

Radiology Pre-procedure Note Inpatient Outpatient

Date _____ Time _____ Referring MD _____

Diagnosis/Indications: _____

Procedure _____

Brief History	Yes	No		Yes	No
Cardiac/Vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary/Respiratory impairments	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Kidney/Renal impairments	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Seizure/Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>

Allergies: Previous adverse reaction to Drugs/Contrast No Yes

Describe: _____

Current Medications: MAR (Medication Administration Record) Database HIS/LCRPhysical Exam: WNL Yes No Comments: _____

Tobacco/Alcohol/Drug History _____

Relevant Labs or Diagnostic Studies: _____

Signature of MD	MD #	Date	Time

Complete below for patients receiving sedation.Current Physical Assessment: Airway— Open, uncompromised Not intubated, requires support Intubated/securePrevious Anesthesia: None known General MAC Conscious sedation RegionalProblems/Adverse reactions to sedation: No Yes Describe: _____ASA Classification: ASA 1 (normal/healthy) ASA 4 (severe systemic disease & constant threat to life) ASA 2 (mild systemic disease) ASA 5 (moribund) ASA 3 (severe systemic disease) Emergency situationSedation/Analgesia Plan Moderate sedation General anesthesia MAC OtherRecovery Plan Holding Discharge as outpatient if no apparent complications Return to floor Admit to ICU/IMC Admit to hospital

Immediate Pre-sedation Evaluation (within 5 minutes of sedation)

B/P _____ P _____ R _____ O₂ SaT _____ Comment: _____

In light of the above evaluation, I believe this patient is an acceptable candidate for sedation/analgesia.

Signature of Credentialed MD (LIP)	MD #	Date	Time

Immediate Pre-sedation Evaluation: Assessment unchanged, okay to sedate Sedation Consent on chart NPO status adequate

Signature of Evaluating Practitioner (MD/ARNP/PA)	MD #	Date	Time

Shands
at
the University of Florida
Gainesville, Florida 32610



HP0001

History/Physical Examination
Pre-procedure/Sedation Note (page 1 of 1)

Department of Radiology

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Patient Name: _____

Patient Identification #: _____