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## Moderate Sedation Record

Main Diagnosis			
Date of Procedure		Time of Procedure	
Name of Procedure			
Allergy / Adverse Reactions			
<b>Pre-Sedation Assessment (To be completed by Principal Doctor)</b>			
Medical History		<b>ASA Classification.</b> <i>Tick (✓) the appropriate ASA Classification.</i>	
		<b>Definition</b>	<b>ASA</b>
Surgical / Anaesthetic History		A normal healthy patient.	<input type="checkbox"/> I
		A patient with mild systemic disease.	<input type="checkbox"/> II
		A patient with severe systemic disease.	<input type="checkbox"/> III
		A patient with severe systemic disease that is a constant threat to life.	<input type="checkbox"/> IV
		A moribund patient who is not expected to survive without the operation.	<input type="checkbox"/> V
		A declared brain-dead patient whose organs are being removed for donor purposes.	<input type="checkbox"/> VI
		An 'E' after the appropriate classification denotes an emergency surgery. <b>Tick (✓) if applicable.</b>	
<input type="checkbox"/> E			
Current Medication		Airway Assessment      Mallampati Score OSA / Snoring <input type="checkbox"/> Yes <input type="checkbox"/> No <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <input type="checkbox"/> I  </div> <div style="text-align: center;"> <input type="checkbox"/> II  </div> </div> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <input type="checkbox"/> III  </div> <div style="text-align: center;"> <input type="checkbox"/> IV  </div> </div>	
Weight _____ kg	Height _____ cm		
Heart <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Specify if abnormal: _____		Other Airway Abnormalities	
Lungs <input type="checkbox"/> Clear <input type="checkbox"/> Wheezing		Denture <input type="checkbox"/> NA <input type="checkbox"/> Removed	
BP <input type="checkbox"/> Cuff _____ / _____ <input type="checkbox"/> Invasive		Pulse	SpO <sub>2</sub>
Others			
Doctor's Name & Signature _____			
<b>Pre-Sedation Assessment (To be completed by Nurse)</b>			
<input type="checkbox"/> Consent taken <input type="checkbox"/> Fasting > 6 hours / <input type="checkbox"/> NA (for emergency cases) <input type="checkbox"/> Loose tooth / Dentures removed <input type="checkbox"/> I/V Access <input type="checkbox"/> Physical accessories removed <input type="checkbox"/> Other relevant investigations reviewed (specify) _____			

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<b>Verification (To be completed by Doctor or Nurse)</b>	
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☐ Correct Patient      ☐ Correct Procedure      Acknowledged by Doctor (Name & Initial) \_\_\_\_\_  
☐ Correct Site / Side      ☐ Correct Medication (7 rights)      Acknowledged by Nurse (Name & Initial) \_\_\_\_\_

## Medication Record

## Administration (If Applicable)

[illegible]Administration of Reversal Drugs ☐ No ☐ Yes (State the information in the Medication Record)

**Intra Sedation Care** \*Vital signs are documented at 5 minutes interval

## Sedation Level (Modified Ramsay Scale)

Awake State
-------------

<b>Sleep State (Caution)</b>
------------------------------

- |   |   |
|---|---|
| 1. Patient is anxious and agitated or restless, or both | 4. Patient asleep, brisk response to loud auditory stimulus                                     |
| 2. Patient is co-operative, oriented and tranquil       | 5. Patient has sluggish response to loud auditory stimulus but does respond to painful stimulus |
| 3. Patient responds to commands only                    | 6. Patient does not respond to pain stimulus  |

		Time (min)											
		15				30				45			
		15				30				45			
● Pulse	200												
	180												
	160												
	140												
	120												
X Respiration	100												
	80												
	60												
	40												
	20												
Type: _____													
1-Nasal Cannula													
2-Face Mask													
3-Venturi Mask													
4-Non-Rebreather Mask													
5-Others													
SpO <sub>2</sub>													
O <sub>2</sub> L/min													
Type _____													
Sedation Level (Scale 1 – 6)													

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### Post- Monitoring Unit Orders

Monitoring ☐ Routine ☐ Invasive

Position ☐ Supine ☐ Prone ☐ Lateral ( L / R ) ☐ Others \_\_\_\_\_

### Discharge Orders

Discharge to ☐ IPS ☐ CMZ ☐ ICU ☐ EC ☐ DSS ☐ Others \_\_\_\_\_

Special Instructions \_\_\_\_\_

### Post Procedure Care \*Vital signs are documented at 15 minutes interval

	15	30	45	15	30	45	15	30	45
● Pulse									
X Respiration									
v Systolic									
^ Diastolic									
Type:									
1-Nasal Cannula									
2-Face Mask									
3-Venturi Mask									
4-Non-Rebreather Mask									
5-Others									
SpO <sub>2</sub>									
O <sub>2</sub> L/min									
Type _____									
Pain Score (Scale 0 – 10)									
Sedation Level (Scale 1 – 6)									

### Discarded Controlled Drugs

Name of Drug	Dosage	Signature of Doctor	Signature of Nurses
			/
			/
			/
			/
			/
			/
			/
			/

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**DISCHARGE ASSESSMENT (To be completed by Doctor or Registered Nurse)**

Modified Aldrete Criteria (Circle & Total Score)	Prior to Discharge / Transfer	Reassessment	Reassessment	Reassessment
<b>Movement</b>				
4 extremities	2			
2 extremities	1			
0 extremities	0			
<b>Respiration</b>				
Deep breath & cough	2			
Dyspnoea / Impaired breathing	1			
Apnoea / Mechanical ventilation	0			
<b>Blood Pressure</b>				
± 20mmHg of baseline	2			
± 20 – 50 mmHg of baseline	1			
± 50 mmHg of baseline	0			
<b>Sedation Level</b>				
Awake & Responding	2			
Arousable on calling	1			
Not responding	0			
<b>Oxygen Saturation</b>				
Maintain value > 94% on room air	2			
Maintain value >94% with supplement oxygen	1			
Saturation < 94% with supplement oxygen	0			
<b>Total Score</b>				
<b>Time of Assessment</b>				
<b>Name of Assessor</b>				

*\*If initial score is less than 9, reassess the patient for another 15 minutes. Inform the Anaesthesiologist/ Doctor when the reassessment score is not attained\**

Discharge Assessment (By Medical Practitioner)	Disposition
<input type="checkbox"/> Modified Aldrete Score _____ <input type="checkbox"/> Normal vital signs <input type="checkbox"/> Orientate to time, place & person <input type="checkbox"/> Motor function appropriate for age (ambulates or sit without support) <input type="checkbox"/> Responsible parent / Caregiver present	<input type="checkbox"/> Discharge (Home) <input type="checkbox"/> Admitted for complications of sedation <input type="checkbox"/> Admitted otherwise <input type="checkbox"/> Transfer to IPS/ ICU <input type="checkbox"/> Others (including AOR) _____
<input type="checkbox"/> Discharge / Transfer Instructions:	
Date of Discharge/Transfer:	Time of Discharge/Transfer:
Name of Attending Doctor:	Signature of Attending Doctor:
Name of Registered Nurse:	Signature of Registered Nurse: