

Anesthesia Record

Patient Name: Doe, Jim "Jimmy"
Date: 5/21/2022 **DOB:** 1980-02-07 (age: 42)
Ht: 5'7" **Wt:** 158lbs **BMI:** 24.9
NPO Status: food: 8pm day prior, drink: 10pm day prior
ASA Classification: 2
Allergies: Amoxicillin: full body hives
Procedure: EXT: #16-7240, #17-7230
Reason For Sedation: Acute Situational Anxiety, Inability to achieve profound local anesthesia

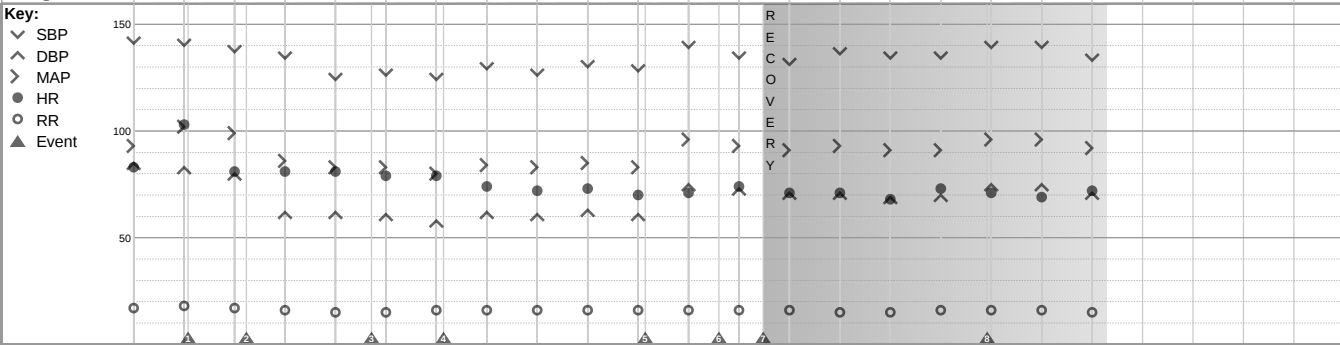
Surgeon: Better Anesthesia Charting
Office: The Center for Ideal Anesthesia Charting, Surgical Suite A
Sedation Provider: Better Anesthesia Charting
Sedation Type: Moderate
Present: Brandi Felts, Erin Lance, Travis Coulter
Responsible Companion: Wife(Jane) 505-555-5454

Anesthesia Times
Start: 12:56
End: 14:10
Anesthesia Minutes: 74
Anesthesia Units (15m): 4.9
Recovery Complete: 14:25

Health History/Systems Review: Pregnant: no. Breastfeeding: no. Surgeries: Tonsillectomy/Adenoidectomy 2y.o.. Non-surgical hospitalization summary: Kidney stone 2015-lithotripsy therapy. Personal anesthesia history: No known anesthesia complications. Familial anesthesia history: Mother diagnosed with malignant hyperthermia .
Renal System:
 - Kidney Stones: March 2015
Endocrine System:
 - Diabetes: Type 2, Metformin 500mg BID, 145, 5.9, 139
Habits:
 - Tobacco: Smokeless, Chewing tobacco (Copenhagen), 1 can per week
Medications: metformin
Physical assessment: Weight distribution: Equal, Mallampati: Class II, Lung auscultation: CTAB, Heart auscultation: RRR w/o murmur

Time:	12:48	12:53	12:58	13:03	13:08	13:13	13:18	13:23	13:28	13:33	13:38	13:43	13:48	13:53	13:58	14:03	14:08	14:13	14:18	14:23	14:28
SpO ₂	99	100	99	98	99	100	100	99	99	100	100	99	99	100	100	99	99	100	100	100	100
ECG	NSR	ST	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR
EiCO ₂	38	39	38	37	38	37	38	38	38	39	38	38	37	36	37	35	36	38	37	37	

Initial:
 BP: 141/85
 SpO₂: 99%
Final:
 BP: 135/75
 SpO₂: 99%



Inhalation Agents:

Oxygen	4	2																			
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Parenteral Drugs

Drug	Dose	Time	Used	Waste
Dexamethasone (mg)	4 IV	12:56	4	0
Fentanyl (mcg)	25 IV	12:56, 13:12, 13:26	75	25
Ketorolac (mg)	15 IV	13:56	15	0
Midazolam (mg)	2.5 IV, 1.5 IV	12:56, 13:13, 13:31, 13:42	9	1
Ondansetron (mg)	8 IV	12:52	8	0

Local Anesthetics

Drug	Dose	Time	Total	Epi
2% Lidocaine (1:100,000 epi)	36, 27	12:56, 13:12	63	0.032
0.5% Bupiv. (1:200,000 epi)	9, 9	12:56, 13:12	18	0.018
			81	0.05

Events: ▲ 12:54: Procedure Started ▲ 12:59: Drew 4 red top vacu-sealed viles of blood through the IV cath port. Centrifuged at 2700 RPM for 11 minutes. ▲ 13:12: Completed removal of tooth #17. ▲ 13:19: Completed socket preservation bone graft and PRP membrane cover site #17 ▲ 13:39: Completed removal of tooth #16. ▲ 13:46: Completed socket preservation bone graft with PRP membrane cover. ▲ 13:51: Procedure Ended ▲ 14:13: Captured current BGL: 122.4 oz of apple juice administered.

