SOMERSET AMBULATORY SURGICAL CENTER

PRE-PROCEDURE FORM

General

Name:

Date of Procedure:
/ /

Surgeon:

Procedure:

Interview Source:
- € Patient
- € Spouse
- € Parent
- € Other

Anesthesia Type:

Home Phone:

Cell Phone:

Age:

Height:

Weight:

BMI

History / Background

Personal history of Anesthetic problems?
- € Yes
- € No

Family history of Anesthetic problems?
- € Yes
- € No

Do you have any of the following?:
- € Metal Implants
- € Glasses / Contacts
- € Pacemaker / ICD
- € Hearing Aid

Airway Evaluation:
- € Yes
- € No

_____
_____
_____
_____

List previous surgeries and any anesthesia problems:

_____
_____
_____
_____
_____

Medical History

CARDIAC
Please check all that apply:
- € HYPERTENSION
- € ANGINA
- € HEART ATTACK
- € MURMUR
- € HIGH CHOLESTEROL
- € MITRAL VALVE PROLAPSE
- € CARDIAC STENT

ARRHYTHMIA:
_____

NEURO
Please check all that apply:
- € STROKE/TIA
- € SEIZURES
- € MIGRAINE
- € OTHER:

_____

LIVER DISEASE
Please check all that apply:
- € HEPATITIS
- € CIRRHOSIS
- € OTHER:

_____

AUTOIMMUNE DISEASE
Please check all that apply:
- € LYMES DISEASE
- € LUPUS
- € HIV
- € MULTIPLE SCLEROSIS

GASTROINTESTINAL
Please check all that apply:
- € ULCERS
- € GERD / REFLUX DISEASE
- € HIATAL HERNIA
- € DIVERTICULOSIS

RENAL DISEASE
Renal Disease type:
_____

HEENT
Please check all that apply:
- € GLAUCOMA
- € HARD OF HEARING
- € VISUAL IMPAIRMENT
- € SINUSITIS

PULMONARY
Please check all that apply:
- € ASTHMA
- € COPD / EMPHYSEMA
- € SLEEP APNEA C-PAP
- € SLEEP APNEA B-PAP
- € SHORT OF BREATH / DIFFICULTY BREATHING

C-PAP DEVICE SETTINGS:
_____

B-PAP DEVICE SETTINGS:
_____

OTHER:
_____

ENDOCRINE
Please check all that apply:
- € DIABETES TYPE I
- € DIABETES TYPE II
- € THYROID DISEASE

GYN
Please check all that apply:
- € HYSTERECTOMY
- € MENOPAUSE

Date of last menstrual period:
_____/_____/_____

HEMATOLOGY / ONCOLOGY
Please check all that apply:
- € BLEEDING DISORDER
- € ANEMIA
- € SICKLE DISEASE/TRAIT
- € CANCER:

_____

OTHERS
Please check all that apply:
- € BACK PAIN
- € NECK PAIN
- € ARTHRITIS

MENTAL HEALTH HX
Please check all that apply:
- € DEPRESSION
- € ANXIETY
- € BIPOLAR DISORDER

Alcohol Consumption
- € None
- € Social
- € Moderate
- € Heavy

History of IV Drug use:
- € Yes
- € No

SMOKING/DRUG/ETOH

History of Smoking?
- € Yes (_____ppd)
- € No

Cigar / Pipe?
- € Yes
- € No

STOP-BANG screening tool for OSA risk		
Snoring	Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	Yes No
Tiredness	Do you often feel tired, fatigued, or sleepy during the daytime?	Yes No
Observed apnea	Has anyone observed you stop breathing during your sleep?	Yes No
Pressure	Do you have or are you being treated for high blood pressure?	Yes No
BMI	BMI > 35 kg/m2	Yes No
Age	>50 years	Yes No
Neck circumference	>40 cm (17 inches)	Yes No
Gender	male	Yes No
Fewer than 3 Yes = low risk of OSA; 3 or more Yes = high risk of OSA; 5-8 Yes = high probability of moderate to severe OSA		

ADVANCE DIRECTIVES/ PATIENT RIGHTS & RESPONSIBILITIES/DISCLOSURE OF OWNERSHIP

€ PATIENT HAS RECEIVED WRITTEN AND VERBAL NOTIFICATION IN ADVANCE OF THE DAY OF THE PROCEDURE ON THE ASC'S POLICIES ON:

- ADVANCE DIRECTIVES
- PATIENT RIGHTS & RESPONSIBILITIES
- POLST
- DISCLOSURE OF OWNERSHIP (IF APPLICABLE)

Is English your primary language?

