## MODERATE (CONSCIOUS) SEDATION RECORD 1 of 4

### NURSING PATIENT ASSESSMENT & FOCUSED HISTORY

<table>
<thead>
<tr>
<th>DATE</th>
<th>UNIT</th>
<th>Plan of care:</th>
<th>☐ Inpatient</th>
<th>☐ Outpatient Transfer from:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Accompanied by a responsible adult:</td>
<td>☐ No</td>
<td>☐ Yes</td>
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<td>Contact name:</td>
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<td>Phone/Family pager:</td>
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</table>

### PROCEDURE:
- AGE: kg
- HEIGHT: cm
- ☐ NPO @

### ALLERGIES
- ☐ NKA
- ☐ Latex
- ☐ Contrast
- ☐ Meds / Food / Product
- ☐ ALLERGY BAND ON

### Procedure Prep:
- ☐ Isolation, type:
- ☐ Patient pregnant | ☐ No | ☐ Yes, LMP

### History of Adverse Reaction to Sedation / Anesthesia, describe:

### Previous Anesthesia / Operations:

### Medical History in chart, if not-complete focused history

### History of anticoagulation, Medication & Last Dose:

### Procedure Prep:
- ☐ Isolation, type:
- ☐ Patient pregnant | ☐ No | ☐ Yes, LMP

### Medical History in chart, if not-complete focused history

### History of anticoagulation, Medication & Last Dose:

### MEDICATION RECONCILIATION

### HISTORY AND PHYSICAL EXAM BY PHYSICIAN OR LICENSED INDEPENDENT PRACTITIONER

### HPI (History of Present Illness) / Indication for Procedure:
- ☐ See H&P if Updated within 24 hours of procedure (must complete sedation assessment below if not on H&P)

### Medication Reconciliation:
- ☐ See Inpatient or Observation OR ☐ See Outpatient Medication Reconciliation form(s)

### Area

#### General appearance
- ☐ WNL
- ☐ Abn
- ☐ Obese
- ☐ Malnourished
- ☐ Infection
- ☐ Pressure ulcer (stage ___)
- ☐ Tracheostomy
- ☐ Cooperative

#### HEENT
- ☐ WNL

#### Cardiovascular
- ☐ WNL
- ☐ Abn
- ☐ Cyanotic
- ☐ Murmur

#### Lungs
- ☐ WNL

#### Abdomen
- ☐ WNL

#### Neurologic
- ☐ WNL

#### Other
- ☐ WNL

### SEDATION ASSESSMENT
- ☐ Provided on H&P or
- ASA Classification:
  - ☐ I
  - ☐ II
  - ☐ III
  - ☐ IV
  - ☐ V
  - ☐ E
- Mallampati Airway Assessment:
  - ☐ I
  - ☐ II
  - ☐ III
  - ☐ IV
- Mental / Emotional
  - ☐ Alert, oriented to name, place and time
  - ☐ Calm
  - ☐ Anxious
  - ☐ Agitated
  - ☐ Restraint

### APPROPRIATENESS FOR SEDATION
- Based on H&P, airway assessment, and planned procedure, this patient is an appropriate candidate for procedural sedation.
- ☐ Risks/Benefits/Complications explained & understood
- ☐ Moderate Sedation
- ☐ Deep Sedation
- ☐ Emergency Procedure - see chart for risk/benefit statement

### Provider Signature:
- Date
- Time

### Attending Signature:
- Date
- Time
*Intra-procedure documentation completed by RN/RT for moderate sedation & credentialed LIP for deep sedation, all medications given IV unless specifically indicated.

**Document pain scale used to score patient pain: □ Wong-Baker® FACES Pain Scale 0-10 □ Numerical rating score (0-10) □ Peds FLACC Behavioral Pain Scale □ Other_______

<table>
<thead>
<tr>
<th>TIME (I / P)*</th>
<th>TEMP °C</th>
<th>BP</th>
<th>HR</th>
<th>O₂</th>
<th>O₂</th>
<th>End tidal CO₂</th>
<th>PAIN SCORE**</th>
<th>SEDATION SCORE</th>
<th>Midazolam mg</th>
<th>Fentanyl mcg</th>
<th>Meperidine mg</th>
<th>Initials</th>
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</tbody>
</table>

**Reminder: Circle TOTAL amount MEDICATION given INTRA-PROCEDURE**

<table>
<thead>
<tr>
<th>Type of Fluid</th>
<th>Intravenous Amount</th>
<th>Fluids/Boluses</th>
<th>Date</th>
<th>Time</th>
<th>Initials</th>
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</table>

<table>
<thead>
<tr>
<th>Sedation Classification</th>
<th>Sedation Score</th>
<th>Description</th>
<th>Signature / Credentials</th>
<th>Initials</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>S</td>
<td>Sleep, easy to arouse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minimal</td>
<td>1</td>
<td>Awake and alert</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>2</td>
<td>Slightly drowsy, easily aroused</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>3</td>
<td>Frequently drowsy, arousable, drifts off to sleep during conversation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deep</td>
<td>4</td>
<td>Somnolent, minimal or no response to physical stimulation</td>
<td></td>
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</tr>
</tbody>
</table>

* I = intra-procedure; P = post-procedure

**Pasero Sedation Scale**

<table>
<thead>
<tr>
<th>Sedation Classification</th>
<th>Sedation Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>S</td>
<td>Sleep, easy to arouse</td>
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<tr>
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<tr>
<td>Deep</td>
<td>4</td>
<td>Somnolent, minimal or no response to physical stimulation</td>
</tr>
</tbody>
</table>
Patient Name
Date of Birth    Admission/Visit Date    Site
Medical Record Number    Financial Number
Patient ID Area

