

Anesthesia Service Standard

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1. Standard Scope

1.1 This standard applies to all healthcare facilities offering anesthesia services for both inpatient and one-day surgery cases. It covers the complete anesthesia care cycle, including pre-anesthesia assessment, intraoperative management, and post-anesthesia recovery.

1.2 This standard encompasses:

1.2.1 General anesthesia

1.2.2 Regional anesthesia

1.2.3 Sedation

1.3 This standard aligns with key international accreditation frameworks and sets minimum requirements to support safe, high-quality anesthesia services across inpatient and one-day surgery settings, with a focus on patient safety, perioperative monitoring, and standardized emergency response.

1.4 This standard does not cover sedation modalities provided in dental clinics or dental centers when performed on an ambulatory (outpatient) basis. Sedation and/or general anesthesia for dental procedures performed within DoH-licensed hospitals or one-day surgery facilities remains within scope and shall comply with this standard.¹

2. Definitions and Abbreviations

No.	Term / Abbreviation	Definition
2.1	AAMEN	The Abu Dhabi Healthcare Information Security Program (AAMEN) aims to ensure that healthcare facilities in the Emirate of Abu Dhabi comply with information security and data privacy requirements to protect sensitive patient healthcare data, as defined under applicable laws and regulations.
2.2	Aldrete Score	Scoring system to assess a patient's recovery from anesthesia in the Post-Anesthesia Care Unit (PACU).
2.3	Anesthesia Record	The formal documentation of all anesthetic care provided.
2.4	Anesthesia Technician	Allied health professionals who are trained to support in technical aspects of anesthesia services. They are responsible for assisting the operating/anesthesia team, managing anesthesia equipment and supplies, and monitoring patients. They work under the supervision of anesthesiologists, anesthesia technologists and anesthesia nurses.
2.5	Anesthesia Technologist	Allied health professionals qualified to provide fundamental and advanced technical and clinical activities that assist the anesthesiologist/operating physician to deliver safe anesthesia and efficient patient care, manage equipment and supplies and monitor patients across various settings. They work under the supervision of an anesthesiologist.
2.6	ASA Classification	American Society of Anesthesiologists physical status classification system.
2.7	Consultant Anesthetist	A licensed anesthesiologist classified and privileged as a Consultant under DoH PQR requirements.
2.8	Deep sedation/analgesia	A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation.
2.9	EMR	Electronic Medical Record.

2.10	EtCO ₂	End-tidal Carbon Dioxide.
2.11	Floating Anesthetist	An anesthesiologist who is not assigned to a specific surgical case or operating room.
2.12	General Anesthesia	General anesthesia is a drug-induced loss of consciousness during which patients are not aroused, even by painful stimulation.
2.13	Malaffi	Abu Dhabi's Health Information Exchange platform.
2.14	MDT	Multidisciplinary Team.
2.15	Minimal sedation (anxiolysis)	A drug-induced state during which patients respond normally to verbal commands.
2.16	Moderate sedation	A drug-induced depression of consciousness during which patients respond purposefully to verbal commands.
2.17	NPCM	National Platform for Controlled Medicines.
2.18	One-Day Surgery	Surgical procedures where the patient is discharged on the same day.
2.19	PACS	Picture Archiving and Communication System.
2.20	PACU	Post-Anesthesia Care Unit.
2.21	PONV	Postoperative Nausea and Vomiting.
2.22	Pre-induction assessment	Assessment immediately prior to the administration of any anesthesia-inducing medications or the start of the anesthesia procedure in the operating room or equivalent area.
2.23	Regional Anesthesia	Anesthetizing a specific body part (e.g., spinal, epidural, or peripheral nerve blocks).
2.24	Sedation	Involves a continuum of consciousness.
2.25	Sentinel Event	An unexpected occurrence involving death or serious physical or psychological injury.
2.26	SPA	Society for Pediatric Anesthesia.
2.27	Specialist Anesthetist	A licensed anesthesiologist classified and privileged as a Specialist under DoH PQR requirements.
2.28	Tiering	A local facility privileging classification used to stratify supervision and case assignment for anesthesiologists, which shall be consistent with DoH Professional Qualification Requirements (PQR), licensing, and privileging frameworks. Where a DoH-defined classification is available, it shall take precedence.

