

Intervention Form

This covers the perioperative period from premedication until the patient leaves recovery

Section 1 - Participant Details

Trial Number:     Initials: *First, Middle, Last*    Site: \_\_\_\_\_

Section 2 - Operative Details

Date of thoracotomy:   D  D   -   M  M  M   -   Y  Y  Y  Y   Time anaesthetist first meets patient in theatre complex (e.g. to site iv access / perform regional blockade) *In 24 hour format*

Time of Knife to skin *In 24 hour format*     Time left theatre *In 24 hour format*

Time left recovery *In 24 hour format*

Section 3 - Analgesia

Were any of the following analgesics given from pre-medication to recovery including intra-operatively?  No  Yes

'Premedication' refers to all analgesics prescribed by the anaesthetic / surgical team administered prior to theatre (the night before or day of surgery)

Analgesia	
	Used (tick if applicable)
Paracetamol	<input type="checkbox"/>
NSAIDS e.g. diclofenac, ketorolac	<input type="checkbox"/>
Codeine	<input type="checkbox"/>
Tramadol	<input type="checkbox"/>
Remifentanyl	<input type="checkbox"/>
Alfentanil	<input type="checkbox"/>
IV Fentanyl (including PCA, <i>provide dose below</i> )	<input type="checkbox"/>
IV Morphine (including PCA, <i>provide dose below</i> )	<input type="checkbox"/>
IV Diamorphine (including PCA, <i>provide dose below</i> )	<input type="checkbox"/>
IV Oxycodone (including PCA, <i>provide dose below</i> )	<input type="checkbox"/>
Oral Oxycodone ( <i>provide dose below</i> )	<input type="checkbox"/>
Oral Morphine ( <i>provide dose below</i> )	<input type="checkbox"/>
Topical Fentanyl ( <i>provide dose below</i> )	<input type="checkbox"/>
Pre-Gabalin	<input type="checkbox"/>
Gabapentin	<input type="checkbox"/>
Ketamine	<input type="checkbox"/>
Other	<input type="checkbox"/>

Please specify other(s) \_\_\_\_\_

Please provide total dose given from premedication until the patient leaves recovery

Total IV fentanyl dose (including PCA) <i>if applicable</i> _____ . ____ mcg	Total IV morphine dose (including PCA) <i>if applicable</i> _____ . ____ mg
Total IV diamorphine dose (including PCA) <i>if applicable</i> _____ . ____ mg	Total IV oxycodone dose (including PCA) <i>If applicable</i> _____ . ____ mg

Please continue to next page

Trial Number: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Initials: <i>First, Middle, Last</i> <input type="text"/> <input type="text"/> <input type="text"/>
Total oral oxycodone dose <i>if applicable</i> _____ . ____ mg	Total oral morphine dose <i>if applicable</i> _____ . ____ mg
Total topical fentanyl dose <i>if applicable</i> _____ . ____ mcg/hour	
Please confirm all the analgesia section data items have been considered and all analgesia used has been ticked and recorded? <input type="radio"/> No <input type="radio"/> Yes	

## Section 4 - Intraoperative monitoring

Were any of the following sited pre-/intra-operatively? <i>If yes please indicate below</i> <input type="radio"/> No <input type="radio"/> Yes		
Central line: <input type="radio"/> No <input type="radio"/> Yes	Urinary catheter: <input type="radio"/> No <input type="radio"/> Yes	Arterial line: <input type="radio"/> No <input type="radio"/> Yes

## Section 5 - Analgesic Intervention

Name of anaesthetist who performed intervention:	
Analgesic intervention given:	<input type="radio"/> TEB <input type="radio"/> PVB <input type="radio"/> None <input type="radio"/> Other
If other, please specify _____	
Was the intervention allocated at randomisation given? <input type="radio"/> No <input type="radio"/> Yes	
If no provide reason _____	
Was local anaesthetic delivered pre-knife to skin? <input type="radio"/> No <input type="radio"/> Yes	
If no provide reason _____	

