Pre/Post OP Downtime Form

Pre-Operative Record

HM2510

Procedure Summary

Service Date: ___________ OR Location: __________________________ Pre-op Location: _______________

Procedure(s):____

Surgeon(s): ____

Anesthesia Type: _______________________________ Anesthesia Block: ______________________________

☐ ASA I ☐ ASA II ☐ ASA III ☐ ASA IV ☐ ASA V ☐ ASA VI

Case Cancelled in Pre-op: ☐ Yes ☐ No Reason for Cancellation: ____________________________________

Pre-op Bed #:	Event	Time
	In Facility	
	Surgeon ID	
	In Pre-procedure	
	Pre-procedure Complete	
	Out of Pre-procedure	
Pre-op Nurse:		

Holding Bed #:	Event	Time
	In-Holding	
	Out of Holding	
Holding Nurse:		

Allergies: ____

____

Medical Diagnosis: ____

Medical History: ____

____

Surgical History

Procedure 1: ____

Procedure 2: ____

Family History

Relationship	Name	Status	Conditions
Mother			
Father			

Interpreter

Interpreter used: ☐ Yes ☐ No	Interpreter ID#:	Date:	Time:
Language:	Those present during Interpretation:		
Interpreter used for: ☐ Consent for surgery ☐ Consent for procedure ☐ Discharge instruction ☐ Medication education ☐ Other:			

Completed by RN initials: ___________________

Pre-Procedure Checklist

Patient Verification	
ID band applied?	☐Yes ☐No ☐N/A
Patient ID verified? ☐Verbal ☐Armband ☐Pt. unable to verbalize ☐Peds - Parent ID ☐Emergency ID band	
Pre-op Verification	
H&P verified within 30 days?	☐Yes ☐No ☐N/A
H&P updated on DOS? (within 24hrs for IP)	☐Yes ☐No ☐N/A
Consent confirmed? ☐Operative ☐Informed ☐Photo ☐Anesthesia ☐Blood product ☐Observers ☐Students ☐Other: ________________________________ ☐N/A	
Antibiotic ordered?	☐Yes ☐No ☐N/A
Time patient voided prior to procedure: ____________	
Glasses/Contacts removed?	☐Yes ☐No ☐N/A
Piercings removed?	☐Yes ☐No ☐N/A
Dentures/Hearing aids removed?	☐Yes ☐No ☐N/A
Bowel pre-op results: ☐Clear ☐Unclear ☐Preop incomplete	
Mouth rinse?	☐Yes ☐No ☐N/A
Carb load?	☐Yes ☐No ☐N/A
Sequential compression device? ☐On ☐On while in bed ☐Off Pt. ambulating ☐Off Pt. refused	
Compression stockings? ☐On ☐On while in bed ☐Off Pt. ambulating ☐Off Pt. refused	
CHG Wipes: ☐X1 ☐X2	CHG Liquid: ☐X1 ☐X2
Hair clipping?	☐Yes ☐No ☐N/A
Pressure injury prevention?	☐Yes ☐No ☐N/A
☐Sacral ☐Heel ☐Head ☐Other: __________________	
Hypothermia prevention? ☐Warming gown ☐Warming blanket ☐Warm blanket ☐Other: __________________	
Procedure Verification	
Correct patient?	☐Yes ☐No
Correct procedure?	☐Yes ☐No
Correct laterality?	☐Yes ☐No ☐N/A
Correct site?	☐Yes ☐No
Site marked?	☐Yes ☐No ☐N/A
Correct position?	☐Yes ☐No
Special equipment or implants? (add in comments)	☐Yes ☐No ☐N/A
Chart Verification	
NPO status completed & verified?	☐Yes ☐No ☐N/A
Last liquid: Date: __________ Time:__________ Last solid: Date: ___________ Time:__________	