3. Standard Requirements and Specifications

3.1 Licensure Requirements

3.1.1 DoH-licensed healthcare facilities shall comply with the DoH licensure requirements to provide anesthesia services.

3.1.2 The facility shall meet DoH Facility Guidelines for physical space and safety. In addition, the facility shall ensure anesthesia service areas (including operating/procedure rooms, non-operating room anesthesia locations, and PACU/recovery areas) meet anesthesia-specific minimum requirements for: medical gases and scavenging (where applicable), emergency power, resuscitation capability, safe medication storage, and availability of required monitoring and emergency equipment. Where DoH Facility Guidelines are silent on anesthesia-specific minimums, the requirements of this standard shall apply.¹

3.1.3 The healthcare facility (HF) shall be integrated with the Health Information Exchange Platform (Malaffi) to transmit medical record data and information, enabling review by other medical providers as required.²

3.2 Staffing Model

3.2.1 ASA classification (Appendix 1) shall be completed during pre-anesthesia evaluation.

3.2.2 ASA III and above shall require Consultant Anesthetist review preoperatively.

3.2.3 ASA IV and above shall require an individualized intraoperative plan and ICU readiness.

3.2.4 For pediatric patients, SPA pediatric ASA guidelines shall be used for age-appropriate stratification.

3.2.5 While ASA III and above patients are generally excluded from day surgery, selected cases may proceed subject to a documented Consultant-led risk assessment, adherence to defined physiological criteria, and a documented discharge safety-netting plan. Day-case anesthesia provisions within this standard shall be applied in conjunction with the applicable DoH Day Surgery / Procedure Service Standard (including eligibility, staffing, discharge and escalation requirements)³. In case of inconsistency, the more stringent requirement shall apply, or the provider shall seek DoH clarification.

3.2.6 For the purposes of this standard, qualified peri-anesthesia support staff may include:

3.2.6.1 Licensed Anesthesia Technologists holding a recognized bachelor's degree.

3.2.6.2 Licensed Anesthesia Technicians holding a recognized diploma with documented competency assessment, privileging, and ongoing appraisal.

3.2.6.3 Registered Nurses who have completed formal anesthesia-related training and practice within their licensed nursing scope under the direction and supervision of a licensed anesthesiologist.

3.2.7 All peri-anesthesia support staff shall:

3.2.7.1 Practice within their licensed scope of practice and approved clinical privileges, refer to Scope of Practice for Anesthesia Technologist and Technician.

3.2.7.2 Work under the direction and supervision of a licensed anesthesiologist at all times.

3.2.7.3 Not independently administer, induce, or manage anesthesia. Peri-anesthesia support staff may only perform tasks permitted by their DoH-licensed scope of practice and applicable DoH scope-of-practice documents; local privileging shall not expand scope beyond DoH requirements.

3.2.7.4 Comply with all DoH licensure, competency, training, privileging, and information security requirements.

3.3. Table 1: Adults Anesthesia Staffing Matrix

Category	ASA I & II (Healthy/Mild)	ASA III (Severe Systemic)	ASA IV & V (Critical/Extreme)
Complexity Level	Level 1–2: Minor/Intermediate (standard monitoring)	Level 3: Major procedures (hemodynamic impact)	Level 4: High-risk/Specialized (e.g., Cardiac, Neuro)
Primary Clinician	Specialist Anesthetist (minimum 3 years post-qualifying experience)	Consultant Anesthetist (Tier 1/2) with mandatory oversight. Privileged Specialist or Consultant. ⁴	Consultant-led; senior presence mandatory for induction and emergence
Peri-Anesthesia Support	1:1 peri-anesthesia support: One qualified peri-anesthesia support staff member shall be continuously assigned per patient/operating room to support invasive procedures, medication preparation, advanced monitoring, and MDT coordination	1:1 dedicated peri-anesthesia support: One qualified peri-anesthesia support staff member shall be continuously present to provide bedside support, emergency readiness (airway, drugs, blood), and continuous monitoring	1:1 peri-anesthesia support: One qualified peri-anesthesia support staff member shall be continuously present with immediate escalation to ICU as clinically indicated
Pre-operative Assessment	Nurse-led with Specialist review	Consultant-led mandatory in-person senior review	MDT review with Consultant Anesthesia and Specialty (Cardiology/ICU)
Post-operative Coverage	On-call response within 5–10 minutes	Consultant present onsite until Phase II recovery	Continuous bedside monitoring for the first hour post-emergence

