MEMORIAL HOSPITAL

PERIOPERATIVE PATIENT CARE NURSING RECORD
PATIENT ADMISSION DATA BASE

INFORMATION

- Scheduled Procedure: ____________________________
- Chief Complaint: _______________________________
- Date: ____________________
- Time: ____________
- Anticipated Anesthesia: ☐ General ☐ IV Sed ☐ Local ☐ None ☐ Regional/Block
- Notes: ☐ Same Day Admission ☐ Inpatient ☐ Outpatient

REOP PHONE CALL

- Number: ____________________
- Date: ____________________
- Time: ____________
- Left Message ☐ No Answer ☐ Answering Machine
- Information Given: ☐ Valuables ☐ Escort ☐ NPO ☐ Advance Directives ☐ Insurance Cards ☐ Medications ☐ Blood Bank Protocol
- Location/Directions: ____________________________
- Time to Arrive: ____________
- Nails/Jewelry/Contacts ☐
- Comments: ____________________________
- Signature: ____________________________

PATIENT MEDICAL HISTORY

- ☐ Indicates patient admission database has been completed by Inpatient unit and reviewed by Pre-Op Nurse.
- ☐ Negative
- ☐ Anemia ☐ Arthritis/Gout ☐ Asthma/COPD ☐ Lung Disease ☐ TB ☐ +PPD ☐ EPH ☐ Cardiac ☐ CHE ☐
- ☐ Communicable Diseases ☐ CVA/TIA ☐ Diabetes ☐ GERD ☐ Glaucoma ☐ Hypertension
- ☐ Hypercholesteremia ☐ PVD ☐ Psychiatric ☐ Renal ☐ Renal ☐ Saltrate ☐ Thyroid
- ☐ Other

Reproductive: Self Testicular Exam ☐ Prostate Screen (> 40 Yrs) ☐

Health: Mammogram (> 35 Yrs) ☐ Self Breast Exam ☐ PAP Smear ☐

PREVIOUS SURGERIES

CURRENT MEDICATIONS LAST DOSE CURRENT MEDICATIONS LAST DOSE

Are you taking any over the counter herbal medications?
- ☐ Yes ☐ No

SUBSTANCE USE ☐ Noni

SUBSTANCE AMOUNT/DURATION LAST USED
- ☐ Alcohol ____________________________
- ☐ Drugs ____________________________
- ☐ Tobacco ____________________________
- ☐ Cessation Teaching - Desire Smoking Cessation Teaching? ☐ Yes ☐ No

Comment: ____________________________

SIGNATURE OF NURSE: ____________________________

DATE: ____________

TIME: ____________

PERIOPERATIVE PATIENT CARE NURSING RECORD
PATIENT ADMISSION DATA BASE

09-4930 (INIT 1/03) (F3P)
### Preop Checklist

**Patient Identification:**
- Verbal
- ID Band
- DOB
- Family
- Blood Band

**Planned Procedure:**

**Name Preference:**

**VITAL SIGNS:**

- T
- P
- R
- O2 Sat
- BP

**FBG:**

- Time:

**Enforced Consents:**
- Surgical
- Anesthesia

**Patient Label:**

- Dentures removed/loose teeth noted
- Jewelry/Bod piercing removed/taped
- Glasses/Contacts removed
- Hearing aid removed
- Other

**For Reattachment of Blood Bank Bracelet:**

1. I certify the patient has presented one picture ID or two other forms of ID before reattachment of band from pink envelope.

2. I have presented the pink envelope and identified my signature before reattachment of the blood bracelet.

**Patient Signature:**

### Skin Assessment

**Nursing Diagnosis:** Skin Integrity/Body Temperature

**Goal:** Identify alterations in skin integrity/body temperature & support as appropriate.

**Evaluation:**
- Meets goal
- See comments

- Pale
- Flushed
- Jaundiced
- Cyanotic
- Cool
- Warm
- Dry
- Diaphoretic

- Rash(es):
- Blisters:
- Ulcers:

- Abdominal Asessment:
  - N/A
  - Soft
  - Firm

- Round
- obese
- distended
- non-distended

**Comments:**

### Respiratory Assessment

**Nursing Diagnosis:** Gas Exchange/Tissue

**Goal:** Identify alterations in gas exchange & support as appropriate.

**Evaluation:**
- Meets goal
- See comments

- Lung Clear
- Wheezes: Left Right
- Rates: Left Right
- Hoarseness - Cough
- O2 Method:

- Lungs Per Minute:

- SaO2:

- N/A

- Comments:

### Physical Limitations

**Nursing Diagnosis:** Physical Mobility/Sensory Deterioration

**Goal:** Identify limitations in mobility/ambulation & support as appropriate.

**Evaluation:**
- Meets goal
- See comments

- Hearing
- Vision
- Speech
- Mobility
- Walker
- Crutches
- Cane
- Prosthesis

**Comments:**

### Mental Status

**Nursing Diagnosis:** Altered Thought Process/Coping Ability/Anxiety

**Goal:** Identify alterations in thought process/coping ability/anxiety level.

**Evaluation:**
- Meets goal
- See comments

- Alert
- Oriented
- Confused
- Unresponsive
- Drowsy
- Asleep
- Agitated
- Comatose
- Crying
- Abusive

- Non-communicative

- Flatlining
- Patient

- Other:

**Comments:**

### Developmental Level

**Nursing Diagnosis:** Altered Growth and Development

**Goal:** Identify alterations in growth & development & support as appropriate.

**Evaluation:**
- Meets goal
- See comments

- Appropriate For Age
- Unable To Assess
- Inappropriate For Age

**Comments:**

### Fall Risk Assessment

**Nursing Diagnosis:** Potential for Injury

**Goal:** Identify / Reduce Risk Factors

**Evaluation:**
- Meets goal
- See comments

<table>
<thead>
<tr>
<th>EACH OF THE FOLLOWING EQUALS 1 POINT</th>
<th>SCORE</th>
<th>EACH OF THE FOLLOWING EQUALS 3 POINTS</th>
<th>SCORE</th>
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<tbody>
<tr>
<td>Age 70 or greater</td>
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<td>Chronic / Cerebrovascular</td>
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<td>Incontinence</td>
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<td>Unsteady gait</td>
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<tr>
<td>Chronic obstructive disease</td>
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<td>History of prior falls</td>
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<tr>
<td>Heart disease</td>
<td></td>
<td>Low risk protocol (0-2 points)</td>
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<td>History of falls</td>
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<td>High risk fall prevention protocol</td>
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<tr>
<td>History of neurosurgical procedures</td>
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<td>Initiated (0-3 points or greater)</td>
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<td>Traumatic head injury</td>
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<td>High risk protocol NOT initiated</td>
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<tr>
<td>Cognitive deficit</td>
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<td>Due to condition:</td>
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**Total Points**

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**PERIOPERATIVE PATIENT CARE NURSING RECORD PATIENT ADMISSION DATA BASE**
### EROPERATIVE PATIENT CARE NURSING RECORD AND PATIENT ADMISSION DATA BASE

**INTRAOPERATIVE NURSING RECORD (CONTINUED)**

**Compression Stockings:** Nursing Diagnosis: Embolism

- Goal: Reduce potential for embolism. **Evaluation:** [ ] Meets goal [ ] See comments
- None [ ] Antembolism Stockings: Right [ ] Left [ ] Knee [ ] Thigh
- Sequential Compression: Right [ ] Left [ ] Knee [ ] Thigh [ ] Foot

**Setting:** mmHg #: Comments:

**Tourniquet #1:**

- **Nursing Diagnosis:** Hemorrhage/Neuromuscular trauma.
- Goal: Reduce potential for hemorrhage & neuromuscular trauma.

**Evaluation:** [ ] Meets goal [ ] See comments
- None [ ] Number: Location: Padded: [ ] Yes [ ] No
- Pressure: mmHg Applied By:
  - On: Off: On: Off:

**Tourniquet #2:**

- None [ ] Number: Location: Padded: [ ] Yes [ ] No
- Pressure: mmHg Applied By:
  - On: Off: On: Off:

**Warming Devices:**

- **Nursing Diagnosis:** Body Temperature. Goal: Maintain appropriate body temperature.

**Evaluation:** [ ] Meets goal [ ] See comments
- None [ ] Warming Lamp [ ] Warmed Solutions: Irrigation/Prep IV
- Warm Blankets [ ] Warm air blanket # [ ] Warm water blanket #
- Other:

**Surgical Skin Preparation:** Site: [ ] None

**Nursing Diagnosis:** Infection. Goal: Reduce potential for infection.

**Evaluation:** [ ] Meets goal [ ] See comments
- None [ ] Betadine Scrub/Betadine Solution [ ] Duraprep [ ] Elixirne
- Alcohol [ ] Other: [ ] No pooling of solution

**IRRIGATION/MEDICATIONS on sterile field: [ ] N/A**

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<th>Time</th>
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**IMPLANT LOG** [ ] N/A [ ] See Implant Record

**Counts:** Nursing Diagnosis: Retained foreign body. Goal: Reduce potential for retained foreign body. **Evaluation:** [ ] Meets goal [ ] See comments

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<td>Final Count</td>
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<td>Time</td>
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- Surgeon notified of count: Action for incorrect count: [ ] X-ray outcome: [ ] Film read by:

**Drains:** [ ] None [ ] Nursing Diagnosis: Infection. Goal: Reduce potential for infection. **Evaluation:** [ ] Meets goal [ ] See comments

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**Dressings:** [ ] None

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<td>Bledsoe Brace</td>
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<td>Deepbrord</td>
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<td>Abdominal Pillow</td>
<td>Eye Pad</td>
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<td>Ace</td>
<td>Eye Shield</td>
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<td>Addictic</td>
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<td>Dextran</td>
<td>EZ Wrap Knee Brace</td>
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<td>Packing</td>
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<td>Scrotal Support</td>
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<td>Shoultner Implant</td>
<td>Wound Vac</td>
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<tr>
<td>Sling, Velpeau</td>
<td>Other</td>
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<tr>
<td>Soft Roll</td>
<td>Xeroform</td>
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<tr>
<td>Strab Strips</td>
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<td>Tape</td>
<td>Tegaderm</td>
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**Procedure:** [ ] N/A [ ] See Procedure Record

**Blood Replenishment:** [ ] N/A

**Estimated blood loss:** [ ] No. of Units: [ ]

**Cell Saver:** [ ] N/A [ ] Operator: [ ]

**Cross Clamp:** [ ] N/A [ ] On [ ] Off

**Pypsum:** [ ] Yes [ ] No [ ] N/A

**METHODOLOGICAL PATIENT CARE NURSING RECORD PATIENT ADMISSION DATA BASE**
## Perioperative Patient Care Nursing Record and Patient Admission Data Base

### Monitoring Local Anesthesia

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<th>Monitors and Equipment</th>
<th>Time</th>
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<td>ECG</td>
<td>220-</td>
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<tr>
<td>BP Cuff</td>
<td>200-</td>
</tr>
<tr>
<td>Pulse Ox</td>
<td>180-</td>
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<tr>
<td>SaO2</td>
<td>160-</td>
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<tr>
<td>Resp.</td>
<td>140-</td>
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<tr>
<td>LOC</td>
<td>120-</td>
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<td>100-</td>
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<td>LOC Scale:</td>
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<tr>
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<td>60-</td>
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<td>Arousable = 1</td>
<td>40-</td>
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### Immediate Post-op Status

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<th>Patient Status</th>
<th>Skin Condition</th>
<th>Transport</th>
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<tbody>
<tr>
<td>Alert</td>
<td>Warm</td>
<td>Stretcher</td>
<td>Anesthesiologist/CrNA</td>
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<tr>
<td>LMA Removed</td>
<td>Cool</td>
<td>Ambulatory</td>
<td>Nurse</td>
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<tr>
<td>Oriented</td>
<td>Pink</td>
<td>Bed</td>
<td>Other</td>
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<td>Intubated</td>
<td>Diaphoretic</td>
<td>Ox, LPM</td>
<td>Surgeon</td>
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<td>Dry</td>
<td>Crib, via:</td>
<td>Physician/Surgical Assistant</td>
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<td>WC</td>
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<td>Agitated</td>
<td>flushed</td>
<td>Ambu/T-piece</td>
<td>Transferred To:</td>
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<td>Side Rails up</td>
<td>Report To:</td>
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<td>Unresponsive</td>
<td>Other</td>
<td>EKG Monitor</td>
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### Nurse Notes

