WRHA Surgery Program

PREoperative Assessment
Patient Questionnaire

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Prepared by Carol Knudson
WRHA Perioperative Nurse Educator
Preamble: In collaboration with the Preoperative Assessment Clinic (PAC) staff and service providers, the WRHA Surgery Program engaged in the initiative to standardize the PREoperative Assessment Patient Questionnaire to facilitate the collection of consistent patient information across the surgical sites within the Region.

The standard WRHA Surgery Program PREoperative Assessment Patient Questionnaire will promote patient safety, and enhance quality of patient care and service delivery to the patient population we serve.

NOTE: This form REPLACES the Patient/Nursing database for the elective surgery patient population.

Purpose of the WRHA Surgery Program Preoperative Assessment Patient Questionnaire:

1. Collect information from patients coming for elective surgery. This information will assist the Health Care Team meet the medical needs of the patient.

2. The information from the questionnaire will be reviewed by a member of the health care team to determine if additional assessments or testing is required prior to the surgery. This will assist with providing the best care possible.

General Information:

1. This questionnaire is intended to be completed by ALL surgical patients (including Day Surgery Patients) scheduled for ELECTIVE surgery EXCEPT: orthopedic total joint hip and knee arthroplasty.

2. The PREoperative Assessment Patient Questionnaire must be completed and MAILED or DROPPED OFF at your surgeon’s office AT LEAST THREE (3) WEEKS PRIOR to the surgery date.

3. This patient questionnaire will be included in the PAC package and is intended to be circulated to the patient by the surgeon/office.

4. The completed questionnaire is required patient documentation for slating the surgical procedure.

5. The right hand side of the questionnaire is intended for documentation by the Nurse and is intended for “Hospital Use Only”.

6. The completed questionnaire is placed in the patient health record and becomes part of the permanent health record.
The patient indicates the following on the PREoperative Assessment Patient Questionnaire:

1. **Personal Health Information Number (PHIN)** (9 digit number found on Provincial Health Card) required on the questionnaire. This will prevent occurrences when patients have the same name and/or birthdate.

2. **Name**
   a. Legal Name (as found on the patient’s Provincial Health Card) in the following order:
      - Surname;
      - Middle Name; and
      - First Name.
   b. Preferred name. This is the name they are commonly called by. This may include a “nickname”.

3. **Date of Surgery DD/MMM/YYYY, Surgeon’s Name, and Type of Surgery.**
   a. It is important to indicate date in the above format. For example if born April 16, 1938 this will be indicated as 16/APR/1938.
   b. Ensure surgeon’s name (including first name or initial) and type of surgery is indicated. There may be more than one surgeon with the same last name.

4. **Health Care Directive** – initiated by the patient and allows the patient to make health care preferences known in the event that they are unable to express them. A Health Care Directive may indicate the type and degree of health care interventions the patient prefers and/or may indicate the name(s) of a person(s) who has been delegated to make decisions on their behalf. **Note: Attach a copy of the Health Care Directive.**

5. Information related to the language spoken and understood assists with determining the potential need for an interpreter during the preoperative (before), intraoperative (during), and/or postoperative (after) surgery. Having this information ahead of time assists in having an interpreter available if required.

6. **Contact person including relationship and contact information.** Ensure that an alternate phone number is indicated if available. The contact phone number must be a number where the contact person would be available.

7. **Provide the name, relationship, and contact information of the person who will pick them up from the hospital.** The contact phone number must be a number that the person would be available at during surgery. **Patients receiving anesthetic or conscious sedation must be discharged in the company of a responsible adult.**
8. If they have been hospitalized for the following in the past six (6) months. If so, additional testing may be required or they may need to be managed in a specific manner to prevent potential spread of infection to other patients.
   a. Antibiotic (Drug) Resistant Organisms:
      - MRSA – Methicillin Resistant Staphylococcus Aureus
      - VRE – Vancomycin Resistant Enterococcus
   b. TB/Alert – Tuberculosis
   c. C-diff – Clostridium- difficile (type of infectious diarrhea)
   d. Other?

