

**PRE-ANESTHESIA AND  
SURGICAL SCREENING ORDERS**



**To be used for all planned surgeries at Presbyterian Hospital**

**Instructions:** Complete this form and fax to (505) 213-0460.

Any questions call (505)724-6990 or email address: [pass@phs.org](mailto:pass@phs.org)

**Planned Surgery Information:**

**Patient Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **MI:** \_\_\_\_\_ **Gender:**  M  F

**Patient is allergic to:** \_\_\_\_\_

**Specify Any Antibiotic Allergies and Symptoms:** \_\_\_\_\_

**Surgeon:** \_\_\_\_\_ **Surgery Date:** \_\_\_\_\_

**Anesthesia Preference:** (check one)  Local  MAC  General  Choice  Acute Pain Block: \_\_\_\_\_

**Patient Status:** (check one)  Inpatient  Observation  Extended Recovery (short stay)

**Precautions:** (check if apply)  MRSA  C Diff  Latex allergy  Other: \_\_\_\_\_

**Cardiac Consult with** \_\_\_\_\_ **Scheduled for** \_\_\_\_\_

**Other Consult with** \_\_\_\_\_ **Scheduled for** \_\_\_\_\_

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**Included Orders:** (These orders are authorized unless otherwise specified by physician per Pre-Anesthesia Surgical Screening Protocol – see reverse side of this page for reference of protocol orders)

1. Initiate Diagnostic Screening Protocol Orders
2. Initiate Surgical Risk Screening Protocol Orders
3. PASS Unit to instruct patient on insulin use on day of surgery per Pre-Anesthesia Surgery Screening Protocol.
4. NPO after midnight unless otherwise directed by physician as written below.

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(Only checked orders will be activated from this point on)

**Additional Orders Including Home Medication Instructions:**

5. Obtain consent for: \_\_\_\_\_

6. Clip and Prep: Location \_\_\_\_\_

7. Additional screening labs not covered by protocol orders:  UA  CBC  Type and Screen

8. \_\_\_\_\_

9. \_\_\_\_\_

10. \_\_\_\_\_

11. \_\_\_\_\_

12. \_\_\_\_\_

Signature: \_\_\_\_\_

Printed Name/ID#: \_\_\_\_\_

Date and Time: \_\_\_\_\_

PATIENT IDENTIFICATION



## Pre-Anesthesia and Surgical Screening Protocol Reference

**Diagnostic Screening Protocol Orders:** Orders for the following Diagnostic Screening Tests are placed on this matrix in accordance with the Pre-Anesthesia Surgery Screening Guidelines.

<b>Medical Condition:</b>	CBC w/o Diff	Type & Screen	EKG	BMP	PT/PTT INR	K+AM DOS	CMP	U-HCG AM DOS	C-Gluc
Cardiovascular			X						
HTN			X						
Pulmonary Disease			X						
Renal Disease	X		X				X		
Dialysis	X		X			X	X+DOS		
Diabetes			X						X+DOS
Bleeding Problems	X				X				
Liver Disease					X		X		
Extreme Obesity (BMI ≥ 40)			X						
Possible Pregnancy								X	
Current Malignancy under treatment	X		X						
<b>Medications:</b>									
Diuretic therapy				X					
Digoxin therapy						X			
Anticoagulant therapy (Warfarin, Enoxaparin, Heparin, Clopidogrel)	X				X+DOS				
<b>Procedures:</b>									
Cardiovascular Surgery		X							
Large Orthopedic Surgery		X							
Cesarean Section	X	X							
Autologous Donors		X							
<b>Other:</b>									
<b>Serum HCG (PASS visit):</b> Medically indicated before hysterectomy, hysterotomy, hysteroscopy, endometrial ablation, LEEP, tubal ligation, and/or other elective abdominal surgery. Offered to women of childbearing age (13-50)									
<b>Urine HCG:</b> Test in morning of surgery if serum HCG is > 48 hours									
<b>Drug Levels:</b> Level drawn on all patients on Digoxin and Dilantin									
<b>CXR:</b> Recent change in sputum quality or color, pneumonia in past 3 months, chronic home O2 use, planned intrathoracic surgery, or if exam reveals rales, rhonchi, or wheezes									
<b>MRSA Screening:</b> Nasal culture for patients for planned post-operative admission to Critical Care Units									

