PRE-OP ASSESSMENT
(DAY OF SURGERY)

DATE: __________ TIME: __________

CONFIRMATION OF SURGICAL SITE:
☐ LEFT ☐ RIGHT

NUTRITIONAL/ METABOLIC
MARK ANY IRUSSES, CUTS, SCARS, WOUNDS, RASHES, ETC.

IF DIABETIC GLUCOMETER _______________________ AT __________ TIME

DOUGH: ☐ PRODUCTIVE ☐ NON PRODUCTIVE

SECRETION:
☐ SORE THROAT ☐ NASAL CONGESTION

MEDS TAKEN TODAY:

PATIENT BILLING: INITIALS: COMMENTS:

HEARING AIDS SENT TO O.R.
FINGERNAIL POLISH REMOVED
ANTIBIOTICS TO O.R. & PATIENT
JEWELRY REMOVED SECURED
HAIRPIN REMOVED

RESPIRATORY

VITAL SIGNS:
SP: P – T – R __________ BP __________ %

ACTIVITY / EXERCISE

COLOR NORMAL: ☐ YES ☐ NO

EDMA: ☐ PRESENT ☐ NOT PRESENT

HEART RHYTHM: ☐ REGULAR ☐ IRREGULAR

COGNITIVE / PERCEPTUAL PATTERNS

BEHAVIORS: ☐ ANGRY ☐ RESTLESS ☐ ANXIOUS ☐ CALM ☐ CONFUSED ☐ WITHDRAWN ☐ NON-RESPONSIVE

SIZE/TYPE: INITIALS: ON CHART: INITIALS: NOT APPLICABLE

SITE: □□□□□□□□□

AMT/SOLUTION Rate: □□□□□□□□

STARTED BY: __________ TIME: __________

MAGNETIC BSIDON:

TIME: DRUG, DOSE, ROUTE: INITIALS:

REQUISITED:

Surgical Consent Signed / Witnessed
Height / Weight on Chart
Temperature / BP Recorded
Vitals
ID Band on
Allergies Noted / on Chart
History and Physical on Chart
No Gum
Gown / No underwear (if sterile)

TIME: COMMENTS:

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