McLaren Flint

FLINT, MICHIGAN

CONSENT TO OPERATION OR OTHER PROCEDURE

1. I have been told by my physician, _____, that my present condition or conditions may effectively be treated by the following procedure(s):_____

_____

I hereby authorize my physician and the associates and assistants selected by him to perform the described procedure(s).

2. I understand that unforeseen circumstances may arise during an operation or procedure, and may require performance of operations or procedures different from or in addition to those originally planned, in order to safeguard and promote the well being of the patient. I consent to such other or additional surgery, procedures, or therapies as may be considered necessary or advisable by my doctors under such circumstances. I authorize and request that my Physician, his assistants or his designees, perform such additional procedures as are necessary. If at an outpatient facility, I consent to transfer to McLaren Flint main campus in the event that my condition warrants such a transfer.
3. I am aware that McLaren Flint is a resident teaching facility and that physician residents and/or medical students may be involved with my care under the supervision of my physician. I consent to their involvement and participation in my treatment planning and care.
4. I understand that such procedure(s) may involve transfusion of blood or blood cell products. I have been made aware that, despite routine screening procedures, use of blood and blood cell products always carries some risk of transmissible disease, including hepatitis virus, or other blood-borne agents. I give authorization to administer to me during the procedure(s):
   ( ) regular blood or blood products from the Blood Bank;
   ( ) autologous blood only (blood I have given); In the absence of the sufficient quantity of blood I have given, I understand regular blood or blood products from the Blood Bank will be used.
   ( ) designated (directed) donations only;
   ( ) no blood products.
5. I agree to the use of anesthesia and/ or sedation as deemed appropriate by the anesthesiologist or his/her designee. It has been explained to me that all forms of anesthesia involve some risks and although rare, unexpected severe complications may occur including but not limited to mouth or throat pain, injury to mouth or teeth, infection, injury to blood vessels, headache, backache and others. It has been explained to me that sometimes an anesthesia technique which involves the use of local anesthetics with or without sedation, may not succeed completely and therefore another technique may have to be used including general anesthesia. I consent to the anesthesia service discussed with the anesthesia provider. I also consent to an alternative type of anesthesia if necessary as deemed appropriate by my anesthesia provider.
6. I acknowledge that full discussion has taken place between my physician and me prior to the procedure(s) herein authorized, that the advantages and disadvantages of such procedure(s) including the risk of infection, have been explained to me, and that alternative methods of treatment have been discussed with me. I have been made aware of certain risk(s) and consequences that are associatedwith the procedure(s) described in Paragraph 1 and understand that submitting to the procedure(s) may endanger my life or future health.I am aware that the practice of medicine and of surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedure(s).

Signature of Patient: _____ Date & Time _____

If patient is unable to sign or is a minor, complete the following:
Signature of Next of Kin
or Legal Guardian: _____ Date & Time _____

Signature Witnessed by: _____ Date & Time _____

I, Dr. _____, hereby attest to providing information regarding the patient's risk, including risk of infection, benefits, as well as alternative methods of treatment available to aid the patient and family in the decision process regarding this procedure(s).

Signature of Physician: _____ Date & Time _____

Anesthesia Provider Signature: _____ Date & Time _____

CONSENT TO OPERATION OR OTHER PROCEDURE

820b

1761 (10/3/13) (Intranet)

PT.

MR.#/RM.

DR.

McLaren Flint
Patient Self Assessment

PLEASE COMPLETE ALL HISTORY INFORMATION IN BLACK INK AND RETURN BY MAIL OR FAX UPON RECEIPT

Patient Name: _____
Surgery/Procedure _____ Reason for: _____
History of Surgical Procedures _____
_____
Height _____ Weight _____ BMI _____ Cardiologist Name _____
Primary Care Physician _____ Phone _____
Allergies & Reactions ☐Latex ☐Tape ☐ Eggs ☐ Peanuts _____

NEUROLOGICAL	**YES**	**NO**
Seizures	☐	☐
Stroke/TIA/Mini Stroke	☐	☐
Numbness or Tingling	☐	☐
Fainting spells	☐	☐
Neuromuscular diseases	☐	☐
Anxiety	☐	☐
Chronic pain / Fibromyalgia	☐	☐

Comments: _____

ENT	**YES**	**NO**
Loose, Chipped, or Missing Teeth	☐	☐
Dentures or Partials	☐	☐
Problems Opening or Closing your mouth	☐	☐

Comments: _____

LUNGS	**YES**	**NO**
* Do you require supplemental oxygen 24 hours a day?	☐	☐
Asthma, Cough, Cold, or Wheezing	☐	☐
Shortness of breath	☐	☐
COPD	☐	☐
*Sleep Apnea; use CPAP/BiPAP Machine	☐	☐
Smoker: amt: _____ yrs. _____	☐	☐

Comments: _____

CARDIAC	**YES**	**NO**
* Do you get short of breath or have chest doing light housework or other activities of daily living?	☐	☐
* Have you been hospitalized in the last 3 months for congestive heart failure, heart attack or an angioplasty?	☐	☐
* Has there been a decrease in activity in the last 3 months?	☐	☐
* Chest pain or Angina (related to your heart)	☐	☐
Heart surgery; bypass or Valve replacement	☐	☐
Arrhythmias, Pacemaker, or AICD	☐	☐
Heart Cath., Stents, Stress Test	☐	☐
High blood pressure	☐	☐

Comments: _____

GASTROINTESTINAL	**YES**	**NO**
Hiatal Hernia or Ulcer	☐	☐
Cirrhosis	☐	☐

Comments: _____

ENDOCRINE/METABOLIC	**YES**	**NO**
* Kidney problems or Dialysis	☐	☐
Diabetes Type _____	☐	☐
Thyroid disease	☐	☐

Comments: _____

MUSCULOSKELETAL	**YES**	**NO**
Arthritis	☐	☐
* Muscle disease/Muscular Dystrophy	☐	☐
Limitation in movement	☐	☐

Comments: _____

COMMUNICABLE DISEASES	**YES**	**NO**
Do you have any signs of infection; fever, open wounds, recent flu or upper respiratory infection?	☐	☐
Do you have difficulty fighting off infection due to a chronic condition?	☐	☐
Are you being treated for any contagious diseases?	☐	☐
*MRSA	☐	☐
Tuberculosis	☐	☐
Hepatitis What type _____	☐	☐

Comments: _____

ANESTHESIA	**YES**	**NO**
Difficult Intubation	☐	☐
Nausea or vomiting	☐	☐
Family/Personal History of Malignant Hyperthermia	☐	☐

Comments: _____

ALCOHOL USE	**YES**	**NO**
Frequency: _____	☐	☐
Substance Abuse	☐	☐

Comments: _____

OTHER		**YES**	**NO**
Bleeding, Anemia, or Sickle Cell disease		☐	☐
*Are you Pregnant?		☐	☐
Last Menstrual Cycle _____	☐N/A	☐	☐

Comments: _____

Patient Signature: _____
Date: _____ Time:_____

PT

MR.#/P

DR.

McLaren Flint
Pre-Op Anesthesia Evaluation

Pre Op Vital Signs	BP:	P:	Resp:	Sp02:	Temp:	NPO Since:	Pain Scale:
ASA Rating	1 2 3 4 5		☐Potential Difficult Intubation				
Mallampati	I II III IV		Poor Dentition ☐Yes ☐No		**Anesthesia Plan**: GA SP Epi Block MAC		

Anesthesia plan, risks, and benefits discussed with: ☐Patient ☐Parent ☐Guardian

Comments:

Systemic Review	**Unremarkable**	**Abnormal Finding**
Mental Status (Orientated x 3)		
Nervous System		
Cardiovascular		
Respiratory		
Gastrointestinal		
Genitourinary		
Musculoskeletal		
Other		
Physical Exam	**Unremarkable**	**Abnormal Finding**
HEENT		
Heart		
Lungs		
Abdomen		
Other / General Condition		

Reviewed by:

CRNA:_____ Date/Time:_____

Anesthesiologist: _____ Date/Time:_____

PT

MR.#/P

DR.

McLaren Flint
Flint, Michigan

AMBULATORY MEDICATION RECONCILIATION FORM

ALLERGIES: _____ Date/Initials_____

ALLERGIES: _____ Date/Initials_____

PHARMACY: _____ Phone: _____

CURRENT HOME MEDICATIONS (PRESCRIPTIONS, OTC, HERBALS, PATCHES, INHALERS, EYE DROPS, SUPPLEMENTS, RESEARCH MEDS, ETC.)

