




OR-ID 53066072100967-01				HN. _____ AN. _____	
		Mahidol University Faculty of Medicine Siriraj Hospital		Name _____	
				Age _____ DOB _____	
				Sex _____ Ward _____	
Pre-anesthesia Evaluation					
Date of surgery _____ Surgeon _____		Allergy <input type="checkbox"/> NKDA		Service _____ Room _____	
Diagnosis _____				ASA : 1 2 3 4 5 6 E	
Planned procedure _____				BW _____ kg. HT _____ cm.	
History, systemic review and physical examination					
Current medication : <input type="checkbox"/> No		Previous Surgery : <input type="checkbox"/> No		Smoking <input type="checkbox"/> No <input type="checkbox"/> Yes _____ <input type="radio"/> stop _____	
				Alcohol <input type="checkbox"/> No <input type="checkbox"/> Social <input type="checkbox"/> Regular _____	
				Drug abused <input type="checkbox"/> No <input type="checkbox"/> Yes _____	
				Anes Family Hx <input type="checkbox"/> No <input type="checkbox"/> Yes _____	
Functional Class 1 2 3 4 NA		Neuro <input type="checkbox"/> NAD		Endocrine <input type="checkbox"/> NAD	
Vital Signs		<input type="checkbox"/> Old CVA <input type="radio"/> Full recovery		<input type="checkbox"/> DM <input type="radio"/> No organ damage	
BT _____ °C BP _____ mmHg		<input type="radio"/> Hemiparesis		<input type="radio"/> With organ damage	
RR _____ pm HR _____ bpm		<input type="checkbox"/> Dementia <input type="checkbox"/> Chr. pain		<input type="checkbox"/> Steroid use	
SpO ₂ _____ <input type="checkbox"/> RA <input type="checkbox"/> FiO ₂ _____		<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____	
Mental status		Cardiovascular <input type="checkbox"/> NAD		Respiratory <input type="checkbox"/> NAD	
<input type="checkbox"/> A&Ox3 <input type="checkbox"/> AOC _____		<input type="checkbox"/> HT <input type="radio"/> Well controlled		<input type="checkbox"/> COPD <input type="checkbox"/> OSA	
Auscultation		<input type="radio"/> Poor controlled		<input type="checkbox"/> Asthma <input type="checkbox"/> Recent URI	
Heart <input type="checkbox"/> NL _____		<input type="checkbox"/> DLP <input type="checkbox"/> CAD/MI		<input type="checkbox"/> Other _____	
Lung <input type="checkbox"/> NL _____		<input type="checkbox"/> CHF <input type="checkbox"/> PVD		Hemato <input type="checkbox"/> NAD	
Airway assessment		<input type="checkbox"/> Arrhythmia <input type="checkbox"/> VHD		<input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia	
Denture <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> Other _____		<input type="checkbox"/> Lymphoma	
Dental problem <input type="checkbox"/> No <input type="checkbox"/> Yes		GI <input type="checkbox"/> NAD		<input type="checkbox"/> Other _____	
Mouth opening <input type="checkbox"/> NL <input type="checkbox"/> Limit		<input type="checkbox"/> Liver dis. <input type="radio"/> No Portal HT		Onco <input type="checkbox"/> NAD	
Neck movement <input type="checkbox"/> NL <input type="checkbox"/> Limit		<input type="radio"/> With Portal HT		<input type="checkbox"/> Solid cancer <input type="radio"/> Localized	
Mallampati 1 2 3 4 <input type="checkbox"/> NA		<input type="checkbox"/> Peptic ulcer		<input type="radio"/> Metastasis	
Thyromental <input type="checkbox"/> ≥6 cm <input type="checkbox"/> <6 cm		<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____	
_____		Renal <input type="checkbox"/> NAD		Other	
_____		<input type="checkbox"/> CKD <input type="radio"/> I-II <input type="radio"/> III-IV		<input type="checkbox"/> Rheumatoid arthritis	
_____		<input type="checkbox"/> Dialysis <input type="checkbox"/> Post KT		<input type="checkbox"/> SLE <input type="checkbox"/> Precaution	
<input type="checkbox"/> Expected difficult airway		<input type="checkbox"/> Other _____		<input type="checkbox"/> _____	
Investigation					
CBC : _____		Blood chemistry : _____		CXR _____	
WBC _____ Hb _____ Plts _____		Na _____ Cl _____ BUN _____		ECG _____	
Hct _____		K _____ HCO ₃ _____ Cr _____		Other _____	
		Glu / HbA _{1c} _____			
		eGFR : _____			
Preoperative preparation and premedication					
<input type="checkbox"/> NPO _____ <input type="checkbox"/> Patient informed		Anesthesia plan		Premedication	
Blood component <input type="checkbox"/> No <input type="checkbox"/> Yes					
<input type="radio"/> PRC : T&S/GM _____ ũ <input type="radio"/> FFP _____ ũ					
<input type="radio"/> PLT _____ ũ <input type="radio"/> Other _____					
ICU reservation <input type="checkbox"/> No <input type="checkbox"/> Yes _____					
Summarized by _____		License No. _____		Date _____	




