Patient: N/A
DOB: N/A (N/A)
Physician: N/A
Procedure Date: N/A

Height: N/A **Weight:** N/A **BMI:** N/A
Procedure: N/A

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Pre-Assessment Survey

Patient Name:

1. Person filling out this form

	Please check all that apply	Explanation
	Self	
	Spouse	
	Family Member	
	Partner	
	POA	
	Other	

2. What name do you prefer to be called by?

_____

3. Gender at birth:

○ Female ○ Male

3A. Women Only

	Please check all that apply	Explanation
	Pregnant or chance of pregnancy	
	Breastfeeding	
	Menopause / Hysterectomy	

4. Patient Contact Information:

Best phone number to reach you (Can we leave a detailed message about your up coming surgery at this phone number): _____

Emergency contact Name and Phone Number: _____

Email address: _____

Physical address : _____

5. Patients primary language

_____

6. Do you require an interpreter?

○ Yes ○ No

If yes, what language.

_____

_____

_____

7. What is your current height & weight (example: 5'8" 160lbs)?

_____

8. Do you have an Advance Directive?

○ Yes ○ No

9. Procedure Information:

Procedure to be performed?: _____

Date of your Procedure?: _____

If you were told a time by the surgery center, what time where you given? : _____

Surgeons name?: _____

10. Have you experienced any of the following in the last 2 weeks? Please check all that apply.

	Please check all that apply	Explanation
	Cough	
	Shortness of breath	
	Sore throat	
	Fever of 101.5 degree or above	

11. Have you or someone you live with traveled outside the U.S. in the last 30 days? If yes, please indicate where and when.

○ No ○ Yes

If yes, please specify which countries.

_____

_____

_____

12. Have you or someone you have been in contact with recently been confirmed COVID-19?

○ No ○ Yes

13. Have you or a member of your family had any problems associated with previous surgeries, anesthesia, or intubation, such as nausea, vomiting (PONV), Malignant Hyperthermia, or Pseudocholinesterase Deficiency?

	Please check all that apply	Explanation
	Yes, I have had problems associated with previous anesthesia or intubation	
	Yes, a family member has had problem associated with previous anesthesia or intubation	
	No	

14. Anesthesia Assessment - Dental History. Do you have any of the following? Please check all that apply.

	Please check all that apply	Explanation
	Loose teeth (which one(s))	
	Chipped teeth (which one(s))	
	Caps (which one(s))	
	Crowns (which one(s))	
	Dentures - Upper	
	Dentures - Lower	
	Braces	

15. Do you wear any of the following? Please check all that apply.

	Please check all that apply	Explanation
	Hear aids (bring case with you)	
	Removable dental wear (dentures or partials)	
	Contact lenses (bring case with you)	
	Glasses	
	Piercings (remove before surgery)	
	Implants	
	Prosthesis	

16. Do you take any prescription drugs or over-the-counter (e.g., aspirin) medications? If yes, what is the drug name, dose, route, frequency & reason for use? Please include all blood thinners, birth control pills, steroids, herbal supplements, diet pills and inhalers, if applicable.

	Medication Name	Dosage	Route	Frequency	Date Last Taken	Reason for use
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

17. Medication Allergies:

	Medication Name	Reaction
1		
2		
3		
4		
5		

18. Do you have any allergies to foods, bee stings, iodine, shellfish, rubber, contrast dye, medical tape, latex?

○ Yes ○ No

If yes, please explain

_____

_____

_____

19. Are you currently using GLP-1 agonists for diabetes and/or weight loss? (i.e Ozempic, Semaglutide, Mounjaro, Wegovy, Trulicity)

○ Yes ○ No

20. Have you been instructed by your physician to stop taking any medication prior to surgery (for example, Plavix, Coumadin, aspirin, anti- inflammatory, Ibuprofen, herbal medication/ supplements, prescriptions and over- the- counter diet pills or vitamin E)? Please follow instructions given by physician's office related to medications. If you have any questions about diabetic medications, or blood thinners, please contact your physician's office.

○ Yes ○ No

Please list all medications that you've been instructed to stop and the date to stop taking:

_____

_____

_____

21. Have you had any past surgeries or procedures that required anesthesia? (Including plastic surgery, dental surgery, colonoscopy, endoscopy, or childhood surgeries such as tonsillectomy). Please list surgery/procedure, date of procedure and type of anesthesia provided, or put "N/A".

