

Ambulatory Surgery or Procedure GRG

GRG: PG-AS (ISC GRG)

MCG Health

General Recovery Care

30th Edition

Ambulatory Surgery Case

Management GRG  GRG

Note: An appropriate Optimal Recovery Guideline (ORG) should be identified and used whenever possible. This General Recovery Guideline (GRG) is intended to aid only in situations in which no ORG appears applicable.

- Care Planning - Inpatient Admission and Alternatives
 - Clinical Indications for Procedure
 - Alternatives to Procedure
 - Operative Status Criteria
- Hospitalization
 - General Recovery Course
 - Benchmark Length of Stay - Ambulatory
 - Discharge Criteria
- Case Management
- Discharge Destination
- Evidence Summary
 - Criteria
- References
- Footnotes
- Definitions

Care Planning - Inpatient Admission and Alternatives

Clinical Indications for Procedure

- Potentially ambulatory^[A] surgery or procedure covered by this guideline (ie, not covered more specifically by another guideline)^[B] may proceed on an ambulatory^[A] basis due to the absence of Ambulatory Surgery Exception Criteria  GRG, as indicated by **ALL** of the following(1)(2)(3)(4)(5)(6)(7)(8):
 - ☐ No inpatient care needed for clinically significant disease or condition identified preoperatively; examples include:
 - Severe infection
 - Altered mental status
 - Dangerous arrhythmia
 - Hypotension
 - Hypoxemia

- Complex surgical approach or situation not anticipated (eg, prolonged airway monitoring due to severe obstructive sleep apnea)(9)(10)
- ☐ Low-risk[C] procedure or patient not identified preoperatively as high anesthetic risk; examples include (examples of elements that can denote high anesthetic risk)[D](3)(11)(12)(13):
 - American Society of Anesthesiologists class IV or greater American Society of Anesthesiologists (ASA) Physical Status Classification System
 - Severe frailty[E](15)(16)
 - Severe valvular disease (eg, severe aortic stenosis)
 - Symptomatic coronary artery disease or heart failure
 - Symptomatic chronic lung disease (eg, COPD, chronic lung disease of prematurity)
 - Severe renal disease (eg, GFR less than 30 mL/min/1.73m² (0.5 mL/sec/1.73m²) or on dialysis)  eGFR - Adult Calculator
 -  eGFR - Pediatric Calculator requiring prolonged monitoring of electrolytes, fluid status, anesthetic recovery, or respiratory status
 - Morbid obesity (eg, BMI greater than 40  BMI Calculator) with hemodynamic or respiratory problems (eg, severe obstructive sleep apnea, hypoventilation)(9)(17)(18)(19)(20)
 - Complex chronic condition in children (eg, ventilator-dependent, neuromuscular, genetic, or immunologic disease)(21)(22)
- ☐ No drug-related risk identified preoperatively; examples include(2)(23):
 - Procedure requires discontinuing medication (eg, antiarrhythmic medication, antiseizure or anticoagulant medication), which necessitates preoperative or prolonged postoperative inpatient monitoring or treatment.[F](24)(25)(26)
 - Preoperative use of drugs that may interact with anesthetic (eg, cocaine, amphetamines, monoamine oxidase inhibitor) such that prolonged postoperative monitoring or treatment is needed
- ☐ No inadequate outpatient care situation; examples include(27)(28)(29):
 - Patient lives remote from medical facility and procedure has urgent complication potential, and temporary nearby residence cannot be arranged.
 - Patient will have postprocedure incapacitation (eg, self-management needs) and has inadequate assistance at home, and alternative level of care cannot be arranged.

Alternatives to Procedure

- Alternatives include(30):
 - Drug therapy for underlying issue (eg, antianginal agents for ischemia or COPD medication)(31)(32)
 - Physical therapy (eg, exercise programs and muscle strengthening for joint or pain problems)
 - Alterations in lifestyle (eg, changing level of physical activity, dietary changes, cane use)
 - Pain management(33)
 - Percutaneous injections (eg, analgesic injections or infusions for pain, steroid injections as alternative to joint or disk surgery)
 - Chemotherapy, radiation therapy, or palliative therapy(34)
 - External support, such as bracing, orthoses, or casting instead of operative repair

Operative Status Criteria

- Ambulatory

Hospitalization

General Recovery Course

Stage	Level of Care	Clinical Status
1	- Emergency department, procedure room, or OR to recovery area[G] - Social Determinants of Health Assessment - Discharge planning - Floor to discharge	Procedure completed Physiologic recovery Stable vital signs Patient alert Temperature appropriate Activity level appropriate Operative site appropriate Postoperative effects resolved or managed Voiding status acceptable Competent person available to accompany patient (if required) No complicating features

(1)(2)(6)(7)(13)(27)(28)

Recovery Milestones are indicated in **bold**.

Benchmark Length of Stay (BLOS): Ambulatory

Discharge Criteria

- Inpatient stay may be needed unless **ALL** of the following are present(1)(2)(28)(35):
 - ☐ Physiologic recovery: cardiovascular, respiratory, and hemodynamic status normal or near preoperative baseline(1)(36)(37)
 - ☐ Stable vital signs: systemic blood pressure and pulse within 20% of the preanesthetic level or appropriate for next level of care(1)(37)
 - ☐ Patient alert (at baseline mental status)(1)(37)
 - ☐ Temperature appropriate: patient afebrile or temperature appropriate for next level of care(38)(39)
 - ☐ Activity level appropriate: ambulatory or appropriate activity level post procedure[H](1)(37)
 - ☐ Operative site appropriate, as indicated by **ALL** of the following(1):
 - Surgical site is dry or as expected for procedure.
 - Bleeding is absent or as expected for procedure.
 - ☐ Postoperative effects resolved or managed, as indicated by **ALL** of the following(1)(2)(36):
 - Pain: absent or managed and appropriate for next level of care
 - Nausea and vomiting: absent or adequately treated and appropriate for next level of care
 - Headache, dizziness, or drowsiness: absent or mild and appropriate for next level of care
 - ☐ Voiding status acceptable, as indicated by **1 or more** of the following(1):
 - Voiding spontaneously
 - Urinary catheter in place and instructions given for follow-up
 - No voiding, but instructions given (eg, return to care if not voiding within 12 hours)
 - ☐ Competent person available to accompany patient (if required) and stay with patient on first postoperative night at next level of care(1)

- ☐ No complicating features requiring inpatient care; examples include(36)(38)(40):
- Severe complications of procedure (eg, bowel injury, airway compromise, vascular injury, hemorrhage)
 - Extensive (eg, dissection far beyond usual scope of procedure) or prolonged (eg, surgery length significantly beyond that expected) surgery performed requiring inpatient postoperative care
 - Conversion to open or complex procedure that requires inpatient care (eg, open vs laparoscopic cholecystectomy, abdominal vs vaginal hysterectomy)
 - Comorbid condition or test result identified during or after procedure that requires inpatient care (eg, severe infection, compartment syndrome)
 - Severe complications of anesthesia (eg, postepidural puncture headache, malignant hyperthermia)

Case Management

See Ambulatory Surgery Case Management GRG [GRG](#) for further information.

Discharge Destination

- Post-hospital levels of admission may include:
 - Home.
 - Home healthcare. See Ambulatory Surgery Home Care GRG [HC](#) for further information.

Evidence Summary

Criteria

The evidence for the clinical indications found in this guideline includes 21 published peer reviewed articles, 4 specialty society or other evidence-based guidelines, and 3 book sections.

References

1. Hyman JB, Goren O, Wilson SH, Philip B. Ambulatory (outpatient) anesthesia. In: Gropper MA, et al., editors. Miller's Anesthesia. 10th ed. Elsevier; 2025:2149-2184.e12. [Context Link 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11]
2. Hernandez A, Sherwood ER. Anesthesiology principles, pain management, and conscious sedation. In: Townsend CM, Beauchamp RD, Evers BM, Mattox KL, editors. Sabiston Textbook of Surgery. 21st ed. Elsevier; 2022:315-348. [Context Link 1, 2, 3, 4, 5]
3. Zaydfudim VM, Hu Y, Adams RB. Principles of preoperative and operative surgery. In: Townsend CM, Beauchamp RD, Evers BM, Mattox KL, editors. Sabiston Textbook of Surgery. 21st ed. Elsevier; 2022:187-222. [Context Link 1, 2, 3, 4, 5, 6]
4. Bilimoria KY, et al. Development and evaluation of the universal ACS NSQIP surgical risk calculator: a decision aid and informed consent tool for patients and surgeons. Journal of the American College of Surgeons 2013;217(5):833-842.e1-e3. DOI: 10.1016/j.jamcollsurg.2013.07.385. [Context Link 1, 2, 3] View abstract...
5. Thompson A, et al. 2024 AHA/ACC/ACS/ASNC/HRS/SCA/SCCT/SCMR/SVM guideline for perioperative cardiovascular management for noncardiac surgery: a report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. Circulation 2024;Online. DOI: 10.1161/CIR.0000000000001285. (Reaffirmed 2025 Mar) [Context Link 1] View abstract...
6. Ianchulev T, Litoff D, Ellinger D, Stiverson K, Packer M. Office-based cataract surgery: population health outcomes study of more than 21 000 cases in the United States. Ophthalmology 2016;123(4):723-728. DOI: 10.1016/j.ophtha.2015.12.020. [Context Link 1, 2] View abstract...
7. Bailey CR, et al. Guidelines for day-case surgery 2019: guidelines from the Association of Anaesthetists and the British Association of Day Surgery. Anaesthesia 2019;74(6):778-792. DOI: 10.1111/anae.14639. [Context Link 1, 2] View abstract...

8. Pang G, Kwong M, Schlachta CM, Alkhamesi NA, Hawel JD, Elnahas AI. Safety of same-day discharge in high-risk patients undergoing ambulatory general surgery. *Journal of Surgical Research* 2021;263:71-77. DOI: 10.1016/j.jss.2021.01.024. [Context Link 1] View abstract...
9. American Society of Anesthesiologists Task Force on Perioperative Management of patients with obstructive sleep apnea. Practice guidelines for the perioperative management of patients with obstructive sleep apnea: an updated report by the American Society of Anesthesiologists Task Force on Perioperative Management of patients with obstructive sleep apnea. *Anesthesiology* 2014;120(2):268-286. DOI: 10.1097/ALN.000000000000053. (Reaffirmed 2025 Jun) [Context Link 1, 2] View abstract...
10. Apfelbaum JL, et al. 2022 American Society of Anesthesiologists practice guidelines for management of the difficult airway. *Anesthesiology* 2022;136(1):31-81. DOI: 10.1097/ALN.0000000000004002. [Context Link 1] View abstract...
11. Walsh MT. Improving outcomes in ambulatory anesthesia by identifying high risk patients. *Current Opinion in Anaesthesiology* 2018;31(6):659-666. DOI: 10.1097/ACO.0000000000000653. [Context Link 1] View abstract...
12. Sweitzer B, Rajan N, Schell D, Gayer S, Eckert S, Joshi GP. Preoperative care for cataract surgery: the Society for Ambulatory Anesthesia position statement. *Anesthesia and Analgesia* 2021;133(6):1431-1436. DOI: 10.1213/ANE.0000000000005652. [Context Link 1] View abstract...
13. Rajan N. The high-risk patient for ambulatory surgery. *Current Opinion in Anaesthesiology* 2020;33(6):724-731. DOI: 10.1097/ACO.0000000000000919. [Context Link 1, 2] View abstract...
14. Varley PR, et al. Clinical utility of the risk analysis index as a prospective frailty screening tool within a multi-practice, multi-hospital integrated healthcare system. *Annals of Surgery* 2021;274(6):e1230-e1237. DOI: 10.1097/SLA.0000000000003808. [Context Link 1] View abstract...
15. Rothenberg KA, et al. Association of frailty and postoperative complications with unplanned readmissions after elective outpatient surgery. *JAMA Network Open* 2019;2(5):e194330. DOI: 10.1001/jamanetworkopen.2019.4330. [Context Link 1] View abstract...
16. Charipova K, Urits I, Viswanath O, Urman RD. Preoperative assessment and optimization of cognitive dysfunction and frailty in the ambulatory surgical patient. *Current Opinion in Anaesthesiology* 2020;33(6):732-739. DOI: 10.1097/ACO.0000000000000901. [Context Link 1] View abstract...
17. Hajmohamed S, Patel D, Apruzzese P, Kendall MC, De Oliveira G. Early postoperative outcomes of super morbid obese compared to morbid obese patients after ambulatory surgery under general anesthesia: a propensity-matched analysis of a national database. *Anesthesia and Analgesia* 2021;133(6):1366-1373. DOI: 10.1213/ANE.0000000000005770. [Context Link 1] View abstract...
18. Tumminello ME, Hogan MG, Leonardi C, Barton JS, Cook MW, Davis KG. Morbid obesity not a risk for serious complications following outpatient surgery. *American Surgeon* 2022;Online. DOI: 10.1177/00031348221103656. [Context Link 1] View abstract...
19. Wu V, Lo N, Lin RJ, Zirkle M, Anderson J, Lee JM. Admission of Patients With Obstructive Sleep Apnea Undergoing Ambulatory Surgery in Otolaryngology-Head and Neck Surgery. *Annals of Otolaryngology, Rhinology and Laryngology* 2022;131(9):941-945. DOI: 10.1177/00034894211048783. [Context Link 1] View abstract...
20. Sharma S, Arora L. Anesthesia for the morbidly obese patient. *Anesthesiology Clinics* 2020;38(1):197-212. DOI: 10.1016/j.anclin.2019.10.008. [Context Link 1] View abstract...
21. Edmonson MB, et al. Association of patient characteristics with postoperative mortality in children undergoing tonsillectomy in 5 US states. *Journal of the American Medical Association* 2022;327(23):2317-2325. DOI: 10.1001/jama.2022.8679. [Context Link 1] View abstract...
22. Kapellen T, et al. ISPAD clinical practice consensus guidelines 2022: Management of children and adolescents with diabetes requiring surgery. *Pediatric Diabetes* 2022;23(8):1468-1477. DOI: 10.1111/pedi.13446. (Reaffirmed 2025 Jul) [Context Link 1] View abstract...
23. Urman RD, Rajan N, Belani K, Gayer S, Joshi GP. Malignant hyperthermia-susceptible adult patient and ambulatory surgery center: Society for Ambulatory Anesthesia and Ambulatory Surgical Care Committee of the American Society of Anesthesiologists position statement. *Anesthesia and Analgesia* 2019;129(2):347-349. DOI: 10.1213/ANE.0000000000004257. [Context Link 1] View abstract...
24. Eljilany I, El-Bardissy A, Elewa H. The dilemma of peri-procedural warfarin management: a narrative review. *Clinical and Applied Thrombosis/Hemostasis* 2021 Jan-Dec;27:10760296211012093. DOI: 10.1177/10760296211012093. [Context Link 1] View abstract...
25. Douketis JD, Spyropoulos AC. Perioperative management of patients taking direct oral anticoagulants: a review. *Journal of the American Medical Association* 2024;332(10):825-834. DOI: 10.1001/jama.2024.12708. [Context Link 1, 2] View abstract...
26. Joglar JA, et al. 2023 ACC/AHA/ACCP/HRS Guideline for the diagnosis and management of atrial fibrillation: a report of the American College of Cardiology/American Heart Association joint committee on clinical practice guidelines. *Journal of the American College of Cardiology* 2024;149(1):Online. DOI: 10.1016/j.jacc.2023.08.017. (Reaffirmed 2025 Mar) [Context Link 1, 2, 3, 4] View abstract...

27. Guidelines for Ambulatory Anesthesia and Surgery. [Internet] American Society of Anesthesiologists. 2023 Oct Accessed at: <https://www.asahq.org/>. [created 2003; accessed 2025 Apr 07] [Context Link 1, 2]
28. Lerman J. Pediatric ambulatory anesthesia: an update. *Current Opinion in Anaesthesiology* 2019;32(6):708-713. DOI: 10.1097/ACO.0000000000000787. [Context Link 1, 2, 3] View abstract...
29. Miller DJ, Nelson SE, Shah AS, Ganley TJ, Flynn JJM. Outpatient pediatric orthopedic surgery. *Orthopedic Clinics of North America* 2018;49(1):55-62. DOI: 10.1016/j.ocl.2017.08.007. [Context Link 1] View abstract...
30. American Academy of Orthopaedic Surgeons. Management of Osteoarthritis of the Knee (Non-Arthroplasty). Evidence-Based Guideline 3rd Ed [Internet] American Academy of Orthopaedic Surgeons. 2021 Aug Accessed at: <https://www.aaos.org/>. [accessed 2025 Sep 04] [Context Link 1]
31. Writing Committee Members, et al. 2023 AHA/ACC/ACCP/ASPC/NLA/PCNA guideline for the management of patients with chronic coronary disease: a report of the American Heart Association/American College of Cardiology joint committee on clinical practice guidelines. *Journal of the American College of Cardiology* 2023;82(9):833-955. DOI: 10.1016/j.jacc.2023.04.003. [Context Link 1] View abstract...
32. Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease. 2025 report [Internet] Global Initiative for Chronic Obstructive Lung Disease (GOLD). 2025 Accessed at: <https://www.goldcopd.org>. [accessed 2025 Sep 11] [Context Link 1]
33. Neuropathic Pain in Adults: Pharmacological Management in Non-Specialist Settings. NICE Clinical Guideline CG173 [Internet] National Institute for Health and Care Excellence. 2020 Sep Accessed at: <https://www.nice.org.uk/guidance>. [created 2013; accessed 2025 Apr 04] [Context Link 1]
34. Walling AM, et al. Palliative Care. NCCN Clinical Practice Guidelines in Oncology [Internet] National Comprehensive Cancer Network (NCCN). v.2.2025; 2025 Mar 31 Accessed at: <https://www.nccn.org/>. [accessed 2025 Apr 29] [Context Link 1]
35. Walke SS, et al. When to discharge a patient after endoscopy: a narrative review. *Clinical Endoscopy* 2022;55(1):8-14. DOI: 10.5946/ce.2021.110. [Context Link 1] View abstract...
36. Redelmeier DA. Postoperative care and complications. In: Goldman L, Cooney KA, editors. *Goldman-Cecil Medicine*. 27th ed. Elsevier; 2024:2672-2677. [Context Link 1, 2, 3]
37. Chang M, Horvath R. The postanesthesia care unit. In: Gropper MA, et al., editors. *Miller's Anesthesia*. 10th ed. Elsevier; 2025:2484-2511.e5. [Context Link 1, 2, 3, 4]
38. Yepuri N, Pruekprasert N, Cooney RN. Surgical complications. In: Townsend CM, Beauchamp RD, Evers BM, Mattox KL, editors. *Sabiston Textbook of Surgery*. 21st ed. Elsevier; 2022:238-283. [Context Link 1, 2]
39. Santos AP, Onkendi E, Dissanaik S. Surgical infections and antibiotic use. In: Townsend CM, Beauchamp RD, Evers BM, Mattox KL, editors. *Sabiston Textbook of Surgery*. 21st ed. Elsevier; 2022:223-237. [Context Link 1]
40. Smith SG, Schreiber MA. Shock, electrolytes, and fluid. In: Townsend CM, Beauchamp RD, Evers BM, Mattox KL, editors. *Sabiston Textbook of Surgery*. 21st ed. Elsevier; 2022:44-94. [Context Link 1]

