STONY BROOK UNIVERSITY MEDICAL CENTER
Stony Brook, N.Y. 11794

* A S 2 C 0 1 0 *

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 verbalize 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 _____ ❑ Escort ❑ Belongings/Valuables
❑ Change in health call ASC ❑ Financial Responsibility ❑ Make-up ❑ Glasses/Contacts
❑ ETOH/Drugs ❑ Jewelry ❑ Dentures/Bridges/Crowns
Medications Instruction _____ Other Instruction _____
RN Signature/ID# _____ _____

PRE-ADMISSION NURSING ASSESSMENT

Date _____ Time _____ NPO Time _____ **Allergy Bracelet** _____ ❑ Yes ❑ No
Other _____

ETOH/Drugs	❑ Yes ❑ No	Glasses/Contacts	❑ Yes ❑ No	EKG	❑ Yes ❑ No
Dentures/Bridge/Crown	❑ Yes ❑ No	Change in Health	❑ Yes ❑ No	CXR	❑ Yes ❑ No
Hair Pins/Clips	❑ Yes ❑ No	Bill of Rights	❑ Yes ❑ No	**Sight Verification**	
Jewelry/Body Piercing	❑ Yes ❑ No	H & P	❑ Yes ❑ No	Verbal	❑ Yes ❑ No
Nail Polish/Make-up	❑ Yes ❑ No	Lab Work	❑ Yes ❑ No	Operative Site Marked	❑ Yes ❑ No
Consent	❑ Yes ❑ No	ID Bracelet	❑ Yes ❑ No	Op. Site Mark Exempt	❑ Yes ❑ No

PAIN ASSESSMENT

Do you have pain? ❑ Yes ❑ No Rating 1-10? ____
Location _____
Description: ❑ Sharp ❑ Burning
❑ Radiating ❑ Aching
❑ Dull ❑ Numbness
Duration: ❑ Constant ❑ Intermittent

What increases pain? _____
What relieves pain? _____
Assessment _____

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

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Planned Procedure _____

Age	HT	WT in Kg.	BMI	NPO	Reflux	Fam HX
BP	HR	SAT	RR	Temp	HCG	
Dental	ETOH	Drugs	Smoke	LMP	Adm Glucose	

Allergies _____

Daily Medications

Previous Surgery _____

RN/ID# Name/Sig _____

Pre-Induction Examination & Evaluation

_____

_____

_____

Resident/CRNA Sig. _____ ID# _____ MD Sig. _____ ID# _____ ASA: _____

Anesthesia:
Start _____
End _____

Tourniquet:
Pressure _____
Up _____ Dn _____
Site _____

Pre-Op Medications and Antibiotics

Chart Reviewed ☐ Anes. Plan Discussed ☐ Anes. Equipment Check ☐

ATTESTATION Pt. Examined ☐

☐ 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 anesthic management, monitored the course of anesthesia services at intervals and was immediately available during the procedure.

I was physically present for: ☐ Induction ☐ Emergence ☐ Not Applicable

Sig._____ MD ID# _____

MONITORS

- ❑ NIBP ❑ EKG
- ❑ PulseOx ❑ O_2 Sensor
- ❑ $ETCO_2$ ❑ Gas Analys
- ❑ Tmp____ ❑ G-Tube
- ❑ BIS ❑ Blan. warm.
- ❑ IV _____

INDUCTION

- ❑ Pre-Oxygenation
- ❑ Intravenous
- ❑ Inhaled
- ❑ Cricoid Pressure

AIRWAY

- ❑ Oral Airway
- ❑ Nasal Airway
- ❑ Mask
- ❑ LMA _____
- ❑ Nasal Canula

TRACHEAL INTUBATION

- ❑ Oral ❑ Nasal
- ❑ Cuff
- ❑ Easy ❑ Difficult
- ❑ Atraumatic
- ❑ Size _____
- ❑ Rae
- ❑ Leak ❑ cm _____

REGIONAL BLOCK

- Type _____
- Position _____
- Prep _____
- Site _____
- Needle _____
- Attempts _____
- CSF _____
- Agent _____

TIME

Oxygen L/min.
L/min.
Vol%

TOTAL

EKG
% O2 Inspired
O2 Saturation
End Tidal CO2
Temperature
BIS Monitoring
Tidal Volume

Fluids:

Urine ml
EBL ml

200
180
160
140
120
100
80
60
40
20

Remarks

PACU

BP _____
HR _____
02 Sat _____
Temp _____

PART 2A-CHART COPY
(WRITE FIRMLY: YOU ARE MAKING 3 COPIES)

