Conscious Sedation Documentation Flow Sheet

Address	Conscious Sear	tion Documentation Flow Sheet
Town, State		
Date:	Department:	Addressograph:
DI	Annual colo Annual	

	cian Section: A ent past and present	Anesthesia Assessmen medical history:	ıt					(a) (b)			
Pertine	ent past and present	medication history:						r See H&P, comprehensiv	ve note or progress		
disease	that is a constant t	Healthy patient r II. M hreat to life r V. Morib lostic studies: r N/A				r III. Severe sys	temic disease, def	r See H&P, comprehensifinite functional limitation. r			
Plan of anesthesia: r Conscious sedation r Other: Ri						Risk/Options discussed: r Yes r No Physician Signature:					
Age: _ ID Bra	Sex: r Ma	No Dentures/bridge re	moved	Temp:	P: R	BP:	SaO2%	:Pain:			
	lure to be done:			Performed by			MD Monitored b	by:	RN		
					nt Outcomes-If	no, explain					
Conse	nt forms signed, dat	nowledge of the planned ed and witnessed r Yes rstanding of the procedure	r No_								
IV T	herapy				4-						
Time	Size	Site		Site condition	Solution	Amt in Bottle	Started by	Comments			
r Arrived with IV r Arrived with Saline		e lock				N/A					
		CORP LIES	_					of Consciousness [LOC] KEY			
ALDRETTE SCORE KEY: Activity: 2 Able to move 4 extremities voluntarily or on command 1 Able to move 2 extremities voluntarily or on command 0 Able to move 0 extremities voluntarily or on command			Pulse Oximetry: 2 > 92% on room air 1 Needs oxygen to maintain 92% 0 < 92% with oxygen			1 = Alert and oriented 2 = Mild sedation, oriented, able to answer questions 3 = Moderate sedation, easily arousable, maintains patent airway, responds to physical/verbal stimuli					
Respirations: 2 Able to deep breathe and cough freely 1 Dyspaca or limited breathing 0 Apoeic			Consciousness: 2 Answers questions appropriately/aware of location 1 Arousable on calling 0 Not responding			4 = Deep sedation, depressed consciousness, NOT easily aroused but maintains patent airway. 5 = Deep sedation, unconscious, unarousable, possible partial or complete loss of ability to maintain patent airway.					
1 BP=	tion: 20% of pre-sedation le 20-49% of pre-sedation 50% or greater of pre-	n level									
Revise	d: December 2000						OVER →				

Start time:		Finish time:												
	Pre-	edure												
Time		- Court												
BP														_
Pulse					_									_
Resp				-										
LOC														
SaO2														
Pain 0-10														
Total Aldret Score	tte													
r REFER TO V	ITAL SIGN STI	UP	•							5				
Time	Medication		Progress Notes											
Time	Medication		Trogress (vo.											
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	Intro Pr	ocedure Patient On	teomes_If ves	vnlain		_	- 1	ost Proced	lure Patier	t Outcome	s—If no. e	volain.		1
Intra-Procedure Patient Outcomes—If yes, explain. Physiological/psychological status changed: r Yes r No				Vital	Post Procedure Patient Outcomes—If no, explain. Vital signs within normal pre-op limits upon discharge. r Yes r No									
Reversal agent administered: r Yes r No				Patier	Patient denies or verbalizes decreased pain. r Yes r No									
DISCHARGE CRITERIA: The patient must have a PSR Total Score of 8-10 or pre-sedation					ation scor	tion score before Discharge unless attending Physician orders otherwise.								
SCORE: r S	8-10 r Equi	valent to pre-sedation	1 score	2000001	. or pre-sea			and an						
DISCHARGE	E SUMMAR	Y: Time:	Disposition: r /	dmitted, roo	m #	r Re	covery r	Discharge	Home. r	Other:		Disch	arged/transfe	rred
r Wheelchair	r Stretcher	r Ambulatory												
			Signature											