

McLaren Print System Order

Order No: 60182 Reprint Previous Order No: 13157
Order Date: 2021-02-05
User: Lisa Ardanowski
Phone: 810-768-2073

Ship Location: McLaren Surgery and Endoscopy Center Attn: Lisa Ardanowski
501 S. Ballenger Hwy
Flint, MI 48532

Forms

Quantity: 100
Paragon Dept No: 30014
Dept Name: Surgery and Endoscopy Center Pain Clinic
Company Number: 60

Order Total Price: 23.40

Item Number: 17489
Item Description: OPS Anesthesia Record
Revision Date: 10/2019
Print: 1 sided black and white
Paper: 2 Part (White, Yellow)
Size: 8.5 x 11
Fold:
Finish: None
Drill: None
Misc Info:

McLAREN FLINT OPS ANESTHESIA RECORD

DATE	TIME	OF	ASA	ORIM #	ANESTHESIA TECHNIQUE	REGIONAL	SAC
Address	W	Star	Star		DA		
ANES START					ANES STOP		

OFFER: _____ Anesthesiologist: _____
Preop dr: _____ Postop dr: _____

PRE-OP CHECKS

<input type="checkbox"/> Pt. identified	<input type="checkbox"/> Allergies	<input type="checkbox"/> Temp	<input type="checkbox"/> Airway assessment	<input type="checkbox"/> O2 sat	<input type="checkbox"/> Heart rate	<input type="checkbox"/> RR	<input type="checkbox"/> SpO2
<input type="checkbox"/> Chart reviewed	<input type="checkbox"/> NPO	<input type="checkbox"/> CXR	<input type="checkbox"/> ASA	<input type="checkbox"/> Wt	<input type="checkbox"/> BP	<input type="checkbox"/> HR	<input type="checkbox"/> RR
<input type="checkbox"/> Medications	<input type="checkbox"/> Allergies	<input type="checkbox"/> Pulse/Oximetry	<input type="checkbox"/> Hx	<input type="checkbox"/> A/P	<input type="checkbox"/> ABG	<input type="checkbox"/> ABG	<input type="checkbox"/> ABG
<input type="checkbox"/> Respiration checked prior to case	<input type="checkbox"/> T1/T2	<input type="checkbox"/> T3/T4	<input type="checkbox"/> T5/T6	<input type="checkbox"/> T7/T8	<input type="checkbox"/> T9/T10	<input type="checkbox"/> T11/T12	<input type="checkbox"/> T13/T14
<input type="checkbox"/> Aortic checked prior to case	<input type="checkbox"/> T1/T2	<input type="checkbox"/> T3/T4	<input type="checkbox"/> T5/T6	<input type="checkbox"/> T7/T8	<input type="checkbox"/> T9/T10	<input type="checkbox"/> T11/T12	<input type="checkbox"/> T13/T14
<input type="checkbox"/> Preop assessment	<input type="checkbox"/> T1/T2	<input type="checkbox"/> T3/T4	<input type="checkbox"/> T5/T6	<input type="checkbox"/> T7/T8	<input type="checkbox"/> T9/T10	<input type="checkbox"/> T11/T12	<input type="checkbox"/> T13/T14
<input type="checkbox"/> Aortic checked	<input type="checkbox"/> T1/T2	<input type="checkbox"/> T3/T4	<input type="checkbox"/> T5/T6	<input type="checkbox"/> T7/T8	<input type="checkbox"/> T9/T10	<input type="checkbox"/> T11/T12	<input type="checkbox"/> T13/T14

ANESTHESIA

<input type="checkbox"/> GA	<input type="checkbox"/> Sedation	<input type="checkbox"/> Local	<input type="checkbox"/> Regional	<input type="checkbox"/> Spinal	<input type="checkbox"/> Epidural	<input type="checkbox"/> Intrathecal	<input type="checkbox"/> Intracranial
<input type="checkbox"/> GA	<input type="checkbox"/> Sedation	<input type="checkbox"/> Local	<input type="checkbox"/> Regional	<input type="checkbox"/> Spinal	<input type="checkbox"/> Epidural	<input type="checkbox"/> Intrathecal	<input type="checkbox"/> Intracranial
<input type="checkbox"/> GA	<input type="checkbox"/> Sedation	<input type="checkbox"/> Local	<input type="checkbox"/> Regional	<input type="checkbox"/> Spinal	<input type="checkbox"/> Epidural	<input type="checkbox"/> Intrathecal	<input type="checkbox"/> Intracranial
<input type="checkbox"/> GA	<input type="checkbox"/> Sedation	<input type="checkbox"/> Local	<input type="checkbox"/> Regional	<input type="checkbox"/> Spinal	<input type="checkbox"/> Epidural	<input type="checkbox"/> Intrathecal	<input type="checkbox"/> Intracranial

POST-ANESTHESIA ASSESSMENT

<input type="checkbox"/> All Evaluation Criteria Met	<input type="checkbox"/> All Evaluation Criteria Met	<input type="checkbox"/> All Evaluation Criteria Met	<input type="checkbox"/> All Evaluation Criteria Met
<input type="checkbox"/> All Evaluation Criteria Met	<input type="checkbox"/> All Evaluation Criteria Met	<input type="checkbox"/> All Evaluation Criteria Met	<input type="checkbox"/> All Evaluation Criteria Met
<input type="checkbox"/> All Evaluation Criteria Met	<input type="checkbox"/> All Evaluation Criteria Met	<input type="checkbox"/> All Evaluation Criteria Met	<input type="checkbox"/> All Evaluation Criteria Met
<input type="checkbox"/> All Evaluation Criteria Met	<input type="checkbox"/> All Evaluation Criteria Met	<input type="checkbox"/> All Evaluation Criteria Met	<input type="checkbox"/> All Evaluation Criteria Met

Discharge Evaluation Note

<input type="checkbox"/> Vital signs in patient's normal range	<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> Respiratory function stable, airway patent	<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> Cardiovascular function and hydration status stable	<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> Mental status recovered, patient participates in evaluation	<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> Pain control satisfactory	<input type="checkbox"/> yes	<input type="checkbox"/> no
<input type="checkbox"/> Nausea and vomiting control satisfactory	<input type="checkbox"/> yes	<input type="checkbox"/> no

Comments: _____

Signature: _____

OPS ANESTHESIA RECORD
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