Methodist Healthcare

attach patient label

# Physician Orders

## REGIONAL ANESTHESIA PROCEDURE NOTE

**[X or R] =** will be ordered unless marked out.

Height: _____ cm  Weight: _____ kg

**Allergies:** [ ] No known allergies

[ ] Medication allergy(s): _____

[ ] Latex allergy  [ ] Other:

| **Progress Record** |
|---|
| Indications: The block(s) was/were placed : |
| [ ] for postoperative pain control |
| [ ] is the primary anesthetic |
| [ ] The procedure was specifically requested for management of postoperative pain by Dr. _____ |
| Assistants: None (Unless otherwise specified) |
| Date of block procedure: ____/____/____ Time _____. |
| Type of block procedure: [ ] Femoral [ ] Sciatic [ ] Lumbar Plexus |
| [ ] Lat. Popliteal [ ] CSE [ ] Post. Popliteal [ ] Ankle [ ] Interscalene |
| [ ] Infraclavicular [ ] Axillary [ ] Epidural |
| Position: [ ] Supine [ ] Prone [ ] RLD [ ] LLD [ ] Sitting |
| [ ] Other _____ |
| Prep: [ ] Chloraprep [ ] Betadine [ ] Other _____ |
| Location of block: [ ] Right [ ] Left [ ] Thoracic _____ [ ] Lumbar _____ |
| Needle: [ ] Short bevel block needle _____ gauge [ ] Touhy ____gauge |
| [ ] Whitacre _____ gauge [ ] Quinke _____ gauge |
| Length _____ [ ] cm. [ ] in. |
| |
| For Epidurals: LOR – [ ] Positive [ ] Negative |
| Aspiration – [ ] Negative [ ] Positive [ ] Blood [ ] CSF |
| Catheter: [ ] No [ ] Yes [ ] Stimcath [ ] Epidural Depth _____cm |
| |
| Nerve Stimulator: Response _____ |
| Stimulator Start:_____ mA to end of twitch _____ mA |
| Aspiration: [ ] Negative [ ] Positive [ ] Blood [ ] CSF |
| Epidural Test Dose: Time _____ |
| [ ] Lidocaine 1.5% w/1/200,000 epi ____ ml |
| [ ] Other _____ |
| CSE: CSF – [ ] Positive [ ] Negative Spinal Dose _____ |
| Level _____ |
| |
| Peripheral Nerve Blocks: Injection was made incrementally with aspiration every 5 ml. No sharp pain was elicited during the injection. |
| There was no indication of IV or spinal injection. |
| [ ] Yes [ ] No – if no please explain _____ |
| |
| Local anesthetic and dose: _____ _____ml |
| |
| EBL: None (Unless otherwise specified) |
| |
| Specimens Removed: NA |
| |
| Findings |
| |
| |
| |

**Date** _____ **Time** _____ **Physician's Signature** _____ **MD Number** _____

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