

Preoperative Assessment Center (PAC) WORKSHEET

Anesthesia Triage Walk-in Day of Surgery

Patients Sticker:			Surgery Date:	Today's Date:
TESTS/Chart review	Ordered	Complete	Times	Vital Signs
EKG			Time in: _____	B/P____/____
CBC			HT Start: _____	R_____
PT/PTT			HT Stop: _____	HR_____
CHEM PANEL			Time Out: _____	O2 Sat_____
UA			Anesthesia Start: _____	Temp_____
UA C&S				Neck_____cm
HCG			Anesthesia Stop: _____	Ht: _____
T& S				Wt. _____kg
T& C				
NASAL SWAB				
OTHER: _____				
Consent Complete				
MDRO Screen Reviewed				
Pre-op teaching reviewed				

Give to patient when applicable.

- CXR:** Your doctor or anesthesia staff has requested that you have a Chest X-Ray required for your surgical procedure. Report to Radiology Depart. Bld. 1, floor 2. If you do not complete your CXR you will be asked to return prior to the day of surgery to complete.

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<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes? Insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid problems (hypothyroid/hyperthyroid/Graves)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Steroid use in past 6 months?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood disorder (sickle cell/bleeding disorder/prior transfusion)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer? Type: Chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Type of medication: Radiation? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurologic problems (weakness/nerve injury/seizure/stroke/recurrent severe headaches)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental health issues (depression, anxiety, PTSD, bipolar, etc.)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle/bone/joint problems (arthritis/weakness/muscular dystrophy)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin problem (current infection/MRSA)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye problem (glaucoma)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Other medical problems?

MISCELLANEOUS QUESTIONS

<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had surgery at Naval Medical Center San Diego in the past year?
Females only:	All females receive a pregnancy test on the day of surgery unless they are post-menopausal or have had a hysterectomy. Please check if this applies to you. Post-menopausal <input type="checkbox"/> Hysterectomy <input type="checkbox"/>
<input type="checkbox"/> Yes <input type="checkbox"/> No	On the day you are coming in for your procedure are you scheduled to have any other procedures, labs drawn or other tests? If yes please explain
<input type="checkbox"/> Yes <input type="checkbox"/> No	On your day of surgery, is there any reason that you would not be able to come in at 0500-0630? If yes, please explain:

POST-OPERATIVE NAUSEA AND VOMITING (PONV) SCREENING # OF POINTS: + 1 = (all start with one point)

<input type="checkbox"/> Yes (1) <input type="checkbox"/> No	Female Gender?
<input type="checkbox"/> Yes <input type="checkbox"/> No (1)	Do you smoke?
<input type="checkbox"/> Yes (1) <input type="checkbox"/> No	History of post-operative nausea or motion sickness?

OBSTRUCTIVE SLEEP APNEA (OSA) SCREENING # OF YES ANSWERS:

<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you SNORE loudly or have you been diagnosed with SLEEP APNEA? (Louder than talking or loud enough to be heard through closed doors)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you often feel Tired, fatigued, or sleepy during daytime?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has anyone OBSERVED you stop breathing during your sleep?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have or are you being treated for high blood PRESSURE?
<input type="checkbox"/> Yes <input type="checkbox"/> No	AGE over 50 years old?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Male GENDER?

Next two Questions below completed by PAC Staff

<input type="checkbox"/> Yes <input type="checkbox"/> No	NECK circumference > 15.75 inches? (Neck Circumference: _____ inches)
<input type="checkbox"/> Yes <input type="checkbox"/> No	BMI more than 35? BMI _____ (Height: _____ inches / Weight: _____ lbs.)

MULTI-DRUG RESISTANCE ORGANISM (MDRO) SCREENING # OF YES ANSWERS:

<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been told by a physician that you have had any Multi Drug resistant organism infection or colonization?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you recently been a patient in a trauma unit, Skilled nursing facility or been in combat theater of operations and have an open wound?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a skin or soft tissue infection?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you a dialysis patient or have you been hospitalized within the last 30 days?
<input type="checkbox"/> Yes <input type="checkbox"/> No	The previous statements are true to the best of my knowledge.

