UNIVERSITY MEDICAL CENTER

THE CENTER FOR AMBULATORY SURGERY PLAN OF CARE

AFFIX PATIENT INFO LABEL HERE

Patient Name _____ **MR#** _____

STO

ADMISSION NURSING ASSESSMENT

PRE-ADMISSION COMMUNICATION

❒ No pre-op call per MD

❒ Pre-op visit Date: _____ ❒ Pre-op call ❒ Unable to reach

❒ Significant other contacted: _____ ❒ Answering machine

Impaired communication _____ ❒ N/A

Aware of NPO ❒

❒ _____ ❒ _____ Instructed to leave valuables / jewelry at home

❒ _____ ❒ _____ Aware of scheduled OR Time / Arrival time

❒ _____ ❒ _____ Morning of surgery meds on hold

❒ _____ ❒ _____ Aware of parking/directions to hospital

❒ _____ ❒ _____ Has arranged for transport home

❒ _____ ❒ _____ Two forms of ID

❒ Morning of surgery meds to be held: _____

❒ Morning of surgery meds to be taken: _____

Additional Instructions: _____

PAT R.N. Signature: _____ Date: _____ Time: _____am/pm

DAY R.N. Signature: _____ Date: _____ Time: _____am/pm

❒ Alternative instructions given _____

ADMISSION TO SAME DAY SURGERY

Reason for admission: _____

Date: _____ Time: _____ am/pm ❒ Male ❒ Female Age: _____

Height: _____ Weight: _____ lbs. Head circumference under 1 year _____

❒ Has advance directive disposition, if yes, Health Care Rep. Name: _____ Phone#: _____

NPO/p Midnight ❒ Yes ❒ No ❒ Explain: _____

Anxiety level ❒ Mild ❒ Moderate ❒ Severe ❒ Unable to evaluate ❒ Explain: _____

Special Health Considerations: ❒ Recent exposure to communicable disease: _____

❒ Arthritis ❒ Cardiac ❒ ASHD ❒ MI ❒ PVD ❒ LMP _____ ❒ N/A ❒ Rh _____ ❒ N/A

❒ CVA ❒ Hepatitis ❒ Hypertension ❒ Glaucoma ❒ COPD ❒ Diabetes _____ ❒ Asthma ❒ Bronchitis

❒ GERD ❒ Depression ❒ Anemia ❒ Dialysis last Rx _____ ❒ Chest Pain/Angina ❒ Seizures

Cancer: _____

Tobacco: ❒ Yes ❒ No How Long?: _____ Type: _____ Amount: _____

❒ Quit: (when) _____

Alcohol ❒ Yes ❒ No type: _____ Amount of drinks per day: _____ Last Drink: _____

Recreational Drugs ❒ Yes ❒ No type: _____ Amount: _____ Last Use: _____

Other: _____

Surgical History: ❒ N/A ❒ Yes: _____

Anesthesia Problems: ❒ N/A ❒ No ❒ Yes: ❒ Family Hx of anesthesia problems _____

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Patient Name _____ MR# _____

ADMISSION NURSING ASSESSMENT

MEDICATIONS/ALTERNATIVE MEDS/HERBAL REMEDIES/VITAMINS		
Name or Purpose	Dose/Route/Frequency	Last Dose

❒ Special Dietary needs/restrictions _____

_____

_____

ALLERGIES: ❒ Denies ❒ Latex ❒ Contrast Dye ❒ Food: _____

❒ Medications: _____

❒ Other: _____

Explain Reaction: _____

_____

Birth Hx: (Ped. Patients) ❒ Full term ❒ Premature ❒ Complications: _____

Present weight: _____ Immunizations: ❒ Up to date ❒ Other Explain: _____

Physical/Sensory Disabilities ❒ None ❒ Other: _____

_____

Prosthetic Devices: ❒ None ❒ Other: _____ Hearing Aid: ❒ N/A ❒ Left ❒ Right Disposition: _____

Eyeglasses: ❒ N/A ❒ Yes Disposition: _____ Contact Lenses: ❒ N/A ❒ In ❒ Out Disposition: _____

Dentures/Bridges: ❒ N/A ❒ Full ❒ Partial ❒ Upper ❒ Lower ❒ Left ❒ Right Disposition: _____

Caps/Loose Teeth: ❒ N/A ❒ Yes Location: _____

❒ Body piercing: Sites: _____

Personal Property (Disposition): _____

❒ Pre-op Teaching Done _____

❒ Post-op Teaching Done _____

❒ Pain Management Plan _____

❒ Developmental Assessment Done _____

❒ Plan of Care Individualized Based on Nursing and patient history _____

❒ Age Specific Assessment Done _____

❒ Special Needs/Cultural Considerations: _____

_____

PAIN INTENSITY SCALE – 0 - 10

0	1-3	4-7	8-10
None	Mild	Moderate	Severe

AFFIX PATIENT INFO LABEL HERE

Patient Name _____ MR# _____

PAIN HISTORY ASSESSMENT

PAIN HISTORY ASSESSMENT:

Do you have pain now? ❒ Yes ❒ No Intensity: _____

Describe: _____

Have you had pain in the last several weeks or months? ❒ Yes ❒ No Intensity: _____

Describe: _____

Is your pain related to your admission today? ❒ Yes ❒ No

How do you express pain? _____

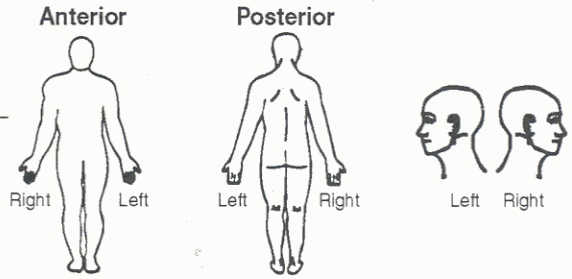
What pain medications has or has not relieved your pain in the past? _____

_____

If current or past pain intensity ≥ 4, continue with pain assessment.