9. **Allergies and/or sensitivities** including sensitivities to medications, latex, tapes, x-ray dyes, dust/pollen, and any foods. This information allows for the healthcare team to individualize patient care as required.

10. If a **Medic Alert Bracelet®** is worn and if so, the reason for the Medic Alert Bracelet®. Also indicate if they have been told that they should wear a Medic Alert Bracelet®, but do not wear it. If this is the case indicate reason told to wear the bracelet.

11. **All medications** taken including:
   a. **Prescription medications** such as birth control pills, creams, eye drops, inhalers, insulins, patches, sleeping pills;
   b. **Over the counter medications** – such as aspirins, cold/allergy drugs, laxatives, vitamins; and
   c. **Herbs and others medications** such as garlic, gingko biloba, St. John’s Wort.

   If coming to the PREoperative Assessment Clinic, the patient should bring the containers of all prescription and over the counter medications with them.

12. **Family Doctor’s Name** (include first name or initial), date of last visit and reason for last visit. There may be more than one Family Doctor with the same last name.

13. **Specialist Doctors Name** (including first name or initial) and phone number. Indicate the date of the last visit and the reason for the visit. There may be more than one Specialist Doctor with the same last name.

14. If they may be pregnant.

15. **Height and weight.** Indicate if weight is in pounds or kilograms. This information is required to calculate dosages of medications, plan for potential complications that may occur and to ensure appropriate equipment is available for the surgery.

16. **Obstructive Sleep Apnea Risk (OSA).** These questions replace the OSA Identification and Risk Assessment in Perioperative Adults form #W-00255 June 2009. OSA is assessed by indicating yes or no to the following questions:
a. Do you have Obstructive Sleep Apnea (OSA)?
b. Have you been told that you have OSA?
c. Do you snore loudly (loud enough to be heard through closed doors)?
d. Do you think you have abnormal or excessive sleepiness during the day?
e. Has anyone noticed that you momentarily stop breathing during your sleep?
f. Is your neck measurement greater than 40 cm?

17. If **shortness of breath or tightness in your chest** occurs when
   • Lying flat in bed;
   • Walking one (1) block;
   • Climbing one (1) flight of stairs;
   • Doing housework; or
   • Getting dressed.

18. **Health History** including if they have any of the conditions listed on the questionnaire.
   a. If the patient is receiving **peritoneal dialysis or hemodialysis**, indicate date of the next treatment.
   b. If patient has previously received a **blood transfusion**, indicate the date(s) of the transfusion.
   c. If they have any **Implanted Electronic Devices** including, but not limited to pacemakers, internal defibrillators, internal pain stimulator, or cochlear implants. Special precautions may need to be taken during surgery if the patient has one of these devices.
   d. Any health problems that run in the family.
   e. If they have had an anesthetic and any problems that may have been experienced from the anesthetic. Also indicate if any family members have had problems with anesthetics. If the patient or a family member has had problems with the anesthetic, explain the problem that occurred. Previous problems with anesthetic by the patient or family member may require modifications to the plan of care by the anesthesiologist.

19. **Operations** including the date of the surgery and where the surgery was performed.

20. **An admission to the hospital for reasons** other than an operation. Include the reason for the admission, date of the admission, and the name of the hospital admitted to.

21. **Special Tests** received including the name of the test, date of the test, and the name of the hospital where the test was performed. These Special Tests may include, but are not limited to:
   • Stress Test;
   • Ultrasound; and
• Angiogram.

22. Transfusion History including any of the following related:
   a. any rare blood type or presence of antibodies;
   b. objection to receiving blood transfusion for any reason; and
   c. receipt of blood or blood products and if so any problems encountered.

23. If a smoker, how much smoked per day and number of years smoked. If no longer smoking, indicate when quit.

24. If they drink beer/wine/liquor include the amount and how often.

25. If recreational drugs are used including amount and how often used. This may include, but is not limited to marijuana, cocaine, meth.

26. Any of the following:
   a. Capped or Loose Teeth;
   b. Eye Glasses or Contact Lenses;
   c. Dentures (Upper or Lower);
   d. Hearing Aid (Right or Left);
   e. Body Piercings (indicate where on the body);
   f. Other prosthetics including but not limited to:
      • Artificial limbs; or
      • Artificial eye.

