**BEDSIDE PROCEDURE TEMPLATES**

**CRITICAL CARE**

**ARTERIAL LINE MACRO**

PROCEDURE NOTE: Arterial Line Placement

Performed by: [Provider Name]

Indication: precise hemodynamic monitoring

Universal Protocol: a time out was performed and the correct patient and site were verified

Consent: the risks and benefits of arterial line placement discussed with the

patient/family, including the risk of bleeding, infection, and technical failure. The risks of not performing the procedure, less accurate hemodynamic monitoring and inability to accurately titrate medications, discussed with the patient/family. The alternatives of performing the procedure, noninvasive blood pressure monitoring, also discussed. The patient/family consented to the procedure.

Anesthesia was obtained with [ ] ml [1% lidocaine]. The [L/R] [wrist] was prepped in the usual sterile fashion. The [ ] artery was cannulated and a 20g Arrow catheter was placed over a wire. Appropriate wave form was noted. The line was secured with sutures. A dressing was placed over the site. The patient tolerated the procedure well. Extremity with good capillary refill and neurovascularly intact distal to arterial cannulization site.

Post-Procedure Diagnosis: [ ]

Complications: [none]

Estimated Blood Loss: [minimal]

Specimens Removed: [no]

Prosthetic devices/implants: [no]

Assistant(s): [none]

**CENTRAL LINES:**

**RIGHT INTERNAL JUGULAR MACRO**

Procedure Note: Central Venous Catheter Insertion- Right Internal Jugular

Indication: [ ]

Performed by: [Provider name]

Universal Protocol: a time out was performed and the correct patient and site were verified

Consent: [ ]

The patient was placed in Trendelenburg. Anesthesia was obtained with local infiltration of [ ] ml 1% lidocaine. Hand hygiene was performed prior to procedure. Chlorhexidine used to prep the skin and dried for 2 minutes prior to skin puncture. Traffic was limited during the procedure. Full barrier precaution utilized. Dynamic ultrasound guidance used and the right internal jugual vein was cannulated. A [7] french [triple] lumen catheter was placed using the Seldinger technique. All lines flushed and drew nonpulsatile dark venous blood appropriately. The line was secured with sutures at [ ] cm. A biopatch and dressing was placed over the site. The patient tolerated the procedure well. A post-line CXR was reviewed demonstrating the tip of the catheter in the SVC.

Post-Procedure Diagnosis: [same as indication]

Complications: [none]

Estimated Blood Loss: [minimal]

Specimens Removed: [no]

Prosthetic devices/implants: [no]

Assistant(s): [none]

**LEFT INTERNAL JUGULAR MACRO**

As above with site specificity

**RIGHT SUBCLAVIAN MACRO**

As above with site specificity

**LEFT SUBCLAVIAN MACRO**

As above with site specificity

**RIGHT FEMORAL MACRO**

Procedure Note: Central Venous Catheter Insertion- Right Femoral

Indication: [ ]

Performed by: [Provider name]

Universal Protocol: a time out was performed and the correct patient and site were verified

Consent: [ ]

The patient was placed in Trendelenburg. Anesthesia was obtained with local infiltration of [ ] ml 1% lidocaine. Hand hygiene was performed prior to procedure. Chlorhexidine used to prep the skin and dried for 2 minutes prior to skin puncture. Traffic was limited during the procedure. Full barrier precaution utilized. The right femoral vein was cannulated. A [7] french [triple] lumen catheter was placed using the Seldinger technique. All lines flushed and drew nonpulsatile dark venous blood appropriately. The line was secured with sutures at [ ] cm. A biopatch and dressing was placed over the site. The patient tolerated the procedure well.

Post-Procedure Diagnosis: [same as indication]

Complications: [none]

Estimated Blood Loss: [minimal]

Specimens Removed: [no]

Prosthetic devices/implants: [no]

Assistant(s): [none]

**LEFT FEMORAL MACRO**

As above with site specificity

**ENDOTRACHEAL INTUBATION MACRO**

PROCEDURE NOTE: Endotracheal Intubation

Performed by: [Provider name]

Indication: [Indication]

Universal Protocol: a time out was performed and the correct patient was verified

Consent: [ ]

Monitoring: Continuous monitoring of heart rate, respiratory rate, pulse oximetry and ETCO2. Pre-oxygenation prior to procedure via [non-rebreather].