Drug Name* (include dose, route, frequency)	Date Reviewed / Initials	Date Reviewed / Initials	Date Reviewed / Initials	Date Reviewed / Initials	Date Reviewed / Initials

*Any new medication orders (new starts or regimen changes) should be entered on a new line.

KEY:

Initials: _____ Name: _____ Clinic:_____ Initials:_____ Name: _____ Clinic: _____

Initials: _____ Name: _____Clinic: _____ Initials: _____ Name: _____ Clinic: _____

Initials: _____ Name: _____Clinic: _____ Initials: _____ Name: _____ Clinic: _____

AMBULATORY MEDICATION RECONCILIATION FORM

17576-A Rev. 12/08

675B

PT.

MR.#/P.M.

DR.

McLaren Flint
Flint, Michigan

SURGERY AND ENDOSCOPY CENTER

CONSCIOUS SEDATION ORDERS:

PREOP ORDERS:

A. IV start LR 500ml at 10ml/hour.
B. Oxygen PRN for saturations less than 94% after sedation or on room air.
C. Diabetic patients- perform glucometer/FBS. Report FBS less than 70 or greater than 300.

Medications:

☐ Midazolam (Versed) _____ mg IVP.
☐ Fentanyl _____ microgram IVP

Physician Signature_____

Date Time

Nurse Signature_____

Date Time

McLaren Flint
Flint, MI 48532

DOCUMENTATION FORM FOR PROCEDURAL SEDATION

PHYSICIAN DOCUMENTATION

Pre Op Diagnosis:	History and physical has been reviewed.
Procedure to be Done:	Risks/ benefits/ alternatives have been explained and questions answered.
Indication for Procedure:	Plan for sedation has been discussed with patient/family and is accepted.
ASA Class: circle one I II III IV V E (see back of this page for definitions)	Anticipated post-procedure needs have been identified.
Plan for Sedation: Moderate Deep	Mallampati Class I  Class II  Class III  Class IV 
Physician Signature (validates that all of the above have been completed).	Patient was reevaluated immediately prior to sedation.
	Negative Pregnancy Test ☐ Confirmed NA

Signature: Date: Time:

NURSING DOCUMENTATION (For Cath Lab procedures use electronic documentation)

Modified Aldrete Scores

Note: Must be done pre and post procedure to determine readiness to be discharged from the immediate "recovery" area.

Category	Criteria	Pre	Post
LOC	Fully awake and oriented to time, place, person	2	2
	Arousable on calling name	1	1
	Not responding to auditory stimulation	0	0
Physical Activity	Moves all extremities on command	2	2
	Some weakness in movement of extremities	1	1
	Unable to voluntarily move extremities	0	0
Circulation	BP ± 20% pre sedation level (baseline =2)	2	2
	BP ± 20-50% pre sedation levels	1	1
	BP ± 50% pre sedation levels	0	0
Respiratory	Able to deep breath and cough	2	2
	Dyspnea or limited breathing	1	1
	Apneic or no spontaneous respirations	0	0
Oxygen Saturation	O_2 sat ≥ 90% on room air or home O_2 regimen	2	2
	O_2 sat ≥ 90% with supplemental O_2	1	1
	O_2 sat ≤ 90% with supplemental O_2	0	0
Pain Assessment	None or mild discomfort (0-2 on pain scale)	2	2
	Moderate to severe pain controlled with IV analgesics (3-6 on pain scale)	1	1
	Persistent severe pain (7-10 on pain scale)	0	0
Emetic Symptoms	None or mild nausea with no active emesis	2	2
	Transient vomiting or retching	1	1
	Persistent moderate/severe nausea or vomiting	0	0
	Total Score		

REFERENCES FOR DEFINITIONS AND CRITERIA
Located on page 3 of 4 and page 4 of 4.
ASA Classification
Sedation Levels
Level of Consciousness (LOC)
Pain Scales: Verbal and Non Verbal
Discharge Criteria: Discharge from Recovery and Discharge from Hospital

Procedure Information

Note: Document all medications, assessments and narrative comments on the grid of page 2

Allergies:

NPO since:

Temp:

Weight: Peds actual: Adult actual or stated:

Permit signed: YES NO EMERGENCY

IV site:

IV solution: Start Time: Stop Time:

Procedure physician:

Other personnel present:

Time Out Done: _____

Correct patient identity Correct side and site
Correct patient position Agreement on procedure to be done
Availability of correct implants and any special equipment or special requirements (as applicable)

Physician approval to begin sedation: YES NO

Time patient entered room:

Time procedure started:

Procedure performed:

Post Op Diagnosis:

Estimated blood loss _____

Tissue Removal _____

Time procedure completed:

Time patient left room:

Total IV solution infused: mL

Procedure-to-recovery report given by: to:

Time patient met Criteria for Discharge from Recovery:

Time patient discharged from recovery:

Post recovery report given by: to:

Outpatients Only

Time patient met Criteria for Discharge from Hospital:

Patient accompanied by:

Discharged by: Time:

Signature and Title:_____ Date_____ Time_____

PT.

MR.#/RM.

DR.

McLaren Flint
Flint, MI 48532

DOCUMENTATION FORM FOR PROCEDURAL SEDATION

MEDICATIONS AND ASSESSMENTS

Time				Medication				Assessment									
Time	Check one			Medication	Dose	Route	Given By (Initials)	BP	HR	Rhythm If Monitored	Resp Rate	O2 Sat	O2 Admin L/min C-M-V	LOC	Pain Score		Monitored By (Initials)
	Pre Proc	Intra Proc	Post Proc												Verbal	Non Verbal	

Return to page 1 and complete the post procedure Modified Aldrete Score
If a reversal agent is used (Narcan or Romazicon) please call Quality Management with patient information, 342-2005

ADDITIONAL NARRATIVE DOCUMEN TA TION

Time	Comments

SIGNATURES

Initials	Name and Title	Date	Initials	Name and Title	Date

Use an additional page 2 if more documentation space is required

DOCUMENTATION FORM
FOR PROCEDURAL SEDATION

PT.

MR.#/RM.

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McLaren Flint
Flint, MI 48532

DOCUMENTATION FORM FOR PROCEDURAL SEDATION

Note: This page is for reference only. It contains the Definitions and Criteria needed to complete page one and two. Do not document on this side.

ASA CLASSIFICATION	
Class I	A healthy patient.
Class II	A patient with mild systemic disease.
Class III	A patient with severe systemic disease that limits activity but is not incapacitating
Class IV	A patient with an incapacitating systemic disease that is a constant threat to life.
Class V	A moribund patient not expected to survive 24 hours with or without procedure.
Class E	If the procedure is performed in an emergency, add an "E" to the assigned classification.

Source: The American Society of Anesthesiologists Pre-Sedation Risk Classification System

SEDATION LEVELS		
LEVEL I	Minimal Sedation/ Anxiolysis	A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.
LEVEL II	Moderate Sedation/ Analgesia	A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.
LEVEL III	Deep Sedation	A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.
LEVEL IV	Anesthesia	Consists of general anesthesia and spinal or major regional anesthesia. It does not include local anesthesia. General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients may require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Source: TJC Accreditation Standards

PT.

MR.#/RM.

DR.

McLaren Flint
Flint, MI 48532

DOCUMENTATION FORM FOR PROCEDURAL SEDATION

Note: This page is for reference only. It contains the Definitions and Criteria needed to complete page one and two. Do not document on this side.

OXYGEN ADMINISTRATION
Designate liters/min and "C" for cannula, "M" for mask, or "V" for ventilator

LEVEL OF CONSCIOUSNESS (LOC)	
Level 2	Patient is fully awake
Level 1	Patient arouses when name called
Level 0	Patient does not respond to auditory stimulation

PAIN SCALE: VERBAL
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

PAIN SCALE: NON-VERBAL		
Facial Expression	No particular expression or smile Occasional grimace, tearing, frowning, wrinkled forehead Frequent grimace, tearing, frowning, wrinkled forehead	0 1 2
Activity (Movement)	Lying quietly, normal position Seeking attention through movement or slow cautious movement Restless, excessive activity and/or withdrawal reflexes	0 1 2
Guarding	Lying quietly, no positioning of hands over areas of body Splinting areas of the body, tense Rigid, stiff	0 1 2
Physiology (Vital Signs)	Stable vitals signs Increase in SBP >20 mmHg or increase in HR >20/min Increase in SBP >30 mmHg or increase in HR >25/min	0 1 2
Respiratory	No change from baseline RR or baseline 02 Saturation If intubated, compliant with ventilator RR > 10 above baseline or a 5% decrease in 02 Saturation If intubated, mild asynchrony with ventilator RR > 20 above baseline or a 10% decrease in 02 Saturation If intubated, severe asynchrony with ventilator	0 1 2
	Total Score	
Score each category 0-2. Add all 5 categories and document this total score using the 0-10 pain scale		

