Monitors: ☐ EKG ☐ NIBP ☐ SaO2

Alarms On: ☐ Yes ☐ No ☐ N/A

Side Rails/Safety Strap

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<th>HR</th>
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Developed 3/2002
Rev 8/04 OPS00001
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<td>I.D. Bracelet Checked</td>
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<td>Surgical Permit Signed</td>
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<td>Risks and Benefits Documented</td>
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<td>Medical Records Contacted</td>
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<td>13</td>
<td>Contact Lenses / Glasses Removed</td>
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<td>14</td>
<td>Dentures Removed</td>
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<td>15</td>
<td>Make−Up / Nail Polish Removed</td>
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<tr>
<td>16</td>
<td>Valuables to Family / Security</td>
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<tr>
<td>17</td>
<td>Clothing to Family / Security</td>
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<td>18</td>
<td>Pre−Op Medication Given</td>
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Signature: ____________________________________________
Reviewed O.R. Nurse: __________________________________
Date: ______________________________________________
# PHYSICIAN’S ORDERS

<table>
<thead>
<tr>
<th>DATE</th>
<th>HOUR</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

## ORDERS FOR PACU ONLY

### ANESTHESIA SOLUTIONS

1. Maintain normothermia: Apply forced air warming blanket to maintain temperature above or equal to 96.8°F. Once temperature reaches 98.8°F, may switch to warm blankets.

2. Analgesia: (Circle one)
   a.) morphine 2 mg to 5 mg IV PRN every 5 minutes up to a maximum of 20 mg if respiratory rate greater than 8.
   b.) hydromorphone (DILAUDID) 0.1 mg to 0.5 mg IV every 5 minutes PRN to a maximum of 2 mg if respiratory rate greater than 8.
   c.) ________________________________ IV every 5 minutes PRN x _____ doses.
   d.) Consult anesthesiologist before giving any prescription pain medication.

3. Nausea: (Use sequentially only if circled)
   a.) ondansetron (ZOFRAN) 4 mg IV PRN x 1
   b.) promethazine (PHENERGAN) 6.25 mg to 12.5 mg IV PRN x 1
   c.) dexamethasone (DECADRON) 8 mg IV PRN x 1
   d.) Notify Anesthesia Solutions for persistent nausea.

4. Post Op blood glucose on all diabetic patients and notify anesthesiologist if greater than 200 or less than 70.

5. Oxygen: Titrate to maintain oxygen Saturation greater than 95%

6. Discharge:
   a.) Awake, alert, able to maintain airway.
   b.) No unretractable nausea and vomiting.
   c.) If SAB, able to move legs.
   d.) PAR score greater than or equal to 9.
   e.) Patients receiving naloxone (NARCAN) will remain in unit for 2 hours and must be evaluated by anesthesiologist prior to discharge.

7. lidocaine 1% (plain) 0.2 mL to 2 mL intradermal PRN for IV insertion.

8. May discharge from PACU when criteria is met.

9. ☐ scopolamine (TRANSDERM SCOP) 1.5 mg patch applied in PreOp. Instruct patient and/or nursing staff to remove the patch within 24 to 72 hours depending on patient’s nausea level.

| RN Signature: ______________________________ | Date: _______ Time: _______ |
| ANESTHESIOLOGIST’S SIGNATURE: ______________________________ | Date: _______ Time: _______ |