Chart Verification Cont'd	
Pre-op test results in chart?	☐Yes ☐No ☐N/A
Pregnancy test: ______________ Pre-op glucose: ______________ MG/DL: ___________ Time: ___________	
Type & screen?	☐Yes ☐No ☐N/A
Confirmation ABO sent?	☐Yes ☐No ☐N/A
Blood products available? # of units: ________ Type of products: _________________	☐Yes ☐No ☐N/A
Allergies reviewed?	☐Yes ☐No ☐N/A
Medication reviewed?	☐Yes ☐No ☐N/A
Disposition of medication? ☐ID & returned to family ☐Sent to pharmacy ☐Stored on unit ☐Med room ☐Pyxis ☐N/A	
Last dialysis date: __________________	
Special needs and other comments: ____	
Medical/Cardiac Clearance?	☐Yes ☐No ☐N/A
Advance Directives (for healthcare)	
Has the patient or surrogate rec'd informational materials on patient's rights and advance directives? ☐Yes ☐No, Pt. unable to receive ☐Declined both ☐Declined Pt. rights ☐Declined info on advance directives	
Has the patient completed an advance directive document such as living will (also called directive to physicians), medical power of attorney, or out of hospital DNR orders? ☐Pt. does not have an advance directive ☐Unable to determine (pt. unable to respond) family unavailable ☐Pt. has a LIVING WILL or DIRECTIVE TO PHYSICIANS ☐Pt. has a MEDICAL POWER OF ATTORNEY ☐Pt. has an OUT of HOSPITAL DNR document ☐Pt. Has a PSYCHIATRIC ADVANCE DIRECTIVE	
Would PATIENT like to develop an Advance Directive **(Patient Must be Alert to Sign).** ☐Yes ☐No ☐Consult complete	
Code Status: ☐Full ☐DNR ☐Other: ____________________	
Healthcare information may be disclosed to: Name: _________________________________ Ph. #: _________________________________	
Comments: ______________________________________ ____ ____ ____ ____	

Completed by RN initials: __________________

Social History

Alcohol Use: ☐Yes ☐Not currently ☐Never ☐Defer
Drinks/Week: ______ Glasses of wine
______ Cans of beer
______ Shots of liquor
______ Standard drinks or equivalent
Comments: ________________________________
____

Illicit Drug Use: ☐Yes ☐Not currently ☐Never ☐Defer

Types: _____________________________________
Other: _____________________________________

Use/Week: __________________________________
Comments: __________________________________
____

Tobacco Use: ☐Yes ☐No

Start date: ____________ Quit date: ____________
Types: ☐Cigarettes ☐Pipe ☐Electric cigarettes
Packs/day:____________ Years: _______________
Education Given: ☐Yes ☐No

Smokeless Tobacco: ☐Yes ☐No ☐Never
Types: ☐Snuff ☐Chew Quit date: _____________

E-cigarettes/Vaping Use: ☐Current daily ☐Current some days ☐Former ☐Never assessed ☐Never user ☐User current status unknown ☐Unknown if ever used

Start date: ____________ Quit date: ____________

Sexual History

Sexual Active: ☐Yes ☐Not currently ☐Never
☐Other: ___________________________________

Birth Control/Protection:

☐Abstinence	☐Coitus interruptus	☐Condom
☐Diaphragm	☐Implant	☐Injection
☐Inserts	☐I.U.D	☐OCP
☐Patch	☐Post-menopausal	☐Rhythm
☐Spermicide	☐Sponge	☐Surgical
☐None	Other: ____________________	

Partners: ☐Female ☐Male

Comments:
____
____
____

OB/Gyn Status

Currently pregnant? ☐Yes ☐No ☐Unknown
Menstrual Status:

☐Ablation	☐Oopherectomy
☐Born w/o uterus	☐Pre-menarcheal
☐Chemotherapy/radiation	☐Pre-menopausal
☐Hysterectomy	☐Peri-menopausal
☐Having periods	☐Post-menopausal
☐Implant	☐Recent pregnancy
☐Injection	

LMP date: _______________ ☐LMP unknown
Breastfeeding? ☐Yes ☐No ☐Unknown

Comments:
____
____
____

Completed by RN initials: _________________

Travel Screening

Designated Visitor Approved? ☐Yes ☐No ☐Comment: ____

Name of Designated Visitor: ___________________________________ Visitor's Phone No: _________________

Travelled outside the U.S in the last month: ☐Yes ☐No ☐Unable to obtain
Travel date range: ________________________ Location(s) travelled: __________________________________

Has patient been in contact with someone who was confirmed or suspected to have COVID-19 in the last month? ☐Yes ☐No ☐Comment: ____

Does patient have of the following symptoms?

