

Centre des sciences de la santé de Kingston





Adult Pre-Surgical Screening Patient Assessment (PSS)

PART 1 - TO BE COMPLETED BY THE PATIENT / GUARDIAN

	narmacy Name and location / phone number					
Ple	ase check "yes" or "no" if you have history of the following:	YES	NC			
	Chest pain or angina					
	Heart attack / Coronary Stent			THIS		
	Stroke / TIA (Mini stroke)			SIDEFOR		
	Do you have high blood pressure, or take medication for this			THIS SIDE FOR USE BY PSS NURSE ONLY		
L	Irregular pulse / palpitations			PSS NUE		
HEART	Heart murmur / Rheumatic fever			OKSE ON .		
ᄩ	Pacemaker / Implantable Cardioverter Defibrillator (ICD)]		
	Heart failure					
	Do you have difficulty climbing one flight of stairs					
	Blood Clot legs or lungs			74.		
	Any previous heart tests / heart surgery			HIS SIDE		
	Shortness of breath with: Normal activity At rest			FORUSE		
	Productive cough			THIS SIDE FOR USE BY PSS NURSE ONL		
	Asthma / bronchitis / emphysema (COPD) / Reactive Airways disease					
LUNG	Pneumonia / tuberculosis			ONLY		
ᆲ	Do you smoke tobacco					
	Have you quit smoking					
	Do you have sleep apnea Oral appliance CPAP BIPAP					
	Do you use oxygen at home			THIS C.		
5	Kidney problems / dialysis / transplant			OIDE FOD.		
۲	Heartburn / hiatus hernia (Acid reflux)			USEBY		
RENAL / GI	Easily nauseated / motion sickness			NUP.		
	Hepatitis / jaundice / liver disease			THIS SIDE FOR USE BY PSS NURSE ONLY		
	Diabetes Insulin Pills Diet Diet					
	Thyroid problems					
	Pituitary or Adrenal Disease					
	Arthritis Rheumatoid Arthritis Osteoarthritis			This		
OTHER	Disease of nerves and muscles			"IS SIDE F		
ОТЬ	Seizures			TOR USE		
	Have you had a fall within the last year			BYPSSAL		
	Mental Health problems			THIS SIDE FOR USE BY PSS NURSE ONLY		
	Significant memory loss			ONLY		
	Cancer Chemotherapy Radiation					



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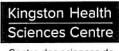




Adult Pre-Surgical Screening Patient Assessment

PART 1 (continued)- TO BE COMPLETED BY THE PATIENT / GUARDIAN

Ple	ase check "yes" or "no" if you have history of the following:	YES	NO			
	Anemia / bleeding disorders					
	sk for Sickle-cell Disease (e.g. African or Caribbean descent)					
	Previous blood transfusion		THIS			
	Could you be pregnant at this time			THIS SIDE FOR USE BY PSS NURSE ONLY		
	Have you had an organ or bone marrow transplant			USEBYPO		
	Drug Resistant Infection MRSA			SSNURSE		
	HIV / AIDS	ONLY				
OTHER	Do you use recreational drugs					
Ė	Do you drink caffeinated beverages (coffee, tea, cola)					
	Do you drink alcohol					
	Have you ever thought you ought to cut down on your drinking			THIS		
	Have people annoyed you by criticizing your drinking Have you ever felt bad or guilty about your drinking			THIS SIDE FOR USE BY PSS NURSE ONLY		
				USEBY		
	Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover. (eye opener)			PSS NUD		
	Would you like to see a member of our pastoral care (spiritual care) team			"SE ONLY		
	Do you have an Advanced Directive (Living Will)			CAGE Score		
ТЕЕТН	Do you have any loose teeth caps / bonding / bridges					
핕	Dentures: Upper Full Partial Lower Full Partial					
S	List your previous operations / hospitalizations (include approximate of	THIS SIDE FOR USE BY PSS NURSE ONLY				
RATIONS / PROCEDURES						
8		OR USE				
/ PR				BYPSS		
ONS		YES	NO	NURSEC		
	History of allergy to latex or rubber	120	110	ONLY		
SOP	Have you ever had a problem with local or general anesthetics					
PREVIOUS OPE	Has anyone related to you ever had a problem with an anesthetic					
R	History of malignant hyperthermia (or any relative)					
	Speaks English Yes No Language					
	Hearing Impaired Yes No Interpreter required Yes No					
173,455,50	Daytime Phone Number: Best time to call: Completed by: Patient Guardian Registered Nurse (R.N.) Other					
-	Printed Name Designation			Printed Name Designation		
2	Cinature Data Time			Signature Data Time		



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Adult Pre-Surgical Screening Patient Assessment PART 2 - TO BE COMPLETED BY PSS NURSE

Assessment completed Te	lephone On Site	٦
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>:		Medication Name (use generic names if possible)		Dose	Route	Frequency / Comm	nents			
SSIC		(use generic names ii possible)					See Progress Notes			
ว็	1.						7			
П	2.									
PSS NURS	3.									
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_	à	Allergies / Adverse Reactions None Known	Symptoms	s All	ergies / Ad	verse Reactions	Symptoms			
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<u>.</u>		2.		5.						
		3.	<u> </u>	6.	ingtion					
	Wildiam	trition Elimination becial diet Yes No No Continent Incontinent Other Continent Incontinent Other Incontinent Incontinent No								
		ecial diet Yes No No No No Present bowel pattern								
		obility Normal Crutches Cane Walker Wheelchair								
		ssistance with None Moving in bed Stairs Eating / drinking Bathing / hygiene								
		osthetics None Glasses / contact lenses Hearing Aid Left (L) Right (R) dy piercing Comments								
		ody piercingOther / CommentsOther / Comments								
		Score: 0 (no pain) - 10 (excruciating) 0 1 2 3 4 5 6 7 8 9 10 Location								
- Harrison		fection Risk dmitted to other health care facilities in last six months Yes No Contact with communicable disease in last 30 days Yes No								
	Adn	nitted to other health care facilities in	last six months Yes	J No∐ Cor	ntact with con	nmunicable disease in las	t 30 days Yes No	Ш		