Surgicare of Lake Charles
Admission Assessment

Patient name:_____ Age: _____ Type of anesthesia: □ General □ MAC □ Spinal □ Regional □Local
□ IV Conscious Sedation □ Female □ Male Surgery Date:_____ Time to arrive Day of Surgery:_____

Scheduled Procedure:_____ Surgeon:_____
Chief Complaint:_____ **Height:**_____ **Weight:**_____ **BMI:**_____

Phone:_____ Work:_____ Cell:_____

YES	NO	MEDICAL HISTORY	COMMENTS	YES	NO	MEDICAL HISTORY	COMMENTS
□	□	Bronchitis/Emphysema		□	□	Jaw Problems/TMJ	
□	□	Difficulty breathing		□	□	Smoking(Tobacco Use)	
□	□	Wheeze/Asthma		□	□	Drinking(Alcohol)	
□	□	Chest Pain/Angina		□	□	Diet pills	
□	□	Heart Attack		□	□	Recreational Drugs	
□	□	High Blood Pressure		□	□	Patient/family history of MH	
□	□	Heart Failure		□	□	Past Anesthesia Problems	
□	□	Irregular/Extra Heartbeats		□	□	History of Latex Allergy	
□	□	Stroke/TIA/Carotid Disease		□	□	AIDS/HIV +	
□	□	Seizure Disorder		□	□	LMP	
□	□	Headaches		□	□	Are you pregnant?	
□	□	Glaucoma		□	□	Children: Full term_____	
□	□	Arthritis		□	□	Premature:_____	
□	□	Muscle Weakness/Paralysis		□	□	Problems at birth:_____	
□	□	Numbness in Arms/Legs		□	□	Gravida ___ Para____ AB____	
□	□	Urinary Tract Infection		□	□	C-Section_____NVD_____	
□	□	Kidney Disease/Stones		□	□	Hysterectomy Abd/Vag	
□	□	Diabetes		□	□	With or without Bilateral S&O	
□	□	Thyroid Disorder		□	□	Unilateral S&O Left/Right	
□	□	GI Ulcers		□	□	Sleep apnea	
□	□	Hepatitis/Liver Disease		□	□	Uses C-pap	
□	□	Hiatal Hernia/Reflux		□	□	**In Last 2 Weeks**	
□	□	Anemia/Sickle Cell		□	□	Cold	
□	□	Bleeding Problems		□	□	Sore Throat or Cough	
□	□	Deep Vein Thrombosis		□	□	Fever	
□	□	Blood Thinning Medication		□	□	Other Illness	
□	□	History of MRSA (explain if yes)					

Have you had thoughts of harming yourself or committing suicide? Are you currently receiving treatment and/or taking medication as part of that treatment? Name those medications, the dosage and frequency. (List on the Medication Reconciliation form)

Have you ever been seen and/or treated for any mental illness? Were you admitted to a facility for care?

If so, where?

Previous surgeries/Past Hospitalizations :

Date of last steroid injection: **Are you on any steroid medications at present either by mouth, eye drops or topical : Yes/No**

If yes, name, route and dose of medications presently taking:

Allergies with reactions:

Handicap/Impairment □ Mentally Challenged □ Blind □ Hearing Impaired □ Language Barrier □ Wheelchair □ Walker □ Cane
□ Contacts/Glasses □ Prosthetics/Implants:_____ □ Dentures □ Upper □ Lower □ Partial □ Caps/crowns □ NA
□ Religious/cultural or ethnic issues Explain:_____ MRSA swab done □ Y □ N □ NA
Labwork:_____Date Performed:_____Where done:_____ MRSA results: □ Y □ N □ NA
EKG: Yes No Date Performed:_____Where done:_____
CXR: Yes No Date Performed:_____Where done:_____ Consents:_____H&P_____
Need done on admit: HCT: □ Yes □ No Blood sugar: □ Yes □ No Orders:_____Rx:_____
Urinalysis □ Yes □ No Urine UPT: □Yes □ No
If a urine specimen is needed, it will be collected at Surgicare the day of admission.
Signature of LPN/RN:_____Date:_____Time:_____
Nurses Notes:_____
Admit Nurses Signature:_____RN/LPN

Surgicare of Lake Charles
Patient Medication Reconciliation Record

Patient name:_____

Medications(include OTC/herbals/vitamins) (Include strength)	Dose	Route	Frequency	Last dose

New Prescriptions given: □ In office □ Today □ NA

Medication	Dose	Route	Frequency
Signature of person receiving prescriptions:			

		Initials
Signature of RN/LPN obtaining medication history		
Signature of RN/LPN reviewing medication history		
Signature of PACU RN/LPN		

Surgicare of Lake Charles
Pre-Admission Assessment

Patient name:_____

Yes	No	N/A	Patient Information Verification
			On or before the day of your surgery you will be given information either by email, mail or in person about:
			Patient Rights and Responsibilities.
			Disclosure of Ownership .
			Information on the facility's complaint/grievance process.
			Surgicare's policy on Advanced Directives.
☐	☐		Do you have a living will?
☐	☐	☐	Did you request an Advanced Directive form?
☐	☐	☐	Have you received the requested Advanced Directive Form?
☐	☐		Notification information reviewed with patient: The patient, patients representative or surrogate have the following rights:
			• You have the right to personal privacy and to receive care in a safe setting, free from all forms of abuse and harassment including neglect
			• You have the right to be fully informed about your proposed procedure and the expected outcomes before it is performed
			• You have the right to exercise these rights without regards to sex or cultural, economic or religious background or the source of payment for care and without being subjected to coercion, discrimination, reprisal or interruption of care
			• You have the right to voice grievances regarding treatment or care that is or fails to be furnished
☐	☐		Do you have any questions about any of this information?
			If yes, summarize patient's questions and information provided to patient:
			_____

Patient Instructions	
☐ Bring Identification/Insurance Cards	
☐ No Make-up, Nail Polish, Jewelry, Piercings or Valuables	☐ Bring Medication List with dosages and time you take them
☐ Appropriate Clothing(based on surgery)	☐ Responsible Adult to drive home:_____
☐ Bring Advance Directives ☐ N/A	☐ No recreational drugs or alcoholic beverages 24 hours prior
☐ Bring Living Will and/or Power of Attorney ☐ N/A	☐ NPO after midnight ☐ Other instructions
☐ Bring empty bottle or sippy cup ☐ N/A	☐ Verbalizes understanding of procedure
☐ No Aspirin or Aspirin Products for 3 days prior to surgery	☐ No tobacco use 24 hours prior

SPECIAL INSTRUCTIONS

☐ Do you have loose teeth or any other dental appliance?

Have you had any medical changes since you last visited your doctor? ☐ Yes ☐ No

If yes, please explain:

Instructions given by: ☐ Phone ☐ In Person Instructions given to:

Nurses Note:_____

_____

_____

RN/LPN Signature:_____Date:_____Time:_____

First contact tried: Date and time:_____By:_____No answer:_____

Second contact tried: Date and time:_____By:_____No answer:_____

Third contact tried: Date and time:_____By:_____No answer:_____

Alternate phone number:_____Who?_____

Alternate phone number:_____Who?_____

If minor child are you the birth parent? Yes_____No_____Other_____