

Memorial Hospital	DATE	PATIENT LABEL
PERIOPERATIVE PATIENT CARE NURSING RECORD PATIENT ADMISSION DATA BASE		

INFORMATION	
Scheduled Procedure: _____ Date: _____ Time: _____	Chief Complaint: _____ Physician: _____
Anticipated Anesthesia: <input type="checkbox"/> General <input type="checkbox"/> IV Sed <input type="checkbox"/> Local <input type="checkbox"/> None <input type="checkbox"/> Regional/Block	
Mode: <input type="checkbox"/> Same Day Admission <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	

PREOP PHONE CALL	
Number: _____ Spoke To: _____	Date: _____ Time: _____ Physician: _____
Information Given: <input type="checkbox"/> Valuables <input type="checkbox"/> Escort <input type="checkbox"/> NPO <input type="checkbox"/> Advance Directives <input type="checkbox"/> Insurance Cards <input type="checkbox"/> Medications <input type="checkbox"/> Blood Bank Protocol <input type="checkbox"/> Location/Directions <input type="checkbox"/> Time to Arrive: _____ <input type="checkbox"/> Nails/Jewelry/Contacts	
Comments: _____ Signature: _____	

PATIENT MEDICAL HISTORY <input checked="" type="checkbox"/> Indicates patient admission database has been completed by inpatient unit and reviewed by Pre-Op Nurse.	
<input type="checkbox"/> Negative	
<input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis/Gout <input type="checkbox"/> Asthma/COPD <input type="checkbox"/> Lung Disease <input type="checkbox"/> TB <input type="checkbox"/> +PPD <input type="checkbox"/> BPH <input type="checkbox"/> Cardiac _____ <input type="checkbox"/> CHF _____	
<input type="checkbox"/> Communicable Diseases _____ <input type="checkbox"/> CVA/TIA <input type="checkbox"/> Diabetes _____ <input type="checkbox"/> GERD <input type="checkbox"/> Glaucoma <input type="checkbox"/> Hypertension	
<input type="checkbox"/> Hypercholesteremia <input type="checkbox"/> PVD <input type="checkbox"/> Psychiatric _____ <input type="checkbox"/> Renal _____ <input type="checkbox"/> Seizures <input type="checkbox"/> Thyroid	
<input type="checkbox"/> Other _____	
Reproductive Self Testicular Exam _____ Prostate Screen (> 40 Yrs) _____	Health: Mammogram (>35 Yrs) _____ Self Breast Exam _____ PAP Smear _____

PREVIOUS SURGERIES	CURRENT MEDICATIONS	LAST DOSE	CURRENT MEDICATIONS	LAST DOSE
	Are you taking any over the counter herbal medications? <input type="checkbox"/> Yes <input type="checkbox"/> No			

SUBSTANCE USE <input type="checkbox"/> None			ALLERGIES	
SUBSTANCE	AMOUNT/DURATION	LAST USED	<input type="checkbox"/> NKDA	REACTION
<input type="checkbox"/> Alcohol	_____	_____	<input type="checkbox"/> Latex	_____
<input type="checkbox"/> Drugs	_____	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Tobacco	_____	_____	_____	
<input type="checkbox"/> Cessation Teaching - Desire Smoking Cessation Teaching? <input type="checkbox"/> Yes <input type="checkbox"/> No			_____	
Comment: _____				

SIGNATURE OF NURSE: _____	DATE: _____	TIME: _____
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PREOP CHECKLIST

Allergies:

Patient Identification: ☐ Verbal ☐ ID Band ☐ DOB ☐ Family ☐ Blood Band # _____

Planned Procedure: _____

Name Preference: _____

VITAL SIGNS: T _____ P _____ R _____ BP _____

Height _____ Weight _____ O2 Sat _____ NPO _____

FBS: _____ Time: _____ Informed Consents: ☐ Surgical ☐ Anesthesia

PATIENT LABEL

	YES	N/A	DATE/COMMENT
H&P	<input type="checkbox"/>	<input type="checkbox"/>	_____
HCT / CBC	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemistry	<input type="checkbox"/>	<input type="checkbox"/>	_____
PT / PTT	<input type="checkbox"/>	<input type="checkbox"/>	_____
UA	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pregnancy Test	<input type="checkbox"/>	<input type="checkbox"/>	_____
EKG	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest X-ray	<input type="checkbox"/>	<input type="checkbox"/>	_____
LMP: _____	<input type="checkbox"/>	N/A	_____

☐ Dentures removed/loose teeth noted _____ Disposition/Locker # _____

☐ Jewelry/Body piercings removed/taped _____

☐ Glasses/Contacts removed _____

☐ Hearing aid removed _____

☐ Other _____

FOR REATTACHMENT OF BLOOD BANK BRACELET

1. I certify the patient has presented one picture ID or two other forms of ID before reattachment of band from pink envelope.