**Please note, delivery of local anaesthetic pre-knife to skin is mandatory**

## Difficulties and complications with block

Any difficulties during performance of analgesic intervention? <i>If yes please complete the section below</i> <input type="radio"/> No <input type="radio"/> Yes	
Insertion difficulty encountered: <i>Please tick if occurred</i>	
<input type="radio"/> Bony obstruction <input type="radio"/> Difficulty in positioning <input type="radio"/> Multiple attempts at insertion <input type="radio"/> Vascular puncture <input type="radio"/> Dural puncture <input type="radio"/> Other	
Other, please specify _____	
Please confirm all the above difficulties have been considered and only those ticked occurred? <input type="radio"/> No <input type="radio"/> Yes	
Were any immediate complications encountered? <i>If yes please complete section below</i> <input type="radio"/> No <input type="radio"/> Yes	
Complication(s) encountered: <i>Please tick if occurred</i>	
<input type="radio"/> Intravascular injection <input type="radio"/> Cardiovascular effect e.g. hypotension, bradycardia, ECG changes <input type="radio"/> Signs of local anaesthetic toxicity <input type="radio"/> Pneumothorax <input type="radio"/> High Block <input type="radio"/> Other	
Other, please specify _____	
Please confirm all the above complications have been considered and only those ticked occurred? <input type="radio"/> No <input type="radio"/> Yes	
Was block re-siting required at any time prior to leaving recovery? <i>if yes complete the below</i> <input type="radio"/> No <input type="radio"/> Yes	
What was the re-sited block? <input type="radio"/> TEB <input type="radio"/> PVB <input type="radio"/> Other	If other, please specify _____

**If PVB given go to page 3, if TEB given go to page 5**

Trial Number: <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/>	Initials: <i>First, Middle, Last</i> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/>
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**Section 6 - PVB Details - ONLY COMPLETE IF PATIENT HAD PVB**

Level of single shot PVB Pre-op: T <input style="width:20px; height:20px;" type="text"/> T <input style="width:20px; height:20px;" type="text"/> T <input style="width:20px; height:20px;" type="text"/>	Technique used: <input type="radio"/> Ultrasound guided <input type="radio"/> Landmark technique
Were catheters subsequently placed by surgeon? <input type="radio"/> No <input type="radio"/> Yes	If no provide reason _____
Level of insertion of PVB Catheter: T <input style="width:20px; height:20px;" type="text"/>	

**Please note, catheter placement by surgeon is mandatory**

**Section 7 - Local Analgesia for PVB- ONLY COMPLETE IF PATIENT HAD PVB**

This section covers all local anaesthesia administered peri-operatively until the patient leaves recovery

**Single Shot Injections**

Were three single shot injections given? <input type="radio"/> No <input type="radio"/> Yes	If no provide reason _____
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**Please note, three single shot injections are mandatory**

Please indicate local anaesthetic given: <input type="radio"/> Bupivacaine <input type="radio"/> Levobupivacaine <input type="radio"/> Ropivacaine	
Concentration: ____ . ____ %	Total volume: ____ . ____ ml
Please indicate opioid added: <input type="radio"/> Fentanyl <input type="radio"/> Morphine <input type="radio"/> Diamorphine <input type="radio"/> None	
Total dose: ____ . ____	Dose unit: <input type="radio"/> mg <input type="radio"/> mcg

**Loading Paravertebral Catheters**

Did loading paravertebral catheters occur? <input type="radio"/> No <input type="radio"/> Yes	
Please indicate local anaesthetic given: <input type="radio"/> Bupivacaine <input type="radio"/> Levobupivacaine <input type="radio"/> Ropivacaine	
Concentration: ____ . ____ %	Total volume: ____ . ____ ml
Please indicate opioid added: <input type="radio"/> Fentanyl <input type="radio"/> Morphine <input type="radio"/> Diamorphine <input type="radio"/> None	
Total dose: ____ . ____	Dose unit: <input type="radio"/> mg <input type="radio"/> mcg

**Analgesic Infusion During And After Surgery**

Local Anaesthetic Agent <input type="radio"/> Bupivacaine <input type="radio"/> Levobupivacaine <input type="radio"/> Ropivacaine <input type="radio"/> None	
Local anaesthetic concentration: ____ . ____ %	Rate of infusion: <i>If rate varies provide rate on leaving recovery</i> ____ ml/hr
Please indicate opioid added: <input type="radio"/> Fentanyl <input type="radio"/> Morphine <input type="radio"/> Diamorphine <input type="radio"/> None	
Opioid Concentration: ____ . ____	Dose unit: <input type="radio"/> mcg/ml <input type="radio"/> mg/ml

**Top-ups**

Any further top-ups given beyond above? <i>if yes, complete table below</i> <input type="radio"/> No <input type="radio"/> Yes
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**Please provide the total cumulative dose of local anaesthetic and opioid used to top-up local anaesthetic block. These are additional to single shot injections and loading catheters**

**Note: If different strengths of the same local anaesthetic used, please average to derive a total dose e.g. 5ml 0.25% and 5ml 0.5% = 10ml 0.375%**

Local Anaesthetic Top up			
	Used	Concentration	Total cumulative volume
Bupivacaine	<input style="width:20px; height:20px;" type="text"/>	____ . ____ %	____ . ____ ml
Levobupivacaine	<input style="width:20px; height:20px;" type="text"/>	____ . ____ %	____ . ____ ml
Ropivacaine	<input style="width:20px; height:20px;" type="text"/>	____ . ____ %	____ . ____ ml

**Please continue to next page**

Trial Number: <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	Initials: <i>First, Middle, Last</i> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
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Any further opioid given via top-up? *If yes complete table below*

 No  Yes

Opioid Top up		
	Used	Dose
Fentanyl	<input style="width: 20px; height: 20px;" type="text"/>	_____.__ mcg
Morphine	<input style="width: 20px; height: 20px;" type="text"/>	_____.__ mg
Diamorphine	<input style="width: 20px; height: 20px;" type="text"/>	_____.__ mg

Please confirm all top up section data items have been considered and all those given have been recorded?
 
 No  Yes

Trial Number: <input style="width:40px" type="text"/> <input style="width:40px" type="text"/> <input style="width:40px" type="text"/>	Initials <i>First, Middle, Last</i> <input style="width:40px" type="text"/> <input style="width:40px" type="text"/>
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**Section 8 - TEB Details - ONLY COMPLETE IF PATIENT HAD TEB**

Level of insertion TEB: T

**NOTE:** please record as higher level of inter-vertebral space e.g. T4/5 insertion level should be recorded as T4

**Section 9 - Local analgesia for TEB - ONLY COMPLETE IF PATIENT HAD TEB**

This section covers all local anaesthesia administered peri-operatively until the patient leaves recovery

**Loading bolus (please do not include test dose)**

Was a loading bolus given?  No  Yes

Please indicate local anaesthetic given: 
 Bupivacaine  Levobupivacaine  Ropivacaine

Concentration: <input style="width:40px" type="text"/> . <input style="width:40px" type="text"/> %	Total volume: <input style="width:40px" type="text"/> . <input style="width:40px" type="text"/> ml
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Please indicate opioid added: *please tick if applicable* 
 Fentanyl  Morphine  Diamorphine  None

Total dose: <input style="width:40px" type="text"/> . <input style="width:40px" type="text"/>	Dose unit: <span style="float:right"> <input type="radio"/> mg <input type="radio"/> mcg         </span>
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**Analgesic Infusion During And After Surgery**

Local Anaesthetic Agent 
 Bupivacaine  Levobupivacaine  Ropivacaine  None

Local anaesthetic concentration: <input style="width:40px" type="text"/> . <input style="width:40px" type="text"/> %	Rate of infusion: <i>If rate varies provide rate on leaving recovery</i> <input style="width:40px" type="text"/> ml/hr
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Please indicate opioid added: 
 Fentanyl  Morphine  Diamorphine  None

Opioid Concentration: <input style="width:40px" type="text"/> . <input style="width:40px" type="text"/>	Dose unit: <span style="float:right"> <input type="radio"/> mcg/ml <input type="radio"/> mg/ml         </span>
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**Top-ups**

Any further top-ups given beyond above? *if yes, complete table below* 
 No  Yes

**Please provide the total cumulative dose of local anaesthetic and opioid used to top-up local anaesthetic block. These are additional to loading bolus**

**Note:** If different strengths of the same local anaesthetic used, please average to derive a total dose e.g. 5ml 0.25% and 5ml 0.5% = 10ml 0.375%

Local Anaesthetic Top up			
	Used	Concentration:	Total cumulative volume
Bupivacaine	<input style="width:40px" type="text"/>	<input style="width:40px" type="text"/> . <input style="width:40px" type="text"/> %	<input style="width:40px" type="text"/> . <input style="width:40px" type="text"/> ml
Levobupivacaine	<input style="width:40px" type="text"/>	<input style="width:40px" type="text"/> . <input style="width:40px" type="text"/> %	<input style="width:40px" type="text"/> . <input style="width:40px" type="text"/> ml
Ropivacaine	<input style="width:40px" type="text"/>	<input style="width:40px" type="text"/> . <input style="width:40px" type="text"/> %	<input style="width:40px" type="text"/> . <input style="width:40px" type="text"/> ml

Any further opioid given via top-up? *if yes complete table below* 
 No  Yes

Opioid Top up		
	Used	Dose
Fentanyl	<input style="width:40px" type="text"/>	<input style="width:40px" type="text"/> . <input style="width:40px" type="text"/> mcg
Morphine	<input style="width:40px" type="text"/>	<input style="width:40px" type="text"/> . <input style="width:40px" type="text"/> mg
Diamorphine	<input style="width:40px" type="text"/>	<input style="width:40px" type="text"/> . <input style="width:40px" type="text"/> mg

Please confirm all top up section data items have been considered and all those given have been recorded? 
 No  Yes

Section 10 - Form Completion

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