McLaren Flint
Flint, MI 48532

Radiology Procedural Sedation Form

PHYSICIAN DOCUMENTATION

Pre Op Diagnosis:	History and physical has been reviewed.
Procedure to be Done:	Risks/ benefits/ alternatives have been explained and questions answered.
Indication for Procedure:	Plan for sedation has been discussed with patient/family and is accepted.
ASA Class: circle one **I II III IV V E** *(see back of this page for definitions)*	Anticipated post-procedure needs have been identified.
Plan for Sedation: **Moderate Deep**	Mallampati 
Physician Signature (validates that all of the above have been completed).	Patient was reevaluated immediately prior to sedation.
	Negative Pregnancy Test confirmed NA
Signature:	Date: Time:

NURSING DOCUMENTATION (For Cath Lab procedures use electronic documentation)

Modified Aldrete Scores

Note: Must be done pre and post procedure to determine readiness to be discharged from the immediate "recovery" area.

Category	Criteria	Pre	Post
LOC	Fully awake and oriented to time, place, person	2	2
	Arousable on calling name	1	1
	Not responding to auditory stimulation	0	0
Physical Activity	Moves all extremities on command	2	2
	Some weakness in movement of extremities	1	1
	Unable to voluntarily move extremities	0	0
Circulation	BP ± 20% pre sedation level (baseline =2)	2	2
	BP ± 20-50% pre sedation levels	1	1
	BP ± 50% pre sedation levels	0	0
Respiratory	Able to deep breath and cough	2	2
	Dyspnea or limited breathing	1	1
	Apneic or no spontaneous respirations	0	0
Oxygen Saturation	O_2 sat ≥ 90% on room air or home O_2 regimen	2	2
	O_2 sat ≥ 90% with supplemental O_2	1	1
	O_2 sat < 90% with supplemental O_2	0	0
Pain Assessment	None or mild discomfort (0-2 on pain scale)	2	2
	Moderate to severe pain (3-6 on pain scale)	1	1
	Persistent severe pain (7-10 on pain scale)	0	0
Emetic Symptoms	None or mild nausea with no active emesis	2	2
	Transient vomiting or retching	1	1
	Persistent moderate/severe nausea or vomiting	0	0
	Total Score		

REFERENCES FOR DEFINITIONS AND CRITERIA

Located on page 3 of 4 and page 4 of 4.

ASA Classification

Sedation Levels

Level of Consciousness (LOC)

Pain Scales: Verbal and Non Verbal

Discharge Criteria: Discharge from Recovery and Discharge from Hospital

Procedure Information

Note: Document all medications, assessments and narrative comments on the grid of page 2

Allergies:

NPO since:

Temp:

Weight: Peds actual: Adult actual or stated:

Permit signed: YES NO EMERGENCY

IV site:

IV solution: Start Time: Stop Time:

Procedure physician:

Other personnel present:

Time Out Done: _____

Correct patient identity Correct side and site

Correct patient position Agreement on procedure to be done

Availability of correct implants and any special equipment or special requirements (as applicable)

Physician approval to begin sedation: YES NO

Time patient entered room:

Time procedure started:

Procedure performed:

Post Op Diagnosis:

Estimated blood loss _____

Tissue Removal _____

Time procedure completed:

Time patient left room:

Total IV solution infused: *mL*

Procedure-to-recovery report given by: to:

Time patient met Criteria for **Discharge from Recovery:**

Time patient discharged from recovery:

Post recovery report given by: to:

Outpatients Only

Time patient met Criteria for **Discharge from Hospital:**

Patient accompanied by:

Discharged by: Time:

Signature and Title: _____ Date _____ Time _____

PT.

MR#/RM#

DR.

McLaren Flint
Flint, MI 48532

Radiology Procedural Sedation Form

MEDICATIONS AND ASSESSMENTS

Time				Medication				Assessment									
Time	*Check one* Pre Proc	Intra Proc	Post Proc	Medication	Dose	Route	Given By (Initials)	BP	HR	Rhythm If Monitored	Resp Rate	O2 Sat	O2 Admin L/min C-M-V	LOC	Pain Score Verbal	Pain Score Non Verbal	Monitored By (Initials)

Return to page 1 and complete the post procedure Modified Aldrete Score

If a reversal agent is used (Narcan or Romazicon) please call Quality Management with patient information, 342-2005

ADDITIONAL NARRATIVE DOCUMENTATION

Time	Comments

SIGNATURES

I have reviewed and agree with the above listed medications that were given per my verbal orders.

Physician Signature	Date	Time

Use an additional page 2 if more documentation space is required

Implant Information Sticker

PT.

MR#/RM#

DR.

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Flint, MI 48532

Procedural Sedation Quality Monitoring

Date of Procedure:_____ **Procedure:**_____
Unit/Department where sedation was given:_____
Physician Name:_____ **RN name:** _____
Medication Administered: _ Ativan Versed Fentanyl _ Demerol_____Morphine Dilaudid
_____other:_____

	YES	NO
1. Was the Consent to Operation or Other Procedure signed by the Anesthesia Provider?		
2. Was there an "Immediate Assessment done prior to the start of the procedure that included: **a. Mallampati assessment?** **b. ASA Classification?** **c. Review of Current Vital Signs?**		
3. Were there unusual difficulties/problems during the procedure such as: **a. Patient became unresponsive?** **b. Obstructed airway requiring placement of an oral/nasal airway, intubation or bag/mask ventilation with ambu bag?** ***c*. Increased oxygen need by either increasing FiO2 or changing the mode of oxygen delivery** *(example: changing from nasal cannula to a mask)* **d. CPR initiated?** **e. Other: Explain**		
4. Was the oxygen saturation documented every 5 minutes during the procedure and every 15 minutes during recovery?		
5. Was any reversal agent required during or after the procedure? **Narcan Romazicon**		
6. If reversal agents were used, did the patient stay 120 minutes following administration of reversal?		
7. Did the patient return to pre-procedure condition upon completion of procedure? If no, explain:		
8. Were there any adverse outcomes/events? If yes, explain:		
9. How long was the patients recovery from end of procedure until an Aldrete score of 10 (or pre-procedure level if baseline was less than 10?) **Less than 60 minutes More than 60 minutes**		
10. Was sedation education provided and documented?		
11. Was the Procedural Sedation Documentation form thoroughly completed?		

*****FAX TO 342-3148 OR MAIL THIS FORM TO THE QUALITY MANAGEMENT DEPARTMENT DAILY*****

THIS DOCUMENT IS NOT PART OF THE MEDICAL RECORD

PT.

MR#/RM#

DR.