RN SIGNATURE/DATE: _____

2. I have presented the pink envelope and identified my signature before reattachment of the blood bracelet.

PATIENT SIGNATURE: _____

SKIN ASSESSMENT

Nursing Diagnosis: Skin Integrity/Body Temperature

Goal: Identify alterations in skin integrity/body temperature & support as appropriate.

Evaluation: ☐ Meets goal ☐ See comments

☐ Pale ☐ Flushed ☐ Jaundiced

☐ Cyanotic ☐ Cool ☐ Warm

☐ Dry ☐ Diaphoretic

Rashes: _____

Bruises: _____

Ulcers: _____

Abdominal Assessment: ☐ N/A ☐ soft ☐ firm

☐ round ☐ obese ☐ distended ☐ non-distended

☐ tender ☐ non-tender

Comments: _____

RESPIRATORY ASSESSMENT

Nursing Diagnosis: Gas Exchange/Tissue

Goal: Identify alterations in gas exchange & support as appropriate.

Evaluation: ☐ Meets goal ☐ See comments

☐ Lungs Clear ☐ Wheezes: Left Right

☐ Rales: Left Right ☐ Hoarseness - Cough

☐ O2 Method: _____ ☐ N/A

Liters Per Minute: _____

SaO2: _____ ☐ N/A

Comments: _____

PHYSICAL LIMITATIONS

Nursing Diagnosis: Physical Mobility/Sensory Deficit

Goal: Identify limitations in mobility/sensorium & support as appropriate.

Evaluation: ☐ Meets goal ☐ See comments

☐ Hearing ☐ Vision ☐ Speech

☐ Mobility ☐ Walker ☐ Crutches

☐ Cane ☐ Wheelchair

☐ Prosthesis: _____

☐ Disposition: _____

Comments: _____

MENTAL STATUS

Nursing Diagnosis: Altered Thought Process / Coping Ability / Anxiety

Goal: Identify alterations in thought process/coping ability/anxiety level.

Evaluation: ☐ Meets goal ☐ See comments

☐ Alert ☐ Oriented ☐ Confused

☐ Unresponsive ☐ Drowsy ☐ Asleep

☐ Anxious ☐ Agitated ☐ Combative

☐ Crying ☐ Abusive ☐ Cooperative

☐ Non-communicative

Historian: ☐ Patient

☐ Other: _____

Comments: _____

DEVELOPMENTAL LEVEL

Nursing Diagnosis: Altered Growth and Development

Goal: Identify alterations in growth & development & support as appropriate.

Evaluation: ☐ Meets goal ☐ See comments

☐ Appropriate For Age ☐ Unable To Assess

☐ Inappropriate For Age

Comments: _____

FALL RISK ASSESSMENT

Nursing Diagnosis: Potential for Injury

Goal: Identify / Reduce Risk Factors

Evaluation: ☐ Meets goal ☐ See comments

EACH OF THE FOLLOWING EQUALS 1 POINT	SCORE	EACH OF THE FOLLOWING EQUALS 3 POINTS	SCORE
Age 70 or greater		Chronic / episodic confusion	
Urinary / bowel - urgency / incontinence		Unsteady gait	
Chronic debilitating disease		History of prior falls	
Use of drugs affecting blood pressure /			
Mental status, urination / defecation		TOTAL POINTS	
Sensory deficit		Low risk protocol (0-2 points)	
Postural hypotension		High risk fall prevention protocol	
Depression / hopelessness		Initiated (3 points or greater)	
Neurological dysfunction /		High risk protocol NOT initiated	
Mobility deficit		Due to condition:	

PERIOPERATIVE PATIENT CARE NURSING RECORD AND PATIENT ADMISSION DATA BASE

IMMUNIZATIONS <input type="checkbox"/> None		ANESTHESIA COMPLICATIONS	
<input type="checkbox"/> Unknown <input type="checkbox"/> Up to date <input type="checkbox"/> Childhood	<input type="checkbox"/> Hepatitis <input type="checkbox"/> Tetanus <input type="checkbox"/> Other _____	<input type="checkbox"/> None <input type="checkbox"/> Unknown	<input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Other _____

INVASIVE LINES, TUBES, AND APPLIANCES ☐ None

Nursing Diagnosis: Altered Nutrition / Skin Integrity / Impaired Swallowing / Infection

Goal: Maintain integrity of identified lines and reduce potential for infection. Evaluation: ☐ Meets goal ☐ See comments

