TRINITY SURGERY CENTER

Patient Name:
Date of Birth:
Surgeon:
Medical Record:
Date of Service

PAIN / SEDATION - CHART CHECKLIST

Top to Bottom

Pg #	Initials	Left Side
1		Chart Checklist (this document)
2		Patient Information
		Driver's License or ID Card – 2 copies
		Insurance Verification and Pre-Cert
3		Assignment of Benefits – Center / Anesthesia
4		Privacy Acknowledgement Form
		Advance Directive (if available)
Chart Review		
		No Blanks on the forms – ANY form!
		Presence/Absence of Allergies noted
		Consent Complete, no blanks, all signees
		Pre-Op labs initialed by RN if normal, by MD if results outside normal range
		Anesthesia evaluation and anesthesia record, complete, signed
		Discharge evaluation signed by MD immediately prior to discharge – TIMED
		Orders signed by MD, noted, timed by RN
		Pathology reports signed by MD

Pg #	Initials	Right Side
Pre-Operative Forms		
5		Procedure Consent
6		Advanced Directives
7		Sedation / Anesthesia Consent
8		Medication Reconciliation
9		History & Physical
		Surgical Consultation (if available/applicable)
10		Pre-Op Orders / Post-Op Orders
11		Pre-Operative Phone Call
12		Nursing Assessment
13		Pre-Anesthetic / Sedation Evaluation
14		Cardiac Strip Mounting Sheet
Labs / X-ray		
		Pathology Report (if applicable)
		Lab Tests/Lab Work (Blood, urine, MRI, X-ray, EKG, off-site pregnancy test, etc.)
Intra-Operative Forms		
		Intra-Operative Nurse Record
15		Surgical Safety Checklist
16		Sedation / Anesthesia Record
Post-Operative Forms		
		Dictated / EMR Operative Report
16		Post-Anesthesia Recovery Room Record
18		Physician's Handwritten Op Note
19		Discharge Instructions Signed, Timed
		Copy of Prescription
20		Post-Op Contact/Phone Call

TRINITY SURGERY CENTER

Patient Name:
Date of Birth:
Surgeon:
Medical Record:
Date of Service

PATIENT INFORMATION	❑ The information below has not changed since my last visit.		
Patient Name:		SS# -- --	
Address:	City:	State:	Zip:
Driver License #:	State:	Gender: ❑ Male ❑ Female	
Date of Birth: Age:	Marital Status:	Home Phone: ( )	
Allergies/Drug Hypersensitivities:			
Employer:	Business Phone: ( )		
Business Address	City:	State:	Zip:
Name of Spouse/Significant Other:		SS#	
Spouse/Significant Address:	City:	State:	Zip:
Spouse/Significant other Home Phone: ( )	Driver License#		State:
Spouse/Parent Employer:	Business Phone: ( )		

EMERGENCY CONTACT

Contact Telephone #: ( ) Name Relationship:

We will be contacting you after your procedure to check on your recovery. Where can we reach you the evening of or day after your procedure? ( ) -

INSURANCE/PAYMENT INFORMATION:

Type of Payment: ❑ Insurance *(attach photocopy of information)* ❑ Cash ❑ Lien *(attach Lien document)*

Primary Insurance _____ Policy #:_____ Policy Holder: _____

Secondary Insurance _____ Policy #: _____ Policy Holder: _____

Patient / Responsible Adult Signature: Date:

Patient / Responsible Adult Print Name: *Relationship to Patient

Interpreter (If required) Signature: Print Name

Interpreter relationship to patient (if applicable)

Fill out this section ONLY if you accept financial responsibility for the patient for whom you have NO legal responsibility.

I, the undersigned person, hereby certify that I have accepted total financial responsibility for the above patient, for the care/treatments rendered to the patient by the Center and all their providers including but not limited to: surgeons, anesthesiologists, radiology, laboratories, and clinical care workers. I understand that I do not currently have any legal responsibility to provide financial support for this patient. I also understand that, by signing below, I agree to personally accept full responsibility for all financial costs associated with the care/treatments/services provided to the patient by Center. Furthermore, I certify that I have had the opportunity to ask all questions related to this matter and was given adequate answers. Please fill in all sections below and sign where indicated.

Last Name:	First	M.I.	SS#: --
Relationship to Patient:	Home phone:		Date of Birth:
Address:	City	State	Zip
Driver License OR other photo ID: #	Type of ID:		State issued:
Occupation:	Employer:	Bus Phone:	

Patient Name:
Date of Birth:
Surgeon:
Medical Record:

Date of Service

Signature of Responsible Party Print Name:

Assignment of Benefits- Center

I hereby authorize my Insurance Company to pay by check made payable and mailed directly to:

Trinity Surgery Center
1610 Blossom Hill Road Suite 10
San Jose, CA 95124

For the medical and surgical benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for the services rendered. I understand that as a courtesy to me, the Trinity Surgery Center will file a claim with my insurance company on my behalf. However, I am financially responsible for, and hereby do agree to pay, in a current manner, charges not covered under my insurance or any balance not covered by the insurance payment.

Actual Plan Benefits cannot be determined until the claim is received by your insurance company and is based upon their determination of medical necessity. The information received from the above stated is not a guarantee of payment. If my insurance company sends me/partner any checks for services provided at the Center, I will immediately bring or mail the check to Trinity Surgery Center. Be sure to endorse the check and annotate "Pay to the Order of "Trinity Surgery Center" or deposit the check, then send a personal or cashier's check. If it is necessary to file a formal collection action, I agree to pay all costs, including reasonable attorney's fees incurred by the outpatient medical center in the collection of the outstanding fees.

