

**THE ENDOSCOPY CENTER
PRE-PROCEDURE ASSESSMENT**

Name: _____

Date: _____

Time: _____

ASA Classification: I II III IV V

Procedure: _____ Stated Indication: _____

Allergies: _____

Baseline Vital Signs: B/P _____/_____ P _____ R _____ SaO2 _____%

Weight: _____lbs Stated [] Measured []

Mobility: normal [] assisted []

Disability: none [] present [] (specify) _____

Skin: warm [] cool [] dry [] diaphoretic [] pink [] pale [] jaundiced [] cyanotic []

Abdomen: soft [] firm [] distended [] non-distended []

Pain: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (Circle one) Location: _____

LOC: alert [] oriented [] confused [] anxious [] other: _____

Evidence of child/elder abuse or domestic violence? No [] Yes [] If yes, see reverse side.

Pt. Ed: brochure [] video [] verbal [] previous procedure [] comprehension _____

Personal Belongings: glasses [] dentures [] h.aide [] removed [] secured [] N/A []

Accompanied by: _____ **Location:** lobby [] phone: _____

Preparation: NPO since _____ Colyte [] Phos Soda [] Enema [] other _____ N/A []

Results: _____ N/A []

IV # _____ **Angiocath Site:** _____ **Solution:** NS [] D5W []

Started by: _____ **Comment:** _____

Have you ever had any problems with anes/Cons. Sedation in the past Yes [] No [] N/A []

Nursing Notes: _____

Reviewed past history sheet for medical and surgical information. Yes [] No []

Nurse Signature : _____

INTRA-PROCEDURE NOTE

Monitoring: EKG [] B/P [X] Pulse Oximeter [X] O2 [] Other _____

Hurricane/Cetacaine Spray [] Viscous Lidocaine [] N/A [] Comments _____

Time	Drug - Dose/Route	Comments

Start Time: _____ **Stop Time:** _____

Endoscope Model#: _____ Video [X] Photography [] N/A []

Biopsy [] Polypectomy [] Brushing [] N/A []

Inj. Hemostasis [] Sclerotherapy [] N/A [] Type & Quantity: _____

Dilatation: [] Savory [] TTS [] N/A [] Sizes: _____

Electrocautery: Cut _____ Coag _____ Pad Site _____ N/A _____

Bipolar _____ Comments _____ N/A _____

Specimens Obtained:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____
- 7) _____
- 8) _____

Post Procedure Diagnosis: _____

Post Procedure VS: B/P _____/_____ P _____ R _____ SaO2 _____%

Skin: Warm [] Cool [] Dry [] Diaphoretic []

Abdomen: distended [] non-distended [] tender [] non-tender []

Cautery pad site: clear [] N/A [] **IV patent** [] **O2 D/C'd:** yes [] no [] N/A []

HOB Elevated: 30 deg. [] 45 deg. [] **Pain:** 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Comments: _____

Nurse' Signature: _____ Tech's Signature: _____

The Endoscopy Center Recovery And Discharge Notes

Vital Signs Record	Comments
See Print Out	

IV D/C'd at _____. _____ cc infused. **Site:** with without complications.

Memory of Procedure: full partial none

Patient ambulatory to dress with without assistance.

Discharged in stable condition at _____ am/ pm.

Via: ambulatory wheelchair other: _____

To: home relative's home friend other: _____

Accompanied by: spouse relative friend other: _____

Written Instructions Given: yes no

Verbal Instructions Given: yes no

Questions Answered: yes no

Verbalized Understanding: yes no

Instruction reviewed with significant other? yes no

Brochures Given: N/A

- | | | |
|---|---|--|
| <input type="checkbox"/> Barretts Esophagus | <input type="checkbox"/> Gas | <input type="checkbox"/> Lactose Intolerance |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Heartburn/Reflux | <input type="checkbox"/> Lap Choly |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Helicobacter | <input type="checkbox"/> Liver Biopsy |
| <input type="checkbox"/> Colon CA/Polyps | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pancreatic Disease |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> PUD |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Rectal Bleeding |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> High Fiber | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> IBS | <input type="checkbox"/> _____ |

Nurse/Tech Signature _____

Post Procedure Phone Call: Date: _____ Time: _____

Nausea/vomiting yes no Difficulty swallowing yes no

Bleeding yes no Tolerating diet yes no

Pain yes no IV site OK yes no

Comments: _____

Nursing Instructions: _____

Nurse/Tech Signature _____

Post Anesthetic Recovery Score	Immediately Post Procedure	15 Minutes Post Procedure	30 Minutes Post Procedure	Other	Other	Discharge
ACTIVITY						
Able to move 4 extremities voluntarily or on command	2	2	2	2	2	2
Able to move 2 extremities voluntarily or on command	1	1	1	1	1	1
Able to move 0 extremities voluntarily or on command	0	0	0	0	0	0
RESPIRATION						
Able to deep breathe and cough freely	2	2	2	2	2	2
Dyspnea or limited breathing	1	1	1	1	1	1
Apneic	0	0	0	0	0	0
CIRCULATION						
BP + or - 20% of preanesthetic level	2	2	2	2	2	2
BP + or - 20 - 50% of preanesthetic level	1	1	1	1	1	1
BP + or - 50% of preanesthetic level	0	0	0	0	0	0
CONSCIOUSNESS						
Fully awake	2	2	2	2	2	2
Arousable on calling	1	1	1	1	1	1
Not responding	0	0	0	0	0	0
COLOR						
Pink	2	2	2	2	2	2
Pale, dusky, blotchy, jaundiced, other	1	1	1	1	1	1
Cyanotic	0	0	0	0	0	0
TOTAL SCORE						

***Patient must have a total score of 8 - 10 on discharge.**

RN/Tech Signature: _____