Item # 30207
AS2C010 (1/07)

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AMBULATORY SURGERY CENTER PACKET
Interdisciplinary Flow Sheet

ORDERS: Must include physician's signature and ID# STAT ORDERS MUST COMMUNICATED TO NURSE	Trans. Initials/ID
ALLERGIES:	
Allergy _____ **Weight in Kilograms:** _____ **BMI** _____	
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_iO_2 blowby	
IV FLUIDS: ☐ _____ to infuse at _____ mL/hour	
ADULT ANALGESIA:	
☐ **Fentanyl** _____ mcg IV Push every ____ minutes PRN pain X _____ **LIP Init:** _____	
☐ **Oxycodone** 5 mg/**Acetaminophen** 325 mg 1 tab PO X 1 PRN for mild/moderate pain **LIP Init:** _____	
☐ **Oxycodone** 5 mg/**Acetaminophen** 325 mg 2 tab PO X 1 PRN for severe pain **LIP Init:** _____	
☐ **Acetaminophen** 650 mg PO X 1 PRN for mild pain **LIP init:** _____	
☐ Other: **LIP init:** _____	
PEDIATRIC ANALGESIA:	
☐ **Fentanyl** 0.5 **mcg**/kilogram X _____ kg= _____ **mcg** IV every _____ minutes PRN for mild/moderate pain X _____ dose(s) **LIP init:** _____	
☐ **Fentanyl** 1 **mcg**/kilogram X _____ kg= _____ **mcg** IV every _____ minutes PRN for severe pain X _____ dose(s) **LIP init:** _____	
☐ **Hydrocodone** 5 mg with **homatropine** 1.5 mg (**HYCODAN**) = 5 mL syrup 0.1 mg/kg Hydrocodone X _____ kg= _____ mg hydrocodone PO PRN for pain X 1 dose **LIP init:** _____	
☐ **Acetaminophen** 120 mg with Codeine 12 mg = 5 mL elixir **LIP init:** _____ 0.8 mg/kg codeine X _____ kg= _____ mg codeine PO PRN for pain X 1 dose	
ANTIEMETICS:	
☐ Ondansetron _____ mg IV PRN nausea X 1 **LIP init:** _____	
☐ Promethazine (PHENERGAN) _____ mg IV PRN nausea X 1 diluted in 10 mLs normal saline, give slowly, stop if painful. **LIP init:** _____	
☐ **OTHER:**	
LIP init: _____	
DISCHARGE FROM RECOVERY:	
☐ When discharge criteria met ☐ Call physician prior to discharge	
MD/LIP/NP Signature: **ID#:** **Date:** **Time:**	
Nurse Signature: **ID#:** **Date:** **Time:**	

SCAN TO PHARMACY AND PLACE IN PATIENT CHART
PART 3A-CHART COPY
Part 3 (**WRITE FIRMLY: YOU ARE MAKING 3 COPIES**)

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 0_2 Sat >95

Expected Outcomes: Pain maintenance <4, BBS cl. dsg dry and intact, afebrile. ❑ Met ❑ Not Met

TIME

TEMP

200
BP X 180
160
140
P •
120
100
80
60
40
20

RESP
C & DB
0_2 Sat
Alarms Enabled

POST ANESTHESIA RECOVERY SCORE (ALDRETE)		A	D
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 Arousable on calling =1 Not responding =0		
Color	Pink =2 Pale, dusky, blotchy, 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 relives pain? _____
Assessment? _____

MEDICATIONS

DRUG / DOSE / ROUTE	TIME	SIGN

INTAKE AND OUTPUT

INTAKE
TOTAL

OUTPUT
URINE: TOTAL
DRAINS:
TOTAL

NURSES' NOTES

RN Signature/ID# _____

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AMBULATORY SURGERY CENTER PACKET
Nurses Notes

NURSES' NOTES CONTINUATION

DATE	TIME	NOTES

AMBULATORY SURGERY DISCHARGE CRITERIA

❑ Discharge instructions given, verbalizes understanding and signed.
❑ Follow-up appointment given: _____
❑ BP _____Resp _____O_2 Sat _____Pulse _____Temp _____
RN/ID# _____

Time _____
❑ Clothes/valuables returned to: _____
Pain Rating _____

ANESTHESIA DISCHARGE NOTES

_____
_____
_____
_____ MD Signature/ID#_____

POST-OPERATIVE FOLLOW UP CALL

Date	Time	Notes

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# _____