Footnotes

[A] The definition of an ambulatory procedure depends on payer-provider contractual agreement or regulatory language (eg, CMS' Two-Midnight Rule). An ambulatory procedure may include one postoperative overnight stay in a facility; therefore, a Benchmark Length of Stay (BLOS) of ambulatory refers to patients discharged the day of or the day after the procedure. Depending on various patient and procedural factors, some patients undergoing a procedure with an ambulatory BLOS require inpatient care (eg, medical necessity for hospital-based care across 2 or more postoperative midnights). [A in Context Link 1, 2]

[B] This guideline is for procedures that are not covered by an Optimal Recovery Guideline (ORG). [B in Context Link 1]

[C] Low-risk procedures are usually considered those that are not intrathoracic, intraperitoneal, or vascular.(3) Some orthopedic procedures are low risk (eg, arthroscopy).(3) Examples of low-risk procedures include endoscopic gastrointestinal, laryngeal, sinus, intrauterine, ureteral, or bladder procedures; cataract surgery; most breast surgery (eg, biopsy, partial or simple complete mastectomy); hemorrhoidectomy; hernia repair; female incontinence surgery; tonsillectomy; nasal septal or polyp procedures; myringotomy; tympanoplasty; and parotid, thyroid, or parathyroid procedures.(3)(4) [C in Context Link 1, 2]

[D] The risk factors listed do not necessarily or automatically identify a patient in whom a potentially ambulatory procedure should instead be performed on an inpatient basis. Specific details such as which procedure is being considered and the overall clinical status of the patient are necessary to complete assessment of suitability for ambulatory surgery.(3)(4) [D in Context Link 1]

[E] Precise definitions of severe frailty vary. The Risk Analysis Index is one frailty screening tool which has been studied and used in preoperative populations.(14) [E in Context Link 1]

[F] Very few patients with atrial fibrillation or atrial flutter (same criteria for anticoagulation apply) require inpatient care or need to have their inpatient stay extended due to a need to achieve immediate therapeutic anticoagulation (ie, stay in the hospital to receive IV unfractionated heparin until warfarin-induced anticoagulation is sufficient). Most patients, including those with clear indications for long-term anticoagulation, do not need immediate anticoagulation, as the risk of an embolic event within the few days until their warfarin becomes therapeutic is very low (a small fraction of 1% per day).(26) Only patients deemed to be at particular risk for embolization (eg, mechanical valve, recent stroke or transient ischemic attack) are candidates for bridge therapy.(26) In addition, the vast majority of patients are eligible to be anticoagulated through use of an oral direct thrombin inhibitor (eg, dabigatran), an oral coagulation factor Xa inhibitor (eg, rivaroxaban, apixaban, edoxaban), or low-molecular-weight heparin, all of which achieve full anticoagulation rapidly (eg, a few hours after first dose).(25)(26) [F in Context Link 1]

[G] Depending on the nature of the operation or procedure, ICU, intermediate or telemetry care monitoring, catheterization laboratory, floor, recovery room, or fast-track recovery area with chairs may be used. [G in Context Link 1]

[H] The patient may need supported ambulation, non-weight-bearing or partial-weight-bearing ambulation, or transfer and gait training with crutches or walker. [H in Context Link 1]

Definitions

Activity level appropriate

- Activity level appropriate: ambulatory or appropriate activity level post procedure[A](1)(2)

References

1. Hyman JB, Goren O, Wilson SH, Philip B. Ambulatory (outpatient) anesthesia. In: Gropper MA, et al., editors. Miller's Anesthesia. 10th ed. Elsevier; 2025:2149-2184.e12.
2. Chang M, Horvath R. The postanesthesia care unit. In: Gropper MA, et al., editors. Miller's Anesthesia. 10th ed. Elsevier; 2025:2484-2511.e5.

Footnotes

- A. The patient may need supported ambulation, non-weight-bearing or partial-weight-bearing ambulation, or transfer and gait training with crutches or walker.

Altered mental status

- Altered mental status (ie, different from baseline), as indicated by **1 or more** of the following(1)(2)(3)(4):
 - Confusional state (eg, disorientation, difficulty following commands, deficit in attention)
 - Lethargy (eg, awake or arousable, but with drowsiness; reduced awareness of self and environment)
 - Obtundation (ie, arousable only with strong stimuli, lessened interest in environment, slowed responses to stimulation)
 - Stupor (ie, may be arousable but patient does not return to normal baseline level of awareness)
 - Coma (ie, not arousable)

References

1. Maher PJ. Confusion. In: Walls RM, editor. Rosen's Emergency Medicine: Concepts and Clinical Practice. 10th ed. Elsevier; 2023:126-131.e1.
2. Lei C, Smith C. Depressed consciousness and coma. In: Walls RM, editor. Rosen's Emergency Medicine: Concepts and Clinical Practice. 10th ed. Elsevier; 2023:117-125.e1.
3. Abraham G, Maher PJ. Delirium and dementia. In: Walls RM, editor. Rosen's Emergency Medicine: Concepts and Clinical Practice. 10th ed. Elsevier; 2023:1269-1280.e2.
4. Holler-Managan YF. Neurologic evaluation. In: Kliegman RM, et al., editors. Nelson Textbook of Pediatrics. 22nd ed. Elsevier; 2025:3550-3560.

