North Florida Surgery Center

PRE-ANESTHESIA ASSESSMENT

Surgeon/Physician: _____ Date: _____

Drug Allergies:	Height	Procedure?
	Weight	
	BMI	
Latex Allergy? Yes / No	Age	Airway:

Mallampati 1 2 3 4
Heart ☐ RRR
Lungs ☐ Clear Bilaterally

Yes	No	HAVE YOU HAD OR STILL HAVE?
☐	☐	Heart Blood Pressure – Take meds today? Y / N
☐	☐	Heart Murmur / Palpitations / Irregular Heartbeat
☐	☐	Chest Pain / Angina
☐	☐	Heart Attack – Date(s) _____
☐	☐	Angioplasty/Coronary Stents Date(s) _____
☐	☐	Heart Surgery Date(s) _____
☐	☐	Congestive Heart Failure
☐	☐	Shortness of Breath at Rest
☐	☐	Shortness of Breath Walking/Climbing/Stairs
☐	☐	Pacemaker / Defibrillator Last Checked _____
☐	☐	Cold in the Past Two Weeks
☐	☐	Fever in the Past 48 Hours
☐	☐	Smoked Tobacco in Past 10 Yrs? Packs per Y r_____
☐	☐	Asthma / Bronchitis / Chronic Cough
☐	☐	Emphysema / COPD / Tuberculosis / Asbestosis
☐	☐	Pneumonia in Past 6 Months?
☐	☐	Do you snore?
☐	☐	Sleep Apnea CPAP Use regularly? _____
☐	☐	Kidney Problems / Dialysis
☐	☐	Anxiety / Depression / BiPolar / Other _____
☐	☐	Stroke / TIA
☐	☐	Convulsion / Epilepsy / Blackouts
☐	☐	Back Pain / Disc Disease
☐	☐	Back Injury / Paralysis / Neurological Deficits
☐	☐	Arm or Leg Numbness / Muscle Weakness
☐	☐	Cancer – Type _____
☐	☐	Hepatitis / Jaundice / Cirrhosis / Liver Disease
☐	☐	Intestinal Ulcers / Reflux Esophagitis / GERD
☐	☐	Diabetes
☐	☐	Thyroid Disease
☐	☐	Anemia / Blood Transfusion / HIV
☐	☐	Would you refuse a blood transfusion if deemed necessary?
☐	☐	Frequent or Severe Headache - Type _____
☐	☐	Osteoarthritis – Location _____
☐	☐	Rheumatoid Arthritis
☐	☐	Prednisone / Steroid Use – Last Taken _____
☐	☐	Recent Abnormal Weight Loss
☐	☐	Weight Reduction Meds
☐	☐	Alcohol Consumption – Drinks per day _____
☐	☐	Post-Op Nausea / Vomiting in the Past?
☐	☐	You / Family: Other Problem with Anesthesia
☐	☐	You / Family: Bleeding Problem
☐	☐	Is there any chance you could be pregnant?
☐	☐	Chipped, Cracked or Loose Teeth
☐	☐	Crowns / Veneers / Partial / Full Denture
☐	☐	Herbal products in last month?

Previous Surgeries:

Labs/Additional Pre-Anesthesia Evaluation (Including Consults)

MEDICATIONS:

Medication review	**Beta Blocker**
☐ Database	☐ None
☐ MAR	☐ Given at (date/time):
☐ H&P	☐ Not indicated due to:

☐ Patient Evaluated/ History Reviewed
☐ Operative Procedure and Site Verified Risks
☐ Discussed and Questions Answered
☐ HCG Negative / Hysterectomy / Menopause

☐ Consent Obtained
☐ NPO > 8 hours ☐ NPO (other) _____
ASA I II III IV V VI E

ANESTHESIA PLAN Including Potential Anesthesia Problems

MAC/LOCAL
GA Induction IV / Inhal
Maint. IV / Inhal

Postop Analgesia: IV / Oral / Block

Crna Date/time

Surgeon Date/time

X

Signature of person completing form **Date/Time**

North Florida Surgery Center

PATIENT CONTACT INFORMATION FORM

Patient Name: _____ Date: _____

All calls regarding your case, test results, and appointments will be made to your home telephone number or number you provide.

PLEASE CHECK ONE

____ I hereby authorize North Florida Surgery Center to contact me by telephone and if I am not available, they may leave a message on my answering machine or voice mail.

____ Do NOT leave a message other than the name of the caller and the telephone number.

OTHER CONTACT INFORMATION

The following people other than a guardian or conservator are authorized to discuss by medical condition or billing information with a healthcare professional of North Florida Surgery Center.

_____

(Name) (Relationship) (Phone #)

_____

(Name) (Relationship) (Phone #)

_____ _____

Patient Signature Date

North Florida Surgery Center

YOUR RIGHTS AND RESPONSIBILITES AS A PATIENT

At North Florida Surgery Center our goal is to provide the highest quality outpatient care. We believe that it is essential that our patients and their families are respected and supported. The following is a summary of your rights and responsibilities as a patient. If you have any questions about your rights and responsibilities, please ask to see the Administrator.

YOU HAVE THE RIGHT TO…

- To receive services without regard to race, color, age, sex, sexual orientation, religion, marital status, handicap, national origin or sponsor.
- To be treated with courtesy, respect, and dignity, and have privacy concerning your medical care.
- To be provided reasonable physical access.
- To be provided a secure environment for self and property.
- To expect that all disclosures and records are treated confidentially, except when required by law, and to be given the opportunity to approve or refuse their release.
- To be told clearly about your diagnosis, treatment and prognosis. Your physician should be able to provide this information.
- To be given the opportunity to participate in decisions involving their health care, except when participation is contraindicated for medical reasons.
- To receive from his/her physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Such information for informed consent should include the specific procedure and/or treatment, significant medical risks involved, and the probable duration of incapacitation.
- To be informed, when appropriate, of treatment policy for an emancipated minor not accompanied by an adult.
- To refuse treatment, and be informed of consequences of refusing treatment or not complying with therapy.
- To be informed as to conduct and responsibilities as a patient.
- To be informed as to services available from the facility
- To be informed as to provisions for after-hour and emergency care.
- To be informed as to fees for service.
- To be informed as to payment policies.
- To be informed as to right to refuse participations in investigational studies or clinical trials.
- To be informed as to methods of expressing grievance and suggestions to the facility.
- To be informed as to disclosure of ownership.
- To be informed as to procedure for reporting public health concerns to the appropriate authorities.
- To be informed of how to file a complaint during the course of your admission.

IT IS YOUR RESPONSIBILITY TO…

- To provide, to the best of the patient's knowledge, accurate and complete information about present complaints, past illnesses, hospitalization, existence of advance directives, medications and other information relating to health status.
- To follow the treatment plan recommended by the practitioner primarily responsible for the patient's care.
- To accept the consequences of his/her own actions when refusing treatment or not following the practitioner's instructions.
- To assure that the financial obligations for health care rendered are fulfilled as promptly as possible.
- To follow the rules and regulations affecting care and conduct pertaining to the procedures performed.
- To be considerate of the rights of other patients and facility personnel and to assist in the control of noise and smoking.
- To be respectful of the property of other persons and of the facility.

TO FILE A COMPLAINT REGARDING PATIENT RIGHTS, PLEASE FEEL FREE TO CONTACT:

North Florida Surgery Center
ATTN: Administrator
256 Professional Glen, Ste. 101
Lake City, FL 32025
Phone: (386) 758-8937

Agency for Health Care Administration
ATTN: Complaint Administration Unit
2727 Mahan Dr.
Mail Stop #49
Tallahassee, FL 32308
Phone: (888) 419-3456

The Joint Commission
ATTN: Patient Complaints
One Renaissance Blvd.
Oakbrook Terrace, IL 60181
Phone: (800) 758-8937
complaint@jointcommission.org

OR ONLINE AT: https://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

North Florida Surgery Center

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES

This facility requires the following notice be signed by each patient prior to scheduled procedure in order to be in compliance with the Self-Determination Act (PSDA) and State law and rules regarding advance directives. Advance directives are statements that indicate the type of medical treatment wanted or not wanted in the event an individual is unable to make those determinations and who is authorized to make those decisions. The advance directives are made and witnessed prior to serious illness or injury.

There are many types of advance directives, but the two most common forms are:

LIVING WILLS

These generally state the type of medical care an individual wants or does not want if he/she becomes unable to make his/her own decisions.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

This is a signed, dated, and witnessed paper naming another person as an individual's agent or proxy to make medical decisions for that individual if he/she should become unable to make his/her own decisions.

In an ambulatory care setting, if a patient should suffer a cardiac or respiratory arrest or other life threatening situations, the signed consent implies consent for resuscitation and transfer to a higher level of care. Therefore, in accordance with federal and state law, the facility is notifying you it will NOT HONOR previously signed advanced directives for any patient. If you disagree, you must address this issue with your physician or anesthesiologist prior to signing this form.

Do you have an Advance Directive: _____ Yes _____ No

I have read and fully understand the information presented in this release form.

_____ _____
Patient's Signature Witness to Patient's Signature

_____ _____
Date Date

If patient is unable to sign or is a minor, please sign below.

_____ _____
Closest Relative or Legal Guardian's Signature Witness to Relative/Guardian Signature

_____ _____
Date Date