Regional Medical Center

PERIOPERATIVE EVALUATION FORM

Evaluation date: _____ Info Collected by: _____

Procedure: _____

Surg date: _____ Arrival time: _____

Allergies: _____

Latex: ☐ Yes ☐ No IV Dye: ☐ Yes ☐ No

Preferred Name _____ Transportation Home By _____

Local Phone # _____ Caregiver at Home _____

MEDICATIONS	Dose & Frequency	Last Dose	PRIOR SURGERY LIST	MEDICAL HISTORY

SYSTEM REVIEW

Yes No Do you or have you ever had.....

- ☐ ☐ ***take natural/herbal medicines?*** Type/dosage: _____
- ☐ ☐ ***take over the counter medicines?*** Type/dosage: _____
- ☐ ☐ chronic headaches, stroke, seizure or paralysis _____
- ☐ ☐ heart or BP problems, i.e. heart attack, chest pain, mumur, R.F., heart surgery _____
- ☐ ☐ ***lipid profile (2 yr)*** _____
- ☐ ☐ breathing problems, i.e. shortness of breath, asthma, emphysema _____
- ☐ ☐ cough, recent cold symptoms _____
- ☐ ☐ ***history of smoking?*** _____ ***year quit*** _____ ***packs / years*** _____ ***cessation info given by*** _____
- ☐ ☐ drink alcohol/beer Amount: _____ in past 24 hours: _____
- ☐ ☐ ***diabetes?*** _____ ***insulin?*** ☐ Yes ☐ No FBS / Accu-check: _____ ***self-testing?*** ☐ Yes ☐ No
- ☐ ☐ ***Retinal + HA1C Exam 2yr*** ☐ Yes ☐ No ***Hemoglob HA1C Exam 1yr***
- ☐ ☐ any thyroid, kidney, liver problems or history of cancer? _____
- ☐ ☐ Hx of Hepatitis? _____
- ☐ ☐ hiatal hernia? _____ ulcer? _____ acid or sour taste? _____
- ☐ ☐ blood transfusion in past? _____ reaction _____
- ☐ ☐ Do you accept blood products/transfusions? _____
- ☐ ☐ excessive bleeding? _____ you _____ blood relative _____
- ☐ ☐ any cortisone, ACTH, steroid medications in the past year? _____ ASA in the past 2 weeks? _____
- ☐ ☐ any mood altering drugs or street drugs? _____
- ☐ ☐ reaction to local or general anesthesia, including high fever, nausea, vomiting? You _____ relative _____
- ☐ ☐ immunizations up to date? ***Flu vaccine (1 yr)*** ☐ Yes ☐ No ***Pneumonia vaccine (5yr)*** ☐ Yes ☑ No
- ☐ ☐ **Spiritual Cultural practices?** _____
- ☐ ☐ Advance Directives? If yes, are they on the chart? ☐ Yes ☐ No
  Patient intent: _____ If no, info given to Patient by _____
- ☐ ☐ Satisfaction Survey info given
- ☐ ☐ Patient Rights provided

WOMEN ONLY: Is there any possibility you could be pregnant? ☐ Yes ☐ No LMP: _____ Last Mammogram: _____

Are you lactating? ☐ Yes ☐ No

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Date	Ht	Wt	BP	HR	RR	SaO_2	T

Information Collected by ☐ Telephone ☐ In person

Check only if applicable: **PHYSICAL ASSESSMENT**

Self Concept Coping	Communication	Skin Integrity	Respiratory
☐ Alert ☐ Oriented, (Person, Place & Time) ☐ Calm/Relaxed ☐ Disoriented ☐ Lethargic ☐ Angry / Hostile ☐ Anxious / stressful / tearful ☐ Depression / withdrawal ☐ Eye Contact ☐ Abuse Reported ☐ ***Falls in last 6 months***	☐ Normal ☐ Blind ☐ Deaf /Hard of hearing ☐ Wears Hearing Aid ☐ Right ☐ Left ☐ Mute ☐ Language barrier **Speech** ☐ Clear ☐ Slurred ☐ Other	☐ Normal ☐ Rash ☐ Edema ☐ Blister ☐ Open Areas ☐ Other	☐ Regular ☐ Clear ☐ Labored ☐ Wheezes ☐ Assisted ☐ Other ____ ☐ Oxygen _____ ☐ Shortness of Breath Cough ☐ None ☐ Productive for____wk/mth. Blood in sputum, Fever, Night Sweats, Weight Loss Productive cough > 3 weeks c 2 other symptoms, Circle symptom then notify physician.

MUSCULOSKELETAL	CARDIOVASCULAR	GASTROINTESTINAL	GENTOURINARY
Movement ☐ Normal - upper, lower ☐ Diminished _____ ☐ Contractures _____ ☐ Paralysis _____ **Strength** ☐ Normal ☐ Diminished ☐ Numbness/Tingling **Back Problems** ☐ None ☐ Pain - low, mid, high ☐ Radiation to leg ☐ Right ☐ Left **Gait** ☐ Steady ☐ Unsteady _____ _____ _____	**Heart Sounds** ☐ Normal ☐ Distant **Rhythm** ☐ Regular ☐ Irregular **Color** ☐ Pink ☐ Other _____ **Temperature** ☐ Warm ☐ Cool **Edema** ☐ None ☐ Location_____ **Chest Pain** None ☐ Associated symptoms: Dyspnea, Diaphoresis, Nausea, Vomiting ☐ Radiation to LA, RA, back, neck, jaw, other _____ _____ _____	**Nutrition Appetite** ☐ Normal ☐ Increased ☐ ***Decreased*** ☐ ***Weight Loss*** ☐ Nausea ☐ ***Vomiting*** ☐ Difficulty Swallowing **Diet** ☐ Regular ☐ ***Special Diet***_____ **Bowel Movements** ☐ Regular ☐ Diarrhea ☐ Constipation ☐ Incontinence ☐ Bloody/tarry stools ☐ Colostomy **Bowel Sounds** ☐ Normal ☐ Absent ☐ Hypoactive ☐ Hyperactive **Bowel Prep** ☐ Yes ☐ No	**Urination** ☐ Normal ☐ Frequency ☐ Urgency ☐ Burning ☐ Difficulty Voiding ☐ Bleeding or Discharge ☐ Incontinent **Ostomies** ☐ Yes ☐ No **Comments:**_____ _____ _____ _____ _____ _____ Information Collected By: _____

DAY OF SURGERY

SAFETY & SECURITY

Items removed	Yes	N/A	Family	Other
Glasses / Contact lenses				
Jewelry -ALL				
Removable teeth				
Hearing Aids				
Implants				
Clothing & Underwear				
Disposition of Meds				

Pre-op Antibiotics ☐ Yes ☐ No

PAIN ASSESSMENT

Pain & Pain Prevention / Education Measures Addressed ☐ Yes ☐ No

Present level of pain (0-10) _____ Site _____

Is pain > 3 months duration ☐ Yes ☐ No Pain goal for discharge (0-10)____

NPO:_____

☐ Yes ☐ No Perioperative teaching / Discharge planning complete

VITAL SIGNS: T___ P___ BP___ RR___ SaO_2 ___

HT____ cm WT____ kg

IV:_____

Vasoular Potts_____

Nurses Notes:_____

_____

Information Collected by_____

REGIONAL MEDICAL CENTER
PERIOPERATIVE PLAN OF CARE
PAGE 1

Copy 1- Medical Records Copy 2- O.R.

Date: _____

Preferred Name: _____
Allergies: _____

_____

NPO since _____
Comments: _____
Level of Consciousness: Oriented ☐ Yes ☐ No
Other: _____
Communication Ability/Limitations/Aides:
Eye: _____
Hearing: _____
Dentures: _____
Language: _____
Comments: _____
Blood Consent: ☐ Yes ☐ No ☐ Refused
Blood Bank Number: _____
Implants: ☐ Yes ☐ No
☐ Eye: ☐ Rt. ☐ Lt: _____
☐ Cardiac: _____
☐ Vascular/AV Fistula: _____
☐ Spinal: _____
☐ Cosmetic/Plastic: _____

_____
☐ Urology: _____
☐ Ortho: Left: _____ Right: _____
Other: _____
Mobility: ☐ No Limitations
☐ Other: _____
Skin Integrity: ☐ Intact
☐ Do Not Use Extremity: (Description) _____
Other: _____
Tubes/Drains: ☐ Urinary ☐ NGT
☐ Chest Tube ☐ Rt. ☐ Lt.
☐ Other: _____
Lines: ☐ None ☐ Peripheral ☐ Rt. ☐ Lt.
☐ Swan Ganz ☐ Rt. ☐ Lt.
☐ A-Line ☐ Rt. ☐ Lt.
☐ PIC ☐ Rt. ☐ Lt.
Pre-Op Lab Check:
☐ None Ordered ☐ Yes
☐ HCG ☐ Positive ☐ Negative ☐ N/A
☐ LMP: (if applicable) _____
☐ Comments: _____

_____
Nursing pre-op Assessment reviewd by:

_____

PROCEDURAL TIME OUT

✓ when completed in room	Criteria
☐	Confirms: patient identity, schedule, consent(s), pt. position, operative procedure, laterality, and site mark.
☐ ☐ NA	Review medical record for consistency in identifying the correct surgical site or procedural site
☐ ☐ NA	Imaging studies available - confirming patients identity and surgical site
☐ ☐ NA	Implant Systems available Allograft Implantation on consent
☐ ☐ NA	Special equipment available
Who Initiated	**TIME OUT** **TIME OF TIME OUT** _____ Document members present for "TIME OUT" ☐ MD: _____ ☐ Assistant: _____ ☐ Anesthesia: _____ ☐ CRNA: _____ ☐ Scrub: _____ ☐ Scrub: _____ ☐ RN Circulator: _____ ☐ RN Circulator: _____ ☐ Other: _____ **Who Reviewed this Section:** _____

Changes in Care Plan

Please Note Any Changes Resulting from Pre-Op Assessment concerning Plan of Care:

Surgeon Notified:

Action Taken:

☐ Discrepancy Noted
☐ Non-Applicable

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PENINSULA REGIONAL MEDICAL CENTER
PERIOPERATIVE PLAN OF CARE
PAGE 2 OF 5 *Copy 1- Medical Records Copy 2- O.R. Copy 3- Office Copy 4- Physician*

Date:_____ OR#:_____ Pt. Identified By:_____

Admission:_____ Anes:_____ Incision:_____

Operation End:_____ Discharge Time:_____

Pre-Op Diagnosis: _____

Post-Op Diagnosis: ☐ **Same** _____

Operative Procedure:

☐ **See Implant Record**

Complications:

Specimens/Cultures:

EBL:

Physicians Signature:

Wound Classification
☐ Clean ☐ Clean Contaminated
☐ Contaminated ☐ Dirty

Type of Anesthesia
☐ General ☐ MAC ☐ Regional ☐ Local w/ IV Sedation ☐ Local

Tourniquet Times: _____
Clamp Times: _____

Surgeon_____	Scrub 1_____	R Scrub Time_____	R Scrub Time_____
Asst. Surgeon_____	Scrub 2_____	R Scrub Time_____	R Circ Time_____
Assistant_____	Circ 1_____	R Circ Time_____	R Circ Time_____
Anesthesiologist_____	Circ 2_____	R Circ Time_____	X-Ray Tech Time_____
CRNA_____	X-Ray Tech_____	X-Ray Tech Time_____	Reps_____

Observers_____ Perfusionist_____ Reps_____

Observers_____ Student_____ Student_____

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REGIONAL MEDICAL CENTER
PERIOPERATIVE PLAN OF CARE
PAGE 3 OF 5: Expected Outcomes
Copy 1- Medical Records Copy 2- O.R.

Date: _____

POTENTIAL FOR ALTERATION OF SKIN INTEGRITY

Position: Type of Table: _____
☐ Supine ☐ Lateral ☐ Left ↓ ☐ Right ↓
☐ Prone ☐ Jackknife ☐ Beach-chair
☐ Lithotomy ☐ Other: _____

Arms: Left Right
☐ ☐ Tucked
☐ ☐ Padded Armboard
☐ ☐ Extremity Table
☐ ☐ Position of Comfort
☐ ☐ Other: _____

Safety Strap:
☐ Yes/Location _____ ☐ No

Stirrups:
☐ Allen ☐ Swing/Candy Cane
☐ Knee/Crutch ☐ Other: _____
☐ Padded with: _____

Positioning Devices:
☐ Gel Pads ☐ Lateral Positioner
☐ Blanket ☐ Chest Rolls
☐ Pillow ☐ Shoulder Rolls
☐ Pillow/Donut/Padded ☐ Tape
☐ Heel/Elbow Pads ☐ Maquet Fracture Table
☐ Sand Bag ☐ Andrews Spinal Table
☐ Vac Pac ☐ Jackson Table
☐ Axillary Roll ☐ Wilson Frame
☐ Bolster_____ ☐ Mayfield
☐ Kidney Rest ☐ Skull Pins
☐ Footboard Padded ☐ McConnel Positioner
☐ Ortho Peg Board ☐ Lateral Thigh Post
☐ Other: _____ ☐ Star Shoulder Traction

☐ Positioned under the Direct Supervision of the Surgeon:
_____

POTENTIAL FOR INFECTION

Hair Removal: ☐ No ☐ Yes
☐ In O.R. by: _____

Skin Prep to Operative site(s): ☐ Yes ☐ No
☐ Betadine scrub ☐ Ioban
☐ Betadine solution ☐ Hibiclens
☐ Duraprep ☐ Alcohol
By: _____
Reaction Noted: ☐ No ☐ Yes: Type: _____
_____

Lines (inserted in O.R.) ☐ No ☐ Yes:
☐ Peripheral ☐ Rt. ☐ Lt. Size:____
☐ Arterial ☐ Rt. ☐ Lt.
☐ Triple Lumen ☐ Rt. ☐ Lt.
☐ Swan Ganz ☐ Rt. ☐ Lt.
☐ Other: _____

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OR-411 (9/06)

Electrocautery:
☐ ESU # _____
☐ Settings: Coag. _____ Cut: _____
☐ ESU Pad Location _____ By: _____
Hair Removed: ☐ Yes ☐ No By: _____
Skin Clear & Intact Pre-Op. ☐ Yes ☐ No
Post-Op: ☐ Yes ☐ No

BiPolar Cautery:
☐ Bipolar Type & #: _____
☐ Settings: _____

AEM Cautery #: _____
Harmonic Scalpel #: _____

Warming Units:
Bair Hugger: Type & #: _____
☐ Upper Body ☐ Lower Body ☐ Setting: _____
Warming Blanket: Type & #: _____
☐ Adult ☐ Ped. ☐ Setting: _____

Antiembolectomy Devices:
Stockings: ☐ Thigh ☐ Knee High
Sequential Stockings #: _____
☐ Thigh ☐ Knee
Foot Pumps #: _____

Arthrocare #: _____ Settings: _____
Tourniquet #: _____

Location	Applied By:	Pressure Mm/Hg	Up Time	Down Time

Drains (inserted in O.R.)
☐ Hemovac ☐ Sm ☐ Med. ☐ Lg. Location_____
☐ Auto Transfusion Hemovac
☐ Jackson Pratt ☐ Flat ☐ Round Location_____
☐ Blake _____fr. Location_____
☐ Penrose ☐ Sm ☐ Lg. Location_____
☐ Chest Tube #_____ Location_____
☐ T-Tube#_____ Location_____
☐ Salem #_____Fr. Location_____
☐ Mediastinal_____ Location_____
☐ Other_____

Urinary Catheter:
In O.R. #:_____fr._____cc balloon _____cc residual
Inserted by:_____
Total output (including residual) _____cc
Remarks_____
Foley Removed at the end of the case: ☐ Yes

REGIONAL MEDICAL CENTER
PERIOPERATIVE PLAN OF CARE
PAGE 4 OF 5 *Copy 1- Medical Records Copy 2- O.R.*

Date: _____

POTENTIAL FOR INFECTION

MEDICATION	DOSAGE	METHOD/LOCATION	TIME

PHYSICIANS SIGNATURE:

POTENTIAL FOR INJURY

Final Count - Completed and correct: Circ. Scrub
Sponge ☐ Yes ☐ No _____/_____
Sharps ☐ Yes ☐ No _____/_____
Instruments ☐ Yes ☐ No _____/_____
Packing ☐ No ☐ Yes Type: _____
Dressing applied to operative Site: ☐ No ☐ Yes

Blood products administered
☐ Yes ☐ No
(see anesthesia record)

LOCALS:
Oxygen: ☐ Yes ☐ No
l/minute_____
☐ N.C. ☐ Mask
☐ If Conscious Sedation see Conscious Sedation Form
☐ See Vital Signs Record

POST OP EVALUATION

EXPECTED OUTCOMES ACHIEVED:
a. Optimal physiological function maintained ☐ Yes ☐ No
b. Patient maintained in a safe environment ☐ Yes ☐ No
c. Patient is free from injury ☐ Yes ☐ No

Transferred to: ☐ PACU ☐ SDS ☐ ICU #_____ ☐ Inpt Holding ☐ Pt. Room_____
Method of transfer. ☐ Stretcher Side Rails Up: ☐ Yes ☐ No ☐ Bed Side Rails Up: ☐ Yes ☐ No
☐ Wheelchair

Nurses Notes: _____

Nurses full signature and title: _____

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REGIONAL MEDICAL CENTER
PERIOPERATIVE PLAN OF CARE
PAGE 5 OF 5 *Copy 1 - Medical Records Copy 2 - O.R. Copy 3- Office Copy 4 - Physician*

Date: _____ ☐ No Implants/Allografts used

Allograft's

Product/ Company	Description	Reference #	Lot #	Expiration Date	Time Implanted	Allograft Reconstituted Y	Allograft Reconstituted N	Allograft Reconstituted Duration	Package Integrity checked Yes	Package Integrity checked No	Person Transferring Graft	Person preparing Graft

Other Implants

Product/ Company	Description	Reference #	Lot #	Expiration Date	Explanation Date	Reason for Explantation