AMBULATORY SURGERY CENTER PACKET
Interdisciplinary Flow Sheet

PRE-ADMISSION NURSING ASSESSMENT

Planned procedure _____________________________ Telephone Evening Before ______________
Surgeon _____________________________ Telephone Morning Of _____________________________
Date ________________ Interview: ☐ Phone ☐ In Person ________________ Telephone Day After _____________________________
Interpreter/Special Needs ☐ Yes ☐ No _____________________________ Cellular/Work _____________________________
Other _____________________________

Nursing Diagnosis: Potential for increased anxiety related to knowledge deficit, surgery or unfamiliar environment.
Assessment and Intervention: Explanation of peri-operative event, orientation, support and reassurance throughout experience; maintenance of sensory stimuli and activity level to be at a minimum.
Expected Outcome: Positive Identification of patient. Patient displays improvement in symptoms of anxiety by relaxed facial expression and patient/family verbal understanding of peri-operative event.

☐ Met ☐ Not Met

REVIEW OF SYSTEMS

IF PATIENT REPORTS SYSTEM WITHIN NORMAL LIMITS CHECK BOX

Cardio/Vascular ☐ Integ/MS ☐
Neuro/Psych ☐ GI/Reflux/Peptic ☐
Pulmonary ☐ Renal ☐
Reproductive/LMP ☐ Endocrine ☐
ENT ☐ Hematology/Bleeding/Sickle Cell ☐

Allergies _____________________________ RN Signature/ID# _____________________________

PRE-PROCEDURE TEACHING

NPO Time _____________________________ Arrival Time _____________________________
☐ Change in health call ASC ☐ Financial Responsibility ☐ Escort ☐ Belongings/Valuables
☐ ETOH/Drugs ☐ Make-up ☐ Glasses/Contacts ☐ Dentures/Bridges/Crowns
Medications Instruction _____________________________ Other Instruction _____________________________
RN Signature/ID# _____________________________

PRE-ADMISSION NURSING ASSESSMENT

Date ________________ Time _____________ NPO Time ________________
Allergy Bracelet _____________________________ ☐ Yes ☐ No
Other _____________________________

☐ Yes ☐ No EKG ☐ Yes ☐ No
ETOH/Drugs ☐ Yes ☐ No Glasses/Contacts ☐ Yes ☐ No
Dentures/Bridge/Crown ☐ Yes ☐ No Change in Health ☐ Yes ☐ No
Hair Pins/Clips ☐ Yes ☐ No Bill of Rights ☐ Yes ☐ No
Jewelry/Body Piercing ☐ Yes ☐ No H & P ☐ Yes ☐ No
Nail Polish/Make-up ☐ Yes ☐ No Lab Work ☐ Yes ☐ No
Consent ☐ Yes ☐ No ID Bracelet ☐ Yes ☐ No

Sight Verification
☐ Verbal ☐ Yes ☐ No
☐ Operative Site Marked ☐ Yes ☐ No

PAIN ASSESSMENT

Do you have pain? ☐ Yes ☐ No Rating 1-10? ___ What increases pain? _____________________________
Location _____________________________
Description: ☐ Sharp ☐ Burning ☐ Yes ☐ No
☐ Radiating ☐ Aching ☐ No ☐ Lab Work
☐ Dull ☐ Numbness ☐ Yes ☐ No
Duration: ☐ Constant ☐ Intermittent ☐ Yes ☐ No
Assessment _____________________________

Escort Name/Location _____________________________ Pre-Operative RN/ID# _____________________________
Locker # _____________________________ Circulating RN/ID# _____________________________

Part 1
Item # 30207
AS2C010 (1/07)
## Ambulatory Surgery Center Packet

### Interdisciplinary Flow Sheet

#### Daily Medications

<table>
<thead>
<tr>
<th>Age</th>
<th>HT</th>
<th>WT in Kg</th>
<th>BMI</th>
<th>NPO</th>
<th>Reflux</th>
<th>Fam HX</th>
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<thead>
<tr>
<th>BP</th>
<th>HR</th>
<th>SAT</th>
<th>RR</th>
<th>Temp</th>
<th>HCG</th>
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<tr>
<th>Dental</th>
<th>ETOH</th>
<th>Drugs</th>
<th>Smoke</th>
<th>LMP</th>
<th>Adm Glucose</th>
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#### Previous Surgery

