COFFEE REGIONAL MEDICAL CENTER

PRE−SURGICAL CASE REQUEST

CALL TO SCHEDULE CASE AT EXT 6919

Fax Case Request to OR @ 383−5632 and Registration @ 389−2165

1SCR

DATE:	PATIENT NAME:		Surgeon:
DOB:	SOCIAL SECURITY #:	SEX:	PRIMARY CARE PHYSICIAN:
PATIENT PHONE #:		PREADMIT DATE:	PREADMIT TIME:
SURGERY DATE:	SURGERY TIME:	SURGERY DURATION:	
HEIGHT		WEIGHT	

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 OR @ 912−383−5632 Registration @ 866−498−1972 ❑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

2PO

ROUTINE PRE-OP HIP / KNEE / SHOULDER ARTHROPLASTY ORDERS

Pre-Admission Labs and Diagnostics

Pre-Surgery Diagnosis:_____

Scheduled Procedure:_____

Date of Procedure:_____Allergies:_____Weight_____

Precertification #:_____

❑ No Lab Tests Required
❑ Anesthesiology Consultation(Patients with Medical or Surgical issues)

❑ Hgb/Hct
❑ CBC w/diff
❑ PT
❑ PTT
❑ Blood Glucose
❑ Electrolytes-Na,K+,Cl,CO2
❑ BMP
❑ MRSA Screening

❑ Urinalysis
❑ Pregnancy Test
❑ HBsAg
❑ Sickle Cell Screening
❑ Amylase
❑ Hepatic Panel
❑ ECG

❑ CXR
❑ X-ray Type_____
❑ Ultrasound Type_____
❑ Type & Screen
❑ T&S (Crossmatch)___# units PRBCs
❑ T&S (Crossmatch)___# units autologous Blood

Blood for pre-transfusion testing must be drawn within 48 hours of surgery. Typed and Screened blood can only be held 48 hours.

Pre-Surgery Orders ❑ **OPS (Outpatient Surgery)** ❑ **IP (Inpatient)**

Vital Signs: ❑ Per Protocol ❑ Other _____

Diet: ❑ NPO ❑ NPO after _____ ❑ LR at KVO or ❑ 100ml/hr ❑ 200ml/hr ❑ _____ml/hr
❑ NS at KVO or ❑ 100ml/hr ❑ 200ml/hr ❑ _____ml/hr

Pre Op Antibotics:

❑ Ancef on call to OR (Pharmacy to dose per weight, start 60 minutes of incision)

2gm IVPB x 1 **for pt weight < 120kg**
3gm IVPB x 1 **for pt weight ≥ 120kg**

If Allergy to PCN/Beta - Lactam

❑ Vancomycin on call to OR (Pharmacy to dose per weight, start 120 minutes of incision) **Pharmacy to renal dose**

Vancomycin 1gm IVPB x 1 **for pt weight < 70 KG**
Vancomycin 15mg/kg IVPB x 1 **for pt weight ≥ 70 KG (Maximum dose 2 Grams IVPB)**

OR

❑ Cleocin 900mg IVPB x 1 on call to OR (Start 30 min of incision)

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COFFEE REGIONAL MEDICAL CENTER

ROUTINE PRE-OP HIP / KNEE / SHOULDER ARTHROPLASTY ORDERS

Medications:

- ❑ Bicitra 30ml po (on-call to OR)
- ❑ Acetaminophen (Ofirmev) 1000MG IVPB (on-call to OR)
- ❑ Ibuprofen (Caldolor) 800MG IVPB (on-call to OR)
- ❑ Ketorolac (Toradol) 30 mg IVP x 1 (on-call to OR)
- ❑ Gabapentin 300MG PO x 1 (pre Op)
- ❑ Transxamic Acid 1000 mg IV x 2 (on-call to OR)
- ❑ Dexamethosone 10 mg IV x 1 dose (on call to OR)
- ❑ Other_____

Consults:

- ❑ OT/PT Consult
- ❑ Care Management Consult

Preparation:

- ❑ Incentive Spirometry Instructions/pre-admit
- ❑ Thigh / Knee High TED hose
- ❑ Sequential Compression Device in OR
- ❑ Patient Education

Miscellaneous:

- ❑ H&P
- ❑ To be done on admit by_____
- ❑ Consult obtained from_____

Block to Operative Side

- ❑ Consult Anesthesia for Peripheral Nerve Block
- ❑ Supraclavicular
- ❑ Interscalene
- ❑ Femoral
- ❑ Adductor Canal
- ❑ Other

Minimum Testing Guidelines (Anesthesia Service): These guidelines are suggested minimums. They are not replacement for medical judgment, and the patient's medical history and/or the proposed surgical procedure may indicate additional laboratory or diagnostic testing.

No pre-operative laboratory testing is required for asymptomatic patients without significant medical problems who are less than 40 years of age, except for an Hgb/Hct for 0-6 months as per protocol, and except for urine HCG.

ECG: Males, aged 40 and above require an ECG. Males and Females aged 50 and above require ECG

CXR: CXRs are not required in the absence of cardiorespiratory disease. Inpatients with cardiorespiratory disease, a CXR with the past six months is sufficient in the absence of a significant change in status of the cardiorespiratory illness.

Pregnancy Test: A pregnancy test is required for all menstruating females scheduled for anesthesia or surgery, unless not indicated due to sterility. This test will be a serum HCG if blood is drawn for other tests. Otherwise it will be a urine HCG.