	Anesthesia Type	Type Surgery	Date
1			
2			
3			
4			
5			

22. Primary Care Provider Information

Name: _____

Phone Number: _____

23. Have you been hospitalized in the last 6 months?

○ Yes ○ No

If yes, please specify

_____

_____

_____

24. Are you under the care of ANY specialists?

○ No ○ Yes

24A. Specialist Information:

Specialty Type (i.e. Cardiologist, Pulmonologist, Immunologist): _____

Specialist Name: _____

Phone: _____

25. Cardiovascular History. Do you have any of the following conditions? Please check all that apply.

	Please check all that apply	Explanation
	Coronary/Heart Stent(s) (Date of occurrence)	
	Coronary artery bypass (CABG)(Date of occurrence)	
	Heart valve problems	
	Aortic Valve or Mitral Valve replacement	
	Chest pain/ Shortness of breath after climbing 1 flight of stairs	
	Coronary Artery Disease (CAD)	
	Congestive heart failure (CHF)	
	Irregular heart beat or palpitations	
	Heart attack (Date of occurrence)	
	Heart related chest pain (angina)	
	Pacemaker (Manufacture/Brand/Model and date of implant)	
	High Cholesterol (Dyslipidemia)	
	High blood pressure (Hypertension)	
	Defibrillator (Manufacture/Brand/Model, where on body and date of implant)	
	None of the above	

26. Have you had an EKG, ECHO, or Cardiac Stress Test within the last 6 months?

○ No ○ Yes

26A. If yes, when and where did you have it performed?

_____

27. Pulmonary (Lung) History. Do you have any of the following? Please check all that apply.

	Please check all that apply	Explanation
	Emphysema	
	Recent cold, cough, sore throat or flu / COVID symptoms	
	Have / had history of Tuberculosis (TB)	
	Home oxygen use (liter level, type, and when is it needed)	
	Diagnosed Sleep Apnea (Please specify below CPAP, BIPAP, Oral Device, or Other)	
	COPD	
	Asthma	
	Bronchitis	
	None of the above	

28. Have you had blood work done within the last 30 days?

○ No ○ Yes

28A. If yes, where and when did you have it done?

_____

29. Sleep Apnea Assessment: Snoring: Do you snoring loudly? (Louder than talking or loud enough to be heard through closed doors?)

○ Yes ○ No

30. Tiredness: Do you often feel tired, fatigued, or sleepy during the daytime?

○ Yes ○ No

31. Observed Apnea: Has anyone observed you stop breathing while you were sleeping?

○ Yes ○ No

32. Does your neck measure more than 15 3/4" (40cm) around?

○ Yes ○ No

33. Pressure: Do you have (or are you being treated for) high blood pressure?

○ Yes ○ No

34. Neurological History. Do you have any of the following conditions? Please check all that apply.

	Please check all that apply	Explanation
	Epilepsy or history of seizures (Date of occurrence)	
	Stroke or mini stoke (TIA) (Date of occurrence and residual effects)	
	Migraines	
	Neuropathy	
	Alzheimer's/Dementia	
	Multiple sclerosis	
	Muscular dystrophy	
	Dizziness / Fainting spells / Loss of Consciousness	
	Numbness / Tingling	
	None of the above	

35. IF yes to Alzheimer's/Dementia, do you have a Medical Power of Attorney?

_____

36. Dermatology History. Do you have any of the following conditions? Please check all that apply.

	Please check all that apply	Explanation
	Rash	
	Open wounds	
	Psoriasis	
	Eczema	
	Other	
	None of the above	

37. EENT History. Do you have any of the following conditions? Please check all that apply.

	Please check all that apply	Explanation
	Blurred Vision	
	Cataract(s)	
	Glaucoma	
	Macular Degeneration	
	TMJ	
	Sinus Issues	
	Loss of Hearing (which ear(s))	
	Other	
	None of the above	

38. Renal (Kidney) History. Do you have any of the following conditions? Please check all that apply.

	Please check all that apply	Explanation
	Chronic Kidney disease (stage)	
	Kidney stones	
	Bladder/urinary incontinence	
	Kidney transplant (Date of occurrence)	
	Dialysis (where, days scheduled and date of last treatment)	
	Other	
	None of the above	

39. History Hepatic (Liver). Do you have any of the following conditions? Please check all that apply.

	Please check all that apply	Explanation
	Liver disease	
	Cirrhosis	
	Hepatitis (please indicate Type below)	
	Yellowing of skin (Jaundice)	
	None of the above	

40. Endocrine History. Do you have any of the following conditions? Please check all that apply.

	Please check all that apply	Explanation
	Diabetes Type 1	
	Diabetes Type 2	
	Thyroid disease (Type)	
	Other	
	None of the above	

41. Hematologic (Blood) History. Do you have any of the following conditions?

	Please check all that apply	Explanation
	Von Willebrands	
	Bruises easily	
	Anemia	
	Factor V	
	Deep Vein Thrombosis (DVT)	
	Bleeding or blood clotting disorders	
	Pulmonary Embolism	
	Sickle Cell	
	None of the above	

42. Gastrointestinal (GI) History. Do you have any of the following conditions? Please check all that apply.

	Please check all that apply	Explanation
	Ulcers	
	Hiatal Hernia	
	Irritable Bowel Syndrome (IBS)	
	Crohn's Disease	
	Frequent acid reflux/GERD or heartburn	
	None of the above	

43. History Musculoskeletal (Muscles/Bones). Do you have any of the following conditions?

	Please check all that apply	Explanation
	Unusual muscle problems or disease	
	Arthritis	
	Osteoarthritis	
	Unable to lay flat	
	Back pain (limit your movement or mobility)	
	Neck pain (limit your movement or mobility)	
	None of the above	

44. Mental Health. Do you have any of the following conditions?

	Please check all that apply	Explanation
	Bi-Polar	
	Autism	
	Depression	
	Anxiety/Panic attacks	
	PTSD	
	None of the above	

45. Do you use any of the following mobility aids? Please check all that apply.

	Please check all that apply	Explanation
	Cane	
	Crutches	
	Wheelchair	
	Walker	
	Scooter	
	None of the above	

46. Do you have a history, or are you currently at risk of falling?

○ Yes (Date of last episode) ○ No

If yes, please specify

_____

_____

_____

47. Do you have any of the following conditions? Please check all that apply.

	Please check all that apply	Explanation
	HIV	
	AIDS	
	C-diff (Clostridium difficile)	
	VRE (Vancomycin-resistant Enterococcus)	
	MRSA	
	Shingles (current or within the last 6 months)	
	Infection difficult to treat	
	Rheumatoid arthritis	
	None of the above	
	None of the above	

48. Do you or have you ever had cancer?

○ No ○ Yes

49. If yes:

What type of cancer?: _____

When?: _____

Treatment (i.e. chemo, radiation or other types): _____

*** 50. Social Assessment - Please be forthcoming about your drug and alcohol use. This information is kept confidential however, we need to know for anesthesia and medication interaction.**

○ I understand

51. Are you a former user of tobacco/nicotine products? If yes, when did you quit?

○ No ○ Yes

If yes, when did you quit?

_____

_____

_____

52. Do you smoke or use any tobacco/nicotine products?

○ No ○ Yes

53. How much do you use per day? (Example: 1 pack per day) Refrain from using tobacco at least 24 hours prior to surgery.

_____

_____

_____

54. Do you drink alcohol?

○ No ○ Yes

55. How many drinks do you have a week and type? (Example: 1 beer per week)

_____

_____

_____

56. Do you use any recreational drugs, including medical marijuana?

○ No ○ Yes

57. If yes, what drug, how often, and when was the last time you used?

_____

*** 58. Select the activity that most closely represents your level of physical activity:**

	Please check all that apply	Explanation
	I am able to run 2 miles or more	
	I am able to bike or walk 1 mile	
	I am able to climb 2 flights of stairs without stopping	
	I am able to climb 1 flight of stairs or less before stopping	
	I am short of breath at rest	
	Not Applicable	

59. For your safety and protection, you must have transportation home from a responsible person over the age of 18. A responsible person must stay with you for 24hrs after your surgery. Your surgery may be postponed or cancelled if these instructions are not carefully followed. Please call the Surgery Center if you have any questions.

