

Recording the Injection – proforma 2

INJECTION RECORD [2]													
PATIENT ID					DIAGNOSIS								
STERIOD					LOCAL ANAESTHETIC								
Batch No					Lot No								
Expiry Date					Expiry Date								
Dose (mg)					Volume (ml)				Total Volume (ml)				
					Strength (%)								
Checked <input type="checkbox"/>					Checked <input type="checkbox"/>								
Needle length (mm) 16 <input type="checkbox"/> 25 <input type="checkbox"/> 40 <input type="checkbox"/> 50 <input type="checkbox"/> 90 <input type="checkbox"/>					Gauge 21 <input type="checkbox"/>			23 <input type="checkbox"/>			25 <input type="checkbox"/>		
					Green			Blue			Orange		
ABSOLUTE CONTRAINDICATIONS					ABSENT				ABSENT				
Infection local/joint/systemic									Poorly controlled diabetes				
Hypersensitivity to drugs/allergies									Anxious/'the doesn't quite fit' patient				
									Children/adolescent				
CAUTION									Pregnancy/breast feeding				
Recent trauma to affected area									Prosthetic joint				
Haemarthrosis									Other (please specify)				
Immunosuppression - steroids/disease													
Anticoagulant therapy/bleeding disorders													
EXPLANATION													
Treatment options					Verbal information								
Side effects/complications					Expressed consent								
Information leaflet					Advice to patient (recorded in patient notes)								
PRE-INJECTION													
Objective sign			1.				2.						
Can patient perform normal duties at work?										Yes	No	N/a	
Is patient able to participate in usual sporting/leisure activities?										Yes	No	N/a	
VAS (Pre) inj	0	1	2	3	4	5	6	7	8	9	10		
TECHNIQUE					'No touch' technique								
Site marked					Safety aspiration								
Hands washed					Delivery (tick one) : <i>Peppering</i> <input type="checkbox"/> <i>Bolus</i> <input type="checkbox"/>								
Site Cleaned					Safe sharps disposal								
Bottles cleaned					Patient retained (30 mins) to assess effects								
Adverse events (if yes – provide details on reverse AND in patient records)										Yes	No		
VAS (post) inj	0	1	2	3	4	5	6	7	8	9	10		
Practitioner name:					Practitioner signature:					Date:			
REVIEW													
Objective sign			1.				2.						
Can patient now perform normal duties at work?										Yes	No	N/a	
Is patient now able to participate in usual sporting/leisure activities?										Yes	No	N/a	
VAS	0	1	2	3	4	5	6	7	8	9	10		
Date of review:													