Source: University of Rochester Medical Center

DISCHARGE CRITERIA	
Discharge from Recovery*	Discharge from the Hospital
An Aldrete score of 13 (or pre-procedure if it was less than 13)	Patient must meet all criteria for "Discharge From Recovery"
All Aldrete categories must have a post procedure score of 2 (except emetic symptoms which can be a 1)	Patient must be accompanied by a competent adult companion who will escort the patient home.
At least 30 min. have elapsed since last dose of sedation was given	The patient may not drive.
At leas t 120 min . have elapsed since last dose of reversal agent was given	Patient's mobility must be back to pre-sedation baseline
Exception to the 30/120 minute rule: patient may be transferred immediately to critical care by an RN	
* Note: Recovery means an area that provides a direct line-of-site observation by recovery personnel. Depending on where the sedation was given, it could be PACU, a procedure room, a post-procedure recovery area or even a patient room.	

PT.

MR.#/RM.

DR.

McLaren Flint
Flint, MI 48532

Procedural Sedation Quality Monitoring

Date of Procedure:_____ **Procedure:**_____
Unit/Department where sedation was given:_____
Physician Name: _____ **RN name:** _____
Medication Administered: _____ **Ativan** _____ **Versed** ____ **Fentanyl** _____ **Demerol** _____ **Morphine** _____ **Dilaudid**
_____**other:**_____

	YES	NO
1. Was the Consent to Operation or Other Procedure signed by the Anesthesia Provider?		
2. Was there an "Immediate Assessment done prior to the start of the proced **ure that included:** **a. Mallampati assessment?** **b. ASA Classification?** **c. Review of Current Vital Signs?**		
3. Were there unusual difficulties/problems during the procedure such as: **a. Patient became unresponsive?** **b. Obstructed airway requiring placement of an oral/nasal airway, intubation or bag/mask ventilation with ambu bag?** **c. Increased oxygen need by either increasing FiO2 or changing the mode of oxygen delivery** *(example: changing from nasal cannula to a mask)* **d. CPR initiated?** **e. Other: Explain**		
4. Was the oxygen saturation documented every 5 minutes duing the procedure and every 15 minutes during recovery?		
5. Was any reversal agent required during or after the procedure? ☐ **Narcan** ☐ **Romazicon**		
6. If reversal agents were used, did the patient stay 120 minutes following administration of reversal?		
7. Did the patient return to pre-procedure condition upon completion of procedure? If no, explain:		
8. Were there any adverse outcomes/events? If yes, explain:		
9. How long was the patient's recovery from end of procedu **re until an Aldrete score of 10 (or pre-procedure level if baseline was less than 10)?** ☐ **Less than 60 minutes** ☐ **More than 60 minutes**		
10. Was sedation education provided and documented?		
11. Was the Procedural Sedation Documentation form thoroughly completed?		

*****FAX TO 342-3148 OR MAIL THIS FORM TO THE QUALITY MANAGEMENT DEPARTMENT DAILY*****

THIS DOCUMENT IS NOT PART OF THE MEDICAL RECORD

This is a confidential professional/peer review and quality assurance document of the medical center. It is collected as patient safety work product It is protected from disclosure pursuant to the provisions of MCL 333.20175, MCL 333.21513, MCL 333.21515, MCL 331.531, MCL 331.532, MCL 331.533, MCL 330.1143 and all other State and Federal laws providing protection for facility professional review and/or peer review functions. Unauthorized disclosure or duplication prohibited.

PT.

MR.#/RM.

DR.

FLINT

MRI

DISCHARGE INSTRUCTIONS
FOLLOWING SEDATION

ADULT:

The medicine or sedation that was used to relax you for the purpose of acquiring your MRI examination will be acting within your body for the next 24 hours. You may feel sleepy or may be unsteady when you leave the MRI facility.