☐None	☐Cough	☐Fever	☐Muscle pain	☐Shortness of breath
☐Abdominal pain	☐Diarrhea	☐Loss of smell (anosmia)	☐Nausea/Vomiting	☐Sore throat
☐Chills	☐Fatigue	☐Loss of taste (dysgeusia)	☐Severe headache	

Has the patient EVER tested positive for COVID-19 outside of any Houston Methodist Hospitals or clinics?
☐Yes, date: _________ ☐No ☐Comment: ____

COVID-19 Status for Scheduled Procedure:
Out-patient was tested within 5 days of scheduled procedure? ☐Yes ☐No

In-patient was tested within 14 days of scheduled procedure unless the patient has a history of being positive in the last 90 days? ☐Yes ☐No

☐Patient is COVID Negative. PCR test date: _______________
☐Patient is COVID Positive. PCR test date: _______________
☐ **Isolation required, Team notified (Preop, OR, PACU)**
☐COVID Positive History (documented within the last 90 days)
Date of Positive PCR test in the last 90 days: _______________

Does patient have the document with their positive COVID-19 testing results with them?
☐Yes (please scan into chart or place in chart to be scanned in)
☐No (Please request physician enter a new COVID19 testing order)

Where was patient tested outside of Houston Methodist organization? ☐Memorial Hermann ☐CHI St. Luke's ☐HCA ☐LabCorp ☐Quest ☐Bio Reference ☐Remote testing site ☐Other (comment):
____

What date was patient tested outside of the Houston Methodist organization? ___________________________
Masked placed on patient? ☐Yes ☐No
PPE Applied: ☐Gloves ☐Gown ☐Surgical mask ☐N95 mask ☐Face shield ☐Reusable PAPR

Completed by RN initials: __________________

Exposure Screening

Contact with someone with a communicable disease in the last month? ☐Yes ☐No ☐Unable to obtain

Disease Exposed To: _______________________________ **Exposure Date:** ______________________

Symptoms in the last week:

☐None	☐Abdominal pain	☐Bruising or bleeding	☐Cough	☐Diarrhea
☐Fever	☐Muscle pain	☐Conjunctivitis (pink eye)	☐Rash	☐Sensitivity to light
☐Severe headache	☐Sore throat	☐Swollen lymph nodes	☐Vomiting	☐Weakness

Fall Risk Assessment

Date Taken: ______________ **Time Taken:** ________________

Patient Type: ☐Mat=Maternal ☐IP=Inpatient/Non-Maternal ☐BH=Behavioral Health

Last Known Fall: ☐0=No falls ☐1=Within the last year ☐2=Within the last 6 months ☐3=Within the last month ☐4=During the current hospitalization
Mobility: ☐0=No limitations ☐1=Dizziness/general weakness ☐ 2=Immobilized required assist of 1 person ☐3=Use of assistive device/requires assist of two people ☐4=Hemiplegic, paraplegia, or quadriplegia
Medication: ☐0=No Meds ☐1= Cardiovascular OR central nervous system meds ☐ 2=Cardiovascular AND central nervous system meds ☐3=Diuretics ☐4=Chemotherapy in the last month
Mental Status/LOC/Awareness: ☐0=Awake, alert, and oriented to date, place, person ☐1=Oriented to person and place ☐2=Lethargic/oriented to person only ☐3=Memory loss/confusion and requires re-orientation ☐4=Unresponsive/noncompliance with instruction
Toileting Needs: ☐0=No needs ☐1=Use of catheters or diversion devices ☐2=Use of assistive device (commode, bedpan) ☐3=Incontinence ☐4=Diarrhea/frequency/urgency
Volume/Electrolyte Status: ☐0=No problems ☐1=NPO > 24 hours ☐2=Use of IV fluids/tube feeds ☐3=Nausea/vomiting ☐4=Low blood sugar/electrolyte imbalance
Communication/Sensory: ☐0=No deficits ☐1=Visual (glasses)/Hearing deficit ☐2=Non-English patient/Unable to speak/Slurred speech ☐3=Neuropathy ☐4=Blindness or recent visual change
Behavior: ☐0=Appropriate behavior ☐1=Depression/anxiety ☐2=Behavioral noncompliance with instruction ☐3=Ethanol/Substance abuse ☐4=Impulsiveness
Hester Davis Fall Risk: ___________________________ **Maternal Fall Risk Level:** ______________________
Risk Level: ☐Not at Risk ☐Low Risk ☐Moderate Risk ☐High Risk

