UNIVERSITY OF MEDICAL CENTER
AMBULATORY SURGERY CARE UNIT
PREOPERATIVE DATA RECORD

PREOPERATIVE CHECKLIST

PATIENT IDENTIFICATION

DATE	TIME	AM / PM	PATIENT TYPE	ARRIVAL STATUS		PATIENT BELONGINGS: ☐ WITH FAMILY
			☐ SAME DAY SURGERY ☐ SAME DAY ADMISSION	☐ AMBULATORY ☐ AMBULATORY W/ASST ☐ STRETCHER	☐ CARRIED ☐ STROLLER ☐ WHEELCHAIR	☐ LOCKER # _____ ☐ OTHER _____

ALLERGIES (Food, Medication, Latex) ☐ YES ☐ NO

NPO ☐ YES ☐ NO TIME _____	WT	VITAL SIGNS: T=	P=	R=	BP=	Pulse Ox _____

I.V. SITE ☐ NONE ☐ RIGHT ☐ LEFT ☐ HAND, ARM OR OTHER _____	SIZE I.V. CATH ga	SOLUTION	TIME STARTED AM / PM

	UNIT			OR			COMMENTS
	YES	NO	N/A	YES	NO	N/A	(For "No" Answers, Give Reasons and Action)
ID Band Correct and in Place							
Typenex Band on Patient							
Blood Consent							
Operative Permit Complete							
Anesthesia Consent Complete							
Advanced Directives Complete							
Universal Protocol							
H & P Complete and on Chart							
H & P Addendum							
Lab Work on Chart							
CBC							
Urinalysis							
Chemistry							
HCG if Childbearing Female							
Other:							
X-Ray on Chart							
EKG on Chart							
Chart Complete?							
Addressograph Plate/Pt. ID							
Prior Patient Chart							
Voided Time:							
Does the Patient Have:							
Dentures							
Hearing Aid							
Eyeglasses/Contacts							
Glass Eye							
Wig							
Prosthesis							
Valuables Removed (List)							
Pressure Ulcers							
Infections							
Antimicrobial Shower							
Properly Dressed for the OR (Gown on, Undergarments off, Makeup, Nail Polish/False Nails, Lipstick, and Hair Accessories Removed as Necessary)							

TIME	MEDICATIONS GIVEN IN LAST 12 HOURS	DOSAGE	ROUTE	INITIALS

ADDITIONAL COMMENTS:

FAMILY/SIGNIFICANT OTHER WILL BE WAITING AT (LOCATION/PHONE):

R.N. SIGNATURE (FLOOR)	R.N. SIGNATURE (OR)

Patient Name _____ Medical Record # _____ Date _____

VITAL SIGNS / DATA COLLECTION

SEE SEPARATE VITAL SIGNS FORM

TIME	T	P	R	BP	PAIN SCORE (0 - 10)			FINGERSTICK Whole Blood Glucose (Hill Range 70-110 mg/dL)	INITIALS

ADDITIONAL NOTES / RHYTHM STRIPS / TRANSFER NOTE

Patient Name _____ Medical Record # _____ Date _____

DISCHARGE PLAN (IF SAME DAY SURGERY)

TO ACCOMPANY HOME (NAME)	RELATION TO PATIENT	☐ CALL FOR RIDE ☐ WAITING	HOME PHONE	WORK PHONE

	ASSESSMENT		TIME ▶		
NEURO	▲ MENTAL STATUS		(1)		
	▲ MOVEMENT	(S)TRONG / (W)EAK			
		PARESIS	(2)		
		PLEGIA	(2)		
	▲ GAIT (S)TEADY / (U)NSTEADY				
	SENSATION (w/LOCATION IF NEEDED)		(2)		
CARDIOVASCULAR	▲ HEART RHYTHM (R)EGULAR / (I)RREGULAR				
	SKIN TEMPERATURE		(3)		
	SKIN COLOR		(4)		
	CAPILLARY REFILL		(5)		
	_____ PULSE		(6)	(R) (L)	
	_____ PULSE		(5)	(R) (L)	
	EDEMA	SITE			
		SITE			
	IV SITE WITHOUT REDNESS OR EDEMA		(Y)ES / (N)O		
RESPIRATORY	▲ RESPIRATORY PATTERN		(7)		
	BREATH SOUNDS		(8)	(R) (L)	
	COUGH		(9)		
	SECRETIONS		(10)		
	O_2				
GI	ABDOMEN		(14)		
	▲ BOWEL SOUNDS		(15)		
	BOWEL MOVEMENTS / LAST BM				
	INCONTINENT				
	COLOR / CHARACTER / HEME		(10)		
	(N)AUSEA / (V)OMITING				
	GI TUBE DRAINAGE		(10)		
			INITIALS ▶		

