Pre-Op Interview/Medication Reconciliation Form- Pediatrics

Procedure Date: _____

Patient Name: _____ **Gender:** _____ **Age:** _____ **Phone:** _____

Name You Call Your Child: _____ Mother's **Name:** _____ Father's **Name:** _____

Who has Custody? _____ **If not Parent, Legal Guardian Name:** _____

Relationship: _____ **Contact Phone:** _____

*****IF NECESSARY, NEED COPY OF ANY COURT ORDERED PAPERWORK FAXED OR BROUGHT TO SURGERY CENTER PRIOR TO DOS*****

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 *If you use inhalers, please bring them with you.*				ADMISSION MEDICATIONS		DISCHARGE MEDICATIONS	
MEDICATION/DOSE	**FREQUENCY**	**INDICATION**	**LAST DOSE**	**TAKE**	**HOLD**	**RESUME**	**HOLD**

NEW OR CHANGED DISCHARGE ORDERS

MEDICATION/DOSE	FREQUENCY	INDICATION	NEXT DOSE DUE	RX GIVEN

Source of Information: ☐ 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: _____ **Date/Time:** _____/_____

Patient Signature: _____ **Date/Time:** _____/_____

Physician Signature: _____ **Date/Time:** _____ /_____

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 01/09/2020

Significant	Yes	No	Date/Procedure/Illness/Comment
Diabetic			
Asthma/Sleep Apnea			
Hypertension/Heart Murmur			
Hx Rheumatic Fever			
Seizure Disorder			
Neurological Problems			
Bleeding Problems			
Communicable Diseases			
Kidney/Liver Problems			
Muscular/Skeletal			
GI Problems/ Infant Reflux			
Full Term Pregnancy?			If no, NICU Time?
UTD on Immunizations?			
Special Needs?			
Other			
Surgical History/Hospitalizations: _____ _____			

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

Referred to Anesthesiologist regarding: _____

Anesthesiologist Signature: _____ **Date/Time:** _____/_____

NPO STATUS: _____ 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. No other exceptions without consulting anesthesia.

Height: _____ Weight: _____ ***Please circle yes or no below***

Yes	No	Have you experienced any productive cough over two months, unexplained weight loss, or nights sweats?
Yes	No	Have you traveled out of the country in the last 21 days? If so, where?
Yes	No	Have you experienced any of the following symptoms: fever over 101, fatigue, headache, or GI symptoms? If so refer to s
Yes	No	**Have you or any relatives had any problems with anesthesia?** *If yes, refer to Anesthesiologist.*
Yes	No	Could you be pregnant? Last menstrual period? You will be required to provide a urine specimen.____
Yes	No	Have you had any blood drawn, urine, or any other lab work done? Where? _____
		Name and phone number of Pediatrician? _____ **Cardiologist?** _____
Yes	No	Do you wear glasses/ contact lenses? *Contacts must be removed! Told to bring containers.*
Yes	No	Do you wear hearing aids? Left _____ Right_____ *Told to bring containers.*
Yes	No	Do you have an Advance Directive? *Told to bring copy. Told will need to sign "Do Not Resuscitate" Waiver.*
Yes	No	Would you like a brochure of an Advanced Directive?

Transportation/ Caretaker:

_____Children must have 2 adults here, one to drive and one to sit with the child on the ride home. If 2 adults cannot be present we will evaluate each case individually depending on the type of surgery and the child's current medical condition. This will be evaluated by the nurse manager, anesthesia and the surgeon. Who will be with you? _____

_____**PATIENTS UNDER 18 YEARS:** It is **MANDATORY** that a parent or guardian remain in the facility during the procedure/PACU time.

_____Wear clean comfortable and loose-fitting clothing. No onesies for an infant. Bring an extra pair of clothing, pajamas/underwear. Bring favorite blanket, toy, or stuffed animal for comfort. Bring sippy cup, bottle, binky, etc.

_____ No jewelry. Take out earrings prior to arrival to surgery center.

_____ Please bathe child the night before surgery. No creams, lotions, perfumes, deodorant or powder the day of the procedure.

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

_____ 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: _____

_____ _____

Assessment Nurse Signature **Date**

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