Developed: March 1991
Revised: April 2008
Revised: October 2008
Revised: November 2008
<table>
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<tr>
<th>INIT. / SIGNATURE / TITLE</th>
<th>INIT. / SIGNATURE / TITLE</th>
<th>OMISSION CODES</th>
<th>INJECTION CODES</th>
<th>PAIN SCALE</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>R PATIENT REFUSED</td>
<td>LD LT DELTOID</td>
<td>--- 0 NO PAIN</td>
</tr>
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<td></td>
<td></td>
<td>N NPO</td>
<td>RD RT DELTOID</td>
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<td>U OFF UNIT</td>
<td>LG LT GLUTEUS</td>
<td>--- (0–10 SCALE)</td>
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<td>D DIALYSIS</td>
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<td>I IV OUT</td>
<td>LL LT VASTUS LATERALIS</td>
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<td>H HOLD PER ORDER</td>
<td>RL RT VASTUS LATERALIS</td>
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<td>O OTHER–NURSES’ NOTES</td>
<td>LV LT VENTRAGLUTEAL</td>
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<td>RV RT VENTRAGLUTEAL</td>
<td>--- 10 UNBEARABLE PAIN</td>
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<td>LA LT ABDOMEN</td>
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<td>RA RT ABDOMEN</td>
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</table>

**ALLERGIES:**

- Lidocaine 1% .2ml – 1 ml pm ID IV Insertion

<table>
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<tr>
<th>TIME</th>
<th>ID</th>
<th>COMMENTS</th>
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</table>

**INJECTION INFORMATION**

- **Route:** IV
- **Site:** 1000 RL KVO

**Line One:** [ ] Started [ ] Maintained [ ] D/C [ ] Restarted

**Location/Size:** Attempts X

**Site/Condition:** [ ] Without redness/swelling

*Requires Comment: [ ] Flushed easily

**Comments:**

Dev: 10/01 Revised: 03/03

OPS00004
OUTPATIENT SURGERY
PAIN MANAGEMENT

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<th>IN</th>
<th>30</th>
<th>60</th>
<th>90</th>
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<td><strong>ASSESSMENT/REASSESSMENT</strong></td>
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<tr>
<td>Pain Scale (0–10) (Document pain level above/and initials below)</td>
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<tr>
<td>Instructed to call for pain</td>
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<tr>
<td>Pharmacological intervention (refer to MAR for details)</td>
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<tr>
<td>Non-pharmacologic Interventions</td>
<td>Reposition</td>
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<td>Cold Application</td>
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<td></td>
<td>Heat Application</td>
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<tr>
<td></td>
<td>Exercises</td>
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<td></td>
<td>Imagery</td>
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<tr>
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<td>Back rub</td>
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<tr>
<td></td>
<td>Distraction</td>
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<tr>
<td></td>
<td>Relaxation</td>
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<td></td>
<td>Other</td>
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<tr>
<td>Reassessment following intervention (Pain level above/and initials below)</td>
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<tr>
<td>Monitored for possible side effects related to Meds (i.e. nausea, vomiting, constipation, itching, urinary retention, etc.)</td>
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<tr>
<td>Patient and/or family educated related to pain management plan.</td>
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OP000005
### INTRAOPERATIVE REPORT

#### PAGE 1 OF 2

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<th>Date Collection Assessment</th>
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<td>General Appearance</td>
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<td>Emotional/Mental Status</td>
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<td>Behavior Observed</td>
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<tr>
<td>History &amp; Physical</td>
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<td>Chart Reviewed</td>
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<tr>
<td>Blood Available</td>
<td></td>
</tr>
<tr>
<td>Anesthesia Type</td>
<td>Preoperative Assessment</td>
</tr>
</tbody>
</table>

#### POST-OPERATIVE DIAGNOSIS

- **WOUND CLASSIFICATION:**
  - I
  - II
  - III
  - IV
  - ASA: 1 2 3 4 5 6
  - Pt. Identified by: Pt. Name Date of Birth Account #

#### SURGEON:

- ASSISTANT:

#### 2ND PRIMARY SURGEON:

#### ANESTHESIOLOGIST:

- RELIEVED BY: TIME:

#### ANESTHETIST:

- RELIEVED BY: TIME:

#### SCRUB NURSE:

- RELIEVED BY: TIME:

#### RETRACTO R NURSE:

- RELIEVED BY: TIME:

#### CIRCULATING NURSE:

- RELIEVED BY: TIME:

#### ANCILLARY PERSONNEL:

- RELIEVED BY: TIME:

#### LAB:

- X-RAY:
- PERFUSION:
- IT:

