

ANESTHESIA RECORD										START		STOP		
Date _____ OR No. _____ Page _____ of _____ Surgeon(s) _____ Procedure _____										Anesthesia _____		Procedure _____		
PRE-PROCEDURE			MONITORS AND EQUIPMENT			ANESTHETIC TECHNIQUE			AIRWAY MANAGEMENT			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 _____			<input type="checkbox"/> 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 Stimulator <input type="checkbox"/> Warming Blanket <input type="checkbox"/> EEG <input type="checkbox"/> Doppler <input type="checkbox"/> Airway Humidifier <input type="checkbox"/> Fluid Warmer			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 _____			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 <input type="checkbox"/> Eye Care: <input type="checkbox"/> Ointment <input type="checkbox"/> Saline <input type="checkbox"/> Taped <input type="checkbox"/> Pads <input type="checkbox"/> Goggles														
TIME: _____														
Oxygen (L/min) _____ N ₂ O <input type="checkbox"/> Air (L/min) _____														
URINE (ml) _____ EBL (ml) _____														
EKG _____ % O ₂ Inspired _____ O ₂ Saturation _____ End Tidal CO ₂ _____ Temp: <input type="checkbox"/> °C <input type="checkbox"/> °F _____														
Baseline Values _____ B/P _____ P _____ R _____														
Tidal Volume _____ Resp. Rate _____ Peak Pressure _____ PEEP _____ Symbols for Remarks _____ Position _____														
PATIENT IDENTIFICATION														
Anesthesia Provider														
Drug _____ Issued _____ Used _____ Returned _____														
Provider _____														
Witness _____														