McLaren
FLINT

Surgery Packet

This packet contains:

- Consent to Operation or Other Procedure (10/3/2013)
- Anethesia Routine (4/17/2017)
- Patient Evaluation Form (10/16)
- History and Physical (2/2015)
- Post-Operative / Procedure Note (11/2014)

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 _____

PT.

MR.#/RM.

DR.

CONSENT TO OPERATION OR OTHER PROCEDURE

820b

McLaren Flint
Ambulatory Surgery Center
ANESTHESIA
Pre- and Post- Operative ROUTINE Orders

ORDERS **ALLERGIES: See Medication Reconciliation Form**

1. Pre Op Holding Routine Orders for all Patients

a. Oxygen PRN for saturations less than 94% after sedation or on Room Air
b. IV start LR 1000 mL (500 mL for eye, EGD, and pediatric patients) at 10 mL / hour – offer with subcutaneous 1% lidocaine
c. NaCl 500 mL at 10 mL / hour for Dialysis Patients

2. Diabetic Patients

a. Take ½ usual morning dose of insulin (Lantus, Levemir, NPH, N, 70/30, 75/25, 50/50, Toujeo, or Tresiba)
b. Do NOT take the following: Novolog, Humalong, Apidra, Regular insulin, oral diabetes medications, or other injectable diabetes medications
c. Continue Insulin Pump and bring pump supplies to hospital
d. Perform Glucometer / FBS
e. FBS less than 70 mg/dL or greater than 250 mg/dL, contact Anesthesia

3. General Anesthesia Patients

a. Greater than 18 years with diabetes, Obesity, GERD or reflux to receive:
☒ Famotidine (PEPCID) 20 mg PO with sip of water and
☐ Metoclopramide (REGLAN) 10 mg PO with sip of water
b. History of motion sickness or nausea and vomiting give
☐ Scopolamine Patch, apply 1 patch to hairless area behind ear up to 1 hour before surgery; remove 24 hours after surgery

4. **Colons and EGD's with GERD** give
☒ Citric Acid/Sodium Citrate (BICTRA) 30 mL PO, hold if reflux meds taken that day

5. POHA Medications:

☐ Famotidine (PEPCID) 20 mg PO or IVP x1 dose
☐ Metoclopramide (REGLAN) 10 mg PO or IVP X 1 dose
☐ Ondansetron (ZOFRAN) _____ mg IVP
☐ Dexamethasone (DECADRON) _____ mg IVP nausea and vomiting
☐ Hydrocoritsone Sodium (SOLU CORTEF) _____ mg IVP
☐ Labetalol _____ mg IVP
☐ Gabapentin (NEURONTIN) 300 mg PO
☐ Ibuprofen (MOTRIN) 600 mg PO Pain scale 1 - 3
☐ Acetaminophen (TYLENOL) 1000 mg PO Pain scale 1-3
☐ Citric Acid/Sodium Citrate (BICTRA) 30 mL PO
☐ Midazolam (VERSED) _____mg IVP anxiety
☐ Midazolam (VERSED) Syrup _____mg PO anxiety
☐ Fentanyl _____ microgram IVP
☐ Glycopyrrolate (ROBINUL) _____ mg IVP
☐ Scopolamine Patch, apply 1 patch to hairless area behind ear up to 1 hour before surgery; remove 24 hours after surgery
☐ Other:_____

_____ _____ _____
Physician Signature: Date (required) Time (required

_____ _____ _____
PACU RN Signature: Date (required) Time (required

Revised 04/17/2017

PHYSICIANS ORDERS AND INSTRUCTIONS TO NURSE

M – 1708 – 212

640B

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McLaren Flint
Ambulatory Surgery Center
ANESTHESIA
Pre- and Post- Operative ROUTINE Orders

1. Post Anesthesia Orders:

a. O_2 per nasal cannula or face mask (iterate to keep saturations greater then 94% or at pre op baseline
b. Perform blood glucose test on Insulin dependent diabetics. (If less than 70 mg/dL or greater than 250 mg/dL, contact Anesthesia).
c. Discharge to home when discharge criteria met and anesthesia approved.

