Conscious Sedation Airway Assessment  **Yes answers may require Anesthesia Consult**

<table>
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<tr>
<th>Pre-Procedure Assessment Date</th>
<th>Yes**</th>
<th>No</th>
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<tbody>
<tr>
<td>History of Previous Anesthetic problem / Complications including family history</td>
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<tr>
<td>History of airway problems / Difficult intubation</td>
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<td>Airway examination:</td>
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<tr>
<td>Tracheal deviation</td>
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<td>Short thick neck or invisible neck</td>
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<td>Visible anterior neck masses</td>
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<td>Small mouth opening (less than 3 finger breaths)</td>
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<td>Oxygen Saturation &lt; 92% on room air</td>
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PT ___________  INR ___________

Additional Test Results ____________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Signature of MD / NP / FELLOW / RESIDENT: _________________________________________

Date & Time: __________________________

Patient Label
PHYSICAL EXAM

VS:  T _______  P _______  RR _______  BP _______  HT _______  WT _______

GENERAL / PSYCH:  ☐ Cooperative, alert and oriented

SKIN:  ☐ No rashes  ☐ No Ulcerations

LYMPHATIC:  ☐ No Adenopathy

HEENT:  ☐ PERRLA  ☐ Trachea Midline  ☐ Dentures  ☐ No JVD

RESPIRATORY:  ☐ CTA  ☐ NL Percussion

CV:  ☐ RRR  ☐ S1  ☐ S2  ☐ No Murmur/Rubs/Gallops  ☐ Edema

PERIPHERAL PULSES:
0 = Absent
2 = WNL
B = Bruits
NB = No Bruits
D = Doppler Only

GI:  ☐ +BS  ☐ Soft/Nontender No Masses  ☐ No Organomegaly

MUSCULOSKELETAL:  ☐ NL Strength/Tone  ☐ NL Symmetry

NEURO:  ☐ NL Cranial Nerves  ☐ NL Sensation  ☐ NL Gait

GYN:

ADDITIONAL FINDINGS:

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

STUDIES:  ________________________________________________________

_________________________________________________________________

ABI INDEX

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IMPRESSION / PLAN:

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

NP / FELLOW / RESIDENT SIGNATURE:  ATTENDING SIGNATURE:

DATE & TIME:  ___________________________  DATE & TIME:  ___________________________

I agree with the history and physical above. In addition, I have performed a supplementary exam, making changes to the history or exam as noted.

Patient Label

INTERVENTIONAL RADIOLoGY
HISTORY & PHYSICAL