UC Irvine Health

AMBULATORY PRACTICE SURGICAL SCHEDULING ORDERS

Patient Information

Date:	Time:	Dual Case ☐ Yes ☐ No	Surgeon(s):	Perioperative Surgical Home ☐ Yes ☐ No
Patient Telephone ____-____-____	STARS #:	Date of Surgery: ____/____/____	Time of Surgery: ____:____	
Clinic Coordinator:	Nurse:	Office Ext.:	Fax #:	
Height (cm):	Weight (kg):	VS: BP____ P____ R____ T____	Primary Care MD:	

Allergies: Reaction:

☐ Patient Does Not Require Medical Clearance
☐ Referral for Medical Evaluation ☐ Hospitalist Program Fax: 714.456.6429 H & P Source ☐ UC Irvine ☐ Outside ☐ UCI preop appt/time____
☐ Other MD: Name: ____ Office Number: ____ Appt. Date ____
☐ Give Reasons: ____ Clinical Staff Signature: ____ Date/Time: ____
☐ Primary Surgeon to provide orders and pre-operative work up

Physician Orders

☐ UC Irvine Lab ☐ Outside Lab: ☐ CBC w/diff ☐ Hgb/Hct ☐ ACT ☐ PT ☐ PTT ☐ BMP ☐ CMP ☐ UA ☐ Urine C&S ☐ BHCG ☐ UA Preg
☐ STAT ☐ T & H Bleeding Questionaire Positive ☐ Yes ☐ No See Pre Op Testing Guidelines

☐ T & C ____units ☐ T & H ____units ☐ Directed Donor ☐ Autologous ☐ Blood Bank ☐ EKG < 6 mo X-Ray: ☐ Chest PA/LAT

Patient Acknowledgement of Specimen(s) Taken for Laboratory Testing Listed above:
Name (print): ____ Signature: ____ Date: ____ Relationship to patient: ____

Diagnosis:	**ICD10:**
Surgical Procedure (as per informed consent): ☐ Major surgery ☐ Minor surgery	**CPT:**

Length of procedure cut/close: ____ Procedure part of IRB Protocol: ☐ No ☐ Yes IRB# ____ Bleeding Risk ☐ High ☐ Low

Prior Cardiac W/U ☐ ☐ Diagnostic Tests Results / Images Required in Procedure Area: ____

Anesthesia / Regional Services Requested: ☐ Yes ☐ No Specify anesthesia type: ☐ General ☐ Epidural ☐ Regional ☐ MAC ☐ Spinal ☐ Bier Block

Positioning: ☐ Supine ☐ Prone ☐ Rt. Lateral ☐ Lt. Lateral ☐ Lithotomy ☐ Allen Stirrups ☐ Candy Canes ☐ Other ____

Special Equipment or Supplies: ☐ C-ARM ☐ Cell-Saver ☐ ION Monitoring ☐ Prosthesis ☐ Bone ☐ Tissue ☐ Ultrasound ☐ Laser:type ____

VTE Prophylaxis: ☐ **SCDs** ☐ **TEDs** ☐ **Thigh High (preferred)** ☐ **Knee High**

In Preop: ☐ **Enoxaparin** ____ **mg Subcut x 1** ☐ **Heparin** ____ **Units Subcut x 1** ☐ **Other** ____

Cardiac Prophylaxis with Beta Blocker: (Beta Blocker Criteria listed on back panel.)

Beta Blocker: ____ **orally with sips of water with pre-op meds**

Prophylaxis is Indicated or Patient Already on Beta-Blocker
☐ Patient is already on beta-blocker therapy and will take this prior to surgery
☐ Patient meets criteria and was prescribed a beta-blocker to take prior to surgery
☐ Patient meets criteria, but beta-blocker NOT prescribed due to HR<55 or SBP<100
If prophylaxis is indicated or the patient is already on a beta-blocker and HR>65 and SBP>100 ***prior to induction:***
☐ Give additional dose of IV metoprolol 2.5 -5 mg and repeat in 15 minutes to target HR 55-65.

Prophylaxis is Not Indicated
☐ Patient does NOT meet criteria for beta-blocker prophylaxis because patient is scheduled for low-risk surgery or non-AAA surgery with <2 RCRI criteria
☐ Beta-blocker NOT prescribed due to allergy or other major contraindication

Antibiotics: ☐ Antibiotics not indicated
☐ Antibiotic dosage appropriate for weight per pharmacy
☐ MD aware of patient allergy. Proceed with ordered antibiotic.

