COFFEE REGIONAL MEDICAL CENTER

PRE-SURGICAL CASE REQUEST

1SCR

Fax all orders to Phreesia @ 866.498.1972 and the areas checked below.

DATE:	PATIENT NAME:		Surgeon / Performing Physician
DOB:	SOCIAL SECURITY #:	SEX:	PRIMARY CARE PHYSICIAN:
PATIENT PHONE #:		PREADMIT DATE:	PREADMIT TIME:
SURGERY DATE:	SURGERY TIME:	SURGERY DURATION:	

CASE TO BE PERFORMED IN: ❑ OR ❑ CATH LAB ❑ DAY SURGERY

CLINICAL INFORMATION

1	PATIENT TYPE ❑ OPS ❑ IP STATUS ❑ ELECTIVE ❑ URGENT	URGENT JUSTIFICATION:
2	DIAGNOSIS CODES (ICD10)- SURGERY AND TESTING	DIAGNOSIS DESCRIPTION
3	PROCEDURE CODES	PROCEDURE DESCRIPTION
4	SPECIAL EQUIPMENT INSTRUCTIONS: ❑ C- ARM ❑ X - RAY ❑ PATHOLOGY ❑ IMPLANTS_____ -VENDOR _____ -Rep Phone#	ADDITIONAL SPECIAL INSTRUCTIONS: ❑ Post OP Bed Required ❑ Post OP Critical Care Bed Required ❑ Other: _____ _____

INSURANCE: _____ POLICY NUMBER:_____ ❑APPROVED ❑DENIED ❑PENDING

AUTH/REF #: _____

Call to schedule case EXT 6919-OR / 6918-Cath Lab/Day Surgery
Fax Case Request to Registration @ 866-498-1972 and OR @ 912-383-5632
Also ro the performing area ❑Day Surgery @ 912-383-5663 ❑Cath Lab @ 912-383-5664

Patient Care Director Notified (if applicable): ❑ Yes ❑ No Comments:_____
(PCD to be notified of all Add-ons after 5:30pm M-F & Weekends)

Form Completed By:	Faxed By:	Date/Time:

OR_7095_EFR
Rev 04/29/2024

COFFEE REGIONAL MEDICAL CENTER

ASU UNIVERSAL MEDICATION FORM

1MRR

Name: _____ Date of Birth: _____

ALLERGIES (DESCRIBE REACTION)	ALLERGIES (DESCRIBE REACTION)

My Primary Physician's Name is:_____

My Pharmacy Name is:_____

Bring all medicines with you to Pre-Op and Surgical appointments.
LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: Prescription and over-the-counter medications (examples: aspirin, antacids). Also include herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).

Name of Medication	Dose	Route	How Often	Notes: Reason for Taking, etc.	Date Stopped

Signature

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COFFEE REGIONAL MEDICAL CENTER

NURSING/ANESTHESIA PATIENT HISTORY QUESTIONNAIRE

3OR

SURGERY:_____ DATE OF SURGERY:_____

Height_____ Weight_____ Marital Status_____ V/S: T_____ P_____ R_____BP_____SpO2_____

1. Please list the operations or procedures (includes Stents, and heart Catheterizations) you have had in your life, including: Dates (month/year), Doctor, Hospital:

Organ Transplant? ❑ Yes ❑ No Which organ:_____

2. Please list any medical conditions you have or have had (high blood pressure, diabetes, heart attack, etc.)

3. Are you allergic to latex? ❑ Yes ❑ No Are you allergic to any food, medications, or other (specify what and type of reaction)?

4. Have you or anyone in your family ever had a reaction to a local or general anesthetic? ❑ Yes ❑ No

5. Have you ever been diagnosed with cancer? (specify if current or past) ❑ Yes ❑ No

6. Do you smoke? ❑ Yes ❑ No How many packs per day?_____For how many years? _____
Have you recently quit smoking? ❑ Yes ❑ No How long ago & for how long have you quit?_____
Do you chew tobacco / snuff? ❑ Yes ❑ No Do you use "street drugs"? ❑ Yes ❑ No
If so, explain_____ How much beer, wine, or liquor do you drink per day? _____

7. Have you currently or in the past been treated for a mental / emotional condition? ❑ Yes ❑ No

8. Have you had a chest cold or chest infection in the last month? ❑ Yes ❑ No
Do you have chronic bronchitis, asthma, COPD, emphysema, or sleep apnea? ❑ Yes ❑ No
Do you take medicine for breathing or use a CPAP / BiPAP machine? ❑ Yes ❑ No

