SAULT AREA HOSPITAL
PATIENT INFORMATION

Paediatric Day Surgery and Same Day Admissions

Surgery date: _____

CALL DAY SURGERY AT 705-759-3623 BETWEEN 8:00 A.M. AND 2:00 P.M. ON _____FOR YOUR CHILD'S SURGERY TIME.

Write the surgery time here: _____

Write your arrival time here:_____

Surgery may be cancelled if you arrive late. BRING your child's health card and insurance information if he/she is being admitted to the hospital.

☐ South Entrance – Admitting/Registration [Do not go to ED Triage]

☐ Go straight to 1A – Paediatric Unit

Preparing For Surgery

1. Have your child shower or bathe - remove nail polish, makeup, contact lenses, perfume, lotion and any jewelry, including piercings. Do not shave operative area.
2. Have your child brush his/her teeth - reminding him/her to be careful not to swallow any water.
3. If your child is staying overnight, you may bring them: a housecoat, slippers, toothpaste, toothbrush, soap, shampoo, Kleenex, deodorant and any other necessary toiletries. Please bring your child's suitcase to the unit after surgery. The Paediatric unit is on 1A.
4. Your child must **not** smoke 24 hours before admission.
5. If your child develops any illness or is unable to come for surgery, contact the surgeon immediately. If the illness develops on the day of the surgery, contact Paediatrics at 705-759-3621 at 6 am.

Fasting For Surgery

1. Your child **must fast** (nothing to eat) after midnight the night before surgery.
2. The following fluids are allowed:
   a. **Children under age 1.**
      - FORMULA up to 6 hours before surgery
      - BREAST MILK up to 4 hours before surgery
      - CLEAR FLUIDS up to 3 hours before surgery
   b. **Children age 1 and older**
      - Clear fluids up to 3 hours before surgery
3. No candy or gum chewing is allowed.

SAH - PATIENT INFORMATION CONTINUED

ACCEPTABLE CLEAR FLUIDS are: apple juice, ginger ale or water. No more than 1 cup (8 ounces)

Surgery may be cancelled if you do not follow the fasting instructions!

MEDICATIONS

You have been given instructions on how to give your child's medications before surgery. It is important medications be taken exactly as instructed.

If your child is to take medications on the morning of surgery, give them at 6am with a sip of water.

_____ _____ _____

Surgery may be cancelled if these instructions are not followed.

Your child **must not** take the following medications for 7 days before surgery (unless otherwise instructed): Last dose may be taken 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 give your child Tylenol® (acetaminophen) if needed.

Remember to Bring:

☐ All prescribed medications in original containers

AFTER SURGERY

1. A parent or guardian must accompany the child before surgery. If you are not going to be present in the hospital during the procedure, a contact number must be left.
2. Visitor restrictions are in effect. Please limit to 2 people.
3. At the time of discharge you will be given information regarding follow-up care for your child.
4. Discharge time is 11:00 a.m. Please ensure you have transportation available upon discharge.

Please bring this information sheet on the day of your child's surgery.

If you have any questions about your child's surgery, ***please*** contact the surgeon.

For nursing instructions, please call the **Pre-Admit Clinic at:**

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

The Pre-Admit Clinic is open Monday to Friday 8-4pm and closed statutory holidays.

ADDITIONAL INSTRUCTIONS:

_____

_____

_____

_____

SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE

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DEMOGRAPHIC LABEL

Paediatric 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.

Print child's name: _____ Date: _____(dd/mm/yyyy)

English speaking ☐ Yes ☐ No
If no, language spoken: _____
Accompanied by: _____
Any visitor restrictions? _____

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

Glasses/contact lenses: ☐Yes ☐ No
Hearing aid: ☐ Yes ☐ No ☐ Right ☐Left ☐Both
Do he/she require assistance walking? ☐Yes ☐No ☐ Cane ☐ Walker ☐ Wheelchair

For day surgery patients only (if your child is going home the same day his/her surgery is done):
Their surgery will be cancelled if you do not have a responsible adult to provide transportation home and someone to remain with your child overnight.
Have you arranged for a responsible adult to pick your child up and stay with them overnight? ☐ Yes ☐ No

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

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 **Does your child have or have ever had?**	**NURSING ASSESSMENT**
YES NO	CONGENITAL HEART ABNORMALITY/BIRTH DEFECT? Corrected? YES NO	
YES NO	RHEUMATIC FEVER?	
YES NO	ABNORMAL HEART VALVES or MURMUR?	
YES NO	BLOOD DISORDER?	
YES NO	BLOOD CLOT IN LEG OR LUNGS?	
	DELIVERY INFORMATION **If child under two or born premature (if born premature questions only apply to 8 years old and younger)**	
	Type of delivery: Vaginal C/section How many weeks? _____ Complications: _____ Birth Weight: _____	

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	LUNGS/RESPIRATORY Does your child have or ever had?	
YES NO	ASTHMA (wheezing)?	
YES NO	CROUP?	
YES NO	SLEEP APNEA? If so, do they use CPAP? **YES NO** _____**cm H_2O**	
YES NO	recent COUGH/ COLD/ RESPIRATORY INFECTION?	
YES NO	REACTIVE AIRWAY DISEASE?	
YES NO	BRONCHITIS OR BRONCHIOLITIS?	
YES NO	SHORTNESS OF BREATH with minimal activity?	
	GENERAL **Does your child have or have ever had?**	**NURSING ASSESSMENT**
YES NO	DIABETES? Since when? _____ Diet only Pills Insulin BG average _____	
YES NO	HEARTBURN/ GASTROESOPHAGEAL REFLUX?	
YES NO	THRYOID PROBLEMS? Since when?	
YES NO	KIDNEY DISEASE?	
YES NO	JUVENILE ARTHRITIS?	
YES NO	Any WOUNDS/ULCERS that are being treated? Homecare? **YES NO**	
YES NO	CANCER? Type: _____ Year_____ Radiation? Chemotherapy?	
YES NO	MENTAL HEALTH PROBLEMS?	
YES NO	SEIZURES? Most recent seizure: _____	
YES NO	HEPATITIS/JAUNDICE?	
YES NO	MOTOR/COGNITIVE DELAY?	
YES NO	TOILET TRAINED? (if under 5)	
YES NO	BOTTLE FEEDING? BREASTFEEDING?	
YES NO	Immunizations up-to-date?	

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	ANESTHETIC HISTORY	
YES NO	Has your child or your family had any unusual reaction to anesthesia?	
YES NO	Does your child or your family have a history of MALIGNANT HYPERTHERMIA?	
YES NO	Has your child taken oral STEROIDS (Prednisone) in the past 6 months?	
YES NO	History of NEUROMUSCULAR DISEASE	
YES NO	Does your child have a LATEX allergy?	
YES NO	Teeth LOOSE or CAPPED?	
YES NO	BRACES/RETAINERS?	
	Child's response to ANXIETY:	

HOSPITALIZATION IN LAST 5 YEARS		Major Surgical History	
Reason	Date	Reason	Date

Is there anything else you would like to add?

Patient signature: _____
OR
Designate signature: _____ **Relationship:** _____

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

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NURSING NOTES