Checklist for use of the Paper Anesthesia Record (MR Form 26)
Copies are available at the OR Control Desk (Ext 4-2401).

When it is necessary to use a paper Anesthesia Record (e.g., for locums or when the DocuSys record keeper is not functioning or is not available for a particular anesthetizing location), please remember the following:

___The Anesthesia Record must be signed by all anesthesia providers on the team.

(Senior Staff has three places to sign.)

___Note the Timeout in the comments

The following SCIP measures should be documented:

____Preop antibiotic administration (must say "IV" and note time)
(If not given must say why)

____Perioperative beta blocker therapy (If not given must say why)

____Efforts to maintain normothermia (say "forced air blanket" – not Bear hugger)

At the end of the case, when the record is completed:

____Attach one copy of the Anesthesia Record to the billing paper packet.

____Have the Anesthesia Record scanned into Acquire.

When there is a clerk at the PACU desk (usually M-F 6:00a-8:30p), they should be able to scan the original paper Anesthesia Record.

If the clerk is not at the PACU desk, make a second copy of the MR Form 26 and place it in the "To Be Scanned" box (mounted on the column to the left of the PACU desk).

(Anesthesia Records are supposed to be scanned in at discharge, but they have been getting lost.)

____The original Anesthesia Record should go to the patient's chart.

For questions or suggestions contact Dr. Gibson (jgibson@swmail.sw.org).
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