X _____

Patient Signature or Financially Responsible Party Relationship to patient if not patient Date

Assignment of Benefits- Anesthesia

For ANESTHESIA SERVICES rendered, I hereby authorize my Insurance Company to pay by check made payable and mailed directly to:

Trinity Surgery Center
1610 Blossom Hill Road Suite 10
San Jose, CA 95124

For the anesthesia benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for the services rendered. I understand that as a courtesy to me, my anesthesia provider will file a claim with my insurance company on my behalf. However, I am financially responsible for, and hereby do agree to pay, in a current manner, any charges not covered by the insurance payment. If it is necessary to file a formal collection action, I agree to pay all costs, including reasonable attorney's fees incurred by the outpatient medical center in the collection of the outstanding fees.

Actual Plan Benefits cannot be determined until the claim is received by your insurance company and is based upon their determination of medical necessity. The information received from the above stated is not a guarantee of payment.

X _____

Patient Signature or Financially Responsible Party Relationship to patient if not patient Date

TRINITY SURGERY CENTER

Patient Name:
Date of Birth:
Surgeon:
Medical Record:
Date of Service

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read, or have had the opportunity to read, this Notice and I understand the Notice.

_____

Patient's or Authorized Representative's Signature Date

_____

Authorized Representative (Please print if applicable) Relationship to Patient Date

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check ALL that apply):

❑ Home telephone: _____
- ❑ OK to speak to :_____
- ❑ OK to leave message with detailed information
- ❑ Leave message with call back number only

❑ Work telephone: _____
- ❑ OK to leave message with detailed information
- ❑ Leave message with call back number only

Written Communication Ok to:
- ❑ Send mail to my home address
- ❑ Sent to mail my work / office address
- ❑ Fax to _____
- ❑ eMail to _____
- ❑ Other

_____

Patient Signature Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the disclosure of, and requests for, PHI to the minimum to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to the authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information listed below, if completed properly, will constitute an adequate record.
Uses and disclosures for TPO (treatment, payment, operations) may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	**Disclosed to Whom (address or fax number)**	(1)	**Description of Disclosure Purpose of Disclosure**	**By Whom Disclosed**	(2)	(3)

TRINITY SURGERY CENTER

Patient Name:
Date of Birth:
Surgeon:
Medical Record:

Date of Service

PATIENT CONSENT TO PROCEDURE

Your physician, **Dr.** has determined that the operation or procedure listed below may be beneficial in the diagnosis or treatment of your condition. All surgical operations and diagnostic and therapeutic procedures involve risks of unsuccessful outcomes, complications, injury or even death, from both known and unforeseen causes. No warranties or guarantees have been made as to result or cure.

Operation or procedure to be performed:

Your treating physician may be an independent contractor and therefore is not an employee of Trinity Surgery Center ("Center"). Independent contractor physicians also provide anesthesia services at the Center and independent contractor nurse anesthetists (CRNAs).

As a patient you have the right to receive as much information as you may need in order to give informed consent or to refuse the recommended course of treatment. Except in emergencies, your healthcare provider should describe in language you can understand, the nature of the ailment and the or nature of the proposed treatment or procedure, the material risks or dangers involved, the alternate courses of treatment non-treatment, including the respective risk of unfortunate consequences associated with the treatment or procedure, and the relative probability of success of the treatment or procedure. If you have questions, you are encouraged and expected to consult your healthcare provider prior to giving your consent to such operation or procedure. You have the right to consent or refuse any proposed operation or procedure prior to its performance.

Having read and fully understanding the above, and having received and fully understanding the above information from my physician(s) and/or podiatrist(s), I hereby authorize the following:

1. I authorize the above-named healthcare provider and any of their associates or assistants, including residents within their licensed scope of their practice, to perform the above named procedure and to provide such additional services as may be deemed medically reasonable and necessary, including but not limited to:
   a. Those resulting from conditions or discoveries, which make a change or extension advisable;
   b. The administration of anesthesia by a healthcare professional including local anesthesia by the surgeon;
   c. The implant of medical devices
   d. Services involving pathology and radiology;
   e. Transfer to a hospital and issuance of the hospital's discharge summary to the Center.
2. I authorize the pathology services to use its discretion in the retention or disposal of any severed tissue or member.
3. I understand that, if given other than local anesthetic, I am required to have a responsible adult available during and after my surgery and that I will be discharged to that person's custody and must rely on him or her for my return home.
4. I consent to the photographing, filming, or videotaping of the treatment or procedure for diagnostic, documentation or educational use. I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, the Center may disclose portions of my financial and/or medical records to any person or entity which is or may be liable for all or any portion of the Center's charges, including but not limited to insurance companies, health care service plans, or worker's compensation carrier(s) as well as to those individuals the Governing Body may deem appropriate to review the medical record for purposes of medical quality assurance/improvement and peer review.
5. I authorize disclosure of my Social Security number to device manufacturers subject to the Safe Medical Device Act.
6. I have received verbal and written notification of the Center's patient rights and advance directives and understand that in the very unlikely event of an emergent situation we will provide prompt resuscitative care and transfer you to the nearest appropriate facility. If there is an advance directive in place and a transfer to a hospital is required, we will send a copy of your directive with you to the hospital.
7. WOMEN UNDER 60: In order for us to fully evaluate you we are required to take X-rays of some part of your body. It has been predicted that an unborn child in its first trimester would be more sensitive to radiation than an adult. In order to insure that accidentally, knowingly or otherwise, no Fetus (unborn child) be exposed to radiation from X-ray machines we ask you to provide us an answer to the following question. We thank you for the information and this information is strictly confidential and is used solely for the purpose it is intended.
8. Is there a chance that you may be pregnant? ❑ Yes ❑ No ❑ N/A To the best of my knowledge, I am NOT pregnant and by signing this form I have been informed of the effects of radiation to the unborn baby and me signing below indicates my consent to taking the X-ray of my body parts.
9. You, the patient, have the right to choose where your procedure is performed. By signing this consent, you are agreeing to have the procedure performed at Trinity Surgery Center.