9. Have you ever been diagnosed with Tuberculosis (TB)? ❑ Yes ❑ No
Have you been exposed to Tuberculosis (TB)? ❑ Yes ❑ No
Have you ever been treated for Tuberculosis (TB)? ❑ Yes ❑ No
Have you been experiencing night sweats, coughing up blood, & a persistent cough for > 3 weeks? ❑ Yes ❑ No

10. Have you ever had trouble with your heart? (Heart attack, irregular heart beat, Mitral Valve Prolapse, Congestive Heart Failure (CHF), heart murmur, congenital defects, etc.) ❑ Yes ❑ No
Have you ever taken medications for your heart? ❑ Yes ❑ No
Do you ever have pain or pressure in your chest? ❑ Yes ❑ No

11. Have you ever had high blood pressure requiring treatment? ❑ Yes ❑ No

12. Have you ever had any liver disease (hepatitis, yellow jaundice, etc.)? ❑ Yes ❑ No

13. Have you been diagnosed with HIV / AIDS? ❑ Yes ❑ No

14. Do you take medications for heartburn, reflux, ulcers, hiatal hernia, or indigestion? ❑ Yes ❑ No

15. Have you ever had a stroke, mini-stroke, seizure, or frequent headaches? ❑ Yes ❑ No

16. Do you have any paralysis or severe numbness/weakness in your arms or legs? ❑ Yes ❑ No
Do you have a neuromuscular disease? (Parkinson's, Multiple Sclerosis, Myasthenia Gravis, etc.) ❑ Yes ❑ No
Do you have arthritis? ❑ Yes ❑ No
Are you under the care of a Rheumatologist? (Lupus, Gout, Rheumatoid Arthritis, Fibromyalgia) ❑ Yes ❑ No

COFFEE REGIONAL MEDICAL CENTER

NURSING/ANESTHESIA PATIENT HISTORY QUESTIONNAIRE

17. Are you limited to which arm you can have a blood pressure or needlestick? ❑ Yes ❑ No
18. Do you have "sugar" diabetes (problems with your blood sugar)? ❑ Yes ❑ No
19. Do you have thyroid disease? ❑ Yes ❑ No

20. Do you bleed easily or take a blood thinner? ❑ Yes ❑ No
Have you ever had a blood transfusion? ❑ Yes ❑ No
Have you been diagnosed with anemia, sickle cell disease or carry sickle cell trait? ❑ Yes ❑ No
Have you ever had a blood clot? ❑ Yes ❑ No Family history of blood clots / blood clotting disorder? ❑ Yes ❑ No

21. Have you recently been treated for or currently have head lice? ❑ Yes ❑ No

FOR WOMEN: 22. Are you pregnant or could you be? ❑ Yes ❑ No
Do you have menstrual cycles or had a menstrual cycle in past 6-12 months? ❑ Yes ❑ No
Have you had a tubaligation or hysterectomy? ❑ Yes ❑ No
Are you currently breastfeeding? ❑ Yes ❑ No

23. Do you have loose/chipped teeth? ❑ Yes ❑ No Wear dentures? (Upper/Lower) ❑ Yes ❑ No
Wear a prosthesis? ❑ Yes ❑ No Wear glasses? ❑ Yes ❑ No Contacts? ❑ Yes ❑ No
Blind? ❑ Yes ❑ No Cataracts/Glaucoma? ❑ Yes ❑ No Have body piercings? ❑ Yes ❑ No
Have trouble hearing? ❑ Yes ❑ No Wear hearing aide? ❑ Yes ❑ No Deaf? ❑ Yes ❑ No

24. Are you on a special diet? ❑ Yes ❑ No If so, what kind?_____
Difficulty swallowing? ❑ Yes ❑ No Eating disorder? ❑ Yes ❑ No
Unplanned weight loss of 10 pounds or more? ❑ Yes ❑ No

25. Do you have any problems with your skin? (eczema, psoriasis, etc.) Rash, burns, lesions, cuts, or bruises? ❑ Yes ❑ No
Do you have any chronic wound(s) or bed sores? ❑ Yes ❑ No
Have you been treated for Methicillin-Resistant Staphylococcus Aureus (MRSA) or Vancomycin-Resistant Enterococci (VRE)? ❑ Yes ❑ No

26. Do you have kidney disease? (kidney failure, polycystic kidney disease, etc.) ❑ Yes ❑ No
Do you have a history of kidney stones? ❑ Yes ❑ No
Do you have problems urinating? (burning, leaking, incontinence, blood in urine, etc.) ❑ Yes ❑ No
Any problems with your bowels? (constipation, diarrhea, bleeding, irritable bowel, etc.) ❑ Yes ❑ No