American Society of Anesthesiologists (ASA) Physical Status Classification System

- American Society of Anesthesiologists (ASA) Physical Status Classification System^{[A](2)(3)(4)}
 - Class I: Normal healthy patient
 - Class II: Patient with mild systemic disease
 - Class III: Patient with severe systemic disease
 - Class IV: Patient with severe systemic disease that is constant threat to life
 - Class V: Moribund patient who is not expected to survive without the operation

References

1. Sankar A, Johnson SR, Beattie WS, Tait G, Wijesundera DN. Reliability of the American Society of Anesthesiologists physical status scale in clinical practice. British Journal of Anaesthesia 2014;113(3):424-32. DOI: 10.1093/bja/aeu100.
2. Foley C, Kendall MC, Apruzzese P, De Oliveira GS. American Society of Anesthesiologists Physical Status Classification as a reliable predictor of postoperative medical complications and mortality following ambulatory surgery: an analysis of 2,089,830 ACS-NSQIP outpatient cases. BMC Surgery 2021;21(1):Online. DOI: 10.1186/s12893-021-01256-6.
3. Horvath B, Kloesel B, Todd MM, Cole DJ, Prielipp RC. The evolution, current value, and future of the American Society of Anesthesiologists physical status classification System. Anesthesiology 2021;135(5):904-919. DOI: 10.1097/ALN.0000000000003947.
4. Mayhew D, Mendonca V, Murthy BVS. A review of ASA physical status - historical perspectives and modern developments. Anaesthesia 2019;74(3):373-379. DOI: 10.1111/anae.14569.

Footnotes

- A. Note: There is no accepted standardization of terms used in this classification system.⁽¹⁾

Competent person available to accompany patient (if required)

- Competent person available to accompany patient (if required) and stay with patient on first postoperative night at next level of care⁽¹⁾

References

1. Hyman JB, Goren O, Wilson SH, Philip B. Ambulatory (outpatient) anesthesia. In: Gropper MA, et al., editors. Miller's Anesthesia. 10th ed. Elsevier; 2025:2149-2184.e12.

Dangerous arrhythmia

- Dangerous arrhythmia, as indicated by **1 or more** of the following(1)(2)(3)(4):
 - Heart rhythms that are inherently dangerous or unstable, as indicated by **1 or more** of the following(5)(6):
 - Resuscitated ventricular fibrillation or cardiac arrest
 - Ventricular escape rhythm
 - Sustained ventricular tachycardia (30 seconds or more of ventricular rhythm at greater than 100 beats per minute)
 - Nonsustained ventricular tachycardia and **1 or more** of the following:
 - Acute myocarditis
 - Myocardial ischemia
 - Unstable cardiac conduction defects, as indicated by **1 or more** of the following(7):
 - Type II second-degree atrioventricular block
 - Third-degree atrioventricular block
 - New-onset left bundle branch block with suspected myocardial ischemia
 - Heart rhythms of concern due to **1 or more** of the following(8):
 - Hypotension
 - Respiratory distress
 - Association with other significant symptoms (eg, syncope)(7)(9)(10)(11)

References

1. Curtis AB, Tomaselli GF. Approach to the patient with cardiac arrhythmias. In: Libby P, Bonow RO, Mann DL, Tomaselli GF, Bhatt DL, Solomon SD, editors. Braunwald's Heart Disease: A Textbook of Cardiovascular Medicine. 12th ed. Elsevier; 2022:1145-1162.e7.
2. Dalal AS, Van Hare GF. Disturbances of rate and rhythm of the heart. In: Kliegman RM, et al., editors. Nelson Textbook of Pediatrics. 22nd ed. Elsevier; 2025:2844-2859.e1.
3. Joglar JA, et al. 2023 HRS Expert Consensus Statement on the management of arrhythmias during pregnancy. Heart Rhythm 2023;20(10):Online. DOI: 10.1016/j.hrthm.2023.05.017.
4. Myerburg RJ, Lampert R. Cardiac arrest and life-threatening arrhythmias. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:312-317.
5. Garan H. Ventricular arrhythmias. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:332-340.
6. Goldberger JJ, Albert CM, Myerburg RJ. Cardiac arrest and sudden cardiac death. In: Libby P, Bonow RO, Mann DL, Tomaselli GF, Bhatt DL, Solomon SD, editors. Braunwald's Heart Disease: A Textbook of Cardiovascular Medicine. 12th ed. Elsevier; 2022:1349-1386.
7. Patton KK, Olgin JE. Bradyarrhythmias and atrioventricular block. In: Libby P, Bonow RO, Mann DL, Tomaselli GF, Bhatt DL, Solomon SD, editors. Braunwald's Heart Disease: A Textbook of Cardiovascular Medicine. 12th ed. Elsevier; 2022:1312-1320.
8. Kalman JM, Sanders P. Supraventricular tachycardias. In: Libby P, Bonow RO, Mann DL, Tomaselli GF, Bhatt DL, Solomon SD, editors. Braunwald's Heart Disease: A Textbook of Cardiovascular Medicine. 12th ed. Elsevier; 2022:1245-1271.
9. Joglar JA, et al. 2023 ACC/AHA/ACCP/HRS Guideline for the diagnosis and management of atrial fibrillation: a report of the American College of Cardiology/American Heart Association joint committee on clinical practice guidelines. Journal of the American College of Cardiology 2024;149(1):Online. DOI: 10.1016/j.jacc.2023.08.017. (Reaffirmed 2025 Mar)
10. Zimetbaum P, Goldman L. Supraventricular ectopy and tachyarrhythmias. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:322-332.
11. Zimetbaum P, Goldman L. Bradycardias and conduction system delays. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:317-322.

Hypotension

- Hypotension, as indicated by **1 or more** of the following:
 - Hypotension in adult patient, as indicated by **1 or more** of the following:
 - Systolic blood pressure less than 90 mm Hg[A][B](1)
 - Mean arterial pressure[C] less than 70 mm Hg[A][B]  MAP Calculator(1)(2)
 - Decrease in baseline systolic blood pressure of 30 mm Hg or more, with significant signs or symptoms due to lower blood pressure (eg, near syncope, syncope, chest pain)[A][B](1)
 - Hypotension in pediatric patient, as indicated by **1 or more** of the following:
 - Systolic blood pressure less than 110 mm Hg in child 13 to 17 years of age[A][D](3)
 - Systolic blood pressure less than 100 mm Hg in child 6 to 12 years of age[A][D](3)
 - Systolic blood pressure less than 95 mm Hg in child 3 to 5 years of age[A][D](3)
 - Systolic blood pressure less than 90 mm Hg in child 1 or 2 years of age[A][D](3)
 - Systolic blood pressure less than 80 mm Hg in infant 6 to 11 months of age[A][D](3)
 - Systolic blood pressure less than 70 mm Hg in infant 3 to 5 months of age[A][D](3)
 - Systolic blood pressure less than 65 mm Hg in infant 1 or 2 months of age[A][D](3)

References

1. Schriger DL. Approach to the patient with abnormal vital signs. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:32-35.
2. Puskarich MA, Jones AE. Shock. In: Walls RM, editor. Rosen's Emergency Medicine: Concepts and Clinical Practice. 10th ed. Elsevier; 2023:34-41.e1.
3. Anderson CC, Kapoor S, Mark TE. Pediatric parameters and equipment. In: Anderson CC, Kapoor S, Mark TE, editors. The Harriet Lane Handbook: A Manual for Pediatric House Officers. 23rd ed. Elsevier; 2024:i-iii.