I certify that I have read and fully understand the above consent statement, that the explanations herein referred to are understood by me, that all my questions have been answered, that all blanks or statements requiring insertion or completion were filled in prior to the time of my signature, and that this consent is given freely, voluntarily and without reservation. I understand that I have the right to refuse any medical and surgical procedures and treatment.

X _____ _____

Signature of Patient/Date — Person Legally Authorized To Consent for the Patient

_____ _____

Witness/Date — Relationship, If Other Than Patient

Signing

_____

TRINITY SURGERY CENTER

Patient Name:
Date of Birth:
Surgeon:
Medical Record:

Date of Service

Attending Physician/Surgeon

ADVANCE DIRECTIVE

Trinity Surgery Center will respect any Advance Directive that may be in place. However, in the very unlikely event of an emergent situation, it is the policy of this center to provide prompt resuscitative care and transfer you to the nearest appropriate facility. If you bring a copy of an advance directive or living will, a copy will be made and placed in your medical record. Should the need for a transfer to a hospital occur, this copy would be forwarded to the hospital of transfer and they may honor these directives.

The law does not require that patients have or make an advanced directive. Please check the appropriate box below.

- ❑ Yes, I have an Advanced Directive but did not provide a copy.
- ❑ Yes, I have provided the Center with a copy of my Advance Directive/ Living Will. The Center has explained to me their policy regarding the implementation of this document and I agree to proceed with the proposed procedures as scheduled.
- ❑ I do not have an Advance Directive/Living Will. I request the facility provide me with information about Advanced Directives. I understand that Trinity Surgery Center will not implement an Advance Directives, but will transfer this document with me should the need arise.***
- ❑ I DO NOT have an Advance Directive/Living Will. I DO NOT want information.

X _____

Patient's or Authorized Representative's Signature Date

_____

Authorized Representative (Please print if applicable) Relationship to Patient Date

Office Use Only
***Information and Forms Provided to Patient: ❑ Yes ❑ No -- If NO please comment below:

Patient Name:
Date of Birth:
Surgeon:
Medical Record:
Date of Service

PATIENT CONSENT TO ANESTHESIA / SEDATION

I understand that:
(Initial each)

_____(initials) I will need anesthesia services for the surgical procedures(s) to be done on _____ (date), and that the type of anesthesia to be used will depend upon the procedure and my physical condition.

_____(initials) Anesthesia is a specialty medical service, which manages patients who are rendered unconscious or with diminished response to pain and stress during the course of a medical, surgical, or obstetrical procedure.

_____(initials) During the course of the surgical procedure, conditions may require additional or different anesthetic monitoring or techniques, and I ask that the anesthesiologist provide any other necessary services for my benefit and well-being.

_____(initials) In addition to the anesthesiologist whose name appears on this document, my anesthetic services may be provided by another anesthesiologist.

_____(initials) No guarantees have been made by anyone regarding the anesthesia services, which I am agreeing to have.

Type of Anesthesia and Definitions

❑ **Regional Anesthesia**
1. Epidural anesthesia: a small catheter is inserted into epidural (spinal) space so that anaesthetizing agents may be given to prolong the duration of anesthesia, or medications given in single injection into epidural space.
2. Spinal anesthesia: the anesthetic agents are injected into specific areas to inhibit nerve transmission.
3. Caudal anesthesia: anesthetic medications are given into the tailbone area.

☑ **Moderate/Procedural Sedation** and / or ☑ **Monitored Anesthesia Care (MAC)**
Includes the monitoring of blood pressure, oxygenation, pulse and mental state, and supplementing analgesia as needed.

Risks and Complications may include but are not limited to: allergic/adverse reaction, aspiration, backache, brain damage, comas, dental injury, headache, inability to reverse the effects of anesthesia, infection, localized swelling and/or redness, muscle aches, nausea, ophthalmic (eye) injury, pain, paralysis, pneumonia, positional nerve injury, recall of sound/noise/speech by others, seizures, sore throat, wrong site for injection of anesthesia, and death.

I have been given the opportunity to ask questions about my anesthesia and feel that I have sufficient information to give this informed consent. I agree to the administration of the anesthesia prescribed for me. I recognize the alternative to acceptance of anesthesia might be no anesthesia for the procedure.

_____ _____/_____ _____ _____/_____
(PATIENT'S SIGNATURE) (DATE) (TIME) (WITNESS SIGNATURE) (DATE) (TIME)

_____ _____ _____/_____
(PATIENT'S NAME - PRINT) (ANESTHESIA PROVIDER'S SIGNATURE) (DATE) (TIME)

TRINITY SURGERY CENTER

Patient Name:
Date of Birth:
Surgeon:
Medical Record:

Date of Service

MEDICATIONS LIST

Check here if not applicable: ❑ None

(List all prescription, over the counter, herbal and dietary supplements including dose)

Allergies: (Medications/Food) ☐NKA _____

Abnormal reactions to medications: _____

Current medications including prescription, over the counter, dietary and herbal supplements:

Medication:	Dose (strength)	Frequency (how often you take it)	Route (by mouth, IV)	Reason
Reviewed by:			Date:	

Prescriptions added at Center:				

❑ A copy of the medication reconciliation form was provided to the patient at discharge with medication additions or changes.

