Lakeridge Health

Adult PreSurgical Screening Assessment

TO BE USED FOR PATIENTS GREATER THAN 13 YEARS OF AGE
TO BE COMPLETED BY PATIENT/GUARDIAN

Surname (Last Name)	First Name	Name that you go by

Age	Date of Birth (DDMMMYYYY)	Health Card Number

Contact phone number: Home: **Work:**

Cell:

	Yes	No	Comment
HEART, CIRCULATION:			
Do you have chest pain or angina?			How often?
Have you ever had a heart attack?			Date:
Have you ever had a stroke / TIA? (mini stroke)			Date:
Do you have fainting spells or blackouts?			
Are you being treated for high blood pressure?			
Do you have irregular pulse / palpitations / atrial fibrillation? If yes, circle.			
Do you have a heart murmur/rheumatic fever/pacemaker? If yes, circle.			
Do you need to take antibiotics prior to seeing your dentist?			
Are you currently taking Aspirin / Coumadin or Plavix? If yes, circle.			
Do you have any other forms of heart disease?			
RESPIRATORY			
Do you ever wake up with shortness of breath?			
Do you have a productive cough?			
Do you have asthma / bronchitis / emphysema / COPD? If yes, circle.			
Have you ever had pneumonia / tuberculosis? If yes, circle.			
Do you have sleep apnea?			Is it treated?
RENAL / HEPATIC			
Do you have any form of kidney disease?			
Are you on dialysis? If yes how often?			
Have you had hepatitis / jaundice / liver disease? If yes, circle.			When?
ENDOCRINE:			
Are you diabetic: Insulin ❒ Pills ❒ Diet ❒			
Do you have any thyroid problems?			
Do you have pituitary or adrenal disease?			
Do you have rheumatoid arthritis?			Which joints?

	Yes	No	Comment
DIGESTIVE:			
Do you have heartburn or a hiatus hernia? (Acid Reflux)			
Do you have difficulty swallowing?			
OTHER:			
Do you have any disease of nerves and muscles?			
Do you have epilepsy or seizures?			
Have you been diagnosed or treated for cancer?			
Have you had? Chemotherapy ❒ Radiation ❒ Surgery ❒			
Have you had an organ/bone marrow/stem cell transplant? If yes circle.			
BLOOD:			
Do you have abnormal blood conditions?			
Have you had a reaction to a blood transfusion?			
Have you had a blood transfusion within past 3 months? If yes, where?			
ANAESTHESIA:			
Had a problem with local / general / spinal / epidural anaesthetic?			
If yes, describe:			
Has anyone related to you ever had a problem with an anaesthetic?			
Do you or any member of your family have a history of malignant hyperthermia?			
Do you have a history of pseudocholinesterase deficiency?			
GENERAL QUESTIONS:			
Could you be pregnant at this time?			LMP?
Have you been tested for sickle−cell disease?			
Do you use recreational drugs? Please describe:			
Have you ever smoked?			How many years?
			How much per day?
Have you quit smoking?			When did you quit?
Alcohol use: (More than 9 drinks for a female per week and more than 14 drinks for a male per week)			
Do you have any loose or chipped teeth? If yes, location:			
Do you have caps / bonding / bridges? If yes, please circle.			
Dentures Upper Full ❒ Partial ❒ Lowers Full ❒ Partial ❒			
Do you have any prostheses? (Heart valves, pacemakers, hip or kneejoints, etc.) If yes, circle.			Date implanted:
Do you wear corrective lenses or contacts?			
Do you have difficulty hearing?			
Do you wear a hearing aid?			
Do you have any body piercings? If yes, describe location and number.			

List your previous operations / hospitalizations (include approximate dates).

Allergies

Are you allergic to latex or rubber?	Yes	No	Have you been tested?	Yes	No	

Drug / Food Allergies	Adverse Reactions / Sensitivity	Symptoms
1		
2		
3		
4		
5		
6		

1. Have you ever been notified of a positive swab result or exposure to MRSA, VRE or ESBL? Yes ❒ No ❒

2. Have you spent more than 12 hours as a patient/resident in any health care facility or had Home Care in the past 2 years? Yes ❒ No ❒

3. In the last 12 months have you been admitted to a hospital outside of Canada? Yes ❒ No ❒

For PSSC staff:

A "Yes" or "Unknown" response to any question is an indication to swab. Yes to #1 or #3 is an indication for isolation (only exception is ESBL exposure).

Medications Taken At Home: This should include any herbal medications

Drug	Amount	Frequency

Date: (DDMMMYYYY) _____

Signature: _____

Patient to complete the Pre−Surgical Screening Patient Assessment Form and return completed form to the surgeon's office assistant

Telephone PSS Appointment

If the Pre Surgical Screening Patient Assessment form is completed with "NO" answers to all sections, except the **GENERAL QUESTIONS** then a telephone PSS appointment can be booked.

Other Criteria For An On−Site PSS Clinic Appointment

Patient requires blood screening.

Patient being treated with anticoagulants and having therapeutic / surgical intervention e.g. cysto fulgurization bladder tumor.

Patient requires complex teaching e.g. total joint surgery, thoracic procedures, etc.

Patient has communication barriers e.g. hearing impaired, language barriers.

Patient has medical concerns e.g. thyroid problems.

Patients that are DSA admits.

Patient requires an anaesthesiology consultation
(per guidelines for preoperative evaluation by an anaesthesiologist).

Appointment Times

PSS Clinic appointments will be 30 minutes.

Exceptions
Total joints (hips/knees) will be 45 minutes.
Patients 70 years or older will be 45 minutes.
Telephone appointments will be 15 minutes.