The patient was sedated with [etomidate] and paralyzed with [succinycholine]. Using [direct laryngoscopy / video laryngoscopy / bougie], a #[ ] endotracheal tube was [visualized passing through] the cords and secured at [ ] cm at the lips. Placement was confirmed with end-tidal CO2 monitor, bilateral breath sounds and absence of breath sounds in the epigastrium.

The patient was placed on the ventilator. [See respiratory flowsheet for initial settings]

The patient tolerated the procedure well. Post intubation films were obtained which showed [proper placement and position].

**IO PLACEMENT MACRO**

PROCEDURE NOTE: IO Placement

Performed by: [Provider Name]

Indication: [IV access required]. [Multiple attempts at peripheral IV placement were made by the nursing staff without success]

Consent: [Critical Intervention-unable to obtain]

Procedure: The area was prepped in the usual fashion. The [R] [tibia] was cannulated with a [#] gauge IO angiocath. The patient tolerated the procedure well.

Post-Procedure Diagnosis: [ ]

Complications: [none]

Estimated Blood Loss: [minimal]

Specimens Removed: [no]

Prosthetic devices/implants: [no]

Assistant(s): [none]

**ULTRASOUND GUIDED IV MACRO**

PROCEDURE NOTE: IV Placement under Ultrasound Guidance

Performed by: [Provider Name]

Indication: [IV access required. Multiple attempts at peripheral IV placement were made by the nursing staff without success]

Procedure: The area was prepped in the usual fashion. The [R] [IV location] was cannulated with a [#] gauge angiocath with use of dynamic ultrasound to identify the vein. The patient tolerated the procedure well.

Complications: [none]

**ANESTHESIA**

**CONSCIOUS SEDATION MACRO**

PROCEDURE NOTE: Procedural Sedation

Performed by: [Provider Name]

Indications: [ ]

Universal Protocol: a time out was performed and the correct patient and site were verified

Consent: The risks and benefits of monitored anesthesia care, including the risk of aspiration, deep sedation requiring airway management including possible intubation, nausea/vomiting and the risks of not performing the procedure, including severe pain and inability to complete the procedure, were all discussed with the [patient]. The alternatives of performing the procedure, including local anesthesia and IV analgesia, also discussed. The patient has a ride home available.

ASA Class: [I-healthy / II-mild systemic disease / III-severe systemic disease / IV-incapacitating systemic disease]

Pre-anesthesia evaluation, including history, exam, and informed consent is documented in the ED note above.

Monitoring: Continuous monitoring of heart rate, respiratory rate, pulse oximetry and ETCO2. Supplemental oxygen prior to and during procedure via nasal cannula. Resuscitation equipment available at the bedside during sedation.

Intra-service start time: [00:00]

Intra-service stop time: [00:00]

The patient received [ ] and dosages were recorded on the sedation form. The patient was recovered from the sedation without complication or incident. Patient returned to pre-sedation level of awareness. The monitoring was discontinued at this time.

Post-anesthesia evaluation:

Respiratory function, cardiovascular function, temperature, and mental status [did/did not] return to pre-anesthetic state.

Pain [was/was not] controlled.

The patient [did/did not] tolerate p.o.

**CARDIOVASCULAR**

**CARDIOVERSION MACRO**

PROCEDURE NOTE: Electrical Cardioversion

Performed by: [Provider Name]

Indication: [Atrial Fibrillation]

Universal Protocol: a time out was performed and the correct patient and procedure were verified

Consent: [written consent obtained]

Patient was placed on continuous cardiac monitoring and continuous pulse oximetry. Supplemental oxygen was administered via nasal cannula. Electrodes were placed in an [anterior/posterior] fashion. After appropriate level of sedation was achieved (please see separate sedation procedure note), synchronized cardioversion was performed at [ ] joules with [successful conversion to sinus rhythm].

Complications: [None, patient tolerated the procedure well]

**PERICARDIOCENTESIS MACRO**

PROCEDURE NOTE: Pericardiocentesis

Performed by: [Provider Name]

Indication: [cardiac tamponade]

Universal Protocol: a time out was performed and the correct patient and site were

Verified

Consent: [Critical Intervention-unable to obtain]

Procedure: The subxiphoid region was prepped and draped in a sterile fashion. A spinal needle was introduced under the xiphoid process and directed posteriorly toward the tip of the right scapula until the pericardial space was entered and fluid aspirated.