Nurse Signature: Date: Time:

TRINITY SURGERY CENTER

Patient Name:
Date of Birth:
Surgeon:
Medical Record:

Date of Service

HISTORY AND PHYSICAL		
	Date:	Time:
Chief Complaint / Reason for Visit::		
Medications:		
Allergies or Abnormal Reactions: ❒ NKA or List:		
Past Medical History: ❒ NONE ❒ Other:		
Surgical History/Complications: ❒ NONE or List:		
Social History: ❒ NO Alcohol, Tobacco or Illegal Drug Abuse ❒ Other:		
Family History: ❒ Non-Contributory ❒ Other:		
Review of Systems: ❒ 12-Point Negative ❒ Other:		
❒ No ❒ Yes **MH RISK** that includes but is not limited to the following: family history or unexpected death(s) following general anesthesia or exercise, personal history of MH, muscle or neuromuscular disorder, high temperature following exercise, personal history of muscle spasm, dark or chocolate colored urine, unanticipated fever immediately following anesthesia or serious exercise. Describe:		
Skin	❒ Clear ❒ Other:	
Head and Neck	❒ AT/NC ❒ No Lymphadenopathy ❒ Other:	
Heart	❒ RRR ❒ Other:	
Neurologic/Musculoskeletal		
Lungs	❒ CTA ❒ Other:	
Abdomen	❒ NT/Soft ❒ Other:	
Assessment/Plan		

❒ The goals, methods and alternatives (with risks) of this operation were discussed. As well as, lack of guarantee of results, possible need of additional treatment and risk and complications. Patient understands and accepts and wishes to proceed as planned.

❒ **Previous current History and Physical has been reviewed and there are no pertinent changes in patient condition**.

Physician's Signature

Date

PHYSICIAN'S PRE-OPERATIVE ORDERS	RN Initials	Time Noted
Consent to Read:		

TRINITY SURGERY CENTER

Patient Name:
Date of Birth:
Surgeon:
Medical Record:

Date of Service

❒ I have explained the procedure to the patient/family with its complications, risks alternatives and benefits. I have explained the alternatives and the patient/representative verbalized full understanding and would like to go ahead with the proposed procedure.		
Labs:		
❒ Glucose check ❒ Pregnancy test ❒ EKG ❒ Other:		
Other Orders:		
❒ IV Lock or ❒ IV _____ @ 20cc/hr on admit		
❒ IV Antibiotics		
❒ Ancef 1g IVPB pre-op within one (1) hour of surgery		
❒ Other:		
Physician's Signature:	Time:	

PHYSICIAN'S POST- OPERATIVE ORDERS	RN Initials	Time Noted
1. Diet and activity as tolerated		
2. Discontinue IV when patient stable		
3. Patient may be discharged once discharge criteria met		
4. Follow up with Dr. ❒ in 1-2 wks or ❒		
5. In case of emergency call – 911 or go to Emergency Room		
6. Prescriptions: ❒ Continue Pre-operative Medications ❒Other:		
❒ Special orders (*e.g.* packing, catheter, dressing):		
Physician's Signature:	Time:	

PRE-OPERATIVE PHONE CALL		
Patient Phone #:	Time of Procedure:	Procedure Date:
Procedure(s)		

TRINITY SURGERY CENTER

Patient Name:
Date of Birth:
Surgeon:
Medical Record:
Date of Service

Anesthesia Type: ❑IV/Moderate Sedation ❑MAC ❑ Local ❑ Block-Type:	
Allergies/Abnormal Reactions: ❑ NKA or abnormal reactions:	
Advance Directive: ❑Yes (Have the patient bring a copy) ❑ No	
Ride Home/ Aftercare:	Ride Contact #:

Please instruct the surgical patient in the following areas by telling them to:	Done
Do NOT eat or drink 4-6 hours prior to procedure if having sedation. If you eat or drink anything prior to the time advised the day of your surgery, the procedure may need to be cancelled. Local Only-oral as tolerated.	
Shower and wash the surgical areas with anti-bacterial soap (such as Phisoderm Dial of Lever 2000) and wash your face well and to not wear any kind of moisturizer, lotion, eye or facial make-up and do not to use moisturizer or body lotion 24 hours before surgery.	
Brush your teeth the morning of the procedure, but do NOT swallow the water.	
Bring a complete list of your medications (prescription, herbal and dietary supplements) with you the day of surgery including the name of the medication, its strength/dosage and frequency. (If only a few, document below).	
Name Strength Frequency _____ _____ _____ _____ _____ _____ Name Strength Frequency _____ _____ _____ _____ _____ _____	
Wear loose-fitting clothing such as button-up shirt, sweats and flat slip-on tennis shoes. You may want to bring a sweater or a jacket as many people get cold after surgery. If you wear contact lens you should bring your glasses.	
Leave all valuables at home. Do NOT to bring handbags, jewelry including watches, earrings, wristbands and necklaces.	
Please arrive on time. It is extremely important that you arrive at the Center at (time)_____.	
You MUST have a ride home with a responsible adult that can care for you for 24 hours after your procedure. If you do not have a ride home or caregiver, your procedure will be cancelled until you can arrange for someone to take home and care for you.	
Please contact us by calling the Center's number in case of a traffic hold-up or any other reason that they may delay your arrival at your scheduled time.	
If you have any pre-operative lab work or xrays / CT / MRI that were ordered, for this procedure, by your surgeon or primary doctor please complete it well in advance.	
Contact your surgeon post-operatively for any emergency related to your procedure or go to the nearest Emergency Room. Our Center does not handle emergencies.	
1. May we contact you at home following the procedure? ❑ Yes ❑ No 2. May we contact you at work following the procedure? ❑ Yes ❑ No 3. May we leave a MESSAGE at home? ❑ Yes ❑ No With whom: - _____ 4. May we leave a MESSAGE at work? ❑ Yes ❑ No With whom: - _____ 5. May we contact you by eMail? ❑ Yes ❑ No At: _____	

Comments:	
Interviewed by:	Date:

TRINITY SURGERY CENTER

Patient Name:
Date of Birth:
Surgeon:
Medical Record:
Date of Service

NURSING PRE-OPERATIVE ASSESSMENT

Sex: ❑Male ❑Female Patient identification: ❑ Verbal ❑Armband ❑Chart ❑ID Time In:_____

Procedure: _____

BP: _____ P: _____ R: _____ SpO_2: _____ Temp:_____ Wt: _____ Ht: _____ Pain level: ____ /10

Allergies/Abnormal Reactions: ❑ NKA or _____

Current Medications: ❑ NONE ❑See Medication List
Medications taken today prior to arrival: ❑ None, or:_____

Skin Condition: ❑Dry ❑Warm ❑Pink ❑Pale ❑Cyanotic ❑Diaphoretic ❑Other: _____

Abdominal Assessment: ❑ Flat ❑ Soft ❑ Firm ❑ Tender ❑ Distended ❑Other: _____

Physical Limitations: ❑ None ❑ Visual ❑ Mobility ❑ Auditory ❑ Language ❑Other: _____

LOC: ❑ Alert ❑ Calm ❑ Oriented ❑ Confused ❑ Nonverbal ❑ Agitated ❑Other: _____

Time: _____ Gauge: _____ *I.V. Site:*_____ ❑ *IV Saline LOCK* ❑ @TKO or ❑ Rate:_____ ml/hr

Fluid: ❑LR – 1000ml / ❑LR – 500ml or ❑NS – 1000ml / ❑NS – 500ml

Hypertension	❑Yes	❑No	Bleeding Problems	❑ Yes	❑No	Neurological Problems	❑ Yes	❑ No
Heart Disease	❑ Yes	❑No	Hx of DVT/hypercoagulable	❑ Yes	❑No	Hepatitis	❑ Yes	❑ No
Asthma	❑ Yes	❑No	Fainting/Dizziness	❑ Yes	❑No	Smoking	❑ Yes	❑No

Diabetes ❑ Yes ❑ No If Yes Glucose: Time: _____ Result:_____Normal AM fasting Range: Low: 70 High: 99
Other:_____

Language Preference: ❑English ❑Spanish ❑Other: _____ Interpreter:❑ No ❑Yes Name of Translator:_____Relationship to patient:_____

Barriers to learning: ❑ None ❑Spiritual beliefs ❑Reading barrier ❑Vision ❑Hearing ❑Cultural ❑Language ❑Other_____

Barrier addressed by: ❑N/A ❑Consent/Instructions in Preferred Language ❑Other:

Prior surgeries:

Reactions to anesthesia: ❑ None or describe:

MH risk ❑ No ❑ Yes Includes but is not limited to the following: Family history of unexpected death(s) following general anesthesia or exercise, personal history of MH, muscle or neuromuscular disorder, high temperature following exercise, personal history of muscle spasm, dark or chocolate colored urine, unanticipated fever immediately following anesthesia or serious exercise

Pre-op Meds Given	Time	Dose	Route	Effect	Initials

PREOPERATIVE CHECKLIST

Yes	No	N/A		
			1. Consents signed.	
			2. History & Physical complete.	
			3. Labs completed as ordered by physician.	
			4. Physician notified of abnormal results ❑ Glucose ❑ Pregnancy ❑ Given To MD:	
			5. Pregnancy Test if ordered Results: Positive / Negative (Circle one)	
			6. Physical assessment is unchanged since pre-admission evaluation	
			7. Valuables (clothing, jewelry)	❑ Removed ❑ Retained
			8. Dentures/partial plates	❑ Removed ❑ Retained
			9. Contact lens/glasses	❑ Removed ❑ Retained

TRINITY SURGERY CENTER

Patient Name:
Date of Birth:
Surgeon:
Medical Record:

Date of Service

			10. Hearing aid	❑ Removed ❑ Retained
			11. Other belongings:	❑Removed ❑ Retained
			12. Voided Time:	
			13. Discharge instructions reviewed with patient	
			14. Patient reports nothing to eat or drink (including water) since:	Date:

Does the patient have an Advanced Directives: ❑ No ❑ Yes If yes, Center policy explained to patient? ❑Yes ❑No ❑ Forms provided and in the chart

RN's Signature _____ Date_____ Time _____

PRE- AND POST-ANESTHETIC EVALUATION

Proposed Procedure:

Past Medical History/Review of Systems: ❑Healthy Hx of DVT/hypercoagulable ❑ **No** ❑ Yes

Risk of DVT: ❑ **No** or Describe:

Medications: ❑ None

Allergies: ❑ No known allergies or Abnormal reactions

Past Surgical History: ❑ Past Anesthesia - No Complications

MH risk ❑ No ❑ Yes Includes but is not limited to the following: Family history of unexpected death(s) following general anesthesia or exercise, Personal History of MH, Muscle or Neuromuscular Disorder , High Temperature following exercise, Personal history of muscle spasm, Dark or chocolate colored urine, Unanticipated fever immediately following anesthesia or serious exercise : Describe:_____

Physical Exam Height: Weight: Age: Sex: ❑ F ❑ M

Airway: ❑ Mallampati - I ❑ Mallampati - II ❑ Mallampati - III ❑ Mallampati - IV

Cardiac: ❑ S1, S2 ❑ Regular ❑ Irregular ❑ Murmur ❑ PVC's ❑ PAC's ❑ Other:

Lungs: ❑ Clear to Auscultation ❑ Unlabored ❑ Wheezing ❑ Rales ❑ Rhonchi

Other:

Labs:

ASA Status: ❑ I ❑ II ❑ III Other:

Plan: ❑ IV Sedation ❑ MAC ❑ Epidural ❑ Spinal ❑ Local/Block

❑ Anesthesia risks, benefits and alternatives discussed with patient. Patient agrees to proceed.