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**PERIOPERATIVE PATIENT CARE NURSING RECORD AND PATIENT ADMISSION DATABASE**

**IMMEDIATE PRE-OFF ASSESSMENT BY:**

Nursing Diagnosis: Anxiety/Knowledge Deficit/Altered Thought Process/Coping Ability Goal: Identify alterations in thought process/coping ability/anxiety/level & support as appropriate.

Evaluation: [ ] Meets goal [ ] See comments

Patient Identification: [ ] Verbal [ ] ID Band [ ] Chart [ ] Family [ ] Blood Band

Procedure/Site of surgery verified: [ ] Yes [ ] Initial: 

Consents: [ ] Surgical [ ] Anesthesia [ ] Other

Blood Available: [ ] N/A [ ] Type & Screen [ ] Type & Crossmatch [ ] Units

Mental Status: [ ] Alert [ ] Drowsy [ ] Asleep [ ] Unresponsive [ ] Unconscious

[ ] Oriented [ ] Confused [ ] Anxious [ ] Agitated [ ] Crying

[ ] Cooperative [ ] Combative [ ] Abusive [ ] Non-communicative

Historian: [ ] Patient [ ] Other

Comments: 

**ALLERGIES:**

[ ] NKDA [ ] Reaction:

[ ] Latex [ ] Other:

**TRANSPORTATION TO THE OPERATING ROOM**

[ ] Stretcher [ ] Bed [ ] Carried [ ] WC [ ] Ambulatory By: [ ] Other

**INTRAOPERATIVE NURSING RECORD**

Room: [ ] Case #: [ ] ASA #: [ ] Delay Code: [ ] CASE TYPE:

[ ] Elective [ ] Add-on [ ] Urgent [ ] Return to OR

Preoperative Diagnosis:

Postoperative Diagnosis: [ ] Same as Pre-op

Operative Procedure(s):

Wound Classification: [ ] 1/Clean: [ ] 2/Clean/Contaminated: [ ] 3/Contaminated: [ ] 4/Infected

Anesthesia: [ ] General [ ] Monitored Anesthesia Control Sedation [ ] Local [ ] Spinal [ ] Block [ ] Epidural [ ] None

Anesthesia Provider(s): [ ] Anesthesia Relief: [ ] 

Physician: [ ] 1st Assistant: [ ]

2nd Physician: [ ] 2nd Assistant:

CIRCULATING NURSE

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SCRUB PERSON

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<tbody>
<tr>
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Vendor: [ ] Other

Position for Surgery: Nursing Diagnosis: Physical Mobility/Skin Integrity/Body Temperature

Goal: Prevent physical injury & infection, maintain proper body alignment & temperature.

Evaluation: [ ] Meets goal [ ] See comments

Positioning Aids:

[ ] Armbands [ ] Right Left
[ ] Arms Tucked [ ] Right Left
[ ] Axillary roll
[ ] Bariatric
[ ] Elastic Band
[ ] Foot plate
[ ] Head ring
[ ] Headrest
[ ] Heart/Allen
[ ] Yellow Tint

Other:

Comments: [ ]

Equipment: Nursing Diagnosis: Injury

Goal: Prevent injury

Evaluation: [ ] Meets goal [ ] See comments

X-ray: [ ] Flat plate [ ] C-arm [ ] Mini-C-arm

Grounding Pad: Location: [ ] Applied By:

Pre-Op Skin Condition: [ ] Intact [ ] Other

Area Shaved/Circled: [ ] Yes [ ] No

Repositioning Check: [ ] Yes [ ] No [ ] N/A

Removal By:

Post-Op Skin Condition: [ ] Intact [ ] Other

Heart Lung Machine: [ ] Yes [ ] No [ ]

Other: [ ]