	ASSESSMENT	TIME ▶		
GU	▲ (V)OIDING (Y)ES / (N)O			
	(A)URIC / (I)NCONTINENT			
	BURNING / FREQUENCY			
	COLOR / CHARACTER	(10)		
	CATHETER (F)OLEY / (O)THER			
OB-GYN	VAGINAL DISCHARGE	(10)		
	(P)RESENT / (A)BSENT			
	SLEEP/REST (16)			
	BEHAVIOR RESPONSE (17)			

LEGENDS

(1)	MENTAL STATUS	(6)	PULSES	(11)	CHEST TUBE SITE	(15)	BOWEL SOUNDS
A	AWAKE	P	PALPABLE	M	MEDIASTINAL		PRESENT
O	ORIENTED	D	DOPPLER	PL	PLEURAL		ABSENT
D	DISORIENTED	A	ABSENT	A	ANTERIOR		HYPERACTIVE
I	INAPPROPRIATE	(7)	RESP. PATTERNS	P	POSTERIOR		HYPOACTIVE
DR	DROWSY	R	REGULAR	L	LATERAL	(16)	SLEEP / REST
U	UNRESPONSIVE	I	IRREGULAR	(12)	SKIN - TYPE	S	SLEPT MOST TIME
S	CHEM SEDATED	S	SHALLOW	I	INCISION	R	RESTLESSNESS
(2)	PARESIS / PLEGIA	L	LABORED	W	WOUND	AI	AWAKE INTERVAL
Q	QUAD	RT	RETRACTIONS	R	RASH	A	AWAKE MOST TIME
P	PARA	F	FLARING	PS	PRESSURE SORE	(17)	BEHAVIOR RESPONSE
LH	LEFT HEMI	(8)	BREATH SOUNDS	DRAIN SITE - SPECIFY		R	RELAXED
RH	RIGHT HEMI	CL	CLEAR	OTHER - SPECIFY		C	COOPERATIVE
RUE	RIGHT UPPER EXTREMITY	CR	CRACKLES	(13)	SKIN - DESCRIPTION	I	INSTABLE
RLE	RIGHT LOWER EXTREMITY	W	WHEEZING	ST	STAPLES	U	UNCOOPERATIVE
LUE	LEFT UPPER EXTREMITY	I	INSPIRATION	SU	SUTURES	W	WITHDRAWN
LLE	LEFT LOWER EXTREMITY	E	EXPIRATION	SC	SUBCUTICULAR	A	ANXIOUS
	SENSATION	D	DECREASED			CB	COMBATIVE
I	INTACT	A	ABSENT	R	REDNESS	UR	UNRESPONSIVE
N	NUMB	S	STRIDOR	NR	NO REDNESS	(18)	THOUGHT PROCESS
T	TINGLING	R	RHONCHI			A	APPROPRIATE
(3)	SKIN TEMP	(9)	COUGH	RG	RED GRANULATION	H	HALLUCINATION
W	WARM	N	NONE	YF	YELLOW FIBRINOUS	D	DELUSIONS
DR	DRY	D	DRY	BN	BLACK NECROTIC	P	PARANOID
H	HOT	P	PRODUCTIVE	M	MALODOROUS	I	INAPPROPRIATE
CL	COOL	NP	NON PRODUCTIVE			DI	DISORGANIZED
CD	COLD	I	INEFFECTIVE	EX	EXCORIATION	CO	CONFUSED
DI	DIAPHORETIC	(10)	SECRETION / DRAINAGE	ER	EXCORIATION / SKIN BREAKDOWN		
CY	CLAMMY	A	ABSENT				
(4)	SKIN COLOR	SS	SEROSANGUINOUS	MC	MACULAR		
N	NORMAL	SE	SEROUS	P	PAPULAR		
PL	PLUSHED	SA	SANGUINOUS	(14)	ABDOMEN		
P	PALE	Y	YELLOW	S	SOFT		
J	JAUNDICED	G	GREEN	F	FIRM		
C	CYANOTIC	B	BROWN	D	DISTENDED		
(5)	CAPILLARY REFILLS	W	WHITE	T	TENDER		
N	< 3 SEC NORMAL	BL	BLACK				
S	> 3 SEC SLUGGISH	CL	CLEAR				
A	ABSENT	AM	AMBER				
		CD	CLOUDY				