3.4 Pediatric Anesthesia Staffing Requirements

3.4.1 ASA classification shall be completed during pre-anesthesia evaluation (Appendix 1).

3.4.2 High-Risk Definition

High-risk pediatric patients include: ASA III and above, children under 2 years of age, complex procedures, or significant comorbidities.

Table 2: Unified Pediatric Staffing Framework (Best Practice)

Phase of Care	Staffing Requirement
Pre-Operative Assessment	Consultant Pediatric Anesthetist or Anesthetist with documented pediatric anesthesia experience shall assess all high-risk cases, ASA III+, and children under 2 years. Staffing shall be workload-based and supported by pediatric-trained nursing staff.
Intra-Operative Care	1:1 Consultant Pediatric Anesthetist or appropriately qualified anesthetist per case. Specialist Anesthetists may manage ASA I–II children over 2 years under Consultant oversight. 1:1 peri-anesthesia support shall be continuously present.
Post-Anesthesia Care – Phase I (PACU)	1:1 pediatric-trained nurse per patient until stable. Consultant Anesthetist oversight shall be available onsite for complications or escalation.

Post-Anesthesia Care –
Phase II (PACU)

Nursing ratios may be adjusted (1:2–1:4) based on age, acuity, and stability. Consultant support shall be available as per escalation policy.

3.5 Multidisciplinary Team (MDT) Integration and Roles

- 3.5.1 Anesthesia services shall be delivered through an MDT approach.
- 3.5.2 The Consultant Anesthesiologist shall act as MDT Lead with ultimate responsibility for clinical strategy and intraoperative direction.
- 3.5.3 The Specialist Anesthesiologist shall execute the anesthesia plan and escalate instability immediately.
- 3.5.4 The Anesthesia Technologist shall manage advanced airway equipment and invasive monitoring.
- 3.5.5 The Anesthesia Technician shall provide logistical and emergency support.
- 3.5.6 The Perioperative/PACU Nurse shall manage transitions of care and monitoring continuity.
- 3.5.7 Mandatory pre-surgical huddles shall occur for ASA III+ and pediatric cases.
- 3.5.8 Standardized handover tools (e.g., SBAR) shall be used.

3.6 Pre-Anesthesia, Intra-operative and Post-Anesthesia Care

3.6.1 Pre-Anesthesia Process

- 3.6.1.1 Pre-operative assessment shall be completed ≥ 24 hours prior (except emergencies).
- 3.6.1.2 The facility shall document (a) pre-anesthesia evaluation (clinic/ward; timing proportionate to risk) and (b) pre-induction assessment (immediately before anesthesia).
- 3.6.1.3 The pre-anesthesia checklist shall be completed.
- 3.6.1.4 Daily equipment and drug checks shall be signed, and emergency airway equipment shall be continuously available.

3.6.2 Intra-operative Protocols

- 3.6.2.1 WHO Surgical Safety Checklist shall be implemented.
- 3.6.2.2 High-alert drugs shall follow dual verification.
- 3.6.2.3 Anesthesia medication safety controls shall be implemented, including standardized syringe labeling, separation and clear labeling of neuromuscular blocking agents, availability of appropriate reversal agents, standard concentrations for commonly used infusions where feasible, and defined double-check processes for high-alert medications and infusion pump programming.⁵
- 3.6.2.4 Real-time documentation shall be maintained.
- 3.6.2.5 A backup airway plan shall be documented, and a standardized difficult airway algorithm shall be available in all anesthesia locations. A difficult airway cart, resuscitation equipment, and emergency medications shall be immediately accessible and checked per facility policy. The facility shall conduct regular multidisciplinary emergency response drills relevant to anesthesia practice (e.g., failed airway, anaphylaxis), with frequency defined in policy and auditable records.⁵
- 3.6.2.6 Sedation provided outside the operating room shall meet equivalent monitoring, staffing, equipment, and emergency response requirements appropriate to the depth of sedation.