€ Yes
€ No

Do you need a translator?

€ Yes
€ No

If 'Yes', please specify language to be translated:

Any travel outside the country in past 2 weeks?

€ Yes
€ No

Recent Infectious Disease or Exposure

Religion:

Race:

Nutritional Needs:

Special Needs:

Referral Services:

Is there family or other support available?

€ **Yes**
€ **No**

Is the patient a victim of abuse, neglect or domestic violence?

€ **Yes**
€ **No**

Emergency Contact:

Name:

Phone:

Pre-Op Instructions

- Bring all insurance cards & photo ID/ Copy of Advance Directive / Living Will / POLST
- Fasting recommendations for all procedures requiring anesthesia:
  - Nothing by mouth (NPO) after midnight
  - No chewing gum, Lifesavers, mints after midnight
- Please leave jewelry, valuables, credit cards at home
- Do not wear contact lenses
- Remove body piercing
- Do not wear heavy makeup
- Urine test for pregnancy will be done day of surgery (excluding post hysterectomy & post-menopausal x 1 year)
- Bring inhalers with you
- Fill pre-op prescriptions prior to surgery
- Were you given prescriptions to have any pre-op testing performed? If so please have testing done immediately!!

Telephone # we can reach you at the day prior to procedure:

Can information be left on your cell/answering machine or with a family member?

€ **Yes**
€ **No**

Transportation: All patients having anesthesia (except local) need an adult to drive / accompany home

RN Interviewer _____ **Date** _____

SOMERSET AMBULATORY SURGICAL CENTER

MEDICATION RECONCILIATION / ALLERGY FORM

ALLERGIES: ☐ NO ☐ YES LIST ALL MEDICATIONS/BIOLOGICALS & REACTIONS INCLUDING LATEX: NOTE UNKNOWN

	MEDICATION / REACTION	MEDICATION / REACTION

MEDICATIONS PRIOR TO ADMISSION: List all medications, OTC drugs, herbal supplements

☐ Patient takes no medications, OTC drugs or dietary supplements on a routine basis.

MEDICATION: RN Please check if taken day of Surgery	DOSE / FREQUENCY	UN KNOWN	INDICATION (REASON)
☐		☐	
☐		☐	
☐		☐	
☐		☐	
☐		☐	
☐		☐	
☐		☐	
☐		☐	
☐		☐	
☐		☐	
☐		☐	
☐		☐	
☐ BLOOD THINNERS		☐	
☐		☐	
☐		☐	

Source: ☐ Patient ☐ Family ☐ List Obtained by: _____ RN Date: _____

You may safely resume taking all of the above medications, including over the counter medications and dietary supplements prescribed by your physician(s). EXCEPTIONS TO THIS: SEE BELOW.

MEDICATION	Dose / Frequency	Resume Medication: List Date and Time

ATTESTATION: The above is a complete and accurate medication list to the best of my knowledge. It includes over-the-counter and herbal supplements, as well as regular and occasionally used prescription drugs. Your physician is resuming the start of your medication on the information provided by you, including the name of the medications, dosages and frequency.

Patient / Guardian Signature: _____ Date: _____

RN Signature: _____ Physician Signature: _____

New Medication Prescribed Following Your Surgery

MEDICATION	DOSE / ROUTE / FREQUENCY	NEXT DOSE

****Please bring this medication record with you to your physician's office****

Name:
Acct #:
Sex: DOB:
Age: DOS:
Physician:

	POINTS	SCORE
Age:		
64 and under	0	
65 and up	2	
Mental Status:		
NO Deficit	0	
Cognitive Impairment	2	
History of Falls in the last SIX Months:		
No	0	
Yes	3	
Visual Impairment:		
No	0	
Yes	1	
Nursing Home or Special Needs:		
No	0	
Yes	3	
Motor Skills/ADLs:		
NO Deficit	0	
Limited Mobility	2	
Use of Assistive Devices (crutches, cane, walker, wheelchair)	2	
Require Assistance with Activities of Daily Living	2	
Medications – Taken on Day of Admission		
None	0	
TWO OR MORE: (circle all that apply) Tranquilizers, Sleeping Pills, Pain Relievers, Blood Pressure Pills, Diuretics	2	
	TOTAL SCORE:	

Score of 6 or More = HIGH RISK FOR FALLS

Does patient meet criteria for High Risk for Falls (score of 6 or more)? ☐ Yes ☐ No

Facility Falls Risk Protocol initiated? ☐ Yes ☐ No

Signature/Title: _____ Date: _____ Time: _____

Signature/Title: _____ Date: _____ Time: _____