SKIN	SKIN INTACT (Y)ES / (N)O						
	TYPE (12)	SITE	SIZE	STAGE	DESCRIPTION (10, 13)		

RECORD SITE ON DIAGRAM

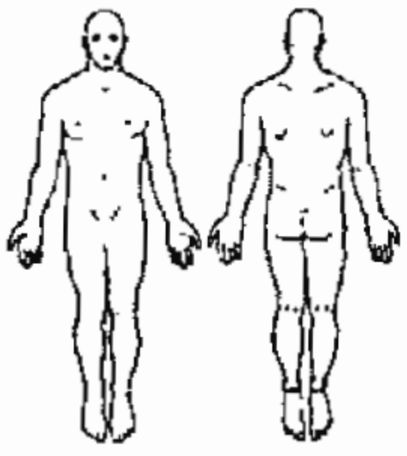
Pressure Ulcers Stages Defined:

I = Nonblanchable, erythema of intact skin.

II = Partial thickness skin loss involving epidermis and / or dermis. Superficial and presents clinically as an abrasion, blister or shallow crater.

III = Full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

IV = Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone or supporting structures.



INITIALS ▶

Patient Name _____ Medical Record # _____ Date _____

PERIOPERATIVE INTERDISCIPLINARY PATIENT/FAMILY EDUCATION SUMMARY

☐ See Clinical Pathway

DATE	CONTENT	METHOD*	LEARNER*	LEARNER EVALUATION*	CLINICIAN TEACHING
	★ **Medications** ☐ NA				
	Routine Medications (hold or take)	Per Anesthesia Disc, Ho			
	Pre-op Medications				
	Anesthesia Plan				
	Post-op Medications				
	★ **Medical Equipment/Devices** ☐ NA				
	Crutches/Slings	Demo, Disc			
	Bra	Disc			
	Drains	Disc			
	★ **Diet & Nutrition** ☐ NA				
	★ **Food/Drug Interaction** ☐ NA				
	NPO Plan	Ho, Disc			
	Pt Bill of Rights	Ho			
	Advance Directives (Bring)				
	★ **Pain Management** ☐ NA				
	★ **Rehabilitation Techniques** ☐ NA				
	Incentive Spirometry (Bring Equip)	Demo, Disc Ho			
	Coughing and Deep Breathing	Ho, V, Demo			
	Early Ambulation	Ho			
	★ **Available Community Resources** ☐ NA				
	Home Care Resources/Health Referral	Disc			
	Agency: Date				
	Special Needs				
	Transport Home				
	★ **Personal Hygiene** ☐ NA				
	Preps	Ho, Disc			
	Wound Care/Post-op Dressings	Ho, Disc			
	★ **Health Problems R/T Admission** ☐ NA	Disc			
	Periop Routine (Home, ASCU, Holding, or	Disc			
	PACU/Designated Unit)				
	★ **Preventive Care** ☐ NA				
	Illness Immediately Prior to Surgery	Ho, Disc			
	When/Where to Obtain Further Treatment				
	★ **Oryx Indicators** ☐ NA				
	☐ Smoking Cessation Counseling				
	☐ Pneumococcal Pneumonia Vaccine Information				
	Given To Patients >65 Years of Age				
	☐ Influenza Vaccine Information Given To Patients				
	>65 Years of Age				