3.6.3 Minimum monitoring requirements (all anesthesia settings)^{6,7}

3.6.3.1 Oxygenation: Continuous pulse oximetry (SpO₂) with audible alarms enabled.

3.6.3.2 Ventilation: Continuous ventilation monitoring. Capnography (EtCO₂) shall be used for (a) general anesthesia, (b) moderate sedation, (c) deep sedation, and (d) any patient with an advanced airway device or where ventilation cannot be directly observed

3.6.3.3 Circulation: Continuous ECG monitoring and blood pressure monitoring at least every 5 minutes during general anesthesia, regional anesthesia with sedation, and moderate/deep sedation, and at a frequency proportionate to patient risk for other settings.

3.6.3.4 Inspired oxygen concentration: An oxygen analyzer (FiO₂) shall be used for patients receiving general anesthesia via an anesthesia machine and shall be documented per facility policy.

3.6.3.5 Temperature: Temperature monitoring shall be available and used for cases of significant duration, vulnerable populations (e.g., pediatrics), or where clinically indicated, and where active warming is used.

3.6.3.6 Alarm management: Alarm limits shall be set appropriately for the patient and clinical context and shall not be disabled except briefly when clinically necessary and documented.

3.6.4 Anesthesia record minimum documentation dataset^{5,8}

3.6.4.1 Pre-anesthesia evaluation: History/physical assessment, ASA Physical Status, airway assessment, allergies, comorbidities, relevant investigations, fasting status per policy, planned anesthesia technique, risk discussion, and optimization plan.

3.6.4.2 Pre-induction assessment: Confirmation of patient identity, procedure, site, consent status, reassessment of airway/clinical status, and readiness of equipment/medications.

3.6.4.3 Intra-procedure record: Start/stop times, anesthesia technique, airway management and devices used, continuous monitoring trend record, vital signs at defined intervals (at minimum every 5 minutes during general anesthesia and moderate/deep sedation), administered medications (dose/route/time), fluids/blood products, estimated blood loss, temperature management, complications and interventions, and handover details.

3.6.4.4 Post-anesthesia / recovery record: PACU admission assessment, monitoring, pain and PONV management, complications and escalation, discharge criteria achievement, discharge instructions for day cases, and receiving clinician/unit handover.

3.6.4.5 System of record: The anesthesia record shall be completed in real time, stored in the EMR, and made available through Malaffi in accordance with DoH requirements and applicable privacy/information security controls.

3.6.5 Procedural sedation and Non-Operating Room Anesthesia (NORA)^{1,2,5}

3.6.5.1 Governance: The facility shall maintain a procedural sedation/NORA policy defining levels of sedation (minimal, moderate, deep), patient selection and exclusion criteria, fasting guidance per policy, and escalation/transfer pathways.

3.6.5.2 Credentialing and competence: Clinicians administering moderate or deep sedation (or anesthesia) shall be credentialed/privileged for that level and shall maintain role-appropriate life-support certification (e.g., BLS/ACLS and PALS/APLS where relevant).

3.6.5.3 Rescue capability: For moderate sedation, the team shall be able to rescue a patient from deep sedation. For deep sedation, the team shall be able to rescue a patient from general anesthesia, including airway management and ventilation support, with immediate access to resuscitation drugs and equipment.

3.6.5.4 Monitoring: Monitoring shall be equivalent to the depth of sedation and at minimum include continuous SpO₂ and ECG, blood pressure at defined intervals, and continuous capnography (EtCO₂) for moderate and deep sedation.

3.6.5.5 Environment and equipment: NORA locations shall have immediate access to oxygen, suction, emergency airway equipment, defibrillator, emergency medications, and a means for summoning help, and shall meet the relevant DoH Facility Guidelines.

