SAULT AREA HOSPITAL
PATIENT INFORMATION

Sault Area Hospital

750 Great Northern Road (705-759-3434)

Day Surgery and Same Day Admissions

Surgery date: _____

DAY SURGERY WILL CALL YOU BEFORE 1:00PM FOR THE TIME OF YOUR SURGERY ON _____

Write your arrival time here:_____

Write your surgery time here: _____

Arriving late may mean cancellation of your surgery. BRING your health card and insurance information if you are being admitted to the hospital.

☐ **Go straight to 3D - Day Surgery Unit (Surgical Services)**

☐ **If coming in for a scheduled caesarean section - follow instructions received from maternity nurse during pre-operative phone call**

PREPARING FOR YOUR OPERATION

1. Shower or bath. Remove all: nail polish, makeup, contact lenses, jewelry (including piercings), fragrances and lotions. Do not shave operative area.
2. Brush your teeth being careful not to swallow any of the water.
3. I*f you are staying overnight*, bring a housecoat, slippers, toothpaste, toothbrush, soap, shampoo, Kleenex, feminine hygiene products, deodorant and any other necessary toiletries. The surgical unit is on 3A (ext. 3618). The maternity unit is on 1A (ext. 3624).
4. **Do Not** smoke or drink alcoholic beverages 24 hours before admission.
5. If you develop any illness or unable to come for surgery contact your surgeon immediately. For last minute illness contact day surgery at 705-759-3623 or maternity (ext. 3624) at 6 am **on the day of surgery.**
6. Do not work night shift the night before surgery.

FASTING FOR YOUR OPERATION

Adults:

7. You must fast (nothing to eat) after midnight the night before surgery
8. If your surgery is before 11am, no fluids after midnight.
9. If your surgery is scheduled after 11am, you may have one 8 ounce glass (1cup) of clear fluid 4 hours before surgery time. No orange juice, milk or milk products.
10. ACCEPTABLE CLEAR FLUIDS are: apple juice, ginger ale, water, black tea or coffee (no milk/cream/whitener). No other beverages are allowed.
11. No candy or gum chewing is allowed.

Surgery May Be Cancelled if You Do Not Follow the Fasting Instructions!

SAULT AREA HOSPITAL
HÔPITAL DE SAULT SAINTE MARIE
iCare

Disponible en français
Available in French

SAH - PATIENT INFORMATION CONTINUED

MEDICATIONS

You have been given instructions on how to take your medications before surgery. It is important that you take your medications exactly as instructed.

If you are to take medications on the morning of your surgery, take at 6 am with a sip of water.

Your surgery may be cancelled if you do not follow the instructions given!

Do not take the following medications for 7 days before surgery (unless otherwise instructed):
Take last dose on: _____

- Advil, Motrin, Ibuprofen, Aleve
- Aspirin or Aspirin products
- Herbal Supplements, Multivitamins, Vitamin E or any vitamins containing Vitamin E
- Non-steroidal Anti-inflammatories (NSAIDS)
-

You may take Tylenol (Acetaminophen) if needed

REMEMBER TO BRING:

☐ All prescribed medications in original containers

☐ TEDS Stockings

☐ CPAP machine

☐ Other Medical Equipment

AFTER SURGERY

1. Arrange for a responsible adult to drive you home and someone must stay with you overnight.
2. Wear loose comfortable clothes home.
3. **Do not** operate a motorized vehicle for 24 hours after surgery. You could be considered legally impaired.
4. At the time of your discharge you will be given information regarding follow-up care.
5. Discharge time is 11:00 a.m. Please ensure you have transportation available upon discharge.

Please bring this information sheet on your day of surgery.
If you have any questions about your surgery, ***please*** contact your surgeon.
For nursing instructions, please call the **Pre-Admit Clinic at:**

☐ **705-256-3488**
☐ **705-256-3478**
☐ **705-256-3476**

☐ **Maternity: 705-759-3434 ext.3624**

DAY SURGERY IS OPEN MONDAY TO FRIDAY 8-4PM CLOSED STATUTORY HOLIDAYS

ADDITIONAL INSTRUCTIONS: _____

_____

_____

SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE

iCare

Disponible en français
Available in French

SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE

iCare

DEMOGRAPHIC LABEL

Adult Questionnaire
Pre-Surgical Patient Information Form

PLEASE USE A PEN, PREFERABLY BLACK INK, TO FILL OUT THIS FORM.

