University of Medical Center

Peri-Procedure Interview

DATE	TIME		
SCHEDULED DATE	SCHEDULED TIME	HOME PHONE NO.	WORK PHONE NO.

INFORMED OF

☐ TYPE OF PROCEDURE AND LENGTH POST PROCEDURE CARE	☐ NO. OF FAMILY ACCOMPANYING (SUGGESTED MAXIMUM)
☐ TIME TO ARRIVE _____	☐ INSTRUCT PARENTS NOT TO BRING OTHER UNATTENDED SIBLINGS ON THE DAY OF PROCEDURE
☐ VALUABLES / MONEY - LEAVE AT HOME	☐ LOCATION OF UNIT / TELEPHONE NO.
☐ HYGIENE / CLOTHING / EQUIPMENT (CRUTCHES, SLING, BRA)	☐ PARKING GARAGE AVAILABLE
☐ ADVANCE DIRECTIVES	☐ OTHER
☐ PROPHYLACTIC MEDICATIONS *(IF ORDERED)*	☐ OTHER

SPECIFIC PRE PROCEDURE INSTRUCTIONS

☐ NO ASPIRIN BEFORE SURGERY	☐ CONSCIOUS IV SEDATION
☐ PATIENT INSTRUCTED TO TAKE DAILY MEDICINE WITH SIP OF WATER; DIABETIC INSTRUCTIONS	☐ CONFIRM TRAVEL ARRANGEMENTS TO HOSPITAL
☐ INSTRUCT TO BRING RED & WHITE BRACELET IF APPLICABLE	☐ BRING INFORMATIONAL PACKET TO HOSPITAL IF APPLICABLE
☐ CONTACT YOUR MD OR DEPARTMENT IF SICK OR UNABLE TO KEEP APPOINTMENT	☐ PRE-OP SURGICAL SCRUBS X 3 IF APPLICABLE
☐ NPO AFTER MIDNIGHT	☐ IF ANY QUESTIONS ARISE THE EVENING BEFORE SURGERY, CALL THE _____ AT 328 _____
☐ PERSON PROVIDING RIDE HOME _____	PHONE NO. WHERE THEY CAN BE REACHED _____

COMMENTS

SIGNATURE OF RN | DATE

☐ **N / A - SAME DAY ADMISSION** **POST PROCEDURE FOLLOW UP CALL** ☐ **UNABLE TO CONTACT**

DATE | PHYSICIAN / ANESTHESIOLOGIST NAME | PROCEDURE

☐ YES ☐ NO ☐ N/A NAUSEA / VOMITING	☐ YES ☐ NO ☐ N/A BLEEDING	☐ YES ☐ NO ☐ N/A TARRY STOOLS
☐ YES ☐ NO ☐ N/A FEVER / CHILLS	☐ YES ☐ NO ☐ N/A COUGH / DIFFICULTY SWALLOWING	☐ YES ☐ NO ☐ N/A SWELLING
☐ YES ☐ NO ☐ N/A MUSCLE ACHES / CRAMPS	☐ YES ☐ NO ☐ N/A PAIN / PAIN SCORE (0-10) _____	☐ YES ☐ NO ☐ N/A CHEST PAIN
☐ YES ☐ NO ☐ N/A NUMBNESS / TINGLING	☐ YES ☐ NO ☐ N/A CONTROLLED WITH PAIN MEDS	☐ YES ☐ NO ☐ N/A DIFFICULTY BREATHING
☐ YES ☐ NO ☐ N/A SORE THROAT	☐ YES ☐ NO ☐ N/A URINARY FREQUENCY / BURNING / UNABLE TO VOID / HEMATURIA	☐ YES ☐ NO ☐ N/A BLURRED VISION
☐ YES ☐ NO ☐ N/A HEADACHE	☐ YES ☐ NO ☐ N/A BLOATING / GAS / REFLUX	☐ YES ☐ NO ☐ N/A DIZZINESS

APPETITE ☐ *GOOD* ☐ *FAIR* ☐ *POOR* *FOLLOW-UP APPOINTMENT ARRANGED?* ☐ *YES* ☐ *NO*

HOW SATISFIED WERE YOU WITH DISCHARGE INSTRUCTIONS GIVEN TO YOU FOR THE FOLLOWING:

	VERY SATISFIED	SOMEWHAT SATISFIED	NOT SATISFIED
A. TREATMENTS / ACTIVITY	☐	☐	☐
B. MEDICATIONS	☐	☐	☐
C. WHO TO CALL FOR PROBLEMS / QUESTIONS	☐	☐	☐

PLEASE EXPLAIN WHY NOT COMPLETELY SATISFIED

HOW SATISFIED WERE YOU OVERALL WITH THE OUT PATIENT SERVICE / PROCEDURE YOU RECEIVED?

VERY SATISFIED	SOMEWHAT SATISFIED	NOT SATISFIED
☐	☐	☐

PLEASE EXPLAIN WHY NOT COMPLETELY SATISFIED

COMMENTS

SIGNATURE OF RN | DATE

(04/01)