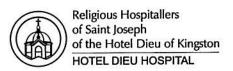




Pediatric Pre-Surgical Screening Patient Assessment TO BE USED FOR PATIENTS LESS THAN 18 YEARS OF AGE

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: **OFFICE USE ONLY** YES NO THIS SIDE FOR USE BY PSS REGISTERED NURSE ONLY Congenital Heart Disease Cyanotic / blue spells Irregular pulse / palpitations Heart murmur / Rheumatic fever Tires Easily **Heart Surgery** Shortness of breath with: Normal activity \square At rest \square 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 THIS SIDE FOR USE BY PSS REGISTERED NURSE ONLY Do you snore at night Do you have sleep apnea Oral appliance CPAP BIPAP Kidney problems / dialysis / transplant Heartburn / hiatus hernia (Acid reflux) Easily nauseated / motion sickness Hepatitis / jaundice / liver disease Born prematurely Genetic disease / syndrome Congenital disease THIS SIDE FOR USE BY PSS REGISTERED NURSE ONLY Disease of nerves and muscles Cerebral Palsy Seizures Aggressive tendencies Mental Health problems **Arthritis** Diabetes Thyroid problems Pituitary / adrenal disease Anemia / bleeding disorders





Pediatric Pre-Surgical Screening Patient Assessment

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

| Ple | ase check "yes" or "no" if you have history of the following: | YES | NO | |
|--------------------------------------|--|--------------------|----|--|
| | Easy bleeding / bruising | | | The. |
| | At risk for Sickle-cell Disease (e.g. African or Caribbean descent) | | 32 | TIS SIDE FOR |
| | Previous blood transfusion | | | USE BY PSC |
| | Cancer: Chemotherapy ☐ Radiation ☐ | | | THIS SIDE FOR USE BY PSS REGISTERED NURSE ONLY |
| | Have you had an organ / bone marrow / stem cell transplant | | | NURSEON |
| ER | Drug Resistant Infection | | | -1473 |
| OTHER | 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 | | | THIS SIDE |
| | Would you like to see a member of our pastoral care (spiritual care) team | | | THIS SIDE FOR USE BY PSS REGISTERED NURSE ONLY |
| + | Do you have any loose teeth | | | PSS REGISTER |
| TEETH | Have you had any special dental procedures | | | ERED NURSE |
| F | Do you have difficulty opening your mouth | | | ONLY |
| | List your previous operations / hospitalizations (include approximate dates) | | | |
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| S/P | | | | THIS SIE |
| ĕ | | | | SIDE FOR USE |
| ¥ | F 15 | | | BYPSS |
| OPERATIONS / PROCEDURES | | | | EGISTERED |
| o sno | | YES | NO | THIS SIDE FOR USE BY PSS REGISTERED NURSE ONLY |
| Š | History of allergy to latex or rubber | | | -,47. |
| PREVIC | Have you ever had a problem with local or general anesthetics | | | Reviewed by PSS Nurse: (initial) |
| | Has anyone related to you ever had a problem with an anesthetic | | | Date Time |
| | History of malignant hyperthermia (or any relative) | | | Patient requires PSS Assessment: |
| | Speaks English Yes No Language | | | Telephone On Site |
| | Hearing Impaired Interpreter required | | | |
| С | ompleted by: Patient Guardian Signature: | Date: "PROVINTADDY | | |
| R.N | | | | |
| Signature: Date: Time: Printed Name: | | | | |
| | | | | |



Pediatric Pre-Surgical Screening Patient Assessment PART 2 - TO BE COMPLETED BY PSS REGISTERED NURSE Assessment completed Telephone On Site Initials: Time (hh/mm) Date (YYYY / MM / DD) Dose Route **Medication Name** Frequency / Comments (use generic names if possible) ETED BY PSS NURSE ONLY See Progress Notes 2. 10. 12. BE COMPL 13. 14. 17. PAGE 19 20. Allergies / Adverse Reactions Allergies / Adverse Reactions Symptoms **Symptoms** None Known 5. 2. 6. 3. Nutrition Elimination Special diet Yes No Recent weight change Yes No No 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 \(\simeg \) No \(\simeg \)

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

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