Findings: [ ]

Post Procedure Diagnosis: [same as indication]

Complications: [none]

Estimated Blood Loss: [minimal]

Specimens Removed: [no]

Prosthetic devices/implants: [no]

Assistant(s): [none]

**TRANSCUTANEOUS PACEMAKER MACRO**

PROCEDURE NOTE: Transcutaneous Pacemaker

Performed by: [Provider Name]

Indication: [Symptomatic bradycardia]

Universal Protocol: a time out was performed and the correct patient and site were

verified

Consent: [Critical Intervention-unable to obtain]

Procedure: The patient was noted to be in a cardiac rhythm requiring pacing. External transcutaneous pacing electrode pads were applied. Pacing electrical amplitude was increased to the point of capture, verified by resulting QRS complex. Hemodynamic response to pacing was monitored. Amplitude of pacing energy was set at 1.25 times the threshold of capture.

Complications: [none]

**TRANSVENOUS PACEMAKER MACRO**

PROCEDURE NOTE: Transvenous Pacemaker

Performed by: [Provider Name]

Indication: [Symptomatic bradycardia]

Universal Protocol: a time out was performed and the correct patient and site were verified

Consent: [Critical Intervention-unable to obtain]

Procedure: Using the previously placed [LEFT/RIGHT] internal jugular catheter, a bipolar pacing catheter was advanced into the Cordis. The catheter was advanced to approximately 15 centimeters whereupon the balloon was inflated. It was further advanced into the right atrium and then the right ventricle to a depth of [ DEPTH in CM ] cm at which point pacing was achieved. The balloon was deflated and the catheter was retracted [ ] cm. The pacer was then advanced an additional [ ] cm and capture was reachieved at [ ] mAmp. The patient tolerated the procedure well.

Post Procedure Diagnosis: [same as indication]

Complications: [none]

Estimated Blood Loss: [minimal]

Specimens Removed: [no]

Prosthetic devices/implants: [no]

Assistant(s): [none]

**DIAGNOSTIC**

**LUMBAR PUNCTURE MACRO**

PROCEDURE NOTE: Lumbar Puncture

Performed by: [Provider Name]

Indication: [Headache]

Universal Protocol: a time out was performed and the correct patient was verified

Consent: [written consent obtained]

The patient was placed in [lateral recumbent] position and was prepped and draped in proper sterile fashion. The spinous process interspace at [the level of the superior iliac spine] was anesthetized with [ ] ml of [1% lidocaine]. A [ ] gauge spinal needle was used to obtain [ ] milliliters of fluid. The opening pressure was [ ]. The fluid appeared [clear] and was sent to the lab for appropriate studies. The patient tolerated the procedure well without difficulty or complication.

Post-Procedure Diagnosis: [same as indication]

Complications: [none]

Estimated Blood Loss: [minimal]

Specimens Removed: [as documented above]

Prosthetic devices/implants: [no]

Assistant(s): [none]

**PARACENTESIS MACRO**

PROCEDURE NOTE: Paracentesis

Performed by: [Provider Name]

Indication: [rule out spontaneous bacterial peritonitis / therapeutic]

Universal Protocol: a time out was performed and the correct patient and site were verified

Consent: [The risks of the procedure including bleeding, infection and bowel perforation were explained to the patient. The patient verbalized their understanding of the procedure, the risks, benefits and alternatives and wished to proceed.]

Procedure: The ascitic fluid collection was identified by [ultrasound]. Local anesthesia with [ ]ml [1%] lidocaine infiltrated at [site]. The site was prepped with [chlorhexidine/betadine] and full barrier precautions were employed. Under sterile conditions, the patient was placed in the [ ] position. [ ] ml of [fluid description] ascitic fluid was obtained. Samples were sent for appropriate studies.

Post-Procedure Diagnosis: [same as indication]

Complications: [none]

Estimated Blood Loss: [minimal]

Specimens Removed: [as documented above]

Prosthetic devices/implants: [no]

Assistant(s): [none]

**THORACENTESIS MACRO**

PROCEDURE NOTE: Thoracentesis

Performed by: [Provider Name]

Indication: [Symptomatic pleural effusion: Diagnostic/Therapeutic]

Universal Protocol: a time out was performed and the correct patient and site were

verified

Consent: [The risks of the procedure including bleeding, pneumothorax and infection were explained to the patient. The patient verbalized their understanding of the procedure, the risks, benefits and alternatives and wished to proceed.]

