PRE-OP ASSESSMENT

Please fill out the following information

NAME: ________________________. **DOS:** __________. **HT:**________ **WT:**________ **kg/lb** **BMI:**_________ **DOB:**___________

PROCEDURE: ____

☐**NKDA** **ALLERGIES:** ____

☐**LATEX** **Reaction** ____ ☐**FOOD** **Reaction** ____________________

Last Menstral Period_______. ☐ **BTL (tubes tied) Yr:** ______ ☐ **Hysterectomy** ☐ **Post Menopausal** ☐ **N/A**

MEDICATIONS: **(Including Herbals and OTC):** **See Medication Reconciliation Form (MRF)**

RESPONSIBLE PERSON AT DISCHARGE: _________________________ ☐**Staying** ☐**Leaving** **Ph #:** ____________________

NURSE TO FILL OUT INFORMATION BELOW

PRE-OP ARRIVAL TIME:__________________ **VITAL SIGNS: T**________ **P**________ **R**________ **B/P**________ **Sp02**_________**%**

SURGICAL CHECKLIST	**PRE-OP INITIALS**	**OR INITIALS**
NPO STATUS: ☐**After Midnight** **Date:**________ **Time:** ________ ☐**Other**________________		
ID BAND: On Patient, used 2 identifiers & allergies verified		
Labs / EKG / Chest X-ray on chart: (circle as appropriate) ☐N/A		
Completed H & P / Physician orders: ☐**On Chart** ☐**Needed & Physician Notified**		
Operative Consent: Complete & procedure verified by: ☐**Patient** ☐**Site Marked** ☐**Other**		
Personal Itens: ☐**Glasses/Contacts** ☐**Hearing Aid** ☐**Jewelry** ☐**Other:** ________ ☐**None**		
Disposition: ☐**With Patient** ☐**To PACU** ☐**Given to Family member** ______________		
Mental/Emotional Status: ☐**Alert** ☐**Oriented** ☐**Anxious** ☐**Crying** ☐**Sedated** ☐**See Notes**		
Translation Provided by: ___________ ☐**N/A** ☐**Social and Cultural needs assessed and met**		
Limitations: ☐**Visual** ☐**Auditory** ☐**Hearing Aid** ☐**Other** ________________________ ☐**None**		
Dental: ☐**Own** ☐**Caps** ☐**Dentures** ☐**Loose Teeth** ☐**Other:** ___________		
Pre-Op Skin I/ Condition: ☐**Intact** ☐**Other:** ____		
Skin Prep: ☐**N/A** ☐**Hibiclens** ☐**Betadine** ☐**Shave** **Site:** _______________________		
DVT Risk Assessment: ☐**Low** ☐**Moderate** ☐**High**		
Fall Potential: ☐**Yes** ☐**No**		
Mobility: ☐**Ambulatory** ☐**Cane** ☐**Walker** ☐**W/C** ☐**Other**____________		
Safety Measures: ☐**Recliner/Stretcher_ Position** ☐**Wheels Locked** ☐**Side Rails ^ X2**		

Pain Scale Instruction: 0-10 Present Pain Score: ____**/10 Location:** ______________ **Description:** __________ **Frequency:**___________

Pain Description: A=Ache B=Burning D=Dull N=Numb PI=Pinching PR=Pressure SH=Sharp SHT=Shooting ST=Stabbing T=Throbbing

Outpatient Surgery Care Plan: Nursing Diagnosis: Anxiety related to knowledge deficit regarding, anesthesia and recovery surgerical procedure

Outcome: Patient verbalized basic understanding & demonstrates decreased anxiety related to anticipated procedure and recovery ☐Y ☐N

IV SOLUTION: ☐LR ☐0.95% NaCl ☐Other:____________ ☐500ml ☐ 1000ml Local used --1% ☐Y ☐N

TIME STARTED:________ SITE: R L ☐Hand ☐Arm ☐Other:__________ Catheter Size: _____ gauge Nurse Initial: ____

PRE-OP MEDICATIONS	NURSE INITIALS	TIME	ROUTE	NURSES NOTES

PRE-OP RN SIGNATURE/INITIALS **O.R. RN SIGNATURE / INITIALS**

____________________________ ____________ ______________________________ ___________

____________________________ ____________ ______________________________ ___________

PRE-ADMISSION ASSESSMENT

PLEASE FILL OUT THE INFORMATION BELOW

HEALTH HISTORY CODE: F = FAMILY P = PATIENT ☐ **PATIENT DENIES ANY HEALTH PROBLEMS**

(CHECK & CIRCLE APPROPRIATELY)

F P
☐ ☐ OSA C-PAP / BI-PAP Y N
☐ ☐ ASTHMA / BRONCHITIS / COPD
☐ ☐ EMPHYSEMA
☐ ☐ TB
☐ ☐ RESPIRATORY INF / COUGH
☐ ☐ SINUSITIS / ALLERGIES
☐ ☐ BLOOD PRESSURE
☐ ☐ NEURO-MUSCULAR
☐ ☐ HEART ATTACK
☐ ☐ HEART MURMER
☐ ☐ HEART DISEASE

