Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg
Caring for Health | *À l'écoute de notre santé*

WRHA SURGERY PROGRAM

PREOPERATIVE History & Physical Form

This form must be submitted to site at least 14 days prior to surgery date. Failure to do so may result in cancellation.

ENSURE ALL CONTACT INFORMATION ON BOOKING CARD IS CORRECT.

Preoperative Testing App:

Please Fax to: ☐ PAC Department Facility Fax # ___-___-___ ☐ Surgeon's Office Fax # ___-___-___

Diagnosis _____

Proposed Procedure _____ Proposed Date D D M M M Y Y Y Y

PART A – ALERTS	No N/A	Yes	Describe (e.g. reason, language, details)
A1. Patient Requires a Proxy	☐	☐	Name _____ Reason _____
A2. Interpreter Required	☐	☐	Language _____
A3. Previous Difficult Airway	☐	☐	Describe, and identify facility of event _____
A4. Known/Suspected Obstructive Sleep Apnea	☐	☐	☐ Clinically Suspected/Assessment Pending _____ ☐ Diagnosed/Severity _____ CPAP Compliance: ☐ No ☐ Yes ☐ N/A
A5. Adverse Reaction to Previous Anaesthetic (patient or relative)	☐	☐	Describe _____
A6. Previous Adverse Reaction to Transfusion	☐	☐	Describe _____
A7. Blood Borne Infections	☐		☐ Hepatitis B Virus ☐ Hepatitis C Virus ☐ Human Immunodeficiency Virus
A8. Other Alerts	☐		☐ Methicillin-resistant Staphylococcus aureus ☐ Clostridium difficile Tuberculosis (TB): ☐ Active TB ☐ Latent TB ☐ Other, Describe: _____
A9. Allergies ☐ See attached*	☐	☐	(include type of reaction) _____

PART B – HISTORY	No N/A	Yes	Describe (e.g. type, quantity, frequency)
B1. Tobacco Use	☐	☐	*Pack years* _____ *Date quit* D D M M M Y Y Y Y
B2. Vaporizer/e-cigarette use	☐	☐	_____
B3. Recreational Drugs	☐	☐	_____
B4. Alcohol Consumption	☐	☐	_____
B5. Previous or Current Steroid Therapy	☐	☐	_____
B6. Date of Last Menses	☐		D D M M M Y Y Y Y
B7. Pregnancy Test	☐	☐	*If done, results:* _____

B8. Medical History (please indicate stable or acute) ☐ See attached*

_____

_____

_____

_____

_____

_____

_____

B9. History of Present Illness

_____

_____

_____

B10. Surgical History ☐ See attached*

_____

_____

_____

B11. Medications ☐ No ☐ Yes (Describe)

☐ Medication Reconciliation attached (check box)

☐ See attached*

_____

_____

_____

_____

_____

_____

* Do not attach extensive encounter notes

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PART C – PHYSICAL (Note any active or unstable system findings)

Height _____ cm Weight _____ kg Body Mass Index (BMI) _____ Blood Pressure _____ Heart Rate _____ SpO_2 _____

CHEST (other)**:** Rhythm _____ Murmurs _____ Air Entry _____ Adventitious Sounds _____

HEAD & NECK: _____ Neck circumference _____ cm

ABDOMEN: _____ **EXTREMITIES:** _____

PART D – REVIEW OF SYSTEMS *Please note abnormal findings below and indicate associated code number (e.g. "D3" for Respiratory)*

	#	
D1. Central Nervous System	☐	
D2. Cardiovascular	☐	
D3. Respiratory	☐	
D4. Genitourinary	☐	
D5. Haematologic & Lymphatic	☐	
D6. Endocrine & Metabolic	☐	
D7. Gastrointestinal	☐	
D8. Neuromuscular	☐	
D9. Dermatologic	☐	
D10. Other	☐	

PART E – OPTIMIZATION

Blood Management Service

☐ Consult initiated

Consider referral if major surgery and anemia, rare blood type, multiple antibodies or patient refuses blood transfusion
www.bestbloodmanitoba.ca 204-787-1277

If possible, please address with the patient any of the following applicable items to reduce the risk of postoperative complications:

Healthy Behaviours

- Active lifestyle
- Healthy diet
- Reducing excessive alcohol use
- Recreational drug cessation
- Smoking cessation

Chronic Diseases Management

- Diabetes screening/Blood glucose control
- COPD/Asthma
- Hypercholesterolemia
- Hypertension
- Malnutrition
- Nutritional Anemias

PART F – LABORATORY SCREENING (patients at least 16 years of age)

☐ Check if indicated test results are attached.

A guideline based app to determine which tests are required is available at: logixmd.com/preop

TESTS WITHIN 6 MONTHS OF SURGERY
are valid, provided there has been no interim change in the patient's condition.

CLINICAL JUDGEMENT IS REQUIRED
as additional tests may be appropriate for some patients.

GUIDELINE DOES NOT APPLY TO
patients undergoing cardiac surgery or cesarean section

Chest X-rays *– Not recommended* for **any** surgery *except* to facilitate diagnosis of new/worsened symptoms, or if ordered by the surgeon in the work up of a malignancy.

FOR MINOR SURGERY*

DO NOT ORDER PREOPERATIVE TESTS
in asymptomatic patients.

* Associated with an expected blood loss of less than 500 mL, minimal fluid shifts and is typically done on an ambulatory basis (day surgery/same day discharge)*. It includes cataract surgery; breast surgery without reconstruction; laparoscopic cholecystectomy and tubal ligation; and most cutaneous, superficial, endoscopic and arthroscopic procedures.

‡Access the complete adult preoperative lab test guideline *– including lists of major and minor surgery, at http://www.wrha.mb.ca/extranet/eipt/EIPT-003.php*

FOR MAJOR SURGERY** If age (years) is:

16 - 49: Order **CBC**. Additional tests may be indicated for comorbid diseases. Consult guideline.‡
50+: Order **CBC, *ECG, Na^+, K^+, Cl^-, TCO_2, CR/eGFR***

Major Surgery: Other tests to consider

- **Oral Corticosteroids, DM** or **BMI greater than 40**: add Hemoglobin A1C or fasting plasma glucose.
- **Malnutrition, BMI greater than 40,** or **Liver disease**: AST, ALT, Alk Phos, GGT albumin, total and direct bilirubin & INR.
- **At high risk for iron deficiency**: add serum iron TIBC and Ferritin.
- **Thyroid disease**: add TSH.

** Associated with an expected blood loss of greater than 500 mL, significant fluid shifts and typically, at least one night in hospital^. Includes laparoscopic surgery (except cholecystectomy and tubal ligation), open resection of organs, large joint replacements, mastectomy with reconstruction, and spine, thoracic, vascular, or intracranial surgery.

^ *If the surgery is typically ambulatory but the patient has a medical or social reason for overnight admission (i.e. OSA, no support at home), still consider the surgery minor in determining which lab tests to order.*

Examining Provider: _____ (SIGNATURE) _____ (PRINTED NAME AND DESIGNATION) Examination Date: D D M M M Y Y Y Y

Address: _____ Phone: ___-___-____ Fax: ___-___-____

☐ It is not necessary to repeat history and physical as no significant change noted in the patient's health status since the last examination.

Examining Provider: _____ (SIGNATURE) _____ (PRINTED NAME AND DESIGNATION) Reassessment Date: D D M M M Y Y Y Y

Comments: _____