Pre-procedure Sedatives:
 Triazolam: 0.25mg, SL, 10:30
Pre-procedure Medications:
 clindamycin: 10:30 300mg PO
Inhalation Agents (list view):
 Oxygen: 13:00 2L/min, 13:51 0L/min
Parenteral Drugs (list view):
 Dexamethasone: 13:00 4mg IV
 Fentanyl: 12:56 25mcg IV, 13:12 25mcg IV, 13:26 25mcg IV
 Ketorolac: 13:56 15mg IV
 Midazolam: 12:56 2.5mg IV, 13:13 2.5mg IV, 13:31 2.5mg IV, 13:42 1.5mg IV
 Ondansetron: 12:52 8mg IV

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Local Anesthetic (list view):

12:55 36mg 2% Lidocaine, 0.018 mg epi.
 12:58 27mg 2% Lidocaine, 0.014 mg epi.
 13:01 9mg 0.5% Bupivacaine, 0.009 mg epi.
 13:03 9mg 0.5% Bupivacaine, 0.009 mg epi.

Pre-op Checks: Equipment readiness check Emergency Meds Present Emergency Equipment Present Confirmed correct patient and procedure Pre-op Instructions Followed
 Reviewed health history Financial arrangements Informed consents Transportation arranged Bathroom Reviewed vitals Answered all questions Made comfortable
 Offered blanket/pillow Pressure points relieved

Airway: Nasal Cannula

IV:

Start / End Time: 12:53 - 14:25
 Location: Right AC
 Solution: NS amount: 410cc
 Secured by: Tegaderm
 Attempts: 1 Gauge: 22
 Room Air SpO2 @ D/C: 99%

Aldrete Score

Vital signs: Within 12% of preoperative value	2
Oxygenation:	2
Respiratory Stability:	2
Consciousness:	2
Post Operative Pain:	2
Nausea and Vomiting:	2
Gait:	2

Total Score: 14

Procedure Notes: Reviewed HHx/Systems. Titrated sedatives to desired effect. Patient was responsive to oral commands and self maintained airway through out the entire procedure. No complications encountered with sedation or surgical procedure.



Recovery Notes: Patient spontaneously recovered in the operatory on room air without transfer to separate recovery. Patient is able to maintain own vitals without stimulation and on room air. No complications encountered. Patient denies PONV, dizziness or pain. Patient consumed juice and denied needing to use the restroom. D/C'd IV-secured with gauze + coban. Patient self ambulated to wheelchair. Post op instructions administered oral and written to RC. Confirmed instructions to continue antibiotic therapy. Administered OTC pain management regimen. ER contact information administered to the RC. Wheeled to patient's vehicle, discharged to wife and confirmed safety buckled.




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Vitals Data Reference

Time	SBP	DBP	MAP	HR	SpO ₂	ECG	RR	EtCO ₂
12:48	141	85	93	83	99	NSR	17	38
12:53	140	83	102	103	100	ST	18	39
12:58	137	80	99	81	99	NSR	17	38
13:03	134	62	86	81	98	NSR	16	37
13:08	124	62	83	81	99	NSR	15	38
13:13	126	61	83	79	100	NSR	15	37
13:18	124	58	80	79	100	NSR	16	38
13:23	129	62	84	74	99	NSR	16	38
13:28	126	61	83	72	99	NSR	16	38
13:33	130	63	85	73	100	NSR	16	39
13:38	128	61	83	70	100	NSR	16	38
13:43	139	75	96	71	99	NSR	16	38
13:48	134	73	93	74	99	NSR	16	37
13:53	131	71	91	71	100	NSR	16	36
13:58	136	71	93	71	100	NSR	15	37
14:03	134	69	91	68	99	NSR	15	35
14:08	134	70	91	73	99	NSR	16	36
14:13	139	75	96	71	99	NSR	16	38
14:18	139	75	96	69	100	NSR	16	37
14:23	133	71	92	72	100	NSR	15	37
19:13	135	75	95	71	99	NSR	16	39



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Preoperative Sedation Checklist

Patient Name: Doe, Jim "Jimmy"
Date of Birth: 1980-02-07 (age: 42)
Procedure: EXT: #16-7240, #17-7230
Sedation Level: Moderate
Reason for sedation: Acute Situational Anxiety,
Inability to achieve profound local anesthesia

History

- Patient medical history:**
 - Renal System:
 - Kidney Stones: March 2015
 - Endocrine System:
 - Diabetes: Type 2, Metformin 500mg BID, 145, 5.9, 139
 - Habits:
 - Tobacco: Smokeless, Chewing tobacco (Copenhagen), 1 can per week
- Allergies:** Amoxicillin: full body hives
- Surgical History:** Tonsillectomy/Adenoidectomy 2y.o.
- Anesthesia History:** No known anesthesia complications
- Family Anesthesia History:** Mother diagnosed with malignant hyperthermia
- Medications:** metformin

Other Preoperative Checks

- Equipment readiness check
- Emergency Meds Present
- Emergency Equipment Present
- Confirmed correct patient and procedure
- Pre-op Instructions Followed
- Reviewed health history
- Financial arrangements
- Informed consents
- Transportation arranged
- Bathroom
- Reviewed vitals
- Answered all questions
- Made comfortable
- Offered blanket/pillow
- Pressure points relieved

Physical Examination

- Height:** 5'7"
- Weight:** 158lbs
- BMI:** 24.9
- ASA Classification:** 2
- NPO Status:** food: 8pm day prior, drink: 10pm day prior
- Initial Vitals:** BP: 141/85, SpO₂: 99%, RR: 17 HR: 83

Anesthesia-Specific Physical Exam

- Mallampati:** Class II
- Weight Distribution:** Equal
- Lung Auscultation:** CTAB
- Heart Auscultation:** RRR w/o murmur

Additional Pre-Anesthesia Risk Assessment Notes

(none)

Medical Consult Notes

(none)