

**Biospecimen Pre-Analytical Variables (BPV)
 Ovary Surgery/Anesthesia Form**

PR-0006-F5

VER. 03.00

Effective Date: 03/11/2013

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Affix BPV Case ID Label

Tissue Bank ID: _____

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Date Form Was Completed:

___/___/_____
 MM/DD/YYYY

Pre-operative Medications Administration (Record medications administered in the holding area prior to patient entering the operating room. If additional space is required, record any additional pre-operative medications administered in #6 below.)

1	Date of Surgery	___/___/_____ MM/DD/YYYY		
2	Pre-operative IV Sedation Administered	<input type="radio"/> Yes <input type="radio"/> No		
		<input type="checkbox"/> Diazepam	Dose: _____ Unit: _____ Time: ___ : ___ (HH:MM)	Select all that apply.
		<input type="checkbox"/> Lorazepam	Dose: _____ Unit: _____ Time: ___ : ___ (HH:MM)	
		<input type="checkbox"/> Midazolam	Dose: _____ Unit: _____ Time: ___ : ___ (HH:MM)	
		<input type="checkbox"/> Other IV Sedation (specify)	Dose: _____ Unit: _____ Time: ___ : ___ (HH:MM)	

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3	Pre-operative IV Opiates Administered	O Yes O No		Select all that apply.
		<input type="checkbox"/> Fentanyl	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	
		<input type="checkbox"/> Hydromorphone	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	
		<input type="checkbox"/> Meperidine	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	
		<input type="checkbox"/> Morphine	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	
		<input type="checkbox"/> Other IV Opiates (specify)	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	
4	Pre-operative IV Antiemetics Administered	O Yes O No		Select all that apply.
		<input type="checkbox"/> Droperidol	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	
		<input type="checkbox"/> Ondansetron	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	
		<input type="checkbox"/> Other IV Antiemetic (specify)	Dose: _____ Unit: _____ Time: ____ : ____	

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			(HH:MM)	
5	Pre-operative IV Anti-acids Administered	<input type="radio"/> Yes <input type="radio"/> No		
		<input type="checkbox"/> Ranitidine	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	Select all that apply.
		<input type="checkbox"/> Other Anti-acid (specify)	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	
6	Other Pre-operative IV Medications Administered	<input type="radio"/> Yes <input type="radio"/> No		
		<input type="checkbox"/> Other Pre-op Medication (specify)	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	Record additional IV medications administered pre-operatively.
		<input type="checkbox"/> Other Pre-op Medication (specify)	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	
		<input type="checkbox"/> Other Pre-op medication (specify)	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	

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Type of Anesthesia Administered (PLEASE RECORD ONLY ANESTHESIA AGENTS ADMINISTERED PRIOR TO REMOVAL OF THE ORGAN. If additional space is required, record any additional anesthesia agents administered in #14 below.)

7	Local Anesthesia Agents Administered	<input type="radio"/> Yes <input type="radio"/> No		
		<input type="checkbox"/> Lidocaine	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	Select all that apply.
		<input type="checkbox"/> Procaine	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	
		<input type="checkbox"/> Other Local Anesthetic (specify)	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	
8	Regional (Spinal/Epidural) Anesthesia Agents Administered	<input type="radio"/> Yes <input type="radio"/> No		
		<input type="checkbox"/> Bupivacaine	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	Select all that apply.
		<input type="checkbox"/> Lidocaine	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	
		<input type="checkbox"/> Other Spinal/Regional Anesthetic (specify)	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	

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9	IV Anesthesia Agents Administered	<input type="radio"/> Yes <input type="radio"/> No	
	<input type="checkbox"/> Brevital	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	Select all that apply.
	<input type="checkbox"/> Etomidate	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	
	<input type="checkbox"/> Ketamine	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	
	<input type="checkbox"/> Propofol	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	
	<input type="checkbox"/> Sodium Thiopental	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	
	<input type="checkbox"/> Other IV Anesthesia Agents (specify)	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	
10	IV Narcotic/Opiate Agents Administered	<input type="radio"/> Yes <input type="radio"/> No	
	<input type="checkbox"/> Fentanyl	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	Select all that apply.