Adult Doses
☐ Cefazolin IVPB
☐ Cefoxitin IVPB
☐ Ampicillin IVPB
☐ Ampicillin/Sulbactam IVPB
☐ Clindamycin IVPB + Gentamycin IVPB (for pt. allergic to Penicillin)
☐ Clindamycin IVPB + Ciprofloxacin IVPB (for pt. allergic to Penicillin)
☐ Ertapenem IVPB 1 gm for:
☐ Open Heart Surgery or ☐ Colorectal Surgery
☐ Clindamycin
☐ Gentamicin ____mg IVPB (1.8 - 2.5mg/kg)
☐ Ciprofloxacin 400mg IVPB (for pt. allergic to Penicillin)
☐ Metronidazole 500mg IVPB
☐ Other ____

REASONS: MUST check all that apply for prescribing Vancomycin:
☐ Beta-lactam allergy
☐ Continuous inpatient stay > 24hrs prior to the principal procedure
☐ Known MRSA colonization
☐ High risk due to acute inpatient care or LTC within past year
☐ Chronic wound care ☐ Chronic dialysis
☐ Prosthetic valve or vascular graft surgery
☐ Skin lesions concerning for possible community-acquired MRSA
☐ Other reason: ____

Vancomycin ____gm (15mg/kg up to 1.5gm rounded to nearest 250 mg) in D5W IVPB
☐ Concentrated Vancomycin for craniotomy and CT surgery patients only
☐ Vancomycin 1.5 gm in NS\D5W 150ml
☐ Vancomycin 1.25 gm in NS\D5W 150ml
☐ Vancomycin 1.5 gm in NS\D5W 150ml
(NS for craniotomy patients. D5W for CT surgery patients.)

Admission Requirements Nursing Unit: ____ Type of Admission: ☐ Elective ☐ Urgent ☐ Emergent Estimated # of midnights ____

☐ Inpatient (PRE & AM Admits) Rationale: ☐ Status post surgery, inpatient stay required for ongoing medical management
☐ Outpatient Surgery / No Post Surgical Bed Needed ☐ Outpatient Surgery / Post Surgical Bed Required ☐ Isolation (give reason): ____

DISCHARGE PLACEMENT: ☐ SNF/Rehab/HH ☐ Home ☐ Unknown

Communication Notes: ____

MD/PA/NP Signature: ____ Date/Time: ____ Attending MD Signature: ____ Date/Time: ____

All documentation must indicate the specific date and time of entry and a signature complete with identify credential, title or classification.

87417

UC Irvine Health

PLASTIC SURGERY TISSUE ORDER FORM

Date of Surgery _____ **Case Confirmation Number**_____

<u>Available Blood Bank Allograft</u> (CPC tube to station 231)

Alloderm (RTU)Thick ____6x16cm ____6x12cm ____8x16cm ____4x7cm

Alloderm (RTU)Contour ____Medium

Cancellous Chips ____15cc ____30cc

Cancellous Crushed ____15cc ____30cc

Cellentra VCBM Viable Cell Bone Matrix ____1cc ____10cc ____15cc

Flex HD Breast Kit Pliable ____8x16cm (2 pieces)

Flex HD Pliable Breast ____6x16cm Flex HD Pliable Thick ____8x16cm

Flex HD Pliable _____ 16 x 20cm

Flex HD Pliable Fenestrated _____ 8x16

Flex HD Pliable Fenestrated Breast Kit _____ (2 of the 8X16)

Flex HD Thick (structural) ____16x20cm Flex HD Thick (structural) ____20x20cm

Tendon (MTF) Semitendinosus ____L>26

<u>Xenograft / Mesh</u> (fax to OR Supplies X 7843)

Integra Wound Matrix Single Layer ____2x2" ____4x5"

Integra Wound Matrix Bilayer ____2x2" ____4x5" ____4x10" ____8x10"

Integra Thin ____4x5" ____ 4x10"

Ethicon Proceed Surgical Mesh ____15x20cm ____30x30cm ____10x15cm ____7x15cm

Ethicon Prolene Mesh ____12x12" (30x30cm) Etihicon Ultra Pro ____15x15cm

Ethicon Vicryl Mesh ____12x12" (30x30cm)

Gore Bio A ____9x15cm ____8x8cm ____20x20cm

Xen Matrix ____15x20cm

Bard Ventrilex Hernia Patch ____4.3cm ____6.4cm ____8cm

Bard Mesh ____5x10cm ____5x31cm ____7x15cm ____15x15cm ____10x14cm

M.D. Name (print)_____ **M.D. Signature**_____

Date/Time: _____

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Preoperative Testing Guidelines

		Urine PREG Test	PT/PTT/INR	CBC	Type & Screen	BMP	EKG (<6 MO)	CXR	Other Disease/ Procedure Specific Studies
Minor Surgery	Low Bleeding Risk		☐ *(Consider IF positive bleeding questionnaire)				☐ M, F > 60	Abnormal lung exam Active Pulmonary process Cardio-thoracic, Vascular thoracic surgery	See Appendix A
	High Bleeding Risk		☐	☐					
Major Surgery	Low Bleeding Risk		☐ *(Consider IF positive bleeding questionnaire)	☐ *(Consider IF positive bleeding questionnaire)			☐ M > 50 F > 60		
	High Bleeding Risk		☐	☐	☐				
Diabetes, Hx of Renal Failure, HTN, Patient on Diuretics						☐**			
Reproductive Age		☐							

