Acute Phase Day 0 Post-recovery

This covers the period post recovery until midnight on the day of surgery

Section 1 - Participant Details

Trial Number: ☐☐☐☐ Initials: *First, Middle, Last* ☐☐☐ Site: _____

Section 2 - Management of the local anaesthetic block

Was additional, unplanned involvement of the pain team required to address pain management? *If yes indicate if block was optimised below* ◯ No ◯ Yes

Was additional, unplanned involvement of an anaesthetist/other doctor required to address pain management? *if yes indicate reason below* ◯ No ◯ Yes

Optimise block? *E.g. addition of bolus, increase in rate* ◯ No ◯ Yes

Resite block? *E.g. reinsertion of the same block or insertion of new block. If yes complete below.* ◯ No ◯ Yes

What was the re-sited block? ◯ TEB ◯ PVB ◯ Other

If other, please specify _____

Section 3 - Analgesia

Were any of the following analgesia given post-recovery to midnight on day of surgery? ◯ No ◯ Yes

Analgesia - indicate if given by ticking the relevant boxes below

	Used
Gabapentin	☐
Pregabalin	☐
Ketamine	☐
PCA Opioid(s) - if yes provide doses below	☐
Oral Opioid(s) - if yes provide doses below	☐
IV Opioid(s) - if yes provide doses below	☐
Topical Opioid(s)- - if yes provide doses below	☐
Top-up Bolus Via Catheter (excluding PCEA top-ups)- if yes provide below	☐

Number of local anaesthetic top-ups via catheter: ☐

Please provide total cumulative doses of each type of opioid - if pump reset add up with previous dose

Opioid 1

Drug: _____ Dose: ___.___ Dose unit: *tick as applicable* ◯ mg ◯ mcg ◯ mcg/hour Route *tick as applicable* ◯ Oral ◯ IV ◯ PCA ◯ Topical

Opioid 2

Drug: _____ Dose: ___.___ Dose unit: *tick as applicable* ◯ mg ◯ mcg ◯ mcg/hour Route *tick as applicable* ◯ Oral ◯ IV ◯ PCA ◯ Topical

Please continue to next page

Trial Number:	Initials: *First, Middle, Last*

Opioid 3

Drug:	Dose:	Dose unit: *tick as applicable*	Route *tick as applicable*
		◯ mg ◯ mcg ◯ mcg/hour	◯ Oral ◯ IV ◯ PCA ◯ Topical

Please confirm all analgesia section data items were considered and all analgesia used have been ticked and recorded? ◯ No ◯ Yes

Section 4 - Return to theatre

Did the patient return to theatre? *If yes please complete below* ◯ No ◯ Yes

Bronchoscopy	Redo thoracotomy	Other
◯ No ◯ Yes	◯ No ◯ Yes	◯ No ◯ Yes

If other, please specify

Section 5 - Form Completion

Completed By (Name)	Signed	PI Confirmation Signature
Date Completed: D D - M M M - Y Y Y Y	**PI name**	**Date Completed** D D - M M M - Y Y Y Y