Procedure: With the patient in a sitting position, leaning forward, appropriate landmarks were identified. The skin was prepped and draped in sterile fashion. 3-5 mL of Local anesthetic was infiltrated in the area of the intercostal space on the [LEFT/RIGHT]. An angiocatheter was then introduced through the intercostal space over the superior edge of the rib and the pleural space was entered. Fluid was aspirated and sent to the lab for appropriate studies. Ultrasound guidance [was/was not] utilized.

A post-thoracentesis chest x-ray [will be] ordered and reviewed.

FINDINGS: [serosanguinous fluid.]

PLEUROMETRICS: [N/A]

Post Procedure Diagnosis: [same as indication]

Complications: [none]

Estimated Blood Loss: [none]

Specimens Removed: [as documented above]

Prosthetic devices/implants: [no]

Assistant(s): [none]

**SURGICAL**

**CRICOTHYROIDOTOMY MACRO**

PROCEDURE NOTE: Cricothyrotomy

Performed by: [Provider name]

Indication: [Emergent Airway]

Universal Protocol: a time out was performed and the correct patient was verified

Consent: [Critical Intervention-unable to obtain]

After the thyroid and cricoid cartilages were identified, the patient was prepped and draped in a sterile fashion. A vertical midline incision was made from the thyroid cartilage extending 3-4 cm caudally and carried down through the subcutaneous tissues.

Procedure:The cricothyroid space was identified and stabilized and a transverse opening was then made through the cricoid membrane. While maintaining stabilization of the cricoid opening, a [#] [Shiley cuffed tracheostomy] tube was place through the membrane. The balloon was inflated and the tube was secured in place.

Post Procedure Diagnosis: [same as indication]

Complications: [none]

Estimated Blood Loss: [minimal]

Specimens Removed: [no]

Prosthetic devices/implants: [no]

Assistant(s): [none]

**I AND D MACRO**

PROCEDURE NOTE: Incision and Drainage

Performed by: [Provider Name]

Indication: [abscess]

Anesthesia was obtained with [ ] ml of [1% lidocaine]. The area was prepped in the usual sterile fashion. A number [ ] scalpel was used to create an incision. Return was [ ] ml of [serous/serosang/purulent] fluid. The abscess [was/was not] probed. Loculations [were/were not] broken up. The site [was/was not] packed with iodoform. Ultrasound guidance [was/was not] needed. A dressing was placed over the site. The patient tolerated the procedure well. Wound care instructions were given.

Post-Procedure Diagnosis: [same as indication]

Complications: [none]

Estimated Blood Loss: [minimal]

Specimens Removed: [no]

Prosthetic devices/implants: [no]

Assistant(s): [none]

**CHEST TUBE MACRO**

PROCEDURE NOTE: Chest tube Placement

Performed by: [Provider Name]

Indication: [ ]

Universal Protocol: a time out was performed and the correct patient and site were verified

Consent: [ ]

The patient was prepped in proper sterile fashion. Anesthesia was obtained with local infiltration of [ ] ml 1% lidocaine. The skin was incised at the [mid / anterior / posterior] axillary line over the [ ] interspace. A curved hemostat was directed superiorly over the rib, entered the pleural space with [positive] air return and a [ ] Fr thoracostomy tube was advanced. The tube was secured with [sutures] and bandaged. The tube was connected to a Pleurovac to wall suction. Initial blood return [minimal]. A portable chest x-ray confirms the position of the chest tube.

Post-Procedure Diagnosis: [same as indication]

Complications: [none]

Estimated Blood Loss: [as documented above]

Specimens Removed: [no]

Prosthetic devices/implants: [no]

Assistant(s): [none]

**GASTRIC BAND ADJUSTMENT MACRO**

PROCEDURE NOTE: Gastric Band Adjustment

Performed by: [Provider Name]

Indication: [ ]

Consent: [The risks and benefits of the procedure were explained and the patient verbalized their understanding and wished to proceed with the procedure.]

Procedure: Area was prepped in the usual sterile fashion. Port was accessed with huber needle. A total of [ ] ml fluid was [removed/injected]. The patient’s swallowing evaluation was normal after the procedure.

