TEANECK SURGICAL CENTER

730 Palisade Avenue, 2nd Floor, Teaneck, NJ 07666

CALL MADE: _____

PREADMISSION ASSESSMENT

PATIENTS NAME: **DOP:** **SURGEON:**

PROCEDURE:

INTERVIEW SOURCE: □ PATIENT □ SPOUSE □ PARENT □ OTHER **ANESTHESIA TYPE:**

HOME PHONE: **CELL:** **BUSINESS:**

AGE **HEIGHT:** **WEIGHT:** **BMI**

ALLERGIES/REACTION: SEE MEDICATION/ALLERGY SHEET

PAST SURGICAL HISTORY:

FAMILY HISTORY OF ANESTHETIC PROBLEMS: ☐ NO ☐ YES

PERSONAL HISTORY OF ANESTHETIC PROBLEMS: ☐ NO ☐ YES

☐ METAL IMPLANTS: ☐ GLASSES/CONTACTS ☐ PACEMAKER / ICD: ☐ HEARING AID

MEDICAL HISTORY

SYSTEM REVIEW (CHECK ALL THAT APPLY)

CARDIAC □ N/A
□ HTN
□ ANGINA
□ MI
□ MURMUR/MVP
□ ARRHYTHMIA: _____

NEURO □ N/A
□ STROKE / TIA
□ SEIZURES
□ MIGRAINE

LIVER DISEASE □ N/A
□ HEPATITIS
□ CIRRHOSIS
□ OTHER: _____

GASTROINTESTINAL □ N/A
□ ULCERS
□ GERD
□ HIATAL HERNIA
□ DIVERTICULOSIS

RENAL DISEASE □ N/A
□ TYPE_____

PULMONARY □ N/A
□ ASTHMA
□ COPD
□ SLEEP APNEA
□ C-PAP □ B-PAP
□ DYSPNEA
□ OTHER: _____

ENDOCRINE □ N/A
□ DIABETES
□ TYPE II □ TYPE I
□ THYROID DISEASE

GYN □ N/A
□ LMP_____
□ HYSTERECTOMY
□ MENOPAUSE

HEENT □ N/A
□ GLAUCOMA
□ HOH
□ VISUAL IMPAIRMENT
□ SINUSITIS

OTHERS □ N/A
□ BACK PAIN
□ NECK PAIN
□ ARTHRITIS

□ ***RECENT INFECTIOUS DISEASE OR EXPOSURE***

□ ***RECENT TRAVEL DESTINATIONS***

□ ***MENTAL HEALTH HX □ N/A***

□ ***AUTOIMMUNE DISEASE □ N/A***

OTHER

HEMATOLOGY/ONCOLOGY □ N/A
□ BLEEDING DISORDER
□ CANCER
□ ANEMIA
□ SICKLE DISEASE/TRAIT

SMOKING HISTORY: ☐ NO ☐ YES PPD: _____ ☐ CIGAR / PIPE # OF YEARS_____

DRUG / ETOH CONSUMPTION: ☐ NONE ☐ SOCIAL ☐ MODERATE ☐ HEAVY

☐ IVDA: _____ ☐ OTHER: _____

STOP-BANG SCREENING TOOL FOR OSA:

SNORING	DO YOU SNORE LOUDLY (LOUDER THAN TALKING LOUD ENOUGH TO BE HEARD THROUGH CLOSED DOORS?	☐ YES	☐ NO
TIREDNESS	DO YOU OFTEN FEEL TIRED, FATIGUED, OR SLEEPY DURING THE DAYTIME?	☐ YES	☐ NO
OBSERVED APNEA	HAS ANYONE OBSERVED YOU STOP BREATHING SURING YOUR SLEEP?	☐ YES	☐ NO
PRESSURE	DO YOU HAVE OR ARE YOU BEING TREATED FOR HIGH BLOOD PRESSURE?	☐ YES	☐ NO
BMI	BMI > 35 KG / M2	☐ YES	☐ NO
AGE	> 50 YEARS	☐ YES	☐ NO
NECK CIRCUMFERENCE	> 40 CM	☐ YES	☐ NO
GENDER	MALE	☐ YES	☐ NO

PRIMARY LANGUAGE: ☐ ENGLISH ☐ OTHER_____TRANSLATOR NEEDED? ☐ NO ☐ YES_____

RELIGION:_____ RACE:_____

☐ NUTRITIONAL NEEDS: _____ ☐ ENVIRONMENTAL ISSUES:_____

☐ REFERRAL SERVICES: _____ ☐ FAMILY / OTHER SUPPORT AVAILABLE:

☐ MAY BE VICTIM OF ABUSE / NEGLECT / DOMESTIC VIOLENCE REFER TO NJ DYFS/COMMISSION OF ELDER ABUSE
(SEE POLICY & PROCEDURE MANUAL)

EMERGENCY CONTACT INFORMATION:

NAME: _____ TELEPHONE: _____

ADVANCE DIRECTIVES/PATIENT RIGHTS & RESPONSIBILITIES/DISCLOSURE OF OWNERSHIP

☐ PATIENT HAS RECEIVED WRITTEN AND VERBAL NOTIFICATION IN ADVANCE OF THE DAY OF THE PROCEDURE ON THE ASC'S POLICIES ON : ● ADVANCE DIRECTIVES ● PATIENT RIGHTS & RESPONSIBILITIES
● DISCLOSURE OF OWNERSHIP (IF APPLICABLE)

PRE-OP INSTRUCTIONS:

☐ BRING ALL INSURANCE CARDS & PHOTO ID / COPY OF ADVANCE DIRECTIVE / LIVING WILL

☐ FASTING RECOMMENDATIONS: NPO AFTER MIDNIGHT NO CHEWING GUM, LIFESAVERS, MINTS AFTER MIDNIGHT

☐ PLEASE LEAVE JEWELRY, VALUABLES, CREDIT CARDS AT HOME.

☐ DO NOT WEAR CONTACT LENSES ☐ REMOVE BODY PIERCING: ☐ DO NOT WEAR HEAVY MAKEUP

☐ URINE TEST FOR PREGNANCY DOS (EXCLUDING POST HYSTERECTOMY & POST MENOPAUSAL X 1 YEAR)

☐ BRING INHALERS WITH YOU. ☐ FILL PREOP PRESCRIPTIONS PRIOR TO SURGERY

☐ WERE YOU GIVEN PRESCRIPTIONS TO HAVE ANY PRE-OP TESTING PERFORMED. IF SO PLEASE HAVE TESTING DONE IMMEDIATELY!!

☐ LABWORK/DATE _____ ☐ CXR/DATE_____ ☐ EKG/DATE_____

☐ MEDICAL ☐ CARDIAC CLEARANCE/DATE _____ MD NAME/PHONE_____

☐ YOU WILL RECEIVE A PHONE CALL THE BUSINESS DAY PRIOR TO YOUR PROCEDURE TO CONFIRM YOUR PROCEDURE/ARRIVAL TIME. IF YOU DO NOT RECEIVE A CALL BY 2PM, YOU MUST CALL US AT 201.928.2160.

☐ CAN INFORMATION BE LEFT ON YOUR CELL/ANSWERING MACHINE OR WITH A FAMILY MEMBER? ☐ YES ☐ NO

☐ TELEPHONE # WE CAN REACH YOU AT THE DAY PRIOR TO PROCEDURE:_____

☐ TRANSPORTATION: ALL PATIENTS HAVING ANESTHESIA(EXCEPT LOCAL) NEED AN ADULT TO ACCOMPANY THEM HOME

RN INTERVIEWER:_____ DATE:_____

NOTES: _____