DATE: ________ OPERATION: ________________

TIME IN: ________ ADMITTING NURSE: ________________ R.N.

NAME TAG CHECK Y ☐ N ☐

ALLERGY BAND CHECK Y ☐ N ☐

PT. HISTORY ▶

ALLERGIES ▶

ANESTHESIA

☐ GENERAL ☐ SPINAL

☐ MAC ☐ OTHER

CRYSTALLOID ______

COLLOID ______

EBL ______

FENTANYL ______

MIDAZOLAM ______

URINE OUTPUT ______

ANTIBIOTIC ______

INTAKE

TIME ▶							TOTAL

OUTPUT

TIME ▶								TOTAL
URINE*								
FOLEY								
NG								
EMESIS								
JP								
HEMOVAC								

LAB RESULTS

TIME				
pH				
PO_2				
PCO_2				
SBE				
TCO_2				
SAT				
WBC				
Hgb				
Hct				
Plts				
Na +				
K +				
CO_2				
C1				
Glu				
PT/PTT				
FS				

TIME ▶

NIBP ☐

BP

A-LINE

● PULSE

220	
200	
180	
160	
140	
120	
100	
80	
60	
40	
20	
RESP.	
TEMP	
SaO_2	

TIME	MEDICATION	DOSE	ROUTE	RN

ANESTHESIOLOGIST'S ORDERS / NOTES	PHYSICIAN
1. Fentanyl _____ mcg IV for pain rated 4 to 10/10. If pain rating remains 4 to 10/10, may repeat dose every 5 minutes _____ times.	
2. Percocet - (circle one dose) one tablet OR two tablets PO for pain rated 4 to 10/10.	
3. Tylenol #3 - (circle one dose) one tablet OR two tablets PO for pain rated 4 to 10/10.	

Discharge Aldrete Score

Activity: able to move voluntarily or on command
- 4 extremities 2
- 2 extremities 1
- 0 extremities 0

Respiration:
- Able to deep breathe and cough freely 2
- Dyspnea, shallow or limited breathing 1
- Apneic. 0

Circulation:
- BP ± 20 mm of preanesthetic level 2
- BP ± 20 - 50 mm of preanesthesia level 1
- BP ± 50 mm of preanesthesia level. 0

Consciousness:
- Fully awake 2
- Arousable on calling 1
- Not responding 0

O_2 saturation:
- Able to maintain O_2 saturation > 92% on room air . . . 2
- Needs O_2 inhalation to maintain O_2 saturation > 90% . 1
- O_2 saturation < 90% even with O_2 supplementation . . 0

A score ≤ 9 was required for discharge

A score of < 6 discharge/bypass Phase one to two

Total Score ☐

PAIN SCORE

(Ask pt. to rate pain intensity)

0 No Pain
1
2
3 Mild Pain
4
5 Moderate Pain
6
7 Strong Pain
8
9
10 Worst Pain Possible
S Patient Sleeping
U Patient unable to give pain rating

Patient Label

OUT PATIENT POST ANESTHESIA CARE RECORD

DATE ______________________

▶ = DISCHARGE CRITERIA
* = SPINAL/EPIDURAL ANESTHESIA ONLY

CODE (-) NO (N/A) NOT APPLICABLE

POST ANESTHESIA ASSESSMENT

SAS - 1. unarousable, 2. very sedated, 3. follows commands, 4. calm & cooperative, 5. agitated, 6. very agitated, 7. dangerously agitated									
	INITIALS								
	TIME								
1. O_2 Therapy: ROOM AIR=RA, NASAL CANNULA=NC, FACE MASK=FM, FACE TENT=FT, T-PIECE=TP, OTHER									
2. AIRWAY NASAL ( ) ORAL ( )									
3. PATIENT INTUBATED ORAL ( ) NASAL ( )									
▶ 4. RESPIRATIONS: SPONTANEOUS=S, REGULAR S EFFORT=R, DEEP=D, MODERATE=M, SHALLOW=SH									
▶ 5. SEDATION-AGITATION SCALE (SAS)									
▶ 6. ALERT & ORIENTED TO PERSON, PLACE AND TIME									
7. SKIN QUALITY: WARM=W, DRY=D, COOL=C, MOIST=M									
8. DRESSING DRY AND INTACT									
9. SURGICAL DRAINS PATENT									
10. IV SIZE/LOCATION IV PATENT?									
▶ 11. SENSORY DERMATOME LEVEL*									
▶ 12. MOTOR FUNCTION* RIGHT/LEFT									
▶ 13. NAUSEA=N EMESIS=E									
▶ 14. ABLE TO AMBULATE									
▶ 15. TAKING PO FLUIDS									
▶ 16. INSTRUCTIONS REVIEWED POST-OP/POST ANESTHESIA									
17. SKIN INTEGRITY EVERY 2 hrs I=INTACT, #=SEE NOTES									
18. PAIN SCALE 0-10									
19. SIDE RAILS UP/BRAKES ON/ALARMS ON									
20. NEUROVASCULAR: Affected Extremity ________ Pulses P=Palpable A=Absent D=Doppler									
21. CAP REFILL B=BRISK S=SLUGGISH (>3 SECONDS)									
22. OTHER									

NURSE'S NOTES

DOCUMENT PAIN CONTROL ASSESSMENT AND INTERVENTIONS ON DISCHARGE AND PRN. ☐ See Progress Notes

SIGNATURE	TITLE	INITIALS	SIGNATURE	TITLE	INITIALS

DISCHARGING NURSE	TIME OUT	TO/WITH	TOTAL TIME ▶
,R.N.			

Patient Label

OUT PATIENT POST ANESTHESIA CARE RECORD