



AMBULATORY SURGERY CENTER PACKET  
Interdisciplinary Flow Sheet

**PRE-ADMISSION NURSING ASSESSMENT**

Planned procedure \_\_\_\_\_ Telephone Evening Before \_\_\_\_\_  
 Surgeon \_\_\_\_\_ Telephone Morning Of \_\_\_\_\_  
 Date \_\_\_\_\_ Interview:  Phone  In Person Telephone Day After \_\_\_\_\_  
 Interpreter/Special Needs  Yes  No Cellular/Work \_\_\_\_\_  
 Other \_\_\_\_\_

**Nursing Diagnosis:** Potential for increased anxiety related to knowledge deficit, surgery or unfamiliar environment.  
**Assessment and Intervention:** Explanation of peri-operative event, orientation, support and reassurance throughout experience; maintenance of sensory stimuli and activity level to be at a minimum.  
**Expected Outcome:** Positive Identification of patient. Patient displays improvement in symptoms of anxiety by relaxed facial expression and patient/family verbalize understanding of peri-operative event.  Met  Not Met

**REVIEW OF SYSTEMS**

IF PATIENT REPORTS SYSTEM WITHIN NORMAL LIMITS CHECK BOX

Cardio/Vascular <input type="checkbox"/>	Integ/MS <input type="checkbox"/>
Neuro/Psych <input type="checkbox"/>	GI/Reflux/Peptic <input type="checkbox"/>
Pulmonary <input type="checkbox"/>	Renal <input type="checkbox"/>
Reproductive/LMP <input type="checkbox"/>	Endocrine <input type="checkbox"/>
ENT <input type="checkbox"/>	Hematology/Bleeding/Sickle Cell <input type="checkbox"/>

Allergies \_\_\_\_\_

RN Signature/ID# \_\_\_\_\_

**PRE-PROCEDURE TEACHING**

NPO Time \_\_\_\_\_ Arrival Time \_\_\_\_\_  Escort  Belongings/Valuables  
 Change in health call ASC  Financial Responsibility  Make-up  Glasses/Contacts  
 ETOH/Drugs  Jewelry  Dentures/Bridges/Crowns  
 Medications Instruction \_\_\_\_\_ Other Instruction \_\_\_\_\_  
 RN Signature/ID# \_\_\_\_\_

**PRE-ADMISSION NURSING ASSESSMENT**

Date \_\_\_\_\_ Time \_\_\_\_\_ NPO Time \_\_\_\_\_ Allergy Bracelet \_\_\_\_\_  Yes  No  
 Other \_\_\_\_\_

ETOH/Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No	Glasses/Contacts <input type="checkbox"/> Yes <input type="checkbox"/> No	EKG <input type="checkbox"/> Yes <input type="checkbox"/> No
Dentures/Bridge/Crown <input type="checkbox"/> Yes <input type="checkbox"/> No	Change in Health <input type="checkbox"/> Yes <input type="checkbox"/> No	CXR <input type="checkbox"/> Yes <input type="checkbox"/> No
Hair Pins/Clips <input type="checkbox"/> Yes <input type="checkbox"/> No	Bill of Rights <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Sight Verification</b>
Jewelry/Body Piercing <input type="checkbox"/> Yes <input type="checkbox"/> No	H & P <input type="checkbox"/> Yes <input type="checkbox"/> No	Verbal <input type="checkbox"/> Yes <input type="checkbox"/> No
Nail Polish/Make-up <input type="checkbox"/> Yes <input type="checkbox"/> No	Lab Work <input type="checkbox"/> Yes <input type="checkbox"/> No	Operative Site Marked <input type="checkbox"/> Yes <input type="checkbox"/> No
Consent <input type="checkbox"/> Yes <input type="checkbox"/> No	ID Bracelet <input type="checkbox"/> Yes <input type="checkbox"/> No	Op. Site Mark Exempt <input type="checkbox"/> Yes <input type="checkbox"/> No

**PAIN ASSESSMENT**

Do you have pain? <input type="checkbox"/> Yes <input type="checkbox"/> No Rating 1-10? _____	What increases pain? _____
Location _____	What relieves pain? _____
Description: <input type="checkbox"/> Sharp <input type="checkbox"/> Burning	Assessment _____
<input type="checkbox"/> Radiating <input type="checkbox"/> Aching	
<input type="checkbox"/> Dull <input type="checkbox"/> Numbness	
Duration: <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	

Escort Name/Location \_\_\_\_\_ Pre-Operative RN/ID# \_\_\_\_\_  
 Locker # \_\_\_\_\_ Circulating RN/ID# \_\_\_\_\_





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**ORDERS: Must include physician's signature and ID#  
STAT ORDERS MUST COMMUNICATED TO NURSE**

Trans.  
Initials/ID

**ALLERGIES:**

Allergy \_\_\_\_\_ Weight in Kilograms: \_\_\_\_\_ BMI \_\_\_\_\_

**VITAL SIGNS:**

Vital signs per recovery routine

Oxygen via:  2 L nasal cannula wean PRN  humidified face tent  
 15 L non-rebreather wean PRN  F,O<sub>2</sub> blowby