***Note: If a patient is actively taking an antiplatelet drug (NSAIDs, ASA) up until the time of surgery, this may increase the risk of bleeding regardless of results coagulation studies.**

****Repeat if older then 6 months or recent change in clinical status, Optional for ALL Minor surgery procedures**

PACEMAKER/AICD – Interrogation report < 6 MO required

Beta Blocker Criteria (Either #1 or #2 below)

1. AAA surgery
2. Patient is not having low-risk surgery and has two or more of the following Revised Cardiac Risk Index (RCRI) criteria:
   a. Intraabdominal (but not pelvic) surgery or high risk surgery (high risk surgeries are emergent surgery, AAA or lower extremity vascular surgery, open craniotomy or cardiothoracic surgery)
   b. CAD
   c. CHF
   d. TIA or CVA
   e. DM requiring insulin
   f. Plasma or Serum creatinine >2 mg/dL

MEDICAL CONDITIONS THAT WOULD NECESSITATE CLEARANCE BY HOSPITALIST/OUTSIDE NETWORK INTERNIST

Cardiovascular
- Unstable or New Onset Angina
- Congenital Heart Disease not followed
- Severe Peripheral Vascular Disease not followed
- Recent or Current CHF
- History of Heart Transplant
- New onset Arrhythmias or changes on EKG

Pulmonary
- Asthma with active wheezing on exam
- Severe Pulmonary Disease
- Shortness of Breath with minimal exertion

Neurological
- Myasthenia Gravis

Hepatic
- Cirrhosis
- History of Liver Transplant

Renal
- Hemodialysis or peritoneal Dialysis
- History of Kidney Transplant Hematologic
- History of a bleeding disorder

Endocrine
- Hyperthyroidism uncontrolled on medication Pheochromocytoma

Cancer Related
- History of Adriamycin or Bleomycin in recent past

Medications
- On Coumadin or Thrombolytic Therapy

UC Irvine Health

PREOPERATIVE ANESTHESIA SCREENING

DOB: ____/____/____ Age: _____ Gender: ☐ M ☐ F **Wt:** _____ lb. **Ht:** _____ in.
Email Address: _____
Primary MD: _____ Last Visit: _____ Surgeon: _____
Previous Surgery at UC Irvine Health? ☐ Y ☐ N Best time to call: _____ Best number to reach you (_____) _____
Best time for Pre Op Visit: _____ Pre Op Phone interview: _____
Will you be arriving from out of the area? ☐ Y ☐ N If yes, from where? _____

Patient Questionnaire

Please answer the following YES or NO questions to the best of your ability. If you are unsure, or have comments, please note the question in the comments at the end of each section.

CARDIOVASCULAR	YES	NO	Year
High Blood Pressure	☐	☐	
***Heart Attack**	☐	☐	
***Angina/chest pain**	☐	☐	
Heart Bypass surgery	☐	☐	
CABG	☐	☐	
***Stents**	☐	☐	
Pacemaker or Defibrillator	☐	☐	
***If "YES," obtain pacemaker interrogation**			
Congestive Heart Failure/ Fluid in lungs	☐	☐	
Palpitations/Irregular heartbeat	☐	☐	
Heart murmur	☐	☐	
Do you exercise	☐	☐	

How often? _____
Type? _____
Comments: _____

PULMONARY	YES	NO	Year
Abnormal Chest X-ray	☐	☐	
Asthma	☐	☐	
Bronchitis	☐	☐	
Emphysema	☐	☐	
***Recent Respiratory Infection** (within last 4 weeks)	☐	☐	
***Shortness of Breath with Exertion/Activity**	☐	☐	
***Can you lay flat on your back**	☐	☐	
Sleep Apnea	☐	☐	
☐ Snoring			
☐ Tired			
☐ Observed Stop Breathing			
☐ CPAP use at home			
Current Cough	☐	☐	
***Cough with mucous production**	☐	☐	
Have you ever smoked	☐	☐	
How many years _____			
Pulmonary Embolism	☐	☐	
Oxygen/Ventilator Use	☐	☐	

Comments: _____

HEMATOLOGIC/ONCOLOGIC/ INFECTIOUS	YES	NO	Year
Anemia	☐	☐	
Sickle Cell disease	☐	☐	
Blood clots in legs or lungs	☐	☐	
HIV	☐	☐	
History of Cancer	☐	☐	

If Yes, Type of Cancer _____
Location _____
Chemotherapy ☐ ☐ _____
When _____
Type _____
Radiation therapy ☐ ☐ _____

GASTROINTESTINAL	YES	NO	Year
Alcoholic liver disease	☐	☐	
Acid Reflux	☐	☐	
Heartburn	☐	☐	
Hepatitis	☐	☐	
Jaundice	☐	☐	
Alcohol use	☐	☐	

Amount: _____

Recreational drugs	☐	☐	

URINARY/REPRODUCTIVE	YES	NO	Year
Urinary/Kidney disease	☐	☐	
***Dialysis**	☐	☐	
***Hemodialysis**	☐	☐	
***Peritoneal Dialysis**	☐	☐	
If Female, could you be pregnant	☐	☐	