#### ANESTHESIA TYPE:

- General
- Spinal
- Epidural
- Bier Block
- Axillary Block
- Local
- Ankle Block
- Mac
- Sur/Sed

#### PREOPERATIVE ASSESSMENT

- Nursing Diagnosis:
- Expected Outcome:

#### Data Base I Reviewed For:

- Chronic Health Problems
- Impairments
- Skin Integrity
- DVT Potential

#### Confirmation of Surgical Site & Side

- by Patient: Yes No Time Out
- by Consent: Yes No
- by Surgeon: Yes No

#### Drains & Catheters on Arrival:

- None
- Yes – Type
- Levine
- Endotracheal
- Foley
- I.V.
- Chest Tube
- Swan
- A-Line
- Other

#### Family/Significant Other Waiting:

- Yes No

#### Patient Complaints:

- None
- Thirsty/Hungry
- Nauseated
- Pain
- Other

#### NPO Since

#### Status:

- AM Admit
- Inpatient
- Outpatient

#### Surgery Type:

- Add on
- Elective
- Emergency
- Urgent

---

REV 02/08 NSG00063
### INTRAOPERATIVE REPORT

**Page 2 of 2**

#### Nursing Diagnosis:
- **Potential for infection.**

**Expected outcome:** Aseptic technique will be maintained throughout the surgical procedure.

#### Hair Removal:
- **Yes**, **No**, **Clipper**, **Depilatory**

#### Surgical Prep:
- **Cida Stat**, **Betadine S + S**, **Alcohol**, **Phisohex**, **Dura. Prep**

#### Irrigation Solutions:
- **NaCl** mL, **Lactated Ringers** mL, **Glycine** mL

#### Specimen:
- **Yes**, **No**, **Exempt**, **F/S**

#### Cultures:
- **Routine C + S**, **Anaerobic**, **Acid-Fast**, **Fungus**, **Cytology**

#### Comments:
- **Routine procedure.**

#### Pressure Points Padded:
- **Heels**, **Elbows**, **Knees**, **Popliteal**, **Ankles**, **Other**

#### Positioning:
- **Supine**, **Prone**, **Lithotomy**, **Sitting**, **Jackknife**, **Beach Chair**

#### Positional Aides:
- **Olympus Pillow**, **Kambin SP Frame**, **Wilson Frame**

#### Pressure (mmHg):
- **Gauge checked**, **Pacing under cuff**, **Unit #**

#### Tourniquet:
- **Gauge checked**, **Pacing under cuff**, **Unit #**

#### Laser:
- **Type**, **Model #**, **Wattage**, **M/Sec**, **Ionizing Radiation**

#### Ionizing Radiation:
- **Type**, **Model #**, **Exposure Time**

#### Hemotherm:
- **Warm Blankets**, **N/A**, **Temp Setting**

#### Laser Safety Precautions Instituted
- **Yes**, **No**

#### Positioning:
- **Supine**

#### Pad Positions:
- **N/A**

#### Pad: Type Lot # Exp. Date
- **N/A**

#### Count:
- **N/A**

#### Code Correct = 1 Incorrect = 2

#### Hair Removal:
- **Yes**, **No**, **Clipper**, **Depilatory**

#### In Preop:
- **in Preop**

#### o.r.:
- **in O.R.**

#### Per Surgeon:
- **Nursing Unit**

#### Surgical Drain:
- **Foley on arrival**, **Foley inserted at**

#### Estimated Blood Loss:
- **ml**

#### Final Count:
- **Resolved by X-Ray**, **Yes**, **No**, **N/A**

#### Pain:
- **N/A**, **Continuous**, **Intermittent**

#### Pain Management:
- **N/A**, **Continuous**, **Intermittent**

#### Cooling:
- **N/A**, **Continuous**, **Intermittent**

#### Warming:
- **N/A**, **Continuous**, **Intermittent**

#### Monitoring:
- **N/A**, **Continuous**, **Intermittent**

#### Autotransfusion:
- **lot #**

#### Biofeedback:
- **Yes**, **No**

#### Other Location:
- **Yes**, **No**

#### ECG:
- **Lead: Type Mode P S Coag Cutting Blend**

#### Counts 1st 2nd 3rd 2nd 3rd
- **N/A**

#### Counts 2nd 3rd
- **N/A**

#### Counts 1st 2nd 3rd
- **N/A**

#### Initial Count:
- **Circulator**

#### Minor Laps
- **N/A**

#### Vessel loops
- **N/A**
### Perioperative Nursing Care Plan

#### EVALUATION / SUMMARY OF NURSING PLAN

<table>
<thead>
<tr>
<th>Nursing Diagnosis</th>
<th>Nursing Intervention</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Anxiety related to impending surgical intervention and anesthesia.</td>
<td></td>
<td>1. Patient will manage anxiety by discussing feelings about surgery, anesthesia, and hospitalization.</td>
</tr>
<tr>
<td>2. Knowledge deficit related to surgical procedure.</td>
<td></td>
<td>2. Patient/Family/Significant Other verbalized understanding of pre-op/intra-op and post-op activities, and participated in decisions affecting his/her plan of care.</td>
