Maine Medical Center
Department of Anesthesiology
and Pain Management

PROCEDURE NOTE
EPIDURAL CATHETER PLACEMENT / SPINAL DRAIN or EPIDURAL BLOOD PATCH

147066

Patient Label Here; after procedure completed, make TWO photocopies and submit one copy to APMS Office, other to Spectrum Billing; original to chart

PATIENT NAME LABEL

PROCEDURE NOTE – EPIDURAL CATHETER PLACEMENT / SPINAL DRAIN or EPIDURAL BLOOD PATCH

Indication:

- ☐ Postoperative pain: Requested/ordered by surgeon who ordered the block for expected unacceptable Post-Op pain.
- ☐ Spinal drainage for CSF leak.
- ☐ Replacement catheter. ☐ Prior catheter removed with tip intact.
- ☐ Spinal fluid loss headache.
- ☐ Other: _____

Requested/ordered by: _____

Placement Period: ❑ PreOp ❑ PostOp **Location:** ❑ Holding ❑ OR ❑ PACU ❑ Other _____

Pre-procedure checklist:

- ☐ Patient identified
- ☐ Site and block technique verified
- ☐ Pre-anesthesia record complete
- ☐ Anesthesia consent obtained
- ☐ Surgical consent obtained
- ☐ Surgery site marked
- ☐ Pre-procedure time-out performed

DESCRIPTION OF PROCEDURE: **Catheter Type:** ❑ Epidural ❑ Spinal Drain ❑ Tunneled

Position: ❑ Sitting ❑ Lateral **Site:** ❑ Thoracic ❑ Lumbar ❑ Caudal

❑ **Sterile preparation and drape:** ❑ Chlorhexidine/Isopropyl Alcohol ❑ Betadine ❑ Other

Tuohy Needle: ❑ 18g ❑ 14g ❑ Other: _____ Interspace: _____ # Attempts at insertion: _____

Blood: ❑ No ❑ Yes **Cerebral spinal fluid:** ❑ No ❑ Yes **Paresthesia:** ❑ No ❑ Yes (describe below)

Catheter: 1. Catheter inserted: _____cm

2. Draw a line across the appropriate catheter diagram to indicate where the catheter exits the skin:

Epidural Catheter:

Tip 5cm 10cm 15cm 20cm

Spinal Drainage Catheter:

Tip | 5 | 7.5 | 10 | 15

Test Dose: Lidocaine 1.5% with epinephrine _____ mL; Other _____

Heart rate change or subarachnoid block: ❑ No ❑ Yes describe

Pedi: ❑ Omnipaque 240 _____ mL ❑ Omnipaque 300 _____ mL ❑ Epidural positioning on x-ray _____

Drugs: **Sensory Block:**

Complications: ❑ No ❑ Yes, describe:

Notes:

Physician Signature/ID _____ Date_____ 24 hr time _____

I was present for the placement:

Physician Signature / ID _____ Date_____ 24 hr time _____

QI Observations ☐ **NO LISTED OBSERVATIONS**

☐ Non-functional in first 24 hours

☐ Replaced on (date) _____ for any reason by (physician) _____

☐ Thoracic ☐ Lumbar ☐ Caudal

☐ Inadvertent dural puncture

☐ Removed or technique changed for side effects

☐ Sedation and/or respiratory depression requiring Naloxone

☐ Infections

☐ New neurological symptoms not relieved by adjusting infusion

☐ Neurology consult requested: ☐ Yes ☐ No

☐ Catheter not secured properly

☐ Catheter disconnection

☐ Catheter displaced

☐ Other (specify)

CONFIDENTIAL: Not a Medical Record. Please return this form to the Anesthesiology Dept.

This record is maintained as part of either (1) a hospital quality program for the identification and prevention of medical injury (including education) pursuant to the Maine Health Security Act (24 MRSA, chapter 21) or (2) a confidential quality improvement program involving review of medical care on behalf of physicians, conducted under the auspices of the Maine Medical Association as authorized under the provisions of 32 MRSA, section 3296.

Department Billing / QI