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		<input type="checkbox"/> Hydromorphone	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	
		<input type="checkbox"/> Meperidine	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	
		<input type="checkbox"/> Morphine	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	
		<input type="checkbox"/> Other Narcotics/Opiates (specify)	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	
11	IV Muscle Relaxants Administered	<input type="radio"/> Yes <input type="radio"/> No		
		<input type="checkbox"/> Pancuronium	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	Select all that apply. Please use the supplemental page at the end of this form when more than one dose/time is administered.
		<input type="checkbox"/> Suxamethonium chloride	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	
		<input type="checkbox"/> Vecuronium	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	

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		<input type="checkbox"/> Other Muscle Relaxants (specify)	Dose: _____ Unit: _____ Time: ____:____ (HH:MM)	
12	Inhalation Anesthesia Agents Administered	<input type="radio"/> Yes <input type="radio"/> No		
		<input type="checkbox"/> Isoflurane	Dose: _____ Unit: _____ Time: ____:____ (HH:MM)	Select all that apply. Specify other inhalation anesthesia agents administered prior to removal of the ovary.
		<input type="checkbox"/> Nitrous Oxide	Dose: _____ Unit: _____ Time: ____:____ (HH:MM)	
		<input type="checkbox"/> Other Inhalation Anesthesia Agents (specify)	Dose: _____ Unit: _____ Time: ____:____ (HH:MM)	

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13	Additional Anesthesia Agents Used	O Yes O No		Record any additional anesthesia agents administered prior to removal of the ovary.
		<input type="checkbox"/> Other (specify)	Dose: _____ Unit: _____ Time: ____:____ (HH:MM)	
	<input type="checkbox"/> Other (specify)	Dose: _____ Unit: _____ Time: ____:____ (HH:MM)		
	<input type="checkbox"/> Other (specify)	Dose: _____ Unit: _____ Time: ____:____ (HH:MM)		

Surgery Information (Indicate whether any of the following medications were administered during surgery.)

14	Other Medications Administered During Surgery Prior to Removal of the Organ	Was insulin administered during surgery?	Dose: _____ Unit: _____ Time: ____:____ (HH:MM)	Please use the supplemental page at the end of this form if you require additional space.
		<input type="radio"/> Yes <input type="radio"/> No If Yes, enter dose and time → <input type="checkbox"/> Specify insulin:	Dose: _____ Unit: _____ Time: ____:____ (HH:MM)	
	Were steroids administered during surgery?	Dose: _____ Unit: _____ Time: ____:____ (HH:MM)		

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	<input type="radio"/> Yes <input type="radio"/> No If Yes, enter dose and time → <input type="checkbox"/> Specify steroid(s):	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	
	Were antibiotics administered during surgery? <input type="radio"/> Yes <input type="radio"/> No If Yes, enter dose and time → <input type="checkbox"/> Specify antibiotic(s):	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	
	Were other medications administered during surgery? <input type="radio"/> Yes <input type="radio"/> No If Yes, enter dose and time → <input type="checkbox"/> Specify other medication(s):	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	
	(This row is merged with the previous one in the original form)	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)	

Surgical Procedure Details

15	Time of First Incision	____ : ____ (HH:MM)	
16	Surgical Procedure	Select One: <input type="radio"/> Hysterectomy with bilateral salpingo-oophorectomy <input type="radio"/> Hysterectomy with left salpingo-oophorectomy <input type="radio"/> Hysterectomy with right salpingo-oophorectomy <input type="radio"/> Oophorectomy, bilateral <input type="radio"/> Oophorectomy, left <input type="radio"/> Oophorectomy, right <input type="radio"/> Pelvic exenteration <input type="radio"/> Pelvic mass excision <input type="radio"/> Salpingo-oophorectomy, bilateral <input type="radio"/> Salpingo-oophorectomy, left <input type="radio"/> Salpingo-oophorectomy, right <input type="radio"/> Other (specify) – Specify other procedure:	Surgical procedure performed.

