Kingston Health Sciences Centre

Centre des sciences de la santé de Kingston

Hôpital **Hotel Dieu Hospital**

Hôpital Général de **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

Weight__________**Kg** **Height** __________**cm**	**Pharmacy Name** ____________________	**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 ☐			
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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Please check "yes" or "no" if you have history of the following:

OFFICE USE ONLY

Section	Item	YES	NO	Office use only
OTHER	Easy bleeding / bruising			THIS SIDE FOR USE BY PSS REGISTERED NURSE ONLY
	At risk for Sickle-cell Disease (Descendants of Africa, Egypt, Caribbean, India, Southern Italy, Northern Greece, Southern Turkey)			
	Born outside of Ontario			
	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)			THIS SIDE FOR USE BY PSS REGISTERED NURSE ONLY
	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)			THIS SIDE FOR USE BY PSS REGISTERED NURSE ONLY
		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			

Completed by: Patient ☐ **Guardian** ☐ **Signature:** ______________________ **Date:** (YYYY/MM/DD)

R.N ☐ **Other** ☐ ______________________

Signature: ______________________ **Date:** (YYYY/MM/DD) **Time:** (HH:mm) **Printed Name:** ______________________

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THIS PAGE TO BE COMPLETED BY PSS NURSE ONLY

Pediatric Pre-Surgical Screening Patient Assessment

PART 2 - TO BE COMPLETED BY PSS REGISTERED NURSE

Assessment Completed Telephone ☐ Onsite ☐

	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 Left (L) ☐ Right (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 ☐

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See Progress Notes ☐

Procedure: ______

Kingston General Hospital: SDA ☐ Outpatient ☐ To be admitted ☐ Hotel Dieu Hospital: Day Surgery ☐ EPACU ☐

Weight kg	Height cm	BMI	Cage Score	B/P R	B/P L	Pulse	SpO_2
Nursing ASA Score ______		Vital signs repeated after ______ minutes:		B/P R	B/P L	Pulse	SpO_2

Required Testing

Enclosed

- ☐ None Required ☐
- ☐ CBC ☐
- ☐ Electrolytes ☐
- ☐ Creatinine ☐
- ☐ HbA1C ☐
- ☐ ALT, ALP, Total Bilirubin, Albumin ☐
- ☐ Blood bank ☐
- or ☐ Surgical Blood Order schedule ☐
- ☐ aPTT, PT/INR ☐
- ☐ NT-proBNP or ☐ BNP ☐
- ☐ ECG ☐
- ☐ X-ray ☐
- ☐ ______ ☐
- ☐ ______ ☐
- ☐ ______ ☐

SHADED AREA TO BE COMPLETED BY WARD CLERK.

Package Review

Chart Complete	☐ Yes	☐ No	
History and Physical	☐ Complete	☐ Pending	☐ Outdated
Consent	☐ Complete	☐ Incomplete	
Other	☐ Blood work	☐ X-ray report	☐ ECG

	Initial	Date (yyyy/mm/dd)	Time (hhmm)
First Check			
Second Check			

Patient Education provided / explained / questions answered

- ☐ Procedure / education pamphlet/ spinal pamphlet
- ☐ Pain after surgery pamphlet / Epidural pamphlet
- ☐ Fasting / medications
- ☐ Blood transfusion information pamphlet
- ☐ Bowel prep
- ☐ Escort home / Care provider on discharge ______
- ☐ No driving or alcohol for 24 hours after surgery
- ☐ Other ______
- ☐ Surgical Consent Yes ☐ No ☐
- ☐ Blood Components Consent not applicable (N/A) ☐ Yes ☐ No ☐

Consults / Referrals / Date (yyyy/mm/dd)

- ☐ Anesthesiology
- ☐ General Internal Medicine
- ☐ Cardiac Rhythm Device Clinic
- ☐ Other ______

Day of Surgery Tests Required Below

☐ CBC ☐ aPTT,PT/INR ☐ Electrolytes ☐ Fasting Blood Sugar ☐ Creatinine

☐ Type and Cross ______ units OR ☐ Type and Hold

☐ Other ______

PRINTED NAME	DESIGNATION	SIGNATURE	INITIALS