Maine Medical Center
PRE-ANESTHESIA / PERIOPERATIVE RECORD
Side 1

Diagnosis / Problem:

Proposed Procedure:

- Otherwise healthy except as noted
  - Respiratory: □ Unremarkable
    - □ Y □ N Asthma
    - □ Y □ N COPD
    - □ Y □ N Smoking _____ packs per day; quit _____
    - □ Y □ N Respiratory Infection
    - □ Y □ N Sleep Apnea
  - Cardiovascular: □ Unremarkable
    - □ Y □ N Hyperlipidemia
    - □ Y □ N Hypertension
    - □ Y □ N Coronary Artery Disease
    - □ Y □ N Valve disease
    - □ Y □ N Atrial Arrhythmia
    - □ Y □ N Ventricular Arrhythmia
    - □ Y □ N Congenital Heart Disease
    - □ Y □ N Congestive Heart Failure
    - □ Y □ N Peripheral Vascular Disease
    - □ Y □ N Activity Limitations
  - Neurological: □ Unremarkable
    - □ Y □ N Cerebrovascular Disease
    - □ Y □ N Seizures
    - □ Y □ N Numbness/Weakness
    - □ Y □ N Neuromuscular disease
    - □ Y □ N Altered mental status
    - □ Y □ N Psych/Depression
  - Systemic: □ Unremarkable
    - □ Y □ N Diabetes
    - □ Y □ N Renal Disease
    - □ Y □ N Thyroid Disease
    - □ Y □ N Liver Disease
    - □ Y □ N Bleeding Problems/Anemia
    - □ Y □ N Cancer
    - □ Y □ N Substance Use
    - □ Y □ N Chronic Opiate Use
    - □ Y □ N Gastroesophageal Reflux
    - □ Y □ N Hx of Post-Op Nausea/Vomiting and/or Motion Sickness
    - □ Y □ N Trauma
    - □ Y □ N Obesity BMI 30 ≤ 39
    - □ Y □ N Morbid Obesity BMI >39
    - □ Y □ N Chance of Pregnancy

Exam:

- Pulse
- BP
- Ht(cm)
- Wt(kg)
- BMI
- SaO2

Airway and other comments:

- □ Y □ N Mouth opens well
- □ Y □ N Neck ROM full
- □ Y □ N Expect no difficulty
- □ Y □ N Dentures U L

Labs and Tests

- □ N/A
- □ Recorded in chart and reviewed

EKG:

- □ Hb
- □ Hct
- □ Plts
- □ INR
- □ PTT
- □ T x S / T x C

- □ Na+
- □ K+
- □ BUN
- □ Cr
- □ Gluc

Pre-Op completed: Sig/ID/Date/Time (24h):

Surgical/Anesthesia History □ NONE

History of airway difficulty □ Y □ N

Patient history of anesthesia problems □ Y □ N

Family history of anesthesia problems □ Y □ N

Adverse Drug Reactions □ NKDA

Medications □ NONE

□ Medication Reconciliation Reviewed

Problem List □ NONE

1.
2.
3.
4.
5.
6.

Anesthesia plan discussed with patient:

- □ Anesthetic
- □ Monitors
- □ Post-Op Pain

- □ General
- □ A-line
- □ Epidural

- □ Spinal
- □ CVC
- □ Caudal

- □ Epidural
- □ PAC
- □ PCA

- □ MAC
- □ TEE
- □ Block:

- □ Block:

ASA:  1 2 3 4 5 6 E

Consent signed: □ Y □ N
Post Anesthesia Evaluation -
General, Regional or MAC.

- **Respiratory Function.** Airway patency, rate and oxygenation within expected parameters
- **Cardiovascular Function.** Pulse and blood pressure within expected parameters
- **Mental Status.** Arousable and able to follow simple commands or returned to pre-procedure baseline
- **Temperature.** Within expected parameters
- **Pain.** Within expected parameters. Post-procedure orders written
- **Nausea & Vomiting.** No acute nausea or vomiting or responding adequately to treatment
- **Hydration.** Appears adequately hydrated

I evaluated the patient and find the above criteria are met. There are no apparent complications attributable to anesthesia at this time. □ No (If No, see Comments below)

**Sig/ID/Date: ____________________________ Time(24°): ____________________________**

Perioperative Procedures and Events, *continued from Anesthesia Record* (Date and time all entries)
1. CONSENT. I hereby consent to and authorize the anesthesiologists, (residents), certified registered nurse anesthetists and other health care providers, as well as students and other trainees acting under their direct supervision, to administer anesthesia care, insert a central venous catheter, arterial line and other procedures necessary for monitoring and/or administer blood or blood products as indicated for my proposed procedure.

2. PLANNED ANESTHETIC TECHNIQUES. The following anesthetic technique(s) is/are planned for my procedure:

☐ General Anesthesia – Treatment that induces a state of unconsciousness during my procedure. This is accomplished by either an injection in my vein or the breathing of gas or both and it may involve the use of a breathing tube in my windpipe or another breathing device.

☐ Regional Anesthesia

☐ Spinal/Epidural anesthesia/Analgesia – The numbing of the lower portion of my body by the injection of drugs through a needle or catheter inserted into the appropriate space (epidural, spinal, block or caudal). General anesthesia may be administered if this method is insufficient.