</tr>
</tbody>
</table>

#### 1. Potential for impaired tissue integrity and injury (nerve damage, foreign body in wound), related to length of surgery, positioning during surgery, use of sharps, sponges, instruments, and electrosurgical unit during surgery.

- **Nursing Intervention**
  - 1. Skin prep solutions will not pool around or under patient.
  - 2. Apply electrosurgical grounding pad securely to appropriate area.
  - 3. Insure that electrosurgical equipment functioning properly prior to use.
  - 4. Patient arms on arm boards at less than 90° angle to body.
  - 5. Insure that pressure areas padded appropriately.
  - 6. Insure the equipment, personnel and instrumentation are not placing pressure on patient.
  - 7. Counts as appropriate for case.
  - 8. Safety strap applied.
  - 9. Side rails up during transport.

- **Expected Outcome**
  - 1. Patient is free from signs and symptoms of electrical/chemical injury.
  - 2. Patient will sustain no nerve injury during surgery, and will demonstrate no loss of movement or sensation post-op due to complications.
  - 3. Patient will be free of foreign body at end of procedure as evidence by a correct count.
  - 4. Patient’s skin exhibits no redness or tissue breakdown post-op.

#### 2. Potential for infection related to surgical incision and possible wound contamination during surgery.

- **Nursing Intervention**
  - 1. Strict aseptic technique maintained throughout procedure.
  - 2. Surgical site prepared with appropriate antiseptic.
  - 3. O.R. door closed.
  - 4. Traffic in and out of O.R. kept to a minimum.
  - 5. Antibiotics given per physician request.
  - 7. If break occurs, take action to correct.

- **Expected Outcome**
  - 1. Patient will be free of wound infection.
# Outpatient Surgery

## Perioperative Count Sheet

<table>
<thead>
<tr>
<th>QTY</th>
<th>INSTRUMENTS</th>
<th>INITIAL</th>
<th>ADD</th>
<th>FINAL</th>
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</thead>
<tbody>
<tr>
<td>8</td>
<td>Curved Hemostats</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Straight Hemostats</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Kellys</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Oschners</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>8</td>
<td>Allis</td>
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<td>3</td>
<td>Babcocks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Laheys</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Straight Haney's</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>6</td>
<td>Curved Haney's</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Vanderbilts</td>
<td></td>
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</tr>
<tr>
<td>4</td>
<td>Right Angles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Needle Holders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Sponge Sticks</td>
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</tr>
<tr>
<td>4</td>
<td>Towel Clips</td>
<td></td>
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<tr>
<td>6/7</td>
<td>Scissors</td>
<td></td>
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<tr>
<td>3</td>
<td>#3 Knife Handles</td>
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</tr>
<tr>
<td>1/1</td>
<td>Suction w/Guard</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>2</td>
<td>Addison Pickups</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>2</td>
<td>Pickups w/ Teeth Short/Long</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Pickups w/o Teeth Short/Long</td>
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<td></td>
</tr>
<tr>
<td>6</td>
<td>DeBakey Pickups</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1/2</td>
<td>Long Russian Pickups</td>
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</tr>
<tr>
<td>1</td>
<td>Balfour Retr 2−Screws</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>O'Connor/O'Sullivan 2−Screws</td>
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</table>