To be completed by patient or designate. Date: _____(dd/mm/yyyy)

Print name: _____

English speaking ☐ Yes ☐ No
If no, language spoken: _____
Accompanied by: _____

Able to read English: ☐ Yes ☐ No
Interpreter required: ☐ Yes ☐ No
Relationship: _____

Glasses/contact lenses: ☐ Yes ☐ No

Hearing aid: ☐ Yes ☐ No ☐ Right ☐ Left ☐ Both

Do you require assistance walking? ☐ Yes ☐ No ☐ Cane ☐ Walker ☐ Wheelchair

Have you had any falls recently? ☐ Yes ☐ No

Your day surgery will be cancelled if you do not have a responsible adult to provide transportation home and someone to remain with you overnight. <u>You are required to arrange for help at home when leaving the hospital.</u>

Have you arranged for a responsible adult to pick you up and stay with you overnight? ☐ Yes ☐ No

Have you arranged for help at home? ☐ Yes ☐ No

PREADMIT : P: _____ **BP:** _____ **O_2 Sats** _____ **BG (am of visit):** _____ **RCRI score:** _____

DAY SURGERY: P: _____ **BP:** _____ **O_2 Sats** _____ **BG:** _____

Instructions: Please circle 'Yes' or 'No' for each question. Fill in blanks for details. The nurse will review the questionnaire with you during your appointment.

	HEART and ARTERIES Do you have or have you ever had:	NURSING ASSESSMENT
YES NO	Are you limited WALKING on ground level? Distance non stop: Less ←1 block—1 mile → MORE	
YES NO	HEART ATTACK? When? Treatment? Did you see a cardiologist?	
YES NO	ANGINA or CHEST PAIN? How often? Degree of exertion:	
YES NO	HIGH BLOOD PRESSURE? Since when?	
YES NO	ABNORMAL HEART VALVES or MURMUR?	
YES NO	CONGESTIVE HEART FAILURE? Most recent hospitalization?	
YES NO	IRREGULAR HEART BEAT?	
YES NO	a PACEMAKER or implanted DEFIBRILLATOR? Since when?	
YES NO	a STROKE or TIA? When?	

Adult Questionnaire
Pre-Surgical Patient Information Form

	LUNGS/RESPIRATORY Do you have or ever had:	
YES NO	Do you SMOKE? Packs per day? For how many years?	
YES NO	Did you used to smoke and stopped? Year you stopped:	
YES NO	ASTHMA (wheezing)?	
YES NO	COPD/ EMPHYSEMA/ CHRONIC BRONCHITIS?	
YES NO	SLEEP APNEA? If so, do you use CPAP? **YES NO** _____cm H_2O	
YES NO	recent COUGH/ COLD/ RESPIRATORY INFECTION?	
	GENERAL **Do you have or have you ever had:**	**NURSING ASSESSMENT**
YES NO	DIABETES? Since when? _____ Diet only? Tablets? Insulin? BG average _____	
YES NO	HEARTBURN/ GASTROESOPHAGEAL REFLUX?	
YES NO	Have you lost weight in the past 6 months WITHOUT TRYING to lose this weight?	
YES NO	Have you been eating less than usual FOR MORE THAN A WEEK	
YES NO	THRYOID PROBLEMS? Since when?	
YES NO	Do you use 'RECREATIONAL' drugs? MARIJUANA? Others? How often? _____	
YES NO	Do you drink ALCOHOL/ WINE/ BEER? How much? _____	
YES NO	KIDNEY DISEASE?	
YES NO	RHEUMATOID ARTHRITIS?	
YES NO	Any WOUNDS/ULCERS that are being treated? Any open cuts, scrapes or skin infection? Homecare? **YES NO**	
YES NO	LIVER DISEASE/HEPATITIS?	
YES NO	CANCER? Type: _____ Year_____ Radiation? Chemotherapy?	
YES NO	MENTAL HEALTH PROBLEMS?	
YES NO	SEIZURES? Most recent seizure: _____	

Adult Questionnaire
Pre-Surgical Patient Information Form

	GENERAL Do you have or have you ever had:	NURSING ASSESSMENT
YES NO	BLOOD CLOTS in legs or lungs? Year: _____	
YES NO	History of MRSA?	
YES NO	History of VRE?	
	Do you have a history of the following BLEEDING DISORDERS ☐ Hemophilia ☐ Von Willebrands Disease ☐ Anemia ☐ Iron Infusions ☐ Blood Transfusions When? ☐ Other_____	

	ANESTHETIC HISTORY Do you have or ever had:	
YES NO	any unusual reaction to anesthesia? Family member? YES NO	
YES NO	history of MALIGNANT HYPERTHERMIA? Family member? YES NO	
YES NO	Have you taken oral STEROIDS (Prednisone) in the past 6 months?	
YES NO	NEUROMUSCULAR DISEASE	
YES NO	LATEX allergy?	
YES NO	Teeth LOOSE or CAPPED?	
YES NO	DENTURES? Partial? Full?	

HOSPITALIZATION IN LAST 5 YEARS			
Medical Conditions Other Than Surgery		Major Surgical History	
Reason	Date	Reason	Date

Adult Questionnaire
Pre-Surgical Patient Information Form

Is there anything else you would like to add?

Patient signature: _____

OR

Designate signature: _____ **Relationship:** _____

Reviewed by:

Nurse signature: _____ **Date:** _____
(dd/mm/yyyy)

NURSING NOTES