History and Physical Evaluation Form

Please fax completed form to 302.777.2111

Patient Name____ Age_______ Gender______________

Pre-Op Diagnosis__________________________________ Proposed Surgery______________________________

Allergies/Reactions_____________________ Latex Allergy___________ HABITS (Smoker, ETOH)_____________

Herbal Supplements_____________________________ (OTHER)____________________________________

Medications/Dosages____

Indications for surgery (how activities of daily living are affected?): _____________________________________

This section to be completed by the examining surgeon or physician:

PAST MEDICAL/SURGICAL HISTORY

□ ICD □ Pacemaker □ HTN □ CAD □ CHF □ Arrhythmia □ Aortic Stenosis □ Sleep Apnea
□ Murmur □ Hyperlipidemia □ DM Type-1/2 □ Dementia □ COPD □ Asthma □ Liver Disease
□ CVAITIA □ Abnormal Bleeding/Bruising □ DVT □ GERD □ Hypothyroid □ Seizure Disorder □ ESRD
□ Dialysis □ Transplant □ Prior Anesthetic Complications

Comments ____

____

PHYSICAL EXAMINATION

HT: _______ WT: _______ B/P: _______ P: _______

For straight local anesthesia physician must assign ASA class ______________

GENERAL APPEARANCE: ____

IF NO SIGNIFICANT FINDINGS, CHECK BOX:	DESCRIBE ABNORMAL FINDINGS	NON-CONTRIBUTORY
□ HEART	______________________________	
□ LUNGS	______________________________	
□ HEENT	______________________________	□
□ GI/AB	______________________________	□
□ GU	______________________________	□
□ BACK	______________________________	□
□ EXT	______________________________	□
□ NEURO	______________________________	□

FOR PEDIATRIC PATIENTS (6 months - 18 years) having surgery in Delaware Surgery Centers: Check appropriate box.

- □ *I have contacted the primary care provider for this patient, Dr.________________________ who agrees that it is appropriate to do the surgery in an ambulato,y surgery center versus a hospital.*
- □ *As the primary care provider for this patient, I agree that it is appropriate for this procedure to be done in a surgery center versus a hospital.*

DATA (LABS, ECG, ETC. - PLEASE REFER TO BACK PAGE)

IMPRESSION (PLEASE SIGN BELOW)

After examining the patient and reviewing the preoperative data, I find this patient to be medically stable for the proposed surgery and appropriate for care in an ambulatory center versus a hospital.

Signature _____________________________M.D., D.O. Date _____________

Printed Name ____________________________ Phone ________________

DAY OF SURGERY PRE OP REVIEW (Required for straight local anesthesia cases only) - I have reviewed this History and Physical and examined the patient for changes since its performance. Based upon my assessment no changes have occurred and the patient may proceed with the planned procedure.

PATIENT LABEL

Surgeon's Signature __________________________Date ___________

GUIDELINES FOR OUTPATIENT PREOPERATIVE TESTING

These laboratory guidelines have been selected as a minimum standard for routine procedures to beperformed at this center. Patients with complicated medical conditions may warrant further work-up as deemed appropriate by the primary medical physician, surgeon and anesthesiologist.

1. CBC with or without differential

- Recommended for patients undergoing Tonsillectomy/Adenoidectomy (T/A)
- Recommended for all patients under 6 months of age.
- Patients undergoing cataract, plastics, orthopedic, and E.N.T. procedures are **NOT** routinely required to have this test.

2. PT/PTT

- Recommended for patients undergoing *TIA*
- Recommended for any procedures to be done under regional anesthesia, including spinal or epidural blocks

3. SMA 7

- Recommended for patients with diabetes, renal disease, or taking diuretic therapy

4. EKG'S

- Recommended for patients with unstable coronary syndromes, decompensated heart failure, significant arrhythmias and severe valvular disease. Please contact the center's Medical Director at 302-777-4800 with any questions on the necessity for an EKG.

5. Bleeding time

- NOT required for routine surgery

6. Chem 19/22

- NOT required for routine surgery

7. Chest X-Rays

- NOT required for routine surgery

TESTING PERFORMED OUTSIDE WILLS SURGERY CENTER OF WILMINGTON WILL BE ACCEPTED UNDER THE FOLLOWING GUIDELINES:

1. EKG tracings MUST have physician interpretations and be signed to be accepted.
2. The following expiration limits prior to surgery will apply: Bloodwork: 30 days
EKG: 6 months
3. Laboratory results must be reported on a Laboratory Reporting Form with documentation as to where and when the specimen was analyzed.

GUIDELINES FOR HISTORY ANDPHYSICAL

1. The surgeon (physician of record) may complete the medical clearance H/P form for the patient, or defer it to the primary medical physician.
2. The H/P's need to be done within 30 days prior to date of surgery.