Methodist Le Bonheur Healthcare

Attach Patient Label

Concurrent- Focused Professional Practice Evaluation - Moderate Sedation Procedure Form

Procedure Date:_____

MD Name:_____**MD#:**_____ **Clinician Monitor:**_____

MRN#:_____ **FIN#:**_____ **Age:**_____**Sex:**_____

Past Medical HX:_____**ASA classification: (Circle One) I II III IV V**

LOCATION Moderate Sedation Administered:

( ) OR ( ) ENDO ( ) RADIOLOGY

( ) Critical Care Unit: _____ ( ) Cardiac Cath Lab ( ) Starlight Room

( ) Emergency Dept. ( ) Other Department:_____**(Specify)**

	YES	NO	N/A	Additional Notes:
Sedation form completed				
Patient selection criteria used, if applicable				
Universal Protocol completed				
Patient's airway and NPO status assessed appropriately.				
Patient's re-assessment done immediately prior to procedure.				
Patient required prolonged recovery period				
Patient required a reversal agent.				
Handoff procedure(s) completed				
Pre-OP and Post OP Diagnosis concur				
if not, list post-op Dx:				

Completed by:_____**Date:**_____

Clinician's NAME and Title (print)

_____

Clinician's Signature

******BELOW TO BE COMPLETED BY PHYSICIAN'S DEPARTMENT CHAIR***

Reviewed by:_____**Date:**_____

Physician

Meets Criteria_____ **Exceeds Criteria**_____ **Needs Improvement/Needs Review**_____

COMMENTS: (Additional writing space on back of page)