Pre-Operative Patient Screening

COVID 19

1. Have you had a fever or been ill in the last 7 days? Y or N (circle)
   If yes explain: ____
2. Have you been exposed to anyone that has had a fever or has been ill in the last 30 days> Y or N If yes explain: ______________________________
   ____
3. Have you or anyone in your household been out of the country in the last 30 days? Y or N If yes explain: ______________________________
   ____
4. Have you or anyone in your household had an unexplained rash in the last 30 days? Y or N if yes explain ______________________________
   ____
5. Have you or anyone in your household had shortness of breath in the last 30 days? Y or N If yes explain: ______________________________
   ____
6. Have you or anyone in your household had a cold or flu-like symptoms in the last 30 days? Y or N If yes explain: ______________________________
   ____
7. Have you been exposed to anyone who has tested positive for COVID19 or have you, yourself, Tested positive for COVID19 in the past 6 weeks?
   If yes, they will need to have a PCR with a confirmed negative result in the past 5 days and bring it to the center the day of their procedure.

Date: ____________ Time: ____________RN Name (please print) ____________________

After the COVID test is completed please instruct the patient to sequester themselves as a precaution.

Day of surgery:

Any changes to the above questions? Y or N

If yes, explain: ____

____

____

RN Name: ____________________ Date: ____________ Time: ____________

Peak Health Surgicare

Date: Time: NPO:			Height: Weight: BMI:
Vital Signs: Temp: B/P: Pulse: Resp:			Pulse ox:
Allergies: NKDA			Patient: Alert Oriented Confused Non responsive
Dentures Artificial limb Glasses Limited/no extremity access Body Piercing Jewelry			Valuables given to:_______________
HOH Deaf Blind Arthritis Obesity			
Name of person who is waiting:			Phone:
Medical History	No	Yes	Comments:
Cardiovascular			
High Blood Pressure			
Congestive Heart Failure			
Peripheral Vascular Disease			
Mitral Value Stenosis			
Arrhythmia			
Coronary Artery Disease			
Myocardial Infarction			
Angina			
Exercise Intolerance			
Pulmonary			
Lungs clear			Breath sounds clear bilaterally Wheezing Crackles Decreased breath sounds
Emphysema			
COPD			
Asthma			
TB			
Sleep Apnea/Snoring/CPAP			
Home oxygen			
Endocrine			
IDDM			
NIDDM			
Blood sugar Pre-op			Results:_______
Thyroid			Hypo:_______ Hyper:_______ Graves Disease:_______
Recent Steroid Intake			

Peak Health Surgicare

Medical History	No	Yes	Comments:
Neurological			
TIA			
Seizures			Type of seizures:______________
CVA			
Cerebral Palsy			
Mentally handicapped			
Migraines			
Gastrointestinal			
Peptic Ulcer Disease			
Hiatal Hernia			
GERD			
IBS			
Crohns			
Kidney			
Kidney Stones			
Chronic Renal Failure			
Dialysis			
Liver			
Fatty liver			
Cirrhosis			
Ever been jaundice			Why:
Hepatitis A, B, or C			Treatment:
Muscular			
Malignant hyperthermia			
Muscular dystrophy			
Muscular dystonias			
Multiple sclerosis			
Blood Dyscrasis			
Polycythemia			
Abnormal bleeding			
Hemophilia			
HIV/AIDS			
Sickle Cell/Trait			
Cancer			
Habits			
Smoke/Dip			How much: How long:
Drink alcohol			How much: How long:
Recreational Drug Use			What: Last time used:
Pregnant			LMP: Hyst Pregnancy Test:
Medical History	No	Yes	Comments
Skin Integrity			
Warm, dry, intact			

Peak Health Surgicare

	No	Yes	
Cuts, bruises, infection			
History of MRSA			
Family Hx of Anesthesia Problems			
Patient Hx of Anesthesia Problems			Difficult intubation Nausea Low blood pressure Respiratory complications
Previous Surgeries			
Recent Falls			
History of fall within last 2 months			
Unsteady gate			
Use of assistive device			
Paralysis/Numbness			Location:
Pain Assessment Guide			
Are you in pain?			
Scale of 1-10 (10 worst)			
Where is the location of the pain?			
What makes it better?			
What makes it worse?			

