Anesthesia Dynamic Documentation

This document provides an overview of where the information that populates the note pulls from and details where you can modify or change the note's content. The template is designed to assist with:

- Review of medical history, including anesthesia, drug, and allergy history.
- Interview and examination of the patient.
- Notation of anesthesia risk according to established standards of practice.
- Identification of potential anesthesia problems, particularly those that maysuggest potential complications or contraindications to the planned procedure (e.g., stress tests, additional specialist consultation).
- Development of the plan for the patient's anesthesia care, including the type of medications for induction, maintenance and post-operative care and discussion with the patient (or patient's representative) of the risks and benefits of the delivery of anesthesia.
- Reporting patient's pertinent Anesthetic history.
- Documentation of physical condition.
- Leveraging information entered elsewhere in the chart to partially complete note.
- Facilitating communication with other services.
- Easily integrating essential regulatory and billing requirements.

Content of the Note

Proposed Procedure

- Flows from the scheduled procedure in the Scheduling Appointment book. This is the same display on the PeriOp Tracking List.

Chief Complaint

- Flows from documentation entered in the Chief Complaint Component on the Workflow Summary.

Allergies

- Flows from the Allergies reviewed and updated as needed by nursing during Pre-Op Assessment and can be modified on the Allergies component on the Workflow Summary.

Problem List/Past Medical History

- Flows from Chronic active & Historical problems documented on the Problem List/Dx component.

Anesthesia Labs

- Displays the following labs resulted within the last 24 hours: Hemoglobin (Hgb), Platelet Count, Prothrombin Time (PT), INR, Prothrombin Time Test (PTT), Fibrinogen, Sodium (NA+), Potassium (K+), BUN, and Creatinine.

Weight

- Flows from nursing documentation in IView or powerforms.

Age

- Flows from Registration based on DOB.

Procedure History

- Flows from OR Nurse documentation of completed Procedures in the IntraOp Doc and encounter specific powerform documentation within the Lines and Procedures, PICC and Circumcision PowerForms. Only displays Procedures/Line Insertion from the current encounter.

Home Medications (Day Surgery and Clinic encounters)

- Flows from Admission Med Rec documentation.
  Note: Does NOT include any Home Medications marked as *Confidential*.

Current Medications (Inpatient encounters):

- Flows from active medications, entered by non-Anesthesia Providers.
  Note: Does NOT include any medications marked as *Confidential*.

Vital Signs & Measurements

- Flows from nursing documentation in IView on inpatients.
- Flows from the Pre-Op Assessment PowerForm on Outpatients.

Respiratory Support

- Flows from the documentation in IView Review of Systems.
- Flows from Review of Systems documentation on the PAE (Pre-Anesthetic Evaluation Z-tool).

Physical Exam

- Flows from Review of Systems documentation on the PAE (Pre-Anesthetic Evaluation Z-tool).

Medical History

- Flows from Anesthesia Medical History PowerForm.

Plan

- Orders for today's visit: Flows from these specific Orders placed by Anesthesia providers within 24 hours: Medications, IV Fluids & Drips, Nutrition, Radiology/Diagnostics, Transfusion, Labs, or Rehab.
- Results flow from Plan section on the PAE (Pre-Anesthetic Evaluation Z-tool).