3.6.5.6 Recovery and discharge: Patients receiving moderate or deep sedation shall recover in an appropriate monitored area with defined discharge criteria (including stable vitals, airway patency, controlled pain/nausea, and responsible escort for day cases) documented in the EMR.

3.6.6 Post-Anesthesia Care (PACU)

3.6.6.1 Discharge shall require Aldrete Score ≥ 9 with clinical confirmation.

3.6.6.2 PACU discharge (Phase I/II as applicable) shall also require documented clinical criteria including stable vital signs, maintained airway patency and adequate ventilation/oxygenation, acceptable pain control, controlled PONV, acceptable surgical-site bleeding status, appropriate return of motor/sensory function following neuraxial/regional anesthesia, and completion of standardized handover documentation to the receiving unit/escort.^{3,7}

3.6.6.3 Day-case discharge shall require a responsible adult and written instructions.

3.7 Pediatric-Specific requirements

3.7.1 Children under 2 years and all high-risk pediatric cases shall be managed by anesthesiologists with advanced pediatric anesthesia competencies.

3.7.2 Neonates under 44 weeks post-conceptual age and ASA IV+ pediatric patients shall be managed exclusively by Consultant Anesthesiologists with specialized pediatric expertise.

3.7.2.1 Evidence of specialized pediatric anesthesia expertise for Consultant Anesthesiologists shall be documented and made available to DoH upon request. Acceptable evidence includes:

3.7.2.1.1 completion of a recognized pediatric anesthesia fellowship/subspecialty training or equivalent;

3.7.2.1.2 a recent pediatric anesthesia case log (lookback period of 12–24 months) demonstrating appropriate case volume and case-mix relevant to the facility's scope (including high-risk age groups where applicable);

3.7.2.1.3 current, in-date PALS/APLS certification;

3.7.2.1.4 facility privileging documentation explicitly granting pediatric anesthesia privileges and defining any limits;

3.7.2.1.5 pediatric anesthesia—specific CPD/CME completed within the last 24 months.

3.7.3 Interim pediatric privileging may be granted to Specialists for children over 2 years (ASA I–III) with documented case volume and valid PALS/APLS certification, pediatric privileging remains subject to DoH approval.

3.7.4 Pediatric equipment, recovery beds, and medications shall be available.

3.7.5 PALS/APLS and safeguarding training shall be mandatory and role-appropriate.

3.8 All healthcare professionals involved shall have completed the information security courses assigned by DoH from time to time. Healthcare facilities shall ensure anesthesia-related connected medical devices and systems (e.g., anesthesia machines, monitors, and interfaces to EMR) are implemented and operated in compliance with AAMEN requirements, including role-based access, device/user authentication, secure configuration, and incident reporting procedures.^{9,10}

4. Key Stakeholder Roles and Responsibilities

4.1 All healthcare professionals involved in delivering anesthesia services must:

4.1.1 Operate within a licensed facility equipped with the necessary equipment and resources to ensure patient safety and quality of care.

4.1.2 Practice in accordance with UAE local and federal laws, ethical values, standards of professional conduct, delineated clinical privileges, scope of practice, and clinical practice protocols, standards and guidelines published by DoH, national or international organizations.

4.2 Responsibilities of Healthcare Providers

4.2.1 The healthcare facility should meet the service specifications and requirements set out in this standard and other relevant DoH regulations.

4.2.2 The healthcare facility should have structured training programs for all healthcare professionals covering evidence-based care protocols/guidelines.

4.2.3 Billing and reimbursement shall be in accordance with Standard Provider Contract, DoH Mandatory Tariff and associated Claims and Adjudication Rules, and the Claims and Adjudication Standard. All documents are available from the DoH website: <https://www.doh.gov.ae/shafafiya/>

4.2.4 Enroll in DoH electronic incident reporting platform for patient safety.

4.2.5 Upon the occurrence of an incident suspected to be a sentinel event (as defined in the DoH standards), healthcare facilities must notify DoH at HCFSQPS@DoH.gov.ae within 48 hours of becoming aware of the sentinel or suspected sentinel event, using the designated sentinel event notification form.