Date of last menstrual period: _____

NEUROMUSCULAR DISEASE	YES	NO	Year
ALS	☐	☐	
Muscular Dystropy	☐	☐	
Multiple Sclerosis	☐	☐	
Parkinsons	☐	☐	
Guillain - Barre	☐	☐	
Other _____	☐	☐	

ENDOCRINE	YES	NO	Year
Diabetes	☐	☐	
Thyroid Disease	☐	☐	
Taken Steroids in the past year	☐	☐	

Comments: _____

MUSCULOSKELETAL	YES	NO	Year
Arthritis	☐	☐	
Rheumatoid	☐	☐	
Neck, Back Arm, Leg Problems?	☐	☐	
Herniated disc	☐	☐	

Comments: _____

NEUROPSYCHIATRY	YES	NO	Year
***Stroke**	☐	☐	
Seizure	☐	☐	
Fainting	☐	☐	
Dizziness	☐	☐	
Headache	☐	☐	
Depression	☐	☐	
Anxiety	☐	☐	
Psychiatric Care	☐	☐	

Comments: _____

FOR PEDIATRIC PATIENTS ONLY

	YES	NO
Was child born prematurely	☐	☐
If YES, how many weeks premature were they _____		
Problems noted at birth	☐	☐
If YES, please explain: _____		

PRIOR SURGERY

Surgery: _____ Date
Complications:

Surgery: _____ Date
Complications:

Surgery: _____ Date
Complications:

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Please complete BOTH pages

UC Irvine Health

PREOPERATIVE ANESTHESIA SCREENING

Please provide the following information so we may contact your other physicians if necessary:

Primary MD Name: _____ Phone No: _____ Address: _____

Cardiologist Name: _____ Phone No: _____ Address: _____

Other Provider Name: _____ Phone No: _____ Address: _____

Patient Questionnaire

1. **Do you have any personal history of anesthetic complications** **YES** **NO**
   If YES, please explain: _____
2. Is there a family history of anesthetic complications **YES** **NO**
   If YES, please explain: _____

BLOOD

1. Do you have any reason why you would refuse blood or blood products **YES** **NO**
   If YES, please explain: _____
2. Do you have an Advance Directive **YES** **NO**
   If YES, please explain: _____

Bleeding Questionnaire (Yes/No marked on order) **(POSITIVE = ONE YES)**

YES	NO	
		Have you had abnormal bleeding following: Dental extractions? Major/minor operations? Major/minor injuries?
		Do you have trouble with any of the following: Easy bruising (bigger than 2 inches)? Frequent nose bleeds? Abnormal heavy menstrual periods? Bleeding into joints or muscles? Oozing a long time from cuts or scrapes?
		Have you ever needed a blood transfusion for unexpected or heavy bleeding after a surgical procedure?
		Is there any family history of abnormal bleeding?
		Do you currently take any sort of anticoagulant (blood thinner) medication? (Coumadin, Lovenox, Pradaxa, etc.)

MEDICATIONS (include over-the-counter and herbal)	Dose	Frequency
☐ I do not take medication		
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
Office Staff: Medications Updated in Quest on:		

Allergies (list all)	Reaction
☐ I do not take medication	
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	

Do you have any **comments or concerns** you would like to share with our staff? **YES** **NO**
You may receive a phone call from the Anesthesia Department based on your medical history.

_____

_____

_____

PATIENT or GUARDIAN (PRINT NAME): *SIGNATURE* *DATE*

X

OFFICE USE ONLY

QUESTIONNAIRE REVIEWED BY: NAME/TITLE: *DATE:*

Please complete BOTH pages

UC Irvine Health

PRUEBA PROPERATORIA DE ANESTESIA

FDN: ____/____/____ Edad: _____ Género: ☐M ☐F Peso: _____ lb. Estatura: _____ pulg.
Correo Electrónico: _____
Médico primario: _____ Última visita: _____ Cirujano: _____
¿Cirugía anterior en UCIMC? ☐S ☐N Hora más conveniente para llamar: _____ Número más conveniente para llamar (____) _____
Hora más conveniente para visita preoperatoria: _____ Entrevista telefónica preoperatoria: _____
¿Llegará usted de fuera del área? ☐S ☐N Si responde sí, ¿de dónde? _____

Cuestionario del paciente

Sírvase contestar las siguientes preguntas SÍ o NO lo mejor que pueda. Si no está seguro(a), o tiene algún comentario, utilice el área de Comentarios al final de cada sección.