☐ Peripheral IV: Site: _____ Size: _____ Fluid: _____ Amount: _____ Inserted By: _____
 Site: _____ Size: _____ Fluid: _____ Amount: _____ Inserted By: _____
☐ Other: ☐ PICC Line ☐ Central Line ☐ Arterial Line ☐ Port-A-Cath ☐ Drain: _____ ☐ Foley: Output: _____ ☐ Pulmonary Artery Catheter
☐ Medlock ☐ Chest Tube ☐ Nasogastric Tube
☐ Ostomy ☐ Rectal Tube ☐ Endotracheal Tube

Comments: _____

CULTURAL, SPIRITUAL, AND PSYCHOSOCIAL NEEDS

Nursing Diagnosis: Spiritual Distress / Anxiety

Goal: Identify individual needs & support as appropriate. Evaluation: ☐ Meets goal ☐ See comments

☐ Cultural Needs: _____
☐ Language Barrier: _____
☐ Spiritual Needs / Religious Preference: _____
☐ Other Special Needs: _____
☐ No specific needs expressed by the patient at this time. Comments: _____

DISCHARGE PLANNING

Nursing Diagnosis: Home Maintenance Management / Family Coping

Goal: Identify individual needs & make referrals as appropriate. Evaluation: ☐ Meets goal ☐ See comments

☐ Family Wailing: Name: _____ Location: _____
☐ Ride Home: Name: _____ Number: _____
☐ Available help after discharge: ☐ Family ☐ Friend ☐ N/A ☐ Needs discharge planning: Notified: _____
 Lives With: ☐ Family ☐ Friend ☐ N/A

TEACHING NEEDS

Nursing Diagnosis: Knowledge Deficit

Goal: Identify individual needs & provide instruction as appropriate. Evaluation: ☐ Meets goal ☐ See comments

Patient, Family, and/or Significant Other Verbalizes Understanding Of: ☐ Surgical Procedure ☐ Pre-Op Care ☐ Intra-Op Care ☐ Post-Op Care ☐ Pain Management

Comments: _____

PRE-OP MEDICATIONS <input type="checkbox"/> N/A	Dose	Route	Time	Given By	Comments

NURSE NOTES

ASSESSMENT COMPLETED BY: _____ REVIEWED BY: _____ DATE: _____

PERIOPERATIVE PATIENT CARE NURSING RECORD AND PATIENT ADMISSION DATA BASE

MEMORIAL HOSPITAL

IMMEDIATE PRE-OP ASSESSMENT BY: _____

Nursing Diagnosis: Anxiety/Knowledge Deficit/Altered Thought Process/Coping Ability Goal: Identify alterations in thought process/coping ability/anxiety/level & support as appropriate.

Evaluation: ☐ Meets goal ☐ See comments

Patient Identification: ☐ Verbal ☐ ID Band ☐ Chart ☐ Family ☐ Blood Band

Procedure/Site of surgery verified: ☐ Yes Init.: _____

Consents: ☐ Surgical ☐ Anesthesia ☐ Other _____

Blood Available: ☐ N/A ☐ Type & Screen ☐ Type & Crossmatch Units _____

Mental Status:

☐ Alert ☐ Drowsy ☐ Asleep ☐ Unresponsive ☐ Unconscious
☐ Oriented ☐ Confused ☐ Anxious ☐ Agitated ☐ Crying
☐ Cooperative ☐ Combative ☐ Abusive ☐ Non-communicative

Historian: ☐ Patient ☐ Other _____

Comments: _____

ALLERGIES: _____

☐ NKDA

Reaction: _____

☐ Latex

☐ Other _____

TRANSPORTATION TO THE OPERATING ROOM

☐ Stretcher ☐ Bed ☐ Carried ☐ W/C ☐ Ambulatory By: _____ ☐ Other _____

INTRAOPERATIVE NURSING RECORD

Room: _____ Case #: _____ ASA #: _____ Delay Code: _____

Times: Room Ready Time

Patient In

Pause Time

Procedure Start

Procedure Stop

Patient Out

CASE TYPE:

☐ Elective

☐ Add-on

☐ Urgent

☐ Return to OR

☐ Emergent

Preoperative Diagnosis: _____

Postoperative Diagnosis: ☐ Same as Pre-Op _____

Operative Procedure(s): _____

Wound Classification: ☐ 1/Clean; ☐ 2/Clean/Contaminated; ☐ 3/Contaminated; ☐ 4/Infected

Anesthesia: ☐ GENERAL ☐ MONITORED ANESTHESIA CONTROL SEDATION ☐ LOCAL ☐ SPINAL ☐ BLOCK ☐ EPIDURAL ☐ NONE

Anesthesia Provider(s): _____ Anesthesia Relief: _____ Anesthesia Relief: _____

Physician: _____ 1st Assistant: _____

2nd Physician: _____ 2nd Assistant: _____

CIRCULATING NURSE	INT.	IN	OUT
Relief:			

SCRUB PERSON	IN	OUT
Relief:		

Vendor: _____ Other: _____

Position for Surgery: Nursing Diagnosis: Physical Mobility / Skin Integrity / Body Temperature

Goal: Prevent physical injury & infection, maintain proper body alignment & temperature.