4.2.6 HF must use the NPCM for prescription and dispensing narcotic-controlled medicines.

4.2.7 For anesthesia-related controlled medicines, the HF shall maintain anesthesia-specific controlled-drug governance aligned with NPCM, including secure storage with restricted access, documented controlled-drug counts and reconciliation where required, audit trails for prescribing/dispensing/administration, and incident escalation for discrepancies in accordance with DoH requirements.^{11,12}

5. Monitoring and Evaluation

5.1 The healthcare facility should have a system in place for continuous quality improvement. All anesthesia-related adverse events (e.g., reintubation, cardiac arrest, PACU transfer to ICU) must be logged.

5.2 The HF should regularly monitor and evaluate its practices and outcomes to identify areas for improvement and make changes accordingly.

5.3 Facilities must implement continuous quality improvement processes. Suggested indicators include but not limited to

5.4 Preoperative Assessment Completion Rate: % of elective anesthetics with documented pre-anesthesia evaluation completed ≥ 24 hours pre-procedure (or per documented exception).

5.5 Percentage of Patients Assessed: % of anesthetics with documented ASA Physical Status (or an approved risk assessment tool).

5.6 % of ASA III+ patients reviewed by Consultant: % of ASA III+ cases with documented Consultant review (per Sections 3.2.2 and 3.2.5).

5.7 Anesthesia-Related Complication Rate: Number of anesthesia-related adverse events per 1,000 anesthetics.

5.8 Perioperative Hypothermia Rate: % of patients with documented core temperature $< 36^{\circ}\text{C}$ during or immediately after surgery (per facility policy).

5.9 Day Surgery anesthesia complications (DS005): As defined by the applicable DoH/JAWDA indicator specification (where adopted by the facility).

6. Enforcement and Sanctions

6.1 DoH may impose sanctions in relation to any breach of requirements under this standard in accordance with the disciplinary regulation of the healthcare sector.

7. Exempted from Scope

7.1 This standard does not cover sedation modalities provided in dental clinics or dental centers when performed on an ambulatory (outpatient) basis. Sedation and/or general anesthesia for dental procedures performed within DoH-licensed hospitals or one-day surgery facilities remains within scope and shall comply with this standard.

8. Relevant Reference Documents

No.	Reference Date	Reference Name	Relation Explanation / Coding / Publication Links
1	2023	Statement on Nonoperating Room Anesthesia Services	https://www.asahq.org/standards-and-practice-parameters/statement-on-nonoperating-room-anesthesia-services
2	2026	DoH Health Information Exchange (Malaffi) – Health Information Exchange standards (minimum data sets and coding standards)	www.doh.gov.ae/en/resources/HIE
3	2020	Standard for Day Surgery/Procedure Service	https://www.doh.gov.ae/en/resources/Standards
4	2025	Scope of Practice for Anesthesia Technologist and Technician	https://www.doh.gov.ae/en/resources/scope-of-practice
5	2025	Joint Commission International Standards for Hospitals – 8th Edition	www.jointcommission.org/en
6	2023	Standards for Basic Anesthetic Monitoring	https://www.asahq.org/standards-and-practice-parameters/standards-for-basic-anesthetic-monitoring
7	2021	Association of Anaesthetists. Recommendations for Standards of Monitoring During Anaesthesia and Recovery	www.anaesthetists.org/Guidelines-and-publications/Guidelines/Recommendations
8	2016	UAE Federal Decree-Law No. (4) of 2016 Concerning Medical Liability (informed consent, documentation, practitioner duties)	https://www.asahq.org/standards-and-practice-parameters/statement-on-documentation-of-anesthesia-care
9	2022	Circular USO/29/2022 Abu Dhabi Healthcare Sector Cyberlearning Program	https://www.doh.gov.ae/en/resources/Circulars
10	Accessed May 2026	DoH AAMEN – Abu Dhabi Healthcare Information Security Programme (ADHICS/ADHICS-related requirements)	www.doh.gov.ae/en/programs-initiatives/Aamen
11	2025	National Platform for Narcotic and Controlled Medicines	https://www.doh.gov.ae/-/media/9044C1D397A044FEB2A6D78F84CF386B.ashx