## Intraoperative Count Worksheet Record

### Suture/Needles

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COUNTS</th>
<th>CONFERMED COUNTS</th>
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<tbody>
<tr>
<td></td>
<td>INITIAL</td>
<td>PRE-CLOSING</td>
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<tr>
<td>1</td>
<td>2 3 4 5 6 7 8 9 10 11 12 13 14 15</td>
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</tr>
<tr>
<td>16</td>
<td>17 18 19 20 21 22 23 24 25 26 27 28 29 30</td>
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<tr>
<td>31</td>
<td>32 33 34 35 36 37 38 39 40 41 42 43 44 45</td>
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<td>47 48 49 50 51 52 53 54 55 56 57 58 59 60</td>
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<td>62 63 64 65 66 67 68 69 70 71 72 73 74 75</td>
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<td>77 78 79 80 81 82 83 84 85 86 87 88 89 90</td>
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<td>91</td>
<td>92 93 94 95 96 97 98 99 100 101 102 103 104 105</td>
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</tr>
<tr>
<td>106</td>
<td>107 108 109 110 111 112 113 114 115 116 117 118 119 120</td>
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</tbody>
</table>

### Blades

<table>
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<tr>
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</thead>
<tbody>
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</tr>
<tr>
<td>1</td>
<td>2 3 4 5 6 7 8 9 10 11 12 13 14 15</td>
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</table>

### Electrode Tip

<table>
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<td>2 3 4 5 6 7 8 9 10 11 12 13 14 15</td>
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</table>

### Hypo Needles

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</tr>
<tr>
<td>1</td>
<td>2 3 4 5 6 7 8 9 10 11 12 13 14 15</td>
<td></td>
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</tbody>
</table>

### Sponges

<table>
<thead>
<tr>
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<th>COUNTS</th>
<th>CONFERMED COUNTS</th>
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</thead>
<tbody>
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<td></td>
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<td>PRE-CLOSING</td>
</tr>
<tr>
<td>Lap Sponges</td>
<td>5 10 15 20 25 30 35 40 45 50 55 60 65 70 75</td>
<td></td>
</tr>
<tr>
<td>Mini Laps</td>
<td>5 10 15 20 25 30 35 40 45 50 55 60 65 70 75</td>
<td></td>
</tr>
<tr>
<td>Dissectors</td>
<td>5 10 15 20 25 30 35 40 45 50 55 60 65 70 75</td>
<td></td>
</tr>
<tr>
<td>Xray 4x4's</td>
<td>10 20 30 40 50 60 70 80 90 100 110 120 130 140 150</td>
<td></td>
</tr>
<tr>
<td>Cottonoids</td>
<td>10 20 30 40 50 60 70 80 90 100 110 120 130 140 150</td>
<td></td>
</tr>
<tr>
<td>Tonsil Spgs</td>
<td>5 10 15 20 25 30 35 40 45 50 55 60 65 70 75</td>
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</table>

### Other

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
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<td>PRE-CLOSING</td>
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Circulator: ____________________________ Scrub: ____________________________

Dev: 5/03  rev 7/03  OPS00009
### PACU PROGRESS NOTES

<table>
<thead>
<tr>
<th>DATE/TIME</th>
<th></th>
<th>M.D.</th>
<th>SIGNATURE</th>
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<table>
<thead>
<tr>
<th>POST–OP NOTES</th>
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</tr>
</tbody>
</table>