**SURGERY - WOUND REPAIR**

**WOUND REPAIR MACRO**

PROCEDURE NOTE: Wound Repair

Performed by: [Provider Name]

Indication: [Laceration]

Procedure: The wound, located on the [location], measured [#] cm and was [superficial/SQ/into muscle] and [linear/stellate/irregular]. The neurovascular exam [was intact]. Skin was prepped with [betadine/chlorhexidine/wound cleanser]. Anesthesia was obtained with [#] ml of [1% lidocaine]. Wound was [clean/mildly contaminated/heavily contaminated]. It was irrigated with [saline +/- extensively] and explored. [No/A] foreign body identified. Removal of [particulate matter] [was not] required. Extensive cleaning/undermining [was/not] required. No apparent tendon or nerve injury. The wound was closed using [#] [#]-0 [suture type] [superficially/SQ/deep].

**SIMPLE WOUND REPAIR MACRO**

PROCEDURE NOTE: Simple Wound Repair

Performed by: [Provider Name]

Indication: [Laceration]

The wound, located on the [location], measured [#] cm and was [superficial/SQ/into muscle] and [linear/stellate/irregular]. The neurovascular exam [was intact]. Skin was prepped with [betadine/chlorhexidine/wound cleanser]. Anesthesia was obtained with [#] ml of [1% lidocaine]. Wound was [clean]. It was irrigated with [saline] and explored. [No] foreign body identified. Removal of [particulate matter] [was not] required. No apparent tendon or nerve injury. The wound was closed using [#] [#]-0 [suture type].

**COMPLEX WOUND REPAIR MACRO**

PROCEDURE NOTE: Complex Wound Repair

Performed by: [Provider Name]

Indication: [Laceration]

The wound, located on the [location], measured [#] cm was [superficial/ into SQ/into muscle] and [linear/stellate/irregular]. The neurovascular exam [was intact]. Skin was prepped with [betadine/chlorhexidine/wound cleanser]. Anesthesia was obtained with [#] ml of [1% lidocaine]. Wound was [clean/mildly contaminated/heavily contaminated]. It was irrigated with [saline +/- extensively] and explored. [No] foreign body identified. Removal of [particulate matter] [was not] required. Extensive cleaning/undermining [was not] required. No apparent tendon or nerve injury. The wound was closed using [#] [#]-0 [suture type] [superficially/SQ/deep].

**MULTIPLE WOUND REPAIR MACRO**

PROCEDURE NOTE: Multiple Wounds

Performed by: [Provider Name]

Indication: [Laceration]

The wounds, located on the:

1) [location], measured [#] cm and was [superficial/ into SQ/into muscle] and [linear/stellate/irregular].

2) [location], measured [#] cm and was [superficial/ into SQ/into muscle] and [linear/stellate/irregular].

3) [location], measured [#] cm and was [superficial/ into SQ/into muscle] and [linear/stellate/irregular].

The neurovascular exam [was intact]. Skin was prepped with [betadine/chlorhexidine/wound cleanser]. Anesthesia was obtained with a total of [#] ml of [1% lidocaine]. Wounds were [clean/mildly contaminated/heavily contaminated]. They were irrigated with [saline +/- extensively] and explored. [No] foreign bodies identified. Removal of [particulate matter] [was not] required. Extensive cleaning/undermining [was not] required. No apparent tendon or nerve injury. The wounds were closed using:

1) [#] [#]-0 [suture type] [superficially/SQ/deep].

2) [#] [#]-0 [suture type] [superficially/SQ/deep].

3) [#] [#]-0 [suture type] [superficially/SQ/deep].

Wounds were hemostatic and well approximated post-procedure. There were no complications.

**NON-SUTURE WOUND REPAIR MACRO**

PROCEDURE NOTE: Wound Repair

Performed by: [Provider Name]

Indication: [Laceration]

The wound, located on the [location], measured [#] cm and was superficial and [linear]. The neurovascular exam [was intact]. Skin was prepped and cleaned with [betadine/chlorhexidine/wound cleanser]. [No] foreign bodies identified. No apparent tendon or nerve injury. The wound was closed using [adhesive glue/steri-strips].

**SUTURE REMOVAL MACRO**

PROCEDURE NOTE: Suture Removal

PROCEDURE: Removal of previously placed [sutures]

DESCRIPTION OF REPAIR:

The wound demonstrates no evidence of infection with adequate tensile strength at the wound margins at this time to warrant suture removal. Sutures were removed individually using [Littauer scissors and forceps], with a total of [#] sutures removed. Re-examination of the wound following the procedure reveals no evidence of any retained foreign bodies and no dehiscence.

Wound care precautions were given to the patient verbally.