IV FLUIDS:  \_\_\_\_\_ to infuse at \_\_\_\_\_ mL/hour

**ADULT ANALGESIA:**

Fentanyl \_\_\_\_\_ mcg IV Push every \_\_\_\_\_ minutes PRN pain X \_\_\_\_\_ LIP Init: \_\_\_\_\_

Oxycodone 5 mg/Acetaminophen 325 mg 1 tab PO X 1 PRN for mild/moderate pain  
LIP Init: \_\_\_\_\_

Oxycodone 5 mg/Acetaminophen 325 mg 2 tab PO X 1 PRN for severe pain LIP Init: \_\_\_\_\_

Acetaminophen 650 mg PO X 1 PRN for mild pain LIP init: \_\_\_\_\_

Other: LIP init: \_\_\_\_\_

**PEDIATRIC ANALGESIA:**

Fentanyl 0.5 mcg/kilogram X \_\_\_\_\_ kg= \_\_\_\_\_ mcg IV every \_\_\_\_\_ minutes  
PRN for mild/moderate pain X \_\_\_\_\_ dose(s) LIP init: \_\_\_\_\_

Fentanyl 1 mcg/kilogram X \_\_\_\_\_ kg= \_\_\_\_\_ mcg IV every \_\_\_\_\_ minutes  
PRN for severe pain X \_\_\_\_\_ dose(s) LIP init: \_\_\_\_\_

Hydrocodone 5 mg with homatropine 1.5 mg (HYCODAN) = 5 mL syrup  
0.1 mg/kg Hydrocodone X \_\_\_\_\_ kg= \_\_\_\_\_ mg hydrocodone PO PRN for  
pain X 1 dose LIP init: \_\_\_\_\_

Acetaminophen 120 mg with Codeine 12 mg = 5 mL elixir LIP init: \_\_\_\_\_  
0.8 mg/kg codeine X \_\_\_\_\_ kg= \_\_\_\_\_ mg codeine PO PRN for pain X 1 dose

**ANTIEMETICS:**

Ondansetron \_\_\_\_\_ mg IV PRN nausea X 1 LIP init: \_\_\_\_\_

Promethazine (PHENERGAN) \_\_\_\_\_ mg IV PRN nausea X 1 diluted in 10 mLs normal  
saline, give slowly, stop if painful. LIP init: \_\_\_\_\_

OTHER:

LIP init: \_\_\_\_\_

**DISCHARGE FROM RECOVERY:**

When discharge criteria met  Call physician prior to discharge

MD/LIP/NP Signature: ID#: Date: Time:

Nurse Signature: ID#: Date: Time:

SCAN TO PHARMACY AND PLACE IN PATIENT CHART  
PART 3A-CHART COPY



STONY BROOK  
UNIVERSITY  
MEDICAL CENTER  
Stony Brook, N.Y. 11794

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POST ANESTHESIA CARE NURSING NOTE

Arrival Time \_\_\_\_\_ Allergy \_\_\_\_\_

**Nursing Diagnosis:** Potential for infection, ineffective breathing and barriers with communication related to surgery and/or anesthesia, alteration in comfort.

**Assessment and Intervention:** Written material, repetition of information and availability of interpreter if appropriate. Family involvement, maintain pain at < 4 on pain scale; administration of pain medication, maintenance of O<sub>2</sub> Sat >95

**Expected Outcomes:** Pain maintenance <4, BBS cl. dsg dry and intact, afebrile.

Met  Not Met

TIME												
TEMP												
BP X												
P •												
RESP												
C & DB												
O <sub>2</sub> Sat												
Alarms Enabled												

POST ANESTHESIA RECOVERY SCORE (ALDRETE)		A	D
Activity	Able to move 4 extremities voluntarily or on command = 2 Able to move 2 extremities voluntarily or on command = 1 Able to move 0 extremities voluntarily or on command = 0		
Respiration	Able to deep breath and cough easily =2 Dyspnea or limited breathing =1 Apneic =0		
Circulation	BP + 20 of preanesthetic level =2 BP + 20-50 of preanesthetic =1 BP + 50 of preanesthetic =0		
Consciousness	Fully awake =2 Arousable on calling =1 Not responding =0		
Color	Pink =2 Pale, dusky, blotchy, jaundiced, other =1 Cyanotic =0		

**PAIN ASSESSMENT**

Do you have pain?  Yes  No

Location \_\_\_\_\_

Rating 1-10? \_\_\_\_\_

Description:  Sharp  Burning  Radiating  
 Aching  Dull  Numbness

Duration:  Constant  Intermittent

What increases pain? \_\_\_\_\_

What relives pain? \_\_\_\_\_

Assessment? \_\_\_\_\_

MEDICATIONS		
DRUG / DOSE / ROUTE	TIME	SIGN

INTAKE AND OUTPUT		NURSES' NOTES	
INTAKE		_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ RN Signature/ID# _____	
TOTAL			
URINE:	TOTAL		
OUTPUT			
DRAINS:			
TOTAL			