### **Surgical Risk Screening Protocol Orders:**

- Patients who are not to be scheduled at a day surgery facility:
  - Patients with BMI > 45 (Up to BMI of 45 is acceptable if no significant, unstable CV, respiratory, or endocrine pathology is present)
    - English BMI Formula =  $(\text{Weight in pounds} / (\text{Height in inches})^2) \times 703$
    - Metric BMI Formula =  $(\text{Weight in Kilograms} / (\text{Height in Meters})^2) \times 703$
  - Obstructive Sleep Apnea Perioperative Risk Score of 5 or 6 (Refer to Pre-Anesthesia Screening Guidelines)
- Preventative antibiotic therapy will be administered within one hour prior to skin incision per SCIP protocol pre-operatively, based on procedure type and patient allergies, unless otherwise ordered by physician
- DVT/VTE prevention methods will be implemented using SCIP Mechanical Prophylaxis Protocol unless contraindicated or otherwise documented in orders by physician.

### **Diabetes Management:**

- Discontinue all oral agents the evening prior to surgery, except Metformin which can be taken the evening prior to surgery but not the day of surgery.
- Discontinue insulin after midnight for AM surgeries.
- Take ½ usual dose of insulin the AM of surgery if surgery is scheduled to start at noon or later.
- Take 100% of Lantus insulin up to time of surgery.
- Consume apple or cranberry juice up till 2 hours prior to arrival to surgery if insulin was used.
- For insulin pumps, set to basal rate and continue throughout pre-operative period.
- C-Glucose will be done on all diabetics in PASS and results >200 reported to anesthesia and surgeon.
- Arrival to Holding Area, C-Glucose will be obtained. Results treated by anesthesia according to NPO Insulin Sliding Scale.

### **NPO Guidelines:**

The PASS unit will instruct all patients to be NPO after midnight and to follow the surgeon's instructions if they differ from these. The surgeon who gives different instructions will be responsible for thorough patient instruction of anything other than these guidelines.

- All patients are equal with regard to NPO guidelines (i.e. gastric emptying time, obesity)
- Clear liquids may be consumed up to 2 hours prior to scheduled arrival time.
- Clear liquids are water, black coffee, and beverages not cloudy and can be seen through. Sugar and artificial sweeteners are acceptable. All broths are NOT acceptable.
- Patient may brush their teeth, but should not swallow tooth paste.
- Gum and candy of any type are not allowed.
- All patients will be allowed to eat a full, regular diet (solid) up to 8 hours prior to surgery. Patient going to the OR at 0730 who were NPO after midnight are considered to meet this standard
- Infants up to 24 months of age will be allowed breast milk up to 4 hours prior to the arrival to the hospital. Infant formula will be considered a solid.

**CONSENT FOR SURGERY OR PROCEDURE AND  
ACKNOWLEDGEMENT FOR RECEIPT OF INFORMATION**



A doctor must have your permission before a surgery or procedure can be done. Your doctor must talk with you about your surgery or procedure. When you sign this form below, it means that you agree to the surgery or procedure. You are also confirming that doctor talked to you about the following:

\_\_\_\_\_ (Print doctor's name)

- The nature of the surgery or procedure that is recommended
- The reason for the surgery or procedure
- Possible risks and benefits and the likelihood of each
- Problems or complications that might happen after the surgery or procedure
- Alternative procedures or treatments for your condition
- Risks and benefits of alternative surgeries or procedures
- What may happen if you do not have the recommended surgery or procedure
- Use of anesthesia
- The possibility that during the surgery or procedure the doctor may need to do other procedures
- Other licensed healthcare workers, including other doctors, may be involved in the surgery or procedure
- Supervised medical or surgical residents may be involved in the surgery or procedure, at the discretion of your doctor
- Photographs, video or other images may be recorded during the procedure if it is necessary or important for your care
- Right not to have the recommended surgery or procedure
- There is no guarantee about the outcomes of the surgery or procedure

Your permission also allows the doctor to do the following:

1. Give blood transfusions, if necessary.  Yes  No
2. Discard tissue that will not be used for testing.  Yes  No
3. Use tissue removed during my surgery for research.  Yes  No  Not applicable
4. Have healthcare persons watch my surgery or procedure as part of their education.  Yes  No  Not applicable
5. Have representatives of companies, whose products my surgeon is using, observe the surgery or procedure  
 Yes  No  Not applicable

I give permission for Dr. \_\_\_\_\_ to do the following surgery or procedure  
(Print doctor's name)

\_\_\_\_\_ (Print name of surgery or procedure)

on \_\_\_\_\_  
(Print patient's name)

I have read this form and understand what it means. I understand what the doctor has told me. I have had all questions and concerns answered by the doctor. All blanks were filled in before I signed the form. I understand and accept the risks of the surgery or procedure.

**Patient's signature (or Patient's Representative)** \_\_\_\_\_

(If signature is not the patient's, note relationship) \_\_\_\_\_

Date \_\_\_\_\_ Time \_\_\_\_\_ a.m./p.m.

If patient is unable to sign, state reason \_\_\_\_\_

**Interpreter used – Print Interpreter's Name** \_\_\_\_\_

**Witness Signature of Licensed Personnel** \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_ a.m./p.m.

PATIENT IDENTIFICATION



# AUTORIZACIÓN PARA UNA CIRUGÍA O PARA UN PROCEDIMIENTO CLÍNICO Y CONSTANCIA DEL RECIBO DE LA INFORMACIÓN

El médico debe recibir su permiso antes de que se pueda realizar una cirugía o un procedimiento clínico. Su médico debe hablarle sobre su cirugía o sobre un procedimiento clínico. Al firmar más abajo este formulario usted indica que está de acuerdo con que se le haga la cirugía o el procedimiento clínico. Además, usted certifica que el médico \_\_\_\_\_ le habló acerca de lo siguiente:

(Escriba el nombre del médico en letra de molde)

- El tipo de cirugía o procedimiento clínico que se recomienda
- El motivo de la cirugía o del procedimiento clínico
- Los riesgos y beneficios de la cirugía o del procedimiento clínico y el nivel de probabilidad de los mismos
- Los problemas o complicaciones que pueden surgir a causa de la cirugía o del procedimiento clínico
- Otros tratamientos o procedimientos para su afección clínica
- Los riesgos y beneficios de las otras cirugías y procedimientos clínicos a su disposición
- Lo que puede suceder si usted no se hace la cirugía o el procedimiento clínico que se recomienda
- El uso de la anestesia
- La posibilidad de que durante la cirugía o el procedimiento clínico, el médico tenga que hacerle algún otro procedimiento clínico
- Otros empleados certificados que prestan servicios clínicos, incluso otros médicos, puedan estar involucrados en la cirugía o el procedimiento clínico
- Los médicos o cirujanos residentes que estén bajo supervisión pueden participar en la cirugía o del procedimiento clínico, a criterio de su médico
- Tal vez se tomen fotografías, videos u otras imágenes durante el procedimiento clínico si es necesario o importante para su atención clínica
- Su derecho de no hacerse la cirugía o el procedimiento clínico
- No hay ninguna garantía con respecto a los resultados de la cirugía o el procedimiento clínico

Su permiso también permite que su médico haga lo que se enumera a continuación:

1. Dar transfusiones de sangre, si fuera necesario.  Sí  No
2. Disponer de tejidos que no se utilizarán para fines de análisis.  Sí  No
3. Utilizar los tejidos que se me remuevan durante la cirugía para fines de investigación.  Sí  No  No es aplicable
4. Que los empleados que prestan servicios clínicos observen mi cirugía o procedimiento clínico como parte de su educación.  Sí  No  No es aplicable
5. Que los representantes de las compañías, cuyos productos utiliza mi cirujano, observen la cirugía o el procedimiento clínico  Sí  No  No es aplicable

Concedo mi permiso para que el(la) Dr(a). \_\_\_\_\_ lleve a cabo la cirugía o \_\_\_\_\_

(Escriba el nombre del médico en letra de molde)

el procedimiento clínico que se indica aquí \_\_\_\_\_

(Escriba el nombre de la cirugía o del procedimiento en letra de molde)

a \_\_\_\_\_

(Escriba el nombre del paciente en letra de molde)

He leído este formulario y comprendo lo que dice. Comprendo lo que me ha dicho el médico. El médico ha respondido todas mis preguntas y aclarado mis preocupaciones. Todas las líneas en blanco se llenaron antes de firmar el formulario. Comprendo y acepto los riesgos de la cirugía o del procedimiento clínico.