Completed by RN initials: __________________

Psychosocial Assessment

Domestic Abuse Assessment

Safe in home? ☐Yes ☐No Other: ___________________________________

Safe in relationship? ☐Yes ☐No ☐Other: ____

Threatened or Abused Physically, Emotionally or Sexually by Partner/Spouse/Family Member:

☐Yes ☐No ☐Other (Comment): ____

PHQ-9 Depression Scale

Indicate: 0=Not at all 1=Several days 2=More than half the day 3=Nearly every day

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Time:		
1. Little interest or pleasure in doing things		
2. Feeling down, depressed, or hopeless		
3. Trouble falling or staying asleep, or sleeping too much		
4. Feeling tired or having little energy		
5. Poor appetite or overeating		
6. Feeling bad about yourself – or that you are a failure, or have let yourself or your family down		
7. Trouble concentrating on things, such as reading the newspaper or watching television		
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being a fidgety or restless that you have been moving around a lot more than usual		
9. Thoughts that you would be better off dead, or of hurting yourself in some way		
PHQ-9 Total Score		
PHQ-9 Interpretation		
If you checked off any problems, how difficult have these problems made it for you to do your work, take care to things at home, or get along with other people?		

Values/Beliefs

Culture requests during hospitalization: ☐Yes ☐No Comment: _____________________________________

Spiritual requests during hospitalization: ☐Yes ☐No Comment: _____________________________________

Consults

Spiritual Care Consult Needed: ☐Yes ☐No Comment: ____

Social Services Consult Needed: ☐Yes ☐No Comment: ____

Palliative Care Consult: ☐Yes ☐No Comment: ____

Completed by RN initials: _________________

Pre-Operative Vitals Flow-sheet

☐Document detail assessment in Pre-Procedure Nurse's Notes, page 10.

Date:							
Time:							
RN Initials:							
Temp							
Temp Source (e.g.: oral, skin, tympanic, etc.)							
Heart Rate							
Heart Rate Source (e.g.: monitor, left, right, etc.)							
Respiratory Rate							
BP							
SpO2							
Pain Assessment: ☐No/denies pain ☐0-10 ☐ Wong-Baker FACES ☐FLACC ☐NIPS ☐PIIP							
Patient Score							
Patient's Stated Pain Goal							
O2 Delivery Method							
Pulse Oximetry Type							
Pulse Oximetry Location							
Dosing Weight/Admit Weight							
Estimated Dry Weight							
Infant Position							
Weight							
Height							
Weight Method (e.g.: stated, actual, scale type)							
Height Method (e.g.: stated, actual, estimated)							

ADHERE PATIENT LABEL WITHIN THIS AREA

Head to Toe Assessment

WDL=Within Defined Limits X=Exceptions to WDL

☐ If there are any X's please refer to Pre-Procedure Nurse's Notes, page 10, for assessment exceptions.

