Southern Health Santé Sud

SURGERY PROGRAM

PREOPERATIVE History & Physical Form

This form must be submitted to site at least 14 days prior to surgery date.
Failure to do so may result in cancellation. This form is valid for 1 year.
ENSURE ALL CONTACT INFORMATION ON SURGICAL FORM
IS CORRECT.

Please Fax to: ☐ PAC Dept   Facility Fax # └┴┴┴┘-└┴┴┴┘-└┴┴┴┘   ☐ Surgeon's Office Fax # └┴┴┴┘-└┴┴┴┘-└┴┴┴┘

Diagnosis _____

Proposed Procedure _____   Proposed Date └┴┴┴┴┴┴┴┘
                                                          D D M M Y Y Y Y

PART A – ALERTS	No	N/A	Yes	**Describe** (e.g. reason, language, details)

A1. Patient Requires a Proxy ☐ ☐ Name _____ Reason _____

A2. Interpreter Required ☐ ☐ **Language** _____

A3. Previous Difficult Airway ☐ ☐ Describe, and identify facility of event _____

A4. Known/Suspected ☐ ☐┐ ☐ Clinically Suspected/Assessment Pending _____
Obstructive Sleep Apnea └ ☐ Diagnosed/Severity _____ CPAP Compliance: ☐ No ☐ Yes ☐ N/A

A5. Adverse Reaction to ☐ ☐ **Describe** _____
Previous Anaesthetic
(patient or relative) _____

A6. Previous Adverse ☐ ☐ Describe _____
Reaction to Transfusion

A7. Blood Borne Infections ☐ ☐ Hepatitis B Virus   ☐ Hepatitis C Virus   ☐ Human Immunodeficiency Virus

A8. Alert: Blood Clots ☐ ☐ Methicillin-resistant Staphylococcus aureus   ☐ Clostridium difficile
   Tuberculosis (TB): ☐ Active TB ☐ Latent TB ☐ Other, Describe: _____

A9. Allergies ☐ ☐ (include type of reaction) _____
   ☐ See attached* _____

PART B – HISTORY	No	N/A	Yes	**Describe** (e.g. type, quantity, frequency)

B1. Tobacco Use ☐ ☐ *Pack years* _____
   Date quit └┴┴┴┴┴┴┴┘
              D D M M Y Y Y Y

B2. Vaporizer/e-cigarette use ☐ ☐ _____

B3. Recreational Drugs ☐ ☐ _____

B4. Alcohol Consumption ☐ ☐ _____

B5. Previous or Current ☐ ☐ _____
Steroid Therapy

B6. Date of Last Menses ☐   └┴┴┴┴┴┴┴┘
                                 D D M M Y Y Y Y

B7. Pregnancy Test ☐ ☐ *If done, results:* _____

B8. Medical History (please indicate stable or acute) ☐ See attached*

_____
_____
_____
_____
_____

B9. History of Present Illness
_____
_____
_____

B10. Surgical History ☐ See attached*
_____
_____

B11. Medications ☐ No ☐ Yes (Describe)
   ☐ Medication Reconciliation attached (check box)
   ☐ See attached*
_____
_____
_____
_____

* Do not attach extensive encounter notes

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PART C – PHYSICAL (Note any active or unstable system findings)

Height_____ cm   Weight_____ kg   Body Mass Index (BMI)_____   Blood Pressure_____   Heart Rate_____   SpO$_2$_____

CHEST (other)**:**   Rhythm_____   Murmurs_____   Air Entry_____   Adventitious Sounds _____

HEAD & NECK:_____   Neck circumference_____ cm

ABDOMEN:_____   **EXTREMITIES:**_____

PART D – REVIEW OF SYSTEMS *Please note abnormal findings below and indicate associated code number (e.g. "D3" for Respiratory)*