**STAPLE REMOVAL MACRO**

PROCEDURE NOTE: Staple Removal

PROCEDURE: Removal of previously placed [staples]

DESCRIPTION OF REPAIR:

The wound demonstrates no evidence of infection with adequate tensile strength at the wound margins at this time to warrant staple removal. Staples were removed individually using a [standard staple remover], with a total of [#] staples removed. Re-examination of the wound following the procedure reveals no evidence of any retained foreign bodies and no dehiscence.

Wound care precautions were given to the patient verbally.

**ORTHOPEDIC**

**ARTHROCENTSIS MACRO**

PROCEDURE NOTE: Arthrocentesis

Performed by: [Provider Name]

Indication: [rule out septic joint]

Universal Protocol: a time out was performed and the correct patient and site were

verified

Consent: the risks and benefits of arthrocentesis discussed with patient, including the risk of bleeding, infection, and technical failure. The risks of not performing the procedure, failure to diagnose septic joint with resultant systemic infection, discussed with the patient. The alternatives of performing the procedure also discussed. The patient consented to the procedure.

The [ ] joint was prepped and draped in proper sterile fashion. The overlying skin was anesthetized with [ ] ml of [1% lidocaine]. A [ ] needle was used to aspirate fluid from the joint using appropriate anatomic landmarks. [ ] fluid was obtained from the joint. Approximately [ ] milliliters of fluid was obtained. The fluid was then sent to the lab for appropriate studies.

The patient tolerated the procedure well, was bandaged, and had no complications.

Post-Procedure Diagnosis: [same as indication]

Complications: [none]

Estimated Blood Loss: [minimal]

Specimens Removed: [as documented above]

Prosthetic devices/implants: [no]

Assistant(s): [none]

**FINGER REDUCTION MACRO**

PROCEDURE NOTE: Finger reduction

Performed by: [Provider Name]

Indication: dislocation of [left/right] [1st-5th] finger at the [DIP/MIP/PIP] joint

Universal Protocol: a time out was performed and the correct patient and site were verified

Consent: [The risks and benefits of the procedure were explained and the patient verbalized their understanding and wished to proceed with the procedure.]

Procedure: Adequate analgesia was administered. The patient's distal [left/right] [ 1st-5th] finger was grasped and longitudinal traction applied with slight exaggeration of the deformity. The joint was gently manipulated into its normal position. A [finger splint] was applied. Neurovascular function intact after reduction.

Post reduction films obtained and demonstrated [an adequate reduction].

Complications: [none]

**FRACTURE REDUCTION MACRO**

PROCEDURE NOTE: Fracture reduction

Performed by: [Provider Name]

Indication: [Acute fracture with displacement, requiring fracture reduction.]

Universal Protocol: a time out was performed and the correct patient and site were verified

Consent: [The risks and benefits of the procedure including incomplete reduction, nerve damage and bleeding were explained and the patient verbalized their understanding and wished to proceed with the procedure.]

Procedure: [Neurovascular exam intact] prior to fracture reduction. Anesthesia/pain control with [ ]. Reduction of the [left/right] [fracture site] was accomplished via [axial traction and careful manipulation]. Following adequate reduction and alignment of the fractured bone, the fracture was immobilized with a [splint]. [Neurovascular exam intact] after fracture reduction. The patient tolerated the procedure well.

Post reduction films obtained and demonstrated [an adequate reduction].

Complications: [none]

**JOINT REDUCTION MACRO**

PROCEDURE NOTE: Joint reduction

Performed by: [Provider Name]

Indication: dislocation of [left/right] [joint]

Universal Protocol: a time out was performed and the correct patient and site were verified

Consent: [The risks and benefits of the procedure including incomplete relocation, fracture, nerve damage were explained and the patient verbalized their understanding and wished to proceed with the procedure.]

Procedure: [Neurovascular exam intact] prior to joint reduction. Anesthesia/pain control with [ ]. Reduction of the [left/right] [joint] was accomplished via [ ]. The joint was [immobilized with a splint]. [Neurovascular exam intact] after joint reduction.

The patient tolerated the procedure well.

Post reduction films obtained and demonstrated [an adequate reduction].

Complications: [none]

**SPLINTING MACRO**

PROCEDURE NOTE: Splinting

Performed by: [Provider Name]

Indication: [fracture/dislocation]

The [area to splint] was appropriately positioned. An [orthoglass] splint was applied. The [splinted body part] was neurovascularly intact following the procedure. The patient tolerated the procedure well.

**ENT**

**NASAL PACKING MACRO**

PROCEDURE NOTE: Nasal Packing

Performed by: [Provider Name]

Indication: Epistaxis

Universal Protocol: a time out was performed and the correct patient and site were

verified

Consent: the risks and benefits of nasal packing discussed with the patient, including the risk of bleeding, infection, technical failure, and development of toxic shock syndrome. The risks of not performing the procedure, including persistent bleeding, discussed with the patient. The alternatives of performing the procedure also discussed. The patient consented to the procedure.

After administration of [ ], the patient underwent nasal pack placement with a [RapidRhino] in the [R/L] nare. Hemostasis was achieved after placement. The patient tolerated this procedure with moderate discomfort.

**PERITONSILLAR ABSCESS DRAINAGE MACRO**

PROCEDURE NOTE: Peritonisillar abscess drainage

Performed by: [Provider Name]

Indication: [peritonsillar abscess]

Universal Protocol: a time out was performed and the correct patient and site were

verified

Consent: [The risks and benefits of the procedure were explained and the patient verbalized their understanding and wished to proceed with the procedure.]

Procedure: Topical anesthetic was introduced over the area of greatest fluctuance on the [LEFT/RIGHT]. The tongue was depressed with a tongue blade and a small amount of local anesthetic was introduced superficially over the area of greatest fluctuance. An 18-gauge needle and syringe was used to aspirate the area of greatest fluctuance to a depth of less than 1 cm and directed away from vascular structures. Purulent material was aspirated.

FINDINGS:[ ]

Post-Procedure Diagnosis: [same as indication]

Complications: [none]

Estimated Blood Loss: [minimal]

Specimens Removed: [no]

Prosthetic devices/implants: [no]

Assistant(s): [none]

**GI/GU**

**FOLEY PLACEMENT MACRO**

PROCEDURE NOTE: Foley Catheter

Performed by: [Provider Name]

Indication: [Urinary retention]

Universal Protocol: a time out was performed and the correct patient and site were

verified

Consent: [The risks and benefits of the procedure were explained and the patient verbalized their understanding and wished to proceed with the procedure.]

Procedure: A fenestrated drape was placed over the perineum. The urethra was exposed and controlled with the nondominant hand. Cotton balls soaked with antiseptic solution were then used to prepare the area in a sterile fashion, running the cotton balls over the meatus in an anterior posterior direction 3 separate times. The tip of the urinary catheter was covered in lubricant. A [ ] Fr [foley catheter] was then introduced into the meatus and quickly advanced into the bladder. Position was verified by the free flow of urine from the bladder. The catheter balloon was then filled with 10 mL of saline solution. The urine collection system was secured in place.

Complications: [None]

**GASTRIC LAVAGE MACRO**

PROCEDURE NOTE: Gastric Lavage

Performed by: [Provider Name]

Indication: [evaluation for GI bleeding]

Universal Protocol: a time out was performed and the correct patient and site were

verified

Consent: [The risks and benefits of the procedure were explained and the patient verbalized their understanding and wished to proceed with the procedure.]

Procedure: After insertion of a nasogastric tube (please see separate procedure note) and confirmation of its location and the stomach, tap water was instilled down the NG tube and subsequently aspirated. The gastric contents were tested and were found to be Gastroccult negative. [ ]

Complications: [none]

**GASTRIC TUBE REPLACEMENT MACRO**

PROCEDURE NOTE: Gastric Tube Replacement

Performed by: [Provider Name]

Indication: [G-tube malfunction/displacement - required for medications and nutrition]

Universal Protocol: a time out was performed and the correct patient and site were

verified

Consent: [ ]

Procedure: The patient was prepped in the usual fashion. A [ ] Fr [G tube] was placed in the existing tract, the balloon inflated and gastric contents aspirated. A KUB [was/was not] obtained to confirm the position of the G tube.

Complications: [none]

**NG PLACEMENT MACRO**

PROCEDURE NOTE: NG Placement

Performed by: [Provider Name]

Indication: [gastric decompression]

Consent: [ ]

Procedure: Analgesia administered. A [14] Fr NG tube was placed in the [R] nares and passed into the stomach. Position of the tube was confirmed by auscultating over the stomach during insufflation of air through the tube. Gastric contents were aspirated.

Complications: [none]

**OG PLACEMENT MACRO**

PROCEDURE NOTE: OG Placement

Performed by: [Provider Name]

Indication: [gastric decompression]

Consent: [ ]

Procedure: A [14] Fr OG tube was placed in the stomach through the mouth. Position of the tube was confirmed by auscultating over the stomach during insufflation of air through the tube. Gastric contents were aspirated.

