

P31

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NM

# PERIOPERATIVE RECORD

Ph (H) NO PHONE  
Ph (B)  
No R



MUSCIAN

Pre Operative Nursing Assessment:

Adverse Drug Reactions:

All Known.

For pericardial window and insertion of pericardial (L) side removal of pericardial pig tail drain and (R) side pericardial drain.

Signature:		Printed name:				Designation:			
Date	Time	Temp	BP	Pulse	Resps	Weight	BSL	ECG	O2 Sats
17/08/03	1115		149/105	107	16			ST	96%

### Pre Operative Check

### Post Operative Check

Patient states procedure and site of same ..... Right or Left

I.D. Band

Consent

Charts with patient

X-Rays

X-match/Path (Current)

Remove Make-up/Jewellery

Remove Contact Lenses

Hearing Aid

Prosthesis/Implants

Loose Teeth

Dentures - Removed/Left in situ

Full upper/lower

Partial upper/lower

Toy/Dummy

PreOp Wash

Premed Given

Yes/No/NA	
Ward	OT
✓	YES
✓	YES
YES	YES
✓	YES
✓	YES
N/A	N/A
✓	YES
N/A	N/A
N/A	N/A
N/A	N/A
N/A	N/A
N/A	N/A
N/A	N/A
N/A	N/A
N/A	N/A
N/A	N/A
✓	✓
NO	NO

I.D. Band

Patient Charts

X-Rays

Medication Sheet

IV Fluid Sheet

OP Notes

Anaesthetic Notes

Check Drains

Check Dressings

Hearing Aid

Prosthesis/Implants

Loose Teeth

Dentures - Removed/Left in situ

Full upper/lower

Partial upper/lower

Toy/Dummy

Yes/No/NA	
OT	
YES	
YES	
YES	
YES	
NO	
YES	
✓	
✓	
N/A	
N/A	
N/A	
N/A	
N/A	
N/A	
✓	
✓	

Any alerts to OT Staff or Anaesthetist:

Last Ate: 0730

Last Drank: 0730

Last Voided: 0730

AN Signatures/printed name/designation:

*Boisen RW*

ward

*JLW*

theatre

*JLW*

theatre

# ANAESTHETIC RECORD

Surname: \_\_\_\_\_ U.R. No.: \_\_\_\_\_

Given Names: \_\_\_\_\_

Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

(Please affix Patient ID label here if available)

Planned Operation: \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_ Weight \_\_\_\_\_ Date \_\_\_\_\_

**Pre-Operative assessment:**

Previous Anaesthetics: \_\_\_\_\_

Significant History: *ESRF*  
*Researched often*

Medications:	NBM:
	Neck Mobility
	Jaw Mobility:
CVS:	Mallampati score:
	Teeth Dentures:
	Loose:
ECG:	
RSP:	
CXR/Pulm. Func:	B.P.:
OTHER:	Pulse:
Any Allergies:	A.S.A.: <i>IV E</i>
Prodedure explained:	

**Special Investigations:**

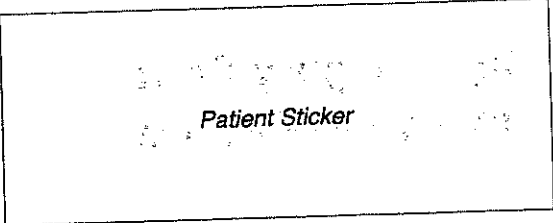
Hb	Platelets	WBC	INR	
Na	K	CL	Urea	Creat
Glucose	Protein	Bilirubin	GAMM GT	CA

X-Match: \_\_\_\_\_ no. of units: \_\_\_\_\_ Grp and hold: \_\_\_\_\_

PAC Anaesthetist: *M. Paul*  
Date: *12/8/05*

**Premedication:**

Date	Time	Drug & Dose	Route	Doctor	Nurse	Time Given



**Post Operative Orders**

**General Instructions**

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**Day Stay Surgery Post Operative Orders**

**Fluid Orders For Day Surgery**

Fluids	Rate	Duration	Signatures	

Post - Operative Medications for Day Case Surgery				
Drug	Route	Frequency	Ordered by	Given by

**Discharge Criteria:**

Vital signs  
 2 = within 20% of preoperative value  
 1 = 20-40% of preoperative value  
 0 = 40% of preoperative value

Ambulation and mental status  
 2 = oriented and has a steady gait  
 1 = oriented or has a steady gait  
 0 = neither

Pain or nausea and vomiting  
 2 = minimal  
 1 = moderate  
 0 = severe

Surgical bleeding  
 2 = minimal  
 1 = moderate  
 0 = severe

Intake and output  
 2 = has had po fluids and has voided  
 1 = has had po fluids or has voided  
 0 = neither

Patient score  Time \_\_\_\_\_

\* The total score is 10; if the patient's score is 9, then the patient is fit for discharge.