Evaluation: ☐ Meets goal ☐ See comments

☐ Sitting ☐ Beach Chair
☐ Jackknife ☐ Supine
☐ Lateral, Left sideup ☐ Other:
☐ Lateral, Right sideup *If prone, Breasts/Genitalia
☐ Lithotomy Checked By: _____
☐ Prone* _____

OR Bed:
☐ Standard
☐ Fracture
☐ Cysto
☐ Eye Stretcher
☐ Stretcher
☐ Pl. Bed
☐ Isolette
☐ Jackson
☐ Bariatric
☐ Vascular
☐ OR Specialty Table

Positioning Aids:
☐ Armboards Right Left ☐ Foot plate
☐ Arms tucked Right Left ☐ Head ring
☐ Axillary roll ☐ Headrest
☐ Bean Bag ☐ Kidney Rest Right Left
☐ Bump ☐ Lateral Arm Positioner
☐ Bypass Leg Positioner ☐ Leg Holder Right Left
☐ Cardiac Pillow ☐ McGuire hip rest
☐ Chest rolls Right Left ☐ Pillows
☐ Eggcrate Padding ☐ Sand bag
☐ Knee Right Left ☐ Schiell
☐ Eyes ☐ Shoulder roll
☐ Elbow Right Left ☐ Shoulder traction
☐ Heel Right Left ☐ Sled device _____ lbs.
☐ Stirrups: ☐ Allen ☐ Yellow Fin ☐ Candy Cane

☐ Thornton Head Rest

☐ Table Extension

☐ Wilson/Hall/Andrews

☐ Wrist protective wraps

☐ Other _____

Comments: _____

Safety Strap: ☐ Yes ☐ N/A

Applied By: _____

Location: ☐ Across thighs

☐ Other: _____

Equipment: Nursing Diagnosis: Injury

Goal: Prevent injury Evaluation: ☐ Meets goal ☐ See comments

Electrosurgical Unit: #1 _____ Cut _____ Coag _____

Bipolar: #2 _____ Cut _____ Coag _____

Argon Beam: # _____ Cut _____ Coag _____

Endoscope: # _____

Ligasure: # _____ CUSA: # _____ Harmonic Scafel: # _____

X-ray: ☐ Flat plate ☐ C-arm ☐ Mini C-arm

Grounding Pad: Location: _____ Applied By: _____

Pre-Op Skin Condition: ☐ Intact ☐ Other: _____

Area Shaved/Clipped: ☐ Yes ☐ No

Repositioning Check: ☐ Yes ☐ No ☐ N/A

Removed By: _____

Post-Op Skin Condition: ☐ Intact ☐ Other: _____

Heart Lung Machine: ☐ Yes ☐ No # _____

Other: _____

INTRAOPERATIVE NURSING RECORD (CONTINUED)

Compression Stockings: Nursing Diagnosis: Emboli

Goal: Reduce potential for emboli. Evaluation: ☐ Meets goal ☐ See comments

☐ None ☐ Antiembolism Stockings: ☐ Right ☐ Left ☐ Knee ☐ Thigh

☐ Sequential Compression: ☐ Right Leg ☐ Left Leg ☐ Knee ☐ Thigh ☐ Foot

Setting: _____ mm/Hg #: _____ Comments: _____

Tourniquet #1:

Nursing Diagnosis: Hemorrhage/Neuromuscular trauma.

Goal: Reduce potential for hemorrhage & neuromuscular trauma.

Evaluation: ☐ Meets goal ☐ See comments

☐ None # _____ Location: _____ Padded: ☐ Yes ☐ No

Pressure: _____ mm/Hg Applied By: _____

On: _____ Off: _____ On: _____ Off: _____

Tourniquet #2:

☐ None # _____ Location: _____ Padded: ☐ Yes ☐ No

Pressure: _____ mm/Hg Applied By: _____

On: _____ Off: _____ On: _____ Off: _____

Warming Devices:

Nursing Diagnosis: Body Temperature. Goal: Maintain appropriate body temperature.

Evaluation: ☐ Meets goal ☐ See comments

☐ None ☐ Warming Lamp ☐ Warmed Solutions: Irrigation/Prep/I.V.

☐ Warm Blankets ☐ Warm air blanket # _____ ☐ Warm water blanket #: _____

☐ Other: _____

Shave Prep Area: _____ By: _____

Surgical Skin Preparation: Site: _____ ☐ None

Nursing Diagnosis: Infection. Goal: Reduce potential for infection.