- **DO NOT** perform any activity requiring mental alertness or physical coordination, even if you feel that you are no longer under the influence of a sedative. (This could be up to 2 days.)
- **DO NOT** operate a motor vehicle or heavy equipment
- **DO NOT** make decisions which may have legal consequences or require the signing of a contract (up to 2 days)

You may resume normal activities tomorrow.

If you have any questions or concerns, contact your family physician or the physician that referred you for this exam. That physician may contact McLaren-Flint MRI for specifics as to drug, dose, route, time, and the supervising Radiologist overseeing your exam.

_____ _____ _____
PATIENT SIGNATURE DATE TIME

_____ _____
WITNESS DATE

McLaren Flint
FLINT, MICHIGAN 48532

Date _____

HISTORY & PHYSICAL

Patient _____ Physician _____

Chief Complaint _____

HISTORY
Present Illness _____

_____

_____

_____

_____

Allergies _____

Current Medications _____

_____

Past Medical History (check √ if present) or ☐ None

- ☐ Hypertension
- ☐ Coronary Artery Disease
- ☐ Myocardial Infarction
  Date: _____
- ☐ Irregular Heart Beat
- ☐ Pacemaker/ICD

Heart Failure:
- ☐ Systolic
- ☐ Diastolic

- ☐ Valvular Heart Disease
- ☐ Chronic Respiratory Failure

- ☐ COPD
- ☐ Asthma
- ☐ Bronchitis
- ☐ Tuberculosis
- ☐ GERD
- ☐ Hepatitis
- ☐ Ulcers
- ☐ Peripheral Vascular Disease
- ☐ CVA
- ☐ Transient Ischemic Attack
- ☐ Seizures

Diabetes Mellitus:
- ☐ Type I
- ☐ Type II

Thyroid:
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

- ☐ Cancer
  (Type) _____
- ☐ Bleeding Disorders

_____ Pregnancies
_____ Deliveries

Chronic Kidney Disease Stages:
- ☐ Stage I – GFR > 90 with proteinuria
- ☐ Stage II – GFR 60-89
- ☐ Stage III – GFR 30-59
- ☐ Stage IV – GFR 15-29
- ☐ Stage V – GFR < 15 or dialysis
- ☐ ESRD

- ☐ Obesity
- ☐ Underweight
- ☐ Anemia
- ☐ Other _____

Past Surgical History _____

_____

Social History
- ☐ Occupation _____
- ☐ Smoking _____
- ☐ Drugs _____
- ☐ Alcohol _____
- ☐ Abuse (Psychosocial) _____

Family History
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Bleeding Disorders
- ☐ Cancer
- ☐ Malignant Hyperthermia

Review of Systems (check √ if present) or ☐ None
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Sore Throat
- ☐ Fever/Chills
- ☐ Dizziness
- ☐ Nausea/Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Visual Disturbance
- ☐ Hearing Problems
- ☐ Light-headedness
- ☐ Altered Bowel Habits
- ☐ Altered Bladder Habits
- ☐ Dyspepsia/Dysphagia
- ☐ Anorexia/Weight Loss
- ☐ Fatigue/Weakness
- ☐ Weakness in Extremities

PT.

MR.#/RM.

DR.

PHYSICAL (Explain any abnormalities under "Other"):

Vital Signs: ☐ Reviewed ☐ Other _____

HEENT: ☐ Normal ☐ Other _____

Neck: ☐ Normal ☐ Other _____

Breast: ☐ Normal ☐ N/A ☐ Other _____

Thorax: ☐ Normal ☐ Other _____

Heart: ☐ Normal ☐ Other _____

Lungs: ☐ Normal ☐ Other _____

Abdomen: ☐ Normal ☐ Other _____

Genitalia: ☐ Normal ☐ N/A ☐ Other _____

Pelvic: ☐ Normal ☐ N/A ☐ Other _____

Rectal: ☐ Normal ☐ N/A ☐ Other _____

Extremities: ☐ Normal ☐ Other _____

Neuro: ☐ Normal ☐ Other _____

Pertinent Labs & X-Rays:

_____

_____

_____

Provisional Diagnosis / Plan of Treatment:

_____

_____

_____

_____

_____

For Breast Patients only: Reconstructive Surgery Discussed ☐ Yes ☐ No

Date: _____ Time: _____Physician Signature _____

PT.

MR.#/RM.

DR.