27. Religion _____Any religious "do's or don'ts" regarding your treatment? ❑ Yes ❑ No

28. Do you need assistance from someone or use an assistive device? (cane, walker, etc.) ❑ Yes ❑ No
Do you live alone? ❑ Yes ❑ No Who will assist with your care after surgery?_____
Who will provide transportation home from your procedure? _____
Do you receive nursing care at home? ❑ Yes ❑ No What agency?_____

29. Are you an Organ Donor? ❑ Yes ❑ No
Do you have a Living Will or Durable Power of Attorney? ❑ Yes ❑ No Does the hospital have a copy? ❑ Yes ❑ No

30. Have you been exposed to communicable diseases (chicken pox, measles, etc.) recently? ❑ Yes ❑ No

31. Have you had a flu shot within the last year? ❑ Yes ❑ No When?_____
Have you ever had a pneumonia vaccine? ❑ Yes ❑ No When?_____

FOR MINORS: 32. Are there any guardianship/custody issues? ❑ Yes ❑ No
33. Are his/her immunizations (shots) up-to-date? ❑ Yes ❑ No

34. Are you currently in pain or having discomfort? ❑ Yes ❑ No Where:_____
What level is the pain? (Circle One) No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

Patient Signature:_____ **Date:**_____

Nurse Signature:_____ **Date/Time:**_____

Pre and Post Op Teaching Given ❑ Yes ❑ No Patient/guardian/spouse/other verbalizes understanding? ❑ Yes ❑ No

COFFEE REGIONAL MEDICAL CENTER

OUTPATIENT OBSERVATION / SURGERY

1HPRPT

Patient Name: _____

Chief Complaint: _____

MEDICAL HISTORY

Present Illness: _____

Past History: _____

Family History: _____

Psychosocial: _____

Immunizations: _____

Current Meds: _____

Allergies: _____

REVIEW OF SYSTEMS

SKIN:

HEENT:

RESP:

CV:

GI:

MS:

GU:

GYN:

NEURO:

PSYCH:

PHYSICAL EXAM

Vital Signs: BP _____ Pulse _____ Resp. _____ Temp. _____

Skin: _____ Abdomen: _____

Head/ Neck: _____ GU: _____

Chest: _____ MS: _____

Heart: _____ Neuro: _____

Lungs: _____

Admitting DX: _____

Treatment Plan: _____

PHYSICIAN SIGNATURE **DATE** **TIME**

DISCHARGE SUMMARY

Diagnostics: _____

Procedures/ Rx: _____

Discharge DX: _____

D/C Status: _____

Instructions: _____

Activity: _____ Diet: _____

Meds: _____

Follow−up: _____

PHYSICIAN SIGNATURE **DATE** **TIME**

HPRPT_9004_EFR
Rev. 10/10/2023

COFFEE REGIONAL MEDICAL CENTER

NURSING / ANESTHESIA
CRMC Sleep Screening Questionnaire

1ANES

SURGERY:_____ DATE OF SURGERY:_____

PLEASE COMPLETE THE QUESTIONNAIRE TO THE BEST OF YOUR ABILITY. IT WILL BE REVIEWED BY A NURSE AND ANESTHESIA PROVIDER PRIOR TO YOUR SURGERY. THE INFORMATION YOU PROVIDE IS CONFIDENTIAL.

1. **SNORING:**
   Do you ***snore*** loudly (louder than talking or loud enough to be heard through closed doors)?

   Yes No

2. **TIRED**
   Do you often feel ***tired***, fatigued or sleepy during daytime?

   Yes No

3. **OBSERVED**
   Has anyone ***observed*** you stopping breathing during your sleep?

   Yes No

4. **BLOOD PRESSURE**
   Do you have or are you being treated for high blood ***pressure***?

   Yes No

5. **BMI –**
   BMI more than 28?

   Yes No **BMI Score_____**

6. **Age**
   Age over 50 years old?

   Yes No

7. **NECK CIRCUMFERENCE**
   Neck circumference greater than 17 inches for male, 16 inches for female?

   Yes No

8. **GENDER**
   Gender –male?

   Yes No

SCORE:_____ (Score is number of Yes responses)

❑ **HIGH RISK OF OSA – "YES" TO SIX (6) OR MORE ITEMS–**
Refer patient to their preferred sleep lab for further study/treatment prior to surgery

❑ LOW RISK OF OSA – "YES" TO LESS THAN SIX (6) ITEMS

❑ I understand that I am high risk for OSA but refuse further sleep testing and understand that admission after surgery may be necessary.

_____

Patient signature Date/Time

ANES_9183_EFR
Rev. 07/15/2013

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