2. PACU PRN Medications:

Pain Medications

Severe Pain– Parenteral

☐ HYDROmorphone (Dilaudid) 0.5 mg IVP as needed every 10 minutes for pain level greater than 5 and RR greater than 10, maximum of 4 doses (2 mg).
☐ Morphine 2 mg IVP as needed every 10 minutes for pain level greater than 5 and RR greater than 10 if pain not relieved by HYDROmorphone, maximum of 5 doses (10 mg).
☐ Fentanyl _____ mcg IVP every _____ minutes for pain level greater than 5 and RR greater than 10, after 2 mg HYDROmorphone AND 10 mg Morphine, maximum of _____ doses.

Moderate Pain– Parenteral (May ONLY select one)

☐ Ketorolac (Toradol)_____ mg IV PRN moderate pain x 1 (maximum IV dose= 30 mg) (15 mg dose if 50 kg or less or 65 years or older) (Do not give if already given in OR)

Moderate Pain- PO (May ONLY select one)

☐ Acetaminophen with Codeine (12 mg codeine/ 120 mg acetaminophen / 5 ml) _____ ml PO PRN moderate pain x 1 dose
☐ Hydrocodone/Acetaminophen oral elixir (10 mg hydrocodone / 300 mg acetaminophen / 15 ml) _____ ml PO prn moderate pain x 1 dose
☐ Hydrocodone/Acetaminophen 5/325 mg PO PRN moderate pain x 1 dose
☐ Hydrocodone/Acetaminophen 7.5/325 mg PO PRN moderate pain x 1 dose
☐ Oxycodone IR 5 mg PO PRN moderate pain x 1 dose

Mild Pain- PO (May ONLY select one)

☐ Ibuprofen (Motrin) _____ mg PO prn mild pain X1 dose (Do not give if already given in OR)
☐ Acetaminophen (TYLENOL) 160 mg/ 5 mL suspension _____ mg PO PRN mild pain x 1 dose
☐ Acetaminophen (TYLENOL) 325 mg, 2 tablets PO PRN mild pain x 1 dose

Post-operative Nausea and Vomiting (May ONLY Select one; additional orders needed for additional medication)

☐ Promethazine (Phenergan) 12.5 mg IVPB (in 50 ml NaCl over 10 minutes) x1 dose
☐ Metoclopramide (REGLAN) 10 mg IVP x 1 dose
☐ Dexamethasone (DECADRON) 4 mg IVP x1 dose
☐ Ondansetron (Zofran) _____ mg IVP, q4hr
☐ Scopolamine Patch, apply 1 patch to hairless area behind ear, if not applied in pre-op; remove 24 hours after surgery

Other Medication

☐ Albuterol 2.5 mg/ 3 ml nebulized solution PRN for wheezing x 1 dose
☐ Labetalol _____ mg IVP PRN for SBP greater than 160 mmHg
☐ Other meds:_____

_____	_____	_____
Physician Signature:	Date (required)	Time (required
_____	_____	_____
PACU RN Signature:	Date (required)	Time (required

PHYSICIANS ORDERS AND INSTRUCTIONS TO NURSE

M – 1708 – 212

PT.

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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:_____

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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:_____

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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
- Heart Failure
  ☐ Congestive ☐ Systolic
  ☐ Diastolic
- ☐ Peripheral Vascular Disease
- ☐ Murmur
- ☐ Pacemaker/ICD
- ☐ COPD
- ☐ Asthma
- ☐ Tuberculosis
- ☐ GERD
- ☐ Hepatitis
- ☐ Ulcers
- ☐ CVA
- ☐ Transient Ischemic Attack
- ☐ Seizures
- Diabetes Mellitus
  ☐ Type I
  ☐ Type II
- Thyroid
  ☐ Hypothyroidism
  ☐ Hyperthyroidism
- ☐ Cancer
- ☐ Chronic Kidney Disease
- ☐ Bleeding Disorders
- _____ Pregnancies
- _____ Deliveries
- ☐ 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

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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 Consultation ☐ Yes ☐ No

(Place corresponding order in CPOE)

Date: _____ Time: _____Physician Signature _____

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McLaren Flint
Flint, Michigan

POST-OPERATIVE/PROCEDURE NOTE

NOTATIONS **All BOLD Elements REQUIRED by CMS & Joint Commission. Please Fully Complete.**
Pre – Operative Diagnosis:
Post – Operative Diagnosis:
Procedure(s) Performed:
Physician/Surgeon(s): **Assistant(s):**
No Specimens unless noted:
No Blood loss unless noted:
Findings:
Complications:
Anesthesia: ☐ General ☐ Local ☐ Spinal ☐ IV Sedation
Teaching Physician Addendum:
Physician's Signature: _____ Date/Time: _____

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