\_\_\_\_\_  
 Signature

# Day Surgery Post Operative Record

BUNDABERG HEALTH SERVICE DISTRICT

Surname: \_\_\_\_\_ U.R. No.: \_\_\_\_\_

Given Names: \_\_\_\_\_

Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

(Please affix Patient ID label here if available)

Time											Comments	
200												
180												
160												
140												
120												
100												
80												
60												
40												
Respirations												
Conscious state												
Colour												
Dressings												
Drains												
Oxygen												

Conscious State: 1. Aware 2. Rousable 3. Unrousable

Colour: 1. Pink 2. Pale 3. Cyanosed

### Nursing Report

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Discharge Checklist

Vital signs stable	<input type="checkbox"/>		Dressing checked	<input type="checkbox"/>
Respirations normal	<input type="checkbox"/>		Patient escort	<input type="checkbox"/>
Nausea/vomiting minimal	<input type="checkbox"/>		Take home medication	<input type="checkbox"/>
Able to ambulate	<input type="checkbox"/>		Discharge instruction sheet	<input type="checkbox"/>

M.O. Signature: \_\_\_\_\_

R.N. Signature: \_\_\_\_\_

Discharged to: \_\_\_\_\_

Follow-up Appointment: \_\_\_\_\_

Date: \_\_\_\_\_

Time: \_\_\_\_\_

Clinic: \_\_\_\_\_

BUNDABERG HOSPITAL

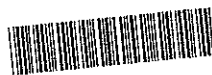
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NM

SURGEON'S REPORT

Ph (H) NO PHONE  
Ph (B)  
No R



MUSCIAN

DATE: 17.8.03

DIAGNOSIS & OPERATION PERFORMED: - ~~PERICARDIAL~~

PERICARDIAL EFFUSION, RENAL FAILURE, SEPTIC  
PERICARDIAL WINDOW, REMOVAL OF PERMACATH.  
INSERTION OF DIALYSIS CATHETER CT. 3J

SURGEON: DATEL

ASSISTANT:

ANAESTHETIST: CARTER.

DETAILS OF OPERATION:

Notification Correct Count

IV Sedation.

ABDOMEN, RT NECK GILEY & DRAPED

1% LIDOCAINE

UPPER MIDLINE INCISION

DISSECTION PROXIMALLY TO XIPHISTERNUM

DIAPHRAM RETRACTED, PERICARDIAL FLUID

ASPIRAED - (SENT FOR CULTURE)

PERICARDIAL WINDOW CREATED -

SMALL PIECE OF PERICARDIUM SENT FOR  
CULTURE

2 OFR. CATH. TUBE. ~~IS~~ INSERTED INTO THE  
PERICARDIAL SPACE & BROUGHT VIA SEPARATE

SMALL INCISION CROTHERED & 200 DIALYSIS

1 STRAP IN PERICARDIUM AT THE SITE OF ACCIDENTAL  
SPONTANEOUS

CONCA ALBA SUTURED & D. MOUTH

SKIN APPROXIMATED & 3/0 BIRSEN

RT. NECK PERICATH REMOVED -

TIP SENT FOR THE CULTURE.

CT. 3J Line for DIALYSIS inserted by

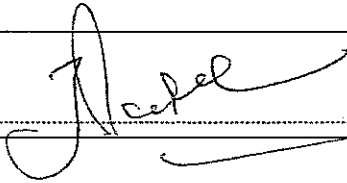
Dr. Carter

OPERATION RECORD

POST-OPERATIVE ORDERS:

Rescuing all previous order E.N  
orders per medical team

SURGEON'S SIGNATURE: \_\_\_\_\_

A handwritten signature in cursive script, appearing to read "J. Patel", written over a horizontal line.

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