Evaluation: ☐ Meets goal ☐ See comments

☐ Betadine Scrub/Betadine Solution ☐ Duraprep ☐ Exidine

☐ Alcohol ☐ Other: _____

By: _____ ☐ No pooling of solution

Placed in OR: ☐ None

☐ I.V. lines: Periph Right Left By: _____

A-Line Right Left By: _____

CVP Right Left By: _____

Pulmonary Artery Catheter Right Left Other

IABP Right Left By: _____

☐ Foley / Catheter By: _____

☐ Coude Size: _____

Clear, yellow, cloudy, amber, bloody urine;

Initial output: _____ cc

Final output: _____ cc

☐ Removed in OR ☐ Continuous bladder irrigation _____

Specimens: ☐ None

☐ Permanent _____

☐ Aerobic Culture _____ ☐ Fresh _____

☐ Anaerobic Culture _____ ☐ Cytology _____

☐ Other _____ ☐ Frozen _____

_____ ☐ FIO _____

Disposition at relief: _____

By: _____

Blood Replacement: ☐ N/A

Estimated blood loss: _____ No. of Units: _____

Cell Saver: ☐ N/A Operator: _____ # _____

Cross Clamp: ☐ N/A On _____ Off _____

Bypass: ☐ Yes ☐ No ☐ N/A

IRRIGATION/MEDICATIONS on sterile field <input type="checkbox"/> N/A	Dose	Route	Time	Given By	Comments

IMPLANT LOG ☐ N/A ☐ See Implant Record

Counts: Nursing Diagnosis: Retained foreign body. Goal: Reduce potential for retained foreign body. Evaluation: ☐ Meets goal ☐ See comments

Sponge ☐ Correct ☐ Incorrect ☐ N/A Comments: _____

Sharp ☐ Correct ☐ Incorrect ☐ N/A Comments: _____

Instruments ☐ Correct ☐ Incorrect ☐ N/A Comments: _____

Initial Count: Circulator: _____ Scrub Person: _____ Time: _____

Relief Count: Circulator: _____ Scrub Person: _____ Time: _____

Relief Count: Circulator: _____ Scrub Person: _____ Time: _____

Final Count: Circulator: _____ Scrub Person: _____ Time: _____

☐ Surgeon notified of count Action for incorrect count: _____ ☐ X-ray outcome: _____ Film read by: _____

Drains: ☐ None Nursing Diagnosis: Infection. Goal: Reduce potential for infection. Evaluation: ☐ Meets goal ☐ See comments

Size	Location	Size	Location	Size	Location
<input type="checkbox"/> T-tube	_____	<input type="checkbox"/> Nasogastric	_____	<input type="checkbox"/> Jackson Pratt	_____
<input type="checkbox"/> Peppose	_____	<input type="checkbox"/> Hemovac	_____	<input type="checkbox"/> Blake	_____
<input type="checkbox"/> Chest	_____	<input type="checkbox"/> Drain activated @ _____	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Pleurovac/Emerson Pump	_____				

Dressings: <input type="checkbox"/> None	<input type="checkbox"/> Band aid	<input type="checkbox"/> EZ Wrap Knee Brace	<input type="checkbox"/> Packing _____	<input type="checkbox"/> Scrotal Support	<input type="checkbox"/> Telfa
<input type="checkbox"/> 4 x 4's / 2 x 2's	<input type="checkbox"/> Benzoin	<input type="checkbox"/> Frederick Mammary Support	<input type="checkbox"/> Peri Pad	<input type="checkbox"/> Shoulder Immobilizer	<input type="checkbox"/> Wound Vac
<input type="checkbox"/> ABD Pads	<input type="checkbox"/> Bledsoe Brace	<input type="checkbox"/> Island Dressing	<input type="checkbox"/> Philadelphia collar	<input type="checkbox"/> Sling, velpeau	<input type="checkbox"/> Xeroform
<input type="checkbox"/> Abdominal Binder	<input type="checkbox"/> Cervical Collar, soft	<input type="checkbox"/> Kerlix	<input type="checkbox"/> Plaster/Fiberglass cast	<input type="checkbox"/> Soft Roll	<input type="checkbox"/> Other _____
<input type="checkbox"/> Abduction Pillow	<input type="checkbox"/> Dermabond	<input type="checkbox"/> Kling	<input type="checkbox"/> Plaster/Fiberglass splint	<input type="checkbox"/> Steri Strips	
<input type="checkbox"/> Ace	<input type="checkbox"/> Eye Pad	<input type="checkbox"/> Knee Immobilizer	<input type="checkbox"/> Post op shoe	<input type="checkbox"/> Tape _____	
<input type="checkbox"/> Adaptic	<input type="checkbox"/> Eye Shield	<input type="checkbox"/> Laminated Splint	<input type="checkbox"/> Red Cross Cotton	<input type="checkbox"/> Tegaderm	