CARDIOVASCULAR	SÍ	NO	Año
Presión arterial elevada	☐	☐	____
***Ataque al corazón**	☐	☐	____
***Angina/dolor de pecho**	☐	☐	____
Cirugía de bypass de corazón	☐	☐	____
Cirugía de bypass de injerto de arteria coronaria	☐	☐	____
***Stents**	☐	☐	____
Marcapasos o defibrilador	☐	☐	____
***Si responde "SÍ", inicie el protocolo de marcapasos**			
Insuficiencia cardíaca congestiva/ Líquido en los pulmones	☐	☐	____
Palpitaciones/Latidos irregulares	☐	☐	____
Soplo en el corazón	☐	☐	____
Hace ejercicios	☐	☐	
¿Con cuánta frecuencia? _____			
¿Tipo? _____			
Comentarios: _____			

PULMONAR	SÍ	NO	Año
Radiografía de tórax anormal	☐	☐	____
Asma	☐	☐	____
Bronquitis	☐	☐	____
Enfisema	☐	☐	____
***Infección respiratoria reciente** (durante las pasadas 4 semanas)	☐	☐	____
***Falta de aliento por Esfuerzo/Actividad**	☐	☐	____
***Puede acostarse boca arriba**	☐	☐	____
Apnea del sueño	☐	☐	____
☐ Ronquidos			
☐ Cansancio			
☐ Se detiene la respiración			
☐ Utilización de equipo de Presión positiva continua en las vías respiratorias (CPAP)			
Tos actual	☐	☐	____
***Tos con producción de esputo**	☐	☐	____
Fuma	☐	☐	____
Hace cuántos años _____			
Embolismo pulmonar	☐	☐	____
Uso de oxígeno/ventilador médico	☐	☐	____
Comentarios: _____			

HEMATOLÓGICO/ONCOLÓGICO INFECCIOSO	SÍ	NO	Año
Anemia	☐	☐	____
Anemia falciforme	☐	☐	____
Coágulos de sangre en piernas o pulmones	☐	☐	____
Virus de la inmunodeficiencia humana (VIH)	☐	☐	____
Tiene antecedentes de cáncer	☐	☐	____
Si es Sí, indique el tipo de cáncer _____			
Lugar _____			
Quimioterapia	☐	☐	____
Cuándo _____			
Tipo _____			
Terapia de radiación	☐	☐	____

GASTROINTESTINAL	SÍ	NO	Año
Enfermedad hepática alcohólica	☐	☐	____
Reflujo ácido	☐	☐	____
Acidez estomacal	☐	☐	____
Hepatitis	☐	☐	____
Ictericia	☐	☐	____
Uso de alcohol	☐	☐	____
Cantidad: _____			
Droga/fármaco recreacional	☐	☐	____

URINARIO/REPRODUCTIVO	SÍ	NO	Año
Enfermedad urinaria/renal	☐	☐	____
***Diálisis**	☐	☐	____
***Hemodiálisis**	☐	☐	____
***Diálisis peritoneal**	☐	☐	____
Si es mujer, podría estar embarazada	☐	☐	____
Fecha de su último periodo menstrual: _____			

ENFERMEDAD NEUROMUSCULAR	SÍ	NO	Año
Esclerosis Lateral Amiotrófica (ELA)	☐	☐	____
Distrofia muscular	☐	☐	____
Esclerosis múltiple	☐	☐	____
Enfermedad de Parkinson	☐	☐	____
Síndrome de Guillain - Barre	☐	☐	____
Otro _____	☐	☐	____

ENDOCRINO	SÍ	NO	Año
Diabetes	☐	☐	____
Enfermedad de la tiroides	☐	☐	____
Consumió esteroides durante el año pasado	☐	☐	____
Comentarios: _____			

MÚSCULOESQUELETAL	SÍ	NO	Año
Artritis	☐	☐	____
Reumatoide	☐	☐	____
Problemas de cuello, espalda, brazos, piernas	☐	☐	____
Disco herniado	☐	☐	____
Comentarios: _____			

NEUROPSIQUIATRÍA	SÍ	NO	Año
***Derrame cerebral**	☐	☐	____
Convulsión	☐	☐	____
Desmayo	☐	☐	____
Mareo	☐	☐	____
Dolor de cabeza	☐	☐	____
Depresión	☐	☐	____
Ansiedad	☐	☐	____
Cuidado psiquiátrico	☐	☐	____
Comentarios: _____			

PARA PACIENTES PEDIÁTRICOS SOLAMENTE	SÍ	NO
Nació su hijo(a) prematuro(a)	☐	☐
Si responde SÍ, de cuántas semanas _____		
Problemas observados al nacer	☐	☐
Si responde SÍ, explique: _____		

CIRUGÍAS PREVIAS

Cirugía: _____ Fecha
Complicaciones:

Cirugía: _____ Fecha
Complicaciones:

Cirugía: _____ Fecha
Complicaciones:

Toda la documentación debe indicar la fecha específica y la hora de entrada y una firma con su respectiva credencial, cargo o clasificación

88377 (Rev 3-17-14)

Sírvase llenar AMBAS páginas

UC Irvine Health

PRUEBA PROPERATORIA DE ANESTESIA

Proporcione por favor la información siguiente así que podemos contactar a sus otros médicos si es necesario:

Nombre de su MPC: _____ Teléfono: _____ Dirección: _____

Nombre de su Cardiólogo: _____ Teléfono: _____ Dirección: _____

Nombre de otro proveedor: _____ Teléfono: _____ Dirección: _____

CUESTIONARIO DEL PACIENTE

1. **Tiene usted algún historial personal de complicaciones durante la anestesia** **SÍ** **NO**
   Si responde SÍ, explique cuál: _____
2. Existe historial familiar de complicaciones anestésicas **SÍ** **NO**
   Si responde SÍ, explique cuál: _____

SANGRE

1. Existe alguna razón por la que usted rehusaría al uso de sangre o productos sanguíneos **SÍ** **NO**
   Si responde SÍ, explique cuál: _____
2. Tiene usted una Directiva Anticipada **SÍ** **NO**
   Si responde SÍ, explique cuál: _____

Cuestionario sobre hemorragias (Sí/No, según lo marcado en la descripción) **(POSITIVO = UN SÍ)**

SÍ	NO	
		¿Ha tenido hemorragias anormales luego de: extracciones dentales? ¿Cirugías mayores/menores? ¿Lesiones mayores/menores?
		¿Tiene problemas con lo siguiente?: ¿Se amorotona fácilmente (hematomas más grandes que 2 pulgadas)? ¿Le sangra la nariz con frecuencia? ¿Tiene periodos menstruales abundantes anormales? ¿Le sangran las articulaciones o los músculos? ¿Secreta durante mucho tiempo debido a un corte o raspón?
		¿Alguna vez necesitó una transfusión sanguínea debido a una hemorragia inesperada o intensa luego de un procedimiento quirúrgico?
		¿Existen antecedentes de hemorragias anormales en la familia?
		¿Actualmente toma algún tipo de anticoagulante (adelgazantes de la sangre)? (Coumadin, Lovenox, Pradaxa, etc.)

MEDICAMENTOS (incluya medicamentos sin receta y herbarios)	Dosis	Frecuencia
☐ No tomo medicamentos		
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
Personal de Oficina: Medicamentos actualizados:		

ALERGIAS (enumérelas todas)	Reacción
☐ No tomo medicamentos	
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	

¿Tiene usted algún **comentario o preocupación** que desearía compartir con nuestro personal? **SÍ** **NO**
Es posible que reciba una llamada del Departamento de Anestesia basado en su historial médico.

_____

_____

_____

PACIENTE o CUSTODIO (ESCRIBA EN LETRA DE IMPRENTA): *FIRMA* *FECHA:*

X

SÓLO PARA USO OFICIAL

CUESTIONARIO REVISADO POR: NOMBRE/CARGO: *FECHA:*

Sírvase llenar AMBAS páginas

Preop Medication Instructions

Antihypertensives

ACEI/ARBS: only continue if this is the only antihypertensive medication patient is on

Beta Blockers: continue

Calcium Channel blockers: continue

Diuretics: Thiazides & loop acting such as Furosemide: continue

Diabetes medications

Metformin and other oral meds: Hold on day of procedure

Non-Insulin Injectable meds such as Victoza: Hold on day of procedure

Long acting insulin

- Once daily
    - Evening: continue unless instructed otherwise by hospitalist, PCP, or endocrinologist
    - Morning: continue unless instructed otherwise by hospitalist, PCP, or endocrinologist
- Twice daily: continue unless instructed otherwise by hospitalist, PCP, or endocrinologist

Combo insulin

- Once daily
    - Evening: Continue the night before procedure
    - Morning: Hold on day of procedure
- Twice daily: Hold on day of procedure

Short acting insulin: Hold on day of procedure

Insulin pump: continue basal rate as instructed by physician managing it

Anti-coagulants

ASA: as directed by managing PCP/physician, cardiologist, neurologist or surgeon

Warfarin: as directed by managing PCP/physician, cardiologist, neurologist or surgeon

ADP receptor inhibitors like Clopidogrel (Plavix): as directed by managing PCP/physician, cardiologist, neurologist or surgeon

Direct thrombin inhibitors like Dabigatran (Pradaxa): as directed by managing PCP/physician, cardiologist, neurologist or surgeon

Direct Xa inhibitors like Rivaroxaban (Xaralto), Apixaban (Eliquis): as directed by managing PCP/physician, cardiologist, neurologist or surgeon

Lovenox/Heparin: as directed by managing PCP/physician, cardiologist, neurologist or surgeon

NSAIDS:

- Short acting: Hold 1 day prior to procedure
- Intermediate acting: Hold 3 days prior to procedure
- Long acting like Meloxicam: Hold 10 days prior to procedure

Pain management/addiction

- Suboxone: Hold 3 days prior to procedure

Multivitamins: Hold on day of procedure unless directed otherwise by surgeon or PCP.

Rheumatological Meds:

- DMARDS such as Hydroxychloroquine, Methetrexate, etc: Continue without stopping
- Biologics such as Humira: Direct patients to see their Rheumatologist or the hospitalist group. Each biologic has its own suggested pre and post cessation period. Also the severity of disease would influence the recommendations.