F P
☐ ☐ CIRCULATORY PROBLEMS
☐ ☐ MOTION SICKNESS
☐ ☐ HIATAL HERNIA
☐ ☐ ACID REFLUX / GASTRIC ULCERS
☐ ☐ STOMACH / BOWEL
☐ ☐ KIDNEY / BLADDER
☐ ☐ DIABETES
☐ ☐ GLANDULAR PROBLEMS
☐ ☐ ARTHRITIS
☐ ☐ HEPATITIS
☐ ☐ CANCER

F P
☐ ☐ ANEMIA / BLEEDING PROBLEMS
☐ ☐ SICKLE CELL
☐ ☐ SEIZURES / CONVULSIONS-LAST ONE _____
☐ ☐ FAINTING SPELLS
☐ ☐ GLAUCOMA
☐ ☐ PSYCHIATRIC
☐ ☐ ANXIETY / DEPRESSION
☐ ☐ HYPERLIPIDEMIA
☐ ☐ OTHER: ____________________________
☐ ☐ OTHER: ____________________________

ALCOHOL HABITS	DRUG HABITS	TOBACCO HABITS	HERBAL / DIET PILLS
☐YES ☐ NO	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO ☐STOPPED
DURATION ___________	DURATION ___________	DURATION ___________	DURATION ___________
AMT / TYPE ___________	AMT / TYPE ___________	AMT / TYPE ___________	TYPE ________________

☐ MINOR CURRENT IMMUNIZATIONS: ☐Y ☐N & Information Given ☐Patient/Guardian Instructed to Remain until Discharged

☐ SEE ACTIVE PATIENT SUMMARY LIST

MEDICAL HISTORY / SURGERIES / ANESTHESIA PROBLEMS ☐YES ☐NO EXPLAIN: ______________________

PCP: ______________________ LAST VISIT: __________ LAST EKG: __________ WHERE: ______________________ ☐ N/A

PRE-ADMISSION EDUCATION & INSTRUCTIONS FOR DAY OF PROCEDURE

****PLEASE DO NOT WRITE BELOW THIS LINEE: FOR MEDICAL STAFF****

DOCTOR: ________________________ DATE:___________ TIME:___________ OF ARRIVAL ☐ Y ☐ N ☐ PER DR.

PATIENT INSTRUCTED ON: NPO AFTER ☐ MIDNIGHT ☐ LIGHT MEAL / CLEAR LIQUIDS BEFORE 6AM

- ATTIRE ☐ APPROPRIATE FOR PROCEDURE
  ☐ BUTTON DOWN SHORT SLEEVE TOP
  ☐ ELASTIC WAIST BOTTOMS
- REMOVAL OF JEWELRY / VALUABLES
  CONTACT LENSES AND MAKE-UP ☐ Y ☐ N
- BRING EYE GLASS/CONTACT CASE ☐ Y ☐ N
- TRANSPORTATION ARRANGEMENTS ☐ Y ☐ N
- TRANSLATOR NEEDED ☐ Y ☐ N

- MEDICATION INSTRUCTIONS DAY OF PROCEDURE ☐NONE
  ☐ TAKE WITH SIPS OF WATER ☐ ACID REFLUX
  ☐ HYPERTENSION
  ☐ OMIT ☐ DIABETES MEDICATION
  ☐ BLOOD THINNERS
- INFORMATION OBTAINED VIA ☐PHONE ☐IN PERSON
- INFORMATION OBTAINED BY ☐PATIENT ☐FAMILY
  ☐OTHER ____________

PRE-ADMIT NOTES: ____

ASSESSMENT
DATE: ___________ TIME:__________

PRE-ADMISSION
RN SIGNATURE / INITIALS ________________ ______
RN SIGNATURE / INITIALS ________________ ______

TEXAS PRECISION SURGERY CENTER

MEDICATION RECONCILIATION LIST

******PLEASE FILL OUT THE INFORMATION BELOW******

Completed By: ______________________________ Date: _______________ Source(s): ☐ PT ☐ Family ☐ MD ☐ H&P

Name of Pharmacy Used: Primary Care Physician:

Medication Allergies ☐ NKDA ☐ See Allergy / Sensitivity Reaction List

Current Medications

Medication Name Include vitamins & herbal supplements	**Dose** Example: mg, units	**Route** By Mouth Unless Otherwise Indicated.	**How Often** Example: daily, twice a day, As needed	**Discontinued**	**Taken Day of Surgery**
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
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					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

☐ Resume All medications as previously prescribed.
Do NOT resume blood thinners until instructed by your physician.

Medication Name	**Dose** Example: mg, units	**Route** ☐ Right Eye ☐ Left Eye	**How Often** Example: daily, twice a day, As needed	**Discontinued**	**Taken Day of Surgery**
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Medication Lists Reviewed with each Admission

ASC USE ONLY	Med list reviewed with Patient	☐ Yes ☐ No	Date	By:
	Med list reviewed with Patient	☐ Yes ☐ No	Date	By:
	Med list reviewed with Patient	☐ Yes ☐ No	Date	By:
	Med list reviewed with Patient	☐ Yes ☐ No	Date	By: