PINE CREEK MEDICAL CENTER Outpatient Pre-Operative Checklist

Patient Name: _____

Date Surgery Scheduled: _____ Time: _____ AM / PM

Arrival Time at Hospital: _____ AM / PM or as instructed by your physician.

Please complete the enclosed forms and bring them with you to the center.

The Night Before Surgery:

- If you take daily medication, check with your physician about what to do the morning of your surgery regarding your medication.
- **Do not eat or drink anything** after midnight, or as ordered by your physician. This includes water, chewing gum, mints, and tobacco.

The Morning of Your Surgery:

- Bathe or shower to reduce the chance of infection. Do not shave the surgical area for 24 hours before surgery.
- Do not wear makeup or nail polish. Remove any false nails.
- Arrive at the facility at the time directed. Your surgery could be canceled if you do not arrive on time.
- Wear comfortable clothing that is easy to take off and put on.
- Leave your valuables at home.
- If you wear glasses, contacts, or hearing aids, bring along a case in which to store them during surgery.
- If you wear dentures or removable bridgework, etc., remove them before surgery or as directed by Anesthesia Department policy.
- If you have a cold, a fever of 100°F or higher, a skin rash, or an infection of any kind, notify your physician before your surgery.
- Smokers should not smoke for twenty-four to forty-eight (24-48) hours before surgery, to enhance breathing. Your physician may request a longer smoking cessation period.
- Check your blood glucose if you are diabetic and usually check it.

After Your Surgery:

- After you leave the operating room, you will be taken to the recovery room.
- For your own safety, a responsible adult MUST drive you home.
- Someone responsible should stay with you at home the first twenty-four (24) hours after surgery.
- You will be given detailed instructions for your postoperative care.
- You will be discharged when deemed ready and meet discharge criteria.

Special Tips:

- If you have any problems, please contact your physician.
- You will receive a telephone call following surgery from one of our nurses to inquire about your recovery and well-being. If you have any concerns, please discuss them with the nurse.
- Please limit the number of people accompanying you to two (2). These people are welcome to wait at the facility or we will call them when you are ready to go home.
- Times vary. Plan to be with us from four to six (4-6) hours.

I understand that admission to the hospital may be a possibility if my physician so decides.

NINETY THIRTY-TWO HARRY HINES BOULEVARD | DALLAS, TEXAS 75235-1720
PHONE: 214-231-CARE | FAX: 214-231-2274
WWW.PINECREEKMEDICALCENTER.COM

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH NFORAMATION

I hereby authorize: Pine Creek Medical Center
9032 Harry Hines Blvd.
Dallas, TX 75235
214-572-7137 . Fax: 214-572-7138

To Release To: _____ Recipient Name

_____ Street Address

_____ City, State, Zip

Telephone #_____ Fax# _____

The following information from the medical record of:

Patient Name_____ Date of Birth_____

Dates of Treatment _____ Social Security No. _____

Information to be released:

__ Discharge Summary __ History & Physical __ Operative Report __ Path Reports
__ Laboratory Reports __ Consultation Report __ Medication Report __ EKG/ECHO
__ Progress Notes __ X-ray Reports __ Blood Type
__ Other_____

The information specified above is to be released for the following purposes:

__ Treatment/Consultation __ Patient Request __Billing or Claims __Attorney
__ Social Security Disability __ Other (specify) _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing records contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, 1-lepatitis B or C testing, and/or oilier sensitive information, I agree to its release. I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at the above address. This authorization will automatically expire 180 days from the date of my signature unless revoked prior to that tine or unless otherwise specified as follows

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Information Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative

I understand that Pine Creek Medical Center may not condition my treatment whether I sign this authorization form. I authorize Pine Creek Medical Center to use and disclose the protected health information as specified above. I further understand that a reasonable copy fee may be charged for record copies.

Signature of Patient or Legal Representative_____
Date _____

Authority to sign if not Patient (documentation required) _____

Identity of Requestor verified by __Photo ID __Matching Signature Verified by: _____ Initials

PINE CREEK
MEDICAL CENTER

PRE-ANESTHETIC EVALUATION

PATIENT QUESTIONNAIRE:

What Procedure is being done today? _____

(To be completed by patient, family member, or responsible party. Please review and mark any problems you may have now, or have had in the past.)

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Breathing Problems
- ☐ Angina
- ☐ Cancer
- ☐ Unable to Exercise
- ☐ Rheumatic Fever
- ☐ Chronic Cough
- ☐ Bleeding Tendency
- ☐ Hemophilia
- ☐ Easy Bruising
- ☐ Anemia
- ☐ Blood Transfusion
- ☐ Chest Pain
- ☐ Leg Pain/Cramps
- ☐ Asthma
- ☐ Bronchitis
- ☐ Short of Breath
- ☐ Pneumonia
- ☐ Sinus
- ☐ Recent Cold/Flu
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Stroke
- ☐ Fainting/Blackout
- ☐ Seizure
- ☐ Mental Problems
- ☐ Migraine Headache
- ☐ Nerve Injury
- ☐ Paralysis
- ☐ Back Injury
- ☐ Neck Injury
- ☐ Herniated Disc
- ☐ Weakness
- ☐ Arthritis
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Steroid Use
- ☐ Irregular heartbeat
- ☐ Chemotherapy
- ☐ Radiotherapy
- ☐ Liver Problems
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Hiatal Hernia
- ☐ Frequent Heartburn
- ☐ Ulcers
- ☐ Kidney Problems
- ☐ Loose/Chipped Teeth
- ☐ False Teeth/Caps
- ☐ Neck Pain/Stiffness
- ☐ Hoarseness
- ☐ Difficulty Opening Mouth
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐

Tobacco: No / Yes Amount:_____ Packs / Day for _____ Years
Alcohol: No / Yes Amount: _____
Street / Recreational Drugs: No / Yes Types: _____
_____
Could you be pregnant? No / Yes
Start date of last menstrual period _____/_____/_____
Ever tested for AIDS or HIV? No / Yes Results: _____
_____
Drug Allergies: _____
_____
_____
Medications: _____
_____
_____
_____

List any medical problems not listed above: _____
_____
_____
List previous surgery: _____
_____
_____
Problems with anesthesia: No / Yes

- ☐ Family History of Problems
- ☐ High Temperature
- ☐ Allergic Reaction
- ☐ Delayed Awakening
- ☐ Prolonged Weakness
- ☐ Nausea and Vomiting
- ☐ Hoarseness/Sore Throat
- ☐ Muscle Soreness
- ☐ Jaundice
- ☐ Headache
- ☐ Excessive Bleeding
- ☐ Difficulty w/ Breathing Tube

I have fully reviewed this questionnaire and answered all questions truthfully and to the best of my knowledge, I am aware that my answers could affect my healthcare, or that of the patient for whom I am responsible

Date: ____/____/____ Relationship: _____ Signature of Patient, Parent, or Responsible Party: X _____

NURSING ASSESSMENT: *(To be completed by nurse)*
Age: _____ Height: _____ Weight: _____ Blood Pressure: _____ / _____ P: _____ R: _____ T: _____ C/F O2 Sat RA: _____ %
Questionnaire reviewed with patient/family; patient's history and health status as noted above, Additional notes by nurse: _____
_____ ☐ Additional comments on separate sheet.
Signature of Nurse:_____ Date: ____/____/____ Time: _____ : _____ a.m. / p.m.

ANESTHESIA PRE-OPERATIVE EVALUATION: Must be completed by Anesthesia Provider. Immediately prior to surgery.
Questionnaire review with patient/family; patient's history and health status as noted above. Additional comments including pertinent findings from history, physical exam, and diagnosis tests: _____
_____
Physical Examination: C-V system:_____ Lungs:_____
PRE-OPERATIVE TEST RESULTS: Labs _____ ECG: _____ CXray:_____
Impression: ASA Classification: 1 2 3 4 5 E
NPO Status: _____
Airway: _____
Problem List: _____
_____
_____

Plan: _____
Premed:_ _____
Monitors: Routine: _____
I have discussed the anesthetic plan, alternatives, benefits, risks, and complications with the patient (or responsible party). Questions have been invited and answered. Patient or the guardian understands and consents ☐ Additional comments on separate sheet.

CRNA: _____ ANESTHESIOLOGIST: _____ Time: _____ : _____ a.m. / p.m.
Date: ____/____/____

PINE CREEK MEDICAL CENTER

PRE-ANESTHETIC EVALUATION

Questionario Paciente:: ***Que precedimiento se esta hacienda hoy?*** _____

(Ser terminado el paciente, el miembro de la familia, o el partido responsible. Por favor la revisión y marca cualquier problema que usted pueda tenoer ahora, o lo ha tenido en el pasado).