MONITORING LOCAL ANESTHESIA ☐ N/A

IMMEDIATE POST-OP STATUS

<u>PATIENT STATUS:</u>		<u>SKIN CONDITION:</u>		<u>TRANSPORT:</u>		<u>ACCOMPANIED BY:</u>		
<input type="checkbox"/> Alert	<input type="checkbox"/> LMA Removed	<input type="checkbox"/> Warm	<input type="checkbox"/> Cool	<input type="checkbox"/> Stretcher	<input type="checkbox"/> Ambulatory	<input type="checkbox"/> Anesthesia/CRNA	<input type="checkbox"/> Nurse	<input type="checkbox"/> Resident/Intern
<input type="checkbox"/> Oriented	<input type="checkbox"/> Extubated	<input type="checkbox"/> Pink	<input type="checkbox"/> Diaphoretic	<input type="checkbox"/> Bed	<input type="checkbox"/> Oz LPM _____	<input type="checkbox"/> Surgeon	<input type="checkbox"/> Physician/Surgical Assistant	
<input type="checkbox"/> Awakening	<input type="checkbox"/> Intubated	<input type="checkbox"/> Dry	<input type="checkbox"/> Pale	<input type="checkbox"/> Crib	via: _____	<input type="checkbox"/> Other: _____		
<input type="checkbox"/> Agitated	<input type="checkbox"/> Airway oral/nasal	<input type="checkbox"/> Flushed	<input type="checkbox"/> Mottled	<input type="checkbox"/> WC	<input type="checkbox"/> Ambu/T-piece	Transferred To: _____		
<input type="checkbox"/> Drowsy	<input type="checkbox"/> Tracheostomy	<input type="checkbox"/> Other: _____		<input type="checkbox"/> Side rails up	<input type="checkbox"/> EKG Monitor	Report To: _____		
<input type="checkbox"/> Unresponsive				<input type="checkbox"/> Ambulatory	<input type="checkbox"/> Pulse Ox	Signature: _____		
<input type="checkbox"/> Comments: _____				<input type="checkbox"/> Other: _____		_____		

NURSE NOTES

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.

IMMEDIATE PRE-OP ASSESSMENT BY: _____

Nursing Diagnosis: Anxiety/Knowledge Deficit/Altered Thought Process/Coping Ability Goal: Identify alterations in thought process/coping ability/anxiety level & support as appropriate.

Evaluation: ☐ Meets goal ☐ See comments

Patient Identification: ☐ Verbal ☐ ID Band ☐ Chart ☐ Family ☐ Blood Band

Procedure/Site of surgery verified: ☐ Yes Init: _____

Consents: ☐ Surgical ☐ Anesthesia ☐ Other _____

Blood Available: ☐ N/A ☐ Type & Screen ☐ Type & Crossmatch Units _____

Mental Status:

☐ Alert ☐ Drowsy ☐ Asleep ☐ Unresponsive ☐ Unconscious
☐ Oriented ☐ Confused ☐ Anxious ☐ Agitated ☐ Crying
☐ Cooperative ☐ Combative ☐ Abusive ☐ Non-communicative

Historian: ☐ Patient ☐ Other _____

Comments: _____

ALLERGIES:

☐ NKDA ☐ Latex ☐ Other _____
 Reaction: _____

TRANSPORTATION TO THE OPERATING ROOM

☐ Stretcher ☐ Bed ☐ Carried ☐ W/C ☐ Ambulatory By: _____ ☐ Other _____

INTRAOPERATIVE NURSING RECORD

Room: _____ Case #: _____ ASA #: _____ Delay Code: _____ CASE TYPE: ☐ Elective ☐ Add-on
☐ Urgent ☐ Return to OR
☐ Emergent
 Times: Room Ready Time Patient In Pause Time Procedure Start Procedure Stop Patient Out

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Preoperative Diagnosis: _____

Postoperative Diagnosis: ☐ Same as Pre-Op _____

Operative Procedure(s): _____

Wound Classification: ☐ 1/Clean; ☐ 2/Clean/Contaminated; ☐ 3/Contaminated; ☐ 4/Infected

Anesthesia: ☐ GENERAL ☐ MONITORED ANESTHESIA CONTROL SEDATION ☐ LOCAL ☐ SPINAL ☐ BLOCK ☐ EPIDURAL ☐ NONE

Anesthesia Provider(s): _____ Anesthesia Relief: _____ Anesthesia Relief: _____

Physician: _____ 1st Assistant: _____

2nd Physician: _____ 2nd Assistant: _____

CIRCULATING NURSE	INT.	IN	OUT
Relief: _____			

SCRUB PERSON	IN	OUT
Relief: _____		

Vendor: _____ Other: _____

Position for Surgery: Nursing Diagnosis: Physical Mobility / Skin Integrity / Body Temperature

