


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 <b>I</b> <b>II</b> <b>III</b> <b>IV</b> <b>V</b> <b>E</b> (see back of this page for definitions)	Anticipated post-procedure needs have been identified.		
Plan for Sedation: <b>Moderate</b> <b>Deep</b>	Mallampati 		
Physician Signature (validates that all of the above have been completed).	Patient was reevaluated immediately prior to sedation.		
Signature:	Negative Pregnancy Test	confirmed	NA
Date:	Time:		

NURSING DOCUMENTATION

(For Cath Lab procedures use electronic documentation)

Modified Aldrete Scores				Procedure Information	
Note: Must be done pre and post procedure to determine readiness to be discharged from the immediate "recovery" area.				Note: Document all medications, assessments and narrative comments on the grid of page 2	
Category	Criteria	Pre	Post		
LOC	Fully awake and oriented to time, place, person	2	2	Allergies:	
	Arousable on calling name	1	1	NPO since:	
	Not responding to auditory stimulation	0	0	Temp:	
Physical Activity	Moves all extremities on command	2	2	Weight: Peds actual: Adult actual or stated:	
	Some weakness in movement of extremities	1	1	Permit signed: YES NO EMERGENCY	
	Unable to voluntarily move extremities	0	0	IV site:	
Circulation	BP ± 20% pre sedation level (baseline =2)	2	2	IV solution: Start Time: Stop Time:	
	BP ± 20-50% pre sedation levels	1	1	Procedure physician:	
	BP ± 50% pre sedation levels	0	0	Other personnel present:	
Respiratory	Able to deep breath and cough	2	2	Time Out Done: _____	
	Dyspnea or limited breathing	1	1	Correct patient identity Correct side and site	
	Apneic or no spontaneous respirations	0	0	Correct patient position Agreement on procedure to be done	
Oxygen Saturation	O <sub>2</sub> sat ≥ 90% on room air or home O <sub>2</sub> regimen	2	2	Availability of correct implants and any special equipment or special requirements (as applicable)	
	O <sub>2</sub> sat ≥ 90% with supplemental O <sub>2</sub>	1	1	Physician approval to begin sedation: YES NO	
	O <sub>2</sub> sat ≤ 90% with supplemental O <sub>2</sub>	0	0	Time patient entered room:	
Pain Assessment	None or mild discomfort (0-2 on pain scale)	2	2	Time procedure started:	
	Moderate to severe pain (3-6 on pain scale)	1	1	Procedure performed:	
	Persistent severe pain (7-10 on pain scale)	0	0	Post Op Diagnosis:	
Emetic Symptoms	None or mild nausea with no active emesis	2	2	Estimated blood loss _____	
	Transient vomiting or retching	1	1	Tissue Removal _____	
	Persistent moderate/severe nausea or vomiting	0	0	Time procedure completed:	
<b>Total Score</b>				Time patient left room:	
				Total IV solution infused: _____ mL	
<b>REFERENCES FOR DEFINITIONS AND CRITERIA</b> 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-to-recovery report given by: _____ to: _____	
				Time patient met Criteria for <b>Discharge from Recovery</b> :	
				Time patient discharged from recovery:	
				Post recovery report given by: _____ to: _____	
				<b>Outpatients Only</b>	
				Time patient met Criteria for <b>Discharge from Hospital</b> :	
				Patient accompanied by:	
				Discharged by: _____ Time: _____	

Signature and Title: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_





### 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***

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PT.
MR#/RM#
DR.