

# Nursing Pre-Admit Screening Flow Sheet

## Treasure Coast Center for Surgery

1411 East Ocean Boulevard, Stuart, FL 34996

(772) 286-8026 Fax (772) 283-6628

Place Patient Label Here

**CHECK ANY PROBLEMS/CONDITIONS WHICH PERTAIN TO THE PATIENT (Past or Present)**

<b>COMMUNICATION</b> <input type="checkbox"/> Speaks English <input type="checkbox"/> Language Barrier <input type="checkbox"/> Translator: _____ <input type="checkbox"/> Slurred Speech <input type="checkbox"/> Other: _____  <input type="checkbox"/> Barriers to Learning  	<b>NEURO/HEAD/NECK</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Stroke <input type="checkbox"/> Seizures <input type="checkbox"/> Dizziness/Fainting <input type="checkbox"/> Freq. Headache/Migrains <input type="checkbox"/> Cervical Problems <input type="checkbox"/> Vertigo <input type="checkbox"/> Muscle Disorders <input type="checkbox"/> Tremors <input type="checkbox"/> Paralysis <input type="checkbox"/> Other _____ 	<b>EYE/EARS</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Vision Impaired <input type="checkbox"/> Glaucoma    R        L <input type="checkbox"/> Cataracts    R        L <input type="checkbox"/> Contact Lenses <input type="checkbox"/> Glasses <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Hearing Aids <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Other _____ 	<b>CARDIAC</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Hypertension <input type="checkbox"/> Chest Pain <input type="checkbox"/> CHF <input type="checkbox"/> Heart Surgery <input type="checkbox"/> Pacemaker/Defib <input type="checkbox"/> Heart Attack/MI <input type="checkbox"/> Bleeding Problems <input type="checkbox"/> Clotting Problems <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Any Valve Replacement <input type="checkbox"/> Irreg Heart Rate <input type="checkbox"/> Atrial Fib <input type="checkbox"/> Heart Stents 	<b>RESPIRATORY</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Pneumonia <input type="checkbox"/> Emphysema/COPD <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Cough <input type="checkbox"/> SOB <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> C-PAP at home <input type="checkbox"/> O2 Use _____ <input type="checkbox"/> Inhaler <input type="checkbox"/> TB <input type="checkbox"/> Other _____ 
<b>MOBILITY</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Numbness/Weakness <input type="checkbox"/> Paralysis <input type="checkbox"/> Pain on Movement <input type="checkbox"/> Gait Unsteady <input type="checkbox"/> Hx of Falls <input type="checkbox"/> Arthritis <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Wheel Chair <input type="checkbox"/> Hx of Falls <input type="checkbox"/> Other _____ 	<b>MOUTH/STOMACH</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Ulcers <input type="checkbox"/> GERD/Indigestion <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Weight gain / loss <input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> TMJ <input type="checkbox"/> Other _____ 	<b>BLOOD/LIVER</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding Problems <input type="checkbox"/> Taking Coumadin <input type="checkbox"/> Taking Plavix / Aspirin <input type="checkbox"/> Other _____ 	<b>BOWEL</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Uses Laxatives <input type="checkbox"/> Ostomy <input type="checkbox"/> Abd Pain <input type="checkbox"/> Other _____ 	<b>BLADDER/KIDNEY</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Dialysis <input type="checkbox"/> Incontinence <input type="checkbox"/> Stone <input type="checkbox"/> Prostate Problem <input type="checkbox"/> Hx Flomax Use <input type="checkbox"/> Other _____ 
<b>REPRODUCTIVE</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Discharge/Bleeding <input type="checkbox"/> Translator: _____ <input type="checkbox"/> Date LMP _____ N/A <input type="checkbox"/> Pregnant <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Tubal Ligation <input type="checkbox"/> Other _____ 	<b>VASCULAR</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Phlebitis <input type="checkbox"/> GERD/Indigestion <input type="checkbox"/> DVT <input type="checkbox"/> Neuropathy <input type="checkbox"/> Other _____ 	<b>SKIN PROBLEMS</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Rashes <input type="checkbox"/> Wounds <input type="checkbox"/> Breakdown <input type="checkbox"/> Hx of Bruising <input type="checkbox"/> Shingles <input type="checkbox"/> Other _____ 	<b>INFECTIOUS DISEASES</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Hepatitis B or C <input type="checkbox"/> HIV+ <input type="checkbox"/> AIDS <input type="checkbox"/> MRSA    act./hx <input type="checkbox"/> Other _____ 	<b>BEHAVIORAL</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Claustrophobia <input type="checkbox"/> Other _____ 
<b>ENDOCRINE</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Thyroid <input type="checkbox"/> Diabetes <input type="checkbox"/> NIDDM/IDDM <input type="checkbox"/> Diet Control <input type="checkbox"/> Other _____ 	<b>SOCIAL HISTORY</b> Tobacco use anytime in the past year <input type="checkbox"/> Yes <input type="checkbox"/> No Packs per day _____ Quit _____ X _____ years <input type="checkbox"/> Alcohol Use <input type="checkbox"/> Social <input type="checkbox"/> Daily <input type="checkbox"/> Street Drugs _____ 		<b>SUPPORT SERVICES</b> <input type="checkbox"/> Lives Alone <input type="checkbox"/> Lives with _____ Primary Caregiver _____ Admitted from Nursing Home _____ Are there any situations in your life that makes you feel unsafe or fearful. <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, refer to nurse: _____ 	