Patient Signature (or Parent/Legal Guardian)

ADULT SURGERY PREADMISSION INSTRUCTIONS

1. I am scheduled for surgery on _____. My surgeon is _____.
2. I **will** complete all ordered labs, x-rays, and diagnostic tests today unless otherwise instructed.
3. I **will not** eat, drink alcohol, smoke, or chew tobacco, gum or candy after midnight the night before my surgery. I may drink clear liquids up to 2 hours prior to my scheduled surgery arrival time. The following are acceptable clear liquids: Water, clear apple juice, 7-up/Sprite, Pedialyte, Gatorade or other sports drink, black coffee (No creamer). **NO OTHER CLEAR LIQUIDS ARE AUTHORIZED AT NMCS D.**
4. I will take a shower and wash the area of surgery once the night before and once the morning of surgery as instructed with:
 Antibacterial soap 2% HCG Cloth N/A hibiclens® betadine Other
5. I will not wear makeup or nail polish. (DO NOT APPLY LOTION, PERFUME, COLOGNE, SCENTED DEODORANT, OR POWDER AFTER SHOWERING. DO NOT SHAVE AREA OF SURGERY).
6. I will **not** take aspirin, aspirin containing products or anti-inflammatory medication (Motrin®, Advil®, Naprosyn®, Ibuprofen, Celebrex®) for 2 weeks prior and during post-operative care **unless otherwise directed by my surgeon** (excluding Ophthalmology patients). Patients, who have had heart stents, please consult your cardiologist before stopping any medication.
7. I will complete all pre-op preparations as instructed by my surgical clinic: Colyte® Enema Fleets Phosphosoda® Magnesium Citrate® Other _____
8. I **will** take regularly scheduled medications with a sip of water the morning of surgery **unless** otherwise instructed by anesthesia and/or my surgeon.
9. I will bring my Military ID Card for identification purposes or any other necessary paperwork. If you have an advanced directive, please bring it on the day of surgery. If you would like information about advanced directives, you may obtain this information at the front desk or at the NMCS D legal department.
10. I will bring crutches, braces, or support garments as directed by my surgeon. I will bring containers and solutions for contact lenses, glasses, dentures, hearing aids, and a small bag with toiletries if staying overnight.
12. I will not bring jewelry (including wedding bands and body jewelry/piercings), money, credit cards or other valuables. If I choose to keep valuables or prosthetics such as glasses, dentures, or hearing aids, I understand that I assume liability and agree to hold harmless the U.S., the Dept. of the Navy, NMCS D, and/or any employee or agents of the foregoing for any claim that might arise as the result of loss of such valuables or personal effects.
13. I will call my surgeon if I develop a fever, rash, cold, or other illness between now and my scheduled date of surgery.
14. Only ONE person is allowed to accompany you into the pre-operative area. Children under 12 years old are not permitted.
15. I **will** have a responsible adult to take me home and stay the night after being discharged. **Active duty members CANNOT spend the night in the barracks or on the ship.**
16. Active Duty: A signed **AND** approved copy of your Command Authorization for Surgery form is required to be faxed no **later than noon the day before surgery** to 619-532-8363. (Bring a copy on your surgery day.) Confirm receipt by calling 619-532-6530.
17. If I do not receive an automated message by 4 PM one business day prior to surgery I will call (619) 532-6844 (option 1) or (619) 532-6335 for my arrival time. The unit is closed on weekends and holidays and you should call (619)532-9000 for your time.
18. I will check-in day of surgery at the Main Operating Room surgery check-in window located on the 4th floor of building 1.
19. If you have any other questions, please contact your surgical clinic.

I acknowledge I have read and understand the preoperative instructions as stated above. Not following these instructions may result in case delay or cancellation!

Patient / Legal Guardian Signature / Date

Nurse/Corpsman Signature / Date

NMCS D 6000/31(5/14)

Patient Label

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**Naval Medical Center San Diego
MRI QUESTIONNAIRE**