Date:					
Time:					
RN Initials:					
Head					
Neuro (If X document in nurses notes, date time, detail on exception)					
Sedation Scale Used					
HEENT (add details in Nurse's Notes)					
Dental Status (e.g.: loose, chipped, missing teeth, braces, etc.) Add details in nurse's notes.					
Chest					
Respiratory					
Cardiac					
5M Walk Test/Frailty Test					
First Trail (in seconds)					
Second Trail (in seconds)					
Thirds Trail (in seconds)					
Test not completed due to					
Extremities					
Peripheral Vascular					
Pulse:					
☐DP					
☐PT					
☐Radial					
Skin					
Integumentary					
Does patient have tattoos?					
Does patient have any piercings?					
Type of wound					
Musculoskeletal					
Abdomen					
Gastrointestinal					
Pelvis					
Genitourinary					
Anus/Rectum					
Other					
Implanted devices: ______________________					
Is the patient tetanus up to date?					
Has the patient received the influenza vaccine?					
Has the patient previously rec'd pneumococcal vaccine?					

LDAs – OR Lines/Drains/Airways

Date:				
Time:				
RN Initials:				
Peripheral IV				
Site/gauge				
# of attempts				
Dressing				
Foley				

I/O Assessment

Date:				
Time:				
RN Initials:				
P.O.				
I.V.				
Voided Urine (ML)				
Urinary Incontinence (yes, no)				
Unmeasured Urine Occurrence				
Unmeasured Urine Amount (e.g.: small, medium, large, etc.)				
Urine Color (yellow/straw, amber, etc.)				
Urine Appearance (clear, cloudy, hazy, etc.)				
Urine Odor (fruity, no odor, unable to access, etc.)				
Post void residual (bladder scan)				
Stool Output/Assessment				
Last BM Date				
Stool (mL)				
Bowel Incontinence (yes, no)				
Unmeasured Stool Occurrence				
Unmeasured Stool Amount (smear, small, etc.)				
Stool Appearance (formed, loose, soft, etc.)				
Stool Color (black, brown, clay, etc.)				
Emesis Output/Assessment				
Emesis (mL)				
Unmeasured Emesis Occurrence				
Unmeasured Emesis Amount (small, med., etc.)				
Emesis Color/Appearance				
Blood Output				
Est. Blood Loss				

Sign-Off

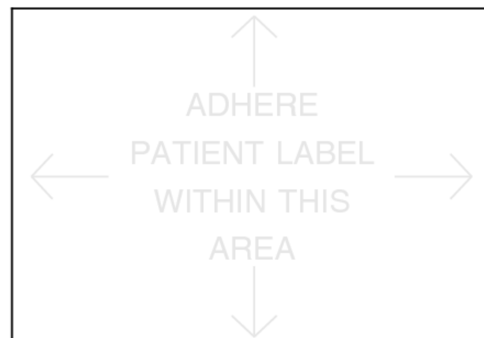
______________________________ **Admitting Nurse - Signature**

______________________________ **Admitting Nurse - Printed Name**

______________________ **Date/Time**

Handoff Report

	Given By	Given To	Date	Time
1				
2				
3				



Date	Time	Pre-Procedure Nurse's Notes	Initials

☐ Use additional pages as needed. Page _____ of _____

ADHERE PATIENT LABEL WITHIN THIS AREA

Pre-Operative Medication Given

☐Please refer to document home medication history to reconcile admission orders

	Medication Name	Dose	Route	Date Given	Time Given	RN Initials
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
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17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						
31						

☐ Use additional pages as needed. Page _____ of ______

___________________________________ ______________________________ ___________________

Pre-op Nurse's Signature   Printed Name   Date/Time

Pre-Operative Signature Page

Date	Time	RN Printed Name	RN Signature

ADHERE PATIENT LABEL WITHIN THIS AREA

HM2536

Home Medication History Form

For Epic Downtime, use this form to reconcile admission orders and use the red instructions for the right three columns ➡						Reconcile with Admission Orders		
						Med Ordered	Med Therapy Modified	Med NOT ordered ADDRESSED
Medications **(List prescriptions meds first,** then include over-the-counter, inhalers, eye and ear drops, lotions, vitamins, herbal therapies, etc.)	Strength (i.e. 25 mg)	Dose (i.e. 1 tab)	Route (i.e. oral)	Frequency (i.e. daily)	Last Dose if known	**Patient instructions after a procedure**		
						Continue at home	Stop taking until this date:	Contact prescribing doctor before continuing medication
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								

☐ Use additional pages as needed. Page _______ of _______

Use the following section for additional medications or instructions to the patient:

A.							*Comments:*
B.							
C.							

Patient Preferred Pharmacy: ____

Address: ____ Phone #: ______________________

____

Source of Information (e.g.: patient, spouse, parent, etc.):

____

Medication History Completed Nurse's Signature: Date/Time:

____

Reconciling Provider's Signature: Date/Time:

HOUSTON Methodist LEADING MEDICINE

Pre/Post OP Downtime Form

HM2537

Patient Belongings

Belonging sent with family? ☐Yes ☐No   Name: ____________________________ Phone #: _____________________

Were all patient belongings collected returned? ☐Yes ☐No   Valuable Tag #: __________________________________

Patient Personal Property Belongings List

Admission	Money/Jewelry	Brief Description	Discharge
☐	Bracelet		☐
☐	Earrings		☐
☐	Necklace		☐
☐	☐Ring ☐Watch		☐
☐	Other Jewelry		☐
☐	Money		☐
	Personal Equipment		
☐	Contact Lenses	☐Right ☐Left ☐Both	☐
☐	Dentures	☐Upper ☐Lower ☐Partial Upper ☐Partial Lower	☐
☐	Eyeglasses		☐
☐	Hearing Aid	☐Right ☐Left ☐Both	☐
☐	Prosthesis	Type:	☐
	Medical Equipment		
☐	☐Cane ☐Walker		☐
☐	Wheelchair		☐
	Electronic Equipment		
☐	IPad/Tablet		☐
☐	Cell phone		☐
☐	Laptop		☐
	Clothing		
☐	Bathrobe/Pajamas		☐
☐	Coat/Jacket		☐
☐	Shirt/Blouse		☐
☐	Shoes/Slippers		☐
☐	Socks/Hose		☐
☐	Underwear		☐
	Other		
☐	Medications		☐
☐	Other		☐

I agree with the above listed items and relieve the Hospital of any loss or damage to my belongings, where reasonable precautions have been taken. I assume full responsibility for articles in my possession, including articles brought to me later in my stay.

Admission - Patient/Family Signature	**Admission – Staff/Witness Signature**	**Staff Date/Time**
Discharge - Patient/Family Signature	**Discharge – Staff/Witness Signature**	**Staff Date/Time**

Pre/Post OP Downtime Form

Post-Operative Record

HM2538

Service Date: _____________ **OR Location:** ____________________________ **AOD Location:** _______________

Phase II Bed #:	Event	Time
	In Phase II:	
	Out of Phase II:	
	Phase II Complete:	
	Return to PACU:	
	Procedural Care Complete:	
Phase II Nurse:		

Return to Phase II Bed #:	Event	Time
	Return to Ph. II	
	Out of Ph. II (2nd time)	
Return to Phase II Nurse:		

Discharge Plan

Living Arrangement: ☐Alone ☐Children, adult ☐Children, dependent ☐Domestic partner ☐Friend(s) ☐Grandparent(s) ☐Parent(s) ☐Sibling(s) ☐Significant other ☐Other (comment): ____________________

Support Systems: ☐None ☐Spouse/significant other ☐Parent(s) ☐Children ☐Family members ☐Case manager/social worker ☐Church/faith community ☐Friends/neighbors ☐Home care staff ☐Shelter ☐Therapist ☐Other (comment): ____________________

Assistance Needed: ☐Bath bench ☐Cane, quad ☐Cane, straight ☐Commode ☐Crutches ☐Dressing device ☐Feeding device ☐Grab bar ☐Hospital bed ☐Lift device ☐Nutrition supplies ☐Prosthesis ☐Raised toilet ☐Respiratory supplies ☐Slide board ☐Walker ☐Wheelchair ☐Wound care supplies

Type of Residence: ☐Private residence ☐Homeless ☐Group home ☐Assisted living ☐Home care staff ☐Nursing home ☐Other (comment): ____________________