☐ Tensión arterial Alta
☐ Enfermedad cardiaca
☐ Alaque Del Corazon
☐ Problemas De Respiracion
☐ Angina
☐ Cancer
☐ Incapez ejercitar
☐ Fiebre Reumática
☐ Tos Crónica
☐ Tendencia De Sangrado
☐ Hemofilia
☐ Contusion Fácil

☐ Anemia
☐ Transfusión De Sangre
☐ Dolor Del Pecho
☐ Calambres De la Perna/ Dolor de Pierna
☐ Asma
☐ Bronquitis
☐ Corto de la respiración
☐ Pulmonia
☐ Sinusitis
☐ Frio/Gripe Reciento
☐ Enfisema
☐ Tuberculosis

☐ Embolia
☐ El desmayarse/Apagón
☐ Epilepsia
☐ Problemas Medtales
☐ Dolor de cabeza/Migranta
☐ Lesion Del Nervio
☐ Paralisis
☐ Lesion Dorsal
☐ Lesion Del Cuello
☐ Hernia en el Disco
☐ Debilidad
☐ Artritis

☐ Diabetes
☐ Problemas De la Tiroides
☐ Usa Esteroides
☐ Latidos del Corazón irregulares
☐ Quimioterapia
☐ Radioterapia
☐ Problemas Del Higado
☐ Hepatitis
☐ Ictericia
☐ Hernia Hiatal
☐ Acidez Frecuente
☐ Úlceras

☐ Problemas Del Riñ¿on
☐ Dientes Flojos/Saltados
☐ Dientes/Casquillos Falsos
☐ Dolor De Cuello/Tiesura Del Cuello
☐ Voz Ronca
☐ Dificultad Para Abrir La Boca
☐ _____
☐ _____
☐ _____
☐
☐ _____
☐ _____

Tabaco: No / Si Cantidad:_____ Paquetes por dia Por_____ Años
Alcohol: No / Si Cantidad:_____
Drogas Calle/Recreacionales:: No / Si Types: _____
_____
¿Podria usted estar embarazada? No / Si
Fecha incial de su ultimo periodo menstrual _____/_____/_____
A Sido Evakuado en conra del SIDA or el VIH? No/Si
Resultados:_____

Alergia A la Medicina:: _____
_____
_____
Medicamento _____
_____
_____

Enumere cualquier problema médico no enumerado arriba:_____
_____
_____
Enumere sum as reciento Cirugia:_____
_____
_____

Problemas con anestesia: No/ Si_____

☐ Antecedentes familiars do problemas
☐ De Alta temperatura
☐ Reaccion Alérgica
☐ El Despertar Retrasado
☐ Debilidad Prolongada
☐ Nausea y vomito
☐ Voz Ronca / Garganta Dolorida
☐ Dolor Del Múscolo
☐ Ictericia
☐ Dolor de cabeza
☐ Sangrado Excesivo
☐ Dificultad con el tubo para respirar

He repasado completamente el custionario y he contesdao a todas las preguntas verazmente y al major do mi conocimiento, estoy enterado do que mis respuestas prodrian afectar mi cuidado medico, o del paciente de quien soy resonsable.

Fecha ____/____/____ Relaciõn:_____ Firma del paciente, del padre o de la parte respondable:X_____

NURSING ASSESSMENT: *(To be completed by nurse)*

Age: _____ Height: _____ Weight: _____ Blood Pressure: _____ / _____ P: _____ R: _____ T: _____ C/F O2 Sat RA: _____ %
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CRNA: _____ ANESTHESIOLOGIST: _____ Time: _____ : _____ a.m. / p.m.
Date: ____/____/____

PINE CREEK MEDICAL CENTER

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ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received a copy of the Notice of Privacy Practices of Pine Creek Medical Center on this date.

_____ _____

Patients Name Date

****

Pine Creek Medical Center's Documentation of Good Faith
Effort to Obtain Acknowledgement of Receipt

If the Acknowledgement could not be obtained prior to the date of first service to the patient, or, in an emergency situation, as soon as reasonably practicable after the emergency has resolved, describe below the efforts made to obtain the written Acknowledgement and the reasons why the written Acknowledgement could not be obtained. If the patient refused to provide the written Acknowledgement, please so state.

Efforts to obtain written Acknowledgement:

Reasons written Acknowledgement could not be obtained:

_____ _____

(Signature of health care provider/clerk) Date

_____

(Printed name of health care provider/clerk)