# PREOPERATIVE ANESTHESIA/ SEDATION CHECKLIST

| Patient Name: | DOB: | Surgeon: |
|---|---|---|
| Procedure (Timeout): | Procedure Date: | Level of Sedation:<br>____ Nitrous/ Minimal<br>____ Moderate<br>____ Deep<br>____ General Anesthesia |
| Sedation Services Delegated: Yes or No | Sedation Provider: (Only if Delegated) | |
| Notes: | | |

**Pre-Op Vitals (Day of Procedure):**

| Height: | Weight: | Blood Pressure: |
|---|---|---|
| Pulse Rate: | | Respiration Rate: |

**Pre-Procedure Medical Review (To be completed by Surgeon Only):**

| | | |
|---|---|---|
| Patients Medical Hx | Yes or No | Notes: |
| Patients Allergies | Yes or No | Notes: |
| Patients Surgical Hx | Yes or No | Notes: |
| Patients Family Surgical Hx | Yes or No | Notes: |
| Patients Sedation Hx | Yes or No | Notes: |
| Medical Consult (If Necessary) | Yes or No | Notes: |
| ASA Status | Yes or No | I II III IV |
| Airway Status | Yes or No | I II III IV |
| NPO Status | Yes or No | Last Meal: |
| Auscultation | Yes or No | Notes: |

**Equpment Readiness Check**

| Date Completed: | Completed By: |
|---|---|
| Notes: | |

I hearby attest that the patient is cleared for surgery and the proper preprocedure systems and items have been reviewed. The patienthas also received post-operative instructions in-advance of the surgery.

Suregeon Name (Printed): _____

Signature: _____ Date: _____

Staff Name (Printed): _____

Signature: _____ Date: _____