Signed: , MD / CRNA Date: Time:

TRINITY SURGERY CENTER

Patient Name:
Date of Birth:
Surgeon:
Medical Record:

Date of Service

POST-ANESTHESIA EVALUATION

BP: _____ P:_____ R:_____ SpO_2: _____Temp: _____

Patient is: ❑ Awake ❑ Drowsy ❑ Somnolent ❑ Unarousable

❑ Stable ❑ Unstable❑ Intubated

Vital signs stable: ❑ **Yes** ❑ No

Anesthesia Complications: ❑ **No** ❑ Yes

Patient has: ❑ Room Air ❑ Nasal O^2 ❑ Mask O^2 ❑ T-Piece O^2 ❑ Oral/Nasal Airway ❑ Other _____

Post Anesthesia Note (comments on above, if appropriate): _____

_____

_____

Anesthesia provider: _____ , MD / CRNA Time: _____

CARDIAC STRIP MOUNTING SHEET

Pre-Procedure Strip

TRINITY SURGERY CENTER

Patient Name:
Date of Birth:
Surgeon:
Medical Record:

Date of Service

SURGICAL SAFETY CHECKLIST		
Sign In (Pre-Op)	Time Out (Intra-Op)	Sign Out (Post-Op)

TRINITY SURGERY CENTER

Patient Name:
Date of Birth:
Surgeon:
Medical Record:

Date of Service

❑ PATIENT HAS CONFIRMED ❑ IDENTITY ❑ SITE ❑ PROCEDURE ❑ CONSENT ❑ SITE MARKED/NOT APPLICABLE ❑ ANESTHESIA SAFETY CHECK COMPLETED ❑ PULSE OXIMETER ON PATIENT AND FUNCTIONING DOES PATIENT HAVE A: MED--ALLERGY or SENSITIVITY? ❑ NO ❑ YES – DOCUMENTED IN CHART DIFFICULT AIRWAY/ASPIRATION RISK? ❑ NO ❑ YES, AND EQUIPMENT/ASSISTANCE AVAILABLE RISK OF >500ML BLOOD LOSS (7ML/KG IN CHILDREN)? ❑ NO ❑ YES, AND ADEQUATE INTRAVENOUS ACCESS AND FLUIDS PLANNED	❑ CONFIRM ALL TEAM MEMBERS HAVE INTRODUCED THEMSELVES BY NAME AND ROLE ❑ SURGEON, ANESTHESIA PROFESSIONAL AND NURSE VERBALLY CONFIRM ❑ PATIENT ❑ SITE ❑ PROCEDURE ❑ TIME OUT @ _____ ANTICIPATED CRITICAL EVENTS ❑ SURGEON REVIEWS: WHAT ARE THE CRITICAL OR UNEXPECTED STEPS, OPERATIVE DURATION, ANTICIPATED BLOOD LOSS? ❑ Routine case. No rapid or major blood loss anticipated. ❑ ARE THERE ANY PATIENT-SPECIFIC CONCERNS? ❑ Routine case. No special concerns. Or; ❑ See Surgeon's Notes. ❑ ANESTHESIA TEAM REVIEWS: ARE THERE ANY PATIENT-SPECIFIC CONCERNS? ❑ NURSING TEAM REVIEWS: HAS STERILITY (INCLUDING INDICATOR RESULTS) BEEN CONFIRMED? ARE THERE EQUIPMENT ISSUES OR ANY CONCERNS? HAS ANTIBIOTIC PROPHYLAXIS BEEN GIVEN WITHIN THE LAST 60 MINUTES? ❑ YES ❑ NOT APPLICABLE IS ESSENTIAL IMAGING DISPLAYED? ❑ YES ❑ NOT APPLICABLE	CIRCULATOR VERBALLY CONFIRMS WITH THE TEAM: ❑ THE NAME OF THE PROCEDURE RECORDED (ESPECIALLY IF PROCEDURE MODIFIED) ❑ THAT INSTRUMENT, SPONGE AND NEEDLE COUNTS ARE CORRECT (OR NOT APPLICABLE) ❑ THAT ANY SPECIMEN IS LABELLED ACCURATELY (READ ALOUD PATIENT'S NAME, SPECIMEN DESCRIPTION AND ORIENTING MARKS) EQUIPMENT ❑ NO EQUIPMENT ISSUES TO BE ADDRESSED OR ❑ ANY EQUIPMENT PROBLEM WAS IDENTIFIED AND ADDRESSED ❑ ALL ESSENTIAL EQUIPMENT IS PRESENT AND OPERATOINAL ❑ SURGEON, ANESTHESIA PROFESSIONAL AND NURSE REVIEW THE KEY CONCERNS FOR RECOVERY AND MANAGEMENT OF THIS PATIENT
Checklist completed by:		
Print Name	Signature	

ANESTHESIA/SEDATION RECORD

TRINITY SURGERY CENTER

Patient Name:
Date of Birth:
Surgeon:
Medical Record:

Date of Service

Page ___of___

Assistant Surgeon: ❑None

	START	STOP
ANESTHESIA		
PROCEDURE		

To OR (time)

Procedure(s):

PATIENT INFORMATION

Age	Sex	Ht	Wt

Allergies

Medications

Positive Hx/Med. Problems

ASA 1 2 3

Pre-Op Meds

PRE-PROCEDURE

❑Pt Identified ❑Chart Reviewed
❑Consent Signed ❑NPO since _____
Pre-Anesthesia State: ❑ Calm
❑Awake ❑Asleep
❑Apprehensive ❑Confused
❑Uncooperative
❑Unresponsive