1. **Pre–Operative Diagnosis:**
2. **Post–Operative Diagnosis:**
3. **Procedure:**
4. **Surgeon:**
5. **Anesthesia:**
6. **EBL:**
7. **Specimen:**
8. **Complications:**
9. **Condition:**
10. **Findings:**

<table>
<thead>
<tr>
<th>FINAL DIAGNOSES:</th>
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<th></th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>CONDITION ON DISCHARGE:</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>PROGNOSIS ON DISCHARGE:</th>
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</table>

<table>
<thead>
<tr>
<th>DISCHARGE SUMMARY TO BE DICTATED BY:</th>
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</table>

<table>
<thead>
<tr>
<th>M.D.</th>
<th>DATE</th>
<th>SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
# PHYSICIAN’S ORDERS

## Intraoperative Orders

<table>
<thead>
<tr>
<th>DATE</th>
<th>HOUR</th>
<th>QC</th>
</tr>
</thead>
</table>

### 1. LABS:
- CBC
- Hematocrit
- Hemoglobin
- Glucose
- Type & Crossmatch
- ABG’s

### 2. ADMIN:
- PRBC
- Platelets
- FFP

### 3. X–RAY:
- Portable
- C–Arm
- Dye Type

### 4. CULTURE:
- Routine
- Anaerobic
- Acid Fast
- Gram Stain
- Fungus
- Cytology
- Pelvic Washings
- Other

### 5. FOLEY CATHETER:
- Insert with
- regular catheter bag
- urimeter bag

### 6. SPECIMEN:
- To Lab
- Frozen Section
- Other

### 7. WARMING BLANKET:
- Upper Body
- Lower Body
- Other

### 8. IMMOBILIZER:
- Knee
- Shoulder

### 9. SCDs:
- Apply SCD’s, unless patient is excluded, has a contraindication, or has a physician’s order to not apply.

### 10. MEDICATIONS:
- bacitracin 50,000 units in ______ mL Normal Saline
- kanamycin (KANTREX) 1 g in 3 mL Normal Saline
- neomycin and polymyxin B (NEOSPORIN G.U.) irrigant ______ mL Normal Saline
- heparin ______ units in ______ mL of ________________
- papaverine 30 mg per mL in ______ mL of ________________
- topical thrombin ______ units
- lidocaine topical 2% jelly or 2% uroject
- gelatin sponge (GELFOAM)
- Fibrillar
- Nu Knit
- Local
- Nufoam
- Nufoam Nu
- sodium bicarbonate ______ mL (for local)
- Other

---

**Blood & Body Fluid Exposure**
- 8900 HBs Ag
- 8902 HCAB
- 8903 HIV AB (with consent) message "rapid HIV"

---

**Note:**
- Apply forced air warming blanket to all open abdominal procedures and laparoscopic colorectal procedures.

---

**Developed:** December 2005  
**Revised:** April 2008  
**Revised:** July 2008  
**Revised:** November 2008

---

**SURGEON SIGNATURE:** ______________________ Date: ____/____/____ Time: ____
## PHYSICIAN SURVEY

(Please check the block that is most representative)

<table>
<thead>
<tr>
<th>SERVICE ELEMENT</th>
<th>EXCEEDED EXPECTATIONS (4)</th>
<th>MET EXPECTATIONS (3)</th>
<th>DID NOT MEET EXPECTATIONS (2)</th>
<th>IMPROVEMENT NEEDED (1)**</th>
</tr>
</thead>
<tbody>
<tr>
<td>My Case started on time.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All required instrumentation was ready for my use and functional.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All supplies were available.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The scrub was attentive to my needs throughout the case.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The RN circulator anticipated my needs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anesthesia met my expectations.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This was a to-follow case and my turnover time was:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

DATE: ___________________________
CIRCULATOR: __________________________
SCRUB: __________________________

SURGEON'S SIGNATURE: __________ DATE: __________

PLEASE PLACE COMPLETED FORM IN EXECUTIVE DIRECTOR'S BOX.