Goal: Prevent physical injury & infection, maintain proper body alignment & temperature. Evaluation: ☐ Meets goal ☐ See comments

☐ Sitting ☐ Beach Chair **OR Bed:** ☐ Standard ☐ Foot plate ☐ Thomson Head Rest
☐ Jackknife ☐ Supine ☐ Fracture ☐ Head ring ☐ Table Extension
☐ Lateral, Left sideup ☐ Other: ☐ Cysto ☐ Headrest ☐ Wilson/Hall/Andrews
☐ Lateral, Right sideup *If prone, Breasts/Genitalia ☐ Kidney Rest Right Left ☐ Wrist protective wraps
☐ Lithotomy ☐ Eye Stretcher ☐ Lateral Arm Positioner ☐ Other _____
☐ Prone ☐ Stretcher ☐ Leg Holder Right Left
☐ Pt. Bed ☐ Bump ☐ Bypass Leg Positioner ☐ McGuire hip rest
☐ Isolette ☐ Cardiac Pillow ☐ Pillows
☐ Jackson ☐ Chest rolls Right Left ☐ Sand bag
☐ Bariatric ☐ Eggcrate Padding ☐ Schlein
☐ Vascular ☐ Knee Right Left ☐ Shoulder roll
☐ OR Specialty Table ☐ Eyes ☐ Shoulder traction
☐ Elbow Right Left ☐ Sled device _____ lbs.
☐ Heel Right Left ☐ Stirrups: ☐ Allen ☐ Yelow Fin ☐ Candy Cane

Safety Strap: ☐ Yes ☐ N/A

Applied By: _____

Location: ☐ Across thighs

☐ Other: _____

Equipment: Nursing Diagnosis: Injury

Goal: Prevent injury Evaluation: ☐ Meets goal ☐ See comments

Electrosurgical Unit: #1 _____ Cut _____ Coag _____

Bipolar: #2 _____ Cut _____ Coag _____

Argon Beam: # _____ Cut _____ Coag _____

Endoscope: # _____

Ligasure: # _____ CUSA: # _____ Harmonic Scapel: # _____

X-ray: ☐ Flat plate ☐ C-arm ☐ Mini C-arm

Grounding Pad: Location: _____ Applied By: _____

Pre-Op Skin Condition: ☐ Intact ☐ Other: _____

Area Shaved/Clipped: ☐ Yes ☐ No

Repositioning Check: ☐ Yes ☐ No ☐ N/A

Removed By: _____

Post-Op Skin Condition: ☐ Intact ☐ Other: _____

Heart Lung Machine: ☐ Yes ☐ No # _____

Other: _____

INTRAOPERATIVE NURSING RECORD (CONTINUED)

Compression Stockings: Nursing Diagnosis: Emboli

Goal: Reduce potential for emboli. Evaluation: ☐ Meets goal ☐ See comments

☐ None ☐ Antiembolism Stockings: ☐ Right ☐ Left ☐ Knee ☐ Thigh

☐ Sequential Compression: ☐ Right Leg ☐ Left Leg ☐ Knee ☐ Thigh ☐ Foot

Setting: _____ mm/Hg #: _____ Comments: _____

Fourniquet #1:

Nursing Diagnosis: Hemorrhage/Neuromuscular trauma.

Goal: Reduce potential for hemorrhage & neuromuscular trauma.

Evaluation: ☐ Meets goal ☐ See comments

☐ None #: _____ Location: _____ Padded: ☐ Yes ☐ No

Pressure: _____ mm/Hg Applied By: _____

On: _____ Off: _____ On: _____ Off: _____

Fourniquet #2:

☐ None # _____ Location: _____ Padded: ☐ Yes ☐ No

Pressure: _____ mm/Hg Applied By: _____

On: _____ Off: _____ On: _____ Off: _____

Warming Devices:

Nursing Diagnosis: Body Temperature. Goal: Maintain appropriate body temperature.

Evaluation: ☐ Meets goal ☐ See comments

☐ None ☐ Warming Lamp ☐ Warmed Solutions: Irrigation/Prep/I.V.

☐ Warm Blankets ☐ Warm air blanket #: _____ ☐ Warm water blanket #: _____

☐ Other: _____

Shave Prep Area: _____ By: _____

Surgical Skin Preparation: Site: _____ ☐ None

Nursing Diagnosis: Infection. Goal: Reduce potential for infection.