PATIENT SAFETY

❑Anesthesia machine checked
❑Pressure points checked & padded
❑Safety Belt On ❑Axillary roll
❑Arms tucked ❑Restraints
❑EYE CARE: ❑Ointment ❑Saline
❑Taped ❑Goggles ❑Pads

MONITORS & EQUIPMENT

❑Stethoscope: ❑Precordial
❑Esophogeal ❑Other
❑Noninvasive B/P: ❑L ❑R
❑Continuous EKG ❑Temp_____
❑Pulse Oximeter ❑NG/OG Tube
❑End Tidal CO_2 ❑Fluid Warmer
❑V Lead EKG ❑Gas Analyzer
❑Nerve Stimulator
❑Foley Catheter
❑Airway Humidifier
IV(s): _____
Site: _____
Gauge: _____

ANESTHETIC TECHNIQUE

REGIONAL: ❑Spinal
❑Epidural ❑Axillary
❑Bier Block ❑Ankle Block
❑Position_____
❑Local_____
❑Drug(s)_____
❑Dose_____
❑Needle_____
❑Site_____ Attempts x___
OTHER: ❑ MAC
❑ Sedation
❑Local Only

AIRWAY MANAGEMENT

AIRWAY: ❑Oral ❑Nasal
CIRCUIT: ❑Circle ❑NRB
❑Difficult See Remarks

❑Mask Case ❑Nasal Cannula
❑Via LMA ❑ O_2 Mask

TIME:

DRUG TOTALS

AGENTS

Oxygen (%)	
Propofol (mg)	
Versed (mg)	
Fentanyl (mcg)	
Lidocaine (mg)	
Ancef (g)	
Toradol (mg)	
Dexamethasone (mg)	

MONITORS

End Tidal CO2
EKG
O_2 Saturation
Other:
Temp: ❑°C ❑°F

VITAL SIGNS

BASELINE VALUES

_____ B/P

_____ P

_____ R

_____ T

200-- 180-- 160-- 140-- 120-- 100-- 80-- 60-- 40-- 20--

FLUID TOTALS

FLUID

Patient Position

TRINITY SURGERY CENTER

Patient Name:
Date of Birth:
Surgeon:
Medical Record:

Date of Service

Intra-Operative Remarks															

Anesthesia Provider Print Name

Anesthesia Provider Signature / MD Co-signature

POST-OPERATIVE NURSE RECORD

TIME TO PACU:
Report received from sedation nurse / anesthesia re: pre-op condition and sedation / anesthesia care from:
Problems ❒ Yes – See Sedation / Anesthesia Record

ALDRETE EVALUATION/SCORE

VITAL SIGNS
ALDRETE SCORE

Pre-op
IN
OUT

TIME
BP
HR

Resp

0^2 Sat
et-CO2
Pain Level
0 - 10
O2 @
L/mim

Able to move 4 extremities 2
Able to move 2 extremities 1
Able to move 0 extremities 0

ACTIVITY

Able to breath deep & cough 2
Limited breathing & good airway 1
Apneic or obstructed airway 0

RESPIRATION

Baseline

BP +/- 25% Preanesthesia level	2
BP +/- 25-50% Preanesthesia level	1
BP +/- 50% Preanesthesia level	0

CIRCULATION

Awake & oriented	2
Arousable on calling	1
Not responding	0

CONSCIOUSNESS

Normal for Race	2
Pale, dusky, blotchy, jaundice, etc	1
Cyanotic	0

COLOR

POST ANESTHESIA RECOVERY SCORE TOTAL:
POLICY: *Score must be ≥ Pre-Op to Discharge*

Pain Assessment - No pain = 0 to Severe Pain = 10 or
1 to 5 on Picture scale.

TRINITY SURGERY CENTER

Patient Name:
Date of Birth:
Surgeon:
Medical Record:

Date of Service

POST-OP ASSESSMENT
POST-OPERATIVE MEDICATIONS

Color: ❒ Pink ❒ Pale ❒ Dusky ❒ Ruddy
Dressing: ❒ Dry/Intact ❒ N/A ❒ Drainage
IV Site: ❒ No Redness ❒ Infiltrated ❒ Reddened ❒ Painful
Skin: ❒ Warm/Dry ❒ Cold/Clammy
Level of Consciousness: ❒ Awake ❒ Drowsy ❒ Reactive ❒ Restless
N/V: ❒ N/A ❒ Present ❒ Total Emesis PACU _____ml
Respiratory Rx: ❒Nebulizer ❒ Incentive Inspirometer ❒ TCDB

TIME w/ RN INITIALS	ORDER BY:	DRUG	DOSE	ROUTE	RESPONSE

TRINITY SURGERY CENTER

Patient Name:
Date of Birth:
Surgeon:
Medical Record:

Date of Service

IV THERAPY
POST-OP INTERVENTIONS

Fluid: _____BTL#_____

Total IV Intake: OR _____ ml PACU _____ ml Secondary TC _____ ml

IV DISCONTINUED @ _____ (Time) SITE CLEAR: ❒YES ❒NO∗∗

❒IV CATHETER REMOVED INTACT

∗∗If other than normal anticipated result, give details under Nurses Notes.

OTHER :

❒URINARY CATHETER

❒PACKING

❒REMOVED @ _____ (Time)

O2 APPLIED

@ _____ (Time)

VIA :

❒CANNULA ❒ MASK ❒ NON-REBREATHER

@ _____ L/M

AIRWAY:

❒ORAL ❒NASAL

O2 DISCONTINUED

@ _____ (Time)

POST-OP NURSE NOTES

PHYICIAN DISCHARGE EVALUATION

❒Vitals Stable ❒ Pt. Alert/Orient ❒ No Dizzy/Active Vomiting ❒ No wound compromise ❒ M.D. Postop Orders given ❒Able to Ambulate ❒ Patient Voided/❒N/A

M.D. Evaluation: I have evaluated the patient and the patient is stable and ready for discharge.