_____ _____

Physician Signature Date/Time

PO_9096_EFR

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
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COFFEE REGIONAL MEDICAL CENTER

OUTPATIENT PROCEDURE/SURGERY HISTORY & PHYSICAL / DISCHARGE SUMMARY

1HPRPT

MEDICAL HISTORY

Present Illness/ Admitting Diagnosis: _____

_____

Past History: _____

Past Surgery: _____

Family History: _____

Psychosocial: _____

Allergies: _____ Immunizations: _____

Current Medications (prescription/OTC/Herb): _____

_____

PHYSICIAN PRE-SEDATION ASSESSMENT

PHYSICAL EXAM Vital Signs: BP_____ Pulse_____ Resp._____ Temp_____

Head/neck: _____

Heart: _____

Skin: _____

Lungs: _____

Abdomen: _____

GU: _____

MS: _____

Neuro: _____

ASA Level: 1 2 3 4 5 E (Not a candidate for surgery)

Airway: Teeth - Condition: _____

ROM Head % Neck: _____

Neck Thickness/Length: _____

Oropharyngeal Classification (Check)

Class 1 Class 2 Class 3 Class 4

Treatment Plan: _____

YES_____ NO_____ Based on the pre-procedural assessment/H&P and the lack of allergy to sedation, patient is a suitable candidate for moderate sedation/analgesia during the planned procedure.

DATE:_____ TIME:_____ PHYSICIAN SIGNATURE:_____

❑ Reassessment Immediately Prior to Sedation

DISCHARGE SUMMARY

Discharge Diagnosis: _____

Procedures/Treatment: _____

Diagnostics: _____

Activity: _____ Diet: _____

Prescription/Medications: _____

Follow-Up: _____

DC Status\Disposition: _____

_____

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

COFFEE REGIONAL MEDICAL CENTER

Pre-Surgery Patient-Reported Functional Assessment
Knee
As per AAOS PROMs

2NN

Check one answer per row	Excellent	Very Good	Good	Fair	Poor
In general, would you say your health is:					
In general, would you say your quality of life is:					
In general, how would you rate your physical health?					
In general, how would you rate your mental health, including your mood and your ability to think?					
In general, how would you rate your satisfaction with your social activities and relationships?					
In general, how well you carry out your usual social activities and roles? (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)					

Check one answer per row	Completely	Mostly	Moderately	A Little	Not at all
To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?					

Check one answer per row (In the past 7 days)	Never	Rarely	Sometimes	Often	Always
How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?					

Check one answer per row (In the past 7 days)	None	Mild	Moderate	Severe	Very Severe
How would you rate your fatigue on average?					

How would you rate your pain on average? (Circle one) 0=No pain; 1 = Mild Pain; 10 = Worst Imaginable Pain	0	1	2	3	4	5	6	7	8	9	10

Check one answer per row (In the past 7 days)	Not at all	A little bit	Somewhat	Quite a bit	Very Severe
How much did pain interfere with your day to day activities?					
How much did pain interfere with work around the home?					
How much did pain interfere with your ability to participate in social activities?					
How much did pain interfere with your enjoyment of life?					
How much did pain interfere with the things you usually do for fun?					
How much did pain interfere with your enjoyment of social activities?					
How much did pain interfere with your household chores?					
How much did pain interfere with your family life?					

Signature of RN Noting Assessment:	Time:	Date:

NN_8140_EFR
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Instructions: This survey asks for your view about your knee. This information will help us keep track of how you feel about your knee and how well you are able to do your usual activities.

Answer every question by ticking the appropriate box. Only one box for each question. If you are unsure about how to answer a question, please give the best answer you can.

What amount of pain have you experienced in the last week in your other knee/hip (in the knee/hip not being treated?)

None ❑	Mild ❑	Moderate ❑	Severe ❑	Extreme ❑	Not Applocable ❑

My back pain at the moment is...

None ❑	Very Mild ❑	Moderate ❑	Fairly Severe ❑	Very Severe ❑	Worst Imaginable ❑	Not Applocable ❑

How comfortable are you filling out medical forms by yourself?

Not at all ❑	A little bit ❑	Somewhat ❑	Quite a bit ❑	Extremely ❑	Not Applocable ❑

Stiffness: The following question concerns the amount of joint stiffness you have experenced during the **last week** in your knee. Stiffness is a sensation of restriction or slowness in the ease of which you move your knee joint.

1. How severe is your knee stiffness after first wakening in the morning?

None ❑	Mild ❑	Moderate ❑	Severe ❑	Extreme ❑

Pain
What amount of knee pain have you experienced the last week during the following activities?

2. Twisting/pivoting on your knee

None ❑	Mild ❑	Moderate ❑	Severe ❑	Extreme ❑

3. Straightening knee fully

None ❑	Mild ❑	Moderate ❑	Severe ❑	Extreme ❑

4. Going up or downstairs

None ❑	Mild ❑	Moderate ❑	Severe ❑	Extreme ❑

5. Standing up

None ❑	Mild ❑	Moderate ❑	Severe ❑	Extreme ❑

Function, daily living: The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities please indicate the degree of difficulty you have experienced in the last week due to your knee.

6. Rising from sitting

None ❑	Mild ❑	Moderate ❑	Severe ❑	Extreme ❑

7. Bending to floor/pick up an object

None ❑	Mild ❑	Moderate ❑	Severe ❑	Extreme ❑