Driver's name: _____

Phone number: _____

Relationship to patient: _____

60. Pre-Visit Instructions -- I acknowledge the following (Please check each box after reading):

	Please check all that apply	
	A staff member will call you the day before your procedure to review your scheduled procedure time, arrival time, NPO status, Medication instructions and address any questions or concerns you may have regarding your procedure.	
	You are required to bring a Photo ID, Insurance card and form of payment, if required. Failure to provide a photo ID may result in cancellation of your procedure.	
	NO ASA/ ASA products, Advil, Aleve, Bufferin, Ibuprofen, Motrin, anti-inflammatory drugs, Coumadin, or other blood thinners- check with cardiologist, family doctor, or surgeon.	
	DO NOT eat or drink after MIDNIGHT (no food or drink, gum, mint, candy) or surgery will be cancelled. (Risk of aspiration pneumonia will be explained by staff.) If you are having a GI procedure (colonoscopy and/or upper endoscopy), follow the preop instructions provided to you by the physician's office. If you do not have your instructions please call the office as soon as possible so they can get those to you.	
	You may be able to take some medication with a SIP of water only, 2-2 1/2 hours prior to your surgery (insulin- follow protocol). A staff member will call and discuss this information with you before your scheduled procedure. Local patients may take scheduled medications.	
	DO NOT smoke after MIDNIGHT. It is best to stop smoking 24 hours before your procedure.	
	NO alcohol beverages at least 48 hours before your procedure.	
	NO illegal drugs of any kind.	
	NO makeup; NO fingernail Polish.	
	REMOVE all jewelry.	
	For Female patients of child bearing age, who have not had a hysterectomy or in menopause for at least 1 year, we will need a urine sample for a pregnancy test. If you need to use the restroom upon arrival please let the front desk know so we can collect your urine sample prior to registration.	
	A shower or bath is recommended prior to surgery.	
	Leave all money, credit cards, jewelry or other valuables at home, EXCEPT for a form of payment if required day of surgery.	
	Glasses/ contacts, and dentures must be removed before having procedure. Please bring case with you.	
	PEDIATRIC PATIENTS: bring favorite toy, blanket, pacifier, a change of clothes, formula or favorite drink and a bottle or sippy cup, if needed.	
	If you feel ill or have a fever greater than 100.5, have a cough, cold, chest congestion or any other changes in your medical condition, contact your surgeon and the nurse at the surgery center.	
	Bring Advanced Directive (living will or durable power of attorney for healthcare) with you.	
	You may be called to arrive SOONER than scheduled time, if there are cancellations.	
	For your safety and protection, you MUST have transportation home from a responsible person over the age of 18. A responsible person must stay with you for 24hrs after your surgery. Your surgery may be postponed or cancelled if these instructions are not carefully followed.	
	Failure to follow these instructions may lead to the cancellation of your procedure.	
	We thank you for choosing us to care for you and if you have any questions/ concerns please contact your surgeon or nurse at the surgery center.	

Patient: N/A
DOB: N/A (N/A)
Physician: N/A
Procedure Date: N/A

Height: N/A **Weight:** N/A **BMI:** N/A
Procedure: N/A

Patient: N/A
DOB: N/A (N/A)
Physician: N/A
Procedure Date: N/A

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Height: N/A **Weight:** N/A **BMI:** N/A
Procedure: N/A

BSW Fall Risk Assessment

MRN: N/A

Age
- [ ] <3 years of age (3 points)
- [ ] >65 years of age (3 points

Dizziness/Vertigo
- [ ] patient has DIZZY SPELLS/FAINTING/VERTIGO/VASOVAGAL EPISODES (1 point)

Impaired Mobility
- [ ] Patient requires assistive device to ambulate such as cane, walker or wheelchair (2 points)
- [ ] Patient has amputation to lower extremity (2 points)

Visual Impairment
- [ ] Patient uses glasses/contacts or is having a eye related procedure (2 points)

Cognition
- [ ] History of dementia or Alzheimer's (3 points)

Altered Elimination
- [ ] Patient has history of incontinence (3 points)

History of Falls
- [ ] Patient has had a fall in 6 months (7 points)

Medications
- [ ] Patient takes two or more (circle all that apply) Tranquilizers, sleeping pills, pain relievers, blood pressure pills, diuretics (2 points)

PEDIATRIC PATIENTS ONLY - Falls risk initiated for all pediatric patients - parents at bedside
- ○ Yes ○ No

Total Score: _____

Score of 6 or more = HIGH RISK FOR FALLS

Does patient meet criteria for High Risk for Falls?
- ○ Yes ○ No

Facility Fall Risk Protocol initiated?
- ○ Yes ○ No

_____ _____
RN Signature Date/Time

Latex Allergy Questionnaire

Please answer all questions below.	Yes	No
Do you have allergies, asthma, rhinitis (hay fever), eczema, or problems with rashes related to a latex exposure?		
Have you ever had respiratory distress, rapid heart rate, or swelling?		
Have you ever had a rash on your hands following glove use that lasted longer than a week?		
Are you known to be allergic or do you have any adverse reactions when you eat the following foods: avocados, bananas, chestnuts, kiwi, hazelnuts, chestnuts, peaches (or other stone fruits), tomatoes or raw potatoes?		
Have you ever had swelling, itching, or hives around your mouth after blowing up a balloon?		
Have you ever had swelling or hives following a vaginal or rectal examination or after contact with a diaphragm or condom?		
Have you ever had swelling, itching, or hives around your mouth during or after a dental examination?		
Have you ever had swelling or hives on your hands during or within an hour of wearing rubber latex gloves?		
Have you ever had swelling, itching, or hives around your waistline during or after wearing underwear with elastic waistband?		
Have you ever noticed a runny nose, watery eyes, wheezing during or immediately after contact with latex products or in an environment where latex use is high?		
Have you ever been diagnosed by a physician as to having a latex allergy?		
Have you ever had a serious allergic reaction (anaphylaxis) or other unexplained reaction during a medical exam or procedure where contact with latex was involved?		

TOTAL YES ANSWERS	

Patient: N/A
DOB: N/A (N/A)
Physician: N/A
Procedure Date: N/A

Baylor Scott & White Surgicare Waxahachie

HST Case Coordination™

Height: N/A **Weight:** N/A **BMI:** N/A
Procedure: N/A

Anesthesia Assessment

MRN: N/A

Do you smoke or use any tobacco/nicotine products?
○ No ○ Yes

Do you drink alcohol?
○ No ○ Yes

Do you use any recreational drugs, including medical marijuana?
○ No ○ Yes

Have you or a member of your family had any problems associated with previous surgeries, anesthesia, or intubation, such as nausea, vomiting (PONV), Malignant Hyperthermia, or Pseudocholinesterase Deficiency?
☐ Yes, I have had problems associated with previous anesthesia or intubation
☐ Yes, a family member has had problem associated with previous anesthesia or intubation
☐ No
If yes, please specify

_____
_____
_____

Cardiovascular History. Do you have any of the following conditions? Please check all that apply. ☐ None of the above ☐ Coronary artery bypass (CABG)(Date of occurrence) ☐ Coronary Artery Disease (CAD) ☐ Congestive heart failure (CHF) ☐ Irregular heart beat or palpitations ☐ Heart attack (Date of occurrence) ☐ Heart related chest pain (angina) ☐ Coronary/Heart Stent(s) (Date of occurrence) ☐ Pacemaker (Manufacture/Brand/Model and date of implant) ☐ Defibrillator (Manufacture/Brand/Model, where on body and date of implant) ☐ High Cholesterol (Dyslipidemia) ☐ High blood pressure (Hypertension) ☐ Heart valve problems ☐ Aortic Valve or Mitral Valve replacement ☐ Chest pain/ Shortness of breath after climbing 1 flight of stairs
If yes, please explain.

_____
_____
_____

Pulmonary (Lung) History. Do you have any of the following? Please check all that apply. ☐ Emphysema ☐ Have / had history of Tuberculosis (TB) ☐ Home oxygen use (liter level, type, and when is it needed) ☐ Diagnosed Sleep Apnea (Please specify below CPAP, BIPAP, Oral Device, or Other) ☐ Asthma ☐ Recent cold, cough, sore throat or flu / COVID symptoms ☐ COPD ☐ Bronchitis ☐ None of the above
If yes, please explain.

_____
_____
_____

Renal (Kidney) History. Do you have any of the following conditions? Please check all that apply. ☐ Chronic Kidney disease (stage) ☐ Kidney stones ☐ Bladder/urinary incontinence ☐ Kidney transplant (Date of occurrence) ☐ Dialysis (where, days scheduled and date of last treatment) ☐ Other ☐ None of the above
If yes, please explain.

_____
_____
_____

History Hepatic (Liver). Do you have any of the following conditions? Please check all that apply. ☐ Liver disease ☐ Cirrhosis ☐ Hepatitis (please indicate Type below) ☐ Yellowing of skin (Jaundice) ☐ None of the above
If yes, please explain.

_____
_____
_____

Patient: N/A
DOB: N/A (N/A)
Physician: N/A
Procedure Date: N/A

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Height: N/A **Weight:** N/A **BMI:** N/A
Procedure: N/A

Neurological History. Do you have any of the following conditions? Please check all that apply. ☐ Epilepsy or history of seizures (Date of occurrence) ☐ Stroke or mini stoke (TIA) (Date of occurrence and residual effects) ☐ Migraines ☐ Neuropathy ☐ Multiple sclerosis ☐ Muscular dystrophy ☐ Alzheimer's/Dementia ☐ Dizziness / Fainting spells / Loss of Consciousness ☐ Numbness / Tingling ☐ None of the above
If yes, please explain.

_____
_____
_____

Gastrointestinal (GI) History. Do you have any of the following conditions? Please check all that apply. ☐ Ulcers ☐ Hiatal Hernia ☐ Irritable Bowel Syndrome (IBS) ☐ Frequent acid reflux/GERD or heartburn ☐ Crohn's Disease ☐ None of the above
If yes, please explain.

_____
_____
_____

Hematologic (Blood) History. Do you have any of the following conditions? ☐ Pulmonary Embolism ☐ Sickle Cell ☐ Deep Vein Thrombosis (DVT) ☐ Bleeding or blood clotting disorders ☐ Anemia ☐ Factor V ☐ Von Willebrands ☐ Bruises easily ☐ None of the above
If yes, please explain.

_____
_____
_____

Endocrine History. Do you have any of the following conditions? Please check all that apply. ☐ Diabetes Type 1 ☐ Diabetes Type 2 ☐ Thyroid disease (Type) ☐ Other ☐ None of the above
If yes, please explain.

_____
_____
_____

History Musculoskeletal (Muscles/Bones). Do you have any of the following conditions? ☐ Unable to lay flat ☐ Arthritis ☐ Osteoarthritis ☐ Back pain (limit your movement or mobility) ☐ Neck pain (limit your movement or mobility) ☐ Unusual muscle problems or disease ☐ None of the above
If yes, please explain.

_____
_____
_____

Mental Health. Do you have any of the following conditions? ☐ Depression ☐ Anxiety/Panic attacks ☐ PTSD ☐ Autism ☐ Bi-Polar ☐ None of the above
If yes, please explain.

_____
_____
_____

Women Only ☐ Pregnant or chance of pregnancy ☐ Breastfeeding ☐ Menopause / Hysterectomy
Date of last menstrual cycle:

_____
_____
_____

Gender at birth:
○ Female ○ Male

Height: N/A **Weight:** N/A **BMI:** N/A
Procedure: N/A

Anesthesia Assessment - Dental History. Do you have any of the following? Please check all that apply. ☐ Loose teeth (which one(s)) ☐ Chipped teeth (which one(s)) ☐ Caps (which one(s)) ☐ Crowns (which one(s)) ☐ Dentures - Upper ☐ Dentures - Lower ☐ Braces

If yes, please specify

_____

_____

_____

Sleep Apnea Assessment

Sleep Apnea Assessment: Snoring: Do you snoring loudly? (Louder than talking or loud enough to be heard through closed doors?)

○ Yes ○ No

Tiredness: Do you often feel tired, fatigued, or sleepy during the daytime?

○ Yes ○ No

Observed Apnea: Has anyone observed you stop breathing while you were sleeping?

○ Yes ○ No

Pressure: Do you have (or are you being treated for) high blood pressure?

○ Yes ○ No

Does your neck measure more than 15 3/4" (40cm) around?

○ Yes ○ No

BMI: Higher than 35?

○ Yes ○ No

Age: Older than 50 years of age?

○ Yes ○ No

Gender: Male?

○ Yes ○ No

Total Score: _____

☐ High Risk of OSA (answered yes to 3 or more questions)

☐ Low Risk OSA (Answered yes to less than 3 items)

I have reviewed the above history and sleep apnea assessment.

_____ _____

Anestheisa Signature Date/Time

Patient: N/A
DOB: N/A (N/A)
Physician: N/A
Procedure Date: N/A

Height: N/A **Weight:** N/A **BMI:** N/A
Procedure: N/A

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Medication Reconciliation and New Prescription Form

MRN: N/A

Allergies

- ○ No Known Allergies
- ○ Allergies to:

List Allergies:

_____

_____

_____

Do you take any prescription drugs or over-the-counter (e.g., aspirin) medications? If yes, what is the drug name, dose, route, frequency & reason for use? Please include all blood thinners, birth control pills, steroids, herbal supplements, diet pills and inhalers, if applicable.

	Medication Name	Dosage	Route	Frequency	Date Last Taken	Reason for use
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Preop RN Signature _____ Date/Time _____

Home Medication Plan

- ○ Resume All Home Medications
- ○ Hold this Medication: _____ Until _____
- ○ Prescriptions have been escribed to pharmacy provided to office

New Prescriptions

	Medication	Dose	Route	Frequency
1.				
2.				
3.				

Physician Signature _____ Date/Time _____

PACU RN Signature _____ Date/Time _____ Patient's Caregiver Signature _____ Date/Time _____

Patient: N/A
DOB: N/A (N/A)
Physician: N/A
Procedure Date: N/A

Height: N/A **Weight:** N/A **BMI:** N/A
Procedure: N/A

Baylor Scott & White Surgicare Waxahachie

HST Case Coordination™

PRE-OPERATIVE RECORD

MRN: N/A

Pre-Operative Assessment

Vitals: BP:_____ P:_____ R:_____SpO2:_____% Temp_____ Height_____Weight_____

Preop Checklist

NPO Status ☐ Date/Time: _____ ☐ Sip of water with meds at: _____

Colonoscopy Prep ☐ N/A ☐ Sutab ☐ Suprep (liquid) ☐ Golytely ☐ Miralax/Dulcolax ☐ Other: _____
Time of Last Dose: _____ Results: _____

Fall Risk Assessment: UNIVERSAL / HIGH ☐ Oriented to surroundings ☐ Side Rails up x2 ☐ Bed in low position ☐ Call light in reach ☐ High Risk noted on bracelet ☐ Side rails padded

LABS ☐ N/A ☐ Blood Glucose: _____ ☐ HCG: _____ ☐ EKG ☐ Anesthesia Notified: Abnormal Results

VTE Prophylaxis: SCDs ☐ N/A ☐ Left ☐ Right ☐ Bilateral ☐ at Bedside

Op Site Prep ☐ N/A ☐ Shaved _____ ☐ 2% Chlorhexidine Wipes x2 ☐ Other _____

Glasses/Contact Lenses ☐ N/A ☐ Removed ☐ Not Removed

Dentures / Partials / Brides / Loose teeth / Retainer ☐ N/A ☐ Removed ☐ Not Removed

Hearing Aid: Right / Left ☐ N/A ☐ Removed ☐ Not Removed

Implants ☐ N/A ☐ _____

Jewelry ☐ N/A ☐ Removed ☐ Not Removed ☐ Waiver Signed

Personal Items ☐ Under bed ☐ given to family/friend ☐ Other _____

Ok to discuss care information with family/friend ☐ yes ☐ no ☐ Accompanied by & Phone #: _____

Level of Consciousness ☐ Alert ☐ Oriented ☐ Disoriented ☐ Drowsy ☐ Other: _____

Emotional Status ☐ Calm ☐ Cooperative ☐ Agitated ☐ Fearful ☐ Anxious ☐ Other: _____

General Appearance ☐ Clean/Well Groomed ☐ Unkempt ☐ Other: _____

Abuse/Neglect Suspected ☐ no ☐ yes ☐ Physician Notified ☐ Supervisor Notified ☐ See Nurse Notes

Religious or Cultural Concerns/Requests ☐ none ☐ _____

Respiratory Depth/Quality: ☐ Even/Unlabored ☐ Labored ☐ Shallow ☐ Rapid ☐ Dyspnea

Oxygen: ☐ Room Air ☐ Other _____

Cardiovascular ☐ Regular ☐ Irregular ☐ 3 lead ECG printed ☐ Reports No Problems

Gastrointestinal ☐ Reports No Problems ☐ Nausea / Vomiting ☐ Diarrhea ☐ Constipation ☐ Rectal Bleeding ☐ Other

Abdomen ☐ Soft/Non-tender ☐ Hard/Tender ☐ Pain

Genitourinary ☐ Reports No Problem ☐ Burning ☐ Difficulty Urinating ☐ Urinary Catheter ☐ Other _____

Integumentary ☐ Warm/Dry ☐ Cool/Diaphoretic ☐ Intact ☐ Color: Normal for pt's skin tone ☐ Other _____

Musculoskeletal ☐ No Limitations with ROM / Sensation ☐ Limited ROM to Right / Left Upper / Lower ☐ Limited Sensation to Right / Left Upper / Lower ☐ Use of Cane / Walker / Wheelchair

Patient: N/A
DOB: N/A (N/A)
Physician: N/A
Procedure Date: N/A

Height: N/A **Weight:** N/A **BMI:** N/A
Procedure: N/A

Baylor Scott & White Surgicare Waxahachie

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Pain ☐ No Pain ☐ Chronic Pain ☐ Acute
Current Pain Level: _____ Locations: _____

Duration ☐ Constant ☐ intermittent ☐ With Movement

Quality: ☐ Aching ☐ Stabbing ☐ Tingling ☐ Burning ☐ Throbbing ☐ Tight/Pressure ☐ Shooting ☐ Dull ☐
Sharp ☐ Numbness ☐ Other _____
0 - 10 Numeric Pain Intensity Scale
0 - 1 None 2 - 3 Mild 4 - 6 Moderate 7 - 9 Severe 10 - Worst (Reference posted in each bay)

IV started at _____ ☐ IV ☐ Saline Lock - flushed with 10cc normal saline ☐ 1% Lidocaine intradermal use for IV start

Location: ☐ Right _____ ☐ Left _____
Gauge: _____ Fluid/Rate: see MAR Attempts: _____ Started by: _____ NOTES: see nurse notes

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Holding Evaluation

	Time	IV Patent	Side Rails Up	Comfort Assessed	Family at Bedside	OR Status Updated	Call Button Within Reach	RN Initials

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Education

☐ Pt/significant other confirms/understands the scheduled procedure and perioperative expectations / concerns addressed.
☐ Pt instructed not to get up without assistance.
☐ Pt/significant other notified of OR wait time and PACU visitation guidelines.
☐ Pt/significant other confirms home transportation home and assistance upon discharge for 24 hours..

NURSING DIAGNOSIS

1.Potential or actual Alterations of comfort related to: pain, temperature, nausea/vomiting.
2. Potential for injury related to infection, falls
3. Potential or actual anxiety related to surgery, pain, knowledge deficit.

GOALS DURING ADMISSION

1. Vital signs within acceptable limits. Nausea/vomiting controlled.
2. Remains without S/S of infection. Safety maintained.
3. Appropriate affect for age. Verbalizes understanding of expected outcomes and teaching.

Outcome

☐ Patient demonstrates appropriate physiological and psychological responses to surgical/procedural preparations.
☐ Expected Preoperative outcomes met.

Transport to OR ☐ Pt voided prior to OR ☐ Site Marked ☐ Stretcher, side rails up ☐ Side rails up ☐ Wheelchair ☐
Other _____

Preop RN Signature	Date/Time	Circulating RN Signature	Date/Time

Patient: N/A
DOB: N/A (N/A)
Physician: N/A
Procedure Date: N/A

Baylor Scott & White Surgicare Waxahachie

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Height: N/A **Weight:** N/A **BMI:** N/A
Procedure: N/A

Anesthesia Allergy & Medication List

MRN: N/A

Medication Allergies:

	Medication Name	Reaction
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		

Do you have any allergies to foods, bee stings, iodine, shellfish, rubber, contrast dye, medical tape, latex?

○ Yes ○ No

If yes, please explain

_____

_____

_____

Are you currently using GLP-1 agonists for diabetes and/or weight loss? (i.e Ozempic, Semaglutide, Mounjaro, Wegovy, Trulicity)

○ Yes ○ No

Patient: N/A
DOB: N/A (N/A)
Physician: N/A
Procedure Date: N/A

Baylor Scott & White Surgicare Waxahachie

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Height: N/A **Weight:** N/A **BMI:** N/A
Procedure: N/A

Do you take any prescription drugs or over-the-counter (e.g., aspirin) medications? If yes, what is the drug name, dose, route, frequency & reason for use? Please include all blood thinners, birth control pills, steroids, herbal supplements, diet pills and inhalers, if applicable.

	Medication Name	Dosage	Route	Frequency	Date Last Taken	Reason for use
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

ADDITIONAL INFORMATION: _____
_____
_____
_____