**Firma del paciente (o del representante del paciente)** \_\_\_\_\_

(Si la firma no es la del paciente, explique su relación con el paciente) \_\_\_\_\_

Fecha \_\_\_\_\_ Hora \_\_\_\_\_ a.m./p.m.

Si el paciente no puede firmar, explique por qué no: \_\_\_\_\_

Si se utilizaron los servicios de un intérprete: Escriba el nombre del intérprete en letra de molde: \_\_\_\_\_

**Firma del testigo del personal certificado** \_\_\_\_\_

Fecha \_\_\_\_\_ Hora \_\_\_\_\_ a.m./p.m.

IDENTIFICACIÓN DE PACIENTE



# PERMIT FOR ANESTHESIA



Your doctor has requested that anesthesia be given to you as a part of your care. It is your right to approve the methods of anesthesia that will be used and to refuse techniques or drugs that you object to. The risks and benefits of the various techniques and drugs will be explained to you to your satisfaction by an anesthetist. As in any medical procedure there are risks involved in any anesthetic. Serious problems are infrequent, but they do occur. It is impossible to guarantee results or to know ahead of time which patients may have a problem under anesthesia. Your health status, the procedure that you are undergoing, and your desires are considered when choosing an anesthetic plan. The attempt is made to minimize the risks to you. These risks include, but are not limited to the following:

COMMON	NOT COMMON	RARE
Sore Throat Hoarseness Vomiting Headache Bruising from Needles Backache	Infection Lung / Breathing Problems Nerve Injuries Tooth Damage Eye Injury Drug Allergy Irregular Heart Beat	Awareness During Anesthesia Stopping of the Heart Brain Damage Seizures Death

I have read and understood this permit. Anesthesia alternatives, when possible, have been discussed with me and I agree to receive the following type of anesthesia:

\_\_\_\_\_, but I realize that in some cases a change in anesthetic plan may be deemed prudent at the time of my procedure and I consent to such changes as necessary. The risks and benefits have been explained to my satisfaction and my questions have been answered. I understand that the anesthetist who counseled me may not be the one who gives me my anesthetic.

**FINANCIAL RESPONSIBILITY: I understand that I am responsible for payment of all Anesthesia services. I accept financial responsibility for payment for services if my insurance company does not cover these services.**

Patient \_\_\_\_\_

Date \_\_\_\_\_ Time \_\_\_\_\_

Patient cannot request or authorize because \_\_\_\_\_

\_\_\_\_\_  
(Legally Responsible Person)

\_\_\_\_\_  
(Relationship to Patient)

I have counseled this patient as to the proposed methods of anesthesia and the risks and benefits of same to the patient's satisfaction.

\_\_\_\_\_  
Signature of Counseling Anesthetist

\_\_\_\_\_  
Printed Name

PATIENT IDENTIFICATION



## PERMISO PARA ANESTESIA

Su médico ha solicitado que, como parte de su atención médica, se le administre anestesia. Usted tiene el derecho de aprobar los métodos de anestesia que se le administren, o a rehusar aquellas técnicas o drogas contra las cuales usted tenga objeciones. Un anesthesiólogo le explicará con detenimiento y claridad acerca de los riesgos y beneficios de las diversas técnicas y drogas. En el uso de anestésicos, al igual que en todo procedimiento médico, existen riesgos. Los problemas graves son poco frecuentes, pero ocurren ocasionalmente. Es imposible garantizar los resultados o saber de antemano quiénes son los pacientes que pueden presentar problemas bajo los efectos de la anestesia. El estado de su salud, sus propias preferencias y el procedimiento médico al cual le estén sometiendo a usted son factores que se foman en consideración cuando se va a seleccionar el plan anestésico a seguir. Lo que intentamos es minimizar los riesgos. La tabla que aparece a continuación muestra los riesgos relacionados con la anestesia, aunque éstos no se limitan a los aquí mencionados.