Complications: [none]

**HEME/ONC**

**BONE MARROW BIOPSY MACRO**

PROCEDURE NOTE: Bone Marrow Biopsy/Aspiration

Performed by: [Provider Name]

Indication: [Anemia

 Diagnosis of possible leukemia

 Erythyrocytosis

 Hemochromatosis

 Infectious disease

 Leukemia

 Leukemia under active treatment/evaluation of response

 Leukocytosis

 Leukopenia

 Lymphoma

 Metastatic evaluation of a solid tumor

 Multiple myeloma

 Myelodysplastic syndrome

 Myelofibrosis

 Neuroblastoma

 Neutropenia

 Pancytopenia

 Polycythemia

 Thrombocytopenia

 Thrombocytosis]

Universal Protocol: a time out was performed and the correct patient and site were verified

Consent: [The risks and benefits of the procedure were explained and the patient verbalized their understanding and wished to proceed with the procedure.]

Procedure: Under aseptic technique with [local anesthesia], a bone marrow aspiration and biopsy were performed.

Location: [Left posterior iliac crest

 Right posterior iliac crest

 Left anterior iliac crest

 Right anterior iliac crest]

Moderate sedation: [30 minutes or less

 31 minutes to 45 minutes

 46 to 60 minutes

 Greater than 60 minutes]

Assisted by: [Nurse]

Specimen sent for: [Flow Cytometry and Cytogenetics

 Flow Cytometry

 Cytogenetics

 Histopathology

 FISH

 Comprehensive panel]

Sterile dressing applied wtih direct pressure for [ ] minutes

Instructions/comments: The procedure was [well tolerated]. The patient was given instructions for home monitoring and care of the biopsy site

Post-procedure diagnosis: [same as indication]

Complications: [none]

Estimated Blood Loss: [minimal]

Prosthetic devices/implants: [no]

**NEPHROLOGY**

**TUNNELED CATHETER MACRO**

DIAGNOSIS: [DIAGNOSIS]

PROCEDURE: Insertion of [Right/Left] internal jugular vein tunneled cuffed [##] cm MedComp Split hemodialysis catheter (36558) using real-time ultrasound guidance (76937) and fluoroscopy (77001)

OPERATOR: [NAME]

INDICATION: [INDICATION] with requirement for long-term venous hemodialysis access

PROCEDURE: The procedure was explained to the patient in detail & informed consent obtained. The [RIGHT/LEFT] internal jugular vein was imaged by ultrasound and was found to be widely patent without thrombus or stenosis. There was normal compressibility and respiratory variation. A digital image was obtained and stored in the permanent electronic health record.

The [RIGHT/LEFT] anterior neck and chest were prepped with chorhexidine and alcohol and draped sterilely. The skin over the posterior approach to the internal jugular vein was anesthetized with 1% lidocaine and a nick made with a #11 scalpel. The vein was imaged and punctured using real-time ultrasound guidance with a 21 gauge needle and a 0.18 wire advanced into the right atrium under fluoroscopic guidance. A micropuncture sheath was placed and the wire exchanged for a 0.035 Rosen wire advanced into the right atrium and inferior vena cava under fluoroscopic guidance. The incision was extended 1 cm laterally and the subcutaneous tissues dissected bluntly. An exit-site was anesthetized and incised on the anterior chest wall medial to the original catheter site. A [##] cm MedComp Split catheter was then tunneled from the exit site to the neck incision and pulled through. The vein was dilated with a 14 French vessel dilator and the catheter inserted over the wire without resistance. Both ports drew freely without resistance. The catheter was flushed and packed with 1000 units/cc Heparin. Under fluoroscopy, the bend was well formed in the neck, and the tip was at the [LOCATION] in the supine inspiratory position. The neck incision was closed with layered 3-0 Vicryl and 4-0 Monocryl sutures and Steri-strips. The exit site was secured and the catheter anchored with Nylon suture. The site was dressed with antibiotic ointment and a sterile Tegaderm. The patient tolerated the procedure well and there were no complications. The patient received Versed [##] mg, & Fentanyl [##] mcg with adequate sedation & analgesia.

POST-PROCEDURE DIAGNOSIS: [same as indication]

Complications: [none]

Estimated Blood Loss: [minimal]

Specimens Removed: [no]

Prosthetic devices/implants: [no]

Assistant(s): [none]