

ENDOSCOPY UNIT

PRE-PROCEDURE WORKSHEET

PLACE LABEL HERE

Address: _____ Emergency Contact: _____

Relationship: _____

Phone #: (Home) _____ Person Accompanying Pt. _____

(Work) _____ Relationship: _____

Procedure: _____ Dx/Indication: _____

ID Verification: YES Consents: Procedure Sedation

Prep Used: _____ Result: _____ Any problems with Prep: _____

NPO Since: _____ Last Solid Intake: _____

Previous complication with sedation: Y N N/A Reaction: _____

Allergies: Meds: _____ Latex: _____ Tape: _____

Anticoagulants / Blood Thinners: Y N _____ Last Dose _____

Present meds reviewed with patient: Y Pre-Med given: _____

Changes / New Meds:

1. _____ Wt. _____ kg Temp _____

2. _____ Ht. _____ O2 Sat _____

3. _____ BP _____ Pain: Location: _____

4. _____ P _____ RR _____ Quality: _____ / 10

History / Physical Assessment

See H+P for complete med list

<p>Cardiac / Neuro</p> <input type="checkbox"/> CAD <input type="checkbox"/> MVP <input type="checkbox"/> HTN <input type="checkbox"/> Murmur <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Arrhythmia <input type="checkbox"/> MI <input type="checkbox"/> TIA / CVA <input type="checkbox"/> Seizure <input type="checkbox"/> Bleeding Other _____		<p>Surgical</p> <input type="checkbox"/> _____ Mastectomy <input type="checkbox"/> _____ Lumpectomy <input type="checkbox"/> Appendectomy <input type="checkbox"/> Cholecystectomy <input type="checkbox"/> TAH BSO <input type="checkbox"/> Colectomy <input type="checkbox"/> CABG <input type="checkbox"/> C-section <input type="checkbox"/> _____ Hernia Repair Other _____		<p>Prosthesis</p> <input type="checkbox"/> _____ Implants <input type="checkbox"/> _____ Dentures / Bridge <input type="checkbox"/> _____ Hearing Aids <input type="checkbox"/> Hearing Aids <input type="checkbox"/> Metal / Plates / Pins <input type="checkbox"/> Valve Replacement <input type="checkbox"/> _____ Hip Replacement <input type="checkbox"/> Stents Other _____		<p>Respiratory</p> <input type="checkbox"/> Asthma / COPD <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> NIDDM/IDDM <input type="checkbox"/> Pregnant / Menses <input type="checkbox"/> Glaucoma <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts			
<p>Mental Status</p> <input type="checkbox"/> Alert <input type="checkbox"/> Awake <input type="checkbox"/> Oriented Other: _____		<p>Respiratory</p> <input type="checkbox"/> Easy <input type="checkbox"/> Unlabored <input type="checkbox"/> SOB Other: _____		<p>Skin</p> <input type="checkbox"/> Pink <input type="checkbox"/> Dry <input type="checkbox"/> Warm <input type="checkbox"/> Pale <input type="checkbox"/> Cool Other: _____		<p>Abdomen</p> <input type="checkbox"/> Soft <input type="checkbox"/> Non-distended <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Heartburn Other: _____		IV size _____ IV site _____ Solution _____ <input type="checkbox"/> HL Attempts X _____ Inserted By _____	

Procedure + Discharge Instruction reviewed with patient by: _____