***See key at top of page 5 for completion of Patient/Family Education Summary**

Patient Name _____ Medical Record # _____ Date _____

PATIENT/FAMILY EDUCATION SUMMARY KEY

KEY: METHOD:	LEARNER:	LEARNER EVALUATION:
HO = HANDOUT DISC = DISCUSSION V = VIDEO DEMO = DEMONSTRATION GRP = GROUP TV = PATIENT ED CHANNEL (41, 42, 43)	P = PATIENT F = FAMILY S/O = SIGNIFICANT OTHER NA - NOT APPLICABLE AT THIS TIME * STANDARD DRIVEN	1 = LEARNING GOALS **MET** (LEARNER EITHER: RESTATES CONTENT CORRECTLY, GIVES RETURN DEMONSTRATION, OR ASKS APPROPRIATE QUESTIONS) 2 = LEARNING GOALS **NOT MET** (LEARNER EITHER; GIVES INCONSISTENT PERFORMANCE, NEEDS PRACTICE, HAS QUESTIONABLE COMPREHENSION) **REQUIRES PROGRESS NOTE**

PERIOPERATIVE INTERDISCIPLINARY PATIENT PLAN OF CARE

Date/ Initial / Sign	Problem Description	Problem Status	Goals and Interventions	Outcome
	1. Actual or Potential knowledge deficit related to procedure and recovery period		1. Provide patient and/or significant other with information regarding pre, intra, and post-procedure phase. Explanation to include: a. Adult Accompaniment NPO Status Required Prep: b. Expected length of stay and/or possibility of admission: c. Allow patient to verbalize knowledge of procedure d. Provide explanation of equipment to be used on patient and environment where procedure will be performed i.e. OR, PACU, IV lines, Monitors, Blood Pressure Cuff etc. e. Discharge teaching related to procedure to include: Physician's discharge summary with emergency callback #, prescriptions or changes in meds, and appointments for other diagnostic tests or procedures.	1. Patient will understand purpose, techniques, and risks associated with procedure: a. Patient will be compliant with adult accompaniment, NPO status, and required prep. b. Patient will have increased knowledge and decreased anxiety. c. This will identify any misconceptions the patient may have and should increase knowledge and decrease anxiety. d. Patient will have increased knowledge and decreased anxiety related to environmental factors including equipment. e. Patient will understand findings and follow-up as directed. Patient will also have a document of discharge instructions for reenforcement and for their personal records.
	2. Actual or Potential Adverse Reaction or Complication Post-Procedure		2. Pre-Procedure nursing assessment should include: a. Baseline vital signs, level of consciousness, pain assessment, medication list, allergies, NPO status, any changes in the patient's condition since they last saw their doctor b. Monitoring of the patient during post-procedure phase II c. Appropriate emergency equipment including reversal agents will be readily available at all times, and used as required.	2. a. Any adverse complications will be assessed and managed per established criteria. b. Any adverse complications will be assessed and managed per established criteria c. Any adverse complications will be assessed and managed

Guidelines for Plan of Care

PURPOSE: The purpose of the plan of care is to establish measurable goals or outcomes based on the patient's problems. These problems are identified through the assessment and re-assessment processes. This is an interdisciplinary process and plan. All licensed care providers will document the evaluation of the effectiveness of the plan throughout hospitalization.

1. The plan of care will be initiated after a licensed care provider completes the initial assessment.
2. Each care provider should discuss and review the plan of care with other disciplines prior to documentation to avoid redundancy in problem identification.
3. Clinical pathways may be utilized as a plan of care unless there is a variance. Problems that are not noted on a clinical pathway must be documented on the plan of care.
4. Any problem identified as a risk in the Intake and Triage process must be addressed on the plan of care.
5. Each assigned care provider is accountable for ongoing evaluation on the plan of care.
6. Revisions to the plan of care must be noted, and reasons for changes must be addressed in daily documentation
7. Complete each area above according to the following:

Date/Signature: Enter date and initials.
Problem Description: Describe the actual problems.
Problem Status: State whether problem is resolved (outcome achieved) or active (outcome not achieved)
Goals: Identify measurable goals with expected time of completion if applicable.
Interventions: List measures that will be implemented to meet outcomes.
Outcomes: Describe progress toward achieving goals.

Comments:

Signature/Initials:

Patient Name _____ Medical Record # _____ Date _____

PROGRESS NOTES

DATE Mo. / Day / Year	TIME 24 HOUR	