

**Pre-Surgical Evaluation**

Patient: \_\_\_\_\_

**Pre-Surgical Orders**

D.O.B. \_\_\_\_\_ Age: \_\_\_\_\_

Date of surgery: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Surgeon: \_\_\_\_\_

**History:** Include reason for surgery any significant history, precautions, anticipated complications.

Medications

Smoker: Yes No Daily ETOH: Yes No \_\_\_\_\_

PMHx: Diabetes Pulmonary Hepatic disease Warfarin \_\_\_\_\_

Hypertension Cardiac Renal disease Antiplatelet \_\_\_\_\_

Functional Hx: Can patient climb 1 flight of stairs? Yes No \_\_\_\_\_

Anesthesia: General Regional MAC Local \_\_\_\_\_

Ordered: CBC CMP EKG CXR INR UA \_\_\_\_\_

Other Orders:

Pre-op diet: Standard NPO Take  $\checkmark$  meds with sips of water \_\_\_\_\_

Cardiac Clearance: Needs cardiac clearance Cardiac clearance done Dr. \_\_\_\_\_

**Examination:**

Weight: \_\_\_\_\_ BP sitting: \_\_\_\_\_ Resp: \_\_\_\_\_

Height: \_\_\_\_\_ Pulse: \_\_\_\_\_ Temp: \_\_\_\_\_

No Significant Abnormality Describe Abnormal

Reviewed CBC

Reviewed Chemistry panel

EKG report noted

Xray report noted

Reviewed Coagulation profile

Urine noted

Reviewed physician consultation

HEENT

Lungs

Heart

Abdomen

Extremities

**Plan:**

**ALLERGY**

[Redacted Allergy Box]

Anesthesia review \_\_\_\_\_

Surgeon review \_\_\_\_\_

Procedure \_\_\_\_\_

Clearance \_\_\_\_\_ Date \_\_\_\_\_

**SURGICAL CLEARANCE**

Class I Healthy no medical Problems

Class II Mild systemic disease

Class III Severe systemic disease stable

Class IV Severe systemic disease unstable

# INJURY REPORT Initial Follow-up

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Claim/Case Number: \_\_\_\_\_ Insurance: \_\_\_\_\_

Type of injury: motor vehicle work related other \_\_\_\_\_

Date of injury: \_\_\_\_\_ Date reported: \_\_\_\_\_ Employer: \_\_\_\_\_

Passenger Driver Wearing seat belt: yes no Air bag triggered: yes no

Injury while wearing: back brace helmet gloves mask goggles other

Vehicle's impact site: front rear side driver side passenger side

Injury to: Head Neck Chest Abdomen Back R L Arm R L Leg

Symptom(s) onset: immediate 24-48 hrs ≥48 hrs Previous similar injury? yes no

At this visit symptoms are: Absent Improved Unchanged Worse Pain 0/10

Subjective:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Objective:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Imaging or lab ordered: \_\_\_\_\_

Treatment: \_\_\_\_\_

Last day at work: \_\_\_\_\_ Return to work: \_\_\_\_\_

Restrictions: \_\_\_\_\_

Still under care for same condition: yes no Anticipate surgery? yes no

Referred to: \_\_\_\_\_

Disability: partial total from \_\_\_\_\_ to \_\_\_\_\_

Date \_\_\_\_\_



**GERIATRIC Screening for:**

**DOB:**

**Depression Score**                      Normal 0-2    Mild 3-5    Moderate 6-9    Severe >10

	0	1	2	3
Do you feel sad?	No	sometimes	most of the time	all the time
Are you happy living here?	Yes	mostly	sometimes	no
How do you see your future?	Fine	worry sometimes	little good to come	it's hopeless
Do you mingle or participate?	Yes	usually	sometimes	No
Are you satisfied with your life?	Yes	usually	sometimes	No

Score:	Sensory	Points
	Able to read magazines or the paper	1
	Able to understand spoken voice in either ear	1
	<b>Mental Status</b>	
	Put your hands on your knees, close your eyes, then touch your nose with any finger.	3
	What is the Season?	1
	What is the month?	1
	Where are we now?	1
	Spell your first name	1
	What is this called: Pen	1
	What is this called: Doorknob	1
	How much is 2 quarters and a nickel?	1
	Points for naming:	
	0-2=1   3-4=2   5-7=3   8-9=4   ≥10=5	
	How many can you name: colors	
	How many can you name: cities or towns	

Score:	Function	YES	NO
	Toilet self	1	
	Feed self	1	
	Dress self	1	
	Groom self	1	
	Do you pay your own bills?	1	
	Any trouble using the phone?		1
	Any trouble operating the TV or radio?		1
	Can you pick up something you drop?	1	
	Maneuver within confines of your room?	2	
	Rise from chair, walk to the door and come back to the chair and sit		
	Able to accomplish in 7-10 seconds	3	
	Tell patient to "Please do this."	2	

**Analysis of Geriatric Assessment:**

**Sign your name.**

	Sensory	Mental Status	Function
TOTALS:			
Most independent	≥1	≥19	≥12
Requires some supervision	≥1	16 - 18	8 - 11
Requires 8 hrs or more of supervision	≤1	6 - 15	3 - 7
Requires living arrangement with 24 hrs of care	≤1	<6	<3

**Notes:**

Date