COMMUNITY MEMORIAL HOSPITAL OF SAN BUENAVENTURA

RETURN TO MEDICAL STAFF SERVICES

DEPARTMENT OF ANESTHESIOLOGY
PROCEDURE EVALUATION

To assist the Department in evaluating the appropriateness and quality of care rendered by members of the Provisional Staff, please complete the following questionnaire.

PHYSICIAN:_____

NAME OF PATIENT:_____ AGE:_____

Medical Record Number_____ Date of Procedure:_____

Type of Surgery: _____

Anesthesia Technique and Agents:_____

Observer (Please print name)_____

1. Was the pre-anesthesia evaluation of the patient adequate? Yes ____ No_____

Comment:_____

2. Was there a plan of action? Yes ____ No_____

Comment:_____

3. Was there adequate preparation of equipment before induction? Yes ____ No_____

Comment:_____

4. Did anesthesia management demonstrate reasonable expertise? Yes ____ No_____

Comment:_____

5. Was PACU care reasonable and documented? Yes ____ No_____

Comment: _____

6. Special procedures performed? Yes ____ No_____
   Appropriate indications? Yes ____ No_____
   Reasonable expertise demonstrated? Yes ____ No_____

Comment:_____

7. Suggestions for improvement? Yes ____ No_____

Comment:_____

OBSERVER'S SIGNATURE_____ **DATE:**_____