INHALATION / ANXIOLYSIS SEDATION PROCEDURE SHEET

PATIENT NAME:	AGE: Years: ____ Months ____	GENDER: ☐ Male ☐ Female	WEIGHT:
ASA: ☐ I ☐ II	DATE (DD MMM YYYY)	LAST PE (DD MMM YYYY)	CONSENT REVIEWED AND SIGNED? ☐ YES ☐ NO

REASONS FOR MEDICATIONS: ☐ PRECOOP ☐ COMBATIVE ☐ ANXIOUS ☐ AMT / TX TYPE

RESTRAINTS: ☐ NONE ☐ PAPOOSE BOARD ☐ MOUTH PROP ☐ STAFF ☐ PARENT

MONITORS: ☐ BP CUFF ☐ PULSE OXIMETER ☐ PRECORDIAL STETH ☐ AUTOMATIC BP MACHINE

EQUIPMENT CHECK: TANKS: OXYGEN: FRONT _____ psi / BACK _____ psi

NITROUS: FRONT _____ psi / BACK _____ psi

☐ FAIL SAFE TEST ☐ CIRCUIT LEAK TEST ☐ FITTINGS TIGHT ☐ CONTROL FUNCTIONS

☐ FLOW METER ☐ SEALS / WASHERS / GASKETS ☐ SCAVENGING ☐ EMERGENCY EQUIP

BASELINE VITAL SIGNS:
BP: _____ / _____ PULSE: _____ RESP: _____ / _____ MIN O2 SAT: _____

POST-PROCEDURE VITAL SIGNS:
BP: _____ / _____ PULSE: _____ RESP: _____ / _____ MIN O2 SAT: _____

100% O2 for 5 minutes post-procedure: _____ Last set of vital signs on room air: _____ Max % N2O _____ at _____ l / min

NITROUS OXIDE [CONCEN] LESS 100% OXYGEN

50% 40% 30% 20% 10%

210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10

PREMEDICATION TIME:	
mg	MEDICATION

LEGEND	
BP	▼ = Syst.
	▲ = Diast.
PULSE	●
RESP	○
O2 SAT	○
ADM MED	x
PROC	○
DISCH	x

PATIENT IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; DOB; Rank/Grade.)*

PRACTITIONER'S NAME:

SIGNATURE: DATE:

HOSPITAL OR MEDICAL FACILITY

SPONSOR'S NAME

SSN/ID No.

DISCHARGE CRITERIA:

☐ AIRWAY STABLE ☐ CV STABLE ☐ SITTING UNAIDED

☐ ALERT ☐ TALKING ☐ AMBULATE (MINIMAL ASSISTANCE)

LEVEL OF SEDATION:

☐ PRE / NON-SEDATE ☐ QUIET, RESPONSIVE, COOP ☐ SLEEPY, RESP TO VERB STIM

☐ SLEEPY, RESPON TO PHYS STIM ☐ SLEEPY, DISRUPTED WITH STIM ☐ DISRUPTED, INADEQUATE SED

OTHER: _____

EFFECTIVENESS OF SEDATION:

☐ INEFF ☐ EFF ☐ VERY EFF ☐ SEDATED

SIDE EFFECTS:

☐ NAUSEA ☐ VOMITTING ☐ RESP DEPRESSION OTHER: _____

POST OP INSTRUCTIONS:

☐ WRITTEN ☐ VERBAL

NAME OF ESCORT:	PATIENT HOME TELEPHONE NUMBER:	POST-OP TELEPHONE F/U DATE:

PATIENT CONDITION:

PATIENT IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; DOB; Rank/Grade.)*

PRACTITIONER'S NAME:

SIGNATURE: DATE:

HOSPITAL OR MEDICAL FACILITY

SPONSOR'S NAME

SSN/ID No.