GOVERNMENT OF MEGHALAYA
HEALTH & FAMILY WELFARE DEPARTMENT

PRE-ANESTHETIC RECORD STANDARD MEDICAL DOCUMENTATION

Patient's Name:						MRD No./UHID No.	
Age:		Gender	M	F	O	Ward No.	
Date of Admission	DD/MM/YY					Bed No.	
Provisional Diagnosis							

Particulars						Remarks
Name of Surgeon						
Name of Assistant Surgeon						
Name of Operation/Surgery						
Date of Operation/Surgery						
Pre-Anaesthetic Check Up						
Type of Anaesthesia	GA	SA	RA	Epidural	LA	
Duration of Anaesthesia (approximate)						
Advice and Medication (if any)						

Name of Anaesthetist: ____

Signature: ____________________________

Date: ________________________________

Time: ________________________________