USUAL	POCO USUAL	RARO
Dolor de Garganta Ronquera Vómitos Dolor de Cabeza Magulladuras infligidas por las agujas Dolor de Espalda	Infecciones Problemas Pulmonares/Respirando Daño a los Nervios Lesiones en la Dentadura Lesiones en los Ojos Alergia Drogas Palpitación de Corazón Irregular	Consciente Durante Anestesia Paro al Corazón Daño Cerebral Permanecer Consciente Convulsiones Muerte

He leído y entendido este permiso. Cuando posible, alternativas de anestesia, han discutido conmigo, y estoy de acuerdo al recibir la siguiente anestesia:

\_\_\_\_\_ pero comprendo que existe la posibilidad de que durante el procedimiento médico se considere prudente cambiar el plan establecido para anestesiarme y de ser así, doy mi consentimiento para que se hagan los cambios que sean necesarios. Estoy bien satisfecho con las explicaciones que me han dado acerca de los riesgos y los beneficios de la anestesia y me han contestado mis preguntas sobre ese particular. Tengo entendido que el anestesista que me orientó no es necesariamente el que me ha de aplicar la anestesia.

**RESPONSABILIDAD FINANCIAL: Yo entiendo que yo soy responsable por los pagos de todos los servicios de Anestesia. Yo acepto financiera responsabilidad por pagos de servicios, si mi compañía de seguros no cubre por estos servicios.**

Paciente: \_\_\_\_\_

Fecha: \_\_\_\_\_ Hora: \_\_\_\_\_

El paciente (las paciente) no puede dar su autorización debido a \_\_\_\_\_

\_\_\_\_\_  
(Persona Responsable Legalmente)

\_\_\_\_\_  
(Parentesco con Paciente)

Le he ofrecido orientación a este(a) paciente acerca de los métodos de anestesia que proponemos emplear y el (la) paciente se siente totalmente satisfecho(a) con mi explicación que le he ofrecido acerca de los riesgos y beneficios que estos métodos envuelven.

\_\_\_\_\_  
Firma del Anestesista Asesor

\_\_\_\_\_  
Apuntar Su Nombre

PATIENT IDENTIFICATION



**DISCLOSURE AND CONSENT TO RECEIVE  
OR REFUSE BLOOD TRANSFUSION**



**TO THE PATIENT AND/OR LEGAL REPRESENTATIVE: Patients have the right to be informed about blood transfusions so that they may make the decision whether or not to undergo this transfusion after knowing the potential benefits, risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so that you may give or withhold your consent.**

I have been informed that \_\_\_\_\_ may need one or more transfusions, during this hospital admission or in the future. Such transfusions include red blood cells (carry oxygen) and/or other blood products such as platelets and plasma (help to clot blood), or white blood cells (fight infection).

I understand that the source of blood and/or blood products may be either (a) blood from donors or (b) my own blood that had been collected previously. I understand that it may not be possible to donate my own blood in advance due to such factors as my medical condition; or, if surgery is recommended, the date on which surgery is scheduled; or the amount required exceeds the number of units that I could donate in advance.

I understand that all blood and/or blood products are currently tested and screened for the presence of potentially transmissible infectious agents according to standards established by the Food and Drug Administration (FDA) and the American Association of Blood Banks (AABB). I also understand that the current screening of donated blood does not eliminate the potential transmission of every harmful infectious disease.

I understand that the transfusion of blood and/or blood products involves risks of allergic reaction, fever, hives, and in rare circumstances, infectious diseases such as hepatitis, HIV/AIDS and bacterial infections.

I have been given the opportunity to ask questions about this procedure and its risks and the risks of refusing. I have been informed and I understand that I am able to withdraw my consent and to refuse transfusion at any time, and that such withdrawal of consent may affect the outcome of my treatment or may change my treatment options.

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PATIENT IDENTIFICATION



**DISCLOSURE AND CONSENT TO RECEIVE  
OR REFUSE BLOOD TRANSFUSION**

**CONSENT TO THE FOLLOWING: (Check only one)**

- 1. To be transfused with blood and/or blood products from donors.
- 2. To be transfused with my own blood and/or blood products collected in advance to the fullest extent possible before using blood and/or blood products from any other source. I also consent to the use of blood, and/or blood products from any other source, depending on my medical condition and the availability of sufficient amounts of my own blood.
- 3. To be transfused with only the following components:  
\_\_\_\_\_
- 4. I do not consent to the use of any blood products at any time.

