

# HARMONY SURGERY CENTER, LLC

## Patient Admission Assessment Form

<b>**PATIENT: PLEASE BEGIN HERE AND COMPLETE THE INFORMATION BELOW</b>		
List your allergies to Medicines, Latex (rubber), Food, Tape, Other:		
List your previous surgeries/hospitalizations:		
Prior to your discharge, do you grant our staff permission to go over procedural information, medications and discharge instructions with your ride home? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name and phone number of ride home (note - patient is advised to have a responsible adult with them for 24 hours after procedure):		
Who is your Primary Care Physician:		
Health History:	Yes	No
<b>Height:</b> _____ <b>Weight:</b> _____		
Seizure/stroke or other neurological problem?		
Problems with your heart?		
Chest pressure, chest pain?		
Shortness of breath with exertion or exercise?		
Pacemaker or defibrillator?		
Cardiac stent/blood vessel stent or cardiac bypass?		
High blood pressure?		
Blood thinner medication? Clotting problems?		
Take aspirin or aspirin-like meds (i.e., Motrin®, Aleve®, etc.)?		
Blood disorder?		
Autoimmune disorder?		
Lung problems or problems breathing?		
Do you currently smoke?		
Have you ever smoked? When did you quit?		
Supplemental oxygen?		
Sleep apnea?		
Kidney problems?		
Gastrointestinal or liver problems?		
Diarrhea and/or abdominal cramping? For how long?		
Thyroid, Parathyroid, or adrenal gland problems?		
Cancer treated with chemotherapy or radiation?		
Currently have a contagious or infectious condition?		
Illness, infection or fever in the past 2 weeks?		
Diabetes and/or high blood sugar?		
Taken steroids (i.e. Prednisone) in the last year?		
Suffer from anxiety, nervousness, or panic attacks?		
Mental health concerns?		
Used recreational drug(s) within the last 3 days?		
Smoked or consumed marijuana in the past 3 days?		
Drink alcohol? Frequency?		
Dentures or problems with your teeth?		
Eye or vision problems?		

	Yes	No
<b>Health History Continued:</b>		
Hearing problems?		
Physical restrictions?		
Frequent heartburn?		
Object to blood products under any circumstances?		
Problems with anesthesia (self or blood-relative)?		
Any concerns about anesthesia?		
Is there <b>any</b> possibility you could be pregnant?		
Currently breastfeeding?		
Date of your last menstrual period?		
Do you have an advance directive: <input type="checkbox"/> CPR Directive <input type="checkbox"/> Living Will <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Other		
Do you have someone who can help you at home if needed?		
Do you have any anticipated discharge needs?		
<b>Belongings</b>		
Please list any belongings you have with you upon admission to HSC <input type="checkbox"/> Wallet <input type="checkbox"/> Purse <input type="checkbox"/> Rings <input type="checkbox"/> Glasses <input type="checkbox"/> Other: <input type="checkbox"/> Phone <input type="checkbox"/> Piercings <input type="checkbox"/> Dentures <input type="checkbox"/> Hearing Aid(s) <b>Note:</b> HSC cannot be responsible for belongings. Please give valuables to your ride home.		
<b>Education Assessment</b>		
Do you or your responsible party need information on the following? <input type="checkbox"/> None <input type="checkbox"/> Rehab Techniques <input type="checkbox"/> Medications <input type="checkbox"/> Treatment/Procedures <input type="checkbox"/> Current Illness <input type="checkbox"/> Access to follow-up care <input type="checkbox"/> Diet/Nutrition <input type="checkbox"/> Personal Hygiene/Grooming/Oral Care <b>Care</b> <input type="checkbox"/> Home Care <input type="checkbox"/> Community Resources <input type="checkbox"/> Equipment <input type="checkbox"/> Other		
<b>Preferred Learning Method:</b>		
<input type="checkbox"/> Listening <input type="checkbox"/> Demonstrations <input type="checkbox"/> Videos <input type="checkbox"/> Reading <input type="checkbox"/> Hands-On <input type="checkbox"/> None		
<b>Barriers: Check all that apply</b>		
<input type="checkbox"/> None <input type="checkbox"/> Language <input type="checkbox"/> Physical <input type="checkbox"/> Cognitive <input type="checkbox"/> Culture <input type="checkbox"/> Financial <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Desire/Motivation <input type="checkbox"/> Read/Write <input type="checkbox"/> Emotional <input type="checkbox"/> Religion <input type="checkbox"/> Other:		
<b>Pain Evaluation</b>		
<b>Pain:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, please complete the following:</b> <b>Pain Level (1-10)</b> _____ <b>Location:</b> _____ <b>Onset/Duration:</b> _____ <b>Description:</b> <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Burning <input type="checkbox"/> Aching <b>Current pain treatment:</b> <input type="checkbox"/> Meds <input type="checkbox"/> Ice <input type="checkbox"/> Elevation <input type="checkbox"/> Heat <input type="checkbox"/> Massage <input type="checkbox"/> Other:		
<b>Signature of patient or person completing form:</b>		
<b>X</b>		



## Medication Reconciliation Form

**\*\*Please list all medications on this form. We are NOT able to accept a copy of your medications\*\***

Patient: Please list all medications taken on a regular basis (including over the counter and herbal preparations).

Medication Name	Dose	Route	Frequency	Last Taken	RN to complete: Continue after discharge <u>OR</u> refer to prescribing physician:	
					CONTINUE	REFER to MD
1.					<input type="checkbox"/>	<input type="checkbox"/>
2.					<input type="checkbox"/>	<input type="checkbox"/>
3.					<input type="checkbox"/>	<input type="checkbox"/>
4.					<input type="checkbox"/>	<input type="checkbox"/>
5.					<input type="checkbox"/>	<input type="checkbox"/>
6.					<input type="checkbox"/>	<input type="checkbox"/>
7.					<input type="checkbox"/>	<input type="checkbox"/>
8.					<input type="checkbox"/>	<input type="checkbox"/>
9.					<input type="checkbox"/>	<input type="checkbox"/>
10.					<input type="checkbox"/>	<input type="checkbox"/>
11.					<input type="checkbox"/>	<input type="checkbox"/>
12.					<input type="checkbox"/>	<input type="checkbox"/>
13.					<input type="checkbox"/>	<input type="checkbox"/>
14.					<input type="checkbox"/>	<input type="checkbox"/>

New Prescriptions Prescribed at HSC	Dose	Route	Frequency	Last Taken	Use
1.					
2.					
3.					
4.					

I will be provided with a copy of this list upon discharge. Please note, all routine medications marked "REFER to MD" should be clarified with the prescribing physician before continuing. **Medication Safety:** To safely manage routine and new medications, it is important to give a copy of your Medication Reconciliation Form to your primary care physician. It is also important to update the information when medications are discontinued, doses are changed, or new medications (including over-the-counter products) are added.

Patient/Responsible Party Signature: \_\_\_\_\_

Date: \_\_\_\_\_

RN Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Identification