

		<b>MODERATE SEDATION / ANALGESIA FOR DIAGNOSTIC AND THERAPEUTIC PROCEDURE: PREASSESSMENT NOTE</b>	
Date	Time	ALL PROGRESS NOTES MUST BE SIGNED WITH DATE AND TIME	
		<b>History of Present Illness:</b>	
		<b>Medical History:</b>	
		ETOH / Tobacco / Substance use? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:	
		Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A LMP:	
		Previous Problems with anesthesia / sedation? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:	
		Any history of sleep apnea or snoring? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:	
		Major organ systems problems? (chronic pulmonary, cardiac, hepatic or renal disease) <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Comments:	
		<b>ASA Physical Status Classification (choose one)</b>	
		<input type="checkbox"/> I. Healthy patient	
		<input type="checkbox"/> II. Mild systemic disease: no functional limitation	
		<input type="checkbox"/> III. Severe systemic disease: definite functional limitation	
		<input type="checkbox"/> IV. Severe systemic disease that is a constant threat of life	
		<input type="checkbox"/> V. Moribund patient not expected to live with the operation	
		<b>Physical Exam:</b>	
		Review of systems (Cardiac / Respiratory, etc) WNL? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Comments:	
		<b>Airway Assessment:</b>	
		Neck: <input type="checkbox"/> Normal <input type="checkbox"/> Restricted Neck motion <input type="checkbox"/> Short neck <input type="checkbox"/> Obese head/neck area	
		Mouth: <input type="checkbox"/> Normal <input type="checkbox"/> Loose Teeth <input type="checkbox"/> Large tongue <input type="checkbox"/> Other / comments:	
		Mental Status / LOC <input type="checkbox"/> Not responding <input type="checkbox"/> Arouses to verbal stimuli <input type="checkbox"/> Fully Awake	
		Vital Signs Reviewed (recorded on monitoring flowsheet) <input type="checkbox"/> Yes <input type="checkbox"/> No	
		<b>Current medications:</b>	
		<b>ALLERGIES:</b> <input type="checkbox"/> NKDA List:	
		<b>Pertinent Lab Abnormalities:</b> <input type="checkbox"/> None <input type="checkbox"/> List	
		<b>Last oral intake</b> [NPO since _____ (time)]	
		<input type="checkbox"/> No solids or milk products in 6 hours <input type="checkbox"/> No clear liquids in 2 hours	
		<b>Sedation / Analgesia plan:</b>	
		<input type="checkbox"/> Versed <input type="checkbox"/> Demerol <input type="checkbox"/> Fentanyl <input type="checkbox"/> Other: list	
		<b>Site Marked:</b> _____ (location) <input type="checkbox"/> N/A	
		In light of the above evaluation, I believe this patient is an acceptable candidate for sedation / analgesia and have discussed the indications for and risks of sedation with the patient / parent / guardian, who understands and consents. <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Signature of MD: _____ Date: _____	
		Supervising Physician: _____	

Patient Label

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