

**LSU Health Sciences Center-Shreveport  
Radiation Oncology/Gamma Knife  
Proc. 19.13.5**

**Nursing Assessment**

**Policy:**

To define the role of the nurse in performing patient assessment and documentation of assessments.

**Procedure:**

1. Pre-op is done prior to procedure in Ambulatory Care Clinic. All labs, EKG, and History and Physical are obtained during pre-op. Neurosurgeon or resident obtains consent. MRI Questionnaire is filled out by the Gamma Knife Nurse the day of pre-op.
2. The form titled "23-Hour Observation/ Day Surgery Assessment"(S/N 1414) is a pre-op/pre-admit assessment. It will be performed and recorded on each patient by the Gamma Knife nurse and kept in hospital chart. It is initiated on the day before procedure; signed and completed the day of procedure.
3. Gamma Knife Nurse to complete Medication Assessment History Form. This is initiated on pre-op and completed and signed the day of procedure by the Gamma Knife Nurse. Original copy of this form is to be placed in hospital chart. If the patient is sent to the floor, the nurses on floor will give patient a copy upon discharge. If the patient is discharged from the Gamma Knife Unit, the Gamma Knife Nurse will give patient a copy.
4. Patient Sedation Monitoring Record (S/N 1021) will be initiated by the Gamma Knife RN, and completed by RN upon discharge. This record will be maintained in patient's hospital record.
5. All medication given will be documented on the Downtime Medication Administration Record (S/N 1287) form the day of procedure. This form is to be placed in hospital chart.
6. Education is given to patient on day of pre-op and day of procedure and day of procedure before medication is administered. Education is documented on hospital education form by Gamma Knife nurse.
7. Post-Operative Instructions are given to Gamma Knife patient after completion of the Gamma Knife procedure. They are to be given upon discharge whether by the floor, or by Gamma Knife nurse.

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