**D r . Y u & A s s o c i a t e s**

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**PRE-OPERATIVE SEDATION/ANESTHESIA CHECKLIST**

Patient Name: \_\_\_\_\_\_ \_\_ DOB: \_\_\_\_ Date: \_\_\_\_\_\_\_

Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sedation Level:** Nitrous Oxide Level 1 2 3 4

**Medical History:**

Medical History Review \_\_ \_\_\_\_\_\_\_\_\_

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

Medication Review \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Medical Consult/Clearance Needed N/A Y Recv’d Modification (ie: Meds, Recs) N Y

NKDA Medication Allergies:

SOC Hx TOB \_\_\_\_\_\_pk-yrs EtOH \_\_\_\_\_\_\_ Illicit Drug Use \_\_\_\_\_\_\_\_\_Last used?\_\_\_\_\_\_\_

Previous Surgical/Anesthesia Complications: N Y \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Surgical/Anesthesia Complications: N Y \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

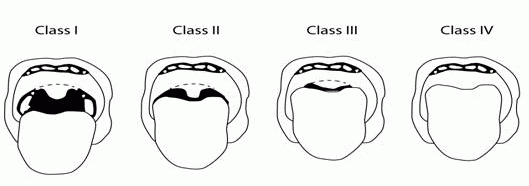
**Physical Exam:**

ASA Classification 1 2 3 4

\*\*\*NPO status and Vitals (BP, HR, EKG, Auscultation) recorded in the Sedation Record\*\*\*

**Anesthesia Exam:**

Mallampati Score I II III IV



Snoring: Yes No Sleep Apnea: Yes No

Pre-procedure equipment readiness check: Confirmed by (initials): /

Pre-procedure treatment review: Confirmed by (initials): /

Written & verbal pre/post-op instructions: Patient Parent Legal Guardian Caregiver

Confirmed by (initials): /

Special Considerations for high-risk: \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Reason for omission of any item above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pre-procedure verification of above information: Confirmed by (sedation provider’s initials):