Medication Reconciliation Form

Medication	Frequency	Last Dose	Continue	Discontinue

Patient Signature/Date

Nurse Signature/Date

OSA Screening Questionnaire

1. Have you been diagnosed with SLEEP APNEA? YES NO

If yes, what is your current treatment: CPAP Bi-Pap Oral Appliance Other:

2. Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? YES NO
3. Do you often feel tired, fatigued, or sleepy during the daytime? YES NO
4. Has anyone observed you stop breathing during your sleep? YES NO
5. Do you have or are you being treated for high blood pressure? YES NO
6. ***Body Mass Index (BMI)*** more than 35? YES NO

   Height:_______inches/cm Weight:__________lb/kg BMI__________________
   (use standard formula to calculate)

7. Age Over 50 years old? YES NO
8. Gender: Male Female

Scoring:

High Risk of OSA

1. Answering yes to question #1 or #6 or
2. Answering yes to four or more questions
3. Notify Physician/Anesthesiologist

Disposition (May select more than one):

Attending Notified: YES NO

Anesthesia Notified: YES NO

*If no, why____________________________________

Low Risk of OSA: answering yes to less than four questions.

____

Questionnaire completed by: (Name/Date/Time)

____

Completed by (Name/Credentials/Date/Time)

Obstructive Sleep Apnea Screening (OSA) Tool
Ref: American Society of Anesthesiologists

(Patient Label)

PEAK HEALTH SURGICARE

IV START:

Gauge	Location	Attempts	By

Medication	Dose	Route	Rate	Time	Initials
Lactated Ringers	1000ml.	IV			
Lactated Ringers	500ml.	IV			
0.9% NaCl		IV			
Hep-lock/saline flush	10ml	IV			

Nurses Notes: ____

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Nurse Signature: ______________________ Date: ____________ Time: __________

Chart Audit

PRE-OP CALL RN:

___ H&P (Within 30 days)
___ Labs
___ EKG if available
___ Cardiac clearance if EKG is abnormal check with anesthesia
___ NOTIFIED FRONT DESK of needed documents

Comments:____

Printed Name: ________________________ Date: ___________ Time: ___________

PRE-OP RN (IN PERSON):

___ H&P (Within 30 days) also requires a reassessment and updates morning of surgery by surgeon.
Weight in KG ______________
___ Labs if required.
___ EKG if abnormal does anesthesia require cardiac clearance?
___ Cardiac Clearance ___ Yes ___ No
___ HCG for females up to age 55 without hysterectomy
___ GLUCOSE CHECK for all diabetics preop.
___Consent completed without abbreviations and complete for appropriate procedure, risks and benefits, patient signature, surgeon signature, timed and dated by surgeon.
___ Anesthesia Consent: patient initials, dated and timed, provider signature dated and timed?
___ Allergies reviewed

Printed Name: ________________________ Date: ___________ Time: ___________

Circulating (OR) RN:

___ H&P (Within 30 days, update date for today, reassessment documented)?
___ HCG for females under age 55 without hysterectomy
___ Patient's site is marked (if laterality it is required prior to taking back to the OR)
___ Consent complete, without abbreviations, signed by patient, witnessed by RN, dated and timed by patient, RN, and surgeon? Do not take back to OR if not complete!
___ Anesthesia consent initialed, signed, dated and timed by Provider?

Printed Name: ________________________ Date: ___________ Time: ___________

COVID-19 PATIENT ACKNOWLEDGEMENT FORM

☐ Patient attests that he/she has not been in contact with anyone showing symptoms of Covid-19 in the past 7 days, including fever and congestion.

☐ Facility nurse took my temperature and it was normal/no fever at time of surgery.

☐ Patient acknowledges that further deterioration is likely to occur if the procedure or surgery is not undertaken immediately and/or the surgery or procedure is significantly delayed.

______________________________	____________________
Patient Signature	Date