<p>OR-ID 53066072100967-01</p> <div style="text-align: center;"> Mahidol University Faculty of Medicine Siriraj Hospital </div> <div style="text-align: center;"> <h2 style="margin: 0;">Anesthesia Record</h2> </div>		<div style="display: flex; justify-content: space-between;"> <div> HN. _____ AN. _____ Name _____ Age _____ DOB _____ Sex _____ Ward _____ </div> </div>										
Service Unit <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> Surgery <input type="checkbox"/> Ac.care <input type="checkbox"/> Colo <input type="checkbox"/> CVT <input type="checkbox"/> ENT <input type="checkbox"/> EYE <input type="checkbox"/> GYN <input type="checkbox"/> H&N <input type="checkbox"/> HPB <input type="checkbox"/> MIS <input type="checkbox"/> Neuro <input type="checkbox"/> OB <input type="checkbox"/> Ortho <input type="checkbox"/> PED <input type="checkbox"/> Plastic <input type="checkbox"/> Vascular <input type="checkbox"/> Uro </div> <div style="width: 50%;"> Outside <input type="checkbox"/> Broncho <input type="checkbox"/> Cath <input type="checkbox"/> Chemo <input type="checkbox"/> CT/MR <input type="checkbox"/> ECT <input type="checkbox"/> GI Scope <input type="checkbox"/> IR/RT <input type="checkbox"/> Nuclear Others <input type="checkbox"/> ALIST <input type="checkbox"/> Dental <input type="checkbox"/> Pain <input type="checkbox"/> Painless <input type="checkbox"/> PM&R <input type="checkbox"/> Bone marrow <input type="checkbox"/> _____ </div> </div>	<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> Procedure _____ Date : _____ Diagnosis : _____ Operation : _____ _____ Surgeon : _____ Patient _____ <input type="radio"/> Special clinic <input type="checkbox"/> In patient <input type="checkbox"/> Sameday <input type="checkbox"/> Ambulatory Surgical safety checklists <input type="checkbox"/> Patient identified <input type="checkbox"/> Informed consent <input type="checkbox"/> Reassessed with no interval changes <input type="checkbox"/> Surgical site identified <input type="checkbox"/> Briefing </div> <div style="width: 35%;"> Location / Room : _____ ASA Classification : 1 2 3 4 5 6 E BW _____ kg. HT _____ cm. Allergy _____ Anesthesia providers Attending : _____ CRNA : _____ Resident/Fellow : _____ N.Student : _____ Med student : _____ </div> </div>											
Anesthesia Management												
Anesthesia technique <input type="checkbox"/> General anesthesia <input type="checkbox"/> Neuraxial anesthesia <input type="checkbox"/> Peripheral nerve block <input type="checkbox"/> Moderate/Deep sedation <input type="checkbox"/> MAC/Mild sedation/Topical <input type="checkbox"/> _____ Special Technique <input type="checkbox"/> One lung ventilation <input type="checkbox"/> Jet ventilation <input type="checkbox"/> CPB / ECMO <input type="checkbox"/> _____ Position <input type="checkbox"/> Supine <input type="checkbox"/> Prone <input type="checkbox"/> Sitting <input type="checkbox"/> Litho <input type="checkbox"/> Lateral Lt. ↓ / Rt. ↓ <input type="checkbox"/> Head ↓ (Trend) <input type="checkbox"/> Jackknife <input type="checkbox"/> Head ↑ (R.trend) <input type="checkbox"/> LUD <input type="checkbox"/> Parkbench <input type="checkbox"/> _____	Airway Device <input type="checkbox"/> Undermask <input type="checkbox"/> SGA _____ No. _____ <input type="checkbox"/> ETT _____ Cuffed/Uncuffed Size _____ Depth _____ <input type="checkbox"/> DLT Lt / Rt Size _____ Depth _____ cm. <input type="checkbox"/> Tracheostomy _____ <input type="checkbox"/> Other _____ Intubation <input type="checkbox"/> DL : Blade _____ <input type="radio"/> Macintosh _____ <input type="checkbox"/> VL : Blade _____ <input type="checkbox"/> Fiberoptic Attempt _____ LV 1 2 3 4 <input type="checkbox"/> Rapid sequence <input type="checkbox"/> Cricoid pressure <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> Difficult ventilation <input type="checkbox"/> Difficult SGA insertion <input type="checkbox"/> Difficult intubation </div> <div style="width: 50%;"> Confirmed <input type="checkbox"/> BBS <input type="checkbox"/> ETCO₂ <input type="checkbox"/> FOB <input type="checkbox"/> X-ray </div> </div>		Neuraxial block _____ Time _____ <input type="checkbox"/> Spinal : level _____ <input type="checkbox"/> Caudal <input type="checkbox"/> Epidural : level _____ Needle : Type _____ No. _____ Cath _____ at skin _____ in space _____ cm. Agent : _____ Anes Level : _____ Peripheral Nerve Block _____ Time _____ <input type="checkbox"/> BPB – Approach _____ <input type="checkbox"/> Chest wall <input type="checkbox"/> FNB <input type="checkbox"/> ACB <input type="checkbox"/> Pop.NB <input type="checkbox"/> Abd wall <input type="checkbox"/> FICB <input type="checkbox"/> Other _____ Needle : Type _____ <input type="checkbox"/> US <input type="checkbox"/> NS Agent : _____ <input type="checkbox"/> Cath _____ Mark _____ cm.									
Line acceses _____ _____ _____ <input type="checkbox"/> CVL _____ Site _____ Needle _____ Attempt _____ Mark _____ <input type="checkbox"/> US <input type="checkbox"/> ECG guide Event <input type="checkbox"/> No <input type="checkbox"/> Yes _____	Remarks (events/procedure note) 											
<input type="checkbox"/> Eyes protected <input type="checkbox"/> Pressure points checked <input type="checkbox"/> Active warming _____	Dispatch <input type="checkbox"/> PACU <input type="checkbox"/> ICU <input type="checkbox"/> Ward BP _____ HR _____ RR _____ SpO ₂ _____ Temp _____ PS _____		Extubation <input type="checkbox"/> Yes <input type="radio"/> Extubation criteria assessed <input type="checkbox"/> No <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:25%;">Start anes</th> <th style="width:25%;">Start op.</th> <th style="width:25%;">Op. finish</th> <th style="width:25%;">Anes finish</th> </tr> <tr> <td style="height: 30px;"></td> <td></td> <td></td> <td></td> </tr> </table>		Start anes	Start op.	Op. finish	Anes finish				
Start anes	Start op.	Op. finish	Anes finish									




OR-ID
53066072100967-01





Mahidol University
Faculty of Medicine Siriraj Hospital

Anesthesia Record



Name _____

Age _____ DOB _____

Sex _____ Ward _____

Time																	Total
Medication	O ₂ / Air / N ₂ O																
	Sevo / Des / Iso (Et)																
	Prop / Thio / Eto / Ket																
	Fen / MO / Peth																
	Cis- / Atra / Roc																
Monitoring	ECG																
	SpO ₂																
	ETCO ₂																
	Temp																
	Paw/PEEP																
Vital signs		220															
		200															
		180															
		160															
	X BP	140															
	X MAP	120															
	· Pulse	100															
		80															
	A Start anesth	60															
	T Intubation	40															
	⊙ Start Op.																
	⊗ Finish anesth																
Symbols																	
Intake / Output																	
	Urine																
	EBL																
Remarks																	
Attending. CRNA. R/F. N. Student.																	



1150

Page of