MODERATE (CONSCIOUS) SEDATION RECORD 3 of 4

COMMENTS: □ See Pentax □ See Sensis

PATIENT DISCHARGE FROM SEDATION

Temp:       Mental status □ Calm □ Oriented □ Anxious □ Disoriented  Amount IV fluids infused: mL  Output: mL

IV discontinued at ___________ by___________ Condition of IV site □ No apparent problem □ Other__________

□ Discharge instruction given to □ Patient □ Family □ Friend

□ Patient meets criteria for recovery from sedation (see Sedation Scale on page 2)

□ Patient has NOT recovered from effect of sedation, plan □ Transfer to ICU □ Other:__________________

BP __________ HR __________ RR __________ T __________ SaO2 __________

PATIENT'S POSSESSIONS □ NA □ Glasses □ Contacts □ Hearing aid(s) □ Ring(s) □ Watch □ Earring(s) □ Other:__________________

□ Xray / CD __________  Patient belongings returned to/or sent with: □ patient □ family member

□ Reversal agent administered, patient recovered for 90 minutes

□ Patient transfer time: Report given to RN: Unit:__________________ Date:      Time:__________________

PATIENT LEAVING HOSPITAL / CLINIC - RESPONSIBLE ADULT

Discharge RN: ____________________ Time: ____________________ □ Home    □ Other: ____________________

□ Ambulatory □ Wheelchair □ Ambulance Accompanied by □ Self □ Family □ Friend □ EMS □ Other: ____________________

SEDATION RECOVERY

Follow up care ____________________

BP __________ HR __________ RR __________ T __________ SaO2 __________

Hydration □ Acceptable □ Hydrating
Nausea/Vomiting □ None □ Nausea □ Nausea and Vomiting

Pain Score __________

Mental Status □ Return to baseline □ Other: ____________________

Appropriate for DC □ Yes □ No

Provider Signature: ____________________ Date:      Time: ____________

PATIENT DISCHARGED FROM DEEP SEDATION; COMPLETE DEEP SEDATION PROVIDER ASSESSMENT

Follow up care ____________________

BP __________ HR __________ RR __________ T __________ SaO2 __________

Hydration □ Acceptable □ Hydrating
Nausea/Vomiting □ None □ Nausea □ Nausea and Vomiting

Pain Score __________

Mental Status □ Return to baseline □ Other: ____________________

Appropriate for DC □ Yes □ No

Provider Signature: ____________________ Date:      Time: ____________
MODERATE (CONSCIOUS) SEDATION RECORD 4 of 4

CLINICIAN RESOURCES

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal</th>
<th>American Society of Anesthesiologists Classifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal healthy patient</td>
<td>Normal healthy patient</td>
<td>I Normal healthy patient</td>
</tr>
<tr>
<td>Mild systemic disease, no limitation of activity</td>
<td>II Mild systemic disease, no limitation of activity</td>
<td>II Mild systemic disease, no limitation of activity</td>
</tr>
<tr>
<td>Severe systemic disease, limitation of activity</td>
<td>III Severe systemic disease, limitation of activity</td>
<td>III Severe systemic disease, limitation of activity</td>
</tr>
<tr>
<td>Severe systemic disease that is constant threat to life</td>
<td>IV Severe systemic disease that is constant threat to life</td>
<td>IV Severe systemic disease that is constant threat to life</td>
</tr>
<tr>
<td>Moribund, patient is not expected to survive 24 hours with or without procedure</td>
<td>V Moribund, patient is not expected to survive 24 hours with or without procedure</td>
<td>V Moribund, patient is not expected to survive 24 hours with or without procedure</td>
</tr>
<tr>
<td>Emergency</td>
<td>E Emergency</td>
<td>E Emergency</td>
</tr>
</tbody>
</table>

Airway Assessment

Mallampati Classification: Have the patient perform the following in the upright sitting position: a. Open mouth as wide as possible; b. Protrude tongue as far as possible (no phonation). Identify the following structures: a. Uvula; b. Tonsillar pillars; c. Soft palate

<table>
<thead>
<tr>
<th>Class I – complete view of uvula, tonsillar pillars, soft palate</th>
<th>Class II – partial view of uvula, tonsillar pillars, complete view of soft palate</th>
<th>Class III – view of soft palate only</th>
<th>Class IV – soft palate not visible</th>
</tr>
</thead>
</table>

NOTES:
1. Medication may be taken with one sip of water.
2. Oral contrast, if required for the procedure, may be given according to the Department of Radiology protocol.
3. If patient is emergent, see risk / benefit statement.
4. Clear, carbonated soft drink is permitted. Alcohol is not a clear liquid.
5. All patients with documented delayed gastric emptying should be NPO at least 8 hours. This includes patients with diabetes, obesity, pregnancy, gastric bypass patient, trauma or chronic renal failure.

Nothing by Mouth (NPO) Guidelines for Sedation / Analgesia – 2011

<table>
<thead>
<tr>
<th>Clear Liquids</th>
<th>Breast Milk</th>
<th>Non-human Milk/Formula</th>
<th>Light Meal (toast/clear liquids)</th>
<th>Solids</th>
<th>Upper Gastric Tube Feeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stop 2 hrs prior to procedure for otherwise healthy children and adult</td>
<td>Otherwise healthy neonates and infants &lt; 44 gestational weeks stop 4 hrs before procedure</td>
<td>Otherwise healthy stop 6 hours before procedure</td>
<td>Stop 6 hours before procedure</td>
<td>Stop 8 hours before procedure</td>
<td>Stop transpyloric feed 2 hours before procedure</td>
</tr>
</tbody>
</table>

NOTES:
1. Medication may be taken with one sip of water.
2. Oral contrast, if required for the procedure, may be given according to the Department of Radiology protocol.
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