99-4850 (INT 10/0) (FLP)
**ERIOPERATIVE PATIENT CARE NURSING RECORD AND PATIENT ADMISSION DATA BASE**

**INTRAOPERATIVE NURSING RECORD (CONTINUED)**

**Compression Stockings:** Nursing Diagnosis: Embolii
Goal: Reduce potential for embolus. Evaluation: □ Meets goal □ See comments
☐ None ☐ Anticoagulation Stockings: □ Right □ Left □ Knee □ Thigh
☐ Sequential Compression: □ Right Leg □ Left Leg □ Knee □ Thigh □ Foot
Setting: mmHg #: Comments:

**Fourniquet #1:**
Nursing Diagnosis: Hemorrhage/Neuromuscular trauma.
Goal: Reduce potential for hemorrhage & neuromuscular trauma.
Evaluation: □ Meets goal □ See comments
☐ None #: Location: Padded: □ Yes □ No
Pressure: mmHg Applied By:
On: Off: On: Off:

**Fourniquet #2:**
Nursing Diagnosis: Body Temperature. Goal: Maintain appropriate body temperature.
Evaluation: □ Meets goal □ See comments
☐ None #: Location: Padded: □ Yes □ No
Pressure: mmHg Applied By:
On: Off: On: Off:

**Warming Devices:**
Nursing Diagnosis: Body Temperature. Goal: Maintain appropriate body temperature.
Evaluation: □ Meets goal □ See comments
☐ None □ Warming Lamp □ Warming Solution: Infusion/Prep/IV.
☐ Warm Blankets □ Warm air blanket #: ☐ Warm water blanket #: Other:

**Shave Prep Area:** By:
Surgical Skin Preparation: Site: □ None

**IRREGINATION/MEDICATIONS on sterile field □ NA □ Dose □ Route □ Time □ Given By □ Comments**

**IMPLANT LOG □ NA □ See Implant Record**
Counts: Nursing Diagnosis: Retained foreign body. Goal: Reduce potential for retained foreign body.
Evaluation: □ Meets goal □ See comments
☐ Sponge □ Correct □ Incorrect □ NA Comments:
☐ Sharp □ Correct □ Incorrect □ NA Comments:
☐ Instruments □ Correct □ Incorrect □ NA Comments:
Initial Count: Circulator: Scrub Person:
Relief Count: Circulator: Scrub Person:
Relief Count: Circulator: Scrub Person:
Final Count: Circulator: Scrub Person:
Surgeon notified of count: Action for incorrect count: □ X-ray outcome: Firm read by:

**Drains:** [None] Nursing Diagnosis: Infection. Goal: Reduce potential for Infection.
Evaluation: □ Meets goal □ See comments
☐ T-tube ☐ Nasogastric □ Sterile Gauze
☐ Penrose □ Hemovac
☐ Chest罩 ☐ Drain activated #: Other:

**Dressings:** [None] Band aid ☐ EZ Wrap Knee Brace
☐ 4x4/3x3 % ☐ Frederic Mammary Support
☐ ABC Pads ☐ Philadelphia collar
☐ Abdominal Binder ☐ Plaster/Fiberglass cast
☐ Abdominal Pillow ☐ Plaster/Fiberglass splint
☐ Ace ☐ Post op shoe
☐ Adaptic ☐ Red Cross Cotton

**Catheters:** [None]

**Intravenous Lines:** [None]
□ I.V. lines: Periph Right Left By:
□ Central Line Right Left By:
CVP Right Left By:
Pulmonary Artery Catheter Right Left Other
IABP Right Left By:
□ Foley / Catheter By:
□ Co2, SO2 Size:
☐ Clear, yellow, cloudy, amber, bloody urine:
Initial output: cc
Final output: cc
□ Removed in OR □ Continuous bladder irrigation

**Specimens:** [None]
□ Permanent
□ Acrylic Culture ☐ Fresh
□ Anaerobic Culture ☐ Cytology
□ Other: Frozen
□ H.O.D

**Disposition at relief:**
□ Blood Replacement: N/A
□ Estimated blood loss: No. of Units: 
□ Cell Saver: N/A
□ Cross Clamp: N/A
□ Gaps: □ Yes □ No □ NA

**PERIOPERATIVE PATIENT CARE NURSING RECORD PATIENT ADMISSION DATA BASE**
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