27. Nutritional Status:
   a. Type of diet eaten. If a Special diet is normally eaten, indicate type of special diet;
   b. Difficulty eating or swallowing;
   c. If weight has been stable. If there has been a weight gain or loss, indicate amount and time period of the gain or loss.
   d. If the following are being experienced:
      • Nausea;
      • Vomiting;
      • Choking;
      • Indigestion;
      • Reflux; or
      • Anorexia.

28. If bowel and urinary elimination is regular or if an ostomy is present. Ostomy may include ileosotomy or colostomy.
   a. Urinary pattern: Indicate if any of the following:
      • Urgency (sudden almost uncontrollable need to urinate);
      • Incontinent;
      • Frequency ; or
      • Nocturia (excessive or frequent urination after going to bed).
b. Bowel pattern:
   - Diarrhea;
   - Constipation; or
   - Incontinent.

c. Other may include having a catheter.

29. **Functional Status**
   a. Changes to activities of daily living.
   b. Assistance required with toileting, bathing, dressing, and walking. If assistance is required, explain what assistance is required.
   c. If any of the following is used explain when/how they are used:
      - Crutches;
      - Cane;
      - Walker;
      - Wheelchair;
      - Scooter;
      - Mechanical lifts; or
      - Bathroom assists.
   d. Any changes to normal sleep pattern.
   e. If having any pain, provide details of the pain indicating intensity using a pain scale for example 1 -10 with 10 being the worst pain experienced and 1 being no pain.

30. **Living Arrangements** as follows:
   a. Live alone, with a spouse/partner, with child(ren), with pets, or with someone else;
   b. Live in an apartment, house, group home, Personal Care Home (PCH), Supportive Housing, Assisted Living, or other (if other indicate where);
   c. Stairs used in the home including the number. Indicate if there is railing on one or both sides of the stairs.

31. **Community Services** currently being used:
   a. No Services, Home Care, Dietitian, Handi-transit, Physiotherapy, Day Hospital, Occupational Therapy, or Lifeline®;
   b. Social Assistance indicating Case Worker Name, phone#, and case #;
   c. Treaty Number and Band Name (if applicable); and
   d. If other services are being used, indicate the service.

32. If hospitalization will cause difficulties at home, at work, with finances, or other. If so explain the difficulty.

33. **Name of the person completing the questionnaire.** If other than the patient, the name and relationship to the patient must be indicated. Include the date the questionnaire was completed.
The nurse completes the following Hospital Use Only Section from information obtained during the patient assessment:

1. Patient vital signs including:
   a. Temperature
   b. Pulse
   c. Respiratory Rate
   d. Blood Pressure – indicating left or right arm
   e. O₂ SATS

2. Indicate that Medication Reconciliation completed.

3. Indicate Height (cm)

4. Indicate Weight (kg)

5. Calculate BMI (refer to chart or calculate as Weight in kg/Height in m²)

6. Based on patient response to questions related to OSA and reference to laminated poster “Guidelines: Obstructive Sleep Apnea (OSA) Interpretation of Risk Score, determine patient OSA risk as either:
   a. Known OSA (PAC referral required);
   b. High Clinical Suspicion (PAC referral required); or
   c. Low Clinical Suspicion.

7. Indicate if consults have been initiated and if so where.

8. Indicate if Risk for Falls Protocol.

9. Indicate any other pertinent assessment information gathered from the patient during the assessment in the space allotted on the right hand side of the questionnaire.

What happens to the questionnaire once it is returned to the Surgeon’s office?
1. Surgeon’s office forwards Questionnaire, Booking Request Form, HX & PX, all completed tests and Consent Form to PAC.

2. Complete package is triaged by clinicians.

3. Patient is contacted by phone if clarification is required.

4. PAC books clinic appointments and notifies patient of same (if applicable).

5. At clinic appointment, nurse documents any additional information on the right-hand side of the questionnaire.
6. Nurse required to sign and date questionnaire. NOTE: Questionnaire is part of the patient’s health record.