Date: _____

Name: _____

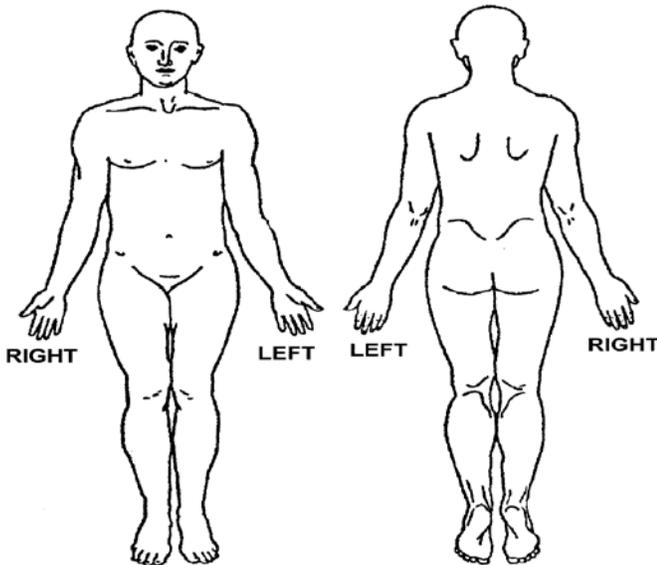
Birth Date: _____ Weight: _____

Phone Number: _____

The MRI scanner uses extremely strong magnetic fields that can produce heating, movement, or electric currents in ANY metal in or on your body. **WARNING:** This can be hazardous to you, if you have certain metal objects in or on you. Please complete this accurately and carefully.

Please circle Yes or No to ALL the following:

- YES NO Is this your first MRI?
- YES NO Are you claustrophobic (fear of confined spaces)
- YES NO Do you have any metal or objects possibly containing metal in your body? If so, please circle where and give any known information below:



Description of device(s): _____

Date(s) placed: _____
(Continue on back if needed)

- YES NO Cardiac pacemaker / lead wires
- YES NO Stents
- YES NO Aneurysm clip / coil
- YES NO Artificial heart valve
- YES NO Shunt (programmable/ non-programmable)
- YES NO Neurostimulator (any type)
- YES NO Leads or electrodes
- YES NO Possibility of any metal slivers in the eye
- YES NO Any electronic implant or device
- YES NO Medication patches
- YES NO Surgical staples, clips, or metal mesh
- YES NO Fractured bone/joint treated with pins, screws, nails, wire, or plate
- YES NO Dentures, partial plates, or braces
- YES NO Permanent makeup or eyeliner
- YES NO Prosthesis of any kind (eye, limb, etc.)
- YES NO Piercings or jewelry (remove prior to entry)
- YES NO Hearing aids (remove when instructed)
- YES NO IUD (Females) Type: _____
- YES NO Are you pregnant (Females)
- YES NO Have you ever been injured by a metallic object or foreign body (e.g. BB, bullet, **metal shards in the eye**, or shrapnel)?
- YES NO Have you had ANY surgery other than dental? Please, list date (approx.) and type:

(Continue on back if needed)

I attest that the above information is correct to the best of my knowledge.

Signature of Patient/ parent/ guardian:

Verified by (Tech initials): _____

**Naval Medical Center San Diego
MRI QUESTIONNAIRE**

(Continued from front side) _____

The following is to be completed for patients who may receive MRI CONTRAST (GADOLINIUM)

Your doctor has ordered an examination requiring the administration of an injectable contrast medium for MRI (Gadolinium DTPA). This contrast has proved very safe although there have been some mild reactions reported such as headache, nausea, and much less common adverse reactions (less than 1%) involving pain at the injection site, decreased blood pressure, fainting, abdominal discomfort, tingling, skin rashes or hives, seizures, and drowsiness. In patients with significant kidney failure there is also the risk of a serious disease named "Nephrogenic Systemic Fibrosis" which can lead to severe scarring of the skin and other organs and can be fatal. The risks, if any, to the human fetus during pregnancy are unknown. Because many drugs are excreted in human milk, we recommend temporarily discontinuing breast feeding for 24 – 48 hours if you are nursing.

Please circle Yes or No to ALL the following:

- YES NO Renal failure or kidney disease
- YES NO Hypertension (high blood pressure)
- YES NO History of diabetes
- YES NO Severe liver disease
- YES NO Previous reaction to Gadolinium DTPA
- YES NO Are you nursing? (Females)

For Tech use only:

Privacy Statement

This document is covered under the Privacy Act, 5 USC 552(a), the Health Insurance Portability and Accountability Act (PL 104-191) and its various implementing regulations and must be protected in accordance with those provisions. Healthcare information is personal and sensitive and must be treated accordingly. Disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized disclosure or failure to maintain confidentiality subjects you to application of appropriate sanction.

Tech (Sign): _____

(Print): _____

GFR _____ as of _____ Amount _____

Magnevist Eovist Gadavist Multihance Ablavar

Other _____