System	
D1. Central Nervous System	
D2. Cardiovascular	
D3. Respiratory	
D4. Genitourinary	
D5. Haematologic & Lymphatic	
D6. Endocrine & Metabolic	
D7. Gastrointestinal	
D8. Neuromuscular	
D9. Dermatologic	
D10. VTE Prophylaxis	
D11. Other	

PART E – OPTIMIZATION

Blood Management Service   *If possible, please address with the patient any of the following applicable items to reduce the risk of postoperative complications:*

☐ Consult initiated
Consider referral if major surgery and anemia, rare blood type, multiple antibodies or patient refuses blood transfusion
www.bestbloodmanitoba.ca 204-787-1277

Healthy Behaviours
• Active lifestyle
• Healthy diet
• Reducing excessive alcohol use
• Recreational drug cessation
• Smoking cessation

Chronic Diseases Management
• Diabetes screening/Blood glucose control
• COPD/Asthma
• Hypercholesterolemia
• Hypertension
• Malnutrition
• Nutritional Anemias

PART F – LABORATORY SCREENING (patients at least 16 years of age)

☐ Check if indicated test results are attached.

A guideline based app to determine which tests are required is available at: logixmd.com/preop

TESTS WITHIN 6 MONTHS OF SURGERY
Are valid, provided there has been no interim change in the patient's condition.

CLINICAL JUDGEMENT IS REQUIRED
as additional tests may be appropriate for some patients.

GUIDELINE DOES NOT APPLY TO
patients undergoing cardiac surgery or cesarean section

Chest X-rays – *Not recommended* for **any** surgery *except* to facilitate diagnosis of new/worsened symptoms, or if ordered by the surgeon in the workup of a malignancy.

FOR MINOR SURGERY*

DO NOT ORDER PREOPERATIVE TESTS in asymptomatic patients.

Associated with an expected blood loss of less than 500 mL, minimal fluid shifts and is typically done on an ambulatory basis (day surgery/same day discharge). It includes cataract surgery; breast surgery without reconstruction; laparoscopic cholecystectomy and tubal ligation; and most cutaneous, superficial, endoscopic and arthroscopic procedures.
‡Access the complete adult preoperative lab test guideline – including lists of major and minor surgery

FOR MAJOR SURGERY** If age (years) is:

16 - 49: Order **CBC**. Additional tests may be indicated for comorbid diseases. Consult guideline.‡
50+: Order **CBC, ECG, Na$^+$, K$^+$, Cl$^-$, TCO$_2$, CR/eGFR**

Major Surgery: Other tests to consider
• **Oral Corticosteroids, DM** or **BMI greater than 40**: add Hemoglobin A1C or fasting plasma glucose.
• **Malnutrition, BMI greater than 40,** or **Liver disease**: AST, ALT, Alk Phos, GGT albumin, total and direct bilirubin & INR.
• **At high risk for iron deficiency**: add serum iron TIBC and Ferritin.
• **Thyroid disease**: add TSH.

** Associated with an expected blood loss of greater than 500 mL, significant fluid shifts and typically, at least one night in hospital^. Includes laparoscopic surgery (except cholecystectomy and tubal ligation), open resection of organs, large joint replacements, mastectomy with reconstruction, and spine, thoracic, vascular, or intracranial surgery.
^ If the surgery is typically ambulatory but the patient has a medical or social reason for overnight admission (i.e. OSA, no support at home), still consider the surgery minor in determining which lab tests to order.

Examining Provider:_____
SIGNATURE _____ PRINTED NAME AND DESIGNATION

Examination Date: |__|__|__|__|__|__|__|__|
                  D D M M Y Y Y Y

Address:_____

Phone:|__|__|__|-|__|__|__|-|__|__|__|__| Fax:|__|__|__|-|__|__|__|-|__|__|__|__|

☐ It is not necessary to repeat history and physical as no significant change noted in the patient's health status since the last examination.

Examining Provider:_____
SIGNATURE _____ PRINTED NAME AND DESIGNATION

Reassessment Date: |__|__|__|__|__|__|__|__|
                   D D M M Y Y Y Y

Comments:_____