I acknowledge by my signature below that this form has been fully explained to me, that I have read it or have had it read to me, that I understand its contents and that I have indicated my consent or refusal to consent above. I understand that my consent may be withdrawn at any time and that I am responsible for informing my physician(s) of such a change.

\_\_\_\_\_  
SIGNATURE OF PATIENT

\_\_\_\_\_  
SIGNATURE OF WITNESS

\_\_\_\_\_  
SIGNATURE OF OTHER LEGALLY RESPONSIBLE PERSON,  
IF PATIENT IS UNABLE TO SIGN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
TIME

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

If applicable, this form has been translated to the patient/other legally responsible person by:

\_\_\_\_\_  
SIGNATURE OF TRANSLATOR

The risks, hazards, limitations and benefits, as well as alternative treatment possibilities have been reviewed with the patient.

\_\_\_\_\_  
PHYSICIAN (or PRACTITIONER) SIGNATURE  
(or documentation by physician in the Progress Note)

PATIENT IDENTIFICATION



**CONSENT FOR PRESENCE OF A VISITOR IN THE  
SURGICAL OR INVASIVE PROCEDURAL AREA**



Patient Name: \_\_\_\_\_

Date of Procedure: \_\_\_\_\_

I, \_\_\_\_\_, hereby consent to the  
NAME OF PATIENT/LEGAL REPRESENTATIVE

Presence of \_\_\_\_\_  
NAME OF VISITOR and SPONSOR or SALES/TECHNICAL REPRESENTATIVE and/or COMPANY

in the room during my procedure, I release Presbyterian Healthcare Services, its personnel, and the physician from any legal responsibility which may result from the above named person's presence.

I acknowledge that I have read and fully understand the above consent, the explanations referred to were made, and that all blanks or statements requiring insertion or completion were filled in before I affixed my signature.

Signature of Patient or  
Patient's Representative \_\_\_\_\_

Witness \_\_\_\_\_

Current Date \_\_\_\_\_ Current Time \_\_\_\_\_

PATIENT IDENTIFICATION



# OUT PATIENT PHYSICIAN ORDERS AND DOCUMENTATION



ORDERS PROVIDERS

DATE:	TIME:
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CHIEF COMPLAINT:	
HISTORY OF PRESENT ILLNESS:	
ALLERGIES:	MEDICATIONS:
PAST SIGNIFICANT MEDICAL HISTORY:	

PHYSICAL EXAM	HEAD AND NECK:
	CHEST:
	CARDIOVASCULAR:
	ABDOMEN:
	GENITO-URINARY:
	EXTREMITIES:
	<b>ADMITTING / PRE-PROCEDURE DIAGNOSIS:</b>

<b>PHYSICIAN'S ORDERS</b>	PHYSICIAN SIGNATURE:
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PROCEDURAL/OPERATIVE PERMIT FOR:
LAB WORK TO BE DONE:
OTHER ORDERS:

<b>POST PROCEDURE NOTE</b>	PHYSICIAN SIGNATURE:
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1. DATE:	2. TIME:
3. POST-PROCEDURE DIAGNOSIS:	
4. PROCEDURE:	
5. FINDINGS: <input type="checkbox"/> Same as Post-Procedure Dx. <input type="checkbox"/> Other: _____ <span style="display: block; text-align: right; font-size: small;">(Please describe)</span>	
6. SURGEON/PROCEDURALIST:	
7. ASSISTANT SURGEON/PROCEDURALIST: <span style="float: right;"><input type="checkbox"/> NONE</span>	
8. ESTIMATED BLOOD LOSS: _____ ml <span style="float: right;"><input type="checkbox"/> NONE</span>	
9. SPECIMEN:	
10. OPTIONAL COMMENTS:	

POST PROCEDURE INSTRUCTIONS & ORDERS:	
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PATIENT IDENTIFICATION

PHYSICIAN SIGNATURE:

