PEAKONE SURGERY CENTER

Label

PRE-OPERATIVE ASSESSMENT / SURGERY

Pre surg.testing date: ___________ Time ___________
Date of procedure: _________ Surgeon: ___________
Preferred Name: ______________________________
Caregiver after surgery: _______________________
Contact phone #: ____________________________
Scheduled surgery (patient's words) _______________
____
Instructed on: OR time _________ Arr. Time ________
NPO solids @____________ Liq. @ ________________
HT _________________ WT ____________________
Allergies/symptoms to medications, food, contrast dye,
Latex – Reaction: _____________________________
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MEDICATIONS: Prescription, OTC, herbs, vitamins, diet pills	See Medication Reconciliation form

Past Surgeries:

Health History/Review of Systems	Y	N
Anesthesia: Self/family member had problems associated with anesthesia?		
Respiratory problems: Asthma, COPD, SOB walking up 2 flights of stairs HX of TB Home oxygen CPAP React. Airway(RAD)Smoke Y N pack/day_______Quit_______		
Cardiac: Hypertension MI Chest pain Valve problems CHF Irregular HR Pacemaker cardiac workup		
GI: Diarrhea Vomiting Constipation Ulcers Acid reflux Appetite changes Difficulty swallowing other__________		
Blood: Anemia, Sickle cell anemia, Hepatitis, HIV, Blood clots Other_______________		
Kidney/bladder: Urinary frequency/ incontinence Kidney stones Burning w/urination		
Diabetes Insulin Oral med Diet controlled **Thyroid** How long______		
EENT: Cataracts Hard of hearing Sinus condition Tonsillitis Ear infection		
Chronic Disease: Cancer Lupus First Diagnosed**:**		
Neurological: Stroke Seizures TIA Head/Neck/Back injury Other:		
Skin: Rash Itching Hives Eczema		
Infection: MRSA (copy of lab result) Other:		
Mental Illness: Depression Anxiety Other:		
GYN: Could you be pregnant		
Muscle, Joint, Bone : Osteoporosis Arthritis Artificial joint		
Social history: chew tobacco Y N Drink alcohol? Y N how much/wk? _______________ Street drugs? Y N type _______________________ How much/wk?________________		
Communication barriers: Language/Other Interpreter needed?		
PAIN: Words_________________________________ **I**ntensity_____ (0-10) **L**ocation__________________________ **D**uration:______ **A**lleviated w/________________		
Pediatric: Immunization up to date: Recent exposure to: _____________________________ Activities: sit alone stand crawl walk		

Arrival time/POSC phone # 970-668-1458		
Patient instructed on directions		
Instructed: No public transportation home/need ride home		
Caregiver with you X 24 hours		
NPO status understood		
Approximate discharge time		
Need for crutches or durable med. equipment		
Leave valuables/jewelry at home		
No make-up, lotion – wear loose, comfy clothes.		
Bring insurance card/papers from Dr.'s office		
DVD/player available/book		
Patient received information about advance directives _________________ date		
Patient received Rights and Responsibilities **Patient** received information about physicians part ownership ______________date		
Do you feel physically/emotionally safe at home?		
Parents advised on child safety		

Pre**S**urgical **T**esting scheduled_______		
Scheduled for lab/EKG?		
Where		
When_________________________________		
Received lab/EKG result?		
Previous record/H+P/Anesthesia Record		

NURSES NOTES:
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____
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Fall risk assessment: wheel chair crutches medication: _____________other:______________________________
Information obtained from: () Patient () Other
RN Signature/Title/Initial: ____Date:___________________Time:_______