SAMPLE PREOPERATIVE SEDATION/ANESTHESIA CHECKLIST

Patient Name:	Patient DOB:	Surgeon:
Procedure (timeout):	Procedure Date:	Level of Sedation: _____ Nitrous/Minimal _____ Moderate _____ Deep _____ General Anesthesia
Sedation Services Delegated : Y or N	Sedation Provider: (only if delegated)	Note: :

PRE-OP VITALS (day of procedure):

Height:	Weight:	Blood Pressure:	Pulse Rate:	Respiration Rate:

PRE-PROCEDURE MEDICAL REVIEW (to be completed by surgeon only):

Patient's Medical History	Y or N	Notes:
Patient's Allergies	Y or N	Notes:
Patient's Surgical History	Y or N	Notes:
Patient's Family Surgical History	Y or N	Notes:
Patient's Sedation History:	Y or N	Notes:
Medical Consult (if necessary)	Y or N	Notes:
ASA Status	Y or N	I II III IV
Airway Status	Y or N	I II III IV
NPO Status	Y or N	Last meal:
Auscultation	Y or N	Notes:

EQUIPMENT READINESS CHECK (Positive-pressure oxygen delivery system, reversals, stethoscope)

Date Completed:	Completed By:	Notes:

I hereby attest that the patient is cleared for surgery and the proper preprocedure systems and items have been reviewed. The patient has also received post-operative instructions in-advance of the surgery.

Surgeon Name (Printed): _____Signature: _____ Date: _____

Staff Name (Printed):_____Signature: _____ Date: _____