Pre-Op Interview/Medication Reconciliation Form - Adults

Procedure Date: ________________

Patient Name: ____________________________________ **Gender:** ________ **Age:** ________

Phone: ______________________

Surgeon: _________________________ **Procedure:** ____ **Procedure Verified(circle): Yes/No**

Allergies and Reaction (including food allergies): ____NKA or ____

Include topicals, ointments, liquids, parenterals, oxygen, inhalers, drops, over the counter medications, herbals & vitamins

☐ NO CURRENT MEDICATION				ADMISSION MEDICATIONS		DISCHARGE MEDICATIONS	
MEDICATION/DOSE	FREQUENCY	INDICATION	LAST DOSE	TAKE	HOLD	RESUME	HOLD

NEW OR CHANGED DISCHARGE ORDERS (for physician use only)				
MEDICATION/DOSE	FREQUENCY	INDICATION	NEXT DOSE DUE	RX GIVEN

Blood Thinners: your surgeon should have given you instructions about continuing or d/c; if not, patient must discuss with surgeon ASAP
Insulin: No insulin prior to arrival. Bring insulin, appropriate syringe and other diabetic medication with you the morning of surgery
Take heart, blood pressure with small sip of water the morning of surgery if you normally take in AM** ***Brings Inhalers with you

Source of Information: (circle one) No home medications Patient Medication List Patient's Family Medication bottles Old Chart Nursing Home Doctor's Office Pharmacy Other: _________________ **Copy given to patient by:** _____________________

Patient Signature: ____ **Date/Time:** _________________/____________

Physician's Signature: ____ **Date/Time:** _________________/____________

Additional Comments:

Blue Water Surgery Center 6830 S US Highway 1 Port St. Lucie, FL 34952 Phone: 772-873-6700 / Fax: 772-465-5499	Patient Label Here Revised 08/23/2018

Patient Preop Instructions

Primary Physician Name ________________________ Phone # _____________________

Cardiologist Name ____________________________ Phone # ______________________

_____ Patients having general or MAC anesthesia - NPO after midnight. **EXCEPTION:** Surgery scheduled at 11:00 AM or later may have clear liquids up to 7:00 AM

_____ Transportation/ Caretaker **- All patients** We cannot do your surgery unless you have someone drive you home and stay with you until the following morning
Who will be with you? _______________________________________

_____ Patients **under 18 years old:** It is **MANDATORY** that a parent or guardian remain in the facility during the procedure/PACU time

_____ Wear comfortable and loose-fitting clothing. Bring any special garment if instructed by surgeon.

_____ No jewelry (**Exception**-if patient can't remove wedding ring; we will put tape over)

_____ Bring your photo I.D. and insurance cards so we can copy them for correct billing information. Bring co-payment if instructed.

_____ Bring walker, crutches, braces, orthopedic shoe etc. for arthroscopy/podiatry procedures - Center does not provide.

_____ Do you have an Advanced Directive? Bring a copy if available. Will need to sign a "Do Not Resuscitate" Waiver.

_____ Would you like information on Advanced Directives?

_____ Do you know where we are located? **6830 S. US Highway 1~ Port St. Lucie, FL 34952**

_____ Do you have any questions regarding your surgery? **Phone #:772-873-6700**

_____ Information given to: ____

(Additional comments if needed):

Assessment Nurse Signature ___________________________ **Date** _________________________________

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PRE-ANESTHESIA ASSESSMENT FORM

Procedure:___________________________________ **Right / Left (if applicable)**
Surgeon: __________________ **DOS** ________
Age______ **Gender** ______ **Height** ______ **Weight** ______ **BMI** ______ **Procedure Verified: Yes**

	Do you now have or have you ever had a history of:		**Do you now have or have you ever had a history of:**
 ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Cardiovascular Disease** Chest pain/Tightness/Pressure/Heart Attack Irregular Heartbeat Pacemaker/Defibrillator Brand:_________ Last interrogation:_________________ Circulation problems History of Blood Clots High Blood Pressure Recent EKG/Stress/Echo Test date:________ Where:_________________ Other____________________________	 ___ ___ ___ ___ ___ ___ ___ ___ ___	**Neurological Disorders** Stroke/ TIA Seizures Back or neck problems Physical restrictions or limitations Forgetfulness, memory loss, confusion Multiple Sclerosis/Muscular Dystrophy Nerve or Spinal Cord Injury Neuropathy Other ____________________________
___ ___ ___ ___ ___ ___ ___ ___ ___	**Respiratory Disease** Smoke ______PPD; Quit___________ Asthma Emphysema/Bronchitis/COPD/ SOB Upper Respiratory Infection in the last two weeks Sleep Apnea Use CPAP Chest XRay, when _________________ Other ___________________________	 ___ ___ ___	**Gastro-Intestinal Disease** Liver disease (jaundice, hepatitis) Hiatal hernia/reflux, heartburn Other____________________________
		  ___ ___	**Endocrine** Diabetes: __ Insulin/Pump ___ Oral ___ diet controlled Thyroid
 ___ ___ ___ ___	**Kidney/Bladder/Prostate** If yes, specify:__________________ Inability to urinate after anesthesia Dialysis: when__________________ Other ______________________________	 ___ ___ ___ ___	**Psychiatric/Social History** If yes, specify __________________________ History of regular alcohol use or within 24 hours History of "street drugs" Other _________________________________
 ___ ___	**Muscular/Skeletal** If yes, specify _________________________ Implants/Hardware: ____________________ ___________________________________	 ___ ___ ___	**Female Patients** Could you be pregnant? First day of last menses _________________ Post menopause / hysterectomy
 ___ ___ ___ ___ ___ ___ ___	**Blood Disorders** Abnormal bleeding Taking blood thinners Sickle cell disease or trait History of blood transfusions HIV positive Cancer: Chemotherapy / Radiation If yes, specify__________________________	 ___ ___	**Eye/Ear Disorder** Glaucoma / Retinal detachment - glasses / contacts Ringing in the ears/ hearing loss – Hearing aids L/R
			Surgical History ____________________________ ____ ____ ____
 ___ ___ ___ ___	**Communicable Disease / Infections** Unexplained weight loss or night sweats in the last 2 months? Have you traveled outside the country in the last 21 days? Have you experienced any of the following: fever >101, fatigue, headache, cough or GI symptoms? Specify ___________________________________	 ___ ___ ___ ___ ___ ___	**Anesthesia Related Information** Anesthesia within the past year History of difficult intubation or adverse reaction Specify ____________________________ Any relative with Malignant Hyperthermia Loose teeth _______ caps _______ Dentures upper ________ Lower _________

**If extensive and/or significant Medical/Surgical history, or if problem related to airway management, refer to anesthesia provider. If patient reports any heart related problems due to serious illnesses, surgeries or medications refer to anesthesia provider* ______________________________

Assessment completed by: _______________________________ **Date:** __________ **Time:** ____________

Assessment Reviewed by Anesthesia Provider: ________________ **Date:** __________ **Time:** ____________

Revised 10/24/2019

Patient Label Here