12	Apr 2024	DoH Circular on Launch of the National Platform for Narcotic and Controlled Medicines (NPCM) – inpatient setting	https://www.doh.gov.ae/-/media/5120B15C0FD54FC1B90BF0BF863AB77E.ashx
13	2025	Royal College of Anaesthetists. Guidance on the Provision of Pediatric	www.rcoa.ac.uk/gpas/chapter-10
14	2020	Basic Standards for Preanesthesia Care	www.asahq.org/standards-and-practice-parameters/basic-standards-for-preanesthesia-care

10. Appendices

APPENDIX 1 - American Society of Anesthesiologists (ASA) Physical Status Classification System

ASA PS classification	Definition	Adults' examples	Pediatric examples	Obstetrics examples
ASA I	Normal healthy patient	Healthy, non-smoking, no or minimal alcohol use	Healthy (no acute or chronic disease), normal BMI percentile for age	Normal healthy patient
ASA II	A patient with Mild systemic disease	Mild diseases only without substantive functional limitations. Current smoker, social alcohol drinker, pregnancy, obesity (30<BMI<40), well-controlled DM/HTN, mild lung disease	Asymptomatic congenital cardiac disease, well controlled dysrhythmias, asthma without exacerbation, well controlled epilepsy, non-insulin dependent diabetes mellitus, abnormal BMI percentile for age, mild/moderate OSA, oncologic state in remission, autism with mild limitations	Normal pregnancy*, well controlled gestational HTN, controlled preeclampsia without severe features, diet-controlled gestational DM.
ASA III	A patient with severe systemic disease	Substantive functional limitations; One or more moderate to severe diseases. Poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis,	Uncorrected stable congenital cardiac abnormality, asthma with exacerbation, poorly controlled epilepsy, insulin dependent diabetes mellitus, morbid obesity, malnutrition, severe OSA, oncologic state, renal failure, muscular dystrophy, cystic fibrosis, history of organ transplantation,	Preeclampsia with severe features, gestational DM with complications or high insulin requirements, a thrombophilic disease requiring anticoagulation.

		history (>3 months) of MI, CVA, TIA, or CAD/stents.	brain/spinal cord malformation, symptomatic hydrocephalus, premature infant PCA <60 weeks, autism with severe limitations, metabolic disease, difficult airway, long term parenteral nutrition. Full term infants <6 weeks of age.	
ASA IV	A patient with severe systemic disease that is a constant threat to life	Recent (<3 months) MI, CVA, TIA or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, shock, sepsis, DIC, ARD or ESRD not undergoing regularly scheduled dialysis	Symptomatic congenital cardiac abnormality, congestive heart failure, active sequelae of prematurity, acute hypoxic-ischemic encephalopathy, shock, sepsis, disseminated intravascular coagulation, automatic implantable cardioverter-defibrillator, ventilator dependence, endocrinopathy, severe trauma, severe respiratory distress, advanced oncologic state.	Preeclampsia with severe features complicated by HELLP or other adverse event, peripartum cardiomyopathy with EF <40, uncorrected/decompensated heart disease, acquired or congenital.
ASA V	A moribund patient who is not expected to survive without the operation	Ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction	Massive trauma, intracranial hemorrhage with mass effect, patient requiring ECMO, respiratory failure or arrest, malignant hypertension, decompensated congestive heart failure, hepatic encephalopathy, ischemic bowel or multiple organ/system dysfunction.	Uterine rupture.
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes			

- 1) The classification system alone does not predict the perioperative risks, but used with other factors (eg, type of surgery, frailty, level of deconditioning), it can be helpful in predicting perioperative risks.
- 2) Although pregnancy is not a disease, the parturient's physiologic state is significantly altered from when the woman is not pregnant, hence the assignment of ASA 2 for a woman with uncomplicated pregnancy.
- 3) Age-Appropriate Stratification: For all pediatric patients, clinicians must refer to the specific age-appropriate examples and clarifications provided within the official ASA Physical Status Classification System with Pediatric Examples endorsed by the Society for Pediatric Anesthesia (SPA)