UNIVERSITY MEDICAL CENTER

PACU RECORD

Procedure:

Date:

Time:

Anesthesiologist:

Surgeon:

Patient Name _____ MR# _____

ID BRACELET ❑ ON

ALARMS ❑ ON

Warm Blanket ❑ Bair Hugger ❑ Overhead Warmer ❑

DATA COLLECTION

Anesthesia Signature:

Allergies:

Post OP Condition

History:

OXYGENATION:

TYPE	CONC	START	CHANGE	END
NC				
MASK				
T-PIECE				

AIRWAY	SIZE	TIME REMOVED
OT		
NT		
Trach		
RNA		
ROA		
POA		

ANESTHETIC AGENTS:

General ❑ Regional ❑ Epidural ❑ Local Block ❑

Spinal ❑ Caudal ❑ MAC ❑

ONGOING ASSESSMENT

PAIN INTENSITY:									
TIME									OR TOTALS
EKG									INTAKE
SAT									
TEMP									
RR									OUTPUT
ALINE									EBL
PAS/PAD									
CVP									
PCWP									
CO/CI									
SVR									
ICP									

BP V ^

A Line Pressure ⊥ T

Pulse •

200 150 100 50

Pain Scale 0 - 10

HEMODYNAMIC ASSESSMENT

EVALUATION

INITIAL ASSESSMENT

NEURO: ❑ FULLY AWAKE ❑ DROWSY ❑ LETHARGIC ❑ NON-RESPONSIVE

MOVES EXTREMITIES: ❑ ALL 4 ❑ 2 ❑ 0 ❑ NA

ABLE TO FEEL: ❑ ALL 4 ❑ 2 ❑ 0 ❑ NA

RESPIRATORY: *RESPIRATION:* ❑ NORMAL ❑ DEEP ❑ SHALLOW ❑ LABORED ❑ VENTED

BREATH SOUNDS: ❑ CLEAR ❑ CRACKLES ❑ RHONCHI ❑ DIM/ABSENT ❑ WHEEZE

COLORS: ❑ NORMAL/PINK ❑ PALE ❑ FLUSHED ❑ DUSKY ❑ CYANOTIC ❑ JAUNDICED

GU: FOLEY/CBI: ❑ NA ❑ CLEAR AMBER ❑ HEMATURIA ❑ DARK AMBER ❑ OTHER _____

GI: ABDOMEN ❑ SOFT ❑ DISTENDED ❑ OTHER _____

NAUSEA: ❑ YES ❑ NO EMESIS: ❑ YES ❑ NO

SKIN: *DRSG. DRY/INTACT:* ❑ YES ❑ NO ❑ NA

REINFORCED: ❑ YES ❑ NO

DRAINAGE: ❑ NONE ❑ SEROUS ❑ SANGUINEOUS ❑ PURULENT

IV SITES: ❑ PATENT ❑ NA ❑ OTHER _____

GYN: ❑ NA *VAGINAL BLEEDING:* ❑ SCANT ❑ SMALL ❑ MOD ❑ LARGE ❑ NONE

AFFIX PATIENT INFO LABEL HERE

Patient Name _____ MR# _____

EVALUATION

POST ANESTHESIA RECOVERY SCORE

		ADMIN	15	30	1 hr	Discharge
ACTIVITY	4 extremities	2	2	2	2	2
Able to move voluntarily or on command	2 extremities	1	1	1	1	1
	0 extremities	0	0	0	0	0
RESPIRATIONS	Able to breath and cough freely	2	2	2	2	2
	Dyspnea, shallow or limited breathing	1	1	1	1	1
	Apneic	0	0	0	0	0
CIRCULATION	BP ± 20	2	2	2	2	2
Pr-op BP _____	BP ± 21-40	1	1	1	1	1
	BP ± 50	0	0	0	0	0
CONSCIOUSNESS	Fully awake	2	2	2	2	2
	Arousable on calling	1	1	1	1	1
	Not responding	0	0	0	0	0
SATURATION	SAT >92% on RA	2	2	2	2	2
	0_2 needed for SAT >92%	1	1	1	1	1
	SAT <90% with 0_2 on	0	0	0	0	0

Discharge Criteria: Score 8 and VSS
If score <8, M.D. notified and OK discharged

VENT SETTINGS

TIME		
TV		
F_1O_2		
MODE		
PEEP		
R.R.		

ABG'S

TIME		
F_1O_2		
pH		
pCO_2		
paO_2		
SATs		
HCO_3		
BE		

FLUID/ELECTROLYTE BALANCE

INTAKE

SITE/SIZE	SOLUTION	AMT	START	LIB	ABS
	PACU TOTAL				

OUTPUT

TIME								TOTAL
URINE								
CBI								
NGT								
REINF.								
CT								
HEM/JP								
PACU TOTAL								

NEUROVASCULAR ASSESSMENT

TIME																		
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L
LEVEL OF CONSCIOUSNESS 5 = Alert 2 = Stuporous 4 = Confused 1 = Obtunded 3 = Incomprehensible Sounds																	Size Reaction	
PUPILS SIZE: ● 2mm ● 4mm ● 6mm B = Brisk S = Sluggish N = None																		
TONGUE M = Midline Deviates R-L																		
MOVEMENT S = Strong W = Weak Ø = None																	Upper Ext. Grips Lower Ext.	
PERIPHERAL PULSES P = Palpable D = Doppler A = Absent																	Radial DP PT	
SENSATION (Dermatome Level)																		

PACU INTERVENTION

TIME	DRUG	DOSE	RTE	INIT.	TIME	DRUG	DOSE	RTE	INIT.

DATA COLLECTION

NURSING NARRATIVE

SIGNATURE

AFFIX PATIENT INFO LABEL HERE

Patient Name _____ MR# _____

DATA COLLECTION

ACCUCHECK: TIME _____

LAB RESULTS: RESULT _____

Time								
WBC			BS			Na		
HGB			BUN			K		
HCT			Creat			CL		
PLT			Ca			CO_2		
PT			Mag			CK / MB		
PTT			PO_4			Tr		

TITRATED INFUSIONS

Drug - Amount Solution | Weight in kg _____

	TIME						
	RATE						
	TIME						
	RATE						
	TIME						
	RATE						

Pulse Oximeter Alarm On/Lower Alarm Limit Set at 90% Initial ☐

Cardiac Monitor Unit Based
Blood Pressure Alarms On/Limits Set at (50/120) Alarms On/Limits Set at (90/180) Initial ☐

NURSING NARRATIVE

NURSING NARRATIVE

SIGNATURE

Full Signature/Title	INIT	Full Signature/Title	INIT