NPO instructions for adults

- Solids: 8 hours prior to coming in for procedure
- Milk: 6 hours prior to coming in for procedure
- Clear liquids: 2 hours prior to coming in for procedure

GHEI Ophthalmology Preop Tests

- Cataracts: no EKG, no labs
- Corneal transplant, Trabeculectomy, low risk surgery: No labs unless indicated; Obtain EKG for *BOTH male and female 60yrs and older* if none present within 6 months
- Cataracts PLUS Corneal transplant, Trabeculectomy: No labs unless indicated; Obtain EKG for *BOTH male and female 60yrs and older* if none present within 6 months

EKG Testing Guidelines:

- Minor (Low) risk surgery: both male and female 60yrs and older
- Major (Intermediate and High) risk surgery: Males 50yrs and older; Females 60yrs and older

Fasting Guidelines (NPO Guidelines)

Adults

- No **SOLID** food after midnight (regardless of time of surgery)
- **Liberal clear liquids** (apple juice, water, fruit juices *without* pulp (no orange juice), clear soup broths such as 99% fat free chicken, beef, or vegetable only, clear tea, black coffee) **up to 4 hours before surgery time.**

Children

- **8 hours** prior to surgery time may have solids
- **6 hours**: infant formula
- **4 hours**: breast milk
- **2 hours**: clear liquids

Diabetic Patients

- **PLEASE SCHEDULE ELECTIVE CASES AS EARLY IN THE MORNING AS POSSIBLE FOR ALL DIABETICS**
- No **SOLID** food after midnight regardless of time of surgery
- **Clear liquids** (apple juice, water, fruit juices *without* pulp (no orange juice), clear soup broths such as 99% fat free chicken, beef, or vegetable only, clear tea, black coffee) **up to 4 hours before surgery time.**
- Monitor Blood sugar level at home **at least once** prior to arrival to UC Irvine for an afternoon surgery.
- **REGARDLESS** of surgery time, if feeling HYPOGLYCEMIC or Blood sugar level is **less than 80**, treat with APPLE JUICE and recheck blood sugar level within 30 minutes of having apple juice.

Please note: gum, candies, and breath mints are included in the NPO guidelines and should NOT be consumed within the fasting time span!

Patient Label

UC Irvine Health

CONSENT FOR OPERATION/PROCEDURES OR RENDERING OF OTHER MEDICAL SERVICES

SECTION I: SURGEON OR OTHER PHYSICIAN

1. I hereby authorize and direct _____ M.D. to perform the following operations or medical procedures upon the patient named above:

_____
Name or description of operation(s) or procedure(s)

_____

_____

_____

_____

2. I hereby authorize and direct the above named surgeon to provide or arrange for the provisions of such additional services as he/she or they may deem necessary or advisable, including but not limited to the administration and maintenance of anesthesia and the performance of services involving pathology and radiology, and I hereby consent thereto.

3. The University *of* California, Irvine Healthcare is a research institution. I understand that any data or specimen(s) obtained during any examination, treatment, or procedure, including any laboratory or surgical procedure, of the patient may be used in research which may or may not be related to the patient's treatment or condition. Specimen means and includes, without limitation, any organ, tissue, bone or other bodily fluids of any kind. I further understand that the patient has no property or ownership interest in such specimen(s) or data and no right or entitlement in any research or research product using or derived from the specimen(s). I further authorize the pathologist to use his/her discretion in the disposition or use of any member, organ, or other tissue removed from my person during the operation(s) or procedure(s) identified above.

4. My physician does not have any independent financial or research interest in the procedure/treatment, other than usual or customary, unless checked below.
   ☐ My physician has informed me he/she does have independent financial or research interest in this procedure/treatment.

5. I understand that there may be a healthcare industry manufacturer's representative present during the procedure/treatment and I consent to this, at the discretion and approval of my physician and hospital, unless checked below.
   ☐ I do not consent to the presence of any healthcare industry manufacturer's representative.

6. The University *of* California is a teaching institution, I understand that Fellows and Residents, acting under the supervision of the primary surgeon/practitioner, may be performing important procedural tasks related to this surgery or procedure in accordance with hospital policy and based upon their skill set. These tasks may include but **are not** limited to: opening/ closing, harvesting grafts, dissecting tissue, removing tissue, **transplanting tissue**, implanting devices and placing monitoring or invasive lines.
   ☐ I also understand that qualified medical practitioners, who are not physicians (e.g. Physician's Assistants), may also be performing important procedural tasks that are within their scope of practice as determined by California state law and regulation and for which they have been granted privileges by the University *of* California, Irvine Healthcare.

SECTION II: PHYSICIAN STATEMENT OF INFORMED RISKS AND COMPLICATIONS

The nature and purpose of the operation or medical procedure has been explained by a member of the procedure team. The risks, complications, and expected benefits of such operation and/or medical procedure and/or sedation (if applicable) have also been explained. The therapeutic alternatives to the operation and/or medical procedure and/or sedation (if applicable) and their risks and benefits have been explained. No warranty or guarantee has been made as to the result or cure.

