**แบบฟอร์มการเขียนรายงานแพทย์ประจำบ้านวิสัญญีฯ**

Patient identification (ชื่อ อายุ HN) …………………………………………………………………………………...…

Diagnosis ………………………………………………………..…………………………………………………………

Operation (date…………… OR………) ……………...…………………………………………………………………

Preanesthetic evaluation (present and past history, physical examination, investigation)

Patient aspect…………………………………………………………..………………………………………………….

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Preanesthetic preparation

General condition………………………………………………………..…………………………………………..........

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Specific condition………………………………………………………..……………………………………………...... ………………………………………………………..………………………………………………………………..……

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Problem lists and ASA classification

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Anesthetic consideration and correlated management

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Intraoperative management and anesthetic goals

(technique, monitoring, anesthetic agents, airway management, fluid management, other specific concerns)

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Postoperative care

(monitoring, cardiovascular/respiratory supports, complications, investigations, consultations, pain control)

At PACU ………………………………………………………..………………………………………………………………..……………………………………………………………..………………………………………………………………..……………………………………………………………..………………………………………………………………..……………………………………………………………..………………………………………………………………..……………………………………………………………..………………………………………………………………..……

At surgical ward/ intensive care unit (at least 24 hours)

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