



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

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: _____

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