Kingston Health Sciences Centre

Centre des sciences de la santé de Kingston

Hôpital Hotel Dieu Hospital

KGH Hôpital Général de Kingston General Hospital

# Adult Pre-Surgical Screening (PSS) Patient Assessment

## PART 1 - TO BE COMPLETED BY PATIENT

**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 | Chest pain or angina | | | THIS SIDE FOR USE BY PSS NURSE ONLY |
| | Heart attack / Coronary Stent | | | |
| | Stroke / TIA (Mini stroke) | | | |
| | Do you have high blood pressure, or take medication for this | | | |
| | Irregular pulse / palpitations | | | |
| | Heart murmur / Rheumatic fever | | | |
| | Pacemaker / Implantable Cardioverter Defibrillator (ICD) | | | |
| | Heart failure | | | |
| | Do you have difficulty climbing one flight of stairs | | | |
| | Blood Clot legs or lungs | | | |
| | Any previous heart tests / heart surgery | | | |
| LUNG | Shortness of breath with: Normal activity ☐ At rest ☐ | | | THIS SIDE FOR USE BY PSS NURSE ONLY |
| | Productive cough | | | |
| | Asthma / bronchitis / emphysema (COPD) / Reactive Airways disease | | | |
| | Pneumonia / tuberculosis | | | |
| | Do you smoke tobacco | | | |
| | Have you quit smoking | | | |
| | Do you have sleep apnea Oral appliance ☐ CPAP ☐ BIPAP ☐ | | | |
| | Do you use oxygen at home | | | |
| RENAL / GI | Kidney problems / dialysis / transplant | | | THIS SIDE FOR USE BY PSS NURSE ONLY |
| | Heartburn / hiatus hernia (Acid reflux) | | | |
| | Easily nauseated / motion sickness | | | |
| | Hepatitis / jaundice / liver disease | | | |
| OTHER | Diabetes Insulin ☐ Pills ☐ Diet ☐ | | | THIS SIDE FOR USE BY PSS NURSE ONLY |
| | Thyroid problems | | | |
| | Pituitary or Adrenal Disease | | | |
| | Arthritis Rheumatoid Arthritis ☐ Osteoarthritis ☐ | | | |
| | Disease of nerves and muscles | | | |
| | Seizures | | | |
| | Have you had a fall within the last year | | | |
| | Mental Health problems | | | |
| | Significant memory loss | | | |
| | Cancer Chemotherapy ☐ Radiation ☐ | | | |

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## TO BE COMPLETED BY THE PATIENT / GUARDIAN

PLEASE CHECK "YES" OR "NO" IF YOU HAVE HISTORY OF THE FOLLOWING:

| Section | Question | YES | NO |
|---|---|---|---|
| OTHER | Anemia / bleeding disorders | | |
| | At risk for Sickle-cell Disease (Descendants of Africa, Egypt, Caribbean, India, Southern Italy, Northern Greece, Southern Turkey) | | |
| | Previous blood transfusion | | |
| | Could you be pregnant at this time | | |
| | Have you had an organ or bone marrow transplant | | |
| | Drug Resistant Infection MRSA ☐ | | |
| | HIV / AIDS | | |
| | Do you use recreational drugs | | |
| | Do you drink caffeinated beverages (coffee, tea, cola) | | |
| | Do you drink alcohol | | |
| | Have you ever thought you ought to cut down on your drinking | | |
| | Have people annoyed you by criticizing your drinking | | |
| | Have you ever felt bad or guilty about your drinking | | |
| | Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover. (eye opener) | | |
| | CAGE Score ____________ | | |
| | Would you like to see a member of the spiritual care team ☐<br>Do you have a Living Will | | |
| TEETH | Do you have any loose teeth ☐ caps / bonding / bridges | | |
| | Dentures: Upper Full ☐ Partial ☐ Lower Full ☐ Partial ☐ | | |
| 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 Yes ☐ No ☐ Interpreter required Yes ☐ No ☐

Daytime Phone Number: ______________________ Best time to call: __________

Completed by: Patient ☐ Guardian ☐ Registered Nurse (R.N.) ☐ Other ☐

______________________________
Printed Name

______________________ ____________ ____________
Signature Date (yyyy/mm/dd) Time (hhmm)

THIS SIDE FOR USE BY PSS NURSE ONLY

| SLEEP APNEA SCREENING QUESTIONS: | YES | NO |
|---|---|---|
| **S** Do you snore loudly | | |
| **T** Do you feel tired | | |
| **O** Has anyone observed you stop breathing | | |
| **P** Have you been, or are you being, treated for high blood pressure | | |
| **B** Body Mass Index (BMI) greater than 35 | | |
| **A** Age greater than 50 years | | |
| **N** Neck circumference greater than 40 cm | | |
| **G** Male Gender | | |
| STOPBANG Score ________ | | |

THIS SIDE FOR USE BY PSS NURSE ONLY

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THIS PAGE TO BE COMPLETED BY PSS NURSE ONLY

## Adult Pre-Surgical Screening (PSS) Patient Assessment

### PART 2 - TO BE COMPLETED BY PSS 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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# Adult Pre-Surgical Screening (PSS) Patient Assessment

See Progress Notes ☐

**TO BE COMPLETED BY THE PRE SURGICAL SCREENING (PSS) NURSE**

Procedure: ____________________

Kingston General Hospital Site: SDA ☐ Outpatient ☐ To be admitted ☐ Hotel Dieu Hospital Site: 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 preparation

☐ 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 |
|---|---|---|---|
| | | | |
| | | | |
| | | | |