_____ Date _____ Time _____
Signature of Patient/Patient's Representative

_____ _____ M.D. _____
Relationship of Representative to Patient — Resident Physician Providing Information (Signature) — Date

_____
Resident Physician Providing Information (Printed Name)

_____ Date _____ Time _____
Signature of Witness or Interpreter

_____ M.D. _____ _____
Attending Physician (Signature) — Date — Time

_____
Attending Physician (Printed Name)

SECTION III: EXCEPTIONAL SIGNATURE REQUIREMENTS ARE REFERENCED BELOW
(please check appropriate box(es))

1. If the patient is a MINOR, the parent or guardian must sign as "Patient's Representative" unless the patient is legally permitted to sign.

2. If the patient is LEGALLY INCOMPETENT, the court approved guardian or conservator must sign as the "Patient's Representative"

3. If the patient reads no English, Spanish, or Vietnamese, an interpreter shall read this form to the patient. The patient and the interpreter shall sign at the end of Section II and the interpreter shall indicate the language used: _____

4. If the patient is PHYSICALLY INCAPABLE OF SIGNING, then:
   a. If the patient can make a mark, the patient should do so, witnessed by a University employee, or
   b. If the patient is physically incapable of signing, a University employee, and when possible, the patient's spouse or next of kin, should sign in witness of the patient's having given verbal consent.

   In either case, an Employee-Witness or interpreter will sign as Witness and write in the reason in the space provided:

   _____

5. If the person having legal capacity to consent for the patient is not otherwise available, consent for medical or surgical treatment has been obtained by telephone. Note (telephonic) next to patient's representative's name.

6. **THIS IS AN EMERGENCY.** _____, **M.D.**

UNIVERSITY *of* CALIFORNIA · IRVINE HEALTHCARE

CONSENTIMIENTO DE OPERACIÓN/ PROCEDIMIENTOS O PARA PRESTAR OTROS SERVICIOS MÉDICOS

SECCIÓN I: El CIRUJANO U OTRO MÉDICO

1. Por el presente le autorizo e indico a _____ M.D. que realice las siguientes operaciones o procedimientos médicos en el paciente que aparece identificado arriba:

_____

Nombre o descripción de las operaciones o procedimientos

_____

_____

_____

_____

2. Por el presente autorizo e indico al cirujano nombrado más arriba a que proporcione o haga los arreglos para que se me proporcionen los servicios adicionales que él o ella considere necesarios o aconsejables, incluyendo, sin limitación, la administración y el mantenimiento de anestesia y la realización de servicios que involucren patología y radiología, y por el presente consiento a todo esto.

3. University *of* California, Irvine Healthcare es una institución de investigación. Entiendo que toda información o muestra obtenida durante cualquier examen, tratamiento o procedimiento, incluyendo todo procedimiento de laboratorio o quirúrgico, del paciente podrá ser utilizada en investigaciones que podrían estar o no relacionadas con el tratamiento o la condición del paciente. Muestra, significa e incluye, sin limitación, cualquier órgano, tejido, hueso u otros fluidos del cuerpo de cualquier tipo. Además entiendo que el paciente no tiene ningún interés de propiedad sobre tales muestras o datos ni ningún derecho o legitimación a cualquier investigación o producto de investigación derivado de o que utilice la muestra(s). Además autorizo al patólogo para que use su discreción en el desechamiento o uso de cualquier miembro, órgano u otro tejido extraído de mi cuerpo durante las operaciones o los procedimientos identificados más arriba.

4. Mi médico no tiene ningún interés independiente de investigación o financiero sobre el procedimiento o el tratamiento, otro que el usual o tradicional, a menos que se marque la casilla a continuación.
   ☐ Mi médico me ha informado que él o ella sí tiene un interés independiente de investigación o financiero sobre este procedimiento o tratamiento.

5. Entiendo que un representante de un fabricante de la industria de la salud podría estar presente durante el procedimiento o tratamiento y yo consiento a esto, a la discreción y aprobación de mi médico y hospital, a menos que se marque la casilla a continuación.
   ☐ No consiento a la presencia de ningún representante de cualquier fabricante de la industria de la salud.

6. University *of* California es una institución educativa. Entiendo que los Miembros y Residentes, actuando bajo la supervisión del médico o cirujano principal, podrían estar realizando importantes tareas de procedimiento relacionadas con esta cirugía o procedimiento de acuerdo con la política del hospital en base a sus conocimientos y destrezas. Estas tareas pueden incluir, pero **no se** limitan a: aperturas y cierres, obtención de tejidos, disección de tejidos, extracción de tejidos, **transplante de tejidos**, implantación de dispositivos y colocación de líneas invasivas o de monitoreo.
   ☐ También entiendo que otro personal médico calificado, que no son médicos (por ejemplo, asistentes de médicos), también podría estar realizando importantes tareas de procedimiento que están dentro del alcance de su práctica según como lo determinan las leyes y reglamentos del estado de California y para las cuales University *of* California, Irvine Healthcare les ha otorgado privilegios.