

PASIENT NOTAS

PRE OP:	Kg.	M				
MALL:	P	HAM				
ASA: 1 2 3 4 5 6	C	X R				
BLOED:						
Rx						
TYD	DIPR	HYPN	DORM			
KET	ALLOF	NMB	FSM			
PAV	SCOL	TRAC	NORC			
MIVA	SUF	RAP	ULTIVA			
ATROB		ROB				
NEOST						
TRID	ALG	HYPOT	DEXMET			
NARKOSE	LOK	TIVA				
REGIONAAL	AREA		200			
BYSTAND	SEDASIE					
H	E	I	S	D	LUG	N2O
O	N	RAE	LM	DLT	PVC	
BUIS:						150
NO:						
VENTILATOR:						
SISTEEM:	A	D	E	ADE	S	
FIO2:	Mv	VCV	SIMV			
VI:	f	PCV	PEEP			
POSISIE:	L	R	M	R	G	TRD
TANDE	OË	BIS				100
DRUKPUNTE	OXIM	INVO				
EKG	ARTLYN	KU				
NIBP	PAP	NMT				
SVD	KAPNO	TEE				50
TEMP	URIE NE KAT	CVPI/PAP				
LUGFILTER	NG BUIS	SPO2				
KEELPAK	BLOEDVERW:	PECo2				
KUITPOMPE	EXTERNE VERW:	KRISTALL				
POSTOP:		KOLLOID				
WAKKER	SLAAP	BLOED				
EXTUB	INTUB	URIE NE				
KOPOPLIG	TOF	BLOEDVERLIES				
FIO2	SPO2	D STIX				
BP	P	VOORVALLE				
SAAL	ISE					
PCA	TEMP					

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**D** HAS THE PATIENT THE FOLLOWING YES NO DETAILS  
HET DIE PASIËNT DIE VOLGENDE GEHAD BESONDERHEDE

Previous anaesthetics ( if, when? ) Vorige narkose ( indien wel, wanneer? )	<input type="checkbox"/>	<input type="checkbox"/>	
Problems with previous anaesthetics ( details ) Probleme met vorige narkose ( besonderhede )	<input type="checkbox"/>	<input type="checkbox"/>	
Any family member with anaesthetic problems ( what? ) Enige familielid met narkose probleme ( wat? )	<input type="checkbox"/>	<input type="checkbox"/>	
Allergy / unusual reaction to medicines ( which? ) Allergie / vreemde reaksie op medisyne ( watter? )	<input type="checkbox"/>	<input type="checkbox"/>	
Are you taking any medication / pills? ( names ) Neem u enige medikasie / pille? ( name )	<input type="checkbox"/>	<input type="checkbox"/>	
Cortisone treatment in the past 12 months Kortisonbehandeling in die afgelope 12 maande	<input type="checkbox"/>	<input type="checkbox"/>	
High blood pressure Hoë bloeddruk	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma, bronchitis or emphysema Asma, bronchitis of emfiseem	<input type="checkbox"/>	<input type="checkbox"/>	
Heart disease(e.g.Chest pain, heart attack, rheumatic fever) Hartsiekte (bv. Borspyn, hartaanval, rumatiekkoors.)	<input type="checkbox"/>	<input type="checkbox"/>	
Recent cold , cough or flu Onlangse verkoue, hoes of griep	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes or thyroid problems Suikersiekte of skildklier probleme	<input type="checkbox"/>	<input type="checkbox"/>	
Jaundice or hepatitis ( if so, when? ) Geelsug of hepatitis ( indien wel, wanneer? )	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney or bladder disease Nier- of blaassiekte	<input type="checkbox"/>	<input type="checkbox"/>	
Muscle weakness or stroke Spierswakheid of beroerte	<input type="checkbox"/>	<input type="checkbox"/>	
Tendency to bleed or bruise Bloeï of kneus maklik	<input type="checkbox"/>	<input type="checkbox"/>	
Previous thrombosis / embolism ( legs / lungs? ) Vorige trombose / embolisme ( bene / longe? )	<input type="checkbox"/>	<input type="checkbox"/>	
Epileptic convulsions or blackout of any sort Epileptiese aanvalle of floutes van enige soort	<input type="checkbox"/>	<input type="checkbox"/>	
( Are you pregnant? ( if so, how long? ) Is u swanger? ( indien wel, hoe ver? )	<input type="checkbox"/>	<input type="checkbox"/>	
False, loose or crowned teeth ( if so, where? ) Vals, los of gekroonde tande ( indien wel, waar? )	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol consumption Alkohol verbruik	<input type="checkbox"/>	<input type="checkbox"/>	
Do you smoke? ( if so, how many per day? ) Rook u? ( indien wel, hoeveel per dag? )	<input type="checkbox"/>	<input type="checkbox"/>	
Porphyria, malignant hyperthermia or scoline apnoea Porfirie, Maligne hipertermie of scoline apnee	<input type="checkbox"/>	<input type="checkbox"/>	
Do you use any herbal medicine? Gebruik u enige kruie-medisyne?	<input type="checkbox"/>	<input type="checkbox"/>	
When did you last eat and / or drink? Wanneer het laas u geëet en / of gedrink?	Time Tyd		
Is there anything else your anaesthetist should know? Is daar enigiets anders wat u anestesiooloog behoort te weet?			
Weight: Gewig:	Kg	Height: Lengte:	M