Sample B

Hysteroscopy and NovaSure® Procedure Notes and Orders

MINOR PROCEDURE RECORD Date: _____

Pt. Name: _____ Time In: _____

Nursing Diagnosis: Potential for injury and infection, impairment of skin integrity

Expected Outcome: Patient will be free of injury; skin integrity will be maintained; patient will be free from signs and symptoms of infection.

Physician: _____ Nursing History Allergies: _____

Procedure: _____ Identification Verified: _____

_____ H&P _____ Permit Signed

Pre-op Diagnosis: _____ NPO Since: _____

_____ Pre-op History Reviewed Current Medications: _____

_____ No Change _____ Change: _____

Pre-op VS: T _____ P _____ B/P _____ R _____ O2 Sat _____ % Ht _____ Wt _____

Initial Assessment of Pain

What is your pain goal? _____ pain scale education provided ☐

Are you currently experiencing pain? ___ YES ___ NO (**if yes continue**)

Do you have a history of chronic pain? ___ YES ___ NO Have you experienced pain in the last 24 hours? ___ YES ___ NO

Physical description of pain site: _____

Are you able to manage your pain? ___ YES ___ NO

Intensity of pain now: ___ 0 ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8 ___ 9 ___ 10 (0 no pain – 10 worst pain)

Intensity of pain at its worst: ___ 0 ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8 ___ 9 ___ 10 (0 no pain – 10 worst pain)

Intensity of pain at its best: ___ 0 ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8 ___ 9 ___ 10 (0 no pain – 10 worst pain)

Description of pain: _____

Frequency of pain: ___ Daily ___ Less than daily Length of pain and its effects: _____

When does the pain occur? ___ Morning ___ Afternoon ___ Evening ___ Bedtime ___ Other: _____

What causes or increases the pain? _____

What makes the pain better? ___ Moist Heat ___ Massage ___ Relaxation ___ Repositioning ___ Medications ___ Scheduled ___ PRN

Current Pain Meds: _____

Are your current pain meds working? ___ YES ___ NO Barriers to reporting pain/using meds _____

Does your pain impact: ___ Sleep ___ ADLs ___ Appetite ___ Relationships ___ Emotions ___ Concentration

Nursing Notes: _____

Pre-op Medications

Time	Medication Given	Dosage	Route

Nurse's Signature _____

Patient Name: _____ Date: _____

Procedure Start: _____/_____ Stop: _____ Time Out: _____

Procedure: ___ Hysteroscopy/NovaSure Endometrial Ablation ___ Dx Hysteroscopy

Other: _____

Anesthesia: ___ Local only (no sedation) ___ PO/IM Sedation ___ IV Sedation

Local Meds: _____

Physician			Sedation Nurse		
Circulator			Scrub/Assistant		
Other			Other		
Prep Site:		Prep Solution:		Comments:	
Equipment Used		**Settings**		**Comments**	
NovaSure SN#		Watts: Tx Time: min sec		Length:	Width:
Bovie		Cut: Coag:			
Other					
Devices/Implants ___ YES ___ NO					
Manufacturer / Type		Lot # and Expiration Date		Location	
Sponges:	Sharps:	Count Correct? ___ YES ___ NO		Comments:	
Dressing:					
Specimens: ___ YES ___ NO		1.		2.	

Vital Signs	**Time**	**B/P**	**02 Sat / Resp.**	**Pulse**	**Initials**
Admission					
Pre-procedure					
Post-procedure					
Post-procedure					
Post-procedure					
Post-procedure					

Discharge Criteria	**Yes**	**No**	
Alert & oriented to time/place/person			
VS WNL (P 50-100, R‹`24,			
B/P +/-20 Pre-op; SaO2 › 90%)			
Pain score _____ Pain goal _____ Met			
Controlled nausea and/or vomiting			
Prescriptions given			
Discharge instructions to pt/significant other			
Pt. & caregiver verbalize understanding			

Discharged home with responsible person

Name: _____

_____ Ambulatory _____ Wheelchair _____ Other

Nurse Signature: _____

Physician Signature: _____