Religious Hospitallers of Saint Joseph of the Hotel Dieu of Kingston
HOTEL DIEU HOSPITAL

KGH Kingston General Hospital

Pediatric Pre-Surgical Screening Patient Assessment

TO BE USED FOR PATIENTS LESS THAN 18 YEARS OF AGE

PART 1 - TO BE COMPLETED BY PATIENT / PARENT / GUARDIAN

Pharmacy Name and location / phone number

	Please check "yes" or "no" if you have history of the following:	YES	NO	OFFICE USE ONLY
HEART	Congenital Heart Disease			THIS SIDE FOR USE BY PSS REGISTERED NURSE ONLY
	Cyanotic / blue spells			
	Irregular pulse / palpitations			
	Heart murmur / Rheumatic fever			
	Tires Easily			
	Heart Surgery			
LUNG	Shortness of breath with: Normal activity ☐ At rest ☐			THIS SIDE FOR USE BY PSS REGISTERED NURSE ONLY
	Breathing problems after birth			
	Productive cough			
	Asthma / bronchitis			
	Pneumonia / tuberculosis			
	Cystic Fibrosis			
	Do you smoke tobacco			
	Do you snore at night			
	Do you have sleep apnea Oral appliance ☐ CPAP ☐ BIPAP ☐			THIS SIDE FOR USE BY PSS REGISTERED NURSE ONLY
RENAL / GI	Kidney problems / dialysis / transplant			THIS SIDE FOR USE BY PSS REGISTERED NURSE ONLY
	Heartburn / hiatus hernia (Acid reflux)			
	Easily nauseated / motion sickness			
	Hepatitis / jaundice / liver disease			
OTHER	Born prematurely			THIS SIDE FOR USE BY PSS REGISTERED NURSE ONLY
	Genetic disease / syndrome			
	Congenital disease			
	Disease of nerves and muscles			
	Cerebral Palsy			
	Seizures			
	Aggressive tendencies			
	Mental Health problems			
	Arthritis			
	Diabetes			
	Thyroid problems			
	Pituitary / adrenal disease			
	Anemia / bleeding disorders			

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

OFFICE USE ONLY

	Please check "yes" or "no" if you have history of the following:	YES	NO
OTHER	Easy bleeding / bruising		
	At risk for Sickle-cell Disease (e.g. African or Caribbean descent)		
	Previous blood transfusion		
	Cancer: Chemotherapy ☐ Radiation ☐		
	Have you had an organ / bone marrow / stem cell transplant		
	Drug Resistant Infection ☐ MRSA		
	Could you be pregnant at this time		
	HIV / AIDS		
	Do you use recreational drugs		
	Do you drink caffeinated beverages (coffee, tea, cola)		
	Do you drink alcohol		
	Would you like to see a member of our pastoral care (spiritual care) team		
TEETH	Do you have any loose teeth		
	Have you had any special dental procedures		
	Do you have difficulty opening your mouth		
PREVIOUS OPERATIONS / PROCEDURES	List your previous operations / hospitalizations (include approximate dates)		
		YES	NO
	History of allergy to latex or rubber		
	Have you ever had a problem with local or general anesthetics		
	Has anyone related to you ever had a problem with an anesthetic		
	History of malignant hyperthermia (or any relative)		
	Speaks English Yes ☐ No ☐ Language		
	Hearing Impaired Interpreter required		

THIS SIDE FOR USE BY PSS REGISTERED NURSE ONLY

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Reviewed by PSS Nurse: (initial)_____

Date _____ Time _____

Patient requires PSS Assessment:

Telephone ☐ On Site ☐

Completed by: Patient ☐ Guardian ☐ Signature: _____ Date: _____

R.N ☐ Other ☐ _____

Signature: _____ Date: _____ Time: _____ Printed Name: _____

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PART 2 - TO BE COMPLETED BY PSS REGISTERED NURSE

Assessment completed Telephone ☐ On Site ☐ Initials: _____

Date (YYYY / MM / DD) _____ Time (hh / mm) _____

THIS PAGE TO BE COMPLETED BY PSS NURSE ONLY

	Medication Name *(use generic names if possible)*	Dose	Route	Frequency / Comments See Progress Notes ☐
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				

Allergies / Adverse Reactions None Known ☐	Symptoms	Allergies / Adverse Reactions	Symptoms
1.		4.	
2.		5.	
3.		6.	

Nutrition

Special diet Yes ☐ No ☐ _____

Recent weight change Yes ☐ No ☐ _____

Elimination

Continent ☐ Incontinent ☐ Other ☐ _____

Present bowel pattern _____

Mobility Normal ☐ Crutches ☐ Cane ☐ Walker ☐ Wheelchair ☐

Assistance with None ☐ Moving in bed ☐ Stairs ☐ Eating / drinking ☐ Bathing / hygiene ☐

Prosthetics None ☐ Glasses / contact lenses ☐ Hearing Aid ☐ L R

Body piercing ☐ _____ Other / Comments ☐ _____

Pain Do you suffer from chronic pain Yes ☐ No ☐

Score: 0 (no pain) - 10 (excruciating) 0 1 2 3 4 5 6 7 8 9 10 Location _____

Infection Risk

Admitted to other health care facilities in last six months Yes ☐ No ☐ Contact with communicable disease in last 30 days Yes ☐ No ☐