Patient expects to be discharged to: ____________________

Ride Caregiver Provider: ____________________

Phone Number for Ride/Caregiver: ____________________

Interpreter

Interpreter used: ☐ Yes ☐ No	Interpreter ID#:	Date:	Time:
Language:	Those present during Interpretation:		
Interpreter used for: ☐ Consent for surgery ☐ Consent for procedure ☐ Discharge instruction ☐ Medication education ☐ Other:			

Completed by RN initials: ___________________

Education

Education was provided? ☐Yes ☐No   Did the patient verbalize understanding? ☐Yes ☐No

Patient response and reaction: ____

Comments:

Care Plan

Comments:

☐ Use additional pages as needed. Page _____ of _____

Completed by RN initials: ___________________

Vitals
Post-Operative Assessment

☐Document detail assessment in Post-Procedure Nurse's Notes, page 6.

Date:								
Time:								
RN Initials:								
Temp								
Temp Source								
Heart Rate								
Heart Rate Source								
Respiratory Rate								
BP								
SpO2								
Pain Assessment								
Patient Score								
Patient's Stated Pain Goal								
O2 Delivery Method								
Pulse Oximetry Type								
Pulse Oximetry Location								
Dosing Weight/Admit Weight								
Estimated Dry Weight								
Observation								
Infant Position								

Post-Anesthetic Discharge Scoring System (PADSS) and Richmond Agitation-Sedation Scale (RASS)

Date:					Scoring Guide
Time:					
RN Initials:					
Vitals Signs					0=BP & Pulse w/in >40% 1=BP & Pulse w/in 20-40% 2= BP & Pulse w/in 20%
Activity Level					0=unable to ambulate 1=requires assistance 2=steady gait, no dizziness
Nausea & Vomiting					0=severe: continuous despite treatment 1=moderate: treated w/IV/IM meds 2=minimal: treated w/ PO meds
Pain					1=not controlled w/ PO meds 2= controlled w/ PO meds
Surgical Bleeding					0=severe: > 3 dressing changes 1=moderate: up to 2 dressing changes 2=minimal: no dressing changes
Post-Anesthetic Discharge Scoring System (PADSS)					
Richmond Agitation-Sedation Scale (RASS)					+4=combative +3=very agitated +2=agitated +1=restless 0=alert & calm -4=deep sedation -3=moderate sedation -2=light sedation -1=drowsy

LDAs – OR Lines/Drains/Airways

Date:					
Time:					
RN Initials:					
Peripheral IV – Removal					
Wound site					

Patient Discharge Transport

Transport Mode: ☐Ambulatory ☐Cane ☐Crutches ☐Stretcher ☐Walker ☐Wheelchair
☐Other (comment): ____

Transport between locations: **From:** ________________________________ **To:** ______________________________

Sign off

_______________________________ _____________________________ _________________
Discharge Nurse's Signature **Printed Name** **Date/Time:**

Post-Operative Medication Given

☐Please refer to document home medication history to reconcile admission orders

	Medication Name	Dose	Route	Date Given	Time Given	RN Initials
1						
2						
3						
4						
5						
6						
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☐ Use additional pages as needed. Page _____ of ______

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Post-Op Nurse's Signature Printed Name Date/Time

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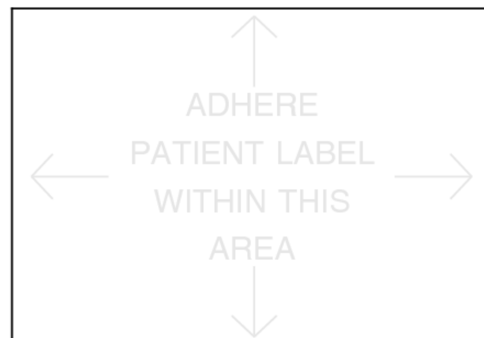
Post-Op Nurse's Signature Printed Name Date/Time



Date	Time	Post-Procedure Nurse's Notes	Initials

☐ Use additional pages as needed. Page _____ of _____

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Post-Operative Signature Page

Date	Time	RN Printed Name	RN Signature

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