Hartford Hospital
A Hartford HealthCare Partner
Hartford Hospital Eye Surgery Center

571075

LASER PROCEDURE ROOM DOCUMENTATION

Patient Name:_____ **Date of Birth:** _____**Procedure Date:**_____
Physician:_____

Date:			**Anesthesia:** ☐**Topical** ☐**Local**	
Diagnosis:			**Eye Treated:** ☐**Right** ☐**Left**	
Indications for Procedure:				
Prior Ocular Surgery and Dates:	**Vital Signs** **Pre-Procedure**	**Post-Procedure**	**Intra-ocular Pressure (SLT only)**	**Pain (scale 0-10)**
	BP P Resp	BP P Resp	Pre-Procedure:	Pre-Procedure:
			Post-Procedure:	Post-Procedure:

Allergies: ☐No Known Allergies ☐Latex List:_____

Present Medications: ☐ **See Patient Medication List**

Ocular Medications	**Medications**	

Physician H&P	Chest/Lung: ☐ WNL ☐Not Assessed ☐ Abnormal:_____
CV: ☐ WNL ☐ Not Assessed ☐ Abnormal:_____	CNS: ☐ WNL ☐ Not Assessed ☐ Abnormal:_____
GI: ☐ WNL ☐ Not Assessed ☐ Abnormal:_____	GU: ☐ WNL ☐ Not Assessed ☐ Abnormal:_____

Other Findings Pertinent to Planned Procedure:

Eye Exam

Best Corrected Vision:	Distance	Right eye:	Left Eye:
	Near	Right Eye:	Left Eye:
Intra-ocular pressure:		Right eye:	Left Eye:
BAT:		Right eye:	Left Eye:

NOTES:

Laser Assistant:

Laser Type: ☐Nidek Yag 1064nm ☐Nidek Green Diode(Argon)532nm ☐Lumenis SLT 1064 nm

Laser Key Obtained: ☐Yes	**Laser Self-Test performed:** ☐Yes

In event of failure, Biomed notified: ☐Yes

Name:	Time:	Response: ☐Yes	Biomed#:

Procedure Room Doors Closed: ☐Yes	Consent form signed by surgeon and patient: ☐Yes
Fire Extinguisher Immediately Available: ☐Yes	Laser in Standby mode when not in use: ☐Yes
Laser Turned off when laser left unattended: ☐Yes ☐N/A	
Eye Protection for patient and staff: ☐Yes	Laser Signs Posted: ☐Yes / Windows Covered: ☐Yes ☐N/A

Procedure: ☐**Photocoagulation** ☐**SLT** ☐**ARGON** ☐**Trabeculoplasty** ☐**Iridectomy** ☐**Photodisruptive** ☐**NdYag Capsulotomy** ☐ **NdYag Peripheral Iridotomy** ☐**Other** _____

Surgeon Participating in Time-Out:	**Time-out performed prior to laser-ready mode activation** ☐Yes
	Site Confirmed:☐Yes **Side Confirmed:**☐Yes **Procedure Confirmed**:☐Yes

Power:_____ Spot Size:_____ Pulse per Burst:_____
Duration:_____ No. of Pulses:_____ Energy Level:_____

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PRE-OP MEDICATIONS				
☐**Yag Capsulotomy** ☐**Peripheral Iridotomy** ☐**Argon/SLT/ALT**				
☐Proparacaine (Alcaine) 1% ophthalmic solution one drop	☐Right ☐Left	Date:	Time:	Initials:
☐Tropicamide (Mydriacyl) 1% ophthalmic solution one drop	☐Right ☐Left	Date:	Time:	Initials:
☐Phenylephrine (Neosynephrine)2.5% ophthalmic solution one drop	☐Right ☐Left	Date:	Time:	Initials:
☐Timolol (Timoptic) 0.5% ophthalmic solution	☐Right ☐Left	Date:	Time:	Initials:
☐Phenylephrine (AK Dilate) 10% ophthalmic solution 1mL	☐Right ☐Left	Date:	Time:	Initials:
☐Iopidine 0.5% ophthalmic solution one drop	☐Right ☐Left	Date:	Time:	Initials:
☐Pilocarpine 1% ophthalmic solution one drop	☐Right ☐Left	Date:	Time:	Initials:
Other:	☐Right ☐Left	Date:	Time:	Initials:
Other:	☐Right ☐Left	Date:	Time:	Initials:
Other:	☐Right ☐Left	Date:	Time:	Initials:
POST-OP MEDICATIONS				
☐Prednisolone 1% ophthalmic solution one drop	☐Right ☐Left	Date:	Time:	Initials:
☐Iopidine 0.5% ophthalmic solution one drop	☐Right ☐Left	Date:	Time:	Initials:
☐Nepafenac (Nevenac) 0.09% ophthalmic solution one drop	☐Right ☐Left	Date:	Time:	Initials:
☐Timolol ophthalmic solution one drop	☐Right ☐Left	Date:	Time:	Initials:
Other:	☐Right ☐Left	Date:	Time:	Initials:
☐Discharge instructions reviewed with patient or family member ☐Discharge instructions given to patient upon leaving facility Translator Needed: ☐Yes ☐No If yes: ☐Language Line OR Name of translator:_____				
☐**Call MD office for appointment**				
☐**Follow-up Appointment on:**				
Comments/Complications:				

PATIENT DISCHARGE INSTRUCTIONS: ☐N/A	
☐Prednisolone (Predforte) 1% ophthalmic solution	1 drop in ☐Right ☐Left Eye take____ times a day for _____days
☐Nepafenac (Nevanac) 0.1% ophthalmic solution	1 drop in ☐Right ☐Left Eye take____ times a day for _____days
☐Bromfenac (Xibrom) 0.09% ophthalmic solution	1 drop in ☐Right ☐Left Eye take____ times a day for _____days
☐Difluprednate(Durezol) 0.05% ophthalmic emulsion	1 drop in ☐Right ☐Left Eye take____ times a day for _____days
Other:	____drop in ☐Right ☐Left take____ times a day for _____days
Other:	____drop in ☐Right ☐Left take____ times a day for _____days
Patient may be discharged without a responsible adult	

MD Signature:_____ **Date:**_____ **Time:**_____

LPN Signature: :_____ **Date:**_____ **Time:**_____ **Initials:**_____

RN Signature:_____ **Date:**_____ **Time:**_____ **Initials:**_____