Time: _____ _____, M.D./D.O.

Patient discharged in satisfactory condition at: _____AM/PM ❒ Ambulatory ❒ Wheelchair ❒Patient released to: ❒Home ❒Other_____ Via: _____

Name of accompanying adult:_____ Relationship to patient: _____

Valuables given to / received by: _____ ❒ Written instruction reviewed ❒ Received by: _____

Comments: _____

Discharge Nurse Signature: _____ Time :_____

PHYSICIAN OPERATIVE NOTE

Surgeon

Assistant ❑ N/A

TRINITY SURGERY CENTER

Patient Name:
Date of Birth:
Surgeon:
Medical Record:
Date of Service

Pre-Op Diagnosis: 1. Description
2. Description

Post-Op Diagnosis 1. Description
2. Description

Anesthesia ❑IV/Moderate Sedation ❑MAC ❑ Local
❑ Block-Type:

Primary Procedure

Secondary Procedure

EBL ❑ None or
Specimen ❑ N/A
Complications ❑ None or

Condition to Recovery

Surgeon's Notes (*e.g.* catheter, dressing, packing)

Surgeon's Signature

Date:

DISCHARGE INSTRUCTIONS

You were administered ❒ moderate sedation and / or monitored anesthesia care ❒ general anesthesia during the procedure so you will be sleepy for the rest of the day and, maybe, tomorrow. DO NOT drive, operate any machinery or do anything requiring coordination for the rest of the day. Do not sign any legal documents or make any important business decisions in the next 24 hours. If you are a smoker, you may experience a rise in body temperature tomorrow. After general anesthesia, you should breathe deeply and cough vigorously each waking hour in order to keep the lungs clear. Consult your doctor about when you can resume normal activities.

You have received an injection that may temporarily interfere with your ability function normally. Common mild side effects that are not serious include: flu-like symptoms such as headache, upset stomach, nervousness, and insomnia, skin flushing increased heart rate and/or palpitations. The instructions listed below should help you reach optimum comfort and safety following this procedure.

1. It is normal to experience mild aches at/in the injection site during the next few days. Apply an ice pack to the site if you experience pain, discomfort or swelling.
2. You may eat anything you like. However, we suggest that you start off with light foods such as soup and Jell-O and drink plenty of fluids.
3. If you've received steroid type injection you may notice improvement in your usual pain within 2 to 3 days, although it may take as long as 10-14 days for the medication to fully take effect. If you are diabetic it is important to monitor

your blood sugars more frequently, as steroids can temporarily elevate your blood sugar levels. You are advised to rest today and stay off your feet. You may continue normal, non-strenuous activity tomorrow.

4. Take medications ONLY as directed. You may take previously prescribed medications at home.
5. A responsible adult should be with you for the rest of the day and during the night for your protection and safety.
6. **Contact our office if you experience excessive bleeding from the site of injection, persistent nausea or vomiting, pain that is unusual (not relieved by Tylenol or ice after forty- eight (48) hours), swelling, fever (when temperature is over 101 degrees). Any new excessive numbness and weakness in arms and legs lasting more than 24 hours, loss of bowel and/or bladder control, or headache longer than three (3) days not relieved by medication, please call your attending physician.**
7. **If unable to reach your physician, go to the nearest hospital emergency room**.
8. Special instructions: _____

❒ **<u>All Facet Block Patients</u>**: **Please keep a diary of your pain for three days after the procedure. 2-3 times a day record the progress (increase or decrease) in pain. Bring this to your next office visit.**

_____

Attending physician: ❒ Petros, MD ❒ Vaidya, MD

Phone number: ❒ (408) 528-8833 Allied ❒ (408) 790-2900 Alliance ❒ Other: _____

Follow-up appointment confirmed: ❒ in 1-2 weeks ❒on (date)_____ ❒ Patient will call to schedule

Prescription given: ❒Yes ❒ No

I have received and understood my discharge instructions:

_____ _____

Patient's signature Date Time Witness signature Date Time

TRINITY SURGERY CENTER

Patient Name:
Date of Birth:
Surgeon:
Medical Record:

Date of Service

POST-OPERATIVE PATIENT CONTACT

Phone Number: _____

PROCEDURE(S): _____

Telephone call made to: ❒ Home ❒ Office ❒ w/Family/Friend ❒Other:_____

Date: _____ Time: _____ Phone Call made by: _____ ❒ No answer ❒ Contact

Date: _____ Time: _____ Phone Call made by: _____ ❒No answer ❒ Contact

Date: _____ Time: _____ Phone Call made by: _____ ❒ No answer ❒ Contact

Note: If the first two attempts are unsuccessful try another number or a different time.

PATIENT EXPERIENCING:	YES	NO.	Notes of conversation:
Any nausea / vomiting / loss of appitite?	❒	❒	_____
Eating and drinking well?	❒	❒	_____
Fever / chills?	❒	❒	_____
Swelling, redness or drainage from:	❒	❒	_____
IV site?	❒	❒	_____
Surgical Site?	❒	❒	_____
Unusual or Excessive Pain?	❒	❒	_____
Excessive bleeding?	❒	❒	_____
Chest pain, rapid heart rate or shortness of breath?	❒	❒	_____
Sore throat?	❒	❒	_____
Numbness or weakness?	❒	❒	_____
Is patient taking pain medication?	❒	❒	_____
Has follow-up appointment?	❒	❒	_____

If yes, when? _____

Pain Level: 0 1 2 3 4 5 6 7 8 9 10
(circle level)

❒ MD Notified Date : _____ Time : _____ By : _____