☐ Block – The numbing of a part of my body by an injection of drug(s) around the appropriate nerves. This may be supplemented by sedation or general anesthesia as appropriate.

Type of block: ______________________________

☐ Sedation/monitored anesthesia care – An injection of medications in my vein or the breathing of a gas or both to make me feel sleepy and relaxed.

☐ Central Venous Catheter/Arterial line – The placement of a catheter inserted into a vein or artery. The central catheter (line) will be placed in a large vein near my heart. My team will determine the safest site for the insertion of my central line. The physician responsible for my care will determine the duration of time the catheter will be left in place based on medical necessity.

3. RISKS AND HAZARDS. I have been informed that anesthesia carries some risks that cannot be eliminated.

Risks of General Anesthesia/Sedation: The usual and most frequent risks and hazards inherent in general anesthesia and sedation include nausea, vomiting, drug reactions, sore throat, tongue or lip numbness, hoarseness, muscle soreness, changes in blood pressure, anaphylaxis, aspiration and damage to teeth or dental hardware including chipping, cracking, loosening and removal. Pre-existing poor dentition or dental hardware will increase the risk of dental damage. Rare but serious risks of general anesthesia include: heart attack, stroke, organ damage, recovery of consciousness during the procedure resulting in awareness of surgery and death.

Risks of Regional Anesthesia: The usual and most frequent risks and hazards inherent in regional anesthesia include nerve injury resulting in temporary or permanent numbness, paralysis, weakness or pain, infection and IV site injury. Regional anesthesia during labor can also affect the course of labor. Rare but serious risks include: reaction to medication leading to seizure, depressed breathing, heart failure and/or death.

4. OTHER TECHNIQUES. I am aware that unforeseen problems may arise prior to or during the management of my anesthesia care which may require the use of additional or different techniques. If a change in technique is indicated, I hereby request and authorize the use of additional techniques, procedures and treatments deemed by my attending anesthesiologist (or other anesthesia provider) to be medically appropriate.

5. CPR. I consent to receive cardiopulmonary resuscitation (CPR) in the event of a cardiopulmonary crisis during this procedure.

This consent overrides any wishes I may have previously expressed in an advance directive or in conversations with other health care providers. This consent to receive CPR is valid for this procedure and during the recovery period from anesthesia or sedation. My consent to receive CPR during this procedure does not necessarily reflect my preferences regarding CPR in other circumstances and settings.

☐ Patient does not consent to CPR. Document discussion with the patient or authorized representative:

6. CENTRAL VENOUS CATHETER EDUCATION ON INFECTION PREVENTION: I have been notified of the potential for infection and instructed in the ways to prevent infection including, but not limited to, hand hygiene and keeping the insertion area clean and dry.

7. BLOOD PRODUCTS. I understand that the transfusion of blood components (red blood cells, plasma, platelets, cryoprecipitate) may be necessary or appropriate as part of this surgical procedure or to treat conditions arising during this hospital stay after my surgery or procedure. Mild reactions such as fever and hives are quite common. Despite testing, the risk of an extremely rare but serious reaction or infection exists, including HIV, hepatitis, lung injury, and death. Under some clinical situations and with appropriate planning, alternatives to transfusion may be considered. Additional discussion of the risks and alternatives has been offered. If a change in technique is indicated, I hereby request and authorize the use of additional or different techniques. If a change in technique is indicated, I hereby request and authorize the use of additional or different techniques.

☐ No, I do not consent to Blood Products

8. NO GUARANTEE. I am aware that the practice of medicine and surgery, including anesthesia, is not an exact science and I acknowledge that NO GUARANTEES HAVE BEEN MADE TO ME CONCERNING THE RESULTS OF MY ANESTHESIA CARE OR PROCEDURE(S).

I acknowledge that the anesthetic techniques listed above, their respective risks and benefits, and the alternatives to the chosen technique, if any, have been explained to me to my satisfaction. I understand that I have the right to refuse any suggested techniques or procedures.

Signature of Patient __________________________________________ Date _______________ 24hr Time __________

Signature of physician or designee __________________________________________ Date _______________ 24hr Time __________
If the patient is a minor or is unable to give informed consent, the following MUST be completed:

The patient is unable to sign this consent form for himself/herself because: __________________________________________________________

Signature of Parent or Guardian Date / 24 hour time
Identification of Relationship or Authorized Capacity to Consent: __________________________________________________________

Signature of Physician or Designee Date / 24 hour time

If consent is obtained by telephone, the following MUST be completed:

Name of the person giving consent and relationship to patient: __________________________________________________________

Name of third party witness (please print): ___________________________ Phone number

Signature of Third Party Witness Date / 24 hour time

Signature of Physician or Designee Date / 24 hour time

Use of Interpreter or Special Assistance

If consent is obtained by use of an interpreter or special assistance, the following MUST be completed:

☐ Foreign language
☐ Sign language
☐ Patient is blind. Consent form was read to patient.
☐ Other (specify): __________________________________________________________

Interpretation provided by __________________________________________ Name of interpreter and title or relationship to patient