**Allergies / Sensitivities (Reactions)**     No known drug allergies = NKDA

**(IF YES NOTIFY NURSE)**

Are you allergic to Latex?     No     Yes    reaction \_\_\_\_\_

Are you allergic to Eggs?     No     Yes    reaction \_\_\_\_\_

Are you allergic to Soy?     No     Yes    reaction \_\_\_\_\_

Are you allergic to Shellfish?     No     Yes    reaction \_\_\_\_\_

ENVIRONMENTAL ALLERGIES \_\_\_\_\_

DRUG	REACTION	DRUG	REACTION

SURGERIES	YEAR	SURGERIES	YEAR

REFER TO MEDICATION RECONCILIATION FROM

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Place Patient Label Here

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

DOB \_\_\_\_\_ Prior Visit \_\_\_\_\_ Spoke with Patient or \_\_\_\_\_

Phone# Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Surgeon \_\_\_\_\_ Procedure \_\_\_\_\_

Date of Procedure \_\_\_\_\_ Arrival Time \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ lbs/Kilo \* **if > 300 pounds bring to Nurses Attention.**

**\* If yes to either question - Bring to nurses attention**

NO  YES Have you ever had a problem with anesthesia? Difficulty intubation, breathing difficulty, high fever, other.

NO  YES Have any relative had problems with anesthesia?

NO  YES Do you have a Primary Care Physician? Who? \_\_\_\_\_

NO  YES Have you been to any physician to get "cleared" for this surgery? \_\_\_\_\_

NO  YES Have you had any blood drawn, urine, or any other lab work done? \_\_\_\_\_

NO  YES Have you had a EKG or other cardiac testing recently (i.e. stress test)? \_\_\_\_\_

NO  YES Do you have an Advance Directive? \_\_\_\_\_ Bring a copy along.

NO  YES Do you have an Medical POA? \_\_\_\_\_ Bring a copy along.

Comments: \_\_\_\_\_

*Any patient with serious health conditions must be cleared prior to surgery; if patient had labs and EKG, they probably need clearance as well. If patient has stated "no clearance" and has health conditions, refer to Anesthesiologist. If patient reports any heart related problems via serious illnesses, surgeries, medications, refer to Anesthesiologist.*

Are there any medications your doctor had you stop for this procedure? (List above)

Blood thinners (Coumadin, Aspirin, Plavix, Aspirin Products, certain anti-inflammatory, vitamin e, herbal remedies, etc.) Your surgeon should have given you instructions about continuing or D/C; if he hasn't as yet, patient must discuss with surgeon ASAP.

Diabetics: no insulin or diabetic meds prior to arrival; bring insulin along the AM of surgery.

Exception: Specific M.D. orders or for procedures 11:00AM or later, refer to Anesthesiologist. STOP Glucophage and Glucovance one (1) day prior to general anesthesia.

Take heart, BP and other oral meds the AM of surgery with small sip of water if you normally take in the AM.

Are you taking any diet drugs? \_\_\_\_\_

YES  NO Are you taking any herbal remedies? \_\_\_\_\_

All patients: We cannot do your surgery unless you have someone drive you home and stay with you until the following AM.

Who will drive You? \_\_\_\_\_

Who will stay with you \_\_\_\_\_

Do you desire and permit the physician and/or nurse to speak with is individual about the outcome and plan after your procedure?  NO  YES

Patients up to 18 years old. It is MANDATORY that a parent or guardian remain in the facility during the procedure and recovery time.

Wear comfortable and loose clothing. No makeup, hair pins, clips or rollers. No button down shirts.

No Jewelry (exception - some patients can't remove their wedding ring, we will tape over it). We are not responsible for any articles of value (like jewelry) that are given to us at the center. DO NOT BRING VALUABLES WITH YOU (Rings on effective/operative site, must be removed or cut off).

NO  YES Do you wear glasses, contact lenses? Contacts must be removed. Bring container / case.

Bring eye bag provided (if applicable).

Bring your insurance cards to copy for correct billing information; bring co-payment if instructed.

Bring photo ID

Walker or crutches for arthroscopy procedures; center does not provide.

Walker or crutches for arthroscopy procedures; center does not provide. Have you had instructions given about how to use crutches / walker? (TCCS does not do) If possible to wet shave operative knee without cutting site.

Do you know where we are located?

Adult General / MAC anesthesia - NPO 12 midnight. If surgery scheduled 1:00 PM or later, may have 1/2 to 1 cup of clear liquid up to 8:00 AM. If a smoker, should not smoke DOS

Children up to one year of age - 4-6 oz. formula or clear juice 6 hours prior to admission; the NPO

Endoscopy NPO 12 midnight except for your physician's specific instructions (i.e. prep) Clear liquids include black coffee, tea, gatorade, clear juices such as apple juice or cranberry. No milk; children should bring bottle, sippy cup, special toy or blanket.

The legally responsible parent must accompany their child and sign consent; if a legal guardian, bring documents of guardianship.

Do you have any questions regarding your surgery?

Phone number where you can be reached surgery day in the event of a schedule change? \_\_\_\_\_

I have reviewed the information previously given to the Center as described above by me or my designee, and to the best of my knowledge the information is accurate.