

Intraoperative Anesthesia Record

There must be an intraoperative anesthesia record or report for each patient who receives general, regional or monitored anesthesia. (§482.52(b)(2))

Current standard of care stipulates that an intraoperative anesthesia record, at a minimum, includes:

- Name and hospital identification number of the patient;
- Name(s) of practitioner who administered anesthesia, and as applicable, the name and profession of the supervising anesthesiologist or operating practitioner;
- Name, dosage, route and time of administration of drugs and anesthesia agents;
- Techniques(s) used and patient position(s), including the insertion/use of any intravascular or airway devices;
- Name and amounts of IV fluids, including blood or blood products if applicable;
- Timed-based documentation of vital signs as well as oxygenation and ventilation parameters;
- Any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment. (§482.52(b)(2))