Evaluation: ☐ Meets goal ☐ See comments

☐ Betadine Scrub/Betadine Solution ☐ Duraprep ☐ Exidine

☐ Alcohol ☐ Other: _____

By: _____ ☐ No pooling of solution

Placed in OR: ☐ None

☐ I.V. lines: Periph Right Left By: _____

A-Line Right Left By: _____

CVP Right Left By: _____

Pulmonary Artery Catheter Right Left Other

IABP Right Left By: _____

☐ Foley / Catheter By: _____

☐ Coude Size: _____

Clear, yellow, cloudy, amber, bloody urine:

Initial output: _____ cc

Final output: _____ cc

☐ Removed in OR ☐ Continuous bladder irrigation _____

Specimens: ☐ None

☐ Permanent _____

☐ Aerobic Culture _____ ☐ Fresh _____

☐ Anaerobic Culture _____ ☐ Cytology _____

☐ Other _____ ☐ Frozen _____

☐ FIO _____

Disposition at relief: _____

By: _____

Blood Replacement: ☐ N/A

Estimated blood loss: _____ No. of Units: _____

Cell Saver: ☐ N/A Operator: _____ # _____

Cross Clamp: ☐ N/A On _____ Off _____

Bypass: ☐ Yes ☐ No ☐ N/A

IRRIGATION/MEDICATIONS on sterile field <input type="checkbox"/> N/A	Dose	Route	Time	Given By	Comments

IMPLANT LOG ☐ N/A ☐ See Implant Record

Counts: Nursing Diagnosis: Retained foreign body. Goal: Reduce potential for retained foreign body. Evaluation: ☐ Meets goal ☐ See comments

Sponge ☐ Correct ☐ Incorrect ☐ N/A Comments: _____

Sharp ☐ Correct ☐ Incorrect ☐ N/A Comments: _____

Instruments ☐ Correct ☐ Incorrect ☐ N/A Comments: _____

Initial Count: Circulator: _____ Scrub Person: _____ Time: _____

Relief Count: Circulator: _____ Scrub Person: _____ Time: _____

Relief Count: Circulator: _____ Scrub Person: _____ Time: _____

Final Count: Circulator: _____ Scrub Person: _____ Time: _____

☐ Surgeon notified of count Action for incorrect count: _____ ☐ X-ray outcome: _____ Film read by: _____

Drains: ☐ None Nursing Diagnosis: Infection. Goal: Reduce potential for infection. Evaluation: ☐ Meets goal ☐ See comments

Size	Location	Size	Location	Size	Location
<input type="checkbox"/> T-tube	_____	<input type="checkbox"/> Nasogastric	_____	<input type="checkbox"/> Jackson Pratt	_____
<input type="checkbox"/> Penrose	_____	<input type="checkbox"/> Hemovac	_____	<input type="checkbox"/> Blake	_____
<input type="checkbox"/> Chest	_____	<input type="checkbox"/> Drain activated @ _____	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Pleurovac/Emerson Pump	_____				

Dressings: <input type="checkbox"/> None	<input type="checkbox"/> Band aid	<input type="checkbox"/> EZ Wrap Knee Brace	<input type="checkbox"/> Packing _____	<input type="checkbox"/> Scrotal Support	<input type="checkbox"/> Telfa
<input type="checkbox"/> 4 x 4's / 2 x 2's	<input type="checkbox"/> Benzoin	<input type="checkbox"/> Frederick Mammary Support	<input type="checkbox"/> Peri Pad	<input type="checkbox"/> Shoulder Immobilizer	<input type="checkbox"/> Wound Vac
<input type="checkbox"/> ABD Pads	<input type="checkbox"/> Bledsoe Brace	<input type="checkbox"/> Island Dressing	<input type="checkbox"/> Philadelphia collar	<input type="checkbox"/> Sling, velpeau	<input type="checkbox"/> Xeroform
<input type="checkbox"/> Abdominal Binder	<input type="checkbox"/> Cervical Collar, soft	<input type="checkbox"/> Kerlix	<input type="checkbox"/> Plaster/Fiberglass cast	<input type="checkbox"/> Soft Roll	<input type="checkbox"/> Other _____
<input type="checkbox"/> Abduction Pillow	<input type="checkbox"/> Dermabond	<input type="checkbox"/> Kling	<input type="checkbox"/> Plaster/Fiberglass splint	<input type="checkbox"/> Steri Strips	
<input type="checkbox"/> Ace	<input type="checkbox"/> Eye Pad	<input type="checkbox"/> Knee Immobilizer	<input type="checkbox"/> Post op shoe	<input type="checkbox"/> Tape _____	
<input type="checkbox"/> Adaptic	<input type="checkbox"/> Eye Shield	<input type="checkbox"/> Laminated Splint	<input type="checkbox"/> Red Cross Cotton	<input type="checkbox"/> Tegaderm	