

ANESTHESIA RECORD				Procedure				START	STOP				
Date		OR No.		Page of		Surgeon(s)		Anesthesia					
PRE-PROCEDURE				MONITORS AND EQUIPMENT				RECOVERY					
<input type="checkbox"/> Identified: <input type="checkbox"/> ID Band <input type="checkbox"/> Questioning <input type="checkbox"/> Chart Reviewed <input type="checkbox"/> Permit Signed <input type="checkbox"/> NPO Since _____ Pre-Anesthetic State: <input type="checkbox"/> Calm <input type="checkbox"/> Awake <input type="checkbox"/> Asleep <input type="checkbox"/> Apprehensive <input type="checkbox"/> Confused <input type="checkbox"/> Uncooperative <input type="checkbox"/> Unresponsive				Steth: <input type="checkbox"/> Precord <input type="checkbox"/> Esoph <input type="checkbox"/> Other <input type="checkbox"/> Non-Invasive B/P: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Continuous EKG <input type="checkbox"/> V Lead EKG <input type="checkbox"/> Pulse Oximeter <input type="checkbox"/> Oxygen Sensor <input type="checkbox"/> End Tidal CO ₂ <input type="checkbox"/> Gas Analyzer <input type="checkbox"/> Temp. _____ <input type="checkbox"/> Nerve Simulator <input type="checkbox"/> Warming Blanket <input type="checkbox"/> EEG <input type="checkbox"/> Doppler <input type="checkbox"/> Airway Humidifier <input type="checkbox"/> Fluid Warmer <input type="checkbox"/> NG / OG Tube <input type="checkbox"/> Foley Catheter <input type="checkbox"/> Art. Line _____ <input type="checkbox"/> CVP _____ <input type="checkbox"/> PA Line _____ <input type="checkbox"/> IV(s) _____ <input type="checkbox"/> _____				General: <input type="checkbox"/> Pre-Oxygenation <input type="checkbox"/> LTA <input type="checkbox"/> Rapid Sequence <input type="checkbox"/> Cricoid Pressure <input type="checkbox"/> Intravenous <input type="checkbox"/> Inhalation <input type="checkbox"/> Intramuscular <input type="checkbox"/> Rectal Regional: <input type="checkbox"/> Spinal <input type="checkbox"/> Epidural <input type="checkbox"/> Axillary <input type="checkbox"/> Bier Block <input type="checkbox"/> Ankle Block <input type="checkbox"/> _____ <input type="checkbox"/> Position _____ <input type="checkbox"/> Prep. _____ <input type="checkbox"/> Local _____ <input type="checkbox"/> Needle _____ <input type="checkbox"/> Drug(s) _____ <input type="checkbox"/> Dose _____ <input type="checkbox"/> Attempts x _____ <input type="checkbox"/> Site _____ <input type="checkbox"/> Level _____ <input type="checkbox"/> Catheter _____ <input type="checkbox"/> See Remarks Other: <input type="checkbox"/> MAC <input type="checkbox"/> _____		Intubation: <input type="checkbox"/> Oral <input type="checkbox"/> Tube size _____ <input type="checkbox"/> Stylet Used <input type="checkbox"/> Nasal <input type="checkbox"/> Regular <input type="checkbox"/> Magill's <input type="checkbox"/> Direct <input type="checkbox"/> RAE <input type="checkbox"/> Fiber Optic <input type="checkbox"/> Blind <input type="checkbox"/> Armored <input type="checkbox"/> Blade _____ <input type="checkbox"/> Laser _____ <input type="checkbox"/> Secured at _____ cm <input type="checkbox"/> Endobronch. <input type="checkbox"/> Attempts x _____ <input type="checkbox"/> ET CO ₂ Present <input type="checkbox"/> Breath Sounds _____ <input type="checkbox"/> Uncuffed, Leaks at _____ cm H ₂ O <input type="checkbox"/> Cuffed <input type="checkbox"/> Min. Occ. Pres. <input type="checkbox"/> Air <input type="checkbox"/> NS Airway: <input type="checkbox"/> Oral <input type="checkbox"/> LMA <input type="checkbox"/> Nasal <input type="checkbox"/> Difficult, Circuit: <input type="checkbox"/> Circle <input type="checkbox"/> NRB <input type="checkbox"/> See Remarks <input type="checkbox"/> Mask Case <input type="checkbox"/> Nasal Cannula <input type="checkbox"/> Via Tracheostomy <input type="checkbox"/> Simple O ₂ mask		Location _____ Time _____ B/P _____ O ₂ Sat. _____ P _____ R _____ T _____ <input type="checkbox"/> Awake <input type="checkbox"/> Stable <input type="checkbox"/> Nasal Oxygen <input type="checkbox"/> Drowsy <input type="checkbox"/> Unstable <input type="checkbox"/> Mask Oxygen <input type="checkbox"/> Somnolent <input type="checkbox"/> Intubated <input type="checkbox"/> T-Piece Oxygen <input type="checkbox"/> Unarousable <input type="checkbox"/> Ventilator <input type="checkbox"/> Oral/Nasal Airway Recovery Notes _____	
PATIENT SAFETY													
<input type="checkbox"/> Anes. Machine # _____ Checked <input type="checkbox"/> Safety Belt On <input type="checkbox"/> Axillary Roll <input type="checkbox"/> Armboard Restraints <input type="checkbox"/> Arms Tucked <input type="checkbox"/> Pressure Points Checked and Padded Eye Care: <input type="checkbox"/> Ointment <input type="checkbox"/> Saline <input type="checkbox"/> Taped <input type="checkbox"/> Pads <input type="checkbox"/> Goggles													
TIME:													
FLUIDS / AGENTS				Oxygen (L/min)				TOTALS		FLUID TOTALS			
				N ₂ O Air (L/min)						Crystalloid _____		EBL _____	
MONITORS				Urine (ml)				SYMBOLS		Blood _____			
				EBL (ml)						<input type="checkbox"/> ANESTHESIA <input type="checkbox"/> OPERATION <input type="checkbox"/> B/P CUFF PRESSURE <input type="checkbox"/> ARTERIAL LINE PRESSURE <input type="checkbox"/> MEAN ARTERIAL PRESSURE <input type="checkbox"/> PULSE <input type="checkbox"/> SPONT. RESP. <input type="checkbox"/> ASSISTED RESP. <input type="checkbox"/> CONTROLLED RESP. <input type="checkbox"/> TOURNIQUET			
VENT				EKG				Baseline Values 200 180 160 140 120 100 80 60 40 20 B/P P R		REMARKS			
				% O ₂ Inspired _____ O ₂ Saturation _____ End Tidal CO ₂ _____ Temp: <input type="checkbox"/> °C <input type="checkbox"/> °F									
Tidal Volume													
Resp. Rate													
Peak Pressure													
PEEP													
Symbols for Remarks													
Position													
PATIENT IDENTIFICATION				Anesthesia Provider									
CONTROLLED DRUGS				Drug		Issued		Used		Returned		Provider	
												Witness	