LOCATION OF PAIN: Mark site with letter A or B if more than one site

PAIN SITE:



Location of Pain _____

Appearance of Pain Site _____

Worst Pain Felt (Intensity Score) _____

Least Pain Felt (Intensity Score) _____

Qualities (ache, dull, burn, sharp, etc.) _____

ONSET/DURATION:

When did your pain begin? _____

How long is the pain episode? _____

Is it constant or does it come and go? _____

Does the pain radiate? If yes, where _____

What causes or increases the pain? _____

What relieves the pain? _____

_____

_____

What accompanies the pain? (dizziness, nausea, anxiety, etc.) _____

Do you feel pain interferes with your everyday life/activities? If yes, How? _____

_____

_____

PATIENT/FAMILY GOALS

❒ **Complete Relief** ❒ **Acceptable level of pain** _____

❒ **Other** _____

PRE-OP CHART VERIFICATION

I.D bracelet on: name & number verified	❒ Yes	❒ No	
Consent #1 signed and in chart	❒ Yes	❒ No	
Consent #2 signed and in chart	❒ Yes	❒ No	
H & P completed on form & in chart	❒ Yes	❒ No	
Pre-operative diagnosis on chart	❒ Yes	❒ No	
CBC/H&H results on chart	❒ Yes	❒ No	❒ N/A
PT / PTT / INR	❒ Yes	❒ No	❒ N/A
Electrolyte results on chart	❒ Yes	❒ No	❒ N/A

Type & screen on chart	❒ Yes	❒ No	❒ N/A
Urinalysis results on chart	❒ Yes	❒ No	❒ N/A
EKG report on chart	❒ Yes	❒ No	❒ N/A
Chest x-ray report on chart	❒ Yes	❒ No	❒ N/A
Abnormal P.A.T. results	❒ Yes	❒ No	❒ N/A

Abnormal results reported to: _____

Pre-op orders completed & charted ❒ Yes ❒ No ❒ N/A

Outcome: Patient properly prepared for surgery. Verbalizes understanding of plan of care. Preprocedure assessment complete.

_____ R.N., D.A.R. Signature

Comments: _____

_____

_____

_____

DISCHARGE OUTCOMES

POST-OPERATIVE RECORD

AFFIX PATIENT INFO LABEL HERE

Patient Name _____ MR# _____

Time received from PACU: _____

Dressing: ❒ No ❒ Yes Site: _____

Drainage ❒ No ❒ Yes ❒ Scant ❒ Mod. ❒ Large

Drain: ❒ None ❒ D/C'd ❒ Intact on Discharge Drainage Color: ❒ Serous ❒ Sero-sanguineous

Wound: ❒ Edges approximated

❒ Dressing ❒ N/A

Pain: ❒ Related to surgical procedure

❒ Unrelated to surgical procedure

❒ Pre-existing condition

TIME	V/S	B/P	TEMP.	PULSE	RESP.	Pain Intensity
	Pre-Op					
	Post-Op					
	Discharge					

ASSESSMENT							EVALUATION/FOLLOW-UP				
Time	Pain Site	Pain Score	Medication/Treatment	Dose	Route	Initial	Time	Pain Site	Pain Score	Comments	Initial

Alert and Oriented: ❒ Yes ❒ No Other: _____

Tolerating Oral Fluids: ❒ Yes ❒ No ❒ N/A Tolerating Food: ❒ Yes ❒ No ❒ N/A

Voiding: ❒ Yes ❒ No

❒ Other: _____ V/S Consistent with Pre-Op Levels: ❒ Yes ❒ No

Skin Integrity: _____ ❒ Cane ❒ Post-op shoe ❒ Crutches ❒ Ice Pack ❒ Sling ❒ Other: _____

❒ Prescription given ❒ Written post-op instructions given

Outcome: Patient has good post operative pain control. Patient ready for discharge.

❒ Discharge planning contacted for: _____

_____ R.N., C.A.S. Signature

Verbalized and demonstrated understanding of discharge instructions ❒ Yes ❒ No ❒ Other: _____

Mode of Discharge: ❒ Ambulatory ❒ W/C ❒ Carried Discharged with: _____

❒ Via Private Car ❒ HMC Transport ❒ Other: _____ Escorted By: _____

Discharged to: ❒ Home ❒ HMC ❒ Other: _____ Discharge Time: _____ am/pm

Signature: _____ R.N. _____ R.N.

PROGRESS RECORD

Time: _____ AM/PM _____

_____

_____

_____

_____

_____

POST-OPERATIVE TELEPHONE FOLLOW-UP

Phone: _____ ❒ Patient requests no post-op phone call to be made

Date: _____ Time: _____ am/pm

Pain: ❒ None ❒ Mild ❒ Mod. ❒ Severe

Temp Elevation ❒ Yes ❒ No Vomiting ❒ Yes ❒ No Nausea ❒ Yes ❒ No

Cough ❒ Yes ❒ No Dizziness ❒ Yes ❒ No

Other: _____

Comments: _____

_____

_____

_____R.N. Signature

SECONDARY POST-OPERATIVE FOLLOW-UP

❒ N/A ❒ Yes ❒ Date: _____ Time: _____ am/pm

Comments: _____

_____

_____R.N. Signature