

Regional Anesthesia Procedure Record – Perineural

Date _____ Referring Service / MD _____
 Start Time _____ Vital Signs: BP _____ mmHg; HR _____ bpm; SpO₂ _____ RA Nasal Cannula _____ L/min
 End Time _____
 Intravenous sedation: alfentanil _____ mcg midazolam _____ mg
 Other _____ operative anesthesia post-operative analgesia

Pause Initiated: Correct patient / procedure / site confirmed prior to block. Patient is NOT on low molecular weight heparin (enoxaparin or dalteparin) or other blood thinning medication. PT/INR _____/_____
 Patient positioned: Sitting Supine Prone Lateral R/L
 Skin prepared: chlorhexidine / alcohol Other _____
 Blood pressure, EKG, respirations and O₂ Sat monitored continuously. *See print out reverse side.*

Needle – <input type="checkbox"/> Stimuquick <input type="checkbox"/> 50 mm x 22ga <input type="checkbox"/> 90 mm x 21ga <input type="checkbox"/> 150 mm x 21ga <input type="checkbox"/> Other _____ Continuous nerve block needle <input type="checkbox"/> 17/18 ga x 2” <input type="checkbox"/> 17/18 ga x 3 1/2” <input type="checkbox"/> 17/18 ga x 5 15/16” <input type="checkbox"/> Other _____ Catheter – Stimucath <input type="checkbox"/> 19/20 ga x 60 cm <input type="checkbox"/> 19/20 ga x 90 cm <input type="checkbox"/> Other _____ Needle placed at _____ Needle Point Confirmed: <input type="checkbox"/> Nerve stimulation _____ mHz <input type="checkbox"/> Ultrasound <input type="checkbox"/> Ultrasound / hydrodissection <input type="checkbox"/> Electrical impedance <input type="checkbox"/> Other _____ <input type="checkbox"/> Raj test: <input type="checkbox"/> Positive <input type="checkbox"/> Negative See comments Catheter secured: <input type="checkbox"/> Mastisol <input type="checkbox"/> Tegaderm <input type="checkbox"/> Medipore tape <input type="checkbox"/> Stat lock <input type="checkbox"/> Tunneled <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, depth at skin _____ <input type="checkbox"/> Other _____	Main Dose: <input type="checkbox"/> Ropivacaine _____% _____ mL <input type="checkbox"/> Bupivacaine _____% _____ mL <input type="checkbox"/> 2% lidocaine with 1:200:00 epinephrine _____ mL <input type="checkbox"/> Other _____ <input type="checkbox"/> Additive(s) _____ _____ <input type="checkbox"/> Aspirating every _____ mL With injection, there was: Pain: <input type="checkbox"/> Yes See comments <input type="checkbox"/> No Paresthesia: <input type="checkbox"/> Yes See comments <input type="checkbox"/> No Blood: <input type="checkbox"/> Yes See comments <input type="checkbox"/> No
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ICD9 Code:	Single Injections	Catheters	Events, Check Below
Block request in chart	<input type="checkbox"/> 64415 Interscalene Nerve Block	<input type="checkbox"/> 64416 Interscalene Catheter	<input type="checkbox"/> Patient did not go to OR
<input type="checkbox"/> 338.18 Post-op pain	<input type="checkbox"/> 64415 Infra/supraclavicular Block	<input type="checkbox"/> 64416 Infra/supraclavicular Catheter	<input type="checkbox"/> Failed Block
<input type="checkbox"/> 338.12 Thoracotomy	<input type="checkbox"/> 64417 Axillary Nerve Block	<input type="checkbox"/> 64416 Axillary Catheter	<input type="checkbox"/> Wet Tap
<input type="checkbox"/> 338.11 Pain from Trauma	<input type="checkbox"/> 64445 Sciatic Nerve Block	<input type="checkbox"/> 64446 Sciatic Catheter	<input type="checkbox"/> Hematoma
<input type="checkbox"/> 338.19 Other Acute pain	<input type="checkbox"/> 64447 Femoral Nerve Block	<input type="checkbox"/> 64448 Femoral Catheter	<input type="checkbox"/> Allergic Reaction
	<input type="checkbox"/> 64445 Popliteal Nerve Block	<input type="checkbox"/> 64446 Popliteal Catheter	<input type="checkbox"/> Toxic Reaction
	<input type="checkbox"/> 64450 Field Block		<input type="checkbox"/> Block higher than planned
	<input type="checkbox"/> 76942 Ultrasound		<input type="checkbox"/> Pneumothorax
	<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____
			<input type="checkbox"/> See Progress Note

Patient tolerated the procedure well and there were no complications

I was present for the entire procedure / scrubbed: Yes No Comments: _____

 Teaching Physician personally performed the procedure _____
 I was present for key portions of the procedure. _____
 Resident _____
 Fellow _____

Attending _____ MD# _____ Date / Time _____
 RN _____ Date / Time _____




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Patient Name: _____ Patient Identification #: _____