Summit OUTPATIENT SURGERY

OUTPATIENT SURGERY DEPARTMENT

Patient Label **3**

Allergies: ❑ NKDA ❑ Verified ❑ See attached list for extensive allergies

Medication/Food_____ Reaction _____

_____ _____

_____ _____

Medication Information Obtained From:

❑ Patient ❑ Family member of patient ❑ Other

CURRENT HOME MEDICATION LIST

TO BE COMPLETED PRE-OPERATIVELY

(Including: Prescription, Over the Counter, Herbal Remedies, Vitamins, Dietary Supplements)

TO BE COMPLETED BY NURSE/PHYSICIAN ON DAY OF SURGERY

Medication	Dosage/Strength	When last dose was taken	Continue After Discharge
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No

Patient Acknowledgement:

- I have provided as accurate a list as I can of my home medications. I will continue to follow the medication orders of the prescribing physician unless instructed to change. If I have questions about my home medications, I will call the doctor who prescribed them.
- I understand that my medication list may be shared with my other physicians unless I decline. ❑ I decline.

Patient (designee) Signature: _____ Date: _____

- Current home medication list has been reviewed with patient pre-operatively.

RN Signature: _____ Date/Time: _____

NEW MEDICATIONS TO BEGIN TAKING

Medication/Dose	How Is It Taken	How often Is It Taken	Rx Given at	Med Info Given
			❑ Pre-Op ❑ DOS	❑ Yes
			❑ Pre-Op ❑ DOS	❑ Yes
			❑ Pre-Op ❑ DOS	❑ Yes

Physician Signature: _____ Date/Time: _____

RN Signature: _____ Date/Time: _____

Please complete prior to your surgery date!

Summit Outpatient Surgery

ANESTHESIA EVALUATION REPORT		
Height:	**T:**	
Weight:	**HR:**	
BP:	**O2 Sat:**	**R:**

PLEASE CIRCLE ALL THAT APPLY		
Medical History	**No ✔**	**Yes–As Indicated**
Cardiovascular		Heart Trouble Chest Pain CHF Pacemaker Defibrillator High Blood Pressure
Pulmonary		Lung Disease COPD Asthma TB Exposure Positive PPD Sleep Apnea
Endocrine		Diabetes Type 1 Type 2 Thyroid Lupus
Neurological		Stroke Seizure Epilepsy
Gastrointestinal		PUD Hiatal Hernia GERD
Kidney		Kidney Stones Renal Failure
Liver		Hepatitis Jaundice
Muscular/Skeletal		Muscle Weakness Paralysis Arthritis Back Trouble Neck or Facial Fractures Plates/Pins or Screws
Blood Dyscrasias		Abnormal Bleeding Blood Thinners Blood Disease Clotting DVTs
Other		Cancer HIV/AIDS Depression Anxiety Mental Illness Glaucoma Cataracts

❑ Chest X-ray in the last year
❑ Electrocardiogram in the last year
❑ Other medical illnesses (please list)_____
_____

DO YOU: (✔ if brought to Center)	✔	Yes	No
Wear dentures?			
Have loose teeth/caps/bridges?			
Wear glasses/contacts			
Wear prosthesis?			
Wear hearing aid?			
Do you smoke? (pkg/day)			
Have you ever smoked?			
Use alcohol? (amt/day)			
Females: Could you be pregnant?			
Have religious objection to blood transfusion? Explain:			

PATIENT LABEL HERE

Food/Drug Allergy	Reaction

Date of last anesthetic: _____

Any abnormal reactions? ❑ Yes ❑ No Describe:
_____
_____
_____

Relatives with abnormal reactions to anesthetics ❑ Yes ❑ No
COMMENTS _____
_____

Do you have any questions for your anesthesiologist? _____
_____
_____

Surgery	Date

Drug	Frequency	Last Taken
When did you last eat or drink? Date:_____ Time:_____		

Pre-Op Medications: _____

PHYSICAL EXAMINATION

ANESTHESIA EVALUATION (for Anesthesiologist use)

General Appearance _____
Sensorium: ❑ AA&O ❑ Drowsy ❑ Confused ❑ Age Appropriate_____
Head and Neck: WNL _____
❑ Class I ❑ Class II ❑ Class III ❑ Class IV
Cardiovascular: ❑ RRR ❑ Murmur _____
Chest: ❑ BS CTA Bilat _____
Abdomen: ❑ WNL ❑ Distended _____
Extremities and Back: ❑ WNL _____
Skin: ❑ p/w/d ❑ Intact ❑ Pale ❑ Diaphoretic _____
I.V. Infusion: ❑ Patient Site:_____
Risks, Benefits and Alternatives Discussed
Anesthesia Plan: General Spinal Epid Regional MAC/L. Standby
Understands and Agrees to Anesthetic Plan ASA Class - 1 2 3 4 5 6 E

_____ ❑ AM ❑ PM _____
DATE TIME ANESTHESIOLOGIST

POST-ANESTHESIA EVALUATION

Time_____
Status: ❑ Stable ❑ AA ❑ Drowsy
❑ Under Effect Anesthetic ❑ Age Appropriate
Vital Signs: BP _____ SpO_2 _____
P_____ Temp_____
RR _____
Respiratory: ❑ Regular/Unlabored/Symmetrical
❑ Shallow/Symmetrical ❑ Intubated ❑ Vent ❑ Flow by
Cardiovascular: ❑ RRR ❑ Other _____
Comments: _____
_____

_____ ❑ AM ❑ PM _____
DATE TIME ANESTHESIOLOGIST