Footnotes

- A. Criteria based upon clinician-acquired numeric values (eg, vital signs, oxygen saturation) should be used if they are accurate reflections of the patient's condition. Transitory findings (eg, abnormal only upon initial emergency department intake or only one time out of multiple readings) that rapidly improve with no or minimal treatment usually do not reflect disease severity or risk for deterioration. This does not imply that an initial or one-time reading cannot ever be applicable. The goal is to separate erroneous or incidental findings from those that truly represent the patient's clinical picture.
- B. Interpretation of blood pressure requires clinical judgment and consideration of several patient-specific factors, such as the patient's baseline blood pressure, medications, and clinical impact. For example, an elderly patient with heart failure may be prescribed medication with the intentional goal of a reduced pressure. If the patient's baseline SBP is 92 mm Hg to 96 mm Hg, absent signs or symptoms of hypotension, an emergency department SBP of 86 mm Hg should not automatically be categorized as hypotensive. This would hold for mean arterial pressure (MAP) as well. The numeric values included in this definition are provided to allow for consistency in terms of a technical definition of the term hypotension. Whether a blood pressure below the technical threshold is clinically meaningful is a matter of persistence, context, and clinical judgment.
- C. The mean arterial pressure (MAP) takes into account both SBP and DBP readings.
- D. Interpretation of blood pressure requires clinical judgment and consideration of several patient-specific factors, such as the patient's baseline blood pressure, medications, and clinical impact. The numeric values included in this definition are provided to allow for consistency in terms of a technical definition of the term hypotension. Whether a blood pressure below the technical threshold is clinically meaningful is a matter of persistence, context, and clinical judgment.

Hypoxemia

- Hypoxemia, as indicated by **1 or more** of the following(1):
 - Patient without baseline need for supplemental oxygen with oxygen saturation (SpO₂) of less than 90% or arterial blood gas partial pressure of oxygen (PaO₂) of less than 60 mm Hg (8.0 kPa) on room air[A][B]
 - Patient without baseline need for supplemental oxygen who now requires supplemental oxygen to keep SpO₂ greater than 89% or PaO₂ greater than 59 mm Hg (7.9 kPa)[A]
 - Patient with baseline need for supplemental oxygen who now requires increased supplemental oxygen to maintain oxygenation at baseline or acceptable level

References

1. Schrager DL. Approach to the patient with abnormal vital signs. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:32-35.
2. Jamali H, et al. Racial disparity in oxygen saturation measurements by pulse oximetry: evidence and implications. Annals of the American Thoracic Society 2022;19(12):1951-1964. DOI: 10.1513/AnnalsATS.202203-270CME.
3. Rojas-Camayo J, et al. Reference values for oxygen saturation from sea level to the highest human habitation in the Andes in acclimatised persons. Thorax 2018;73(8):776-778. DOI: 10.1136/thoraxjnl-2017-210598.

Footnotes

- A. Pulse oximetry (SpO₂) may underestimate arterial saturation (SaO₂), especially in people with dark skin pigmentation, thick skin, cold body temperature, or who are wearing colored nail polish, and thus may not accurately detect hypoxemia.(2) Where appropriate, pulse oximetry should be measured after warming fingers or removing nail polish. Pulse oximetry results should be assessed within the context of the patient's clinical presentation, and performance of an arterial blood gas considered for a more accurate assessment of oxygenation if indicated.(2) Specific target values may require adjustment when care is delivered at high altitude.(3)
- B. Criteria based upon clinician-acquired numeric values (eg, vital signs, oxygen saturation) should be used if they are accurate reflections of the patient's condition. Transitory findings (eg, abnormal only upon initial emergency department intake or only one time out of multiple readings) that rapidly improve with no or minimal treatment usually do not reflect disease severity or risk for deterioration. This does not imply that an initial or one-time reading cannot ever be applicable. The goal is to separate erroneous or incidental findings from those that truly represent the patient's clinical picture.

No complicating features

- No complicating features requiring inpatient care; examples include(1)(2)(3):
 - Severe complications of procedure (eg, bowel injury, airway compromise, vascular injury, hemorrhage)
 - Extensive (eg, dissection far beyond usual scope of procedure) or prolonged (eg, surgery length significantly beyond that expected) surgery performed requiring inpatient postoperative care
 - Conversion to open or complex procedure that requires inpatient care (eg, open vs laparoscopic cholecystectomy, abdominal vs vaginal hysterectomy)
 - Comorbid condition or test result identified during or after procedure that requires inpatient care (eg, severe infection, compartment syndrome)
 - Severe complications of anesthesia (eg, postepidural puncture headache, malignant hyperthermia)

References

1. Yepuri N, Pruekprasert N, Cooney RN. Surgical complications. In: Townsend CM, Beauchamp RD, Evers BM, Mattox KL, editors. Sabiston Textbook of Surgery. 21st ed. Elsevier; 2022:238-283.
2. Redelmeier DA. Postoperative care and complications. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:2672-2677.

3. Smith SG, Schreiber MA. Shock, electrolytes, and fluid. In: Townsend CM, Beauchamp RD, Evers BM, Mattox KL, editors. Sabiston Textbook of Surgery. 21st ed. Elsevier; 2022:44-94.

Operative site appropriate

- Operative site appropriate, as indicated by **ALL** of the following(1):
 - Surgical site is dry or as expected for procedure.
 - Bleeding is absent or as expected for procedure.

References

1. Hyman JB, Goren O, Wilson SH, Philip B. Ambulatory (outpatient) anesthesia. In: Gropper MA, et al., editors. Miller's Anesthesia. 10th ed. Elsevier; 2025:2149-2184.e12.

Patient alert

- Patient alert (at baseline mental status)(1)(2)

References

1. Hyman JB, Goren O, Wilson SH, Philip B. Ambulatory (outpatient) anesthesia. In: Gropper MA, et al., editors. Miller's Anesthesia. 10th ed. Elsevier; 2025:2149-2184.e12.
2. Chang M, Horvath R. The postanesthesia care unit. In: Gropper MA, et al., editors. Miller's Anesthesia. 10th ed. Elsevier; 2025:2484-2511.e5.

Physiologic recovery

- Physiologic recovery: cardiovascular, respiratory, and hemodynamic status normal or near preoperative baseline(1)(2)(3)

References

1. Hyman JB, Goren O, Wilson SH, Philip B. Ambulatory (outpatient) anesthesia. In: Gropper MA, et al., editors. Miller's Anesthesia. 10th ed. Elsevier; 2025:2149-2184.e12.
2. Redelmeier DA. Postoperative care and complications. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:2672-2677.
3. Chang M, Horvath R. The postanesthesia care unit. In: Gropper MA, et al., editors. Miller's Anesthesia. 10th ed. Elsevier; 2025:2484-2511.e5.

Postoperative effects resolved or managed

- Postoperative effects resolved or managed, as indicated by **ALL** of the following(1)(2)(3):
 - Pain: absent or managed and appropriate for next level of care
 - Nausea and vomiting: absent or adequately treated and appropriate for next level of care
 - Headache, dizziness, or drowsiness: absent or mild and appropriate for next level of care

References

1. Hyman JB, Goren O, Wilson SH, Philip B. Ambulatory (outpatient) anesthesia. In: Gropper MA, et al., editors. Miller's Anesthesia. 10th ed. Elsevier; 2025:2149-2184.e12.

2. Hernandez A, Sherwood ER. Anesthesiology principles, pain management, and conscious sedation. In: Townsend CM, Beauchamp RD, Evers BM, Mattox KL, editors. Sabiston Textbook of Surgery. 21st ed. Elsevier; 2022:315-348.
3. Redelmeier DA. Postoperative care and complications. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:2672-2677.

Respiratory distress

- Respiratory distress, as indicated by **ALL** of the following(1)(2)(3)(4):
 - Patient with **1 or more** of the following:
 - Dyspnea (difficulty breathing)
 - Tachypnea
 - Abnormal breathing pattern (eg, chest retractions)
 - Other evidence of difficulty breathing
 - Evidence of respiratory compromise, as indicated by **1 or more** of the following:
 - Hypoxemia
 - Altered mental status
 - Other evidence of respiratory compromise (eg, respiratory acidosis)

References

1. Braithwaite SA, Wessel AL. Dyspnea. In: Walls RM, editor. Rosen's Emergency Medicine: Concepts and Clinical Practice. 10th ed. Elsevier; 2023:194-201.e2.
2. Naureckas ET, Solway J. Disturbances of respiratory function. In: Loscalzo J, Fauci A, Kasper D, Hauser S, Longo D, Jameson JL, editors. Harrison's Principles of Internal Medicine. 21st ed. McGraw Hill Education; 2022:2133-2139.
3. Matthay MA, Ware LB. Acute respiratory failure. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:642-652.
4. Rakoczy K. Acute respiratory failure. In: Gershel JC, Rauch DA, editors. Caring for the Hospitalized Child: A Handbook of Inpatient Pediatrics. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2023:749-754.

Social Determinants of Health Assessment

- Risk of poor health outcomes may be increased by the presence of **1 or more** of the following social determinants of health(1)(2)(3):
 - Housing insecurity, as indicated by **1 or more** of the following:
 - Individual or caregiver's current living situation is **1 or more** of the following(4):
 - Does not have own housing (eg, staying in a hotel, shelter, or with others)
 - Has own housing (eg, house, apartment), but at risk of losing it in the future (ie, behind on rent or mortgage)
 - Has own housing (eg, house, apartment), but has lived in 3 or more places in past year
 - Current housing has **1 or more** of the following:
 - Electrical appliances (eg, stove, refrigerator) not working or unavailable
 - Insufficient heating or cooling
 - Insufficient ventilation
 - Lead paint or pipes
 - Mold
 - Pests (eg, bugs) or rodents
 - Smoke detectors not working or unavailable
 - Food insecurity, as indicated by **1 or more** of the following(5):

- In the past year, individual or caregiver ran out of food and did not have money to buy more food.
- In the past year, individual or caregiver worried that they would run out of food before they received money to buy more food.
- Insufficient transportation, as indicated by **1 or more** of the following(6):
 - In the past year, individual or caregiver missed medical appointments or could not get medications due to lack of transportation.
 - In the past year, individual or caregiver missed nonmedical activities, work, or could not get things needed for daily living due to lack of transportation.
- Insufficient utilities, as indicated by **1 or more** of the following(7):
 - Utilities (eg, electricity, water, gas, or oil) are currently shut off or unavailable.
 - In the past year, electric, water, gas, or oil company threatened to shut off services.
- Personal safety risk, as indicated by **2 or more** of the following(5):
 - Individual is sometimes or frequently physically hurt by another person (including family member).
 - Individual is sometimes or frequently insulted or talked down to by another person (including family member).
 - Individual is sometimes or frequently threatened with physical harm by another person (including family member).
 - Individual is sometimes or frequently screamed or cursed at by another person (including family member).
- Insufficient dependent care, as indicated by **1 or more** of the following:
 - In the past year, individual or caregiver was unable to work due to lack of dependent care.
 - In the past year, individual or caregiver was unable to work more (additional) hours due to lack of dependent care.
 - In the past year, individual or caregiver missed medical appointments or could not get medications due to lack of dependent care.
 - In the past year, individual or caregiver missed nonmedical activities (eg, school, church, social activity) due to lack of dependent care.
- Depression risk, as indicated by **ALL** of the following(8):
 - In the past 2 weeks, individual had little interest or pleasure in normal activities on at least several days.
 - In the past 2 weeks, individual felt down, depressed, or hopeless on at least several days.

References

1. Scanlon A, Reinisch C. Social determinants of health. In: Harding MM, Kwong J, Hagler D, Reinisch C, editors. Lewis's Medical-Surgical Nursing: Assessment and Management of Clinical Problems. 12th ed. St. Louis, MO: Mosby; 2023:18-20.
2. Billioux A, Verlander K, Anthony S, Alley D. Standardized Screening for Health-Related Social Needs in Clinical Settings: the Accountable Health Communities Screening Tool. [Internet] National Academy of Sciences. 2017 May Accessed at: <https://nam.edu/>. [accessed 2025 Sep 12]
3. Addressing social determinants of health. In: Perez R, editor. CMSA's Integrated Case Management. 2nd ed. Springer Publishing Company LLC; 2023:62-75.
4. Sandel M, et al. Unstable housing and caregiver and child health in renter families. Pediatrics 2018;14(2):e20172199. DOI: 10.1542/peds.2017-2199.
5. Children's HealthWatch Survey. Screening Instrument [Internet] Children's HealthWatch. 2024 Feb 13 Accessed at: <https://childrenshealthwatch.org/>. [accessed 2025 Mar 31]
6. PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences Screening Tool. 2.0 [Internet] Association of Asian Pacific Community Health Organizations (AAPCHO) and National Association of Community Health Centers (NACHC). 2025 Accessed at: <https://prapare.org/the-prapare-screening-tool/>. [accessed 2025 Sep 08]
7. Cook JT, et al. A brief indicator of household energy security: associations with food security, child health, and child development in US infants and toddlers. Pediatrics 2008;122(4):e867-75. DOI: 10.1542/peds.2008-0286.
8. Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: validity of a two-item depression screener. Medical Care 2003;41(11):1284-92. DOI: 10.1097/01.MLR.0000093487.78664.3C.

Stable vital signs

- Stable vital signs: systemic blood pressure and pulse within 20% of the preanesthetic level or appropriate for next level of care(1)(2)

References

1. Hyman JB, Goren O, Wilson SH, Philip B. Ambulatory (outpatient) anesthesia. In: Gropper MA, et al., editors. Miller's Anesthesia. 10th ed. Elsevier; 2025:2149-2184.e12.
2. Chang M, Horvath R. The postanesthesia care unit. In: Gropper MA, et al., editors. Miller's Anesthesia. 10th ed. Elsevier; 2025:2484-2511.e5.

Tachypnea

- Tachypnea,[A][B] as indicated by **1 or more** of the following:
 - Respiratory rate greater than 20 breaths per minute in adult[A][B](1)
 - Respiratory rate greater than 18 breaths per minute in child 13 to 17 years of age[A][B](2)
 - Respiratory rate greater than 22 breaths per minute in child 6 to 12 years of age[A][B](2)
 - Respiratory rate greater than 25 breaths per minute in child 3 to 5 years of age[A][B](2)
 - Respiratory rate greater than 30 breaths per minute in child 1 or 2 years of age[A][B](2)
 - Respiratory rate greater than 40 breaths per minute in infant 6 to 11 months of age[A][B](2)
 - Respiratory rate greater than 45 breaths per minute in infant 3 to 5 months of age[A][B](2)
 - Respiratory rate greater than 55 breaths per minute in infant 1 or 2 months of age[A][B](2)

References

1. Schrager DL. Approach to the patient with abnormal vital signs. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:32-35.
2. Anderson CC, Kapoor S, Mark TE. Pediatric parameters and equipment. In: Anderson CC, Kapoor S, Mark TE, editors. The Harriet Lane Handbook: A Manual for Pediatric House Officers. 23rd ed. Elsevier; 2024:i-iii.

Footnotes

- A. Criteria based upon clinician acquired numeric values (eg, vital signs, oxygen saturation) should be used if they are accurate reflections of the patient's condition. Transitory findings (eg, abnormal only upon initial emergency department intake or only one time out of multiple readings) that rapidly improve with no or minimal treatment usually do not reflect disease severity or risk for deterioration. This does not imply that an initial or one-time reading cannot ever be applicable. The goal is to separate erroneous or incidental findings from those that truly represent the patient's clinical picture.
- B. Interpretation of respiratory rate requires clinical judgment and consideration of several patient-specific factors, such as the patient's baseline respiratory rate and whether the respiratory rate is indicative of significant underlying respiratory or other pathology. A mildly increased respiratory rate (eg, 20 to 22 breaths per minute in an adult), absent other indications of serious illness (eg, hypoxemia, metabolic acidosis, decreased tidal volume, pain), may be transitory and not clinically important. The numeric values included in this definition are provided to allow for consistency in terms of a technical definition of the term tachypnea. Whether a respiratory rate above the technical threshold is clinically meaningful is a matter of persistence, context, and clinical judgment. In addition, the measurement of the respiratory rate is subject to error. A medical textbook states that because there can be significant breath-to-breath variation in respiratory rate, the rate should be assessed for at least 30 seconds, preferably for a full minute.(1) This same textbook also states that new technologies designed to measure the respiratory rate have not proved to be clinically useful.(1)

Temperature appropriate

- Temperature appropriate: patient afebrile or temperature appropriate for next level of care(1)(2)

References

1. Yepuri N, Pruekprasert N, Cooney RN. Surgical complications. In: Townsend CM, Beauchamp RD, Evers BM, Mattox KL, editors. Sabiston Textbook of Surgery. 21st ed. Elsevier; 2022:238-283.
2. Santos AP, Onkendi E, Dissanaika S. Surgical infections and antibiotic use. In: Townsend CM, Beauchamp RD, Evers BM, Mattox KL, editors. Sabiston Textbook of Surgery. 21st ed. Elsevier; 2022:223-237.

Voiding status acceptable

- Voiding status acceptable, as indicated by **1 or more** of the following(1):
 - Voiding spontaneously
 - Urinary catheter in place and instructions given for follow-up
 - No voiding, but instructions given (eg, return to care if not voiding within 12 hours)

References

1. Hyman JB, Goren O, Wilson SH, Philip B. Ambulatory (outpatient) anesthesia. In: Gropper MA, et al., editors. Miller's Anesthesia. 10th ed. Elsevier; 2025:2149-2184.e12.

MCG Health
General Recovery Care 30th Edition
Copyright © 2026 MCG Health, LLC
All Rights Reserved

Last Update: 1/25/2026 12:58:52 AM
Build Number: 30.0.2026012500524.025256