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	Surgical Method Performed	Select One: <input type="radio"/> Abdominal <input type="radio"/> Vaginal <input type="radio"/> Laparoscopic <input type="radio"/> Laparoscopically Assisted Vaginal Hysterectomy <input type="radio"/> Supracervical <input type="radio"/> Robotic <input type="radio"/> Other (specify) - Specify other method:	Surgical method by which ovary was removed.
17	Time of First Clamp	____:____ (HH:MM)	Time first clamp was applied.
18	Time of Second Clamp	____:____ (HH:MM)	Time second clamp was applied.
19	Time of Organ Resection	____:____ (HH:MM)	Time organ was resected.
20	In Vivo Intra-operative Ischemic Period (minutes)	____ (minutes)	Elapsed time from first application of first clamp to organ resection.
Patient's Vital Signs (PRIOR TO EXCISION OF ORGAN)			
21	Describe BP excursions from time of anesthesia induction to 15 minutes post.		Note duration of variances of greater than 20 mmHg from patient's pre-operative baseline during first 15 minutes

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				after anesthesia induction.
22	Describe BP excursions from 15 minutes post anesthesia induction to organ excision.			Note duration of variances of greater than 20 mmHg from patient's pre-operative baseline from 15 minutes post anesthesia induction to organ excision.
23	Temperature	First patient temperature recorded in OR _____ °F or °C (Circle temperature scale)	Time of first temperature ____:____ (HH:MM)	
		Second patient temperature recorded in OR _____ °F or °C (Circle temperature scale)	Time of second temperature ____:____ (HH:MM)	
24	Describe Epochs of Oxygen (O ₂) desaturation of <92% for >5 minutes prior to organ excision			
25	Carbon Dioxide level (CO ₂) recorded at time closest to organ excision			

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Intra-operative Blood Product Administration

26a	Albumin	_____ (ml)
26b	Packed Red Blood Cells	_____ (# units)
26c	Platelets	_____ (ml)
26d	Fresh Frozen Plasma	_____ (# units)

Patient Fluid Output

27	Blood Loss	_____ (ml)	At what point was blood loss recorded? Select one: <input type="radio"/> Prior to organ excision <input type="radio"/> End of surgery	Intra-operative blood loss.
28	Urine Volume Excreted	_____ (ml)	At what point was urine output recorded? Select one: <input type="radio"/> Prior to organ excision <input type="radio"/> End of surgery	Urine volume excreted.
29	Record Pelvic Washing Collection?	Select One <input type="radio"/> Yes _____ (ml) <input type="radio"/> No		
30	Was Ascites Fluid Collected?	Select One <input type="radio"/> Yes _____ (ml) <input type="radio"/> No		

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Additional Information:			
31	Duration of Fasting Prior to Surgery	_____ (hours)	
32	Describe Pre-operative Bowel Preparation Prior to Surgery		
33	Other Notable Events During Surgery		Unusual events or extreme variations from usual procedure.
34	Time Specimen Left OR	____:____ (HH:MM)	

Supplemental Medication Administration		
Additional Pre-operative Medications Administered:	Medication	Dose and Time
Notes:		Dose: _____ Unit: _____ Time: ____:____ (HH:MM)
		Dose: _____ Unit: _____ Time: ____:____ (HH:MM)

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	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)
	Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)

Additional Anesthesia Agents Administered:	Anesthesia Agents	Dose and Time
Notes:		Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)
		Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)
		Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)
		Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)

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Additional Intra-operative Medications Administered:	Medications	Date and Time
Notes:		Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)
		Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)
		Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)
		Dose: _____ Unit: _____ Time: ____ : ____ (HH:MM)