- [ ] RN/ID# Name/Sig

### Allergies

- [ ] Pre-Induction Examination & Evaluation

- [ ] Resident/CRNA Sig. ID# MD Sig. ID# ASA:

- [ ] Anesthesia: Tourniquet: Pressure

- [ ] Start: Up Dn

- [ ] End: Site

#### Pre-Op Medications and Antibiotics

- [ ] Chart Reviewed

- [ ] Anes. Plan Discussed

- [ ] Anes. Equipment Check

- [ ] ATTESTATION

- [ ] I was physically present for the entire course of anesthetic management and performed all procedures on this patient as indicated on the record.

- [ ] I was present for key portions of anesthetic management, monitored the course of anesthesia services at intervals and was immediately available during the procedure.

- [ ] I was physically present for: Induction Emergency Not Applicable

- [ ] MD ID#

### Monitors

- [ ] NIBP
- [ ] EKG
- [ ] Pulse Ox
- [ ] O₂ Sensor
- [ ] ETCO₂
- [ ] Gas Analyer
- [ ] Temp
- [ ] G-Tube
- [ ] BIS
- [ ] Blan. warm.
- [ ] IV

### Induction

- [ ] Pre-Oxygenation
- [ ] Intravenous
- [ ] Inhaled
- [ ] Cricoid Pressure

### Airway

- [ ] Oral Airway
- [ ] Nasal Airway
- [ ] Mask
- [ ] LMA
- [ ] Nasal Cannula

### Tracheal Intubation

- [ ] Oral
- [ ] Nasal
- [ ] Cuff
- [ ] Easy
- [ ] Difficult
- [ ] Atraumatic
- [ ] Size
- [ ] Ra
- [ ] Leak

### Regional Block

- [ ] Type
- [ ] Position
- [ ] Prep
- [ ] Site
- [ ] Needle
- [ ] Attempts
- [ ] CSF
- [ ] Agent

### Remarks

#### Time

- [ ] Oxygen Limit
- [ ] Liner
- [ ] Vo₂%

#### Total

- [ ] EKG
- [ ] % O₂ Inspired
- [ ] O₂ Saturation
- [ ] End tidal CO₂
- [ ] Temperature
- [ ] BIS Monitoring
- [ ] Tidal Volume
- [ ] Fluids
- [ ] Urine ml
- [ ] EBL ml

---

**PACU**

BP ________

HR ________

O₂ Sat ________

Temp ________

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**Part 2**

**PART 2A-CHART COPY**

*(WRITE FIRMLY: YOU ARE MAKING 3 COPIES)*

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**Item # 30207**

**AS2C010 (1/07)**
**ALLERGIES:**

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Weight in Kilograms</th>
<th>BMI</th>
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</thead>
</table>

**VITAL SIGNS:**

- Vital signs per recovery routine
- **Oxygen via:**
  - [ ] 2 L nasal cannula wean PRN
  - [ ] humidified face tent
  - [ ] 15 L non-rebreather wean PRN
  - [ ] F<sub>O</sub><sub>2</sub> blowby

**IV FLUIDS:**

- [ ] _______________ to infuse at __________ mL/hour

**ADULT ANALGESIA:**

- [ ] Fentanyl _____ mcg IV Push every ___ minutes PRN pain X _____
- [ ] Oxycodone 5 mg/Acetaminophen 325 mg 1 tab PO X 1 PRN for mild/moderate pain
- [ ] Oxycodone 5 mg/Acetaminophen 325 mg 2 tab PO X 1 PRN for severe pain
- [ ] Acetaminophen 650 mg PO X 1 PRN for mild pain
- [ ] Other:

**PEDIATRIC ANALGESIA:**

- [ ] Fentanyl 0.5 mcg/kilogram X _______ kg = _______ mcg IV every _______ minutes

**HYCOCODAN (HYCOCODAN)**

- [ ] Hydrocodone 5 mg with Homatropine 1.5 mg (HYCOCODAN) = 5 mL syrup
- [ ] Acetaminophen 120 mg with Codeine 12 mg = 5 mL elixir

**ANTIEMETICS:**

- [ ] Ondansetron __________ mg IV PRN nausea X 1
- [ ] Promethazine (Phenergan) __________ mg IV PRN nausea X 1 diluted in 10 mLs normal saline, give slowly, stop if painful.

**OTHER:**

- [ ] ____________

**DISCHARGE FROM RECOVERY:**

- [ ] When discharge criteria met
- [ ] Call physician prior to discharge

<table>
<thead>
<tr>
<th>MD/LIP/NP Signature:</th>
<th>ID#:</th>
<th>Date:</th>
<th>Time:</th>
</tr>
</thead>
</table>

| Nurse Signature: | ID#: | Date: | Time: |
**Post Anesthesia Care Nursing Note**

**Arrival Time**

**Allergy**

**Nursing Diagnosis:** Potential for infection, ineffective breathing and barriers with communication related to surgery and/or anesthesia, alteration in comfort.

**Assessment and Intervention:** Written material, repetition of information and availability of interpreter if appropriate. Family involvement, maintain pain at < 4 on pain scale; administration of pain medication, maintenance of O₂ Sat >95

**Expected Outcomes:** Pain maintenance <4, BBS cl. dsg dry and intact, afebrile.

### Post Anesthesia Recovery Score (ALDRETE)

<table>
<thead>
<tr>
<th>TIME</th>
<th>TEMP</th>
<th>BP</th>
<th>P</th>
<th>Resp</th>
<th>C &amp; DB</th>
<th>O₂ Sat</th>
<th>Alarms Enabled</th>
</tr>
</thead>
<tbody>
<tr>
<td>200</td>
<td>180</td>
<td>160</td>
<td>140</td>
<td>120</td>
<td>100</td>
<td>80</td>
<td>60</td>
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#### Activity
- Able to move 4 extremities voluntarily or on command = 2
- Able to move 2 extremities voluntarily or on command = 1
- Able to move 0 extremities voluntarily or on command = 0

#### Respiration
- Able to deep breath and cough easily = +2
- Dyspnea or limited breathing = +1
- Apneic = 0

#### Circulation
- BP = 20 of preanesthetic level = +2
- BP = 20-50 of preanesthetic = +1
- BP = 50 of preanesthetic = 0

#### Consciousness
- Fully awake = +2
- Amnestic on calling = +1
- Not responding = 0

#### Color
- Pink = +2
- Pale, dusky, blanchy, jaundiced, other = +1
- Cyanotic = 0

### Pain Assessment
- Do you have pain?  Yes  No
- Location
- Rating 1-10?
- Description:  Sharp  Burning  Radiating
  - Aching  Dull  Numbness
- Duration:  Constant  Intermittent
- What increases pain?
- What relieves pain?
- Assessment?

### Medications

<table>
<thead>
<tr>
<th>DRUG / DOSE / ROUTE</th>
<th>TIME</th>
<th>SIGN</th>
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### Intake and Output

<table>
<thead>
<tr>
<th>INTAKE AND OUTPUT</th>
<th>NURSES’ NOTES</th>
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<th>WATER</th>
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<th>OUTPUT</th>
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<tr>
<td>TOTAL</td>
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RN Signature/ID#
# NURSES’ NOTES CONTINUATION

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>NOTES</th>
</tr>
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## AMBULATORY SURGERY DISCHARGE CRITERIA

- Discharge instructions given, verbalizes understanding and signed: [ ]
- Follow-up appointment given: [ ]
- BP Resp O₂ Sat Pulse Temp: [ ]
- Clothes/valuables returned to: [ ]
- Pain Rating: [ ]

## ANESTHESIA DISCHARGE NOTES

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MD Signature/ID: [ ]

## POST-OPERATIVE FOLLOW UP CALL

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Notes</th>
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</thead>
</table>

- N/V: [ ] Yes [ ] No
- Do You Have Pain: [ ] Yes [ ] No
- Location: [ ]
- Rating: 1-10 [ ]
- Pain Control: [ ] Adequate [ ] Not Adequate
- Needs further follow-up: [ ] Yes [ ] No
- RN/ID: [ ]